UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Cocoa Beach, Florida

Monday, March 1, 2010

PARTICIPANTS:

GREGORY POLAND

ROBERT CERTAIN

NANCY DICKEY

JAMES LOCKEY

MICHAEL OXMAN

MICHAEL PARKINSON

ADIL SHAMOO

COLONEL MICHAEL KRUKAR

COMMANDER ERICA SCHWARTZ

LIEUTENANT COMMANDER JULIA SPRINGS

CAPTAIN NEAL NAITO

ROSS BULLOCK

CHARLES FOGELMAN

JOSEPH SILVA

DENNIS O'LEARY

FRANK BUTLER

CAPTAIN ALAN COWAN

COMMANDER CATHERINE SLAUNWHITE

THOMAS MASON

RUSSELL LUEPKER

JOHN CLEMENTS

PARTICIPANTS (CONT'D):

COMMANDER EDMOND FEEKS

WAYNE LEDNAR

COLONEL DONALD NOAH

REAR ADMIRAL DAVID SMITH

CHRISTINE BADER

LARRY LAUGHLIN

COLONEL CHRIS COKE

DICK MEYERS

BRIGADIER GENERAL BRYAN GAMBLE

COLONEL JOANNE MCPHERSON

REAR ADMIRAL ALI KHAN

COLONEL SCOTT STANEK

VICE ADMIRAL JOHN MATECZUN

LIEUTENANT COLONEL KATHRINE PONDER

GEORGE LUDWIG

COLONEL WAYNE HACHEY

COLONEL MICHAEL GRINKENMEYER

COLONEL JONATHAN JAFFIN

RIDGELY RABOLD

CAPTAIN CHRISTOPHER DANIEL

COLONEL SCOTT WARDELL

PARTICIPANTS (CONT'D):

LIEUTENANT COLONEL PHILIP GOULD

REAR ADMIRAL SELECT CLINTON FAISON

ERIC CARBONE

LIEUTENANT COLONEL MELINDA SCREWS

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P R O C E E D I N G S

(9:03 a.m.)

DR. LEDNAR: Good morning, everyone. Is this microphone on now? Good morning, everyone, and welcome to this meeting of the Defense Health Board. I'd like to welcome everyone who has come to Cocoa Beach for this meeting.

We have several important topics on our agenda today. So let's get started with Colonel Noah. Would you please call the meeting to order, Colonel Noah?

Col NOAH: Thank you Dr. Lednar. As the Alternate Designated Federal Official for the Defense Health Board, a federal advisory committee and a continuing independent scientific advisory body to the Secretary of Defense via the Assistant Secretary of Defense for Health Affairs and the Surgeons Generals of the military departments, I hereby call this meeting of the Defense Health Board to order.

DR. LEDNAR: Thank you, Colonel Noah. In keeping with our tradition of the Defense

Health Board, I'd ask you to please join me to stand in a moment of silence to remember the men and women and families who are defending.

(Moment of silence.)

DR. LEDNAR: Thank you. Now, please be seated. I'd like now to introduce Ms. Christine Bader who has, since the last time we've met as a board, accepted the offer to be the Director of the Defense Health Board and has been serving in that capacity since early December. So she's now several months into this position. And Ms. Bader brings with her to us and for all of the work that we do together for the Department a tremendous energy, for those of you who know Ms. Bader.

Organization. She knows how to take complex work and turn it into a plan. She knows how to execute. Very importantly, has strong and effective relationships with leaders in the Department of Defense and the Defense Health Board. And something that we always appreciate is that she's a solutions-oriented, can-do, mission-focused person. So please join me in

welcoming Ms. Bader as our new director of the Defense Health Board.

(Applause)

MS. BADER: Thank you all very much. I'd like to just briefly express my sincere appreciation, my gratitude, and I'm very proud to have been selected for this position. There's a lot of work to be done, and I look forward to this -- to the way ahead. And I hope to serve you well. Thank you.

DR. LEDNAR: Thanks, Ms. Bader. This is an open session of the Defense Health Board, and before we begin the work of the Board, I'd ask that we go around the room, first with the table and then in the audience and introduce ourselves. Please, if you'd mention your name, the position that you serve in, and if you are on the Defense Health Board or are a liaison. If you would mention that connection so that we can understand from each other the various aspects of how we work together as a board. So can I start with Colonel Noah and then we'll go around this way.

Col NOAH: I'm Don Noah. I'm the Acting Deputy Assistant Secretary of Defense for Force Health Protection and Readiness within OSD Health Affairs.

CDR FEEKS: Good morning. Commander Ed Feeks, Executive Secretary.

GEN (Ret) MYERS: Good morning. Dick Myers, Core Board member.

DR. LOCKEY: Good morning. Jim Lockey, Occupational Pulmonary Medicine, University of Cincinnati. Core Board member.

DR. CLEMENTS: John Clements, the Chair of Microbiology and Immunology and Director of the Tulane University Center for Infectious Diseases and a Core Board member.

DR. LUEPKER: Russell Luepker, Professor of Epidemiology and Medicine at the University of Minnesota and a Core Board member.

DR. MASON: I'm Tom Mason, Professor of Environmental Health, College of Public Health at the University of South Florida and Core Board member.

DR. O'LEARY: Dennis O'Leary, I'm President Emeritus of the Joint Commission and Core Board member.

DR. SILVA: Joseph Silva, Professor of Medicine, University of California Davis, Dean Emeritus, and Core Board member.

RADM SMITH: I'm Dave Smith. I'm the Joint Staff Surgeon and the Joint Staff Lead.

BG GAMBLE: Good morning. I'm Bryan Gamble. I'm currently the Commander of the Eisenhower Army Medical Center and the Acting Commander for the Southern Medical Regional.

Col MCPHERSON: Good morning. I'm Colonel Joanne McPherson. I'm the Executive Secretary for the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces, a Subcommittee of the Defense Health Board.

DR. FOGELMAN: Good morning. I'm Charles Fogelman. I'm Chair of the Psychological Health Subcommittee of the Board.

DR. BUTLER: Frank Butler, Chair of the Technical Combat Casualty Care Committee and

sitting in for John Holcomb, Chair of the Trauma and Injury Subcommittee.

CAPT NAITO: Captain Neal Naito, Navy liaison to the Board.

CAPT COWAN: Alan Cowan, I'm the U.K. Liaison in the field of Deployment Health in the U.S. Department of Defense. I work for Colonel Don Noah.

CDR SLAUNWHITE: Good morning. I'm Commander Cathy Slaunwhite. I'm a Canadian Forces Medical Officer, and I work in a liaison role at the Canadian Embassy in Washington, D.C.

Lt Col GOULD: Good morning. Phil Gould, Air Force liaison.

CDR SCHWARTZ: Good morning. Commander Schwartz, Coast Guard liaison.

COL STANEK: Good morning. I'm Colonel Scott Stanek. I'm the Deputy Functional Proponent for Preventive Medicine, Army Surgeon General's Office, and I'm serving as the Army liaison for Colonel Robert Mott who's currently deployed to Iraq.

COL HACHEY: Wayne Hachey, Director of Preventive Medicine, OSD Health Affairs, and I'm the OSD Health Affair's liaison.

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

RADM KHAN: Good morning. Ali Khan, Assistant Surgeon General and CDC liaison to the Board.

DR. BULLOCK: Ross Bullock, I'm a neurosurgeon from the University of Miami and head of the Traumatic Brain Injury Subcommittee.

RDML (sel) FAISON: Captain Clinton Faison, I'm the Chief of Current and Future Operations for Navy Medicine and here representing Admiral Robinson.

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

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

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

Rev CERTAIN: Robert Certain, I'm an Episcopal priest in Marietta, Georgia, and member of the Core Board.

VADM MATECZUN: John Mateczun, Commander of Joint Task Force National Capital Region Medical.

DR. POLAND: I'm Greg Poland, Professor of Medicine and Infectious Diseases at the Mayo Clinic in Rochester, Minnesota, and one of the VPs of the Board.

MS. BADER: Good morning. Christine Bader, Director of Defense Health Board.

DR. LEDNAR: Wayne Lednar, Global Chief Medical Officer for the DuPont Company and along with Dr. Poland a Co-Vice President of the Defense Health Board.

DR. LAUGHLIN: I'm Larry Laughlin, Dean of the School of Medicine, Uniformed Services University.

LTC PONDER: Lieutenant Colonel Kathy Ponder, Assistant Director of Reserve Medical Manpower and OSD Accession Policy.

DR. LUDWIG: I'm George Ludwig, and I'm the Deputy Principal Assistant for Research and Technology at the Army Medical Research and Materiel Command.

Col GRINKENMEYER: Good morning. Mike Grinkenmeyer, I'm currently the Air Force Deputy Director at the Armed Forces Institute of Pathology.

Col COKE: Good morning. Chris Coke, Joint Operations Director at Joint Staff.

MR. RABOLD: Good morning. Ridge Rabold, Project Manager, Office of the Director, Armed Forces Institute of Pathology.

CAPT DANIEL: Good morning. Chris Daniel, Deputy Commander, U.S. Army Medical Research and Materiel Command.

Col WARDELL: Scott Wardell, Deputy Chief of Staff and Acting Deputy Director of Operations for the Joint Task Force, National

Capital Region Medical.

COL BAKER: Tom Baker, I'm the Interim Director of the Joint Pathology Center within JTF CAPMED.

COL JAFFIN: Jonathan Jaffin, Director of Health Policy and Services, Army Office of the Surgeon General.

COL LUGO: Good morning. Angel Lugo, Chief of Staff, Northern Regional Medical and Walter Reed Army Medical Center.

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

MS. CAIN: Christina Cain, DHB support staff.

MS. GRAHAM: Hi. Elizabeth Graham, DHB support staff.

MS. VISSER: My name is Linda Visser, and I will be the court reporter today.

MS. KLEVENOW: Jen Klevenow, DHB support staff.

LCDR SPRINGS: Julia Springs, Health Services, Headquarters Marine Corps.

DR. LEDNAR: Thank you, everyone. I'd encourage us all to please take an opportunity at the breaks, if you see someone you've not met before, please go up and introduce yourself. And we want everyone to feel welcome. The relationships that we build here really help to further the work that we do offline in between meetings in service of the Department of Defense. Thank you all for coming, and please reach out and make everyone feel welcome.

I would ask now for Commander Feeks to share with us some administrative remarks before we begin this morning's session. Commander Feeks?

CDR FEEKS: Thanks, Dr. Lednar. Good morning, everyone, and welcome. Thank you for being here. I want to thank the Doubletree Hotel for helping with the arrangements for this meeting. I'd like to thank Todd for the setup. I'd like to thank all the speakers who worked so hard to prepare briefings for the Board.

I'd like to thank my staff: Jen Klevenow, Lisa Jarrett, Elizabeth Graham, Olivera

Jovanovic, Christina Cain, and back at the home office, Jean Ward for arranging this meeting of the DHB. I'd like to thank Andrew on sound, who thought he was going to get away anonymous this morning.

This is a public meeting of the Defense Health Board, and the law requires us to keep a record of everyone who attends. So I would ask that you sign the general attendance record on the table outside if you have not already done so. For those of you who are not seated at the tables, handouts are provided on the table in the back of the room. Restrooms are located outside of the meeting room just at the end of the hall. For telephone, facsimile copies, or messages, please see Jen Klevenow or Lisa Jarrett.

Because the open session is being transcribed by Linda Visser, I would ask that you please make sure that you state your name before you speak and use the microphone so that she can accurately report your questions. Also, if you find that your name is easily misspelled, you can

give your name on a piece of paper to Linda. Also, if there are other words in your brief that are likely to be misspelled, it wouldn't hurt to give her that on a piece of paper.

Refreshments will be available for both morning and afternoon sessions. We will have a catered working lunch here for the Board members, ex-officio members, service liaisons, and Defense Health Board staff. Lunch will also be provided for speakers and distinguished guests.

For those looking for lunch options, the hotel restaurant is open for lunch, and located across A1A in the Banana Square Shopping Center are a few dining options, including Sonny's BBQ, Silvestro's, and New China. There are many other dining options all within a few mile radius. If you need further information, please see a staff member of the hotel front desk staff.

The group dinner tonight is scheduled for 6:30 p.m. at Milliken's Reef. Milliken's Reef is located about five miles from the hotel at 683 Dave Nisbet Drive in Cape Canaveral. Shuttle

service for the official attendees is being provided for this. We will leave the hotel around 6 p.m. Return transportation from Milliken's Reef to the hotel will also be provided. And if you have not RSVP'd for the dinner, please see Jen Klevenow.

The next meeting of the Core of the Defense Health Board will be held June 8 and 9, 2010. It will be in the National Capital Region.

The meeting on June 8th will take place at the Sheraton National, located in Arlington, Virginia, during which the Board will receive a series of updates on Subcommittee activities and draft recommendations.

The meeting on June 9th will take place at the Industrial College of the Armed Forces at Fort McNair during which the Board will receive the annual classified briefing on the Agents of Concern and the Chairman's Threat List.

And finally, if you would please, put all portable electronic devices on silent. And those conclude my remarks. Dr. Lednar?

DR. LEDNAR: Thank you, Commander Feeks. We'd like to begin the work of the Board now, and our first speaker this morning is Colonel Thomas Baker, who is the Interim Director of the Joint Pathology Center.

Colonel Baker is board certified in Anatomic and Clinical Pathology with subspecialty expertise in Renal and Transplant Pathology.

Prior to his selection as the Interim Director, Colonel Baker served as Chief, Integrated Department of Pathology at Walter Reed Army Medical Center and the National Naval Medical Center and as the Associate Chair of Pathology at the Uniformed Services University of Health Sciences.

Colonel Baker currently serves as the Associate Pathology Consultant to the Army Office of the Surgeon General and is a member of the Department of Defense Laboratory Joint Working Group and the College of American Pathologists Cancer Committee and is the Army alternate delegate to the College of American Pathologists

House of Delegates.

Colonel Baker will provide an information brief regarding issues pertaining to the establishment of the Join Pathology Center.

As you may recall the Board issued recommendations to the Department in December, 2008, following a review of the Department's concept of operations for the establishment of this Center. Since that report was issued, the Board has requested additional information pertaining to the Department's response to its recommendations as well as updates concerning the Department's progress in establishing this new center, the Joint Pathology Center.

The presentation slides that Colonel Baker has prepared for us may be found under Tab 5 of your binder. Without further delay, thank you, Colonel Baker.

COL BAKER: Thank you, sir. I appreciate it. And I appreciate the opportunity to give an update to the Defense Health Board. This update is -- and what it's going to do, it's

going to highlight us points in questions that were provided to us. We had written questions that were provided to us after the last briefing, and we basically gave very detailed answers for those questions submitted. This will highlight that, and then we'll also talk a little bit about our establishment plan.

And after that, if there is time, I would be happy to entertain any questions, address any concerns, anything that wasn't clarified.

So a little bit of background information, and I think people are familiar with some of this.

BRAC 2005 states that the AFIP must be disestablished by September of 2011. National Defense Authorization Act of 2008, Paragraph 722, authorizes the establishment of the Joint Pathology Center within DoD in a matter that's consistent with BRAC law.

And the four pieces, as most of you are familiar with, with the Joint Pathology Center: Consultation -- so it's pathology consultation,

education, research, and then management of the tissue repository that's currently owned by the AFIP.

The mission was delegated to the Department of Defense in April of 2009 and was ultimately delegated to the Joint Task Force CAPMED about 10 weeks ago in December of 2009. The Joint Task Force, anticipating delegation, put together an implementation team in July to start looking at the pieces of the JPC.

The members of that committee included representatives from all three Services, the VA, the USUHS, AFIP, Joint Task Force CAPMED, the Army Executive Agent which oversees the administration of the AFIP and Health Affairs.

And the activities that were performed include, basically, taking the original concept of operations and doing an extensive gap analysis where the pieces that were missing in our original concept of operations that we need to include in the final version.

Based on that, we went ahead and

developed a detailed concept of operations with the implementation team and drafted a JPC establishment plan.

Prime delegation in December. This reverted to a change to a transition team mode to be able to execute the mission. And the activities that the transition team is looking at basically is developing an operation plan and then doing a lot of the nugwork of establishing the JPC. The J-shops of the Joint Task Force are assisting in personnel, equipment budgets, facility issues, all the little pieces that need to be done to establish a Joint Pathology Center.

So in terms of consultation in our final concept of operations, our detailed concept of operations, we have 36 pathologists. And I have them listed there, the subspecialties, as well as the number of pathologists per area. And one of the things you will see -- a lot of this was a result of the gap analysis; for example, you see there is veterinary pathology, environmental pathology, cardiovascular pathology,

nephropathology. Those all came up as a result of our gap analysis.

Take a look on the right there. You see under support services, I've listed several things. It's not inclusive, it's several things that will support the consultative service.

First one there is the environmental/biophysical toxicology. This is basically -- we are going to take this from the AFIP en bloc so it's the mission that the AFIP is currently doing, which is, in terms of a clinical mission, is largely DU testing as well embedded fragment testing. They do this to support the VA team follow-up program as well the embedded fragment program of the Department of Defense.

This is the majority of what they do, but there's also a lot of other pieces that we do for other federal agencies and elsewhere within DoD. Additionally, they also do quite a bit of original research as well as collaborative research in support of other research things. So we are going to be taking that en bloc as is.

The next one on the list there is cohort registries. This also came up as a result of our gap analysis. And the cohort registries, I believe the AFIP calls them the war registries right now, but these are registries including the POW agent forms, leishmaniasis, Afghanistan registries, things like that, that are used largely, you know, in terms of public health and research.

But I think that probably the biggest user of the cohort registries is by the VA in terms of determining benefits for -- you know, VA benefits for their beneficiaries. We see opportunity bringing this under in terms of expanding and in terms of using it for research and so on. So we see a lot of opportunity with that.

Automated Central Tumor Registry. This is the umbrella organization that oversees -- the umbrella process that oversees the Department of Defense tumor registry system.

We also see opportunity in terms of

opening that up and using that data board for research -- more for research and then also looking at working with the VA to kind of develop or work on more of a comprehensive military health care system tumor registry process. And I know that's one of the things that the AFIP had been working on and, and we're going to carry that on into the Joint Pathology Center.

Third thing there listed is telepathology. In telepathology, we're going to be taking the AFIP mission, once again in whole, in terms of providing telepathology services. And right now the biggest end-user of telepathology in the federal government or in the military health care system are the VA and the Army. And the Navy and the Air Force aren't participating in this as much as the other Services.

And so when we go back, when we look at it, a couple of things that we have to address as we stand up this process; number one, that there are significant firewall issues which really limit the usability of telepathology within the

Department of Defense. These are, you know, process services as well as across other federal agencies. So that's something we have to address.

Additionally, we have to address software and hardware issues, some of the antiquated equipment that the AFIP currently is using for telepathology. So that's -- we're going to get back to the basics, develop that, or address that first.

I've engaged the three Service consultants as well as the VA consultant in terms of coming up with an enterprise wide, you know, solutional process for telepathology. And this will include the JPC. So it's going to be across the services and in the VA but helping the JPC as a centerpiece for that, you know, kind of -- be a part of that enterprise-wide solution for telepathology. And I think whenever we get that piece in place, the next step then is how can we apply telepathology to the federal government, to the other federal agency stakeholders.

And one of the things that the Defense

Health Board brought up was the utilization of telepathology in terms of, you know, assisting in mass disaster-type situations. The Air Force is already partnering with the University of Pittsburgh on this, so I think this is a great opportunity, you know, once we get the basic issues addressed. A perfect opportunity to be able to engage with the Air Force and with their partners on this. So lots of work there, but we do have the plan in place.

The next one is molecular laboratories. A couple of things with molecular laboratories. We're going to be taking the molecular laboratory mission of the AFIP in whole. This includes about 20 -- they do 20 probes for clinical use, largely in the diagnosis of hematologic malignancies. So we're going to go ahead and take that, you know, as is.

That's going to be integrated, at least initially, into the Walter Reed molecular laboratory. That's a new laboratory that's being stood up. A lot of space, very high tech, and

this will actually fit in there well, initially anyway, in terms of supporting the Joint Pathology Center.

And one of the unique capabilities of this molecular laboratory are basically some of the homebrews, some of the things that the AFIP has developed to support the diagnosis of hematologic malignancies, and that is fluorescent probes that are used on paraffin embedded tissue. That's a unique diagnostic capability. So we're going to be taking all those pieces, you know, on and off and looking for ways to improve that.

As a part of our strategic plan, where we want to stand up is a separate standalone molecular laboratory that will serve as the reference molecular laboratory for the Military Health System. But that's, once again, that's part of our strategic plan.

Next is histology, immunohistochemistry, special stains immunofluorescence. All that will be done. It would be integrated into the Walter Reed National Military Medical Center process.

That is, once again, going to be a state-of-the-art high-speed process. Twenty-four six services that will be provided, and we'll be doing that with quality in mind -- number one, quality, and then secondly, some of the other metrics that we have to look at like turnaround time.

And some of the things we've been looking at is, like, next shift turnaround time for special stains, immunos, and things like that. Many of them that are going to stand up for the Joint Pathology Center in terms of immuno stains will be about 250 stains. It's going to be a pretty robust menu as well as all the immunofluorescence stains necessary to support the Joint Pathology Center. So we have a lot of opportunity there.

Since our initial concept of operations, we've more than doubled the support staff to, you know, that the JPC is going to provide to Walter Reed to support this mission. So I'm comfortable that with the process in place, as well as the

staffing that we have in place, that that'll be enough to accomplish the mission.

One of the things that was brought up by the neuropathologist at the AFIP was, who's going to do the muscle biopsies? Muscle biopsy interpretations, is what we're talking about. And that's a critical mission for both DoD and the VA in terms of force health protection. So it was something that, you know, after discussing it with them, we talked about it as a part of our gap analysis and decided to include that in. That will be -- the interpretation will be done by the neuropathology branch of the Joint Pathology Center.

Next on the list is electron microscopy. We'll have that in place, that is also new from our initial concept of operations, support nephropathology pathology, neuropathology, and the veterinary pathology program. The personnel providing direct support to the consultation service now will be 46. We've added several administrative people throughout to really enhance

or better define the administrative mission in support of the pathologists.

In our detailed concept of operations, we've had a better opportunity to better delineate the education that we're going to be providing within the Joint Pathology Center as well as the research that we're going to be doing there as well. In terms of education, graduate medical education, we're going to continue on the AFIP mission of providing subspecialty rotations for the federal agency residency programs. Those are key, I think, you know, in terms of providing training for a lot of the programs.

We will also -- this will also be a key part of the National Capital Consortium's new Graduate Medical Education Pathology Fellowship Program, which is taking its first -- it's going to have its first person -- it's going to actually stand up this summer and have its first person start July 1st. So once the JPC is established, this is going to be a key part for that. And that's been our, you know, in terms of

establishing that fellowship, that's been part of it all the way along as this was -- the JPC would be a part of that.

We will continue to provide support of the oral -- the Navy oral pathology residency program, and we'll very likely provide the full third year of training for the residency program.

And then we hadn't really talked about the -- there will be another slide. One of the missions that we identified in the gap analysis, was the veterinary pathology mission so we will be continuing the AFIP's mission of veterinary pathology residency training, in which they train about a dozen people at any given time.

In terms of continuing medical education, in talking to the stakeholders and to the consultants of the various services and what it is we need to put in place, we have decided to really focus on a robust online continuing medical education offering. We're still working the details of that, but -- well, what we're looking at are webinars, teleconferences. We're looking

at putting together a very robust digital slide repository for continuing medical education use as well as online courses.

And like I said, in talking to our end-users and talking to the stakeholders, at least initially our focus is going to be on maintenance of the certification for pathologists as well as focusing on the solo or deployed pathologist. That's going to be initial, but we see opportunity to expand that mainly based on the needs of our end-users at a later date.

Couple of things with that. We're going to try not to focus on just the subspecialties that are provided by the JPC but rather broaden the menu in terms of educational offerings. And we'll do that through partnering with other DoD and non-DoD entities as well as other -- perhaps even civilian entities to establish course offerings for the online continuing medical education.

One example would be, the psychology school down at Brooke Army Medical Center wants to

do online education, which we would incorporate in that. We could also incorporate clinical pathology course offerings as well with them.

The Joint Pathology Center will not be offering live courses, but what we will be doing is actually supporting the DoD live courses that are going to be remaining; and, for example, the Armed Forces Medical Examiner and the Medical Museum will be continuing their courses. And we will provide the support for that.

And then there's also opportunity for support of non-DoD courses and civilian courses. And the one that comes to mind, we have been approached by the American College of Radiology through Health Affairs. They approached us about the possibility of supporting a radiologic pathology course similar to the one that the AFIP is doing right now. Since the JPC will be holding the material for this radpath course, that the AFIP is currently giving, we see an opportunity to partner with them on that. We would have to see the detailed plan, but we definitely see

opportunity there.

On the other half of the slide is research. And, once again, our approach to research is a little bit different than the AFIP. But we see research basically, pathologist-driven research, lots of opportunity through collaboration. There's lots of support, lots of funding available through various existing established mechanisms throughout the National Capital Region as well as across the Services, across agency lines, and even into the civilian community. So it's been -- there is a lot of opportunity there for pathologist-driven research.

Utilization of repository. When we talk about the tissue repository, that's going to be a big piece of our research portfolio. And, of course, the Joint Pathology Center will support ongoing clinical initiatives; for example, traumatic brain injury initiatives that are going on in the National Capital Region Comprehensive Cancer Care Center and so on. So that's going to be one of its missions as well in terms of

research.

