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HONORABLE TOGO WEST JR.

GAIL WILENSKY, Ph.D.

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DR. WILENSKY: Good morning. I'd like to welcome everyone to this meeting of the Defense Health Board and to extend a special welcome to our new Board members. We have several important topics on the agenda, so I'd like to have us get started. Thank you also for being here so early this morning. We have a full agenda to cover today. Mr. Middleton, would you call the meeting to order?

MR. MIDDLETON: On behalf of Ms. Embrey, the Designated Federal Official, as the Alternate Designated Federal Official for the Defense Health Board, a Federal Advisory Committee and a Continuing Independent Scientific Advisory Body to the Secretary of Defense via the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the Military Departments, I hereby call this meeting of the Defense Health Board to order.

DR. WILENSKY: Thank you, Mr. Middleton.
Now in carrying out a tradition of our Boards, I would ask that we stand for a minute of silence to honor those we are here to serve, the men and women who serve our country.

(Moment of silence.)

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

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

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

GEN MYERS: Dick Myers, retired Chairman of the Joint Chiefs of Staff, Core Board member and clearly retired from the military.
MR. UNTERMeyer: Good morning. I'm Chase Untermeyer. I have a private business in Houston, but previously was a political appointee as Ambassador to Qatar and other federal positions.

DR. SHAMoo: Adil Shamoo, University of Maryland School of Medicine.

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

DR. WALKER: David Walker, Chair of Pathology and Executive Director of the Center for Biodefense, and I'm working on infectious disease in Galveston, Texas.

DR. LUEPKER: I'm Russell Luepker. I'm a Professor of Cardiology and Epidemiology at the University of Minnesota.

DR. MASON: I'm Tom Mason, Professor of Epidemiology, College of Public Health, University of South Florida, Tampa.

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

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

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

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


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

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

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

SGT MAJ HOLLAND: Command Sergeant Major
retired Larry Holland, just recently retired from active duty.

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

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

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

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

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

DR. WILENSKY: I forgot to introduce myself. Gail Wilensky, President of the Defense
Health Board and Senior Fellow at Project Hope.

I'm going to ask now so that we can have people
who are over with you introduce themselves as
well.

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

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

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

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

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

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

DR. COHOON: Barbara Cohoon with the
National Military Family Association, and I sit on
the TBI Caregiver Family Panel.
CPT GIRZ:  Good morning.  Martha Girz from JTF CapMed.

LT COL SILVER:  Aaron Silver, Joint Staff Liaison.

LT COL STONE:  Jay Stone from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

COL LUGO:  Good morning.  Angel Lugo, Chief of Staff of DCOE.

DR. ROPPER:  Allan Ropper, Neurology, Brigham and Women's Hospital and Harvard and a member of the Traumatic Brain Injury Advisory Committee.

COL KRUKAR:  Good morning.  Michael Krukar, Director of the Military Vaccine Agency.

DR. RICE:  Charles Rice, President, Uniform Services University of the Health Sciences.

DR. BLAZEK:  I'm Bill Blazek, and I am at the Center for Clinical Bioethics at Georgetown University.

MAJ PEIPELMAN:  Eric Peipelman, AFIP.
MR. TOBEY: Good morning. Phil Tobey, health care architect and planner, Washington, D.C.

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

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

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

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

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

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

CPT MALLAK: Good morning. I'm Craig Mallak. I'm the Armed Forces Medical Examiner.
MS. GRAHAM: Elizabeth Graham, DHB

support staff.

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

CMDR FEEKS: Good morning and welcome.
First, you'll notice an empty seat at our table
over to my right. Dr. Francis Ennis is unable to
be with us because his sister passed away on
Saturday. Let's remember that family in our
thoughts and prayers. I'd like to thank the staff
of the Marriott Beachside Hotel for helping with
the arrangements for this meeting and all the
speakers who've worked hard to prepare briefings
for the Board. I also want to thank Jen Klevenow,
Lisa Jarrett, Beth Graham, and Olivera Jovanovich
for helping with the arrangements for this meeting
of the DHB. And finally I also want to thank Ms.
Jean Ward back at the home office for her
invaluable assistance in putting this meeting
together. If you have not already done so, please
be sure to sign the general attendance roster on
the table outside. For those of you who are not
seated at the tables, handouts are provided on the
table on the side of the room here on my right.
For telephone, fax, copies or messages, please see
Jen Koevanow who is over my left shoulder at the
door with her hand raised. Lisa Jarrett and Beth
Graham can also help with that. They're at the
table just outside the door for the time being.

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

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

Refreshments will be available for both
morning and afternoon sessions. For Board
Members, invited speakers and liaisons, we'll have a catered working lunch here at the Marriott Beachside Hotel just in the next room over. There are a number of restaurants nearby. I want to apologize for the condition of some of your binders. Some of them didn't take the shipping very well.

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

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

COL REIST: Good morning. Ms. Wilensky, Mr. Middleton, Members of the Board, ladies and gentlemen, as noted earlier my name is Colonel
Paul Reist. I'm from the Joint Staff Operations Directorate. On behalf of Lieutenant General Jay Paxton, I want to thank you for the opportunity to speak today and provide you a quick overview of our global operations and all the operations and activities that our DOD forces are conducting. Although we do these kinds of briefs very often, rarely do we get a chance to do them in places like Key West, and in 20-plus years this is one of the few times if not the only time that on a short notice tasker I actually looked forward to coming and it was a place where other people pay to come. So again I thank you for that. More importantly, I want to thank you for your efforts here on behalf of all of our troops and their families. My purpose today is to give you as I've noted a brief overview of the operations and activities currently being conducted across the globe. Obviously in 45 minutes it will be an overview, but I intend to leave time for your questions and I welcome them. Before I begin, let me just make one critical comment. I will discuss
a great number of activities and operations that
are being conducted, and I know you all know this,
but keep in mind that at the end of the day it is
our tremendous 18-, 19-, 20-year-old young
soldiers, sailors, airmen and Marines that are
making things happen executing our national
military strategy and for whom all of us are here
today.

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

As seen by the proximate number of
forces assigned to each combatant command noted on
the slide, you can quickly note that our main
effort remains the Central Command Area of
Responsibility and our operations in Iraq and
Afghanistan. In addition to those though there are many other key parts of these regions that are critical, and I'll talk about those briefly. In addition to the Central Command Area of Responsibility though, it's important to note that our other combatant commanders are equally busy. All one has to do is read the paper or watch the news to understand that there are a large number of flashpoints across the globe that at any moment could quickly become our top priority.

Just to touch on a few as you see on the slide, within the CENTCOM AOR in addition to the fight going on in Iraq and Afghanistan, Israel and Gaza and the recent operations in Gaza are of obvious concern as we seek to establish some semblance of peace in the region. Likewise in Iran and their continued efforts to develop a nuclear capability. Outside of the Central Command Area of Responsibility, last summer's engagement in Georgia and the emergence of Russia and the great deal of uncertainty of their
intentions is cause for concern. Likewise in the
Africa Command, the recent indictment of the
President of Sudan is cause for significant
concern and subsequent consequences and potential
for tremendous humanitarian suffering that might
result. Likewise, in Somalia with the continued
lack of governance leads to a great deal of
problems not the least of which is the resurgence
of sanctuary for terrorists, and as we've more
recently seen, the emergence of piracy is a
significant concern in the region. In PACOM,
North Korea's efforts to continue to develop
nuclear capability and potentially to launch
ballistic missiles. Likewise, in our Southern
Command, Cuba is always of concern as are
Venezuela and Colombia.

Let me start however again in our main
area of focus and that is in the Central Command
region. As you see here, it is of obvious
strategic importance not only for us for to many
of our allies and nations across the globe. In
addition to fighting two wars though, security and
stability here hinges on more than winning these wars. It also hinges on engagement and the responsible action of several other countries in the region most notably Pakistan and stability there as it relates to our operations in Afghanistan. In addition to that, Iran's continued efforts to develop nuclear power and possibly more importantly their continued efforts to destabilize the region in Iraq and other places. Continued safe havens in Yemen and throughout other areas of the region are continued cause for concern. Engagement with these states and others is necessary to accomplish our national objectives.

Let's look first at our operations in Iraq. We continue to transition from our surge operations of last summer and transfer security to our Iraqi Security Forces. We continue to train them and they continue to take leadership in an increasing number of operations. As all of you know, just last week President Obama announced a timetable for the completion of our combat mission
in Iraq. In August 2010 our combat mission will be complete. As he also noted, there will remain a significant force there to provide training, assistance and a limited effort at counterinsurgency and counterterrorist operations. There are three critical points to the President's plan. The first of these is the withdrawal of forces. The second is the continued support to Iraq as it continues to build the capacity for governance, to provide services for the rule of law and all the other aspects that are necessary to provide long-lasting peace and stability there. Lastly, the third part of his plan as he outlined it last week is an increased emphasis on regional diplomacy.

There is certainly some good news in Iraq. Regardless of what you may or may not hear in the press, the security situation there is significantly improved over the same time last year. Security incidents are down by over 60 percent from their highs of last summer during our surge operations. More importantly, the security
incidents that we see there today is less than it has been since 2004 shortly after the initial invasion of Iraq. In addition, we're starting to see the reduction of our requirements there as we've brought home many of the surge forces that were sent there last summer. And most recently we've seen probably one of the more important signs, and that is the successful and relatively peaceful provincial elections that were conducted just recently.

2009 will be a year of transition in Iraq. In addition to the force reductions that we will begin in the months ahead and throughout the next 18 months, we anticipate and have seen the departure of many of the Coalition partners. The reasons for these departures are numerous. Some have to do with political will, some have to do with pure economics, others have to do with the inability to establish appropriate agreements to support their troops there. Regardless of that, the bottom line is that both Coalition presence as well as our own presence will continue to
decrease. As that happens, we continue to anticipate the successful assumption of security tasks by Iraqi forces. The training will continue, and as the pictures there depict, success depends on the ability of our Iraqi partners to provide security for themselves. The pictures there represent operations just in the last few weeks, specifically in Mosul where the last remnants of al-Qaeda continue to cause concern, and Iraqi forces are leading the effort there to attempt to clear this region of continued al-Qaeda influence.

That is not to say there not challenges ahead. There are additional elections in the coming year that will be important to the country. In addition to that, there are still significant numbers of extremists that could possibly cause continued sectarian violence. As already noted, Iran continues to provide a malign external influence. In addition to these security concerns, other concerns exist. As is true in our own country and around the world, budget issues
The reduced price of oil is contributing to that. The ability to provide basic services, the capacity to provide rule of law, effective governance and other necessary services continues to need attention. Lastly, the Northern part of Iraq is also cause for concern as continued tensions between the Kurdish population there and Iraq as well as their northern neighbor Turkey continue to exist.

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

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

Likewise here there are significant
challenges. The Afghan-Pakistan border is
probably the most significant of those. The
continued sanctuary provided to the Taliban and to
other terrorists and opposing forces continues to
provide them the opportunity to operate with
relative impunity and to affect the security
situation in Afghanistan. We certainly expect notwithstanding the addition of forces to see increased levels of violence in the year ahead. Another change is the synchronization of U.S.-led efforts with those of our allies. Part of this is being addressed by the fact that General McKiernan was recently designated as both the commander of all U.S. Forces in Afghanistan as well as commander of the NATO forces which should significantly improve our ability to coordinate those efforts. Having said that, it is anticipated that we will see continued efforts to encourage our NATO allies as well as those non-NATO countries that are participating in our operations in Afghanistan to increase their commitment there. Most notably in the near term is the Afghan election. The election right now is scheduled for August. Recently in the news, President Karzai announced that he believed and the constitution provides for the fact that that election was to occur prior to his departure from office. His term expires in March. The
International Election Commission has established and as is supported by the Afghan Parliament that the election will occur in August. This is a good thing for us as we continue to flow those forces in there that will provide the security necessary for that election to occur.

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

One other area of concern before I leave the Central Command area of responsibility is that of piracy in part due to the profitable nature of the business and the fact that many of the shipping companies find it more profitable to pay the occasional ransom rather than to establish security for their oceangoing vessels. In addition to that, the relative lack of governance...
in Somalia, the increased incidents of piracy has
been significant especially since last summer.
About late August to early September we saw a
significant effort by the international community
to counter this. There is certainly some good
news to report. We have several maritime task
forces that we participate in are having an impact
in this area. The first of those is Combined
Joint Task Force 150. This task force dates back
to the start of our operations in Iraq and
Afghanistan. It was established to conduct
maritime operations in the Gulf of Aden, the Gulf
of Oman, the Arabian Sea, the Red Sea and the
Indian Ocean. The purpose is to disrupt violent
extremists' use of the maritime environment as the
venue for attacks or to transport personnel,
weapons or other material. This effort continues
currently under the command of the Germans and is
also having an impact on piracy.

Because of the increased incidents in
the recent months, in January of this year, we
established Combined Joint Task Force 151. This
was specifically designed to counter the piracy 
operations. As recently as early February, a U.S. 
ship was involved in its first seizure and in its 
first apprehension as you see in the photo there 
of pirates caught basically in the act of 
attempting to pirate another vessel.

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

Moving on from the Central Command area 
of responsibility, turning our attention to that
of our most recent combatant command established 1 October 2008, and that is the Africa Command.

This is a change of business for us. This is a focused whole government approach to a combatant command. Unlike our other combatant commands which are primarily military organizations, the Africa Command has a complementary mix of military and civilians with interagency members in leadership positions. General Ward is the first commander of AFRICOM. However, one of his two deputies is Ambassador Mary Yates. She is the Deputy to the Commander for Civil and Military Affairs. AFRICOM's goal is to enhance the capacity of Africans to care for their stability so that development can take place and Africans can prosper. They do this through building partnerships with governments, organizations and the international community to enable the work of Africans and help them provide for their own security. There are numerous theater security cooperation events that go on to this end. Some of those are highlighted here. The Africa
Partnership Station is a maritime effort and it is
an international initiative aimed at strengthening
West and Central African regional maritime
capabilities. The picture at lower left shows
some of the training going on in conjunction with
our Africa Partnership Station.

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

Lastly is the Combined Joint Task Force
Horn of Africa established in October 2002 to
combat terrorism and bring security and stability
to our regional partners there. They increasingly
are conducting day-to-day operations focusing on
engagements with partner nations to include the
provision of technical advice and mentoring.
Ongoing projects include repair of municipal
infrastructures, medical and education facilities,
combined with engagement operations with the
various governments and militaries within the Horn
of Africa. Again there are significant challenges
here as well. AFRICOM has some wide expanses that
make transit difficult, and they do so with
limited resources. As you noticed on the slides
showing the various commands, only about 3,300 DOD
members are assigned to the Africa Command at this
time.

The Africa Area of Responsibility used
to belong to the European commander. The EUCOM
command plays a significant role in support to
NATO. Their mission is to maintain ready forces
for full spectrum operations unilaterally or in
concert with our coalition partners. They enhance
our Transatlantic security through support to
NATO, promote regional stability, counter
terrorism and advance U.S. interests in the area.
They do this through numerous operations. Many of those shown here involve our NATO allies. Joint Enterprise in 2005 consolidated NATO operations in the Balkans, specifically in Bosnia and Herzegovina as well as those in Kosovo, Macedonia and Albania. These operations continue to maintain the peace even through Kosovo's recent declaration of independence. Operation Active Endeavor, similar to the operations in the Gulf of Aden, is a NATO effort to conduct surveillance in support of the global war on terrorism. Maritime operations here are using a variety of NATO contributing nations, their ships, operate in the Mediterranean from the Straits of Gibraltar throughout the Mediterranean Sea in an effort to ensure that weapons of mass destruction or other components are not transiting illicitly.

Finally, OIF and OEF are both supported by the United States European Command. Not only do they provide forces to the effort, but they play a significant role in training our NATO allies who are also providing forces. In
addition, the United States European Command plays
a role in the Middle East peace effort. They do
this through their engagement with Israel through
the United States Security Coordinator. In
addition to this effort which has obviously become
more important through the recent operations in
Gaza, last summer's emergence of Russia and their
operations within Georgia are cause for
significant concern which continue to be a high
priority for the United States European Command.

Moving on to our last two combatant
commands, they have similar challenges that EUCOM
and AFRICOM have. They have forces assigned and
are primarily focused on fostering peace,
democracy, freedom, promoting U.S. Interests and
doing so through theater security cooperation.
Within the PACOM AOR, these forces primarily
include our forward deployed naval forces, air
forces, and our U.S. forces that continue to be
assigned to Korea. There are numerous issues that
the Commander of the Pacific Command must
confront, but I'd like to highlight a couple. The
recent attack in Mumbai highlights the tenuous situation along the Indian/Pakistan border. Increased tensions threaten to spill over into differences over Kashmir and will continue to require extended and sustained talks to challenge and maintain some semblance of normalization. In addition, recent concerns within North Korea and the continued effort by the North Koreans to develop a nuclear capability, and most recently what appears to be their intent to launch a ballistic missile in violation of U.N. sanctions continues to be a focused area for the Pacific Command as well as for all aspects of the United States government.

Lastly, our Southern Command, our command closest to our own continental United States and the focus of a recent trip by the Chairman just last week to this region. SOUTHCOM's area of responsibility encompasses about one-sixth of the Earth's surface, has 32 countries and 13 territories, over 460 million people. U.S. forces continue efforts to interdict
the flow of drugs throughout the region and helped
to stop more than 200 metric tons of cocaine from
reaching U.S. shores in 2008. Counterdrug efforts
highlight the successful partnership of our
partner nations' forces, U.S. government agencies,
the U.S. Military and U.S. Coast Guard units led
by SOUTHCOM's Joint Interagency Task Force South.

One of the more recent aspects of the
drug war that has been confronted by SOUTHCOM is
the use of self-propelled semi-submersibles.

Traffickers increasingly prefer these for the
movement of narcotics at sea because of the
vessel's stealthy design. SOUTHCOM continues to
support Colombia in their counternarcotics efforts
by providing training, logistical and intelligence
support. Over 90 percent of the cocaine in the
United States emanates or passes through Colombia.

In addition to our counternarcotics efforts,
humanitarian assistance and disaster relief are
significant. We have conducted humanitarian
efforts there twice in 2008, once in Haiti in
September and in Costa Rica and Panama in
November. In both missions, U.S. troops airlifted thousands of pounds of aid to victims. In addition, two U.S. Navy amphibious ships brought health care and other relief services to eight Latin American and Caribbean nations during humanitarian and civil assistance Operation Continuing Promise, provided medical care to 71,000 patients, conducted 348 surgeries and completed numerous community renovation projects.

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

In addition to these current operations that are ongoing across the globe, we continue to look ahead to what may cause us significant
challenges in the future. Numerous stress points exist as you see depicted here. Most recently, the global economic crisis, crises in energy, and the lack of governance continue to lead to significant challenges. There are a few areas that show positive signs. Transnational violent extremism although no longer rising probably because of military action has had an effect. Events could force this trend line to be reversed. Cyber competition and cyber warfare continues to be a significant concern. The U.S. continues to possess robust capabilities and infrastructure. However, the number of highly skilled actors and sophistication of attacks will continue to increase. We saw this most recently in Russia's operations in Georgia where they were able to employ cyber attacks against the Georgian government to defeat much of their command-and-control capability, although limited as it may have been, and even more recently within our own DOD. The competition for natural resources has become more urgent much more quickly.
and is much more complex. Russia's natural gas capabilities and the dependence of European nations on Russia's supply is a great example of this.

