PARTICIPANTS:

GAIL WILENSKY, Ph.D.
ALLEN W. MIDDLETON
COMMANDER EDMOND FEEKS
LIEUTENANT COLONEL CHRISTOPHER COKE
SHAKIR JAWAD, M.D.
JEAN LANGLOIS, Sc.D.
CHARLES FOGELMAN, Ph.D.
KENNETH W. KIZER, M.D.
COLONEL (RET) ROBERT G. CERTAIN
JOHN D. CLEMENTS, Ph.D.
GENERAL (RET) RICHARD A. CODY
WILLIAM E. HALPERIN, M.D.
COMMAND SERGEANT MAJOR (RET) LAWRENCE W. HOLLAND
EDWARD L. KAPLAN, M.D.
WAYNE M. LEDNAR, M.D.
MARK A. MILLER, M.D.
GENERAL (RET) RICHARD B. MYERS
DENNIS O'LEARY, M.D.
MICHAEL N. OXMAN, M.D.
JOSEPH E. PARISI, M.D.
MICHAEL D. PARKINSON, M.D.
PARTICIPANTS (CONT'D):
GREGORY A. POLAND, M.D.
CHARLES A. SANDERS, M.D.
ADIL E. SHAMOO, M.D.
JOSEPH SILVA JR., M.D.
HONORABLE CHASE UNTERMeyer
WILLIAM BLAZEK, M.D.
RICK ERDTMANN, M.D.
PIERCE GARDNER, M.D.
GROUP CAPTAIN ALAN COWAN
WALTER DOWdle, M.D.
ALI S. KHAN, M.D.
H. CLIFFORD LANE, M.D.
ANNE MOESSNER, MSN
COLONEL ROBERT L. MOTT
COLONEL (RET) JOHN HOLCOMB, M.D.
COMMANDER CATHERINE Slaufwhite
PHILLIP TOBEY
BONNIE BEnETATO, Ph.D.
BRIGADIER GENERAL LOREE K. SUTTON
RAYMOND F. DUBOIS
DR. WILENSKY: 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 our agenda today, so let's get started. Mr. Middleton, would you please call the meeting to order?

MR. MIDDLETON: Thank you, Dr. Wilensky. As the Alternate Designated Federal Official for the Defense Health Board, a Federal Advisory Committee and a Continuing Independent Scientific Advisory Board 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. And now in carrying on the tradition of our Boards, I 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'd like to go around the table and have the Board and distinguished guests introduce themselves, and the new Core Board Members and Subcommittee Members, please tell us a little about yourselves. Let me start. My name is Gail Wilensky. I am President of the Defense Health Board and also chair the Health Care Delivery Subcommittee.

COMMANDER FEEKS: Good morning. Commander Ed Feeks, Executive Secretary of the Executive Health Board.

MR. MIDDLETON: Good morning. I'm Allen Middleton. I'm the Acting Principal Deputy Assistant Secretary of Defense for Health Affairs, sitting in for Ms. Embrey today as the Alternate Designated Federal Official.

DR. LUDWIG: My name is George Ludwig, and I'm the Civilian Deputy Principal Assistant for Research and Technology at the Medical
Research and Materiel Command, and I'm here representing the Director, Dr. Frazier Glenn.

DR. LONGACRE: Good morning, Dr. Longacre here representing Dr. Rice at the Uniformed Services University.

GENERAL MYERS: Dick Myers, Core Board Member.

DR. KAPLAN: Good morning, Ed Kaplan, Professor of Pediatrics, University of Minnesota, Core Board Member.

DR. CLEMENTS: John Clements. I'm the Chairman of Microbiology and Immunology at Tulane University School in New Orleans and a Core Board Member.

DR. CERTAIN: Robert Certain, retired Air Force Chaplain, Core Board.

MR. UNTERMEYER: I'm Chase Untermeyer. I'm in private business in Houston, and a member of the Core Board.

COMMAND SERGEANT MAJOR HOLLAND: I am Larry Holland from Houston, Texas, retired Command Sergeant Major, Core Board Member.
DR. SILVA:  Good morning, Joe Silva, Professor of Internal Medicine, University of California, Davis, Dean Emeritus, School of Medicine, and Core Board Member.

DR. MILLER: I am Mark Miller. I am Director for Research in the Division of International Epidemiology Population Studies at the NIH and Core Board Member.

DR. SHAMOO: Adil Shamoo, University of Maryland School of Medicine, Core Board Member, and the Chair of the Medical Ethics Subcommittee.

COLONEL HOLCOMB: John Holcomb. I'm Chair of the Trauma Injury Subcommittee, just recently retired from the U.S. Army where I was a trauma critical care surgeon and ran a research laboratory and now a Professor of Surgery at the University of Texas in Houston.

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

DR. SANDERS: I'm Charlie Sanders. I'm the Chair of Project HOPE, Chair of the University
of North Carolina Health System, and Core Board Member.

BRIGADIER GENERAL LEE: Good morning. I'm Carol Lee. I'm the Deputy Joint Staff Surgeon, and I'm here representing Admiral Smith.

COLONEL NOAH: I'm Colonel Don Noah, the Acting Deputy Assistant Secretary of Defense for Force Health Protection and Readiness and another alternate DFO.

DR. POLAND: I'm Greg Poland, Professor of Medicine and Infectious Diseases at Mayo Clinic, the immediate past DHB President, now Vice President, and Chair of the Infectious Disease Control Subcommittee.

DR. WILENSKY: You've already gotten a chance to experience what happens if too many of us have our mikes on at the same time, so be sure and put them on when you speak, but after you speak just shut them off so we don't pick up the vibrations. Commander Peeks has some administrative remarks before we begin the morning session.
COMMANDER FEEKS: Thank you, Madam President. Good morning and welcome. First, there is an empty seat at our table. Dr. William Halperin is not with us this morning. His wife passed away a couple of weeks ago, and let's keep that family in our thoughts and prayers.

I want to thank the staff of the Sheraton Crystal City Hotel for helping with the arrangements for this meeting, and I want to thank all the speakers who have worked hard to prepare briefings for the Board. I want to thank my staff, Jen Klevenow, Lisa Jarrett, Elizabeth Graham, Olivera Jovanovic, and our newest staff member, Kim Lundberg, for arranging this meeting of the DHB. Finally, I also want to thank Ms. Jean Ward for her invaluable assistance in putting this meeting together.

In keeping with the rules of Federal Advisory Committees, please do sign the general attendance roster on the table outside if you have not already done so. For those who are not seated at the tables, handouts are provided on the table.
in the back of the room. Rest rooms are located
down the corridor on the left-hand side. For
telephone, fax, copies or message services, please
see Lisa Jarrett or Elizabeth Graham. Because
this open session is being transcribed, please
make sure you state your name before speaking. If
your name is difficult to spell, please spell it
the first time you say it. And please use the
microphones so our transcriber can accurately
report your questions.

Refreshments will be available for both
morning and afternoon sessions. We will have a
catered working lunch here at the Crystal City
Sheraton for the Board Members and speakers and
liaison officers, and there are a number of
restaurants nearby.

Finally, the next meeting of the Core
Board will be held on August 17 and 18 of this
year in Colorado Springs, Colorado, at the Air
Force Academy. The Board will then receive a
series of updates on subcommittee activities and
draft recommendations. Before we move on, I'd
like to ask if anyone is on the phone with us
today. That concludes my remarks, Madam
President.

DR. WILENSKY: Before we start, I would
like to be sure that the people here at the table,
the Core Board members and Subcommittee
chairs, know that the working lunch is truly a
working lunch and we will count on your presence
here between 12:30 and 2:00, similar to the
arrangement that we did in Key West. So we'll
give you some time to attend to other matters
including grabbing your lunch, but please regard
that as a working session.

Our first speaker this morning is
Lieutenant Colonel Christopher Coke from the Joint
Staff in Washington who will present an update on
U.S. military operations worldwide. I've been
reminded that there's a tradition of having people
in the audience also indicate who they are for
purposes of the public record, so while we're
getting ready for Colonel Coke, maybe just go and
say your name and who you represent.

COLONEL KUKAR: Good morning. Colonel Michael Krukar, Director of the Military Vaccine Agency.

GROUP CAPTAIN ALAN COWEN: I'm Group Captain Alan Cowen. I'm the British Liaison Officer in the Department of Defense. I'm also in the Veterans Agency.

COLONEL MOTT: Colonel Bob Mott, Preventive Medicine in the Army Surgeon General's Office.

MS. LUDWIG: Sharon Ludwig, I'm representing the U.S. Coast Guard Surgeon General.

MS. BENETATO: Bonnie Benetato, Department of Veterans Affairs War Related Illness and Injury Study Center.

MR. ERDTMANN: Good morning, Rick Erdtmann from the Institute of Medicine.

COMMANDER SLAUNWHITE: Good morning, I'm Commander Kathy Slaunwhite. I'm a Canadian Forces
Medical Officer stationed at the Canadian Embassy in a liaison role here in Washington, D.C.

DR. FOGELMAN: I'm Charlie Fogelman.

I'm Chair of the Psychological Health Subcommittee of the Board.

MS. MOESSNER: Good morning, Ann Moessner from Mayo Clinic and chairing the TBI Family Caregiver Subcommittee.

DR. LANGLOIS: Good morning, I'm Jean Langlois, and I'm a member of the TBI Advisory Subcommittee.

MR. RAYBOLD: Ridge Raybold, Office of the Director, Armed Forces Institute of Pathology.

MS. COLADA: Sandy Colada, Defense and Veterans Brain Injury Center.

DR. GARDNER: Good morning, I'm Pierce Gardner. I'm a Professor of Medicine and Public Health at Stony Brook University School of Medicine and a member of the Infectious Disease Subcommittee.

MR. DONELAN: Good morning, I'm Walter Donelan with the Task Force for Global Health and
Phone (703) 519-7180  Fax (703) 519-7190
a member of the Infectious Disease Subcommittee.

MS. KITCHEN: Lynn Kitchen, Military Infectious Disease Research Program.

MS. CARTY: Jill Carty, Force Health Protection and Readiness, Psychological Health, Strategic Operations.

MR. TOBY: Good morning, Phil Toby, member of the BRAC Subcommittee.


DR. BLAZEK: Good morning, I'm Dr. Bill Blazek. I'm from the Center for Clinical Bioethics at Georgetown University.

MS. COATES: Good morning, Marianne Coates, Public Relations Communicator and Adviser to the Defense Health Board.

Major OBAMWONYI: Good morning. My name is Major Obamwonyi from the Department of Occupational and Environmental Health at the USAF School of Aerospace Medicine.

MR. LANE: Cliff Lane, National Institute of Allergy and Infectious Diseases and the Infectious Diseases Subcommittee.

DR. SHAKIR: Good morning, Shakir Jawad
from the International Health Division of the
Office of the Assistant Secretary of Defense for
Health Affairs.

CAPTAIN MATOS: Captain Peter Matos,
Preventive Medicine, Occupational Medicine
Resident, Walter Reed.

CAPTAIN SHERRY: Captain Scott Sherry,
Preventive Medicine Resident, Walter Reed Army
Institute of Research.

LIEUTENANT COLONEL STONE: Lieutenant
Colonel Jay Stone, Defense Centers of Excellence
for Psychological Health and Traumatic Brain
Injury.

COLONEL JOHNSON: Colonel George
Johnson. I work for Ms. Embrey, Force Health
Protection and Readiness, currently working for
Colonel Noah.

DR. WILENSKY: Thank you very much.

Colonel Coke?

LIEUTENANT COLONEL COKE: Good morning.

If everybody can hear me, I tend to wander away
from the mike, so please keep me on it.
Like I said, Chris Coke. I'm a Marine aviator. I fly CH-46s, our medium-lift helicopter, and I'm a former Squadron Commander and have served in Iraq, Afghanistan and over in Africa and in the Europe theater, particularly in the Balkans. I currently work on the Joint Staff in the Joint Operations Directorate. We deal with current operations, and my area of specialty is Europe.

It's a pleasure to be with you this morning. Thank you for the opportunity to get out of the Pentagon and see some light. One thing I'll preface with is just like most professions, we are riddled with acronyms, so if there's something that I say that doesn't make sense, please stop me. And I hope this is a discussion as well as a presentation, so at any point please feel free to stop and discuss a particular issue that we may touch on.

Because I'm not a very good joke teller, the other course of action I have is to present a short video, so we'll do that.
(Video played.)

LIEUTENANT COLONEL COKE: Now, why that?

A couple of reasons. It's always cool to talk about yourself, so that's actually one of the first landings I did in Iraq and it was taken by DASH-2, the second aircraft, and as you saw, you could see some of the dust being pulled up and away aside from where this helicopter was and that was DASH-2 figuring out that it probably wasn't a good idea to land at that particular time, so they took it around and decided to land when the dust had settled. It kind of exemplifies the conditions, and if you imagine at nighttime it complicates issues. Particularly when you talk about MEDEVAC and you talk about pulling people out, you don't get to choose where you land. So quite often this is what the pilots are dealing with, as well as also you don't get to choose where you fight. So we may employ Marines or other servicemen and women, it is inherently dangerous just trying to get them there, never mind the actual fight that takes place or ensues.
afterwards.

I always have to start off with a thank you too. I recognize as we all do that your effort leads to many good things for our service folks, and I just use this example of Brad Mellinger, a Lieutenant in the Army who was injured in Iraq and very quickly was taken to Germany for follow-on care and is today with this family and multiple tours in Iraq and Afghanistan. This alludes to a very pleasing statistic that we like exemplifying, and that is right now about a 7 to 1 ratio of mortality when you talk about people who have been injured. It's much better I am to understand than 3 to 1 in the Korean War and 2 to 1 in previous wars. What has allowed that to happen? I think there are two areas which you have been a part of, and again thank you. One is the equipment, whether we're talking about flak jackets or protection or the new MRAP vehicle with the V-shaped hull that the engineers have figured out that allow the explosion to be taken to the side of the vehicle instead of up through
it is certainly a contributor.

The second contributor is just in medicine alone. I'll use the example of QuikClot that I've seen personally work so very, very well at arresting bleeding and allowing people to not bleed out and get to the appropriate care that they need to get fixed. So again your efforts are truly appreciated. Thank you.

Where are we at? I'm going to go around the world and just kind of touch on a couple of things in each theater. As you can see, we've got service folks deployed around the world. As one would expect, in Central Command which I'll abbreviate as CENTCOM but it really encompasses the area around the old Persian Gulf and those countries around there, and of course we've got about 22,000 folks deployed there. But it's important to remember also EUCOM has almost about 90,000, the Pacific has 150,000, Africa which is a new command is growing with 3,300, and of course our friends to the south, Southern Command, about 5,300. So this is where your servicemen and women
are around the world. Of course, they're broken out into geographic commands which own those particular regions and employ them as required in the national security interests of the United States.

In the national security discussion we talked about the belt around the world that happens to coincide with the equator, but it's basically the hot points or the flash points. As you can see, it's pretty much true to form around the world this is where we are engaged, whether it be off Haiti and humanitarian efforts, and we'll go into some detail about a few of these, all the way around to the Philippines and everything in between.

We'll start with Africa which is a newly shaped command as of 1 October of last year. A little bit different. It's just not military, and we recognize and have recognized that the solution to national issues as far as foreign strategy is just not a military solution. The second in command is broken into two parts. One, you have
an ambassador that looks at the diplomatic aspects and building partnerships within those individual countries, and then you have the military aspect that looks at all things military. But what are they involved in? They're involved in partnership development, theater security, involved in the old contingency operations dealing with extremists, but the Task Force Horn of Africa, they're in Djibouti is still much alive and well, and then of course Enduring Freedom which is alluding to counterterrorism operations there in the Trans-Saharan.

Central Command, again the area around the Persian Gulf is really our focus right now. There are really three areas, and I'm going to touch on each of these. One is Afghanistan, Iraq, and then maritime, and tied in there to a great extent is counterpiracy which has taken the headlines recently. It's relatively small in space as far as geography goes with only 20 countries as opposed to 90 plus in Europe and other commands, but nonetheless has our attention.
The other aspect as we all know is there's a lot of energy out of this area.

Let's talk about Iraqi Freedom. There's a lot of success there. It's not absolute, we continue to have setbacks, but we are at that point as you well know where we're able to start drawing down and moving forces over to Afghanistan. I think it's important to recognize that there are very many positive indicators starting with the provincial elections that have taken place and the transition of the military and our assistance to the Iraqi people, to the Iraq government and to their military and police systems. We're down now to about 14 brigade combat teams as opposed to over 20 a year ago. Violence is down about 60 percent from last summer and that continues to go that way. Like I say, there are always setbacks that we hear in the news, but violence continues to go down. We still view the area around Mosul up in the north as being an area that we still need to pay particular attention to. The fight hasn't ended there, but
we're at a point where we can start refocusing,
and if you've heard the news and words that have
come out of the Secretary and the Chairman is of
reorientation, certainly the President, and focus
into Afghanistan but certainly not allowing any
backwards movement of progress or success in Iraq.

I'd like to talk about Sergeant
Martinette, another hero who received the Bronze
Star With Valor. Again when we talk about IEDs
and we talk about the favorite weapon of choice
for the insurgents, countering IEDs is an issue
and who was responding to an IED that have gone
off. One of the most injured in the quick triage
of the scene was an Iraqi civilian and so he
attempted to move him, and in the process of
moving him, a second blast went off.
Miraculously, he was injured but no one was killed
that day, but as soon as he got up and shook off
the dust, he turned to and started doing his
practice, and like I said, no one was killed that
day. So he's a local hero from Virginia Beach.

Moving over to Afghanistan, there's a
lot of work here. As you've heard in the news, deploying an additional 17,700 folks there, 4,500 to 4,800 additional to help with rebuilding and reconstruction and other things than military operations. There's a lot of emphasis in this area in the south in what we call RC South where we're going to be assisting. The Canadians have it now and then it will be going to the British, and then we'll eventually have a two-star headquarters there. So this is our new focus of effort. Certainly I've seen some setbacks, but when you look at the successes, this is truly a coalition effort. There are 35 contributing nations and they're growing. And they're just not NATO nations, being that this is ISAF, Security Assistance Force Afghanistan which comes under NATO, it also has many non-NATO contributors, for example, Australia, and Jordan is thinking about playing, and other countries.

Two concentrations that we're focused on right now are obviously the elections coming up in August and making sure that we have the forces
there to be able to support those elections. Then afterwards to continue counterinsurgency operations within Afghanistan, particularly the south and the east. We're in the poppy growing season so there's a lot of counternarcotic operations taking place as well. Lastly, I'll say we recognize, as we all have been hearing in the news, that this just isn't an Afghanistan issue. Our success is tied to the success within Pakistan, so they really are interlinked.

The forces continue to develop there as far as our Afghan partners, and to be honest, we still have a ways to go there both in the security and the policing. Again I'd just like to talk about Petty Officer Chandler. He was deployed out in one of the remote areas. He's a Petty Officer, a Navy type, and he's a hull mechanic or hull engineer, and was deployed on a PRT, provincial reconstruction team, as a mechanic for their vehicles. While he was in his area where they were staged, his outpost, they came under mortar attack and one hit directly in the motor pool. He
put together a quick team and went out and was
able to counter the attack, and for his efforts he
received the Bronze Star as well. He was a Navy
engineer who works on hulls is in Iraq doing
something very different than his trade, a good
every of what's going on.

Maritime operations. Obviously there's
a lot of focus on counterpiracy and efforts to
that extent. We'll talk about what took place in
the "Maersk Alabama" in a second. There are
several task forces, 150 which deals
counterterrorism activity within and around the
Horn of Africa region, and then there's 151 which
focuses on counterpiracy. It's important to note
that this is an international effort. The U.N.
has passed several Security Council resolutions
which allow ships to operate with consent of
Somalia within their costal waters, and actually
to go ashore. No one has really gone to that
point, but the authorities are building in
recognition that this piracy is a real issue
particularly when you talk about what we call
lines of communications, but the ability to move
freely at sea, and then counterpiracy which is a
new Task Force 151, focused specifically on that.
I have a couple of pictures here. You'll see the
big cargo ship. I don't know if you can see from
where you're at, but there are some small skiffs
or small vessels right next to it. Those are
pirates attempting to board. These are pretty
audacious folks when you consider the sizes of the
ships that they're capturing, and they're actually
successful. Prevention may be as simple as
bringing in our ladders and ropes and things that
dangle off your ship so that folks can't climb
them, so there is some education is going on here.
But this is how they're doing it, these large
cargo ships, these large tankers, they're doing it
from small platforms with certainly no
sophistication, AK-47s, RPGs, very simplistic
tactics, but it works.

In the case of the "Maersk Alabama" and
what was in the news recently where Captain
Phillips was a hostage for several days, the
commander of the "Bainbridge" which is the ship where the snipers shot off from is depicted there on the left welcoming him aboard his ship once they were able to effect that rescue, graduated from the Naval Academy, went to the Naval War College, many years at sea, many years on shore, and was at the right place at the right time and did exactly what was right and made the call when there was an opportunity and Captain Phillips's life was at risk and made that call to eliminate the pirates and was able to effect the rescue, so good success there. It's important to note that the French had similar success albeit I think one fatality a few days earlier, so it's an international effort and first and foremost in everybody's mind. The main effort is still Afghanistan.

Moving over to the European Command, EUCOM. This encompasses NATO as well. The Commander holds both hats. We still have activities there to the extent of about 90,000 Service members still employed in the EUCOM area.
of responsibility. Kosovo is still alive and well. We still have about 1,600 folks there. There's a lot of emphasis to the north when we talk about Mitrovica and Serbian dissent and influence within Kosovo. It's not all quiet yet.

The good news is all things Bosnia continue to go in a very positive direction, and our presence there in Sarajevo is about down to 28 folks, so it's good there. We still have an enduring mission, the USSC, which is a mission to train Palestinians in the West Bank to provide for their own security. Lieutenant General Dayton still has that, then as well to the main effort, the European Command provides forces and equipment to help the fight.

The Pacific Command. There's a lot going on there and I'll highlight just a couple of things. The Philippines is a tremendous success with operations countering terrorism, and it's important to realize that it trained the trainers and trained the Filipinos to be able to conduct operations themselves, and they've been able to
counter much. The PRC and what appears to be an expansionist or at least certainly on the economic front when we look at China and Taiwan, but when the election last year about this time of Ma in Taiwan things are looking better, but it's still a focus. As to Korea, obviously the Teapodong-2 launch continues to be worrisome, the departure from the Six-Party Talks and bringing everybody back to the table with the idea of how do you denuclearize North Korea or the Korean Peninsula. Then two, dealing with what we thought may be rather imminent, the departure or death of Kim Jong-il and the rapid assimilation potentially of North Korea into South Korea and bringing the Koreas back together, or how do we deal with that crisis that may be there. Of course, the Pacific Command also has India with the India-Pakistan Mumbai incident which continues to be troublesome. Looking at Southern Command which is pretty much south of Mexico and includes Cuba and Haiti, I'll talk about two real efforts. One is counternarcotics. The slide on the left shows the
distribution of narcotics. Certainly you have a supply and demand issue there and the demand generates, frankly, from the northern part of the Americas, so you see many arrows pointing in that direction. The other picture there is dealing with humanitarian assistance and theater security cooperation. Recently one of the hospital ships deployed down, and this is Commander Andy Malley who used to be, coincidentally, a former flight surgeon within one of my squadrons years back, but she's off the coast of Haiti doing preventative medicine. I think that's a mosquito trap that she's inspecting in Haiti, so there's good stuff there.

Then our back yard. It's kind of interesting how it focuses on Mexico, one, talking about counternarcotics and the drug trade. Again to the top left, you probably can't see it, it's in your slides, where the cartels are and the issues that are being brought up to the front dealing with the trafficking of drugs north and of course weapons south. Calderon, the President of...
Mexico, certainly has been engaging, and one could argue that the wrath of violence may be contributed because of Mexico's engagement now as well as perhaps Colombia and we see successes in Southern America forcing distribution up north.

Secondly, and certainly near and dear to I think everybody is the swine flu, and this is about a week old, the genesis from Mexico, but again there is still much discussion within the Joint Staff and within Northern Command as far as protecting our borders and our folks and contributing to what we can globally.

In closing, working on the Joint Staff we're away from the front obviously but we're supporting, and so we never forget where the emphasis is. Like I said, there are many organizations and many groups that contribute to our overall collective success, just not of the military, but of the United States, and so we always try to keep in mind our place. With that, that's my presentation. I have some backup
slides. I can get into strategy. I can get into policy. A lot of times I talk at Joint Staff talks and to visiting war colleges, and that's where they like to lead to, but I open the floor to any discussion or any questions that you may have.

DR. WILENSKY: Thank you, Colonel Coke. Are there any questions that people have? I actually have one that had to do with your comment about the maritime protection. I think all of us were impressed with the chaos that the pirates are able to create for shipping in the area around Somalia and going up through Yemen and the Aden Straits. Is there anything that you can share with us about what is reasonable and feasible to do either by the U.S. itself or in collaboration with other countries?

LIEUTENANT COLONEL COKE: Yes, ma'am. To begin with, it's readily recognized across the international community that this is a problem, so identifying the problem is one of the most important things because it's such a major sea
lane for many nations. That's why we have the
U.N. involvement, we have NATO involvement, we
have E.U. involvement, European Union involvement,
as well as individual countries that are involved
either solely or in a bilateral relationship. So
there's recognition. Most spheres of strategy
when you talk piracy, really to solve piracy you
have to go ashore. Unfortunately Somalia is at
best less than governed if not completely
ungoverned space, so where the safe havens are is
where you have to go to be able to really tackle
the problem. I don't think we're there yet.
That's really the ultimate solution, but it takes
a lot to get to that point. We already have
experienced Somalia in the recent past and that
was a tough one.

But there are things that we can do. I
talked a little bit about education and standards,
and the Navy brethren can certainly talk better to
this, as far as what you do to save your ship.
There are efforts right now within the 5th Fleet,
which is the naval component under Central Command,
to look at ships and to provide matrices as far as
risk factors and how you can mitigate that,
whether it you travel at night, the speed of your
travel, the location of your travel, what
protective measures you have taken. These are all
defensive things. Obviously organizations like
Blackwater and the military have looked at putting
armed folks aboard ships. That's one course of
action. Then the other course of action is simply
escorting ships. Unfortunately that's very
inefficient from the logistics aspect of moving
cargo through that area. So those are some of the
things that are being discussed and being done,
but I think there is general recognition that if
you really want to attack this problem we got to
go ashore, but we're not quite there yet.

DR. WILENSKY: Does anyone else have any
questions? Thank you very much for your
presentation. Our second speaker this morning is
Dr. Shakir Jawad. He currently serves as an
international health analyst at the International
Health Division, Office of the Assistant Secretary
of Defense for Health Affairs. He is also an
Assistant Professor at the Uniformed Services
University of the Health Sciences, Department of
Military and Emergency Medicine. Before coming to
the United States, Dr. Jawad worked for the Iraq
government where he held senior leadership
positions at the Iraqi Ministry of Health. Prior
to the liberation of Iraq, he served as a
Brigadier in the Iraqi Ministry of Defense and
spent most of his career as an orthopedic surgeon
in various Iraqi hospitals. Dr. Jawad will
provide the Board with an overview of the Iraqi
health sector. His presentation slides may be
found under Tab 3 of your meeting book. Dr.
Jawad?

DR. SHAKIR: Good morning. Thank you
very much for inviting me to talk here. I'm
really privileged. Through the background I have,
I think I can confidently speak about health in
Iraq. I have the experience of 26 years working
inside the country, inside Iraq as a health care
provider extending across the private health care
sector, the government health care sector, the military health care system and in a senior position I was the Assistant Secretary for the Ministry of Health for Operations and Technical Affairs for some time. So I would like to deliver the experience that I have to you.

This is just to start with to demonstrate to you self-service. I have a lot of photographs in the presentation. Before you faint, you can still help. That's the principle of this guy holding his fluid bottle. If we talk about history in Iraq, I'm sorry to go back like 5,000 years. It's a long history. Iraq was for some time the best in the world in health. That was in 2200 B.C., and in 900 -- that's during the Abbasid Empire and then it went down and never regained the top level again. If you look at the Hammurabi Code, and in the year 2200, medical malpractice and the concept of civil and criminal liability for improper and negligent medical care and fees were fixed, those were all written in Hammurabi's Code, so you can see how much
developed the thinking of the principles of health and health as a human right. During the Abbasid Empire -- hospital of Baghdad in 1978 was tremendous. If you read details, I've read a lot about the details of this hospital, patients were admitted and given a uniform in this hospital, a white gown and white sheets and there was music played in the halls to entertain patients in the afternoons and food was provided. It's unbelievable. And they had a patient records system and they were having and keeping the disciplines of surgery, ophthalmology, orthopedics and general medicine at that time.

This is Almustansiryeah School in Baghdad. I hope some of you were able to go and see it. It's inside Baghdad. This is still there. There was a 10-year medical program for this school and the graduates were working at that hospital, the one I just mentioned. So that's going back to history. But in the year 1258, Baghdad was occupied by the Mongol invasion. By the way, the Mongol Empire was the second largest
empire in history after the British Empire. Iraq kept on going down until the year 1917. That's a picture of British troops getting into Baghdad in 1917. That's General Stanley Maude on the first horse, and he was leading. This is how Baghdad was looking at that time. Of course, they were shocked. They were thinking of the 1,000 nights and palaces and dancers and all those things, and they found ruins of a city.

