DR. POLAND: Good morning, everybody.

Welcome to this meeting of the Defense Health Board. My name is Dr. Poland. I am President of the Board. We have a variety of extremely important topics to discuss today, so we'll go ahead and get started, and I'll ask Ms. Embrey to call the meeting to order.

MS. EMBREY: Thank you, Dr. Poland. As the Delayed Designated Federal Official for the Defense Health Board which is a federal advisory committee to the Secretary of Defense, the Surgeons General, and the Assistant Secretary of Defense for Health Affairs, I hereby call this meeting of the Defense Health Board to order.

DR. POLAND: Thank you, Ms. Embrey. A tradition that we have established with the board is a moment of silence to honor and remember those who have served and those who particularly during this season are away from their families and are sacrificing on our behalf. So if all in the room
would please stand and observe a moment of silence.

(Moment of silence.)

DR. POLAND: Thank you very much. I particularly want to welcome Dr. Ward Cassells who is the Assistant Secretary of Defense for Health Affairs. It's an honor to have you here with us today, and we want to thank you for your support of the board and interest in the board's activities and joining us today. I understand you have some welcome remarks, but let us greet you formally.

SEC CASSELLS: Dr. Poland, I don't have any prepared remarks. I'd just like to thank you, Ellen Embrey, and Roger Gibson, for your service here and all the board. This is a tremendous turnout and testament to the importance of what we all collectively are doing. And Gail Wilensky, there aren't words to thank you for the work that you did on the other task force and this task force which you had led. This is the final of the six major task forces. It is keenly awaited, and
you will find not just me but the whole defense
department taking notes and working toward
implementation of these results. So we thank you
for the tremendous numbers of hours you've put
into this working long and working hard and
working smart. And I am sure that the board will
be able to add their perspectives too and they are
very, very welcome. So Dr. Poland, thank you so
much for doing this.

DR. POLAND: Colonel Gibson will have
some administrative remarks I think and then we'll
begin.

COL GIBSON: I want to thank the staff
at the Crystal City Sheraton for helping make the
arrangements for the board members and also thanks
to my staff, Karen Triplett and Lisa Gerrett for
all their hard work in preparing for this, and Ms.
Ward back home.

If you haven't done so, please sign the
attendance roster that is on the table outside the
room. There are also rosters for those folks who
want to make statements, and there is a roster for
the press.

For those who are not seated at the tables, for this afternoon's sessions we'll have handouts available for the briefings that are given at that time. Restrooms are around the corner outside to your left when you leave this room. And if you need telephone, fax, copies, et cetera, see Ms. Triplett. The next meeting of the board will be April 23rd and 24th in Tacoma, Washington. Our host will be Mattigan Army Regional Medical Center at Fort Lewis. At this meeting we'll complete deliberations on a number of open board business items.

Through the Uniform Services University we have been able to get 2.6 continuing education credits for this meeting. To receive the credits you need to sign the CME attendance roster and complete the evaluation form and attestation statement for the meeting and hand it in to Ms. Gerrett or Ms. Triplett. For board members, your evaluation forms are in your notebooks. We will mail out the CME certificates when we receive them.
USU. Refreshments are available for both the morning and afternoon sessions. We will have a catered working lunch for the board members, preventative medicine officers, distinguished guests, and speakers. There are a number of hotels right around here for others who will be breaking for lunch.

Finally as a reminder, this meeting is being transcribed so please speak clearly into the microphones and state your name before you begin. And please turn off your pagers, Blackberries, and cell phones. The Blackberries, for the board members, keep them below the table. They do interfere with the microphones from what I am told.

DR. POLAND: Our first order of business today is the deliberation of the draft findings and recommendations of the task force on the future of military health care. As the board members will recall, the task force was formed last year at the direction of Congress and charged with examining matters related to the future of
health care with the Department of Defense. The task force was to make assessment of and recommendations for sustaining the health care services being provided to members of the armed forces, retirees, and their families. A copy of the congressional language is at Tab 2 of your briefing books.

As a subcommittee of the Defense Health Board, the task force and board are required by federal advisory committee statutes to deliberate task force findings and recommendations in an open session before they are finalized. The task force will deliver the final report to the Secretary of Defense in the very near future. The report is a product of the task force. The board as a part of the committee will provide any comments regarding the task force report in a separate document.

All of the members have received a copy of the task force draft findings and recommendations. I remind you that this document is a draft and not yet a public document. Our discussions today will center on primarily the
For those in attendance, the discussions today will be between the members of the Defense Health board and the Task Force on the Future of Military Health Care. If time allows, at the end we'll take questions and statements from the public. We ask that you register to speak at the desk right outside this room. Everyone however has the opportunity to submit written statements to the board. Those statements can be submitted today at the registration desk or by email at dhb@ha.osd.mil, or they mailed to the Defense Health Board office. The address is also available on fliers located at the registration table.

I'd like for us now to go around the table and introduce ourselves, and I'd like to start by having our newest member, Colonel Retired Reverend Robert Certain introduce himself.

COL CERTAIN: I think you just did, sir,
but I'm Robert Certain, retired Air Force Chaplain, Colonel. During Vietnam I was a B-25 crew member POW.

DR. POLAND: Thank you and welcome.

Other distinguished guests today include Dr. Floabel Mullick, principal director of AFIP, Brigadier General William Fox, a member of the Board's Panel for the Care of Individuals with Amputations and Functional Limb Loss, Major General Retired Mary Ann Matthewson, Chaplain for the V.A., and Mr. Larry Leitner from USAMRID here representing Mr. Bill Howell.

So if we could, we'll go around and introduce ourselves and I'll turn to Ms. Embrey and then Dr. Wilensky.

MS. EMBREY: I'm Ellen Embrey. I am the Designated Federal Official for the board, and in my real job I am the Deputy Assistant Secretary for Force Self- Protection Medical Readiness.

MS. WILENSKY: I'm Gail Wilensky. I'm Co-Chair of the Task Force on the Future of Military Health Care. And since Bill Fox is here,
I'd better also indicate I have a real day job which is a Senior Fellow at Project HOPE, although for the last year I have thought my day job is actually worrying about military health care.

RADM SMITH: I'm Dave Smith. I'm the Joint Staff Surgeon and a member of the task force, and I am also a customer of the Defense Health Board.

MS. BADER: Good morning. Christine Bader, Executive Secretary.

MR. HALE: I'm Bob Hale, task force member, former Comptroller of the Air Force.

MR. HENKE: Bob Henke, task force member, CFO to V.A.

MG ADAMS: Nancy Adams, Major General, U.S. Army Retired, task force member.

RADM MATECZUM: John Mateczum, task force member.

GEN MYERS: Dick Myers, General Retired, task force member.

LTG ROUDEBUSH: Jim Roudebush, task force member, Surgeon General of the Air Force.
MG SMITH: Bob Smith, Major General Retired Reserves, and task force member and former international controller of Ford Motor Company.

MG KELLEY: Joe Kelley, task force adviser and retired Major General.

MR. GARDNER: Pierce Gardner, Defense Health Board member and a professor of medicine and public health at the State University of New York at Stony Brook.

DR. WALKER: David Walker, Defense Health Board member, chair of pathology, University of Texas Medical Branch at Galveston.

BG FOX: Bill Fox, subcommittee member for the Amputee Care and Functional Limb Loss Subcommittee, and Chief Operating Officer for Project HOPE.

DR. SILVA: I'm Joe Silva, professor of internal medicine, dean emeritus, University of California at Davis School of Medicine.

DR. SHAMOO: Adil Shamoo, professor of bioethics, University of Maryland School of Medicine.
DR. PARKINSON: Mike Parkinson, president, American College of Preventive Medicine, member of the Defense Health Board.

DR. PARISI: Joe Parisi, member of the Defense Health Board, Chair of the Subcommittee for Pathology and Laboratory Services, and professor of pathology at the Mayo Clinic.

DR. OXMAN: Mike Oxman, member of the Defense Health Board and professor of medicine and pathology at the University of California at San Diego.

DR. MILLER: Mark Miller, member of the Defense Health Board and associate director for research at the Fogarty International Center, National Institutes of Health.

DR. MCNEILL: Mills McNeill, board member, and Director of the Public Health Laboratory at the Mississippi State Department of Health.

DR. LEUPKER: I'm Russell Leupker, and I'm a board member and a cardiologist and epidemiologist from the University of Minnesota.
DR. LOCKEY: Jim Lockey, professor of international medicine and environmental health at the University of Cincinnati and a board member.

DR. LEDNAR: Wayne Lednar, member of the Defense Board and global chief medical officer for Dupont.

DR. HALPERIN: Bill Halperin, member of the board, chair of preventive medicine, New Jersey Medical School, Newark, New Jersey, and chair of quantitative methods, School of Public Health, Newark, New Jersey.

DR. CLEMENTS: I'm John Clements. I'm a member of the health board. I am the chairman of microbiology and immunology at Tulane University School of Medicine in New Orleans.

COL GIBSON: I'm Colonel Roger Gibson. I'm the Executive Secretary for the Defense Health Board.

DR. POLAND: And I'm Greg Poland, professor of medicine and infectious disease and vice chair of the department of medicine at the Mayo Clinic, in Rochester, Minnesota. I am going
to read a statement I wrote, and it is better to
come clean. I just flew in from Amsterdam last
night so hopefully what I have to say is coherent,
but we'll give it a try here.

It was of interest in that it gave me
about 10 hours in a coach seat to read through
this report in detail. I was amazed as I think
you will be to learn that in fiscal year 2001 the
cost of the military health mission was $19
billion, and by fiscal year 2007 it had increased
by more than 100 percent to $40 billion serving 9
million beneficiaries. Pharmacy benefits have
gone up from $1.6 billion to $6.5 billion in a
7-year time period. And the task force has
estimated that at it current rate of growth, the
military health system costs will be $64 billion
by 2015 which will be 12 percent of the DOD
budget. To give you a number or an anchor with
which to understand that 12 percent, that number
was 4-1/2 percent in 1990.

The military health system includes
133,000 personnel, 86,000 military medical folks,
and 47,000 civilians, working at over a thousand geographic locations. This morning the DHB will as the parent board vet the report produced by the task force on the future of military health care. The task force you will recall delivered an interim report focusing primarily on pharmacy benefits in May 2007. The report before you is now the draft of their final report. It's obvious that much work and thought have gone into its formulation and we thank the co-chairs General Corley and Dr. Wilensky for such a deep dive into a complex topic as this one and the very honest assessment that came from it. Thank you very much.

I have read it with interest and indeed selfish interest. By way of disclosure, my family since 1955 have been beneficiaries of the military health care system, and 5 days ago my son Eric received his letter of acceptance from the Air Force Academy. So we are fully in this one. The changes proposed and the implications of it will affect him and all other beneficiaries long after
virtually every one of us in this room have retired. So this is an important step on the never-ending journey needed to provide for those who ensure our safety and security while being financially prudent.

I also want to just by overview talk a little bit about the recommendations of the task force. I was pleased that they started with a set of guiding principles, something you often do not see in a task force, and those included three overarching ones, that DOD must maintain a health care system that meets readiness needs, that they must make changes in business and health care practices aimed at improving effectiveness of the military health care system, and that veterans and their dependents, and I like the word they chose, deserve a generous health care benefit.

They had a series of specific recommendations, and I will just read the topics of those without going into detail of them. I guess maybe the co-chairs will read some of those. That's fine. The one area that the task force
addressed but did not give recommendations on for very good reasons is this issue of the DOD organizational structure and the committee noted that the lack of an integrated system here resulted in a "cumbersome disintegrated system with adverse effects primarily related to fragmentation, the inability to coordinate, manage, and implement best practices, and the lack of a uniform cost-accounting system."

I want to now move us as a board to discussion of the task force's report. Costs and fees are not really within the board's sphere of decision making and I would ask that we not focus on these but, rather, spending our time on discussion of the substantive issues before us. Similarly, issues outside of the task force's charge would be less relevant or fruitful in our discussion this morning. Finally, while those in attendance as I mentioned earlier are welcomed and encouraged to listen, this first discussion is between the task force and the Defense Health Board, and later is there is time and if you have
registered, we will provide time for the public to
make statements.

So if I can, I will move to Rear Admiral
Smith who is here representing General Corley, and
then Gail Wilensky for their opening remarks.

RADM SMITH: Good morning, Dr. Poland,
Defense Health Board, Dr. Cassells, Ms. Embrey,
task force members, and guests, welcome. And on
behalf of the task force, thank you for the
opportunity to appear before you this morning to
share Task Force on the Future of Military Health
Care's final report, findings and recommendations.

General Corley, our co-chair, sends his
regrets. He could not be here this morning, and I
think it is telling of senior flag officer and
general officer schedules that even a four star
cannot control his schedule because he sincerely
wanted to be here but has to be overseas at this
time. So Dr. Wilensky will carry on without him.

Earlier this year in our interim report
the task force provided you preliminary findings
and recommendations relative to DOD health care
costs in general, and recommendations concerning
cost sharing in the pharmacy program in
particular. Those preliminary findings and
recommendations have been further developed and
supplemented in the final report. Congress asked
the task force to address a broader array of
elements in its final report such as the DOD
wellness initiatives, disease management programs,
the ability to account for true and accurate costs
of health care in the military health system, the
adequacy of military health care procurement
systems, as well as an assessment of the
government cost-sharing structure required to
provide military health benefits over the
long-term.

Earlier in our term as Dr. Poland
pointed out, we adopted a set of guiding
principles presented in our interim report that
have remained the same and helped us frame our
final assessments and recommendations. With those
in mind, we have sought to preserve the best
aspects of the current system, which has many, and
to identify ways to further enhance delivery of acceptable quality health care for the long-term. With that short introduction, I will now turn over the presentation and the discussion to our co-chair, Dr. Gail Wilensky, for her remarks.

DR. WILENSKY: Thank you very much Admiral Smith. As he indicated and as I have had email correspondence with General Corely, he very much wishes he could be here today but has been a very active member of the task force.

It has been just about exactly a year that the task force has been meeting to assess and make recommendations for sustaining military health care services for members of the armed forces, retirees, and their families. The work that we have been engaged in has been a very large task indeed. The 14 members of the task force and our executive director and very able staff have worked very hard to make this actually come to fruition within the course of 12 months. We have during the last 12 months convened some 15 public meetings in order to gather information. We have
visited areas in different parts of the country to try to better inform ourselves. Several of us had the opportunity to travel to Qatar, Iraq, and Germany, to better understand some of the forwarding- operating base health care delivery operations and morale issues that our servicemen and -- women are facing.

We would like people to understand that in trying to look at these very complicated issues that Congress asked us to address, we did it within the context of the U.S. health care system since it is impossible to assess what is going on in any other way. The task force is independent. All of us came on to this activity agreeing that we would have not preconceived outcomes or opinions or recommendations, but would let ourselves be guided by what we heard and the facts as we know them, and that is what we have done.

As has been indicated, this is a final piece in what has been a deliberative, open, and transparent process and it is important that it is regarded in that way.
In looking at the issues that we have been asked to address with regard to the future of military health care, we understand that health care in the military is increasing just as it is increasing everywhere else in the United States. It is a problem that has been an issue for this country. In making sure that we get both the best value and find ways to moderate spending on health care has been an issue for all of health care as well as the Department of Defense. We also note that the Tricare premiums and cost-sharing provisions have been level, that is flat in actual dollar terms, for nearly a decade and that has been contributing to some of the issues that we have been facing.

As Dr. Poland indicated and as we very much believe, that looking at the role of the military and the role of military health care places it in a unique position. The deployments and duties of people who are part of the military is different from that which most of the rest of us face in this country. Military health care has
been an important part of the compensation and
benefits system. In trying to go forward as you
heard again, we set out some guiding principles
that we felt were important to articulate at the
beginning at our first formal document, our
interim. That is that the Department of Defense
must maintain a health care system that meets
military readiness, appropriately sized and
resourced; able to withstand and support the long
war on terror as well as the support of
conventional war; and that equally it is important
that quality, accessible, cost-effective health
care is available and provided for the long-term.
We have recognized and we have said it in our
interim report and say it again multiple times as
we go forward that it is important that we have a
generous health care benefit in recognition of the
importance service that our members, retirees, and
their families have provided.

But we also recognize that it is
important for the American taxpayers to be
comfortable that there is some balance in terms of
quality and efficiency, fiscal responsibility, and affordable cost. What we have attempted to do over the course of these last 12 months is to bring some balance.

We believe that many of the recommendations if implemented will affect how health care is provided through the military health care system and that it is important that the recommendations that we are making to the extent that they involve changes in cost will not affect active-duty personnel or their families for health care and we thought this was an important principle that we should maintain.

I am going to describe the major recommendations that we have come to agreement on as a task force. The action items will be something that we can discuss in greater detail as we come to complete deliberation for this report. But the recommendations themselves have been discussed sufficiently that we feel comfortable saying this is where the task force now is and reflects the best belief of this group as ways to
go forward.

In our final report we will indicate those activities that can be accomplished administratively by the Department of Defense, and those relatively few items that will require congressional action. As a member of the Dole-Shalala Commission, I have learned two important strategies over the course of this year. The first is to try to limit the number of recommendations that we are making. We are making 12, and actually in many ways 10 with the last two of a somewhat different level of order. And also to indicate those areas that can be accomplished administratively, therefore we can try to pressure the Department of Defense to go do what it is able to do now without waiting for congressional action but highlight those things which will require congressional action and try to have that occur in as expeditious manner as is possible.

The recommendations are the following. The first and in many ways the most overarching recommendation is to develop a strategy for
integrating direct and purchased care. That is, the department needs to have a more deliberate planning and management strategy that integrates the direct health care system with the purchased health care system and to promote the integration at the level where health care is being provided. We understand the need for having flexibility and the desire for optimizing the delivery of health care to all DOD beneficiaries and we think that it will be very difficult to have this function well without better integration at the local level where care is actually provided than occurs in the current environment.

Our second recommendation is that there be a better collaboration with other payers on best practices. Specifically, we think there should be an advisory group to enhance military health care collaboration with the private sector and other federal agencies in order to share, adopt, and promote best practices. There are some areas where the Department of Defense and the Veterans Administration already represent best
practices, but there are other areas where there
is much to be learned from best practices that go
on in the private sector and we think more needs
to be done here.

The third is that there should be an
audit of financial controls. DOD should request
this audit to determine the adequacy of the
processes by which the military ensures that only
those who are eligible for health benefit coverage
receive such coverage and that there is compliance
with law and policy regarding Tricare as a
secondary payer and that it be done in a uniform
way. While we do not have explicit indication
that there is a problem, we are that when such
audits have been done elsewhere in the private
sector they have usually indicated a possibility
for improved processes and we think that is likely
to be the case in the military and will only know
that when such audit occurs.

The fourth recommendation is that there
should be wellness and prevention guidelines
implemented. That is, the department should
follow the national wellness and prevention
guidelines and promote the appropriate use of
resources through standardized case management and
disease management programs. It is not that these
do not occur in any way, they do not occur in a
sufficiently uniform way across all of the health
care delivery sites.

The fifth is that there should be
priority given to acquisition at the Tricare
management activity. DOD needs to restructure the
Tricare management activity in order to place
greater emphasis on its role in acquisition.

The sixth recommendation has to do with
implementing best practices in procurement.
Because the Department of Defense is such a large
procurer of health care services, it is important
that ways be found to aggressively assess and
incorporate the best practices that go on in both
the public and private sectors with respect to
health care purchasing.

The seventh recommendation has to do
with existing contracts. We are recommending that
the department reassess requirements for purchase
care contracts to determine whether more effective
strategies can be implemented to obtain those
services and capabilities.

The eighth recommendation is to improve
medical readiness of the Reserve component. We
believe it is important that the department
improve the medical readiness for the Reserve
component recognizing that its readiness is a
critical aspect of overall total force readiness
and that it is not operating in that way during
the current environment.

The ninth recommendation is that there
should be a change in the incentives in the
pharmacy benefit. Congress and DOD need to revise
the pharmacy tier and co-pay structures based on
what is known about clinical and cost-effective
standards in order to promote greater incentives
to use preferred medication and more cost-
effective points of service.

The tenth recommendation has to do with
revising enrollment fees and deductibles for
It is a multiple-part recommendation.

We believe that the department should propose and Congress should accept phased-in changes in enrollment fees and deductibles for retirees under the age of 65 that would restore cost-sharing relationship put in place when Tricare was created. We believe that most of these fees and deductibles should be tiered so that they are higher for those receiving higher retirement pay.

The task force also recommends changes in other features such as co-payments and a catastrophic cap which should be phased in over a period of years and which should be reassessed in a periodic manner.

In addition, we believe that the department should propose and Congress should accept a modest enrollment fee for Tricare for Life beneficiaries. This is not being proposed in order to reduce the department's cost but, rather, to foster personal accountability and consistent with the task force's philosophy that military retiree health care should be very generous but
not free. It is also a change even though there is a very modest enrollment fee that should be phased in order a number of years. The task force believes in addition that DOD should propose and that Congress should accept automatic annual indexing of enrollment fees that maintain the cost-sharing relationship put in place when Tricare was created to account for future increases in per capita military medical records. Unless there is an automatic indexing put in place, the cost shares restored at any one point in time in terms of retiree cost sharing will not be maintained. Other elements of cost sharing such as deductibles and co-payments should not be indexed annually, but they should be reassessed at least every 5 years.

The eleventh recommendation is that pilot programs be considered and studied that would aim at having a better coordination between Tricare and private insurance coverage. The department should commission a study and then consider pilot programs aimed at better
coordinating insurance practices among those
retirees who are eligible for private health care
insurance as well as for Tricare.

Finally, as the twelfth recommendation,
we believe that metrics need to be developed so
that the success of the military health care
system's transformation can be assessed
appropriately. That is, as these changes are
being implemented, the department should develop
metrics so that the success of any of the planned
transformations of the command-and-control
structure of the military health care system which
is now in process of occurring will be able to be
considered along with its costs and benefits.

In summary, what we are suggesting is a
focus on strategy integration, preserving what we
regard as the best aspects of the current system,
creating efficiencies by streamlining operations,
improving effectiveness and the accessibility of
quality care, borrowing where appropriate the best
practices from both the public and private
sectors, and changing in ways that will not
diminish the trust of beneficiaries or lower the
current high quality of health care services
provided military personnel, family members,
retirees, and their families. We believe it is
urgent that the department and the Congress act
now. Given the current and likely future military
commitments, there needs to be a sense of urgency
in resolving the persistent problems that the
department has been facing and is likely to face
in terms of new challenges. Thank you.

DR. POLAND: Thank you very much, Dr.
Wilensky. I would also like to give an
opportunity for members of the task force to make
any comments that they would like to make or any
additions.

DR. WILENSKY: I would like to indicate
though the enormous amount of work that the task
force has provided in coming to the
recommendations and in writing up the various
chapters. This has very much been a collective
effort and it would have been impossible to
produce a document such as you have seen in draft
form without the very hard work of the task force members in addition to the very able staff supporting them.

DR. POLAND: Yes, ma'am?

MG ADAMS: Actually I was going to say almost the same thing that Dr. Wilensky said. This task force really did our homework. We did not take anything at face value. If there was information to be gathered on a topic, we aggressively went after it. There was much debate among the group, but I am proud to say there was total consensus. Everyone's voice was heard and these recommendations reflect our collective support of the recommendations. So it did not come easy, but I think what we put forth is very worthwhile and will stand the test of time, and I want to thank the assistant secretary for the opportunity to with this group. I cannot think of a better group of professionals who could have come forth with this type of report, so thank you.

DR. POLAND: Other comments from members of the task force? We will open it up to the
board. I will maybe give my own opinion first. I always have a morbid of being on an airplane without enough work to do and you have prevented that fear from becoming reality. So I really did have time to in-depth look at it several times.