On a day-to-day basis, there are several other things that we've talked about that in the near term that cause us concern. Many we have already touched on. One that we haven't is support for homeland defense. Operations in Mexico highlight the concerns that impact even those nations most closely aligned with us geographically. In addition, we continue to be concerned about threats to the homeland, be they nuclear, biological, counter IED or any potential for additional terrorist attacks, and looking ahead to some of those strategic challenges will force us to consider the balance of forces spread across the geographic combatant commands that I've highlighted here. Training, modernization and readiness are all significant concerns, especially readiness as we see a drawdown of forces in an effort to try to reset some of those forces, not
just the equipment, but the personnel as well. A
growing number of ungoverned spaces continue to be
a significant concern as highlighted by several
points throughout, but especially in Somalia and
in the Northwestern Region of Pakistan.

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

DR. WILENSKY: Thank you, Colonel Reist.

Are there any questions that people have?

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

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

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

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

CMDR FEEKS: Yes, sir. These briefings are prepared for the press, so certainly. And we could do better than that, too, as a matter of
fact I think more specifically for this Board.

Yes, sir, I'll work on that.

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

DR. WILENSKY: Any other questions?

Thank you very much. Our second speaker this
morning is Mr. James E. Brooks, Public Affairs
Officer at NAS Key West. He will brief the Board
on the military in Key West past and present.

MR. BROOKS: Good morning. My name is
Jim Brooks, and I'm the Public Affairs Officer at
Naval Air Station Key West. First of all, as one
of the folks that lives down here, I'd like to
welcome you to Key West. I understand that you
arrived a couple days ago and you had the
opportunity to join some of our weather yesterday.
Let me just say that was probably one of the
warmest days we've had in the last couple of
weeks. We've been suffering with some cold
temperatures. It's been down in the low 70s, high
60s for us, and that's cold.
I'm a transplant from the Navy. In fact, General Myers was an old boss of mine. I was on the Joint Staff, and while some of us retire and stay working in D.C. making the big dollars, some of us decide to come to Key West to retire. But I'm very happy still working with the U.S. Navy. The alternative was teaching high school English down here, but a good decision.

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

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

Fast-forward a year later, David Porter
arrives with a fleet of ships in 1823, and Porter
is actually going to establish the very first Navy
base here. I know you're going to be going down
to Mallory Square tonight to watch the Sunset
Celebration. That is the site of the first Navy
base. Over there there's a small shopping mall
with small shops. That was the first Navy
building built here and that building is roughly
150 years old. So when you're down there, just
always understand wherever you go in Key West,
you're probably walking on property that was once
owned by the U.S. Navy.

It was shortly after the Navy got here
that the Army arrived in 1831. The base was
officially established 5 years later, and it's
really about where our Navy housing is, Perry
Housing across from Trumbo Point. At the time
that was waterfront property and that's where the
Army established their base. The Army wasn't
really here that long because the troops there
were called up North to support the Indian wars in
Florida. Congress passed the Indian Removal Act
in 1830 and something had to be done with the
Seminoles. Unfortunately, Major Francis Dade, one
of the Army commanders here in Key West, took his
company of troops up North and unfortunately met
with a massacre by the Indian Chief Osceola. That
was eventually settled when the federal government
trapped Osceola and forced him out, but Key West
troops were involved with the Second Seminole
Indian Wars and eventually the Army came back to
Key West.

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

During this time we're talking the 1840s
to 1850s, the big Navy mission down here was
piracy. Yes, we had piracy issues down here.

It's also the first time that we actually really
see steam ships being used by the U.S. Navy.

Porter used steam ships to pull flat-bottomed boats full of sailors into the mangroves to chase out pirates. Then the steam ships arrived to combat piracy. Back then piracy was defined largely for the slave trade. The slave trade was declared piracy and the Navy went out there and intercepted the slave ships. This picture actually portrays the USS Wyandotte who captured a slave ship and brought over 400 slaves into Key West, and another ship, the USS Mohawk, brought another 400 slaves. So at one point in time, Key West was trying to take care of about 1,000 slaves that were here. They were eventually repatriated to Liberia. Unfortunately, when we did capture the slaves and bring them in here, many of them were sick. We had over 200 die. They were buried in a cemetery outside of town. Now there's a monument down near Higgs Beach that designates where those graves were.

Fast-forward. We're now in 1856 in Key West. Keep in mind that Key West is a very
Southern town. We're seeing Confederate flags being built here. We've got discussions between the Army Corps of Engineers to the Army troops here about finishing Fort Jefferson, or correct, Fort Zachary Taylor. That's the fort that's here. Fort Taylor was just about being completed and it actually would be completed in 1860, but this is a very Southern town. So Southern in fact we have a young woman here by the name of Mrs. Ellen Mallory. She is the mother of Stephen Mallory. Stephen Mallory at the time was an Alabama Senator and also on the Board of Naval Affairs. He was considered a strong proponent and extremely knowledgeable on naval operations. He actually introduced some reforms for retiring old and inefficient naval officers. He was also pushing the Navy's use of steam-powered and ironclad technology. Unfortunately when he was a Senator for the Union, he never really got those initiatives in place. When Florida and the Confederate States did stand up, Stephen Mallory became the Confederate Secretary of the Navy. He
was well trusted by Jefferson Davis. He understood that it was highly unlikely that the Confederacy would ever have any success against the Union Navy. He knew the Union Navy. So he actually pushed for many revolutions in military affairs such as ironclad ships and submarines. Unfortunately they didn't make a difference. But when you go down to the Sunset Celebration tonight, Mallory Square is named after Stephen Mallory, so Key West considers him a native son.

The Civil War here. Key West never fell into Confederate hands. This is Fort Taylor. It was completed in 1860. While Florida was having discussions on whether or not to secede, the Army Corps of Engineers had talked to the Army colonel over at the base here, the Army barracks here, about taking the fort. So during a midnight march in 1860, the 11th of December 1860, the Army commander marched his troops through the center of town at midnight to capture the fort for the Union. It surprised a lot of folks in town that the Union troops here would do something like
that. There was concern whether or not the South could react to that quick enough. They didn't, and the fort was eventually reinforced with troops from Texas. So Key West never fell into Confederate hands and that was considered a very big move. A lot of folks will argue that it shortened the Civil War by 3 years because we never lost this fort largely because Key West had a huge impact on the blockade running that the Confederacy was trying to do. Key West was home to the East Gulf Blockading Squadron and we were responsible for the Florida coast from Cape Canaveral to Pensacola.

We had intercepted about 300 blockade runners down here. They were here during the war. We were also a staging place for a lot of raids up North along the Florida coast especially around Fort Myers going up into Pensacola. Some of the troops that supported those efforts were the 2nd U.S. Colored Troop Squadron. They supported raids into Southwest Florida specifically around Pensacola, and again they had a big impact down
With that the Civil War ended and Key West again resumed its place down here as an Army base and a Navy base. In 1880, President Grant came and visited here, and actually one of the things while you're here, you're going to probably be hearing about Harry S. Truman. Key West has actually a legacy of hosting many presidents. It just happens that President Grant was the first President to visit Key West.

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

Things start to heat up, and in 1897 the Navy sends USS Maine down here. If you're joint warfare qualified or a joint warfare student, this
is known as a flexible deterrent action. The USS Maine comes here and actually begins a very close relationship with the city. The sailors are out in town and the USS Maine played in a baseball tournament for the Atlantic Fleet and beat a team from the USS Marblehead 18 to 3. This was a picture of the baseball team. This picture was taken here in Key West. One of the more interesting parts is that this was -- up there in the upper right was the pitcher. Unfortunately, every single one with the exception of the gentleman in the back would be killed in the explosion. Their goat mascot was left in Key West. The USS Maine left here on January 25, 1898, to try to soothe some of the tensions over there in Cuba. And of course as you know your history, the USS Maine blew up on February 15. Here in Key West many of the Maine dead were brought here, not all of them, but some of them, and they were buried out in the Key West Cemetery. The Custom House in the background, that's a prominent landmark here in Key West. That's where
the first board of inquiry into what caused the
explosion was held. The board came out and said
it was a naval mine that caused the explosion. In
1911 there was a second board of inquiry and they
essentially reaffirmed that the sinking was caused
by an external explosion. Unfortunately, the
debate grew in 1976 when Hyman Rickover, the
father of the nuclear Navy, opened his own
investigation and he declared that it was actually
a fire in the coal bunker which was located next
to a magazine. It's still debated today. A
National Geographic study in 1998 went back and
said, no, we looked at this again using high-tech
modeling devices and said it was an external
explosion. So the cause of the explosion is still
under debate.

I mentioned that many of the dead from
the USS Maine are buried in the cemetery and the
city went ahead and erected a memorial there. If
you have an opportunity to visit the cemetery
while you're here in Key West, that's definitely
one of the tourist locations on the island that
they talk about. We also have several other

The Spanish American War. Key West as

you could imagine was a key logistics base.

Everything pretty much was staged here and came

from here and also from Tampa. The war was

resolved, and we move forward to 1905. Key West

was one of the first places in the U.S. Navy to

receive navy radio. It was still very new and

nobody really knew exactly how to use it at the
time so we were on the cutting edge of development

on how to use radio here. Largely what they were
doing was time checks and weather checks for Navy

ships off the coast. Obviously time is very

important to the sailor when using it for

navigation, so that was a key part. Also in 1914,

President Wilson was trying to coordinate orders
to the troops in Veracruz, Mexico and this a very

important relay station for relaying orders from

Washington to Mexico.

While you're here you're going to hear

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

On to World War I. That's when Naval
Air Station Key West was first established. That
was there at Trumbo Point. We had sea planes and
what was known as kite balloons. As it turns out,
we went ahead and made good relations with the
railroad because we leased the land for the air
station from the railroad about where our primary
visitor's quarters building is is where the blimp
hanger was and everything to the right of that
which is where our housing is is where the air
station was. We also started seeing submarines
come down here. Anti-submarine warfare training
was very good down here because the weather up
North in Groton, Connecticut was bad, so we
started seeing submarines come down here for the
first time. And a man by the name of Thomas
Edison came down here to do some work with the
Navy Consulting Board. He actually worked a lot
on anti-submarine warfare. Josephus Daniels who
was the Secretary of the Navy at the time
approached Edison about doing some research.
Thomas Edison formed the Navy Consulting Board on
Technology which was actually the predecessor for
the Navy Research Lab. Unfortunately, Edison and
the Navy didn't see eye to eye on a lot of things. Edison thought that naval officers and Navy leadership were not creative and very difficult to work with. So after World War I, Thomas Edison and the Navy parted ways and Edison never worked on another defense research project again.

Ernest Hemingway. You're probably asking how can Ernest Hemingway, probably Key West's biggest figure, factor into military history. During the 1930s, the military footprint here all but disappeared. The only sailors we really had were at the radio station and keeping the naval station in a caretaker status. Ernest Hemingway in 1935 woke up one day to find a lot of tourists on his front lawn and asked the tourists what are you doing here and they told him the city gave me this tourist map and your house is on it. Thus began a battle between Ernest Hemingway and the City of Key West. So Hemingway told the city I'm going to build a brick wall around my house. The city wasn't too keen on that idea so they went around to every bricklayer in the city and said
don't sell bricks to Hemingway. Hemingway
happened to have some friends over at the Navy
base and Hemingway got all his bricks from the
Navy which the city couldn't do anything about.
So when you go down there and see the Hemingway
House and see the brick wall around the house,
you'll know that's courtesy of the U.S. Navy.
Also his boat, Pilar, was often moored in the
Navy's harbor over there. It rode out the famous
1935 hurricane there tied up. In 1935 the
railroad was all but destroyed because of the
hurricane that crossed the Upper Keys region. It
essentially bankrupt the Florida East Coast
Railroad which allowed the Navy to buy the
property at Trumbo Point. So while we objected to
it, we later on went and bought it from the
railroad.

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

Key West was so happy when they arrived that they
had a parade in their honor.

During the war as the war kept on, the
Navy established its Fleet Sonar School here.
From World War II all the up into the 1970s, all
Navy fleet sonar training was here. We had
submarines here on the waterfront and we had
destroyers supporting that training evolution.

When you go over to the Joint Interagency Task
Force South for a tour if that's on your schedule
this week, you'll be going into the original
buildings from the Fleet Sonar School because
that's where the command is now. During the war
they would have over 18,000 students.

The other thing that we did here for the
City of Key West is we brought water to Key West.

When we were starting to expand operations here in
the 1930s, we realized that the water situation
was very difficult. The distilling plants that
were here did not have the capability of supplying
the fleet down here. So the Navy entered into
talks with the Florida Keys Aqueduct Authority which had stood up in 1939 wanting to bring water down here. They just didn't have the money. So between the Navy and the Aqueduct Authority we built a pipeline down the length of the Overseas Highway to bring water here, and water started arriving in 1942.

Key West Airport. That was just a commercial strip. The Army came in here and turned it into an Army airport. The Army at the time had the mission of anti-submarine warfare. They had the fixed-wing aircraft and they flew them out of there. But that mission had quickly changed over to the Navy and the Navy took over the airport there. That wasn't enough room really, and what we did is we used the Key West International Airport for an auxiliary field and we built a new one up on Boca Chica Key. That's where the main naval air station is now up at Mile Marker 8. By 1945, the Navy had gone from 50 acres before the war to over 3,200. We're still the largest landowner in the Keys. Trust me, the
local county and city are always reminding of that
because they're always interested in obtaining
more land.

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

You're here today doing a conference.

We've had many high-level conferences in Key West.
Probably the most important one was the Key West
Conference of 1948. This was post-World War II.
We were trying to refine the roles of the various
armed services especially in light of the nuclear
age and the primary meeting for determining the
future roles of the armed forces were decided here
in Key West. We see James Forrestal right there
and Omar Bradley, the first Chairman of the Joint
Chiefs of Staff in that photo.
President Kennedy was here on two occasions, once was in 1961 to meet with the British Prime Minister. The official reason of this visit was to discuss the situation in Laos and what should be done, but given the timing of this visit in 1961, it was 3 weeks before the Bay of Pigs, many will argue that this conference was to decide or to determine whether or not there will be an invasion of Cuba using U.S. troops. Nobody seems to really know. That's something that's debated today. But given that it's 1961, tensions with Cuba are increasing now with Fidel Castro in power. Both Eisenhower and Kennedy had obviously made gestures toward Castro and getting him out of power, so it was no surprise when Castro would strike up a relationship with the Soviet Union which would then touch off the Cuban Missile Crisis that began here. Key West obviously is at the tip of the sword here. It looks like there's going to be a standoff. The crisis down here actually began in the summer of 1962. We had many Russian aircraft with
aggressive acts toward the Navy's S-2
anti-submarine warfare aircraft flying out of Key
West. We had harassment. We had a patrol boat
fire on Navy aircraft. So the situation between
the military forces was certainly increasing down
here and the military situation was ramping up.
The Army and the Joint Chiefs of Staff made a
decision to buffer up the air defense forces down
here and ordered down the an Army Hawk Battalion
and within a very short time we had missile
defenses and a command-and-control system set up
around the city, and these were really set up
right on the beaches to prepare for the showdown.

That showdown did occur, and rather than
going into all the details, obviously the military
situation here, the military base here played a
very prominent role. Ships and submarines that
were based here took part in the quarantine. The
air station was extremely busy with thousands of
sorties. The two most important sorties were
probably with the F-8 Photo Reconnaissance
Squadrons, a Navy and Marine Corps one, and this
is President Kennedy thanking the F-8 squadrons
for the work they did in providing real-time
tactical low-level reconnaissance and information
that was required for determining the status of
the missile bases in Cuba. But also after the
situation was resolved, making sure that they were
in fact dismantling them and moving them out. So
here they were presenting the Navy Commendation
Medal to the unit.

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

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

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

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

Key West was relatively quiet during the 1980s and early 1990s under President Reagan. We did have a hydrofoil squadron come down here during the advent of a 600 ship Navy. That never came to pass. It was too expensive. The
hydrofoils ended up leaving. As an ensign surface
warfare officer I had the opportunity to spend a
month down here on them. It was fun ship to
drive, it was a fun ship to be on, but manpower
intensive and it really didn't have the legs that
you really needed to do sustained operations at
sea.

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

This brings us today back to the future.
What's the future down here? I would say it's
kind of a back to the future situation. Last
summer we had a blimp come down here. We had
blimps down here during World War II all the way
up through the 1960s. We had a joint project
between the Coast Guard and the Naval Air Systems
Command to test out a manned blimp for sustained intelligence surveillance over the Florida Straits. There's human smuggling going on there, there's a lot of drugs being run through the Florida Straits, and we're looking for a long-term sustainable something that can be there 24/7 and with the blimp they wanted to see if that was a good alternative.

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

Key West is still a test bed of research and development. Over there on the bottom right is an underwater UAV, so to speak, a wire-guided test device that was tested down here 2 years ago.
And of course bottom left is the F-22. We had a squadron of F-22s down here. The air station supports all the armed forces and also all the other federal agencies. Radio Marti is a program run by the State Department to broadcast television and radio into Cuba. They fly out of the air station and we support them. We also support the National Weather Service that flies a UAV out of here that flies into the storms and gathers research on hurricanes down here. So we've become a very valuable base for homeland security and many of the other federal agencies.

And probably most important, the base realignment and closure committees over the past several years have kept Key West off of the closure list or the realignment list largely because we're an irreplaceable training site. We have hundreds of thousands of air space to train in and we don't have the problems of commercial airliner routes. When our guys take off to train, they can begin training 5 minutes after taking off. In fact, they can begin training based upon
how quickly they can go through their checklists
after taking off. They're right on the range. So
we do support that, and everybody wants to come to
Key West. I hope you enjoy your stay here in Key
West, and just remember that this conference is
part of our legacy of many important conferences.
Thanks a lot. If anyone has any questions, I can
certainly take them.

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

MR. UNTERMeyer: Yes, I have a question.
Who makes those submersibles that the bad guys
used?

MR. BROOKS: I don't know if you're
going to be talking to the Joint Inter-Agency Task
Force, but they're probably the best ones to ask
about that. Essentially what I've seen and the
one that's on display, it kind of looks like a
barge that's been welded over that has the
capability of bringing on water so it goes below
the surface. A lot of times it's towed. I don't
know if they have independent propulsion systems.
I understand some of them do. But the one that
they do have on display was designed to be towed
after being flooded.

DR. WILENSKY: Anything else?

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

MR. BROOKS: Sure. I do know a little
bit about it. A lot of the research on preventing
malaria or the mosquito problem was actually done
down here and the original thought was what we
need to do is keep the lands drained. So when you
drive through the Lower Keys you'll see a lot of
drainage ditches that were dug to aid in draining.
That was the first attempt and that had some
effect. It didn't really have a lot because when
we go back and look at the history of World War II
we find out that they had a huge mosquito problem
at Boca Chica that they estimated would reduce
nighttime work by 50 percent. They just couldn't
do work because of the mosquitoes. So the Navy
actually went out and would dump diesel fuel in a
lot of the places where the mosquitoes bred. They
kept track of where the mosquitoes were breeding.

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

DR. WILENSKY: Thank you very much. We
appreciate that. Our third speaker this morning
is Captain Martha Girz. She currently serves as
J-3 Assistant Chief of Clinical Operations for the
Joint Task Force National Capital Regional
Medical, JTF CAPMED. She's also Assistant
Professor of Medicine at the Uniform Services School of Health Sciences in Bethesda, a position she has held since September 2001. Captain Girz will update the Board on the Department of Defense Joint Pathology Center Work Group progress on the development of the strategic plan for the establishment of the Joint Pathology Center. Her presentation slides can be found under Tab 2 in your meeting notebooks.

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

We wanted to thank the subcommittee headed by Dr. Parisi for their excellent report. It had a lot of very thorough review of our concept of operations and we thank you for that
review. What we're going to look at today is the recommendations. The end of the report had nine numbered recommendations. What the group at JTF and then the Joint Pathology Working Group did was actually look at all of the recommendations that were in the body of the report numbering somewhere about 30. So if it seems confusing that there were more numerated on the slides than were in the actual recommendations, those were from the body of the report. The process that we took once you delivered the report to us was that the JTF Working Group went through each of the recommendations, determined whether we concurred or nonconcurred, then brought that to the Health Affairs Joint Pathology Working Group and we discussed then those areas where we had some noncurrence.

