THE DEPARTMENT OF DEFENSE

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1 P R O C E E D I N G S

2 (9:00 a.m.)

3 DR. POLAND: Good morning, everybody.
4 Welcome to the second day of the Defense Health
5 Board's meeting here in San Antonio. We have a
6 number of important topics to discuss, so we're
7 going to try to get started a minute or two early
8 here and try to keep everybody focused and on
9 time. We've got an aggressive agenda. And being
10 where we're located in the U.S., a lot of people
11 who've got to catch planes otherwise stay until
12 the next day. So we'll try to keep
13 things on time if not a little
14 sooner.
15 Dr. Kilpatrick is the DFO. Would you
16 call the meeting to order, please?
17 DR. KILPATRICK: Good morning. As the
18 duly appointed alternate designated federal
19 official for the Defense Health Board, which is a
20 federal advisory committee to the Secretary of
21 Defense, and serves as a continuing independent
22 scientific advisory board to the Secretary of

1 Defense via the Assistant Secretary of Defense for
2 Health Affairs and the Surgeons General of the
3 military department, I hereby call this meeting of
4 the Defense Health Board to order.
5 DR. POLAND: Thank you. And as is our
6 practice, prior to the start of every official
7 meeting, we'll stand for a minute of silence to
8 honor those who have served our country.
9 (MINUTE OF SILENCE OBSERVED)
10 DR. POLAND: Thank you. We have a
11 number of distinguished guests with us today. Dr.
12 Chip Roadman, Retired Air Force Surgeon General
13 and also a member of the IRG. Major General
14 Michael Tucker. Brigadier General Retired William
15 Fox from the amputee panel. Colonel Jim Neville,
16 who was here yesterday. I don't see him right
17 now, Air Force Institute for operational health.
18 Colonel Mike Bunning, the Associate DFC Corps
19 Chief and others. Since this is an open session,
20 before we start, we'll go around and introduce
21 ourselves. We'll go first around the table and
22 then to both sides.

1 (INTRODUCTIONS)
2 DR. POLAND: We're honored as our first
3 speaker to have Brigadier General Michael S.
4 Tucker, Deputy Commanding General North Atlantic
5 Regional Medical Command, with us today. General
6 Tucker entered the United States Army as a private
7 in 1972 and served as a Calvary scout for the 1st
8 Battalion 35th Armor (off mike) in Germany. He
9 was accepted in 1979 for Officer Candidate School
10 where he graduated as a distinguished military
11 graduate. He had a very distinguished career as
12 outlined in the bio which you have in your
13 briefing books. He's currently serving as the
14 deputy commanding general North Atlantic Regional
15 Medical Command and Walter Reed Army Medical
16 Center. General Tucker is here to speak on the
17 Army Medical Action Plan for wounded warriors. As
18 members will recall the IRG group, a DHG
19 subcommittee led by secretaries Togo West and John
20 Marsh investigated the issues at Walter Reed Army
21 Medical Center earlier this year and developed a
22 series of recommendations.

1 General Chip Roadman, here with us
2 today, was a member of the IRG. The Army Medical
3 Action Plan was developed and implemented in
4 response to the IRG's recommendation. So, without
5 further ado General Tucker.
6 BG TUCKER: I heard a medical joke the
7 other day where a physician called a patient in
8 and said I've got some results back from your test
9 and I've got some good news and bad news. And the
10 patient said, Well go ahead and give me the good
11 news. Well, the good news is that you've got 24
12 hours to live. And he said, Well, you've got to
13 be kidding me, that's good news? What's the bad
14 news? I've been really trying to get a hold of
15 you. I've been calling since yesterday. So just
16 when you think you're having a bad day.
17 I am so not a doctor. I'm an Army
18 Calvary officer. I have been all my life. I was
19 in Nirvana running the tank school at Fort Knox,
20 Kentucky. And in early March, after 2-18 --
21 nation had 9-11, Walter Reed had 2-18, I got a
22 call from General Cody and he said, "I need your

1 help. We've got some problems at Walter Reed." I
2 said, "Sir, I'm tracking problems at Walter Reed."
3 I had seen the newspaper and CNN. And he said,
4 "Well, I need you to come and help me with that."
5 "Sir, I'm not tracking that. I'm out here at Fort
6 Knox, life is good, you know, da-da-da-da-da." He
7 said, "I need your help. Can you come?" And of
8 course you know how you answer those kinds of
9 questions. That was Thursday, I reported on
10 Friday and I've been there ever since. So as I
11 began to get my hands around this problem of
12 soldier, wounded, ill and injured care, initially
13 at Walter Reed, I began to discover that the
14 problem is not isolated at Walter Reed. Walter
15 Reed was nothing more than a microseism for the
16 rest of the Army and I'll share that with you
17 today. At Walter Reed in some sorts found itself
18 in a perfect storm. Next slide.
19 This is a spin chart, so just kind of
20 hang on to your seat when we get this thing
21 turning because it goes pretty fast. This thing
22 links like a hundred different slides. So if I

1 get off key, we'll be here until midnight trying
2 to get out of this thing. But I click on the
3 Washington Post article. So there's Staff
4 Sergeant Shannon on 2- 18. You may recall his
5 face, he was on the newspaper last Saturday in
6 Washington, he's a Calvary Scout 101st shot in the
7 left, with a sniper, has a pretty good case of TBI
8 and some rotary cuff problems. And of course
9 that's the famous building 18. What I determined
10 was that cases like Staff Sergeant Shannon
11 explained about were certainly not isolated that
12 there were many more, even worse and more
13 surprisingly there were building 18s, so to speak,
14 across the entire Army, there were lots of
15 building 18s out there. Go back to the perfect
16 storm here.
17 So Walter Reed -- USS Walter Reed, we
18 got the Navy to commission this. General
19 Schoomaker, we sat down, we came up with this as
20 we can harvest facts, and as you well know we have
21 an unprecedented battlefield survival rate. Some
22 statistics reflect that if metal entered your body

1 in WWII, if metal entered your body on the
2 battlefield in WWII, you had about a 20 percent
3 chance of survival. Today that's 92 percent. The
4 physical disability evaluation system was written
5 in 1947, so essentially it was written to handle
6 20 percent survivability; it's now handling 92
7 percent. And the injuries that our surgeons are
8 dealing with are injuries that are certainly
9 peculiar -- not peculiar to war, but are
10 characteristic of war, but what's different is
11 that these soldiers never survived those injuries
12 before. So the surgeons up there in the 16
13 operating rooms at Walter Reed who conduct up to
14 15 major operations a day up there. It's just
15 phenomenal, are dealing with injuries that we
16 really haven't had to deal with before because
17 they didn't survive those injuries and they're
18 able to give these kids a quality of life that not
19 only are they alive, but they're giving them a
20 quality of life later on. The Army's been
21 enormously criticized for hanging on to soldiers.
22 There's the DoDI, the Department of Defense

1 Instruction that says once a soldier, marine,
2 airmen or coast guard are unfit for military duty,
3 no longer medically retainable is the term, that
4 they automatically go to the VA. True statement?
5 Everybody understands that? That's what it says.
6 They go to the VA. The Army doesn't do that
7 necessarily in all cases. The Army will continue
8 to try to rehab you. Our surgeons don't want to
9 let you go. The parents certainly are not going
10 to let you go until your rehabilitative state is
11 stabilized. If you're in 6 of 26 operations,
12 complex operations, you may want to see
13 that through if you're a surgeon and many of
14 you are surgeons and you can certainly appreciate
15 that. Before I go further, let me say thank you
16 to all of you for doing what you're doing for the
17 DoD, and I just appreciate you taking time out of
18 your schedules and your professional regimen to
19 come together on this Board and help advice the
20 DoD. It's tremendous and I think it's great and
21 speaks well for our country and our open
22 transparent new government. That's one of the

1 things that we differ on is we will hang on to a
2 soldier. We will never leave a fallen comrade,
3 never, ever will we leave a fallen comrade and we
4 enjoy a pretty high return to duty rate. In fact,
5 in about the 365-day mark, we're up in the 80
6 percent of return to duty. That's what we try to
7 do is return to duty. The Army is about soldier
8 and it's hard to replace a staff sergeant, it's
9 hard to replace a Sergeant first class and so we
10 want to rehab these soldiers and get them returned
11 to duty. Now that's generating a lot of fault,
12 I'm sure, as to how we're going to tool this
13 health system in the future. But this kind of
14 came to us as we began to mine our way through the
15 problems that we had.
16 Every medic in the Army is an EMT.
17 Every single medic in the Army is an EMT who gets
18 recertified every year. Every soldier, now,
19 effective this summer every soldier that graduates
20 boot camp, basic training in the Army, becomes a
21 certified combat lifesaver. That's a lot of
22 syringes and IVs at basic training. It's kind of

1 a scary thought, but every soldier is a combat
2 lifesaver. Every combat lifesaver carries a
3 combat lifesaver bag. They can put an IV in, they
4 can do a bypass to your airway, they can -- and
5 they also carry the HNCON bandage, which you're
6 familiar with that no kidding stops the bleeding,
7 and we developed a new first aid kit called an
8 IPAC. When I deployed my armor brigade out of
9 Germany to replace a third IV in April of '03, my
10 first aid kit was a small little gauze pad with to
11 strings hanging off of it. The same first aid kit
12 I had when I came into the Army as a pilot in
13 1972, the same one. Six months later we had an
14 IPAC that has a no kidding tourniquet in it that
15 you can put on with one hand. We found out a
16 phenomenal thing about operating in the desert,
17 about tourniquets, is that there's not a lot of
18 sticks in the desert.
19 (off mike) no stick, you can't lose
20 either, kind of stuck in there (off
21 mike), but I just share those with
22 you because those have helped us

1 with the survivability and we get
2 you to a combat area hospital alive
3 there's a 97 percent chance you're
4 going to remain alive. Again,
5 unprecedented in military medicine.
6 So that causes you to be a victim
7 of your own success, so to speak.
8 Hallelujah, thank the Lord; we're a
9 victim of our success. Soldiers
10 are surviving injuries that they've
11 never survived before.
12 We have medical regulating challenges.
13 Transportation commander in St. Louis was
14 bickering the larger portion of our soldiers ride
15 into Walter Reed. They come into Landstuhl, get
16 stabilized sometimes only hours, and then they're
17 back up to Walter Reed. So we've made great
18 strides at de- regulating that to the point to
19 where we can vector you to other places where
20 healthcare can be provided as good, if not better,
21 than it could have been at Walter Reed. I know
22 that's working because the commanders out here at

1 San Antonio, and at Madigan, and at Womack at Fort
2 Bragg, and at Eisenhower down in Augusta, are
3 complaining because their populations are getting
4 too large. That's a good thing. We also have set
5 it up so that as you fill out your pre-deployment
6 form, where you talk about your next of kin, you
7 also can identify if we can provide -- if you have
8 a medical condition that can be treated at more
9 than one location, where, based on your family
10 care plan, where would you prefer to be cared for?
11 Now we can vector you in closer to home because we
12 do know that soldiers heal quicker and better when
13 they're closer to family and that way we don't
14 have to move the family. I mean, it's a terrible
15 thing when mom and dad are running the company
16 store and their son is in a traumatic injury and
17 now they have to uproot themselves from Topeka to
18 get all the way up to Walter Reed and live in a
19 hotel room for 11, 12, 14 months. It's just
20 ridiculous. As you well know Walter Reed is a
21 tertiary care center, you don't go on sick call at
22 Walter Reed, you go there -- you get referred to

1 Walter Reed, but yet right now we have 738 wounded
2 soldiers there and about 350 families. Now we
3 stood up a wounded warrior clinic to handle those
4 people and these soldiers, that population. But
5 you can kind of see as well we had problems with
6 that. And Walter Reed is a terrific medical
7 center, but it's not a very good Marriott resort.
8 It's trying like the dickens to be a good Marriott
9 resort and these families show up and they're part
10 of the equation. I spend a lot of time talking to
11 soldiers, wounded, ill and injured soldiers, but I
12 spend more time talking to families, because the
13 families are in your face if they think their son
14 or daughter or loved one is not getting the proper
15 care, as you would be in someone's face if you
16 felt the same way. So that's part of the
17 equation, we have to take care of them, see to it
18 that their needs are met.
19 BRAC and A76, you know, BRAC says that
20 if you're under Walter Reed, which is about 100
21 years old, and there's a water pipe leaking and
22 you say, well it's leaking right here, there's the

1 leak right there, let's get that fixed. Oh, wait
2 a minute, it's starting to leak here, it's about
3 to rust through here, it's coming undone down
4 here; we need to replace the whole pipe. Well
5 BRAC says no, you can't do that you just got to
6 fix the leak. So you find yourself dying of a
7 thousand cups. In A76, the privatization of the
8 contracts was causing people to leave (off mike)
9 job is not going to be here. We're going to move
10 this whole thing to Walter Reed and we're changing
11 contracts and the new contractor doesn't want you
12 so people are leaving, but the buses from Andrews
13 Air Force Base kept coming. The buses kept
14 coming, three days a week, 41 passengers. The
15 buses never stopped coming, but, yet the place is
16 falling apart. I mean, there was no one there for
17 four months. There was no one there to fix the
18 leaks, fix the lights, fix the heat, fix the air
19 conditioning, fix electricity. No one. No one on
20 the other end of the phone.
21 And then this longstanding PDS system
22 that I just described. Then we have this

1 fragmented wounded warrior command and control.
2 The TDA, the table of distribution allowances, for
3 medical hold soldiers in the Army, was 200 and we
4 didn't fill that 200 as we should have. We didn't
5 keep that full up at 100 percent. So the medical
6 command had to back fill that. The MEDCOM had to
7 pull a soldier out of lab, a lab tech, someone out
8 of pharmacy, someone out of records, and poof,
9 you're a platoon Sergeant, take care of these
10 wounded soldiers. The soldier may not have
11 even been to NCO education system or leadership
12 courses, but you had to do something because the
13 buses were still coming. When we rebuilt the
14 barracks in the Army -- when we rebuilt barracks
15 in the Army, and I was a battalion commander at
16 Fort Stewart when the big surge was happening, we
17 didn't rebuild any medical hold barracks.
18 Wounded, ill and injured soldiers are like broken
19 furniture. What do you do with broken furniture?
20 You put it down at the end of a dark hallway in a
21 storage room, up in the attic, down in the
22 basement, but you put it out of sight, out of

1 mind. So what I came to the conclusion with, as I
2 briefed General Casey on the second day in the job
3 as the Chief of Staff of the Army, Sir, this is
4 not a MEDCOM problem, this is a Army problem.
5 This is an institutionalized Army problem. We
6 didn't man the TDA; we didn't give them any
7 facilities to stay in. And Walter Reed was
8 subject to a perfect storm. By the way, I've been
9 out to 39 camp installations and I got Walter
10 Reed's everywhere. So, sir, we got to fix this.
11 And he said, You're exactly right. So that's what
12 we're doing and we stood up the Army Medical
13 Action plan. By the way, where we had 200, we put
14 in 2,463 Calvary members to watch after their
15 soldiers. Where we had 200, we're putting 2,463
16 soldiers off the line, coming back, that are now
17 becoming squad leaders, platoon Sergeants, company
18 commanders and staff officers in warrior
19 transition units across the Army, 35 of them to
20 handle the 10,000 medically non-deployable
21 soldiers on active duty in the United States Army.
22 10,000 medically non-deployable soldiers on the

1 active roles in the Army. That counts a little
2 bit against your end strength and if your force
3 managers, that's a big deal and we've got to put
4 (off mike). Next slide. I just wanted to kind of
5 give you an appreciation for the work at Walter
6 Reed that's going on. I mean that's a lot of
7 patients. I know that a lot of you work in large
8 medical facilities, but these are pretty
9 respectable statistics. It's a busy place
10 obviously. And you know nothing ever was wrong
11 inside that building, our problems related to the
12 outside of the building. And when I got to Walter
13 Reed I got all those doctors in a big room and
14 boy, there's a lot of doctors there. I said,
15 "Listen, if you think I just want to get up there
16 on the fourth floor and tell you how to do your
17 job, you're out of your mind. Okay? I am not
18 going to put my finger in your rice bowl. But I
19 will tell you this: If you're doing something
20 stupid, you will stop it immediately. That's an
21 order. No one in this organization will continue
22 to do anything that's stupid anymore. So just

1 knock it off. You're not authorized to do
2 anything stupid." It's amazing is how simple that
3 sounds, but they were -- one of the 06 doctors
4 said, Are you serious, sir? Yeah, I'm serious.
5 You are not authorized to do anything stupid.
6 It's kind of profound. Next.
7 So we set up an AMAP cell. Go to the
8 sync conference. So we had a conference out at
9 Lands Down, Virginia, out near Dulles airport,
10 because this is a huge problem. So brought in
11 about 160 people from 40-plus different agencies.
12 These are the field units, these are actual
13 regional medical commands in the Army, hospital
14 commanders, a lot of people from Army agencies,
15 DoD agencies, VA; and we worked from Monday until
16 Friday until 11:00 at night. It was not your
17 typical conference, look, see, drink coffee, eat a
18 donut, that's real nice, nice to see you again,
19 have a nice day I'm going back home and look at my
20 slides. We rolled our sleeves up every night
21 until 11:00 and we dug our fingers into the dirt
22 of this problem and we raked it clean. We got

1 every old car tag, every boot, every root, every
2 beer can, anything under there that dealt with the
3 entire scope of this problem, the entire scope at
4 echelon and we discovered about 156 things that
5 are just all messed up. We obviously discovered
6 that things are at echelon. Some things are right
7 there at Walter Reed, some things are at the
8 MEDCOM, some things are at the Army level, some
9 things are at DoD, some are at VA and some are in
10 legislation. So we broke it down and conducted --
11 go back to the spin out. I went out to the school
12 of advanced military studies at Fort Leavenworth,
13 Kansas, that's where we teach our strategic
14 thinkers. The other services have a similar
15 program. These are like Jedi knights and we teach
16 them how to do critical thinking and I hired me
17 about six of these high speed guys for about 45
18 days, I locked them up in a room, threw a bunch of
19 coffee and donuts in there and locked the door and
20 we made sausage, because we took these findings
21 and we created -- we did an old Army, military
22 decision-making process, MDMP, it makes your gum

1 bleed. It's taught at Leavenworth. Everybody in
2 the Army that's ever been to Leavenworth knows it,
3 but it no kidding is a fine filter. And you can't
4 do MDMP by the book and let some problems still
5 remain. You have to address it and you have to
6 decide what you're going to do about it. It's
7 really good. So we did MDMP because you had to
8 create an execution order for implementation of
9 the Army Medical Action plan, because if I just
10 did a MEDCOM order, people stick their nose up at
11 it. I need to do an Army order signed by the vice
12 chief of staff of the Army, signed by a four-star
13 that says, you will do this, you will do that.
14 And we did. We created a "no kidding" execution
15 order. We published it on the 2nd of June and
16 it's terrific. It's got legs, the thing is
17 holding ground, but it's making commanders do what
18 they should have been doing all along, but we just
19 didn't know what we didn't know. Go to the Triad.
20 At the heart of this program is the
21 wounded soldier in transition. We call them
22 warriors in transition. General Casey said,

1 "Mike, this is not a status. These are warriors.
2 I want them to be treated like warriors and
3 they'll act like warriors. We're not giving up on
4 these kids." I said, "Sir, you're exactly right."
5 And we created this definition. So their job is
6 to heal. When I talked to the soldiers in a
7 town-hall meeting once a month and I talk to them
8 in the morning, all 700 of them, I listen up.
9 Make sure that you are perfectly clear with what
10 I'm about to tell you, because your job is to
11 heal. That is why you're on active role, that's
12 why you're drawing a pay check, that's why you are
13 breathing oxygen. Your job is to heal. That
14 means that going to physical therapy, occupational
15 therapy, taking you treatment, doing all your
16 rehab, taking your medications as prescribed is
17 your job. That is your job and I will hold you
18 accountable for doing your job. And I've now got
19 squad leaders at a ratio of one to 12 and a
20 platoon Sergeant at one to 36. Kind of a novel
21 concept came out of FM7-8 the Infantry platoon, a
22 proven way to command and control soldiers. So

1 now I have soldiers at a command, lead to lead
2 ratio that is commensurate with the level of
3 command and control that they have to have with
4 these soldiers. Because reality is, the soldiers
5 who needed the most help in the Army go the least.
6 The guys, who should have been cared for the most,
7 got cared for the least. When they asked me about
8 well what do you think these billets should be?
9 You want them to have good facilities, what do you
10 want a Taj Mahal? I said, No. A warrior in
11 transition should live in barracks on any camp or
12 station that is as good if not better than any
13 soldier living on that camp or station. That's
14 all I'm saying. They should live in barracks that
15 are as good, if not better. And they need to have
16 concerned leadership at ratios at the level that
17 it needs to be to care for these soldiers. So at
18 the heart of this thing if obviously this mission
19 and then this soldier has this triad of support; a
20 squad leader, a registered nurse case manager and
21 a primary care manager. Primary care manager is a
22 doctor, now this will knock your socks off, at a

1 ratio of 1 to 200. Now some of you who are
2 physicians, don't you wish you only had 200
3 beneficiaries to deal with? 1 to 200 and that's
4 being serious about this problem. Now we're
5 putting 2,463 leaders in there and I'm putting
6 physicians in there at 1 to 200, so you can see
7 the price we're paying. And you know, it's not
8 new work, it sounds like new work, but as I've
9 taught the commanders out in the field who are
10 busy as hell fighting this doggone war, God bless
11 them, I tell them, sir, this is not new work.
12 We're making up lost ground. We've lost ground
13 with American people. We've lost ground with the
14 Army leadership and we've got to make this ground
15 back up and we're doing so in a big way. We pick
16 the families up at the hospital; we bring them
17 into this thing called the Soldier family
18 assistance center. This thing is like -- we have
19 a thing in the Army called ACS, Army Community
20 Services, which is kind of like a community center
21 where people can get counsel on check cashing and
22 how to raise your kids and how to take care of the

1 pets and where's the day care located, and where's
2 the youth activity sports program, school
3 immunizations, everything is all there. Well this
4 is the ACS on steroids, focused on these families
5 because these families have different issues than
6 a normal family would have. First of all, what
7 you see depends on where you sit. Their world has
8 been turned upside down. They sent Johnny to war,
9 Johnny came back without any legs and now I've got
10 to quit my job, I'm a schoolteacher, I can't teach
11 anymore, I've got to go to Walter Reed and be
12 non-medical attendant for my son or my daughter.
13 My world is upside down. I've got to make things
14 easier for them, not harder. But the bureaucracy
15 will make things awful damn hard if left on its
16 own, it will absolutely drive you insane. So we
17 now extend this to the families coming here. They
18 don't go anywhere else. They get an ID card, they
19 get all their paperwork done, they get (off mike)
20 they get their per diem payments; they get all
21 their benefits explained to them and linked to
22 them. All the charities in the world, 360-plus,

1 get plugged into the family right there. One
2 spot. They go nowhere else. They don't get told,
3 go to this building, go to that building, go down
4 here, go over here, see this person, don't forget
5 the Irish make the team, can't make it that time,
6 one place. Making it easy for these families.
7 And then they go down that long hallway to meet
8 their warrior in transition. When I called the
9 nurse case managers, I said; Tell me how you spend
10 your time? Well, we're helping soldiers get
11 promoted, we're helping them get their pay, we're
12 trying to get their family in from the airport,
13 I'm trying to make them make their appointments.
14 You know they've got an appointment in
15 orthopedics, but they've got to go get an MRI
16 first. Tracking them down, where are they
17 convalescing, it's just so much work. I said,
18 You're not doing any case managing. How do you do
19 case managing? The whole point is that this
20 person does all those things I just mentioned now.
21 So nurse case managers can focus on their core
22 competencies of case management. It's enormous.