But in 1917, the Iraq infrastructure started to develop tremendously and electricity was introduced to Baghdad, clean water, the modernization of Al-Majidi Hospital that was built on ruins of that hospital, the lovely hospital, the one I spoke about. And in 1921, military medicine started in Iraq to support the Iraqi troops that were just being established, and in 1927 Baghdad's Royal School of Medicine started, and that's before any country in the region Iraq started doing those things. This is in 1939. That's in Kut. This is still being used to control the water of the Tigris, and the Baghdad
Railway Station in 1948 was built, and infrastructure was built in a proper way, with communications, airports, water, electricity, dams. The most interesting thing is the construction -- this was the idea of the Iraqi politicians at that time. They thought if they set aside 70 percent of oil revenues on a special account that's going to be outside the ministries because the ministries need to go to the Parliament and you need to approve things, and that was a board created by experts from inside Iraq. I know of the Board members. He was my father's friend. He was a graduate of Johns Hopkins in 1931. He was engineering agricultural projects. Dr. Ahmed Susa is a famous name in Iraq. There were also Americans and Brits on that Board. They were helping the government of Iraq to identify what's required to develop infrastructure in the whole country without going into politics. It was purely scientific and a very proper approach I think at that time. All of Iraq's modern infrastructure which is still being...
used right now, and some of the projects are still
waiting to be implemented were designed by that
Board.

Concerning health, the Board's aims or
goals was to complete the number of hospitals in
Iraq. There were not many hospitals in Iraq, very
few, to 143 hospitals. They just evaluated how
much is required, and they wanted to build 1,000
public health care clinics to go through primary
health care, 29 military hospitals to support the
Iraqi growing military, and they sent thousands of
government funded scholarships for specialty
degrees and training in the West and Iraq became
the world model for a Third World country that's
developing. After that, only 14 hospitals were
added to the system. Nothing was added to the
Iraqi health care system. So the glorious history
of Iraq in medicine everybody speaks about in fact
was designed and built in the 1950s and 1960s.
The plan took 10 to 15 years. They were supposed to
be achieved by 1965. But unfortunately the Iraqi
kingdom was toppled in 1958 by a revolution by
some adventure offices in the Army and Iraq became
a republic ruled by generals from the Iraqi Army
all the time. The project was delayed until 1975,
but Iraq started very early and it's now still
working using this infrastructure.

This is how Baghdad was looking in 1918.
There's nothing on the horizon. Like 40 years
later Baghdad was looking like this. This is
downtown Baghdad -- if anybody has been to
Baghdad. It became like a modern city in the
Middle East, a country that's progressing. This
is the University of Baghdad that was built in
1957, although the School of Law was even started
before the Brits were in Iraq in 1908. And there
was a project for a university in Iraq in 1931 --
but funding was not there. But in 1957 without
the project of -- the Construction Board it was
one of the important things. This is a model of
the 400 bed hospitals that were built by Saddam
later on, the 14 hospitals.

Because of this development of
infrastructure, although it took a model of more
clinical medicine, not a preventive primary health care model, but because the oil revenues were very high and Iraq's population was low at that time and very small, it was like 6 million in 1957, you can see the development. I chose the two health indicators, the under 5 mortality and infant mortality just to demonstrate to you the development in health in Iraq. These are the health measures. It's not what kind of bypass surgery you do, this is how we measure health care as health indicators.

So in 1960s, 1970s, and 1980s, Iraq's ambition was to go to one third or to one half of its health indicators in 40 years. That was the plan, and they really achieved it. Until 1980, Saddam took over in 1979 as President of Iraq and Iraq went into the war with Iran, 8 years of devastating war with 1 million casualties, chemical weapons used and 1 million dead from both sides and a lot of casualties, this is the year 1980. If you look, this is the war on the curve started. Iraq was going up and was progressing.
It was the best in the region. Iraq's health indicators in 1990 were better than the two giant countries in the region, Turkey and Iran. Iraq was better than those in its health indicators.

In 1990 after 8 years of the war with Iran, medical care in Iraq reached 97 percent of the urban population and 71 percent of the rural population, these are WHO figures, and Iraq was very much praised for this, and below 5 infant mortality rates were definitely going down. There was a 10-year plan to make Iraq emerge from a Third World country into a developed country. They were aiming to drop this to more than 50 percent that's reaching European levels of health indicators, and that was the aim. That was supposed to be achieved in the year 2000. But on August 2, 1990, the Kuwait invasion took place and that was the turning point in the history of Iraq. That's what really Iraq is suffering from now. It's not the U.S. Invasion or anything else.

This point is really the most important. If you look at this half a mile road
between Iraq and Kuwait and you can see how much
money is wasted. All these are cars used for
transportation by Iraqis. Can you see the damage?
This is just a simple example of how much money
was lost in that war. That's after the withdrawal
of the Iraqi forces and these are all the cars
damaged. This is the Ministry of Planning which
was not working after that. Saddam took over
planning for the country and he said I don't need
the Ministry of Planning. That was announced many
times by him. These are the countries that stood
against Iraq because of the invasion.

Let's see what happened in 1990 after
the invasion. The systemic air strikes destroyed
92 percent of the electric capacity of the
country, 31 municipal water and sewage facilities,
all major industrial capability, almost all the
country's highways and bridges, very few left.
Communications, oil refineries, central gas and
oil pumping stations, research centers, sports,
airports, railway stations, TV and radio stations.
I remember. I was still there in Iraq. For 5
months continuously we were without electricity.

We were living like sleeping at 7:00 or 6:00 when it gets dark. That was really the turning point because Iraq lost all the infrastructure that was built by the Construction Board, the work of years.

That was followed by 13 years of severe trade sanctions and economic embargo. The oil for food started practically in 1997 and it was abused by the Iraqi government. It was to raise funds for the government to still continue doing the silly things. These are the same health indicators I showed you before, and let's see what happened after 1990. Iraq in 5 years lost the 20 years' achievements and we went back to figures of the 1960s. The health percentage per capita went down to .8 percent because there was no income to the country. 1997 is the most severe year. The country was about to collapse, and this is when the oil for food program started.

Still in 2005, these were the last figures before I left the Ministry of Health, they
were like this, although the Ministry of Health is claiming now they were able to drop it to less than 1990 which is impossible because it took the Iraqi government 40 years to drop that much and now in 1 year they claim they improved 70 percent. Iraqi hospitals were looking like this with two children on the same bed because there were not enough beds and the hospitals are empty. If we calculate by two health indicators and calculate from the percentages of what the infant and below 5 mortality rates came down and up, it seems that Iraq lost 380,000 deaths in infant mortality between 1990 and 2003, and 480,000 below 5 mortality rate. These were figures provided by the WHO. The Iraqi government gave this figure of course. That's the reference for the Iraqi government. I think it's quite inflated for political reasons. They gave the figure of 1,700,000 died because of the embargo. This is a unique situation that Iraq went through. It's called the double burden of disease, Iraq as a country developing emerged from infectious
diseases as the main cause of morbidity and mortality to chronic diseases and degenerative illnesses which are the main causes of morbidity and mortality in developed countries. Iraq was emerging in 1990, but because of the embargo, it went back to the infectious diseases again. So it had both chronic diseases and degenerative illnesses and infectious diseases both as the main causes of morbidity and mortality. This is double burden of disease. It's a unique condition not so many countries have.

Let's see what happened after the liberation and occupation of Iraq in 2003. Iraqis were so happy. If you look at their faces how they were hitting Saddam's statue, they were so angry and so happy that this took place. In fact, if you ask public opinion inside Iraq what do you think of the United States, in spite of all the propaganda that Saddam was using against the United States before 2003, Iraqis loved the United States at that time. They were waiting for the United States to come and help. But unfortunately
after 2003 they were exposed face to face and worked together with the United States, this public opinion went down greatly.

That was Baghdad during the war. The problem, number one, was looting. The Iraqi health care system was looted. If you look at the hospital bed on the left side, the upper picture, that's a hospital bed used to carry things, to steal things, to loot things from the hospital.

This was equipment; that's an echocardiogram. They don't know what this device is. They just break it. They want to get rid of it. They don't want to keep it. So there was some kind of a systemic destruction. Hospitals were empty like this and looting was a big deal. This is a clinic burned in Basra in the south of Iraq. This is the general condition outside because of the infrastructure damage. Health is not the duty of the Ministry of Health alone. This is what the Ministry of Health is suffering from. The outcome of this condition is disease, infection, diarrhea and then and the Ministry of Health will try to
fix this. This also is a unique thing, that we had 11 Ministers of Health in 5 years and there was no strategic plan at the Ministry of Health so they were working according to what they think is right. So every 6, 7, or 8 months we changed the minister and everything has to change and start rethinking again, and that's not the way to work or to develop something. Iraqis started becoming angry. This is the Operations Center at the Iraqi Ministry of Health. That's not working. It's been locked because of $100 payment that has to be done for a bandwidth contract and the ministry is refusing to pay, and they just locked it and they are using cell phones to collect information. The disastrous thing was that the Ministry of Health was given to Muqtada al-Sadr, and between April 2005, I left the end of May 2005, this is the year I left the Ministry of Health after 1 month of Muqtada al-Sadr being in power at the ministry. Until December 2007, this person was in charge of the Ministry of Health and you can see the guys in the pictures on the right side inside the ministry.
walking like this with weapons in their hands. If you ask who these guys are, they will tell you these are the facility protection forces. They were dressed as civilians, and it was a militia inside the ministry. Iraq went into the turmoil of civil war, civil strife, civil unrest, whatever you want to call it. And the double burden of disease, in fact in Iraq is the only country in the world that had the triple burden. It's the only country when trauma became the leading cause of morbidity and mortality in the year 2006 and that's a historic event in any country in the world. That's what the Iraqis used to believe in after that, that the seculars who were prosecuting the fundamentalists, the condition was only trading places, that nothing happened in Iraq really. It was just the other side who took over power and started prosecuting the other side. This is what's in the minds of the people. The direction was so gloomy, we think it's going nowhere. But, fortunately, the war troop surge in
January 2007, and the Iraqi Minister of Health, we were so happy that this minister took place because I know him personally and I know how good he is, and he really proved that he was good. There was dramatic improvement, and yet with cautious optimism. The Minister of Health is the only person who has been changed. He could not change a single person from inside the ministry, all his directors, all his staff are still Muqtada al-Sadr, and they are waiting for Muqtada al-Sadr to come back to restart again. That's unfortunate. He just couldn't do anything. He personally told me that in Chicago when he came to the United States, that I couldn't change this person and this person, although I know they are criminals and they are in charge of a lot of crimes, but I couldn't and I was told not to touch them.

The provisional elections in 2009, it was promising yet still we don't know what's going to happen in the next elections by the end of this year. This is the Minister of Health visiting the
National Children's Hospital in Washington, D.C.

The last Iraqi official from the Ministry of Health who came to the United States was me in August 2004. I visited the United States. No one else came to the United States after I did until May 2008. Imagine Iraq and the United States working together, and for 4 years, almost 4 years, no one is visiting. So there like a cut when Muqtada al-Sadr was in charge.

WHO always emphasized that health care systems are to be looked at in a different way.

The next slide will tell that in the mid-20th century there were two major models for health care, medical care through hospitals and urban centers with concentration of manpower and resources, that's the provider-receiver model. That's the hospital or clinical model. And the other model was the comprehensive care that's promotive, preventive, curative and rehabilitative. That's the population based. In 1948 they started as equal systems. No one was able to know which one is better. But in 1977 it
was proved by evidence that the second model is the best for countries that are developing. Unfortunately, Iraq and the United States took the first model and is still using it. The first model is not cost-effective and really is not developing very much on promoting health while the second model is. This is what's supposed to be the people or factions who are working on health, the country's Minister of Health, government, local governorates, health care providers and NGOs, and they should work the three disciplines, clinical, population and community-based. The target is the Iraqi citizen, or anywhere in the world, the citizen. The problem is in Iraq right now it's only the Ministry of Health developing clinical services. That's the model that's being used right now, and this is not going to work. This is our anticipation. The RAND Corporation named those factors as the main pillars for successful reconstruction, economic stability which is not there yet in Iraq because of oil prices. And education. Iraq is one of the
highest countries in the region with illiteracy for females. And security. All are so happy including myself that Iraq is more secure, but last month there were 400 deaths in Iraq because of violence. If this happens anywhere in the world it's going to be on the news all the time. Basic infrastructure. I don't need to say anything more about this. You just saw what happened. And governance. The Iraqi government is not yet really governing in the right way. They are still doing this and that. Our challenges are the national economic and political structure of Iraq. It's not yet settled or defined, and nationwide infrastructure development requires a lot of money and time. So if we are so optimistic and think that this is going to be better in 10 years, no, it will need like half a century until Iraq is back to where it was for some time. It's very expensive. I don't want to go through this financial debate of how much Iraq would need to develop, but maybe the last slide will show. If Iraq wanted to match any
of those countries on how much they spend on health, you can see how much Iraq's health system requires. Jordan spends $15 billion a year for health, and Oman, Cuba, United Arab Emirates, U.K., Sweden and USA, and the whole budget of the Iraqi government is 59.9. That's the whole government, and Iraq's health was supposed to get $3.9 billion this year and its less because of the oil prices and the economics.

The other challenge is Iraq is doubling its population every 20 years. That's a big challenge. How can you plan for a country that's doubling its population every 20 years? This picture is from Najaf Hospital. Someone was trying to see whether the magnet is still working or not, and of course this was ruined. There was no way to bring this back to work. These are the challenges and weaknesses. I don't want to go through the details. I think you are quite aware now that there are a lot of things like the technology gap. It's in the slide show you have.

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institutions in Iraq is a big problem, and these
are all maybe in your slides. I always like to
show this because I still remember the statement,
we broke it, we fix it. I think this is how it's
being fixed now. It's not very well fixed. Iraq
is still waiting for a lot to be done. Iraq is
not done. It's not okay, let's leave Iraq, that's
it. I think we need to invest on the improvements
that took place in Iraq and keep on pushing just
to demonstrate how Iraq could be a very good model
for our success there.

I just wanted to say this. There is now
the strategic framework for the status of forces
agreement between Iraq and the United States. The
Department of Defense is phasing out from Iraq and
Human and Health Services has been chosen to be
the agency inside the United States to take over
and look for Iraq's health, and no one is really
looking into this in detail. Up to my
understanding, we tried. We talked to USAID and
they said we are not, and the Department of State
is not really very much on this. Health and
Human Services has a small global office which is not really very functional, and I think it's very important because the Department of Defense is going to leave without anybody taking over and this is something to be addressed and maybe looked at. Our office in fact tried to do very much. We talked to CENTCOM, we talked to other partners, and we are still hoping that someone is going to listen to us, and I think that this is a policy thing that has to be addressed right now. Thank you very much.

DR. WILENSKY: Thank you very much. Are there any questions that people would like to ask? Do you know who in HHS, and it is a very small office of Global health, that had previously been in the Office of the Secretary when Bill Steiger was the individual who was responsible, but he has left, is there somebody who's identified in HHS to head that Office of Global Health?

DR. SHAKIR: To my understanding there is no one yet, and I think we are way behind the timetable, and the Deputy Prime Minister of Iraq
in fact is visiting in May the United States, the Deputy Prime Minister for Services is visiting. He had three meetings in Iraq with senior U.S. officials trying to develop on this project and he's coming to the States in May to discuss with someone the handout, the process of delivering. I don't know to who he is going to talk about health. It's not yet clear. It is still the job of the Department of Defense and I think he has to talk with the two sides, the phasing in and phasing out sides so that he can understand what's going on. That's why I'm trying to bring this in front of you. I think it's very important.

DR. WILENSKY: Are the basic decisions that you raised in terms of what the future health care system in Iraq looks like, have those been decided by the current government or is that still under some question as to what kind of model they will use?

DR. SHAKIR: The Iraq government, if you listen to what everybody is talking about, they are talking about the primary health care
preventive model. But if you look to practices, there is not a single dollar for research, and how can you know facts without doing research and understanding the situation in your country? And all the money is going toward building hospitals, bringing modern very high-tech equipment to the country, so they say something but they do the other thing. They are not going in the right line. They need a lot of money to reconstruct the system as it was a very high-tech system and the 1970s technology was cheap and is still being used and it's there, and it's very expensive to go through that model and impossible to go -- there is no strategic plan yet in the Iraqi Ministry of Health. They don't have goals, they don't have timetables, timeframes or implementation plans on how much money is required or where money is put, priorities, and there is nothing like this. It's just like go to work every day and do whatever is in front of your desk. This is what is really going on.

DR. WILENSKY: Are the training
programs, particularly beyond the physicians, up
and running in terms of nurses and primary health
care workers of various types? Are those in
existence now?

DR. SHAKIR: They are still using the
same models and programs that were there in the
ministry since the 1970s and 1980s, and we always
talk about capacity building, but this is not
taking place. HHS brought 28 physicians to Iraq
on an observation program. They went to different
hospitals. They were enjoying shopping. A lot of
them were my friends and they were telling me we
enjoyed shopping and seeing sites. Like we do
surgery there. We do more advanced surgery like
than we were shown or we were allowed to look at.
I think the capacity for management, financing all
those things are so important in Iraq and they
have not yet been looked at. The Minister of
Health is a clinician, all his assistants and top
board of the ministry are clinicians, and none of
them has an MBA, none of them has an MPH at the
Ministry of Health. They are all clinical degrees
including myself. I'm an orthopedic surgeon. I was trying to learn or do something.

DR. WILENSKY: Are there any other comments or questions? Thank you very much for sharing your information with us.

Our third speaker this morning is Dr. Jean Langlois. She is currently the senior scientist, an epidemiologist, at the National Center for Injury Prevention and Control at the Centers for Disease Control. Dr. Langlois will discuss the recent activities of the Defense Health Board's Traumatic Brain Injury External Advisory Subcommittee, including a summary of the Subcommittee's last meeting held on March 24, topics for future meetings, and the questions formally tasked to the Psychological Health External Advisory Subcommittee. Her presentation slides may be found under Tab 4 in your meeting book.

DR. LANGLOIS: Thank you very much for the opportunity to present on behalf of the TBI Advisory Subcommittee. I would just clarify that
since the last time I participated in one of the
Board Meetings, I've since moved to the Department
of Veterans Affairs where I am the Scientific
Program Manager for the research portfolio in
brain injury which includes traumatic brain
injury.

As Dr. Wilensky mentioned, these are the
topics that I'll address, membership, a summary of
our most recent meeting, review of the status of
the questions that were tasked by Ms. Embrey, and
a brief comment on future meetings and activities.
I'll just note that this subcommittee was stood up
last April, so we've been in operation for about a
year.

This is the Subcommittee membership. It
consists of 11 members with a variety of expertise
ranging from concussions, sports concussion
expertise, neurosurgery, trauma care and outcomes
research. We have had a decrease in membership,
and I'll talk about the Subcommittee changes next.
In January of this year, Dr. Jim Kelly who was our
chair was no longer officially the chair as he
accepted a position with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. He is now the Director of the National Intrepid Center of Excellence for TBI and Psychological Health which is located or soon to be located in Bethesda. Dr. Kelly had neurology and sports concussion expertise. Just recently in April we received word that Dr. Ross Bullock, one of the other Subcommittee members, has been approved to be the new chair. Dr. Bullock is a professor of neurosurgery and Director of the Clinical Neurotrauma Program at the University of Miami, a very well-respected traumatic brain injury expert, and we look forward to his leadership. Two other members have departed the Subcommittee, Dr. Robert Cantu, a neurosurgery and sports concussion expert left very soon after his appointment, and Dr. Guy Clifton, more recently neurosurgery and trauma care just to give you a feel for the areas in which we have lost members. We have talked with Commander Feeks about the procedures for appointing new members, and I
believe that's under consideration.

Our most recent meeting was on March 24 and it was a joint meeting for the first time with the Psychological Health Subcommittee. At that time our goals were to establish a working relationship between the Traumatic Brain Injury and Psychological Health Subcommittees because of the overlapping areas of expertise and interests and also overlapping tasks. The details of that session I believe will be reviewed to some extent by Dr. Fogelman in his brief for the PH Subcommittee which is coming up. Also at that time the TBI Subcommittee convened a small working group of concussion experts and epidemiology to begin to address a specific question that we’re tasked with, and I'll talk about that question in a moment, but it has to do with the automated neurocognitive assessment matrices or ANAM. We discussed the limitations through a presentation by Colonel Bruce Crow who is the clinical psychology consultant to the U.S. Army Surgeon General.
Just to review the tasks that we've been assigned by Ms. Embrey, we've been asked to review the automated neurocognitive assessment matrices, and I'll talk a little bit about that in a moment to give you a bit more background. We were asked specifically to determine whether it's an effective pre-deployment tool and provide recommendation for its use. The PH Subcommittee was also tasked with this request which helped to prompt our interest in working together. Also as you may recall from the December Board meeting, we have been asked to review the post-deployment TBI screening tools. These are the post-deployment health assessment, the PDHA, post-deployment health reassessment, PDHRA, which includes screening questions for concussion. I've been asked to determine whether they are responsive to the post-deployment needs of Service members.

A little bit of background to the work that we've been doing to respond to the request for a review of the ANAM, neurocognitive assessment test. In general, our measures of
cognitive performance areas typically affected by concussion include attention, judgment, memory and thinking ability, and there is a range of these types of measures that are in use in various settings, not just in the military but in civilian use, particularly for assessment in the sports concussion area. The ANAM itself is a 15 to 20 minute computerized test that was the test selected for pre-deployment assessment of Service members' cognitive performance. This test was selected in part because of the fact that pre-deployment neurocognitive assessment testing, or NCAT testing, was broadly recommended. I think there were seven recommendations that we were briefed on. Some examples of these are an Army TBI Task Force report in May 2007. Probably the most important was the National Defense Authorization Act of 2008 which recommended pre-deployment NCAT testing, and an Institute of Medicine report that actually was December 2009. I apologize for the error there. Despite all these recommendations, it's still a fairly
controversial area and I believe that's why we were asked to comment on it.

I'll also mention that although the efforts now are focused on pre-deployment testing, many of these recommendations also were for post-deployment assessment, but that has not been implemented. You have this in the back of your handout. This is the Interim Guidance that was given by Dr. Cassells, and I just wanted to point out that it suggested that this was meant to be an interim plan because it states that until ongoing studies are completed that the ANAM would be selected. So I guess we could consider perhaps the implementation of the ANAM as a pilot effort. This is from a briefing by Colonel Fortuin who interpreted the guidance for us and explained it as an effort to collect baseline neurocognitive data on both active and Reserve forces prior to their deployments, that this was put into effect by July 20, 2008, each deploying Service member was to have a baseline within 12 months of deployment, that the ANAM was to be used as I
mentioned, that the guidance would be reviewed on a quarterly basis, and that the Defense and Veterans Brain Injury Center, or DVBIC, would be the designated point of contact.

The status of our work in this area is that we have received several briefings. The most recent one by Colonel Crow was a detailed review of the Army experience. We've assembled most of the published ANAM literature and have begun reviewing it, and I might just mention here that again this is a small subgroup, working group, of interested members that has been involved in this particular task at this point. We have been awaiting documents to be provided by DVBIC. These were documents that were identified in March as being important, and we have since received those, as of Tuesday those have been sent to us, and to members of the Psychological Health Subcommittee who have joined our small work group so that we can provide a combined response between the two subcommittees.

Then lastly, the other question that we’re asked to address that the Board has some
experience with work in this area where we received several briefings. As Dr. Kelly mentioned, in December we had a small working group which met at Fort Carson. Dr. Kelly then presented to the full Board the interim recommendation also last December. And most recently, Dr. Kelly reported that he is preparing a draft written response for submission to the DHB. We haven't seen that in the subcommittee yet, but it will be reviewed by the TBI and the Psychological Health Subcommittees again taking advantage of the expertise of the PH Subcommittee as well.

Future meetings and activities. Our current agenda consists of responding to those requests that I've reviewed today and we await the leadership of Dr. Bullock as the new chair to help us reformulate the agenda for the future. Thank you, and I'll take any questions.

DR. WILENSKY: I had two. Do you have a schedule for your next meeting is one? Then the second just as a piece of information, Dr. Guy
Clifton has indicated an interest in rejoining the Subcommittee. He was unclear whatever formally has to occur to make him no longer a Subcommittee member had actually occurred or not, but in any case he has indicated an interest in rejoining either as a new Subcommittee member or as a reactivated Subcommittee member. It's not quite clear to me what the technical process is to distinguish one from the other, but that will be at least one less person who has left the Subcommittee.

DR. LANGLOIS: I don't have any plans for the next meeting. Dr. Bullock has just received approval from his own department to assume the role of chair. Commander Feeks, do you have any information?

COMMANDER FEEKS: No, he has not gotten that far yet, but we'll be working with him to get set up for your next meeting.

DR. WILENSKY: Dr. Silva?

DR. SILVA: Thank you for this report.

To me and I think to this committee, the hairy dog
is mild TBI and how to define it, and it's quite common. Has your committee made any progress in establishing some criteria for TBI, because there are a lot of compensatory issues that are downstream once you establish a definition. And of course, people within the military have written about this, the "New England Journal of Medicine" a few weeks ago, Dr. Hog and Dr. Castro, so I know you're aware of those data, but that's the big issue I believe. Thank you.

DR. LANGLOIS: There is VA and DOD common definition of traumatic brain injury that's being used in some circles, so your point is well taken that this is an important issue and there are still questions about which definition is best.

DR. WILENSKY: Dr. Sutton, do you want to comment?

BRIGADIER GENERAL SUTTON: Thanks so much for that question. This certainly has been an issue of considerable discussion. Most recently the clinical practice guidelines both for
the non-deployed setting for mild TBI or concussion has been revised from the 2006 version as well as for the first time we've got a single clinical practice guideline for the management of concussion or mild TBI in the deployed setting. In terms of the definition itself and the issues raised in the recent "New England Journal" article, these are precisely the questions that Dr. Kelly and a group of us from DVBIC and throughout the Defense Centers of Excellence is working right now with the VA to come out with a final set of recommendations and we'll certainly work with both of the advisory committees to that end. Thank you.

DR. WILENSKY: Command Sergeant Major?

COMMAND SERGEANT MAJOR HOLLAND: Ma'am, have you done any work with Baylor School of Medicine or UCLA Medical School? They've done some real good work with actual wounded troops to measure and evaluate and even use some mathematical formulas to figure out the degrees of traumatic brain injury. Have you touched base
BRIGADIER GENERAL SUTTON: Thanks, Sergeant Major. Yes, in fact, Dr. Dave Hovda, who is the Director of the UCLA Brain Injury Research Center was just out here last month, and of course we are very interested in his work which, along with his colleagues, has really demonstrated that in the post-acute period following concussion or mild traumatic brain injury that the timing of interventions is critical as the brain goes into a hypometabolic state and where, for example, as we have brought together our experts from the consensus conference on hyperbaric oxygen as an example, it's been very important for us to rely on Dr. Hovda and his colleagues' judgment to guide our actions and to understand that the logic that some have applied to this issue, the brain needs oxygen, the injured brain could benefit from oxygen, is not quite as simple as it might first appear. So, yes, we are working with Dr. Hovda at UCLA as well as many others to address those issues.
DR. LANGLOIS: I just wanted to add that Dr. Hovda is a member of the TBI Advisory Subcommittee, so we're aware of this work. And also with regard to Houston, we are very aware of the work of Dr. Harvey Levin at Baylor College of Medicine. He is funded by the VA and I believe also NIH, and perhaps DOD, I'm not sure, but very excellent work and certainly work that we're considering.

LIEUTENANT COLONEL JAFFEE: Just to add to the comments and specifically address your question again with Baylor and Dr. Levin, Baylor and Dr. Levin and his team were actually selected by your congressionally directed medical research program to be the core of a hub of a TBI consortium last year, so they are very much engaged in coordinating research with the DoD. There have been a lot of collaborative efforts not just with UCLA and with Baylor, but with many, many academic institutions throughout the country through various research partnerships, it's our civilian experts who come in and help contribute
to the practice guidelines that General Sutton and Dr. Langlois were describing, some of the screening tools that we use currently were actually developed mostly from our civilian experts around the country who we're drawing that expertise from. And it was kind of with their input as well getting back to the question of definitions, the current definition we have is consistent with that used by the CDC, with the American Congress of Rehab Medicine and the American Academy of Neurology. That being said, I think the ideas most of the scientists will be able to realize as we are gaining more knowledge, perhaps our nomenclature does need to be modified or adjusted. To that end, we actually had a conference last year that was co-sponsored between NIH and the Department of Defense specifically addressing the question of TBI nomenclature and a lot of those recommendations are also currently being used to help guide and drive various research agendas and the like. So it is an evolving process that we're hoping to use
the knowledge as it comes in to continue to modify
and evolve the way that we are doing our things.

We've been fortunate to have the input
of such expert panels to include the Defense
Health Board and the Institute of Medicine who
recently evaluated the way we're doing screening
and actually had some very good inputs based on
current knowledge to endorse some of the screens
and tools that had been adapted by both the DOD
and the VA. So it's an iterative process which
very much relies on the input of our civilian and
academic experts.

BRIGADIER GENERAL SUTTON: Mike, maybe
you could also comment on the partnership we're
developing with NIH with respect to the
supercomputing analytic capability for both PH and
TBI.