We talked about the cohort registries and the ACTUR database and better utilizing that information through research, and we will be exploring that as well as.

Of course, continuing the veterinary pathology research initiatives that are currently ongoing.

And, as I said, there's plenty of opportunity for collaboration support and funding, not just for research within the JPC, but, as I said, across Service lines, across agency lines, and the civilian community. Those already exist and the JPC will basically tag on to those in terms of finding opportunity for pathologist-driven research.

Tissue repository. This is a big piece of the JPC. And we recognize that tissue repositories are a valuable treasure, and we really need to come up with a good plan in terms of how to appropriately utilize it. And the three things that -- you know, in NDAA 2008 with tissue

repository or maintenance modernization and utilization, we'll, of course, continue the ongoing maintenance of the repository, the day-to-day maintenance that needs to go on.

Modernization. Right now the AFIP has a Congressionally-funded slide and document digitization project that's ongoing. We're going to continue that on, but roll that into our core budget. And one of the things with -- the best I can tell anyway -- with that project right now, is I'm not sure how the slides that are digitized must all be prioritized in terms of digitization. So we need to come up with a prioritization. And we'll be doing clinical research -- a clinical use research education and, you know, who basically determines what slides get digitized, but that's going to be a part of our ongoing modernization of the repository.

One of the things that came out of the Asterand report, the Asterand group looked -- did a formal survey of the tissue repository several years ago, and one of the things that they noted

was the material that came from BRAC facilities that's in the repository. Although it's in good condition, it's not terribly accessible in terms of research and even clinical use. So that's one of the things that we have to look at in terms of how we're going to do that for the tissue repository, how we're going to modernize that piece.

Utilization. Obviously we'll use the tissue that's in there for the ongoing clinical mission, the consultative mission.

And for education, as I mentioned earlier, we're going to look at putting together a robust online digital slide repository for educational purposes. We will be utilizing material to develop online courses and also opportunity for utilization of digitizing material for other courses that we've talked about; for example, the radpath course through the American College of Radiology.

The last piece there is research. And this is where we really have to do this very

carefully in order to really preserve and appropriately utilize the tissue repository.

And when we develop our plan for the tissue repository, we need to do it very carefully and very deliberately, and what we're going to do is utilize repository consensus findings from the -- that were issued in 2005 as well as the Asterand findings and recommendations. We see this as a key opportunity to engage strategic partners, engage in subject matter experts, and the people who are interested in using the tissue repository and really coming up with a way to appropriately utilize it.

And three of the things we want to do is ensure sustainability of the repository. It would be easy to deplete that repository if there weren't any controls, any sort of measures, doing that appropriately.

We want to determine how to provide appropriate access to the material for both not only federal contributors but also for the civilian community. We see an opportunity to use

this across into a civilian community in terms of research and recognizing that there are going to be probably competing priorities in terms of wanting to use the tissue in the repository.

We have to come up with a process that addresses competing priorities and how we're going to prioritize the use of the tissue in the repository. Like I said, this has to be a very careful and deliberate process, and we'll be initiating that soon hopefully.

Veterinary pathology service. For those of you who don't know this, this is truly a unique and one-of-a-kind service that the AFIP has, and it's known the world over so this is actually a piece that we're excited to have as a part of the JPC. And this is one of the things we identified in our gap analysis. And we will continue the AFIP mission of providing consultation within DoD and other federal agencies.

They do -- once again, this is a one-of-a-kind service. There really isn't any other sort of consultative service that looks like

this, on the veterinarian pathology side of the house.

In terms of education, they have a large veterinary pathology residency program. I believe it's the largest in the country. And then they also do a very unique online educational thing on a weekly basis that's available across the world through a webinar. And there are actually at least 125 participating institutions across the world that actually participate in this so very, once again, very unique.

The Vet Path Program will also continue its research in support of DoD priorities, and one of the things we want to do -- and this is true not only for Vet Path but the other parts of the JPC -- we want to ensure no disruption of services during the transition as we move it from AFIP to JPC.

We already have space identified on the Forest Glen campus of 10,000 square feet. That's going to be undergoing remodeling soon, and that will include the electron microscopy suite for the

Joint Pathology Center.

The operating budget. The Defense Health Board -- originally in our initial concept of operations, we had the Joint Pathology Center as a hospital-based process, and the Defense Health Board understandably had concerns about that. And in relooking at it, we agree it's probably best done -- the whole thing done outside of the new Walter Reed.

So the JPC won't be aligned -- or is aligned, actually, under headquarters Joint Task Force CAPMED at this point. And it is a distinct organization -- organization distinct from the hospitals and Centers of Excellence. I as the Interim Director report to the Deputy Commander of the JTF. And then under me, once this is established -- and this is outlined in the answers to the questions that were provided -- there will be four divisions and an Office of Director.

Additionally, we'll also have a board of advisors that are comprised of senior subject matter experts from stakeholder agencies and

services that will advise in terms of services provided, resources, and things like that. So that will all be established in a charter and the details of that will be worked out when we develop the charter for that group.

Budget and Facilities. In terms of operating budget, as I said, separate from the hospitals and Centers of Excellence, it's currently being refined by our budget folks at the Joint Task Force. And this will not be Congressionally funded. Our goal is to roll this into the core budget and the program monies, and this will be in the core budget for fiscal year '11. Our estimated budget at this point is 21.7 million, but that will undoubtedly change as we identify some more pieces that will need to be included, things that we haven't considered.

Facilities. The consultative service will be in 10,681 square feet of almost -- it's space that's being renovated currently, and it will be done I think in the next couple of weeks up on the Forest Glen campus. And that will be

adjacent to the repository proper which will be another 32,000 square feet, about 12,000 of which is being renovated right now and will be state of the art. All that's up on the Forest Glen campus.

Veterinary pathology and electron microscopy, as I mentioned, identified 10,000 square feet. That's not too far from the consultative and repository service, but it is in a separate building. And that will be up on the Forest Glen campus as well. So all that will be fairly close to each other.

The Automated Central Tumor Registries Program Management Office will be on the Bethesda Campus in about 880 square feet of administrative space. We're still working in several different directions looking for space for our environmental/biophysical toxicology lab, but we will do that. We will find space for that.

As I mentioned histology, immunohistochemistry, specimen accessioning, molecular labs, all these will be integrated into the Walter Reed lab space, and there is -- just

those areas right there are almost 8,000 square feet of space in the new Walter Reed lab. And it's actually quite a bit of space for that.

So integrated appropriately into those services at the new Walter Reed, this will work out actually very well and understanding that we need to look at, you know, being able to accept new missions. As missions develop new technologies, develop things like that, we need to make sure that we have an opportunity to grow in the future so we're looking at an opportunity for future modernization as well.

We viewed -- of course, we viewed the Armed Forces Medical Examiner and our support of their mission is critical and so we've been working that actually very closely with the Armed Forces Medical Examiner. And we've got all the pieces into place in the JPC to support that mission.

And one of the things I outlined in the answers to the questions that were provided in more detail is the support of operations in-

theater. And as I mentioned, there are currently no pathologists that are deployed to theaters as pathologists so there is no pathology capability within theater right at this moment, although that could change. But what we will do is be able to support, fully support, the pathology within theater through telepathology and consultation.

Additionally, the veterinary pathology program, our service has an in-theater mission as well in terms of supporting working the animals and things like that.

Other federal agencies. When we started this process initially, one of the things that we looked at was the workload that the AFIP provided to other federal agencies outside the DoD and VA. And then we also talked to our -- of course our stakeholders, the major stakeholders -- the Department of Defense and the VA -- in terms of what services they needed.

Early on we engaged the NIH as a possible and major federal stakeholder. We kind of make sure that we had all the pieces in place

initially for the JPC. Once the mission was delegated to the Joint Task Force, we actually engaged the other federal stakeholders through a formal process. And basically serving a federal stakeholder is -- like I said, it's a formal process so it needs to be done correctly. So we've got that survey in place, waiting for results from that. I've heard some preliminary from the FDA but not the other services -- or the other agencies.

Vet Path will continue to support its federal stakeholder -- or its stakeholders. They provide the National Zoo and the NIH, I believe are the two largest ones that they provide. They will continue on with that mission as well.

And I separated out nonmedical federal stakeholders. We've engaged them too through a survey process, and that includes the Department of Justice, FBI, Homeland Security, and agencies like that. Our goal is also to find out if there's anything that we can do as an organization to help their mission. We haven't heard anything

from them as well. But we feel that the way we went through this process, we've identified the big pieces that need to be in the JPC to support our federal agency stakeholders.

We also feel that, you know, if something does come up, our organization is sufficiently flexible to allow us to incorporate things that we haven't identified. So as soon as the surveying process is over, and we have everything in place, we'll be able to determine whether or not there are other things that we're missing in a concept of operations.

Opportunities for civilian collaboration. I've got four things listed there, and the top three are probably the most where we'll have the biggest opportunity to engage the civilian community.

We talked about utilization of tissue repository already.

Education in terms of helping develop course content for the online programs as well as the JPC providing support of live courses.

And then research of course. You know, capitalizing on existing capabilities now within the Department of Defense in terms of being able to collaborate with the civilian organizations, that will be a big piece as well.

Consultation. Our mission will -- you know, strictly speaking of mission, the JPC for consultation will be to the federal government. But I think when you look at some of the unique capabilities that the Joint Pathology Center will provide, such as Vet Path or embedded fragment analysis, there should be opportunity for us to be able to engage the civilian community in that respect.

Our plan for establishing the Joint Pathology Center. Our plan is for initial operating capabilities 1 October of this year, and it will be fully operational by September of 2011. The Armed Forces Institute of Pathology and the Army will support the Joint Pathology Center as it establishes. And when we look at a plan for establishment, the biggest thing that comes up

from our major stakeholders is continuity of clinical service. So that is the big piece that we are looking at is how to do this without discretion in the consultative service and the clinical service.

We want to do it with a well-established command in control throughout to allow the AFIP to take care of its employees during the transition, understanding that it can be a tough time for a lot of people.

And this here is just kind of a big-picture look at our establishment plan. I didn't really want to go into detail but just show you that we've gone through a lot of the pieces for this.

And then the way forward, as I said, our top priorities to ensure continuity of clinical services during the establishment. We're finalizing our establishment plan with AFIP support. We'll be initiating the hiring process probably fairly shortly.

Finalizing other things such as budget,

facility, logisticals like IT requirements. Need to implement a strategic communication plan to be able to ensure that our stakeholders know what's going on. That's a big piece as well.

We need to refine a lot of our processes, including one of the things that the Defense Health Board brought up was our accessioning process. How are we going to that? We've got a plan in place, but I think we've got some work to do in terms of refining that.

Put all of our policies and procedures in place, initiate pertinent contracts, get GME accreditation. And then somewhere in there engage our partners and develop a strategic plan.

And we talked about two of those pieces for the strategic plan. Lot of nugwork that needs to be done to stand up the Joint Pathology Center, but as I said, we have the full support of the Army in this as our partner in the AFIP will help us as we establish this.

Okay. Questions?

DR. LEDNAR: Colonel Baker, thank you

for that brief. Just as a reminder to all of us, since the last time the Defense Health Board met in November, some important decisions have been taken. The Deputy Secretary of Defense delegated to the JTF CAPMED the authority for the Joint Pathology Center which has really important clarification as to its leadership and its home.

Thanks to Colonel Baker and your staff and Admiral Mateczun for the very timely response back to the questions of additional information that the Board had after the last time we had a chance to meet. So thank you for that work to give us that additional information.

At this point I'd like to open up the floor to any questions or comments. Dr. Parisi?

DR. PARISI: Dr. Parisi from the Mayo clinic, and I'm a member of the Core Board as well as the Chair of the Subcommittee for Pathology and Laboratory services. Thank you, Colonel Baker. I think the response and your presentation today represented a very good beginning, but I don't think it fully addresses some of the issues and

concerns that we have that will ultimately determine the success of the JPC.

And this is something we want to see happen. We want this to be a successful venture. And we're certainly willing and able and welcome the opportunity to assist you as the plans move forward. So I just want to emphasize that.

There are some issues both practical and maybe philosophical which I think are not fully -- have not been fully articulated or are still controversial. And one of them, just for example, the logistics of having the pathologists at remote-sited Forest Glen and laboratories at Walter Reed, Bethesda, are going to be potentially problematic.

So if I'm a pathologist sitting in my office in Forest Glen and the case is accessioned at Walter Reed and somebody takes the slides over to me, I determine we need special stains, they go back to Bethesda, the stains are done, the stains come back to me for further interpretation and I decide I need FISH or something, that goes back to

Bethesda, it seems like this back-and-forth thing is not really a very efficient and somewhat cumbersome process. And I guess I don't understand why other avenues are not being pursued.

I think a reference center that -- a federal reference center, all have really strong educational and research components. And I think you certainly describe the consultative part, but I think a lot of the details regarding education and research are not -- have not been fully resolved.

For example, I was at -- I was part of the 48th Annual Neuropathology Review Course held in Bethesda last week, and this is the 48th consecutive year this course has been given. There is no other course like that in the universe. And there were 133 registrants. And that course continually attracts more than 133 people, I mean, that's probably on the lower side of number.

I'm a little surprised or, you know, why

are you not pursuing these as well? I mean, these are potentially money-making. Not only are they money-making opportunities, but they're also great networking -- everybody benefits from these kind of things. The radiology pathology course is another example. So I guess I'm a little surprised that you're not really pursuing these issues.

Research wise, I think you've identified some places; for example, the research for the TBI that I think is a very important ongoing function, but you said that the research was going to be pathology-centric or pathology-driven, but are the pathologists going to have laboratory space? Are they going to have the resources to develop new techniques, to explore new techniques? Where are these going to be located? Are they going to be in Forest Glen, or are they going to be over in Bethesda? And is that going to require somebody going from point A to point B all the time?

Even study of the TBI brains, where is the wet lab going to be? Is the wet lab going to

be in Forest Glen or is it going to be at Dover or is it going to be at Walter Reed? I mean, I think these are all great important logistical problems that really need to be resolved if you're going to have an efficient Center.

There's also an issue of scientific oversight, and I'm glad to see that you are pursuing an advisory board. I think an advisory board, though, should not be just stakeholders. It's got to be external. And I would propose, and I think we've suggested, that maybe there would be a scientific oversight review of the activities of the Center just to keep the science moving forward. So the science is driving the Center.

And, again, I think that's key in making a world-class pathology-type Center that I think we all want to see happen. So those are some of my thoughts.

Actually I've put together some of these comments on a sheet, and I think Lisa has got them. And we're going to distribute them round.

But I'd be happy and look forward to

sitting down and talking with you, talking about some of these and trying to assist you in any way possible.

COL BAKER: Absolutely true. Thank you very much, and I look forward to that. I think some of these do represent some philosophical differences in moving forward, but I -- you've pointed out a lot of things that we do need to address and things that we haven't quite thought through completely. And so I think there's a lot of opportunity for improvement so I look forward to talking to you about this.

DR. PARISI: One other thing I wanted to bring forward, and I'm sure you thought of this, but where are you going to get the people that are going to be -- where are the physicians, the pathologists coming from? Realistically speaking, in our place it takes a year and a half to get somebody aboard, you know, from the time that he signs the contract or agrees to come to the time he walks into the door. And how are you going to attract higher level or senior kind of people? It

has to be more than just salary, and I'm not sure that the salary can be resolved, but, you know, it's got to be laboratory space, educational opportunities. So you've got to have some carrots to draw these people to you, and I think those are very important, you know, as this evolves, and it's going to be an evolution obviously.

COL BAKER: Thank you, sir.

DR. LEDNAR: Are there other questions or comments for Colonel Baker? Dr. Oxman?

DR. OXMAN: Yes, sir. Mike Oxman from the University of California, San Diego. I'm also concerned with the real ability to stand up a first-class consultative service by September 11th of 2011. And that is, just to echo what Joe said, in terms of recruitment. I don't see how you can possibly recruit first-class people in that length of time so there's going have to be some method of bridging for several years, the expertise, and I don't -- you really need a plan for that.

The other thing I want to emphasize is that no first-class pathologist that I know would

accept the position that didn't have a major research component, which means space and support. And the FDA has learned this. They've had a major problem with attracting good people in the last decade because of the absence of sufficient time and facilities for combining research and service.

COL BAKER: Well, if I could just address very quickly, I mean, our process for hiring folks, you know, obviously since this is a newly established organization that will be assuming functions from the AFIP, we have to do what's called a transfer function of folks from the AFIP to the JPC. That will, in terms of the pathologist, that will address a chunk of those positions but not all the positions. We'll still have several open positions that will require us to put them up for competitive hire.

And we've actually had quite a few people, current and former staff members of the AFIP, who wouldn't otherwise be available for this transfer function; for example, the distinguished scientist at the AFIP who approached us about

wanting to the come over to the JPC.

So I agree with you, sir. I think that this could take awhile, but I'm not sure that we're approaching it from a pool of -- we've got a lot of people who are at the AFIP and want to come over. And so I think that at least is a good start.

I do appreciate your comment about attracting some quality people and what is it going to take, and I think we need to take a look at that.

DR. LEDNAR: Okay. The Joint Pathology Center is a very, very important initiative in the Department of Defense and very important in continuing support to the federal agencies as Congress has requested. So the Defense Health Board for both Colonel Baker, your staff, Admiral Mateczun, we stand ready to work with you to be of assistance in any way we can.

I think there's a lot of insight and expertise that can be brought to the table to help you think as you're developing the plan going

forward. And we look forward to continuing a collaboration with you to have a successful launch of the Joint Pathology Center later this year.

COL BAKER: Thank you, sir. Appreciate it.

DR. LEDNAR: Thank you. That concludes our discussion of the first agenda item. Do we hear Dr. Kizer dial in? Ken, are you on the line?

DR. KIZER: Yes, I am.

DR. LEDNAR: Thank you for joining us. Our next speaker, Ken Kizer was unable to be with us here today, but he is participating by phone from California, where it's still early. And Dr. Kizer, we appreciate your joining us.

Dr. Kizer is the Chairman of the Board of Medsphere Systems Corporation, the leading commercial provider of open source information technology for the health care industry.

Previously Dr. Kizer served as the Under Secretary for Health in the U.S. Department of Veterans Affairs and held the position of Founding President and CEO of the National Quality Form,

President and CEO of Medsphere Systems Corporation.

Dr. Kizer also served as Chair of the Defense Health Board's National Capital Region Basal Realignment and Closure Health Systems Advisory Subcommittee. He will be providing us today an update regarding the Subcommittee's report submitted to the Secretary of Defense in May of 2009 entitled “Achieving Word-Class.”

Dr. Kizer's briefing slides may be found under Tab 4 of the meeting binder. Dr. Kizer?

DR. KIZER: Thank you. Good morning. Let me just check and see if you can hear me okay.

DR. LEDNAR: Sounds good, Ken.

DR. KIZER: Okay, thank you. And first of all, my apologies for not being there in person. I regret that and hopefully this will serve as a reasonable substitute. And actually my comments will be brief, and I don't expect that it will take the full amount of time since there is not a whole lot to report since our last discussion of this topic.

The slides that I have briefly recount the chronology of events that have occurred since August of 2008 when the Subcommittee was convened and we did our work and delivered our report, as was noted, in May, and that was officially delivered to the Department in July.

Then there was a response from the Department that listed some further comment that was discussed at some length in the meeting in November of last year. Subsequently, there was a joint hearing of the two relative subcommittees of the House Armed Services Committee in early December.

And there really hasn't been much of any communication with anyone since then. I've tried to follow this from afar, but we've not gotten any official information from any source. We do understand, or I understand at least, that the approval to the master plan that was required in the Defense Appropriation Act that was signed last October. We understand that the approval was granted a couple of weeks ago.

And other than that, the Subcommittee which was -- all of our terms officially ended September or October except for Dennis O'Leary, member of the Core Board. We've not heard any further as to reappoint, so I think everyone is in a bit of limbo. And I think some have assumed -- well, I should say that they've probably moved on in the absence of any communications, assuming that nothing is pretty much going to happen in that regard.

And then the last item, and I think it was included in your handout, was a short commentary that was published online a few weeks ago and will be officially out in another week or two in print in the *American Journal of Medical Quality*.

And other than that, I think -- I and a few other people have some concerns about what we've heard as far as moving forward, and perhaps Admiral Mateczun in his comments can put those to rest, but other than that, I don't have much else to report since not much else has happened, at

least from the Subcommittee.

DR. LEDNAR: Okay, Ken, thank you for that update. What I would propose is that we move directly to Admiral Mateczun's comments for this, and then at the end of Admiral Mateczun's comments, we can come back and have any questions or a discussion.

Admiral Mateczun, I assume that's okay with you?

The Board is grateful to have here with us today Vice Admiral John Mateczun who is the Commander of the Joint Task Force, National Capital Region Medical. Admiral Mateczun has served as Joint Staff Surgeon and Medical Advisor to the Chairman of the Joint Chiefs of Staff as well as the U.S. delegate to the NATO Committee on Chiefs of Medical services.

Present in the Pentagon on September 11, 2001, Admiral Mateczun subsequently served on the Joint Staff during Operations Noble Eagle, Enduring Freedom, and Iraqi Freedom. Vice Admiral Mateczun's ensuing flag assignments were as Chief

of Staff Bureau of Medicine and Surgery, Commander of the Naval Medical Center San Diego, and Deputy Surgeon General of the Navy.

He has also served as Director of the Military Health Office System Transformation and is a member of the Congressionally-mandated Task Force on the Future of Military Health Care.

Vice Admiral Mateczun's briefing slides may be found under Tab 11 of the meeting binder.

Thank you, Admiral Mateczun.

VADM MATECZUN: Thank you, Dr. Lednar and Dr. Poland. Ms. Bader, congratulations on your new position. Actually, Christine and I were on the Joint Staff under General Myers together back during some of the things that Dr. Lednar was talking about. It was a privilege to serve with you. It's great to see you here.

Board members, distinguished Board members, guests, there has been a lot that's happened since the last time I was here. I was here in November. We had a hearing with the House, Personnel, and Readiness Subcommittees in

December.

Since that time I can tell you that -- kind of bottom line is that the Department has identified $250 million worth of budget that will go in FY10 and FY11 towards many of the projects that we'll talk about here. I'll be glad to give you some detail about how that money is going to be spent and working towards achieving world-class.

We go back a little bit as Dr. Kizer mentioned. I want to provide you with an update on what's been happening with these plans, talk a little bit about the background, what the DHB found, how we're adjusting, and then where we're going. And I will be glad to take any questions.

In 2005 we had the BRAC. I need to tell a little bit of a story here because one of the questions I get is about cost growth in the National Capital Region.

What happened to these projects? The projects as they were originally identified under BRAC were less than $1 billion for both the Fort

Belvoir and the Walter Reed Medical Center -- National Military Medical Center. And we are about 2.4 billion now. So the question is: well, what happened? Well, the Services went back after that 2005 date, said, you know, we kind of really have to go back and take a look at the space, the capabilities that we need. Added almost 70, 80 percent on to that budget.

In addition, you may remember Katrina. Hurricane Katrina happened during this time, and the construction costs went up fairly dramatically so there was a lot of inflation and construction costs.

Then in 2007 -- maybe you may not remember -- the February 2007, articles in *The Washington Post*. Dole-Shalala, the Presidential Commission, and the Secretary's independent review group that met to go through what the Department needed to do to respond, and the Joint Task Force was formed. The Joint Task Force was formed in 2007.

But the Department also took a hard look

at the construction projects that were going on and moved to enhance and accelerate, which was a second stage in the evolution of what's been happening in the NCR. That enhance and accelerate added almost another 700 million into the costs that were going on.

In response and since then we've been working with the DHB Panel recommendations. You know, the DHB Panel submitted its review to the DoD and to Congress in summer of 2009. And those were codified by the Congress in Section 2714 of the NDAA. So they accepted those recommendations as did the Department in its response. And the -- this is the third evolution in what we're doing which is now kind of getting to world-class.

So let me go back and remind everybody, there's three things that have happened here, this is not all about BRAC, the Base Realignment and Closure Commission. We have BRAC, enhance and accelerate on the part of the Department, and now we have a third initiative of getting to world-class. Each of those had set different standards

as we've gone.

The Department has maintained a steadfast commitment to providing the best care for our warriors. The Secretary tells us that second to the war itself, there is no more important priority for the Department.

So in October of 2009, about the same time that Congress was legislating, the Department submitted its response to the Panel review, adopted the philosophy of the review itself. There's been a little bit of discussion about that, and adopting the review of the -- adopting the Panel's view of what it took to achieve world-class, the Department said, you know, this is a continuous journey, and we're committed to that.

Some, however, portray that, that, you know, we're just procrastinating and delaying in getting there. This is not at all the case, and I think that those of you that have been involved in performance improvement, continuance improvement of any sort realize that even, if you get there today, that doesn't mean you're going to maintain

it until tomorrow and into the future. So the Department is committed to achieving world-class and sustaining it into the future.

I kind of go through the -- a summary of the Defense Health Board's findings and recommendations. And this is exactly what we talked about last time. Let me get into some of the details about what has happened. The DoD has provided $125 million in fiscal year '10, that's this current year, to address a number of the DHB Panel's recommendations, and I'll go through those in some detail.

Additionally, the Department has provided $65 million in fiscal year '10 to achieve world-class operating rooms in Bethesda. I'll show you the plan for those operating rooms, at least the planning state that we're in today.