1 And then we also have included and access to care.
2 These soldiers receive routine care in three days,
3 three days. Specialty care no more than seven
4 days and that moves them back to the head of the
5 line of all the beneficiaries. Now the Veteran's
6 Service organizations got up on their hind legs about
7 this, the Veteran's Service Organization, big
8 time, and I spoke to them at a conference at the
9 Pentagon and the MSO organizations. I said, I'm
10 sorry, but these soldiers are products of this
11 war. We can no longer allow them to languish in
12 the system. I'm going to see a psychiatrist on
13 the 1st of July and my next appointment is the 3rd
14 of August, because I put back in line behind
15 another beneficiaries. What am I doing between
16 now and the 3rd of August, working on my Nintendo
17 handicap? What am I doing? I've got to get back
18 in line and I've got to go back to the head of the
19 line. I've got to see that psychiatrist when the
20 psychiatrist wants to see me next, or when that
21 orthopedic surgeon wants to see me next, not go
22 back behind the line. So we moved them back to

1 the head of the line, access to care, it's had
2 enormous effect and efficiency. And I told the
3 VSOs, I said, First off you're all veterans so you
4 should understand. But number two, if this was
5 your love one standing in line, I think you'd want
6 them to move to the head of the line too. And
7 they powered down with that. They understood once
8 it was explained to them. But we've got to do
9 that. The only person to get in front of this
10 soldier in line is another soldier who is on a
11 prepare-to-deploy order, because they're going out
12 the door and we've got to get them fixed so they
13 can get out the door. That's the only person that
14 gets in front of them. But they're warriors in
15 transition, that's why they call them warriors in
16 transition, because they're going to transition
17 back to duty or they're going to transition to the
18 VA and be a citizen. But they're in transition
19 right now. That's why we call them transition.
20 And by the way, when we built the warrior in
21 transition unit, we combined reserve and active
22 duty together. They were different medical

1 holder, we combined them together. We should take
2 the have and have not's and put them together.
3 And then we took the injuries, the nature of the
4 injury. If you stepped in a pothole on the
5 streets of Arumadi (?) and twisted out your ACL or
6 you stepped in a gopher hole in Camp Shelby,
7 Mississippi, both of you did that in the line of
8 duty, both of you did that serving your country.
9 You're both equally injured. You're both equally
10 have a physical impairment. Whether it's having
11 your leg torn off in central corridor in a Humvee
12 accident at the national training center or having
13 your leg torn off with an IED in Telefar; it
14 doesn't matter. And I think as some of the
15 commissions come out they're trying to develop a
16 two-tier system. Well, the physical disability
17 evaluation system creates a two-tier system
18 anyway. I mean, it does, based on percentages.
19 That will take care of itself; but if we come in
20 from the start and say all you people are over
21 here and all you people are over here. I don't
22 think that's a good thing. That's a slippery

1 slope. You know in the Army we say, and I've
2 mentioned it before, that we will never leave a
3 fallen comrade. There's a period at the end at
4 the end of that statement. It's not comma, with
5 the exception of dot, dot, dot. We will never
6 leave a fallen comrade, period. If you are hurt,
7 ill or injured while serving your country on
8 active duty then we're with you and we're going to
9 stay with you and we're going to see you through
10 this and I think we've got to hold our ground in
11 that. So anyway, we take care of the families,
12 we're taking care of the soldier and we're trying
13 to prepare them for this transition to VA/VA
14 assistant, or more importantly back to being on
15 active duty. Next.
16 I just want to share with you just a
17 taste of some of the things inside our execution
18 order, show you about ten of the things in here.
19 As I told you, we stood up these warrior
20 transition units across the Army that means we've
21 got leader for every 12 soldiers. I did have one
22 leader for every 50 to 60 soldiers and that wasn't

1 necessarily a qualified leader, it was the best we
2 could do. Now I've got 1 to 12 and it works. We
3 have put this nurse case manager at a MEDCEN,
4 that's 1 to18 and at MEDAC, it's 1 to 36, because
5 MEDCENs have more polytrauma cases and the case
6 management is a little more complex. Next slide.
7 We have put these facilities at the top
8 priorities on our camps and stations. We have
9 town hall support for this population to discuss
10 their issues. We now put them on par with keen
11 essential. If you're in a 10 to 11 month
12 rehabilitative regimen, you know, why don't I just
13 put you in government quarters. Why don't I
14 create an Army Fisher house? Why can't I do that?
15 I have vacant quarters everywhere and you're in
16 proximity to the medical treatment facility and I
17 can do that, so we did. And we're doing it right
18 now and it makes sense because the soldier would
19 heal quicker in a home than he will in a hotel
20 room, because you've got a kitchen, you can move
21 around, he can be with his family. It's very
22 important. Next.

1 We pick them up at the airport, I told
2 you that. We've created this handbook to put
3 things in living room language so that these
4 families can understand. Now an Army spouse will
5 understand Army speak. They've been kind of
6 raised in that. But mom and dad from Topeka, who
7 sent their single son to war, do not understand
8 Army talk. So we've got to put this thing in
9 perspective for them. And we hired a family-
10 readiness support assistant. Now these families
11 get together in the lobby of the Malone house at
12 night and they've got issues. They've got
13 enormous issues that are particular to their
14 population, which you can appreciate. Who's going
15 to help to channel that energy? We have these
16 people for our regular combat units already, the
17 deployable units, so we're building a family
18 readiness group and then we have this full time
19 support assistant who is a GS employee that's now
20 trained to help these people, getting guest
21 speakers, take them out to see things, do meetings
22 with them. And then everything for these warriors

1 in transition and their families is that doggone
2 exception to policy, because they're out of the
3 norm. They're not in the normal cycle; they're
4 not in the normal paradigm of PCSing from one
5 station to another, moving. They're out of whack,
6 so they have these enormous exceptions to policy
7 so we're having to consolidate a policy. And what
8 we started with -- I said take every exception to
9 policy over the last four years and make that
10 policy because if it's not illegal, immoral or
11 unethical, I'm just going to do it and ask for
12 forgiveness. So we're putting it in as policy.
13 I've got the draft right now. It's about an inch
14 thick and it's going to be terrific because it's
15 going to create a policy for this population,
16 which we should because the bureaucracy will
17 absolutely take you to your knees. It is designed
18 to protect the government, but in doing so it
19 filters out those most deserving and it doesn't do
20 it on purpose, but it just does it because it's
21 institutionalized and there's 100,000 people in
22 that system that have been there their whole life

1 and I call them toads in the road, they're just
2 going sit there -- but you know what happens
3 sometimes with toads in the road. We've got the
4 standard operating procedure for these warrior
5 transition units. It's like the Dennig principle;
6 we've got to reduce variation here. You can
7 achieve enormous efficiency by whether you have
8 two black-belt Linksys projects going on right now
9 with the MEB; we're making great headway with
10 that. Then we've established this PTSD/TBI
11 awareness training. We had a problem out at Fort
12 Carson, Colorado you may have heard of or read
13 about. But here's the typical vignette, actually
14 this vignette happened and the secretary sent me
15 out to take a look at this. So I'm late for
16 formation, I'm late to get to PT. My excuse is I
17 thought I set my alarm clock, but I didn't. I got
18 lost coming to work this morning. I got in a
19 fight with my wife, I'm just all confused and I
20 think I've got this PTSD thing or TBI, Sarge, what
21 do you think, says the private to the staff
22 sergeant. And the staff Sergeant says, Hey,

1 listen Jones. I have seven IEDs down-range; you
2 only had one, what's your damn problem? I think
3 you're weak, why don't you just rough-up and move
4 out like a soldier. Now, if you're the soldier
5 standing three ranks back and you hear that
6 conversation, are you likely to come forward
7 yourself? So as we begin to go out there -- and
8 Marie Dominguez, by the way is my executive
9 officer and she's like a "no kidding" doctor. We
10 went out there and we interviewed chain of
11 command, hospital staff and then late into the
12 night all those soldiers. And so what it kind of
13 came to me was, back in the '90s had a heck of a
14 problem with sexual harassment. We didn't know
15 that women didn't want -- we didn't know that
16 women didn't want you to put your hands on them.
17 We didn't know that. We didn't know that women
18 didn't appreciate an off-color joke and we were
19 really messed up. So we had, in fact, in the '90s
20 I'll forget I was the tank battalion commander
21 Fort (off mike) Georgia. We did a thing called
22 "Leader teach," and this thing was given to me.

1 Listen up, Tucker, you will brief this program, do
2 you understand? I opened the book -- this is the
3 instruction: Open the book, read first sentence
4 and I (off mike) this thing, so you couldn't screw
5 it up. It was terrific. I was on the tank range,
6 got everybody out of their tanks up under a big
7 old tree by the tower and I gave them this "Leader
8 teach," and we were better for it. We woke up and
9 we smelled the coffee. I called General Cody that
10 night from Fort Carson, I said, Sir, we've got to
11 do "Leader teach" just like we did in the '90s
12 with sexual harassment, because people at that
13 lowest echelon do not get it. So we're doing it.
14 We're going to be complete by the 19th of October
15 across the entire Army; we're doing PTSD/TBI
16 Leader Teach. It's a terrific program. You can
17 get it, it's on the web, it's all over the place.
18 And we got another package for family members.
19 But what it does simply is it makes sure that
20 staff sergeant understands, number one, how to
21 recognize it and number two, what his or her
22 responsibilities are in facilitating that soldier

1 to get the treatment. But there's an obligation
2 and a responsibility to get that soldier to
3 treatment. Don't give the soldier the high sign,
4 because what happened in many, many cases was the
5 soldier obviously had to seek other ways to cope
6 with this program, turns to drugs, turns to
7 alcohol, DUI, wrecks a car, drives without a
8 license, character of service changes, soldier is
9 discharged bad conduct discharge, how much VA can
10 you get with that? None. And the truth is that
11 this could have all be prevented, we could have
12 saved this soldier, we could have stopped that
13 from happening. So it's just an education and
14 awareness thing. And it's having great success.
15 We sent it out to every prominent psychiatrist,
16 mental health professional in the civilian sector,
17 let them look at it first, to give endorsement.
18 Is it what you think it should be, what do you
19 think? We tweaked it and it's a great program,
20 it's very important. Next slide.
21 We have joint patient tracking. We can
22 track a soldier from the time they enter the

1 combat support hospital. Actually we can get them
2 at the ford surgical unit and track them all the
3 way through the system. A web-based program. We
4 sent a letter to the commander; Jones is in our
5 capable hands within 24 hours after arrival. I
6 mean, I had soldiers who were injured and they
7 just kind of went off into the dust. I didn't
8 know where the hell they went and you'd hear about
9 it by rumor mill about a week or two later,
10 sometimes three weeks later. Yeah, Jones has made
11 it. Wow, I hope he's okay. Now we send a letter
12 saying he's here, he's okay. If you want to send
13 him an e-mail you can do so at this e-mail
14 address. The soldier come up on army knowledge
15 online. If you want to come visit, this is how
16 you visit. If there's any awards due to this
17 soldier let us know we'll present these awards.
18 By the way we got the award backlog completed at
19 Walter Reed. We do award ceremonies, Purple Heart
20 ceremonies there once a month and they're
21 terrific. We do them at Joel auditorium and
22 there's not a dry eye in the house. I mean, it's

1 just unbelievable. And those soldiers, to a
2 person, when I present them their award and I say,
3 Would you like to say something? And they hobble,
4 limp, roll up on the front of that stage, and the
5 first thing that comes out of their mouth is: I
6 just want to say thank you to the doctors and the
7 nurses putting me back together. The first people
8 they thank and I think it's great.
9 I told you we allow these soldiers to
10 get a preferred treatment location. It just makes
11 sense. And the VA's been very receptive to allow
12 us to co-locate VA LNOs with our nurse case
13 managers because there was this chasm. I mean,
14 you know people falling into the cracks so to
15 speak and so now with the VA LNOs shoulder to
16 shoulder with nurse case managers, there's a lot
17 more sharing. It's more of a seamless transition.
18 I'll tell you that we've been accused of being
19 like this. I think now we're kind of like this,
20 but where we need to be is this. At 60 days, my
21 perspective, at 60 days out from discharge, I
22 should have a VA counselor already assigned, I

1 should have a VA doctor sign, I should know which
2 VA center I want to be treated at. I should have
3 my first appointment. I should know what my
4 benefits are going to be. I've submitted for my
5 benefits and they have been pre-approved waiting
6 my DD214. Pre-approved. I know what my VA benefits
7 are and they have been pre-approved. I know what
8 they are and I know what to expect. I'm going to
9 discharge you before the 27th of the month so that
10 my VA check comes on day number 30 when I get out.
11 And I know what my VA benefits are going to be and
12 that will happen as well 30 days out. If we do
13 that, we'll be fine. We'll have truly seamless
14 transition. But until we get there -- what's
15 happening is the soldiers give -- you're going to
16 be discharged on the 10th of the month and here's
17 a phone number for the VA, have a nice day. See
18 you later. That is wrong. If you don't believe
19 it, ask soldiers, they'll tell you. That is so
20 wrong. And the VA doesn't want it that way and
21 the Army doesn't want it that way and the
22 government doesn't and the people damn sure don't

1 want it that way, but it's that way. It drives me
2 crazy. So we're going to bring them in their
3 shoulder to shoulder. You can't get out. We're
4 going to set up so the VA has to stand up there;
5 no, no you can't get around me. Here I am. I'm
6 the VA and I'm in your face. I think that's the
7 way to go. I've talked to the VA, I spoke to
8 Admiral Cooper and Dr. Kusman, I think is his
9 name, both of those great people want to help and
10 get this thing fixed for our soldiers, our
11 sailors, airmen and marine. Next slide.
12 We created a My MEB. We have a thing in
13 Army AKO, you may have heard of Army knowledge
14 online, and other people are doing it too. But
15 you can now go into your MEB file. You log on and
16 you can look at your medical evaluation board.
17 You can see the chronology of your treatment. You
18 can see exactly where your file is right now,
19 which is really good. You can see the exams, I
20 mean, it's just crazy. Because, as you well know,
21 you will police up yourself real quick and so the
22 physical evaluation board liaison officers and the

1 MEB docs and all that they're all on the hot seat
2 now because soldiers are saying, Hey, wait a
3 minute. This form is wrong. This I is not
4 dotted, that T is not crossed, that data is
5 incorrect, that Social Security number is not
6 right. So it's good. It's self-cleansing and
7 they've got every right to see their own file. In
8 fact, we're creating my PEB now as well along with
9 the physical disability agency. I told you we've
10 got a physician dedicated -- we also have an MEB
11 doctor. We have a doctor at each MTF that's
12 dedicated to do MEBs. And I told you about the
13 access to care standard. And then finally,
14 General Casey kind of laughs at this, a soldier
15 will go out and rob a bank and steal a car and
16 we'll give him a doggone lawyer to represent him.
17 Guaranteed. We're going to give him a lawyer.
18 But a soldier going before a physical evaluation
19 board that's going to affect his healthcare and
20 his family for the rest of his life, on his own.
21 Have a nice day. So now we have 18 lawyers that
22 we've activated to act as legal advocates for that

1 soldier to help them make those decisions and work
2 their way through that. Go back to the spin.
3 Publish an order. You can see here
4 where these warrior transition units are located
5 by size, the color code. And so you can -- you
6 now it's one thing to publish a piece of paper and
7 say, Okay, all you knuckleheads need to start
8 doing these things. But you've got to go out and
9 check too. You've got to go out and say, okay.
10 So we've created staff assistant visits. Go back
11 to the spin out and go to the SAVs.
12 So we go out and we check these larger
13 sites. There's 22 people on each team. They are
14 subject-matter experts. There are four teams and
15 they check these units on 409 different items, 400
16 different requirements. When I get the trends and
17 I'll brief those trends to the secretary of the
18 Army and the vice chief of staff of the Army every
19 month. I'll do it again on the 1st of October and
20 it's just terrific. We follow that with a BTC
21 with every MTF commander and warrior in transition
22 unit commander across the Army and General Cody

1 will absolutely crush their knuckles if they don't
2 do what they're supposed to. Go back to the spin
3 out and go into Leadership business.
4 So you can see this is a cohort of a
5 population and there's the windows of the
6 population. Go to the next slide.
7 This is where we combine active duty and
8 reserve component soldiers. You can see that
9 built the warrior transition unit. My problem is
10 that half of my population of the 10,000 are still
11 in their units out there, drives me crazy. These
12 soldiers are still out there in their infantry
13 platoon and they're not medically deployable.
14 Why? Why haven't they moved over to the warrior
15 transition unit? Because they're the permanent
16 staff duty officer, they're the permanent charge
17 of quarters, their the PowerPoint Ranger in the
18 operations staff, so we're having to pull them out
19 and get them over to warrior transition to get
20 them healed and General Cody is absolutely
21 ruthless with commanders because they want to hold
22 on to these kids, so we're moving them across.