I am going to keep this report because I think it is a model of how reports should be written. What I mean by that to reiterate again, I very much like and appreciate that it started with a set of guiding principles and as best I can tell, every recommendation fits under the rubric of those guiding principles. Even more importantly, in a task as complex as this, I appreciate that there was not a simplistic view of let's do these five things and it fixes the system. Indeed, what I saw, and I would almost like to add a subheading to the title of your report, is a roadmap for transformation, and to me that is what this actually provides. It provides 12, wounds like a twelve-step problem, but 12 steps by which to begin the process of this journey of further improving the health care
I also want to say my personal opinion is that military health care is one of the crown jewels of DOD and I would not like to have somebody think that this is a task force or a recommendation designed to fix a failing system. I do not believe that to be the case. I have been the beneficiary of military health care. I have seen it as president of this board and as a member of the predecessor board, the AFEB. Members of this board have been for example to the Center for the Intrepid. It is a state-of-the-art facility that is the envy of the world. What is at issue here I believe is how to take this crown jewel and keep it in a way that is fiscally feasible to continue into the future. In a way, maybe to put another word on it, this is sort of a sleeping beauty and it just needs that roadmap to reach the next level of evolution. So again I commend you very much on a superb report, very well thought out. I often approach reports much like reviewing a grant where my job as a reviewer is to fine the
hole. I did not find holes. Every recommendation I saw was data driven. The data was transparent. It is available to anybody that would want to have it. So bravo and congratulations for just a superb report.

Let me now open it to other members of the board to ask questions or to make comments that you may have. Mike?

DR. PARKINSON: Thanks, Greg, and thank you, Dr. Wilensky for the overview of the report and for all the hard work. I agree with Dr. Poland's comments.

As a veteran of the DOD and working on a not exactly similar project for the last 2 years of my military career called the MHS Optimization Plan which was designed in many ways to deal with the staffing issues and the financing issues related to Tricare, I know how difficult this is. I really hope that the integrated 12 recommendations can make an impact in the department as well as on the Hill.

I have some comments that I am going to
make in really no particular order and if you deem
so to respond or react to them, that is fine, but
they are really meant to be constructive in the
sense of reading through the report much as Dr.
Poland did with a fine-tooth comb.

Full disclosure, I spent 6 years as a
medical director in a consumer-driven startup plan
that was subsequently acquired by the nation's
largest health insurer so I come at this a little
bit from just having left the inside of a big
industry, if you will, and some of the
perspectives might be very personal at this point,
but they are personal. And also with kind of a
long commitment to prevention and behavior change
which also is kind of the core sine qua non and if
the country is going to get ahead of this it has
to do that. So it is really those two recent
experiences that I do that.

As Dr. Poland mentioned, DOD in certain
areas of medicine and health care has been the
unparalleled leader in infectious disease, trauma
care. Certainly these are the areas that are the
foundation of the EPE Board and now the
reenergized Defense Health Board. But in other
areas where DOD could exert tremendous market
power and also clinical innovation and business
innovation, for a variety of well-understood
reasons we have not done it. I would hope that
one of the tones of the report is that DOD commit
to being a cutting-edge innovator. Given that
there are political challenges with benefit
structure, there is no reason that we should not
be as innovative in the way we deliver peacetime
health care or the way we buy peacetime health
care as we are in the way we do trauma care or the
way we do preventive medicine. So we have a
benchmark, and as Greg noted we have those, and
part of what I see us doing not so much in this
report, but we should surpass best practices with
a very innovative prototyping R&D type of entity
just as we would do for new weapons systems to
demonstrate to the country that DOD can lead as
well as just catch up to whatever the big Fortune
500 companies are doing with large health plans.
So it is a sense of tone that we should commit to leading perhaps the nation.

Daniel Fox who is in at Milbank and came down and saw our effort in 1998 and 2000 said this is important. The military should lead just as they led in such major areas as racism and discrimination under Eisenhower. If we have a country that is amok and a medical industrial complex that will spend all the GDP, maybe DOD can offer something there as well. It is in the report, but the way it is articulated might be a little more proactive and positive. Just a thought.

The V.A. is an example, and I am not going to make any comments about the Unified Medical Command except to say somewhere in here there is a best practice and I sometimes opine out loud. If the progress that the V.A. Has made in relatively dramatic fashion around certain quality and standardization across facilities all over the country, a rhetorical question, could they have done that without Ken being the strong head of the
V.A. that he was and a structural line of sight that went from him to the visns (?). We will leave that aside, but in an organization that knows command and control, who knows it better than DOD, and I would urge us around this table to go with all the political considerations aside, what is the best practice to get efficiency so that cost goes down faster in DOD than it goes up anywhere in our U.S. health care system? It should. We are blessed with people who come with better risk factors, they are healthy enough to be in the military, 10, 20, 40, 60 years downstream we should benefit from that if you will health capital that we bring in in the way we make them a fit and healthy fighting force.

David Walker I saw met with your committee which is great. David is on a campaign as you know as the Comptroller General of the United States going around and essentially saying from a unique platform because he is a relatively free voice which I should we all listen to, is that unless we do three things, it does not matter
what system you are in and you are not going to cap costs and hurt the economy any more than it has with health care, and that is true of DOD's overall budget. In DOD we see the tail of health care wagging the dog of DOD rather than vice versa in a way, and that is just the same that every corporate employer has seen.

Those three things are align incentives at all levels. So if the individual does the right thing, they should be rewarded for it meaning lower health care costs not higher health care costs, more incentives, premium differentials, whatever that might be, all of which are being pushed and experimented with in the private sector, as you know, Dr. Wilensky. And the tone of their report had in little bit in there about incentives, about smoking cessation, and we don't really cover that, but there is dramatic work being done in the private sector. You do not need to go into it in the report if you do have a best practices panel that says no, many employers have dramatic differentials in smoking
and in weight and in things like that you see, and
there is some allusion to those in couple of
places but it might be stronger around incentives.
Number two as David Walker says is
foster transparency. That is not co-pays, it's
not deductibles, it's the full cost of the
services. You do mention in that in your
recommendations. We want transparency to the
beneficiary not to the doctor or the MTF, but they
need to see it as well because they don't have a
clue how much a drug costs either I can tell you.
But everybody needs to see the full price of the
drug, not the co-tiered payment, that's a
structure, but even if I pay $10, you should know
that the drug itself is $180 or whatever the
number is. So an emphasis on transparency which I
liked in there, but there might be an exclamation
point around it because it drives dramatic changes
in personal behavior when people see the full cost
of a doctor's visit.
Then finally, the notion of
accountability. So incentives, transparency, and
accountability. They are in your report, but I would just hope that as we go forward in this effort that we pull those front and center because those are the reorganization of magnetic fields that drive behavior change throughout the whole system.

Specific areas for comment, and I'll just throw these out to get our discussion going. I have spent a lot of time with Fortune 50, Fortune 100, Fortune 1,000 employees over the last 6 years and I will tell you that they are not aware and frankly they may not care that Tricare was ever intended as a second payer. They are in business to survive globally and if you find employees who have a $460 family benefit versus whatever, it is good economic sense for the company to promote that, and they do. From a public good as a citizen, is that bad? If I'm giving a $187 billion tax exemption to employers and we can debate whether or not we should do away with that and go to an individually purchased which is on the platforms of the presidential
campaigns, but I am not sure what to do with that because good employers are saying why in the world would they be on mine if they already are entitled after 20-plus years in the military to a reasonable benefit that is just as good, and as a matter fact, we don't even pay them to move that way? You know, Dr. Wilensky, many people are saying I'll pay you to take somebody off of our coverage. I am glad you raised that issue, but I will tell you after doing this for 6 years there is no awareness among employers that it was ever intended as a second payer, nor I think among the beneficiaries who are now military retirees who understand that. It's just if it's a better deal, why not? So I am think I'm glad you raised that. I do think some specific language around consumer-driven account-based plans would be nice. It doesn't have to be in here.

You can underwrite these models even with the Tricare benefit, and the rapid prototyping of a Tricare choice or Tricare consumer model might be something to look at very
quickly and roll out and determine how that might fit because even though there's relatively little out of pocket now, particularly if you raise co-pays and deductibles, you could put enough bucket of money together to initially fund a health reimbursement arrangement or health savings account and go forward such that people have the right behavior and they monetize the benefit.

Even Medicaid is doing that for Medicaid disabled now, giving the voucher equivalent of purchasing power to Medicaid rather than the usual co-pay models.

So, just something to think about. I know it's in your import to have best practices, but it might emphasized because McKinsey will be releasing their second report shortly, looking at the experience of consumer-driven plans. They mitigate healthcare costs faster and, if done with incentives, with higher satisfaction than traditional PPOs or HMOs.

One of the questions I had at the end of reading the report is would a DoD beneficiary be
able to take advantage, under this scenario, of emerging low-cost, high-value innovations in the provider sector? Can I walk in to Wal-Mart, if I so choose, and get one of the 400 drugs for $4 if I'm a DoD beneficiary? Isn't that a good deal?

Okay?

Can I walk into a MinuteClinic and, for 60 different services at $40, pay out of my pocket as an alternative to whatever I might get under one of the big three mega-contracts?

So we might want to think because the provider sector is rapidly fleeing some of the practices of traditional managed care contracts. So, 2000 retail clinics staffed by physician assistance and nurse practitioners who, by the way, we started in DoD, are growing all over the country, flat fee, totally transparent, $40. Those are the types of innovations that I would ask, going forward, do we allow those types of things in our contracts?

Just again, positive questions:

Reimbursable e-visits; if I want to pay my doctor
$25 over the internet as opposed to waiting to see
him through a Tricare support center, can I do
that? You've got that in your best practices
panel. They can talk about that.

Incentives with teeth; as I mentioned
before, financial incentives right back into the
accounts, premium differentials up-front,
additional rewards for care engagement and
completion. You've mentioned some of those
things, but they're very impactful. I notice that
Congress wants to hear a lot about incentives.

And, then, you say it in here very
nicely, but I would just put an exclamation point.

In 2007 or 2010, our big mega national contracts,
which are farther away from transparency, farther
away from direct interaction of the consumer with
a doctor and the consumer with a facility, is that
the direction that is going to create a highly
efficient that roots out inefficiencies and the
consumer, the beneficiary, benefits? If we can
find those low- hanging fruit, it may not be
possible to do it through mega regional contracts,
and you've raised that nicely in the questions through some of the things you've talked about, looking at the best business practices.

So, a long-winded way of saying, yeah, there are some things there that I would have liked to see personally a little bit more based on our experience in dealing with a lot of employers, but you hit the mark. It's just yea, verily, you know, exclamation point under the recommendations you did make.

So, thank you for the opportunity to comment.

DR. POLAND: Thank you, Mike. Other comments from Board members? Wayne?

DR. LEDNAR: Wayne Lednar. I'd like to add to Dr. Poland and Dr. Parkinson, my appreciation for the real Herculean task the taskforce took on, and I really like the crispness of the recommendations and how they fall together.

I guess a couple of just impressions that I would share: I like the fact that this is data-supported. Decisions really need to be made
in a fact-based way.

I like the fact that it's mission-focused. Much of healthcare is, in fact, focused on healthcare and not the real question of why do we provide it. So the mission focus for DoD is a very critical area that I think you've brought attention to, and I wish more of our colleagues in the healthcare business would attend to that as you have.

We shouldn't forget, as Dr. Poland mentioned, this is an activity which is global in presence. It's not just domestically placed; it's global. In effect, what we want to do is build on the long tradition of success of military healthcare and make it even better for the future.

When I think back of some of the evidence of some of that success, the DoD has been a leader in clinical diagnostics and therapeutics, techniques that have been adopted by the private sector because of the response to the need, particularly on the battlefield.

I think about providing support for good
care management, the electronification of medical
records, the challenge of trying to coordinate
care from the battlefield and the theater of
operations back to the tertiary care medical
centers, whether they're in Europe or back in the
U.S., a very complex set of moving parts, and I
think we want to build from that success in the
future.

SO, a couple of ideas: One is to really
promote and encourage innovation with
accountability, not just new ideas but
accountability, and accountability in a way that
ties the parts together. You mentioned sourcing,
and logistics is a very important area of
activity.

I think that there are some activities
in the private sector, perhaps in government,
around sourcing which is not only looking at the
individual contract and contractor and their
performance but rather how do the parts fit
together, in fact, to sign up the entire supply
chain for a common goal with revenues at risk for
the performance of the chain, not just their
individual part. This will get parts talking to
each other and making decisions that rationalize
for the good of DoD rather than the individual
contracting company.

When we think about metrics, clearly
important to know, keep the focus on priorities to
make sure progress is being made, but I would
encourage that we need more than just metrics on
transactional care process. We need more metrics
on outcomes. Is it really helping patients? Does
it make a difference, and especially does it make
an impact on mission? Not just healthcare, health
outcomes, does it make an impact for line
commanders and to make that link very explicit and
to really show that?

Then the last thought I'd offer is a
solution that has the goal of sustainability.
Clearly, we want a system that continues, that can
get the mission accomplished, can meet the future
needs regardless of what they are. We have an
aging healthcare task, a healthcare set of
providers. We have an aging set of capital facilities. We have needs for bringing in new technology. How do we develop a system that doesn't just patch it for the ability to continue today but really to thrive as we go into the future?

So, thank you from the Board's point of view for your hard work and for these recommendations and the chance to comment.

DR. POLAND: Thanks, Dr. Lednar. Mike mentioned his area of expertise in this area. I should also say Dr. Lednar has been a critical mover in first Kodak's and now DuPont's, healthcare delivery transformation too.

Other comments? Dr. Silva?

DR. SILVA: I want to also add my congratulations to your committee. It took on a lot of tough issues which obviously the civilian community is also dealing with, and there are a lot of different formulations that are corrected.

I wonder, was there any thinking within your committee, how to sequence these changes in?
Are there some components that are so interconnected that they should be pieced out into a stage one versus stage two or can all these be implemented at variable speeds?

Thank you.

DR. POLAND: Let me now, before taking further comments, allow Dr. Wilensky or other members of the Board. I'm sure this will have stimulated some thoughts or comments that you may want to make.

DR. WILENSKY: Let me respond to a couple of the issues. These are very good, thoughtful points that people have raised and reflect the fact that you have read our drafts and given them a lot of thought, and I appreciate that.

One of the areas that we have struggled the hardest with is the notion of coordination with private plans for retirees who are still working. The Congress has made it illegal for employers, as I understand it, to actually pay to push people out of their healthcare plans, but we
recognized that there are two issues that are still important to be dealt with. The first is making sure for people who actually carry both Tricare and private insurance, that Tricare does function as the second payor. We think there is some reason to believe that does not happen all the time and that we need to make sure it does happen.

There's a comparable issue for employed individuals after the age of 65 where their employer-sponsored insurance is first payor and Medicare is second. In this case, Medicare is also a first payor to Tricare. But to make sure that Tricare, when they're in the face of held existing insurance, is really the second payor and that there are a number of strategies that can be done to make sure that the system is functioning as the Congress intended and as all of us think it should.

The more complicated issue, which we've raised -- I think we've raised it more than we've resolved it -- which is why the recommendation was
to study, assess and consider doing pilots, is recognition that there are issues of both benefits and economics on the one hand for individuals to consider. We were as worried about the downside of not having a good integrated plan for individuals and believe that having one coordinated plan, whichever that is, Tricare or the private plan, is superior for many times for most people to using two plans.

And so, what we are suggesting in our recommendation to assess and do pilots is whether there may be ways to focus on a single plan but of a plan of the choosing of the individuals and to structure in a way that all parties feel they are better off. Not easy to do, but that was the thinking that underlay the recommendation number 11 that I mentioned during my presentation.

We very much agree with the notion of being an innovator in wellness and in aligning incentives and try to reward the kind of behavior that we think is appropriate and try to indicate the importance of wellness and prevention for DoD
to carry on its mission readiness functions as
well as providing best healthcare, and so, we'll
have to see as to how to best frame it.

The notion, I was attracted to the
comment you made that we all recognize the
innovations in trauma care and surgery that occur
during wartime and maybe having that as a model in
our minds for the role that the Department of
Defense for military healthcare can have in terms
of prevention and wellness are to be taken with
that same drive. I'm not sure that we quite
thought about it that way. I thought that was a
very interesting way to look at it.

The challenge will be something that
we'll think about over the course of the next week
or 10 days about the sequencing of activities.
Some of them fit together more obviously than
others. In changing either some of the benefits
or the payments, our interest is in doing so in
what we think is a fair and predictable way. So
we have a lot of emphasis on phasing in. Our
phase-in is presumed to be, for the most part, a
four-year phase-in and to have periodic
reassessments for those things that don't lend
themselves to annual indexing so that, on a
regular basis, you look to see where you are.
Those, I think, are one set of activities.

But with regard to the contracting and
the assessment of changes in the unified command
and particularly the need with regard to better
integration between the purchased care and the
direct delivery of care. Those are as soon as at
all possible to get started on, but the realities
will depend somewhat on the contracting cycles
that are beyond the control, basically, of
probably anybody in this room, even Dr. Cassells,
because they're in motion already in terms of what
the contracting schedules are.

But we had, as our first recommendation,
a better integration between the purchased care
and the direct delivery care, not because no one
has thought of this before -- we're aware that
this type of recommendation has been made to the
Department -- but that it is so integral to
everything else that comes after, that it is
impossible to really have an alignment of
incentives at any stage including the interesting
one of putting revenues at risk for the
performance of the chain.

None of this can occur without having a
better integration between purchased care and
delivery care, and everything that spins off of
that, all of the procurement, all of the
contracting, all of that is contingent on this
notion of what it is you're trying to produce at
the end of the day and all of the pieces that
move. So, thinking about what has to go together
and what not is something we'll have to ask people
on the taskforce, particularly those who are more
involved in that portion to give us more thought.
That is not something I personally have thought
about.

Are there comments from any of the other
taskforce members, specifically about the issues
that have been raised thus far? Dr. Roudebush?

LTG ROUDEBUSH: I thought Dr. Parkinson
provided some very thoughtful points for
consideration, and I think many of those were
raised during the deliberations relative to
various aspects that we addressed.

Something I would offer for your
consideration as you discussed alignment of
incentives, and command and control is an
opportunity to drive efficiency. Those are
certainly things that we considered. I think
efficiency, in and of itself, is obviously an
important aspect of what we considered and
continue to consider.

But, quite honestly, effectiveness is a
significant and perhaps more important driver in
much of what we do. If you look at what our
military medical system is asked to do in terms of
providing a healthy, fit force that's protected
and prepared to go forward and do what we ask our
military to do in virtually any situation around
the globe, that's one aspect. Providing medical
personnel that are prepared, trained and able to,
one, do all that's necessary to produce that
healthy, fit force and then support them wherever
they find themselves, take care of them and bring
them home safely should something adverse occur is
an aspect of what we do.

Providing the healthcare to our
beneficiaries, which, one, provides that healthy,
fit force and, two, provides those trained,
current and competent and capable medics to go
forward, all of these activities with the
incentive being that healthy, fit force, that
prepared medic, that operationally-effective
military, those incentives are not necessarily
always efficient. So much of what we considered,
we considered on the basis of cost-effective.
Managing each resource so that the best benefit
was derived in the most responsible and
cost-effective way is one of those guiding
elements that helped us in our deliberations.

So, as we align incentives, the
incentive of that operationally-effective force,
well supported medically at home and deployed, is
not always efficient, and a coalesced command and
control does not necessarily drive that kind of effectiveness, particularly as we look at doctrinally-effective forces: Airspace and cyberspace, (off mike) at sea, subsurface.

There were aspects of that that we did deliberate on, and I think our considerations drove the report to reflect those considerations, but I think your suggestions relative to opportunities to, in fact, engender efficiency wherever and whenever we can is an important aspect. I think that, as Dr. Wilensky pointed out, really drove the consideration of a strategy that appropriately integrates both the direct care system and the contracted or the private care system, so that we manage those both to best effect, to mutual benefit and to best cost and, most importantly, to best outcome. Whether it's a healthy, fit force, whether it's a healthy family member, whatever that best outcome should be, I think, really drove us in our deliberations and allowed the construct of the recommendations as we provided those.
So I think your observations certainly reflect the importance of doing that, and I thought your issues and ideas relative to innovation were also telling and I think should inform the execution and the further deliberations of this report as it's crafted and as it's delivered. So I truly appreciate that. Thank you.

DR. POLAND: Dr. Luepker?

DR. LUEPKER: Yes, Russell Luepker.

Your last point, Dr. Wilensky, talks about metrics and measurement. I guess I'd like to hear a little more. In this very complex system and a multilevel set of recommendations, how would you know you've succeeded here?

DR. WILENSKY: That is an excellent question. We were at least clever enough to recognize if we didn't put a directive of setting up metrics so you can assess where you go to in addition to where you've been from, you'll never be able to answer the question of have you succeeded.
Well, our concern about metrics was very much focused both at the first recommendation and with the last recommendation but frankly is true all the way through. That is, as I've indicated, we are not the first group to reflect that the incentives driving the direct care system and the purchased care do not always seem to be aligned. Within each, they may be aligned more or less all right. But in terms of being able to produce the desired outcome at the local level that makes the most sense, given the complex missions which is the medical readiness plus delivery of healthcare per se to the people using the system, how do you try to set up an alignment of incentives that has the best outcomes for the costs that you are incurring?

What that requires is deciding what defines success. As General Roudebush indicated, it is more a focus on the outcome, the health outcome and the readiness outcome, and not on the inputs specifically that are used. So we recognize that the difficulty of saying this is
what you're trying to do and this is how you
numerically define that and then try to measure
how well you've achieved it or not achieved it.

It was also in reflection to a recently
released GAO report that had to do with command
and control and going to the issues of unified
medical control. We recognized that when we
started this taskforce, this had been an issue
under considerable debate and discussion in the
Department for the preceding year or two or maybe
decade or two at some levels and that some initial
levels of decision-making -- yes, forever.

Some initial decisions had been made as
to how to proceed going forward, but there had
been noted in the GAO report that it wasn't clear,
if it occurred, what metrics had been used by the
Department in terms of assessing the costs and
benefits of the various options under
consideration, yet alone the actual choice that
was ultimately arrived at. And so, what we were
indicating is, given that a process is unfolding
now, it is important to establish the metrics of
what will define success and then assess how this
strategy looks in comparison to those metrics and
to the extent that there are other measures of
success that could be considered when different
strategies or choices are made going forward, that
that's clearly defined.

So it is trying to be as clear as we can
throughout the report that our concern is a focus
on clinical outcomes, on meeting the readiness
mission first and foremost which makes all of this
more complicated to what is already a complicated
issue of how do you know when you've had good
quality, cost-effective healthcare being provided.
As all of you know, this is not a slam-dunk issue.
In the private sector that doesn't have to worry
about medical readiness, it becomes much more
important.

Complicated, when you do, but not making
the metrics clear and measuring as best you can
doesn't resolve anything. We just need to
acknowledge the complexity of the combined
mission.
RADM SMITH: And just to further pile on to that, part of the intent of the first one is that there's been a fair amount of concentration on unit cost but because of the lack of a common accounting system, because we segregate the purchased care from the direct care system, it's difficult to get the whole cost associated and whether or not, as has been shown in other systems, if you spend too much time on the unit cost, you may not actually be reducing the overall whole cost and also may not be helping ultimate outcomes which is clearly our highest priority.

DR. WILENSKY: This was in the discussion, some of the discussions we had on pharmacy benefit, for example. Trying to look at this point, that it is important in general when we're looking at military healthcare, as in healthcare all over, to remember that even if you minimize unit cost, however defined, the cost of producing good, healthy outcomes may not be minimized and that it may require not minimizing unit cost but allowing enough flexibility with an
alignment of incentives and reward structure so that overall healthcare is provided in the way that makes the most sense.

In some instances, that will be different configurations between purchased and direct delivery care and, in some instances, may be to allow for a different view of the use of pharmacy care versus the rest of healthcare and to remember the focus is on the healthcare outcome. It's easy to focus on what you can most easily measure which are the unit costs of care, but that misses the point of what we're trying to do.

DR. POLAND: Dr. Walker had a comment, and then we'll have a response and then maybe take a break and come back to the conversation. Go ahead.

DR. WALKER: I'm another David Walker. I'd like to address recommendation number eight which I think you did excellent an excellent job of explaining the difficulty and the importance of this problem. Maybe it's my lack of insight, but I don't see the solution. I see the
recommendation to do it, but how will it come about?

The recommendation is the Department of Defense should provide medical readiness for the Reserve component which seems to me the most detached and difficult group to maintain their health, recognizing that its readiness is a critical aspect of the overall task for the force readiness.

MG SMITH: I'll take a stab at that. The genesis behind is that more than 50 percent of the medical assets for readiness and for delivery of medical services around the world is in the Reserve components. If you don't have those people coming to the colors and going forth, we cannot have a future military healthcare system when you've got an asset that's over 50 percent.

Recognizing that, we're saying to DoD, you have to ensure that an asset will be in place as we go to the future, and that asset is not always a reach out and touch with an order in 24 hours. That asset has to come from the employer,
has to come from the families and come from America all over.