LIEUTENANT COLONEL JAFFEE: Thank you
for bringing that up, General Sutton. And DCoE
has really facilitated this real partnership in
that we're able to provide really advanced types
of data and informational analysis through an
array of supercomputing things both in terms of
data archiving as well as more advanced IT
technologies in data analysis using a variety of
data to include not just information but
multimedia aspects, neuro-images, pathological
specimens and the like, and we're hoping, and the
plan is, that this will be a repository for a lot
of people throughout the DOD and other federal
agencies to kind of pool their information by
using more of these super-analyses being able to
gather more information. One of the models that
this is being based upon is the success that some
people are aware of with the National Database for
Autism Research, NDAR, which was developed by the
same people with whom we're in partnership. So I
think we are setting an infrastructure for
research and information gathering that will
further accelerate the knowledge that we're
gaining by instead of taking the pockets of
information, being able to correlate them and look
more for these overarching trends which may
accelerate our knowledge.
COMMAND SERGEANT MAJOR HOLLAND: I'd like to direct this to General Sutton. All you great technical folks get way above a Sergeant Major's head, but I'm down with a line unit way of I've already seen UCLA medical and Baylor School of Medicine take three or four of our great young wounded who were having real struggles with things that triggered events, et cetera, and helped them through that. Now it has taken 3, 6, 9 months of 100 percent of care, but at least UCLA has just taken two of the wounded that I deal with on a daily basis, and now another one has just been accepted into the program. I just hope that we're collecting all of this data and making sure that we're all sharing our great knowledge and we don't just gather the data like we do AARs and put them in a file cabinet and never use them again. So I'd really like to make sure that we do this, and I commend all the folks for what they're doing out there and we have a lot of challenges. We just had our first two family members finally break and go into a traumatic brain issue and we found an
organization in Arizona to help these family
members. I'm pretty sure it's Arizona. So thank
you very much, but we just need to keep gathering
whatever we can, ma'am.

BRIGADIER GENERAL SUTTON: Thanks so
much, Sergeant Major. I'll count on you to keep
us on the road of reality and common sense, and I
couldn't agree with you more. Our collaborative
network goes far beyond the federal government and
extends to our civilian colleagues around the
country and, yes, throughout the world, and we'll
continue to reach out and maintain that learning,
that sharing, those collaborative relationships
that make us all able to reach out and serve
our troops better. Thank you.

DR. WILENSKY: Mike?

DR. PARKINSON: Yes, thank you, Dr.

Wilensky. One of the issues that continue to --
trouble is too strong a word, but we've got to pay
attention to is obviously what is our normative
data in an area that clearly will have a lot of
good information right now? I guess if you could
comment a little bit on not only within DoD, but
it seems to me as I listen to this that it's a
moving target in terms of what is the normative
value for the general population that come into
the military when we see increasingly lowered
attention spans as a result of technology at least
anecdotally. Have you had any exchange or could
you consider talking a little bit even to folks at
the National Health and Nutrition Examination
Survey to create a simple screening instrument or
something that could be a subset of the automated
DoD assessment that you could actually plug into
to begin to get true normative data from the
general population about this? Because
particularly for mild TBI, mild concussion, mild
cognitive effects, I'm very concerned about
labeling, case definitions and those types of
things. We have the opportunity here to really
define a new baseline I think, and maybe that's in
your work plan, just a reaction and comment to
that general approach.

DR. LANGLOIS: I think that's an
excellent idea and certainly we'll bring that idea back to the small working group that's addressing the issues. It certainly is of great concern that the normative data be reflective of the general population. There are issues though that were raised with regard to what's the appropriate normative example for our military population. Is it other military personnel? So we're balancing the various issues and trying to determine in research as well as in testing which is the appropriate normative example. But it hasn't been suggested before and certainly we'll bring that back into the small working group.

BRIGADIER GENERAL SUTTON: If I could just add, this is such a critical point, and to this end, this spring we are moving forward with a 15 year longitudinal study and Colonel Jaffee is working close with both our TBI and our PH folks, joining hands with the millennial cohort PIs to make sure that we really do pose these critical questions and then launch the rigorous scientific scrutiny that will allow us increasingly over time
to answer them. Colonel Jaffee, is there anything you'd like to add to that?

COLONEL JAFFEE: The way I understood the question from Dr. Parkinson was can we advance our understanding of how combat traumatic brain injuries may be differing from our more traditional civilian injuries in terms of diagnosis, prognosis, treatments and the like, and that is a very key aspect of information. So as General Sutton mentioned with the congressionally directed 15 year longitudinal study that the DoD is doing, we've been working with the CDC and NIH to make sure that there are civilian components to that to provide that civilian comparison. Along those same lines, we have a robust interaction and collaboration with the VA, and the VA actually just entered into an agreement with the Model Systems part of the National Institute of Disability, Rehabilitation and Research which is a civilian network of hospitals that treat moderate to severe injuries from civilian aspects. So these relationships that are being formed I think
will lead to a much more robust comparison of our
combat injuries to our civilian injuries which I
think is very important for us to further advance
our knowledge. Some of the fruits of that
research are just now coming out. Some data was
released last week comparing civilian injuries to
combat injuries using various types of imaging
modalities that actually did illustrate that there
were significant differences in the patterns, so
we're beginning to learn more and more about these
differences and the next step is translating that
to prognosis and treatments.

DR. WILENSKY: Ed Kaplan?

DR. KAPLAN: This has been very
enlightening to hear. My question is more I guess
an organizational one. We have a Traumatic Brain
Injury Advisory Subcommittee and yet we've heard
in the last few minutes of numerous other
collaborations, organizations and so forth that
are addressing the same area. To what extent does
the Traumatic Brain Injury Subcommittee of this
Board fit into those, participate in those either
actively or passively? Because it seems like there are many different parallel lines of activity going ahead. I don't know who I should ask that to.

DR. WILENSKY: I'll give you my limited information, but maybe we can have participants from the committee share more. There has been an attempt to make sure we're crossing within our own structure and we'll hear after the break from Dr. Fogelman about a recent meeting that included a joint meeting, for example, between Psychological Health and the TBI Subcommittee. So we're trying to make sure, and this will come up in a number of other areas, that internally we cross subcommittees where appropriate. Generally in the subcommittees that I've seen, there have been participants from some of these other activities or at least reports on what they've been doing, but if it's something, Dr. Langlois, that you want to comment to more specifically with regard to the VA and some of the university activities.

DR. LANGLOIS: The main way that we
learn about the activities of these other groups as a subcommittee is through briefings, and I think we'll be looking in the future to broaden the base of information that we're getting because we've become aware of the wide diversity of views and the wide array of research that's done throughout the Department of Defense, so I think that's an important way. And certainly the support that we've received has allowed us to have quite a wide range of briefings already. There are individual subcommittee members like myself who are involved in a number of other activities and other committees and receive briefings for example on the millennium cohort study. I also have consulted on the planning for the 15 year follow-up study that was mentioned today. So in that way certain subcommittee members bring information from their outside activities that are relevant to the subcommittee. Those are two ways.

DR. KAPLAN: Just a short follow-up.

This is exactly the point that I was trying to make, that there are multiple activities going on
and it seems to me that the TBI Subcommittee of
the Board needs to be involved in those if it's to
make appropriate recommendations to this Board.

DR. WILENSKY: Are you suggesting formal
involvement, that we attempt to have a
subcommittee member actively participating in
these, or just to be aware of where they are so
that they can make sure that the work of these
other groups is reflected in the determinations of
the Subcommittee?

DR. KAPLAN: To the extent that it's
hopeful in drawing conclusions from the TBI Board,
I think this is almost essential to do so.
Whether it's our responsibility or the
responsibility of the Board to what extent they
should be involved, somebody else has to answer
that question. But it seems to me there are a lot
of parallel activities going forward and they
should be connected particularly if this is to
make recommendations to the Board.

DR. WILENSKY: Colonel Jaffee, did you
want to comment?
COLONEL JAFFEE: Again just to follow-up on some of the ideas expressed by General Sutton and Dr. Langlois, a lot of the major initiatives that were described today including the clinical practice guideline developments for the deployed setting, the recent DOD-VA guidelines, a lot of these research meetings and initiatives do involve a lot of civilian experts and it so happens I think back on each of these major initiatives that some of the members who are currently on the TBI External Advisory Committee have been invited and are active participants in that, and if I think back even longer before the TBI External Committee was organized, a lot of the participation and expertise of these civilians actually led to their being nominated to serve on the Defense Health Board panel and their participation has continued in the context of their being on the DHB as well.

DR. WILENSKY: And I notice when people were introducing themselves today and at previous Core Board Meetings that we always have individual from the VA who are involved with Institute of
Medicine representation. So the fact that individuals representing these organizations are present during our meetings as well as get included in the briefs. I think it probably occurs, but we can have discussions whether there's anything more that needs to occur. Dr. Holcomb?

DR. HOLCOMB: General Sutton, it's nice to see you again, ma'am. We've discussed diagnosis, definitions and touched on maybe a little bit of treatment, but we haven't talked about prevention especially for the more milder form of TBI concussion. Can you discuss that aspect a little bit for this group?

BRIGADIER GENERAL SUTTON: Thank you, Dr. Holcomb. It's great to see you as well. It's good to know there's life after retirement.

Before I get to your comment, let me just get back to Dr. Kaplan's point for a moment because I think, sir, that you raise a critical point. All of what has been said in response to your point certainly is true, but I think it still remains a
communications challenge, that we can continue to foster that dialogue on a real-time basis. What I would offer to that end would be perhaps if the Board is interested, we could certainly share our monthly summary that encompasses all of the work that's been going on in all of our component centers as well as headquarters. So, ma'am, I'd be glad to share that with you and perhaps that could give folks a more robust idea and avenue for input. Thank you for raising that point.

Back to prevention. As you know, John, our work I guess now over a year ago, first of all working with the helmet community, and our work is not done there, although that's not our immediate domain of responsibility of authority, it certainly has been a critical area. Dr. Holcomb and former Surgeon General Carleton last year brought to our attention some very interesting data. First, it was a study that was performed by the Riddell football helmet company comparing the concussive protection provided by their helmet pads versus the new Army combat helmet pads. That
of course was not sufficient to take it from the company itself. Dr. Holcomb then had an independent study that was done showing the same results, and then the Army aviation community conducted a third study showing similar results. The upshot of it was that while there's been tremendous advances made certainly in providing ballistic protection perhaps on the concussive protection front there could be some improvements and I think that the material community over this last year has proceeded down that road and we'll need to follow-up with them and see what the current status is, but it's a very important point in terms of prevention.

Also I would say that the work that DVBIC has been doing in terms of developing the MACE, the Military Acute Concussion Evaluation, and socializing that both within the medical community as well as, importantly, the line community because the real challenge here is to get as close as we can to the actual point of exposure or injury, document it, have the medical evaluation
and when indicated make sure that that troop takes
-- for a day or two, sometimes a week or more, to
prevent the long-term effects of concussion and
mild traumatic brain injury. That is continuing
in theater, the implementation of that program.
The awareness of the line leadership has certainly
been keen to this issue. For example, Lieutenant
General Clyde Vaughan who just yesterday retired
from the National Guard Bureau, but his work over
this last year partnering with the medical
community developed this personnel blast tracker
system that is an event reporting system that
links up with the medical reporting systems, that
we have not only real-time awareness and the
opportunity for intervention, but we also then
have a longitudinal and historical record, so as
individuals get into their communities and perhaps
may need further on intervention down the line
will have that visibility. All of these are works
in progress. We're not where we want to be at
this point, but I would welcome any thoughts that
you might have at this point that could really
augment our efforts at prevention. And of course, it's not just on the battlefield. We know at home with skateboard injuries, skiing, there are many opportunities for us to heighten the awareness of providing head and brain protection.

DR. HOLCOMB: I think that's a great assessment and update. Thank you. I would just comment that as a person who has taken care of a lot of combat casualties and now works at a place with about 6,000 trauma patients a year who come in to one's hospital, there are I think many more similarities than differences. My physiology now as a civilian is remarkably similar to yours as a military person and our body only reacts in a number of ways to external injury. They look remarkably similar when as a surgeon I open them up or as a non-surgeon look at a CAT scan. I think there are lots of lessons to be learned from the great volume of injury that occurs in the United States every day, and every time we've looked at this whether it's a burn patient, military or civilian, a hemorrhagic shock patient, military or
civilians, they are almost super-imposable
physiologic responses. I'm not an expert in TBI.
I've taken care of a lot brain injured people both
military and civilian and they strike me as
remarkably similar.

Most clinicians work on the treatment
side. Most folks as we heard from our Iraqi
colleague recognize that if you're going to make
big changes, it's on the prevention side. I would
suggest, and I know it's been discussed, but as
you said there are not many changes yet, that
prevention of TBI is something we really ought to
look at very carefully. I know people have done
this, I know it's been raised before, yet I'm not
sure any changes have occurred from a mild TBI
point of view from a prevention point of view in
theater. It's something that should be looked
at probably at very high levels and consciously
decide to move forward or not.

DR. WILENSKY: It would be helpful if
you would make sure you maintain; however, you want
to do some informal ties with the TBI
Subcommittee. Obviously your areas of expertise have a lot of crossover, and however you want to arrange it with Dr. Bullock would be fine. Dr. Ludwig?

DR. LUDWIG: My comments have largely been OBE'd at this point, but I would like just to make a quick comment again about communication because I think it's very critical and largely addressed by the Colonel and General Sutton. The Medical Research and Material Command has been responsible for now executing almost a billion dollars of money directed toward traumatic brain injury and psychological health since 2007, and again the use of not only a broad diversity of expertise within the DoD, it has been very responsible for pulling that together, but also bringing in expertise from the private sector, and again largely with some members who are already closely associated with the Board, and we would just like to continue that level of interaction to ensure that we are addressing the most important problems, identifying critical research gaps,
finding out what work is being done in those
particular areas, and then directing new research
to fill those gaps is a critical component to that
execution strategy for ensuring that that money is
actually put to the best use. We would just like
to continue to encourage the Board to take an
active role in that process to make sure that we
are in fact doing that.

DR. WILENSKY: Sergeant Major?

COMMAND SERGEANT MAJOR HOLLAND: Dr.
Holcomb, good to see you again, General Sutton.
All I would like to ask you to do is-- we've had
five different tests of helmets for my troops to
wear and we've tested those out but we've not
fielded very much of anything different than what
I was wearing in 2002 in Afghanistan. So sooner
or later we need to start moving forward before we
start having dollars cut because everyone thinks
the war is over, and to try to help protect these
young men and women or the numbers that everyone
keeps saying will be reduced, ma'am, I just do not
see that there will be a reduction. So the
concussive type issue that we've been talking about and we've all talked about them in a working group together, I would really like to see us try to see how we can take some of those forward, ma'am.

BRIGADIER GENERAL SUTTON: Thank you, Sergeant Major. I absolutely agree and perhaps could recommend at the next meeting to work with the material combat development community to bring a status report on helmet protection and where things stand at this point. That might be very, very useful.

Also, sir, to your point, I would just like the offer the Board sort of save the date, I guess I don't have an exact date yet, but a save the month. February of next year we are planning to hold a State of the Knowledge Summit which will feature really all of the things that we've learned over the last by then 3 years in terms of PH and TBI and the tremendous investment that you noted and would really invite the Board's participation in pulling together that conference.
and really making it count. Thank you.

DR. PARISI: Joe Parisi from the Mayo Clinic. I'm glad to hear that you mentioned the research component because I think this is a key piece of this whole puzzle that's still very elusive and really requires a lot more coordination. I know there's a lot of research being done, animal models by people in the civilian sector as well as military, but who's coordinating all of this? I guess I'm not sure exactly who's in charge. I think this is a major problem. We're hearing different pieces, but I'm not sure who is actually coordinating everything together.

BRIGADIER GENERAL SUTTON: That is a work in progress. Right now I will tell you that the investment that has been made has been coordinated through sort of a joint team effort led by the team at MRMC at Fort Detrick, but pulling in the other services and their research activities. Certainly as DCOE has stood up, we are now in a position as Ms. Embrey has made very
clear that ours is the final approving authority
for research funds and to develop the strategy,
but clearly that is something that is not just
developed in a vacuum within the Services or DoD
or even within VA. We want to make sure that
that's a very broad coordination and organization
of efforts and that's where the project that
Colonel Jaffee mentioned a couple of minutes ago I
think is going to be very helpful as we make the
current data transparent in this sort of
supercomputing platform as in the autism community
as well as the cancer community has been able to
benefit from so that we can really advance and
catalyze knowledge as well as assess where are we
in terms of filling the knowledge gaps that were
identified in summer 2007 and then laying the
groundwork ahead, where does our strategy need to
take us. So I completely agree with you that this
is an area that we could certainly come to the
next Board and provide a lay down of where we are
at this point, but we'd want to invite your input
because we know that this is still a challenge for
us to pull all of this together and integrate and
coordinate in the way that you have mentioned.

DR. WILENSKY: Consider your offer accepted.

DR. LANGLOIS: I'd like to add that the
Department of Defense through the DCOE has really
reached out to the VA to try and coordinate our
research efforts. Large sums of money have become
available very quickly and often those processes
happen so quickly that there is a need to reflect
and to be more thoughtful about how we put forward
future announcements for research. So I really
commend the DCOE for their efforts to work with
the VA on future coordination of our research. In
addition, there has been an effort over several
years to bring together in a voluntary effort
research organizers and funding representatives
from NIH, from HHS, from VA and from DoD in a
group called the Federal TBI Research Working
Group who meet on a regular basis to compare notes
on what research we're doing, what's needed to be
done, and that's led to a number of efforts to
help improve research to improve the
standardization across federal research efforts.
It's a huge animal and it's one that we haven't
conquered yet, but there are unprecedented efforts
I believe at this point to move in the direction
that you've indicated as important.

DR. WILENSKY: Are there any further
questions or comments? I think it was a very
informative discussion. Thank you, Dr. Langlois.
We are now going to take a break. We'll
reconvene at 10:15.

(Recess)

DR. WILENSKY: Our fourth speaker this
morning is Dr. Charles Fogelman who currently
serves as Executive Coach, Principal Leadership
Development and Management Consultant at Paladin
Coaching Services. Dr. Fogelman is also Chairman
of the Defense Health Board's Psychological Health
External Advisory Subcommittee and will provide a
summary of the Subcommittee's last meeting held
March 23 and 24 of this year, topics for future
meetings, and the questions formally tasked to the
Subcommittee. His presentation slides may be found under Tab 5 in your meeting book and has already been referenced. Part of the meeting was the joint meeting with the TBI Subcommittee. Dr. Fogelman?

DR. FOGELMAN: Thank you. It wasn't just referenced. Jean gave me an assignment, but she didn't tell me that she was going to give me the assignment, so I'll pretend that I'm responding to it.

Before we start I'd like you to imagine this to be a blank slide for a second and visualize a gear shift knob. Most of you in this room are old enough to know what a gear shift knob looks like. Right? It has the gears on it. You may recall at the last couple of meetings I said the first one was organization and then we were trying to gather information and we're sort of getting ourselves together. I think we're either just in second gear or reengaging the clutch between first and second gears. We're not in third or fourth or heaven knows in fifth is
overdrive, but I do hope within the year we will
get there. So bear that in mind if you are
looking for substance and don't hear any. That's
what we're going to do today and I think that's
what Gail just said. You've seen this slide
before. That's the folks who are on the
committee.

We took a couple of steps to try to move
ourselves forward. I've told you before that I
and at least one of the other people on the
Subcommittee were going around interviewing folks
and having individual meetings and we continued
with that. But we have begun to focus a little
bit more in regard to what we want to know about
and what we want to talk about. In a few moments
you'll hear me talk about our skeletal, but
standard, agenda.

Among our ongoing agenda items would be
we'd like to learn about something new, about
something old. This is not about weddings. There
is nothing borrowed or blue here. Maybe there's
the borrowed part too. The psychological fitness
which is about resilience was something we had
begun to talk about and wanted to learn a little
bit more about. That's why we had that
presentation. Second, we met individually with
several of the folks from DCOE. Part of our
responsibility is to try to figure out the best way to
provide advice to DCOE and in order to do that we
wanted to learn as much about what's going on and
try to establish what the baseline and the
aspirations are, and we thought the best way to do
that was to have a series of individual
conversations, and those are the various folks
whom we met with at DCOE, and I'd like to thank
Dr. Sutton for allowing us to meet at her facility
in Silver Spring the last time. That was nice.

The two NCAT references, maybe that and
the combined TBI screening, are the assignment I
think that Jean gave me, but I actually think that
she summarized pretty well where we are. The
reason that we established an ad hoc working group
between our two committees was because of what
was to us obvious overlap between psychological
health issues and TBI issues. We had thought first to have a joint meeting of the two committees so we could talk about what we did together. In order to do that, that's what Jim Kelly came and talked to us about, and then ensued a discussion about what we should do together and adding that to the NCAT or as we were referring to it, ANAM, and as Jean did, discussion, we decided to have an ad hoc joint, I think there's a noun and I don't know what the noun is that goes with that, group, consisting of four people from our committee and four people from the TBI committee specifically to address the ANAM issue and to work it through and then come back to our respective committees either separately or perhaps in another joint meeting so that finally we can get to some recommendations and make formal recommendations to the Board for it to go on to make formal recommendations.

Starting with something new and then something borrowed and I don't know what's in the middle, and then the something new, we had Dr.
1 Michael Dineen come and talk to us about the
dashboard of metrics in the military health
system, and that was fun for us to see what hard
research is going on and what questions are being
asked and how they're being approached.

As I said before, we actually have moved
into another gear. Every time I've spoken to you
before I've said we're not quite there, but I'm
happy to report to you that we actually did some
things at our last meeting, and since I am an
inpatient sort, that makes me feel better. The
first thing is I got -- it's odd to say that we
took action when the second thing is that we
deferred an action. We had planned to finish up
the first part of dealing with the autism
question, but the person who was to brief us had
jury duty that day and therefore we couldn't do
that. We have a teleconference scheduled for
about a week and a half to 2 weeks from now to get
that accomplished, and I'm hopeful that by the
next time the whole Board meets that we will have
something to say to you about that as well. I
already talked about the ad hoc task force.

In the Executive Committee meeting yesterday which was a kind of prefatory meeting, among the things that we were talking about was how do questions come before the Board to be answered, do subcommittees only respond to questions or do they generate areas on their own? This is an unsettled question for the Board and we're going to discuss it and discuss it in an administrative session later. But in anticipation of that, we began thinking about what we might do in the future. One of the things we did was think about how we could shape our relationship with DCOE and we came up with some ideas about that which we're going to put formally through the Executive Committee and get their feedback and then I'm going to talk to the DCOE folks and say this is what we think, do you think this will work, and we will proceed and that help us we hope with our oversight. And that last item is-- we thought a lot about what we would do if we were given the freedom and the charge to decide what
areas we should really go into and look at in some
detail. That again is not a formal thing yet and
depends on what the Core Board as a whole decides.
And we have a schedule of meetings for the year.
Not listed here is the teleconference
we're going to have about autism which is as I
said in a few weeks, and I'm guessing that we will
have one or two other teleconferences in the
interim as well, and depending on what we may
attend to, we may have subgroups who actually go
out and meet in other places and visit. I drew up
an agenda template and circulated it to the
members of the committee and came up with a final
version. It's here as a supplemental slide just
as the questions we were asked before is as a
supplemental slide. I'll show you briefly what it
looks like. It looks like that. My anticipation
is that every meeting will look like this now, and
that brings us to the end. I have time for 15
minutes, but it took me 14. So I'm open to
questions.

DR. WILENSKY: Thank you. Are there any
questions that people would like to ask?

DR. LEDNAR: A thought I had offered to the Subcommittee is in the area of metrics. There may be an opportunity for another of the Board's standing subcommittees to be a resource to this discussion, and that's Dr. Halperin's Subcommittee, which is the first on occupational and environmental health and you might ask what's the relevance, but it includes medical surveillance. So a population health monitoring of data to understand and then take action is a competency with this subcommittee and it may provide some insight to your discussions.

DR. FOGELMAN: That's a good idea. I'll ask. I don't know how much psychological health stuff they survey and gather, but I certainly will ask them. Thank you.

DR. WILENSKY: Do you anticipate continuing the jointness of some portion of future meetings with TBI as you did in the last one?

DR. FOGELMAN: Where it stands now is we're going to wait until our ad hoc group has
something to say, and then at that point I suspect
we will have, as we did this time, an overlapping
meeting with the TBI folks, since up until now
there was no named replacement chairman and I
didn't have anybody to talk to about it, but my
sense is once we have something to discuss with
the ad hoc people, we'll do what we did here which
is we had a Monday and Tuesday meeting, they had a
Tuesday and Wednesday meeting and overlapped for
part of Tuesday and I suspect that's what will
happen. We don't have it as a formal plan. It
may be that we wind up with joint meetings with
other subcommittees. Frankly, I liked doing it
and I think most of the members of the
Subcommittee liked doing that, so any of you who
is a subcommittee chair who thinks that there
maybe a useful overlap, I'm happy to talk to you
about that.

DR. WILENSKY: I'd also like to
encourage you to be in contact with Dr. Bullock
either as he develops his agenda now for the
subcommittee or whenever it's appropriate just so
that you're aware of what each is doing.

DR. FOGELMAN: Absolutely.

DR. LEDNAR: When I see the title of the group is Psychological Health, I have a thought. This may or may not be in scope for your committee, but I thought I'd share it. In thinking about the messages that Colonel Coke in the global operations update, and I'm reflecting on a discussion at the break that General Sutton and Dr. Erdtmann and I had, it's the needs of our senior leaders in the Department of Defense, civilian or military in this very, very challenging time, to keep up with all of the inputs, to keep up with all the challenges, to keep winning the war. There are more inputs than there is time or bandwidth to process. This has been going on for years and it's not likely to let up. So the needs of our senior leaders in terms of psychological health and system structure so that they can be maximally effective for the long term, this is a marathon and not a sprint, and if this is something that is in scope to the
Subcommittee, I think there is special expertise in your group that might be --

DR. FOGELMAN: Let me be certain that I understand what you're asking. Is it the case that you're asking about providing advice on things like leadership development and organizational structure and organizational climate and strategic planning? Is that the question you're asking?

DR. LEDNAR: Can you say that just a little differently? I'm not sure I've caught your --

DR. FOGELMAN: Is the question you're asking should we be advising senior leadership about the way they conduct their own jobs? Should we be advising them on organizational questions, on professional leadership development questions? Or are you talking about should we find ways to make sure that they are kept informed of what we are doing? For example, should we meet with the Surgeons General? Are you talking about both of those things or one of the other?
DR. LEDNAR: We'll talk in the administrative session about yesterday's discussion, but thinking about that, I do not think that we as an independent external board may be the best source of advice on how to structure and operate the business of the Department. I don't think we are the people to advise on that. But we do have experience in recognizing how work can affect the effectiveness particularly in our senior leaders that may become an insight, an optic that is an input that can be offered to the senior leaders. I'm not quite sure what the forum for that is, the right way, but it's an expertise that I feel is an expertise in the Board and there's a reality in the Department, and if there is some way to have those two come together in a constructive way that the Department finds of value, then let's not miss the opportunity.

DR. FOGELMAN: I think that most of the folks on the Subcommittee who can assist with that expertise or have that expertise would be more than happy to do it, and if there are ways for the
committee to do it or the Subcommittee to do it as a whole, then we will.

DR. WILENSKY: Dr. Silva?

DR. SILVA: You have a lot on your agenda. I didn't hear anything about suicide and suicide prevention. That's clearly in the news all over the place.

DR. FOGELMAN: Actually, you didn't hear anything about any of the specific items we have on our agenda because as I said, we need to talk in the administrative session and later about what the committee or what subcommittees can initiative and not. There is a list of things that we're thinking about and among them is probably suicide, but I would say that there is a very active suicide task force and duplicating their work probably doesn't make sense, but keeping informed about it or assisting them if they ask might.

DR. WILENSKY: Our fifth speaker this morning is Dr. Ken Kizer of the Medsphere Systems Corporation, a leading commercial provider of open source information technology. I don't know
whether that was provided by Ken as a definition.

Previously he served as the Under Secretary for
Health in the U.S. Department of Veterans Affairs.
He's also Chairman of the Defense Health Board's
National Capital Region Base Realignment and
Closure External Advisory Subcommittee. He will
provide an update on the Subcommittee's report
which was sent out earlier this week for your
review in preparation for the discussion. His
presentation slides and the Subcommittee draft
report may be found under Tab 6 in your meeting
book. Ken?

DR. KIZER: Thank you, Gail. Good
morning. Hopefully everyone has received the
report, everyone on the Board at least, and were
able to look at at least the relevant sections
that were called out in the transmittal e-note.
It at first blush might appear more daunting to
get through than it actually is. I do
apologize for the short time that the Board had to
review it, but hopefully in looking through it the
large amount of work that has been done to prepare
this or to come to these findings and
recommendations is apparent by what's included
there.

I would at the outset, and this is just
to give other Subcommittee members a heads up,
certainly invite comments from other members of
the Subcommittee who are here at the end of this
either to underscore things that they think are
important or to correct any lies that I've told.
And I would also note that the report that you've
received should not be viewed as the final report
in terms of formatting and some other issues.
It's a Word document that was set out, but it will
be formatted. There are several dozen additional
references to be added and a few miscellaneous
items, but basically the findings and
recommendations are as you see them and the report
as presented to the committee for action today. I
would also underscore that much of what I'm going
to say you've heard before at the presentations at
both the December and March meetings at least in
substantive part. The last introductory comment I
would make is that while our report focuses on some deficiencies that have been identified and some problems that need to be corrected, I want to make sure that these don't obscure or make less evident the very large amount of very good work that's been done and the diligent efforts that have been put forth by a large number of people to make this a success, as is often in reports where basically the job is to point out the problems, we lose sight of the good things that have been done, and there is a lot that the folks who have been working on these projects can be proud of and feel very good about.