1 Next.

2 An article came out in the Associated

3 Press last night -- go to ANAM. How many of you

4 have heard of ANAM? That's what it is. It is the

5 famous baseline. We now have it. 101st Airborne

6 in Fort Campbell, Kentucky, just completed it and

7 we're moving it out to every unit before it

8 deploys. It establishes the baseline. You cannot

9 cheat this form. We do a post-deployment health

10 assessment, PDHA, but that's kind of a

11 hit-and-miss form. You know some kids get that

12 form and say I'm not going to check anything on

13 this form that's going to prevent me from going on

14 (off mike) leave and I don't want to end up on the

15 5th floor in a padded room in any hospital. Have

16 a nice day. I'm not going to do that. So this

17 test, you've got to by firing on all cylinders up

18 here. This measures your cognitive response. You

19 can't cheat. You've got to remember number sets,

20 color combinations, symbology relationships. I

21 took this test, it made my head hurt. If you're

22 drinking the night before, don't take this test,

1 because it's a hard test, but the beauty of the
2 test is you can't cheat on it and it will
3 establish a "no kidding" baseline that we put in
4 your digital medical record and so we can track
5 you and establish a baseline before you deploy.
6 When you come back we do another baseline on you
7 and we can account for what happened in between
8 and I think it's terrific.
9 We've got a handheld down at every unit.
10 Every medic platoon has these which can send
11 information wireless to this CHCS computer into
12 the theater management database into their central
13 deposit recovery reservoir, whatever that thing
14 is. Central data registry. And AHLTA, as you
15 well know is kind of our digital medical record.
16 But that's the way we can enter -- Go to the MACE
17 form.
18 This is a DoD form. It's been out since
19 August of '06, but when I talked to commander's
20 down-range, some are using it, some are not. This
21 is a great form. And I go out and talk to
22 commanders in the field, Listen you've got to

1 start using this form. When (off mike) fog at
2 night and they've had -- you do your post-patrol
3 report what happened, we had an IED at checkpoint
4 37. Who's involved? Smith, Brown and Jones.
5 Okay, get them down to the (off mike) station ASAP
6 and fill out a MACE form on them and get it put
7 into AHLTA, because that way when they come back
8 into the PDHA and health assessment we've got a
9 record of this event and we can get you into more
10 high-level care if we need to as we're screening
11 you when you get back. Very important we close
12 that loop. Go back to the spin out. Go to the
13 recommendations.
14 I think this came out of one of your
15 papers and what I want to do is focus in on some
16 of your observations from where we sit. These are
17 things you said consider, this is from the IRG,
18 and develop a set of highest clinical standard,
19 evolutionary, cost effective, actionable. We see
20 that in the Army Medical Action Plan that I've
21 shared with you today, from the Army's perspective
22 being a subset of a subset of a subset of this

1 larger problem at DoD and VA is that AMAP is our
2 answer to that concept. The road map is this
3 holistic rehab. We put a vocational/occupational
4 therapist in the warrior transition unit down at
5 the company level, because it's more than just
6 your legs. We want to have a holistic approach to
7 rehab. We want to get your brain working. We
8 want you think about what you want to be when you
9 grow up. What are your aspirations? What are you
10 goals? What do you want to be? And get you
11 thinking about that as well and then set the
12 conditions to allow you to do that and we've hired
13 four more college education counselors at Walter
14 Reed because at Walter Reed, not going to class,
15 not taking college education is the exception.
16 Not taking college education classed is the
17 exception. I am tired of soldiers up there
18 working on their Nintendo handicap in their spare
19 time. I want them to get their head working as
20 long as they can cognitively do so. It's terrific
21 because it's a win/win. It's a win/win. You
22 can't just go off. So once you get them started

1 you can nudge them along and give them some
2 support they'll do and they feel better about
3 themselves and that's part of healing. So that's
4 how we kind of see that. These metrics. We have
5 got metrics that make your head hurt and we brief
6 them every Friday. We have them called gumball
7 charts. We track every single thing required in
8 that execution order and we have commanders brief
9 either amber, green or red in that area. And why
10 are they not green? And when are they going to
11 get green? Because my glide path takes me out to
12 January '08. I had initial operating capability
13 on the 3rd of September which means we're all
14 here, we're doing this now, we may not be at full
15 operational power yet, but we're 50 percent.
16 Actually we're at 54 percent and then 100 percent
17 in January. And we've got a plan to measure that.
18 And the department of Army IG we have trained on
19 how to inspect the AMAP program. So the
20 department of Army IG team will go out and start
21 doing compliance visits in November and they'll be
22 armed and dangerous and check these units. Then

1 these resources, the (off mike) road map, the
2 warrior transition unit TDA, 2,463 soldiers off of
3 our end strength to man the CODRE positions in
4 these warrior transition units across the Army and
5 my office has stood up. My office will remain.
6 There will always be this Army and Medical Action
7 plan team in the office of the surgeon general.
8 Again, this holistic rehab in the developmental
9 phase so that we define responsibility, who is
10 responsible for what at each step. Next.
11 We're endorsing and got approval to use
12 the CEP, which stands for Center for Enhanced
13 performance up at West Point in New York. A lot
14 of NFL teams are using that program. It deals
15 with the -- Marie, which two of these -- mental,
16 motivational and emotional. It helps enhance
17 those to help you achieve what you aspire to do.
18 It helps you reach your potential whether you
19 realize you can reach it or not. It's a great
20 program. In fact, the Redskins are wanting to
21 come over and use it. Next. Go to Commanders
22 intent.

1 When I go out and talk to people I share
2 this with them. This, in the world of priorities,
3 this has a priority. It really does. When I'm
4 sitting with a General, usually it's a 3-star
5 General or post commander and I've been out and
6 I've noticed that their warrior in transition
7 barracks are not exactly up to par, you know,
8 they're not manning their WTU, warrior transition
9 unit, to standard. I'll have a little office call
10 with a high ranking officer and I'll have this
11 hard copy and I'll just kind of slip that across
12 the coffee table as we're talking. And I talk
13 about nesting yourself with the commander's
14 intent. Sir, we've got to ask ourselves, are we
15 nested with the commander's intent. Now just to
16 be frank with all of you, who else has to say
17 something here? Who else do we need to hear from
18 so that we get it, so we understand where we stack
19 up, where this problem stacks up in the hierarchy
20 of all other things competing? Especially from
21 the Army perspective. From here down I get it. I
22 don't need anything else to work from here down.

1 This is good enough for me. But Lord have mercy,
2 so usually when I get this in front of them and
3 they take time and read it, the lights come on and
4 things start to happen. You can appreciate that
5 they're out there fighting this war. They're
6 turning brigades around like a turnstile. I mean,
7 10th Mountain Division, Fort Drum, New York, God
8 bless them. If all the brigades of the 10th
9 Mountain Division came home to Fort Drum, New
10 York, they'd have to live in tents because they
11 only have enough barracks for two of their four
12 brigades and they just hot bed them. They don't
13 have to worry about it because they've always got
14 two deployed all the time. It's not a big
15 problem. We're not all home. Oh, my goodness.
16 It's like having all your kids come home to see
17 you and you're living in a one-room trailer park.
18 They can't all come to see you; they've got to
19 stay in a hotel. So anyway, this kind of helps us
20 out. Go back to the spin and go up to the way
21 ahead.
22 This is kind of my road map. You see

1 full operational capability out here. I keep
2 telling Secretary Gerren (?) that -- he says, What
3 happens here? I said, Sir, that's when I work
4 myself out of a job. Because if I'm still -- sir,
5 if I haven't accomplished what you want me to do
6 by that day you need to fire me because I've been
7 ineffective. But anyway we do strategic
8 communications. Today is part of that strategic
9 communications. We've got to get the word out
10 what we're doing. Congressional engagement. Been
11 on the hill 19 times. I just found out last night
12 I'll be up there on number 20 tomorrow in my Class
13 A uniform, which is just fine because I want to
14 maintain an extremely high level of transparency.
15 The Army's been accused of being kind of close
16 holed and you can't see and we'll tell you about
17 it later and submit your request and original
18 forms on the 15th Sunday of the 14th month type of
19 organization. I tell professional staffers, come
20 any time you want. Bring your member with you.
21 Anytime you want. Just call me before you come so
22 I'm there, because if I'm not there I can get

1 there. But I have nothing to hide from you.
2 That's done us a lot of good too. I've been very
3 honest and very forthright with them. You can
4 see, we've got a pretty good plan and we track
5 what we're doing. The MEDCOM has enormous
6 tracking mechanisms. It makes my head hurt
7 because where I come from we didn't have that good
8 tracking.
9 This kid here, he's an inspiration.
10 He's on Delta Force down-range. He is one of how
11 many, Chuck? Nine?
12 CHUCK: We had nine return to duty.
13 BG TUCKER: Nine return to duty that are
14 down range? Chuck's sitting over there with a
15 duffle bag full of legs. 59 amputee return to
16 duty. So kids like this, you can imagine when the
17 Iraqi's see that, what kind of statement that
18 sends. And every time the President comes to
19 Walter Reed, and he comes there a lot, he will
20 talk with the soldiers and he'll say, You know,
21 what do you think? What's going on? Sir, I just
22 want to continue to serve my country. I don't

1 want to quit. I'm a soldier. I want to continue
2 to serve. And the President says, every single
3 time, I want soldiers like this to stay in our
4 military. If they want to serve, we need to find
5 a way for them to serve. I think it's important
6 we allow them to do that. Go back. Go to the
7 families and leaders and I'll end with that one.
8 This Sara Wade and her husband Ted.
9 Sara Wade, her husband had no right arm. Am I
10 correct, Chuck? He's got right arm prosthetic,
11 has moderate TBI. He can't remember what he had
12 for breakfast. Sara had to quit her job. I'm
13 thinking she was a teacher in Chapel Hill, North
14 Carolina. She had to quit her job and she cares
15 for her husband. And they've been going out to
16 see Chuck at the prosthetics lab at Walter Reed
17 for about a little over two years. Never got
18 compensated for it, drive from Chapel Hill to
19 Walter Reed and the bureaucracy said, Well, yeah,
20 we can reimburse you for that, but we need every
21 single gas receipt, every time you went to
22 McDonald's, every time you stayed at the Holiday

1 Inn, da-da-da-da-da. I got with Chuck and went up
2 into the computer up there where he logs in people
3 being seen and treated. When the soldier arrived,
4 when the soldier left, gave that to TRICARE and I
5 said, You have got 48 hours to give this family
6 their money and I'm not kidding with you a bit.
7 You've got 48 hours. And they gave them a check
8 for $14,900. Staff Sergeant (off mike)
9 poly-amputee, multiple amputees. That's his
10 mother. Re-enlisted in the Army for a $6,000
11 bonus. Was in an IED that created these injuries
12 about a month later. The bureaucracy went after
13 him because he hadn't fulfilled his re- enlistment
14 contract for $6,000. This woman -- he can't even
15 feed himself, he can't dress himself, his mother
16 had to quit her job to care for her son and we're
17 going after them for $6,000. That is but two
18 cases that just puts tears in your eyes and there
19 are hundreds. Those are the things that keep me
20 up at night. I can tell you that since we've
21 started the Army Medical Action Plan, stood up the
22 warrior transition unit -- on the 15th of June we

1 stood it up, like no kidding. We're doing fine.
2 All those people are doing fine. They've got
3 leadership, they're getting tracked. It's these
4 older cases, because they left Walter Reed in
5 2004. Was it the spring of 2004? 2005. And they
6 were before we had any of this. So I think we got
7 it right. We're going to have efficiencies in our
8 system. Our access to care is efficiency in the
9 system. The triad of support of the nurse case
10 manager, the primary care manager, squad leaders
11 putting efficiency in the system. The Lean Six
12 Sigma for the MEB. The single physical evaluation
13 that we're going to do that Dole-Shalala came up
14 with. So as we continue to move out, the Army is
15 moved out at a blistering pace. One of the
16 commanders said, How can you move out so fast
17 without all the resources necessary? I said,
18 Well, when you find yourself in what we call an
19 engagement area, and as a Calvary officer, an
20 engagement area is where you're on the battlefield
21 and you're stuck in a mine field and the enemy is
22 shooting artillery at you and firing you with

1 direct fire weapons. You're in an engagement
2 area. And there's only one thing to do. Get the
3 hell out of it, real quick. So we got out of the
4 engagement area. We moved out really fast.
5 When I briefed General Casey on this, as
6 I talked a bit earlier, I said, Sir, I've got some
7 things here. I call them low hanging fruit.
8 Quick victories. Got about 10 things here we can
9 do. How much time you need? Sir, I need about 75
10 days to get these things done. He said, you got
11 30. So that kind of sent a message to me and I
12 moved out. I didn't even look back at that point.
13 When he said that, I moved out. And I've had
14 enormous support from the highest level of the
15 Army and the government on this program.
16 I'll just leave you with this. These
17 soldiers in the warrior transition unit, I've
18 discovered because the Cadre is enormously
19 strapped, these soldiers need enormous amount of
20 care. You take the first guy in the formation, in
21 the rank, he's missing two legs, this soldier is
22 missing a foot, this soldier's missing an arm,

1 this soldier is blind, this soldier can't remember
2 what he had for breakfast, this soldier has such
3 traumatic injury that he can't even wear a uniform
4 without having a mental breakdown and you're going
5 to stand in front of them as a squad leader using
6 the leadership skills that were very effective for
7 you in your last unit and you go stand in front of
8 them and call them to attention and one of them
9 doesn't act right you're going to say, Okay, let's
10 all get down and knock out 20 push-ups. You see
11 what I mean? The skill sets that they come to us
12 with, may not work and so we develop a
13 certification course for these squad leaders and
14 platoon Sergeants because the skill sets that have
15 made them very successful so far in the Army may
16 not work here. So all these kids are on a
17 different emotional plain. Some of them are
18 enormously fragile and right behind them is a
19 family, standing right there. Sometimes they'll
20 just come to formation so they're a factor to deal
21 with that normal squad leaders and platoon
22 Sergeant off the line are not normally having to

1 deal with. So we've got to include sensitivity
2 training, give these CODRE skills that they need
3 to help to do their job because we're asking a
4 hell of a lot of them. I've got some Sergeants in
5 there who just came off of being a DI, drill
6 Sergeant duty and said, Sir, this job is hard.
7 We're working until 11:00 every night. Being a
8 drill Sergeant was a walk in the park compared to
9 being a leader for these soldiers. We're going to
10 do the job, sir, but it was not what I thought it
11 was going to be and we'll get it done. But these
12 people need a lot of help; they need a lot of
13 leadership. That's a big calling for these kids
14 and we're going in for special duty pay for them
15 and get them certified and get them the skills
16 they need and God bless them for coming out and
17 doing this work. So that's kind of what I've got.
18 I'm more than willing to entertain some questions
19 that you may have and I appreciate your time this
20 morning.
21 DR. POLAND: Thank you, very much,
22 General Tucker. This has obviously been an area

1 of great concern to the nation, but also to this
2 Board. I'm very pleased to see as a part of your
3 presentation, the DHB recommendations, pleased to
4 see the progress that's been made and the obvious
5 planning and the obvious passion that you for this
6 mission. Much appreciated and the nation is
7 grateful for that.
8 I'll start with one question. In my
9 mind, all of this traces back fundamentally to a
10 leadership issue. My question is, well, the
11 Marine Corps has something called a "Lessons
12 learned" unit, which they're finding of immense
13 value. There are lessons learned from this, let's
14 call it an engagement. How will those lessons
15 learned get institutionalized in the Army and
16 taught and learned by the next generation. When
17 you and I are gone, how will Army remember this
18 and learn from this and move forward from this?
19 BG TUCKER: That's a great question. I
20 think, first of all we'll never go back. We will
21 never go back to where we were in terms of the
22 care of ill and injured soldiers. Number two,

1 training this consolidated policy that I talked
2 about, this one-inch stick, puts everything into
3 policy that's been wrong and it crosses so many
4 different echelon's of commands and directorates
5 in the Army, most of them within HRC and G1
6 personnel, but there's a lot finance and there's a
7 lot of legislation, but all that's going in there
8 to correct it for the long term. We have a
9 lessons learned organization that we filter back
10 in. Then once a month -- we do a BTC once a week
11 to track our progress here, but once a month, I do
12 a lessons sharing BTC with all the MTF and
13 transition commanders and I'll do one tomorrow in
14 fact, where we talk and share with each other the
15 stories, like some of these I've shared with you.
16 The story of Staff Sergeant Shannon in last
17 Saturday's Washington Post will (off mike) one
18 person brought the whole program down and how can
19 we prevent one person taking down the whole
20 program.
21 DR. POLAND: You're going to send a big
22 message.

1 BG TUCKER: Big time. But that's a
2 great question. We've moved at a blistering pace
3 and what scares me right now is that the VA and
4 DoD are down here and they're moving out. Not at
5 the same pace we are because we're a little
6 smaller, we're a little more nimble and agile and
7 we can move out pretty fast. But the VA and the
8 DoD can't move out as fast just because they're
9 behemoths, I mean, they're huge and they've got a
10 lot of strings tied to them that I don't have tied
11 to me. So they're starting to move on this
12 particular subject and it scares me to death,
13 because tactically I'm way out in front and my
14 flanks are exposed.
15 DR. POLAND: That actually leads to the
16 next question and that is, for the purposes of the
17 Board here: What are areas that we could be
18 helpful? What are barriers that we could help
19 look at or make recommendations on?
20 BG TUCKER: I think Dole-Shalala is spot
21 on. I think their recommendations are sound.
22 They've had good studies. They've listened to the

1 field. I'm afraid of the definition. I think the
2 first thing that has to happen is we must define
3 who this soldier is, who this soldier, sailor,
4 airmen or marine is that we're going to take care
5 of. That's the first thing I deal with the
6 Secretary General; sir, let me define for you the
7 warrior in transition. The warrior in transition
8 is a medically non-deployable soldier going
9 through an MEB who require rehabilitative
10 treatment that will exceed six months. If you
11 approve that definition then everything else will
12 become relatively simple, at this point, in terms
13 of who the population is. So I think we should
14 try to prevent a have and have not approach.
15 Because to do so otherwise is a slippery slope and
16 we will remain under attack from America for not
17 taking care of people who are serving their
18 country.
19 I think we need to work really hard at
20 defining who the recovery care coordinator is or I
21 believe -- I brief the SOC, by the way on Monday
22 this week, the SOC staff, not the SOC proper, that

1 I believe they're calling it Federal Care
2 Coordinator now or Federal Recovery Coordinator
3 now is what they're calling it (off mike) recovery
4 is federal now. Define what that job is because
5 it brings to this point, when you ask for help;
6 we've got to make sure that we've got seamless
7 transition. If you were to ask me where do you
8 see the biggest void in the continuum care that we
9 all often -- we often throw that term out quite
10 easy, the continuum of care -- the continuum of
11 care is at risk when you go from active duty to
12 release from active duty. That's where you're
13 vulnerable, that's your point of risk and so we've
14 got to pile on and we've got to make sure that
15 this is seamless and just at the Army level, I
16 mean, we have worked with the VA, kind of in a
17 side bar relationship, to bring in where we have
18 VA representation on camps and stations, we have
19 gotten permission to move them physically on our
20 camps and stations in with the nurse case
21 managers, and they're willing to do that. Why?
22 Because it's for the right reasons. I mean, you

1 need to go see the VA; where are they? They're at
2 some building on post at the end of a long dark
3 hallway and have a nice day. No. Or the VA is
4 calling you, hey, I understand you're going to
5 release from active duty in 60 days, I need to get
6 an appointment with you to come in and start
7 talking about your VA benefits, start lining you
8 up and get your applications put in, you see. So
9 those are two areas that I'm concerned.
10 DR. POLAND: Let me give the
11 opportunity, first, for General Roadman to make
12 any questions or comments that he may have as he
13 was part of the IRG.
14 LT GEN ROADMAN: General Tucker, thank
15 you. I really appreciate all the work you all
16 have done. Quite frankly my emotions have gotten
17 a booster shot here going through looking at this
18 and the town hall meetings that we had.
19 I agree with you that you are way out
20 ahead of the headlights in fixing this problem
21 that is larger than Army, much larger than Walter
22 Reed. I disagree with you with the issue of the

1 large bureaucracy cannot move out. My impression
2 from listening to things that we've had already is
3 that in -- and I like to frame it this way: If we
4 go to war will the bureaucracy come in on our
5 side? Quite frankly, I think the answer at this
6 point is, no. That they are going to continue at
7 the same pace, same rate, business as usual while
8 we're taking casualties and not solving the
9 fundamental issues, which are much larger than
10 what you have to deal with. They have to deal
11 with guard and reserve issues, they have to do
12 with people who are in the shadows of the
13 bureaucracy. I think you are, as I listen to you,
14 you're absolutely on the right track. Our
15 problem, as we present this to be comprehensive,
16 is that the signal-to-noise ratio becomes very
17 difficult to pull out and I think the presentation
18 is absolutely complete. The real issue is: Will
19 our nation accept its moral obligation to care for
20 our wounded warriors? And then the bureaucratic
21 approach that we take is how we fix that. But I
22 think quite frankly the DHB has got to be the

1 conscience of the Department of Defense. And I
2 worry.
3 I wanted to make some wrap-up. My view
4 of transition from the AFEB to the DHB, actually
5 the epidemiology part is the easy part. What this
6 Board is now going to take on is the culture, the
7 tendency to worry about the cost rather than worry
8 about what should we have done. And I don't -- I
9 really don't mean to get emotional Greg on doing
10 this, but I think, General Tucker you're
11 absolutely on the right track. I think the volume
12 of the tasks present will overwhelm even the 2,000
13 people that we have now in support. I think there
14 will be a tendency in this next year for the
15 administration to be a lame duck for another year
16 as the new administration comes in to be on the
17 learning curve and it will be a fight between the
18 rational approach to what we're doing to gain the
19 minds of the people who are in power and that's
20 where you have great opportunity to have the story
21 correct, to be pressing forward because there will
22 be a fight by the staff to regain the minds of the

1 leadership, so there's an opportunity that is
2 coming here to make fundamental change, but only
3 if we get it concise, right and boiled down to the
4 moral obligations that we have. I didn't mean to
5 make a sermon.
6 DR. POLAND: No. That's exactly right.
7 LT GEN ROADMAN: Yeah, I did. But I
8 think that I am quite frankly worried. I don't
9 believe that we can institutionalize this as
10 lessons learned because there is always a fight by
11 the bureaucracy in peacetime to whittle this down
12 to efficiency and effectiveness, which takes away
13 our surge capability and then we will always be on
14 the low side of the power curve fighting our way
15 back up having to call air strikes on our own
16 position in order to get out the engagement zone.
17 So I applaud what you're doing. I applaud the
18 speed that you're doing it and quite frankly am
19 embarrassed that I don't think the support systems
20 are there to make that job executable, otherwise I
21 have no opinion.
22 DR. SILVA: Thank you for the Board.