So what we're saying is what are the inhibitors, whether it be access or the inhibitors for these people coming to the colors. We have found the data at mobilization sites that dental readiness is the number one deterrent for a person being mobilized, and you have other medical things. Well, we don't control the daily lives of the civilians because of their civilian status.

And so we're saying, what can we do to help increase the awareness of a Reservist that they need to be medically fit? What are the processes and procedures that we can employ and help them with? So that if their unit is called, they can come, get through the mobilization site, and we can send those units forward as necessary to do what we have to do for the medical readiness.

And so, we've recognized that, saying that there are some things that we're seeing that need to be emphasized and implemented. We talk
about it. I haven't seen it. We talk about more
of the individual understanding that when they
sign up for the Reserve components, they're also
signing up to say: I want to be medically fit and
I'm going to be medically fit and I'm going to do
what is necessary through lifestyle, through
physical fitness, through eating, diet and various
things. So that when our unit is called, I'm
going to go forth.

So this is what I think we're really
addressing is that we can't have an asset for
America, but we can't access that asset or then
when we access it, it's not there because they're
not medically fit. This is I think what we're
trying to drive in recommendation eight and the
awareness of this asset.

DR. WILENSKY: There's also a
recognition that there have been a number of
changes with regard to the Reserve in the last few
years, and so we think it's important to assess
whether or not some of the changes that occurred
with regard to the Tricare Reserve Select Program
have the kind of impact that was hoped for or
presumed when they were being implemented. It's
something that we think needs to occur but will
require a two or three-year period before the
effects of having this change occur.

It is a very big issue. As you've just
heard from General Smith, most of our focus has
been on education, trying to make clear the
personal responsibility and accountability of
medical readiness by the Reservists. Whether or
not this is being appropriately engaged in, in
terms basically as a condition of participation,
both in terms of the individual and the
leadership, is important to be able to achieve
this sense of medical readiness and assessing
whether what has been done both in terms of
medical and dental has improved what existed prior
to that or not and, if not, what else might be
considered.

DR. POLAND: I think there was another
comment.

GEN MYERS: Let me just make one
I think the context for this is a Reserve component that's used a lot differently today than when it was conceived, and so this medical readiness issue is a huge -- a huge issue. As Gail said, this Tricare Reserve Select is an attempt, another attempt to try to fix the medical readiness in the Reserve components.

Whether or not it's going to succeed or not, we don't know, and that's why our recommendation reads as it does. Somebody ought to assess that because there's no question that the Reserve component medical readiness has lagged that of the Active component and, given the way the fundamental shift in the way we use the Reserve component today, that needs to change.

We're hoping the changes have already taken place, but we've increased emphasis here, and we recommend that the Department monitor that to see if it's having the effect, the intended effect that Congress wanted when they implemented Tricare Reserve Select.
DR. POLAND: Ms. Embry?

MS. EMBRY: I'm responsible for medical readiness in the Department. About four years ago we instituted a metric to evaluate individual medical readiness in the services, and it's a metric that every individual is measured in their units by their commanders for their medical readiness. Reserve components are among those that are being tracked.

We use those metrics to push accountability and responsibility in the Reserve components, and we implemented a rather aggressive Reserve component health program to institute annual reviews of health and to accomplish the important immunizations, physical assessments, mental health assessments and so forth as required to achieve and monitor readiness in the Reserve components.

The catch is that it is the Reserve components that pay for that, not the Defense health program, as is appropriate. And so, I think the issue is, for the Reserve components,
there is not enough money. If they actually paid
everything they needed to pay for that, they would
have little left to pay for the training and
readiness of the force to perform the mission. So
it's a fiscal issue.

But I do think the Department is doing a
considerable amount to address the issue of
Reserve component readiness. It's a matter of
fiscal priority.

DR. POLAND: Okay, I think we'll take a
brief break here and reconvene about 10 to.

Again, if there are members of the
public or audience that would like to make
comments, if you would register at the desk, I
think we should have time in the hour following
our reconvening here to entertain those questions.

Thank you.

(Recess)

DR. POLAND: Thank you, everybody.

We'll reconvene here and continue our discussion
of the Task Force on the Future of Military Health
Care Report. From the Board members, any
additional questions or comments; Doctor Oxman?

DR. OXMAN: First of all, I'd like to thank the Task Force for a fantastic job. As somebody who's relatively the ignorant in the area, I found the reading compelling and the organization fantastic.

I wanted to ask if you could expand a little bit upon the -- your thoughts about taking advantage of the enormous buying power of the DOD to minimize -- maximize the quality and minimize the cost, particularly in the area of pharmacy benefits?

MG KELLEY: Well, let me just take a stab at that to start off with. And we did talk quite a bit about maximizing the benefits in terms of the ability and using volume for discounts. Most of the people that we discussed that with felt that -- because we talked about it in terms of combining with the VA for even a bigger possibility of a volume, and because of the size of both the VA and the DOD programs, the feeling was that there would be very little marginal gain,
because you've already taken the volume discounts
and there's not that much. And so there is some
pieces of that, and currently the federal pricing,
where we get the volume discounts, is only
available in the MTF's and also in the mail order
pharmacy, and so none of the retail pharmacies
provide that. So it's much more expensive to use
the retail pharmacy.

We certainly don't want to take that
ability to use the retail pharmacy away, but we
want to incentivize the use where we get the
volume discounts.

DR. OXMAN: Thank you.

MG ADAMS: Another aspect of that that
we talked long about, and without getting into
specifics, was that we're aware that there are
other practices available in the commercial side
of it, where you better manage the pharmacy
benefit in terms of the therapeutics of the health
care that you're providing.

And looking at some of those unique
arrangements, where you're able to prescribe the
drugs, take into effect the clinical efficacy, as well as the cost. And the Department does some of that, but we do it at such a high level that we have not really penetrated the market like we could if we were taking advantage of some of those commercial practices. So I think it was not only the buying power, but also then in terms of what type of new practices based upon the new therapeutics that we're taking advantage of.

DR. WILENSKY: This was one of those issues where lowest unit cost may not give you either best outcome or lowest cost for the treatment of care provided, and it was important to look at that, as Nancy was just indicating, as to whether or not there were best practices that either weren't being or could only be adopted with difficulty.

But we also have felt that the incentives in place didn't reflect the actual cost differences, and part of the changes that need to go forward is to incent and reward those who make use of the lowest cost therapeutics available to
them in the lowest cost setting. And so part of
what our recommendations will do is to try not to
prevent people from going wherever, but to incent
and reward those who make use of the lower cost
potentials available.

DR. PARKINSON: There are a couple of
questions. I was trying to intuit reading through
your introduction the level of analysis that
you've done, which is obviously exhausted. But a
couple of basic questions. Were you able to parse
out for the appropriate comparison population
whether or not the DOD, particularly our purchase
care benefit, is accelerating equal to, greater
than, or less than a civilian health care benefit
as purchased by a fortune 1000 company, I mean is
that possible even to do? So the rate of
acceleration that we see and the numbers that
Doctor Poland cited, is that greater than, equal
to, or less than what we've seen over the seven
year period of time for the civilian sector,
because that says something I think about how we
purchase, maybe, okay.
The second question is, in terms of the three major buckets that we look at, pharmacy, out-patient services, and perhaps surgery/advanced imagining, which is right now the focus of most of the traditional managed care industry, is looking at the dramatic growth in out-patient surgeries, dramatic growth in advanced scanning, MRI, CT, things like that; do we have any sense in the reports that we get back through the managed care contracts that we're monitoring at least the major building blocks of what makes up trends?

So the first is, our trend versus civilian, and second is components, pharmacy, out-patient services/advanced diagnostics, or scans.

RADM MATECZUN: I'll try to answer both of those, Doctor Parkinson, and some of the dialogue that we had. Try to take a look at the cost and the increase in cost. We did -- were able to parse out part of the root causes of that increase over that time span. Number one cause is increased benefit, so that Congress has added
benefit over time that has added significant cost
to that structure, including the Tricare Reserve
Select program as an example that we were talking
about, so that's number one.

Number two is that as the benefit has
not changed in terms of the price structure that's
out there, and as people have left the insurance
plans that they are in, that has driven an
increased population into the benefit population,
or at least the population that is actually using
the benefit.

That seems to have leveled off. But
those are the two causes, root causes of the
increase in cost. Therefore, over that period of
time, with those two things happening, very hard
to compare with a civilian population where the
benefit hasn't changed in their plan and try to
come to any kind of conclusion.

The second piece on the components of
the contract, I guess in short I would say, no,
there is no structured way of looking at that. In
fact, that is why we recommended that the
Department should have a strategy, to take a look at the components in the purchase care sector, what's going on. I mean there is a cost, we know what the cost is for each of those. But are we able to compare that cost and the effectiveness and efficiency with the cost and the direct care system? No, we are not.

DR. LOCKEY: Just briefly to the first part of your question, we looked at a number of indices in connection with our studies, and the rates of growth and things like the defense, the Military Expenditure Panel Survey, the Kaiser Foundation data, are similar especially since 2000 than we're seeing in Tricare, they're not identical, but they're in the same mix especially since 2000, so I think that goes to the first part of your question.

DR. PARKINSON: Doctor Lockey, a question.

MR. LUEPKER: I found this is an incredible work product, and I really enjoyed reading it. One of the questions I had was
regarding Chapter 11, and that chapter dealt with
the mix of military and civilian personnel, and
the Task Force was addressed -- was charged to
address this appropriate mixture of military and
civilian personnel to meet future readiness and
high quality health care service requirements.
And the problem is well outlined. The problem was
that there's always been a -- retain the high
quality personnel, that's been a chronic problem
for the Armed Forces, and then this conversion of
military to civilian health care professionals has
created I guess some problems.

But in the conclusions, the issue really
was not addressed. It seemed like pending
legislative initiatives acted as an impedient in
order for the Task Force to address these issues.
And it wasn't clear to me why that was the case.
I mean it's a very innovative report overall, but
in this particular area, there really are no
solutions offered.

MG ADAMS: I think the reason why we
ended up with that conclusion was that
historically, the services have approached the
military/civilian mix differently. But in recent
times, within the last three to five years, all
three of the military departments were directed to
convert more military positions to civilian
positions.

And following the direction of Congress,
all three military departments significantly
increased the number of civilians working in
military medicine. However, recently, within the
last year to 18 months, the Congress realized that
there were problems that were inherent to
converting more military to civilian; most
importantly, you decrease the rotation base, and
therefore, you influence quality of life for those
dedicated men and women who are serving in a
hostile environment, so they gave the departments
permission then to slow down the conversion. So
that's -- we're kind of left in the middle flux,
where we saw the ramp up with the civilians, but
we realize we're not sure how steep that ramp
needs to be.
We've got a holding action right now, so I think we need also to let the department sort it out in terms of what is going to be the proper mix for the services for the way ahead, taking into account the deployment needs, as well as the recruiting retention implications when you civilianize more of your rotation basis, which is what we have in terms of the civilian places that are back in the United States.

DR. WILENSKY: This was one of the areas where I hope we were clear, that it's complicated, we think it needs to be assessed, both in terms of understanding where we are now and particularly the appropriate strategies that are available for the future, and that we just -- we're not able to take the time that it requires in order to be able to provide good strategies and alternatives going forward. So there are a lot of ramifications with regard to future work force needs in terms, not just of the civilian military, but the whole reserve, active duty, particularly as it relates to the medical component that ought to be
considered as we go forward, but we really weren't able to do it. So unlike other areas where we thought we understood the issue sufficiently well, that we could make recommendations for a change, this is -- more needs to be done.

LTG ROUDEBUSH: If I might add just one additional perspective to that. I think the Task Force made a wise decision in not being prescriptive, because the appropriate balance of military and civilian members within the MHS is something that begins at a very high level in terms of -- and missions, a national strategy that translates into a national military strategy, and all the forces that are required in order to support and execute that strategy, and that's an evolutionary process.

There is no one prescriptive mix that allows you to fight today's fight and fight tomorrow's, as well. So I think the recommendations that we made support the ongoing process within the department that will, in fact, drive the appropriate balance and mix to give us
the kind of forced structure, both military and
civilian, that allows us to meet the mission and
deliver the benefit, as well. So I think it
almost goes a bit beyond the purview of this Task
Force. Although it's clearly within the purview
to support and facilitate and help inform that
process as it goes forward, with the over arching
strategy to appropriately integrate the direct
care system and the private sector or contracted
care to achieve the best outcome for all the
sectors.

So I think it is, as Doctor Wilensky
points out, a very complex, but it's a very
dynamic and evolutionary process, as well, that
does not foster a prescriptive or one time
solution.

DR. LOCKEY: Just one follow-up comment.

DR. PARKINSON: Go ahead and follow up
and then --

DR. LOCKEY: Does that also apply to the
statement about recruiting and retaining high
qualified health professionals that's been a
chronic problem for the military? Is this something the Task Force was not really asked to address?

RADM MATECZUN: I'd like to address it a little bit with you right now. The work force and how we get the work force, the necks of the work force are critical questions for us. I think that you heard, we have about 133,000 people working within the military health system. That doesn't include those people that are out there working within the purchase care sector. That's within the direct care system. So it's a very big system, and we have a need for high quality personnel to be able to stay within that work force.

We have not done as well in recruiting in the services over the last few years, and, for instance, our scholarship programs for physicians. This is a problem kind of across the services, and the Department needs help, it needs help from people like yourselves as you go back to your institutions.
And when people are looking for a career, when they're looking for a place to work, would you recommend the military health system? I would, unhesitatingly. The military health system is a great place to work, be in uniform or a civilian, and it's got a fundamental mission that's required for our national security.

So we have I think something to offer all of those members of the work force, regardless of what the mix is. There is a tenure in the nation right now that has to do with taking a look at the military as a career option, not just a career option for military medicine, but a career option for anyone that's looking to serve their county. I think we have to make sure that when we talk to people, that we've been as clear as we can in our own minds that we've sorted through what it is that we want to recommend or not.

When your son graduates from the Air Force Academy, he might like to go to -- to become a military medical physician in uniform. So there's a lot of different pieces to it.
Recruiting and retention has been difficult over the last few years.

DR. WILENSKY: But again, these are -- we recognize these are major issues for the Department, they are very big issues, and I think somewhere specifically we indicate that we think this ought to be the subject of a separate task force, because there are so many issues that go to recruitment and retention, the mix of civilian and military, the mix of active duty and reservists, and how you try to project where you want to be in the future, that was beyond what we thought we could give any justice to, and therefore, other than laying out what we have recognized as the problem, didn't feel it was appropriate to go forward. But it was not because we don't think it's serious, it's really the opposite, we think it's such a big issue that we didn't want to make recommendations that didn't begin to do justice to this issue, so we hope it will be taken with the seriousness going forward that it deserves.

DR. PARKINSON: Let me just point out
before I get to you, Kevin, that Doctor, for the
record, that Doctor Dan Blazer has joined us.
Dan, we went around and introduced ourselves. Do
you want to just briefly tell your affiliation?

DR. BLAZER: Dan Blazer,
psychiatrist/epidemiologist, Duke University, I've
been on this Board for a while.

DR. PARKINSON: Okay; Kevin.

DR. McNEILL: Thank you. As a former
practitioner in the military health care system
and now a retiree and beneficiary, I'd like to
thank the committee for this excellent report and
all of the hard work that went into it. And I
mentioned this as -- aside to a couple of members,
but I would really like to commend particularly
the idea of a better coordination between Tricare
and private health insurers. This would be
extremely beneficial for retirees such as myself
who live in undeserved areas, there's no military
installation anywhere around, and there is
basically no provider network. And the idea of
being able to access either/or, even if it meant
additional, you know, financial contributions by
me, I would consider that a wonderful improvement
to the current system, because even though the
benefits are there, gaining access is very
difficult, so I commend that idea, and I think
it's certainly a mix for the duration.

DR. PARKINSON: Doctor Parisi.

DR. PARISI: I'd like to echo everyone's
congratulations on this very excellent and
complete report. I'm impressed with the care and
the thought that has been given to many of the
issues.

One comment is that the report is great
at identifying the problems, but my reality part
of me asks is, implementation possible or
practical. And I'm sure the committee wants to
deliberate about maybe legislative activities that
are -- legislative actions that would be necessary
to allow the implementation of some of these
recommendations, and I just would ask for some of
your comments about that.

DR. WILENSKY: The good news is that
relatively few of the recommendations require statutory change, and I regard that at least as the good news. We will be very clear when we issue our final report in terms of the 12 recommendations with the action items as to what we believe can be done administratively and what requires new statutory authority. Most of it is able to be done administratively. That doesn't make it easy, it just makes it easier than needing actions by Congress before you can proceed.

Probably the more difficult issue is that while we tried to be as specific as we could in the action items underneath each recommendation to give guidance as to where or what would be required in order to achieve the outcome we're recommending. They almost by necessity always stay, if not at 30,000 feet, will probably never get much under about 12,000 feet, except for some of the financial changes that we discuss more explicitly.

And therefore, it will require follow-on activity to be embraced by the Department, to pull
together individuals appropriate and concerned to
try to make these changes happen.

It doesn't happen that often with task
forces, but it can happen. Again, my experience
on the Dole Shalala Commission earlier in the year
has resulted in what are enormously gratifying
efforts by the Department to try to embrace along
with the VA those areas that can be done
administratively. So there is clear indication
that the Department can take these areas that are
identified and begin to implement them in a very
quick order if it is agreed that they are
important and the kind of interest to do so.

So we will make very clear, at least
according to the guidance we have, there's always
some dispute that goes on as to whose general
counsel opines as to exactly who has what
authority, but we think probably we will be
relatively safe in designating those areas, which
probably need legislative change as opposed to the
others. But I will tell you, most of what we are
recommending, as best we can tell, can be done by
the Department directly.

    DR. PARKINSON: Doctor Shamoo.

    DR. SHAMOO: Thank you. The military

has been at the forefront of issues of equities

once they make up their mind. And I think part of

my question was asked the last time we were

together. There's two types of equity, equity in

terms of type of health care services we render,

especially behavioral versus other medical ailment

issues, and equity, currently it's superb, it's at

the peak, and that is equity to, regardless of the

service rank, we provide the same health care

services. The two part question is, should we

have some kind of safeguard, because no one can

predict that societal ills don't creep into the

system of some inequity, and at the same time, to

ensure the equity of the type of health care

services we render.

    DR. WILENSKY: I don't dispute what

sounds like an admiral goal. I'm not sure

specifically what, other than following metrics

that focus on outcome, that recognize that what it
takes to produce good health may differ in terms of the health care, how it's provided, and when and where it's provided.

That's basically a presumption of medical readiness, that you take individuals as they come in, and achieve a medical readiness so that they can be deployed as the military sees appropriate.

And it is -- it functions more on the desired outcome rather than on the specific inputs that might be required in order to get there. So I mean it strikes me in general, that is the function that the military, particular with regard to its active duty, provides.

It's a little hard to have quite that same specific focus in terms of retiree care, which you can provide our benefits to individuals after they leave active duty military, but other than putting in safeguards that contractors do what they say they will do, and using metrics to make sure that when you think you've changed the system in a way to improve it, that you monitor
the outcomes and not just the input changes. So
if you have something else specifically in mind --

DR. PARKINSON: General Kelley and then

General Adams.

MG KELLEY: Doctor Shamoo, I think that
we did consider this, and as we talked about
discussing adjusting co-pays, enrollment fees and
that, we talked about the tiering process, so that
those individuals who have retired at lower rank
or with lower retirement pay would pay less than
other individuals.

And so specifically to address your
concern about those at economic disadvantage, a
disincentive to using the system, we adapted the
recommendations to have a tiering process to make
it easier for them to use the system.

DR. PARKINSON: General Adams, did you
want to --

DR. SHAMOO: May I comment on that? I
appreciate your answers, but inequity -- the
current inequity crept in from our society, and
that is between behavioral coverage versus
non-behavioral coverage. It's in everywhere in
this society, and was not by design, and everybody
measures out. So contrary to the existing
practices, mental health coverage is one-tenth of
what ought to be in all health insurance, whether
it's -- everywhere, so I am not -- that the
outcomes alone will take care of it, any segment
of our society.

    DR. WILENSKY: Well, actually, it's rare
that people look at outcomes. They mostly --
because they're harder and there's more dispute
about measurement. Normally what they do is,
focus, if at all, on the amount or the cost of the
inputs, and not on the outputs.

    With regard to the issues relating to
mental health, that has clearly become a much more
prominent an issue because of the interest and
focus on PTSD and also traumatic brain injury. We
do not deal specifically with that issue in terms
of the overall strategy of the report. Again,
there are a number of other task forces that were
specifically focused to that issue. So I mean I
think those are better places to look to.

DR. PARKINSON: Ms. Embrey.

MS. EMBREY: Being the designated federal official and not being a member of the Board, I did not have an opportunity to review the draft. But I do want to -- based on the conversation, I would appreciate it if you could elaborate more specifically on what you mean by improving integration between direct and purchase care system. Is this the management of both in the delivery of care, is it system integration, is it provider focused, is it -- I don't understand what integration means.

RADM MATECZUN: Ellen, I think that's why we said what the Department needs is a strategy for taking a look at the integration. If the Department defines the outcomes that are desires, all of those things you mentioned, any of those things you mentioned, then you can align the two systems to achieve the outcome and work across them to make sure that you haven't disincentivized or given the wrong incentives.
If you're not able to do that, if you don't know, if you don't have a strategy for the outcomes you'd like to achieve, then you're going to achieve the outcomes that you get. So I think that, in part, it was, yeah, the Department needs to take a look at that and say, what are the outcomes that we desire.

MS. EMBREY: So the message is then that we have two systems of care that are not focused on the same goals, and we need to figure out what that is?

RADM MATECZUN: They may or may not be, but there's no strategy that says that they are.

DR. WILENSKY: There was also an intent to recognize the need to make sure there's an alignment of incentives at the place where care is actually delivered, which is at the local level. There may be higher level views of how the integrated -- the purchase care and the direct care align themselves in general, but that doesn't provide the incentive or flexibility to have the best outcomes occur at the place where care is
actually divided, which becomes particularly complicated in areas like our own because of the National Capital region has not only multiple providers between the direct and the purchased, but multiple services active in each.

So it is not clear it is happening at the local level, even when there is just one installation, and it is particularly complicated in the region of the country where there are multiple installations. We visited San Antonio. That was an obvious one. The National Capital region is an obvious one.

But there are others as well. And that's all in addition to making sure that there is a well articulated strategy at the top about what you're trying to do with these two.

But even if that occurs, and we think that more needs to be done to articulate that strategy, that doesn't necessarily mean at the local level, where the care is being provided, there's enough flexibility with the right incentives so that the movement back and forth
between purchased care and direct care can occur
in the most effective way.

It's not that there isn't any
flexibility. Our sense in interviewing and
listening to what people told us is it was very
hard and cumbersome to happen, and that was true
both from the direct care's point of view and from
the contractor's point of view. Thank you.

LTG ROUDEBUSH: And it also underpins
the requirement for an accounting system that
allows you to properly characterize the cost of
delivering that particular type of episode of care
so that you can look at best outcome and best
cost. And the outcome is certainly a favorable
health outcome, but it's also a favorable
operational outcome so that you can begin to
strategize and put that kind of capability in
place and leverage each system, which has
strengths, in order to get to the best integrated,
not coalesced, but best integrated system overall.

DR. WALKER: That does raise a question,
and, you, of course, being currently serving, we
have a joint budgeting process, but we don't have an integrated cost accounting system. Each service has their way of doing that. So from a practical standpoint, is the Committee or is the Task Force recommending that we centralize the cost accounting system for this purpose?

RADM MATECZUM: Standardization I think is, how do you cross those systems. Once again, this is part of the Department's strategy. If the Department doesn't do that, it can never arrive at costs that can be accountable.

DR. WALKER: Well, as you know, each service has to live within the accounting system of that service in order to get its budgets and manage its people and, you know, operate. And so if we had a separate health accounting system that would divorce you from your service accounting systems.

So the challenge is difficult. I would like your views.

LTG ROUBUSH: I don't think it necessarily separates us from our services'
accounting system. I think the standardization across the systems because the health accounting system is something that is a bit set aside from much of what the services do. But in terms of how we're able to compare the military systems, one with another and with the private sector, until we have those standardized methods of characterizing those costs and inputs, we have a very difficult time saying this is the best cost for the best outcome.