And then for fiscal year '11, the Department had requested $80 million in the President's budget for additional parking and for wounded warrior lodging ability on the Bethesda campus.

Congress has appropriated some money for off-base traffic mitigation that the Department is trying to understand. And then the Department has made and will continue to make significant progress on these DHB Panel's recommendations.

And I'll tell you this -- and I'm going to get to this at the end again -- but I want to bottom line it here. You know, getting to world class is not going to -- as defined in the FY10, NDAA is not going to happen concurrent with the BRAC. The BRAC is over in 18 months. We have 19 months left to finish the BRAC here.

And we've got a lot of projects left to do that will require additional projects. Construction is at saturation point on the Bethesda campus right now. The Naval Facilities and Engineering Command Commander, Rear Admiral Shear, has expressed his concern to me that we had additional projects on that campus. He's the guy that it's in charge of safety there. We have to listen to, I think, to what he says.

Additionally, the renovations that were

going on in the existing operations at Bethesda have also reached a saturation point. There's only so many things that you can move around on campus before the Commander is going to feel you starting to give me pause about patient safety.

So there is a lot going on on the campus. It's not going to add additional construction projects at this point in time, and I'll talk a little bit about that in our vision for getting to the rest of this world-class piece.

Now, here are some of the Defense Health Board's findings in relation to the construction and the state that it was back in 2008 and in early 2009 when they were looking at it. And all of these things have been resolved. If anybody has any specific questions, at the end, I provide this for your reference. I'll be glad to answer any specific questions about it. We're not going to go into each of these. But you can see there's been significant design and reconstruction. It's going to be addressed with that $125 million that was just approved in November -- December.

These are the operating rooms. A significant portion of the DHB's report was addressed to the operating rooms as they existed in Bethesda. And if you see up there in the upper right-hand corner, it's kind of a layout of the operating rooms. Some of them, you'll see, there were 14 that were in the 400- to 550-square-foot range. The Defense Health Board thought that that was not world-class, set out a standard for us.

The three that are over kind of on the left-hand side there on the bottom, you can see them kind of clearly in a sort of light green. 800- to a 1,000-square-foot operating rooms coming online with the new construction.

And here's our plan now to move into that world-class definition with $65 million just approved by the Department. On the bottom on the side, you will see that there are no operating rooms left in the end state that will be in that 400- to 550-square-foot range. They are now all 550 square feet and above with many of them being in the 650- to 1,000-square-foot range.

Additionally, there is room for frozen pathology here. Although I must tell you that, you know, I defer to Dr. Baker and our experts, but there are people that believe that this is an evolving standard, that we may not need that co-placement given the communication tools in telepathology that's developing. So there will be room, though, in that kind of white space down at the bottom of the picture there for frozen pathology. And so we believe that we moved ahead to meet the recommendations there for world class. This money was just approved as of the 2nd of February.

Here's sort of a summary of what's going on on the Bethesda campus, and the way that I view the -- you know, how we responded to the Defense Health Board recommendations.

Plans meet JCAHO. There are no JCAHO deficiencies. There were -- many, many that were potential -- potential deficiencies were identified in the design and planning process. All of those are now designed out and we have full

confidence that there is nothing in the new construction or the renovation that will not meet JCAHO standards. That's been a primary concern.

Single-bed rooms. Single-bed rooms is a standard that I think we discussed last time that I was here. The Department is moving to this standard, JCAHO does not require it. Clearly it's seen as a world-class accommodation for the patients that are there. There are both infection control and privacy concerns that we have to be able to accommodate. However, there are -- after the renovations are done within the existing campus of Bethesda, there are still 50 rooms that are double that were intended to be double-bed rooms after BRAC and even after enhance and accelerate.

Did not move to an enhance -- into a single-patient -- single-room standard after enhance and accelerate, primarily in response to the Commandant of the Marine Corps who wanted to make sure that we have the cultural ability to house two Marines together if they didn't family

members present. And the Marine saw that as one of the things that they wanted to do. We're working through now, finishing that up.

But I've told you renovations have saturated. We can't go back in, and even if we did renovate those existing -- the remaining 50 rooms into single-patients, that would leave us 50 beds short. So we're going to have to look at new construction as a solution to that standard. And that will not happen until after BRAC; however we will be incorporating this into our comprehensive master plan for the future. And we'll identify the funding requirement that would be necessary to get there, and we'll put it into the plan.

You know, I was just up at Johns Hopkins. They have construction going on right now. They are moving to a single-patient standard. I doubt that anybody thinks that Hopkins isn't world-class, and they have a lot of, you know, two-bed rooms as well, although they're moving to the new standard. So it's an interesting evolution. Don't dispute that it's a

standard out there that's world-class, and we will move towards it.

Surgical suites, I described. Support services. Once again the requirements identified in support services will require some additional construction into the future. Not something that we're worried about in terms of the clinical capabilities but certainly -- when you're renovating an entire campus, a lot of the support services spaces will need renovation too.

There are -- even after we finished the renovations here in the clinical spaces, about 70 percent of the space on campus will require renovation in those buildings that were built in the ‘40s and then in the ‘70s. And, in fact, as we open those buildings up, we found additional requirements for renovation to make sure that we meet code and JCAHO standards. And so we've been meeting those as we go.

The dialysis unit. Interestingly, there was I think some perception that the dialysis unit was going to be above central sterile processing.

This is not exactly true. It's not true.

And there are storage areas that are underneath that we put in in the design precautions to provide -- we've done a water barrier infrastructure under that dialysis equipment. We understand completely what the architects were saying, and we think we've mitigated that. And further, if we need to make further modifications, we would be able to in the master plan.

Patient observation. An interesting difference here between maybe military practice and what happens in civilian practice. When somebody is in an emergency department and you may or may not want to admit, if you want to hold them for 23 hours and 59 minutes, so it's not over a day, then a lot of people -- a lot of facilities are building space into their emergency departments to do that. We don't exactly have that problem.

We admit them if we need to, and our current plan would be to admit into the ambulatory

procedure unit for observation if we needed to, and that's what NNMC currently uses. So even if we admitted or didn't admit, I'm not sure that keeping them in the ED is the right way, you know, kind of for our standard operating procedures.

However, it does require staffing solutions to provide that observation capability whether we admit or not. So we are kind of -- we're still working through that, but I believe that we have met the intent of the Board's recommendations on them. That's the Bethesda part.

We're working here on other things, and we're working on the master plan, somebody with the organizational and budgetary authority in the National Capital Region, and we will be responding to Congress. We have a report that is due under the fiscal year '10 NDAA by the end of March. We're working through that. We will address the issues, and I can tell you kind of where we are on some of them.

We know, I think, what buildings will

define the campus. We've got some pictures at the end. I'll show you. And how we are going to do the money? There are some other things that we are still working with the Chairman and the Joint Chiefs and with inside the Office of the Secretary of Defense's capabilities to finish up with those others. So I can't discuss that until the Department has come up with a decision. But I believe we're going to be able to respond positively to all of those questions.

Comprehensive master plan. The road map. This plan, you know, I'll tell you we -- NDAA we've got in, you know, November; and March wasn't long after November. It's very hard to get to what we call "1391". Those are the forms that you have to submit to Congress with construction level detail.

I don't think we're going to have 1391s by that time, but we will be able to identify within the Department the requirements of putting the budgetary requirements to get to world-class at the best estimate. And then we'll have an

interview process where we'll -- and we've already contracted with design firms to turn those concepts into the 1391-level detail that would be necessary.

We believe that what Congress wanted and why they wanted a March report was so that this could enter into the budgetary cycles of the Department, the Planning, Programming, Budgeting, and Execution System. It seems to be their intent on having this come in, but we're not going to have 1391-level detail on it.

Here's what's going to go into that comprehensive master plan. Several things. We've been doing -- completing the National Capital Region market analysis. Like most markets, we have about 500,000 beneficiaries in the Capital Region. About 298,000 of those are enrolled to us but about 350,0000 have used services at various points in time within the region. So we've looked out there. We believe that the market analysis supports the capabilities that exist.

Currently, there's always a desire to

review whether or not the demand has decreased. Certainly demand is not decreasing. The number of users have actually increased over the last two years. Certainly with the recession that's going on out there, a lot more enrollees have come into our system from other health care insurance systems, the programs that they had. And so we believe that we're certainly going to be able to utilize the capabilities that we're building well into the future.

Integrating military health care culture. Then there's a lot of talk about the Service cultures and what that means in terms of integration, and I know that any of you that have worked with the Services in a joint or combined sense before and knows that the services have different operating processes, hard to cross over between them.

But here, what we really are dealing with is an integration primarily of the health care cultures at Walter Reed and Bethesda. It's more about their cultures than it is about the Service

cultures that are out there.

In fact, we have identified the core values that cross over all of our cultures, particularly in relation to quality, quality of graduate medical education programs research and patient care, and the fact that patients have to come to us, particularly those wounded warriors being taken care of in the National Capital Region. Those are the overarching values that will form the basis of this culture. That will result in the joint facilities that are going to be in the National Capital Region in the future.

I'll show you some of the detail here within that $125 million approved by the Department for the Bethesda campus. We are incorporating many of the end-user comments that I think were recognized by the Defense Health Board panel. And I've got a slide here that talks about some of them.

And for instance, here are some of those end-user -- and this is not an exhaustive list, but these are some of the end-user comments that

were incorporated.

And we're moving ahead. Now we've got an implementation team for our comprehensive cancer center concept. Like many of the end-users that were concerned came out of the Centers of Excellence for Cancer, and you'll see many of them there are oncology related. We're putting them together in a new concept. They didn't deliver -- they delivered services separately before. We're putting them together in a comprehensive cancer center.

We are working with the National Cancer Institute, Dr. John Niederhuber, right across the street from us, to set the goal of achieving a National Cancer Institute designation as a NCI comprehensive cancer center. That would be the first cancer center in the military to do that. So we think we've certainly incorporated their end-user comments and going beyond that to take a look for a new model for the delivery of care.

I've got a couple of back-up slides. Before I wanted to go to the conclusions, I want

to show you a couple of these. This is the Walter Reed campus. The last time I was here, you can see down at the bottom, the state of completion of some those buildings. The parking garage over on the left has 944 spaces, and it is now completed. So that parking garage is open, which has started to alleviate some of the parking difficulties on campus.

Next to that is Building A. That's the outpatient building, which is the big green building to the lower left. And you'll see that it is all closed in. They're working on the inside. They're actually putting up walls, doing the other things that are necessary there.

Building B is the new inpatient building where the 15 new ICU beds, and three new ORs laboratory capabilities are going to be. Working on the inside of that now.

And then that sort of yellow building to the right, that's the National Intrepid Center of Excellence for Traumatic Brain Injury and Psychological Health, donated by Mr. Arnold Fisher

and the Intrepid Foundation.

Well on its way to completion. They're starting to outfit that building now. They hope to have the building turned over to the Department by May.

So things are progressing very, very rapidly on the campus. We're working with incorporating the NICoE now into the concept of operations for the new Walter Reed Army Military Medical Center.

If you take a look at the campus, we think that we've arrived at a definition of the medical center. Now, I'll just -- I'll draw a line. Basically this is the central campus here. And then a couple of buildings are over there. The medical center itself will be all of those buildings. And then some of the new buildings that we're building, I'll show you, would be maintained by the medical center, not necessarily run by the medical center. And Building 17, which is sort of up in the top upper left, is also an administration building that will belong to the

medical center. So the medical center itself, we think, is defined.

So we're working to finalizing the relationship between the base commander and the medical center commander. This medical center clearly will be the main mission on the base, and so I make sure that the installation command is in support of that primary mission on the base.

This is the Wounded, Ill, and Injured Lodging and Admin complex. Two towers on either side of a lodging -- of an admin complex and dining facility. You'll see that we moved to a different concept here.

This is really a new mission for us. We haven't been involved in past wars and the rehabilitation mission, but as the Department has moved into the prosthetics and traumatic brain injury capabilities that it's had, the Secretaries and Chiefs of the Services have asked the medical personnel to rehabilitate people that otherwise in past years -- past wars would have been identified as not fit for duty and given medical boards and

sent to the VA for their rehabilitation.

Since we're dealing with these folks, we have many of them that are moving into activities of daily living as part of their rehabilitation. So once they're discharged from the medical center, they have to move in to these spaces over here as we're doing on the right.

And that's one of the suites you will see here over on the right. It's all ADA compliant with ample space, whether you're in a wheelchair, undergoing limb salvage, whether you're an amputee, it now has to -- we try to accommodate these new spaces or a traumatic brain injury so that there is a bedroom on either side of that common area where activities of daily living -- there's a small kitchen, a small laundry, small common living space there for them to allow that transition.

We find that the wounded warriors, many of whom are on campus now for more than a year, need to be able to transition sequentially into areas of a higher functioning for their

rehabilitative needs. So this will be a, I think, a very good space to be able to do that in.

There are 300. 150 of these suites are being built that will add 150 -- 306 rooms. And those will be available before the new medical center opens.

And then additionally, for fiscal year '11, the Department has identified now $80 million, that I indicated, to do another 100 of these suites, 200 more rooms, and add a parking garage for use with them. So I believe that we've met the needs for lodging for the wounded warriors.

In addition, many of them now have either family members or what we call nonmedical attendants that are working with them, and so they can now be potentially lodged, if it's necessary, you know, with that service member.

Right now, we don't have any capability to do that in this kind of suite or apartment. And the Mologne House on the Walter Reed campus, it's kind of a hotel room kind of function.

This is the Fort Belvoir campus. You'll see it's moved substantially towards completion. Once again, that's a nine-holes of a golf course that you're looking at. It's a very, very big complex. It's an aircraft carrier from the one parking garage into the middle and the length of an aircraft carrier from the middle out.

The clinic buildings as you come in from the parking garages, the clinic buildings that have the signature swoop which is a "green" rain collector on top. So four large clinic buildings.

They're nearing construction -- completion. We are getting ready to start outfitting them. And then the central tower that's going up in the middle where the support and inpatient capabilities will be located. We're moving ahead really dramatically there in terms of the construction as well.

Conclusion. We appreciate the DHB's groundbreaking efforts in helping us to identify this new world-class standard and to work with all of the stakeholders to help us to get there.

We're committed to achieving the remaining standards that are left; and I'm go to reiterate it once again, this is a new standard defined in November of 2010, and we're not going to be able to have everything in place to meet that new standard. This does not mean that those capabilities that are world class today at both Walter Reed and Bethesda won't be world-class tomorrow.

In fact, all of these attributes that existed there at Walter Reed Army Medical Center and the National Naval Medical Center, particularly in relation to the amputee care, which I believe is the best in the world, not just world-class.

Open traumatic brain injury at Bethesda. Pretty much the same. Those capabilities and the rehabilitation capabilities that go with them, will be incorporated into this campus and enhanced so that the attributes of world-class that exist today are there and even better.

There will be more attributes of world-

class; for instance, this comprehensive cancer center that we're working towards. But then there are some infrastructure portions of achieving this world-class status that we will not be able to do because of saturation of the construction projects until after their completion of BRAC.

So sometimes in Congress they tend to view things as an all-or-none phenomenon. You're either completely world-class or you're not. The Defense Health Board Subcommittee certainly identified the attributes of world-class, set out a standard saying, you need to meet 16 out of the 18 of these attributes. And we are diligently working towards doing that. But the attributes that are world-class today will certainly be on this campus in the future.

Then we think that we've addressed a majority of the certainly concurrent construction concerns that the Subcommittee had. In fact, this master plan that we're submitting will address the rest of those. We will be submitting that as soon as we can.

With the deadline of the 31st of March coming up, it's difficult to get these things coordinated through the Department sometimes. And we will be able to then, I think, discuss further what the comprehensive master plan contains with you.

But since some of it's predecisional, certainly the budgetary requirements for new construction, and then it would be premature for me to discuss it today other than to say the Department is committed to getting there.

You know, we're sometimes out of cycle, I think. You have a lot of questions as an advisory board, I need to take those back, work them in the Department, you want answers and sometimes we don't have answers yet.

I learned as a young commander when I went up to a Congressional Panel once, it was about the -- there was a question about research, and I had to go up to a panel of very senior Navy people who were prepping me to go give this testimony. They said, so, Doc, you know, research

would be a good thing, wouldn't it, if the Congressman asked you. I said, yeah, research is a great thing; and, you know, they said, that's not the right answer. The right answer is: I support the President's budget.

And so I learned that early, and I learned it well. And it's served me in good stead there, you know. Because what happens is, you know, you're up there as Department of Defense witness testifying. They said, well, Dr. Mateczun said research was a damn good thing. And so we're taking money from, you know, you name it, some other account, and then you're putting it into this research account, which we might all think isn't good. But I support the President's budget, you know, is our answer.

And so there are some things that I'm unable to talk about early, and not, you know, quite in as much detail as we like, and that's certainly the position I felt myself in here last November.

I knew that we were working these

details, that this funding was coming, but since Congress hadn't been notified and since it hadn't been completely approved, then it would have -- I couldn't come in and honestly tell you that it was going to happen. And I still support President's budget. So we are a little out of cycle on those things.

I think that after March when we get this comprehensive master plan submitted, I'll be able to tell you some more details about the other parts of getting to world class. I'll stop there, and I'll be glad to take any questions that you have.

DR. LEDNAR: Admiral Mateczun, thank you for that brief and thank you for joining us in person today to update us on this very important project. Thank you.

I'd like to ask Dr. Kizer, who's on the phone, if he wouldn't -- first, if you have any comments, Ken, or questions that you'd like to ask. Ken?

DR. KIZER: Thank you. The -- and

again, just let me check, can you hear me okay?

DR. LEDNAR: Yes, we can hear you very well, Ken.

DR. KIZER: Okay, thank you. Let me also thank Admiral Mateczun for his comments. This is -- much of this I'm hearing for the first time just like all of you. And also I'm mindful of his staged comments about supporting the President's budget. I've been there, and I understood it quite well.

There are several things that I might just put on the table that are a possible concern. One of which is not directly related to comments that Admiral Mateczun made, but just as a reminder for the Boards that the Subcommittee that I chaired was originally convened for purposes other than reviewing the Walter Reed -- or the plans for Walter Reed as worked out for. And while the design plans for those two facilities certainly bear on and are important to the charge of the Subcommittee, that Committee never actually was able to address its original charge of advising on

the -- an integrated care delivery network in the National Capital Region because we got psyched, if you will, on this particular matter.

And since the Committee has not been -- I just want to remind the Board that we are aware that the purpose and charge that was given to the group has not been realized for reasons that the Board understands. So that grabs one point.

A second is simply that I don't feel that we are in a position to offer much in the way of constructive or other comments because we have no information and aren't officially a group anymore. Again, we listen with interest, and are supportive of what's been done, although, I think a number of the Committee members might (inaudible) if they had the opportunity to ask.

A third is -- in listening to some of the incentives and some of the observations from afar, it sounds a bit like there is a check strategy being followed, and that may or may not be a reason for it in that we wouldn't want this to become a -- or that approach to become a

barrier to looking more broadly at what's needed and the evolving needs of this campus, and this, you know, check all the trees but miss the forest. And, again, it's probably general comments than anything specific at the moment.

Just two or three other of -- again, not being perfect is exactly how the comprehensive master plan is being developed, but one concern that has been expressed by folks is the question of whether the approach is one of developing that master plan based on a composite of a number of the different components or whether there is overarching strategy that is going to guide the evolution of those components. And that's tied into the plan, and it's a fundamental approach.

And the concern -- or a possible concern is that if it is the former where the master plan is an aggregate of a bunch of component plans, that wouldn't be the spirit of -- and strategically in the long term wouldn't be the approach the Subcommittee was recommending.

Another issue is just the -- what might

be viewed as extraordinary cost escalation of the project. Two and a half million or so, another 250 million has been added. I've heard that number may be in the range of 700 million. And, again, I don't know for sure, but there's certainly -- we're moving in the direction of a cost figure that might be viewed as not a good model for how to approach these facilities, and understanding the history of this is maybe unavoidable, but there's just the cost concern.

And then finally I guess the last thing I would (inaudible) at least at this point is what some have labeled as mission creep and the long-term viability of such. As was noted, the capability for dealing with (inaudible) has been greatly expanded, and the rehabilitation has been expanded.

And I think from the quality-of-care perspective that's currently being provided that the (inaudible) or whether that ultimately was going to be viable when demobilization has occurred from the current conflicts, and interest

shifts to other concerns, whether this ultimately will end up being a good thing for us and whether this -- the current enhancement capability -- kind of the expense of other organizations who would normally have this responsibility, is an issue that warrants being thought about, certainly if history is at all a predictor of the future.

We know that when -- or that interest in these types of things is ephemeral and when budgets get tighter, these are all types of things that get compromised, and that's not good ultimately for patients who come to rely on these services.

So that's a bit of a wandering but those are some of the concerns that I would put on the table at this point.

DR. LEDNAR: Thank you, Dr. Kizer. Admiral Mateczun, did you want to make any comments to Dr. Kizer?

VADM MATECZUN: Yes. All comments that I think that we were aware of as well. I think the question of what is the strategy and how you

construct a Congressional report may be different things. And clearly we need to have a strategy that takes a look at where the integrated delivery system within the National Capital Region is going to move in into the future, how does the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital fit into that strategy. I couldn't agree more that there are, you know, going to be budgetary pressures too in the future.

In fact, right now, we're at war, you know, our casualty population over the last two months has come back up again within the National Capital Region.

And I think that there is a desire on the part of many people that we wouldn't have to see casualties anymore; in fact, almost everyone. It would be great if we didn't have to see casualties coming back from Afghanistan or Iraq or wherever our country sends folks.

Even, you know, when those casualties are not there, though, I think that part of the underlying message here is that with the

population studies, we have the capability to support the needs of the population and act as a worldwide referrals medical center.

This Walter Reed National Military Medical Center would be the military's largest medical center by almost 50 percent. So it's much, much bigger than any of the other medical centers that are out there today. And so it will continue to act as a, you know, tertiary subspecialty and super subspecialty referral center, you know, well into the century.

And so those patients are going to be coming and serving the needs of the population just to live within the NCR. We would able to take up the capabilities.

What we're searching for I think is -- and I know Ms. Bader was also the Executive Director for the Military Health System of the Future, a board that met and reported out here at the Defense Health Board. Their primary finding was that we needed to find a strategy to integrate the private sector care and direct care systems

for the military. We're still struggling with that. We have here an opportunity to do that.

Right now, there is $600 million worth of care going out into the private sector care within the National Capital Region, you know, every year. So there is plenty of opportunity for us to work with our partners and the contracts to bring some of that back, you know, in house.

We'd have to have the cases that we need to support our GME training programs. And, you know, the surgery, the general surgery program is now an integrated program. The RRC just accredited the joint program. It's now one of the largest surgery training programs in the country, seven chief residents working at the top end of that surgical pyramid. And so we have to have the cases to be able to support that.

Putting all of these things together as Dr. Kizer points out, not a trivial thing, the greater we write a report may not exactly reflect that strategy.

It is a challenge answering questions,

in particular those things that identify specific deficiencies while keeping it in the context of an overall strategy. So I agree with Dr. Kizer completely, and certainly on that. We'll be careful to try to do both the best that we can.

DR. LEDNAR: Thank you, sir. We have time for one or two questions. Dr. O'Leary and Dr. Silva?

DR. O'LEARY: Thank you for that report. I think there was a lot in there you could be very encouraged about, and you're making a huge amount of progress. Just a couple of things. I couldn't glean entirely from your comments whether you thought that it is going to ultimately be feasible to move to all single-patient rooms making announcements for the buddy rooms, but it is going to be feasible to do that.

VADM MATECZUN: That's going to be -- well, in the master plan we will address that question.

DR. O'LEARY: Yeah, I figured that that's probably where you would deal with that. I

think that -- I like Johns Hopkins too, but they're one of a number of elite-named institutions whose physical facilities don't permit them to achieve world-class, and I think we probably do have that opportunity here.

The other comment is a little bit -- simply to urge that you're not underestimating the challenge of creating the kind of culture necessary. It is -- you allude to more than simply melding the cultures of the various services, but it is really creating a culture that supports quality improvement, patient safety and a learning culture, particularly in an institution that's heavily involved in a graduate education and undergraduate education.

VADM MATECZUN: Yes. I agree completely. This is another one of those areas where I believe that the Department has to be committed to a continuous process. I could not stand here today and tell you we will have a culture in place by September 15th of 2011 that will do all of those things. And I would

challenge anyone to do that at any institution.

But we are committed to give the foundations that culture and then incorporate it into the system. It will take five to seven years is the best advice we can get before it becomes so ingrained that it's part of the culture.

DR. O'LEARY: And it's a continuous process because there is always a risk of falling back and I think one of the -- you know, a couple of the obvious challenges that are -- that this institution uniquely faces is the desirability of optimizing transparency and minimizing hierarchical structures which are kind of, you know, inherent problems which you're dealing with.

VADM MATECZUN: Thank you.

DR. SILVA: Thank you, Admiral, for your comments. I sort of had the same question Dr. O'Leary had. I was one that was particularly critical of you, could you employ the word "world-class," and I think you can. I think from my point of view in the future, you mentioned that there are still areas that will be developed under

the master plan but are deficient. It's a lot of data you present, but I'd like to see those pulled out so at some point we can continue to track them, to know if you're on target. But I really liked your report today. Thank you.

VADM MATECZUN: Thank you. We will be incorporating those into the comprehensive master plan I think in the way that's identifiable to everybody.