So with all that as a preface, let me quickly go through some materials again. You've seen much of this, so I will go through this relatively quickly. The Subcommittee was originally convened just about a year ago, a little less than a year ago, to advise the Department on the efforts to have an integrated service delivery network among the Services here in the National Capital Region. There is a
parallel project going on down in San Antonio that we are not involved with. A few months after that we were additionally charged with conducting the independent review of the design and construction plans of the new Walter Reed National Military Medical Center and the Fort Belvoir Hospital as was required by the 2009 Defense Appropriations Act.

As noted, the bill calls for this independent review because of concerns that the Congress had reflecting concerns of others I think would be a fair way to characterize it, in that they also posed a number of corollary questions that I'll get to in a moment, but the fundamental charge that we were given was to make an assessment as to whether the design and construction of these facilities would meet the congressional standard that had been imposed, that they be designed to be world-class medical facilities, and if not what changes should be made to ensure that they meet that standard. As is not atypical, the Congress made its intent clear in
saying that they should be world-class medical facilities and gave some rather superficial verbiage as to what that might mean but provided no meaningful or operational or functional definitions of what world class meant or what definition might be used to actually complete the review that they required. So the first charge to the group really was to define or come up with an operational definition of what is a world-class medical facility, and I would just note at the outset that while that term is used widely now in health care, no recognized body has established any type of meaningful definition for what that means. It's a marketing term that has taken off without any truth in advertising if you will for the consumer.

Corollary questions that were asked in the report also are the Department's approach to the design and construction of these facilities which is different than what has been done in the past, were those sound approaches, is there a reason to halt the construction at this time if
the conclusion was that the design was not being
done to world-class standards, and were there
other things that should be dealt with, the
catch-all what else needs to be considered.

The process was straightforward,
Committee membership had been identified and the
Committee had been convened. When the additional
charge was given there was a need to add some
subject matter expertise that was not among the
original membership. That was done. The
Committee had a number of meetings both in person
and by conference call. A very large number of
documents were reviewed both in the general
literature and different documents about what
forward-looking hospitals might like, design
considerations, as well as the specific planning
and design documents for the facilities in
question.

There were a lot of presentations
presented at the various meetings from folks
involved in different aspects of the project.
Additionally, to I think gain some reassurance or
some validity of what the Committee was defining
as world class, I also invited several dozen other
health care luminaries or health care leaders,
folks like Denis Cortese at the Mayo Clinic and
George Halverson and others at Kaiser Permanente,
John Perlin at HCA and again a large number of
folks, to opine and to weigh in on the definition
that we had advanced, or at least the draft
definition that was advanced, at that time. They
provided helpful comments, many of which were
included in the definition after the Committee had
looked at them.

Further, this definition was presented
to a meeting of the American College of Physician
Executives a couple of months ago where at least
200 or more folks had the chance to review and
comment on it, and again those comments were
considered by the Committee and some of them were
incorporated. The bottom line is this wasn't just
the Committee's definition although the Committee
had quite ample expertise I think to opine in that
regard, but it was looked at by a lot of other
The conclusion, and I don't intend to get into the weeds on how the Committee defined it--it is included in the report as Appendix B. It is a fairly substantive document to wade through particularly insofar as many of the measurable attributes are by reference to other documents and there is a certain amount of expertise that is probably required to know what is in those other documents and understand the relevance to it and that probably goes beyond the scope of this meeting. The attributes, or at least the things that we felt could be measured at this point in time, fell into a half a dozen domains and a number of specific condition areas and then a menu of things under those conditions, and again I would refer you to Appendix B for the details in that regard which we can certainly discuss as we go forward, but I don't intend to present them. I think it was also clear from our discussions as well as outside input that there's a lot of what goes into a "world-class" anything,
but certainly a world-class medical facility, that can't be measured with current methods of measurement and has some of the attributes as noted on the slide about routinely going above and beyond what's expected and that there's a synergy among the different parts that's a little hard to explain. And that I guess it really goes to the last point there, that what makes a world-class facility is their ability to make the extraordinary ordinary and to make the exceptional really routine. There is some significant verbiage in there about these things, and I would refer you to the document if you want to discuss any of them in more detail, but I would again emphasize that this has been looked at by a lot of people and there seems to be a lot of agreement that we've captured at least some of the main points there.

This slide is intended for a couple of purposes, but mainly to highlight some of the key findings of the report, and really in a sense at least the first five here. I think it's the
Committee's assessment that if these points aren't addressed that simply it will not be possible for the facility to achieve world-class status. There are a lot of findings enumerated, a lot of specific things, and I think it's important to call out these more major issues that really are threshold issues if indeed the goal is to be a world-class facility and I think that that is a goal that the Subcommittee was quite strong in its feeling that it should be the Walter Reed National Military Medical Center should be, indeed, a world-class facility and should be the type of facility that when people talk about how health care should be delivered, they say as is done at Walter Reed, that it really is the model or a model for how to do it right in all respects, and I think that's kind of the general tenor or the flavor which the Subcommittee approached this.

I'm going to come back to many of these things, but again I just want to call them out up front and highlight them, that the BRAC funding process has limitations and those limitations
fundamentally prevent the ability to make a comprehensive design plan for a facility like what is envisioned for Walter Reed which involves extensive renovation of an existing facility, new construction, merging them all together, and to do that because of the limitations in BRAC funding, funding has to come from multiple sources and at the moment there is no way to integrate and bring those different sources together so that there is indeed a singular funding stream that supports a comprehensive plan, renovation, new construction, whatever else needs to be done, that ultimately would lead to a design and construction of a world-class facility.

The second point is that the vision and mission, certainly it appeared to the Subcommittee that these weren't clear, not that they haven't been clearly articulated as Admiral Mateczun, I think, has articulated a clear vision, but in some ways this is just a corollary issue of the funding problem in that there are multiple commands involved, different commanders, different members.
of those commands don't necessarily see it the
same way, and because the authority is fragmented
it results in people perceiving the end game
somewhat differently and that, at least in our
judgement, is a fundamental flaw. This leads into
the third point about the fact that both
organizational authority and funding authority are
fragmented. Some comes from BRAC some comes from
others. Some of the commands that bear on this
are under the joint command structure, some are
under service specific, and there isn't the
integrated and singular authority that is needed.
I think an example of that recent vintage is
the decision about how to define or redefine what
is the medical center at the Bethesda campus.
Again we can go into details as needed, but there
is some redefinition there that affects the
ability to bring all the pieces together.
There are clearly service specific
cultures, and the military health care culture,
much like the rest of health care culture, is very
facility centric and this is not necessarily
conducive to or supportive of an integrated delivery system. Indeed, they fundamentally conflict. Again, this is not a DoD or military specific issue, and one of the reasons why I think that I harp on this is having seen this played out in the private sector in multiple instances is an issue everywhere and that if there isn't a concerted effort to engineer a culture that supports an integrated delivery system, it's going to fail and there is a long list of private sector ventures in this regard which have failed because they fundamentally didn't understand what it means to be an integrated delivery system and bring all the assets together. When one thinks about the different assets, if you focus on where a health care delivery system and hospital and clinics and hospices and home care are just different tactics by which one accomplishes that mission, that's a different way of thinking about it than if you're focused on the hospital and preserving the hospital. Again, we could go into a long discussion about this, but there is a fundamental
need to engineer a culture there that deals with
the different service specific cultures and the
facility centric mindset that prevails.

There is no comprehensive master plan
which is really an outgrowth of some of these
other things, not the least of which is the
funding, and as I think will become clear as we go
forward because we keep coming back to the funding
issue, if you can't decide up front what you're
going to fund to pay for and design, then it's
really hard to develop that master plan to do
other things that are ultimately contingent upon
that, so that it is a fundamental threshold issue.

Finally, because this was specifically
asked in the congressional language, is there a
need to halt construction, it is our conclusion
that there is a not a need to halt construction
if, and this is a qualified statement, a master
plan that addresses the deficiencies in the need
for renovation and that addresses the funding
issue and the authority issue can be completed in
a timely manner, then halting construction would
not only be very costly and demoralizing, but would probably be the only thing worse than not correcting the deficiencies going forward. Again, there is much we can talk about on that, but it is a really fundamental issue and our judgment at this time is that we should not halt construction if these other things can be addressed in an appropriate timeframe which is, frankly, not very long.

Just addressing a couple of the other corollary questions, was the approach that was used sound? Yes. I think that we can give that an unequivocal endorsement. There were different approaches used for the Fort Belvoir hospital versus Walter Reed. Both of them appeared to be improvements in the traditional process. One of the deficiencies that we'll come to though is that there isn't an identified plan and funding to support an assessment of these things to inform future military or other federal hospital or health facility construction and these are wonderful case studies that should be learned from.
for future projects because I suspect this isn't
the last time that the federal government is going
to construct a medical facility, again going back
to the simple fact that some of the needed
renovations at the existing Bethesda site can't be
accomplished because of the funding issues and
that this is serious problem.

Other findings, and I'll quickly go
through these. Again a threshold question, is
this idea of constituting an integrated delivery
network in the National Capital Region a good
idea? Again the committee I think resoundingly
agrees that it is and that efforts should move
forward to in fact create an integrated delivery
network of the various military commands in the
area and that would be likely to better serve both
active duty and retired military personnel and
their families. Again, a lot of work has been
done, but despite best efforts, there are some
issues that are beyond the control of the folks
who are doing the work to effect it, things we've
already touched upon, the varying visions, the
unclear or fragmented and complicated chain of command, the funding issues, really are root problems that have to be addressed if in fact the goal is to be achieved.

The Fort Belvoir hospital really presented a different set of issues, and frankly was much easier to assess, but it was done very differently. It didn't involve the complexities of the Walter Reed project. It didn't involve large renovations. It was basically a green field project, they started construction, and that's quite a different scenario than what is occurring at the Bethesda site and with the Walter Reed facility.

Some of the other findings as noted here, and again these are elaborated on in the report about whether input particularly from frontline clinicians and patients was incorporated as much as it might have been, and the culture issues I think I've already touched on sufficiently. The need for what we believe is a better demand analysis. The demand analysis that
was one is a static assessment that was based on 2004 utilization figures, and while I think it was very commendable the efforts that were made to address this issue, it really wasn't a forward looking demand analysis that looked at future service delivery needs based on population changes and other sorts of things as well as where health care is going to go and some of the likely changes that are going to be seen in health care in the next few years, to say nothing of the long term. So we would suggest a more dynamic demand analysis be made. The need for a master plan for both the Walter Reed site as well as for the overall National Capital Region. That is as I think I've already said two or three times precluded because of issues of funding authority and some other things, but that clearly needs to be addressed. Finally one more time, the inability to complete renovations because of the BRAC problems. As far as the specific plan or the plan that has been put forward, a number of specific deficiencies were noted, and again I don't know
that it would be a productive use of time to go into all the nitty-gritty details. These are detailed in the report. This lists a number of them, and I may highlight a couple. But I would also again couch this in terms of we shouldn't lose sight of looking at these things, about the large amount of good work that's been done, about the changing nature of many of these requirements, for example, nonconformance with joint commission standards. Those standards are actually quite different today than they were 4, 5 or 6 years ago in a number of cases when the plans started to be advanced and they were working on draft standards and other sorts of things, and the key is not so much I think the fact that it didn't meet these because they can be addressed with appropriate design changes, but that it's reflective of the very dynamic nature of health care and the need in any sort of plan to have flexibility and to accommodate to changing circumstances and changing technology, changing standards and other sorts of things. That will continue to occur, and whatever
is designed today even if it's designed to meet all the specifications for example that are in the plan, are going to be different 2 or 3 years from now because the world is changing very rapidly in health care and so this has to be a very dynamic and flexible process.

I would also note I think in fairness that in some cases we identified issues that the committee thought were of concern and didn't necessarily understand the logic for, for example the siting of the dialysis clinic above some of the central supply and more sensitive areas of the hospital where the plumbing to dialysis is always a problem because of the corrosive materials that are used and so you continually have to get in there and change things and putting that above central supply and some other things, the logic wasn't necessarily clear, but there may be reasons that that might be acceptable, it wasn't clear, but that we maintain an open door to hearing perhaps alternative explanations as this goes forward.
The information technology plans, part of the issue there is simply funding. A number of things were identified that made sense, but then on peeling back the skin, it was apparent that there really wasn't the ability to execute those plans because funding hadn't been approved. So it sounds good, but is it actually going to happen? And there were some other areas where we think some additional things need to be looked at.

I anticipate that the issue of on-site simulation labs is going to be controversial and I think it's the Subcommitte's position that this is just simply a must do today and that certainly as is demonstrated in the aviation industry, simulation is critical. Simulation has come into its own in health care largely because of the efforts of the military, the military has clearly been the leader in this regard and in some ways the Committee found this ironic that these weren't on-site. While there may be plans for an offsite location, just don't think that given the nature of how busy health care practitioners are and
other things that that's going to be a workable
design in the future.

The need to go to essentially all single
patient rooms is clearly the norm in health care
today. Again, there are things that we could talk
about here, I think you get the flavor that there
are a number of things, but again the important
point, and what may appear incongruous at first, is
that when you look at this list, one might say how
can you on the one hand recommend that
construction not be halted when you've identified
these problems, and they actually do make sense.
We aren't totally schizophrenic, although maybe
Dr. Fogelman might want to weigh in on that, maybe
delusional, again if in fact design or a master
plan can be created and we can address some of the
other funding issues, we think that renovation and
changes can be made that would address these
things such that there would not be a need to halt
construction because we think that would be very
injurious to the process.

Some of the specific recommendations are
as noted here. We think bottom line a single person has to be in charge and have the commensurate organizational and budgetary authority to bring all the pieces together. As someone commented along the way, all you have to do is count the number of stars on the shoulders to figure out, or to see, that there's a problem here because if everyone has the same number of stars or someone in command has fewer stars than others, it's not going to work and that somebody on top has to have more stars than everybody else. That may be somewhat simplistic, but I think judging from the body language of the folks in the audience that the point is made. There needs to be a master plan and it needs to be developed as quickly as possible, a culture change has to embark on the engineering, and this isn't something that is a 2-week course and you're done. Certainly if you look at cultural change in organizations or successful cultural change in other organizations, people talk about 5 year or 7 year or 10 year timelines. This is going to be an
ongoing process. This raises a number of issues as far as military and rotation of leaders and other sorts of things, are some of those practices compatible with the idea of having stability of culture, stability of leadership that are necessary if you're going to really create a world class culture or world class facility. Obviously these deficiencies need to be addressed. We need to make sure that the folks who are most impacted, i.e. the patients and their families and the frontline clinicians, have their opportunity for input and to be involved in the planning and design process. Their issues need to be addressed as much as possible, recognizing it often is simply not possible to accommodate everybody's interests. That's a balance that always has to be achieved, but insofar as possible that that input needs to be consciously addressed and if a decision is made not to do something, it needs to be understood why.

The processes need to be evaluated to inform future federal construction projects. I
think this is really critically important if we're
going to invest hundreds of millions if not
billions of dollars that is being spent here,
there should be some assessment being done as to
how the lessons learned might be applied in the
future.

Finally, we think that the construction
can continue if the renovation issues are
addressed which requires that the funding issues
and authority issues be addressed and that there
be a master plan that addresses these things. So
while there are a few words there, there are some
qualifiers that need to go with that as well.

As far as further Subcommittee process
in this regard, the report is presented to the
Board for action today. Depending on that action,
it will be finalized, formatted, published, and
advanced after review and comment by the
Department, but advanced to the Congress. We do
expect that this isn't the last time we will hear
about these issues, that given the history and the
level of interest in these projects that this will
be a topic for further discussion on the Hill and
elsewhere and may be a fairly visible topic of
discussion. While the Committee has not been
charged with doing this, we do think that the
further design and construction efforts would
benefit from this type of outside review on an
ongoing basis. The Committee, after completing our
work in this regard, intends to go back and
continue working on the issues related to the
design and development of the integrated delivery
network in the Capital Region unless it's directed
to do otherwise, but that we think that with the
promulgation of this report, that at least
completes the assignment that it was specific
charged with to conduct this, at least, initial
independent review.

With that I will stop. I think there is
going to be a fair amount of time for discussion,
but before we do that I would invite, as I said at
the outset, Ray or Phil Tobey who participated in
the Subcommittee process to make comments as they
see fit. With that, Ray?
MR. DUBOIS: No doubt a number of you are puzzled when we commented that no master plan existed. As a matter of fact, I would ask Admiral Mateczun perhaps to address this, multiple master plans existed or exist, and what we found out was, and this blends, if you will, to Ken's comment of multiple funding sources, for those of you who have dealt in the Department of Defense authorization and appropriation process, often times you have multiple funding sources to achieve a singular mission at some point in the future on purpose. In this case, and General Myers can back me up because he was present when I presented the BRAC recommendations to the Infrastructure Executive Council of which he was a senior member, and I made the comment at that time that of all the BRAC recommendations in the United States in all three military departments, the most complex one and the most expensive one was going to be the establishment of the new Walter Reed National Military Medical Center at Bethesda.

We also understood then albeit we were
focused strictly on BRAC, base realignment and
closure recommendations to the BRAC Commission,
that there were already planned extensive
renovations and new construction for the National
Naval Medical Center at Bethesda. There is also,
as we heard from previous speakers, the new Fisher
family funded Defense Center of Excellence for TBI
at Bethesda. There were also plans to address the
Uniformed Services University of the Health
Sciences construction, technological upgrades, et
cetera, at Bethesda. Admiral Mateczun has in a
rather exemplary fashion, and I'm not trying to
suck up to him because I don't have to anymore,
the issue is he has a plan and he has I think
correctly suggested to his supervisor, the Deputy
Secretary of Defense, that these multiple funding
sources and these multiple plans which were
developed in the past need now to be pulled
together. It will also, I think, reveal not
surprisingly that there are some funding gaps when
one looks at a comprehensive, integrated master
plan for not just the new Walter Reed National
Military Medical Center- Bethesda, but as Ken was suggesting, the integrated delivery network of the National Capital Region which includes this new community hospital at Fort Belvoir. So that slide that shows the significant deficiencies, de novo you could say, my God, time out. Let's start all over again.

It's not that the military has gone too far to stop. I think that the military hasn't gone far enough to accomplish what the Congress in its infinite wisdom has said is world class. No medical institution today anywhere in the world given our definition of world class would qualify, and I suspect world class as has been indicated is something that is not static but moveable, expandable. World class 5 years ago certainly won't be world class 5 years from now. So there is a dynamic here that we tried to embrace and the Congress demanded and the Defense Health Board deserves to know what we in our respective disciplines concluded as deficient, but also we collectively recommended keep moving forward.
There are ways to do this.
I will conclude by saying we believe that Admiral Mateczun should be given the responsibility of pulling these multiple plans together along with the multiple funding sources that attach to the individual plans to in point of fact create, and I believe, and I defer to Admiral Mateczun, that he is already moving in this direction because that in our view is our collective judgment, and I want to emphasize I, as a layman and not a doctor, not an architect, not an engineer, although my son sometimes calls me a political engineer, the fact is the people who served on this Committee and the subject matter experts, everybody from Phil Tobey, the country's leading health care design architect, to Tammy Duckworth of Illinois, a multiple amputee as you know, soon to be hopefully Assistant Secretary of Veterans Affairs, these people came to grips with a lot of disparate and sometimes conflicting information and synthesized it in my estimation rather well. I would be happy to hear from
Admiral Mateczun in respect to the issue of unifying the command and control if you will.

DR. WILENSKY: First, Phil, do you want to comment and then Admiral Mateczun?

MR. TOBEY: Thank you. I'm Phil Tobey, and as was noted, I am an architect and a health care planner, so I'm going to wear that hat for just a moment. I want to underscore a couple points that Ken made, one of which is an emphasis on urgency and focus a moment on the renovation piece of the project where most of the deficiencies that we noted actually occur.

I think as a committee we pretty much decided that the new construction component of the project which is well under construction, in fact I believe is going to be topped out here in the next week or two, was fine, and that the area that was under greatest concern for us because of the BRAC funding was the renovation piece which obviously follows the new construction, and that's why I say we have an opportunity here I think to fix that piece of the project.
The BRAC constraints and limitations if you will forced the planners to develop a renovation plan that looks like Swiss cheese. There are pockets of renovation all the way through the existing complex that express the BRAC constraint of addressing what has to move over to the new facility, but there are no funds there to fix the facility itself. So the Swiss cheese if you will I don't believe is capable of being constructed in a strategic way. For example, you can draw a line around a department on a plan and say we're going to renovate that department, but all of you who have ever done any construction know that you're probably going to have to tear out the floor below because of all the plumbing and so forth. Those kinds of things I think need to be addressed.

What I want to reiterate one more time is the critical nature of a master plan that steps back and looks holistically if you will at the planning for the renovation piece and then moving out very quickly with the authority issue and the
funding issue in making that happen. We do have
an opportunity, but it has to happen quickly.

DR. WILENSKY: Are there any other
Subcommittee members who are here who want to
speak? Admiral Mateczun?

VICE ADMIRAL MATECZUN: Secretary Kizer,
Mr. DuBois, and Mr. Tobey, thank you for the
tremendous work that the Subcommittee did. I
think that when you originally accepted the jobs
on the Subcommittee you didn't know that you'd be
defining world class and doing all of the tasks
that Congress has requested you to do, but you've
done a great job pulling together all of that
information. In fact, these definitions will now
inform medical construction I believe not just
within the DOD but within the DVA and other
federal hospitals at the very least and will now
become terms of reference for construction and
projects that go well into the future.

It's been daunting working this project
and I appreciate you very much coming in and
taking a look at what was happening and providing
these recommendations. There were a number of the recommendations, I guess a lot of things come together when the Task Force on the Future of the Military Health System which Dr. Wilensky co-chaired and General Myers was on as well, had an overarching recommendation of bringing an integrated delivery system together with the military health system's direct care system and private sector care. So as we look at this integrated delivery network and your recommendations and findings about service specific, facility centric cultures and conflicting with the needs of an independent delivery system, it goes beyond the Services and really reaches into this question of how do we put together the private sector care, the direct care system for the benefit of our patients not just now, but well into the future. So thank you for recognizing those problems and challenges that we have.

All of the things that are going on, I will tell you part of this process is that we are
constantly moving. There are already things going
on. We have an independent architect now working
for the Joint Task Force that is diligently going
through around 150 joint commission standards
questions with the contractor and we'll be working
all those to completion. We're down to about 50
right now and so we're working ahead on that. The
on-site simulation labs, we're working with 5,000
square feet right now that will be incorporated.
So many of the things that you've brought up we
continue to work on. It's not a static process,
it is very dynamic, and we have incorporated most
of these things I think already into the process
and will be glad to come back and let you know
what's happening with each of those and appreciate
your continuing to look at them with us.

In terms of the process from here and
the recommendations and findings, it's been my
experience that there is a possibility of focusing
on the negative side of the recommendations and as
different people look at these recommendations
they'll see validation of their viewpoint or need
to do other things. A very helpful, I think, piece to us is the executive summary of the reports as they come forward so that in the department as we review the recommendations, or the findings and the recommendations, we sort of understand the priorities that you have put into them so that we can focus on those priorities. As I understand them here, there is certainly this need for a master plan in particular about the chassis at Bethesda, but reaching out into the whole integrated delivery system and how we view that, the need for authorities to be aligned and the need to identify funding streams. So if that's true that that's in an executive summary some place and then we're able to point to that and say here are what the priorities we believe were that the Subcommittee found, then we can work those within the Department diligently and make sure that we've responded to those findings. Dr. Wilensky, thank you.

DR. KIZER: Just two comments I think to underscore a couple of points. One that I think I
made before, but it's just the whole dynamic
nature of what's happening and that one shouldn't
view what's occurring in military health care as
all that separate and distinct from what's
happening in larger health care. Indeed, if you
look at the health care reform proposals, it is I
think undoubtedly the model that will be advanced
are integrated delivery networks because they work
better and it's a better model than having
facility based care, and that will be a part of
health care reform when and if that happens in the
next several months, next 2 or 3 years, or whatever
the timeline happens to be.

The second point is I think one of the
advantages to having an open and participatory
process such as we've had going back to last
October is that based on at least a review of the
documents and some of the things we hear now, it
would appear that some of the issues that the
Subcommittee has identified have been taken to
heart and indeed are being addressed. At least at
one point in time they were identified as issues
because it didn't appear that they were, it's reassuring and comforting to know that a number of these things are being addressed going forward, and again I think that's part of the value in doing this collaboratively and working together with the common idea that we all want to arrive at the same place where the National Military Medical Center is a premier health care facility not just in the United States, but indeed in the world.

Gail, with that I'm happy either to try to respond to any questions or comments or avoid them if that's the better part of valor.

DR. WILENSKY: General Myers?

GENERAL MYERS: I've got a question for the Commander here in terms of one of these recommendations which is to empower a single official with complete organizational and budgetary authority. As difficult as that is, what's your view of that recommendation. Do you feel empowered?

VICE ADMIRAL MATECZUN: I feel accountable most days.
GENERAL MYERS: There's a difference there.

VICE ADMIRAL MATECZUN: Yes, sir, I think that that is a challenge, certainly, sir, under your leadership in the Department and moving ahead in the joint world the challenges in working with the Services and the unified command plan and crossing those, the technicalities of those we need to address. I think that I believe I did understand the intent of what's being asked for here to bring together the authorities in the way that we can legally to accomplish the mission, yes, sir, I think that we can do that.

DR. WILENSKY: Can I try to just pursue that as a nonmilitary person? Ken referenced the flat structure of having you as a three star and other three stars heading the Services. Is it actually possible to have the unified accountable responsible individual with that structure? I thought that's what you were asking, but I somehow don't feel comfortable that I see how that can happen with a flat ranking, but if you tell me it
can, I will accept your word for it. It seems problematic for a nonmilitary person when you have that arrangement.

VICE ADMIRAL MATECZUN: Dr. Wilensky, I don't want to speak for anybody else in the Department, but as we're working through the ultimate governance for the Joint Task Force, where will the Joint Task Force ultimately reside, it can't report to the deputy secretary forever although it's a great way to get resolution to issues that come up, but ultimately will need to fit into the overall Unified Command Plan in some way or fit into some other governance structure, so I know that within the Department there are a number of joint medical activities for which that governance is still being worked out. There are other fora where the question of what will happen with the organization of military medicine is also being considered and so those are sort of separate lines of action if you will that will come together I believe at some point.

MR. DUBOIS: Gail, may I just comment
briefly? The future of the management of health
care in the Department of Defense for all of its
constituencies, the active component, the Reserve
component, retirees, families, is certainly
something that the Joint Task Force, National
Capital Region, will have implications for, but
the step that was important was to put a third
star on Admiral Mateczun, number one. Number two
in my view, to have him remain reporting to the
Deputy Secretary of Defense not forever, but for
the purposes of creating this new Walter Reed
National Military Medical Center at Bethesda which
is a project that will be at least for the next
several years, and as long as he reports not to
any of the three Surgeons General and can in point
of fact can have budget authority over the project
and his supervisor being the Deputy Secretary, I
think the former chairman would agree that that's
enough clout to get things done.

DR. KIZER: I think the important caveat
there, Ray, is that that may be enough clout to
get things going. Whether it's enough clout to
sustain in the long term I think is another question. As a former naval officer, it was always my impression that in a hierarchical organization, those with the same number of stripes or stars on their shoulders had difficulty being more equal amongst their peers and that issues were usually best resolved when someone had more stars or more stripes on their shoulder than the folks who were debating the issue.

DR. WILENSKY: I understand that kind of logic completely.

DR. KIZER: It's really not that hard.

DR. WILENSKY: The reason I had elaborated on General Myers's question was the fact that you raised it as the number one issue in terms of your recommendations indicate that at least as I would read it as a Subcommittee, you don't believe that it has as yet occurred and is the most important single step going forward. I realize that this is still in process and there is a mechanism as long as Admiral Mateczun is reporting to the Deputy Secretary, that could be
invoked if it were necessary. I didn't know whether it also meant that the budgetary authority as it now exists does not grant -- I heard him say he's accountable, but whether or not he has the authority and budget control that goes with that accountability was not clear, and I assumed by its positioning you regarded that as a very significant recommendation.

DR. KIZER: Just so there is no confusion, I would make three points. One is the Subcommittee does not feel that it has happened yet despite good intentions. I've lost the second one, but perhaps the most important aspect here is that we don't believe that the goal or the standard that Congress has set forth that it be a world class medical facility can be achieved unless that occurs.

GENERAL MYERS: I guess as you think about this, I just hope the report is fairly strong in this area and it sounds like it will be, but accountability is kind of the last thing in the chain. The first thing is you get somebody
with responsibility and authority and then you
hold them accountable, and I'm afraid the good
Admiral here, we might give him the responsibility
and not all the authority and then in the end say
you really screwed this up. That's not fair. The
corollary is that anything gets done well in this
life, there is somebody who is responsible that
has authority and then you can hold them
accountable. I have a very good feel for the
problems that you're up against.

DR. KIZER: That really was the second
point, that there is accountability without
empowerment which is a prescription for an
unsatisfactory result.

GENERAL MYERS: Right, and I guess my
point would be that this read well in the report
because I think it's an important part of that and
I think people will take notice and I think it
will help with the mission.

DR. WILENSKY: I think actually it is
stated clearly without ambiguity in the report and
is positioned number one in terms of the
recommendations, so I think both the language and
the positioning helps. But you ought to look at
the wording, and if you have any suggestions, any
of you, to try to get them back quickly to Ken so
that those comments can be incorporated.