So I think, as Admiral Madison, points out, it's not so much centralization as it is standardization and getting to a common accounting methodology that allows us to make that comparison.

DR. WALKER: It was one of the issues perhaps not emphasized enough in response to the earlier question of how does the Department of Defense compare relative to the civilian sector.

Yeah, it would be very difficult to make that comparison because there have been rather extensive changes in the benefits during this
decade, and that makes it hard to compare.

But even if that hadn't happened, the problems with the accounting system would make it extremely difficult to be able to make that assessment within and across the Department of Defense.

DR. LUEPKER: Dr. Walker?

DR. WALKER: Thank you.

DR. LUEPKER: Yeah, Russell Luepker.

I'd like to go back to Dr. Shamoo's question. We heard a report a few minutes ago from the mental health task force. And they suggested that everything wasn't just fine for either active personnel, reserve personnel, and or their families.

When you said, well, that's a different committee, and it's true, their recommendations were structural ones about how to better integrate the system and deliver services, and it worries me a bit to hear you not talk much about how this comes together.

If we continue to treat behavioral and
mental health problems as separate and out there, they will continue to be problems. And I personally see the overlap with what you're doing a hundred percent. It's part of health services, but it's particularly unique in that it's not doing well.

MS. EMBREY: In my other job, I serve as the line of action lead for the Department of Defense on the Department's response to the Mental Health Task Force recommendations and many other recommendations relating to the subject of how the Department is organized to address traumatic brain injury and mental health and PTSD, and, as we've re-characterized it, psychological health, which sort of embodies not only the medical, but the pre-clinical and non-medical services that support psychological health. We've made a series of accepted all nine -- well, 94 of 95 recommendations coming out of the Mental Health Task Force, and we are actively engaged in implementing many of those as we speak.

So they'll become a component of our
health system, but frankly, some of the new aspects of those programs were not under consideration by this task force, particularly those on the early intervention and prevention programs and the building of resilience in our service members and their families to address stressful situations, such as a war or financial difficulty or whatever.

So I do think that the Department is addressing this issue and expanding capacity, both in personnel and systems.

We will be implementing an electronic mental health record as part of our overall health system record, so it will be accessible to primary care providers. We are embedding mental health professionals in our primary care settings, and we're embedding them in our war fighting units; and we are engaging in significant amount of training and outreach to individuals about what it is to have psychological health and how to maintain that health in the same way that we adjusted for physical health and fitness.
So the impact that we'll have is we will have an infrastructure to address in the mental health realm anyway, and we also have similar initiatives going on in TBI, but I didn't talk about that.

So I think whatever the future of the military health system is going to be, it's going to be part of that infrastructure, and these new programs will have to be addressed as part of that.

So I don't think it will be an equity issue because this is focused on the total force, not only the service members, but their families.

DR. WALKER: It was also -- I served as the liaison between this four-year task force and the Dole-Shalala Presidential Commission that ran from March to the end of July. PTSD and TDI, its impact in active duty military and in the veterans population and the crossover in between and how to try to have that be better effect and more effective as a health care service was one of the six subcommittees of that presidential commission.
We were also aware that there was a task force specifically focused on mental health issues. Our value added was not to be in those areas given the work that was done, but to attempt to look at what was a very large set of issues that we were asked to look at in terms of the congressional language. Now I don't think it's in any way a sense that more effective care and integration of mental health with the rest of health care is a question in our minds. But if we're going to try to focus on the 10 or 12 most important changes going forward, knowing the work that's been done during the course of the year, it wasn't clear what else we would say on that issue, particularly because our expertise was really designed to try to respond to the issues that were in our charge, and it is I think a very unusual mix of private sector, public sector non-military, and military across the service group that we have put together, but not particularly, starting with myself, expert in terms of mental health per se.
COL GIBSON: Just as a reminder to the Board, we have established a Behavioral Health External Advisory Subcommittee for the Department, as we all as a TBI, Traumatic Brain Injury subcommittee, so you will be hearing more about this and you folks will be part of that Department's solution to these problems.

DR. BLAZER: Just as a member of the Mental Health Task Force, just to make a couple of statements. I think we on the Task Force were very pleased with the initial response of the DoD to the recommendations that we've made. We also are very pleased with the response of Congress in fusing new monies.

There are concerns. This is not a small hill to climb that we'll climb this year. This is a long mountain that's going to take quite a while for us to traverse, and so the issues of sustained funding and sustained emphasis I think is going to be important.

I don't think now is the time to evaluate the DoD's response to the Mental Health
Task Force. I think it's going to take probably three to five years to see how things go.

But we do have a steep hill to climb on this, and I just feel like that we need to recognize that and keep that emphasis for a while. This is not a one-time thing.

DR. POLAND: Yes. Other comments?

RADM MATECZUM: In terms of the question of addressing parity separate from mental health and the benefits that are contained within the current structure, I was trying to think of an example of any time that a coverage has been reduced, and I couldn't think of any.

So the parity may change in proportion, but there -- the Congress has never reduced a benefit once it started, once it's in place.

DR. POLAND: Roudebush, did you have a comment?

LTG ROUDEBUSH: Actually, my comment was a question, and I would direct it back if I would be interested in your thoughts.

Do you see anything in this report that
would preclude the Department and the military health care system from being responsive to the inputs of this task force and others, which, you know, we anticipate will inform both deliberations and actions in the days, weeks, months, and years ahead?

So are you seeing something that takes you in a rather different direction from the work that the task force has provided?

DR. LUEPKER: No, I don't. I was looking for some reassurance that this was being integrated. Ms. Embrey provided that, and I'm comforted by the way this is going forward.

It again is a unique area that has more difficulties than some of the other health-related areas, and but needs to be integrated desperately.

DR. POLAND: Okay. Dr. Halperin, maybe one other comment and then if there are any comments from the public or audience, we'll take those.

DR. HALPERIN: Halperin, from the Board. It is very gratifying to hear the prominence of
wellness and prevention in the major focus of the
report.

There has -- and also the idea of
creating metrics, and it's also good to know about
the implementation of the electronic medical
record within the military.

But many of these things as far as are
there going to mandated offers; are there going to
be mandated benefits? Are people participating
in? What's the rate of participation compared to
other medical systems -- really does hover around
the issue of data. And the source of the data is
the electronic medical record.

So I'm wondering whether someone might
want to comment about the issue of the focus on
electronic medical records within the various pay
orders, if you will, and various systems that are
-- that are part of this -- these recommendations?

DR. WALKER: We did spend some time with
-- in discussions with people from DoD about their
progress in terms of the development of the system
within DoD and across DoD and VA in terms of where
they were in being able to integrate information
which is at the moment primarily outside of the
hospital rather than inside in the ancillary care,
but movement ahead in terms of the development of
in-patient record with plans for how that will
integrate with the VA system.

One of the issues we did not
specifically address, but since you've mentioned
it, I will at least raise, is that there may well
be for some time in the future difficulties in
integrating purchased care and direct care so long
as much of the outside purchased care is not using
electronic medical records, and that is probably
an issue too big for DoD per se to resolve,
although hopefully other pressures and interests
in trying to get electronic medical records and
interoperability, and the private sector will help
resolve that issue.

So we did -- this was not a specific
focus, but we did get briefed on where the
Department is and how it's progressing and, again,
in the Dole-Shalala, we spent more time looking at
how each VA and DoD are moving forward. One of
the concerns we had is as much as we want to have
it pushed faster, it has taken so long to get it
going as well as it is now. There's a lot of
reluctance to change its course because it will
ultimately delay the process even longer, so we're
mindful of that.

But it will be harder to get direct care
or "downtown care." However, you want to
categorize it, fully integrated, if they're not on
the same information systems or at least
interoperable information systems.

DR. POLAND: We didn't have anybody sign
up, but are there any audience questions or
comments?

BG FOX: Dr. Poland, I'm a subcommittee
member and therefore did not have the opportunity
to read this very detailed report, and I will do
so in subsequent time following this.

I would offer the same applause that
everyone has in appreciation for the level of work
and intensity that went into this and the
recommendations, and the thoughtful health board members who have articulated points back and forth. I would like to come back and illustrate perhaps a little bit that General Roudebush, if I might, sir, your comment about effectiveness, because it's in the understanding of effectiveness of the MSH and what is its purpose that I think we should perhaps put some exclamation points to the unparalleled and Herculean efforts that have been accomplished by the MSH given its primary mission for effectiveness to support a military at war and the defense of the nation. It is a fact that the disease and nonbattle injury rate is the lowest it has ever been in the history of conflict. It is also a fact that the battlefield life-saving capability of our military health system is the best it has ever been in history of conflict. It is also a fact that the military health system that exists today deployed multidisciplinary doctors, nurses, and medics to that battle space and have accomplished that mission in an echelon health care system that is unparalleled by
anything that human history has seen to date.

At the same time that the MHS system has maintained to my knowledge every hospital passing JACO standards, every hospital integrating in doctors and nurses who are from the civilian sector into a military infrastructure and health care system and yet providing quality. So while this panel has rightfully pointed out perhaps a roadmap as you suggest, Dr. Poland, for future reviews and critical reviews of efficiencies, I hope one does not lose the perspective that effectiveness of that system to deploy doctors and nurses and medical staff to not only deal with the complexities of the military environment themselves but be able to deliver the kind of quality of care that they have heretofore delivered to our soldiers, sailors, airmen and Marines in combat should not be lost. Tomorrow's battlefields will not be the same battlefields of today and we are compelled like all military infrastructure is compelled to look at the future, and the system has to be creative and allow that
future to be reviewed and assessed so that we can deploy the right kinds of medical teams to deal with the very flexible and agile battlefields of tomorrow and the very flexible and agile and growing capabilities are combat forces have to deliver combat power in austere places around the globe simultaneously.

That infrastructure has to exist and in that is effectiveness. It may not be the most efficient cost-effective system from the perspective of a civilian health care model which looks at maximum efficiency for the dollar. So I only offer that opinion and comment as one who has been a member of that distinguished system and very proud of it and one who has been equally blessed to be a member of a subcommittee who is very focused on taking care of soldiers, sailors, airmen, and Marines who have been wounded in combat. Thank you.

DR. WILENSKY: I hope, Dr. Fox, as you have a chance to read the report you will see we went to great pains to try to make exactly that
point, that when you look at what is provided by DOD in terms of military health care, you have to be very careful not to judge it by a real cost efficiency point of view because of the complex mission that it has in terms of being able both for the present and in the future to respond to the needs of the military present and retired. So hopefully when you see it you will say, yes, you made that point. If we didn't, we will all feel a little chagrin.

DR. POLAND: Let me say thank you for that comment too. It is why I consider it to be one of the crown jewels of DOD. Seeing no other respondents or comments, we are going to end the morning session of the Defense Health Board. I again want to thank Dr. Wilensky and the other members of the task force for your hard work and for coming to address the draft findings. The process from this point is prior to the board's next meeting, the task force will be disestablished but we will take the comments that we receive today, try to synthesize those into a
cover letter that will accompany the task force's final report.

I would also like as we close here to offer the task force committee members a token of appreciation and remembrance of your service on the task force with the Defense Health Board coin. I will give one of those to each of you as a thank you for the hard work that you have done.

One other thing before we close here is the CME form has gotten lost in somebody's stack of papers, and so we do need to find that. Lisa can take that. Colonel Gibson, do you want to make any other comments with regard to lunch?

COL GIBSON: The board subcommittee members and task force members will have a working administrative lunch in the break room and the liaison officers and other invited guests are welcome. We will reconvene at the appointed time.

DR. POLAND: Very good. 1:30.

COL GIBSON: 1:30. That's all I have.

(whereupon, a luncheon recess was taken.)
AFTERNOON SESSION

COL GIBSON: I was remiss at the end of the last session to not formally thank Colonel Christine Bader and her staff detailed to that Task Force on the Future of Military Health. They put in a tremendous amount of hours and that task force would not have been able to complete that project without them. So for the record, the Board and I thank them very much for their work.

DR. POLAND: Our first speaker for this open session is Mr. Bill Carr, Deputy Under Secretary. He oversees recruiting, retention, compensation and related resource management for the 1.4 million active-duty military members of the U.S. armed services. Mr. Carr will update the board and discuss the disability evaluation system reengineering plan. As the members of the Board will recall, Mr. Carr briefed us at our last meeting. Since that time, a Board subcommittee has met with Secretary Cassells and Mr. Carr to discuss a number of matters related to how the DOD and VA are addressing the concerns outlined by the
Board's Independent Review Group and Mental Health
Task Force as well as the Dole-Shalala Commission.
Progress has been made in a number of areas, and
Mr. Carr is here to update us. His slides I
believe are in tab 3. Mr. Carr?

MR. CARR: I am Bill Carr. I am the
Deputy Under Secretary for Military Personnel
Policy. For this first slide, I will not be on
this long. It simply says that in the course of
looking at improvements to the Disability --
System, that there was no shortage of advice from
the various panels and commissions that assembled.
There was enormous overlap in terms of the
recommendations' commonality in terms of the
recommendations that came from those commissions
and the system that we have come up, and you be
the judge and I would be delighted to take your
comments, is one that the services seem pretty
satisfied with that will make the system quicker,
although quicker as was pointed out to us by the
Army Surgeon General yesterday, is not necessarily
anyone's objective because the Army more so than
the other services is interested in saving the
career, rehabilitation, and I will report my own
appraisal that the Marine Corps and the Air Force
on the other hand if the career is not going to
work out or rehabilitation is going to be
protracted and the member is willing to separate
than they normally would separate, so there is a
little bit of difference among the services and
the way they would approach.

But having said that, we set out to and
we have apparently achieved in a small scale the
capacity to proceed more quickly than has been the
case in the past and also far more simply. This
simply shows that there were a lot of things that
informed us, and I've got only one slide and that
is this slide.

If you look at the top, the essential
changes are the ones shown with the Xes. I will
describe the flow as it used to exist typically
for someone with a broken leg at Fort Bragg, North
Carolina. They would go to the emergency room
with the broken leg. If it was a severely
compromised knee then the emergency room and their physician may refer them down the hall to the Medical Evaluation Board because it appeared their career was in trouble. At the Medical Evaluation Board they would develop the facts about that injury, they would ask the commander for his appraisal of the sergeant's capacity to do his job, and they would also query about whether or not the injury was incurred in the line of duty, all of which bears on the government's treatment and cognizance over that particular injury.

They would then package that information together if it appeared that the member was going to be probably unfit, meaning they wouldn't meet retention medical standards that are laid out in detail in various policies. In this case, if the flexion in the knee were severely compromised, they probably would not meet retention medical standards. So Fort Bragg, Womack, would pack up the packet from Womack Hospital and sent it to the Army Physical Evaluation Board. There an informal board would be conducted. Let's look at the
papers. I see the knee. I know what the
retention medical standards are and I know the
person's capacity to do their job. From that I
will render a decision about fit or unfit and then
I will afford a rating. There is of course a
Disability Manual. Proponency rests with the VA,
but it is used by VA and DOD. It says, for
example, if the flexion in the knee is less than X
degrees, then you have a severely compromised knee
and the disability is 30 percent. So the Physical
Evaluation Board looks at it and says 30 percent
and you are unfit, and because it was 30 percent I
am medically retired. Had it been 20 or 10, I
would have been given a severance payment instead
of a retirement and separated from the service.
That is the process. So I leave DOD.
But then I start all over again after that line
that says separation and I walk across the street
to VA, and this is the case today at Fort Bragg,
and I submit a claim for the injuries that I have.
It is not only knee. I will talk about my sleep
apnea and my hypertension. The VA will then
conduct another physical exam. After they have
done that, the VA will conduct another rating
using the same manual. When that is all done,
then VA would award a claim, and that is going to
take 6 months minimum.

In the case of an injury of this
compromised knee at Fort Bragg, I have been
treated at Fort Bragg. They have determined I am
in trouble. They have sent it to the Physical
Evaluation Board who has the authority to decide I
am unfit and to award a rating. They did that. I
went to VA and the whole process repeated itself.

What we have done for the National
Capital Region, and we started on November 26th,
and when we think it is working okay, that may be
January, February, or March, whenever we are
satisfied that the bugs are worked out, and it
appears to be working pretty well so far, then we
will begin to gradually extrapolate it worldwide.
The way it will work is that we will eliminate DOD
doing the rating because that will be done by VA
in a means I will describe in just a minute, and I
won't have to submit a VA claim after leaving active duty. I will have already done that while I'm on active duty and VA then would give me the rating. Let me explain how that works, and now I am working from the picture on the bottom.

I have had the injury and I have gone to the physician and the physician said that I'm in a bad way. I have then gone to the Physical Evaluation Board and they have looked at it and said you are probably not going to meet retention medical standards. Here is where the change starts. I will fill out a VA form listing all of my maladies and it will go to a VA certified physician who will conduct the physical exam using templates that the VA has long designed saying if it's hypertension, gather this evidence, if it's a bad elbow, gather that evidence. When all of that is completed by the VA certified physician, in the case of D.C. probably at the VA Hospital, although it may be the physician going over to Walter Reed to do it, those are logistical matters that do not matter, I have been to the Medical Evaluation
Board at Walter Reed, they have decided I am headed for trouble and they've sent me to get a physical exam. I now have that physical exam at the Medical Evaluation Board and I send it to the Army Physical Evaluation Board. Just as in the past, that board makes a decision as to whether or not I'm fit or unfit. Here is another change. If the decision is that I'm not fit, then it's sent to VA to do the rating and DOD will accept their rating unquestioned. Sometimes that leads to the question, I always heard that the VA rates a lot higher, and the answer is, not really. We found in a sample of 12 what one of the commissions found in a sample of 33,000 and just by sheer luck they were identical, and that was that there was an 8-point difference when looking at the same condition. So if DOD and VA look at the same knee or elbow or what have you, they will come up somewhat different, VA a little bit to the high side. Fine. Who knows what's right? Who knows whether it was a 30 or a 20 or a 40 or a 50? So we will simply accept VA's and we will action it
under law on DOD's side of the fence. Remember,
DOD's side of the fence addressing only unfit
conditions and so in this case if I had
hypertension and a bad knee, it is the bad knee
that prevents your continued service, not the
hypertension, probably. That is treatable on oral
meds and so forth and so it is certainly not a
reason to be separated.

So I would leave for my bad knee 30
percent disability medically retired, and then I
would walk across the street to VA. Remember,
they did the physical exam or at least it was done
to their standards, they did the rating, and they
already have me in their system. So when I walk
across the street, within weeks, I'll say a month,
the VA says less than a month, but sure faster
than 5 months, then my VA payments will commence.
So I have done fewer pushups in the system in
terms of getting a physical exam and filling out
documents and experiencing ratings and it is fully
actionable, and it was a lot simpler for me.

That takes us through that turquoise
area and we are now over in the purple area. I went through this new experiment in D.C. I had a bad knee because of a motorcycle accident, it could have been something from the theater as well, but I will work on a Beltway motorcycle accident that compromised the knee, and I have been determined medically unfit. I have been rated by the VA at 30 percent. I have been informed now in a communication from the department that it is 30 percent disability and that I am unfit. I may quarrel with either of those facts. I might say I'm fit, in which case DOD takes care of that. Only the military services decide on fitness for the military. Clearly those are not problems of VA and couldn't be. But if it comes to the rating and I say you rated me at 30 and I believe it to be 50 because of my familiarity or someone has showed me the rating manual and I think it's 50, then VA will give one rebuttal opportunity, and it's a powerful one. While still on active duty you will, just as if it would have happened if it had occurred after
you were separated and you had a quarrel with VA,

if I am on active duty and I have a quarrel with
the rating, then there is a disability review
officer from the VA. They are high-paid talent, a
sharp group, they are very good at settling things
authoritatively and usually are successful in
remaining within the rules and so forth and good
government. But in any event, that official will
talk to me and that will decide whether or not the
rating is 30 or 40. If that official looked at it
and said I have looked at it, it's 40, DOD will
take that and run with it. Fine. Forty. Then
the person is retired at 40 percent disability.

So the system is simple. But let's take
one other complication and say I got through all
of that. I am now 40 percent retired, but I said
50 and I just don't think I really got justice.
Then I would continue after I separate to go
through VA appellate processes, appeals courts and
so forth, and if one of those decided it was 50,
then the case comes back to the secretary of the
military department in what is frankly a fairly
straightforward administrative process called the Board for Correction of Military Records and I say here's the deal, here's my packet, there's my file. I got 30, then I got 40, I thought it should be 50, and look here, an appeals court agrees with me that it should be 50. The Board for Correction of Military Records says 50 it is, fixes your record, and it's done.

So we have got this from just about any angle in a straightforward, who's responsible, who's going to say yes or no, I want to talk to an empowered individual, kind of context. So that's what we have delivered for the National Capital Region and we'll be looking at whether or not we could proliferate it.

DR. POLAND: Bill, before you leave that point, is there a double-jeopardy process within that? Might that board say it's 20?

MR. CARR: As a technical matter, yes, they could do that. As a practical matter, it virtually never happens. And that is not my lane. That is a commentary, but that's the way I would
DR. MILLER: Two questions. First of all, does that delay the separation point?

MR. CARR: No. It accelerates it.

DR. MILLER: The separation is accelerated? It looks like your diagram, the old way puts separation early in the process rating and now it is later.

MR. CARR: Do you know what I didn't say that I wish I had said? The separation point is about the same. The time to the end of that arrow which involves both system times is cut about in half, but the separation point is about the same because most of the period that was invested prior to your separation was invested in diagnosis and treatment. The administrative part rarely is the long pole in the extent except to the extent that the member would like to protract it and sometimes they do, and that's okay if that's what satisfy them that they received due process, they ask to hold off while they consult with an attorney, then that's okay too. So I would say the separation, I
have no reason to believe it would be anything other than identical, but the total system time would be cut in half.

DR. MILLER: The other question, I hope I am not answering something you already said when I was out of the room answering a page, and that is has anyone looked at 70 people with the same injury in the VA and looked at the range of their ratings?

MR. CARR: They did. What I was told, I asked that question of Tom Pamperin, the Deputy Director of Compensation and Pension Services for the VA, and they do that as a matter of routine. There are something like 58 boards around the nation. So they evaluated them and there were a couple of outliers and I can't quantify it. He qualified it as saying I was amazed at how closely they overlaid. Again that is really a question of the VA and I am parroting what a knowledgeable VA colleague shared with me, but their assertion was that if you went across New Mexico, Arizona, Phoenix, and those various rating panels that VA
was very consistent with a few oddballs.

DR. MILLER: I must say I would like to see that data before betting the ranch.

MR. CARR: That is fair enough. That one will come probably from the VA, but I can gather that from Pamperin and pass that over to the board. That's perfectly legitimate.

CPT JOHNSTON: The VA's rating system, is it compartmentalized between the various conditions that a patient has?

MR. CARR: Let me see if I've got this. Let's say for example I have an orthopedic problem and a cardiovascular problem. It would go to one physician. He may employ specialty consults and so forth. But it all ends up in a package describing templates I talked about that would describe the cardiovascular and the orthopedic. And when they went to VA for a rating, it would just be a single rating panel comparing the medical conclusion which asks for certain empirical facts against a book as an administrative determination.
If there were medical question, then it 
would go back to a physician, but for the most 
part these templates force the physician to 
respond in ways that allow an administrator to 
cross and walk to the cookbook.

RADM SMITH: But there is a percentage 
given for each separate diagnosis, if that's your 
question, if they're compensable.

CPT JOHNSON: Yes, that was it. If 
you're looking at rating it is that's being used 
to discharge the person or separate the person, 
are you only taking into account the bits of it 
that are applied to the discharging condition?

RADM SMITH: That's correct. It is only 
the unfitting condition applies on the DOD side.

MR. CARR: Let's take for example there 
was a 30 percent orthopedic and a 20 percent 
cardiovascular. We know that the template cause 
the facts to compare to the cookbook and I decided 
30 and 20. Then what that means in terms of 
rating is I am 30 percent which subtracted from 
100 is 70, plus 70 times 20 percent, round up,
that's the way it's mathematically accomplished.

DR. POLAND: Dr. Halperin?

DR. HALPERIN: I am never quite sure I
get this, so let me use this as an example. I
think you know what I'm going to ask you. I have
been in for 20 years and I have this horrendous
accident or injury and I'm 50 percent disabled. I
get 50 percent times 20 years times 2-1/2 per
year, so I get 25 percent of my regular pay. If
I've been in for 2 years and I'm 50 percent
disabled, I get 50 percent times 2 years times
2-1/2 percent, so I get 2-1/2 percent of my
regular pay for being permanently disabled for the
rest of my life?