DR. LEDNAR: Admiral Mateczun, thank you for the very insightful and informative report that you shared with us today. Thanks to Dr. Kizer for participating remotely from California. We miss you, Ken, being here. We appreciate the time that you did spend with us.

And, Admiral Mateczun, the Board continues to be a resource to you, anyway we can be helpful both in looking at the master plan and moving forward to implement to achieve world class, the Board is here to be a partner with you.

VADM MATECZUN: Thank you.

DR. LEDNAR: Thank you.

(Applause)

DR. LEDNAR: We're going to take a 15-minute break, and then we will reconvene for the next agenda items. So we will break now for 15 minutes.

(Recess)

DR. LEDNAR: Okay. We are restarting with our next agenda item. Since we are all here to serve the men and women who defend our country, our next brief this morning is an overview of U.S. military operations throughout the world given by Colonel Christopher Coke of the Joint Staff.

Colonel Coke serves as the EUCOM Division Chief of the Joint Operations Directorate. This division is responsible for the monitoring and coordinating of all Joint Staff actions for operational activities within NATO Headquarters in U.S.-European Command.

Among Colonel Coke's numerous awards are the Bronze Star, Meritorious Service Medal, Air Medal, the Third Strike Award, Navy and Marine Commendation Medal, and two Navy and Marine Corps

Achievement Medals. The Board would also like to congratulate Colonel Coke on his recent promotion to his current rank as full Colonel 06. Well deserved. Let's congratulate Colonel Coke.

(Applause)

DR. LEDNAR: Colonel Coke's brief will highlight the medical and public health situation in Haiti as well as the Department's relief efforts to date. Colonel Coke's presentation slides may be found under Tab 2 of your meeting binder. Colonel Coke?

Col COKE: Thank you, sir, I appreciate your comments and always a pleasure to be here. And, again, I'm here from the Joint Operations Directorate and hopefully to provide you all an overview of what's going in the world, at least with our military. And, please, as I progress if there's any questions, I don't mind taking a question en route so please feel free to jump in.

Really, I mean, the bottom interests don't change that much. I mean, there are some nuances that take place, but again, you know, the

bottom line is to protect the homeland and to protect the commons. When I speak of commons, I'm talking about those means to be able to move things across the seas or the air to be able to allow the global community to trade, to interact with each other fairly and kind of on a fair field. So that's really, you know, what it boils down to, how we use instruments of national power, specifically the military in this case, to be able to sustain that, to leverage it as required. So that really remains kind of bottom line of vital interest.

You know, it's important to keep in mind that you have to remain relevant today, in today's fights as also being able to look out to 2020, 2030 and try to, as best you can, forecast what's going to be coming, what are the adversaries in the future and what are we going to have to do to be able to posture, to be able to with deal with those. And just not from a military standpoint but from an interagency, from a -- all of government, and global standpoint.

And, you know, the other comment before we get started is -- and there are two very good examples. Why is it important for another country to succeed? Well, I mean, obviously there's an altruistic interest to see everybody succeed.

But, you know, we just look at the recent incident in Haiti and then just what took place over the weekend in Chile. Look at the capacity of those individual countries to be able to take care of themselves. And obviously there is a huge difference, you know. And I'll talk a little bit about Haiti and as far as the DoD effort to support Haiti. But it was tremendous, tremendous across the whole nation and tremendous across the globe. So a huge investment as opposed to Chile. And, of course, we'll all be helping out there as well, but it won't be to the same magnitude.

So that's why it is so important and vital to us that we, you know, help and foster other nations to be successful and also so we have a good trading partner as well. So moving on.

You know, again, we're challenged and again how we foster ourselves for today and tomorrow is where do we put up foot. And as you see -- and it's probably better to read within your slide deck -- is, you know, the preponderance of the force is obviously in the Middle East, about 220,000. Although we still have 100,000 in Europe and about 160,000 in the Pacific. Only have about 3,500 down in Southern Command.

Well, that presents some interest when you have an incident like Haiti, and you need a much more robust capability to be able to take care of an incident like that. So those are -- that's a very real risk that you face as you look to apportion forces across the globe and where do you best put them.

And obviously we spent a lot of time in the Joint Staff this last month helping and supporting and actually flying people down to Miami to be able to help out Southern Command because that was a risk that we took collectively to be able to better force -- allocate forces in

Central Command and other areas that have, you know, more real and sustained situations to deal with.

Really the -- before we get on the tour of the world, it is important to also recognize and probably just as recent is the Secretary's discussion with the permanent representatives to the NATO, I believe this last Friday. We talked about being relevant and the importance to be able to transform.

We all know that we're out of the Cold War, but we have to be able to foster these countries to remain flexible and responsive and engage in what's happening now as well as the future. So this is a continual battle to move forward because the scene is quite different. It's not the model that we lived with, you know, 20, 30 years ago.

AFRICOM. Again, our newest combatant command talked about this. Been here with us for about 18 months. The uniqueness of having -- and he's actually pictured there, but Ambassador

Holmes the Deputy for all things civilian and working with the Guiana folks as far as engagement -- a lot of theater security engagement in Africa.

We obviously have sustained operations in the Horn of Africa and Djibouti. But as depicted here, a lot of joint training.

Marine Corps working specifically in engagement in Liberia. Liberia seems to be a common place for the Marine Corps to go back to on regular occasions. But also the support, like the elections within Sudan here in April. And then Darfur, we've seen some progressions as the Janjaweed Militias deal with the differences in Islamic there.

So Africa continues to be an evolving project. Again, only about 3,500 people there so we recognize we're going to have to put more energy into this to be able to really move it forward.

CENTCOM. Really the center of efforts and the predominance of the fight right now. Really three things that come to mind: obviously

Iraq, Afghanistan, and piracy.

Iraq real quick. You know, we're down below 100,000 folks there, first time since 2003 and will flow down to 50,000 at the end of the August. And now Afghanistan actually has more U.S. troops there than Iraq.

Again, all eyes are on the elections here in the next two weeks. And that will really set the stage for our planned, you know, responsible drawdown per se, but it's important to recognize that, you know, even though we have this off ramp built, it is condition based. And if things do not, you know, go as well as we anticipate, we do have means to be able to continue a level of engagement or, you know, hit particular areas perhaps up to the north that may need engagement beyond what is, you know, planned right now.

Piracy continues to, you know, be an annoyance off the Gulf of Amman and, of course, you know, the pirates continue to develop their techniques and tactics, and we continue to

counter. The nice thing is that it is a coalition effort, and through a lot of bilaterals as well, Russia and China are engaged as well. So we continue to work with that.

And then Afghanistan, and I'll talk a little bit more about Afghanistan in the next slide. But it's important to recognize that, as you'll all know, General McChrystal announced a strategy.

And really the focus of last semester, per se, was how to resource this. And as you know in the Presidential announcement, 30,000 was a result. But it's important to recognize that there's another 10,000. McChrystal asked for 40. Well, U.S. provides 30. And the anticipated hope was that we would be able to get 10,000 for our coalition partners. And we're about 9,500 out so we are drawing in very close.

But like so many things as you get close to the final objective, it gets harder and harder. But actively engaged in our partners around the world to be able to get the strength -- get the

people there that we need.

And it's important to recognize that the strategy, it's just not to fight. I mean, that's a part of it, but it's also the engagement and this recognition to be able to build a capacity of Afghanistan to solve its own issues, to build its governance, its policing, and its military.

And there are specific numbers that have been recognized and built into the strategy and continue to be reinforced that we need to drive through.

So it's just not the battalions and the air support to be able to fight, but it's also the trainers and the ability to train the police of the national military to be able to sustain their own clearing and holding operation as it is right now.

And I'll talk about Moshtarak in a minute, but, you know, the ability to be able to just not take an area but to be able to hold it and then to be able to allow for that governance to work within that particular sector. So let's

see, we'll move on.

We'll talk about Moshtarak here. Really centered around the Helmand River valley. You've got the Lahskar Gah and the Nad Ali and the river and then of course the valley. And Moshtarak is sort of the focus, the main effort. So why this area? Well, one, it's a stronghold of the Taliban and the insurgency. The terrain favors it. So they're drawn to it. It's also one of the more fertile areas and thus one of the higher poppy cultivation areas.

So this was the point of attack. We actually went in here about a year ago, year and a half ago. Just didn't have the forces to be able to hold so why bother going in if you can't hold it. It doesn't make sense. So with the plus up and the right forces in place, we're able to build up to a point that we can go in and hold.

This a 15,000-man operation -- men and women, sorry -- and about 8,000 were Afghanistan. It's Afghan led. Obviously with a lot of help from us and these other countries that are listed

right here. But it's important, the majority were Afghanistan, and it was Afghan led. And the objective is to go in and to clear and to basically take ownership of Marjah and then to -- they call it sort of a government in a box, but basically with a local governance to be able to go in very quickly because remember the Taliban had shadow governance, which are actually very effective unfortunately in these areas.

So you've got to be able to go in very quickly and replace those that you've just kicked out, removed. And that's what we did with the government -- the governor of Helmand province.

So right now, we're still in some clearing operations, but now we're sort of moving into the holding and to be able to hold this territory so that now you can start building and then allow the governance to start taking effect, build that confidence within the population, that you actually have a better alternative than what was there before.

So this is an example. This is a huge

operation, nothing like this since 2001. But this is the example of General McChrystal's strategy, the ISAF strategy, of how we think we're going to get Afghanistan. It's too early to tell if this a tide breaker or a tide turner, but I think it is safe to set that we have stopped the regression of our capability and the advance of the adversaries.

I think we're at a point where we've stopped that momentum, and now we're trying to get it into the other directions. So I think good news so far. Okay moving along.

Old EUCOM. You know, we're still dealing with Russia and what does Russia mean to us and what are their intentions. And, you know, we have reminders. Georgia obviously is one. So that is always an issue with EUCOM.

It's important to recognize that they've continued their surveillance and increased their surveillance to not quite to post-Cold War -- or pre-Cold War levels, but they are increasing their sub activity and their aircraft activity. The Bear flights, in fact, one came very close within

Hawaii, 40 years since Hawaii has had a Bear flight come close to it. So that continues to be a concern.

But what's at hand right now is obviously supporting NATO. NATO's number one mission is ISAF, and they continue to provide that support to it. But we also have forces in Kosovo. They aren't drawing down. We'll be turning that over not before too long.

And then other standard maritime groups. One of the maritime groups refer back to the piracy is actually directly involved. We call it Standard Navy. Standard NATO Maritime Group I is actually engaged in kind of piracy operations.

The other two aspects -- the picture up top left -- is pertaining to Georgians, one of our success stories. We're going to put 750 Georgians into the fight, into Helmand actually, to work with the Marines, and they'll deploy in April.

The other one is relief efforts -- or not really relief efforts -- but this was the USS Grapple. If you remember, there was a Lebanese --

or Ethiopian flight that flew out of Lebanon about month ago, three weeks ago. So they're doing salvage ops trying to look for the black box. So still a fair amount of just theater engagement.

The picture down to the lower right are patriot batteries, again, where we've just evolved from an old -- or the previous ballistic missile defense program to a new one what we call Phased Adaptive Approach, which encompasses more of a robust, more low-key system such as our Aegis ships and patriots and other mechanisms to create this umbrella of protection along the same intent as what was on the old program and working with such countries as the Czech and the Polish.

And then Israel. Israel remains -- it is part of EUCOM but obviously also closely tied to CENTCOM, and, you know, we had Gaza a year and two months ago. Continued tensions Hezbollah in to the north and then Iran.

And really, you know, what's Iran's intention? There are no real defined red lines, per se, but we know that there's -- you know, Iran

gets too froggy frankly and Israel is going to react and how do we manage that so that we don't have sort of an implosion within the Middle East. So very -- a lot of concern there.

Northern Command. Again Homeland Defense. The interesting thing is it -- and I'm trying to show you on the picture I put in here -- was basically Northern Command working with Mexico to put in a field kitchen to fly down to Haiti. So, again, intermittently involved.

To the right is basically a civilian support training team that's looking at if there was a weapon of mass destruction within the boundaries of the United States. Obviously the military provided a fair amount of support to that. And this is one of the areas that it would to basically assess, advise, and assist as required, you know, whatever that was, and this was the training evolution that took place in Las Vegas. And of course, you know, a lot of integral interagency working with just not only the first responders but also with the FBI.

Last thing, counter drugs, counternarcotics activity. You know, Calderon with Mexico and working to help Mexico shape because it definitely relates to us as far as, you know, our number one flow of narcotics coming up through Columbia but also Mexico as well. And then the weapons heading south.

Pacific Command. Again, there is security but this issue right here, North Korea, is you know, never is out of our mind. The shadows, and you probably see this in your book a lot better, but this Taepodong-2 which can't reach the United States much longer. It can't carry a nuclear warhead. Had a failed attempt at testing a little while ago. But they are moving toward that. So that's an unstable country. With that kind of capacity it's not a good thing. So our engagement obviously remains heavy there.

Other things. You know the regional threat things, we think things are going fairly well with Taiwan and the relationship with China. And then, of course, we have weapon sales. So,

you know, it's balancing all things in a broad perspective and yet at the same time, trying not to increase -- or actually diminish these natural tension lines.

And then the more and more engagement -- a lot of success in the Philippines but continuing to work with the Philippines as far as this is an EOD team, Navy EOD team, that was working with the Philippines. But they've done a lot of good work as far as help, countering help Al Qaeda in that region.

Southern Command. Normally what I'd be talking about Southern Command, it would be, you know, the counternarcotics flow, the success we've had, and the work we need to do, such as Colombia. A lot due to security. Hospital ships being flowing down there engaging, and then being ready for mass migration issues that always seem to come out of Haiti and Cuba whenever there's crisis to join.

So having said all that, we'll just move right on to Haiti because this has really brought

Southern Command to bear. As you all know, fairly significant earthquake, 7 on the scale. Epicenter right near Port-au-Prince, 16 miles away from Port-au-Prince.

Really 3 million people affected, but 200,000 and the count keeps going up and down, but between 210,000 and 230,000 people dead. And about 30,000 injured and about a million homeless. So that's what was presented.

In here you can see the actual population and the severity of the quake but quite a lot of population within the extreme just because of its vicinity to Port-au-Prince or some of the other capital areas.

The response obviously as you all have read and know was huge. And, you know, as kind of alluded to earlier, this is the poorest country in the Western Hemisphere so not much capacity within to be able to manage an incident of this scope.

And then a lot of things that, you know, from building codes to just governance to infrastructure to be able to support and deal with

this. So the DoD response, as depicted 22 ships. And it's important to talk about the type of ships. You had a carrier strike group, you had two amphibious ready groups with MEUs, Marine Expeditionary Unit forces, embark. You had standard cruisers and frigates and destroyers, and then of course you have hospital ships. So 22 total.

And then of course coming off those ships as well as at some land base was about 83 rotor wing helicopters that were able to support this effort. And then the total ground force of about 18 and a half thousand folks.

So that's what -- this is just a snapshot in time -- I can't remember -- 26 January, but that's what we had on the ground. Interesting thing -- just a sidenote -- everything that we did within the National Military Command Center within (inaudible) unclassified. We did start migrating some things to a classified system, but complete transparency as far as what we were doing in conjunction with interagency

partners and nongovernmental organizations and of course other reliefs.

Speaking to this effort, I obviously talked about the infrastructure. Immediately both the port and the field, the airfield was closed. Got the airfield up and running fairly quickly which was fortunate to be able handle upwards of about 100 sorties a day, flights coming in a day. And we used almost every bit of those flights so about a week, week and a half into it. And then it began getting down to about 90 sorties a day going in and out.

And then the port. Port more problematic. Some of the pilings and things like that were severely damaged. So using some new technologies to be able to bring these sort of floating ports in and to be able to hook them up so that you can roll on, roll off equipment and things off the ships.

So was able to get the port up to a capacity of about -- I don't know if you've all seen those 20 cubes, but the huge containers. But

basically if you can imagine 200 of those being able to be offloaded at the same time.

So as with everything, you've got to get equipment and supplies, and I know people are glad about the prioritization of what we were flowing in but initially very difficult. But within a week we were able to get to this capacity which was important.

The second part of that is obviously the infrastructure within to be able to distribute.

This is more the military in addition to, you know, the security aspect of it. And fortunately, the security -- what we thought would be a security issue was really diminished quite a bit, which was very fortunate.

But our ability to focus on the infrastructure and help, provide, and supply relief efforts, you know, across into Haiti proper.

And this is where, you know, the helicopters obviously came in and then getting into those roads, bridges, trying to work it so

that we can start moving things inland.

On the medical end, obviously Comfort was there. 946, I think, bed capacity. Flew in a 200 person augment to be able to bring the capacity up and pretty much used that capacity within the first week or two. One of the issues that did come up was, okay, you fixed the person, now what do you do post-surgery, post-medical?

You've got to -- so we actually -- and Haiti and DHS actually built these camps, just not camps for refugees but also camps for post-care to be able to flow these people back in because there's nowhere for them to go. Most of them, they were homeless, and there was no structure there for post-trauma care.

And then, again, the whole intent is to turn this over, you know, and get the military back on the road, so to speak. And that's the phase that we're kind of in right now is turning things over to USAID and getting them to take over completely. I mean, they always owned the mission. It's just basically getting the DoD

support out of that mission so that they can make it and continue their more enduring engagement with Haiti to get them on the long road of recovery.

Really, I mean, a couple of takeaways; one, it's a feel-good mission even though it's catastrophic what took place. It's immediate gratification. But more importantly is the ability of our Department to be able to mass this type of effort in concert with what is already going on in the world. It's tremendous. So we have a lot of depth and a lot of breadth to be able to do that.

It's also a very good strategic message to our adversaries that we have this capacity, that we're not tapped out. And so that's good. And perhaps because we were not messed with, so to speak, during this time period, maybe they're tapped out. We can only be so lucky.

But the point being is that we have a lot of resilience within our -- and a lot of depth and capacity to be able to do these things. So

good there.

I'll just wrap up with kind of concerns and where we're going. Interest items. Again, you know, as we move out of one and move into the other, and we're kind of at like crossroads right now. Talked about more people in Afghanistan than in Iraq, it's balancing this appropriately so that we don't off ramp too fast or we don't on ramp and overload those infrastructures and abilities to be able to absorb what it is we need in Afghanistan. So that's continued.

Pakistan and India. Always on our mind because we recognize that Pakistan and Afghanistan intrinsically interlink. Success in one demands success in the other.

Talked about Israel, Palestine, Gaza, external actors, ties into Iran and Israel. But that is one that continues to be on our minds.

Threats to the Homeland. Christmas Day bomber, call him what you may, we have a continued reminder that we do have a threat here at home that we need to keep engaged on.

North Korea, talked about that. And then, you know, the global criminality and being linked to terrorism. In the long term, again, and some of you all listened to my briefs, these don't change too much, but it's as important, as we're dealing with today's fight, that we look out in the future and we continue to try to shape what we think will be our adversaries, what we need to be able to counter those adversaries and be able to help shape leverage, you know, our foreign policy in 2020 and 2030.

So how do we stage ourselves? You know, if you're a F22 guy, you're probably not as happy. If you're a SOC guy, you're probably fairly happy. But that's today. We have to look toward tomorrow and try to balance that. Recognizing that, you know, cyber is very real, it shuts things down, and it's global and it's very easy. You know, the Chinese were very interested in this particular domain.

Terrorism, and, again, the long-term Middle East. Middle East peace, it's been with

us, and it will be with us for some time in the future. And, again, just because we are focused in one area does not preclude us from being focused into other areas and to build strategies and -- just mentioned Russia in passing -- but it's just not a passing, that's a very real threat.

China. What is China's eventual goal and how -- you know, bring them along as a friend hopefully as opposed to an adversary or somebody that we have to reckon with.

So and, again, this economic crisis, what is it going to unveil for us, what rocks is it going to turn over for us in the next years that we will have to deal with. The unknowns.

And, again, to wrap things up, one more slide. How things have changed for the commanders. And these are, you know, as you go from, you know, your company-grade-type commanders up to general officer up to, you know, the national level, you obviously go from an operational to sort of a strategic mindset. But

you have to recognize in today's world, very much, those actions that take place at the very -- we call them the sort of the strategic corporal, but an action that could take place on the battlefield can have a huge implication, you know.

That's why we are paying so much attention to civilian casualties. We're really trying to mitigate and zero that number out as we engage in Afghanistan because, you know, an inadvertent shot or inadvertent drop can really have a huge effect on the overall strategy in, you know, in winning their hearts and minds, so very important.

Kind of tied into it, everything happens faster and quicker. And the adversaries using all instruments. He's using cyber. He's using population. He's -- it's just not a conventional fight to them. We have to recognize that. And our response isn't just going to be conventional or unconventional. It's going to be a hybrid of the two. So we have to be able to address that.

And again, you know, intelligence-led

operations, the ability to be able to take the picture at the time and to be able to respond to that and have that level of one fidelity, but that's -- to be able to do that, it's paramount. And so this is what the commander today is dealing with. So with that, I think that is it.

So are there any questions or comments or concerns?

DR. LEDNAR: Questions for Colonel Coke? Dr. Shamoo and then Dr. Oxman.

DR. SHAMOO: In the media there is a great deal of writings regarding the drones, and there are two types of drones; one, presumably -- again, this is from the media -- intelligence services are (inaudible). And the media claims -- this is in print, that -- there's a book also -- that the logic tree of how that decision is made is not known. However, the same print media says the military does have a logic tree how decisions are made. Since we're talking about counterinsurgency in civilian, my question to you is: is there a classified version of the logic

tree of how we make decisions to use drones in a given operation?

Col COKE: My depth of knowledge in this area is limited. I would say that most logic trees dealing with drones or UAVs and ISR are classified. It would not be in a, you know, public. But, I mean, I would also add that paradigms aren't changing.

Operation Moshtarak was completely announced at the beginning. I mean, you know, days before, the enemy knew we were coming. And so things are changing, but I cannot foresee, at least on the military side, that our specific information would be, you know, provided real time especially outside of a classified environment.

DR. OXMAN: Mike Oxman. I think that the humanitarian efforts by the military have enormous benefits in many areas, and I wondered -- I understand that Chile has requested some -- at least some medical help. And I wonder if we're deploying anything to help them.

Col COKE: You know, I would imagine we

are, but I don't know. I flew here yesterday so I haven't been tapped in to what's going on, but I will imagine that we'll be involved, certainly not to the scale of Haiti, but we'll be flowing things there.

RADM SMITH: This is Dave Smith. We don't know the answer to that right now. There's a meeting -- or teleconference afternoon. The Department states working the issues to determine who is appropriate for those various requests from all the willing contributors from around the world to do that, so the answer is unknown but standby.

DR. LEDNAR: Any more questions for Colonel Coke? Well, before Colonel Coke gets away, this is a bit of a watershed moment because this is Colonel Coke's last brief to us, the Defense Health Board, as he's preparing to go onto his next assignment.

And we want to, as a Board, recognize Colonel Coke for the understanding the broad view of the Joint Chiefs, how it helps us think about what the medical and force health protection needs

of the force are throughout the world as it's been changing and to put it in terms that makes it easier for those of us with a medical background to understand about some of the ways that we can help.

So but we'd also like to give you something to take as a memento, and I'd ask Dr. Poland, Ms. Bader, and Commander Feeks to just join me up with Colonel Coke for just a moment.

What we're presenting to Colonel Coke is a Defense Health Board medallion which in military tradition is a remembrance as you go from assignment to assignment about the relationships you've made and the important work that's been done.

And as you go onto your next assignment, please keep us in mind, and we are here to serve.

Col COKE: Thank you very much.

(Applause)

DR. LEDNAR: Our next agenda item will be presented by Dr. Frank Butler. Dr. Butler is the Chair of a Tactical Combat Casualty Care Work

Group of the Trauma and Injury Subcommittee as well as a member of the Subcommittee.

Dr. Butler is a retired Navy Captain and former Navy SEAL who helped develop many of the diving techniques and procedures used by Navy SEALS throughout the world today. He served as the Task Force Surgeon for a Joint Special Operations Counterterrorist Task Force in Afghanistan and was the first Navy medical officer selected to be the Command Surgeon at the United States Special Operations Command.

Dr. Butler has numerous military awards. They include the Defense Superior Service Medal, the Legion of Merit, the Bronze Star, the Defense Meritorious Service Medal, and the Navy Meritorious Service Medal.

In addition, he received a Special Award for Innovations in Tactical Combat Casualty Care from the U.S. Army Medical Research and Materiel Command and was the first recipient of an award named for him and presented annually by the Committee on Tactical Combat Casualty Care for

exemplary contributions in the field of trauma management on the battlefield.

Dr. Butler is a board-certified ophthalmologist and currently serves as Co-Chairman of the Undersea and Hyperbaric Medical Society Decompression Sickness and Gas Embolism Treatment Committee.

As you may recall from the last Core Board meeting, Dr. Butler presented proposed Tactical Combat Casualty Care burn management strategies for the Board's consideration and endorsement, after which the Board requested additional time and information to examine this issue.

On behalf of Dr. John Holcomb, Trauma and Injury Subcommittee Chair, he will be presenting these proposed strategies today for the Board's deliberation in open session. These proposed strategies and background information were provided to the Core Board by Commander Feeks in preparation for today's discussion and vote.

Dr. Butler's presentation slides may be

found under Tab 3 of your meeting binder.