COMMAND SERGEANT MAJOR HOLLAND: Dr. Kizer, I guess my concern is as I go through the
Committee's review it seems like an effort was put
on Bethesda and the events and all that is going
on there, but you have Fort Belvoir that's going
to be a really important piece to this. Have we
looked to the missions that Fort Belvoir will get
that are different from what they have today and
the mission that we, the medical community, going
to ask them to do in the future?

DR. KIZER: I think the short answer is
that given what the Committee looked at and
reviewed, the situation at Fort Belvoir would be
perceived as much less problematic than at Walter
Reed and I think some of the issues that you
highlighted about mission and other things are
actually incorporated in or a part of the
statements having to do with the need for a master plan and a clear vision for the Integrated Delivery Network. Perhaps that's not clear enough, but indeed you can't have that integrated delivery network with these two pieces as well as multiple others unless there is something that ties it clearly and the mission is clearly stated and other things. So actually your thoughts are embedded in the recommendations having to do with the need for some clarity about the Integrated Delivery Network.

DR. WILENSKY: Admiral Mateczun, do you want to respond?

VICE ADMIRAL MATECZUN: Sergeant Major, this is a chance for me to talk a little bit about the Fort Belvoir hospital, an extraordinary facility that's going up. It's going to be the country's leading example of evidence based design. Today it's a pretty sleepy, small hospital, about 10 beds. It's going to be 120 beds. There are a set of capabilities going there, linear accelerators for radiation oncology,
cardiac catheterization. Half of the population
of the region lives in the south and so it's going
to be a truly extraordinary addition to that part
of the region.

DR. WILENSKY: Mike and then Ed.

DR. OXMAN: I had the privilege of
attending the last I think full Subcommittee
meeting in January and I'd like to say first of
all that I was enormously impressed by the efforts
and the breadth and the expertise that was present
around the table at that meeting and was applied
to the issue. The main focus in my mind was the
issue of the physical plant if you will and
subsequent operations in the Bethesda campus. I
have to tell you, my military service is confined
to 3 years in the Yellow Berets at the NIH. My
only war wound is lymphocytic choriomeningitis,
and I'm quite naive in that respect. I've always
been as a taxpayer troubled by the degree to which
the individual services are rivals, and I think
this is an area of great importance to medicine,
Military Medical Center, not an Army, not a Navy, and there is where I think the importance of the authority structure for both command and funding, as well as obviously the responsibility for the entire endeavor, is a crucial issue. I think it's well covered in this report and I, as an independent and more ignorant and naive observer, feel that it's far and away the most important issue because without it there is no possibility of having an integrated physical plant and without having an integrated physical plant it's impossible to think of delivering world class medical care. What we really care about is delivering world class medical care. That doesn't require that every piece of the machinery that's used is the best in the world, but it requires a level of all of it and it's integration that is at least above a certain level, and unless there is that authority over funding, I don't think that's going to happen. I think that the last point in the five of stopping construction is not something that's recommended and is contingent upon rapidly
resolving the command and control of the plant and
the funding stream.

DR. KIZER: Could I just make one
comment in response before you go to the next?
Mike underscores a really important point that may
be resonating or moving around in people's heads
here in that the design and construction is only a
piece of creating world class and I think that we
addressed this well in the actual definition or
the statement about what is world class. It would
be very wrong to conclude that if you design it
and construct it to be the best that you're going
to end up with world class. Much more about world
class is about processes of care and how the
people come together and how they function as
teams and other sorts of things which can't be
necessarily designed and constructed in the sense
that the Congress was looking at. This goes to
culture and some of the more nebulous parts of
this, but it's absolutely paramount that people
understand that being world class isn't
necessarily about physical plant. It's partly
about physical plant, but largely about how people
and process come together.

DR. KAPLAN: It's quite clear that
people very strongly about how this is worded, and
General Myers has pointed out that it has to be
clearly stated. When this report is so stated and
is clear and reflects what we've heard here today,
what's its trail up on the line in the sense of
taking this message to heart?

DR. WILENSKY: Admiral Mateczun?

VICE ADMIRAL MATECZUN: Sir, generally
what happens within the Department with reports
that come from any number of places that the
Secretary is in charge of is that the report goes
back from the Defense Health Board endorsed to the
Secretary. The Secretary then takes some period
of time to review the findings and recommendations
and may or may not agree with them but lays out
then a way ahead, particularly if the report is
going over to Congress. So the Secretary would
then endorse the report back over to Congress with
what the Secretary is going to do or not do or his
agreement or disagreement with the findings and recommendations.

Then separately those pieces start working within the Department. For instance, the master plan is a recommendation. We're already in the process of starting to contract for a master plan and get it constructed in the right way, and the Secretary will say that as he sends it over to the Congress. Congress then takes it and does whatever they're going to do with it which is sort of up to them.

DR. KIZER: Gail, if I might, and this is really meant as a question, but it was my understanding that the action that was requested or that was sought from the Defense Health Board was an acceptance of the report as opposed to necessarily an endorsement. It might be difficult to actually endorse something if you've not conducted the review that the Subcommittee has, but that's a point which may warrant further discussion.

DR. WILENSKY: That's not correct. All
of the reports that are presented to the Defense Health Board are done for the acceptance of the Defense Health Board and it then forwards the report to the Secretary or whoever in the line of command has requested it, but is true of all. And at some level your comment is true of all reports that came in. The Task Force on the Future Military Health Care that General Myers and Admiral Mateczun and I participated in represented 15 months or 15 months of work. We presented it twice to the Defense Health Board, once in May in an interim form and a final report in December. You could have easily have made the same statement that spending an hour and a half listening to our recommendations would not have put the Defense Health Board in a position of accepting or not our recommendations, but indeed that is what happened and some suggestions about how wording was presented or tone were made and reflected in the final report, so that this is what the Defense Health Board does with all of its reports.

GENERAL MYERS: Just one more comment in
conjunction with clarity and Dr. Kaplan's remarks.

In reading through the executive summary again,
the recommendation is pretty clear, but it's not
clear in the findings why we come to that
recommendation. We say this isn't right, this
isn't right, this isn't right, but we never say
it's not right because we got too many cooks and
not enough bottle washers working this thing.

DR. KIZER: Are you referring to the
findings in the executive summary or the findings
in the body of the report?

GENERAL MYERS: I didn't have time to go
through the second time through the findings in
the body of the report. They looked more robust.
But what people on the Hill are going to read and
what the Secretary is going to read is going to be
in the executive summary. This is just a
recommendation. I don't have to do the work. I'm
happy to help you. There ought to be some tie
there because this is such an important issue.

DR. WILENSKY: I actually would like to
continue on the same line. You've been around
this place long enough. You know this as well as
anyone, Ken. You need to have a stand alone
executive summary on the assumption that 99
percent of the Congress is going to at most look
at the executive summary and it needs to be
coherent in terms of both the message and the tone
that you want to have delivered, and I agree with
what General Myers just said in terms of the
findings need to support why it's such a critical
number one recommendation. The other two issues
that, one of which I'd shared with you earlier, is
I believe both in terms of the findings and in
terms of the recommendations, if the Subcommittee
believes this as it said it did, that the final
conclusion has to be clear which is that stopping
the construction or halting the construction would
present many difficulties and is not necessary or
desired provided that, and then your provisions.
That also needs to be very clear and very boldly
stated. Otherwise it is likely to get lost in the
shuffle with all of the deficiencies. So there is
either disagreement or you don't believe it,
that's one thing. If you believe what is said, I
don't think it is clearly and strongly enough
stated in a way that it can't get lost.

The other issue which I don't feel as
strongly about as the point I just made, and this
is offered merely as a suggestion, I think that
you have a large enough number of recommendations
that it would be helpful if you could prioritize
the recommendations in terms of the most critical
things to have happen. As people on the Task
Force used to hear me say ad nauseam, I learned
evermously from Donna Shalala that the power of
the Dole-Shalala Report, aside from all of its key
participants having good suggestions, was having
six recommendations and that unlike some reports
that had large numbers of recommendations, those
could be put in focus, they had some sub-bullets,
but it made it much easier to have the most
important issues, clearly the most important
issues. So I have taken it to heart. It was
something Donna insisted on. You might even want
to give her a call and talk to her about some of
this. I think it is a very effective way to make sure that the most serious issues for you and your Subcommittee are very clear to the Department and the members of Congress going forward and if you want to do less than the six that's fine, but it's just a powerful way to make your message.

Let's do Mike Parkinson and then Mike Oxman.

DR. PARKINSON: Ken, congratulations to you and the Committee. I think you've done a great service for health care generally, the whole notion of world class more broadly. I'd like to reflect on two things, and in the spirit of truly trying to make the military health system if you will to borrow from one of our commanders-in-chief, the shining city on the hill, that it should be. Some of you know that I left the Air Force in 2000 and my parting conversation was then with Dr. Ed Martin who was running the Department after I had among other things worked closely with then Colonel Middleton to put together a 18-month to 2-year state-of-the-art
population health improvement plan for the entire Department. It was reporting directly to Dr. Martin with three of the senior most colonels, two of which I think became surgeon generals after my departure. The reason that I left the military was in a frank conversation with Ed Martin, that you're not organized to execute. I said as much as I love the military and spent two decades in it, you cannot execute this plan. Yet everybody in the world from George Halverson to Dennis Cortese is looking for something like we worked on in 2000. So much so that we then had Dan Fox come down from Milbank saying what you guys have done here is as big as Eisenhower integrating the Services. I'm not saying that for any personal reason, but in a decade we have not advanced is really what this case study says. I'm being a little harsh around the edges here. But now we're talking in a region within a military health system which is a regional attempt which is really where we were in 1996-1997 when we started talking about regional comments in TRICARE when we had 12
and then we had six and now we have three.

So in the words of a great philosopher who I now think is the Chief of Staff for this particular President Obama, "Never let a crisis go to waste," and I would never suggest to create a crisis where there is not one, but sometimes you do make hay where there is sun shining and I would just ask if the notice layman or congress person were to look at the deficiencies, how could we not meet JCAHO standards? JCAHO standards are not world class. They may be state of practice. I'm not sure they're state of art with all due respect to Dennis O'Leary. They're really not consumer focused which is where the entire focus of the world is going, they're really not electronically enabled, so that I don't have to go to Walter Reed, I can do it online, fill a new prescription, many of the things that Dr. Wilensky's Task Force brought to this same DHB a year ago. Is it time to say stop the presses? Again I realize there's a lot of downside and this is all about collegiality here and trying to do this, but this
is just kind of a smoking gun again.

A provocative question, a sincere motivation, been there, done that, 10 years or a decade later to my parting constructive colleagues, and I realize it's not about unified command, it's about a unique way of doing this, but I just wonder if we're not passing up on Rahm Emanuel's word, a crisis, that there may be a great opportunity, because we may not come this way again just for probably happy hour
collection.

DR. KIZER: I don't know whether that falls under the category of those that you avoid or actually try to respond to, but I will take the latter tack in a couple of ways. One is that much of the discussion that is occurring today is quite déjà vu in the sense that more than 10 years ago when Ed Martin and I chaired the Joint VA-DOD Executive Council, these issues were being discussed then. They're still being discussed, and frankly not much has happened in the interim.

My only hope is that 10 years from now we won't
still be discussing them because the train will
have long left the station by then.

There is a great opportunity here and I
think that if these recommendations are actually
acted upon, there is a tremendous opportunity for
military medicine to be the shining light that I
think many of this room would like it to be. I
think to answer your specific question, the
Committee debated and extensively mulled over the
question is it time to stop the presses and our
conclusion was that it's not if the master plan
can be developed, if the authority issue can be
resolved, if the funding issue can be resolved.
So it's a conditional no and it really is
incumbent upon the Department to find the ways to
actualize the recommendations, but at some point
in time, and I think this goes back to Phil
Tobey's comments, that at some point down the
road, and it's probably not all that far down the
road, it will be too late and then we will have to
actually come back and ask the question again.

There is a window of opportunity now to continue
moving forward if these other things are done.

Just the last point, I would say one of the reasons why the recommendations are as they are because I frankly agree completely with Gail's comments about narrowing it down, indeed I've always had a standing rule that you should not have more than five because at least most people have that many fingers that they can count on and then if you go above that it's too complicated, but one of the reasons why there as many, because the intent was to make them actionable, and I think as Admiral Mateczun commented, that this really does provide a bit of a template you can go down or a checklist if you will, was this addressed, was this addressed, was this addressed. I don't think it's going to be hard to repackage them in a way that that can be done to accomplish both, but I think the Subcommittee was of the mindset that it would really like to see its recommendations acted upon and tried to make them pretty clear as to what needed to be done but not tell the Department or anyone else how that needed
to be done because I think that would exceed the
authority and responsibility of the Subcommittee
to actually say how it has to be done. And in
many ways that's a microcosm of the thinking of
integrated delivery networks. You can lay out
some goals and expectations that have to be clear
and actionable, but in the end it depends on the
pieces and how you make it happen, and how it
happens in the National Capital Region is likely
to be significantly different than how it happens
in San Antonio or in Southern California or
wherever else this may occur in the future, and
that's part of the adage that all health care is
local. That's true to a point, but if you're in a
national system, there is also a systemization
that needs to occur and so it's that balance of
what is laid out at the top and what occurs at the
bottom that I think always has to be strived for.

DR. WILENSKY: I have the following
three people, Mike Oxman, Jeff Longacre and John
Holcomb.

DR. OXMAN: First of all, I'd like to
really agree with and underline Gail's point that
most people are going to read an executive summary
which better be short and to the point, and I
would recommend that although there may be
flexibility in time for many of the aspects of the
capital plan, there is no flexibility in time for
the construction that's currently going on on the
Bethesda campus which I walked by yesterday. As
Phil Tobey made that point, I think that I would
recommend that you take slide number eight which has
your five critical points and then no need to halt
construction if a master plan addressing the need
for backfill can be completed in a timely manner,
and there I think as a member of the Board timely
needs to be defined with a timeline if the
construction that's going on now on the Bethesda
campus is continuing to go on. The other thing I
would recommend is that you turn these points of
criticism around by adding perhaps another phrase,
for example, the organization and funding
authority are fragmented but must be concentrated
in the hands of a single person with authority.
In other words, I think this is a great framework which can be turned into more positive recommendations, but I do think time is critical when it comes to what's going on on the Bethesda campus and I think there is really little to spare.

DR. LONGACRE: We have the unique opportunity to implement the original vision of a world class medical center and a premier academic health center collocated at the Walter Reed National Military Medical Center, JTF CAPMED, the Uniformed Services University, National Intrepid Center of Excellence, NIH, with our ultimate goal being to create the very best for our deserving beneficiaries. We can do that by creating a premier academic health center that emphasizes quality clinical care, medical education and clinical and basic science research. Several members of the Board and Committee come from highly esteemed institutions that exemplify how it's excelled incorporating all three of these, so I'd like to submit that we continue to emphasize
that the NCR World Class Medical Center be looked
at as a premier academic health center. One of
the comments earlier mentioned was that in order
to grow and evolve and be on the cutting edge, and
one of the best ways that we can continue to be on
the cutting edge is to make sure that we emphasize
all three of those, the clinical care that we
provide, the basic science and clinical research
as well as medical education. Thank you.

DR. WILENSKY: John?

DR. HOLCOMB: Thank you, Dr. Wilensky.

I'd just like to make a comment that this is a
very Washington, D.C.-centric presentation. I
know that was your task. The systems issues
you've identified are largely replicated in every
other BRAC site in the country. They're not
unique. There will be some idiosyncratic
differences at each site, but the system issues
especially command and control, responsibility and
authority are the same around the country, so your
report might serve as a template for many other
places.
Dr. Longacre, your comments on world class are the ones that I was thinking of as well that we've been mumbling over here a little bit. You can have a great facility, but if you don't have great education, great research and great patient care, it's not world class, it's just a great building. I didn't see that really addressed in your slides very clearly. I don't know if in your larger report you addressed those three pillars of world class, the fourth one I guess being the building.

DR. KIZER: Again the slides didn't address a lot of things, and what I would encourage you to do is actually read the statement about what is world class and I think that you will find that all of the thoughts and ideas that have been addressed by the previous two speakers are fully embedded there, and I see several people who have read it seem to agree.

DR. WILENSKY: I agree, and I strongly encourage you to go to Appendix B to read the discussion. It's a two or three page discussion.
There is a lot of emphasis on all four of these areas. Dr. Silva?

DR. SILVA: It's really a great report, very disturbing, Ken. As you know, I've developed a couple of large hospital wings, but just from the bottom line, it's not too late to make these corrections. A lot of these recommendations are very important for a modern day facility. I guess there's a whole in the ground. Right?

DR. KIZER: It's actually being rapidly filled, if not largely already filled.

DR. SILVA: It's the renovation. Thank you. So you have plenty of time. The master plan would involve not only the integration, I agree with Dr. Parkinson that's critical how to save money. But also the budget. Do we have this thing costed out? Do we have a bottom line yet? Or is it so diffuse and in different ledgers that no one has really been able to add it up?

DR. KIZER: That's a key issue and it's impossible to cost out something that you don't know what you're costing which is kind of the
essence of much of the discussion, until there's a comprehensive master plan that addresses renovation and new construction, you simply can't put a dollar amount on it. So you got to do the plan, figure out where all the pieces are and then what the cost is going to be and then go back and look at the multiple funding streams to see what currently exists and what may be, as Ray said, the gap between the multiple current funding streams and what the price tag is. But that's something that is not doable at the moment because the necessary work hasn't been done.

DR. WILENSKY: Wayne and then Charley.

DR. LEDNAR: I have a question and then a thought. The question just for my clarification and education is we've used the term this report will be given to the Secretary several times. As a body, the Defense Health Board gets questions from a variety of sources and many times the term "the Secretary" means the Assistant Secretary of Defense for Health Affairs, but is the Secretary in this conversation the Deputy Secretary of
Defense? Is that person who will get this report?

DR. KIZER: I think that's actually up to the Department. I think the Department would be remiss if this didn't reach the level of the Secretary or at least the Deputy Secretary because it would seem based on the history of this event or this project, if you will, and the level of interest by multiple constituencies not the least of which being the Congress that we're going to hear a lot more about this in the future and certainly having been around this town a bit, it occurs to me that the Secretary would probably be well served by being informed in some significant degree about it, but that's a decision that the Department has to make.

DR. WILENSKY: I don't think there's any question but that this will go to the Deputy Secretary and Secretary. This is much too political an issue.

MR. DUBOIS: The issue is the Congress directed the Secretary of Defense to stand up an independent panel to assess and evaluate the
construction and design-build aspects of the new
Walter Reed. So technically speaking, this report
goes to the Secretary of Defense, it passes
through several hands to get there, and then he in
turn responds to his charge from the Congress in

DR. WILENSKY: Again this is precisely
the chain that went through with the Task Force on
the Future of Military Health Care which was
congressionally directed in the NDA of 2008 and
that is not that unusual in any congressionally
directed task force, commission, et cetera. But I
don't think you have to worry that this is going
to get lost somehow at a lower level than the
Secretary or the Secretary's office.

DR. LEDNAR: That's good to hear, but
now my thought, we've heard about the importance
of timing, the urgency for moving forward on the
conditionals that the Committee has identified,
this is important in answering the question about
the National Capital Region, but as the Committee
has put an awful lot of thought into the operation
of an integrated health system for the future, we have probably as I understand it by early July in the Congress proposals that will be presented, will be drafted by early July for national health care reform in the Senate. Congress is the one that asked for this report and I don't know how there's any interchange eventually of the insights of this work, but it will miss an opportunity for a much larger affect if it gets to the Congress too late. So for lots of reasons I hear there's an urgency to get this report completed, get it submitted to the Department, work through all of the hands that it has to, but it can serve a much larger national benefit if it can also get to the Congress in time for it to inform some of these other larger discussions that are ongoing.

DR. WILENSKY: I suspect some of these larger discussions are going to go on a little later than July, but it's important for many reasons that we not delay this report's moving forward. Chase, did you have a comment?

MR. UNTERMeyer: Yes, Madam President.
It's a question for you. That is, what do you see as the ongoing role of this Board in overseeing, monitoring, getting further reports in the implementation of these recommendations?

DR. WILENSKY: My hope is that this can be an ongoing activity for the Subcommittee. I'll need some advice from the Department, but because there were so many directives or recommendations of what needs to happen, there should be, in my opinion, some kind of a follow-on. I'm not saying this is necessarily a good guide, but again the Task Force on the Future of Military Health Care had its recommendations reviewed by the Department and the Department chose to accept some, not accept others. The Subcommittee that I chair is going to be monitoring the implementation by the Department of the recommendations that it has chosen to accept and presumably opine on the ones that it didn't choose to accept as to whether those issues still exist. But it may also depend on the results of this Subcommittee report going up the chain as to whether or not there's a
specific direction as to what happens next.

MR. UNTERMeyer: What I might suggest is
we make this perhaps a semi-annual item to invite
Admiral Mateczun or Dr. Kizer or whoever is
continuing to look into this matter to report back
to us on progress.

DR. WILENSKY: That would make sense,
and if nothing else occurs in a more directive
capacity, that would be the least that we could
do.

GENERAL MYERS: Just to pick on what Dr.
Longacre commented on on the university up there
on the Bethesda campus for background and maybe
some of you know this, but there was a very strong
effort during BRAC to do away with USU and we
would do all our education at other universities.
We didn't call it world class at the time, but
that that was a real adjunct to the Bethesda
campus and it did make us provide better care. So
I took your advice. I read the appendix and back
there on K it has two lines that addresses this,
or three lines or five, make it 100. It's not
enough in my view. My view is you're never going
to drive a stake into the heart of bad ideas in
this town, but you could really help the cause if
you think that university is important to military
medical care, which I happen to believe as a
layman. I can tell you my personal story. I was
threatened by a couple of anesthesiologists on the
way into surgery who were graduates of USU and
they said we know you're on the BRAC Executive
Committee. They already had me under sedation and
they were extolling the virtues of their education
there and why it made sense, and I said anything
you guys want I want. I'm being facetious. I
already believed it and I've already made my
argument. I'm not sure we don't want to make that
tie just a little -- it would be very helpful to
those in Congress and maybe even to some in the
Department to understand this value of this
integrated facility.

DR. WILENSKY: That was only the latest
threat. As those of you who have had any
involvement know, there have been multiple times
when USU has almost died. This would be under the
same rubric of advice that you may want to look at
it and see whether there is any strengthening with
regard to the language that would be appropriate.

DR. FOGELMAN: I certainly want to
endorse the six or five headlines. It's certainly
something I'd recommend. But also when putting
things together, if you add a timeline, we heard
some talk about a timeline being attached to the
master plan which I think is absolutely correct,
but I think each of these ought to have some idea
of what the time beyond which it should not be
completed might be. And at the same time, each of
these can have attached to it a measure, empower a
single official, when that happens it's pretty
clear I think, or actually there may be some
disagreement about what that means, each of these
can have some measure. The one that it seems to
me the hardest to measure, speaking as an
occasional cultural change engineer, is to begin
engineering needed culture change. That's a big,
vague thing and it's unarguable that the cultures
don't necessarily fit now and they need to be somehow made to fit better, but I'm not sure that that's an easy item to put among these. So if you have to take one out even though this one is dear to my heart, I would take that out and embed it in some of the others.

DR. MILLER: There was an allusion or statement of world class and looking at the immediate issues, but I wanted to bring up an issue about long term strategies as well. What is world class today is not necessarily what it is 5, 10 or 15 years from now. Look at Kennedy Airport when it was built and now look at it today. So the question is there actually a process to look at not only the immediate with the BRAC closure and the BRAC situation and the process that's underpinning and funding it, but also longitudinally to the future how will it be ensured that this facility which will be a legacy for the next 50 years perhaps that there is some type of maintenance process to ensure that it is still up to the standards that you have originally
envisioned.

DR. KIZER: If I could respond to both that and a few of the other comments, for example, Recommendation J is I think quite explicit in recommending that there be an ongoing review process or independent review. How that is done and whether it's this Subcommittee or some other body or whatever I think is an issue that could be debated and opined upon by others, but clearly we felt that it should. Another point is as I think has been said three or four times this morning by myself and others is the dynamic and changing nature is what is state-of-the-art and what is world class, and I think as I said quite clearly, what it was 5 years ago is different than what it is today and it's going to be different 5 years hence, and embedded certainly in the definition or the description of what is world class is that understanding and the need for continual evolution and adaptation as technology changes, as medical science changes, processes, et cetera, that this is a continually moving target.
Finally, I think the issue of the university was discussed. Indeed, the board of the university has contacted me on several occasions how wanting input and I have no problem in including verbiage about that, but I would also note that in doing that we shouldn't overlook that there are parallels, for example, the Joint Pathology Center should probably be in the same dialogue, the role of NIH should probably be in the same dialogue, and there may well be other facilities or institutions that would be in that same level of detail if indeed we go that way.

Finally, just as a pragmatic matter, several people have commented upon the urgency and the need to move this forward which we fully underscore, and I would just remind everyone that the Committee is composed of volunteers who have very busy daytime jobs and extensive other commitments and an extraordinary amount of time has already been committed and put into this and the realities of how much further effort and not to delay the process is something that we should
be mindful of.

DR. SHAMOO: I guess we have come to almost the conclusion of this. My thinking is that we approve it with a proviso of several suggestions basically most of them are tweaking such that Gail will ensure that the final copy reflects some of the comments here rather than bring it back. This way, we'll expedite it.

DR. WILENSKY: That was certainly my intention, that before we break, which I hope we will do shortly, that we approve it, but we request that you incorporate the comments that have been made to reflect the spirit of the comments as they were given.

I don't think this is a huge rewrite. I think it's some -- a little bit of repackaging and something that the drafters of the report, which -- who did an excellent job, could do in a day.

I mean, I don't think this is a long-term effort. Mike?

DR. OXMAN: Just one thing that I think is an important distinction when I talked about a
timeline, and it's a little potentially confusing
when you talk about a comprehensive design plan.

    I think the timeline that's critical is
the design plan for the construction that's going
on on the current Bethesda site.

    That's the timeline and the final plans
for that that have to be done quickly and
properly. And that's where the timeline is
critical.

The planning for how we evolve the
delivery of healthcare in the capital area doesn't
have to be accomplished in the next month or two,
but the former does.

DR. WILENSKY: Any further comments? Is
there an agreement that, subject to reflect the
discussion that we have had here today, that
people are comfortable that this report should go
forward?

Okay. Approved. Let me see a copy as
soon as it's possible to get some of these changes
reflected.

MR. KIZER: Sure. Let's talk offline a
little.

DR. WILENSKY: Thank you very much. An awful lot of work has gone into this, and we appreciate the effort that you and your Subcommittee have ably done for the improvement of this process.

(Applause)

DR. WILENSKY: Ed?

DR. KAPLAN: Short question: Will a copy of the revised or added to with the remarks be sent out to the Board members, too?

DR. WILENSKY: It will. We'll check with the Department in terms of how and when they would like that to happen.

But, yes, I'm just not sure exactly at what point in the process they'll do that.

It is 12:30 p.m. We're running a half hour behind our timeline.

If it would be possible for the Core members (sic.) -- and -- Core Board members and the Subcommittee chairs to take 20 minutes, make phone calls, and get your lunch.
We're going to have a working session.
I want to bring all of you up to date with
previous discussions that we've had on some of our
anorganizational structure issues.

We do have some administrative -- yes,
here -- we do have some administrative time at the
end of the day, if we need to use it to conclude
those discussions or to at least continue them.
This is probably not -- this is going to be an
ongoing process.

But if we can reconvene as the group
I've indicated here in 20 minutes, and the open
meeting will reconvene at 2:15 p.m. Thank you.

(Recess)

DR. WILENSKY: We're going to reconvene
for this afternoon's meeting now, and our first
speaker this afternoon is Dr. John Holcomb.

He is currently Professor of Surgery and
Director of the Center for Translational Injury
Research at the University of Texas Health
Sciences Center at Houston.

Recently retired from the Army, his last
assignment was commander of the U.S. -- sorry --
U.S. Army Institute of Surgical Research at Fort Sam Houston in San Antonio.

He is also the newly appointed chair of the Trauma and Injury Subcommittee.

Dr. Holcomb will discuss the recent activities of the Defense Health Board's Trauma and Injury Subcommittee, including a summary of the Subcommittee's meeting last week in San Antonio.

His presentation slides may be found under Tab 7 in your meeting book.

DR. HOLCOMB: Thank you, ma'am.

DR. WILENSKY: Mm-hmm.

DR. HOLCOMB: It's an honor to get up and speak in front of you all, and we'll get right into it.

So one of the first things -- I think it's important just to reiterate, probably have every time I brief this Committee is the Tactical Combat Casualty Care Committee is a subpanel to the Trauma and Injury Subcommittee, which is a
subcommittee to the Defense Health Board.

So while a new subcommittee, we actually have a fair amount of structure. The Tactical Combat Casualty Care Group has been meeting for at least the last four or five years.

It publishes a book that is the military companion to the civilian PHTLS. The PHTLS is the bible for pre-hospital trauma care in the civilian world.

Tactical Combat Casualty Care is the bible for military pre-hospital combat casualty care. Published in book form, signed off and validated and approved the American College of Surgeon's Committee on Trauma, and used in all of the NATO countries to teach their medics and in many non-NATO countries to teach their medics.

So this Tactical Combat Casualty Care coming underneath this Trauma and Injury Subcommittee, which comes underneath the DHB, is actually a very good thing and provides that group a fair amount of structure for an existing group that's been meeting for a long time and has been
highly productive, and, frankly, fairly
influential in trauma care across many countries
in the world.