MR. CARR: Yes. One of the provisions
we have proposed to the Hill is there be a minimum
attached to that, but, yes, that is correct.

DR. HALPERIN: The clearance of the
impediments is really very good, but in many ways
it's a short-term alleviation of the pain of going
through the system. The long-term pain is I'm 50
percent disabled, I'm 20 years old and I'm getting
2-1/2 percent.

MR. CARR: You are correct. For DOD that is the answer. But remember then I would go to VA and I would say to VA I am 70 percent because VA looked at this other stuff like cardio and VA says if you're 70 percent then you receive so many hundreds of dollars per month and that in the case of a retirement is additive.

DR. HALPERIN: If you don't mind if I follow-up on this a little bit, it is a very complex system and as a semi outsider it's -- but I thought if you were disabled, what the VA did was give you that amount of money tax free.

MR. CARR: They do.

DR. HALPERIN: They do?

MR. CARR: They do. That monthly stipend I was talking about, if I were let's say 50 percent disabled, it's going to be something like, and this figure isn't going to rock you, but it's going to be about $500 a month tax free.

DR. HALPERIN: Tax free. So a 50 percent disabled person when you combine the DOD
pension and the VA pension would be getting about $500 a month?

MR. CARR: I would have to do the math. It would be more. $500 is the VA part, but added to that would be whatever pension I was drawing from DOD for my disability retirement.

DR. HALPERIN: Which could be 2-1/2 percent.

MR. CARR: Right.

DR. HALPERIN: So it could be let's say $550 a month for somebody who is 50 percent disabled?

MR. CARR: Yes.

DR. HALPERIN: I think that for us to fully understand this system, whenever I hear this and go through the math I kind of don't really believe that I'm really understanding it.

MR. CARR: For disability, we say 50 percent and it can be tempting to say that means I'm half capable. I wish I could think of a good example of a 50 percent. It may be I think hysterectomy was roughly that. The VA if you look
at the bases for ratings, hemorrhoids, so there
are some things that are less sympathetic in terms
of capacity to earn a living. I am not talking
about quality of life. That's a whole different
ballgame. But with regard to capacity to earn a
living, we could say 50 percent, but it doesn't
mean half capable of earning. It can mean of
course that your quality of life for hysterectomy,
for example, would be affected, but when we say 50
percent, please don't jump as I did years ago to
the notion that it means you're half capable. The
person could be considerably less sympathetic.

DR. POLAND: Maybe Bill what you were
going to say is it might be nice for the board to
see a couple of logical scenarios in order to
appreciate how it really works.

DR. HALPERIN: Yes. I would appreciate
it. Good idea.

DR. POLAND: It is hard for the board to
understand. Dr. Shamoo, and then Dr. Leupker.

DR. SHAMOO: This is not a good analogy,
so this is backwards from heaven forbid in a car
accident, the younger you are the more money you get, the older you are thinking gainful number of years is smaller. So if you are 70 years old and have a car accident the average lifespan is 77, so they pay you only for 7 years, whether it's 50 percent or 20 percent, so it's backwards from liability.

MR. CARR: It is. There are actually words for this stuff.

DR. SHAMOO: Yes, I understand.

MR. CARR: I can't remember, but the lifetime earning part is short and the other one is something like -- but you're right, this is not the tort future earnings.

DR. SHAMOO: I understand. I understand. So a young man who volunteered to serve his country and he is truly 50 percent disabled, he will get less money than a 60 year old or a 66, my age who volunteered to serve his country, and we got hurt the same way, that poor young man will get way less than I would?

MR. CARR: It could be.
DR. SHAMOO: I have a second question.

MR. CARR: And we will cover that in the examples so that you can be the judge of that.

DR. SHAMOO: The separation point you have delineated here, do they get paid at the point of separation, and what do they get paid at the point of separation and what do they get paid after the disability has been determined? Could you tell me that? At the point of separation do they get money, a check?

MR. CARR: In the case that you are less than 30 percent disabled, remember, I said if you are 10 or 20 you get a severance pay lump sum, that is one answer, something like $20,000. If on the other hand you're retired, then you don't get that lump sum, you begin an annuity stream.

DR. SHAMOO: At the point of separation?

MR. CARR: At the point of separation.

DR. SHAMOO: What do they get after they are declared disabled 50 percent after all the process after the separation? Do they get additional disability payments?
MR. CARR: Before they separate they will be categorized. So let's stipulate 50 percent at the point of separation. Then in that case they would not receive a lump sum, they would begin an annuity stream. Then they would walk across to VA and they would begin an additional annuity stream.

DR. SHAMOO: After the disability has been determined?

MR. CARR: After.

DR. SHAMOO: After.

MR. CARR: Because the disability is the predicate for all of it.

DR. SHAMOO: Sure.

MR. CARR: In our example where we talked about a percent person who is separated, presumably we are talking about somebody medically separated.

DR. SHAMOO: But is there a way between the point of separation to the point of determination of disability that they get paid something as if they are disabled in order to
compensate for their loss of gainful employment and other things?

MR. CARR: I love the question, and that is going to come up at 3 o'clock. We've got a meeting with Secretary England and the Senior Oversight Council and one of the slides raises that point which we have raised from our office for a while, and that is the following. If you were to ask RAND or someone does the disability system work, then they will answer it by saying let's look at life stream earnings, and the answer is, yes, it works out. The disabled work fewer hours, but, yes, it works out. But they said lifetime earnings. It is absolutely indisputable that in the months immediately following separation you're in a whole because you will have moved from $50,000 a year to $500 a month while you're looking for a job.

DR. SHAMOO: That's right.

MR. CARR: At issue is is that satisfactory to the government or should it be satisfactory to the government. VA might not in
an appropriation context welcome that question,
but it is one DOD asks out of interest and so
forth, and I'm sure VA asks it of itself too. We
unambiguously take somebody at $50,000 or $40,000
and they move to $400 a week until they find a
job. Granted, we don't want in the case of a
relatively moderate condition --

DR. SHAMOO: No, I understand that.

MR. CARR: But it sure is the case that
you've got to come back from Germany, reintegrated
yourself in some community, go look for a job. So
in any event, that is coming up at 3 o'clock
today. I can't answer the question, but I share
precisely the point and the concern that you
expressed.

DR. POLAND: I am going to ask Colonel
Gibson to comment. Then Russ, did you have your
hand up? And then Mike and Mark.

COL GIBSON: Just a quick question for
clarification. This goes to concurrent receipt.
What you are talking about here is a person who is
let's say 22 years in service eligible to retire,
is medically retired. From what I am hearing from
you, and I know that this is issue of combat, that
person would get an annuity from the department
and an annuity from --

MR. CARR: I was jumping to the Senate
mark-up of the defense authorization. You are
quite right. When the Senate passed concurrent
receipt which means simply if you are getting
money from the VA and you are getting money from
DOD, keep them both because before that provision
was enacted you could keep either, and you would
always pick the VA amount because it was tax free.

But if the MDAA proceeds as expected, then what
are called Chapter 61 retirees, that means
disability retirees, could benefit, would benefit,
from concurrent receipt. So I answered it in that
context.

COL GIBSON: That individual, if I
understand the legislation and granted it is still
in mark-ups at this point, correct?

MR. CARR: It's not in mark-ups. It has
passed. The conference bill has been produced.
It's going back to both chambers. The likelihood of the Congress passing it approaches 100 percent. The promise of the president signing it I don't know, not for that reason, but for other reasons.

COL GIBSON: This does not have an impact on an individual who retires, goes to the VA, is found to be 40 percent disabled. That person in the way I read it is not eligible for concurrent receipt.

MR. CARR: That person is not a part of my presentation. They are not disability retirees.

COL GIBSON: And this would take away the issue of just strictly for combat medically retired, this would open it up for all folks who are DOD medically retired?

MR. CARR: I think we got too many questions collinear. With regard to a retiree, that's a longevity transaction, not disability, not medical. Granted, a retiree for longevity might pursue a claim with VA and they are welcome to. That's a separate matter which we could talk
about, but I'm not talking about it in this context. Then the second part of the question?

COL GIBSON: The question was that the legislation before made concurrent receipt possible for combat veterans, people who were disabled due to combat or training for combat. Will this new legislation open that up for noncombat medical disability?

MR. CARR: That I'm going to have to get back with you on. I frankly can't remember that aspect.

COL GIBSON: Thank you.

MR. CARR: Thank you.

DR. POLAND: Dr. Leupker?

DR. LEUPKER: When you were here a few months ago one of the questions that was raised was duration that it was taking to do this. It looks like it's been simplified, and I realize you are in pilot testing, but do you have any estimate what kind of dwell time you're likely to have if this all works as planned?

MR. CARR: There is an answer to that
and I will get back with you. What we had stipulated for the pilot is a threshold for each event. VA has 30 days to do this, and then for those metrics would then have a data plan proving it. That is knowable, answerable, and I will pass that back to the committee. It's going to be something on the order of 4 or 5 months, something like that. Most of that is spent again in medical procedures and so forth, not in administrative procedure.

   DR. POLAND: Mike?
   SPEAKER: I think Colonel Gibson approached this, but let me clarify it for myself a little bit. Is there a different between somebody whose knee injury occurred in combat versus somebody whose knee injury occurred when they were on leave and on their motorcycle?
   MR. CARR: In terms of the military disability system, no.
   SPEAKER: Thank you.
   MR. CARR: There is I will comment for traumatic injuries, loss of a limb, loss of
vision, loss of hearing, for traumatic injuries there is a special lump-sum payment. That aside, the treatment is identical.

DR. BLAZER: And that has nothing to do with combat?

MR. CARR: You are right, that does not have anything to do with combat. Let me clarify that. The traumatic, if I lost a leg whether it be in a motorcycle accident or an IED, then I would receive that amount which brings me back to the first point, the simple answer is, no, there is not a difference.

DR. POLAND: I think it was Dr. Miller, Dr. Lednar, and there was one other. Then we will need to wrap up here to move on to the next one.

DR. MILLER: Is there any differentiation between this system and mental-health disorders, or are mental-health disorders also incorporated into this?

MR. CARR: It's incorporated in this.

DR. MILLER: Posttraumatic stress
disorders and others?

MR. CARR: The administrative handling of it becomes you are faced with when will PTSD be comfortably diagnosable. So what VA does is for a claim of PTSD knowing that it's going to take some time to answer that question, they start it at 50 percent. So if I were to present with PTSD and it appeared reasonably that that could be medically possible, then VA will immediately start payments at 50 percent. I might subsequently be rated at 30 or 70, but they will start immediately at 50 because that is an ambiguous area, so they will give substantial benefit of the doubt to the affected veteran.

DR. MILLER: How about for a naturally occurring disease like multiple sclerosis, for example? How is that compensated for?

MR. CARR: If one were found unfit for a congenital disease, it falls under the same rating. There is a different rule for how long you have in service, frankly. So if I were with more than 8 years of service, then it would be as
if I just acquired it or any other injury that rated at 40 percent. If however I had fewer than 
8 years of service the MDAA seeks to make it 6 months, then it would be until it does change if I 
had less than 8 years, then it is preexisting and it's not compensable. So again at the 8 year 
point, but that 8 year point is about the slide to the left to 6 months. So it's a practical matter. 
If it's when it's discovered then it would be as compensable as a broken knee.

DR. POLAND: Dr. Lednar and then Mike.

DR. LEDNAR: Would it be fair to say that a goal of this process change is to speed up the cycle time from beginning to decision?

MR. CARR: It is to speed it up, but it's to make it transparent and friendly just about as equal imperatives.

DR. LEDNAR: So simpler and more customer friendly?

MR. CARR: Simpler, friendlier, faster, all in about equal quantity.

DR. LEDNAR: Part of the reason I'm
asking is if there are steps that you can take out of the current system if the pilot works, should the board have confidence that someone else in the department is not going to try to cash those savings, shrink the staff, and end up basically in the same position we started with?

MR. CARR: There is never a guarantee except that we would say it is something for 10 years, 12 years, the public conscience is going to be wounded on this one as is defense's for a good 10 to 20 years. So could those savings be pulled off to a tank? I don't think so because first the administrative costs are not very great. The medical costs simply stay in medical. So I don't see how you can dent things very much as a programmatic possibility.

DR. LEDNAR: The clarity of the goal of the change and keeping that right up front?

MR. CARR: Yes, sir, you are right. It is not a money saver.

DR. LEDNAR: So the solution is judged against that.
MR. CARR: Yes. In fact, a lot of times that's a wrap that comes out in the media, let's see if we can do personality disorders instead of PTSD, a whole new area. We can go there if you have a lot of time. But the notion being that we are going to try and save some money, there is no incentive like that. It doesn't exist. I have never heard of it, never felt it, never sensed it. Ask those in uniform if you're -- look, please don't give them this diagnosis, we want to get them out on the cheap, I have never met any physician military or civilian that can tell me any of that stuff exists in Earth. I don't know. If it does, say it. But I don't sense it does. So I don't think it is about saving money, never was, never is.

It is about faithful execution of what can be a government rule that looks cheap to us. So we might say for example I've looked at the cookbook and it says you lose your leg, you're 10 percent. It doesn't say that. But that's a fair hit because that's a systematic government
behavior. But to say that we would try to
diagnose this way which by the way requires a
psychiatrist or a Ph.D. or a psychologist and that
they are in collusion with us to save a few bucks,
it just can't happen.

DR. POLAND: Dr. Parkinson?

DR. PARKINSON: I recently reread Kafka.

I just got to shake my head. We have been
knocking at this for 46 minutes. People don't
know how this works.

MR. CARR: Pardon me?

DR. PARKINSON: People don't know how
this works. Have we missed the mark?

MR. CARR: I don't think so.

DR. PARKINSON: Let me just say this.
The average American does not know the distinction
between DOD and VA.

MR. CARR: Right.

DR. PARKINSON: They don't understand
any of this. In any company in America, you get
hurt on the job, off the job, there is some
process to determine disability and to pay you
promptly or recourse to do it.

MR. CARR: Right.

DR. PARKINSON: That's what they know.

MR. CARR: Right.

DR. PARKINSON: Way upstream of this, and I just don't remember in the multiple reports we've seen, in the legislative agenda of DOD and VA is there a bill or something in place that would eliminate three-quarters of that slide?

MR. CARR: Yes. The president has proposed the Dole-Shalala Bill.

DR. PARKINSON: Where is that bill and what do we need?

MR. CARR: In the hands of the Congress. It wasn't adopted.

DR. PARKINSON: I appreciate you going to one slide, but there's another whole set of slides on the other side which is the VA system when they go into the DVA, that little box down there that says oops, hop to the next slide which is the DVA claims going over there now. You know, so I'd have hoped that because we're feeling
uncomfortable with the lingo that to the average
citizen and the person of the military and their
dependents, it's still (off mike).

MR. CARR: Right.

DR. PARKINSON: And so if we can maybe,
Mr. Chairman, if we can have an update perhaps,
Roger, on this status of legislation to take out
the things that -- you're a good job, you have to
execute the statute --

MR. CARR: Um-hmm.

DR. PARKINSON: -- but the statute needs
to be changed so that as soon as I know that I'm
disabled, I can no longer serve in the Air Force,
wham. I can either have one or two things: If
the law is going to continue to say, you're belong
30 percent and you get a single check, great; or,
if I'm above 30 percent, even if that's true, then
you get a check from sustenance for the rest of
your life.

MR. CARR: Right.

DR. PARKINSON: (off mike) pride, which
is not to understand the grid, it's to change the
MR. CARR: Good. There is -- my answer is not complicated. You're right, the President proposed what Dole and Shalala suggested. What they suggested is simply this: DoD decides if you're unfit; and if you are, you immediately leave with an annuity. And VA hikes up the benefits. I can talk about how. That's what the President proposed.

By the time he proposed it, by the time Dole/Shalala finished their work, the House and the Senate had their ideas, and they chose not to go there, and I think there was some partisan considerations in there -- my opinion just as a taxpayer, not a public official. And so the Congress stayed with really the current framework, and they embellished a little bit and talked about workload management, but it didn't change the fundamentals, and the President's would have.

So if what were the legislation, Dole/Shalala, read the President's things, whitehouse.gov. It's very straightforward, and
it's very clear, it's no mystery. And the Congress chose not to do that. While anybody in the administration agrees with you, that is not what the Congress did.

DR. POLAND: Roger -- Colonel Gibson, you wanted to ask a couple of questions?

COL GIBSON: Yes, just a couple of technical questions. Where are the -- for this pilot, where are the VA physicals being done, at VA or in DoD facilities?

MR. CARR: I've got to ask Dr. Cassells or one of the health affairs colleagues. Karen, do you know?

LTC FAVRET: All that --

COL GIBSON: Use the mike.

MR. CARR: It varies. It's going to be by VA protocols, but HA, that's their line and they're still working that out, Health Care.

LTC FAVRET: But we decided for the -- because you needed a VA certified provider to actually do these exams, the only ones in the area that we have right now are at the VA Medical
Center. So anybody who is capable of being transported -- I mean, we're not taking inpatient folks and bringing them down to the VA Medical Center, but they are able to schedule the exams at multiple providers in one day.

So we think it may shorten it because we have access to these certified examiners. At least here this may be false, but we at least get an idea that we can use the VA exam, and it is more equitable. That, to me, if you're going to take away something, each member will have an equitable exam. What we saw was different ones, and so the VA has the worksheets. The VA is going to do these at the Medical Center. They're going to do review of medical records for people who cannot be transported and give them their rating.

MR. CARR: Goods. And as Karen would say, well, that's the case for D.C., when we go to another little site, it's a whole new ball game, might be done at DoDMTF.

LTC FAVRET: We have --

MR. CARR: But for DoD for D.C. that's
COL GIBSON: Very quick follow-on question. MEBs are making narrative sums up to make their decision on fit or not fit. Is that information being forwarded to VA, and is it part of their decision process?

MR. CARR: No.

LTC FAVRET: What is being boarded to the VA is the -- is a referral, which is pretty consistent with the normal narrative summary that most docs write.

Once the referral goes with all the conditions that the doc thinks, and a basic medical history and the complete medical record, the VA will have a copy of the complete medical record. Every member will get a general medical exam, and then whatever the claim conditions are, it's specified in --

MR. CARR: Let's be clear about one term.

LTC FAVRET: And that --

MR. CARR: You used the term "narrative
summary." It has a distinct meaning.

LTC FAVRET: Right.

COL GIBSON: Purposely.

MR. CARR: It is that which happens at the end of the MEB.

LTC FAVRET: Right.

MR. CARR: Now, we don't know what should be in that summary until the physical, therefore your question is, does the "nar sum" go to the VA doctor? It cannot, because it has to be written after that.

LTC FAVRET: Right. So there's a terminology that we did site about initial Navy term of "nar sum" will be called a referral across the Services, and the narrative summary which will be the final evaluation of all the records, they may agree with the VA, they may not, but here's the provider, referring provider, to the MEB who will write the narrative summary.

COL GIBSON: I asked that narrative sum purposely, and thank you very much for the answer.

DR. POLAND: Okay, I'm going to end.
We're about a half hour over, but I think it reflects the importance of the issue.

Thanks again, Mr. Carr, you're very patient with our questions. The Board, obviously, remains very interested in how DoD and the VA are working to make the disability system more in line with the needs of our service member. Please engage with us in any area where you think we can help, and I'd also say that we'll plan on inviting you for yet another update at our April meeting, particularly to see if we can look at some of the scenarios of the legislative issues and any results of the pilot that might be available by then. So thank you very much.

Okay, the next part of our meeting will be on the Psychological Health External Advisory Committee Report. Our speaker will be Lt. Colonel James -- is it Favret? Favret. He will brief us on their information. You can look under tab 4 for his information.

LTC FAVRET: Thank you and good afternoon. I would also, should like to just give
a -- rather than go through slide by slide -- to
give a synopsis, if that would be preferable,
given the time?

DR. POLAND: That's fine.

LTC FAVRET: Okay, very good. Just is
102 -- this is an informational briefing. I've
been working on the Red Cell, which is a team of
folks put together to work Live Action 2, which is
working traumatic brain injury and PGSD, which we
extended out to the broader psychological health.
And this briefing was just to inform you of two
conferences that were held in the fall on some
topics, specific topics that are recommended by
the DoD Mental Health Task Force.

One was on women's psychological health
needs and there was a recommendation from Task
Force to do certain things with regard to
addressing women's psychological health needs in
DoD and VA. And the other was a recommendation
from the Task Force that we look across DoD at
imbedding psychological providers into operational
units as a way to make our services more
accessible and to decrease stigma.

So real quickly, you can look at your slides. The COFT reports are included in your information. Both these conferences are brought together, subject matter experts, essentially with the women's psychological health issues. The thrust of the recommendations were that the DoD and the VA try to discern where are women's psychological health needs different than men?

And, specifically, with combat trauma, with sexual assault trauma, with treatment, with surveillance, do we need to consider -- we do need to consider and look at how do we best serve women and where their needs and issues and concerns are different from men, and is there a better way to do it?

When we develop things such as the battle mind program that the Army put together to foster resilience in soldiers, are we including women in those scenarios to try to address their issues and needs?

There was also a portion of that conference that dealt with two issues where the
preponderance of victims are women, and that is
domestic violence and sexual assault. A few years
ago you may be aware that DoD offered restricted
reporting to victims of sexual assault as a means
to enable them to seek treatment and care without
having to trigger an investigation. So further
assessment and evaluation of how we're dealing
with restrictive reporting, and how effective is
it getting folks into treatment and care sooner,
and having more victims get the help that they
need?

The other area that I mentioned, it was
a separate conference at looking at imbedding
mental health providers into line units. And,
essentially, what they found is that each of the
Services have -- are doing this to a limited
extent, and it seems to be effective. But each
Service is different in how they're configured and
how they deploy, so what the Conference tried to
do is look at sort of the commonalities and the
needs of, you know, how does it make sense to try
to imbed mental health providers? How does it
make it work for commanders and for troops and so forth? And again, I would refer you to the conference report for specific recommendations and highlights from those conferences.

And I will entertain any questions that you have. Sorry so brief, but I do want to try to get you heading back to getting on time, if possible.

DR. POLAND: Questions or comments from the Board?

DR. BLAZER: Dr. Blazer. Just one comment. If you do rev up the imbedding of individuals into combat forces, it seems to me that that's something that would lend itself very well to documenting what the effectiveness of that is. I just would hope that an effectiveness evaluation mode is put into that.

LTC FAVRET: Yes, sir, thank you.

COL GIBSON: This is Colonel Gibson. I would add again, we do -- we have stood up to subcommittees that are going to be working very closely with the Center of Excellence on doing
exactly the types of recommendations that Dr. Blazer has mentioned. We also have two members of that subcommittee sitting right beside me here, so --

LTC FAVRET: Thank you.

COL GIBSON: -- that’s basically what I add at this time.

LTC FAVRET: Yeah, there’s a strong push in the Mental Health Task Force recommendations for using evidence-based treatment, and I think with the Center of Excellence is going to help us so each Service isn't just going out doing whatever they think is going to work that, especially when it comes to assessment and treatment for psychological needs, we use things based on good research evidence.

DR. POLAND: Very good. Thank you very much.

LTC FAVRET: Thank you very much.

DR. POLAND: Just to let everybody know that I've approved the establishment of the Board Psychological Health External Advisory Committee,
and I understand from Colonel Gibson that
candidates to serve on the subcommittee have been
identified, and they'll be forwarded for
nomination in the next few weeks.

Okay, our next speakers are Ms. Kathy
Helmick and Ms. Hollman. They'll present
information on the new subcommittee traumatic
brain injury family caregivers panel, and
information on their presentation is under tab 5.

MS. HELMICK: Thank you. Good afternoon
to the Board. I wanted to give you a quick brief
on a new initiative called the Traumatic Brain
Injury Family Caregiver Panel. The creation of
the TBI Family Caregiver Panel came about in
December 2006 when Congress addressed the needs of
current former armed service members and their
families. They passed the National Defense
Authorization Act which was an unfunded mandate
given to MRMC up at Fort Detrick, and therefore
given to the Defense and Veterans Brain Injury
Center, DVBIC, whom I represent today.

This mandate was given to us in April
2007. Of note is that this congressional mandate originally went to uses and was transferred over due to DVBIC's expertise in the spring of 2007. The funding for this project came through in September 2007, and staff was hired to begin the project.