Under the clinical scope of service, I actually have two slides. The first slide you will see that we concurred with all of the recommendations, both the JTF and the Health Affairs Working Group. On the second slide here
which also is the clinical scope of service, there
was one recommendation that we had a comment from
the JTF. So the recommendation was encourage and
embrace civilian collaboration. We may have
misinterpreted this at the JTF to mean that the
Joint Pathology Center would take on civilian
cases for consultation and review, and so our
comment was that we were not looking to expand the
mission of the NDAA 2008 when it refers to
clinical cases. When we discussed this at the
Working Group at Health Affairs, the
interpretation there was that it really was for
collaboration in research and education and not
necessarily for civilian cases, and the Working
Group concurred that, yes, we would definitely
want civilian collaboration for research and
studies, and perhaps if there is clarification
from the subcommittee, that would be helpful for
us to determine. The other piece was that
certainly on a case-by-case basis if there were
civilian consultations for clinical work, we would
certainly look at that.
The next area was positioning of the JPC within the command structure where we had some bit of disagreement with the recommendation. The CJTF is very interested in looking at gaining efficiencies and so the initial positioning that we had putting the Joint Pathology Center under the Department of Pathology would definitely extend those efficiencies. The other piece is that it would maintain focus on the clinical services provided by the Joint Pathology Center and it's consistent with some civilian models. When we went to the Working Group, the Working Group had a long discussion about this issue and felt that perhaps positioning it in a different part of the organizational structure at the JTF may help with some of the inequities that would be perceived because it was under a pathology department. This is actually an area that's of interest to Vice Admiral Mateczun because in the National Capital Region as you well know we have many centers and institutes, some which have been directed by Congress, some which have developed on
their own, and some such as the Joint Pathology Center. Vice Admiral Mateczun’s interest is that these centers and institutes that fall within his joint operating area have similar function meaning that their governance looks similar, that clinical functions that occur have the same oversight both privileging and credentialing for peer review, for documentation. Any of these centers that have basic science would have good liaison with USU. And his interest is that in those areas that have the core competence, that those are the areas that are overseeing what these centers and institutes are doing. What the CJTF in conjunction with USU has done is brought forth a proposal to Health Affairs looking at how all these centers and institutes could potentially be housed within the National Capital Area potentially under the JTF. So this is an area that we're still working on, hoping to come up with a solution that will then be exportable to all centers and institutes within the DOD in terms of health. And that proposal that was brought forward is working its way
through Health Affairs and the service Surgeons General.

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

Major equipment special design requirements. The issue of a split functioning Joint Pathology Center where some of the functions would be on the Bethesda campus and some on the Forest Glen campus was a discussion I know of length for the subcommittee. Our issue at current is that given the timeline that we have, we cannot build a MILCON project. We would love to, but it's not possible to have the Joint Pathology Center open with the BRAC timelines in a single facility both because of space limitations on the Bethesda campus and the Forest Glen and because of environmental impact implications on both of those bases. But certainly we agree with the committee.
that we would love to have the Joint Pathology Center stand up in a single building, but we don't see that it's possible currently. We are looking for options which would take us into the 2015 range for bringing them into a single facility, and you all know the issue with MILCON projects and how long all of those types of processes take. So certainly we are looking at those options, but in order for us to have this stood up by the time that the BRAC law is in effect in 2011, we will need to proceed with our current plan and do future planning as we go.

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

Another area where we had a bit of
discussion was in the staffing. The recommendation was professional staffing issues, junior versus senior level may not be adequate. We based our staffing recommendations on mission requirements. Our goal is obviously for the highly qualified individuals. And as you know, we are DOD and we must follow regulatory hiring requirements and certainly would take any further recommendations for other models that may be out there that we haven't considered. And likewise in addition for staffing, the ratio of professional staff to admin, the comment was that it appeared inadequate. Once again we used our current DOD standards and so we would look to any models that you may have that we could then consider to address this issue. I'm subject to your questions.

I'm sorry. Let me just tell you what our next steps are. We are in the process at the JTF of developing the implementation plan. That will then be presented back to the Health Affairs Working Group in April with the presentation then
going to the SMMAC hopefully in May. Part of our implementation plan that needs to be reflected is the report from ASTRAND which looked at the holdings in the tissue repository. We are developing a plan to take their findings which as you are aware were excellent. The state of the tissue repository is in excellent condition. There is tremendous potential there. What we want to do as we develop the plan for the JPC is to ensure that we do not decimate our national treasure but that we use it for purposes for both the DOD and medicine in general to further molecular science, pathology, et cetera. To do that we will be looking at putting together a group of subject matter experts who will help us look at the findings, look at the potential and come up with a plan so that we can appropriately utilize what's in the tissue repository and appropriately determine whether research should be done with it, et cetera. So that will be part of our implementation plan. Additionally we need to develop a process to select a director. That
process we cannot determine currently until the
governance issue is decided with the newest
proposal from Vice Admiral Mateczun. So some of
those things are on hold until we have some of
those other decisions made.

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

DR. WILENSKY: Any questions? Dr.
Parisi?

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

CPT GIRZ: No, the current proposal puts
the Joint Pathology Center actually under the JTF.

However, the areas that have primary clinical responsibility will be embedded within the MEDCEN.

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

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

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

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

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

CPT GIRZ: The plan for organizational structure?

DR. PARISI: Yes.

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

DR. PARISI: One of our concerns obviously is that you want to make sure that the
JPC is positioned so that it has the visibility and the stature that it deserves if indeed it's going to satisfy the directive from Congress that it be a world-class diagnostic center. So that's one of our concerns, obviously, and I guess I'm still a little confused about how that's going to be positioned.

CPT GIRZ: The current concept is to have a director at the JTF with multiple centers underneath one of which would be the Joint Pathology Center. That director will then fall under the CJTF organizationally. Admiral Mateczun's concern is that he wants clinical areas to function with clinical areas, that they have appropriate oversight. This is a concern for all of the centers in the area because he has tactical control and will have operational control of the Walter Reed National Military Medical Center, and patient care that is being done in his joint area of operation he has responsibility for and so those areas where the competency exists is where he wants things to fall so that the proper
oversight is occurring. We haven't worked out all of the dotted lines. As I said, it's in a draft, it's in discussion, and the other piece that we think about is the Walter Reed National Military Medical Center is going to be unlike any other military treatment facility and so trying to work out some of these subtleties of where these centers and institutes will interface is part of our ongoing challenge. It's an attempt to address the issues of where it falls and how it's perceived, but still maintaining the clinical competency piece is paramount.

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

CPT GIRZ: The proposal we have is as I said is a proposal. It's a draft. Three other major centers. And then there are a whole host of clinical centers that somehow need to be tied in that function a little bit differently currently at Walter Reed and as they merge to the Walter Reed National Military Medical Center we need to
figure out how those are going to function as well. So it ends up if you include those it's about 10.

DR. WILENSKY: Do you have another question?

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

DR. WILENSKY: Dr. Oxman?

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

DR. WILENSKY: Yes, Wayne?

DR. LEDNAR: As the JPC is beginning to
move into its future, and I appreciate how DOD is
trying to look at all the institutes and centers
in a kind of harmonized way, I don't know how
similar or different the JPC's mission from
Congress is to the other centers, but with its
expectation to be world class, with its
expectation to be a federal facility in DOD
supporting other aspects of the federal
government, it would be very important to get that
input from those other federal stakeholders about
how they might be served by the JPC. That will
then drive some of the staffing issues, some of
the mission requirements, some of the
capabilities. And as you look for a group of
external advisers, it'll be important that they
are not just experienced clinical pathologists,
but they really have an expertise relevant to
being a world-class center of excellence and
that's different than just being an experienced
tertiary care center pathologist. So it's going
to be an important, thoughtful exercise about the
kind of perspectives that will be important and
then how the director the center will be rationalizing the input given the requirements of DOD.

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

The third thing is military relevance and clearly that's something that they've tried to keep in balance at the AFIP by having a military
director there but the military director was not usually someone who was academic enough or scholarly enough to really do the job of everything else at the level of leadership that was required. Indeed, for whatever reason, I think that the military relevance of it probably was one of its downfalls, that it didn't somehow maintain that customer base as its strong support. So accomplishing all those things must be done in the new organization and I think that identifying the right leader and giving them the resources are going to be what will make it happen or not.

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

CMDR FEEKS: Yes, Madam President.

First, there will be times when the slides presented are a more recent version than we have in our binders. Just for your information, the most recent version of the slides will be posted to the website and available to you that way. Second, Captain Girz, later you made reference to a body known as the SMMAC, and for the benefit of
those not familiar with it, can you tell us what
the SMMAC is?

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

CMDR FEEKS: Who composes that council?

CPT GIRZ: I'm sorry?

CMDR FEEKS: Who composes that council,
please?

CPT GIRZ: The Surgeons General are
represented.

DR. POLAND: Can I help?

CPT GIRZ: Someone help me.

DR. POLAND: The SMMAC is comprised of
the Assistant Secretary of Health Affairs, Dr.
Cassells, the Surgeons General, the Deputy
Assistant Secretaries, the Principal Deputy
Assistant Secretary, and it's an advisory council
for Dr. Cassells to help make decisions about the
MHS in general. It meets almost every Wednesday.
So items are refreshed and renewed and they're
current. The surgeons can bring topics to that.
The assistant secretary or the DASDs could bring
topics to that. So this is the forum where the
Surgeons General actually get to speak and really
vote their stock on the issues in the MHS.

CPT GIRZ: Thank you.

DR. WILENSKY: Thank you from me too.

Any other questions or comments?

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

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

MR. UNTermeyer: Is this a

jurisdictional issue? Is that why people wanted
an advisory board rather than a governing board?

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

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

(Recess)

DR. WILENSKY: Our fourth speaker is Dr.
Gregory Poland. Dr. Poland will provide an update
on the report of the Defense Health Board's Task
Force Review of the Department of Defense
Biodefense Infrastructure and Research Portfolio.
Tasked to provide an external review of the
department Biodefense Research Infrastructure
Portfolio, this group answered a series of
questions related to DOD's scientific and
strategic investments, its processes and
procedures related to product development and
licensure, and evaluated the scientific or
strategic return on investment for previous and
current research, development, training and education efforts. The Core Board has been sent a draft report on the 18th of February for their review and in preparation for discussion and vote. You may also find a copy of the draft report in the meeting notebooks. Dr. Poland's presentation slides may be found under Tab 3 of the binders.

Dr. Poland?

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

Just a bit of background. The Department of the Army, Office of the Surgeon General actually asked this question of the DHB and I've sort of given them one word headlines, that is, need translation and return on investment. So under need the question was was there a national or strategic need for the MSD to own and operate an infrastructure in support of mission requirements for defense capabilities abroad and homeland for biodefense. For translation, were the current processes effective
in transferring the results of primarily basic biologic research to advance product development and licensure. And lastly, did the current infrastructure provide scientific or strategic return on investment for previous and current research, development, training and education efforts. There were also questions about surety but those are being investigated and answered separately by the DSB rather than us.

We received that memo October 3 and asked for a report by December so we had a very limited timeline at a busy time of year within which to do it. So our subcommittee made the decision that this would be a high-level review with interim findings and recommendations which you've seen in the past and will vote on today. We would focus the initial review on biologics and not for example on personal protective equipment or drugs or the other aspects of biodefense. Again because of the timeline and the nature of the individuals involved, we could only look at the unclassified programs and thought all the
other follow-on issues that I've excluded would be topics for a separate entity. I'm reporting on behalf of a work group that included myself, Wayne Lednar, Dr. Breidenbach, John Herbold, John Clements, Frank Ennis and Joe Silva, some of whom are here today. Just to point out one thing which Dr. Clements hasn't really told the subcommittee but I think important in terms of his value to this part, and that is he's a certified U.N. weapons of mass destruction inspector.

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

Taking the first thing, need, we felt that there was no dispute that the DOD Biodefense Research Portfolio was unique and that DOD needed a BD infrastructure. This was for a variety of reasons that I'll just sort of summarize up there. One, simply having this provided in part a deterrent capability. Second was the responsiveness and turnaround of military labs which is very agile. As an example, we heard very clearly how DOD responded and assisted DHHS in the anthrax letter attacks, so it certainly provided the nation with a critical surge capacity. There is some reluctance, not always, but some reluctance in academia and industry in particular to engage in research that has a high level of risk and would result in for example an orphan vaccine. For example, pharmaceutical manufacturer X is not going to sell a lot of E. bola vaccine probably so why should they engage in the risk of
There is a surprisingly high demand for BSL-4 containment laboratories especially driven by the FDA animal rule for, for example, biodefense type vaccines which requires two animal models, so these animal ethical studies can only be done in those sorts of facilities and again that provides a unique capability to the government. They have unique aerosol and aero-medical isolation capabilities, a unique critical agent and culture archive asset and a capacity to receive unknown pathogens which very few if any other entities are willing to take. Under translation we felt that the basic science research was sound but there were barriers toward advanced product development and licensure. Some of those included a fragmented organizational structure that strayed from an industry best-practices model, lack of one-person accountability and senior leadership that had experience and credibility in vaccine development.
There were a number of complex management and oversight issues by DTRA. A lot of intellectual capital due to difficulties in transitioning junior-level military personnel to higher-level leadership positions. And then retaining their qualified scientists primarily because a lot of money has been made available through BARDA and other mechanisms for academia to now engage in some of this work. Difficulties with separate lines of funding from different entities that were not multi-year and hence not amenable to project sustainability. A set of processes that we sort of encapsulated as being relatively more concerned with inputs rather than outputs. So we would frequently hear briefs of this is how many people we have, this is how many square feet we have, this is how many monkeys we have, rather than you would think that the sole focus would be this is how many new products, this is how many patents, so that sort of idea. Then a very complex and unwieldy table of organization with multiple and separate lines of authority. As we would be
briefed by different entities, they themselves
could not simplify for us what that table of
organization looked like.

In defense of all of that I want to
point out something that might seem a nuance but
is extremely important and that is the directive
from DOD now has been to move from a goal of take
the basic science and move it to the stage of IND
or investigational new drug, to a develop an
FDA-licensed product. This developed FDA-
licensed product just to give you sort of a rule
of thumb generally takes in excess of a decade and
about a billion dollars for an industry who is
highly efficient and focused toward making a
profit to do that. So that that is a sea change
in terms of what the mission actually is. And
that directive occurred without any concomitant
change in staffing, resources, facilities,
organization or project management and processes.
So this is a major barrier that I think DOD is
struggling with.

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

Some other issues was lack of communication between the responsible entities and a strong feeling that this should be a joint program. To answer part of that concern was that the Integrated National Portfolio had really just
gotten feet over the year or two prior to this and we thought that was a good start as was TMTI which we thought was sort of a novel experiment, and again it's only a couple of years old and the results of that need to be watched and evaluated. We were also concerned that the extent of external scientific review and input was unclear but from what we could see inadequate.

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

So our recommendations were as follows, that productive biodefense research required centralization and joint programmatic planning, the development of clear evaluation metrics, sustained and identifiable leader accountability,
timelines with multi-year funding. Science doesn't progress with being funded for a year and then having a gap and then coming back to it when somebody thinks it's a priority again. Collaboration or jointness, clear priorities and biosurety. In particular, John and I reviewed some of these facilities and felt that a red team ought to be authorized to define and exploit vulnerabilities. Just as one example, I think it was the day that we were out at Edgewood, several of the contracted lawn mowers had come through the gate and not been stopped and it wasn't until they were inside the wire so to speak for some time that somebody realized nobody had inspected this truck and the people who came in with it. On their side they of course think that we've got a great program. We've got video cameras and security and fences and things like that, but you don't actually know what your vulnerabilities are until a red team tries to go in there Christmas Eve in the middle of a snow storm when the guy who was supposed to be on duty is sick and he managed
to talk one of his buddies who's never actually
been oriented into what to do to stand duty for
him.

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

We felt it was critical that there be
credible, identifiable leaders with authority and
accountability in each of these units, that there
be mechanisms to train future DOD biodefense
scientific leadership, realistic timelines and,
again, the collaboration involving not only other
federal agencies, but also industry and academia,
and those efforts are in place but they need to be further incentivized and accelerated.

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

Finally, I do want to say because this...
sounds like a critical report that our observation
was of very highly dedicated and hard-working
scientists and administrators who were determined
to make a difference but they were failed in our
view by a system that was slow, tolerated
complexity, lack of clear priorities, inadequate
accountability, redundancy, lack of funding and
lack of experienced leadership. So I will end
there and take questions.

DR. WILENSKY: Any questions?

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

DR. POLAND: I can summarize the service
secretaries' response to this brief in one word,
amen. They felt very strongly that we had hit it
right and agreed with our findings and I thought
took is seriously. I subsequently received a
letter from one of them thanking us for the
quality of the work that we had done and the
critical nature that we brought to evaluating
this. So I think they'll take it seriously.

DR. KAPLAN: And the next step is?

DR. POLAND: Up to them.

DR. WALKER: I agree with everything you
said and support it, Greg. This is something I've
been observing for decades and I think that this
is a good way to address it. I'm also on the
National Academy of Science Standing Committee for
Biodefense that's sponsored by the Department of
Defense. Its role is to help TMTI to accomplish
its mission, to give them advice about ways to
move these products and they're identifying and
working on. Something I have been disturbed with
by that process is the setting of priorities of
what they're going to work on. We came in after
they had done that. They identified viral
hemorrhagic fevers which I will concur with, but
then they chose -- to put all the agents into and
I don't know why they didn't work on adenoviruses,
hantaviruses and other -- and some things that I
think really might be more important.
Similarly, I notice in your report you refer to the choice of agents as inter se or meaning between cells, they had said intra se which means inside cells, but they did not do that. They chose bacteria that were mostly extracellular bacteria and didn't have any of the -- a true gap that needed to be addressed.

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

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

DR. POLAND: It's a good question and I'm not prepared to answer that, but I think as I...
mentioned on my slides, I think it's the topic of our subsequent evaluation where we get some depth on that. In part, some of those programs are not unclassified so we didn't deal with them.

DR. WILENSKY: Wayne?

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

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

DR. WILENSKY: Russell also had a
question to ask.

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

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

DR. WILENSKY: Greg, I actually wanted to pursue this point. I read through the executive summary that you had provided and I was surprised when I got to the end and you used the comments that you had on the final slide about a failed system that slow, tolerates complexity, lack of clear priorities, inadequate
accountability, redundancy and lack of experienced leadership. That seemed to me a very harsh statement relative to the other information that is in here. So I think that there needs to be somewhat of a recasting, and I'm not going to tell you which way to recast it, but that is a very harsh statement. If you want to make that harsh statement then I think you need to have a different lead-up than what you have in this written report that makes it not a surprise that's your final statement.

I actually from what you had presented and what I had heard at the presentation took away what you've just said at the end which is there are a number of successes that have happened at the research stage, there has been a distinct change in mission, but there hasn't been a follow-on support structure and/or maybe resource, but at least support structure and leadership change to reflect the newly articulated mission and that is a situation that can succeed. That's a very different flavor than the paragraph I just read...
and it didn't sound like what you actually had meant at least in the written form.

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

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

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

DR. WILENSKY: General Myers?

GEN MYERS: I guess my concern is I suppose this kind of report could have been written anytime in the last two decades probably. You pick any year and you could write something like this on this issue. But I don't think it's ever been more important than it is today given our security environment. So I'm a little worried about the question that Wayne asked. So we
briefed the secretaries back in December. We need
to brief the new group when the new group becomes
the new group because we have so many actings and
interims that I think this of sufficient importance?
that we just do that.