The Trauma and Injury Subcommittee
membership I'll show in just a second. We've had
two meetings.

The first meeting in 3 February was
really an organizational meeting, led by Commander
Feeks and Dr. Butler, who's been -- is the chair
of the Tactical Combat Casualty Care Group.

And then we met again on the 29th of
April, and I'll provide a meeting summary. And
this question is -- I'll state again at the end --
and we talked a lot about this yesterday in the
executive committee -- is what issues do you want
us to address.

This is the membership of the committee,
and I'll just briefly go through. We have
representatives -- an ex-astronaut and a VA
representative, an issues representative, a trauma
surgeon at the national- international level from
Tulane -- Don Jenkins, retired Air Force. He's
now up at Mayo.

Jay Johannigman is in the Air Force Reserve in Cincinnati. John Gandy just retired. I'm not sure where he's going yet. Ed Otten is from Arizona. And Dave Callaway is from Boston. Peter Rhee is from Arizona, and Brad Bennett is -- has a company.

So we have a variety of surgeons, emergency medicine folks, who have really worked for a long time in injury.

The 3 February meeting agenda, as I said, was really just organizational in nature. There is one little -- one little section I'd like to highlight is that occasionally we will need very rapid approval of the minutes and comments that come out of the Tactical Combat Casualty Care Group, because there are operational issues that come up that are very time sensitive, and so for the Defense Health Board core membership is they vote to approve what we do in our subpanel and Subcommittee.

If there is an operational issue
springing from the Tactical Combat Casualty Care Committee, we may ask for rapid approval or discussion.

I'm now going to go into the agenda items, and with a lack of input on what our agenda should be, we made an agenda and had eight briefers that came and briefed us on the 29th of April.

The first was, as you can read, the Life Savings Benefits of Fresh Whole Blood. Dr. Charles Wade is the DoD representative. He's a senior scientist for combat casualty care. The title carries a fair amount of influence in the combat casualty care arena.

And what he presented was an abstract with outcome data from over 2000 combat casualties; about 400 that had received fresh whole blood, case matched controlled to about 302 patients who hadn't.

And so, 302 patients had received all component therapies, including platelets, and the other 302 patients had received all of those
components plus fresh whole blood.

And despite the fresh whole blood group being sick or by every measure that we currently use -- with injury severity score, blood pressure, heart rate, respiratory rate -- the survival was significantly improved in the group that received fresh whole blood; at a 15 versus 24 percent, which was highly significant.

Those are long-term outcome data, all in U.S. Casualties coming back through the United States.

I bring this point up, because Dr. (inaudible), this obviously would go against a little bit of the Defense Health Board policy letter that came out a year ago that really spoke to fresh whole blood and untested blood transfusions in theater; unfortunately, it didn't have any outcome data associated with it.

So we will generate this data in a little bit more standard format, bring them up to the Board, and present the Board the outcome data in the conventional format that you guys are used
to seeing.

And I think it'll be a topic for discussion for the full Board to kind of readdress with some new information.

Okay. Do you want to stop at each time and get questions? Or how do you want to?

DR. WILENSKY: Why don't we stop at -- normally, the answer would be no.

DR. HOLCOMB: Right.

DR. WILENSKY: But because particularly with regard to this issue represents a change in position or a potential change in the position by -- for the Defense Health Board.

Is there anything that people want to address? Greg?

DR. POLAND: Yes. I don't -- I didn't know any of the other individuals on the air, but you've sort of implied that they were from a variety of specialties. And I wanted to be reassured that that was the case.

I think having -- well, let me say it a different way. I think having people with some...
study and methodologic expertise in designing and presenting the results, particularly for this one, is going to be critical. A case-matched approach would not meet that definition, for example.

So I think particularly in contentious issues like that where there is the opportunity to probably even randomize people and collect data that would be definitive and for which we could claim causality would be critical.

DR. HOLCOMB: Right. So this is a great lead-in to a comment that you'll see later where we are going to ask our Ethics Subcommittee to address the ethics of randomization without individual consent in a theater of operations, which would be the population that we're speaking of, because these patients would be in profound hemorrhagic shock, many of them with head injuries, and not -- most people would feel -- not be ethical or even possible to get individual consent. Community consultation with CFR 50.24 has really been considered by the military not doable in the theater of operations.
And so what you're left with is something less than prospective -- the ability to do prospective randomized data and should we then not look at the retrospective data that is collected in the best way we can.

Dr. Wade is really a world-famous scientist in combat casualty care. That's why he's named as the senior scientist in combat casualty care for the Army; and is the first author of the study that will be presented at the American Association for the Surgery of Trauma.

So we can have Dr. Wade come and talk to us in the future, or we can have these data presented. But I think that the Board needs to look at this pretty carefully, and think through falling back on our standard recommendations for prospective randomized data sounds good, but most people feel can't be done in theater.

So then what you're left with is what should we do? I think it's a great discussion to cross committees.

All right. So next is the-
DR. WILENSKY: Steve, let me just be clear now.

DR. HOLCOMB: Yeah.

DR. WILENSKY: What is the next step on what will happen? Will this be a recommendation coming out of your Committee?

DR. HOLCOMB: Yes. What we'll do is --

DR. WILENSKY: So we will have a chance when you would present in a more fulsome way to --

DR. HOLCOMB: Right.

DR. WILENSKY: -- be able to address these questions?

DR. HOLCOMB: I think right now is, frankly, I'm learning how the process works. We had our first meeting on, you know, just a couple days ago and addressed to some topics that we have had some previous information on -- were new or fairly topical.

And I need to reformat this now in the method that you guys, the core Board, is used to seeing.

This was a fairly uniform
recommendation out of our Subcommittee that we
relook at the DHB recommendation from June of last
year based upon these outcome data. They are the
largest outcome data associated with fresh whole
blood in the trauma population that anybody is
aware of.

DR. WILENSKY: Mike?

DR. PARKINSON: Mike Parkinson. John,
first of all this is great but the whole process
has matured such that we're now talking about the
full scope of what is military medicine healthcare
in general, because this type of topic, except for
falling out of the sky in the traditional old day,
if you be -- you probably wouldn't be here.

So I'm glad that this is here, because
it's all about, you know, how do we learn better,
and give value to the troops, et cetera.

But it does bring up kind of another one
of these cross-cutting issues and that is where in
-- and it's not for an answer, but just to frame
this -- is where and how do we differentiate
ethically, epidemiologically things like what is
essentially INDs for therapy.

Now the therapy can be lifesaving. The therapy can be for vaccines. The therapy can be for -- but there's different cultures coming here, which is exactly what DoD has to come up with probably a value-added approach.

So while physicians -- I technically have a license in Maryland -- I could do brain surgery, technically -- no one's telling me I can't, but I don't.

Likewise -- but I mean the broad scope of life saving license that we're given as doctors or surgeons or as combat casualty care specialists in the field, where, and if, does that ever cross over into experimental therapy and IND type of thinking.

And that's where I think we're churning here a little bit, which I think is a great discussion. There is no other place in the world that probably would have it in a constructive way than the DHB.

So I think it's great. And so I think
it's wonderful that this dialogue may occur in the future, not only for this, but for other issues.

And I think in classic fashion a rising tide will lift all boats. There will be great things that come out of this dialogue.

DR. HOLCOMB: Yeah. Just to continue that for a second, whole blood actually is an AABB-approved product. It's the American Association of Blood Bankers.

So for whole blood, there's no need to have an IND, which brings a whole different discussion into play.

And so it's an approved product. It's been a long-standing product; been in the policy for the DoD since World War I.

If you look at any of the policy and field manuals, et cetera, the walking blood bank is in there.

In addition, one of the things that's not widely appreciated or discussed is that the amount of testing or not testing that's not done on whole blood is equivalent to that for apheresis
platelets.

So the component therapies we use in theater include apheresis platelets, which has the same level or not of testing that whole blood has.

So many issues around this, and I think it's worth discussing the depth and breadth of these issues in an open fashion. And that's really the reason to put that number one on that agenda item.

Traumatic brain injury obviously absolutely crossing the Subcommittee efforts here. We looked at the impact of concussion and potential prevention.

Again, Dr. Wade, representing the combat casualty care scientific community from the Army and Lieutenant General (retired) P.K. Carlton, the Air Force Surgeon General, almost two times ago now, and talked about a very simple prevention measure that we discussed a little -- that we alluded to this morning.

If we are just talking about concussion, the pads that are in the helmets at least in three
independent studies that have been conducted previously show up to 90 percent improvement in concussion prevention using standard, testing measures.

Just by taking the pads that are currently in the Army combat -- or the ballistic helmets and replacing them. So a fairly cheap, a very simple thing that's begun in place in theater could decrease concussion significantly.

And, ma'am, I do think this is -- you know, General Sutton signed on to bring people to this Committee and welcomed the opportunity to bring folks in front of her to talk about why or why not this hasn't happened.

And I think we ought to work with her and let her lead those efforts to bring folks together.

We would certainly welcome the opportunity to help ordinate those I think from our Committee and with General Sutton.

The Transition Military Care Guidelines,

the civilian sector Dr. Rick Hunt is an emergency
medicine physician at the CDC, who -- he and I
have been talking for some time in a different
forum, and I thought this was a great opportunity
to bring Rick and his group to this Committee.

As many of us have discussed, there are
lot of lessons learned in combat for military
medicine that should translate into the civilian
sector, and they have. The history is replete
with these examples going back as far as you can
document, back to the time of the Roman legions --
it's easily documented.

And I don't think this war is going to
be any different. I think that as opposed to
diffusing from the military into the civilian
sector, the civilians should pull, and the
military should push those lessons.

I think everybody expects future
terrorist activity to occur on her soil again.
Most people expect that to be remarkably similar
to what we're experiencing in Iraq and
Afghanistan.

The U.S. military has the world's
experience in those type of injuries right now, and those -- that experience can be pushed and pulled into the civilian sector and I think we would like to see more of this effort come forward. And again, we're not ready to put forward the white papers yet, but we will present that to the Committee.

Dr. Howard Champion, many of you all know, who lives in this area, has presented on data-driven changes in personal protective equipment. For those of you all who have worn all the body armor, all the PPE, it's heavy and it's bulky, and for the area that it's on your body, it's highly effective.

And so, people have been -- they may not like it when they go into the first firefight, but they certainly wear it on the second. All right. And I'm sorry, Major, would you agree with that?

MAJOR HOLLAND: Yes, sir.

DR. HOLCOMB: Unfortunately, it's not -- those things are designed with data. They are
really designed in an absence of medical data. And with computers now and with our software platforms, you can actually plot out on 3-D diagrams of a body where the holes are.

And you can plot out -- you aren't going to be able to cover all the holes on this body, but you can take 3,000 or 4,000 casualties -- and this has all been done -- and plot out where the majority of the holes are.

And if they're right around where that body armor is coming you would then go to the material developers and the guys who have to wear this and say, "Look. This area has one hole."

And they'll say, "No, don't cover that. But this area has got 10 holes, and it's a truncal area that is -- right underneath that is a big blood vessel." And they might want to then cover that area.

So you can drive developments in body armor with data, and think this would be a great topic for us to look at as well when we're ready to bring that forward in the right format.
There is -- most people are surprised that there's not prospective randomized human data for hardly anything we do in the trauma world. The ABC's that everybody's heard of -- airway, breathing, circulation -- has essentially no data associated with it.

And that's not changed by this war, as we were just discussing. We have a lot of retrospective data and no prospective randomized data.

As an IND holder and they -- right before the war started in all the countries surrounding in Iraq, those -- that concept of prospective randomized studies in a theater of combat is extremely difficult and likely ethically, I feel, not doable.

So where are going to do this? Well, I think we should do this in the civilian community. I think that the DHB will -- when we bring forward the proposal -- hopefully will look at this very clearly and we can then send soldiers into combat and have their care driven by data in an
academically sound fashion so we can maximize their outcomes.

The last two really deal with systems and data as well -- institutionalizing the Joint Theater System.

You know, in Vietnam, redeveloped trauma systems and helicopters and moving folks rapidly off the battlefield with a helicopter scooping and running and bringing them to a hospital, and had rapid surgery done within 30, 45 minutes -- from those concepts bring the trauma centers that now populate the United States and are the subject of many reports from the Institute of Medicine publications and the New England Journal, et cetera, describing improved outcomes when trauma centers are implemented in a region to take care of trauma patients.

It's not just the surgeon turning his wrist just right at 2:00 a.m. It's all the things that go around that guy to bring the patient laying on the table, so that the surgeon can turn his wrist just right at 2:00 a.m. that really
improve outcomes.

So at the beginning of the war, we didn't have a trauma system. We had a system to develop in Vietnam. We gave it to the civilians, and in the intervening 40 years, 50 years, forgot how to do trauma systems in the DoD, which is the conversation, Gail, as we were talking about I had with General Peak.

When he was the Army Surgeon General, he wasn't very happy about that. He asked us to implement a trauma system, and we spent a lot of time doing that or the DoD spent a lot of time doing that over the last six or seven years.

The trauma system has clinical practice guidelines. It has a registry. It has education. It has research. It has performance improvement, rapid feedback, and really all the elements of a fairly mature system, as defined in the United States and around the world.

Unfortunately, it's still operating in a temporary structure within the DoD. And most people -- the three Surgeon Generals, the
Department -- everybody kind of feels this is a good idea. I think we need to help the DoD and recommend to the DoD that this system be institutionalized and made permanent.

And that is a memorandum that we did send to you yesterday. So, we need to get it out to the whole Board and ask the Board to look at. I think this is a fairly easy thing for us to recommend. The Departments are funding this already. And we just need to help them institutionalize it.

And hopefully, as the war gets smaller, then this system will decrease, but still remain the capability to expand when the next war comes around the pike.

And then, Dr. Kaplan, this briefing actually sprang from the discussions we were having by e-mail. We -- there's not a really good infection registry like there are in the hospitals.

Now we are having folks who get injured in multiple places in Iraq and Afghanistan or in
Africa or elsewhere move through a fairly complicated three- or four- continent wide evacuation system with multiple cultures and multiple antibiotics being started and stopped and taken at each level.

And that system doesn't communicate from an ID point of view all into one central repository. And we have lots of ID folks here. You all know Colonel Clint Murray knows a little bit about this at multiple levels.

And I think it will be a real opportunity to take the leap forward in how best to treat our combat casualties and what infections they really do have and what infections really are problematic as opposed to -- and this is my personal bias -- what gets published in the newspapers and the Washington Post and gets on CNN; and try to do that in a data-driven fashion.

So those were our eight issues that we went over. They're all -- will generate, you know, one- or two-page executive summaries -- white papers -- that at the appropriate time when
they're ready we'll send forward.

We did discuss the major issues for --
our major issues on this is, as I said, we'll have
multiple white papers. We wondered how we would
interact with TBI, Ethics, and the ID Subcommittees.
I think we've answered that over the last day and
a half, and we'll affect those discussions.

We did discuss new agenda items. And I
don't think we are quite done with the old agenda
items. And before launching the new big ones, I
do want to finish those. I think they are
important.

But there are many things to do here --
many opportunities for discussion on prioritizing
research, you know, from our Trauma and Injury
Subcommittee point of view.

We really don't know what happens at the
medic level. So at that point of care, honestly,
there's not a lot of understanding of what happens
-- when it happens, what was done, what works
well, what doesn't work well.

And that needs to get integrated into
the joint theater trauma registry.

There's not an evaluation. Every trauma center in the country evaluates every death as being preventable, potentially preventable, or non-preventable.

So every -- there's 1,200 trauma centers, and they all do it the same way every week and put it into their trauma registry.

We don't do that with every death. And I think that we probably, as the DoD, the DoD probably needs to do that because that really drives performance improvement; it drives research; it drives improvement to clinical practice, because there are potentially preventable deaths that occur pretty frequently.

In the Journal of Trauma last month was a paper by Matt Martin that documented that 40 percent of the deaths that occurred in combat support hospitals were likely potentially preventable -- 40 percent.

That's a number that's replicated in many trauma centers around the country. And then
we would like to go to hear issues from previous
level-three, -four, and -five commanders and see
what their issues are versus what we think the
issues are.

Dr. Butler I think can describe changes
in the Committee on Tactical Combat Casualty Care
process, after integrating it into the DHB and how
that's working.

There is lack of service compliance with
TC-3, and we can define those areas, and then we
do need to really merge this actual medical data
from an intervention point of view on research and
medical care in theater from the AFIP on the
deceased.

Our next meeting will be 5 August 2009.
Ma'am, you're invited, as any of the members of
the Core Board are.

We'll be meeting with the Tactical
Combat Casualty Care Committee -- that works out
pretty well for us -- sometime in November, and
then obviously tentative agenda items pending
feedback in both directions from our subpanel and
from the Core Board.

Any questions?

DR. WILENSKY: Any questions that anyone has? Yes.

SGT MAJOR HOLLAND: Hey, sir. It always amazed me that the care on the battlefield was just always great and all, and then when we get in our command tent and whatever and we have the entire staff there, it seems like my JAG and my medical folks if they're a little testy at one another, they really get at one another.

And so, as much as we can about any of these processes that we feel like need to be as clear as possible, you know, when we need to try to help there, because if not, we're going to continue to always have this JAG-legal debate with the medical guys.

DR. HOLCOMB: Yeah. Sir, I mean, I think that most of these items need to be turned -- we need to turn a lot of this -- the way the line guys -- and the line guys, for those of you all who haven't been in the military, really drive
everything. The medics are advisors on the battlefield and recommenders.

They don't really drive much, and I think, Sergeant Major, you're shaking your head yes.

We got to put -- I think that recommendations need to come in the words that the line folks understand, and that would largely be with a unit status report, the USR red, yellow, and green.

And line folks understand that. General Meyer, you know if your fighter airplanes weren't up, you had a red. That was a big deal. And they understand that.

Prevent potentially preventable deaths might-- should be a yellow and preventable should be red. And that will get some attention. Okay. We just got to speak the right language.

DR. WILENSKY: Any other questions or comments? Yes.

DR. PARISI: Joe Parisi. I think there's some real -- first of all, thanks for your
report. That was very informative.

I think there's some real opportunities here for cross-fertilization with other federal agencies, and in particular the evolving JPC.

You've already mentioned the medical examiner as part of this, but the JPC also has a repository of infectious disease tissues that you may or may not be aware of, but potentially can provide some expertise in interpreting some of the changes.

DR. HOLCOMB: Right.

DR. WILENSKY: Any other comments or questions? Adil.

DR. SHAMOO: Maybe the DHB sometime should consider the following question: What quality data and what type of data one uses in order to effectuate change in public policy versus an individual case or group, small group case, because public policy you have somewhere between one million to a hundred million. People are going to use that.

What quality data? Is it -- I'm just
going to throw this number -- things around type
I, which is randomized double control trial; okay
-- double blinded, I'm saying.

And sometimes, you cannot get that, so
you get lesser than that -- type two and type
three.

Type three is expert opinions, which, to
me, is worthless, but anyway, because who are
those experts and who chose them. Who chose them?

But for changing public policy, DHB, I
mean, public policy within DoD, what quality of
data DHB thinks ought to be used for changing
public policy?

Is a case study, for example, of 20
versus 26? I'm not saying either way. I'm
just saying this board can look at the literature
-- what's available -- and nobody has made that
linkage really between type of data versus public
policy.

DR. WILENSKY: I'm not sure this would
-- I mean, this will be if at all one of these
summer institute notions. I think it might be
better to have this discussed on an issue by issue basis, because it really will depend on the urgency of the issue and the amount of data available and likely to be available.

It's also an area -- yesterday I was at a meeting on pragmatic trials, and the whole issue and debate going on between the Basians and the Frequentists in terms of the type of tests that ought appropriately be presented as part of the FDA submissions.

So I don't -- and very interesting debates going on about whether the type I, type II, type III data is a worthless concept. A very interesting lecture that was given is the Harvane ratio by Sir Michael Rollins in October, which I have a copy and can e-mail to you if you want that looks at that whole hierarchy of evidence.

But the issue is a serious one, and it was obviously at least part of the issue with regard to the whole blood dispute. So I think we ought to be mindful that the soundness of the data is an issue we need to consider whenever we are
looking at a study or recommendation.
And if it is not in our opinion adequate
to answer the question that's being posed, then we
ought to be willing to say that it's not an
answerable question at present or the best
evidence suggests one course, but it's of very
questionable scientific value -- so I -- rather
than doing a general one. Greg?

 DR. POLAND: I would agree with that.
And, in fact, there are well-established, heavily
vetted, well accepted standards of evidence. And
I think that for -- I think the answer is actually
pretty easy: We make recommendations based on the
data we have, but we're honest enough and
transparent enough to say at what level of
evidence is this recommendation coming from.
And so, there are standards and matrices
of how to do that.

 DR. SHAMOO: I don't want to argue the
point, but that's not really my question. She
addressed my question. Your comments are well
taken. I am -- what I'm saying is at what stage
it becomes a public policy.

   Even if it's one clinical trial or two

or four or five or half or case study, whatever,

that's the question I'm asking.

   Nobody -- and there is no paper has

addressed that issue. When do you transfer that

data into public policy?

   DR. HOLCOMB: I'd just like one last

comment on that.

   DR. WILENSKY: Again, I think that we --

this is an issue. It's a serious issue, but we

ought to take it up on a case-by-case basis.

   Excuse me.

   Any other questions?

   DR. HOLCOMB: Yeah. Just one comment,

if I may. The data that drove massive

transfusion, which is what we are talking about --

and this is really getting down into the weeds a

little bit -- but the data that drove massive

transfusion at least in North America through ATLS

was a single paper from 1985 that had 21 patients

in it.
So a single paper from 1985 with 21 patients with no control -- not even an attempt to make a retrospective control group, a case match, and all the problems that that entails really drove therapy for about 40 years.

And on the whole blood point of view and it's interesting to go back and read these older papers, you know, that are referenced that most of us don't have time to do, and see how -- what -- how they're really designed and what the level -- the quality of the data really are.

It's hard to find in a surgical patient a paper that says whole blood is bad. It's really difficult to find a bad outcome associated with whole blood. Thank you very much.

DR. LEDNAR: Thank you, Dr. Holcomb.

Our second speaker this afternoon is Dr. Greg Poland.

Dr. Poland is Professor of Medicine, Molecular Pharmacology, Experimental Therapeutics, and Infectious Diseases, as well as Director of the Mayo Vaccine Research Group.
Dr. Poland also serves as the Chairman of the Defense Health Board Subcommittee on Infectious Disease Control. He will provide the Board with a presentation on the findings and recommendations of the Vaccine Safety and Effectiveness Work Group from their initial meeting.

The Core Board has been sent a draft of this report on April 29th for review in preparation for discussion and vote today. You may also find a copy of the draft report in your meeting book. Dr. Poland's presentation slides may be found on Tab Eight in the binders.

DR. POLAND: Although there are some changes to them. Thank you.

Let me just take you through this. We were requested to form a workgroup that had, in many ways, and impossibly broad set of objectives associated with it.

One was to discuss post-licensure vaccine safety, effectiveness, and surveillance
studies. There are whole federal agencies that
devote all they do to just that; review and
discussion of published and unpublished data from
DoD vaccine research; vaccine safety,
effectiveness, and surveillance studies, with a
focus on FDA-approved vaccines.

And we were to provide guidance and
advice on what studies should be done, what the
priorities were, identify research gaps, and areas
of research that should be further developed.

Myself, Ed Kaplan, Joe Silva, Mark
Miller, Dave Walker were in attendance there down
at USUHS in June of last year.

A couple of things that went into our
work understanding -- and I say this in the way of
context -- is that short of actual injuries due to
being on the battlefield, no other issue has
impacted force health and readiness more than
infectious diseases.

It is -- we are informed by history over
and over on this particular point. And from that
perspective, surveillance issues are important.
The other thing is that for some vaccines only DoD can provide answers to issues that sometimes immediately, oftentimes mid-or longer-range, become critically important to the public, for example, anthrax vaccine safety.

That is not a vaccine that's used in the civilian population, with a few exceptions.

So understanding the safety of that is only going to be done because of the fact that that vaccine is administered in the military.

It was the military that picked up on the myopericarditis issue and defined it for the modern-day use of smallpox vaccines. The safety studies being done with ACAM 2000 are only going to be done in the military.

New vaccines that might result, like vaccines against viral hemorrhagic fevers, as you might imagine, are going to be done within the military.

Similarly, the idea of multiple simultaneous immunizations, while done outside the military, has been an issue of particular concern.
within the military and would inform public
policy.

Oops. Did I skip a slide there? We had
a number of briefings. I won't read them all, but
just in an attempt to show you that we got a wide
diversity of opinion and of expertise.

There were some specific issues that, I
think, brought about the charge to us. One was
enhanced interactions, coordination, and
collaborative efforts across DoD with respect to
vaccine surveillance; external validation of
vaccine research initiatives, which we get much
into; and particularly there were concerns that
DoD had been dealing with actually for some time
in regards to anthrax, smallpox, and influenza
vaccines.

Some of them were recipient concerns
regarding long-term safety, reproductive health
issues, hospitalization, et cetera.

Another issue was, to some degree, the
lack of cross-specialty interdisciplinary research
when it came to reproductive health studies and
vaccine recipients.

ACAM 2000 was coming on board, and continuing issues with adenovirus vaccine.

So I'm going to take you -- the way we organized our work -- and, again, a little bit of background -- in 1999, the then AFEB spent about two years -- I'm looking at Roger, who's just joined us -- working on this issue. We had outside contract support, and we did a mammoth study of cross -- a deep and wide study -- across DoD on vaccine issues.

So we went back to that '99 report and used it as a checklist to begin our work.

The format for the report -- we just sort of used green, yellow and red lights, with green meaning significant progress; yellow meaning there had been some notable progress; and red, little or no progress.

That, by the way, was published as a monograph and resulted in a series of 12 major recommendations. I'm going to run through them quickly with you.
So recommendation one was that policies and practices that ensured the ready supply to the military of vaccines essential to the mission be developed with a watchdog organization within DoD, funding of collaborative projects.

And the question had been raised about a government-owned or maybe a government-operated manufacturing facility. And we sort of rated that as some notable progress had been made.

In particular, MILVAX had been in operation by this time, and they were monitoring the supply situation and engaging other DoD entities.

Adenovirus vaccine project was funded, but, as you all know, we -- that has just had multiple delays.

And the one area that we did note here was that new vaccine development was inadequately funded and slow.

That's not a reflection on the quality of the research. It's to say there are 30 agents and enough money to do -- pick a number -- a third
of those well.

Recommendation two was to further develop and expand efforts towards standardized and computerized record-keeping and tracking, including the ability to rapidly access information -- standardize this across services and facilities.

We thought substantial progress had been made here, but there were still -- there was still some significant work to be done, some included shipboard systems, even for routine vaccines and trying to understand what people had gotten and not gotten; the ability to track family members and retirees; to exchange electronic immunization records, and the ability to give retirees and separated personnel access to their immunization records.

And at the end of this, I'm going to ask Mike to make a comment or two on that.

Recommendation three was that services should measure and report up-to-date immunization rates as key indicators of medical care delivery.
in force readiness. The particular issue of
immunization rates of the troops had been done.

There was some remaining work in terms
of immunization rates of communities based on age
or underlying risk factors; and some issues with
getting timely data on National Guard and Reserve
components.

Recommendation four was to consider some
sort of a vaccine or immuno-biologics oversight
board, and this had been achieved primarily
through MILVAX, who we thought had performed
really an outstanding job in synchronizing and
coordinating programs among the Services.

Recommendation five was developed and
disseminate a new joint instruction, and that was
also done. There was some issues about screening
for immunity, which we thought had been achieved
with great success in the Air Force and Army, but
there were some remaining issues for Navy, Marine
Corps, and Coast Guard.

Recommendation six was address whether
current procedures and resources were sufficient
to ensure personnel were aware of current official vaccine policy. There were a number of issues identified there over time and historically; and again, substantial progress, primarily through MILVAX.

This will never go away. It's an ongoing effort to educate providers, medics, troops, family members, et cetera.

Recommendation seven was committed to informing every service member of the health risks, personal and military benefits, and proper use of vaccines and other medical countermeasures. And again, we felt that there was substantial and admirable progress here, primarily through MILVAX.

And we had some minor suggestions that are not relevant to today's suggestions -- discussion.

Recommendation eight was address issues of standardized training and proficiency of immunization delivery practice.

And, again, substantial progress here, in particular Immunization University and the
quality improvement tools, we thought, really were precedent-setting; and, in fact, are now the standard in the civilian world to try to match that. So nobody actually was doing it better than the military.

Again, this is always an issue, because you've got people rotating in and out, so it's an ongoing effort to try to get 100 percent of people trained up towards standardization.

Nine was developed a policy statement for how vaccines and other immuno-biologics might be used in the specific case of humanitarian missions. And that, by that point, had not been achieved. I don't know if there's been further progress on that.

Ten was maintained the current centralized procurement system while at the same time providing some flexibility at the local level. And, again, we were quite pleased with the progress that we have seen demonstrated there.

Eleven was continue to participate in the development of a comprehensive pandemic
influenza planning document -- boy, were we right in tune with what was going to happen just a year or two later -- and devise, disseminate, and test a DoD-wide plan. And this -- just huge progress in this.

One sort of minor thing, but we still gave it an A grade there, was for DoD to be very visible and sort of have a seat in interagency deliberations. That's actually a continuing concern among the Pandemic Response Committee.