DR. BUTLER: Thanks, Dr. Lednar. It's a pleasure to be back with the Core Board and distinguished lead, liaison members, and guests. I think it is good that we have a reprise of some previous items right before lunch. So hopefully we'll move through these quickly, but we'll take the time that we need. These were presented as mentioned in November to the Core Board, and the first item is the treatment of burns in TC3. And it's a fair question to say, hey, TC3 has been around for 15 years now, why are we just getting around to burns. Well, burns have not historically been a leading cause of preventable death on the battlefield, but with the increasing incidents of wounding from these IEDs that you read about in theater, we're seeing a lot of burns. So the group tackled this, and I have to thank, at this point, the Army Institute of Surgical Research. We weren't about to tackle this ourselves internally when we had a resource like this that we could turn to. And Lieutenant

Colonel Booker King and Colonel Evan Renz from the Burn Center at ISR are largely responsible for what you see, and we're very indebted to them for their help.

So, as you know, the care on the fire part of TC3 is when you're in the middle of a gunfight and your main focus is suppressing hostile fire. In that setting and this point of the continuum of care, your attention is focused in just getting your casualties out of the burning vehicle or building and stopping the burning process.

So when we move into the tactical field care phase where hopefully the shooting has stopped, first, facial burns, especially those that occur in closed spaces may be associated with inhalation injuries so you have to carefully monitor the airway and respiratory status and be aware of the need for possible early intervention with their airway.

After that's done, you estimate the total body surface area burned to the nearest 10

percent using the Rule of Nines, which is a standard in burn care.

Okay. Cover the burn area then with dry, sterile dressings. If you've got a large burned area, we have a hypothermia prevention blanket that will serve nicely so you can just enfold the casualty in that, and it will serve.

Fluid resuscitation. It has been the observation of the ISR that burn casualties tend to be over-fluid resuscitative when you resuscitate them using the classic Parkland or Modified Brook's Formulas. So they have developed a new formula, the ISR Rule of Ten, which is both simpler much easier for the provider on the field to calculate and underresuscitates the casualty a little bit compared to the traditional formulas.

So if burn areas are greater than 20 percent, fluid resuscitation should be initiated. It may be done with Lactated Ringer's, normal saline or Hextend®. If you do choose to use Hextend®, don't give more than 1000 cc's, and then follow on with Lactated Ringer's or normal saline.

The 1000 cc limit is because of concerns about coagulation status above that volume.

Okay. So the initial IV/IO fluid rate is calculated as percent burned area times 10 for adults between 40 and 80 kilograms. That's much nicer than the old formulas. If you have a bigger person, then you need to add 100 cc's per 10 kilograms over 80 kilograms.

If you have hemorrhagic shock, hemorrhagic shock will kill you prehospital, burns typically don't. So the precedence is to treat for hemorrhagic shock if that is coexistent in a casualty.

Analgesia. In accordance with a previous section of the guidelines, ISR says, hey, you do not need to start antibiotics prehospital. Similarly, you don't need to spend $200 for antibiotic impregnated dressings to put onto the burn casualties. They say that the -- you know, if you need to give antibiotics for other things, fine, but you don't need to do that for burns.

And then the last item: tactical field

care. Whatever you need to do, it's okay to do it through burned skin. This question comes up a lot; and ISR says, do what you have to do. In tactical field care, it's basically the same except that there's an extra emphasis on hypothermia.

In Afghanistan, you're flying over the Hindu Kush. A lot of the time, it's cold in these helicopters. And burn patients are very susceptible to hypothermia. So extra emphasis on preventing that.

So those are the proposed changes. They were reviewed after the TC3 Committee reviewed them -- or approved them on 3 November. They were reviewed by the Trauma and Injury Subcommittee and approved unanimously by everybody who was there for the meeting on 4 November. So one of the proposed actions for today is to re-present these to the Core Board and answer any questions and see if we can get a vote on this change.

DR. LEDNAR: The floor is open for, first, the Core Board. Are there any questions

for Dr. Butler?

DR. LOCKEY: This is Dr. Lockey. I'm just curious like in Afghanistan what provisions were made to heat the IV fluids. How was that done?

DR. BUTLER: In the tactical field care phase, there are two IV fluid warmers that are currently used more than others. One is the Thermal Angel and the other is enFlow. And we use -- absolutely use those especially if they need relatively large volumes of fluid as burn patients might. However, as you know, with heat loss, it's tough to put back in the volume of heat that you lose so the emphasis is on prevention.

DR. LEDNAR: Other questions for Dr. Butler?

BG GAMBLE: Yes, Bryan Gamble here. One of the things to remember too is these patients are polytrauma, usually complexed, so it's not just a burn isolation. One initial thing that, you know, my distinguished colleagues from the ISR noted was that using normal resuscitative measure

and formulas would often create secondary tertiary problems; namely, abdominal compartment syndrome, which was, again, compromised cardiovascular function and necessitate opening the abdomens, decompress the belly and improve cardio pulmonary function.

However, these people would then become increasingly more susceptible to intra-abdominal infection and their survival was much less. And fortunately John Holcomb and the rest of the pioneers in this field, saw this and created this formula. It really has made a substantial leap in survival of these previously wounded individuals.

DR. BUTLER: Thanks for that, General Gamble. And it reminds me to mention the comment that Booker King made when he was presenting this to the group in Denver. He said, it is critical to think of these patients as trauma patients with burns, not burn patients with trauma. The trauma, the other trauma, that General Gamble mentioned is what probably will kill them.

DR. LEDNAR: Other comments or questions

for Dr. Butler? Okay. Then what we have for the Board is an action to consider. There's been a lot of discussion, presentation by Dr. Butler.

The recommendations that have been made for the Board's consideration have been developed in the TC3, reviewed in the Trauma and Injury Subcommittee, who really are our experts on this question. We've had an opportunity as a Board since last time we've met for any additional clarification that the Board wished to have.

All that communication is available and transparent for anyone who's interested in knowing what those questions were.

So at this point I'd entertain a motion to accept the recommendations as proposed. Is there a motion?

SPEAKER: So moved.

SPEAKER: Second.

DR. LEDNAR: Any further discussion about the recommendations? Hearing none, then I would ask, by a show of hands, all those on the Core Board who are in favor of approving these

recommendations, please raise your hand and say aye.

SPEAKERS: Aye.

DR. LEDNAR: Any apposed or nay? None. Dr. Butler, these recommendations are approved by the Board and thank you to you personally to the Trauma and Injury Subcommittee and to the work of the TC3. There will be many who will survive because of these recommendations. Thank you.

(Applause)

DR. BUTLER: Thanks very much to the Board for their comments and considerations. We are going to mention two quick things additionally.

The first is the issue of fluid resuscitation in TC3. Now, this is the iconic battlefield intervention. When you see pictures of Corpsmen and medics on the battle field, what are they doing? They're starting IVs. So that's what they do. I will tell you that in an age of evidence-based medicine, this iconic intervention is not well supported by human trials.

That's a huge understatement. "The New England Journal" study by Bickell in 1994 that was done at Ben Taub is perhaps the best randomized control of human trial on this, and it found that survival was improved by delaying, delaying, fluid resuscitation until the surgeons get their hands on whatever is bleeding and stop it. So that's what the original TC3 guidelines said. Don't give -- if it's penetrating torso trauma, which is what Ben Taub's study addressed, don't start fluids because the literature says you're going to make them worse.

Well, we got outvoted a couple of years later by a group that was convened by the Army Medical Research and Materiel Command and the Office of Naval Research. This was a huge international panel of experts. And they looked at what we had at the time and said, hey, we can do that better.

And this was what they recommended: that we use a tactical definition of shock which was somebody who has been bleeding and now has

altered mental status or an absent or thready radial pulse.

If the person is in shock, using that definition, then you treat with Hextend®, a hetastarch colloid, and you only get 500 cc's, the thought being if you pump too much blood in there, then you may interfere with the hemostasis that is hopefully ongoing in the casualty at this point. Then you wait 30 minutes. If they're still in trouble, then you give them another 500 cc's and then you stop.

They also recommended that PO fluids were okay, even for somebody who was going to need surgery in a few hours because a dehydration is more of a problem than vomiting preoperatively.

So those were presented at the Committee, and the Committee acknowledged the expertise that went into developing these guidelines so that's what we've had, and we've continued to have sort of a relative lack of information coming in about this protocol.

And I want to give you a heads up about

a paper that is about to break that is going to be controversial to say the least. This was done at the University of Miami at Ryder, which the Army folks will know as the Level I Trauma Center that trains all the Army surgeons getting ready to go take care of our casualties in the war.

So they tested the TC3 Hextend® protocol prospectively in their emergency department. It's a large study: 1700 patients. There were some study design problems that I'll be glad to go into or not go into as the Board wishes. There are some study design issues that really make the efficacy that they thought they demonstrated questionable, even though they cut mortality in half.

Efficacy maybe is not well proved in this study; however, the issue of does it cause a clinical coagulopathy was pretty definitively put to rest. If you stick with the guidelines, you're not going to cause a coagulopathy from the hetastarch.

The second thing is, despite the

study design issues, the Level I Trauma Center emergency staff -- the emergency physicians and the trauma physicians -- looked at the data and said, okay, from now on, this is how we're doing fluid resuscitation.

So of civilian places that have looked at the military option for fluid resuscitation now, we have one that has done this study and has changed their standard of care to reflect what the military is doing.

So ISR, knowing that this was coming down the works or coming down the line, reconvened another of these large groups of experts on fluid resuscitation. This took place just last month -- well, 8, 9 January.

About 120 people, all over the world, the leaders in the field. People who have published extensively and have lots of different opinions about fluids and how they should be used.

Some of the take-home points. One was that there was no evidence that made it imperative, desirable for the military to change

from this hypertensive resuscitation with Hextend® strategy that I just outlined.

The second take-home point was, there was no, zero, support for the large volume crystalloid resuscitation that's still the standard of care in most hospitals other than Ryder.

The third thing was is that they really came down strongly for dried plasma studies. What's special about dried plasma? Well, in addition to the volume, they provide some assistance in coagulation so maybe you can help to stop the bleeding.

So next slide. So we looked at this slide in November. If you look at John Kelly's paper, which came out in 2008, 982 deaths of which about 230 were potentially preventable. 85 percent of those were hemorrhagic.

So next slide. Offered to you at that point that these were the research priorities identified by the Committee. And understand that it's -- the Board is kind of handicapped in this

area because they don't have the full context of the DoD research effort. Absolutely understand that.

However, I will just point out again that, you know, if you were looking to save American lives on the battlefield, this is where the money is: non-compressible hemorrhage control and damage control resuscitation. Now, this has come out over and over again. Everybody that I know and that deals with battlefield trauma care, I think would support this. Next slide.

Questions about that, before we move on to the last issue briefing?

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: Is there any data on the concern about brain swelling and TBI with fluid resuscitation?

DR. BUTLER: There absolutely is, and the TC3 guidelines say a couple of things about it. First is, it wasn't our primary purpose, but if you wish to not cause cerebral edema, then don't give a crystalloid, which most of the people

out there now are. And cerebral edema is not the TBI patient's friend as you know. So Hextend®, again, remains intravascular and does not go out and contribute to cerebral edema.

We also have a separate section for fluid resuscitation and TBI, which basically says that the rules for uncontrolled hemorrhage do not apply for TBI. In that situation you have to restore to a full radial pulse so that you will maintain your cerebral perfusion pressure. Thank you for catching that point.

DR. BULLOCK: If I could just come in on that point. I think that there had previously been concern that some of these low molecular weight Dextrin-based resuscitation strategies might cause worse coagulation in intercranial bleeding, but with Hextend® that doesn't seem to be borne out. So it seems that that's another push towards using that for TBI patients.

DR. BUTLER: Well, good. Just move on to this last issue. I wish the Board had the

chance to listen in to the Thursday worldwide video teleconferences where -- they're organized by the Joint Theater Trauma Service in cooperation with CENTCOM and they're -- every hospital that is involved with the care of these patients, multiple supporting organizations, all these people are on a worldwide video conference -- or teleconference every Thursday. And we discuss every patient and what happened to them at every hospital, what their wounds were, what was done for them, and how they're doing. It's an amazing process to see. So I do that on Thursdays.

And one of the things that occurred to me as I looked at these patient lists, week after week, is there are a lot of spinal fractures right now. A lot of spinal fractures. So we asked the Joint Theater Trauma System to take a look at that and put a number on that for us.

Next slide, please. So they did that. And in their review of casualties from July through December, 2009, there were 119 spinal fractures, mostly thoracic but some cervical, some

lumbar. That's a lot, and it's because of the acceleration, deceleration forces of these armored vehicles with the increasing explosive quantities that you're seeing in the IEDs.

So 119 spinal fractures, that's bad news. Worse news is 14 spinal cord injuries, people who can't move arms, legs or don't have a sensory function there.

So the question that we were not able to answer is: Did it occur during transport, or did it happen at the time of wounding? The system does not have the information to answer that question for us.

So we entertained at the last TC3 meeting after a working group headed by Dr. Holcomb, Don Jenkins from the Mayo Clinic and a number of other people. We came out with a proposed change that would spell out some techniques that people could use in a combat setting to prevent any of these spinal cord injuries from happening, if possible.

And I will tell you that the prehospital

-- once you get into the literature of prehospital spinal mobilization -- I will tell you the things that we think we know are not supported in the literature.

The 2009 Cochrane Review found that there was no good data to support the current standard of care, which is spinal mobilization according to various criteria. If the mechanism of injury is penetrating trauma -- there is a paper that just came out last month -- it documented worse outcomes from penetrating trauma after spinal mobilization.

So the Committee looked at all this and said, hey, we don't have a handle on this. We don't have enough data, the data is conflicting, we don't have a good agreement on what things ought to be done.

Next slide. And to put this in a tactical context, you're thinking, well, why not just immobilize? Why are we making a big deal out of it? There's a book by David Finkel called "The Good Soldiers." Anybody here look at this book at

all?

So it's an Army battalion in Iraq. On 29 March, 2008, this -- they had a Humvee convoy that was hit by an IED. The driver had shrapnel to his arms and his back. The passenger in the right front seat had a traumatic left arm amputation and penetrating head trauma. The person in the right rear seat had a traumatic hand amputation. The person in the left rear seat was decapitated. The person in the turret had catastrophic torso injuries. And as soon as this went off, they were taken under fire. So there's your tactical context.

Now, this is what the young men and women out there are having to deal with. You've got the possibility of secondary IEDs, RPG attacks following this, you know, it is a nightmare.

So the combat medics in the group said, look, until we have a better handle on this, we should not try to do anything that's going to take away from the tactical context.

So next slide. So about the best that

we can do is that we said to at least be aware of trying to maintain spinal alignment and blunt trauma casualties with -- if they have neck or back pain, and there it sits for the moment.

Next slide. So couple of young sailors enjoying a day at SEAL training.

(Laughter)

DR. BUTLER: I'll be glad to try to answer some questions for you. There are really more questions than answers in the spinal immobilization arena, but I wanted you all to know that was an area of concern for us. And, you know, we've taken our first run at it. And now we're in the middle of a tactical pause, and we're going to readdress it.

DR. LEDNAR: Questions for Dr. Butler?

DR. DICKEY: Dr. Butler, it's my understanding that the injuries -- there's an awful lot of the spinal injuries coming out of the IEDs, as you said. What kind of work are we doing to prevent the injuries even while you're working to figure out to immobilize them. We do one thing

and it gets -- it gets something better and then something else gets worse. Somebody -- one of my staff tells me these look a lot like ejection injuries, and that somebody should be looking at pilot ejection kinds of intervention.

DR. BUTLER: Right. So when I was in Afghanistan, this IED that hit this vehicle. We were driving around in Toyota Hiluxes with no armor at all. We would have all been blown to pieces.

So the injuries that we're now seeing are a measure of our -- this vehicle design success. We are now surviving these IED attacks where we wouldn't have previously.

Now trying to figure out the -- how to, from an engineering standpoint, prevent the injuries that we're seeing. We have not been involved with the vehicle engineering, but I will say that this has come up in other contexts and special operations, and we would be glad to steer them towards some of those people if the group were approached about that.

We have not been doing vehicle engineering, but we ran into this in special operations with high-impact, high-speed boats. If you have to chase those pirates in the open seas, you need a high-speed boat. And you get a Cigarette racer going about 80 knots in six-foot sees, it would beat you to death.

And so some engineering solutions were approached, and that context that may work here. There are sort of a shock-absorbing systems that could be designed for those seats but obviously expensive and, you know, trying to figure out the risk benefit.

DR. LEDNAR: General Gamble?

BG GAMBLE: Sir, just a comment for the Board and to echo Dr. Butler's comment on the value of the Joint Trauma Registry VTC on Thursdays, it really is a critical piece to point together information from across the spectrum of care to really, in the short period of time, change the clinical practice guidelines and the care standards for those wounded in theater.

Another good example is, as we discussed before, was on the burn care management, which was another product of the Joint Theater Trauma Registry VTC. That was an anecdote, an observation by people across the spectrum that came together to really develop better management of care for our wounded. In fact, Dr. Don Trunkey, who I'm sure many of you know, really has espoused this as being one of the highlights and most forward-thinking advancements for medical care in this theater. Thank you.

DR. LEDNAR: Dr. Silva?

DR. SILVA: Silva. Thank you, Frank, for a nice presentation. I know for the sake of time you had to go through that last slide. Potential is I'm going to look at it in the future, but do you have a 30-second sound bite about truncal tourniquets?

DR. BUTLER: So the concept of a truncal tourniquet -- and there's two applications. If you read Ken Mattox's paper from some months ago, it was a thing called "Leaky Buckets." Very

interesting perspective for noncompressible hemorrhage.

So if you're bleeding from your neck, we can get combat gauze on. If you're bleeding from your leg, we can get a tourniquet on. We've got it. We can take care of those kind of hemorrhages. It's the people who are shot in the belly.

So there are some things that you could do. What if, you had an encircling band and you raised the intra-abdominal pressure so that the transluminal pressure was reduced. Would that help? Would it cause more problems? Would it interfere with their respiration? Complex.

There is -- and we have actually taken a look at the T-POD. One of the sources of torso hemorrhage is an unstable pelvic fracture. So using -- there's an external binding device called a T-POD which will reapproximate the pelvis and is advertised to reduce the bleeding. The Committee looked at that and decided they weren't impressed with the evidence for the T-POD.

The last thing that's just come down the road -- it was demonstrated to the Committee in Denver -- for wounds of the groin, the people -- Richard Schwartz, who is the Chair of the Department of Emergency Medicine at the Medical College of Georgia, had developed a device which compresses the abdominal aorta. In the area of the bifurcation, you crank that down, and it has been demonstrated in animal models to stop high femoral bleeding.

Again, you have the issues of what are the secondary problems that this sort of an approach might create. So we absolutely are looking at it and, you know, watching the technology develop in this area.

Is that enough, Dr. Silva, or were there some other specific things?

DR. SILVA: No. Thank you. I am aware of that in old-time (inaudible) practices, they were having some devastating hemorrhages. And there was some data on that. I think it was just a block of wood and some very strong rope which

they cranked down like a tourniquet. That was a last-minute effort to save someone.

DR. BUTLER: Well, you know, MAS trousers are an area -- and if you ever want to start a fight at the TC3 Committee, just show up and talk about MAS trousers in any context.

(Laughter)

DR. LEDNAR: Colonel and then Dr. Poland.

COL GRINKENMEYER: Yes, sir, Colonel Grinkenmeyer from the AFIP. We have -- we do autopsies, as you may know, on all the casualties that come from Afghanistan and Iraq. And we have advised, and some changes have been made in the vehicles that are being used based off of some of our autopsy studies.

And also on the hemostatic agents, we're able to look at some of these different granular products and QuickClot® and that sort of thing and evaluate it on what we see in the aftermath on those.

So there are some novel unique things

that we're looking at the AFIP with all the autopsies that we're doing to advise them to try to make changes on what's being done in the field.

We -- for example, as long as they leave the body armor on and we do an autopsy, we do CT scans of the entire decedent. And we can look at the body armor and evaluate the effectiveness of that and what should be changed about body armor, et cetera. I just wanted to make that comment.

DR. BUTLER: We are incredibly grateful for the ongoing support from the AFIP. We have interacted with them a number of times; and most recently last week, I sent out to the TC3 distribution group a picture of a tracheal -- it's a surgical airway device where the autopsy was done, and it was found not to be in the airway so it doesn't do much good if it's in other fascial planes.

So, you know, AFIP -- Dr. Harkey came and showed us a -- two pictures actually of needle decompressions, for tension pneumothoraxes that were attempted with 2-inch needles, and the plural

space was here and the 2-inch needle stopped there. So these two people died. So now we're using three-and-a-quarter-inch needles which he, through follow-up CT autopsy imaging, demonstrated will work and reach the plural space of 99 percent of the population -- of the military population, which is different from the civilian population. So thank you, thank you.

DR. LEDNAR: Dr. Poland?

DR. POLAND: The Colonel's comment was the perfect segue to what I wanted to say and that is in medicine, we have traditional and time-honored ways of sharing knowledge but those are sometimes slow ways. So the example talked about, you know, the Corpsman doesn't know what the internist knows, the internist doesn't know what the ISR knows, the ISR may or may not know what AFIP knows.

And it's a way of saying that there are ways; for example, on the tactical operation's side. I'm very familiar with -- the Marine Corps has a Center for Lessons Learned. I think the

Army has a similar center, but I'm not sure about the other services. But they do detailed reviews of basically every MEU that comes back.

There's detailed after-action reports, thousands of pages of transcripts are generated and distilled into lessons learned which then become a part of doctorate.

Is there a place for us to start thinking about knitting together some of the components -- you have the ISR, the AFIP, the TC3, et cetera -- into some formal aspect of a center for lessons learned where these questions could be raised where, what the Army knows, the Navy would now know and, et cetera, through the Services.

DR. BUTLER: That's a beautiful question. Two-part answer. The first is both the ISR and the Navy Medical Lessons Learned Center have a quarterly newsletter, and it is a -- their newsletters have a much broader scope than just tactical trauma care. But for the articles that deal with tactical trauma care -- I write the articles for both of those newsletters every

quarter -- and we do -- in fact, you guys just wrote my article for the next quarter, thank you. The burn care item will be featured.

The second thing is when we come to the TC3 meetings, we need for the group to have a common knowledge base. So everybody who has ever requested -- and that includes about a thousand people now -- we'd be glad to add the Board to this list. We do a systematic search of the literature using key search terms every month and identify the things that might change the way that we do business and send those articles out to the TC3 interest group.

So, please, if Core Board members or other guests have an interest in being included in that, I would be honored to do that.

DR. LEDNAR: For the Board, Dr. Butler, thank you for the additional information you shared with us today.

(Applause)

DR. LEDNAR: I think as we reflect on what Dr. Butler has done with us in the last 15

minutes, several points come to my mind; one is, rapidly, regularly, sharing experience globally, the Thursday telephone calls.

As we learn together, always asking, is the way we approached things in the past still the best way to go forward? And if not, what's the information we need to be scientifically rigorous to suggest that some other way is better. Look at data. Use research design. Really build a critical evidence set. Don't expect the world to stay still.

The types of injuries that will occur over time may, in fact, change as we get better at vehicle design and other kinds of personal protective equipment. So always thinking and always bringing good science to bear and then not taking a decade to produce the fix. So I think that's a dynamic, Dr. Butler.

Thank you for showing us the -- not only is it important, but it can be done, so thank you for that.

(Applause)

DR. LEDNAR: What we'll do now is take a break for lunch. An administrative session will be held over a catered working lunch right next door, beginning just a few minutes after we adjourn.

Ex-officio members, service liaisons, DHB staff, and the Core Board are welcome to join us. Distinguished guests and speakers are welcome to join us as well. For other attendees, please consider the several options that Commander Feeks mentioned to us earlier.

We will reconvene in this room for our afternoon session starting at 1:45.

So we'll look forward to seeing you at 1:45. Thank you.

CDR FEEKS: A quick clarification. That's for lunch. Board members not just Core Board members are welcome to join us for lunch.

(Recess)

DR. LEDNAR: Let's reconvene for our afternoon session on a really very important and serious topic that Colonel Joanne McPherson is

going to brief us about.

Colonel McPherson is the Executive Secretary of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces. This Task Force is an activity of the Defense Health Board.

Prior to this recent appointment, Colonel McPherson served as the Chief Financial Officer for the Air Force Medical Service, big job, and was responsible for the execution -- I'll say management rather than execution -- of a $5.1 billion annual budget supporting 74 military treatment facilities and 2.6 million beneficiaries throughout the world.

Colonel McPherson also served as the key fiscal advisor to the Air Force Surgeon General and major command for medical staff on all Air Force financial matters. She had some specific responsibility for financial statement preparation and audit readiness for the Air Force Medical Services in supporting Defense Health Program budget submissions and prepare the Air Force

Surgeon General and Deputy Surgeon to represent Air Force Medical Service financial matters appearing before the Senior Military Medical Advisory Council, Congress, or the Chief of Staff of the U.S. Air Force.

Colonel McPherson's presentation slides may be found under Tab 6 of your binder. Colonel McPherson, thank you.

Col MCPHERSON: Can you hear? Is that on? Yes. Working off of our lunchtime discussion on our friends at DTS. So there I was on Sunday evening after the great snow. I had just shoveled myself out of 27 inches on my driveway and my corner parking lot. The nice widowed lady next to us could hardly lift her hands anymore. Had gone into the Superbowl, canceling out of every party because we were too exhausted, only to find that a new Army family had not gotten their power back on.