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

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

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

DR. WILENSKY: That's actually one of
the issues we'll discuss a little bit after lunch
in terms of as we transition forward not
specifically with relation to this report, but in general how we try to help make that happen.

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

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

CMDR FEEKS: No.

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

DR. WILENSKY: Adil?

DR. SHAMOO: Greg, you and I talked
about this a little while you were the President
of the Board and I think John may have been also
in one of the teleconferences. Anything
biodefense is also bio attack and there is a huge
enormous moral component to this.

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

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

DR. POLAND: Part of that may be the
common mistake that people who focus their
professional time in an area think that already
knows certain background material. To just
briefly state that, since I think it was 1972 when
President Nixon signed into law that the United
States would not engage in any offensive biologic
research, only defensive, such that even the sort
of if you will weapons-grade type organisms are by law in tiny quantities that merely allow for example diagnostic testing and other things like that. So there is no biologic research of an offensive nature as opposed to defensive, diagnostic, drugs and biologics.

DR. WILENSKY: John?

DR. CLEMENTS: At the outset this was by its definition an abbreviated look at a very complex problem because of the very short timeline. I had hoped that once this got to the service secretaries that would say now we would like you to go back and do a more thorough and in-depth analysis and actually take some time to look at this. So I guess that's my question of whether or not we actually might have a possibility to really get down into some of the substantive questions because the best we could respond to was the abbreviated reports that we received from the service laboratories but there really was not a chance to go in and actually look at that and try and make some sense out of all of that. So I
guess I have a question with a question and that
is do you think we might have an opportunity to
get back in and actually follow-up on this?

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

DR. WILENSKY: Yes.

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

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

DR. OXMAN: Greg, you made the point of
the tremendous difference between when the mission
changed to have an FDA-approved product as opposed
to an IND-ready product. I understand
superficially why that's beneficial. On the other
hand, I think it makes it an almost impossible
task given the diversity of the threats and
potential threats. I wonder if you visited that
at all and if there's any opportunity to revisit
that decision because I don't think it's really
possible to have FDA-approvable products in the
tremendous spectrum of threats.

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

RADM KHAN: That was excellent. Thank
you very much. It actually dovetails very nicely
with the presentation on USAMRID that you gave at
the last Board meeting in December I believe which
had some of the same themes when you look at the
recommendations. I have a comment and a proposal
to the Board. The comment was, and apologies
because I have not had an opportunity to read the
full report, but the back end of your presentation
spent a lot of time on this product development stuff and I hope that wasn't to the exclusion of the unique role DOD has in I think you mentioned it briefly capture and discovery, surveillance, basic research. There's a lot of activities that they conduct that are critical. There is really no other place.

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

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

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

RADM KHAN: The proposal is back to the Board and to the Chairperson of the Board, the
proposal that actually this Board could as the
external advisory committee and if there's an
effort underway to take all these various
components and structure them into a single unit
or some unified command, this Board could serve as
an external advisory committee and actually do
what's really needed with the sort of critical gap
analysis what is not occurring outside in the
private sector that really needs to be done within
DOD.

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

LT COL SILVER: Just a little bit. I
worked peripherally with the Armed Services
Biomedical Research Evaluation and Management
Board, that is, money and evaluation of how
programs are doing for the medical piece and then
there's another Board for the AT&L, acquisition,
that's the NBC kind of stuff. My understanding is
they're combining and it may be even this week
that they're meeting. So some of that stuff that
you're talking about I think is underway. I just
don't have enough other than what I just said,

that they are --

DR. POLAND: Changing landscape.

LT COL SILVER: Yes, sir.

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

DR. WILENSKY: Yes.

DR. DEDRE: This is an excellent report
but I was wondering whether the structure proposed
is the structure that would really promote
efficiency because the number and the diversity of
the problems involved in biodefense is such that
it calls for input by a large number of basic scientists coming from different disciplines. Perhaps what would better is to create a collaborative relationship between boards, the Department of Defense, university laboratories as well as industry. I don't think the DOD is the place to manufacture vaccines for instance because it has no experience in that area. Moreover, as I said, because of the diversity of basic science is needed to solve these very complex problems urgently, perhaps a different structure ought to be considered and do it like a Manhattan Project because delaying this further is highly dangerous for the security of this country.

DR. WILENSKY: Mark?

DR. MILLER: I'd like to follow-up on what Mike was asking before with the change of mission from going more of a translational model as well. I didn't hear very much talk about the budget and uniformity and FTEs and other structures over time. Has it been relatively uniform and sustained? And how has it changed
with the changing mission? The second comment I'd like to make is related to the previous comment, that there are wonderful public-private partnerships already. The NIH has worked very well with the BET mechanism, with CRADAS and working with universities and federal scientists, as well with the DOD to a certain extent although I think it could be a lot better.

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

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

DR. POLAND: That's the key.

DR. LUDWIG: We do it collaboration with a large number of other organizations including academia and industry. Of course, those relationships that we build over the years are exceedingly important to making sure that we do bring those products to market. In fact, the Medical Research and Material Command has over 1,300 CRADAs right now, far outnumbering all the other Army cooperative research and development.
agreements. USAMRIID by itself has 700 cooperative research and development agreements. So it's the interaction of the Army and Navy laboratories with academic and industry partners which is critical for getting these products to market.

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

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

Thank you.

DR. WILENSKY: David?

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

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

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

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

DR. HALPERIN: Greg, maybe this should
under kind of editorial comments. There's a large
focus on military, academic and industry yet we've
talked about the various roles of the military in
surveillance and recognition of problems, et
cetera, but we only talk about the U.S. Military,
academic and industry, and there is this other
DHHS component out there. What worries me just a
little bit is for example on your future slide.
It's the second to the last. I know you're trying
to summarize, but the two last lines are a bit of
oversimplification.

DR. POLAND: Yes.

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

DR. POLAND: I understand you. For
example, there would be no direct connections in the example you gave of bioterrorism and food borne.

DR. HALPERIN: That would be my worry.

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

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

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

DR. HALPERIN: I'm just commenting on who ought be on the campus, and maybe not just
these three entities, but maybe there's this fourth entity.

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

DR. WILENSKY: Any further comments?

DR. LEDNAR: It's easy in this kind of discussion to focus on technologies and moving to licensure and having products to use, but coming back to Bill's point, I think very importantly in the threat assessment and the needs in GAP assessment, what we haven't heard much about but I think is an important existing relationship to just reinforce is call it the military medical
intelligence globally. It's always been very helpful to the Defense Health Board to have liaisons from the U.K., from Canada, from other partner military agencies because we really want to have the very best information on the threats related to our defense that we should have to protect our forces and some of that may have a different optics to our military medical specialty expertise in other countries and that's a critical input at the very front end of this whole technology development stream.

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

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

DR. WILENSKY: Yes.

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

DR. WILENSKY: Ed?

DR. WALKER: I'm sorry. What are we voting on?
DR. POLAND: Acceptance of the report.

DR. WILENSKY: Right. The acceptance of the report that's put in your material.

DR. WALKER: Did I understand that there were a lot of suggestions and issues offered that might modify a report? So if that's the case, is it appropriate to put this on the table until we get a final report to vote on?

DR. POLAND: You could do that or we could vote with the couple of amendments that have been suggested.

DR. WALKER: I would prefer to see it. Not that I don't trust anybody. That's not the point, although we could raise that question. But seriously I think it would be more appropriate if it's going to be changed or modified that we have a final report to vote on.

DR. POLAND: It's the committee's pleasure.

DR. WALKER: It seems that's the right thing to do.

DR. LUEPKER: I think we should vote on

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

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

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

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

DR. POLAND: Yes, I got that.

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

Our fifth speaker this morning is Dr.
Charles Fogelman who currently serves as Executive
Coach and Principal Leadership Development and Management Consultant at Paladin Coaching Services. He also provides clinical care one day per week at an adult outpatient clinic. Dr. Fogelman will discuss the recent activities of the subcommittee including a summary of the subcommittee's last meeting held at the end of January, topics for future meetings, and the questions formally tasked to the Psychological Health External Advisory Subcommittee. His presentation slides can be found under Tab 4 of the binders.

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

That's us. That's what I'm going to talk about. And there's another line here is which is we're still open -- that's us. There are
two of us others in the room. Want to raise your
hands so people can attack you as well? I should
say that nearly everybody -- we only had two
meetings so far. One was utterly organizational
and one as you'll was kind of start-up substantive
and nearly everybody attended both meetings.

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

Most of this represents people who were
actually presented or called in because of the
snow. Not everybody was there. We really had
been trying to educate ourselves in a very broad
way. I talked about that a little bit last time,
but it continues to be true. The landscape that
we're trying to understand and about which we will
comment we hope as time goes on is not small and
is populated by not a small number of people of
organizations and is characterized by not a small
amount of overlap and duplication and multiple
interests. But will give you some sense of the
breadth of the things we've been talking about.

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

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

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

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

This one says, "Establishment of list of
issues to explore." That goes to trying to figure
out what we're actually doing. Since it's something I know about, I'm kind of conducting this sort of like a strategic planning exercise. We're brainstorming, we're thinking about the various things. I am dumping the contents of my now overstuffed brain because I have met with several dozen actors and made three or four or five site visits to places just to educate myself. But we're going to try to figure out what are the main things that we should be talking about, what are the main things about which we can possibly be giving sensible advice. We have some housekeeping things. We need to set up a schedule for the next year or 18 months to try to make sure that nearly everybody can in fact continue to attend. I accepted this job for these two meetings that we had so we have to determine who the continuing chair will be. And I'm going to tell everybody all about my journeys and all about the people I met. I'm reasonably confident that most of you don't want to know that. And we know for sure that one of the things we want to discuss is the
concept of resilience and what makes a resilient warrior. What's a good program to create a resilient warrior? So as a substantive matter we really will be getting into that.

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

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

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

Dr. LEDNAR: Straight up. The thought I'm having is perhaps a logical one. As we try to come around this area of psychological health is to avoid going narrow but deep in sort of a subspecialty area around psychology and mental health, behavioral health, things like testing
technologies and these kinds of things, but remember the connectedness that's important and that's the psychological health with the physical health, call it the more traditional medical surgical sides of the medical system and people's needs. Secondly and perhaps most importantly is the functional impact, the force readiness, the force health protection, the ability to work individually and as a coordinated team in getting the mission accomplished. And that's not something that we as health care people often think of enough and I would encourage at the inauguration of this important effort that we keep it very visible, that this is not a silo separated from the rest of the whole taking care of the health of --

DR. FOGelman: Absolutely. I can tell you that already in our beginning strategic planning both of those things have come up and we're on board with both of those things. It's in our awareness. In terms of the specific technology, we were asked the question, we can't
not answer the question was asked to us. But
you're absolutely right. And the notion of whole
persons, whole warriors is always right in front
of us. Dr. Dedre, would you agree that we said
that?

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

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

DR. FOGELMAN: I think you can certainly
count on Dr. Shelly McDermott Wadsworth
representing that position at our meetings.
DR. COHOON: That's why we're glad Shelly is on board. Thanks.

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

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

DR. WILENSKY: Any further questions or comments? Thank you. Our next speaker is retired
Captain Dr. Frank Butler, an ophthalmologist and former Navy SEAL. He is currently serving as a medical consultant to the Navy Medical Lessons Learned Center as well as an Adjunct Professor of Military Emergency Medicine at the Uniformed Services University of the Health Sciences. The Board believes trauma and injury treatment and prevention should be a Defense of Defense core competency and is pleased to have the members of the subcommittee participate in ensuring that such efforts optimally meet the needs of our service members. As Chairman of the Committee on Tactical Combat Casualty Care, a subpanel to the Trauma and Injury Subcommittee, he'll provide an update on the revisions to the Tactical Combat Casualty Care Guidelines after which there will be a discussion and vote. His presentation slides can be found under Tab 5 of the meeting binders. Without further delay I present Dr. Butler.

DR. BUTLER: Thank you. Dr. Wilensky, Mr. Middleton, Members of the Board and guests, thanks for the chance to be here today. We're
going to be talking about tactical combat casualty

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

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

As an advanced look at the proposed
22 action, we're going to ask for the Board to
endorse the recommended changes and that Health
Affairs endorse TC3 for battlefield trauma care to
both the surgeons general of the services but also
and perhaps more importantly to the line
leadership as well, and we'll talk about that some
more as we go on.

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

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

What accelerated the use of TC3 was the
war. After 2001 as we started to look at the
casualties and what the implications of our
fatalities were, the services quickly began to
realize that we were pretty close to being on the
money with these recommendations. Now at this point pretty much all the services have adopted TC3 in some fashion as have the FBI pre-hospital folks, the CIA, major allied countries such as Canada, the U.K., Germany, Israel. So we've had those measures of success. One of the challenges that that has presented is with this big user base, how do we go about changing and getting endorsements for changes that we propose?

The group that develops these proposed changes is the Committee on Tactical Combat Casualty Care. It's been around 2001 originally funded by the Special Operations Command out of Tampa. It was after the first couple years as a pilot program taken over by Navy medicine and supported through the Navy Surgeon General, and I have to acknowledge the incredible support that we've gotten from the Army Surgeon General and MRMC, the Army Medical Research and Material Command, and the Institute of Surgical Research the last few years. The committee comprises members from all of the services and the civilian
sector, and we have a tremendous mix of trauma, emergency critical care, medical educators, and very importantly, we've got the combat medics at the table and that's a change from the way that things used to be done.

As of March 2008, we belong to you for better or worse. Who's in this group? It's a pretty interesting crowd. Some of our members have included the U.S. Surgeon General. You may or may not know that Dr. Carmona was an old Delta Special Forces medic back in the day and he was a tremendous participant for a while. Dr. Dave Hoyt when he was Chairman of the American College of Surgeons Committee on Trauma took part in the meetings. We've had trauma consultants from all three of the services, five trauma directors from level-one trauma centers. Currently the Vice President's physician is a committee member and they follow what we do very closely for the purposes of taking care of our nation's leaders. And we have a mix of operational guys from all over the place.
I will go back and touch on a couple of the metrics that we saw before when you ask what is the evidence for this actually working. One of the studies that I think is important is one that was published by Dr. Holcomb and Howard Champion a couple of years ago and it defines or outlines that the U.S. casualty survival rate in the current war is the best in our country's history going, from 19 percent fatality rate in World War II, to 15 in Vietnam, to about 10 percent currently. That's certainly a multifactorial outcome, but one of the things that they identified as important was trauma combat casualty care.

The medical educators are buying into this in the services. This is quote from Bob Mabry and John McManus who are in charge of doing combat medic training for the Army and this was from their paper last year on critical care medicine. In their words, TC3 has revolutionized the management of combat casualties in the pre-hospital tactical setting.
To look at some specific interventions, and I will touch on this paper, one of the things that is most closely associated with TC3 and presents one of the most definitive differences between what TC3 recommends and what the civilian trauma sector recommends is the use of tourniquets. Two months ago the largest tourniquet paper as far as I know that's ever been in the medical literature was published. John Craig from the Institute of Surgical Research looked at the association of tourniquet use and survival and he has documented that tourniquets are saving lives on the battlefield. They looked at one 7-month period at one hospital in Baghdad and estimated 31 lives saved in that timeframe. When asked by the Army Medical Research and Material Command to say can you take these numbers and tell us how many lives have been saved throughout the way from using tourniquets, the number that Colonel Craig and ISR provided them was 2,000 lives. That seems like a big number, but when you look at scenarios like this, this was
when HM1 Jeremy Teresi from the Marine Corps Special Operations Command presented last month at the TC3 Committee. He presented one scenario in Afghanistan where his unit was ambushed. They had 15 casualties. He was the only corpsman, and he was shot himself. In that one scenario they had four tourniquets applied, three lives were saved and the fourth casualty died from a chest wound. So that is remarkable input directly from the war fighters.

What about the concept that we've all learned when we went through medical school that if you put a tourniquet on somebody's arm or leg, that limb is going to be lost? Using the same cohort of patients described before, Colonel Craig published a paper last year where he looked at his 232 patients from his hospital in Baghdad and looked at complications. In those 232 patients with tourniquets, the number of amputations resulting from tourniquet use was zero. So what about this popularly held concept that tourniquet use is going to result in extremity amputation?
That's starting to look like a little bit of an urban myth at this point because the mean tourniquet time in this paper was 1.3 hours. I don't want to imply that we don't have good rapport with the civilian pre-hospital trauma sector. This is an excerpt from a letter written by Dr. Jeff Salamone who's a trauma surgeon at Grady Hospital and as the Chair of the Pre-Hospital Section of the Committee on Trauma. This letter is a letter to Dr. Cassells congratulating him on the advances made by the U.S. military in saving lives with TC3. I think it's safe to say at this point if you look at civilian trauma care in the very near future you're going to see convergence toward what we're doing in the military on at least four or five pre-hospital care points.

What are we up to at the moment in the committee? We try to keep the guidelines updated and we do that based on input from the war fighters, from the Army laboratories, the Navy laboratories, the Air Force laboratories, and
based on our reading of the pertinent literature.
As we update the guidelines, we also have to
update the training curricula and periodically we
update the Pre-Hospital Trauma Life Support
Manual.

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

Tourniquets. We are convinced that
we're doing good with tourniquets. However,
learning largely from Colonel Craig and the
Institute of Surgical Research, we are polishing
up our technical a little bit. First of all, we
are being more specific about saying use a
recommended tourniquet. We're not in the
tourniquet selling business, but I will tell you
that all tourniquets are not equal and the
military is buying some of the ones that don't
work, and the IRS has a great study from 2005 that
shows you which ones do work and we are going to
have a suggestion that people use those
tourniquets that do work. We recommended that the
tourniquets be applied over the uniform in care
under fire for speed and then later on move to
directly over the skin where they can be a little
bit more effective. We recommend now tourniquet
use for all traumatic amputations because if there
is no distal extremity, you can be more aggressive
in using these tourniquets. Colonel Craig has
nicely demonstrated that there is a need to
eliminate the distal pulse. If you put on a
tourniquet and blood is still coming into the
extremity but blood is not able to return to the
central circulation, that is not a good
physiologic state.

If your first tourniquet doesn't work,
don't take it off and put another one, put a
second one on because tourniquet effectiveness is
associated with width and if you use a second
tourniquet you've effectively doubled the width of
your first tourniquet. Then lastly, expose and
clearly mark the time of amputation. For anybody
who doesn't believe that we went to this war
without tourniquets in large part, take a look at
this. This is what our medics were doing. We
wouldn't give them a good tourniquet at the start
of the war. They tried to fashion them from
T-shirts and bandages. The effectiveness rate of
these makeshift devices is about 25 percent as
opposed to 80 to 100 percent for manufactured
tourniquets. Hemostatic agents have been
pioneered by the Army, and clearly the Institute
of Surgical Research has been the leader in this
field. We're now recommending combat gauze as
opposed to the older agents HemCon and QuikClot.
Studies done at both ISR and the Navy have
demonstrated that this is a dramatically more
effective material to use. It's basically gauze
with kalin impregnated in it and kalin activates
the clotting system and promotes clotting in
wounds. That's important if you have an injury
not in your arm down here, but what if the injury
is up around your axilla or on your neck or in
your groin? There you can't use a tourniquet and
go to one of these hemostatic agents.

Important in this decision were the
medics saying these older agents that we used to
use, the powders, those are a problem on the
battlefield because it's windy and they tend not
to go down into narrow wound cracks, again great
combat medic input to the discussion. If any of
you have followed the literature that's been
recent about WoundStat, the answer to one of the
questions that might come up is, yes, WoundStat is
more effective but we also caveat that by saying
that there are some real safety concerns with
WoundStat, and I'd be happy to get into that if
you would like.