Number 12 was review faxing policy, practice, and use recommendations every two to three years instead of letting it get to four or five just because everybody's busy with other things.

So overall, we tried to assign a letter grade, and the letter grade that we gave to DoD was an A for the substantial progress in virtually every area.

In fact, the only area where major progress had not been officially made was in the policy statement for use of vaccines in
humanitarian missions. Not that there were huge
issues there. It's just that there wasn't a
written policy.

We saw some opportunities and that's to
further enhance the electronic immunization
tracking system, the humanitarian policy I
mentioned, ensuring availability of all vaccines,
and adenovirus remains the poster child for that;
certification of vaccinators; and a larger one,
enhancing vaccine safety research capability.

So this is the background then to the
recommendations that we have made after spending a
day hearing the briefings and catching up on what
had happened within DoD.

So, we noted continuing delays in
adenovirus vaccine deployment; lack of vaccine
immuno-genetics research work done within DoD.
And this came about primarily one, my own
awareness of it, but, two, as personalized and
individualized medicine is pushing forward and
industry beginning to use this in the directed --
or some call it rational -- development of
vaccines.

DoD wasn't participating in that. It was hard to find good examples of Guard and Reserve components being included in safety studies. Now, from a scientific point of view, there's no pressing reason to include them.

The reasons to include them are really sort of non-scientific, and that is to answer concerns that that Guard and Reserve members specifically have and feel sometimes outside of the mainstream active duty types of studies that were done.

There was no established -- it doesn't mean it didn't happen de novo here and there -- but no overall established post-marketing entity within DoD for vaccine safety research.

And some of them, ACAM is a good example of where this is happening, but where it could only happen in DoD, when you're going to enroll whatever it might be -- in fact, for one study with an avian influenza vaccine, 40,000 people are going to be enrolled in a study. That's hard to
do, with the exception of Mike's study, outside of
the DoD.

And we wanted to say in writing and I'll
say it publicly today that MILVAX we thought was
just an outstanding asset to DoD.

So specific recommendations that came
from this first set of meetings that we had was
that prioritization of research, given the limited
time, personnel, and other resources was
necessary.

We saw this also -- and you'll recall
this from when we did the Bio Defense or Bio
Surety recommendations.

There's an overwhelming amount to do,
but a limited amount of resources. So it has to
prioritized.

Particularly in the issue of vaccine
safety, which is something DoD has had to spend a
lot of time, resources, and man hours on, we
thought it was time to really develop
cross-disciplinary approaches in teams, for
everyone, including a cultural anthropologist or a
psychologist in some of these teams -- people who understand reproductive safety research, which is not something we standardly get trained in.

Because of the importance of phase four safety research, we thought this was best done through some sort of central entity.

Our tentative recommendation was that MILVAX would be an appropriate place for that, to address long-term health concerns, and to carry out or at least to provide oversight.

They may not be the ones actually doing it, but provide the office for reproductive and pregnancy studies.

Some of these are fertility questions, for example, that people have. And then particularly when it came to AVA, DoD was the leader in anthrax vaccine absorbed research, but that, we thought, despite that locus of expertise needed to become diminished in intensity because of new anthrax vaccines coming online.

So it's not to take away from the research in anthrax, but not so focused on one
vaccine.

Next, develop the capability for immuno-genetic vaccine research. We specifically pointed out where we thought the -- and this was a recommendation to consider. We didn't, in the course of a day, have enough time to say, you know, we've looked at this inside and out, and MILVAX should be the one.

This is our impression that we're wanting to put forward; that we thought the MILVAX role should be considered for expansion.

They could be the coordinating office for phase four research, the coordinating office for vaccine safety studies and for Guard and Reserve studies.

And in some ways, and I think both formally and informally members of the group that were involved in this have expressed this; it's a little hard to understand, in part, because it's evolutionary what the boundaries and roles are of organizations that sometimes are playing in the same arena -- NHRS, MILVAX, the Health
Surveillance Center, VHC, and others -- and how might those be best integrated.

So to try to summarize that down using Gail's rule of thumb, I'm going to use a Midwest farmer's hand -- I think I got three or four here; okay?

One is to put this sort of together create an interdisciplinary, cross-specialty, collaborative, joint effort to answer significant questions. These include long-term safety studies, reproductive studies, phase four studies, and immuno-genetic research.

The second was we thought there were significant opportunities for DoD to conduct pre-licensure clinical studies and provide rapid answers to important questions that are -- important not only to DoD, but to the public.

To do that, again, you'd need a centralized office with authority and accountability, and lest I not point this out, it's in DoD's interest to materially assist with moving vaccine candidates to FDA licensure,
because we want to use them in DoD, and we're not going to use them short of some sort of an EUA type situation.

So it also provides funding, provides expertise and training opportunities, et cetera.

The third was an external advisory group of some sort to help with prioritization. Often, among their largest roles might be to provide external validation and assessment of efforts.

It's hard sometimes -- I know this is true in my own institution -- to say to my colleagues, you know, this is really no longer a productive area of inquiry. We need to sort of sunset that area and build up a new area that's coming.

That's hard to do internally. It's easier to do with an external committee.

And opportunities to further involve academia and pharma.

And then next steps, we thought there were some further meetings that would be likely to be productive, including agendas specific to
particular vaccines -- anthrax and smallpox in particular; overall integration, coordination, and management of vaccine surveillance efforts; and then prioritization, as I mentioned, of research efforts.

And I think that's it.

(Applause)

DR. WILENSKY: Are there any questions for Dr. Poland?

DR. POLAND: Mike?

DR. OXMAN: Have you integrated plans to involve the Millennium Cohort, the Millennium Cohort in this for post -- you know, for phase four studies? It's an ideal group to look at.

DR. POLAND: Well, it is and it isn't, depending on what the research question is, because that's not the actual intent of the Millennium Cohort, and they are widely dispersed after they're enrolled, as opposed to a group that you're going to have available to you, for example, for blood tests or something over a six-month or a year or two-year time period.
So we didn't specifically address that. The only place it came up was in the integration of efforts with NHRC, who's sort of taking the lead on that, as you know, on the Millennium Cohort studies.

But yeah, you know, that would be a potential opportunity.

DR. WILENSKY: Wayne?

DR. LEDNAR: Wayne Lednar. Greg, you identified in your discussion that one of the opportunities is developing a humanitarian vaccine policy.

DR. POLAND: Yes.

DR. LEDNAR: I'm wondering, do you think we are becoming adequately informed about what some of the infectious threats might be? So I was thinking about our first briefing this morning on global operations.

It's becoming, you know, a fairly substantial part of the operations of our military around the world, and are we getting the right kind of data to learn from that experience, to
inform potential vaccine policy?

DR. POLAND: We didn't look specifically at that. I guess I would say outside of this meeting from other meetings we've had that yes, there's a lot of surveillance data available.

This really pertains more to -- how to say it -- suspend the Western way you've been taught to -- you've been taught to think; okay? Of course, it's good to prevent disease; okay?

Well, we go to the Philippines, and we provide vaccines. And what do they think? The military is providing vaccines that have reproductive control measures within them. It's crazy. It's fantasy thinking.

But who would think of that? We wouldn't think of that. I'm very heavily influenced by the story my dad told me, where they went through -- during Vietnam -- and immunized a village of Hmong and shortly after that the NVA came through and every child that had an immunization mark on their arm, they held the child down and amputated their arm. It sent a
strong message about cooperation with Americans.

Now that's not -- that's sort of humanitarian in the intent of the Navy folks that went in there to immunize them, but they're just issues surrounding that.

Those are rather dramatic ones -- but issues surrounding that -- record-keeping, surveillance, et cetera -- where you need a policy, because you're going to go in there once, assist, and then you're leaving with no intent of follow up.

DR. WILENSKY: Other questions or comments? Yes, Chase.

MR. UNTEMEYER: I'm just curious to know from an immunological point of view why are the Guard and Reserve any different from the active force?

DR. POLAND: They're really not, and that's why I say it's not so much a scientific issue, although you could argue sometimes that they might be older or less active, et cetera.

But it was more sociologic in them
feeling that they were excluded from some of the studies; them feeling that they are different, and, you know, their concerns not being taken into account.

So it was just to try to include that, but not necessarily on a scientific or immunologic basis.

DR. WILENSKY: Mike?

DR. PARKINSON: Yeah. Thank you, Greg.

Mike Parkinson.

There's -- as I think about the scope, the charge of the Committee, and what's happening in the external world, this whole area of risk communication, not just around vaccines, but also around all pharmaceuticals, is huge right now.

And I know pharma is dealing with it.

FDA certainly has got a mandate to deal with it.

So there may be, as your Committee moves downstream, there may be an interface around not just monitoring safety, but risk communication in a way that could be very synergistic with national need.
It's something you've always dealt with with anthrax and vaccines, but now it's for chemoprophylaxis; it's for antibiotics; it's for antidepressants -- a huge issue. And I think we can shed any light on that based on --

DR. POLAND: Great question. And I think nowhere did we learn that more than with anthrax, and AVIP and then subsequently MILVAX were critical in addressing that. I did want to just ask Mike if he wouldn't make a couple of comments, and he may even want to give a few examples, particularly about the immunization tracking.

MR. KRUCHAR: Yes. Thank you. Michael Krukar from MILVAX.

That is probably one of our biggest pressing needs is what we need is an effective universal immunization tracking system. We feel that this would be the basis for all future -- potential future resource.

Really there is not that type of mechanism that we have effectively used in ALTA
right now.

I know that Dr. Holcomb, probably his last talk as an active duty soldier last year, very passionately explained the problems with ALTA that we presently have. And our senior leadership clearly heard that message, and they are trying to work the issue now. But that is probably one of the biggest hindrances that we have that's facing us presently right now.

DR. WILENSKY: Other questions or comments? Yeah. Oh, sorry. Dr. Ludwig?

DR. LUDWIG: Sure. Thank you. You know, I look at your specific recommendation regarding prioritization of research given the limited time, personnel, and resources.

And I couldn't agree with you more that prioritization is very critical. But I did notice back and looking at the briefings that you got that you actually didn't receive -- at least it doesn't appear that you received any briefings from the military infectious disease research program.
And I would just point out that that program is very highly prioritized and what direction it works towards, mainly because of the issues you pointed out -- lack of resources. And that prioritization is very highly threat-based and very thoroughly worked through.

I just wondered if you had visibility of that, and, if not, to make sure that you looked in that direction to make sure that you did get visibility.

DR. POLAND: Fair point. No, they were not -- we did not get briefed by them in that particular arena, although we'd had interactions with them prior to that.

And this was sort of focused on vaccines, not pre-vaccine research work, and on FDA-licensed vaccines. So we sort of viewed them in the context of this set of briefings as we before that period or that point.

DR. LUDWIG: Yeah, fair enough. Thanks.

DR. WILENSKY: Any other questions or comments? Thank you very much, Greg.
DR. POLAND: So we're -- were we going to vote on this, I think?

DR. WILENSKY: This.

DR. POLAND: On the -- this was --

DR. WILENSKY: On the assessment or the action items?

DR. POLAND: -- on the action items, because this was meant to be our report back to the DHB for approval. Thanks, Mike.

DR. WILENSKY: Okay. You're asking then for --

DR. POLAND: Am I right about that?

DR. WILENSKY: -- well, I didn't -- no, I actually had asked Ed whether this was a vote, and was told it was not.

DR. POLAND: Oh. Okay.

DR. WILENSKY: That it was just an update, which is why I'm hesitant.

DR. POLAND: Okay. Well, members of the Committee all had -- it was vetted with them, so I guess it was to just get your all's approval before this gets signed off on as a letter and
then forward it up the chain.

DR. WILENSKY: Is there -- well, in that case, if it's going up the chain, then we need to have the whole Board opine.

This is the specific recommendations, of which there are the six specific recommendations or --

DR. POLAND: There's -- well --

DR. WILENSKY: -- the comments? It's not clear to me what you're asking us to approve?

DR. POLAND: To approve this report so that it can then -- and the letter that accompanies it, which had been circulated so that it can be signed off on.


DR. POLAND: Thank you. And again, the Committee, I think, just wants to publicly give its congratulations to MILVAX for a job well done.

So.

(Applause)

DR. WILENSKY: Our final speaker this
afternoon is Dr. Ed Kaplan. He is a Professor of Pediatrics at the University of Minnesota Medical School, and holds an appointment as adjunct professor in the Division of Epidemiology at the University of Minnesota School of Public Health in Minneapolis.

Dr. Kaplan will brief the Board on the Warren Air Force Base Cohort Serum Repository and data assets. Dr. Kaplan’s presentation slides may be found under Tab Nine of the binder. Actually, I think they were handed out separately.

MR KAPLAN: Thank you very much for the opportunity to represent to the Board the current status of a very unique collection of serum (sic.).

I will present briefly the background of this, and in the audience are Drs. Rick Erdtmann, Roger Gibson, and Ed Feeks, who will help me to answer questions at the end.

The purpose of this briefing is to seek confirmation of an AFEB and ASD action from 2004 and 2005 to maintain this valuable Warren Air
Force Base Serum Repository, dating back to the late 1940s and early 1950s. This series of studies was carried out under the auspices of the Armed Forces Epidemiologic Board, and the information about this is in some of the briefing material you have. Just for background, here's a picture of United States Air Force hospital at the Warren Air Force Base, where these studies were carried out. This slide I won't go through in detail because you have this word for word in the material that you were given. Briefly, these were studies that were carried out for understanding streptococcal infection and preventing rheumatic fever, which was a major problem in the military up to the Korean conflict. These studies were delegated to Dr. Charles Ramelkamp, and a streptococcal research laboratory was started at Warren, and these studies were carried out. Shortly before his retirement, Dr. Ramelkamp, in the late 1970s, asked me to act as
guardian for this collection, the details of which will be presented in just a moment.

These samples were moved from Cleveland, where he had them in a frozen state, to Minnesota, where they've been since the late 1970s.

As far as can be determined, there's not been any evidence of any significant deterioration of antibody between these constantly frozen samples.

You will see in pictures in just a moment what the vials look like. There are 48,000 approximate serum vials.

The mean volume for 43,000 of those was four milliliters. The mean number of sera per individual was almost five, and approximately a half of these subjects had six or fewer serum samples available.

This bar graph shows you the total samples available and the number of individuals. As you can see there were acute and convalescent sera for over 3,500 of these individuals. And I'll go into who they were in just a moment.
Of interest at the far right side of this graph, you'll notice that there were a few, including one individual who had 107 serum samples taken as far as we can tell during recruit training.

And I hope Dr. Shamoo doesn't ask me any question about the ethics of that.

This slide, I'm sorry it basically just showed the number of individuals and the amount of serum, and it didn't reproduce properly.

The brief recent history that I'd like to bring to your attention is outlined here.

In December of 2004, before I became a member of the Board, I was asked to brief the Board and presented the collection at an AFEB meeting, as I said, in December of 2004.

The Board favorably looked at this, and agreed that this unique sample, at that time almost 50 years, was too valuable to be discarded.

And in May of 19 -- sorry -- of 2005, Greg Poland and Roger Gibson wrote a memorandum stating this, and a copy of that is in your
briefing book, to Dr. Winkenwerder.

In September of 2005, Dr. Winkenwerder wrote a letter acknowledging this, agreeing to it, and at that time suggesting that the AFIP receive and store these samples. Now this was before the BRAC action took place.

From 2005 to 2008, we made some attempts to find a home for these because of the fact that the AFIP was going to be -- have a status change in 2011, I believe.

And so this past November, Dr. Gibson and I went to Wright Patterson where the Ranch Hand Study samples are stored, and met with Lieutenant Colonel Woodruff who has space available, and basically agreed to act as the storage site for these samples.

In April of this year, last month, there was a telephone conference and a memo from Dr. Erdtmann, and it was decided at that time that this idea should be brought back to the Board for confirmation of its earlier action -- the earlier action of the AFEB -- and also at the request of
Ms. Embry, I'm here at this point.

I'll show you some quick run throughs.

Many of you have seen these when I did the original briefing. These are the cards from each of the individuals where you can see and I -- this was before the days of HIPAA, so I apologize for not blacking out the names.

Each person had a card with their service number, these studies they participated in, and the date the sera was obtained.

Nowadays, these are stored. The volumes and the storage space have been computerized. And these are stored into large freezers, which you see here at, at minus 20.

And one serum specimen from each of the 9,500 individuals was aliquoted into one milliliter aliquot in order that there would be a repeated freeze and thaw cycle.

These are the original vials that the majority of the samples currently are stored in. And you can see the identify information on this sample.
The aliquoted samples are stored also at
minus 20 in other freezers, and they are all
catalogued in order, as you can see on these
slides.

We believe that it is time that these be
transferred back to the custody of the DoD. It's
a very valuable collection of sera.

I have nightmares about breakdowns in
freezers and think that there is some reason to
expedite this action.

There have been a number of awards given
for the studies done at the Warren Air Force Base.

But studies are continuing to be done.

I'll just run through -- you can see some of the
papers that were published earlier on with this
collection.

More recently, a collaborative effort
between the NIH are rare, where a lot of the
funding for this came from, looked at the presence
-- looks for the presence of hepatitis C infection
in military recruits. This was published in the
More recently, in collaboration with the gastroenterologists at the Mayo Clinic, they have looked for evidence using genomics of celiac disease and that is another example of how these samples might be used.

Our hope is there are several options as to what might happen to these. The option which I think almost is ready to go would be to store these at Wright-Patterson, to have the supervision of these samples looked at by the Institute of Medicine, and particularly Dr. Erdtmann, who I'll let explain in just a moment. And what is needed now is a small amount of funding from DoD, and Ms. Embry is seeking reconfirmation of this.

I don't think because -- I don't want to put words in her mouth -- I don't think because she has any doubts about it, but this has been going on now for five years.

So, Rick, do you have anything to add in terms of the role of the IOM and the medical follow-up agency?

GENERAL CODY: Well, I don't have any
formal comments. But I do want to just make a couple of things known to the group.

I think many of you may know that the medical follow-up agency has been in existence since 1946 in order to try to understand the implications, the long-term health effects, of the military experience.

Dr. Michael DuVage started this agreement with the National Academy of Sciences to study, using medical records and personnel records of military personnel, study the effects of tropical diseases, war trauma wounds, and other kinds of conditions that soldiers were exposed to during World War II.

And so we've been doing this for lots of years, and this is just another opportunity to take advantage of information on military personnel and try to understand some of the implications of military service.

One of the things that we have been able to do in the past is to provide medical oversight of studies that are actually being done by other
And perhaps the quintessential example of this is the large registry of twins that were members of -- they were both members of the pair were involved in military service in World War II. We have 46,000 twins that were involved in this registry, and a lot of information about the inheritability of disease has been done using this twin registry.

When an investigator wants to look at an issue, they would come to the medical follow-up agency, and we have an advisory board of experts that can look at the scientific merit of various studies that could -- that might be done, in this case, in the Twins Registry.

So we could use that same kind of model at the medical follow-up agency to provide oversight, professional, medical, research, scientific oversight, over any research that could be done with this asset that Ed has just described.

And I think that would be the principal
role that we would like to play in the future with this.

There's a couple of other things you might be interested to know. One is that one of the things we've already done with the Warren Cohort asset is that we have the morbidity and mortality information on these 8,000 or 9,000 folks at least up through 1996.

And we have been asked by the Department of Defense to update to currency. And we are in the process of, in fact, doing that as we speak.

So we have -- he has the serum, and we have the morbidity and mortality data; and, therefore, we have a tremendous asset to do future research.

I think one of the things that should be done in the future is to actually try to track down these 9,000 people and get them officially integrated into the research program, get their permission, because if we're going to do biomarker research, we're going to need to do that for future purposes and for ethical reasons.
So I think there's a lot of potential here. And the medical follow-up agency historically and currently has a great deal of interest to participate in.

DR. KAPLAN: Thank you. Colonel Gibson is here and probably has had more contact with this collection than any of us, myself included. So, Roger, would you please fill in the blanks?

COLONEL GIBSON: I just wanted to add a bit to Dr. Kaplan's discussion of where we went since 2005. As he mentioned, we -- the recommendation was for AMIP to (inaudible) to them, to there. Almost exactly after the recommendation was signed, BRAC was published. That created big-time problems with this.

We went to AFIP to discuss with them where they were headed, and if there was a possibility to integrate this with their specimen collections, their histology collections as a -- in that entire program to make sure that they had a home.

There were questions at that time, and,
to some degree, they still remain of who owns
these samples, and the involvement of the
University of Minnesota and a few other issues
that were worked through.

As Dr. Kaplan pointed out today, this
study was actually funded by the AFIP -- or excuse
me, by the Armed Forces Epidemiological Board. In
those days, back in the late '40s and '50s, the
Armed Forces Epidemiological Board has its own budget.
It was sort of a mini NIH.

They got their dollars through DoD, but,
they, in fact, went out and bid for work; usually
one of the Board members or what we can now call
Subcommittee members ended up running the study.

And those samples were collected, and
they (inaudible) and we can technically say
potentially these still belong to the AFEB, and
not (inaudible).

So, with that, when -- we also pursued
the DoD Serum Repository. Really, we were told
that really wasn't a good fit. Those samples are
part of a surveillance system rather than a
research system.

The big concern was that they get in a place where they aren't forgotten, where we have somebody to arbitrate how they're used, and that they're properly stored and maintained.

It's -- when a (inaudible) hadn't occurred, and Congress passed legislation moving those Ranch Hand samples to the fiduciary care of the Institute of Medicine, it seemed like that's a segue. We would use the same sort of a model in pursuing that. We're back to the Board today to ask for confirmation of (inaudible). (Inaudible) still agrees that these samples are worth saving and DoD needs to move them into their care.

DR. KAPLAN: Commander Feeks has been recently involved. Ed, do you have anything you'd like to add?

COMMANDER FEEKS: I've been working a couple of issues at once while the conversation has been going on, so forgive me if I'm repeating myself.

One of the issues is convincing
policymakers, who are not scientists, of the value of the sample collection.

I don't know if that's been discussed yet or not, but that's important. I think -- I don't have any trouble imagining the value of this collection. But my checkbook is no good to you.

The second thing is, speaking of money, there are still some blanks on the sheet as to what money will be required to do this. And I don't know if it's been brought out if Wright-Pat planned to -- if there was a cost associated with storing the collection at Wright-Pat.

I have spoken to a couple of people about costs, and don't have data back from them yet. I do know, for instance, I've had this conversation, though, with Rick Erdtmann about what it would cost to have the IOM do the role that was described by Dr. Gibson.

And I think, if I remember, sir, initially it was rolled up with the Ranch Hand custody funds, but depending on the demand for the collection, there could be additional costs in the
out years. Is that a fair statement, sir?

DR. ERDTMANN: That's right.

COMMANDER FEEKS: Okay. And that's all I have to add.

DR. WILENSKY: Greg?

DR. POLLAND: So this first came up during my tenure, and so I want to speak to it.

We also at the time as a Board felt very strongly that this has value. We subsequently had a phone conversation with the then ASD, Bill Winkenwerder, who felt the same.

It may be hard for some people that maybe don't think of some of these diseases, but just to use one example, the hepatitis C example.

It was thought that that was virtually a death sentence, universally, if you were detected to have hepatitis C; and it would require fairly morbid treatment to try to treat it and not very effectively at that.

This -- the results of that study changed practice throughout the world and what we do with it.
There are possibilities here that intermittently come up. An example is smallpox, where, because of what was assumed to be a threat, it was not clear what the level of antibody or immune memory would be five decades later in people who had been immunized. Well, there wasn't a cohort where we knew what their immunization records were, and we had there sera.

This is one such. Just as one example now, they're trying to find people who got immunized with the 1976 swine flu vaccine; get sera, and try to look at immune memory.

Well, they didn't have it -- that vaccine, but it's just an example of how these kinds of repositories are helpful. A variety of toxicology studies that could be done in people where you have phenotype over five decades and sera.

With the availability now of biomarkers research, including proteomics, and the way these, undoubtedly the way these were spun and cared for in the 1940s, they are "contaminated" with DNA.
And nowadays, you need such a little bit
to be able to do genomic studies, which would make
this an incredibly powerful and useful collection
and database.

So it's just to say through a handful of
examples I can think of quickly off the top of my
head of what the value of these would be, and let
me just add that often times that value is
unpredictable until a new threat or a new question
comes up; and everybody scrambles around trying to
say, well, where would we find sera from 50 years
ago.

Well, the number of databases where you
have sera and phenotype data over five decades I
think you can count on two or three fingers.
That's the value of this collection.

So I would hope that we would again
re-endorse strongly the value of this, and that
this is an asset for DoD.

DR. WILENSKY: Mike?

DR. OXMAN: Two issues. First of all,

although I'm not an expert on cost, if it's
already in a place where monitoring is done and
you're just talking about the cost of maintaining
them frozen with adequate safety backup, it's very
low.

And any studies that would be proposed
to be done with the serum could be self-supporting
in that if they were important enough to do and to
use this valuable serum, then it would be
important enough to get some funding for from the
NIH or from the DoD.

And thirdly, one other aspect that's
important to the military if people come back from
a tour of Afghanistan and there's some evidence of
a new disease, it can be very useful to know that
that disease existed in 1949 before anyone visited
Afghanistan.

So there's enormously valuable data in
these sera and in the medical records that go with
them.

And so I would be a strong advocate for
not only storing them, but keeping the DoD in the
driver's seat with respect to what happens to
them.

DR. WILENSKY: Mark?

DR. MILLER: Yeah. I'm just thinking of an immediate study with four letters -- H1N1, and that you have a wonderful specimen collection here that people who haven't been exposed to, I mean the H1N1 viruses at that time, a unique opportunity?

DR. WILENSKY: Joe?

DR. PARISI: I'd just like to second everything that's been said. I think there is a lot of parallels with this -- of this collection with the tissue repository at AFIP. I mean, it's an invaluable resource. We ought to do everything possible to preserve and maintain these. These are not only natural resources. They're international resources. And they're good for mankind. These are kinds of resources we can't replace, and potentially can answer lots of questions. As Greg said, a lot of them we don't even know what the questions are yet. And it's just -- I think it's a no-brainer. We need to
support these.

DR. WILENSKY: Mike.

DR. PARKINSON: Mike Parkinson. Just to be responsive to Ed's comment about declaring the value, it seems to me in kind of the new value proposition of the DHB that probably what we need to do is to say, we'll give you the three most prioritized studies, given the current threat to DoD where these might be applicable, because, absent something specific, in almost a prioritized threat list potential use of this database, I don't think it's -- because, again, it's the dilemma of the comments.

I mean it might be good for the NIH. It might be good for mankind. How is it good for the Defense Health budget, you know, and the role of DoD.

And today, we could probably sit down and say here's five studies if you wanted to fund that could be relevant to this threat list that we're going to hear about tomorrow or something.

I don't know.
But we got to connect the dots so that these people have an easier job of it.

DR. WILENSKY: Colonel Johnson?

COLONEL JOHNSON: Thank you. Ms. Embry tasked me to look into that -- and to this issue and to make a recommendation to her, and we're in the process of doing that.

We're gathering information. There's never been any question about the importance of this information. I mean, this is clearly unique and very important information.

The question has been is this operationally significant to DoD? Is DoD the right place for this? Maybe NIH is the better place for it. Maybe this is a national asset rather than a DoD asset.

We're trying to look at lots of different options, and that's -- give us some time. Clearly, we don't want to throw this out. This is an asset that has been protected very well. We appreciate that.

But we're not sure the best location for
DR. KAPLAN: Could you continue please hear and tell us a little bit about what your concerns are?

COLONEL JOHNSON: Concerns as far as?

DR. KAPLAN: The right place, the relevance and so on.

COLONEL JOHNSON: We just -- there's no question that it's scientifically valid and important information. The question is where's the right location for this to be.

I would think that just about any university in the country would be thrilled to have this to use with their own research at no cost to DoD. And is it the proper use of DoD funds to -- for us to hold this and control it. We don't know.

We're looking at the different options, and our plan is present that up the chain once we get -- once we've developed the different options.

DR. WILENSKY: Well, I'd just like to -- as I read the statement of the purpose of this
briefing, it's agnostic as to where it's housed;
j ust that it should be maintained. Is that
correct? Is that a correct reading?

DR. KAPLAN: I'm sorry. I didn't.

DR. WILENSKY: As I read -- as I read
your statement about the purpose of the briefing,
the positive action is to maintain the valuable
serum repository.

I don't read it that you're saying it
necessarily needs to be at Warren Air Force Base.

DR. KAPLAN: Well, it won't -- excuse me
-- it won't be at Warren Air Force Base.

The purpose of the briefing was that we
went through this five years ago, and it went
through rather extensive investigation, which
resulted in the ASD confirming the recommendations
of the AFEB; and these sera do belong to DoD.

This was never given to the University
of Minnesota. It was given to me, the truth be
told.

So I -- the purpose of the briefing was
simply to say that the predecessor to this Board,
the AFEB, went through the assigned task,
discussed it, voted on it.

It was sent in a message to Dr.
Winkenwerder in the message in May of 2005. And
he subsequently basically agreed, if you read
that. So the issue was to reaffirm that this is
-- that we should go forward with this.

DR. POLAND: Could I jump in, Ed? I
think what we're really saying here is it's
confirmation of what the previous ASD's
determination was. And that determination was
that it be transferred to DoD.

He requested the Department of the Army
and AFIP. Other things have intervened there.
But the intent of his memo and what you're seeking
confirmation of is that DoD take possession --

DR. KAPLAN: Yes. Yes.

DR. POLAND: -- of these.

DR. KAPLAN: Yes. Thank you.