Although most of us had been out all day Saturday and chunks of Sunday, at 6 p.m., they still had no power, and it was 45 degrees in their

house. So I invited them over, and we had a Superbowl party at our house.

And at 11 o'clock at night, I thought, well, I'll just double check. The airport is supposed to open at noon, and I have a noon flight, I should be safe for my trip down south to work on the Task Force and found out that even though the airport opens at noon, no noon flights were going out.

So after three hours on hold with the CTO people, I will have to tell you they were extremely friendly, and 2:00 in the morning, I was able to rebook myself onto my flight at 2:45 and spend the entire week working down in South Carolina when the rest of D.C. had off. I still can't quite figure out how I managed to do that. But the DTS people are very friendly, and you can do anything with those flights once you book them through.

So the reason I left town that day was to go ahead and start the very first of our Task Force site visits as the Task Force has taken off

in travel.

So what I'd like to do is give you a quick update on some of the issues and things that we've been working on. I first spoke to you in November about six days after I had come on to the Task Force and had just at that point been able to not speak very well, I think, to the issues.

I hope I -- if you have any questions, I can certainly help you this time after three months in the seat, four months in the seat. I think I've learned quite a bit, but I ask your indulgence.

Quick overview. I'll touch on the Task Force membership -- just to remind you since it has been three and a half months since we've been here -- and the questions that we are to address, the December and January summaries, a little bit of what we've been doing on our Task Force visits in February, and where our plans ahead are at this point in time.

All right. General Volpe. Since the time that we've last met, General Volpe has PCS'ed

from the number to a JTF CAPMED to take over the regional headquarters for the Army in Washington State. So he has been on the road pretty much the whole month of February PCS'ing. On a peril is with the Task organization, and then we have a variety of folks up there that I think some of you will recognize, certainly they are clearly experts in suicide prevention suicidology, our own Dr. Certain.

And then we do have in the enlisted force, we have a personnel enlisted in the Air Force and a couple of Marine Corps enlisted by a gentleman who been very great to work with as we go from base to base; especially, since our original -- our starting visits have been with the Marine Corps.

There's a whole list of questions here, but in general terms they fall into about three general categories: trends and common causal factors in suicides, an assessment of the current services suicide education prevention programs, what are the MOSs or the Air Force specialty code,

the AFCs that are most affected, and then just about everything after that has to deal with how suicides are investigated and reported. The general issues surrounding that is that depending on whether the suicide occurred on base, off base, or if it's Army, Navy, or Marine Corps.

A host of other chapters. The amount of data and how quickly the data is gathered and the results come out, and who gets the results are issues of concern to DoD and to Congress.

And as I understand it some of the concerns relate to the fact that it's a very, of course, unpleasant and emotional event when something like this happens. You may very well have your son who's newly married to a young lady who's now the next of kin. And technically then, the parents have no next-of-kin rights to know what happened to their son.

And these are some of the issues we're trying to tackle. Additionally, it does sometimes take a very long time for the results to get back to the family members.

And, again, depending on where it occurred and how the investigation is done, you tend to get different answers. We're working with the Army Task Force and DCoE and some other folks as to what is a better way to pull this together so that we have consistent information in a timely manner available to the family members who are concerned about what happened.

Next, please. And again, the rest of these all deal with investigations and who conducts the investigations and the timing of them.

So on December 14th, we tried to come up with a bit of a theme to some of the meetings so that folks could wrap their brains around what was happening.

And so our theme in December was investigations. And this was actually a very good meeting. We had the Army STARRS, Dr. Ursano came, we had the Army CID folks, the Air Force OSI, NCIS.

We also had the -- what's missing off of

the slide is we also had the Air Force Safety Center and the Air Force JAGs come in brief on the accident investigation boards and the safety investigation boards processes, both of which the aircraft investigation processes considered a model for excellent investigation with the goal being to prevent the next one from happening. And so clearly the Task Force is looking at that to determine if that might be a model for suicide investigations in the future.

Next slide. In January, we tagged on at the end of the DoD/VA conference that was held in Washington, D.C., that we finished up with two more briefings related to investigations, that now we walked away from and came over to the medical side. And we talked with Dr. Rake on the root cause analysis.

And then we had already heard, prior to my coming on board from the Armed Forces Institute of Pathology, but we went into very specific questions on the actual autopsy process and how that was formed into psychological autopsies.

And then we went into some of the research studies that are going on and the information that is available, again, some of these through the Army Task Force.

So the MHAT VI study, the army studies program over all, the RAND study which is about to -- the results are in at the Army, and we're waiting for them to come out publicly.

And then we had a Service member panel discussion with surviving folks who had attempted suicide but had not been successful but had gone on to have successful military careers. In November we have had that with several females, and in January we had some males.

Next slide. Where we are right now is February, March, and April are set up to be traveling pretty much every other week as we go across to all four Services and visit three to four installations on each. So Camp Lejeune and Norfolk Navy Base and Portsmouth Navy Hospital in February.

The slides -- oh, so we were to do that.

I'm sorry. We were to come back and meet in Norfolk and have a full Task Force meeting. And we were unable to do that. That was, again, the week of the big snow. And so those of us who made it out of town were able to conduct the Task Force site visits. But we were unable to get ourselves into Norfolk because five of our six speakers were out of the Mid-Atlantic area, and the sixth speaker was out of Michigan. And there was not one airport that any of those speakers could access that would get them to a Task Force meeting.

So what we've done is taking -- much of what we should have done in Norfolk on the second week of February, moved it to the second week of March down in San Antonio.

Next slide. So the time these slides were turned in, the February 22nd through 26th visits were future. We have since conducted those. It was at Beaufort, and Parris Island this past week, and another team was out at King's Bay.

We are looking at Fort Bliss, Lackland,

and then a Task Force meeting, again the second week in San Antonio. There's also now visits for the third week in March at Fort Benning and several other areas in the central part of the country.

Then we will have another Task Force meeting in Colorado Springs where we're rolling in. Carson was unable to host us so we are looking to work with some of the Guard and Reserve Units in the Colorado Springs area because it's been brought very forcefully to our attention that the Guard and Reserves really are tackling some very difficult issues that we think it's difficult on the active duty side to get our arms around. What is going on and how to best do the education and prevention and the resiliency building for the folks out there who are in distress due to multiple stressors.

The Guard and Reserve where they are -- don't have these people on active duty and, you know, perhaps can't even send them downtown because that person may not have another job plus

does not have enough health insurance.

You have commander-directed issues that you are having much less flexibility on as you try to work to get your Guard and Reservist care.

So in the March meeting we are looking to, again, bring over some of the folks that were going to speak to us in February, specifically the Guard, the Reserves, the Coast Guard.

We also had lined up several apparently very successful civilian programs that have some evidence behind them as to their success. We will probably hold those a little bit longer and continue to get some research.

I know we're going to be working with the Air Force as well in San Antonio in their briefing that they're giving to the full Task Force on the 11th of March.

Next slide. That is a short overview. I could entertain questions you might have. Suggestions certainly.

DR. LEDNAR: Are there any questions for Colonel McPherson and the work of the Task Force?

I'd ask you to please use the microphone. If you'd please start by mentioning your name, it would be very helpful to the transcriptionist.

Are there any questions? Dr. Parisi.

DR. PARISI: Joe Parisi. Thanks for your report. Two quick questions. How many of you go on these -- one of these reviews? And also is the data automated? Do you have a registry of these patients that you're capturing?

Col MCPHERSON: I'm sorry, could you repeat the second -- the registry of --

DR. PARISI: Do you have a registry of the patients?

Col MCPHERSON: We're not specifically -- oh to the ones that we talked to who attempted suicide but survived?

DR. PARISI: Both the survivors and the nonsurvivors.

Col MCPHERSON: We -- the number who go on the Task Force trips is about six. Working around the Task Force members' schedules, which are very full, given their very high caliber. We

are building the Task Force trips around a variety of their clinical backgrounds and their other backgrounds trying to have at least one of the enlisted guys with us when we go, an 06 or above with us when we go and then a cross section of the clinicians when we go so that we can do a full range of questions.

We do have certainly a list of the folks that we have talked to who are suicide attempters and survivors. We have been working with them, and some of the folks actually keep in touch with them. The girls especially.

The other ones have -- for example, one of the males that we talked to has basically made it some of his life's work to go out and publicize that you can be in this kind of a depressed state and make this kind of attempt and get the help that you need and continue your career, and in this case in the Army. He's actually since been promoted as an officer.

So I do have that list there for the -- we are pulling the data from AFME and the DoD

SERVE on the suicides that have occurred over the last year or two. I believe the Task Force is trying to look.

One of the issues that's come up is, what year were these people assessed into the Armed Services. Although there is certainly the 17- to 24-year-old age range that is most prone to do this. Are there some issues or were there some standards changes when they were assessed that perhaps they had -- a waiver was provided.

Anecdotally, we've heard both sides that, yes, the standards were lowered a little bit, or we've also heard that the waivers just vary a bit in kind but not necessarily in number or in severity. And so we are pulling that data for the Task Force.

DR. LEDNAR: Dr. Mason and then Dr. Luepker.

DR. MASON: Tom Mason, University of South Florida. If I could, you have two slides that refer to questions to be addressed by the Task Force, and if I could just point you to the

ones where it says the required information to be determined by an investigation in order to determine the causes and factors surrounding suicides by members of the Armed Forces.

Can you give us a sense of what information is presently being collected or when we might hear from you in terms of recommendations as to information data elements that arguably should be collected, prospectively and retrospectively, among those individuals who've attempted suicide and among surviving family members of those who have succeeded in committing suicide.

Col MCPHERSON: Sir, I am not sure of all the pieces that are in the DoD SERVE data, that is where most of it's coming from. I know that a lot of our time has been spent on determining whether or not investigating whether or not a psychological autopsy should be done on each successful suicide. I understand that it's, give or take, $250 an hour. Somebody has priced it out, I think the Army has done that. I do

sense that the Task Force is very interested in having that done. And apparently at one point in the past perhaps that was done on every suicide.

I will -- in June, I can brief on what the elements of the DoD SERVE are that are being pulled together, and I don't know that I will be able to give a recommendation yet from the Task Force; but, certainly, we'll have that for you at our July briefing.

DR. MASON: Thank you very much. One of the things that I would encourage as you have these discussions is that there are data that are starting to come together which make a strong argument for we need to pay attention at the front end in terms of suicide ideation as adolescents.

And some of the factors that are associated with suicide ideation -- and I'm just not talking about acne medications -- that we need to pay attention to in terms of pre -- if you will -- enlistment and certainly precommissional.

And that some of these issues -- I'm not looking for a recommendation, I'm just sort of

looking for a timeline because, you know, these issues go way beyond, way beyond just simply capturing the information that's readily available.

And I would be the last one to argue against that particular autopsy, but first argue for the fact that I'm willing to vet -- we collectively -- and I'm just -- I'm talking just about uniforms, anybody who is interested in suicide, is that we have yet to really figure out exactly what we should be paying attention to when and how best to anticipate persons and intervene in a very early stage.

Col MCPHERSON: Yes, sir. I know that there is much talk in the Task Force about collecting data on the ideations and the gestures for the active duty folks. And numerous people have brought up the issue of moving further back in time, and before the folks came on active duty, what sort of backgrounds are we seeing.

I believe that the Army Task Force, Dr. Cox, through a database he is establishing, is --

that's on the to-do list. I don't believe it's going to be in the next year or two, but once he gets this database built that has as much data in there as he can, and they try to do start beginning their predictive analyses.

And I do believe that they are talking about trying to step further back in time to the prior coming on to active duty for exactly the issue you brought up.

DR. MASON: Thank you very much.

DR. LEDNAR: Dr. Luepker?

DR. LUEPKER: Yes. Russell Luepker. You know, perhaps you've mentioned this and I just missed it. You did say that you are planning to look at Reserve and Guard suicides, but isn't a large part of the question people who have been discharged and is -- are you looking at this group of people, or is the VA looking at this group of people? Those are the ones that seem to hit the newspaper more commonly than active duty people.

Col MCPHERSON: Yes, sir. That is one of the larger issues. My thoughts right now are

that there are going to be in the report several areas that we recommend be further investigated that we simply can't get to. And quite truthfully, the whole Guard and Reserve issue will be -- I think will be part of that because there are so many issues they're trying to tackle.

One of the concerns is that after 120 days, once you come off active duty for good or for temporarily, as you are in the Guard and Reserve, you fall out of the system in terms of what DoD tasks.

One of our -- the Chief on the Task Force is actually their first personnel for life that he indicates that there must -- he believes there is way to keep track of these people because at age 60, should they stay in the system, they will draw a paycheck. So somebody knows where they are and that there would be a way to track them. We just have to figure out how to do it. But they don't fall out of the system and disappear. They're just in some sort of not-looked-at status during that time frame.

Yes, we have Dr. Jen Kemp from the VA with us, and we're very concerned about that whole piece that you talk about because as you are probably very well aware, a lot of the issues and the troubles do not arise immediately upon deployment but months and months afterwards.

DR. LUEPKER: Thank you.

DR. LEDNAR: Other questions for Colonel McPherson?

Col MCPHERSON: Does Dr. Certain want to add -- I mean, since he's on our Task Force.

DR. LEDNAR: Dr. Certain?

DR. CERTAIN: The other issue that we have out there with veterans is that there's -- it may or may not be reported to us by county coroners. That question may not be asked if somebody commits suicide as a veteran; and even if they do, they may or may not report it up chain to the service that they were a veteran for. And so the civilian suicides out there that are completed by veterans are outside the reporting processes.

As you know, the CDC does not -- is not

able to get a complete year to us for about three years after it's over because the states are slow to report to CDC and get to us. So we don't have a good way of -- at this point -- of knowing what's out there. And I would hope that the Task Force will add that to our recommendations to try to speed up the reporting data out of the communities and to get some kind of standard form of collection of information so that we can more readily identify the veteran population.

But this Task Force is limited to active duty members of the Armed Forces largely, so the Guard and Reserve, while they are on active duty, is what falls into this parameter. And we have to rely upon the Army in its continuing work and the Marine Corps and its continuing work since those are the two Services that are most affected to continue to watch after their members while they are not currently on active duty and to identify the stressors that seem to be in the theme work of leading towards suicide.

But it's a big issue, and this Task

Force clearly isn't going to live long enough to get our arms completely wrapped around it where our hope is that we can at least answer some of the questions on these two slides so that the ongoing suicide prevention folks in the services can focus their work perhaps a little better.

DR. LEDNAR: Dr. Parkinson, Colonel, and then Dr. Poland. Dr. Parkinson?

DR. PARKINSON: Yes, thanks, Wayne. Mike Parkinson. You know, Joanne knows this well because Colonel Litts is on her Task Force, but probably one of the best systematic efforts to look at this, that I was aware of, the military got us involved with it, was under General Fogleman, and we took about a year, year and a half, to -- actually lifted a CDC community prevention model and used it as the analyzing structure to kind of go through this problem block by block. And I think that model, what you're going to probably brush off again and look at it with a lot of diligence, is still very much valid.

And where we tend to fall down,

unfortunately, is uniform execution policies that actually were early on showing to mitigate -- at least be correlated with mitigation the Air Force suicide rate.

But if I ask myself one of the three things since 1997, which is when I think we did this, 97, 98, the first time we saw a blip in Air Force suicides.

There's probably three things that I think are new, and you talked about one of them. One of them is, I think, is our clinical or medical awareness of the long lasting effects of pediatric psychological trauma. I don't think we knew that 13 years ago what we do today, and that is emerging and showing a variety of different ways that it plays out. So I think that's something that we can talk about.

The other thing clearly was the impact of constant three, four, five times deployments, 24/7 readiness, and we were just beginning to get into this notion of, you know, a mobile Air Force with people to unravel things. That's changed

dramatically. That's something to look at it.

Another thing is what I see in the civilian sector is an absolute over-medicalization of this problem. I don't see a company in America where the number one and number two prescription drug is an antidepressant or anxiolytic. We have medicalized this to the point that most people are on some type of psychoactive drug. So employers all the time will say to me, we have an epidemic of depression. I said, partly right. We have an epidemic of antidepressant prescribing. There is not really a depression epidemic. What we've got to do is get coping and resiliency.

So the last thing is this whole notion of individual family community unit resiliency which is really the key, and that's flip side of some the other things we've talked about here, that is the immunization, if you will, the antidote.

How do you train to resiliency in people who, through no fault of their own, had pediatric psychological trauma or were abused or -- so there

has to be something beyond what we did 13 years ago, beyond executing the policies well. I think you'll find that too. When you find it, you should call it out and say, You know, we have a good policy, didn't follow through. Because that's what we need to hear, I mean, I think we need to know.

Col MCPHERSON: My understanding is that the Air Force program was supposed to be promulgated DoD-wide and that there was a DoD construction started on it. I don't know that that actually got finished. I just heard that the other day, so we'll be hunting that down to see if that actually did happen.

DR. LEDNAR: Colonel?

COL JAFFIN: Jon Jaffin, J-a-f-f-i-n. I'm speaking as -- having been a member of the Army Suicide Prevention Task Force for the past year, and many of Dr. Parkinson's comments we found to be very true.

One, it is very hard, even when somebody in the Guard and Reserve just not actively serving

at the time, working with local police departments and things like that to get the information. And even then, we aren't sure.

We've started pushing much harder to get the epidemiologic information on suicides that occur not on active duty, and suicides that occur at the time of transition, whether to leaving service, going off active duty, or whatever because those clearly are major stress periods. It's hard. It's a very multifactorial thing.

We are seeing huge numbers of -- especially SSRIs -- prescriptions being written. The added suicidal ideation that goes often with those may or may not be associated with completed suicides, but they're definitively a suicidal ideation trying to get a better screening tool for soldiers for the MEPS stations. And not just soldiers but any service member at the MEPS station because, again, it -- these usually don't spring de novo, but there are precursors and predictors, but it's hard to figure that out in a -- I mean, I jokingly tell people that when I came

on active duty, I was having my MEPS physical in 1977. The extent of the psychological evaluation is to be called in a room and asked, Are you normal?

(Laughter)

COL JAFFIN: Typical wise-ass college kid, I asked him what "normal" meant. He asked me if I liked girls. I told I did, and I was fit to serve.

(Laughter)

COL JAFFIN: So far he was actually a better predictor, I haven't done any of those things to get in trouble. But the other thing that we found to build on the multiple deployments is especially in the Army. We deploy them for a year, often breaking or stretching family bonds during that year, 15 months, 16 months, 18 months depending on how long and how much training.

When they come home, we then scatter the unit so we break the bonds that they've build in that time period while they were away. And so the ones who are at risk are the ones who don't have

strong bonds to anything or anybody. And so that's another area where we've been struggling with the OPTEMPO in trying to break it. Thank you for allowing me to comment.

Col MCPHERSON: I would just add that when we're doing our site visits, we are asking to meet with junior enlisted, senior enlisted, middle enlisted and young officers, and then the very senior staff on the base. We are also meeting with chaplains and the other support staff as well as the medics.

And we're also meeting with the spouses. We ask for a number of spouses, and, by golly, those ladies are very vocal in what they see and what they think and what information they wished they had. And the things that they're wrestling with is when they see something in their soldier or their marine and how do they deal with that and who do they turn to, and is it going to hurt their career. But they're certainly the ones who know whether or not somebody is hiding something, when they go to the medics, and clearly they report

that everything is just fine.

DR. CERTAIN: And the other one category you slipped past was said -- we also -- they asked for people who have been deployed and returned and those who have not been deployed because suicides are almost as prevalent amongst the never deployed as they are most that deploy.

DR. LEDNAR: First Dr. Poland and then Captain Cowan.

DR. POLAND: Greg Poland. I just had a quick question and that is if we have anything to learn from our British and Canadian liaisons and any programs that are sort of bubbling up on your ends, and are you experiencing the same sorts of issues that we are in the U.S.?

CAPT COWAN: Thank you. I only work part of my time at the Department of Veterans Affairs so I have the privilege of looking at both sides of the issue. I was looking at some data that the VA produced; and what's staggering, frankly, is that those in the VA who are actually in VA health care and who have a mental health

diagnosis -- I just dug it out of my notes -- are 42.8 per 100,000. They're almost double the risk of those on active duty.

There are all these pockets of people who are clearly out there at nonactive duty but clearly represent a much greater risk than those who we often focus greater on. And the VA are all up to that.

To answer your questions specifically, we have an organization in the U.K. called the Defense Analytical Statistics Agency. And it's they who collect the standardized data for suicides and stuff like that. And I share that with both my duty colleagues and my VA colleagues once a year.

And to answer your question, yes, we are seeing the same issue, but it's not to the same extent or the same depth. But it's significant enough to attract a lot of attention, and we're doing much the same sort of things as you are to try and get to the heart of it.

CDR SLAUNWHITE: Hello. Commander Cathy

Slaunwhite. In Canada there was a suggestion about two years ago that our suicide rates were going up very significantly. When that was checked into further, the data was military police reported. Suspicious deaths rather than confirmed suicide deaths.

In fact, in Canada in the last two years our rates of suicide seemed to have gone down amongst active duties. So I think we are well below the 10 per 100,000 agents, actually adjusted, which I think is what the number, the norm would be in Canada.

And I don't think we're certain why the rates have gone down, but we've had a very big focus on improving mental health services in the CF and have had very high-profile individuals, I think as your campaigns have had as well.

People like General Romeo Dallaire, who lost Belgian troops in Rwanda, speaking about personal struggle publicly with mental health conditions.

So I'm not sure if our activities result

in the lower numbers. The one area we are watching just now is looking for suicide deaths linked with physical injury on deployment. And there's one Quebec-based soldier who, I think, had a partial amputation of a foot; and nine months after returning home was lost to a death by suicide. So I think that's one of our watchful areas, those in rehabilitation for physical injuries, looking to see if they are a more vulnerable population.

GEN (ret) MYERS: Dick Myers. This question is Colonel McPherson. When you say you meet with these young enlisted, seniors, and so forth, I assume there's nobody from the command there present?

Col MCPHERSON: Yes, sir. We've had -- only one instance -- I think there was intentionally a commander representative in the room and we asked him to leave. Otherwise -- just inadvertently sometimes had our escort in there and we asked them to leave too. So it's completely anonymous. We talked to them about

that. We have one of our senior dudes enlisted to pound that home. And we think we've had some pretty frank and open discussions about that.

DR. LEDNAR: Colonel McPherson, can you just share what's ahead in terms of time table and when the Board can expect to hear a little bit more about what you're learning.

Col MCPHERSON: We will go ahead and hopefully conclude our site visits by the end of April. At this point it's pretty an off-week, on-week, off-week, on-week travel schedule for two teams at any point in time. With 6 people and only total 14 on the Task Force, that pretty much covers everyone out on the road seeing multiple sites at the same time.

At the end of April, then we have in May we have scheduled some multiple days, sort of locked into a room to lay down what we think is going to be at least the framework for the report. We've actually started that. We work with them.

Almost every time we have a public meeting, we have a complete day with just the Task

Force members as we sit down and try to structure what we think the report is going to look like, where they think it's going to fall.

So then in May, the very hard bragging starts. Hopefully in June at your next meeting, I can provide a bit of an update and have hopefully General Volpe with us since we actually overlap. So we should be in town the same days that you are and perhaps can provide a quick glimpse as to what the recommendations are going to be, and then the full report in July. And then the -- up to SECDEF on the 6th of August. Is that enough detail?

DR. LEDNAR: That's good. Thank you. So what that means for the Board is as we talked about this morning in our administrative session, we may be looking for a date in the first three weeks of July to basically be available to Colonel McPherson and the Task Force to hear about the report because they do have a due out to Congress in August.

So as an activity of the Defense Health Board, it's important that we understand their

work, and we will be expected to take a position on it before it goes to Congress.

Any other questions on the support work that Colonel McPherson and her Task Force are leading? If not, thank you for the work you're doing, and we look forward to what lessons you have for us as you know them.

Col MCPHERSON: Thank you very much for your support.

DR. LEDNAR: Thanks, Colonel McPherson. Thank you.

(Applause)

DR. LEDNAR: Our next speaker is Lieutenant Colonel Philip Gould. Colonel Gould is Chief of Preventive Medicine Operations at the Air Force Medical Support Agency, Office of the Air Force Surgeon General, where is principal focus is immunization policy development.

In addition to serving on the Defense Health Board as a service liaison officer, he also serves as Chair of the Joint Preventive Medicine Policy Group which encourages cross-Service

discussion of key preventive medicine and public health issues.

Colonel Gould is board certified by both the American Board of Family Medicine and the American Board of Preventive Medicine.

His prior positions include lead epidemiologist for the DoD Global Influenza and Respiratory Virus Surveillance Program and serving as the Air Force representative to the Military Infectious Disease Research Program.

The Board would like to congratulate Lieutenant Colonel Gould on his recent selection for promotion to full colonel effective May of 2011. So let's please congratulate Colonel Gould.

(Applause)

DR. LEDNAR: Colonel Gould in his brief will be providing us an information brief, back brief, regarding the recent Joint Preventive Medicine Policy Group response to the Defense Health Board's recommendations issued in September of 2009 regarding pandemic influenza preparedness and response in DoD.

Colonel Gould's presentation slides may be found under Tab 10 of the meeting binder. Colonel Gould?

Lt Col GOULD: Ladies and gentleman, distinguished guests. The Joint Preventive Medicine Policy Group was asked to review the recommendations of the Defense Health Board to present to the Force Health Protection Council this past month, which we did. And there were no major issues raised at that time; however, they did discuss financial issues which were outside of the scope of this particular review.