Management of tension pneumothorax has
been changed somewhat. We still recommend that
for someone who's shot in the chest and who has
progressive respiratory distress and circulatory
compromise. However, now we're more specific
about using a 3.25 inch needle. It's that getting
down into the weeds? It is, but there's a lot of
recent literature that is showing that the
standard 2 inch needle does not work reliably, and
I will credit Dr. Mallak and his great team at
the Armed Forces Medical Examiner's Office. We
had Ted Harkey come and present to us, and this
was precipitated by two cases that he looked at at
autopsy where a tension pneumothorax was attempted
to be decompressed with a 2 inch needle and he
could see in his CT scan that it didn't go far
enough, it didn't get through the chest wall. And
in doing further research they've now demonstrated
that only about 50 percent of the time will a 2
inch needle work. So now we're using a bigger
needle.

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

Management of sucking chest wounds. As
you know, a sucking chest wound is when you have a
big hole in your chest and when you inspire the
air enters not into the lung on that side but
preferentially through the whole in the chest and
management of that has historically been an
occlusive dressing. I'm sorry, a three sided
dressing. This is a representative hole in the
chest that might cause this type of respiratory
compromise. Conventional wisdom is a three sided
dressing so that if there is a buildup in pressure
and you start to get tension pneumothorax that it
could decompress through that third side. There's
no data to show that that works and it's harder
for the medics to do. So we said just put an
occlusive dressing on there. Watch closely for
the development of a subsequent tension
pneumothorax. If that happens, put a needle in
their chest.

Management of penetrating eye injuries.
There's nothing new here. This is pretty much
standard management of eye injuries. It's just
that this is the first time that the committee has
addressed eye injuries. Basically, if you're in
the field and you can see this more subtle globe
penetrating injury here -- pupil and the pigment
at the limbus. A quick check of vision, cover the
eye with a rigid shield, not a pressure patch, and
give antibiotics. This eye might do very well.
If it gets infected it will not do well.
One of the biggest areas is documentation of care. We're all sort of pinging on the medical record, but the medics have this perspective that extensive data entry and continuing to be in a battle don't really go hand in hand. I don't know where this idea. As a result, we had a conference on this topic in September 2007 led by Don Jenkins from the Air Force who used to be the trauma consultant for them. This is an amazing number. Of the 3,000 wounded that we had at that time, less than 10 percent had any pre-hospital care documentation, and in only about 1 percent of the cases was that information adequate. Interestingly enough, where it was adequate it was largely due to the group that Dr. Dickey and her folks from Texas A&M have been working with. It is the Rangers who using their medics developed a simplified casualty card. It's waterproof paper. There's not any writing. You just circle or check. It's designed to be very fast and to minimize the lack of situational awareness that the medic has to the tactical
situation while he's doing the documentation.

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

The last change that I will mention
briefly is changing the third phase of care, care
under fire, tactical field care and then it used
to be casualty evacuation care. Some of our
medical doctrine developers pointed out that that
term was a little bit outdated. If you've ever
read the great book "We Were Soldiers Once and
Young," it talks about how if you don't understand
the difference between these two things, it can
result in disaster if you have a mass-casualty
situation. So we've tended in TC3 to emphasize
CASEVAC care which is where you call one your
units or your support unit's combat capable
aircraft that can fly in horrific conditions as
you see here. They've got guns and they can
defend themselves. They will come into a gunfight
and get you. As opposed to the Red Cross marked
MEDEVAC choppers which are very medically capable
but in many situations they can't come in because
of flying restrictions or because there's a
gunfight going on. But now we're changed our
thinking to incorporate both types of things
because in fact in theater you're using both types
of assets extensively at this point in time to
clear the battlefield of your casualties.

So we're doing some things well. We
certainly have a lot of room for improvement. One
of those is that we need to train TC3 to everybody
in the medical department and not just the combat
medics. The combat medics got it. The doctors
and the nurses not too much. You don't get it in
nursing school and you don't get it in medical
school. You don't get it in internship. How are
you supposed to know about this? They only teach
it in combat medic school. So we need to do
better on that. I will point out that the Army is
the exception. Last month they sent out a message
that said from now on everybody in the Army
Medical Department, before you go to the war is
going to get this training. We need this. We've
talked about having a better definition of our
change implementation process and when we make a
change how do we get it out to all the people who
use TC3.

This is maybe the most important bullet
here. Combat leaders need to understand combat
medicine. I'll give you two pretty amazing
two examples. We have had repeated episodes where the
lieutenant or the captain has come up to his medic
and said, Why are you putting on that tourniquet?
You should be starting an I.V. They have an
experience based on maybe a family experience with
civilian sector medicine or watching TV or who
knows what. But we need for them to have
appropriate expectations of their medics, and they
don't necessarily. The second thing is that they need to incorporate medical planning more definitively into their mission planning. All combatants on the battlefield should be trained in the basic TC3 lifesaving skills. You've heard about the Golden Hour? Forget about the Golden Hour. If you get shot in the leg and you are bleeding from your femoral artery, how long do you have? You've got a Golden 5 Minutes. And if somebody doesn't get a tourniquet on, your leg in that Golden 5 Minutes, that's the ballgame. So everybody needs to know how to do this. Then lastly as we talked about, better pre-hospital trauma care documentation.

What is the potential for improvement with these suggestions? This is some amazing data. If you look at John Holcomb's paper from 2007 where we looked again with Dr. Mallak's team's help, we went and pulled all the autopsy records for our first 82 fatalities in special ops to look at cause of death and to see if they were inevitable deaths, airplane crash, or potentially...
preventable deaths. The number we came up with
for potentially preventable deaths was 17 percent.
That's a lot. More recently, Dr. Kelly in his
2008 paper in his cohort had 19 percent, and in
his second cohort he had 28 percent preventable
death estimation. Contrast that with the
presentations made by Lieutenant Colonel Russ
Kotwal who is the senior medical officer for the
Rangers. He presented in September at the First
Responder Conference that the Ranger regiment has
had 482 casualties to that point. They've had 37
fatalities. But the incidents of preventable
deaths was zero according to their own internal
evaluation. Lieutenant Colonel Andy Pinart from
the Army's Special Missions Unit 3 weeks ago came
and presented his experience from his unit, 201
casualties, 12 fatalities, number of preventable
deaths, zero. What they have in common is that
they since the start of this war have trained both
their leaders and every operator in TC3.

So our proposed action to the Board is
that Secretary Cassells endorse TC3 both to the
surgeons general as the basis for combat trauma training. And secondly, to the service line leadership so that they will incorporate an overview of TC3 at the entry, midlevel and senior leadership courses for their officers and enlisted. And then to train all combatants in at least the basic TC3 lifesaving skills. I will mention at this point that Secretary Cassells has gotten a little bit of a head start on this and this part has happened as of last week. He did send out a memo that Commander Feeks was nice enough to send me that said surgeons general, here are the new changes. We recommend that you take a look at them and consider them for use in training your combat medics. Please, questions.

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

DR. BUTLER: It was general, and it referred to the updated TC3 changes as a whole.
rather than addressing specific changes.

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

DR. BUTLER: There are three competing
schools of thought to the Ranger casualty card.
One is that some of the medics will say I don't
have time to do this at all. There is a Standard
Form 1380 which is sort of a longish card and asks
a lot of irrelevant questions like your religion,
a lot of demographic data that you just don't need
to document care. The third competitive is the
BMIST which is an electronic handheld device which
the medics would be possibly given to go out onto
the battlefield and actually initiate the
Electronic medical record on the battlefield and that's not been well accepted by the medics. There have been a number of pilot programs to try to do that and somehow those things keep getting broken.

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

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

DR. WILENSKY: Nancy?

DR. DICKEY: I think my question is the same as yours. Would we create any problems by recommending strongly that the data suggests that
the entire trauma service ought to begin using the

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

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

DR. BUTLER: It has been, and I'm
thinking back years to when Health Affairs
convened a group to look at this that had some of
the best trauma minds in the country and there
were two to three really big impediments to that.
Number one is we didn't have good predictors until
you had somebody with essentially a blood pressure
of 50/0 and at that point it's not hard to tell
they're in trouble. The second thing was that
tactical leaders, and I provided this input to
them because as a former SEAL platoon commander, I
don't want any transmissions going out from my
unit that I don't absolutely have to send out
because the bad guys have direction finding too
and it is a tactical compromise to send out a
transmission from your location. The third thing
is that it's an immensely expensive and
complicated thing.

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

DR. BUTLER: You could do that. Again
you have the expense and the complexity and you
wouldn't really capture the interventions that
were attempted unless you had some way for the
medic to interact and enter data into this
recorder so that you could track what was
happening physiologically with what you're doing
to intervene, but it is a question that does come
up.

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

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

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

DR. BUTLER: Dr. Miller, that's a great question. The best example of that sort of a
system is personified by the Joint Theater Trauma
System that is run out of the Institute of
Surgical Research. They take all this data that
is collected in theater and very methodically look
at what we can infer from that data. Colonel
Holcomb is going to come in in the future with
some other pretty amazing things that have
occurred in the hospital-based setting. The
missing link to being able to do that in the pre-
hospital care arena is that we have no
pre-hospital data in the Joint Theater Trauma
Registry and this medic card hopefully will give
us that data. But I would look at a program that
is analogous to what the Joint Theater Trauma
System does for in-hospital trauma to pre-hospital
trauma. I think that’s very, very important and
should have been more specifically outlined on my
slides. Thank you.

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

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

DR. BUTLER: To dispose of your last question first, this is not the only study. It's just the most recent. We have lots of others that I would be glad to share. But his methodology, Dr. Craig was in a combat support hospital in Baghdad and he looked at every patient that came into their hospital in a 7-month period in 2006 with tourniquets on, and that was his cohort. It's interesting. There were some other things that we didn't touch on like we think we had the
tourniquet problem licked. Not exactly. If you read that paper, there were five people who are discussed in the paper who came into the hospital without tourniquets and who expired. But his methodology was one hospital, one time period, all tourniquets.

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

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

DR. BUTLER: I think that does happen certainly in the Rangers and in the Army Special Missions Unit. That flow of information from the relatively young medics up to the commander
occurs. I don't think we can fairly represent
that that happens in the 82nd Airborne and the
101st and the 3rd Army Division. There's a big
gap there.

DR. WILENSKY: Command Sergeant Major?

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

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

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

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

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

DR. POLAND: Thank you. This is just an
informational and discussion item. As Gail said,
I’ve been to the DSB a number of times on behalf
of the DHB. It’s interesting to see, in fact let
me just say, that DSB is a Board that is in many
ways analogous to the DHB. They're a DOD Advisory Committee of outside experts who provide critical advice on scientific topics. Some were nuclear proliferation, chemical weapons capabilities, mechanical and other forces involved in TBI secondary to IEDs. So they don't deal with medicine or health per se, but other sort of scientific aspects surrounding that.

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

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

The have sessions that run 1 to 2 weeks held in various facilitating venues. I think their last one was held at Stanford. So they go there for a week or two in the summer. We couldn't make a copy of the executive summary because that alone is 100 pages. That doesn't sound like an executive summary, but it was on the future of war. Talk about an overarching topic, and it was specifically called Challenges to Military Operations in Support of National Interests. I handed out to you, you have a piece of the executive summary. They were tasked with this question, Is the United States maintaining
its capability to deter and defeat a nation or nonstate actor who might employ unconventional as well as conventional means in nontraditional as well as traditional ways to thwart U.S. interests? Over the course of a week or two they had a variety of experts come in in sort of a study section, almost university-like atmosphere with subject matter expert input, presentations, vigorous debate, development of overarching principles and then integration. So for the question I just read to you, they divided it into seven topic areas, the future of war, unconventional weapons and technology proliferation, the special case of nuclear proliferation, unconventional operational concepts in the homeland, what we know and don't know about adversary capabilities in regards to intelligence, and fighting through asymmetric counterforce, and lastly, strategic communication, another instrument of U.S. power. So while I'm talking I'll just pass the summary report around and you can take a glance at it.
These integrated recommendations then are published comprising reports of various lengths, often 50 to 100 pages which I mentioned, only to tell you the depth of what they have gone into. As I said, I've sent around the three or four pages that comments on the final report. The danger of presenting an example to this Board is that you'll focus on the example. I'm wanting to just use it as an illustration to discuss the concept, not this. But for example, we have bitten away at a variety of little pieces of human health research, but maybe we could for example use a Summer Study Session where we would look at what are the current and future priorities. We have in the 14 years I've been associated with this Board continually talked about problems with databases that don't talk to each other. What is the electronic infrastructure that's used to collect these data? And there has never been a broad report from DHB looking at that trans-service issue. How do we capture, maintain and preserve specimens and data in large
databases? How do we integrate preclinical T-1, T-2 and T-3 research? What about research oversight? What about war versus peacetime needs and capabilities? And what about this continuum from prediction and prevention all the way through chronic and rehab sort of care? Just examples of how you might take a broad overarching issue, divide it into subareas, bring together a group of experts for a week, really dig in on this and then integrate those aspects into a comprehensive sort of report.

Peter Drucker has said management is doing things right, leadership is doing the right things and I use that as a fulcrum, if you will, with the Board to say that service members and their families, DOD and the nation deserve the very best advice available that's thoughtful, critical, comprehensive, forward looking and characterized by impressive breadth and depth, and I present to you just one mechanism for our consideration. Should we consider a similar sort of mechanism? What sort of topics might those be?
And would it actually offer advantages? Dick Myers stepped out of the room, but there may be others who have been exposed to DSB reports. I don't pretend to speak for him, but I asked him about this at breakfast and as the Chair of the Joint Chiefs he found these comprehensive, in-depth DSB reports often times critical to the kinds of decisions they would make. Comments? Discussion?

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

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

DR. LOCKEY: I'll give you an example of why your idea is so appealing. About 2 weeks ago I was asked to give a presentation on the role of epidemiology and the prevention of nanotechnology-related adverse effects. These are like atomic-level things. Naive me going into
this meeting, I thought I wonder if this has any relevance to the military? When I chaired a breakout session and the Navy was there, Air Force was there, they were all there. They were all dealing with nanotechnology-related particles but we as the Defense Health Board might want to say what should we be doing, how should we envision problems associated with nanotech. I think it's an example of where you would need to step back, we'd need to bring experts in. We'd need to think of how it's relevant, et cetera. But it can't be done just waiting for somebody to ask us.

DR. POLAND: I absolutely agree. That's an important aspect that the Board has exercised in the past where we initiate a question or an issue and not just wait to be asked. If you look in the very back of the report I'm sending around to you, you can see the lists of outside experts and presentations that they brought to bear on this topic. I will say I know that the concept is a bit frightening to say how would I take a week out. I wrestled with that myself before proposing
to Gail that we talk about this because I turned
it around in my mind, we do it anyway, but we do
it discontinuous. And are we really saying that
DOD doesn't deserve a week of our time. They'd
pick one issue a year. Maybe we'd do it at the
committee level where each committee would pick
one, or as the Board, whatever it would be, but
doesn't DOD deserve that from this?

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

DR. POLAND: Right.

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

DR. POLAND: Absolutely.

DR. WILENSKY: General Myers?

GEN MYERS: What I've seen in the
Defense Science Board is that they may dedicate a
week or I think sometimes even longer than that to
the task, but people come and go as their
schedules allow. And they also have a lot of
outside participants which allows you to meet a
lot of people because you're looking for real
extpertise that maybe the Board doesn't have. I've
participated on several of those and I've been the
recipient of several of the briefings, and as the
Vice Chairman of the Joint Chiefs, one of the
things we always tried to do as Vice Chairman was
to get out there for the debrief because they're
pretty extensive. I thought it was a pretty good
process, that is, listen to as any bureaucracy
listens to any of this, but with that caveat I
think it can be pretty influential. Thank you.

DR. WILENSKY: Adil?

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

DR. HALPERIN: I don't understand the
composition of the Defense Science Board. Do they have longer terms than we do? It seems that we have a short enough term that if we invested the energy in educating us, by the time we really understood things we'd be rotating off. The same thing happens with I think in the military where people get into the job and rotate frequently as well.

DR. MASON: I'd like to piggyback on what Dr. Halperin suggested. Since all of us have been on the receiving end of reports that are historic in terms of exposures, I would suggest that it would make perfectly good sense to ask a question and demand a response in a relatively short span of time. Let me be very specific. There is a growing number of members of Congress who are calling for an Agent Orange registry of our forces who are exposed in Iraq and Afghanistan and worldwide to the issues that we have been forced to address after the fact, and I'm talking burn pits and I'm talking carmine Ali. With the third Guard unit now joining the suit, leaving the
suit off the table, there are some very specific
issues. Is our Department of Defense actually
planning and preparing to evaluate biologically
plausible health events, occurrences, among our
returning forces? Are they? What's the plan?
Wouldn't it be nice as opposed to 5 years after
the fact those of us who had active security
clearances being brought to Washington to review a
confidential document, to review confidential
materials, to craft that into something that we
could present in public? Wouldn't it be really
nice to be at the front end? Wouldn't it be
really nice to say here are some issues that we
believe we have complementary expertise to the
Science Board, could work proactively with them,
to basically facilitate a more informed response
to these types of challenges? So I would suggest,
one, I wholeheartedly agree with you, I
wholeheartedly support what General Myers has
said. There are questions, there are generic
holistic questions, that in our considered
opinion, certainly mine, I only speak for myself,
that would it have been the set of circumstances
which is was not that subject matter experts were
actually brought to the table at the front end?
Studies would have been done in a more effective,
efficient and appropriate basis such that you
would not then be hamstrung to evaluate something
when you had nothing at all to do with the design
at the front end.

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

CMDR FEEKS: There is already a program
in place to do occupational and environmental
health site assessments preferably before we go
there, but if conditions don't permit us to do
that before we have troops in place in a
particular place, we get to it as soon as we can.
Then the service member, him or herself on the
post-deployment health assessment that everybody
does has the opportunity to name or to state
concerns related to exposures encountered during
the deployment and then during the post-deployment
health reassessment that's done 3 to 6 months
after coming home, the opportunity is presented again. The member is asked one more time, do you have any deployment related exposure concerns? Do I'd like to say that what you're describing is probably already in place.

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

DR. MASON: Here's the concept. At the concept level I would suggest that as opposed to what is presently being done, wouldn't it not be appropriate to step back a bit and say how could we actually 5 years after a potential exposure address a biologically plausible question, do we actually have adequate information on the individuals to permit recontact? I'll be very specific. I'm very concerned about the Guardsmen and the Reserves. They fall off records keeping and the disconnect and the discontinuity between some of the caregivers, between active duty,
Reserve, Guardsmen and VA, those are conceptual issues and I would suggest that they go beyond what we're presently doing. I'm not arguing that we're bringing persons to the table, that we have environmental health officers and that we have responded in a timely way to any one of a number of questions, but a number of the issues that we're asked to evaluate are going to take years to develop and I for one would love to position ourselves to work more proactively as opposed to reactively to these kinds of questions.

DR. WILENSKY: Let me just ask again to go back first to Greg's point, but to further indicate that this afternoon and again in our main meeting one of the issues we are going to be discussing is what Ellen Embrey and I have been terming the terms of engagement, how we go about as a Board deciding what kinds of issues we might wish to consider and the implications of that when we have not been requested to take on that issue, and this is obviously a case in point. But it really does differ from the issue that Greg raised.
which is whether or not there's a willingness to
find a period of time, 3 to 5 days either in a
seriatim basis or for the group as a whole, where
we would use it to explore an issue in-depth. And
it may be that we will need to come up with some
potential topics that we might want to consider
before people are able to comfortable in making
such a commitment. I think it is an interesting
idea to do basically almost like a strategic
retreat having the routine business of the Board
to go through.