1 We've all been very much bothered by what we see
2 in the newspaper too. I just have several very
3 quick comments; it may not need a response, but
4 just to put them up on your radar screen and the
5 Board's.
6 First is the VA. I visited our VA and
7 the blemish you felt at Walter Reed they feel,
8 because many citizens just don't differentiate
9 between where the problems in care are, so there
10 is (off mike) much as your problem is the VA and
11 the general citizen country problem.
12 You refer to some manuals that sound
13 fascinating and if Roger we could get the links to
14 those I'd like to see what they look like and
15 maybe the other armed services too would like to
16 look at. What is the written (off mike) related
17 to transition?
18 The only other comment is that you still
19 have got to go back to a root analysis. I mean,
20 changing the faucet, it sounds like you've done
21 it. In the military you can sort of get people to
22 incorporate it or you beat the tar out them, I

1 guess the military way. But how about high-level
2 military and officers resigned over this issue?
3 How do you deal with a facility on BRAC? What are
4 politicians going to do about the restraints when
5 you're BRAC to clear? What's their overload? And
6 let me just flip over the coin for you. How does
7 a top-level person, when they're looking at
8 overload ask for help at an early stage so it
9 doesn't boil out of the pot and it's just
10 splattering all over the place?
11 BG TUCKER: I think that, first of all
12 the key infrastructure at the BRAC-identified
13 institution like Walter Reed Congress came back
14 and said, Knock it off. And they gave us all the
15 money we needed to keep Walter Reed. In fact, the
16 word was, the day you leave Walter Reed I want you
17 to turn around and look back at it and be very
18 proud of how well the building is being taken care
19 of and nod it's on its last leg and it's about to
20 crumble to dust. So we have done a complete stem
21 to stern analysis in pumping millions of dollars
22 back into the infrastructure of Walter Reed for

1 that purpose and I think that's a very important
2 lesson we learned, unfortunately, the hard way.
3 The standing up of the Walter Reed national
4 medical center at Bethesda has really caused a
5 clash of cultures so to speak. So simply between
6 us and the Navy, because the Navy doesn't do
7 warrior transition units? I'll just be frank with
8 you, the Navy said, come on over, we want you to
9 come on up here to Bethesda, but leave that
10 warrior transition unit thing down there at Walter
11 Reed, we don't do that. We said, Yes, well, we do
12 do that. So we're in a big -- I talked to the --
13 he's already been designated as the JTF commander
14 up there, Admiral Madsen, and we're toying with
15 the concept of building a joint warrior transition
16 unit. I mean, if we're going to go joint, let's
17 go joint, because one of the concerns is we've got
18 to have equality across all services in terms of
19 this type of level of care. So I've got enormous
20 fidelity of care with this triad of support on
21 every one of my wounded, ill and injured soldiers.
22 (off mike) Raynor had the very same thing with a

1 sailor or an airmen, clearly should have the same.
2 So we're concerned about that, but he's on the
3 team. But boy do we have a clash of cultures that
4 we have now kind of overcome to try to get an
5 overarching joint operation affair in charge of
6 the entire national (off mike) and to leverage the
7 capability in the national (off mike) region to
8 spread that burden of crossing all the medical
9 facilities in the NCR and build surge capability
10 as well. Very important. Those are great points,
11 sir.
12 DR. SHAMOO: Thank you General for your
13 report, excellent report. I really want to
14 associate my opinion with General Roadman's
15 comment. I agree fully with what he said. I just
16 want to add what we are hearing from you and
17 others really is post-event action. What is
18 lacking in all this I think is it's not
19 anticipatory. The post-event planning, whether
20 it's post invasion, post-Washington Post article,
21 or post-9-11, we -- what I would like to see the
22 DHB is to be somehow a beacon to the DoD on

1 medical issues in terms of anticipating the event
2 and have a planning for those events even though
3 they may not happen. That planning could collect
4 dust; it's okay. There's that one in ten, if you
5 hit it right, you may do a great service to the
6 country and I'm going to be very blunt, as some of
7 you know, I'm not; and that is, there's a lot of
8 talk about the next war. Have we done any
9 pre-planning for that event? I have seen none and
10 I wish there will be even though I pray to God
11 we'll never have one.
12 BG TUCKER: I think we need to do better
13 at integrating -- we need to look at our entire
14 medical capability, not just in the DoD, but in
15 the entire -- there's an enormous capability out
16 there using the entire network. We've got to look
17 hard at where those obstacles are that are
18 preventing us from doing that. We work well at
19 the VA in some locations. Not in all locations.
20 We could do better work with the VA in all
21 locations and use that capacity where we need to
22 and use other service hospitals where we need to.

1 We could do better at that. I think we should
2 have a joint- medical unified command in my
3 opinion. I'm a Calvary officer, but I'm just
4 telling you since mining this dirt now since
5 March, it's very evident to me: Why don't we have
6 a joint unified medical command? So we can get
7 the synergy of all these great medical facilities
8 and medical centers across the DoD alone and
9 utilize them for surge capabilities for the next
10 war, because the buses kept coming to Walter Reed,
11 but there was enormous capacity across the United
12 States that wasn't be utilized, and that would be
13 a step in that direction, sir. Thank you.
14 DR. POLAND: One more comment, Mike.
15 DR. OXMAN: First of all, thank you for
16 an inspiring report and obviously making enormous
17 end roads in the problem. I think you mentioned
18 that your concern then is when in the transition
19 to the VA. I think that's a major concern and I
20 don't think that enough thought has been given to
21 that and I think it's going to be a critical issue
22 and I think we need to help you work with the VA

1 to do what needs to be done and which I think is
2 going to be a challenge.
3 But in addition, I believe that our
4 wounded now, your wounded warriors are unique in
5 the history of our country's battles that they are
6 more dependent on the society for a longer period
7 of time than ever before as are their families. I
8 think that one of the things that I hope we will
9 do which will require legislation is to have the
10 support and care for the family in the same place
11 and integrated with that for the warrior, which
12 means that the VA, if that's where it happens is
13 going to need to be tasked to take care of the
14 family, not just the warrior.
15 BG TUCKER: Exactly. Yes, sir. Very
16 good point.
17 DR. POLAND: Mike, go ahead. I saw your
18 hand up there.
19 DR. PARKINSON: General, a couple of
20 observations and I want your reaction to these.
21 We toured the Intrepid yesterday, as you know.
22 And in your presentation today an Army policy the

1 term "warrior" has pretty much come to replace
2 soldier, as best as I could tell. And I'm very
3 concerned about the law of unintended consequences
4 for anything we do. And while warrior connotes
5 one function of DoD a high level, it's certainly
6 not what -- if you read the papers and what many
7 countries around the World want from DoD it's not
8 just warrior, it's many other things. So that
9 aside, what I'm concerned about is the physician
10 is the law of unintended consequences when with
11 tremendous respect and awe, I see nine wounded
12 warriors going back to active duty in theater, but
13 are we sending an inadvertent message as we
14 celebrate their return that either hurts or
15 further psychologically damages some of our
16 troops. And if that is so, are we monitoring that
17 or looking for that just as an aside. As a
18 physician seeing the facility and seeing your
19 presentation here.
20 The other thing I would just say gets to
21 this notion of using the full MHS. One of the
22 things I'm also concerned about as an Air Force

1 retiree is what appears to be the Army's desire to
2 take care of its own. Call everybody a warrior,
3 warrior in transition, either into the Army or
4 out, is that what we're doing is codifying and
5 perhaps solidifying, inadvertently, the walls
6 between the Army and the Navy and the Air Force at
7 a time when heaven knows the Air Force is never
8 going to have as many feet on the ground as the
9 Army or Marines do, but we need to be sharing the
10 emotional support as a service. As a military
11 family. Are these expressions and are these
12 practices and of these ways in a way,
13 inadvertently, creating a bigger distance that
14 doesn't get to what you just said you want, which
15 is that the entire breadth of the MHS and military
16 family, the entire breadth of the DoD/VA continuum
17 do that.
18 Final question is: Have you looked at
19 stationing or seeking to station "no kidding"
20 active duty Army warrior transitions unit in every
21 VA hospital in the country, period? Not based on
22 need, but it's an infrastructure you have to have.

1 And if there's 5,300 or whatever that number was,
2 out there -- and one final question it seems like
3 a huge one. You can't have it both ways. If
4 there are Army commanders who've got 2,600 or
5 2,700 folks in their units which by the way seems
6 to be the goal of the warrior in transition
7 program, I guess, to get them back into the
8 functional Army service and they're doing a
9 valuable function even if it's a PowerPoint
10 Ranger, someone's got to do it.
11 BG TUCKER: Yeah, but they're not
12 healing.
13 DR. PARKINSON: Do we know that?
14 BG TUCKER: We know that.
15 DR. PARKINSON: How do we know that?
16 BG TUCKER: Because we're treating them
17 in our MTFs. They're on permanent profile. We
18 know where they're at. We know what their status
19 is and they're stagnant. They're not healed.
20 DR. PARKINSON: I guess these, as we go
21 forward, some of these things are thing the DHB
22 can help you with. What are the measures of --

1 because at face value it seems they're in a unit,
2 they're there. I mean, if they're going locally
3 to a VA where you had an Army thing perhaps they
4 got some healing plan, et cetera. These are just
5 some impressions and hopefully this will be the
6 first of many engagements with the DHB, because we
7 need to --
8 BG TUCKER: That's important. The triad
9 establishes a healing plan, a holistic healing
10 plan for every single soldier and builds a glide
11 path for their progress and then monitors they're
12 progress in conjunction with the primary care
13 physician who is part of that team who can make
14 sense of all this because many soldiers are seeing
15 multiple specialists, seven, eight, nine
16 specialist. Well, that's all (off mike) but who's
17 giving the horizontal integration to that, it's
18 the primary care manager.
19 The warrior, the term warrior was we
20 chose a neutral term. All the Army ethos says
21 soldier, soldier, soldier. We chose warrior
22 because we felt it to be a neutral term that would

1 apply to all services. Plus a person in the
2 military is somewhat as a warrior in society, so
3 to speak. That was the intent to kind of choose a
4 neutral term. But that's a great point; we need
5 to be sensitive to it.
6 DR. POLAND: Thank you very, much
7 General Tucker.
8 (COIN PRESENTATION MADE)
9 COL GIBSON: While Dr. Poland is walking
10 back up here, please make sure you sign the
11 attendance rosters and the other roster that's
12 going around is the CME roster. We have two -- we
13 can get two CME credits out of this, so please
14 sign it. Your attestation forms for the Board
15 members are in the book and I believe Karen has
16 others for the other attendees.
17 DR. POLAND: Our next speaker this
18 morning is Retired Colonel Dr. Charles Scoville,
19 Chief of the Amputee Service Integrated Department
20 of Orthopedics and Rehabilitation, National Naval
21 Medical Center at Walter Reed Army Medical Center,
22 and the executive secretary for the panel of the

1 care of individuals with amputations and
2 functional limb loss, which is one of our DHB
3 subcommittees. Colonel Scoville will update the
4 Board on the panel's activities. Colonel Gibson
5 and I, last week, were privileged to attend one of
6 their day- long meetings and the opening ceremony
7 of their medical advanced training center, sort of
8 a sister institution to CFI, and just like CFI was
9 equally impressive. So, Chuck, you have the
10 floor. Chuck, I guess you have one of your panel
11 members here with you?
12 COL GIBSON: General Fox, you want to
13 make some comments?
14 GEN FOX: No. Well, I apologize for not
15 being here yesterday. Flying across the world
16 with Project Hope now as the prior commander of
17 Brooke Army Medical Center and integral in
18 establishing the CFI and very proud to do so. A
19 lot of the issues that were raised today by
20 General Tucker, I have intimate familiarity with.
21 I will say that it is an honor and privilege to be
22 a continuing part of the Defense Health Board and

1 in particular continue to work on this panel.
2 Some of the subjects that will come up, I'll have
3 some comments with that Chuck will bring up.
4 DR. POLAND: Welcome.
5 GEN FOX: Thank you.
6 COL SCOVILLE: We established the --
7 initially tried to establish a FACA committee for
8 the care of individuals with amputation and is
9 expanded to include, and we are working on the
10 actual definition of what functional limb loss
11 will include. But back in early 2004, our panel
12 came up the vision for the panel is for a
13 collaboration of multi (off mike) provide amputee
14 care. With 600 patients they return to a lifetime
15 of highest physical, psychological and emotional
16 function, so it kind of sets the bar really high
17 for us to begin with and we continue to work on
18 that.
19 Mission statement we developed goes
20 right along with what our vision was. And we look
21 at the personal goals as continuing to be a
22 productive members of our society. I think we

1 spent almost a full day on just trying to figure
2 out how to word this to show the continuity of
3 care well beyond, just their time in the military
4 and as a healing service member.
5 A very long list of goals. If you look
6 at the goals (off mike) and touch on them briefly,
7 this again was established about February of 2004,
8 and we've come a long way in reaching or moving
9 towards those goals and they are as applicable
10 today with the need to continue on each of those
11 paths as they were when we established them in
12 2004. Looking at them, as a prepared for this,
13 our standard question -- really how well we hit
14 the target at that time of what the needs were.
15 So the same standard for surgical, prosthetic
16 rehabilitative care and care and management of
17 amputee patients. We have developed a number of
18 new techniques. Monday, Tuesday and Wednesday of
19 this week, we were at the Center for Intrepid,
20 developing a textbook for military medicine on the
21 care of the amputee patient. Because there has
22 been such significant change in what we're doing

1 now compared to when the textbook was published in
2 2001, I think is the last version. So just in a
3 five, six-year period there's been tremendous
4 advances.
5 Focused early on with assisting the
6 family members and empowering them so that the
7 decision making was on the family members and the
8 patient part. It wasn't the military saying, this
9 is what you will have, this is how you're going to
10 be cared for, and the programs evolved around
11 that. Once you read down through those -- I think
12 this is also in your book.
13 As you saw yesterday at Center for
14 Intrepid, we have been leveraging leading-edge
15 technology. Many of the things you saw in Center
16 for Intrepid -- if you had a chance to go through
17 the MAPC at Walter Reed, they are one of a kind or
18 the two facilities, two-of-a-kind capabilities
19 that don't exist anywhere in the world.
20 And we have done a lot on collaborating
21 with outside facilities. On Wednesday at Brooke
22 Army Medical Center we did two surgeries on

1 individuals with shoulder disarticulation. The
2 nerve endings that normally go to the arm, median
3 nerve, ulnar nerve, radial nerve, musculotaneous
4 nerve were transposed into spacical of the
5 pectoralis muscle and the litisamis muscles to
6 drive the next generation prosthetic device. So
7 as they think of closing their hand, the median
8 nerve fires, muscles fire and the motive that
9 drives the hand closes that hand.
10 The duties of our Board functions solely
11 as an advisory committee under the FACA committee.
12 (off mike) service and provide advice to Walter
13 Reed, BAMC -- actually, I changed that and I don't
14 see the change; provide advice to the DoD and
15 through the commanders of Walter Reed, BAMC and
16 San Diego Naval Medical Center regarding the
17 program services and the effective organizational
18 planning. So the Board has continually been the
19 driving force in what we do. As we look at what
20 direction we should head, one of the things we
21 need to address; it's been the Board's action that
22 have helped keep our focus on what our mission is.

1 Current scope. Individuals with
2 amputations and functional limb loss. We, as a
3 Board, in our last meeting we spent a lot of time
4 discussing what functional limb loss is and is it
5 the scope of our Board; should we expand our focus
6 or not. We came up with kind of a definition and
7 said, no, we're not sure that's really what we
8 want. Our Board decided that their focus should
9 be primarily on the individuals with amputations.
10 As we try to expand more, we lose some of the
11 visibility and as programs and things come up, the
12 term now "blast trauma" they become more and more
13 diluted and the patients with amputation get lost.
14 Expanding the role. There was
15 discussion on whether our Board should become the
16 board for the rehabilitation medicine or maintain
17 focus on the small population of amputee patient
18 population. The amputee population is only about
19 -- is 2.4 percent of all of the injuries being
20 evacuated from theater, so a very small number.
21 Today, there are now 698 individuals with limb
22 loss, major limb loss, from this conflict. But

1 it's most visible and it's one of the more
2 recognized. Now, TBI is becoming the other
3 signature wound of this conflict, but amputee care
4 has been one of the more recognized and things
5 that we do and the way we progressed has driven a
6 lot of the other things that go on, the return to
7 duty aspect in general.
8 At our last Board meeting we just -- we
9 looked at what are the current issues that are
10 facing amputee care and what the roles of our
11 panels should be and we looked at both external
12 issues and internal issues. Internal issues being
13 those that we can manage locally at our three
14 centers. We've done very well with Walter Reed,
15 the Center for Intrepid, and San Diego Naval
16 Medical Center working together and kind of on a
17 good working relationship keeping continuity and
18 similarity of care. At a higher level, there's a
19 need for advocacy for funding for the care and
20 research for patients with limb loss. Early in
21 the conflict we got Congressional ads that
22 addressed this. More recently the Congressional

1 funds have been bundled under blast trauma and are
2 being paid by the (off mike) for Surgical Research
3 and TBI issues and there is no money identified
4 specifically for amputee care. Not a tremendous
5 issue if you look at it as a large brush stroke,
6 but as it has been pointed out, there are a number
7 of individuals who have lost their limbs in
8 training, in motorcycle accidents, because of
9 tumor, for a variety of reasons; and we have
10 changed the standard of care for those patients.
11 We no longer treat them for a very brief time and
12 say you cannot be retained in the military and go
13 to the VA. The budget that was built for us prior
14 to the war was built on that quick treatment and
15 discharge. Now we have a population, in addition
16 to the war wounded, that are expecting and deserve
17 the high level of care and there is a price tag
18 that goes along with that. When our budget comes
19 entirely out of GWOT dollars and is not
20 specifically identified for amputee care there is
21 no budget line and we keep going back and trying
22 to pull from other sources to cover the costs of

1 caring for that. That's about -- on average we're
2 looking at 40 to 50 individuals a year that lose
3 limbs that are on active duty that are unrelated
4 to the global war on terrorism.
5 You need to ensure that patients with
6 limb loss and families receive all necessary and
7 (off mike) health support. This covers every
8 meeting; every topic that's been discussed here
9 has included that. One of the problems we're
10 having at Walter Reed and at other facilities,
11 there's only a certain pool of people that can
12 provide the support that have the training. And
13 not only is the Army competing for those people,
14 but other services and civilian communities are
15 competing for the same population. It's difficult
16 to fill the vacancies that we have in this area
17 and at Walter Reed you get -- one step more
18 difficult is people look at that BRAC process and
19 gee, Walter Reed is closing, will I have a job in
20 three years, what's going on with the whole budget
21 cycle.
22 Recommend establish an executive agency

1 in amputee care. You've seen the Center for
2 Intrepid. On 15 October, San Diego will open up
3 their combat casualty care center and Walter Reed
4 opened our center last week. We have worked very
5 well together in making sure that we have
6 similarities in care, but there is no one that has
7 authority of any of the three sites. I work for
8 Walter Reed. I am, because of friendships, able
9 to work with San Antonio and San Diego. The Army,
10 when San Diego said we're going to stand up
11 amputee care with you or without you, the Army
12 sent a physiatrist, and a physical therapist that
13 had served in amputee care at Walter Reed for a
14 year out to San Diego to help them set up the
15 program out there so they didn't have to go
16 through the same lessons learned that we did at
17 Walter Reed and at Brooke Army Medical Center. So
18 we've worked well together, but there is no
19 executive agency, there is no lead agency that
20 says they're responsible for seeing that all of
21 our sites have similar capabilities. It works
22 good right now with the personnel. If I go

1 somewhere or if Becky Hooper goes somewhere else,
2 you can give them personnel they can very quickly
3 diverge without senior leadership capability.
4 A need for better clarity on COED, COR
5 versus fit for duty findings and the effect on the
6 service members. That one I can guarantee the
7 MEBP, the counselors that are telling them about
8 this that are at the GS-6, GS-7 level don't
9 understand it because I don't understand it. Most
10 of our patients (off mike) don't understand it.
11 We have individual soldiers like Major Rozell who
12 fought to be found fit for duty. When he retires
13 there is a presumption of fitness because his
14 injury was long before he was able to serve his
15 final year of service, so he has no medical
16 retirement potential from the military. He'll get
17 benefits from the VA for disability, but he does
18 not get a medical retirement from the military
19 after serving a career as a below-knee amputee.
20 If he goes through the COED/COAR process that
21 changes, but he is unsure of which way he should
22 go. He's looked through all the papers and goes,