What does the law really say? It's an establishment of a 15-minute member panel, and this panel should develop a coordinated, uniform, consistent training curricula to be used in training family members in the provision of care and assistance of members and former members of the Armed Forces with traumatic brain injury. So this was Congress' response to allow family members to get clear criteria and guidance to help support them as patients go through the recovery trajectory.

The law stipulates that these 15 panelist members should come from certain categories, and some of these have listed below medical professionals that specialize in traumatic brain injury as well as combat PBI, including
psychologists with expertise in the mental health arena. Family caregivers and representatives of family caregivers or Family Caregivers Associations, DoD and DVA, health and medical personnel with expertise, as well as experts in training criteria -- training curriculum. Finally, family members of members of the Armed Forces.

The panel members are appointed after receiving the DoD and White House approval. Certain tasks of this panel group are to review the literature and evidence for curricula content. They'll develop consistent curricula for TBI caregiver education and recommend dissemination modalities throughout the DoD and VA. So, basically, this panel will assemble, give guidance for development of curricula, and also give guidance in terms of how this curricula can be disseminated to get to the stakeholders, which are families and patients.

The panel selection. How this came about was that panel nominees which we forwarded
to you all were selected via the following methods. We have established the DVBIC network within the TBI field. DVBIC has been around for 15 years and we have a long established collaboration with many federal and civilian agencies.

The panelists were also selected based on the guidelines that I just outlined in the law, at least those five sectors that were represented, as well as geographical representation. We prepared the slate of panel nominees that included ex officio members, expert consultants and contingency members. The nominee slate was forwarded for review on 26 October, and currently the nomination package is at Health Affairs' front office for SIC.

There are two scheduled panelist meetings that are planned. The first one's coming right up within a month 9-10-January, 2008, in Silver Spring. This will be the coordinated meeting to get the work started as well as to discuss the curricula contents.
The second meeting is anticipated during your board meeting in April out at Washington state, and that meeting is slated to present to you at that time the pilot curricula. So about four months to get this curricula planned and be ready to be disseminated.

DVBIC's role at this project is to provide programmatic and logistical support to ensure that the development of the criteria is along with congressional language as well as the content validity and accuracy, and then a very important implementation phase so we get the product out there. Part of the implementation will be evaluation of the curricula and to see what needs to be tweaked, to see what needs to be added so that it compliments the caregiver experience after traumatic brain injury.

The education, the ongoing effort of this family education panel and further education directives will be through the DoD Center of Excellence for Psychological Health and Traumatic Brain Injury.
Currently, activity as we're gearing up to the panel meeting in about four weeks, work is being done to identify health education writers and editors as well as research organizations that specialize in qualitative focus-group type research, family care organizations with curricula experience. And we are in the throes of the logistical work that it takes to assemble folks from around the country to get together and begin their group work.

The benefits of a consistent curricula is exactly that: It provides consistent constant message. The curricula also gives tools for coping and gaining acceptance and assistance as well as giving hope on navigating life posttraumatic brain injury. The curriculum will be informative and accurate, provide self-management skills, be user friendly and culturally appropriate.

Questions?

DR. POLAND: Colonel Gibson?

COL GIBSON: I have a few comments to
add to this that will help clarify for the board members what does this have to do with us.

    If you look carefully at the slide of the members that Congress said had to be on this panel, there are nonfederal folks on there. That, by definition, makes it a federal advisory committee. We went, after discussing this with Dr. Poland, we went to the DoD lawyers and said, Can we make this a subcommittee of the Defense Health Board as a panel?

    After due deliberation, the lawyers came back and said, yes, we can, similar to what we did with mental health and the past, present, and future military health care, and the IRG. This is a subcommittee of the Defense Health Board as soon as Dr. Poland says it can be. DoD says and wants it to be. It's up to Dr. Poland as the president of the Board to say, Yes, that's okay.

    What we have done is through DVBIC come up with the nominees, the candidates for nomination. Dr. Cassells is the only one who can nominate, formally nominate to the Secretary of
Defense those panel members where that package is forwarded to him for his signature, and we are hoping desperately to have everything signed out and these members appointed for this January meeting so they can go to work.

Final piece to this is once this panel delivers that set of recommendations, and, hopefully, that'll be in April, we will then turn over the oversight of that execution, including pilot tests, et cetera, to the TBI External Advisory Committee for long-term follow up.

As you all know, there's no such thing as a final curricula. They are iterative products, and it's going to have to have care and feeding for a long, long time.

DR. POLAND: Thank you, Roger, for that introduction and, obviously, I've agreed to the creation of it. But awful, I think, important for the Board and others to understand that increasingly we'll be doing business this way, given the breadth and the depth to which each of these panels and subcommittees will have to go,
and we'll begin to function more as the Defense Science Board, for example, functions in a very similar way.

So any comments or questions about this? I'll just make one, and I think you answered it when you talked about DVBIC. And it harkens back to Dr. Blazer's question of valuation of the effectiveness in this case of the curricula. And I think I heard you say that they'll actually be responsible for that aspect of it, and it will occur.

MS. HELMICK: That's correct, and that will occur of the focus groups using qualitative research techniques to evaluate the curricula and make recommendations for edits.

DR. POLAND: Dr. Lednar?

DR. CLEMENTS: I guess a question I have about the curricula and its goals, if the goal of the curricula is to convey information that helps caregivers of service member and the PBI understand, that sort of sounds like an informational goal.
If the goal of the curricula is to help the PBI service member and their family, it feels like there would be different activities involved. Well, there's a tool kit to know that you need this, that, and some other resource. If you live in a remote area, you have no transportation, and, by the way. your family cash flow is $35 per week, how is this going to help?

So I guess when it comes to evaluating the curricula, it seems very important to say what is the goal and evaluate to that. But I hope that in the end this will be something that brings a level of understanding, perhaps in a separate pilot, to caregivers, and I mean health care providers to community members, others around not just the family who lives with this every day and probably has quite a large and deep understanding of what it means PBI.

MS. HELMICK: I think it's important to note that the stakeholders are all over the country, so we do have to remember our guard reserve, everybody that are in rural- type areas,
underserved areas, and connect them via this curricula, be looking at the clinical services needed to facilitate recovery as well as those supportive services, the nontangible clinical services that look at supporting family, community resources, vet centers, those other types of things that can help with caregiver fatigue and compassion fatigue as well.

So making sure that we understand all the stakeholders in this endeavor is going to be extremely important.

DR. CLEMENTS: Just a short follow-up question, and then there would be some other evaluation, see if the care for the TBI patient and caregivers is, you know, are utilizing these various resources and this is being helpful.

MS. HELMICK: Yes. The evaluation piece can be twofold: one is to ensure that is there a difference in the care, the type of outcomes that we have from severe and penetrating TBI patients now in 2007 prior to any type of home curricula. So you can compare it that way and as well as to
make sure that it's effective for the care -- for
the family members.

DR. POLAND: Wayne, I think, too, at
least the first part of your question will
actually be under the purview of the TBI External
Advisory Committee and not so much this one.

Other comments? Dr. Parkinson?

DR. PARKINSON: Yeah, it -- first, I
think it's a great effort, obviously. What
cconcerns me a little bit, and I hope just in terms
of our advisory capacity here, that the term TBI,
as we know from a clinical, pathological,
definitional challenge, there's a spectrum in
there and that, as you go forward, clearly people
who represent certain types of flavors of TBI
versus other might need different type of
services. So knowing which type of support to
provide in one instance versus another is going to
be important, and that'll, you know, spread it out
with enough granularity that you're able to do
that. And I'm sure you will.

My second thing gets really to Wayne. I
mean, as a veteran of building and funding many curriculum development in the federal government, as you know, it's rife to go nowhere fast unless you very clearly articulate it -- and it was great the way you said it -- is that what's the skill set I want out of the other end of this thing, and how do I initiate those skills, and how do I sustain those skills?

And what we're learning about behavior change, because this is really about initiation and sustaining new and fatiguing behaviors on the family caregiver, is you need support. You need coaches, you need peers, you need virtual, you need electronics, so I would urge the group to look very early on if not it defines the objective, the creation of meaningful peer-to-peer support so that you use it in advance of going back to wherever you people live with their loved one, so that you already have it in place: You know the people, you know how to log onto the web, you know community chat rooms, you know expert counsel.
I mean, it's all available. There are private sector vendors who are building these out today in such areas as prevention and wellness, disease management, stress, and look right now at what is best to be practices in the civilian sector similar to our first panel who talked about we're not doing enough in the civilian sector about creating communities of support because whatever you learn in the curriculum will not be sustained unless you build in that community support, and kind of said it, but I just wanted to put an exclamation point behind it, because that's going to be very important, and at least some of us will be looking for that coming forward when we meet in April. I think it will be important.

MS. HELMICK: Thank you.

DR. POLAND: Okay, thank you very much. We're going to take a 15- minute break, and we'll reconvene at 3 o'clock. Just so you have an accurate agenda here, we'll talk about emergency blood transfusions, and then Colonel Hachey will talk about pandemic influenza. So we're going to
take the last part of tomorrow and move it to the
last part of today.

(Recess)

DR. POLAND: We're running about 20, 25
minutes behind, so I want to keep us moving.

Our next speaker is our own Dr. David
Walker from the Department of Pathology,
University of Texas, Medical Branch, Galveston.

Dr. Walker is the Chair of the Board's
subcommittee addressing the question regarding
emergency blood transfusions in the combat
environment. And Dr. Walker will lead discussions
on the subcommittee's findings and
recommendations. His slides are under tab 6.

David.

SPEAKER: Hold on just a second. Turn
on his mike.

DR. WALKER: So one of the questions
besides the use of whole blood was the impact of
this practice on the policies now for HIV testing.
And so the 5FOE of combat operations have resulted
in instances of blood collection under emergency
protocol and transfusion without complete
FDA-approved testing. That is, the aligning up
donors taking the blood and using it without being
able to test them for HIV, HCV, and hepatitis B.

And so we were asked to review the
issues associated with the collection and
transfusion of the blood products under emergency
conditions in a combat environment and to provide
comments and recommendations regarding optimal
strategies to minimize risks to the recipients.

So most of the transfusions that are
given in Iraq and Afghanistan and theater come
through a single blood trans-shipment center, and
the center is the control point providing the
blood and blood products in the area of
responsibility, and they really have a pretty good
coverage of being able to get the blood there
twice a week of over 1,000 units. And it only
meets their routine needs, but there have been --
I'm going to give you some more information about
the number of times that they were given the
transfusions. There's more up-to-date data.
But under the emergency conditions, they are sometimes being given with HIV test, this rapid test, but it's not FDA-approved for blood donation. And some donors are prescreened, that is to say the blood samples of their blood is sent to the United States for testing before blood products are given, so the serum can tell them whether they've got hepatitis C or HIV in some instances but not most of the time.

So this is a picture of the order of magnitude. This is a number of whole bloods, that is blood collected fresh and transfused there in Iraq and Afghanistan. And you can see that it ramped up and peaked in 2006, although this year isn't over, and this year it could well go above last year.

And this is the number of patients, so what we're talking about, usually here is the setting of massive transfusion, which is defined as ten or more units over a period of 24 hours. And so you've got a lot of blood going into a few hundred patients. So when service members come in
because the public law and the Department of Defense requirement, they really -- they have their blood drawn, their serum drawn, and there was no testing required but most of them really are tested for HIV. And the sample is collected within any year of deployment by regulation. So they're routinely tested, and I think that's about Ira Howar recommendations every two years, but not -- routinely tested for HIV, but not tested for hepatitis C.

They are screened for hepatitis B virus, immune status, and immunized when they come in, so hepatitis B really should not be a problem.

So there are two scenarios where emergency whole blood transfusions occur. One of the mass casualty events where local blood and blood products supply is exhausted and the state of the art that most people practice is that if you've got a massive transfusion need, you use (off mike) red blood cells, fresh frozen plasma, and that's the ones in which the factored are still at high enough level that they're not below
the level that you need for coagulation. And you
would like to also give platelets, but getting
platelets is a problem in the field because of the
distance of transport and from the time it's
collected.

So the other setting -- so that one, you
know, you can image there's not much you can do
about that. There's no blood, and so you have to
draw it and use it or the patient dies.

The others are situations of mass severe
trauma in which people are getting large number of
transfusions, and the surgeon believes kind of
almost on a mystical basis that fresh whole blood
is better, that the patients are going to do
better. And there's really not strong evidence to
support that this enhances survival.

So the dilemma is that the Department of
Defense has got to provide a safe blood supply,
and there are going to be situations in which
safe, absolutely safe is not attainable, and so
while we can reduce the risks and that's our
charge, we may never be able to get to completely
safe.

And we've got to provide the best care to the soldiers for this often incredibly severe trauma. And, historically, the military and wartime has given ups opportunities to learn new things about how to take care of wounds and to make things that actually translates into civilian -- better care of civilians as well.

A problem that we wrestle with, and I don't have the knowledge to deal with this -- hopefully, as a group we can come up with the right answers -- is that it's hard to collect data under the situation in which you're doing something in an emergency setting, all you can as fast as you can, and trying to keep up. And, of course, that would be the way progress would really be made would be scientifically to have the data and be able to analyze it. And we believe that we really ought to have valid evidence of benefit before subjecting patients to untested blood products risks.

So there are our tentative
recommendations, and they're certainly open to
discussion and change, strengthening or
modification. We recommend that we should limit
emergency blood transfusion protocols, instances
such as mass casualty events where the available
FDA-licensed blood and blood products are
exhausted.

And we also recommend that predeployment
hepatitis C virus testing should be done to reduce
the risk of blood transfusion-related infections,
so the persons will know whether their hepatitis C
virus infected or not and pose a risk if they
donate the blood. And this will reduce hepatitis
C risk in emergency transfusion cases, but we have
to think about the further implications of this
and that it can actually cause the loss of some
soldiers who may not have been in the Service long
enough to where they can be, actually, dismissed
from the Service because they've only between in
six months or less. And this is found to exist.
And there are other second and third order
implications which those of you who understand and
know these can bring them up, and we can discuss
as we consider the recommendation of this
hepatitis C virus testing.

We also recommend that we review the
current area of responsibility there in Iraq and
Afghanistan of the blood supply logistic system.
We believe that a more agile system is required
that's able to meet mass casualty event needs.
And we have stated that we wish to further
investigate establishing blood collection and
processing capability forward in the theater.

As a person who practices medicine in a
resource-limited location, limited by state amount
of funding, we have to decide what we're going to
do and not do all the time. And although it's
going to cost $10 million to set up a blood
processing center, I was quite willing to (off
mike) we can't do it. But luckily, we had some
people there who understand what we're really
doing is giving advice to the Department of
Defense, and I think that's probably not the best
advice. Thankfully, John Clements pointed that
out to us in a teleconference, and we may want to
further strengthen that recommendation.

We also should review the current HIV
interval and predeployment testing policy. The
AFED had recommended every two years based on the
assumption that there would be rare use of a
walking blood bank; but that assumption is really
not valid now, and so we need to consider what to
do. And I would recommend predeployment testing
of all of the blood, testing of all these soldiers
yearly.

We also recommend that we repeat the
Department of Defense hepatitis C virus sero
incidence study. This is a study that shows not
only that there is a low prevalence of infection
with hepatitis C virus in the military but the
incidence, that is, the number of new cases that
occur over each one-year period is very low. And,
but it's been a while since that was performed,
and -- I think it was 2001, so it's been about six
years, seven years -- and so we recommend that
that be repeated to find out exactly what's the
situation now.

We also believe that the Department of Defense should partner with industry to develop new FDA-licensed rapid testing. It's a lot of money put into research. This is something that we should really try to push to see that it happens. HIV rapid test with acceptable sensitivity and specificity exists for FDA -- for testing patients for diagnosis, but not approved for blood collection. So there is one that might be evaluated.

And then the development of rapid hepatitis C, hepatitis B testing is needed. And I think this is something that's going to really turn out to be needed, for example, in a domestic mass casualty event where you don't have time to collect a lot of blood, send it off, get it tested and 24/48 hours later get the answers back as to whether the blood is safe or not.

We also recommend that that comprehensive look-back program so that those patients who have received transfusions that turn
out after the blood is sent to -- the donor sero is sent to the United States and it's found to be infected to find out what happens to the recipient. Did they become infected or not?

So just to reiterate that we believe that the use of untested fresh whole blood and blood products outside the established human subjects protected trauma protocol should be discontinued. It would be good if this novel trauma treatment approach could be evaluated under human subjects approved protocol even in a combat environment and perhaps a joint theater trauma team could lead the effort to improve data collection and evidence for these methods, particularly relating to the use of fresh whole blood and platelets.

So that's the end of our tentative presentation. We've got a draft of recommendations, but they're stated pretty clearly here, and I think we'll take your advice before we come back to you with a final --

DR. POLAND: Thank you, David, that was
a very nice look at this issue. Dr. Shamoo, you had question, and then Dr. Parkinson.

DR. SHAMOO: I don't have a question, I have a clarification, David. When blood is exhausted, we inherently said it's okay, the blood supply is exhausted. But the recommendation is we have to abandon it completely, which I think is inconsistent with the consensus we reached, that is, you're right when the blood is exhausted -- I mean not exhausted, is available. However what we commended which was a little different, and that is we suggest that even when the blood supply is exhausted that they do these, if possible, if humanly possible, under an approved protocol, so we could collect the data, see if there is evidence.

So I think that this is slightly different than the way the slide shows, that's all.

DR. WALKER: You're right. I agree.

DR. POLAND: Dr. Parkinson?

DR. PARKINSON: Thank you, David. It
would help me clarify in my mind of -- and again
not being in the theater and not being a surgeon,
and those are both variables -- other physicians,
because ultimately the surgeon is there and
responsible -- of the 5,000 instances that we're
roughly aware of, do we have even a qualitative
estimate of what proportion fits into what I would
define as three buckets. In other words, are we
answering the right question?

The first is, what proportion of the
5,000 was due to the fact that it was a true
shortage of blood products, to Dr. Shamoo's first
point?

The second proportion is, what
proportion of the 5,000 was due to the logistical
administrative challenges? Even if I had the
products, is there a value seen in the rapidity
with which you can administer that vice whole
blood. So, a) I don't have it at all; b) I've got
the components or whatever the things I'd like to
do, you know, so that's another instance that I
could essentially see of the 5,000.
And the third is kind of the surgeon sense of when I just have a gut feeling that whole blood's going to be better. So if we could parse those three out, then I think we can get into whether it's the randomized controlled trial of whole blood right on the spot versus everything else, which is the third category versus the second, which is just -- it's just kind of clunky to having to do the components, and I've got somebody with multiple trauma, you know, multiple limb injuries where it's just not there.

So is there any, in your analysis as you looked at this, was there any way to break out those 5,000 instances into some typology like that?

DR. WALKER: There was a lot of them given in Baghdad. A lot of these transfusions were given in Baghdad, and so that doesn't mean for sure that they have run out of blood, but it's much less likely that they would have run out of blood than when it was done in a more remote location.
So I think a good proportion of these are the surgeon's belief that the blood is better.

DR. PARKINSON: And if I can follow-up on that, have we got any opportunity to get -- and this almost sounds like an oxymoron -- a focus group of surgeons together to discuss this issue in gathering data, which is somewhat qualitative but, in other words, say why do we feel this way, guys? I mean -- or gals or whatever. I don't know.

SPEAKER: We did that.

DR. WALKER: I got my E.R. director and sat him down and talked to him about it, and he had heard these presentations by these people, and he was not convinced. And he's one of those real cut-and-slash guys. I mean I think he could have gone either way. but he was -- he did not believe that the data supported -- it was just hand-waving.

What were your other questions? You were asking --

COL GIBSON: The focus group exists, a
joint theater trauma team. They're the ones who've been advocates for this approach. They have, taking their data which is spotty, as you could full attest, you know, try to do this in a combat environment, and, as Dr. Walker says, they've presented it in various forum. And they -- the trauma surgeon community is not yet convinced that this is the right way to do.

We're not saying, as you know, that combat casualties has led to major paradigm shifts in trauma care across the United States, historically, for years and years and years. What I'm saying, this isn't, you know, the right way to go; it's just that there's not enough evidence yet, and we need to collect the data correctly so they can validate it.

DR. POLAND: Dr. Oxman?

DR. OXMAN: Two questions. First of all, if you had predeployment data, are we convinced that it would be available when in a urgent situation volunteers were asked to give blood? In other words, would it be available,
would the data be available, reliably in the field
if we knew somebody was HCV-positive before they
were deployed?

COL GIBSON: I was the one who was
supposed to talk about third -- second and third
order of facts of these data collections. That's
part of it.

If we do this very close to deployment,
given the sensitivity specificity of the available
tests and all the other information, it's very
likely that we're going to be calling people back
that are already in Iraq to find out -- to get
them retested to find out what their test results
were because there's still some question on those
data, on the -- with respect to that test.

We have to have a system in place to
notify that individual of his status so that he
doesn't come forward to donate. We have to have
some sort of logistics system to make that data
available in theater in case they do come forward.

We have to consider the second order of
facts of what happens according to the study that
we did on sero incidents and prevalence of HCV in
the military community back in 2001. And, Bob,
correct me if I'm wrong, if something like 80
percent of those folks who are positive are over
30 years of age, you've got a cohort issue here to
deal with that would impact the reserve community
in greater -- to a greater extent than the typical
active-duty community. What does that do to their
military retention? I'm not sure, but it's very
-- it's possible that they may no be able to
remain on reserve status with an HCV-positive
test. I'm not sure.

Certainly, the young airmen -- or,
excuse me -- young soldier who's in that EPTS
window, who is identified as HCV-positive is
disqualified for military service.

SPEAKER: He is.

DR. OXMAN: The other half of that, if
it were decided to do it, the DoD already has
superb, rapid turnaround PCR, which is the, you
know, done right is more sensitive than the
serologic tests for HCV, and certainly at least as
sensitive for done right for HIV. And that could be utilized routinely predeployment.

SPEAKER: Right.

COL McRAE: This is Colonel McRae, Internal Medicine consultant of the Army. Just to complete the thought about the study that was published in 2001, actually it was based on data on service members who were on active duty or in the Reserves in 1997. And that data suggested that of the cases 85 percent would actually be age 35 and older, and that's what led to the policy, DoD's policy not to do forthright screening but to offer screening to service members age 35 and older who were separating from the Service.

Just thinking about the implications, if those prevalences hold true today, it would -- and again you sense the age group skews a little bit older in the Reserve components, it would have a little bit more impact on the Reserves. But we were thinking you're talking age 35 and older, those are your senior NCOs and officers that would be predominantly affected, 85 percent of them.
Now, whether that's true 10 years later I don't know, but I don't have any reason to think it would be that much different, but who knows? I mean, the study does need to be repeated.

But thinking through the implications of this screening, it's interesting because I think this would be the only screening program that we would do if we were to do it. That would actually not be done to protect the individual but his potential implications to transmit it, and so there's some personal implications to the, you know, what do we do with that soldier? You would need a workup.

Right now, hepatitis C positivity, per se, is not -- it does not preclude you from staying on active duty, and we don't screen soldiers for hepatitis C upon accession. It's not an accession requirement. So one would think that one might, you know, think about starting a program of HCV screening that would mimic or parallel the HIV program. That would make -- that would have some appeal to that since we've trod
the ground. But again, I think that the
philosophy would be a little but different than
the HIV program in the sense that it's done to
protect the individual as much as it is to
protect those who might come in contact with it.

COL GARDNER: A couple of questions. Is
there any policy that, when urgent transfusion is
done in the field that the blood is retro- --
samples retrospectively saved, or not ret -- saved
for subsequent testing, and what have we found of
that?

DR. WALKER: Yeah, the blood is -- the
blood is sent back to the United States and
tested.

COL GARDNER: And have they found --

DR. WALKER: They have found that they
transfused HIV-positive blood on at least one
occasion, and hepatitis C-infected blood on about
six occasions. It doesn't have to be only
transfusion, I mean it is actually transmissions.

COL GARDNER: If that were done rapidly
-- if that were done rapidly, it seems to me you
could treat almost the HIV like a needle stick or hepatitis B with immunoglobulin. There's some things you would do acutely, therapeutically, for a recipient of blood that received either of those, so I think that -- that should become a policy part of the protocol that a rapidly -- a rapid assessment be done on all the blood that is given in the field.