Next slide? The Defense Health Board recommendations fell into approximately six different categories, and as you mentioned they were issued on September 11th of 2009. And these categories are listed there. And we'll go through each one of them and the recommendations that fell under that and what the Department of Defense is doing.

I will not claim that this is a comprehensive list; it is what those members of

the Joint Preventive Medicine Policy Group were aware of. These are some initiatives going on right now related to some White House initiatives that may result in newer technologies or newer developments for vaccines, et cetera, but those are as of yet in a working status.

Next slide. So the first two recommendations were related to the use of antivirals, and there were some efforts, of course, to reemphasize that there are select groups within the military that might benefit from the use of antivirals for peripheral access, such as recruits and deployed forces and so forth.

However, given the nature of the current pandemic, H1N1, being a relatively mild disease, even if there are a large number of people becoming ill, the DoD is largely following the current CDC and FDA recommendations. Also the current DoD stockpiling approach is following the national and international standards through the WHO international organizations as well.

We have been able to achieve additional

funding for antivirals as well as personal protective equipment. And those we now have are much more expanded available antivirals to most MTFs and in addition to including Relenza® approximately 1 percent of PAR in addition to the 30 percent of the PAR for oseltamivir.

Next slide, please. The Defense Health Board recommendations recognize that the DoD is an important and integral partner in surveillance for influenza worldwide. And two DoD laboratories were the first to identify H1N1 in the world: the NHRC laboratory in San Diego -- Naval Health Research Center -- and the USAFSAM or U.S. Air Force School of Aerospace Medicine laboratory in San Antonio.

The next two. So I think that shows our importance to the international as well national effort for influenza surveillance. NHRC has expanded laboratory testing capacity by approximately 3 to 5 percent, and it has now tested over 15,000 specimens. The School of Aerospace Medicine has expanded by 68 times and

has tested well over 24,000 specimens.

And pretty much, we've got over 500 different locations, and nearly all locations that have some DoD presence have submitted specimens to one or both of these laboratories. And some of those locations may be floating platforms in the Navy, but there are also specific locations.

Additionally, this says three Army MEDCENs. There are also seven MEDCENs that are going to be -- that could go forward and start testing right now once the assay becomes FDA approved. And there are also two NEPMUs on both coasts that are doing testing there.

Next slide, please? One somewhat curious recommendation was a request that we have a testing algorithm. The DoD has actually had a testing algorithm for quite some time, and that's sort of the bullet number one under the testing algorithm. And that was expanded in the SARS outbreak in 2003 to expand that to those people who are hospitalized as well as those who were antiviral resistant. And in this particular

outbreak, we've expanded it to also include case clusters of five or more in high-risk groups, such as deployed or trainees.

The School of Aerospace Medicine is also now at about -- not quite 100 percent but close -- 100 percent of all of the specimens that had the HA region of the hemagglutinin gene sequenced. And not only have they been sequenced; but, routinely interesting, three-dimensional models of this are being forwarded to the Centers for Disease Control.

And at the most recent WHO meeting of -- to decide the next virus to go into the Northern Hemisphere seasonal recommendation for H1N1, the CDC requested from USAFSAM a copy of one of the models that was related to an Iraq specimen which they then forwarded to them. And that was presented as part of the packet to the WHO for their recommendations for the seasonal Northern Hemisphere vaccine.

The Joint Biologic Agent Identification System has been under Emergency Use Authorization

since August, and it has been validated at five CENTCOM sites. And approximately -- not quite exact -- but approximately 100 specimens at each of those locations have been tested using this system.

Next slide. The number of countries that have surveillance performed in part or wholly by the Department of Defense is now up to 75. And 15 of the countries which provide specimens to the WHO, their sole source for that information is from the Department of Defense Laboratory Efforts. Mainly, those are in Sub-Saharan Africa and in South America as well.

The DoD is also actively involved in hospitalization surveillance, and while we don't necessarily coordinate our activities with the CDC, we do provide them that information.

And importantly also, the Military Vaccine Office, the Armed Forces Health Surveillance Center, and the FDA's Center for Biologics Evaluation Research are actively involved in looking for possible adverse events to

the H1N1 vaccine. And there is an additional slide in the back that shows that we've tested now over -- we've looked at the results of over 1 million active duty members, and there have been no increased number of events noted in that surveillance.

Next slide, please. The MIDRP program held a symposium in September to evaluate the possibility of expanding the scope of MIDRP to include a respiratory disease program. One of my notations to that is the MIDRP funding has been fairly stable for many years and expanding that role would obviously require decrease in the role of other items in that program.

Now, again, there may be some funding coming through alternate mechanisms for purposes of respiratory disease research in the future, but as far as that -- and I'm not quite sure what the MIDRP final conclusion was, but Dr. Lednar can may be fill us in at some -- at a later point.

As I'm sure most of the Defense Health Board and the previous AFEB are aware, the DoD has

had a long involvement in respiratory disease clinical research and epidemiology. And, in fact, the development of the influenza vaccine in the 40s is a direct result of the involvement. And we are currently involved with a variety of agencies and partnering on such research, such as this cross-neutralizing antibody research we mentioned.

The Naval Health Research Center and Navy Medical Research Center are actively involved in vaccine clinical trials, most notably the adenovirus 4/7, which we hope to have FDA approved shortly, as well as a DNA-based H1N1 vaccine.

Next slide. Well, we do a lot. There are some things that perhaps are better done in the civilian sector, such as multidrug antiviral therapy is probably better done in a sort of multicenter trial; nonetheless, the Navy Health Research Center is working with a pharmaceutical manufacturing to evaluate a three -- triple drug regimen involving oseltamivir, rimantadine and ribavirin.

The Naval Medical Research Center has

funded a clinical trial in convalescent plasma therapy and is working to set up a network for that. However, you know, given the relatively benign nature of this particular virus, it's going to be hard to argue for a fairly aggressive treatment, such as convalescent plasma therapy for routine patient care.

Next slide. As far as the vaccine distribution, the DoD was actively involved in the initial decision making; however, that was changed by the White House to some extent, although, you know, the DoD did receive a fair amount of vaccine early on, but most of that went to our deployed locations: CENTCOM, EUCOM, and Korea. And the decision to use the vaccine, which was one of the recommendations in the DHB, was actually taken away from DoD and that was national policy.

And there is a draft policy at ASD for signature on the use of 23-valent pneumococcal vaccine. The recommendation by the DHB was to hold off on aggressive use of this vaccine until such time PSV23 could be fully evaluated. And

once the PSV23 recommendation comes out, once the research is completed -- but that will be probably several years away.

In the interim, the ACIP has recommended that we vaccinate persons of 19 years and older who are smokers or who are asthmatic or have an underlining chronic medical condition that would compromise their ability to respond to pneumococcal disease. And so we're, to the extent possible, vaccinating those individuals.

I don't think it's an appropriate venue to put those into recruits although the original request for review of this policy was driven by the two pneumococcal meningitis staphs in foreign matter growth, neither of which would probably have been prevented by the vaccine.

Next. Communications and coordination. You know, we've been interacting with a large number of organizations, both within the U.S. government as well as some independent agencies, and we've provided a wealth of research on influenza surveillance, influenza transmission,

and so forth. So I think that's well stated there.

And as far as other informational vaccine availability, locations, et cetera, there's been an overwhelming amount of information available on a variety of websites, including Twitter and Facebook. And approximately 8.3 million hits a month ago -- 8.3 million hits on the DoD Watchboard so I suspect that's higher now although H1N1 has more or less died off the map for the moment. Any questions?

DR. LEDNAR: Questions for Colonel Gould? Dr. Parkinson?

DR. PARKINSON: Mike Parkinson. Thank you very much, Phil. Very good. Just a little follow up -- a nice story for the Board. You know, we were at the Academy when the Academy outbreak had just occurred. And some of the prompt steps they took there -- I think it was last week or the week before, before I lose track, Colonel Witkop presented, I believe, the Preventive Medicine meeting in Crystal City, Virginia.

But I wonder for the Joint Preventive Medicine Group if in light of -- you know, we always kind of thought that the academies in concert created a unique surveillance opportunity but it never really seemed to come together at the academy level. That's what's my impression.

And if ever there was a time when all of these places pretty much started at about the same time with a bolus of, you know, 4,000; 8,000; 12,000 people, which is different than the recruit camps, where they come in continuously on a lower level, I wonder if that outbreak in the conversation fostered any more collaboration between the academies, specifically on the summer arrivals of those new students.

Lt Col GOULD: Not at this time, but we could certainly raise that question. I think really the Academy demonstrates that the nonmedical measures are probably as important, if not more important, in the control of communicable diseases because while they did use the oseltamivir here for the treatment, it surely --

the data presented in the paper shows that it wasn't really -- didn't really do much for shortening the course of illness or for transmission purposes.

However, putting -- taking those individuals and moving them out of that training environment into their dorm room and then having a select group of people take care of them, I think is probably what really stopped the outbreak from progressing.

DR. LEDNAR: Other questions? If I may ask Dr. Poland because the Infectious Disease Subcommittee and the Task Force on Pandemic Influenza Preparedness really was the report -- prompted the discussion on February 3rd that Colonel Gould is summarizing for us.

Greg, any comments you'd like to make?

DR. POLAND: None specific other than just to say how pleased I am as an individual, and I speak somewhat for my Subcommittee, with the alacrity with which the Department moved in addressing these issues and in being very

transparent partners with us in trying to get data, figure out what was going on. I mean, as you all can imagine during those days, people were tasked and were working 18-hour days, and no one knew exactly how severe this was going to be, et cetera.

We were talking a little bit this morning and maybe you can give at least order of magnitude numbers about deaths or other indicators that really show that the impact of this was minimized to the extent that was humanly possible given there were delays in getting vaccine, et cetera. So it's more -- my only comment is really to say how impressed I was with how the Department performed in this specific issue.

Lt Col GOULD: I believe the number of deaths of both active duty, retirees, and other dependents is under 15. 10? Oh, he just checked: 10.

DR. POLAND: Just to put that in perspective, we heard last week among colleges that are members of the American College Health

Association, 91,000 college students were ill, 169 hospitalized, and 4 died. We're talking about orders of magnitude larger population here with less in the way of morbidity and mortality. It's just a spectacular performance.

DR. LEDNAR: I think the H1N1 global experience was really quite a lesson. One of those lessons is that pandemic threats continue. We were fortunate with this particular virus that, despite how it was initially appearing in its early days in Mexico, that it did turn out to be a milder infection although it clearly did affect young populations disproportionally.

But pandemic threat continues with other agents so I think it's important to be sure that those lessons that are learned either in surveillance or in communication, working virtually understanding how mission accomplishment can be compromised by pandemics, and therefore the importance of pandemic preparedness on mission accomplishment is understood by the line.

This is a time to take advantage of

things being quieter and settling down into the more seasonal pattern to be sure that those lessons are fully hardwired into our institutional way to run, either in DoD or in the private sector. So I'd encourage you, do everything you can to make sure that those lessons are fully baked in to the way we operate.

Lt Col GOULD: I think the line is very, very acutely aware of the pandemic potential much more so than they might have been several years ago. And I think that perhaps the fact that it was relatively mild is a good thing, but they were definitely involved in most decision making.

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: Mike Oxman. Just to belabor the point that the Defense Health Board and the Subcommittee of Infectious Diseases has made before with respect, although, I fully understand the issue of funding with MILVAX that the respiratory viral research is uniquely a military problem, and that, for example, the new adenovirus vaccine doesn't provide a platform for other

adenoviruses.

There is -- it's an old -- it's an ancient vaccine, and there are currently respiratory problems that are uniquely military, and there will be more for sure. So I would like to continue to plug away for the rebirth of a basic as well as clinical research program that deals with the unique military problem of respiratory disease.

DR. LEDNAR: Any other comments for Colonel Gould? Okay. If not, Colonel Gould, thank you for that brief and for the work that you're doing.

What we'll do now is we're going to take a break until 3:30. So if you would please readjourn or reconvene in this room at 3:30, we will start up for the final session of the Core Board meeting today. Thanks.

(Recess)

DR. LEDNAR: Our next speaker, unlike the agenda, is not Dr. Bill Halperin who, I'm sad to say, is here but is upstairs in his hotel room

sick. Ill. And it takes a lot for getting Bill knocked down to not be here, but he's feeling so ill that he's asked Dr. Tom Mason to stand in in terms of the Subcommittee update that we will be hearing.

So to introduce Dr. Mason, Dr. Mason currently serves as Director of the Global Center for Disaster Management and Humanitarian Action at the University of South Florida. Additionally, Dr. Mason serves as the Vice-Chair of the Medical Institutional Review Board for the University.

He also holds Joint Professorships in the College of Medicine, Department of Internal Medicine, Divisions of Medical Ethics and Humanities and Global Emergency Medical Sciences.

He has most recently been appointed as a Public Member to the Board of Directors of the American Board of Disaster Medicine.

Dr. Mason also serves as a captain in the ready reserve as a Special Assistant for Environmental Health in the U.S. Public Health Service.

Dr. Mason is going to give us a Subcommittee report, and the material that Dr. Halperin had prepared for this agenda item may be found at Tab 7. Dr. Mason?

DR. MASON: Thank you very much. If I could have the next slide. So very simply, we just want to tell you who we are, what

simply, we just want to tell you who we are, what

our charge is, and the status of our site visits and anticipating reports coming from our Subcommittee.

The next slide, please. It's an excellent group of guys to work with. We have had the honor and privilege to work together on a number of issues that relate -- and this is the latest task that we've been given -- if I could have the next slide -- because our mandate is exceptionally broad. We have been selected as the select Subcommittee to serve as a public health advisory board for the DoD Research and Clinical Centers for Deployment Health.

Right. The next slide. So what has happened over the past months is that Bill and Commander Feeks had gone to San Diego, Naval Health Research Center. We have been tasked basically with an evaluation critique commentary on the Millennium Cohort, and many of you are very familiar with when the Millennium Cohort was configured.

And some of the recent publications coming from the Millennium Cohort, not the least of which is one that has been discussed here several times, and that is: pulmonary conditions

identified among individuals with exposures to our burn pits. They went; a draft report was prepared.

Our entire Subcommittee, we periodically have teleconferences so that as many of us can get together to move our schedules around and spend two hours on the phone talking about what they were able to find, the directions that we're interested in going. We have prioritized some very specific issues.

Now, this is -- Mike, keep me honest -- is this is the second time or the third time that people have actually gone to San Diego? It's at least the second. I know that there was a group because I believe you were there and Kaplan was there earlier on with Halperin. So it's at least the second time that this particular Subcommittee has gone to San Diego to ask questions.

As a result of their information gathering, a number of concerns and questions were raised within the Subcommittee. Then we individually ranked them to come up with some

subset, which we consider to be our most important priority questions and issues to address.

We're going back in May. We will spend a large part of a week in San Diego. We will give them a heads up well ahead of our visit in terms of these are the questions we're really interested in, and hopefully we will then be able to glean from that site visit sufficient and adequate information to put together a report. And we will definitely report out at our next meeting of the Core Board in June.

So, again, I'm sorry that Bill was ill. I know he will be back with us. And a number of us, we'll all be together in San Diego in May.

So that's really -- it's just an information update to let you know who we are, what we're doing, the mandate that we've been given, our charge, and a timeline. And this is the first of three because there are two centers which we will visit. And we will use the information that we glean from San Diego as a way in which to put together a template for the other

centers who are basically charged with deployment health issues. Thank you very much.

DR. LEDNAR: Thank you, Dr. Mason. Any questions or comments for Dr. Mason and the work of the Subcommittee? Okay, hearing none, we look forward to the learnings that will come from the site visit in May. I believe it's May 11th and 12th --

DR. MASON: That's the plan, yes.

DR. LEDNAR: -- are the tentative dates at the moment for this visit to San Diego. And just part of the agenda for the Core Board meeting in June, we will have a report about what was learned during that site visit.

DR. MASON: Thank you very much.

DR. LEDNAR: Okay. Thank you, Dr. Mason. Our next speaker is Mr. Charles Campbell.

Mr. Campbell is a member of the Senior Executive Service and Chief Information Officer for the Military Health System. Mr. Campbell is the Principal Advisor to the Assistant Secretary of Defense for Health Affairs and to DoD medical

leaders on all matters related to information management and information technology.

He works closely with all the Services and their Surgeons General to ensure that the military health IT programs are well managed, comply with applicable statutes and policies, and align with the objectives of the Military Health System. He oversees the Information Management and Information Technology program offices on all matters of acquisition, development, testing, and deployment of health-related software systems to the military, including the military's electronic health record.

Mr. Campbell spent more than three decades supporting worldwide military operations, military health care, and veteran health care with 22 years of experience in the IM/IT field. He recently served as Deputy Chief Information Officer for the Veterans Health Administration.

His awards and decorations include the Defense Superior Service Medal, the Meritorious Service Medal, the Air Force Commendation Medal,

and the Air Force Achievement Medal.

Mr. Campbell is a real expert in the electronic medical record as it is being designed and fielded in the Military Health System.

And it's a real pleasure, and I really appreciate, Mr. Campbell, you're joining us today. Mr. Campbell's presentation materials may be found under Tab 8 of the binder. Mr. Campbell?

MR. CAMPBELL: Thank you very much. Just came in from speaking at the Health Information Management System Society, the HIMSS conference, one of the largest in the country. About 28,000 people attending that one. A very good conference. If you ever get a chance to go down there and want to learn more about health IT, that's the place to go.

Next slide, please. What I did was I kept the slides at real high level so we can delve down into whatever details you want to delve down into without me kind of forcing you down in there and left lots of time for questions. I'd like to answer all the questions that you have. We have

lots of things going on. Quick agenda. What kind of things we're going to talk about.

Next slide. Mission. When we talk about my job as the CIO, Chief Information Officer, it's really about information. It's about how do you get information into some type of electronic format, how then do you store it, what do you do with it, how do you then make it available to the right place at the right time. Information that is correct information, stable information, secure information, and it gets to the right person whether that person is a provider, a researcher, a business person, an administrative person. So all that information has to go to the right place, at the right time, and it has to be the right information. That's our job, plus the entire continuum of health care operations.

Next slide, please. So if you look at this, and we have several slides that show this, this is just one that shows from the time someone accesses into the military. We need to capture

that information electronically somehow in a standard way.

And then as they go through the process of training, receiving other types of health care all along the process, as they do get deployed out into theater, they receive care for first responders, forward resuscitative care, theater care, en route care. How do we capture that information as they fly from place to place, as they're in the ambulance from place to place and that care is being received, we have to capture all that information across.

And as they come back, then they go the tertiary care facilities like Walter Reed, National Naval Medical Center, if they're burn victims off to BAMC. And then perhaps they go off to the VA to the polytrauma centers.

And as we know, though, a lot of our care is provided outside of the direct care system and the VA system. Probably they say -- well, depending on how you look at it -- about 60 percent of our care for our 9.6 million

beneficiaries is done outside of the direct care system. Roughly 30 or 40 percent of the care is outside the VA facilities.

So we have to find a way to capture all that information and bring it back in to complete that longitudinal health care record of our beneficiaries. And that just depicts that.

As they go across theater, come back, back again, the Guard and Reserves, we have to make sure we capture the Guard and Reserves because once the Guard and Reserves come back and demobilize, where do they go? They go back to their civilian jobs, they go back to their civilian health care organizations. How do we get that information back in so we know what happened to them and so we can make sure we do the right things.

Next slide. So when you look at the electronic health records and you go back a little bit to AHLTA -- why do we have AHLTA? Why do we even have AHLTA in the first place? AHLTA is really designed as an epidemiological system to be

able to capture computable standardized data in a way that we can do something with, do some research, do the analysis.

Really, really difficult to do that with the old system that we had. So when this system was designed roughly 11 years ago now, that's what it was designed to do. They used the capabilities, the technological capabilities at the time. They actually originally designed AHLTA to work on the internet. Well, the internet wasn't ready, wasn't stable to do that at the time. Of course it is now, but at the time it wasn't.

So they developed this new way of doing business. But they designed the interface, on that the providers used, in a way that allows it to capture that standardized computable documentation. And, of course, at the time those developed, it was -- you followed trees.

If any of you have been on a phone tree trying to call somebody -- your insurance company or your bank -- you know how frustrating that can

be going through a person, and all you want to do is talk to a person.

And all they want to do is document that care, and yet there is click, click, click, click, click down on the trees, to finally get to where they're able to document that piece of information. Not a great way of doing business. It was good at the time.

And out of that, though, came this marvelous database of information that we have that's computable and is big, and it's all available to do whatever type of research, analysis that we'd like to do with it.

Next slide. Just high level view. Since AHLTA has been deployed, more than 135 million outpatient clinical encounters have been captured. In theater, more than 3 million outpatient clinical encounters were captured.

And right now, we have deployed to 67 percent of DoD's inpatient beds an inpatient solution that captures that information and, again, puts that into a database where we can do

something with it. So just kind of an overarching view of the electronic health record. It's about 145,000 encounters per working day that we capture that information and put that into our database.

Next slide. It's not without problems. If you imagine something that large which covers roughly 800 medical and dental treatment facilities and hospitals and clinics and also out into the theater of operations where it has to work sometimes without any communications at all, it has to have a very small footprint. To be able to capture that information, we have some small devices that allow us to capture some information with hand-held devices when you can't use a laptop.

We have it on, right now, 15 ships. And by the end of two more months, we should have it on 20 ships, so that continues to grow. And what they're putting out on the ships is the theater version, which is a much smaller footprint. You can't put large footprint, large servers on ships. So that continues to grow.

But if you look at that environment that we live in, that complexity of that, and people say, well, why can't you just take an off-the-shelf commercial package and use that? They also say, why can't you use this one: the VA system? That's one of the main reasons you can't because it doesn't work in all of those other environments. We have to have it work in those environments, have to be able to capture all that information in a way that's standard across the enterprise.

From the time you treat that care out in theater and all the way back, same information because all that information is shared, collected, stored and then shared off with other individuals who need that particular information. So there are some issues, though, for something that complex and that large: speed, reliability, usability, efficiency, interoperability, capability speed-to-market, health record completeness. And we'll touch on all of those.

Next slide. Speed and reliability. The

way the system was designed, it's a little complex. But it worked at the time and it still works now. So if you can imagine as we modernize our electronic health record system, we're essentially flying a large transport plane and turning it into a fiber plane while it's flying without letting it crash. It has to continue on. We can't just stop providing care. We can't just stop collecting the data, the electronic health record information. We can't stop do that.

But we have to modernize it at the same time in all those same places. So that's our challenge. So we take this and we say, Okay, now we look at the complexity of the particular -- how data flows; for example, if a provider is typing on and getting information for a new patient that comes in, it goes all the way through this process, all the way to the clinical data repository and pulled down that day. And that data then is transferred all the way back to the provider. It actually works, and it actually works pretty fast but not as fast as how folks

would like it to work.

There are some issues of when you talk about speed and reliability. It's not just speed of the electrons that are flowing back and forth, it's speed of the design of the application itself.

How many different screens do you have to get to get what you want? How many clicks do I have to do to get to all the trees to get to where I want? Those things have to be designed in there too. So lots of issues with this. We're working on this, and I'll tell you a little bit more about it when we talk about the way-ahead part.

Next slide, please. Usability and efficiency. So we have one standard application, say, here's the user interface you have to use. If I talk to the IT guys and say, I have an IT problem, and I talked to 10 of them and say, can you tell me how we'd solve this, I'd get 10 different answers. It'd all be different. If I asked 10 providers, what should the screen look like? How many answers will I get? Well,

probably pretty close to 10, if not 12. And that's okay.

So what we have to do, though, we have to design a graphical user interface that is flexible, modular, allows the user to modify how they see fit to fit their needs. What do they want to see on the screen? What order do they want that information? It doesn't matter what's on the screen.

As far as what capabilities they want to pull in there, they can pull in little portlets and drag it in, pops open, just like they do nowadays with a lot of other applications. The important part, though, is the data that's underlying of that is standard. Standard data, same across the enterprise, same across the nation.

That's the other important part. What we're doing is we were going with the national standards -- we are actually helping drive the national standards, working with HHS and VA and others. And so those standards will be built in

so that the data is standardized, and it's much easier to share at that point.

But you've still got to get that in a way that allows the providers to be comfortable with how the system works. Don't force them into any one thing, but at least do that for them.

Single sign-on context management is an application -- well, it's not an application, it's capability -- that the way it is now, if someone is signed on to AHLTA, and then they have to go into, maybe, Essentris™, they have to sign off this one, sign on this one, and then go back, sign off this one, sign on this one. One at the time. Not efficient. Not effective. Can't do it that way.

There's two packages out there, two commercial packages, that do single sign-on with context management. Context management meaning if they're working across multiple systems -- different applications -- if they're working on a patient, that same patient's information is available in all of those. So as I move from application to application, it makes sure that

that individual's record is the one I'm looking at; otherwise huge patient safety issues. So it has to work.

There's only two commercial packages that do that right now. Sentillion is one and CareFacts is the other. We tried Sentillion in a couple of different places, tested it out. Not going to work for us. We went with CareFacts. So we're starting to implement that right now.

So single sign-on context management, a new graphical user interface, you sign on one time, you have access to all your applications, and a graphical user interface that is much easier, much nicer to use. You can design it how you want, it's flexible, that's where we're going.

Next slide, please. Interoperability and capability speed-to-market. If you look at how our system, AHLTA, is designed today, when we make a change to an application, we have to load that change to that application on 110,000 end-user devices across the globe. How long do you think that takes? Typically years. Years.