1 I don't know. He just had another surgery that
2 took nine more inches off his leg, went from an
3 ankle to below knee so he can fit more of the new
4 componentry in so he can run his IMA a little bit
5 faster and he has not yet gone back to another
6 board since he doesn't know what's the best thing
7 to do. I haven't found anyone who can really
8 explain to him, so there's a lot of confusion in
9 that and as the boards and new things come through
10 with Shalala, et cetera, that may change, but it's
11 currently an issue that is above the Army level
12 and needs higher-level intervention.
13 Internal issues. Looking at new panel
14 members and getting those through the nomination
15 process at the Defense Health Board level and DoD
16 level where we would identify them, send their
17 names forward to be nominated and then appoint to
18 our Board. We have a number of people that have
19 been working on the Board since 2003 and we are
20 down to six members right now and need to increase
21 our numbers again.
22 Reviewing the process of transition from

1 inpatient to outpatient and socialization to a new
2 environment, at both Walter Reed and San Antonio,
3 we've identified that as the patients get
4 discharged into at Walter Reed the Malone House or
5 into the Fisher houses, they're changing their
6 whole social environment and their support
7 agencies and things change. So we're studying
8 with our psych-liaison officers in touch to figure
9 out is there a way we can do that better and help
10 them make that transition.
11 The next thing came up and I'm not quite
12 sure yet -- and this was, our meeting was last
13 Thursday, so I'm not quite sure how we address
14 this, but we have service members that are 18, 19,
15 20 years old that are placed in the Fisher house,
16 and we have newly married or have very young
17 children, and we have service members that are 37,
18 38, 39, 40 that are placed in the same Fisher
19 House. They share common living areas, they share
20 common kitchens. An issue that came up down here
21 recently is one of the family members wanted to
22 have a dog in the house and very young and had

1 young kids and wanted a dog and one of the other
2 families was allergic to dogs. And they get into
3 the who does, how do you, the social activities,
4 who parties in the room, how loud they are and
5 things. It's becoming a bit of an issue in our
6 Fisher houses that the populations are staying for
7 longer periods of time. Average length of stay,
8 when I started in August 2003, we kept patients
9 for about two and a half months at Walter Reed
10 with limb loss. And then they were either sent
11 back to their unit or sent to the VA. We had the
12 typical peripheral vascular disease treatment
13 protocols for amputees. You got them up moving on
14 a temporary leg and got them out close to home.
15 We've changed that philosophy tremendously. We
16 now treat them as tactical athletes; we restore
17 them to the highest level of function based on the
18 guidance of our Board. And this, then, patients
19 are staying in Fisher Houses for a longer time so
20 this becomes an issue. Terry Howe is dressed to
21 address spouse and children's needs. We talked
22 about Camp Noah, peer visitors and things which

1 we're going to expand on within the programs now
2 and then developing a web- based chat room for the
3 patients and families. AKO has commanders online
4 which allows junior commanders a chance to get in
5 talk with one another. Look at this, this needs
6 to be a ground up delivered and we have one of our
7 amputees that has now volunteered to now do this
8 for us. So they're going to be developing a
9 web-based program.
10 Our future direction. For our Board
11 they want to maintain their focus on patients with
12 limb loss and they want to be addressing the co-
13 morbidity issues related to patients with limb
14 loss, particularly at TBI and PTSD and then
15 remaining focused on the goals that we established
16 back in 2004. One other thing we're looking at is
17 the sustainment of amputee care as we move
18 forward. As this war ends and we have a patient
19 population that dwindles; how do we maintain the
20 expertise, the focus, the knowledge, the skill
21 bases and things that we've already gained?
22 BG (Ret) FOX: Thanks, Chuck. One of

1 the things, Dr. Poland and to the esteemed group
2 here, one of the things that is clearly evident as
3 we've committed enormous public/private resources
4 to the quality of care and to the applicability of
5 state- of-the-art research to recovering those
6 soldiers, sailor, airmen, marines that have severe
7 limb loss or the worse case, amputations, we've
8 committed enormous resources to that on a
9 doctor/nursing, medical technical side and the
10 multi-disciplinary aspects for a full recovery as
11 expeditious as possible with the intent to return
12 back to duty. The clear intent, I think, of
13 everybody involved from all services and the
14 surgeon general's with their concurrence and
15 approval have put into place a sequence of events
16 which now have led to sustain this beyond the
17 level of a conflict you need to have substantial
18 patients to take care of. Very much like the burn
19 center that was established, the Institute of
20 Surgical Research at Brooke Army Medical Center.
21 We shifted to taking on civilian patient care as a
22 means of retaining the number of patients and

1 therefore the capability and therefore the
2 research ability and the education requirements
3 for teaching people how to maximally take care of
4 to the state-of-the-art level burn care. The
5 similar sort of circumstances are now coming to
6 ear or will come to bear upon these now three
7 amputee care centers, one of which is the -- I
8 would say the most modern, state of the art, but
9 you saw yesterday at the Center for the Intrepid.
10 Walter Reed now has the second one that's really
11 upgraded itself as well; San Diego will be shortly
12 behind with a greater and greater facility. An
13 enormously powerfully talented faculty to take
14 care of those injured soldiers, sailors, airmen,
15 marines now. The question is, for all of us I
16 think, to look at the ways and means to adequately
17 get the financing, resourcing amputation
18 populations in post-conflict era to retain this
19 same level of expertise for yet the next conflict.
20 We will have, I think by all evidence, and Chuck
21 has got some data on this on pre-conflict periods
22 where you have relative peace, of the number of

1 kinds of injuries you'll see throughout the
2 services which would qualify for care in these
3 kinds of amputee care centers, but there's
4 certainly not enough for cohort recovery, which is
5 the optimal way to recover these kinds of
6 casualties where they're being recovered side by
7 side with somebody going through the same stages
8 or similar stages of recovery. Then you'll have
9 the demand for the number of patients that one
10 needs for, again, education, research and
11 development of continued state of the art. So we,
12 in my mind, have faced, and the Board's mind, have
13 faced yet a challenge now to take on a
14 subcommittee just specifically have people put in
15 their -- who want to look at models that we can
16 incorporate and present to the Department of
17 Defense as a way of sustaining these going
18 forward.
19 The question is: Do you need all three?
20 I guess that would be one of the questions. The
21 second question is: What kind of commitments,
22 financial and what kind of models can we use to go

1 forward? It is not an insignificant cost, I might
2 add in using the Institute of Surgical Research,
3 the burn care unit, it's not an insignificant cost
4 to care for those at state of the art levels and
5 they're civilian patients. So that funding is
6 Department of Defense funding and it needs to have
7 a funding stream. I think the commitment has been
8 made here, but we need, as Chuck outlined, a
9 funding commitment and a long-term commitment by
10 the Department of Defense that, yes, we are going
11 to maintain this and we're going to use this kind
12 of model and this kind of funding stream to ensure
13 that we never drop below what we think is ultimate
14 state of the art kind of care, so that we don't
15 have to go through this rapid ramp-up again of
16 these kinds of commitments with not having some of
17 this architecture in place and the funding in
18 place.
19 DR. POLAND: It strikes me, too, that
20 you also have opportunities as, in a sense, ISR
21 has, in a sense how AFIP had where you have the
22 opportunity to establish yourself as, I like the

1 term "state of the world" centers that then as
2 those numbers dwindle, increasingly become VA and
3 civilian national referral centers for these sorts
4 of severe injuries that there's almost no place
5 else that's going to have the kind of equipment
6 that CFI has. Nobody else would have the volume
7 that would justify that.
8 BG (Ret) FOX: There's some complexity,
9 I might add with that, because if you take the VA
10 model and the VA care in post-conflict era, you
11 may not have the patient cohorts that you're
12 seeking to maintain return to duty. They're a
13 different population. A diabetic who has lost a
14 limb and needs to be recovered certainly want to
15 recover as much functional limb utilization as
16 they can, but their ability to go to the step of
17 these kinds of young soldiers, sailors, airmen,
18 marines and their desire to get at a different
19 level is -- so there are some models out there
20 which would suggest we could go to major insurance
21 companies who work with large corporations that
22 have industrial accidents, that population, and

1 offer them certain kind of rates for full recovery
2 and that will allow us to evacuate in the kind of
3 casualties from across the country that are young,
4 relatively healthy individual which we can give a
5 standard of care -- the highest quality of care,
6 but for a standard rate and that will allow us to
7 maintain that. Then it becomes, in essence, a
8 national resource which would shift to soldiers,
9 sailor, airmen, marine care in times of war.
10 DR. POLAND: Okay. Comments? Dr.
11 Lednar.
12 DR. LEDNAR: I think the thinking of
13 these three centers as really a national resource
14 as in the private sector I think of specialized
15 care needs and centers of excellence, there's a
16 way to sort of bring these two together. I'd like
17 to suggest in making them very visible to leading
18 health insurance, I think there will be actually a
19 lot of interest. It may not be in any one company
20 or any one local areas, sort of a high volume,
21 clearly these are special need patients.
22 I think one of the other potential

1 advantages of having not just young -- call it
2 civilian injuries who work side by side with the
3 military is to see the commitment that's possible
4 and focus on getting well and getting back to
5 work. That would be of a great assistance to
6 every patient.
7 BG (Ret) FOX: What we were looking for
8 Dr. Poland from the Board, the (off mike) Board at
9 large is sort of the commitment that, yes you
10 should, indeed you should explore it and in the
11 ways and means that we can use, either perhaps
12 even members of this Board to come onto that
13 committee. I had presented a structure and
14 outline proposal that as we folded up underneath
15 the Defense Health Board it maybe shifts. We've
16 not yet gotten the approval nor have I set into
17 cement the members to go ahead and explore,
18 really, three or four basic key topics to this
19 issue of sustainability of these centers of
20 excellence.
21 DR. POLAND: I think we're going to
22 engage some more on that and I think we can be

1 helpful that way.

2 DR. HALPERIN: Aside from workers'

3 compensation and industry, you might also look to

4 the federal government the National Institute for

5 Occupational Safety and Health within the CDC,

6 which is very interested in the whole area of

7 trips and falls and prevention of injuries, but it

8 seems like a very logical next transition to the

9 rehabilitation of the injured.

10 COL GIBSON: Britt, can you bring those

11 slides back up, please?

12 DR. PARKINSON: Chuck, great

13 presentation. Again, thanks for yesterday. I

14 struggle a lot just -- and again the purpose of

15 the DHB is for us to have the -- this is an open

16 forum to talk. The last time this country had

17 anything that represented a significant surge in

18 amputation as a result of war that was

19 sustainable, frankly, was the Civil War. We

20 established something called the Veteran's

21 Administration as a result of that. Large numbers

22 of people thinking up (off mike) that the country

1 responded and said there's an infrastructure
2 sustainability need here, we've got to have
3 something like this to take care of the veteran.
4 As a citizen, putting aside the wonderful work
5 we're doing, is that infrastructure or model of
6 sustainable amputee centers of excellence at the
7 magnitude and volume, obviously we have an acute
8 need with a big surge in Iraq war with 798
9 individuals going to what, I don't know. The
10 Board, as it's currently constructed, said no we
11 don't want to go into the broader issues of job
12 and worksite training, TBI, PTSD, because the
13 numbers are too big and frankly we come out of an
14 amputee, physical therapy, physiatrist, whatever,
15 which is wonderful, but then we've got to be very
16 frank about the need for three centers when we do
17 have occupational and safety and health where we
18 don't have occupation amputation in this country,
19 thank God, by and large; or if we do they are in a
20 handful. It is a resource of tremendous
21 opportunity perhaps, but I still struggle with, as
22 you heard my earlier question, is most of these in

1 the volunteer Army the majority folks, to my
2 knowledge, are the volunteer services are coming
3 in to get an education. They're coming in to do
4 an in and out by and large. They're not going to
5 do 20 years. Okay. Where's the job training,
6 where's the language skills, where are the
7 mathematics? And they're going to back to Topeka
8 and they've got to get a job. So when I see the
9 recommendation of the Board saying we want
10 functionality around can I balance and the
11 wonderful things we saw, all of which are
12 critically important, to go to the next step and
13 say we've got a challenge to sustain these things,
14 is I'm not sure we're asking the right question in
15 terms of macro need in the MHS infrastructure and
16 the VA/MHS and even the HHS national need. So
17 we've opened a lot of Pandora's boxes here today,
18 but for this person, I'm not sure that we're
19 asking or framing the right issues in the macro
20 sense, in the historical sense around either
21 amputee care or around the broader needs of the
22 wonderful men and women you're taking care of in

1 the amputee center. So there's no answers in
2 there and there's just questions. And as we go
3 forward and talk and work with those committees
4 but you're right up against it now. So that's
5 where you can start from the science and say, what
6 are the totals, what's the end, what's the
7 denominator, what's the plan, what's the goals?
8 And what's the best use of the American's
9 citizen's resource, public or private, to do those
10 things. I just don't -- we can have more
11 dialogue, but that's where I'm coming from. It's
12 not clear to me that the goals to sustain three
13 centers of amputee care in the way they currently
14 think. So we just need to -- just my reaction.
15 BG (Ret) FOX: If I might speak -- at
16 least our Board's position is exactly in line with
17 that. There is a deep emotional and an absolute
18 desired need -- there's an actual need to
19 establish the centers to deal with the amputees
20 that we're seeing. The larger question is is
21 exactly what we're trying to grapple with now.
22 What does the public need? What does the military

1 need? What do the veteran's need? And can these
2 merged together and can we have a model that going
3 forward allows us to sustain the state of the art
4 capacity and capability. Don't forget that the
5 CFI was built on private dollars, private
6 donations, $58 million worth, with a commitment
7 that DoD accepted would be sustained. So we have
8 already bought into at least one for sure has got
9 a sustainment built in as an agreement that we
10 would accept it under those conditions. So I
11 think these are very, very relevant questions.
12 They're obviously absolutely essential in terms of
13 going forward and this Board has got the talents,
14 expertise to help with us tackling this in a
15 bigger --
16 DR. POLAND: Colonel Gibson, I think you
17 have a comment.
18 COL GIBSON: Britt, go to that slide
19 that says "External" at the top. I'm doing my
20 FACA job here. These issues have come from the
21 panel, from the subcommittee to the Board in the
22 form of recommendations that the Board needs to

1 deliberate and then assist and basically provide
2 the second signature on the recommendations as
3 they go forward to the Department. I'd leave
4 those up there, make sure that we have a copy of
5 that that gets to all of our Board members and we
6 will be circulating the report or the
7 recommendations for comment, not only with the
8 panel members but with the Board in the very near
9 future.
10 BG (Ret) FOX: One thing we do know --
11 and as you talk about numbers, we're just starting
12 to look at Gulf War I; there were 14 known
13 amputees from Gulf War I initially. Looking at
14 the VA database and doing a query on Gulf War I is
15 one of the search terms, amputation is another
16 search term and combat injury as the third, there
17 are now about individuals and we're now trying to
18 get through the HIPPA thing so we can find out who
19 those individuals are. But there are about 46
20 individuals listed as amputees from Gulf War I, so
21 (off mike) salvage may take the number we have and
22 triple it over the next five to ten years, which

1 again gives us a growing population. We've had a
2 number of people that have had limb salvage that
3 are now two or three years out that have come back
4 and said, I'm tired of trying to deal with a fused
5 ankle, a numb foot, I'm watching my comrades
6 through the basic (off mike) with me three years
7 ago running iron man and I'm still hobbling
8 around, please do an amputation so I can become
9 more functional. As we get advances in
10 prosthetics and advanced capabilities with that,
11 that number may become even larger, we don't know.
12 We do have a study, a metal study, which is
13 looking at the amputation and limb salvage and
14 what long-term results are from those and how many
15 of those will turn over. There is an unknown
16 number of individuals right now that may continue
17 over the next five to ten years to give us a
18 fairly large population of amputee patients.
19 DR. POLAND: Dr. Lednar, do you have a
20 question?
21 DR. LEDNAR: I appreciate, Dr. Scoville,
22 the so-called -- the intellectual honesty of that,

1 just how many cases do we have? What do we
2 project for the future? Percentage of all the
3 injuries coming out of theater that really relate
4 to the needs for amputee care. One possibility
5 perhaps of looking across these three centers and
6 to take advantage of the learning that has come so
7 far, but I think that if we would say today versus
8 six months ago what we thought was possible, we
9 are in a different place; just hearing yesterday
10 the surgeries that were done. I think that part
11 of sort of managing this resource is insuring that
12 going forward the commitments that are made on
13 amputee care are preserved. But if there is
14 additional capability in capacity across these
15 three centers or there's new technology for care
16 in areas we haven't even thought of yet, but in
17 the wisdom of the caregiver, they're beginning to
18 see and develop, is how to manage that best use of
19 the full resource, staying true to the delivery of
20 the amputee care as a priority and delivering on
21 that. But I think what Dr. Parkinson raised is a
22 really important question we also have to keep

1 visible and that is: This is a precious resource,
2 but an expensive one and how do we size it? And
3 at some point it may be a question about exit
4 strategy for one or more of these centers.
5 DR. POLAND: This I think will be part
6 of how the Board will engage with the panel. I
7 mean, we're not going to solve those issues this
8 morning, but I think the concept is a clear one,
9 that we already need to looking -- I like the
10 comment that General Roadman said, is what's the
11 CFI after the next and it's not too early to begin
12 thinking about that and planning for that.
13 DR. SILVA: It was very much what Wayne
14 had rendered. I don't know if you know the full
15 need out there, not only United States but
16 worldwide. I mean, there are a lot of kids that
17 have limbs blowing off in areas that we put mines
18 or other armies, so I think we should advocate for
19 your future and help in ways is to start deciding
20 a business plan once we're out of Iraq. You have
21 such a good skill set there including the training
22 center for orthopedic physicians around the United

1 States. And the Shriner's should be applying. So
2 there are opportunities there for survival and
3 sustainability.
4 DR. POLAND: Thank you very much. Our
5 next speaker and I want to keep going on this
6 string because they're so nicely related is
7 Colonel Tony Carter from the Office of the Deputy
8 Secretary of Defense for Force Health Protection
9 and Readiness, who will speak regarding the
10 activities of the Department's red cell on
11 traumatic brain injury. We think he will be
12 followed by Colonel Ireland, Program Director for
13 Mental Health Policy at the Office of the Deputy
14 of the Assistant Secretary of Defense Program
15 policy, who will speak on psychological health.
16 Colonel Carter the floor is yours.
17 COL CARTER: Dr. Poland, thank you. Dr.
18 Kilpatrick, General Fox and distinguished members
19 of the Board, I'm here to present an update. I
20 think some of you may recall I was here before to
21 talk about TBI and the Department of Defense's
22 reaction to the Defense Health Board's

1 recommendation on TBI. What I would like to do
2 today is just to give you an update on what we are
3 doing in the Department of Defense with TBI as a
4 result of our involvement in the wounded, ill and
5 injured senior oversight committee action that was
6 set up by the Secretary of Defense. Next slide,
7 please.
8 I'm sure all of you are familiar with
9 what the SOC, Senior Oversight Committee is doing
10 in the effort on the part of the Secretary of
11 Defense to organize the Department's response in
12 conjunction with the VA to the issues that were
13 brought forward by the Walter Reed incident. So
14 what we have is a Senior Oversight Committee, an
15 overarching integrated product team which consists
16 of -- which is led by the principle deputy of
17 personnel and readiness. And we have eight LOAs,
18 or lines of action. TBI, PTSD, psychological
19 health is LOA 2. Next slide, please.
20 The outcome that is desired of this LOA
21 is to provide service members, veterans and their
22 families with comprehensive, standardized

1 screening, diagnosis, treatment, et cetera; also
2 to provide continuing education and outreach on
3 TBI for all members of the Department of Defense
4 and for family members and the communities. Next
5 slide.
6 The charter is to build an integrated,
7 comprehensive DoD/DVA program to identify, treat,
8 document, and follow up those who have suffered
9 TBI. The emphasis here has been on mild TBI,
10 because in general, moderate and severe TBI have
11 been well recognized and there are treatment
12 guidelines for those conditions. But it's mild
13 TBI, which you've seen in the news in other
14 contexts, football, for example, is a more recent
15 context in which we seen newspaper articles about
16 kids who play on football teams and who suffer
17 TBIs and refuse to tell their coach because they
18 don't want to come out of a game. That goes on in
19 major league -- or in the NFL. The key players in
20 the military department, OSD/HA, DVA and civilian
21 experts. Next slide.
22 These are the deliverables. The most