I can't imagine, it seems to me we have to be sure, as sure as we can, that this blood is free of HIV, hep B, and hep C. And so it seems to me a policy needs to be established. I would hope that everybody who goes to the field would be willing to volunteer to be a donor under certain circumstances. And that, if they're going to be on the volunteer list, they would get a -- they would get their blood tested before they were allowed to actually transfuse acutely. That might be a way out, but I think that's the only policy I can look at that would really stand up under the glare of scrutiny.

COL GIBSON: Let me add to that. If all
of them are volunteers, then you've effectively put in a policy for HCV and HIV testing. We looked at one of the concepts of this whole thing was, can you establish a cohort, a smaller cohort of volunteers? The problem is small units, geographically separated, moving around, when you need it -- they may not need in location where you can use them.

SPEAKER: It's not so --

COL GARDNER: I thought maybe you could clarify for me, Roger, I thought you said that if an accession for someone to have the hep C positive in the first few months, they were not allowed to join the Service. But didn't I hear over here that -- I thought I heard something different over here.

COL GIBSON: But we do not test for hepatitis C or hepatitis in general as part of entrance into the military; however, if an individual has hepatitis within the six months of active duty, then that individual has to be -- it is conceived that he had hepatitis before -- it
existed prior to service, and then he's
disqualified from serving.

The rub comes in, the Catch 22 comes in
in the fact that we do blood collection. A lot of
our blood is collected that we use in various
locations at our basic training centers. They're
encouraged to donate blood. They get about, oh,
what, two or three hours off of downtime. They
get cookies and orange juice, so they go over and
they donate, and then they find out that they're
hepatitis C positive, and --

COL GARDNER: You're screwed.

COL GIBSON: -- you know, two weeks
later they're out of the military.

COL GARDNER: But they don't get the
choice with HIV, right?

DR. McNEILL: No, that's right.

COL GIBSON: I'm sorry, say again?

COL GARDNER: For HIV it happens
automatically.

COL GIBSON: HIV is a disqualifying --

COL GARDNER: And for hep B, I thought.
It's a --

COL GIBSON: Hepatitis B is not a disqualifying factor. We deal --

COL GARDNER: Even if --

COL GIBSON: -- screening and immunized for hepatitis B at training centers.

COL GARDNER: What if someone is actually antigen, E-antigen positive for hepatitis E?


COL GARDNER: Yeah.

COL GIBSON: So if he's hepatitis B antigen-positive, I believe -- I'd have to doublecheck -- but I believe that he's then disqualified for Service.

COL GARDNER: No, I don't think so.

COL GIBSON: So what we're testing for, though, is antibodies. We don't test for antigen. And we immunize based on antibodies.

SPEAKER: Surface antibodies.

COL GIBSON: Surface antibodies.
DR. POLAND: Screening not for infection but for the presence of immunity to know whether to give vaccine.

Okay, Dr. Clements, and then there's some others after that.

DR. CLEMENTS: Dr. Clements. So we're really dealing with kind of multiple issues here, and you've got the blood supply that comes in twice a week from Qatar, that's safe. That's fully screened. That goes into the level 3 trauma units. It goes into Baghdad, it goes into Balad. You got the level 2 trauma units, the level 2 units out, and your battalion aid stations, they don't have -- they have some blood on hand that's been screened, but in a mass casualty they're going to go through that very, very quickly. And then, so they may have to turn around and start bleeding the troops in order to get that.

But the troops that are back at level 3 are the troops that give -- evacuated back to level 3 units, there's usually blood back there. And when there's not blood back there, then
sometimes they've actually set up their own little walking blood supply so they have volunteers. So in case of a mass casualty event, then they know who they can bleed, and they can process it.

The problem is that that blood is not screened for infectious diseases either. They take samples of that, and they send that back to CONVUS, and it may or may not be screened, or if it is, it's going to be screened after the fact, and that information may never catch up with the individual that got the transfusion.

So one of our recommendations was actually to establish a regular blood center in theater. You could put that in Balad, you could put that in Baghdad, and at least when you have a local blood supply, you'd have access to all of the FDA-approved processes and procedures that would ensure that.

And also, speaking as an old Marine supply officer, I'll tell you that the closer you are to the pointy end of the spear with your logistics, the better off you are, so that you
have a real possibility, then, because if you had
pack cells and whole frozen, fresh material on
hand in Balad or on hand in Baghdad, you're only
30 minutes to 45 minutes away from a level 2
station. So you can do something to effect that
supply if those are a presence in theater.

So one of our recommendations is to
establish a blood center in theater, and that was
the comment that David made earlier. My
recommendation was, though, that we change the
language, because the languages we have at right
analysis further investigate establishing a blood
collection and processing capability forward. I
would take out the further investigate and must
make the recommendation that we establish a center
forward.

And the question came up, well, won't
that cost $10 million. and my response was, "I
don't care."

DR. WALKER: I would agree with that.
I'd like to point out one more reason why it's
important. It's the platelets. It's the ability
to do platelet pheresis and process tests and have
safe platelets.

    I think the problem we have -- I can't
imagine they have enough platelets there to do
what they need to do now.

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

DR. OXMAN: I think it's important in
talking about a new principle that you would be
screening for HCV to protect someone else. There
has been rapid evolution in the treatment of HCV,
and you have the same reasons for screening
somebody for HCV as you do for HIV.

SPEAKER: Um-hmm.

DR. OXMAN: In other words, there are
appropriate therapies that would improve survival,
long-term survival of those individuals. So I
don't think that's an issue.

DR. POLAND: Dr. Shamoo?

DR. SHAMOO: Just one more additional
information. My understanding, David, of the data
of what number of HIV and HCV they had was
haphazard. This is not the accurate numbers, one and six. This is -- some of them turn out to be one this way and six another way. So you don't have the data at true percentage, or the number of people with infection. Isn't that -- that was my understanding, Colonel Rogers.

COL GIBSON: The -- because we in some cases, is this blood has been given without identification of --

DR. SHAMOO: That's right.

COL GIBSON: So those numbers are incomplete.

DR. SHAMOO: That's correct.

COL GIBSON: Those are the ones we now about. Market -- or surprisingly, though, if you take the, particularly with HIV, you take the probability predictions based on what we know about HIV infections among, actually, deployed folks. It comes out to about the same number.

DR. SHAMOO: That's okay, yeah, but that's different. Wait, I have an additional comment, and that is trauma surgeons, not all of
them are unanimous. But the blood, whole blood, is the best approach. So there is even that kind of data we have to be aware of.

DR. POLAND: Pierce, did you have a comment?

COL GARDNER: I was just going to say we have to take into the possibility that the surgeon might be right and that -- and so the protocol should certainly involve a way to settle this issue as best we can. A lot of times surgeons have ideas that they don't subject to real science, but it turns out to be their hunch is better.

So we don't know. We don't know the answer, but this ought to allow us, if we organize it right, to settle it.

DR. POLAND: I realize the numbers are much different, but I wonder if either our Canadian or maybe -- did we lose our U.K. liaison? -- what their policies are.

CDR SLAVIN-WHITE: I'd have to check to be certain, but one, we don't have HIV testing or
HCV testing as a basic point. So for joining our military or on any basis in regular terms, we're not testing for HIV or HCV.

Now, in theater, we have worked with our Canadian blood service, and in Canada we don't have a military blood service, per se. It's all nation-led, and the problems of Quebec has its own blood service. And we have worked at establishing blood testing and blood collection in theater and I just -- I don't know all of those specifics, but we did work on having small pools, as you were mentioning, small pools of voluntary donors who would agree to testing before deployment, and then again the specifics of the testing in theater, I'd have to get back to you on.

But that was our approach, and just as a second aside, our trauma surgeons at a recent conference were speaking rather positively, but again anecdotally, on the fact that in several cases they thought that the fresh whole blood may have been lifesaving in one or two massively injured casualties. And they probably would not
want to be precluded from making a decision on use of whole blood even if it were not screened to regular Canadian standards, if they believed that it might be lifesaving.

And the presence -- very last point -- the presence of HIV positivity in a serving member is not a reason for exclusion or loss of time in the military. You may serve, but, of course, we'd apply some restrictions and limitations. But we tend to look at some of these conditions as chronic conditions, and if a trained person can continue to serve for five years, eight years what have you, and still serve the country well, it would not be automatically disqualifying.

So there's some cultural and specific --

DR. POLAND: Let's -- we have a surgeon that is waiting to speak, so --

DR. WADE: My name's Dave Wade, and I am a surgeon, at least I used to be. And just I gathered from hearing the comments, it sounded like pathologists in preventive medicine specialists are sort of heavily represented in
this crowd, and I would echo what the commander
just said, that when you talk to the surgical
community. they're not necessarily 100 percent
unanimous, but they're pretty warm on the fact
that this whole blood transfusion has something to
it.

And so I would encourage you to try to,
as party deliberations, to reach out. I know
Roger and we are working on some things to try to
get (off mike) subcommittee involved in that sort
of activity. But there are folks that are
involved in that. And when you read some of these
papers in the surgical literature as to who's who
of American surgery for trauma, that's the authors
on these papers. So you need to take that a
little bit, you know, in your calculus of how you
make these decisions.

DR. POLAND: And yet still, I mean
cautions. It is a fruitless endeavor to assign
particularly good predictive powers to anybody.
And just look at last week's JAMA, and counter to
everybody's intuition antibacterials are not
helpful in acute sinusitis, for example.

So you really have to do these things until you know -- I don't have a problem with somebody exam- -- you know, trying different things and examining the data, but it has to be done to the extent possible under conditions that allow you to make a reasoned decision.

We've still got a lot of hands up. The two Mikes, and then back over to David.

DR. OXMAN: Just a point. If the risk in massive trauma in the field of acquiring HIV is one in a thousand, there are many other corners that are cut that are necessary for survival which greatly increase bacterial infections. And I think if you're really looking at this, you've got to look at the cost benefit analysis as a whole, and it may be that the corner- cutting on transfusions, if it's that low an incidence of infection, that may be very unimportant relative to many other necessary corner-cuts that reduce long-term survival.

So before making the big issue of that,
I think you really have to look at it in a broader perspective.

DR. PARKINSON: I want to come back to Bob Dufrates. Whenever I think I know something, I listen -- I really do listen to Colonel Dufrates, and he generally puts thing in a way that I think it would be a landmark mistake for us to concurrently institute anything related to HCV screening which has -- violates as best I could tell -- some of the core principles of screening in that there's little or no benefit of persons screened, and a theoretical benefit at best.

I mean, if the person is actively in a case of hepatitis is one thing. And then you treat them with globulins and other types of things, and even then the course is like, yeah. But to find the average is HCV positive at any age on the theoretical notion that at some time they'll be in theater, even in predeployment because that person might come up and be one in the 6,000 that comes up and we're not really quite sure whether or not it's better given, you know,
one-on-one case studies that people feel it's better, the energy to this Board should be devoted to getting the study done and helping -- wrapping our warm arms around the surgeons and saying, What would it take to get this study done?

The good news is that -- the bad news/good news is that the level of trauma that we've seen allows -- let's hope it doesn't occur at the rate it has, but if it does, we've got a rapid accumulation of cases, and if we could really apply ourselves as systematically to the issue of collecting the data and designing a good enough study, let's help them.

So that the more I think this through is concurrently instituting HCVd screening before we've absolutely ut 95 percent of our efforts into doing the study in theater to randomize sites, to randomize cases, to go on with trauma scores and do it right, even to the point of putting in an infield blood bank for $10 million, let's take whatever resources we have and (off mike) the Board to help to find the issue.
This is the essence of where the military excels in the unique environment. But we've got to commit to that in a prioritized fashion, not a concurrent fashion. And the ethics of screening around this -- and again I don't want to use the "epic" word lightly, but I got to dig up my four principles of a good screening program and I'm not sure this meets it, globally, even if we say the military's a little different and wartime is different, particularly when we could devote our resources perhaps strategically to help the real issue, is what you mentioned earlier, Greg.

DR. POLAND: David and then Mark.

DR. WALKER: Yeah, I got three, three points. One, Dr. Oxman, I think the government defense has a policy of not using non-FDA-approved products, and transfusion of blood that was not properly tested would not be FDA-approved product.

In emergency situation in which there was no other blood available, of course, that would be waived.
And, Mike, I think that I agree with you, and I point out that if we establish a blood processing center point blank in theater, then you don't need to do the HCV screening on everybody. I mean, it's -- the idea of doing both of those is unnecessary. If we decide to recommend and have the ability to test the blood in theater, then we won't need to screen for HCV.

And I wanted to ask the question about the screening of some donors for hepatitis C prior to their NHIV prior to their being used as donors. Is that blood sent back to the United States and tested by an FDA-approved method, because I know there have been rapid testing using some kits that were bought from a European source that's not FDA-approved for testing for hepatitis C virum and hepatitis B virus, that were woefully insensitive. I think the positive predictive value was about 20 percent.

CDR SCHWARTZ: I will need to get back to you on that to be certain, but I do know that we developed our blood-testing in concert to meet
Canadian blood services standards. But I'll see if I can get that information before we close tomorrow. If not, I'll relay that back.

DR. POLAND: Neil?

MR. NATO: Yes, thanks. Neil Nato, Bureau of Medicine and Surgery. The issue is actually very, as we've all heard, very complicated. And so I've had a lot of -- actually the chip and pig (?) has had a lot of discussions with the Armed Forces blood program personnel. And so, you know, I think it would be good if we all talked with the subcommittee on this issue before these recommendations come out, because there are several issues.

In regards to -- I mean, from my perspective I think the HIV strategy right now is fine because our incidence is very low. And although it's not approved for screen of blood, the rapid HIV test is being used, and so that's at the point of transfusion for these whole blood transfusions, so that helps out a lot in that regards.
And then also, I mean just the population in the military is heavily screened because, you know, we do screen for drugs and other things, and people who misbehave who have those risk factors are also administratively separated from the military.

So I would agree that the HIV testing scheme is fine as it now, and then based on the data, I think maybe one HIV blood-tainted unit may be so. But I think the key thing is basically the look-back program. I mean, I think it should be treated as a like a meal stick.

And, unfortunately, that's where things break down, so if you're using this whole blood, you know, you should screen it, and then you should, you know, capture and send it back, and you could -- although again it's not FDA-approved test for this purpose but again the more quick is very good, and you could test then, and get the answer and then decide if you want to give HIV prophylaxis. And then the other ones, the incidence I think is low enough, based on a
current procedures that I wouldn't be for testing
the HCD or H -- or hepatitis B before they go on
deployment to SANCAL.

COL CLARK: Colonel Stan Clark, Army
Surgeon General's Office. I just wanted to make a
couple comments on reference to look-back. There
has been an aggressive initiative to go back and
identify and inform the individuals who may have
received a non-FDA approved unit of blood which
was collected in theater, and they've been very
successful at finding those individuals. And then
there is a set FDA protocol that testing at 036 12
months out, various tests that may be transmitted
through an infected unit, whatever that disease
agent may be.

But also, I just wanted to point out,
and I'm going to point out, probably, what's
obvious, but I just want to remind people that you
will never drive this risk to zero with
predeployment testing. The only way to really
drive it as close to zero as you can is to test
the unit of blood with some sort of
highly-effective test at the moment you're drawing
the blood from the donor.

You could -- you know, you could test me
today. I could have risky behavior tonight, I
could deploy tomorrow and donate a unit of blood,
and someone else would get infected. And that
certainly can apply where we're sending thousands
of soldiers back and forth every year, every
month, and that same sort of situation would
apply. And, oh, by the way, they do go over
there, and then they come back for R&R halfway
through, and who knows what happens during their
R&R period, their rest and recuperation when they
come back to visit.

So, you know, without totally
controlling what they do, it's going to be
impossible to make this risk zero. And then you
have to ask yourself, what level of risk are we
willing to accept? With the HIV having -- a HIV
test drawn or predeployment serum drawn one year
before deployment or having an HIV test done every
two years, we've sort of gotten that ingrained
into our procedures. But I would urge everybody to be very cautious we start a whole other program with another disease that we wanted to screen for, especially when there's some question as to, you know, validity and how well we can do the screening and how prevalent it is.

To do the large screening program for disease that's low-prevalent in our population runs a lot of epidemiological situations that I don't need to get into with this group, obviously, because you know that.

So just a word of caution we run down a road that we didn't realize we didn't want to go to Abilene, but we're going to be there.

DR. POLAND: Okay. I think we'll move on. I think the consens- -- oh, Mark, did you have another comment?

DR. MILLER: I just wanted to try to get a point of clarification about the military policy in general in terms of the distinction of hepatitis B carriers state, and which is hepatitis B is about two orders of magnitude more
transmissible than at least HIV. Why is there a
distinction between HIV, hepatitis B carrier
state, and hepatitis B? For historical purposes,
is that still relevant?

COL GIBSON: The train of thought, if
you will -- first of all, there's no vaccine for
hepatitis -- or for HIV; there is one for
hepatitis B, in fact, quite effective vaccine.
The Department made a decision that a sessions
would have -- would be either immunized for
hepatitis B and/or tested. If they have
antibodies to hepatitis B, it indicates that
they're immune, therefore we would not give them
vaccine.

So it was a cost-saving measure, but the
whole issue was policy said we will immunize for
hepatitis B, ensure immunity. That's why we went
down this track. It goes to the possibility of a
blood contamination during military service.

Your points are very well taken with
respect to hep C versus hep B and with respect to
transmission. We do have an effective vaccine.
The other things is we believe that because hepatitis B vaccine has been instituted in a pediatric setting in this country for some years now, the number of our population would soon reach a point where they're already immune, and we would not be able -- basically, we'd screen them and we wouldn't be immunizing very many at all.

We did some early work on that, and it looks like about 40 -- when we implemented the program in 2002, it was about 40 percent that were immune and we're a little higher than that now. So the issue was immunity to hepatitis B as part of a program.

DR. POLAND: Okay, it sounds like there's some controversy about the recommendations, and a recommendation made by one of the members that -- or, actually. Was it over here? -- that there's a working group that's looking at blood transfusions beyond our own? Is that right, or conversations that are occurring?

MR. NATO: The Armed Forces blood program?
DR. POLAND: Yes. Push the button.

MR. NATO: The Armed Forces blood program and then joint preventive medicine group had been discussing this back and forth a lot.

DR. POLAND: So I think I heard the recommendation that there be some -- perhaps it's a work group meeting or discussion with that group in order to further clarify your recommendations, and then we'll bring them back to the Board.

Okay, our final speaker for today is -- where is he? -- there he is -- Dr. Wayne Hachey, who will update us on pandemic influenza preparations.

While he's going up there, some of you may have seen that there's concern that there might have been a human-to-human transmission of H5N1 in China, which would be of great concern, but who knows? It's hard to verify those things, and it's an ongoing investigation.

DR. HACHEY: I'd like to thank the Board for allowing me to provide another update on our pandemic influenza preparation endeavors. So the
agenda for this afternoon will be giving you an update of the current status of H5N1 to include an update on antivirals, particularly with resistance. The current draft of the national plan, the draft that DoD antiviral plan, some modeling efforts both in regards to vaccines and antivirals.

    DR. POLAND: Dr. Hachey's slides are under tab 12.

    DR. HACHEY: This is one of a number of slides that I have blatantly stolen from the CDC, and this just describes where H5N1 has been around with a global perspective. And all the little green dots represent where we've seen disease in birds and, more importantly, the purple dots are where we've seen disease in people this year. Of note there's a lot of purple in Indonesia and in Egypt, and we will be talking about those two countries in particular and why they're a bit different.

    This is the hit list for this year.

    These are all the countries, numbering 25, that
have had confirmed H5N1 activity in poultry and wild birds for this year alone. And the majority of the activity has been in poultry, as we'll see.

This next slide, series 6, gives you a little glimpse of the year in birds for H5N1 activity for 2007. So in January we saw a number of countries with disease primarily in poultry, and -- that's not supposed to happen, this may be a short slide. In February, we saw disease in the U.K. and Kuwait first reporting disease in poultry, previously reporting disease in wild birds. And then again a number of other countries with poultry outbreaks.

And the slide is not building the way it was sent, so to summarize the slide, lots of disease in poultry, now up to 60 countries all told, with a few cases of disease in wild birds. And one of the areas specifically with wild bird infections as opposed to poultry infections has been Germany where there's been three distinct H5 strains identified. Two out of the three have been linked with wild bird migration from Russia.
But the overwhelming majority of the cases have been primarily in poultry populations. Each one of these is supposed to disappear as the new one presented. Well, more importantly, where is the disease in people? And there are two hot spots remain Indonesia and Egypt, and, as you can see between the number of cases and deaths, you'd much rather be in Egypt with a drastically lower mortality rate. And this may be due to the Clade may be doing -- may have more to do with what those countries are doing as far as mitigation efforts.

So in Indonesia, Indonesia remains the hot spot with the highest number of new cases for 2007, and it's essentially the sole source of cases of Clayd 2.1 disease. The government of Indonesia continues to refuse to share samples with the rest of the world, although they've recently engaged in the Southeast Asia influenza clinical research network, which may facilitate some sharing.

Their mitigation measures also continue
to be hampered for a number of reasons, but one of
the big reasons is their decentralized government
and decentralized public health system.

In contrast, Egypt has the
second-highest case rate. Instead of Clayd 2.1
they are 2.2, and they have the lowest mortality
rate of any of the regions. And, now, in contrast
with Indonesia, they have a very effective control
measures in place. They have impediment plan that
really serves as a model for the area. They've
begun to exercise their plan. They also have an
extensive communications program that facilitates
early recognition and treatment with subsequently
improved survival.

They notice that most of their cases
were kids, so what they did is they had their PR
program geared towards parents saying, If your
kids play with dead chickens, and they develop flu
symptoms run, don't walk, to your nearest health
care facility. And, in fact, referral patterns
are being seen with referrals to medical treatment
facilities well before 48 hours, in some cases
before 24 hours of the onset of symptoms.

They've also effectively addressed backyard poultry without changing cultural practices. If you take a look at the hieroglyphics in Egypt, you see backyard poultry, so this is something that's been going on for thousands and thousands of years and isn't going to change. So the way they've addressed it is they're vaccinating the chicks before they're sold into the backyard poultry market and have been somewhat effective as far as reducing the burden of disease in their poultry population.

So overall, in 2007 for human cases was not a bad year, particularly compared to 2006. We still have a substantial mortality rate. Today's total now for total number of cases is 337 with 207 fatalities, and actually, it turns out that the suspected case of human teaming transmission in China did turn out to be a communal meal between father and son with some diseased chicken. But there's a new possible person-to-person transmission now in the Northwest Frontier
Province in Pakistan. So there's still hope for
the virus.

Moving on to antivirus, and with
antivirus what I'd like to do is talk to you a
little bit about current resistance -- and again,
this data was again blatantly stolen from the CDC
-- but this slide depicts Ademantane resistance
among the H5N1 viruses, and it differs between
Clade and sub-Clade. So for Clade 1, and for that
matter Clade 2.1, pretty much you have total
resistance to the Ademantanes, whereas Clade 2.2
and 2.3 resistance is minimal, at least at this
time.

Moving to neuaminidase resistance using
the Japanese data with seasonal flu represents
about eight percent of the samples tested, and now
there are two primary mutations responsible for
neuaminidase resistance. The first, the H-274Y,
confers almost complete resistance to oseltamivir.
The good news is that you have decreasant activity
with that particular mutation. So it's really
unpleasant if you are the individual with that,
but it's nice to be standing next to him.

On the other hand, a second mutation, the N295S seen primarily from samples out of Egypt is consistent with reduced susceptibility, so you can still get by with just increasing the oseltamivir dose. One problem with monitoring for neuaminidase resistance, particularly in vitro, is that we're really uncertain of the clinical significance of in reaching resistance against neuaminidases as via molecular markers are not all that well defined yet.

But we do know that there are differences in neuaminidase inhibition susceptibility among H5 isolates. So, for example, Clade 1 is sixfold more sensitive to neuaminidases than seasonal flu as far as an H1N1, which is three to fivefolds more sensitive than a number of the Clade 2 viruses. So we'll just have to wait and see what the particular susceptibility will be when the pandemic actually starts.

There are also two new novel mutations,
one identified in human samples and another in Andean (?) samples. And the bad news about these is potential resistance depending on the sub-Clade to oseltamivir and amavir and paramavir. But then we really want to know, though, is will oseltamivir work if your god-awful sick?