DR. POLAND: I think the idea I have is
if you think it's a good idea, the Executive
Committee will work that idea, come up for example
with a set of principles for what would we do, how
would we do it, what would be the expected outcome
and then flesh out with the Board's help what
would that idea be, what would our first priority
be, for example. So I just more wanted to get a
sense on behalf of the Executive Committee as to
whether there was consensus that this was a good
mechanism and idea.
SECRETARY WEST: Madam Chair?

DR. WILENSKY: Yes?

SECRETARY WEST: Togo West.

DR. WILENSKY: Go ahead, Secretary West.

SECRETARY WEST: I just want to endorse your summation and your comments a few seconds ago about the way to present or to look at a proposal that could be adoptable. The fact is that for decision makers like an Assistant Secretary of Health or an Under Secretary of SECDEF, you are right that they want to see a list of potential steps that would be the subject matter as they consider whether they'd like to see us go forward with something like that. I think that's an important part of how you put together our consideration. What would be the topics or a suggested list of four or five topics that lend themselves from our perspective to a kind of summer study which is roughly an investment I would suspect in 3 to 4 days most likely seriatim all at one time in a place removed much like your meeting today where all the results can be brought.
together and fleshed out.

DR. WILENSKY: Thank you.

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

DR. WILENSKY: Mark?

DR. MILLER: I think the two previous speakers took the words out of my mouth whether or not we want to be proactive versus reactive as a federal advisory committee and I would bring the question back to Greg, how were these recommendations used by the Defense Science Board? Again I think it brings up the issue of process and mission and the political process as well that there should probably be some vetting of the topics so that they are acceptable and welcome to
a certain extent when an independent board brings
up issues that they feel are important. So what
I'd like to ask really is how the recommendations
have been used in the past.

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

DR. WILENSKY: This issue again as I've
indicated I hopefully will spend some time
discussing both this meeting and next meeting
which is the terms of engagement both for issues
where we're requested to look at something but
more importantly because it is dicier, the notion
of taking on issues that we have not been
requested to look at and it's an area where we need as a group to discuss and consider the ramifications. Again, more to come on this.

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

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

DR. LEDNAR: Mark and Greg made two comments that fired a neuron for me. One was vet the topics, be sure that before there is a focused investment of time that it's a topic that clearly is of importance. And Greg said you don't come
with any higher endorsement than someone like
General Myers and the Chairman of the Joint Chiefs
of Staff which in civilian parlance is the CEO.
Clearly the President is the Commander in Chief,
but when you get to the top-of-the-line
leadership, the Chairman of the Joint Chiefs'
opinion is a rather important one. And for our
topics, given that they are so mission essential,
if that level of visibility, this is the
top-of-the-line leadership, not just the top of
the medical house, but the top-of-the-line
leadership on important topics and the connection
around the mission, that would make an interesting
list of topics and probably increase the
likelihood that the advice would both help to
shape the thinking that would probably turn into
important action.

DR. POLAND: Good point.

DR. WILENSKY: Yes, Dr. Khan?

RADM KHAN: Thank you very much. Greg,
again excellent job, thank you, and a good thing
for us to discuss. We've spent the last couple
minutes talking about topics. How about a topic that already exists? What you've just showed us in terms of the future of war, three of these seven items very much could benefit from our insight to think about public health diplomacy when they talk about strategic communications, talk about medical intelligence. I think we've discussed that a little.

DR. POLAND: Didn't escape my notice.

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

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

DR. WILENSKY: Again let's try to not decide the topic. Let's try to decide whether we want to go ahead with this as a concept and we can see whether we can find a time that's suitable
during the summer. We don't need to vote. Are people interested in seeing this explored? We won't regard it as a firm commitment but we'll take it to the next level. Thank you very much, Greg. Commander Feeks, are you going to give us guidance about our lunch and where we do it and when we reconvene or you can hand it off to someone else.

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

DR. WILENSKY: Thank you.

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

DR. WILENSKY: It actually is a better place.
CMDR FEEKS: In here?
DR. WILENSKY: Can we do that?
CMDR FEEKS: Yes.
DR. WILENSKY: Yes, I think it would be preferable. This is really a working lunch. So if you can get your lunch. Make phone calls or whatever and be back ready to start in a half-hour.
CMDR FEEKS: That part of it really is an administrative session. It's only for Board Members and liaisons. So see you back here at 2:15.
(Recess)
DR. WILENSKY: Okay. Guys, people, please take their seats so we can proceed. The next session is reporting on the healthcare delivery subcommittee, which I chair, which met on February 27th.
This is the list of individuals who are on the committee. It's quite a diverse group of experts involved in healthcare delivery and other aspects of medical care.
The primary purpose of the meeting on February 27th was to have a report from the Department with regard to the strategic plan that had recently been submitted to the Congress, indicating which of the recommendations from the Task Force on the Future of Military Healthcare were accepted by the Department and those that they did not concur with, and to help us understand the issues that would follow from the implementation strategies.

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

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

Several were issues of prime interest to the subcommittee. The first has to do with the recommendation for a better way to integrate the care delivery between the direct care and...
purchased care, particularly at the local level, where care is actually provided.

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

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

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

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

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

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

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

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

There had been a discussion during the Task Force about whether or not the new contract that is in the process of being let would allow for more of a best practice focus through the use
of pilots or other changes than had existed in the past. What we were told is yes, that's true; that there are -- that it will be possible with the new contract to do this. However, several of us took the position that we would like to be briefed on the details of the new contract once the contract is let so we can try to assess whether or not that appears to be the case.

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

The second area that we focused on was talking about metrics measurement for healthcare
delivery. We had a very interesting presentation by Michael Daneen about what the Department is doing in terms in setting up an MHS, a values dashboard. We focused on the kinds of measurements that were being used and how they would apply to both direct care and purchased care, and high-priority issues and how to try to keep that in focus.

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

We had some discussion about the notion of tying these measures to the patient-centered home concepts, and how the military has attempted to use this dashboard and metric system in having a pay-for-performance system geared not to individual providers, as it is sometimes discussed.
in the private sector, but rather providing
funding for the unit or the facility that could
then be used to sponsor activities of particular
interest to the setting or to the individuals who
are involved.

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

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

We had a long session where we were
briefed by several individuals in terms of the
progress being made to the electronic health
record system that is being developed by the
Department -- reviewed some of the progress, and
the availability of different components; discuss
some of the interoperability issues with regard to
the VA; had some demonstration of the capabilities
of this system; talked about the focus between
electronic medical records and the personal health
record that is being considered; and discuss the
role of structured text as one of the issues that
seemed to be behind some of the consternation that
we heard when he came to use of the Alta system.
We spent some time discussing what now,
as other new subcommittees have done. What we
have decided is that we will wait until June to
meet again. We need to have some time pass until
there is more of a development in terms of which
the pilots or what kind of pilots are likely to be
undertaken. We would like a chance to review the
contract when it is actually let and released to
the public so that we can assess whether or not
some of these best practices when it comes to
either clinical or business practices appear to be better allowed for in this contract than they were in the previous contract.

We've asked to have an attempt to interchange with the people who will be developing some of the demos or at least be able to review some of the demonstration projects that are ultimately selected.

After having some discussion internally, we thought it was probably not particularly useful for us -- unless someone were to direct us otherwise -- to pursue further discussions about the electronic health care record on the grounds that there are a number of other groups that are already looking at this in its own right, and in terms of the interactions with regard to the VA; and that there were other areas that we could make more of a value added.

We have, as I indicated early on, a very illustrious group of individuals covering a pretty wide area of expertise. And we have discussed the concept of staying in touch by electronic
communications at least once a month, sharing some
issues that individuals think are important for
further consideration or issues that ought to be
raised for potential discussion when we meet in
June. And that will be our plan. But it seems
like, at this point, we needed some curing, so to
speak, to occur before we would actually be ready
to take on any assessment of the implementation
that HA did with regard to the Task Force
recommendations that they had developed, as
reflected in the report to Congress.

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

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

DR. WILENSKY: This was a term, though
you notice I had it in quotes, because it was a
term that HA used in describing what they were
doing. And, as I understand it, although Al can
correct me if I've gotten it wrong, it was to go
in and focus in detail -- that's the micro part of
the monitoring -- in four areas of the country to
see whether or not we were correct in our
assessment that there was a problem at the local
level in terms of integration between direct care
and purchased care -- was the -- what was being
provided downtown, so to speak, integrated with
what was being provided on the MTF. Was the
information brought back? Was there an awareness
by both the direct care facility and the purchased
care about what the other had done? Did people
feel like they were getting the benefits of an
integrated system or basically just going around
to different physicians?
And in areas where there were
overlapping services, in addition to the purchased
care, direct care issue, which is true in all of
these sites, how that integration seemed to go.
Obviously, some of it is being pressed for other
reasons -- NCR and San Antonio have their own
integration issues that they are dealing with and
that will help better whether they are integration
problems.

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

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

I read the handout that was given to us,
which is entitled "Responses to the
Recommendations" of your Task Force by the
Department of Defense Military Health System
Senior Oversight Committee. And I was a bit
surprised -- maybe I shouldn't have been -- to
learn that they rejected some recommendations.
Other recommendations, they said, well, Congress has to do something about that before we can do anything.

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

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

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

That's a fact of life. The second is that there are some changes which require new
legislation, and some changes which do not require
new legislation. And so, usually, on commissions
where I am involved as a chair, having both been
on an advisory commission to the Congress on
several occasions and run the Medicare Program
from the administration's point of view, I'm very
sensitive to people who direct a department to do
things that only Congress can change.

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

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

So I think the more relevant question
for us will be on a number of areas. For example,
the integration was the overriding first
recommendation. The cost share change that was
adopted was actually quite consistent in the sense
that what we said is rather than the numbers,
focus on the fact that you start -- this has been
frozen in time since it was started. You need to
start moving, however. Set it where you think
it's appropriate. Index where you think is
appropriate. He cannot stay frozen in time.

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

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

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

DR. WILENSKY: Oh, yeah.

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

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

Bill?

DR. LOCKEY: As a way of background, I
don't a lot about the system. The purchased care,
there is a contract as to what will be provided or
is it open-ended.

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

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

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

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

They are -- they divide the country up
into three big pieces. And they basically support
the direct care provided by the military,
depending on availability and depending to some extent on the choice of the individuals -- of the beneficiaries -- as to the type of plan that they take.

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

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

So, in San Antonio, you have the Air Force and you have the Army.
And now going through more of an integration of their own facilities. And it will
be looking at how that and the integration between purchased care and the direct delivery care works.

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

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

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

DR. WILENSKY: I would guess it's not left to the contract provider to determine. But Al is probably better -- in a better position. I
think that there are -- there are certain
requirements in terms of screening and access, I
mean, as you would in other kinds of similar
requirements. But, Al?

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

So the purchased care side of it, which
is about twice as big actually -- we purchase
about twice as much care in dollar value than what
we actually expend in the direct care system -- is
really the wrap around contract so that if you
remember the old CHAMPUS days, it's really kind of
the old CHAMPUS days, where if a beneficiary can't
get care in a direct care system, either there's
no direct care system available or there is no
space available for that beneficiary. And
usually, this is retirees or active-duty
dependence. And this is their insurance plan, if
you will, that goes downtown -- so they can go
down to the local physician or the hospital, be
seen, and then we have a triple option. There is
an HMO portion of it. There's a PPO portion of
it. And there's a fee-for-service portion of it,
too. So it's a triple option.

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

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

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

MR. KIZER: I am.

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

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

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

Their efforts will help develop a standard for world-class that will set a precedent within the Department and will undoubtedly leave a lasting legacy for future delivery of care for our wounded service members.
His briefing slides can be found under Tab 8 of the meeting binder. Dr. Kizer?

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

DR. WILENSKY: Yes. Fine.

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

So anyway, let me move forward. What I'd like to do is to provide an update on where the committee is, and recognizing that we're operating under a bit of a pressured timeline.

I'd like to review what the charge to the committee was and what this report is all about, to talk about what I think are the three main points of the report, which is a definition of world-class healthcare, a -- what our findings are, and what our recommendations are at this point, recognizing that the full report is still being drafted. And so I guess I would issue a
caveat at the beginning that they should all be
viewed as a work in progress, albeit near
completion, but it's still is being refined and
worked on.

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

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

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

Shortly after the advisory committee was
convened, we were additionally charged with
conducting the independent design review -- if we
go to the third slide -- of the new Walter Reed
National Military Medical Center and the hospital
at Fort Belvoir, pursuant to the 2009 budget,
which specifically calls for the independent
design review and asks that two primary questions
be answered: First, will the design of achieve
the goal of providing world-class medical
facilities? And world-class medical facilities is
the exact language that is in the law. And
secondly, if not, what might be done or should be
done to ensure that the construction and design
do, in fact, this standard that Congress has
imposed, recognizing at the outset that nobody has
defined what a world class medical facility is,
which is, on an editorial note, a bit of an
unusual way to incorporate a design into federal
law.

But noting that, the -- there are some
corollaries. If I could go to the four slide?
While not specifically asked in the law,
but obviously built into the questions that they
were asking and verbally expressed, were not only
the question of what is, in fact, a world class
medical facility, but was the -- or is the
approach being taken at both Walter Reed and Fort
Belvoir hospitals, recognizing that they are in
different approaches, are they sound? Are they a
good way that the Department should be looking at
capital construction in the future? Is there --
if that's not the case, or if these facilities are
being designed to be world-class, should the
construction be called to a halt? And then
finally basically, were there other things --
other issues -- that should be considered along
with the specific construction and design issues?

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

The initial subcommittee, upon receiving
the additional charge, supplemented its membership
with a number of distinguished subject matter
experts, including patient representatives. We
have had a number of in-person meetings,
conference calls. We have reviewed reams of
documents and have heard numerous, dozens of
presentations, by those involved with the project,
and some specifically focus on trying to define
what is world-class, but largely focused on what
are the plans and what is the design that has been
used to date.

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

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

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

I think I've talked about how we
developed our definition. Basically, we looked at
a large number of documents that were relevant to
this. We use the committee's considerable
collective expertise and then asked for input from a lot of other individuals, and, again, that's what's reflected in Appendix A.

And if I could go to slide number seven.

I am not going to attempt to go through everything that is in Appendix A. I would refer you to the document for the specifics, but a few comments are probably in order.

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

And then there is a number of qualities or characteristics of a world-class facility that might be considered intangible. I would say that they are things that we can't measure or quantify by current methods, so, in that sense, I guess they are in tangible, but it's somewhat like healthcare quality. If you engaged in a
discussion 15 years ago about what is healthcare quality, people would've said, well, you can't define it. And, of course, that's -- we know that's not the case by any means today. So many of these things that currently we can't measure, at some point in time, maybe they can. But I think if you read what's on the slide their in the lower half, you get a sense of what we're talking about, and that clearly, just to summarize this, that in a world-class facility, there are synergies that result from how all the pieces fit and work together.

The -- in trying to make this definition operational, we did look at the -- all of the different information, and it really fell into the six domains that are identified there, and each of those having a number of specific sets of conditions -- the 18 buckets, if you will, that, in many cases, refer to criteria or standards that have been established by other healthcare bodies. And I think one of the things that has become
clear in going over this is that, unless one is familiar with some of these, it may be hard to, in some cases, understand what exactly is entailed by some of the things that are included by reference. If we were to detail all of this information out, though, we would have a document that, just with this information, would involve multiple volumes. And the only way to reasonably do it is to include it by reference.

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

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

And again, I recognize that the full report would include all of the evidentiary base
upon which these findings are based.

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

We also as a second conclusion felt that
the processes used by the Department in
approaching the construction and design at both
Walter Reed and Fort Belvoir, albeit it different,
were both good, and generally felt that anything
that provided a shortened timeline and flexibility
was better than the historical or traditional
approach to military construction.
The -- also the committee, I think, was quite impressed by the amount of work, the dedication, the commitment, the energy that has been displayed by just a very large number of people who have been working on this.

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

Also, we were impressed of the lack of an institutional memory and the traditional rotation of military personnel has often left significant voids in the understanding or recall of how things came to be the way that they are.
Things have not always been documented as fully as they might be. And, with people gone, it's unclear often why decisions have been made as they have what the basis for those were -- those decisions were.

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

Moving on to the ninth slide, the -- actually, I guess I've already covered that except for the last point. I think the -- there is a strong agreement among the subcommittee that the plans for the community hospital at Fort Belvoir appear to be well conceived. They are -- that project has moved quite nicely, although it has some inherent differences than the Walter Reed
Notwithstanding basically doing it quite positively, there were some areas where improvements could be made, as I'll get to at the end.

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

Likewise, culture, in an integrated delivery network, there is a culture that needs to
prevail that is not the culture that has been prevalent amongst the individual military medical services, or at least bringing them together. They haven't been melded into the culture that's going to need to be necessary or that's needed to support the integrated delivery network.

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

Shifting gears to point number six in your handout. There -- all of the planning that has been done has been based on a demand analysis of how things were or what the needs were in 2004. And the committee, from a conceptual perspective, thought this was somewhat problematic, recognizing that they're going to be changed needs in the
future, some of which will be related to population shifts and other sorts of things, some of which will be related to new technologies in healthcare that are either on the drawing board or in the approval process; and that this design really wasn't based on a dynamic demand analysis of looking at the future as opposed to a much more static demand analysis based on how things were five years ago.

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

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

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

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

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

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

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

Shifting gears a bit, the overall hospital bed plan has some significant
deficiencies or at least certainly doesn't comport
with what would be considered world-class as far
as having all single-bed rooms or at least the
overwhelming majority being single-bed rooms; not
be able or not being large enough to cut it family
members, you know, requiring movement of the
patient, and a number of things in that area.

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

The IT or the information technology
infrastructure -- we spent a fair amount of time
trying to dissect that and understand it. And it
certainly appeared that everyone was being
forthcoming, but we just didn't find it adequate
and we're at somewhat of a loss as to why some
issues related to interoperability and use of
open-source software and some other things
weren't considered that we felt should have been
considered and had detailed answers as to why or
why they were not being included in the final
plans.

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

The -- just a couple of other points:
Medical records, we understand that the plan is to
digitize all the medical records there. But
there's no plan for how that's -- or least we
couldn't find any plan as to how that was going to
happen. And, in the event that it didn't happen
in time for the facility when it opens, there's no
storage space included at the new facility -- and
there is -- or other issues related to just the
storage of medical records.

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

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

And then there were the support services
in a variety of areas, whether dietary food
service, materials management, parking, did not
seem to be adequate or, again, based on a
future-oriented demand analysis, and it seemed
like there may well be some deficiencies in that
regard.

Understanding I have just thrown a whole
lot of information out there that you've not had
the benefit of looking at the volumes of
documentation that we did, there may well be
additional questions about that, but, in the
interest of moving forward, let me just shift to
the last area, and that's our tentative
recommendations, which, I said, I think stem
pretty much directly from the findings. The first
and what we would consider the probably single
most important recommendation is the need to
empower a single official with overall authority,
both organizational and budgetary authority, to
pull all of the different pieces together so that
there is, indeed, a, if you will, a more
integrated approach to the management of this very
important project. There is a need for a master
plan. Indeed, we would think that that would be
the first item of business of this new empowered
individual would be to set about developing a
master plan for both the Walter Reed National
Military Medical Center as well as the National
Capital Region Integrated Delivery Network.

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

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

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

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

With that, let me close and open it up for questions. The committee expects to finalize its report in the next few weeks, after which it will be I assume further mulled over by this committee, by this board, and then presented and discussed, otherwise, as requested, and the committee will -- at least anticipates continuing to focus on the National Capital Region Integrated
Delivery Network, as with this just being the first work product that was asked in response to a specific congressional request. And, of course, we'll do whatever else is asked, if it's reasonable. So with that, let me stop and open it up. And I know, at least I understand that Cheryl Herbert and Steve Shinth and maybe others from the committee are there in attendance, and so questions can be directed to either them or to me. And we'll do our best to answer them.