1 important things that we've been working on in the
2 Red Cell, which the cell that is sort of doing the
3 work behind LOA 2, are three things actually: The
4 spend plan. You all know that we got $900 million
5 out of Congress in the supplemental for
6 TBI/psychological health and 600 million was for
7 (off mike), 300 million was for research. So we
8 had to figure out how we were going to spend that
9 money. And there was another mandate that came
10 out about the Center of Excellence and Dr.
11 Scoville talked about who is the overarching
12 authority within DoD for management of amputees,
13 which we were talking about. Who was going to be
14 the overarching authority within DoD for
15 management of TBI? That was going to come out of
16 this center of excellence. Next slide.
17 So we were going to do all these things
18 and then the whole issue was this was of such
19 import that we had to start. We had to get
20 started on many of these issues and even the
21 absence of research, even in the absence of
22 something -- a firm standard accepted by all. So

1 what we're going to do was to make sure that we
2 did start on the basis of expert opinion for those
3 things that did not have research to back it up
4 and then what we do is spiral development. Make
5 sure that we use the $300 million of research
6 funds that we had to fund appropriate research and
7 then use those research results to make changes in
8 what we did and the programs that we had so that
9 we could improve as we went on. Next slide.
10 Lots of groups -- yes, sir?
11 DR. LEDNAR: I don't want to interrupt
12 your train of thought, but may I ask for the 2007
13 deliverables you identified, seeing as there are
14 about only 12 weeks left in this calendar year,
15 are any of those deliverables in jeopardy of not
16 being delivered?
17 COL CARTER: What I will do is go back
18 to that later to talk about what we've done. So
19 there were lots of groups. This was the internal
20 review group that was set up by the Secretary of
21 the Army to review the whole issues of Walter Reed
22 and actually the Department of Defense actually,

1 because they also reviewed Bethesda and had a
2 mandate to review any other medical centers that
3 were thought to be perhaps problematic. So these
4 were the recommendations for LOA 2, specific to
5 TBI, that that group came up with. Lots of
6 recommendations. Next slide.
7 There were the task force GWOT
8 recommendations also from the process -- from the
9 process viewpoint and the outreach viewpoint and
10 they had lots of recommendations too relevant to
11 TBI and psychological health. Some of those were
12 the same recommendations that the Defense Health
13 Board gave with regard to post-deployment health
14 reassessments, TBI questions to the PDHA/PDHRA,
15 the post-deployment health assessment, the post-
16 deployment health reassessment, which occurs three
17 to six months after return from theater and also a
18 periodic health assessment to find out for that
19 population of people who do not deploy, whether
20 they've had incidents in the previous year that
21 may have been TBI or created of TBI. Next slide.
22 These were other issues, recommendations

1 related to coordination with external activities
2 for those who suffered TBI. Next slide.
3 What has the Department of Defense done,
4 what is it doing? I think I told you before that
5 we had implemented the military acute concussion
6 evaluation in theater, the clinical practice
7 guideline for evaluation of people who have
8 suffered or potentially suffered a TBI in theater.
9 We had a comprehensive review including the Mental
10 Health Task Force report came out and right after
11 that we had a mental health summit to decide what
12 to do with the recommendations of the Mental
13 Health Task Force. TBI summits, which I
14 summarized the last time. And then we developed
15 TBI psychological health Red Cell, which was a
16 group within force health protection and readiness
17 comprised of individuals past the services to
18 address these issues and to come up with a
19 comprehensive plan for the Department of Defense
20 how we were going to deal, first of all with the
21 recommendations that were brought forth from the
22 various commissions, because that was our first

1 priority is to be able to respond to those
2 recommendations and decide whether or not they
3 were reasonable recommendations for us to follow
4 and then recommendations that would be applicative
5 and recommendations that we really could not do.
6 We have -- today is the last day of a three-day
7 training course for DoD healthcare providers.
8 It's being held in Bethesda. We have, of course,
9 the Defense and Veteran's Brain Injury Center
10 which has been in existence since '92 and when we
11 talk about the center of excellence you'll see how
12 that is going to folded into the center of
13 excellence. The Center of Excellence for TBI/PH
14 is supposed to stand up on 30 November, 2007, and
15 then we're revising the PDHA/PDHRA/PHA to include
16 in-depth TBI screening questions. Next slide.
17 There was the all Army activities
18 message that was sent out to Army leaders on
19 traumatic brain injury. The TBI task force set up
20 by the Army starting I think last February or
21 January and those -- the result of that task force
22 were incorporated into the Red Cell so that we

1 could use that as a basis because they did a lot
2 of really great work. The 101st Airborne pilot
3 project to do an ANAM screening on all those
4 people who are going to deploy, the plan is to do
5 a pre-deployment cognitive assessment, send them
6 to theater, send the result of the pre-deployment
7 cognitive assessment to theater so that if someone
8 is involved in a potential TBI producing incident
9 then they can be -- their score can be -- it can
10 reassessed with ANAM and then the score compared
11 to the pre-deployment score to see what happened
12 with that. Then there's an in-theater screening
13 documentation process where all those people who
14 are exposed to blast or other potential TBI-
15 producing events and then there's a universal
16 post- deployment screening at Camp Pendleton and
17 at Fort Carson and Fort Bragg and that is going to
18 expand throughout the Department of Defense. Next
19 slide.
20 We're the Center of Excellence. We have
21 -- I'll talk about that a little more, but we're
22 working a concept of operations for the Center of

1 Excellence has gone through a lot of variations.
2 Every day it seems to change, but we're still
3 working it. We're working options for Fisher
4 building. Mr. Fisher has graciously decided he
5 wants to fund the Center of Excellence, but our
6 problem has been that this is a fast moving train
7 and every day the concept of what it is that we're
8 going to build changes. The original thought was
9 that we were going to simply build Fisher houses
10 that were going to be sort of transitional centers
11 for soldiers and their families, service members
12 and their families to live in and learn how to
13 deal with some of the problems that they have as a
14 result of TBI and have a sort of therapeutic
15 environment in the Fisher houses, specifically
16 geared toward those with TBI and with
17 psychological health issues of PTSD. We presented
18 that to Mr. Fisher and Mr. Fisher thought that
19 was good, but he thought that there were other
20 possibilities so we came back to him with six
21 other possibilities and then we ended up, last I
22 heard, with the sort of completion of some of

1 those things which we're not really quite sure we
2 wanted. So it's a process and evolution. We had
3 a meeting with him yesterday and we're still
4 trying to decide exactly what it is that he wants
5 to build for us that we would like to have. I
6 think our final determination is that we would
7 really like for him to build us a center of
8 excellence on the Bethesda canvas because, number
9 one, if we used MILCON, if we wait for MILCON it
10 will be years before we get one. If we allow him
11 to do it, it will be a year. And we're not sure
12 he's going to agree to that, but that's our try.
13 So the spend plan for the 600 million and 300
14 million research, you know, of all the
15 recommendations that came down, what we wanted to
16 do was to take a look at all the recommendations,
17 combine those that could be combined, throw out
18 those that really did not apply and then take a
19 look at what remained in the rack and stack for
20 priority and then for short-term, mid-term, long-
21 term projects. We wanted to be able to identify
22 the current programs the services had for TBI and

1 we wanted to be able to coordinate with other
2 LOAs, the disability evaluation system plays a big
3 role, the case management because those guys need
4 to know exactly what it is that we need to have to
5 help people who have TBI who then go out to the
6 community, the data sharing because the VA needs
7 to know what we have found -- or what we have done
8 with those people who have TBI, and facilities.
9 The last thing we needed to do was to come up with
10 a comprehensive plan, because simply reacting to
11 recommendations does not make a comprehensive
12 plan. We have no idea if we just take all of
13 those recommendations and follow those
14 recommendations you can't say that that's going to
15 be a comprehensive plan with no gaps. So we were
16 going to go from a sort of a clean slate and
17 decide what it was we needed to do for TBI from
18 entry into the system to separation from the
19 system and on into VA care and then make that as
20 efficient and as appropriate as possible.
21 LT GEN ROADMAN: Excuse me. Has that
22 been done?

1 COL CARTER: The last part?
2 LT GEN ROADMAN: Yes.
3 COL CARTER: No, sir. This is the part
4 that we are now starting to work on. We have a
5 six sigma expert that has come in to help us look
6 at the process of intake -- from when we recruit
7 someone, how we evaluate that person on
8 recruitment and so on and just go through the
9 system. Next slide.
10 We had a lot of quick wins. Memo
11 drafted for HA signature with standardized
12 definitions and which list the current ICD-9 codes
13 under which TBI is categorized. Those are various
14 areas that TBI symptomotology falls under. We
15 have gotten the codes approved which will come
16 into place in October so that we can better track
17 the people that we have with TBI. We are working
18 with DVA to come up with a TBI ICD-9 coding system
19 so that in October of '08, we'll have actual codes
20 other than V-codes under which to categorize TBI.
21 And then work also with the VA on, not so much
22 clinical guidelines, clinical practice guidelines,

1 but current practice guidelines that we can use
2 until the DoD/DVA clinical practice guidelines too
3 comes up with an evidence-based guideline. We're
4 trying to get the DO/DVA expert panel. There's
5 already a process to come up with the clinical
6 practice guidelines and we're trying to accelerate
7 that process a bit so that we can get those
8 guidelines created and out early, and then
9 consolidate the existing clinical management
10 guidelines and publish for immediate use. Next
11 slide.
12 Neurocognitive baseline testing, which
13 is a little bit controversial because we're not
14 sure that that does anything, but we now have a
15 mandate to do it. So we're going to publish an
16 OSD-HA policy that's now in staffing to establish
17 the ANAM for now as the tool of choice, establish
18 pre- deployment baseline requirements and then
19 establish in the PHA a yearly assessment.
20 Education and training, again, today is the last
21 day of training at Bethesda for this group of 800
22 providers and then we will publish a directive for

1 services to conduct sort of a stand down, which
2 the Army, by the way, has already done for TBI
3 awareness training throughout the ranks. Next
4 slide.
5 So the general areas that we looked at
6 and we came up with the spend plan are -- our
7 approach to this was to come up with a general
8 plan and then ask the services to come back with
9 programs that they wanted to implement that had
10 relevance to these areas: Access to care,
11 resilience promotion, transition, coordination,
12 surveillance and screening and so on. Next slide.
13 We have a staffing plan for TBI care
14 which is a little more difficult to come up with
15 than for psychological health because -- but what
16 we did was come up with: What do you need in a
17 major medical center to take care of a certain
18 number of people who have TBI? And then we funded
19 hires for proponency staff for the services who
20 requested it, for regional staff and for local
21 staff so that they could have adequate resources
22 to address TBI or to train individual providers at

1 the site to become their SME for TBI.
2 Psychosocial support, we wanted to make sure that
3 the families had support because that's been a big
4 problem with families who see their loved ones and
5 they're changed and they're not really quite sure
6 what to do or what that means to make sure that
7 the families are educated and understand what they
8 should do should they see these changes. Then,
9 telehealth is another issue. A lot of our reserve
10 component individuals are maybe in rural areas and
11 may have difficulty accessing healthcare, mental
12 healthcare or TBI assisted care. So we're using
13 telehealth as a way to approach that. Next slide.
14 Education and training, a little
15 repetitious there, I'm sorry. We wanted to
16 develop a standardized, comprehensive, integrated
17 education package using the Center of Excellence
18 finally who will eventually take over
19 responsibility for this DVBIC and contact the
20 support with coders, legislators, providers and so
21 on as the audience. Then, research I'll talk
22 about a little more direct (off mike) later. But

1 this was the resilience promotion part. You know
2 resilience promotion for TBI specifically was a
3 little bit difficult to figure out because we
4 don't know how to make people -- how to protect
5 people against TBI before they get into the event.
6 We're waiting for research. Some of the research
7 proposals that we received talked about
8 pre-treatment and immediate post- treatment in
9 order to mitigate the effects of TBI. We haven't
10 really gotten to the resilience part for TBI yet.
11 Next slide.
12 Transition and care coordination, TBI
13 registry, which is something that we need to do to
14 make sure that we follow down the line what
15 happens to people who suffer TBI. This first
16 bullet here, identify and screen those who have
17 left service without proper TBI screening, can be
18 -- that's a very difficult task. Program and
19 locate TBI resources, where patients live is
20 another problem where we interface with the case
21 management plan of action in order to make sure
22 that they understand where our people can go who

1 have TBI. They don't stay in military facility.
2 Then, benefits, recommendations for benefits for
3 people with TBI. I think right now we're focusing
4 more towards functional deficits and trying to
5 identify functional deficits and then attach what
6 rating should be attached to that in order to
7 provide compensation for that, then TBI specific
8 case management considerations to the case
9 management LOA. Next slide.
10 Physical disability. We're working with
11 LOA 1 to determine transition timing. You know,
12 when you have somebody who has mild and moderate
13 TBI, when do you want to transition them out,
14 begin medical evaluation for that. And then work
15 with LOA 1 on criteria for TBI disability
16 determinations and the issue there may become of
17 EEFD LOA 1 proposal for disability evaluation and
18 rating goes to the VA which I think is our current
19 track. The transition and community care we need
20 to make sure that we have a bidirectional
21 information exchange with the VA, that the VA
22 understands the people who come out of our system

1 who have a TBI and then the transition
2 coordination with LOA 3, the case management LOA
3 and then community resource ID so that we know
4 where the community resources are and then we
5 train them on the specific issues that can be
6 related to military personnel who have had a TBI.
7 Next slide.
8 Surveillance and screening. The ANAM we
9 already talked about. Mild TBI identification and
10 treatment in theater. We established the MACE as
11 a tool to assess all injuries, document in the
12 electronic medical record. And immediately upon
13 post-deployment the PDRA/PDHA and then we've got
14 the staffing augmentation required to make sure
15 that we can get that done because that takes quite
16 a bit of work. Regardless of the place that the
17 injury occurs, because you have to remember that a
18 lot of TBI occurs in CONUS, at home, at home
19 station, not necessarily in theater. So we have
20 to have a uniform assessment and treatment
21 standards and documentation in AHLTA. Next slide.
22 Quality of care. The Center of

1 Excellence and the DVBIC is going to be the core
2 of TBI Center of Excellence operations. Clinical
3 standards, and we've talked about this before.
4 Next slide.
5 Training and equipment. We're funding
6 some CT scanners, portable CT scanners so that
7 people who have severe TBI can be scanned at
8 bedside rather than taken to the radiologist
9 suite. We're funding transcranial dopplers to be
10 sent to the theater so that the neurosurgeons
11 could do monitoring. Although, in fact, a lot of
12 the issues with regard to spasm which is a new
13 phenomenon for TBI actually occur weeks after and
14 usually these guys are back home, but they might
15 figure, with the transcranial dopplers will be
16 useful in the theater to make decisions about
17 whether to do craniotomies or not. Then TBI and
18 combat stress assessment tools so that we can have
19 uniform tool kits in theater for our mental health
20 personnel to use. Next slide.
21 Colonel promotable Lori Sutton has been
22 appointed the interim director while the Center of

1 Excellence stands up 30 November, temporary leased
2 space, hope to get the near Bethesda. Physical
3 structure on Walter Reed national military medical
4 center campus in Bethesda and the place has
5 already been set out for that. Administrative
6 structure in progress, you know the organizational
7 charts that being worked on. It's going to have
8 psychological health and TBI. The DVBIC is going
9 to be the core, it will remain the DVBIC and come
10 under that as the core for TBI. The center for
11 deployment psychology which is going to come over
12 and be on the psychological health side. There's
13 going to be a telepsychological health center,
14 there are going to be advisory boards that we've
15 already talked about to Dr. Gibson about those
16 being subcommittees with the Defense Health Board.
17 And then we're hoping that this gets built by
18 Fisher. When I get back we'll find out how the
19 conversation with Mr. Fisher went yesterday. And
20 then and adjoining Fisher house for TBI/PH service
21 members and their families. Next slide.
22 TBI research. 150 million from '07

1 supplemental. The MRMC Congressionally-directed
2 medical research program is overseeing this
3 process. 15 percent is reserved for research
4 projects by the Center of Excellence. They're
5 also going to work on a central office to
6 coordinate. One of the things you have with TBI
7 research especially, with both PTSD and TBI is
8 access to service members. How do you get that
9 access? How do commanders know who they should be
10 talking to in terms of researchers who want to
11 come in and talk to their people or to (off mike)
12 other people? So we're going to have a central
13 office to help coordinate that. Then the Center
14 of Excellence will eventually provide
15 strategic/programmatic oversight over this whole
16 research process and we'll also probably set up a
17 central IRB because having individual IRBs is such
18 a pain in the rear. Next slide.
19 So Phase one: fast-track intramural.
20 All the people who are currently doing research
21 within the VA and DoD now will be considered Phase
22 two open solicitation for intramural and

1 extramural research. All the broad area
2 announcements have been out since July and we have
3 conducted already a programmatic review of
4 pre-proposals to figure out which ones were just
5 so outré that we should just forget about them.
6 We decided to let everybody because we didn't know
7 what actually would come when we got the final
8 proposals. Next slide. That's it. Any
9 questions? Usually my object is to talk so long
10 that everybody gets tired.
11 DR. POLAND: Let me just describe what
12 we're going to do here. We need to finish this
13 part and Dr. Ireland's part by 11:30. So we're
14 going to nix the break. There is coffee out there
15 and if you need to grab a cup of coffee out there.
16 If you need to grab a cup of coffee or a biologic
17 break that's fine, but given that and cognizant of
18 the time and the number of members that -- there
19 are last planes out that have to be caught. Let's
20 have any very focused questions or comments.
21 We'll go right into Colonel Ireland's second part
22 of this presentation.

1 COL IRELAND: I'll switch sides if
2 that's all right. Next slide, please.
3 Basically we had 95 recommendations from
4 the task force of mental health and we're going to
5 go and review each one of them detail spending 3.2
6 seconds each. What we're going to do is slice
7 them into various categories and then just sort of
8 broad sweep the categories and try to meet the
9 time line and maybe have a chance for a couple
10 comments. As we slice the various categories
11 there's going to be very rough status indicators.
12 These slides have been carved into stone a couple
13 weeks ago. This is fluid and dynamic. Some
14 things change, sometimes you find out more nuances
15 you have to deal with and they go back and forth.
16 Some things happen more quickly. So there's a
17 rough guideline color metrically of the status as
18 we go through these and you see the various
19 colors. These are the categories and we'll be
20 mentioning them again. So to conserve we'll go to
21 the next slide, please.
22 One recommendation that we did not act

1 upon because to do so would have been to duplicate
2 services. There's a recommendation to treat those
3 with v-coded mental health conditions or problems
4 within the TRICARE medical system. Because we
5 have a fairly robust counseling system within the
6 P & R side both in terms of the various agencies
7 and the advocacy family support and the family
8 support adjunctive services and military OneSource
9 the thought was that if we need to boost the
10 services in that regard we'll do them on that side
11 of the fence and that we will continue to utilize
12 TRICARE for medical care. Next slide, please. By
13 the way, advantages to doing that are many and
14 most in stigma reduction, not having a mental
15 health record established and this type of thing.
16 Looking at quality of care and clinical
17 standards in training, the Center of Excellence
18 has already been described which will have a
19 central role for psychological health as well. I
20 think the status of that has already been
21 explained and half of the funding for it will come
22 from the psychological health slice of the

1 supplemental as well. The division directors and
2 research functions will be sliced up by
3 departments of resilience, clinical care and
4 standards, research, training, advocacy, family
5 and patient education resource center and network
6 support. Help to provide core clinical practice
7 guidelines training for mental health providers.
8 There are six areas of psychological health that
9 are co-developed guidelines by the VA and DoD that
10 are maintained by a group that actually monitors
11 their currency and status and the plans for
12 renewing them as we go. The Center of Excellence
13 will provide one means in which to approach that
14 in a system (off mike). Part of what you do then
15 is you send an e-mail link to the guideline for
16 all your head consultants for various mental
17 health specialties, just have them e-mail the link
18 to their providers or do you do some substantive
19 training. We think we probably need to do more
20 than that. That's part of what the Center of
21 Excellence will do in terms of dissemination of
22 guidelines and also conduct training and refine

1 and compare them to other guidelines. We've had
2 evidence-based training and there's no evidence
3 base established for the best treatment for
4 combat-related PTSD but there is evidence-based
5 protocols for other forms of PTSD and we have
6 initiated that a year ago with 119 trained here in
7 San Antonio with cognitive processing therapy from
8 a VA expert and a train the trainer events. We're
9 going to be expanding that in prolonged exposure
10 therapy training and continue cognitive processing
11 therapy training over the coming year in
12 collaboration with our VA colleagues. So shared
13 training going back and forth. We'll continue the
14 Center for Deployment psychology work where (off
15 mike) picks up the centralized training for
16 psychologists in deployment health combat
17 operation, physical train and COE will be involved
18 in the protocols for each. With regard to
19 training for TRICARE providers the opportunity
20 will be extended to them but what we'll probably
21 end up developing, for their convenience
22 primarily, is some kind of web-based conferencing