DR. WILENSKY: Okay. Well, I guess that
-- given what you've just said, it sounds like --
well we can make that as a recommendation or we
could make an alternative recommendation that DoD needs to make a timely determination of where it should reside and that we continue to support the notion that it be maintained.

I mean, those are -- I mean, those are two alternative ways to frame our support. I haven't heard anybody suggesting anything other than strong positive support for the serum being maintained.

So it's only a question of do we say it should be DoD or would we say DoD needs to make a timely determination of whether it will be DoD or somewhere else, and that somewhere else has to be a credible place.

DR. OXMAN: I do think. Oh, sorry.

DR. WILENSKY: Dr. Ludwig and then Mike.

DR. LUDWIG: Yeah, I think -- you know, I hate to complicate things, but in reality the value of this serum sample -- this serum repository is so great, and in many respects we ought to be looking at where else in the DoD similar repositories exist.
I know for a fact that there's a very large repository of sequential serum samples that were taken as part of the Operation White Coat during the offensive biological days that continue to today.

Long term serum repositories that are part of the special immunization program at USAMRIID. Similar repositories exist, and we ought to try to find out where all of these exist, and make use of all of those for similar types of studies that we might be seeing. So.

DR. OXMAN: Since money is an issue, I would think that Ed could come up with a reasonable estimate of the incremental cost of adding these to a pre-existing monitored facility. And I would bet it would be in the thousand of dollars, not any more, you know, in the thousands, $10,000s, not $100,000 or a $1 million year.

It's basically -- if it's already monitored, it's backup -- it's a couple of freezers that are ballasted, kept frozen, and the electricity.
DR. WILENSKY: I agree -- well, I think it would be useful to have an estimate of what it costs. It seems to me the cost of the maintenance is trivial.

And I don't know whether the cost of the access and monitoring and decision-making about who can access it for various purposes. That might not be trivial.

But the actual maintenance -- now I had asked something earlier, and I don't know whether this is related. I had asked, you know, Ellen maybe or maybe Al Middleton about if DoD doesn't want to maintain the cost of some of the activities, why don't they charge for those activities and was told that DoD does not have the legislative authority to charge institutions. It would have to set up -- or to charge for making available something that it has.

It would need to do some other administrative structure, maybe a foundation like NIH has were something else, in order to be able to accept monies.
But that was why the alternative, which actually Wayne had mentioned, of having a timely determination, if not held in DoD, where held because of the importance of maintaining the valuable serum.

So, as again, I haven't heard anybody suggest anything other than support for maintaining it.

But the question of is that only at DoD or would it be other places? I mean, could it be, you know, through NIH or the National Library of Medicine or some other area as appropriate at NIH because it has the NIH Foundation, which can charge. Adil? Okay.

DR. KAPLAN: We have --

DR. WILENSKY: Go ahead.

DR. KAPLAN: -- if I might interrupt, this didn't just come to DoD without investigating other possibilities. Five or six years ago, we had extensive talks with the National Cancer Institute, for example. And the reason that it settled on DoD is because I think -- and I think
most people would agree -- that this belongs to DoD.

The important thing is -- and what I think adds a little bit of urgency to this decision -- is the fact that this -- I'm worried about this collection. I caught some people in the room, which is beside the point, but trying to do some things with the collection recently. It cannot stay at the University of Minnesota indefinitely at this point.

And if there is -- if this Board does reconfirm what the AFEB did five years ago, then we have to work a way out. To say we're going to start looking all over again, respectfully, I would think is not a very realistic option.

DR. SHAMOO: This Board may want to consider -- put some kind of boundaries; that is, it should remain either in the public sector or non-profit institutions, as well as that should be done with the current ethical use of tissues from human subjects, because some of these people may be alive.
DR. WILENSKY: It may just be because I didn't move through this experience you're talking about five years ago, but I'm not at this point comparable of saying it must be DoD. I'm much more comfortable, particularly listening to what we just heard from Colonel Johnson saying the DoD is trying to decide where it thinks the best place is.

I am comfortable of saying that the decision needs to be made in a timely way. It needs to be in a place that will be accessible -- either university or other portion of government. But, I mean, I don't -- I guess today, given what I've heard, I'm not comfortable saying it has to be DoD.

I'm very comfortable saying the decision needs to be made in a timely way and it must be supported and maintained for use. Wayne?

DR. LEDNAR: I guess just a thought as we're thinking about options leaving this discussion.

I'm just reminded what Dr. Erdtmann
said. Dr. Erdtmann has aspects of information about this cohort that complement the collection of sera. The value to any use of this serum bank is, in part, related to some of the value that the medical follow-up agency manages.

So whoever would be the keeper of the freezers, there's got to be an obligation and an agreement comfortable to the medical follow-up agency and IOM that this is acceptable to them.

So this is not just, you know, finding a place to put some freezers. It really is a management of the whole resource. I don't know if Colonel Irvin has -- is in agreement with that or differs.

DR. ERDTMANN: Yes, I think that's exactly right, Wayne.

One of the options I think that Health Affairs is considering is possibly locating the bio-specimens out at Wright-Patterson Air Force Base where we're going to -- where currently the Ranch Hand materials were trans -- are located.

They were transported from Texas, where
the Air Force project office kept them for 25 years, and then last year moved them to Ohio. They have the space. They have the desire to keep these specimens, and, of course, they don't have whatever marginal funding it would require, but they seem to be in a position immediately to take these specimens. And if there was some urgency or if a need to take care of this quickly, they would be, I think, the ideal spot to move them.

DR. WILENSKY: Roger, did you have a comment you wanted to make?

COLONEL GIBSON: Yeah. I just wanted to echo a comment that as usual the Board comes up with very good, insightful things. I would argue that there's probably among the vaccinology community within the United States, there's probably two or three or five who know that DoD has Operation White Coat, et cetera. It's -- I think it's important that we use these things. I think it's important that the public and the academic public be aware that they
exist and that they can be used in important
research.

One of the draft questions that I've
never quite got to the Board was having the Board
review the repositories and registries within the
Department of Defense -- just to find out where
everything is and make recommendations on whether
we need a central agency or a central look at
those things.

The issue is that these things get put
away and forgot and then 10 years from now,
somebody throws them out. Well, overall
coordination. So.

DR. WILENSKY: Yeah. We had discussed
-- Wayne reminded me -- yesterday talking about
the potential of having coordination of overall
biomedical research in DoD be an issue that the
Board take on.

So I -- I mean, this would clearly fall
within that category -- your suggestion. Oh, yes.

Mike?

DR. OXMAN: Just one point. I do think
that there are almost predictably going to be
issues in the future where having these will be of
direct benefit to the DoD. And so I wouldn't want
to see the DoD lose a significant element of
control and find that they were used up for other
interesting and scientifically important matters,
but which weren't important uniquely to the DoD.

And that's an important point to bring
up.

DR. WILENSKY: I don't disagree, but I'm
hesitant when somebody in Ready Force Protection
tells me they're trying to make a determination
now as to what they're going to recommend in terms
of whether DoD keep it or put it in what would
presumably be a safe and accessible place that we
jump in this moment to say do it this way.

So I would either like to hear what
they're going to do in a timely way or tell them
they need to make a determination in a timely way
that either they keep it or they put it someplace
where it will be safe, protected, and available
for DoD and other users at future times.
DR. KAPLAN: But does that -- I'm sorry.

Go ahead.

DR. WILENSKY: No, and I'm.

DR. KAPLAN: No. But that I can understand. What I have brought before the Board is to say does the Board confirm the fact that this is a valuable -- well, basically does the Board confirm the previous deliberations and the memorandum by Secretary Winkenwerder or not.

If the Board does not support keeping these, then I've got to start someplace else. I'm hearing that the Board thinks these are valuable.

If the Board goes on record as confirming this, then I think that would be valuable advice to give to Force Health Protection and Ms. Embry's office.

DR. WILENSKY: Again, for my purpose, if we're confirming the statements that's there, which indicates its value and is silent on where, I'm fine.

If what you're saying we should reconfirm an earlier document that goes further
than that and says not only that, but that it
should be in DoD, I'm personally not quite ready
to do that.

I am ready to direct DoD to make a
decision in a timely way as to whether it will be
in DoD or elsewhere that will make it available.

So, I just -- if you're asking -- I
don't have any problem with this statement that's
up there on the Board now, but you have each time
sounded as though what was referenced is much more
specific --

DR. KAPLAN: It is.

DR. WILENSKY: -- than what we see up
there.

DR. KAPLAN: If you read it, it's in
front of you. If you read what it says, it's
there.

DR. WILENSKY: Okay. Well, then, I
guess I'm not sure exactly what it is you're
asking us to reconfirm.

DR. KAPLAN: Well, it's -- it's to
confirm --
DR. WILENSKY: Okay. It says to the
DoD.

DR. KAPLAN: -- the letter written by --

DR. WILENSKY: Well, we can't -- but
we're (inaudible) we can't transfer it to AFIP,
because that's no longer a relevant.

DR. KAPLAN: No, but he recognized the
value of it and as did the Board. So if I've
asked for the Board -- forgive me, and I don't
want to sound insubordinate, I guess, but I've
asked the Board for confirmation.

The Board has spoken out, at least those
that have spoken, have spoken in favor of what
I've said, as I understood it.

Is there a difference of opinion and how
is it to be resolved?

DR. POLAND: Perhaps the way forward
here would be to say this as one option: That the
Board reconfirms the importance -- as per the
September 2005 memo, the Board reconfirms the
importance of the Warren collection and believes
that it should be owned by or maintained by DoD.
If DoD in the next -- fill in the time
blank -- feels that that's not appropriate, they
need to notify DHB and Dr. Kaplan so that another
disposition can be made.

So it reconfirms this, but if they
decide they don't want it, then they tell us so in
a reasonable timeframe so that you can make
another disposition of the collection.

DR. KAPLAN: Does your suggestion
include both letters -- the letter from you --

DR. POLAND: Yes.

DR. KAPLAN: -- and Roger --

DR. POLAND: So it's the two.

DR. KAPLAN: -- and as well as the one
by Secretary Winkenwerder?

DR. POLAND: Yes. It's what you have up
there, so the motion would be that we confirm the
intent and direction of the AFEB and ASD letters
for the Warren Serum Repository -- given the
importance of the Warren Serum Repository and the
intent that DoD own and maintain it.

On the other hand, if Health Affairs
decides they don't want it, or don't want to
maintain or own it, they need to let us know that
in whatever we think an appropriate time period
is.

Five years is not an appropriate time
period. Sixty days is.

DR. WILENSKY: As a suggest -- I was
hearing a suggestion that perhaps we can use the
term under DoD oversight, because the reference
that's in the letter is no longer relevant. The
reference in the letter is an AFIP reference.

DR. POLAND: Well, it's a bifid
reference. It's Department of Army and AFAP work
to transfer the samples.

So AFAP isn't here, but the Department
of the Army still is.

DR. KAPLAN: That's correct.

DR. WILENSKY: But I -- okay, I would --
I prefer the notion again. Given that we are
hearing that the Department is in the process of
trying to determine exactly what -- having --
exactly where they want to recommend it, having it
be under the oversight of the Department of Defense, either directly located in or in someplace that they would have oversight and control seems a reasonable way to resolve the issue of that. Does it literally have to be in the Department of Defense?

DR. KAPLAN: Okay. But would that eliminate the Board's reaffirming, as Greg suggested? I mean I think if the -- if Ms. Embry's office is considering this, the purpose of this Board is to advise that office, and we are, by voting or by reaffirming this, we would be advising them that this Board thinks this is important and this is what ought to be done.

They can decide whatever they want to as far as that's concerned, as I think Greg indicated in his suggestion.

DR. WILENSKY: Well, if this were to be at the National Library of Medicine or at the Institute of Medicine under the oversight of the Department of Defense, is that objectionable to people in this room?
I mean, that would be consistent with the alternative language that was suggested. I mean, that's why having a little more latitude as to what it is we want, which is to reaffirm the importance and to have the oversight of the Department of Defense, it seems to be more operative than literally whether it has to be at the Department of Defense or another government agency.

I mean, I could -- it seems to me you could make at least as good an argument that having this be at the National Library of Medicine or the Institute of Health is every bit as important and relevant as having it in DoD.

DR. KAPLAN: The --

DR. WILENSKY: But you would like to have oversight at DoD?

DR. OXMAN: Yeah. I think it's not oversight. It's control by the Department of Defense. It's an asset for the Department of Defense. A lot of deliberation by the AFEB went into this before, and we're supposed to provide,
with good conscience, our best advice.

Now that doesn't mean that everyone agrees, Gail.

DR. WILENSKY: And I understand.

DR. OXMAN: But we should be able to vote or provide our best advice even if we don't all agree.

DR. WILENSKY: I absolutely support that notion. Joe?

DR. PARISI: Could we say something like the most logical place words isn't -- or isn't for it to reside in DoD since DoD already is a stakeholder in the collection. But if DoD decides that it should go elsewhere, then that's their prerogative.

DR. POLAND: I think that's what I'm saying basically.

DR. WILENSKY: Yeah.

DR. POLAND: I mean, in some ways, these belong to DoD. They've been stored somewhere else. But they are -- they belong to DoD and DoD needs to make a decision. The advice of the Board
wastotakecontrolofthese.

If you deem that that isn't what you
want to do, there are other options available to
you, but let us know in a timely manner.

DR. WILENSKY: Well, taking -- I'm less
troubled by the taking of control than I am by
saying it's got to be physically at DoD,
personally. Again, for me, I could make as good a
case it should be at NIH or a lot of other places.

Yeah, it could be a contract. So, I
mean, the notion, what I'm troubled by is that
it's got to be at DoD per se. So I would rather
--

DR. KAPLAN: With respect --

DR. WILENSKY: -- have it -- well.

DR. KAPLAN: -- we have investigated
those other areas, and it means five more years.
We have found a place that will accept them, and
I'm very much afraid, because I consider myself
responsible for this, that someday something is
going to happen -- a freezer is going to blow up
or what have you.
And I think that the -- the sense that I hear from here is that the Board supports the type of statement that Greg Poland just offered. If that's not the case, then I'm sorry --

DR. WILENSKY: I'm not sure.

DR. KAPLAN: -- I misunderstood.

DR. WILENSKY: I'm not sure I hear that consensus yet. Dr. Clements?

DR. CLEMENTS: Well, it seemed to me, though, that there are two problems here, and is the urgency of Ed's problem with what if something happens to this and I'm not confident about the security of the material.

And that's something that has some urgency and immediacy that needs to be dealt with by the Department of Defense, and whether that's moving it to Wright-Patterson or pulling a backup generator and a what ever that is that's really a separate question than who ultimately controls, but not necessarily houses this material.

And I agree with Gail. I think it's less important where it resides but that the DoD
have some opportunity to control at least the
level of access so that they know in the back of
their minds that a certain portion is reserved for
their use, even if the rest of the use is
determined by someone else.

So can we -- I mean, if that's correct,
maybe we could deal with the question of
recommending that the DoD do something immediately
to secure this material however they choose to do
so, and then, as quickly as possible, how they
want to handle the controlled material.

DR. WILENSKY: I am completely
comfortable with that statement.

DR. POLAND: Can I offer a motion? The
motion I put forward would be along these lines:
The Board recommends that -- that the Board
reaffirms the intent of the AFEB and ASD actions
of 2005.

The Board recommends that DoD assume
control of the Warren Serum Repository or
indicate other options in a timely manner.

DR. WILENSKY: That's right. Again, I'm
-- as long as the control --

DR. POLAND: So, I'm looking for a second --

DR. WILENSKY: -- yeah. Well, we're not doing the vote. Is there -- I mean, with -- that's relevant if you're doing a vote. Since we're not -- as they are -- is this the consensus unless you want to have a vote. Wayne?

DR. LEDNAR: I guess just listening to the words, I -- in listening to what John proposed, I'm not so sure that those words exactly achieve John’s thought.

I think that the DoD needs to take control of the serum repository. Period.

Next step is to identify options at where it may be housed and rules of access. But even in step two, DoD maintains control.

DR. POLAND: I'm happy with that amendment.

DR. WILENSKY: Yeah. I -- if we can -- I agree. I think that is what John said and in the right order and the immediacy is clear.
DR. KAPLAN: So, excuse me, does that mean that Colonel Johnson can then go back to Ms. Embry's office and say that the Board supports basically what Greg has said?

DR. WILENSKY: I think the --

DR. KAPLAN: And that will go in the record as supporting by the DHB.

DR. WILENSKY: -- what is -- what should go back is the immediacy of taking control and the near need to make a near-term decision as to where it will be housed. That is the two action step I think we just affirmed as a group; is that correct? John, would you -- was that -- is that a correct way to characterize your statement? And I'm not trying to put words in your mouth.

DR. CLEMENTS: No, I think that the -- yes, that's correct in what it says. But I think the urgency has to do with securing the material quickly so that that relieves Ed of the responsibility. As to how it's controlled, it may ultimately DoD can decide they don't want to control it.
DR. POLAND: Right. Right.

DR. CLEMENTS: I don't think that that's the way to go.

DR. POLAND: The only thing I think missing is the antecedent of reaffirming the importance of the collection.

DR. CLEMENTS: Right. So we reaffirm the importance of this material, and recommend that they DoD take immediate control, and in a reasonable time period make a determination about how it ultimately will be.

DR. POLAND: Where it's housed.

DR. WILENSKY: I would strongly prefer those three statements be made as an independent statement rather than with reference to an exchange that occurred when parts of those -- that exchange are institutionally not relevant.

This is a very clear three-step directive of what we think should happen. But I would -- my suggestion is that's what this Board delivers to the office. Mike?

DR. OXMAN: Gail, you're going to throw
me off the Board. But I think there are two
phrases that are important. One is the immediacy;
the other is that my recommendation is that the
DoD, however they do it, maintain control. And
those are the words -- maintain control of the
collection.

For example, there could be lots of
reasons that have no benefit directly to the DoD,
which would use up all those sera. And that would
be -- that could conceivably be a tragedy to the
DoD five years from now.

And so I think it's important, and from
my responsibility as providing independent expert
advice, it would be for the DoD to take control
now and to maintain control. They don't have to
listen to that advice, but we're supposed to give
them the best advice we can. And that's my
recommendation, which I think is Greg's, and I
would make that motion.

DR. WILENSKY: Sorry. What I would like
to see is the two alternative statements
side-by-side, because we're -- and they were --
they're similar in spirit, but they are -- but I thought initially other than perhaps you might -- I thought people had nodded to the statements that John had suggested.

So I want to put those up, and we can put up what you would like to see and then just see the -- where people felt comfortable.

I thought we had already reached that, but, if not, then we need to -- I'm not sure now how what you're saying differed from what John had said. I'd like to see that. I know that I was comfortable with that.

DR. CLEMENTS: I don't think it does differ. I think that it's just the wording of the last third. And that is the first is to immediately secure or take control -- immediately secure and then take control; and then you could say the Defense Health Board recommends that the Department of Defense maintain control of that material, but, in any event, determine in a relatively short time period what the fate will be.
And that we've made a recommendation that we think the DoD should maintain control, but they are free to not. But at least, we're on record as saying we think that's the best alternative.

DR. POLAND: But I think you do -- you want to include the antecedent statement stating that the Board believes the collection is valuable.

DR. CLEMENTS: The antecedent statement is that the Board believes that this material has inherent scientific value --

DR. POLAND: To DoD.

DR. CLEMENTS: -- and should be -- to the Department of Defense and should be maintained.

DR. POLAND: Right.

DR. WILENSKY: Okay. Here's a -- we may need to circulate, unless we're just -- we can do this now. The finding is that the serum are at risk and that they are valuable. And the recommendation is that the DoD immediately take
control of the serum and make a determination in
the short term about its future.

DR. POLAND: About where it's housed.

DR. WILENSKY: About its future housing.

DR. KAPLAN: Gail, does your statement
include the reaffirm the correspondence of 2005?

DR. WILENSKY: No, it didn't, because I
don't find it relevant. What we are making is a
direct statement that we believe that the sera is
valuable and it's at risk.

I would prefer not to because there is
stuff in there that is I think no longer relevant.
We don't have to say we'll ignore the part that's
no longer relevant.

DR. KAPLAN: If I may again say, I think
that certainly the action of the AFEB in May of
2005 was the result of considerable liberation.
And I think that that could be
influential in the DoD's ultimate decision about
what they want to do with it.

So if it's appropriate, I would suggest
that that be included in the statement, because it
does reflect what happened.

DR. WILENSKY: And this, I guess, I will respectfully disagree. I think the statement is extremely strong to say this -- the finding -- we -- this group is responding to an appropriate request, which is that there is a concern that the serum is now at risk, and that we need to do something; and that our response to that is to agree that this is a valuable asset and that it is potentially at risk. We accept that -- and that we, therefore, recommend that the DoD immediately take control and that it make a deliberation about where it is to be housed in the short -- in the near-term; and that in a timely way; and that that is what we have now done.

I just not -- I mean, we have not spent any time -- I'm not trying to cast aspersions on what you did. It's just -- we're not -- we haven't gone through this activity. I don't see that it in any way strengthens the statement of this Board now.

This Board now is saying it's at risk.
It's a valuable asset. Take control immediately.

Make a determination immediately. I think that's a very strong statement.

DR. POLAND: I think what you could do, Ed, that maybe would be satisfying to you is just as we do with every recommendation that comes from (inaudible) Board, we attach relevant materials -- just attach the background material to it.

DR. KAPLAN: I have no problem with --

DR. OXMAN: Gail, there's also -- excuse me. There's also one subtlety that you left out, and I think should be in.

It is valuable to the DoD, and that was after a lot of deliberation by people before me that it's not just valuable; it's valuable to the DoD. And that's why I think that our recommendation, whatever the DoD decides how they will maintain control, even if it's to give it to the NIH, with certain stipulations, we should recommend in the long-term that the DoD also maintain control.

DR. WILENSKY: Well, I thought we
already recommended that the DoD maintain control as part of our statement.

DR. SHAMOO: No, no. Maintain control -- the way he's saying it -- I'm not saying I agree with -- maintain control for their own use.

DR. OXMAN: No, no. Just maintain control, which means, for example, you ensure that all of it doesn't get used for something else, and none is left by (inaudible).

DR. SHAMOO: But they could have somebody else use it 100 percent, and it's gone.

DR. WILENSKY: Mark? Did you -- are you?

DR. MILLER: Well, I think the word definition is to a matter of degree when you're saying control, because you do have to provide some incentives as well for someone to locally use it. And I think the issue is control or oversight and to what degree.

DR. WILENSKY: Yeah. I mean, I think that it also includes that the DoD needs to make decisions on who can access and under what
circumstances. I mean, that's what having under
its control means.

I guess I regarded that it is valuable
as being a stronger term than it is valuable to
the DoD. It is valuable to the DoD. It's
valuable to the DoD and to the rest of humanity.

So I think you're weakening it myself
with that.

DR. POLAND: Put both in.

DR. OXMAN: Put both in. Yeah. Put
both in. It's -- it has great scientific value
and including value specific to the DoD.

DR. WILENSKY: That's fine. John, the
scribe?

DR. CLEMENTS: That's right. Could we
say then that the Defense Health Board affirms the
value of this material to the Department of
Defense and the larger scientific community and
also believes that this material is at risk; that
the Defense Health Board recommends that the
Department of Defense secure this material
immediately and that the Department of Defense
take control of the material; and that the
Department of Defense determined the fate of the
material quickly or in a relatively short period
of time for the housing in a relatively short
period of time; yes.

DR. WILENSKY:  Do we want to go more --
do we get more specific in terms of devising policies
regarding its use or shall we just stop there?

DR. POLAND:  No, just stop there.

DR. WILENSKY:  Okay.

DR. CLEMENTS:  I would stop there.

DR. OXMAN:  Stop there.

DR. WILENSKY:  Okay?

DR. KAPLAN:  Yes.

DR. WILENSKY:  All right. I think we've
gotten through this and passed. Again, unless
somebody has a need for a vote, I don't see that
we've added. I think we've reached a consensus.

DR. KAPLAN:  As long as it's in the
official transcript that can be taken back by
Colonel Johnson to Ms. Embry, I have no problem
with it.
DR. WILENSKY: It is the same mechanism we have used to have something as non-controversial as our views on the BRAC/NCR Report.

I think it's okay.

DR. KAPLAN: I'm sorry. I didn't understand the answer.

DR. WILENSKY: I said this was the same mechanism we used this morning for Ken Kaiser's report about the National Capital Region and its building.

So, if it was clear enough there, I think it's clear enough here.

DR. KAPLAN: With due respect, Gail, I think this is an entirely different matter, and my question is, will this be -- a simple question -- will this be in the transcript that he goes back and refers to the previous documents? I'm fine with the wording.

DR. WILENSKY: No, that was not what we agreed to. What we agreed to, per Greg's statement, which I'm comfortable with, is that we
have a short statement about the finding and the recommendation, and that it will have attached to it, without any further reference, the previous information from 2005. That's what we agreed to.

SPEAKER: With John's wording?

DR. WILENSKY: With John's -- yes, with John's wording.

DR. SHAMOO: Everything is in the transcript. You don't have to worry. It is everything we say. It's in the transcript. The answer to your question is yes.

DR. WILENSKY: Of course. This is an open meeting. It's been transcribed. You can't get it out if you want it out. Yes, Joe?

DR. SILVA: Madam Chair, the hour's getting late, if I could make one short comment with a little levity.

Dr. Mark Miller and I have agreed to take this collection, if no one wants it, and we'll offer it up for sale on e-Bay and take a 10 percent commission.

(Laughter)
DR. SILVA: Thank you.

DR. KAPLAN: I get 10 percent agent's fee.

DR. WILENSKY: Okay. I'm going to turn this over to Commander Feeks for some administrative comments.

COMMANDER FEEKS: Before I proceed, could I ask the good Dr. Gibson to see if -- actually, let me ask Beth, instead. I'm sorry. Colonel Gibson can relax.

Can you ask either Lisa or Jen to come in, please?

Before I go on, thanks was given for Dr. Kaiser and his Subcommittee's work for that enormous undertaking of the report that they prepared, and I also want to recognize the members of my staff who participate in that -- not the ladies who are coming in in just a minute, but particularly Sheila Bowman and Merrily McGowan -- an enormous amount of work that those women put into that report, and I just wanted to enter that into the record.
COMMANDER FEEKS: Okay. Well, my next item is that for Board members, ex officio members, liaisons, and speakers, tomorrow's briefing at the Industrial at the College of the Armed Forces, at Fort McNair, will be preceded by breakfast at Fort McNair.

I have maps of the post; that is to say Fort McNair, in my hand, if anyone will need a map to get there in the morning. Did the people at Fort -- excuse me -- Fort McNair stipulate which gate?

MS. GRAHAM: Second Street.

COMMANDER FEEKS: Second Street gate.

So enter by the Second Street gate. The map will show you where ICAF is, and the parking lot behind the ICAF building has a marina next to it. You'll recognize it by the boats.

Okay. All right now. I beg your pardon? Yeah, what time does the bus leave, please, Jen, from the hotel?

MS. KLEVENOW: 7:30 in the morning.
COMMANDER FEEKS: The bus leaves the hotel at 7:30 in the morning to go to Fort McNair.

Okay. For those who are joining us for dinner tonight, please convene in the hotel lobby at 6:15 p.m. so that we can walk to the restaurant. If I have it understood right with Dr. Poland, the pre-meeting that the Pan-Flu, the Pandemic Influenza Group, wanted to have tonight, they are going to have tonight, but at the restaurant. They're just going to sit together.

DR. POLAND: So that's a change in plans related to the reservations that we really couldn't cancel it turns out at the last minute, we're actually going to meet at -- with the rest of the group, but I mean at the restaurant, but we'll sort of sit a little bit away from you.

COMMANDER FEEKS: Yeah. And I think that they'll find that they can have the conversation that they want to have --

DR. POLAND: So 6:15 --

COMMANDER FEEKS: -- there's a long enough table that will work.
DR. POLAND: -- will that be, you said?

COMMANDER FEEKS: Yes, sir. 6:15 in the lobby. The regerate -- excuse me -- the reservations are for 6:30 p.m. at McCormick and Schmicks, here in Arlington.

And lastly, if you want to keep your -- if you want to keep your binder, please take it with you tonight. We won't be coming back here tomorrow.

If the binder is too bulky, please remove the contents if you want to keep the contents and take those home with you, and we'll take the binders back to the office.

If necessary, we can send the binder to you by FEDEX, for the members, that is. Of course, it's expensive, and it involves some labor, but we can do that.

We'd prefer not to, if you don't mind.

And with that, let me ask Dr. Wilensky to take over.

DR. WILENSKY: This concludes the public portion of our meeting. We are going to have a
short administrative session immediately
following, so if you would please stay. I've
promised Marianne some time.

And then, as you have heard, the Board
Members, liaison, ex officio members will be
meeting to board the bus by 7:30 to go to Fort
McNair.

Any of you who are leaving for the
airport directly after the meeting, you ought to
bring your luggage with you. Mr. Middleton, would
you adjourn the meeting?

MR. MIDDLETON: This meeting of the
Defense Health Board is adjourned. On behalf of
Ms. Embry, I want to thank all of you for
attending. And I also want to thank all of you
for the tremendous support we received to the
Defense Health Board and particularly to the
speakers, who did such outstanding presentations
today. Thank you.

(Whereupon, at 4:46 p.m., the
PROCEEDINGS were adjourned.)

* * * * *
CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

Notary Public in and for the Commonwealth of Virginia
Commission No. 351998
Expires: November 30, 2012