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

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

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

DR. WALKER: Well, you --

DR. KIZER: It was garbled.

DR. WALKER: -- continue with the
construction and backfill renovations, and one of
the recommendations is that you need a larger
operating room for contemporary equipment. I'm
asking how you accomplish making a larger
operating room if you got one that's too small?

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

DR. WILENSKY: Is there -- Adil?

DR. SHAMOO: Adil Shamoo. Sorry. Adil
Shamoo. I want to congratulate you and the
committee for what an incredible job. Even though
some of us have problems with defining what
world-class is, you attempted and you've done a
great job. And, to my pleasant surprise, you have
almost 10 bullets on adverse events reporting and
medical errors, which is wonderful. Even you want
to the -- at length, even apologizing to the
patient if an error has occurred. And that's
extremely admirable.

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

But you mention nothing about what I
would urge you to mention something that that
clinical research should be done in the most
ethical manner; and adverse events reporting and
other norms -- informed consent -- should be a
high top priority to those research volunteers,
because they are not only patients, they have gone
the extra mile, altruistically, to volunteer
themselves to the public sector.
DR. KIZER: You're preaching to the converted, and I would certainly agree with you. The -- I think the only thing I would say in -- and not really defense but in response -- is that the comments about research or predicated on an ambient culture that includes all those other things in the thinking at least, albeit that perhaps we need to make this more clear, the thinking was that all the -- what you're talking about would, in fact, occur in research just like it would occur in patient care in any other area that might be relevant.

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

DR. KIZER: Well, one were to lay out a process without going into the details of what the culture is, I mean, you know, there is a body of literature on how integrated systems work well
together and what are high performing
organizations. In many of the examples that are
cited for health care are things like aviation or
how Navy Seal Teams operate, and then there are a
number of examples that come from the military as
to how you get the mindset of -- or the teamwork
and the mindset that we are all functioning as a
singular unit as opposed to a bunch of pieces that
have been put together and are somehow supposed to
get it done.

So, to be more specific answer your
question, I think you need to go and develop that
-- what are those attributes of a well functioning
integrated delivery health care system. How's
that different, you know, the gap analysis of how
is that different than what currently exists,
which I think would be fairly obvious to anyone
that looks into this. And then how do you
engineer behavior change. And, again, the
military has robust knowledge about how you turn
individuals into coherent units, and that
knowledge, albeit coming more from the operational
forces than in healthcare, that needs to be turned
to the specific project, where the three services
that do have quite different cultures come
together and function as a singular culture, you
know, regardless of which uniform they may be
wearing or who issues their paychecks, although I
guess they all come from the same source.

DR. WILENSKY: Wayne?

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

DR. WILENSKY: It helps. Thanks.

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

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

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

That -- whether that actually was
carried out is an operational decision that would
have to be made by those in other positions than
I'm in. But yes, I mean, I think we would feel --
because I think one of the things that underlies
all of this concept of world-class, et cetera, is
that it's more than anything else is culture. You
know, you can have the great technology in the
world. You can have all of the, you know, Nobel
laureates they are, but if they don't work
together as a function team and if you don't have
the right culture, you're not going to get a very
good outcome.

DR. WILENSKY: John?

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

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

DR. KIZER: Well, you know, was it in
the current plans or did we think it should be?
Let me just ask you to refine your question. Or
maybe I can answer the question that I posed.
The committee feels that is absolutely critical, and we would resoundingly agree with your observation. And indeed, there is verbiage in several different sections of the definition that makes that exact point. And part of that or part of what we see missing from the current plans, particularly at Walter Reed but also at Belvoir is no apparent operationalization of that concept.

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

And again, the architecture -- I'm quite confident that those are the types of things that can be done without a great deal of effort if they
are thought about and planned for from the beginning.

DR. WILENSKY: Mike?

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

I think the critical two recommendations of the committee, both of which have to be implemented at flank speed if we're going to also support the last recommendation and that is to continue construction and count on backfill, is that the empowering a commander with all of the funding streams in hand in directing him or her to immediately and as quickly as possible develop what doesn't exist now and that is an integrated facilities plan.
Without out those two components quickly accomplish, I think the last recommendation worries me.

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

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

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

DR. KIZER: Well, I don't think that we would underestimate or understate the need for some changes, the need for some changes to be made.
quickly. But we are also mindful that world-class healthcare is also -- or what is considered world-class healthcare by many -- is provided in some facilities that are far from optimal and that we think that if many of the things that have been pointed out or addressed in a timely manner, it would indeed set the -- or lay a foundation or set the stage for this to be world-class facilities in the future, although by no means guaranteeing it.

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

DR. WILENSKY: Chase?

MR. UNTERMeyer: Yes, this is Chase Untermeyer. I want to add my commendations to Ken Kizer and his committee for seeking to define the undefined and maybe even the undefinable. So, everything I'm going to say is within that
But I do believe that we should look upon this document as more than just answering the mail and maybe more than just an inspirational document about quality of care, but rather as the bedrock budget document that eventually were on which could be built years and years of budgetary requests by this facility or the entire Department of Defense.

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

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

So I just want to focus on the first domain, which is basic infrastructure. And the
reason I want to focus on that is that the other
five I would think Congress expects the military
medical system to provide as a matter of course,
because we want to be a quality operation.

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

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

And again, the services may blanch
because they have other facilities around the
world they need to staff, but this is our chance
to define what world-class means, and I think it
needs to reach out to that level. And I'll
conclude by saying that I detect, and I ask Ken to
correct me, a potential self-contradiction here in
this section on basic infrastructure, because the
overall guidance the committee is giving us here
is above and beyond; that that is what makes
world-class world-class.

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

Likewise in number three, it speaks to
the referral and transfer patients for services
not provided at the facility. Well, as a
practical matter, that's probably what's what
happen in some of those. But again, this is our
chance to be bold, and our chance to say we
wouldn't have to refer anybody; that they should
be available at this facility. That's the end of
DR. KIZER: Well, let me address perhaps some of that, although we could have a very lengthy conversation on this. And the first thing I would say is that nationally many of the points that maybe don't deal with basic infrastructure, but in those conditions, there are embedded specific needs or requirements that relate to construction, for example, if you look in six, 6B, having to deal with environmental responsibility. Those things directly affect construction and design. Likewise in 5B, on simulation laboratories, that has direct implications on construction and design. And actually if you go back through each of the domains, I think you will find that while some of them deal with culture and leadership and other (off mike) embedded within those are a number of specific things related to construction and design.

As far as personnel, actually 1B that you talked about is directly -- addresses that as far as which specialties and sub-specialties would
be offered there, recognizing that this is a
generic definition as opposed to being specific to
a military medical center, because our -- a
working premise that the committee had is that you
couldn't be a military world-class facility unless
you were first a world-class facility.
But, for example, if you are in an area
where there is a pediatric hospital next door or
down the street, it wouldn't be appropriate to or
needed for you as a world-class facility to
necessarily have pediatrics there, because that
would be taken care of down the street depending
on, again, the specific community. And so that's
why the caveat about if those services are
appropriate to the needs of the patient population
the community served. And we could go into other
examples of where specific things, while they
might be entirely appropriate and needed at Walter
Reed, may not be in San Antonio were some other
places.
Likewise, on point three there, in San
Antonio, there is, in fact, a world-class burn
center, and so they would need to worry about that. But it really doesn't make a lot of sense because there was or -- you know, the personnel and other costs attendant to those means that there needs to be a special few of these, and facilities all over the country refer patients to -- you know, San Antonio for burn care or some of the other places.

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

MR. UNTERMeyer: Well, just to say -- as I again salute you for all the detail that's there. I'm -- I guess speaking more politically than medically when I say that what we need to have here or we need to add in is a budgetary strategy; that is, in order to get whatever we do get in the end, we have to reach for more than that. And that's why I recommend being bold of asking for things, even a burn clinic, if one does
exist, and then throwing it back to the Congress
to let them tell us what they will or won't give.

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

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

MR. UNTERMeyer: Well, I agree. As a
practical matter, it probably wouldn't happen. But -- and elsewhere in the document, we're talking about a facility that goes above and beyond and is the best. And this is just a way of defining that.

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

So I actually think it's more -- not just practically -- were you not going to do that? I think you could even make a case that -- I'm mean, it's really the regionalization centers of...
excellence and that you don't need to be
everything to all people to be world-class as long
as you have a way to make sure those other
services are directly accessible by your
populations.

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

DR. KIZER: Gail?

DR. WILENSKY: Yes.

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

DR. WILENSKY: David, did you have
another comment?
DR. WALKER: Yes, I think -- you have to remember that its relevance to the population that's going to be served. I mean, for example, I'm not sure you'd be enough business there in TV after cardiac surgery to have a pediatric cardiac surgeon and do that or liver transplantation. I mean, I don't know. Maybe it is. But I would think there would be something like that where you have to do a certain number procedures a year to maintain your ability to maintain accreditation to do it and skill to do it.

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

So, you know, those patients would be better off, you know, being transferred over there.
DR. WILENSKY: Ken, I've looked a little bit in the back of the detail that you've provided and then the recommendations with health IT. It's hard for me to believe actually I have to push this issue much with you, but would it be possible to lean a little stronger in the recommendation about doing something with regard to the health IT issues they haven't yet addressed?

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

DR. WILENSKY: It's really -- and,
again, I appreciate -- you know this better than most people in the country that playing catch up is so hard. Now it may be they're already beyond that stage, and they're just going to be playing catch up. And that's the nature of the beast, but to the extent that there can be more pressure put on to try to have the integration and interoperability coming in, but, I mean, this is not don't go ahead, but just really pressing to remember how hard it's going to be to fix it after the fact.

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

You know, as long as the appropriate infrastructure is there, any decision could be accommodated, albeit it would be certainly nice if the issue were resolved sooner than later, and it
would make it a lot easier to move forward more quickly if the issue were resolved.

DR. WEST: Madam Chair, Togo West.

DR. WILENSKY: Yes, Togo. Go ahead.

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

DR. KIZER: Thank you, Togo.

DR. WILENSKY: Mike.

DR. OXMAN: Mike Oxman. I think the important issue and the reason why an integrated facilities plan is crucial is that although we're not doing -- you're not going to want to do and Chris transplants this year or next year at the
National Military Medical Center. Five years from now, you may want to do them. They may become much more routine. And under those circumstances, you want to be sure that your facilities plan includes options for future change.

DR. WILENSKY: Any other comments?

Chase.

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

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

DR. KIZER: All right. Then let -- just if I could respond to that. Our intent and part of the reason for including just the findings and recommendations is that these, you know, seem reasonable, assuming that they are, in fact, evidence-based, which they are, then we will as quickly as possible put together the final report.
Our hope would be to have it done certainly within the next two to three or, you know, weeks or something along those lines, if at all possible, and get it to the Board for final action and hopefully transmittal to the Secretary and the Congress, because we are mindful that the clock is ticking and this construction is proceeding and the need to get an appropriately empowered figure in place and the master plan all are predicated on that being done in a timely manner.

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

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

I notice that a lot of the comments that you've had and recommendations as far as making
sure they backfill renovations and that the BRAC
process and its funding stream aren't necessarily
aligning properly, but yet I don't see a
recommendation for added funding to make sure that
processes go forward, because it's going to take
extra money if you can't enlarge the ORs and all
those other things. And they really don't have
that extra money in their budget to be able to do
those things.

MAJOR HOLLAND: Ma'am?

DR. WILENSKY: Oops.

MAJOR HOLLAND: Command (off mike) Major Holland. Now I may get thrown out of here in a
minute, but when Secretary West, I know you're on
the phone, sir, but if you remember when we did
the independent review group, we -- what of our
recommendations was to create a czar over this
project. And no disrespect to our great navy or
the great Army or the other services, but I also
feel like there's a tug-of-war here, and I don't
think we've laid that on the table. And if that's
what the case is, then, you know, maybe General
Meyers could help us figure out what level -- what
level -- sorry, I just put that in your basket,
sir -- at what level should that individual come
from and then the working group to work for them,
because, you know, all the folks that are
responsible for different things -- the commander
of Bethesda and the commander of Walter Reed --
they also report up to some other folks that have
their idea of how this should be done and since we
are going for world class and whatever, but those
recommendations, even to the point of these
operating rooms, because we were still having
problems in the ICU at Bethesda and at the ICU in
Walter Reed, when our severely injured was coming
in with all kinds of extra equipment to hook up to
them to keep them alive, and we didn't have any
room.

So it's not like this is a new issue,
ma'am. And so, I think we've danced around it
nicely and the people that put the report together
did a lot of good research, but we need some help
to fix this, ma'am.
DR. WILENSKY: That's why we're here.

Thank you very much, Ken. We look forward to
seeing the report, and we will respond as quickly
as we can when it arrives.

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

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

COMMANDER FEEKS: Commander Feeks. I
just wanted to give credit where it's due to the
degree of cooperation that I have seen between the
Army and the Navy, between Bethesda and Walter
Reed on the campus at Bethesda -- to my eyes has
been truly remarkable, even if we find some ways
in which it falls short of what we'd like to see.
I can add -- and here expose my ignorance -- but
I've learned recently that part of the problem is
that BRAC money is being executed by the Army
under public law, and the renovation money is
being executed by the Navy. And it isn't up to
the services to change that.
DR. KIZER: Well, I think you highlight the -- one of the basic points that they were trying to make is that this -- it's not because of good people not trying hard, but there is just -- you know, there are barriers thrown in their path that they individually can't surmount.

DR. WILENSKY: Yeah. Yes.

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

DR. WILENSKY: Sure.

GENERAL MYERS: -- to kind of --

DR. WILENSKY: Sure. General Myers.

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

But with that kind of situation, I mean, who's really in charge I guess is the question. And do they have the competence? I mean, it can't be run as oh, I'm going to do that as part of my
other duties running the whole Bethesda today. I mean, you can't do it as a part-time job, it doesn't seem to me. This is a huge effort. And I think if we do a cover letter that we ought to get the sense of the Board and see what we can come up with, and whether the committee agrees or not, it ought to be our business.

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

CAPTAIN GIRZ: Hi, Martha Girz, JTF.

That belly button is actually JTF. Dr. Kizer, I'm surprised. Did you not have a presentation by the JTF when you were going to your committee? I mean, Admiral Mateczun is the over -- over all of the Joint Operating Area, so actually this whole process, we claim from the JTF.

Now, given the fact that the money is
coming from different places we're working with,
as you have all noted, cultures that are sometimes
clashing. But we are certainly working on those
issues from the JTF. So I know that Colonel Barb
Jefts was involved at least as a -- sitting in on
the committee, and I don't know if any of her
input was asked for or not from the JTF.

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

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

DR. WILENSKY: General Myers, go ahead.
GENERAL MYERS: I guess my comment would be I think the JTF probably is exactly the right place. Admiral Mateczun is probably exactly the right person. But anytime you give somebody a task not only do you have to give them the responsibility, you have to give them the authority. And if our Department of Defense is too -- I'll use a French word here -- stupid to understand that, then they've got to get over this.

So there are no barriers. So you have -- I'm not talking czars here -- you just have somebody that is was responsible, that has the authority, and, at the end of the day, you hold them accountable. And you can't do that if it's all fuzzed up over many different organizations. And that's -- and in the end, who's it going to hurt? It's going to hurt the troop walking in the front door. That's who it's going to hurt. So, we should not be embarrassed to lay this on the line and tell them they don't know how to manage, which it would not be the first time.
DR. WILENSKY: When we have the report,
I would be glad to have a discussion with you
about what kind of a covering transmittal you
would like to have go with that.

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

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

GENERAL MYERS: Dr. Wilensky, the only
thing I would just -- this is Myers again. The
only thing I would say is that if you can't hold
somebody accountable, then there is no
accountability. And I don't think anybody in
Congress or anybody in the Department of Defense intends that. So, I think we need out with that. I mean, if we can help. Nobody intends that but at the end of the day when Mateczun points to the Navy public works who points to the Army, who didn't get us the funding in time, who points to, you know, somebody else somewhere, then there's no accountability. We get what we get, and we deserve it.

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

DR. KIZER: Thank you so much.

DR. WILENSKY: Sure. Thanks.

DR. KIZER: Bye now.

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

She is manager of the Office of Education for the Defense and Veterans Brain Injury Center, the primary TBI operational component of the DCoE.
DVBIC is the lead agency providing staff support to the TBI Family Caregiver Panel Subcommittee of the DHV.

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

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

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

Can everyone hear me?

DR. WILENSKY: I have one under Tab 9.

DR. CAMPBELL-KOTLER: Oh, good. Good.

Okay.

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

CDR FEEKS: And if I could interject
quickly, for the sake of the transcriptionist, our speaker's name is Margaret Campbell-Kotler. My apologies to Dr. Wilensky. K-o-t-l-e-r. Thank you.

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

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

Okay. Okay. So given the hour, some of the information I have here is information that some of you have heard before at the December Defense Board Meeting, so we'll review the purposes of the Family Caregiver Panel; bring you up-to-date on where we are on the curriculum. I'll review the modules just briefly; talk about some decisions we've made about -- not pilot
testing, but qualitative process review,
refinement and distribution; go over the timeline,
which continues to change; and then I talk about
our last meeting.

As most of you know, the Family
Caregiver Panel was authorized by the 2007
National Defense Authorization Act, creating a
panel of members to develop this curriculum to
help families who are caring for their loved ones
who've had a traumatic brain injury, whether
they're active duty or veterans.

And the law stipulated the categories of
individuals that should be included -- medical
specialists with experience in TBI, family
caregivers, representative organizations, DoD and
DBA health and medical personnel, as well as
experts in development of training curriculum and
family members of members of the Armed Forces who
had sustained a TBI.

The panel members were not appointed
until the 6th of March, 2008, so this project has
had a delayed timeline, simply because of those
The role of the DVBIC as part of the DCoE is to provide the staff support to the panel in helping them develop the curriculum, to try to assure accuracy, and to be responsible for dissemination, implementation, and ongoing maintenance of the curriculum once it's produced.

The panel members were asked to review the literature to assure an evidence base for the curriculum, developed a consistent curriculum, and to make recommendations on dissemination of the curriculum. The benefits of this curriculum we anticipate will be a consistent source of information for family caregivers, tools for coping and gaining assistance, and giving -- sending a message of hope and recovery as they navigate life after a TBI.

We're hopeful that the curriculum will be attractive and usable. They'll teach skills for communicating with healthcare personnel and be user friendly, culturally appropriate, and based on real-life needs and experiences.
So we've divided the curriculum into four modules. In module one -- and this development has taken place between our November meeting at our January meeting. Anne Moessner, the Chair, was the lead content oversight for the -- on the introduction to TBI, talking about the brain -- causes and types of TBI, acute care issues, complications, recovery, helpful suggestions.

Module 2, the lead content oversight was Dr. Sharon Benedict from the VA, and that was looking at -- or helping families understand what the effect of a TBI can be on physical, cognitive, communication, behavioral, and emotional aspects of living.

Module 3, the lead Rosemary Pries. And that was really the caregiver support curriculum chapter, starting the journey of caring for the family member who has had the TBI, helping children cope, addressing family needs, planning for the future, how to be an advocate.

And module 4 the lead content oversight
was Dr. Barbara Cohoon and this is on navigating
the system, understanding the military and
veterans health care system, eligibility for
compensation and benefits, entitlements related to
employment -- not benefits related to employment
and community reintegration.

At our January 8th and 9th meetings, we
had fairly good attendance by panel members -- 17
of the 22. Five DVBIC staff and our curriculum
writers were in attendance.