1 or webcasting kind of training and we've looked at
2 options of that. Next slide, please.
3 School programs. There are a number of
4 them that are engaged already. This can be an
5 ongoing function of the COE division. We've got a
6 mental health self-assessment program is in
7 process as part of an educational activity. The
8 Sesame Street deployment educational program is in
9 gear and fully funded, nominated for an Emmy, I
10 understand. We have a science of suicide program
11 that's now integrated into the school system of
12 DoD and it looks like it's going to be effective
13 in helping kids recognize kids in trouble. We'll
14 be developing psychological health core curricula
15 both leaders, families, medical staff, caregivers.
16 We have some versions of this already in terms of
17 training programs, CD and web based to recognize
18 folks in distress and respond appropriately to
19 them. We'll be expanding these kinds of things in
20 providing training for our professional, military
21 education and in other modalities. Standing on
22 the return and reunion programs identifying best

1 practices and disseminating them. Anti-stigma
2 campaign was recommended. We'll certainly
3 leverage this on existing activities; for example,
4 that's going to be the theme of our suicide
5 prevention conference in San Diego in April this
6 year and reducing the stigma for help. Also it
7 will also be part of an integrated function of the
8 COE and the services and other types of behavioral
9 health conferences that can be assessing the needs
10 in that area, where we need to target, what kinds
11 of stigma campaigns and focusing on leadership
12 attitudes as well as service members and families.
13 The whole issue of resilience with regard to all
14 that it's very complicated. Expanding the issue
15 of embedded mental health providers which we're
16 doing primarily in special operations right now.
17 Marines are transitioning to the operational
18 stress control and readiness program using largely
19 enlisted, but some level of professional support
20 in various units and there's the brigade embedded
21 providers that the Army is using. We had a
22 conference actually about a week, week and a half

1 ago, brought together the subject-matter experts
2 in each of the services. We went through what
3 everyone is doing. We identified core elements,
4 essential elements and we'll be generating a
5 product to look at how there might be a certain
6 level of standardization for those core elements.
7 Obviously it's, depending on the unit, there are a
8 lot of ways that that might be done. Next slide,
9 please.
10 Improve access to care. Basically there
11 was some question about whether the reserves had
12 adequate TRICARE coverage and it turns out that
13 the NDAA of '07 had provided for much more robust
14 supplementation. So on 1, October, a couple
15 weeks, they will have less to pay for fairly full
16 and robust TRICARE continued support. Substance
17 abuse rehab benefits. There was some concern in
18 some states there was only one or two programs
19 that might qualify for TRICARE payments. It turns
20 out that was only counting independent ones. A
21 lot of them are attached to hospitals and have
22 existing certifications are already included in

1 that, multiplied by seven or eight-fold the number
2 of rehabilitation centers in some major states.
3 So I think there's a matter of a clarifying what's
4 available policy in that regard. We need to
5 continue to look at whether it's adequate.
6 Establish and fund long-term casualty assistance
7 support. We're in communication with the office
8 of primary responsibility at P & R, and we're
9 going to leverage with them, also, what I'll be
10 addressing next and that's in terms of what's
11 related to our seven-day access policy. There's
12 been a lot of coordination. We're in the second
13 iteration of a coordination that's probably going
14 to be signed off by the ASDE today, if it's not
15 signed off already. But we're going to accept the
16 seven-day access routine standard. We've had
17 acute access walk in, I think, in all the service,
18 forever. But to do that for routine visits, it's
19 been highly variable from the services and
20 locations within the services. Many have meeting
21 that; many have not been able to. So we're going
22 to go that and one of the ways and what we're

1 going to do is we're going to implement what's
2 going to called a behavioral health provider
3 locater and we're funding that with part of the
4 supplement through TMA so that it's not incumbent
5 upon the person who needs the service, but the
6 locater will figure out who's available to see
7 them, not go through a list of 100 -- not figure
8 out who's still seeing folks, not -- sorting it
9 out and a lot of folks with mental health
10 condition that's acute may not go through all that
11 labor. So we're going to buy that labor and we're
12 going to have the contractors be responsible in a
13 positive way for telling us what's available,
14 rather than going to a website, get all the list
15 of people that have ever been contracted and
16 figure it out for yourself. That's a major player
17 and what we're going to do is make sure that the
18 casualty assistance officer is aware of that too
19 and support them in whatever they need, because if
20 they move beyond traumatic grief counseling which
21 is available to family support from Military One
22 Source to needing clinical care, they should be

1 able to just transition them right to the locater.
2 So that ties in. Increase in contractors and
3 resource sharing as needed, more flexibility in
4 terms of how we meet -- the public health services
5 offered up -- neighborhood of up 200 perhaps
6 mental health providers which may fill in some of
7 the major gaps in care that we have especially on
8 more remote locations. A certain degree of
9 understanding has been worked out already. We're
10 into the specifics now, but it looks like this is
11 a fast moving train that may get into the system
12 and out very quickly especially for underserved
13 areas. Using mental health technicians more
14 fully. Some areas are using them to do intakes on
15 the enlisted and assisting providers preparing to
16 see them. Certainly that's something that can be
17 expanded and we need to look at standards as we go
18 to (off mike) training in San Antonio that will
19 make it easier too. Enhance recruitment and
20 retention incentives. All three services now have
21 the critical skills retention bonuses for
22 psychologists targeting critical year groups.

1 Some are utilizing accession bonuses and
2 re-payback programs as well. Also the multi-year
3 specialty pay for psychiatrist has been
4 significantly increased. Next slide, please.
5 Funding critical staffing needs for Army
6 and Navy as they've already funded for this spend
7 plan as they've identified them. We've developed
8 a very robust staffing model, the first of its
9 kind; expect to see a publication on this.
10 Literature was (off mike) all kinds of ways of
11 staffing, RBU base, population base, no at-risk
12 population base, at-risk and with PTSD population
13 base and patient/outpatient ratio accounting for
14 primary care providers doing mental health care,
15 embedded mental health providers in primary care,
16 and also embedded in the units, but their usually
17 not clinical. Accounting for medical education
18 needs we grow our pipelines primarily for all our
19 psychiatrists; we're not getting a lot from
20 outside and the internship for our psychologists
21 so we have a (off mike) education. And prevention
22 and education needs we can't be (off mike)

1 everybody prevention at the expense of one of the
2 others. So this model put in the numbers and
3 that's the place that we're at right now. We need
4 a certain level of granularity from the services
5 to put the number into the staffing pool to
6 generate what looks to be the most reasonable
7 approach to staffing and COE can be refining that
8 model over time as we look at it. Next slide,
9 please.
10 Focusing on treatment needs for females
11 there's active coordination between the
12 representative and the health affairs program
13 policy with the VA representative on the same.
14 We'll probably have a number of conferences in
15 this regard to sort of look at the areas in which
16 we need to invest more finely (off mike) in terms
17 of detecting problems and making services
18 available. We'll leverage that also with some of
19 our (off mike) sexual reporting program, sexual
20 trauma reporting. TRICARE covered intensive
21 outpatient. Some of that is going on already.
22 It's been under assessment by TMA for quite some

1 time. We'll probably see a more unifying policy
2 on that evolve, but they've been looking at this
3 and they've been paying for it in some areas
4 already, but bottom line is it's evolving and
5 we'll see how it works out in various areas. And
6 we've been using it within some MTFs over time.
7 Whether that's expanded -- I remember when we
8 first went to that one hospital I was at, we had
9 two suicides within the first six weeks. I was,
10 like, What the heck is going on? You have to
11 proceed sort of carefully with those and we'll see
12 how the final (off mike), TMA, but they are
13 looking at -- have been for some time. Next
14 slide, please.
15 Care transitions. We're going to expand
16 what one service is doing already in terms of hand
17 offs. In other words, if somebody PCSs from one
18 facility to the next make sure that if they're
19 mental health patients there's been some kind of
20 hand off. We do that with oversea clearances to a
21 fair degree already, but we're doing it more
22 robust across the service. And that's also for

1 DoD to DVA, but we need to think about hand offs
2 from DVA to DoD as well. That's sort of a new
3 domain people haven't thought about. Why should
4 medical standards of care change when you're
5 changing institutions, because I think it's the
6 same medical standard? Enhancing medical
7 documentation. There has been a mental health
8 module proposed for two years as an application
9 507, I think it's called, for AHLTA. The project
10 has been in development for some time. People are
11 balancing the need for just a SOAP note to protect
12 the confidentiality, reduce stigma with a wide
13 accessibility of the charts versus more robust
14 mental health. But that's in the works, hasn't
15 been funded and the time line on it is not
16 straight, but we've identified what people have
17 thought we should be using. Now maybe we should
18 also be coordinating that with the DVA to make
19 sure we're on the same sheet of music. My
20 understanding is the technical application for bi-
21 directional visibility on the charts will be
22 active at the end of next month. They (off mike)

1 (off mike) about December, we should bank on, so I
2 think we'll probably going to be in the ballpark
3 of November. Lots of issues with that, not time
4 to discuss it here. Next slide, please.
5 Millennium cohort study had integrated
6 for recommendation PTSD about a year or so ago and
7 the study was actually initial before it was a
8 study this year. Research proposal is already
9 covered by Dr. Carter. Basically, needs
10 assessment and he covered that as well. We're
11 going to have integrated health assessment review
12 tools kicking in in terms of the initial A version
13 and assessment that has a lot of psychological
14 health questions. And then the R version will be
15 kicking in later. My understanding is both will
16 be active within a year. The R will be for the
17 periodic health assessment review tool and will
18 cover some mental health (off mike). Expanding
19 the periodic health assessment, will be an iterate
20 process especially if they refine the pilots and
21 the ANAM use and the specificity of that. And
22 then the degree to which face-to-face mental

1 health assessments depending on the responses for
2 coupling those responses to additional skills
3 assessment perhaps using mental health counselor
4 versus a mental health provider. So all that can
5 be worked out COE will probably pick up on a great
6 deal of that. Next slide, please.
7 Psychological health. We have an
8 infrastructure proposed. We'll probably largely
9 go with that infrastructure, but the director of
10 psychological health proposed for each of the
11 service branches. The thought is locate them with
12 the chiefs of staff rather than with the surgeon
13 generals, couple with leadership and also to be
14 very sensitive to psychological health. 80
15 percent or more might be coming more from
16 personnel side rather than the caregiver side.
17 And one is the Bureau of the National Guard and
18 one is the Reserve Affairs as a Reserve forces
19 representative. And then they recommended full
20 time at each of the bases. I think the services
21 are going to have to work out how they do that
22 within the size and the requirements of their

1 areas. We're going to have the internal review
2 subcommittee by having the psychological health
3 counsel report to medical personnel counsel as
4 this membership outlined here. External we
5 proposed and embedded, I'm not sure it's signed
6 yet, a psychological health subcommittee to this
7 Board. Next slide, please.
8 Security question has been modified;
9 they said it was too broad. Have you been in the
10 mental health the last seven years; changed it to
11 have you psychiatrically hospitalized. And that's
12 been pretty much been signed off by Secretary
13 Gates. There's been some issue about whether a
14 quick conflict with some other guidance in terms
15 of an old executive order from the '90s. So they
16 based the recommendations to align some language
17 so it doesn't conflict and it's essentially going
18 to be implemented is what it looks like now. So
19 there's been a lot of things to make sure there
20 was no conflicts among legislative and DoD
21 regulatory, but other guidance in that regard and
22 I think basically the planets are in line with us

1 gong with Have you been psychiatrically
2 hospitalized. Different populations. Revise the
3 alcohol education policy. Basically for people
4 who are not referred involuntarily because they
5 had an alcohol event, if they want education and
6 they don't get an evaluation or if they do get an
7 evaluation, aren't diagnosed with abuse or
8 dependence they're not going to get a command
9 notification. We're working on command-directed
10 evaluation policy changes. That will have to be
11 coordinated with doctor and may or may not require
12 legislative change and there's lots of nuances
13 there that we have to go through. Personality
14 disorder is a personnel issue and that's another
15 one that has a lot of nuances so we won't discuss
16 it here. But having some consistency across
17 services with regard to the extent of the mental
18 health assessment prior to discharge for that is
19 something we can do and will do. And also work
20 with LOA 1 in terms of any of these. I think
21 that's it.
22 DR. POLAND: Colonel Carter, can we have

1 you come up too. We've got about four or five
2 minutes for questions. Wayne.
3 DR. LEDNAR: Just Colonel Ireland, and
4 looking through all the material that you've
5 presented, clearly there's a lot, especially a lot
6 for the medical side of this story. Towards the
7 end you talk about promoting a culture of
8 psychological health. You mention the line
9 commander's sort of being equipped to better
10 recognize, perhaps, signs in their service members
11 that there's a need for them to connect. What I
12 didn't see is can you tell us about how the
13 culture of psychological health will be driven
14 through the line commanders and their leadership
15 in a way that the line commanders own this issue
16 and it's not overly-medicalized.
17 COL IRELAND: I hope I didn't
18 communicate just the other. The reason it would
19 be located with chief of staff is that you would
20 expect that to be from the very highest level up
21 as a staff attitude, as a leadership attitude. If
22 that's not there everything else you do is smoke

1 and mirrors. So I think either the leaders have
2 to own it and it be clear that they own it and
3 have opportunities to stand in front of folks and
4 own it, whether it's a suicide prevention brief or
5 brief in some other resource, but that's just
6 going to have to be coming from the leadership
7 over and over again, that we take care of
8 business. When you go to the target range when
9 you can't shoot right and you get it and figure
10 out how to do it better and if your psychological
11 health is going haywire, you go to the
12 psychological gym or your psychological coach, or
13 whatever you want to call it, and you take care of
14 business there as well. So I think that attitude
15 has to be first. If it's not, everything is just
16 not going to work. There's ways of just going
17 through the motions, but no effective change. And
18 that's a cultural transformative change. That is
19 not legislateable, but I think it's possible with
20 the right kind of advocacy.
21 DR. LEDNAR: I guess, just a suggestion
22 of reaction. If that is true that this is a

1 senior-commander owned issue as a way to operate
2 the military effectively for mission
3 accomplishment, there's a way you can bring that
4 message very clearly front and center as you talk
5 to groups about it. I think that would be very
6 helpful.
7 DR. POLAND: Dr. Parkinson.
8 DR. PARKINSON: Thank you both.
9 Excellent presentation. I'm going to try to get
10 us up again the 158 recommendations that you both
11 are admirably trying to deal with. Something that
12 you said, the list of recommendations doesn't make
13 a plan which is spot on. And I think -- I'm
14 contrasting Persian Gulf II, if I can call the
15 global war against terrorism versus Persian Gulf
16 I. There we created a national infrastructure to
17 deal with something which was a great concern to
18 our nation's veterans and their families which
19 turned out to be a syndrome that wasn't a
20 syndrome. And we did that through the rapid
21 expansion of standardized protocols, tri-service
22 dissemination, using every medical resource and

1 MTF we had to do the same types of things,
2 centrally, track, monitor, followed up and I can
3 argue whether or not it was successful, but the
4 approach and principles were tri-service, not
5 primarily Army. Immediate standard protocols
6 across the country and dramatic attention at the
7 ASD/HA level, week-by-week with metrics. Okay, I
8 was in the middle of that, so I know that
9 happened.
10 Now we've got three real -- and I don't
11 mean to say that, but we've got amputations, we've
12 got TBI, which is a real, severe and repetitive
13 concussive injuries to the brain, and truly PTSD
14 which is well qualified with DSM 4, whatever
15 criteria we use nowadays to do that. What we seem
16 to have is three parallel tracks of an amputation
17 center, of a TBI and maybe blended mental health
18 approach. So you guys are here side by side,
19 which is great, but get us up above here again and
20 getting us back to this wounded warrior and the
21 warrior in transition, why aren't these programs
22 called warrior in transition? Why don't we have

1 -- in other words the ultimate destigmatization of
2 mental health is to say, no, you're a warrior. In
3 your mental health you're going to get your
4 warrior mental status. Whether or not you get
5 back to full status before you had TBI and before
6 you had mental and emotional things that you can't
7 deal with because you've been shot at for 14
8 months, are we again codifying the stigma of
9 mental health by having the wounded warriors
10 literally right across town in these
11 state-of-the-art facility? And I love the fact
12 that we're going back and forth with Mr. Fisher on
13 what should be the content and the programs and
14 the whatever of a COE that he graciously agrees to
15 fund, which is over here, which is the COE for
16 mental health. And over here is the Intrepid,
17 which is the COE for amputated and that group has
18 said, we don't want to do that stuff, really, we
19 want to do amputation. Do we have a
20 responsibility to say wounded warriors are wounded
21 mentally, physically, emotionally, family and we
22 insist that it be the Intrepid for everybody. We

1 insist we have a unified approach and everybody's
2 a warrior if that's what we want to do. So I
3 think we're codifying, yet again, in insidious and
4 maybe even blatant ways what we want to do.
5 Final comment. I'm not a neurosurgeon.
6 Background is in preventive medicine, primary
7 care. I too followed and saw the hit that the
8 Buffalo Bill had the other day. Dramatic
9 application of hypothermia in the hours sustained
10 after to a CNS injury apparently had dramatic
11 effect in reducing the amount of paralysis
12 post-injury. So while we're putting out RFPs,
13 intramurally and extramurally with TBI, are we
14 taking -- are we doing right now, I mean literally
15 today, things a neurosurgical panel that's looking
16 at immediate post-blast applications of
17 experimental therapies pursuing an IND if indeed
18 that's experimental to do rapid brain cooling? I
19 don't know, but it's physiologically appealing to
20 me because it really is trauma, again and again
21 and again that causes some degree and cold works
22 very well. So, that's all the way from 90,000

1 feet right down to what's going on in
2 neurosurgery. But I'm concerned that we're
3 slicing up body parts again and we're codifying
4 with brick and mortar again and we're still trying
5 -- just your reaction to that or thoughts.
6 COL IRELAND: With regard to the first
7 one, sir, I would hope this Defense Health Board
8 could help us precisely in that area, because when
9 we get up to that altitude, we're talking
10 politics.
11 COL CARTER: And I would say with regard
12 to the Center for the Intrepid is that when we
13 talk about the Center for the Intrepid was
14 created, it was created for a specific purpose,
15 with a specific floor plan, specific space
16 required for what it is. And to try to shove in
17 what we're trying to do into that same space would
18 be difficult. Now we do have interaction with
19 service members who are in the Center for the
20 Intrepid because many of them have TBIs as a
21 result of the initial cause of injury. I hear
22 what you're saying, but I'm just not sure that at

1 this point that's going to be feasible.
2 DR. PARKINSON: And I guess the final
3 question is: Do you need a brick and mortar
4 facility to be a center of excellence? I mean, I
5 guess -- again, I'm not trying to be platonic
6 here, you know, (off mike) question you can't
7 answer, but you know what I mean.
8 DR. POLAND: Let me -- I need to
9 interrupt just a bit. I apologize to the Board;
10 I'm going to have to leave. I've never made it a
11 habit to leave a meeting early here, but I'm
12 giving a talk tomorrow morning and this is the
13 last plane out. So I've asked Dr. Lednar if he
14 would perform the remaining duties of the
15 president for me and he's graciously agreed to do
16 that. So, Wayne, can I turn it over to you and
17 keep this discussion going. Thank you all very
18 much. It's been a long three days of meeting.
19 Thank you.
20 DR. LEDNAR: Thanks, Dr. Poland. I
21 think we'll need to bring this discussion to a
22 close.

1 COL GIBSON: We've got a few more
2 minutes that we can do.
3 DR. SILVA: A lot of recommendations and
4 I'm glad you sorted it out as to what's been
5 achieved and what's coming up pretty quickly for
6 achievement. The research here is one that I
7 think I would ask you to look at the speed at
8 which you're taking that one on. Announcing the
9 RFPs, the funding dates, because the war is moving
10 along and you have a patient population that needs
11 to be studied for future conflicts and so I sort
12 of join in with you, Mike, that other technology
13 should be looked at. Transducers, transmitting
14 EEGs, you had CAT scan up there in the field and
15 maybe MRI is even better. Even issues of early
16 cooling and treatment, because that has now been
17 shown and published in the New England Journal for
18 neonates, the preemies. It's a very affective
19 technique right after delivery to do brain or body
20 cooling to reduce subsequent brain damage and
21 retardation. It's now changed the state of art
22 how we deal with preemies. So I think you need to

1 get together a panel of knowledgeable people and
2 move the research along and apply treatment. Just
3 to deal with the psychometrics it's fine, but I
4 think you've got into anatomical and physiological
5 levels to study and get some markers.
6 COL GIBSON: To close this out, two
7 things. The Board has already agreed that we are
8 going to provide an external advisory Board to
9 each one of these entities. That's going to be
10 our conduit to make a difference and to help them
11 with some of the issues that you've just brought
12 up and that Dr. Parkinson brought up.
13 One question for you Bob. I saw that --
14 this is kind of a closeout. I saw a campaign,
15 anti-stigma campaign. One of the things that I
16 heard Admiral Arthur and the other members of the
17 mental health task force say is campaigns are
18 wonderful and fine. We have anti-smoking
19 campaigns every year and everybody smokes. If the
20 idea is to institutionalize this issue of no
21 stigma for psychological problems, I assume that
22 with all of the slides and all of the information

1 we saw there, that that is the end goal for this
2 process, not campaigns for anti-stigma, but end
3 goal is institutionalize that concept.
4 BG (Ret) FOX: Just a comment back to
5 Dr. Parkinson. The points are valid that one has
6 to be very careful about how Centers for
7 Excellence are incorporated and utilized and
8 sustained. That's one of our issues in the
9 amputee care center side of the house. But I
10 don't think it should go unrecognized that that
11 center on the amputee care side is integrated into
12 a gradual medical education center with 23 GME
13 fellowship programs and residencies of which
14 orthopedic surgery is one. And surgical care,
15 general surgery and it is a level 1 trauma center.
16 So the integration of that kind of Center for
17 Excellence only brings to bear the
18 multi-disciplinary experience and technologies
19 necessary to care for the patients. It in no way
20 isolates those patients away from the mainstream
21 of patient care or graduate medical education or
22 the higher level of research that goes with it.