And this one study I just published this month from Canada looked at hospitalized folks with laboratory-confirmed influenza. About 300 adults, median age of 77, about half were male, 75 percent had chronic underlying disease. Most, about 60 percent, presented to the E.R. within 48 hours of symptoms, and they were reasonably ill. Sixteen percent ended up in the ICU, eight percent died. Just about everybody received antibacterial therapy, and 32 percent received oseltamivir. And the reassuring finding was the treatment with oseltamivir was associated with a significant reduction in mortality with an odds ratio of 0.21, which reassure in confidence intervals.

Which leads us to the new draft national antiviral strategies, and the new strategy
proposes an increase in the national stockpile up to 200 million treatment courses. Now, currently, the target is 81 million, and against the 81 million the national stockpile now holds 37 million treatment courses. It also proposes outbreak prophylaxis for a certain high-risk health care settings and for first responders, and starts to initiate a strategy which includes household postexposure prophylaxis.

This is now in the public stakeholder engagement process, so it'll be a few months at least before we know whether this turn out to be the true national policy or not. Even if it is adopted, it's going to take a while. U.S. production capacity is about 80 million treatment courses a year, so, if adopted, it'll take a few years to meet this goal.

The draft DoD policy addendum for antivirals somewhat mimics the national policy. It increases the oseltamivir stockpile to -- actually, it's a little closer to five million treatment courses. It establishes local
stockpiles to equal 30 percent of the population at risk for each geographic CoCOM. So that gives combatant commanders an off-the-shelf robust supply of antivirals for more immediate use while waiting for the strategic stockpile that DoD holds to get to their locales.

It also initiates a postexposure prophylaxis mitigation strategy while maintaining treatment and selected outbreak or operational prophylaxis strategies.

Moving on to modeling efforts, we started modeling, asking the question, where should we be spending our excess money in the short term? We have funding for either antivirals vaccine or a combination of both, and the question is, where are we going to get that, essentially, the biggest bang for our buck, given the current state of science?

But first of all, just looking at NIH-sponsored modeling efforts, they indicate that being a household member containing in influenza cases the largest single risk factor for being
infected, which really shouldn't be an epiphany. But what was surprising is that antiviral postexposure prophylaxis of household of contacts may be effective in reducing attack rates by a third, and peak attack rates by 50 percent. But as we saw, it does require a rather robust supply. Unless treatment can be initiated by Day One, there's really little impact on community infection rates if use the treatment-only strategy. Added onto that, you can get some logistic effect on nonpharmacologic interventions. Alone may reduce the attack rate by half to a third. So if you start out at that baseline, then your antivirals have a much better chance of being effective, and you have a lot more antivirus to go around in adapting a postexposure prophylaxis strategy.

Which leads us to some of the DoD modeling efforts, and the first question we had is, well, just how cost-effective will vaccines be? And we had a detro-model sum for us, and what they did is they addressed the impact by their
zero percent rate of vaccination versus 100 percent vaccination rate using a 30 percent attack rate in a vaccine with 30 percent effectiveness. And they found that if you happened to be in a rural installation, you get about 32 percent infected vaccinating no one, and 17 percent infected if you can vaccinate 100 percent.

Unfortunately, the reality is that it's unlikely we'll ever be able to vaccinate 100 percent with the current prepanademic vaccine.

Shifting to an urban installation, 28 percent were infected with antivaccine, and 15 percent with 100 percent immunization. And this can actually lock the gates and keep everybody inside and not allow anybody from the community inside a no-term installation, which is probably not reality-based unless you're on a submarine or an island. Then you can lower those rates even further.

The one thing that was not terribly reassuring is that there's no herd immunity. Essentially, the folks who are vaccinated are the
folks who have the -- the only folks who have the potential of being protected.

We then took some of DTRA more simple formulas and applied that to some modeling on our own, and what -- we didn't set up zero 100 percent vaccination rates. We had variable vaccination rates with variable attack rates and variable vaccine effectiveness. So we used attack rates of 30, 10, and 20 percent. Thirty percent, we felt, was a reasonable guesstimate of an unmitigated pandemic where no community mitigation efforts were implemented, 20 percent being consistent with effective but not wonderful results from your community mitigation measures, and then 10 percent more consistent with some of the projections with early implementation of those nonpharmacological measures.

Percent being a generous swag at an unmatched unadjuvanted vaccine, 50 it's essentially Christmas in July, our current unadjuvanted vaccine is a perfect match with the pandemic strain, and then 80 percent consistent
with some of the projections of what one might see
with an adjuvented vaccine.

So this gives you an idea of what the
slope of the reduction in attack rate might look
like. Just for illustrative purposes we used a
population of 4 million, a 20 percent attack rate,
and 50 percent vaccine effectiveness. You can see
that the percent infected does go down but not
really a terribly dramatic decrease. Whereas if
we change that to a vaccine that has an 80 percent
effectiveness, for example like the current
adjuvented vaccines are proposed to do, you can
see that you get a much bigger bang for your buck,
that the slope of that curve as far as the
reduction and the percent infected is much more
dramatic and really offers a much more viable for
self-protection measure.

Overall, this one chart looks at the
decrease in the percent infected for every 20
percent vaccinated, and if attack rates decrease,
so does the number of cases prevented with
vaccine. So the worse the pandemic is, the bigger
bang you get for your buck with your vaccine.

Then of course, as vaccine effectiveness increases, you get a greater reduction in the percent infected.

Looking at some of the slopes of proportion infected with increasing the percentage in those who are vaccinated with variable attack rates you can see here in green that if you drive the attack rate down to 10 percent with very effective nonpharmacologic measures but have a vaccine that is probably consistent with what we have right now that the slopes are pretty flat and especially at 10 percent. And even at 30 percent, it is not really a dramatic decrease as far as the proportion infected decreasing.

Bumping up to 50 percent with the higher attack rates you get a little better return from your investment. Still at a 10 percent arrack rate if we're doing everything right, that slope is still kind of flat. Whereas if we have an effective vaccine, again a much more dramatic decrease as far as the projected yield you are
going to get from your vaccine even as you approach 100 percent.

Which leads us to antiviral modeling. From the vaccine modeling it looked like we might be better off waiting until there is a better vaccine available and then putting our resources toward vaccine procurement rather than continuing to purchase a vaccine with limited effectiveness.

The question is then can we get a substantial response from our investment going antivirals. We did a couple of things. We did some very basic modeling using projected impacts on a variety of strategies on the DOD population. We then explored a number of existing models and then used one of those models, actually one developed for the Australian government, in plugging in some DOD data. The universal findings were treatment alone will not help the pandemic, and postexposure prophylaxis will probably blunt a pandemic and may actually stop it if you can combine that with effective nonpharmacologic measures.

This gives you an idea of what it will
cost in antivirals for the number of infected. We have treatment alone, nonpharmacologic interventions and treatment, postexposure prophylaxis, treatment without employing nonpharmacologic measures, and then clearly the best yield as far as reducing the number of infected would be combining nonpharmacologic interventions, treatment, and postexposure prophylaxis with just a modest increase in the amount of antivirals that would be required. Looking at exactly what those numbers would look like, these are estimates based on a presumed population of 4.7 million which is consistent with the number we have enrolled in Tricare Prime at the current time. You can see for a modest requirement that combined therapy gives you a substantial reduction in the number of infected while still having a number of antiviral courses available for outbreak prophylaxis.

This slide addresses some modeling we did again using the model developed for the Australian Department of Health. This defines the
population as either being susceptible, exposed, infectious, or removed, removed being either immune or dead. We then took out the Australian population demographics and stuck in ours, a population of 4.7 million. We examined variable infectivity with effective reproduction numbers of 1.2 to 2.4. We also looked at the variables of 30, 50, or 80 percent being provided postexposure prophylaxis. And then as a baseline, treated 80 percent of those who were infected. With an unmitigated pandemic with an effective reproduction number of 1.2, the pandemic peaks at about 10 months and this curve represents the number of infected at any one point in time. At 10 months you can expect about 50,000 people to be infected at that one point in time, so the total number is the area under the curve.

If you have a more severe pandemic, the curve is a little shaper, it peaks earlier, but it is peaking at about 80,000 cases. When we add postexposure prophylaxis, however, with again an effective reproduction number of 1.2, even with 30
percent of the contacts receiving postexposure prophylaxis, we can essentially stop the pandemic when combined with nonpharmacologic interventions. And instead of dealing with peak infection rates in the tens of thousands, here we are at about 600. With a more severe pandemic with effective reproduction numbers at 2.4, treating 30 percent of the contacts with postexposure prophylaxis does not stop the pandemic, but with 50 and 80 percent of the contacts receiving postexposure prophylaxis, the pandemic again is stopped. Of note is the peak number of cases, again well below the 50- to 80,000, actually down just a little bit under 100. When we first saw the data we didn't believe it. We went back to make sure that we did not skip a decimal point somewhere. But after running it three or four times, we kept on getting the same results. If you look at the Australian data, they show the same kind of significant reduction in the total number of cases. Do the other models tell the same story? The other models do show that postexposure prophylaxis may
stop a pandemic, that postexposure prophylaxis will have a substantial reduction in the number of hospitalizations, and postexposure prophylaxis has the synergistic effect with other measures.

This slide here demonstrates the effective reproduction number achieved by using antivirals for treatment versus postexposure prophylaxis. This is the treatment curve, this is the postexposure prophylaxis curve, this axis is the effective reproduction number, and this axis is the percent of the population who either receive antivirals for treatment or antivirals for postexposure prophylaxis. The thing to note is that using treatment alone, this is the effective reproduction number at 1, so you are never far below 1 using treatment alone. Whereas using postexposure prophylaxis whether combined or not with treatment, here is an arnot (?) of 1, so you quickly fall below an effective reproduction number of 1 at least with this one model. Again, using postexposure prophylaxis as opposed to treatment, that theoretically a pandemic could be
stopped.

The next issue is even with 50 percent compliance, can we significantly reduce the number of hospitalizations using postexposure prophylaxis? The green curve and the blue curve represent no antivirals given versus treatment alone. This axis is the number of hospitalizations and this is time. You can see that the medical treatment facilities would easily be overwhelmed if we did not use antivirals or used a treatment alone strategy. Whereas this curve is what might expect as far as the number of hospitalizations if postexposure prophylaxis were used.

The last slide demonstrates just the additive effect with a load approach that we have been proposing now for months. Daily incidence of infection over time, with no interventions the pandemic comes early and stays late and overwhelms your system. Whereas as you start adding quarantine, quarantine with isolation, quarantine with antivirals and so on, that curve gets lower
and lower as you go on.

In summary, our modeling show that unadjuvanted vaccines will have a modest impact on mitigation but really not a good investment at the current time. Whereas adjuvanted or more effective vaccines will have a substantial effect on pandemic mitigation, and when they are available it may be better to put DOD funds in that area as opposed to again continuing to buy ineffective or less-effective vaccines. Antiviral use limited to treatment alone will not result in substantial reductions in the overall impact on the DOD community, but adding an antiviral postexposure prophylaxis strategy combined with infection control and social distancing may actually halt a pandemic.

DR. POLAND: Very nice. Thank you, Wayne. Comments? Roger?

COL GIBSON: A couple quick questions around the modeling that you presented. What were the fatality rates in the model?

LTC HACHEY: Which model?
COL GIBSON: The first one. The first one is quite effective.

LTC HACHEY: As far as the fatality rates, we did not model for deaths, we modeled for the percent infected.

COL GIBSON: So that you didn't model for deaths. Obviously dead folks leave the cohort.

LTC HACHEY: In the fuel modeling, deaths are built into that and I believe that -- the death rate varies whether you have an effective reproduction number of 1.2 versus 2.4.

COL GIBSON: That's the Australian model?

LTC HACHEY: Right.

COL GIBSON: Was there a coefficient for resistance that was included in those models?

LTC HACHEY: No. We did not model for antiviral resistance.

DR. POLAND: Mark?

DR. MILLER: I think first of all the general purpose of modeling is to highlight and
articulate a lot of the assumptions, many of the assumptions, and in the case of potential pandemic viruses and antiviral agents acting against it are really unknown so the best you can do is put in a range and then run a model and then try to highlight what are the most sensitive parameters and that helps to at least identify and focus areas or research and hopefully identify other policy-relevant issues.

I think the problem with a lot of the models is people take them too much to heart in terms of what they actually show as an outcome and really not use them for what they are really good for, to highlight those particular assumptions and help clarify any policies that are eventually going to be made.

There is a big problem specifically with antiviral modeling. The one that was originally done for Thailand I think tried to show when the MIDAS effort, this is the NIH effort, was tasked to look at a problem, if there was a point source of an outbreak somewhere in Asia could you rapidly
deploy antiviral agents and stop the pandemic from happening? There were about five independent variables each with their own probabilities that each would have to align up perfectly in order to effectively stop an outbreak. People took that paper to realize that actually it is possible, but when you multiply out the probabilities of each of those five independent variables, it is possible, but with a probability of extremely unlikely. Of course if you stop it one time as well, it is highly likely you are going to stop it the second time. So while I think models are useful, they are always wrong but some are helpful and this on in particular also is helpful to identify what are the issues.

I think part of the problem is that the transmission dynamics were not really looked at carefully with these particular models. I think you modeled 4.7 million people and I'm not exactly sure if that just represents the DOD beneficiaries or where you got that number from because part of a model is who is infecting who and if it is
related to DOD beneficiaries, they are scattered throughout the world so you cannot necessarily implement programs uniformly amongst those who you are trying to effectively model.

LTC HACHEY: The question to us as far as developing a model was how does this impact the DOD community. That is why we picked that 407 because that is the DOD community. However, the modeling that DTRA did did take into account for the local community and that is why the differences between a rural and an urban installation were different as far as the overall attack rates because of interaction with the community. But the fuel that we did, we just took the DOD community as a point of reference.

DR. POLAND: Other comments?

DR. MILLER: Sorry, I forgot to make one more comment. I am not sure of your eventual outcome. It looks like your outcome was mitigation of influenza, but there is more to just influenza, it is also the secondary bacterial events. You did look at antivirals, but did you
also look at modeling other prophylactic measures
for severe morbidity/mortality such as
pneumococcal vaccines or antibiotic distributions?
Those would all be part of a particular strategy
for mitigating the impact of a pandemic.

LTC HACHEY: Our modeling was limited to
two specific questions. One is the impact of
vaccines, and the other one was the impact of
antiviral strategies. We did not include the
potential impact of different pathogens and biotic
therapy. But given more time and more money --

DR. POLAND: Kevin?

DR. PARKINSON: Just one quick comment.
I think that most of the strategies and modeling
that I've seen and read, the prediction is the
pandemic is going to spread so quickly, any
effective application of postexposure prophylaxis
is going to quickly break down because your new
cases are going to far outstrip your public
health, we are talking military or civilian here,
capability to track these new cases and get to
them within the I presume still 48 hour window
after onset of symptoms during which the antivirals are felt to be most effective. And then when you look at the modeling that was done at the rapidity of the spread of the 1918 pandemic throughout the United States in about a month or so and considering the limitations on movement of people, transportation and so forth, that prevailed during that early era in time, it's hardly likely that we are going to be able to control a pandemic once it strikes using antivirals or anything else. It's just going to have to burn itself out.

LTC HACHEY: Actually, our plan as far as the antiviral distribution, if someone comes in with symptoms, when they are treated and so are their family members, so hopefully as we target each individual case, then we are also targeting their families, or in the case of a barracks, if one person has the disease then his -- are also treated.

DR. PARKINSON: I should say that's not to imply that we should not do all of these things
and I am not suggesting that you are implying or
anyone is implying realistically we are going to
be able to stop a pandemic, that if anyone
suggests that, I would question it strongly.

DR. POLAND: Dr. Lednar?

DR. LEDNAR: Part of the DOD pandemic
preparedness is around the uniformed force and the
civilian workforce that spends days on military
installations. My question, Wayne, is how
comfortable is DOD that their critical suppliers,
the civilian companies who support DOD so that
operations in DOD can continue, are prepared?

LTC HACHEY: Corporate America does seem
to be bellying up to the bar, at least some of the
larger corporations from what we are told are
starting to stockpile antivirals and developing an
pandemic flu plan of their own to protect their
workforce. The federal government has identified
specific key areas in the national infrastructure
that have to be preserved, down to folks who
deliver baby formula are clearly more important
than folks who deliver bread because there are
more bread deliveries than baby formula
deliveries. So certain key areas in industry have
already been identified as being critical and
deserving of extra protection. In the national
plan, both antivirals and vaccines at least in the
draft form are preallocated to preserve those
critical elements of society which impact on DOD.

Our current plan as far as how we would
use our antivirals does extend to our civilian
workforce to include GS personnel and contractors
now with our new buy of antiviral agents. So
those folks who actually work for us are under our
protective umbrella also.

DR. CLEMENTS: It may be worth a modest
effort for a couple of selected key suppliers to
DOD for some insightful DOD people to go out and
actually verify just how prepared they are.

DR. POLAND: Maybe in some critical
areas.

COL GARDNER: Every time we hear a broad
presentation we hear about the new country that's
immunizing its poultry and I believe you said
Egypt has now started to immunize its chickens. We know what the vaccine is and whether it actually works. If we really were facing a bird-related disease, we don't give much discussion to that approach in the United States. Is it a live or is a kill vaccine? What is the evidence that it works, and how do they make it?

LTC HACHEY: I don't know how they make it. Folks smarter than I do, however. I do know that there are a number of different vaccines depending on which country with variable effectiveness, but we do have some data. It appears that, for example, the vaccine that is used in Vietnam does appear to be effective as far as preventing disease. The problem is that they gave it to a lot of chickens which kept the disease from chickens, but they did not give it to the ducks and then ducks continued to carry the disease.

It is a big depend. It depends on the particular vaccine. There are a couple sub-clades that appear to be resistant to previous vaccines,
so it's somewhat of a crap shoot as far as which
vaccine, which sub-clade and which manufacturer.

DR. POLAND: If I can, I would like to
ask Dr. Bill Halperin to tell the board briefly
about a potentially important paper that has been
published and an idea that he and I have just
briefly talked about.

DR. HALPERIN: Some of you have probably
seen a paper that was circulated by Peter Polisi
from Mount Sinai who was addressing the question
of why influenza propagated in the winter months.
What he did, apparently the first part of it was
to identify that he could tell from an animal
model and he used guinea pigs. The next was to
take groups of guinea pigs and put them into
environmental exposure chambers where he could
modify temperature and humidity. What he shows in
the article is that the colder it is, the more
propagation there is, and that is pretty clear.
With humidity it is a little bit more of a complex
relationship, but it looks like in the middle
range there is lease transmission and when it is
very humid or very dry there is more transmission. And these are in ranges that are conceivably environmentally controlled in normal living situations through air conditioning, heating, and control of humidity.

What he concluded in the article and then probably has regretted is the question of whether this represents a potential nonpharmaceutical approach to control of influenza epidemics. I say conceivably regretted because the discussion has been to rush toward the idea of controlling epidemics this way and a lot of chatter about then why do we need vaccines, et cetera.

All that aside, the question is then if you are going to try to see whether control of environment actually worked in slowing the propagation of influenza, where and how could you test that hypothesis. This is what we were talking about comes out of the article. The issue is ethnically you would have to test this if you were going to do it in humans in a population that
would be highly immunized if there were a vaccine. If there were no vaccine, obviously they wouldn't be highly immunized. If they were highly immunized, you would look for truncation of propagation but that is after the effectiveness of the vaccine was in play. So if you assume that let's say vaccine is whatever, 60 to 70 percent effective, you would be looking for the truncation of the rest of the epidemic. So what population would be large enough that would be well enough controlled, that is, everybody would uniformly have immunization, where you would uniformly have data on propagation of influenza, and where there would not be a huge amount of mixing, that is, you would have cohorts of people that were highly immunized and in environments that were controllable, et cetera, and the only population I could think of like that would probably by the recruits in the services of the military with lots of training programs at various bases around the country where the folks are by and large cohorted, if there is a vaccine they are going to be
immunized uniformly.

    There are several questions. One is what is the level of effectiveness of the vaccine because obviously if it's 100 percent effective then there is no more transmission to be controlled. The second is whether there is any capability of actually controlling temperature in the training barracks between let's say a range of 80 and 60 degrees Fahrenheit and within ranges of humidity. It is an interesting article. It is the first I think article on this issue and obviously there is no confirmation from other laboratories, but that is the nature of the discussion, although very early, that we have had via email.

    DR. POLAND: The interesting thing here would be, one, this potentially could be a suggested study reminiscent of those requested by the Influenza Commission back during World War II. Two, it may be something fairly inexpensive to do in the context of nonpharmacologic interventions. And three, there may be a unique population here
on which it can be done and for which the side
effects or risks would be really essentially nil.

Dr. Shamoo?

DR. SHAMOO: I think doing human subject
experiments on large populations to test this
hypothesis for a disease where I have heard right
here presentations saying may never happen in 100
years, you are going to have a hell of a time
convincing the public that that is a necessary
risk to take with any population. So I would
caution really to even think of those kinds of
experiments.

DR. POLAND: What do you mean risk?

DR. SHAMOO: The risk of having pandemic
flu. You are doing it to prevent pandemic flu,
but the risk of pandemic flu is so low.

DR. POLAND: We should maybe clarify
that the value of a study like that would be of
course during a pandemic, but also during seasonal
epidemics where there may be a mismatch between
the vaccine, for example, and that is circulating.

So it would overlay both seasonal and pandemic
influenza. Bill?

DR. HALPERIN: Just to be perfectly clear, we are talking about perhaps changing the H-factor, humidity, air conditioning, et cetera, if there were evidence of influenza in the population. So there is absolutely no idea of introducing a virus into the population. It is an intervention.

DR. SHAMOO: That is much better.

DR. POLAND: I had trouble understanding what you meant by risk.

DR. HALPERIN: No, this is not experimental. This is more observational epidemiology, the intervention being the control of humidity and heat, if you will.

DR. POLAND: Mark and then Mike?

DR. MILLER: That study was interesting and it follows on actually a study by Ed Kilborn who had done a similar study in mice about 20 or 30 years earlier. It does lend to some interesting issues, but it still doesn't explain a lot of the other issues, why flu circulates year
round in the tropics, and those are some of the
more interesting points about influenza which we
really do not know.

DR. POLAND: Mike?

DR. OXMAN: If this occurs in the
setting of an epidemic, you would immediately
screw up your experiment by using antiviral
therapy as well. I wonder if the place where it
might be even more easily done be on shipboard.
When there is influenza on shipboard it's very
impressive the spread on shipboard, and I would
think if there is any place where you could
control relative humidity it would on shipboard.

DR. SHAMOO: What is your control? One
ship?

DR. POLAND: Let's not get into
experimental details. This is just an idea. I am
going to keep you engaged this late in the day,
but --

COL GARDNER: When the meningococcal
work was first being done suggesting that college
freshmen were at increased risk, one of the
interesting risk factors that never really saw the light of day was not only were first-year students living in dormitories, it was dormitories that had radiator heat rather than other kinds of heat. So it's a little bit concordant with something happens to the mucosa I think presumably that may affect attachment or proliferation.

DR. POLAND: One other comment?

DR. HALPERIN: I would urge reading Polisi's article because what he argues is that the animals were put in the exposure chamber so quickly that they did not have time to dry out the mucosa. So his argument which I probably should have mentioned before is that it all has to do with how long the aerosol particles are suspended and that they last in the environment for different lengths of time if it's hot or cold or dry or wet, and it really has to do with the mechanics of transmission.

DR. POLAND: Thank you, Wayne, and I think we are finished and will adjourn for this event. A couple of things. I am glad Roger is
walking in. I cannot remember what the preparatory session is for tomorrow.

COL GIBSON: Actually what we have done is moved forward tomorrow so that we can get done so that you can get on your airplanes and fly home and get home on time. We are going to start with registration at 7:30 and actually start work at 8 o'clock. That will give us time to move an administrative session to late afternoon, have our annual EPICS briefing, have lunch, and then head on out from there.

DR. POLAND: So we are not meeting at 7:30?

COL GIBSON: This changed very recently.

DR. POLAND: Then we anticipate the formal part of the meeting ending about 11:00?

COL GIBSON: Yes, probably 11:00. It will be in that range.

DR. POLAND: Because we will move this up.

COL GIBSON: Colonel Hachey presented today which will give us more time and we will get
the EPICS briefing in there and have a short
administrative session that will allow us to go
over our organizational charts and a few other
minor things.

DR. POLAND: We are dismissed.

(Whereupon, at 4:50 p.m. the
PROCEEDINGS were adjourned.)

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