I'll go over many of the outcomes of
that meeting, but we were -- two of the highlights
were consensus to work on the multimedia component
of the curriculum with the Center for Excellence
in Medical Multimedia, which is located at the
U.S. Air Force Academy; and also consensus to work
with the Henry Jackson Foundation, which provides
a lot of administrative support to DVBIC for
graphic design and packaging of the curriculum.

We also -- there were some issues that
had been raised at the December Defense Health
Board Meeting that the Family Caregiver Panel
reviewed, one of which was differences in
definition of family caregiver. The Panel
definition, which you see first, is a fairly broad
definition: Any family or support person relied
on by the service member or veteran; anyone who
assumes responsibility is the person that we want
to receive this curriculum and who we consider a
family caregiver.

In contrast, the DoD-VA definition
really uses the term committed designee rather
than caregiver and is much more legally driven,
perhaps benefits driven, legally designated by the
service member and veteran who provides support
deemed necessary by a medical authority for the
care of an injured or ill service member or
veteran.

So it's important, as we go forward,
particularly as we look at dissemination that --
certainly that the caregiver curriculum not be --
be not limited to those persons that fall into the
category of committed designee, nor do we want
someone who receives the curriculum to assume that
they are in the category of committed designee. And I suspect that that will recur, but it is something for everyone to be aware of.
The other issue that was raised by the Defense Health Board at the December meeting was the intellectual property issue. And we were very pleased that the Board was so impressed with the content we were developing that they were concerned about this.

We did turn to the Counsel for the Defense Health Board for an opinion, and basically copyright protection is not available for any work of the United States government. And, unfortunately we cannot designate our right to copyright to a nonprofit organization for that reason.

Also any publisher can republish a U.S. Government work. The publisher cannot claim copyright unless they've added original content, and only the original contents can be copyrighted. So basically, once this is done, it will be out in the commercial world and individuals
will be able to utilize the content.

At the January meeting, we also had some
discussion of the overarching issues of the
curriculum, for example, the appropriate literacy
level. And we've got module one written in both
the eighth-grade and 10th grade level of literacy.
And we're having people at Walter Reed take a look
at that. Also, we're finding some family
caregivers to informally look at those two
together some input about what the literacy levels
should be. We are very heavily toward feeling
that it should be at the eighth-grade level. And
I suspect that's where we'll find the curriculum
written.

We also -- and the Panel members were
very clear about this -- they felt that medical
providers, healthcare providers would need an
orientation to the curriculum so that they would
be able to direct the family to the portion of the
curriculum that could be most helpful to them. We
haven't decided as a panel yet how that's going to
be done. And, of course, there were a lot of
tweaking of the specific modules. Additions and changes were recommended. I didn't think that we would go into that to great detail.

We did have a very, very substantive discussion on mild TBI and concussion. There was a strong feeling that we should be including in the family caregiver curriculum something about the mild TBI, particularly for those folks who have a sequelae, who are suffering headache, insomnia, other problems related to a TBI, you know, three months post injury and the impact that that has on families.

We were also concerned, though, about the message that we would be sending by incorporating mild TBI in a family caregiver curriculum, sending a message that perhaps if you had a mild TBI, you would need a family caregiver, which is definitely not the case.

So we've compromised by creating a standalone product. We're calling it module five, but it will probably be a standalone and not part of the curriculum, which will pretty much take a
lot of the information out of the existing curriculum and repackage it directed toward individuals who have had a mild TBI and are having some problems beyond the point at which we would expect recovery. And that will be coming along as well. I believe it was the Module 1 group who comprised primarily of clinicians who volunteered to write this portion of the manual.

So after we concluded all of this discussion, we created new working groups -- Design and Editing, which Anne Moessner is chairing; Multimedia, which is being chaired by Michael Welsh, who experienced a TBI in theater; Qualitative Process Review -- Dr. Rosemary Pries from the Veterans Administration; and Dissemination, Colonel Nancy Fortuin and Dr. Megumi Vogt from the DCoE.

The Design and Editing Group actually met with the grant writers and with the HJ of graphic staff, so they really rolled up their sleeves and got into the nitty-gritty of how this module would look, what kind of features they
wanted, and they decided we wanted close
coordination with the Center for Excellence in
Medical Multimedia to ensure continuity of design
between the print and the online versions.

We also agreed to 200 copies as an
initial printing this spring for the qualitative
review process, which I'll go into, I think, in
the next slide. Oh, no.

The Multimedia Work Group participate --
had a conference call with CEMM. This work --
this site will be 508 compliant. We'll work
towards the Spanish language version, and it was
recommended that there be links from DoD sites to
the multimedia site, and we'll have to work on the
details of how that takes place.

Qualitative Process Review Work Group.
The Panel members felt very strongly that we
needed to get some focus groups together of family
caregivers to assure that the curriculum that we
were envisioning was indeed going to be helpful to
make sure we've covered -- provided the
information that they want. And, yet, this is not
a research project. This is a qualitative process review. And we hope to -- we do want to certainly gather caregivers, a variety -- severity of injury of their loved one, different types of relationships to the patient, active duty versus veteran status, geographically distributed, as well as representation by the various service areas.

They developed some sample questions, and the goal would be for 150 participants.

The Dissemination Work Group felt -- really raised a number of questions: When will the curriculum best be given to families and who should be the person who gives the curriculum to families; that commands would need some kind of a brief tool summarizing what the curriculum is about, with contact information -- phone numbers and websites, provider instruction prior to the curriculum being provided; distribute widely and often; need for a timely and massive marketing campaign; and dissemination of the mild TBI information will take a different route of the
caregivers.

So we've made a lot of progress since the January 8th, 9th meeting. In the graphic design area, we are looking at four separate modules, each with a spiral binding and also three holes so they can be maintained together in a binder, but also taken out separately and maintain their integrity.

We're -- the Panel Editing and Design Group have been asked to provide input on the logo, and, as I mentioned earlier, we're looking at literacy levels, and the content of all the modules has been finalized. This is a -- the Editing and Design Group were asked to take a look at two concepts that HJF Graphics has developed for the curriculum. And the majority of Panel members in the Design Graphic Group voted for the blue version, which looks more springlike.

And we will use some form of a tree, I think, as a consistent logo through the curriculum, not necessarily this particular one.

But they certainly wanted bright
cheerful colors. The Center for Excellence in Medical Multimedia is reviewing all of the modules to assure that the website covers all the topics of the curriculum. Their website is TBI the Journey Home, and there will be a button dedicated to the family caregiver curriculum, which will be the caregiver's journey.

And we will be posting the curriculum modules as a PDF on the site.

This is a sample of the webpage as it will look. What will happen here -- and we've had a -- since even this slides were put together, we had a telephone conference call between CEMM and Henry Jackson and the staff at DVBIC. One of the things that we're going to do is etch the skeleton of a tree into the granite-looking appearance where it says traumatic brain injury: the journey home, and that logo will appear then on every page. Also, where you see caregiver's journey, that will also have the tree logo so that there will be some consistency between the two products.

Also we're going to look at the color

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scheme that we're using for click at the bottom to
be sure that it's consistent with the modules,
that where we're talking about the brain, that
that is the same color scheme we're using for
Module 1, which is about the brain and how it
works and what happens when there is some injury.

I did want to mention and this slide
does not show that is at the bottom of the slide,
we're planning to have DHB, the Defense Health
Board, as well as CEMM, the Center for Excellence
in Medical Multimedia credited at the bottom of
the page -- of each page.

Right now, the writers are interviewing
family caregivers so that we include real-life
stories in the curriculum, and we're looking for a
variety of stories. We're looking for the
20-year-old service member with a young spouse or
with a girlfriend who is his primary caregiver.
We're looking also at more mature families as
well. Just -- we're looking for minority
families. We're looking for differences in
severity of TBI.
And I think that those are -- we've done about five or six interviews, and we have about four or five more to do.

We also are working on piggybacking onto an existing contract with TMA to obtain the consultants to conduct focus groups, and those would be held at various DVBIC sites around the country.

So, on the timeline, we're looking at April and May at the earliest for the multi-site focus group to refine the curriculum; June for revising the critical mass needed; a panel meeting in June or July to do a final review of the curriculum.

There is a report to Congress due in August, and then August we will also have the review and approval of the curriculum by the Defense Health Board, and hopefully dissemination would begin in September.

Our Panel meetings will be in June or July. We'll review the final print product, the fund marketing and dissemination plans, and
discuss maintenance of the curriculum content. So
that's my presentation. Any questions?

DR. WILENSKY: Thank you very much. Are
there any questions? Yes.

DR. DETRE: I believe and think I
believe that any of these problems exist in pure
culture; for instance, there are people who
believe that PTSD is alone a psychological or
psychiatric disorder without TBI or those who have
mild TBI or even more severe one don't have PTSD.

My superstitions aren't true. But what
is really important that at least in my experience
earlier with different conflicts is that two
issues complicate the clinical picture and the
management of families where there is a member who
is suffering from any one of these disorders.

And the two issues are substance abuse,
particularly alcoholism, which I'm sure needs to
be included in the curriculum, and consultants
need to be made available to family caretakers,
because they won't be able to handle it alone.

And the second, which is rarely
mentioned, although it is in the clinical
literature and it's in the legal literature: The
number of separations and divorces in families.

Now that complicates matters from a
legal point of view in a sense that you can assign
or they may mistakenly assign the caretaker a
position who in fact is already conflicted by
threatened separation or divorce.

So I believe whoever is going to be the
consultant should have at least minimal knowledge
of the legal complications involved.

DR. CAMPBELL-KOTLER: Thank you, and we
have included information about PTSD in the --
under -- in Module 2 on effects, also
substance-abuse we've addressed. I think that
care managers, who perhaps will be the folks who
provide this curriculum are going to have to be
knowledgeable about how to make referrals to the
kinds of mental health or other resources that the
families really need.

There's just so much a book can do. But
I think it can be -- perhaps it can be a jumping
off point. People may not realize what they are experiencing, and when they read some of the reactions of other caregivers, they may realize that they are not alone, which may help the situation; and also recognize that help is available. And it may actually ease the process. That's my hope.

DR. DETRE: May I suggest --

DR. CAMPBELL-KOTLER: Yeah. Well, we'll be -- we do conduct family group meetings now in our DIVBik education and that is certainly something that we can easily implement. Yeah.

Thank you. Thank you.

DR. WILENSKY: Tom?

DR. MASON: Tom Mason. Just a quick question for you. I was just talking with my colleague. What about the gender of the caregiver --

DR. CAMPBELL-KOTLER: Right.

DR. MASON: -- because they're a big cultural differences of a man taking care of his significant other and a woman taking care of her
significant other and how you might actually train
for this particular aspect?

DR. CAMPBELL-KOTLER: Yeah. We are
looking for vignettes, if we can find them for
that, and also in our focus groups it's certainly
something that we've thought about, but the
numbers are just so different in size that it will
be hard to find.

DR. MASON: Understood, but, you know,
since more and more women are placed in harms way
--

DR. CAMPBELL-KOTLER: Mm-hmm.

DR. MASON: -- and potentially impacted
and definitely going in the direction of moderate
traumatic brain, which is tough; you know, the
idea of being able to incorporate some of those
gender-specific issues, which are culturally
laden, no question, I think would be very
important to address.

DR. CAMPBELL-KOTLER: Okay. I'll make
sure when we go back and look at the caregiver
module again and make sure that we have addressed
some gender-specific issues.

DR. WILENSKY: Mike?

DR. OXMAN: Given the young age group of
many of the users, have you considered also
including a option of a DVD format instead of --
or as an alternative to the printed one? Because
not everyone who uses DVDs has Internet access.

DR. CAMPBELL-KOTLER: We have not at
this point. We're just looking at web-based
access, but there probably is no reason why we
couldn't also provide DVD.

DR. WILENSKY: Greg?

DR. POLAND: Yeah, I was going to make
the same point that, you know, not everybody
learns, you know, visual -- by reading, but by
other mechanisms. A couple of comments. One to
further what Tom said. The other thing is just as
parent -- just as grandparents are taking care of
children, it may be that a parent or a grandparent
may end up being the caregiver, so looking sort of
across -- or in some cases even an older
adolescent. So looking across that age spectrum.
I also wondered about -- and I know this is not in your original charge -- but think with an eye toward the future thinking toward expanding to some sort of educational curricula, not caregiver curricula, for young children, maybe in the form of the storybook or something.

And then -- because you mentioned the design and multimedia aspects, I thought I'd mention and maybe you know and it was just new to me, but it is barely scratching the surface of medicine this new concept of knowledge encounter research. It's called KER. And at least one unit I know of has demonstrated with fairly simple graphics really impressive gains in knowledge compliance and reduction and inappropriate behaviors or inappropriate uses of medications, for example.

So I know it's late in the game, but you might look into that.

DR. CAMPBELL-KOTLER: Thank you.

DR. WILENSKY: Dr. Roper?

DR. ROPER: Thank you. Dr. Allan Roper.
Was there a perusal at least of the public sector material on head injury that is disseminated by American Head Injury Society and various large institutions like University of Miami? I'm asking, in part, because my sense is this far surpasses anything that's been done, number one. And although there are military images throughout it, from what you showed, it probably is going to be picked up avidly, very quickly. And some thought might be given to that going forward.

Is there an alliance, for example, with the American Head Injury Foundation or the Brain Trauma Institute or any of these publicly supported entities?

DR. CAMPBELL-KOTLER: We have used -- we've referred to information that the Brain Trauma Foundation, the TBI Model Systems Network, and a lot of the material that they've developed. We've tried to use everything that we could that was in the public domain and was available. We have not developed those relationships going forward, but I think, as we
look at dissemination, that's something that we
should be looking at in terms of alliances with
other organizations, such as the ones you've
mentioned, to get the word out about this
curriculum.

DR. WILENSKY: Thank you. Yes.

MR. KAHN: That was excellent. Thank
you. Very nice progress since the last
presentation.

DR. CAMPBELL-KOTLER: Thank you.

MR. KAHN: A question for you about
monitoring and evaluation: So I see that you do
have what you're calling qualitative review
process --

DR. CAMPBELL-KOTLER: Mm-hmm.

MR. KAHN: -- so some form of monitoring
and evaluation. And I would suggest that you not
be concerned about terms of research or
non-research to really have a robust evaluation of
the product before it's put out there.

My specific question to you is -- does
your charge include after the broad dissemination
some continued monitoring and the evaluation to
see broadly after you've gone to these 150
families, but as you disseminate it a lot more
broadly, you know, is it really what you want and
how do you change it and make it more of a dynamic
product than a static product once it's out there.

DR. CAMPBELL-KOTLER: Yes.

Unfortunately, there isn't an ongoing evaluation,
a review process, built into the charge to the
Panel. That certainly is something. When we
looked at all of this, we really decided that the
evaluation process was really a next step; was a
next part of the process, and would require its
own funding and would require its own search for
who would best do that research.

So that's a next step that I guess the
Defense Health Board would need to think about as
well and we really -- we consider what we're doing
right now in the qualitative -- as qualitative
input. We're trying to be representative and to
try to get the best input we can, but by no means
do we consider this research.
If we were to consider it research, we'd have many other restrictions and parameters also to face, which would very much slow down the process.

DR. WILENSKY: Thank you very much.

DR. CAMPBELL-KOTLER: Okay. Thank you.

DR. WILENSKY: We'll look forward to seeing the curriculum when it's developed.

DR. CAMPBELL-KOTLER: Yes. Thank you.

DR. WILENSKY: Greg, are you ready to give us - Greg Poland will give us an update on the issues we raised earlier this morning.

DR. POLAND: So with regards to the questions raised this morning. It was asked of me if I could make a couple of changes and then would that be acceptable to the Board in terms of a vote on the biosurity question that was asked to us. So there were three changes that a small group of us could recollect being recommended.

The first was a change in that final paragraph, so we would indicate here this. But in the context of a major change of mission to
developing FDA-approved products, blah, blah,

blah.

The second was to take recommendation
two, you have those slides in your folders there,
and divide it so that we would add the point that
was raised about collaborations involving -- we
had academia and industry there, but adding other
federal agencies.

And then divide the last piece of
recommendation two so that it still reads in a way
that makes sense to the red team being a separate
recommendation.

And then finally this one. Given the
restricted time frame within which this task force
developed these initial recommendations, we
recommend that the DHB Task Force further engage
in a more comprehensive overall evaluation of the
DoD defense infrastructure and research portfolio.

So comments on any of those three
changes and then if you find them acceptable.

DR. WILENSKY: Any -- any comments? We
were just having a discussion about whether we
have -- we should vote for these separately and
then the full. But since we hadn't voted for the
full one anyway --

DR. POLAND: Right.

DR. WILENSKY: -- my assumption is we
can just do it once. Those was -- this high level
negotiation was going on there.

Every comfortable? Any dissent? We
have it.

DR. POLAND: Okay. Thank you.

DR. WILENSKY: Thank you. We just did
-- we just did. Yes, that was the vote.

CDR FEEKS: For the sake of the
transcription, what we've just done is accept the
report, as amended, by unanimous vote. So Dr.
Poland's report is accepted, as amended.

DR. WILENSKY: Yes. If I -- I will try
to make that clearer in the future, but I will
always ask for first indication of consent and
indication of dissent. If there's any indication
of dissent, and then we'll have a more there a
discussion and either find a consensus or at least
be clear about the numbers.

So when I -- there doesn't appear to be
any dissent, I don't usually bother. But that is
what I meant.

Do you think we need a small
administrative session?

COMMANDER FEEKS: I don't have any
items.

DR. WILENSKY: Okay. Yes. Would people
like to have a short administrative session before
we end the day? I'm not sure if we need any.
We've been at this for a long time. Okay.
I will turn it over to you for some
administrative comments.

COMMANDER FEEKS: Thank you, Madam
President. This is Commander Feeks. For Board
members, ex officio members, liaisons and
speakers, tomorrow's briefing at the Special
Forces Underwater Operations School, which is
where Green Berets learn to become combat divers.
It's located on Trumbo Point. It will be -- the
brief there will be preceded by breakfast at the
Mess Hall there.

It is kindly requested that you bring exact change. They deal in cash only. The cost of the breakfast is $2.30, so exact change, please.

For those of you joining us for the dinner tonight, vans will be available outside the hotel at 6:00 p.m. to take us to the restaurant, and these vans are vans we've chartered. They're not the hotel shuttle, because there are too many of us to fit all in one shuttle.

And that concludes my administrative remarks. Madam President.

You'll be walking around on an aircraft -- if I call it ramp -- a concrete parking ramp. You won't be on the runway, but you'll be on a concrete parking ramp. You'll also be walking across some grass, if that helps over at the diving school. So, you know, short sleeves I would say. I don't require a coat and tie tomorrow, and I'm going to be in Charlie's tomorrow.

SPEAKER: They won't be wearing ties.
COMMANDER FEEKS: Is that enough to go on for tomorrow. All right, sir.

DR. WILENSKY: Seven -- we meet at 7:30, I believe.

COMMANDER FEEKS: Yes, ma'am. Sorry.

SPEAKER: Can we leave our materials here.

COMMANDER FEEKS: I think it's safe to leave your materials here, but not your electronics.

DR. WILENSKY: This concludes the public portion of our meeting. Tomorrow morning, as you've heard, the Board members, liaisons, and ex officio members will meet in the hotel lobby, so we can board the bus and leave for the site visit at 7:30. An administrative session will follow the site visits tomorrow afternoon. Mr. Middleton, would you adjourn the Board's business meeting.

MR. MIDDLETON: This meeting of the Defense Health Board is adjourned. I want to thank all of you for attending. I want to thank...
the great support from the folks that support the
DHB and particularly to thank all of our
outstanding speakers for their presentations
today. Thank you.

(Whereupon, at 5:15 p.m., the
PROCEEDINGS were adjourned.)

* * * * *
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