1 I would say that it was a very
2 thoughtful process and it is not an isolated
3 incident and in this case Center for Excellence
4 has more to do with the setting and the
5 applicability of multi- disciplinary processes in
6 a very facile way to care for those kinds of
7 extreme limb injuries of which amputation is (off
8 mike).
9 DR. LEDNAR: General Roadman.
10 LT GEN ROADMAN: I think that it's
11 really important for us to realize that there are
12 already multiple agencies that have some of these
13 responsibilities built into their charter and
14 actually built into their funding system. What we
15 have the tendency to do is recognize a problem, go
16 build a brick and mortar organizational structure,
17 which actually relieves people who are statutorily
18 and institutionally responsible for delivering
19 that particular gear. Instead of fixing the
20 communication channels and taking out silos we
21 build more structures and actually make the
22 problem worse. I think we absolutely have to be

1 careful because everything is going to become a
2 center of excellence, which means that the system
3 is now fragmented more, and more and more and
4 more. And the patient coming across that or the
5 family trying to get that care becomes more and
6 more frustrated. And in trying to do something
7 right, we actually make the problem worse.
8 COL CARTER: About the center of
9 excellence for TBI and psychological health, I
10 mean the whole point of that effort was to do the
11 integration and dissemination of information so
12 that the care provider throughout the MHS has the
13 same level of excellence. Instead of building
14 several centers of excellence that provide
15 something that the others can't provide or don't
16 provide is to disseminate rather than to try to
17 centralize.
18 LT GEN ROADMAN: Yes, sir. I understand
19 that. And so we build a building? It isn't a
20 brick and mortar issue. And I would use the
21 example of DVBIC, which is used as a success
22 story, but that actually has four institutions

1 nationwide involved in it. Well, four
2 institutions in something that's been going on for
3 almost eight years, is not progress. It is
4 actually hunkering down, building a program and
5 not necessarily solving problems. Those are the
6 things that we need to be cognizant of as a
7 Defense Health Board.
8 DR. LEDNAR: Just to close this section
9 of the agenda, on behalf of the Defense Health
10 Board, we'd like to thank both of you for the
11 progress report that you've made and all the
12 detail that you brought. And I think as General
13 Roadman reminds us, part of the role of the
14 Defense Health Board is to have the big view
15 across to see where the areas of linkage need to
16 occur to try to learn from the past. There's a
17 saying that "History does not repeat itself, men
18 do" and how we can learn from some of these
19 lessons of prior response to bring the integration
20 that we'd all like to see you succeed at. So we
21 look forward to your reports of continued process.
22 Thank you.

1 The end item before the Board is
2 Lieutenant Colonel King is here to give us a Task
3 Force on the future of Military Health care status
4 report. Colonel King.
5 LTC KING: Good morning, Dr. Lednar,
6 Defense Health Board members. I'm glad to provide
7 the update on behalf of Colonel Bader, who sends
8 her regrets for not being able to be here this
9 morning. That will become evident in a couple
10 slides from now. Next slide.
11 This is a brief overview of what we'll
12 cover. Next slide.
13 My main purpose for being here is just
14 to update you on the progress on the Task Force on
15 the Future of Military Health Care which you heard
16 twice before. Once on the progress report and
17 then once before our interim report. Next slide.
18 Again, just a quick review, overview of
19 our charge that came from Congress in the NDA '07.
20 As you're familiar with two products, a final
21 report and an interim report. Next slide.
22 This is a review of the members of the

1 task force. I just wanted to highlight the fact
2 that Major General Kelley retired and has been
3 replaced by Rear Admiral Smith on the task force.
4 Next slide.
5 However, Major General Kelley was
6 retained as a consultant because of him being so
7 far into the process, he stayed on as part of the
8 task force. Next slide.
9 Again, as you're aware and familiar with
10 the whole reason and purpose for the task force is
11 to review bodies of information and review
12 materials from subject-matter experts so that we
13 can make recommendations ultimately on our final
14 product. We've also included RAND as a consultant
15 for some assistance with respect to digging into
16 some necessary data information in an expedited
17 fashion. Next slide.
18 This is a brief overview of the meetings
19 that we've held since we last briefed the Defense
20 Health Board. And I'll go over these. Next
21 slide, please.
22 Each of these meetings is tied to one of

1 the elements that were in our charge from
2 Congress. And so as you can see here in this
3 April meeting we heard from Mr. Walker and the
4 pharmaceutical industry and the united mine
5 workers. Next slide.
6 Again we had some information regarding
7 the finance issues and these were followed-up by
8 subsequent meetings. Next slide.
9 With respect to disease management and
10 health and wellness -- with respect to these
11 issues it's the task force's main interest to
12 ensure that we try and get as broad and wide of a
13 scope as we can with respect to each of the
14 elements. So we try and review them either from
15 the macro level of TMA, health affairs, drill down
16 into the service respective areas, as well as take
17 public and/or private sector viewpoint of these
18 various issues. Next slide.
19 That was followed up again by another
20 health and wellness perspective where we drilled
21 down into the respective services and heard from
22 each of them as well as TMA. Next slide.

1 Here we dealt with the topic of
2 acquisition and procurement issues as they relate
3 then to how the MHS goes about procuring and
4 getting their respective items. Again, because it
5 was service specific, that's who we were talking
6 to and getting information from. Next slide.
7 Our recent public meeting here in early
8 September had to do with the Command and Control.
9 This has been a topic in the D.C. beltway I know
10 for quite some time and we were eager to hear what
11 had been done with respect to that. Also want to
12 make note that our website allows members to take
13 advantage of feedback to the task force and we've
14 made that public on previous occasions. But for
15 your own interest, it is DoDfuturehealthcare.net
16 and that is another avenue by which we do obtain
17 public comment with respect to what we're going
18 over in our respective meetings. Next slide.
19 This is again the reason why Colonel
20 Bader was not able to attend. There was a
21 concurrent meeting in Norfolk for the task force,
22 where, again, they were delving into issues

1 specific to beneficiary groups and heard from them
2 in a panel format. Next slide, please.
3 Some of the issues that are discussed
4 are better discussed sometimes in a smaller
5 subgroup fashion. So some of the task force
6 members then have stepped up to take on a
7 particular subject matter of their particular
8 interest and they've done so in these kinds of
9 related disciplines. Next slide.
10 These subgroups then meet at their
11 various times and schedules that are beneficial
12 for their busy schedules. And when they do so,
13 they meet and collect their various information on
14 their topics and then bring that to the whole
15 entire task force for ultimate review and
16 discussion where then the whole task force then
17 can decide whether or not it's worthy of any
18 particular finding or recommendation as a whole
19 body. Next slide, please.
20 Again, we have some upcoming milestones.
21 One of the milestones is we'll have an October 3rd
22 meeting where we will discuss TRICARE for live

1 issues as well as the military/civilian ratios
2 that are inherent with respect to the services and
3 how those are changing and what's the best way to
4 go about looking at that. Again, we have the
5 meeting in December. I believe it's December
6 11th. We'll meet in front of this body to present
7 our final paper and that will then go forth to the
8 Secretary of Defense on the 20th of December. The
9 Secretary of Defense has up to 90 days to review
10 that product. While that review is going on, the
11 task force will begin some of the standing-down
12 procedures associated with the task force.
13 Typically the Secretary of Defense doesn't take
14 that long and then he forwards it to Congress.
15 Next slide, please. Any questions?
16 DR. LEDNAR: Thank you. Questions or
17 comments? Dr. Parkinson.
18 DR. PARKINSON: Thank you, Brian. I
19 have not yet gone to the website, but I will when
20 I leave today. Are all the comments in there
21 readable by other participants; in other words,
22 does it read like a discussion room, so you can

1 see comments that have come in and responses? How
2 -- do you mail it in and --
3 LTC KING: Yeah. It will bring up an
4 e-mail dialogue-type box where you'll type in a
5 particular area of your concern or interest and
6 then you'll have a free text area box where you
7 can include that. The rest of the comments are
8 there for review or looking at. It's just a
9 one-way mechanism to get them to the task force.
10 DR. PARKINSON: Since the last time we
11 met you've had some briefings from Health Ways,
12 Cigna, John Hopkins Health Plan. You had a task
13 group, a subgroup entitled "Best business and
14 health practices". One question is: Have you
15 had, through Cigna's presentation a thorough
16 discussion of consumer-driven health plans, both
17 health reimbursement accounts and health savings
18 accounts during the course of your deliberations?
19 LTC KING: No. That particular topic
20 was not brought up by them.
21 DR. PARKINSON: They probably won't.
22 Because this is my concern about your efforts

1 overall in the broad sense is that the established
2 players in many of these industries are not
3 interested in breakthrough models that actually
4 save employers a lot of money. It sounds like a
5 radical statement. But if you look at last week's
6 pronouncement by the national association of
7 manufacturers, which again is how do you get an
8 affordable healthcare benefit? They have one and
9 only one recommendation, rapidly adopt
10 consumer-driven health plans, period. Full
11 replacement. All stop. So they're whole thrust
12 is to get health reimbursement accounts and health
13 saving accounts, properly designed, executed and
14 communicated to their members. The president of
15 that organization is Chip McClure who is the CEO
16 of Arvin Meritor in Detroit. I'm sure (off mike)
17 patriotic duty and have him fly into Washington
18 and talk to your groups to why they did and how
19 they did, he'd like to talk to you a bit, if
20 that's possible.
21 My point is here if you talk to PBMs
22 about the pharmacy benefit and if you talk about

1 health plans or health insurance benefit, you may
2 not have the opportunity to have a breakthrough
3 recommendation whether DoD takes it or not is
4 almost not the point. My concern is is that if
5 the task force, which is very heavily dominated by
6 military members, many of your colleagues and
7 people from the civilian sector who one way or the
8 another are in the current status quo, this may be
9 the only time in ten years that you have a chance
10 to do an outside-the-box exercise. I hope the
11 task force is taking it as an outside-the-box
12 exercise, even just to say the future state would
13 look something like this and here's what our
14 practical recommendations are. From our
15 conversation the last time and Ms. Wilensky, who I
16 respect very much, I got (off mike) well, it's not
17 really politically feasible so we can't really go
18 there. What I would hope is this be a radical
19 outside-the- box vision where American healthcare
20 needs to go with models that are promising that
21 current employers are adopting or trying to urge
22 their colleagues to adopt, rather than saying the

1 best way to do a three-tier formulary is to make a
2 five- tier formulary and get the cross shift in
3 whether or not -- I understand those issues, but
4 this is DoD's chance, probably for a decade, to
5 come out and say this is true north. This is
6 where you should go. I don't know if we're going
7 to hear that December 11th and 12th. If we don't
8 hear that December 11th and 12th, my role here is
9 to make these comments (off mike) missed the mark.
10 To sustain the current healthcare services, just
11 like employers have to sustain, they cannot do
12 HMOs and PPOs. They cannot do five-tier
13 formularies; they cannot do narrow and narrow
14 networks with doctors who don't take services.
15 Those things, I hope are on are your agenda. I
16 apologize for going into some detail, but I did it
17 to give you a flavor of the types of things that I
18 didn't see in the last report. In terms of the
19 players you're talking to, I can assure you
20 Hopkins healthcare is not going to talk about the
21 things that a CEO of a 6,000-person company in
22 Detroit, who is competing with India has to talk

1 about. So please take those as a positive
2 construct and go back. If there's nothing in
3 there and you're not hearing from the (off mike)
4 who are doing those things, chances are it may not
5 be in your report.
6 LTC KING: I appreciate that. I can
7 take that back.
8 DR. LEDNAR: Just to build on Dr.
9 Parkinson's thought. If you can bring back to the
10 task force -- clearly the military has shown for
11 the nation real leadership. We look at the Center
12 for the Intrepid. If we look at the DoD response
13 to TBI, I mean there's real leadership in
14 healthcare that the DoD is brining, not just for
15 the military, but these clearly will have
16 cascading affects broadly across the nation. As
17 we look at, again, in the civilian sector, how
18 healthcare is valued in places like Detroit,
19 healthcare and assuring continued access to
20 affordable healthcare is becoming more valued by
21 people than even pay. So reinforce what Dr.
22 Parkinson is saying, this is a unique opportunity

1 to think about what is possible. And you can
2 expect that in December when the task force comes
3 back -- if the Defense Health Board does not hear
4 about very seriously considered macro issues that
5 are on the table today, like consumer-driven
6 healthcare, we're going to ask about it, because
7 that's not a secret. That's a very macro force
8 that's of great interest and pursuit by the
9 private sector. So we encourage you to take
10 advantage of some of the suggestion of some
11 innovative thought by people who are really
12 particular about kicking the tires. We're not
13 going to adopt something trivially. I think the
14 suggestion of the CEO up in Detroit is an
15 excellent one. So we'd encourage the task force
16 to stay open to possibilities because we'll
17 certainly be probing at that when you come back in
18 December. Other questions. Dr. Halperin.
19 DR. HALPERIN: It's my limitation, I'm
20 sure, but maybe when we do have this 12th meeting
21 there could be a digestion of what the umpteen or
22 (off mike) nature issues are that are being

1 considered and where we are with those issues. So
2 it's not clear to me whether we're talking about
3 healthcare, finance or whether we're talking about
4 the structure of medicine is vis-à-vis the
5 relationship of primary care to referrals or are
6 we talking about completely electronic medical
7 records. If (off mike) what the issues are maybe
8 before the presentation in December we could have
9 a focus of what the nature of these are that the
10 committee is and where we stand with those issues.
11 LTC KING: Yes, sir. Those elements are
12 discussed in the charge in the NDA '07. They're
13 listed on our website. There's 10 of them
14 altogether.
15 COL GIBSON: I will send out the terms
16 of reference which spelled out very, very
17 specifically the issues that -- and basically the
18 NDAA 2007. It's on the website, but each of you
19 will get that next week by the time you get back,
20 you'll have that mail.
21 DR. HALPERIN: Like maybe the
22 presentation could be where the commission is --

1 think what the commission is thinking about each
2 of those issues, so we have a sense of where we're
3 going.
4 LTC KING: I would gather from the way
5 and the structure of the final report, it will
6 very much line up with those various elements.
7 Maybe not in the exact same order, but it will
8 line up with those elements that were in the
9 charge and we will have particular findings and
10 recommendations, I would presume on those and
11 varying (off mike).
12 DR. LEDNAR: Dr. Walker.
13 DR. WALKER: With this final report
14 going forward on December 20th, will we receive a
15 copy of this before the meeting?
16 LTC KING: It's my understanding that
17 you'll have a copy.
18 DR. WALKER: Before the meeting?
19 LTC KING: I believe so. So that you
20 would have the ability to take a look at it.
21 COL GIBSON: This is always a problem.
22 And it's a problem that is built into the suspense

1 system for any type of task force that does these
2 sort of efforts. They are very focused on
3 providing a final report and it always ends up,
4 every time I've been involved in these, it always
5 ends up they're working to that last possible hour
6 before they have a final product. As a
7 subcommittee of this Defense Health Board, what we
8 work for is to get you a draft that's pretty
9 close. You know we're not worried about the last
10 bell and whistle and making sure that every point
11 is covered and we've used a than rather than a
12 then and all of this. You need to be able to get
13 something that you can digest early enough in the
14 process so that you can ask the right types of
15 questions when the presentation is made. We will
16 take a, basically, I don't know whether it's going
17 to be a morning or afternoon, but we will take a
18 long time on this specific issue, very similar to
19 how we did the IRG report and the mental health
20 task force report. And, yes, it's the intent for
21 this Board to get the draft report, which it will
22 be until it's deliberated by the Defense Health

1 Board, with time enough to digest it before the
2 meeting.
3 DR. LEDNAR: Other questions or
4 comments? On behalf of the Defense Health Board,
5 thank you for coming and giving us this report and
6 for all the hard work you're putting in that will
7 bring this very complex challenge to a discernible
8 recommendation and we look forward to your report
9 in December.
10 LTC KING: Thank you, Dr. Lednar.
11 DR. LEDNAR: Thank you. I'd like to
12 start moving now towards closure of this meeting
13 and we'll do it in really three small steps.
14 First, Colonel Gibson has a few comments
15 to make. I do, and then we'll ask Dr. Kilpatrick,
16 as our designated health official to make a few
17 final comments and bring the meeting to
18 adjournment.
19 COL GIBSON: Thank you very much for
20 hanging with us for three pretty long days.
21 Granted we're ending at noon on the third day, but
22 it's been an intense morning I would say.

1 Number two, make sure you sign those
2 sign-in rosters and make sure you get credit for
3 you CME. I know it's only two credits, but please
4 get those.
5 Finally, if there's anything you need
6 shipped back home, let Karen help us with that and
7 we can ship your notebooks back to you so you
8 don't have to lug them on the airplane. Dr.
9 Lednar.
10 DR. LEDNAR: Thanks, Colonel Gibson. As
11 Dr. Poland's stand in, I'd just like to say
12 several things. One is again on behalf of the
13 Defense Health Board we wish Commander Carpenter
14 God speed and we look forward to hopefully your
15 continued staying in touch with us. We look
16 forward to your successes in your next assignment.
17 On behalf of the Defense Health Board, this
18 meeting wouldn't occur without the leadership of,
19 first and most importantly Colonel Gibson. It's
20 no small feat pulling this all together, getting
21 an agenda, trying to get materials identified in
22 advance. Those of us who need continuing medical

1 education to make that possible, even if it is
2 just a smidge, but we appreciate Colonel Gibson,
3 all of the leadership that you bring, because this
4 is clearly a very full agenda.
5 The work of the office, of course,
6 wouldn't get done without the help of Ms. Ward,
7 Ms. Jarik and most especially at this meeting we
8 all want to give a real big appreciation to both
9 Karen and Britt Triplett for all the work you've
10 done for us.
11 The next meeting of the Defense Health
12 Board will be in December. It will be in
13 Washington, D.C. at a location to be determined.
14 That will be obviously a very important meeting
15 given the topics that are coming up. With that
16 I'd like to have the final say by Dr. Kilpatrick.
17 DR. KILPATRICK: I just want to express
18 my appreciation to all the members of the Board
19 having been with you here these three days. The
20 work that you're doing and the way you've embraced
21 the expanded scope of the Defense Health Board,
22 looking at the entire image as far as where we

1 need to be. I think you're in a great position as
2 an advisory Board to help guide and direct a lot
3 of the dynamic and perhaps traumatic changes that
4 are going within DoD to a better outcome than can
5 be driven necessarily internally or legislatively.
6 So I again want to express my appreciation for the
7 work that you do. The comments are extremely
8 important and the advice that the Board gives,
9 while it is recognized as advice, it comes with a
10 great deal of authority because of the expertise
11 of each of you as individuals and the Board
12 collectively as a whole.
13 I've got one more comment and then I'll
14 bring this to a close.
15 DR. LEDNAR: Before we adjourn the
16 meeting, a very important thank you and that is to
17 Dr. Jackie Cattani. Thank you Jackie for all of
18 the work you've graciously given, both at the
19 meetings and between meetings on the important
20 issues over the years. Jackie has shared with us
21 that she's elected that this will be her last
22 meeting with the Board and obviously the work she

1 does will continue to be the way we get important
2 work of supporting the military done in her area.
3 So on behalf of the Board, Jackie, we really
4 appreciate your being here and for all of the work
5 you've done over the years. Thank you.
6 DR. CATTANI: It's been an honor and a
7 privilege to serve and I have made so many good
8 friends and understood so much more the issues
9 involved. It's been one of the best experiences
10 of my professional career. Thank you.
11 DR. KILPATRICK: With that I'll bring
12 the meeting to closure.
13 (Whereupon, the PROCEEDINGS were
14 adjourned.)
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