And that's how it was designed at the time. We can't do that anymore. We have to do it faster, and there are ways to do that faster. And that's the direction we're headed.

So we're going to virtualize the applications, meaning, we're going to have the applications and right now plan for multiple regional sites. The numbers are still to be determined, but we're looking at five. Maybe four is enough, but we're looking at five: three in the continental United States, one in Asia, one in Europe; where that data will be stored, the applications will be stored, so that you'd use the internet to access that information.

What does that mean from the end-user device perspective? They don't have to have all of those things loaded on their device. All they have to do is have access to the internet on their device. Does that mean we have to then standardize every single end-user device? No, we don't have to at that point. They can just use it off the internet. It will work. This has been

tried before. It's actually one of the best practices that are out there right now. So we're implementing that piece.

So if you look at this building-block approach, the bottom of that is the infrastructure. Have to fix the infrastructure first. Get that piece solid. Start building towards how we're going to build on these capabilities in a plug-and-play, modular, flexible way of doing that.

Enterprise service sits on top of that. Next layer, you have some services, like master patient index, terminology provisioning services. Some of these services, like identity management, who in the Department is the expert in that? It's DMDC. We're not building it. They're creating a service for us. They're creating a service for the VA. We don't want to create it, we just want to use their service. And if they design that service so that it plugs into here, we're done. It's a standard service.

On top of that sits the critical EHR

enhancements, business intelligence, surveillance teleconsultation. On top of that sits some more applications: Lab, pharm, rad, inpatient, outpatient. On top of that sits your single sign-on, context management, and your graphical user interface.

This is where the Department of Defense is going, and we get to be the lead. We get to lead the Department, and so the Department is very helpful in making sure we do this correct.

So we have a lot of support and a lot of oversight right now from the Department, which is great because they're going to make sure that we do this right, that it not only works for the Military Health System; but this capability, in the way of doing this, works for the Department so they can start heading more down this path. This is the right way to go, and this is the part that they're focusing on. So this will allow us to do things a lot faster.

And if a capability needs to be upgraded; for example, out of the old CHCS, what

do we have to do? Well, that will take -- it's going to take years because that is a tangled mess. With this approach, you can plug and play based on data standards, architectural standards.

So what we've done, what we're working on right now is a distributed development process that allows us -- I'll give you an example: so I have my iPhone and you see all these little applications on there. If you want to build an application on the iPhone, they will send you -- well, you've got to pay for it, but Apple will send you an application developers tool kit that says, if you build to these standards, you build it this way, it will work on the iPhone.

We're in the process right now -- we just had Phase 1. Release 1 is out now of our distributed development tool kit that says, if you build to these standards, if you build it this way, it will work on our system.

We're also developing this year a common development test environment where those can be tested out. You can test out those applications.

You can test out those services. Is it going to work? It will replicate what's in a large MTF so that we know that this is the environment it's going to work in, and we're going to be able to test it.

It's not a production environment, it's a full test environment. With the test, evaluation, the security piece on there, what this does, it opens up the market to not just the large vendors, it opens up the market to medium vendors, small vendors, very agile vendors. It also opens up to other organizations in the civilian and federal government. Not just us.

So VA, for example, in North Chicago, they're actually developing a patient registration modular for both of us that will fit into this. They're doing that right now.

So this does work, it will work, and we're building the processes today that are going to allow us to do this. This is the future. This takes advantage of a lot of smart innovative people in large, medium, and small companies,

federal government, small mom-and-pop shops. They can do this, and we'll tell them how to do it. Here's your toolkit, build it to this, it will work. So that's the direction we're headed.

Next slide. Do we have all of the information in the electronic health record system that we need? And the answer is no. Wait a minute, let me put that right. Let me restate that.

Do we have all the capabilities in the electronic health record that the functional users need? I don't need it. Functional users need it. And I believe the answer is, no, we don't.

And I was asked the question today in the morning presentation, when are you going to be done with the electronic health record system? I said, never. I said, absolutely never. You should never be done. You should be done with the project where you're working on. But what I want folks to do is say, okay, that part works now. What else can you do for me? I want to add this, I want to add this, I want to add this.

A lot of times what that add-on things are, we don't know. The functional community doesn't know yet. They don't know until they see what they've got. And what they've got works. Then they want more, and that's what we want to see. We want to see more once we get the pieces working. So add on, add on, add on.

So there may be some capabilities you all think, gosh, we really should have this, this, and this. That's great. Let's fix what we've got, modernize it, add those capabilities in, get the functional users, the functional community -- whether it's the theater community, whether it's the clinical community, whether it's the business community -- and ask them. And this is what they're doing now because we worked that out over the last couple of years. The function of the communities in charge of requirements, they're the ones who define what it is that we do.

Our IT folks then take that and say, okay, here's how we can do it, and more importantly, here's what it will cost you because

without -- if you have a plan, and it's not a funded plan, it's a hope.

So we're looking at this: functional community identifies additional data types, what do we need; improve the architecture so we can do the plug-and-play; images and artifacts will be one of the first data types out there.

So at this point can we say we can share all images and health artifacts, videos, EKGs? Can we share that across the enterprise seamlessly? And the answer is no.

That's what this project is. That's what the HAIMS, Health Artifact Image Management Solution, is going to do. So Phase 1: done. Now we take it out to limited user test sites -- three per service -- this year and test it out. Run it through. Run it through the patients. A large, medium, and small for each of the three services. How is this going to work? Are we going to make it work? Let's test it out. That's what we're doing right now.

Next slide. And, again, the important

part for a lot of folks to understand is, my goal is that the information only has to be entered one time. Just one. If it's standardized, you enter it one time, and you use it in a wide variety of ways.

Beneficiary self care. So they're working on a beneficiary portal. And you can have a personal health record, your appointment is online, secure messaging with the provider. All those things that you would want to have to be able to help the beneficiary be able to manage their information better, manage their health better, all that's going to be in there based on the information we have captured in the electronic health record system. It doesn't need to be added again.

Provider care, business decisions, research, command and control for surveillance, third-party billing, collections, coding, just enter it one time. I know I get a little frustrated when I go to the hospital or go to the clinic for an appointment. They always make me

fill out that same sheet of paper every time. Every time. Why? I don't want to fill this out again. Don't you have it on record somewhere? Well, the process is, well, you have to fill it out.

Okay, we're going to stop that. We're going to stop that. You only should do that one time. It's there. So couldn't we have maybe a little kiosk and just hit a couple of buttons: it's me, here I am? If you have a CAC card, throw it in there. Does it work? Yes, it's you, here's what you're going to do. And it works.

With the electronic health record system, the new system, here's something that's really important for you to know. Although it was in the Clinger-Cohen Act, and has been for a long time, they just added this new process back into the latest version of the NDAA, which is: you have to do your business process reengineering before you build your IT systems. Makes sense. Why is that important? Because if you don't, then you have an IT system that you're trying to cramp

down people's throats that they do not necessarily want to use because it doesn't match the business processes.

But if we typically buy COTS packages, commercial off-the-shelf packages, what do we do? Do we buy a COTS package and then rearrange our business processes to match that? The answer is, no, shouldn't be. You should take your business processes first. Make those the most efficient and as effective as possible, then find the application that best supports that new process.

But then your process has to work across three Services. Not one, not two, all three. Otherwise we're chasing after three different ways of doing business. Doesn't make a lot of sense, not effective, not efficient. So capture once.

This is just a depiction of the clinical data repository. We don't want to store everything in one place. It doesn't need to be. It's dangerous. There is no hot failover for the clinical data repository today. There's many backups. We have lots of backup. We're not going

to lose the data. But if this crashes, it's going to take us roughly two days to bring it back up. Two days. That's two days of no electronic health record system at all. That's not good. That has to be fixed. That's what the regionalization of that information is going to help with.

So for example, just like a telephone switch, they have nodes across the country. If one goes down, what happens? It just gets rerouted. The information is still there, it just gets rerouted through another way. That's where we're headed.

So that's why I told them today my goal is that from the end-user provider perspective the systems always work, and the information is always available. Always. That's the goal of setting up the regionalization so that they can't have that failover if something goes down.

The central data repository, right now it's one big thing. You have to maintain it. And to maintain it and do the maintenance on there, you have to take it down. If you have multiple

regionalization system efforts of the CDR, you can take one down, take it offline, reroute the information automatically, and then you can fix it without taking anybody out. That's the direction we're headed. Best practice from the industry for incorporating that into what we're trying to do. And this will work.

Next slide. External interoperability. As I mentioned, a lot of our care is done in the outside, in the civilian sources; however, they don't all have electronic health record systems. So how do we recapture that information? How do we get that in there? One of the solutions is this VLER project. Have you been briefed on the VLER project yet? So it's Virtual Lifetime Electronic Record. President stood up and said, we're going to do this in April. Two Secretaries staying alongside said, yep, we're going to this. And we're actually doing this, which is good.

It's using the Nationwide Health Information Network -- can we go to the next slide please? Let me see if it's -- oh, there it is.

So Nationwide Health Information Network just depicted by the ring. If you look in the upper left-hand corner, you see DoD and VA. That's the VLER Health. That's just a depiction of the two working on that particular project. But essentially it takes that standardized national data; and no matter where that care is given, it becomes visible to those who are trusted agents on this ring.

So the first phase, Pilot 1A, was done in San Diego with VA, DoD, and Kaiser. So if a patient shows up there -- that can receive care in multiple places -- then you can see the information from those other sources in your workflow of your particular electronic health record system. It works. It does work.

We're going to the site next week to go talk to the folks there. I don't think they'd formally announced that. But those of you who know where the Portsmouth area is, it's kind of somewhere in that location.

So this is going to work. But what they

found is, to make this happen requires lot of cost for the smaller medical groups. So what they're doing now is not only keeping this, but they're going to -- they're developing now which is -- I just talked with Vish and a couple of other guys working on this at the conference -- a NHIN 'Lite'. That allows other users to use it without that big footprint and without having to really invest heavily into it themselves. And that will help an increased adoption amongst the smaller healthcare organizations out there where a lot of our care is given. For us that's great. We want everybody to get on this, across the nation, and it allows us to be able to get all that information back in a right way. So this is working. It's working pretty well. So far so good.

Right now, DoD, VA, Kaiser in that one test area are the only ones doing that bidirectional sharing of information. Only ones in the nation. So it's going to grow, but we're not there yet.

So the next phase will increase the organizations that are in there and will also bring in some of the commercial partners that are down in that particular area -- Sentara, Bon Secours, Riverside -- and bring those folks into the fold also so that all the care that is provided out there for our beneficiaries will be able to view that information electronically on the screen of our providers in their own electronic health record system. It's pretty cool.

Next slide. Well, that's it. So I left lots of time for questions. This is exciting stuff. We've made some really great progress. The great thing about having this electronic health record way-ahead plan, which I hopefully will be able to talk about in about a month, has been worked very carefully.

The Department has scrubbed it and scrubbed it and scrubbed it, and the Department is funding it. It's not coming out of Congressional special interest dollars. It's not coming out of,

you know, rob Peter to pay Paul. This is coming from the Service departments so it's coming from Army, Navy, Air Force. They're going to fund this because they understand the importance of fixing the electronic health record system. And so that's what they're doing.

So when we talked about having a plan, a funded plan is the right way to go, and we're there. So this next year is going to be a really exciting time because the planning -- although planning continues -- this is execution year. This is the year things start moving and start happening.

So it's a really exciting time when I brief this. I briefed this two different times in the last couple of days. Folks are just excited. Really excited about this. The technical people have seen what this is supposed to look like. They are really excited. The industry is excited because they want to participate in this. This is great. This is where we're going.

I apologize, I said, open up for

questions, and I kept talking.

DR. LEDNAR: Thank you, Mr. Campbell. If I can start with two questions. One is, you mentioned that so much of the care provided to DoD beneficiaries is purchased care out in the civilian market place. Do you anticipate that this solution will become a sourcing requirement; in other words, if the Department of Defense is going to purchase care for its beneficiaries, from Kaiser, from any kind of non-DoD entity, there won't be business with DoD until and unless they agree to participate in the system.

MR. CAMPBELL: I agree 100 percent. So it's not in the current contracts -- the current contracts that are under protest -- but the current contracts, it's not in those to do this. I don't think it was ready at the time they started working these contracts a year and a half ago, but I completely agree. That is the right way to go, and it's to make them -- not make them -- highly encourage them through contracting to participate and share this way.

Now, outside of the contracts, one of the organizations is already working with us because they want to do this. They want to get out there. They want to get on that Nationwide Health Information Network. They want to do that.

And if they do it on their own, that's even better. You know you have the contract for them and pay for it if you do that. So they want to do this on their own because they want to have that information. They want to be the first ones out there too. So one of the large vendors is actually already working with us on that.

DR. LEDNAR: That's great. The second question I had is one that's an issue that's been identified by the Defense Health Board over time, and that is as -- and you sort of put your finger on it earlier when you were talking about linking together for an individual information from the point of accession through initial training, first assignment, deployment, care in theater, evacuation back, going back into a civilian setting, perhaps on active duty status. But since

so much of the force is in the National Guard and the Reserve, how do you see the system supporting our force who are civilian soldiers?

MR. CAMPBELL: Right. So there's a couple of ways we're doing this. One is from the perspective of when they're on active-duty status or when they're on reserve status and they've come into a base and they do their weekend and they do their training and/or they're active duty. Once if they're active duty, they're going to be captured in our system when they receive health care.

What we've done for the Guard and Reserve folks that are doing the weekend duties, is that we've given them what's called remote -- enterprise remote access. It's a new capability that we put out there last year that allows them to tap directly into AHLTA and use it just as if they're sitting there, off of their internet-based system. So that's a new capability that we gave folks. So from the perspective of when you have someone in a uniform, we should be able to capture

that information.

But your question is why have two, which is okay. They demobilize, they go back to their civilian jobs, they go back to their civilian health care system. The only way we're going to get that information, the best way to get that information electronically, is through that Nationwide Health Information Network as looking at it systematically versus looking at it piece by piece.

There's -- we have -- I think the number was 240 -- I can't remember, but it was on one of my slides this morning. But 240,000 partners in our network that we deal with. That's a lot of folks that are out there. And some may be in hospitals, some may be in small group practices, some may be individual. We don't know. So trying to get them all quickly to get on a way that captures that information in a standardized way and bringing it in, it's going to be difficult.

One of the problems I know that folks have -- I mean, if I was out there as a

practitioner, which I'm not, but if I was, I wouldn't want to invest in something that may be a dead end. Why do I want to spend maybe $50,000, $100,000 on a system that may not be future-based? It may just be a throw away in a couple of years. They don't want to do that.

So right now, they're working with HHS to really find a way to make sure that all that is standardized. There they have the CCHIT, the certification of the different applications that people could use as a way that they can really buy into that.

But at this point all we get back is a lot of scanned documents which is somewhat helpful but doesn't really help when you're doing all the research and things that you need to do. You can see the scanned documents. Really hard to find through it, dig your way through those things.

DR. LEDNAR: I mentioned one other recent observation, and it's a troubling one. As we develop technology to have information available to providers for the same patient so

that you don't need to repeat tests, you've got the advantage of what is already known and documented available at the point of care. In some communities serviced by multiple health plans, there has been increasing reluctance to share information under the fear that I will lose market share.

So when I talk about the sourcing aspect, I think we are going to have to, for the patient's sake, somehow find a way to work through this business reluctance by some of the structure in our health care system, on the purchased side.

MR. CAMPBELL: And I agree 100 percent on that. If you look at the RIOs that stood up a couple of years ago -- and their purpose was to collectively look at information from a variety of different health care organizations. As soon as the grant money went away, it died because there really is no business -- there is no business reason to do that so that then does make it hard. So how then do you incentivize those folks to actually participate and share their information?

That's a tough one. And HHS has got to tackle that one.

DR. LEDNAR: Questions? Yes, Dr. Mason?

DR. MASON: I need some help with an acronym.

MR. CAMPBELL: Oh, sorry.

DR. MASON: No, that's okay. Back up to the slide before your question.

MR. CAMPBELL: Okay.

DR. MASON: Now, I spent 17 years of my life at the National Cancer Institute, and I would like to know what the NCI stands for. And then I want to ask another question. But first I need to know what NCI is.

MR. CAMPBELL: It could be the National Cancer Institute.

DR. MASON: Now, you've done it. I've got you where I want to.

(Laughter)

DR. MASON: I love to do this. I want you in my classroom. In a heartbeat I'll I take him in.

If the NCI is the National Cancer Institute, and if we reflect on the community that you highlighted, which is DoD, VA, and Kaiser Permanente, which we networked together 20 years ago because they, very simply, were willing to play with us. They understood that if we were indeed going to do population-based epidemiology, they had access to this, and it hits on exactly what you're talking about because the Guard and the Reserve in California, in large part, has civilians that are part of that network.

So if that's the National Cancer Institute, I would suggest, and it's really something that you may have already done, if we are really interested in building -- and I believe we are -- longitudinal records, individually identifiable, that build on clinical encounters over a person's lifetime, that places like the National Cancer Institute with respect may play a very small role from the standpoint of facilitating information. But some of their population-based cancer registries in the network

of not-cancer institute supported but state supported, that whole network of NATO, that whole network of registries, which are passive, could indeed facilitate a way in which to address emergent questions, which is exactly the horn of the dilemma that we're sitting on right now, is how can you, how can you basically, with not adequate information in terms of exposures that persons in and out of uniform have realized, may or may not play and be associated with biologically plausible clinical outcomes. So I was really curious as to who is around this ring.

I understood, you know, that network with Kaiser because it works. It syncs. But in some of the other ones, some would really appreciate some sort of free association with you in terms of how you have in mind bringing together and maintaining the contact with anyone of the number of population-based sources of information where you really don't care if the person is in three different systems. The person is the person. And you make the informed decision, which

we do routinely in large parts like this, which is the individual that probabilistic is the person that I want.

MR. CAMPBELL: Right. So just to let you know, these are notional because they're not all on there yet, however, and there will be more. But I think you bring up a very good point, though, is from the perspective of how do you identify -- first of all, so identity management -- how do you identify an individual across all variety of systems and databases and registries that are out there so that you know you're talking about the same person because it's a huge patient safety if you don't.

And so I know the -- I know HHS is working with a variety of folks trying to figure that out because they're doing away with social security numbers. So social security numbers go away, and then we have to modify our systems in non-exemptional security numbers, and try to find a different way to do that.

One of the things that we did in the

Department of Defense is you had a social security number, but you didn't want to use the social security number of a nonmilitary person. So what did you do? You add the member or prefix on there, the 01, the 02 that signified your spouse and your kids and things like that. But that's going away too.

So you have to find a way -- we don't have to find a way, the nation has to find a way to identify -- one way -- each individual so that we can track them across all those systems.

I think what this does, this allows a mechanism to be able to once they've done that, really find that information, wherever it happens to be, in an agreed upon standard way, be able to pull that information in so that it becomes visible. We're working on a variety of registries right now. And we have to get all that information too because people can have -- people can be in multiple registries.

DR. MASON: They will be. And there's -- you know, we just -- the nation just funded the

National Children's Study. That's 100,000 kids in 100 centers followed from pregnancy -- intrauterine development -- to age 21. And many of us have argued, unsuccessfully, let's put a chip on them like we do in vet medicine because they have to be followed.

And I would suggest to you that there are models like that right now, that are sitting out there, that they thought through, and that networking of those particular programs, which are supportive, and they are diverse, and they are dealing with -- I mean, identity management is critical because that's where we want to be. Give me two that are highly likely to be the individual, let me make the informed decision. Don't give me 20.

MR. CAMPBELL: Right. I completely agree. And it is an issue that they're trying to work through right now, trying to figure out the right way to do that. But you're absolutely right. There's such a diverse group of data, data storage everywhere, in a variety of different

formats. We've got to find a way across the nation to bring all that in together so that everybody can see all the information they need to have.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: Thank you very much. Mike Parkinson. I was just at an presentation; as a matter of fact, Tom, with Bill Kurtis, former CBS news correspondent, who by the way is starting a company called Tallgrass Beef in Kansas. Every single cattle they can track worldwide anytime, anyplace.

DR. MASON: Right.

DR. PARKINSON: And we can't figure out how to find the patients. So it was very interesting.

I think it's a lack of will rather than technology to your point. But I would -- we can talk for hours about this topic because it's -- obviously this presentation, one form or another, I have seen for the better part in 20 years.

It's a wonderful vision, and I'm glad to

see the Department moving out on some things that I think are very promising. I like the notion of developing within the parameters of the same system: tailored apps. Very useful.

But I guess I question the commitment to the things that I think are necessary. The things that really get patients committed to a system are the fact that I make my appointments online, I can view my lab tests, I can talk to my doctor in E-Visit, I don't have to take my kid out of school to get medication adjusted.

And I just like some comments about where in the hierarchy I word these. This is traditionally the system that is very provider-centric. It is very facility-centric. It has not been very consumer- or family-centric. So I just like your comments of where that racks and stacks and when most military beneficiaries in the direct care system will be able to see their labs online and essentially e-mail their doctor. I mean, I'm working with large systems in Pittsburgh that do this today. So it's something about timelines.

Secondarily, just to -- you know, the Health Care Delivery Subcommittee of this Board has been relatively a little quiet because of a number of political issues and a number of other things, but when the time comes that that stands up, it gets a little more active.

I think a function by function assessment from the prospective of the patient/consumer for the 10 to 15 things I need to be able to do within a timeline is to when we can deliver that to our beneficiaries because if we do that, we can recapture market share. I don't have to send it down to TRICARE and dispute a contract.

So that to me -- Paul Wallace shows I have three times the number of people in my panel if I can basically have e-contacts versus face-to-face contact. I don't see that happen in our system.

The second point I'd like to make, and that's just to nuance your comment that you do business practice reengineering before the technology. The technology is the thing that --

basically the things you can do to these practices.

So it's really entangled. I agree, it's not one first and the other first.

And the thing we've not done in our system unless I -- two different presenters of the TRICARE conference; one says I'd be able to have three times the number of my patients because all my techs do everything that I shouldn't be doing. Another facility says, AHLTA is terrible because it takes me all day to find the ladders and trees.

There's -- so a little comment on the systematic business practice reengineering standardization across all services that's happening with AHLTA today because that's where we get the efficiencies and effectiveness.

And if we don't have standardization at the command level, whether it's the technician to staff ratio or the flow of the patients into the clinic, the number of things that the tech does versus what the doctor does, we're not going to see effectiveness and efficiency to recapture

market share. And that's what I'm concerned about is somebody who sees is ready, see it just growing and growing.

That's a lot there. To be continued, but just broad areas. It's a wonderful presentation, but as we go forward with the DHB, those are the things we'd like to talk about more.

MR. CAMPBELL: And I'm 100 percent in agreement with -- especially the part about the business process reengineering. Our goal is to provide a system that allows the individuals who are part of that health care team to all work to the maximum capacity of their licensure -- whatever that happens to be -- and their training and experience.

Standardizing that across the enterprise, the three Services, within hospitals and clinics, that's a huge challenge for the commanders and a huge challenge for the medical service leaders and Surgeons Generals to make that a reality, but they've got to find the way to do that. And if you all can help work --

DR. PARKINSON: Right. Let me just ask this: If I'm in a facility today, pre-AHLTA or post-AHLTA, do I have an expectation of efficiency standards or output standards afterwards based on five years of experience at this point? In other words, if we wanted to look at the scorecard the way probably Ken Kizer did in the VA facility when it put in EMR and say, what happened in your endocrinology clinic?

I mean, do we have metrics to be able to see whether or not that facility -- and you don't have to prescribe how to get there, but the whole notion of this is that we're getting better effective with more efficient care. Overuse, underuse, misuse and those buckets, do we have standards like that?

MR. CAMPBELL: We have -- I mean, let's put it this way: we have the data to be able to do that. So the data is there. It's just a matter of them, somebody in the functional community group, to say, this is what we want to do. This is what want to see out of that data

that we've spent so much time putting in there. So capabilities are there to do that.

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: I'd like to make a comment -- two comments from a very different perspective. I'm a relative computer illiterate unfriendly guy who was dragged kicking and screaming into the VA CPRS system, which is not a model of user friendliness, and I have to say I'm enormously impressed and sold on the tremendous advantages that that offers, even for someone with my limited skills and perspective. That when I write a note now, and the patient goes to St. Louis tomorrow that all of that information, all the laboratory information, is instantly available. If somebody has renal functional abnormalities or no data, and their drug is prescribed, it's renally excreted, that's flagged.

Vaccines are beginning to be followed now. The savings in errors and in patient care are very impressive, even to me. And so the -- I think this will be an enormous advantage to the

quality of patient care and to cost savings both.

I'd also like to make a comment, and I don't understand the reasons for this, but the VA system uses the social security number. It works perfectly. There is no confusing and abandoning that is a tragedy.

DR. LEDNAR: Mr. Campbell, I hope you've sensed from the Board a real energy and interest in the work you're doing, in the strategy that you're pursuing. I'd also like to thank Ms. Bader and Dr. Halperin and Mr. Campbell for a prep session that was held several days ago to try to orient Mr. Campbell to some of the interests and questions of the Board because this is a topic that clearly could go in many different directions.

So thank you for incorporating that discussion and bringing us such an important topic to use. Thank you.

Oh, sorry, General Gamble. Last question.

BG GAMBLE: No, I was just going to make

a comment. You know, as a commander of a facility, I am held to efficiency standards on a monthly basis; however, some of it has to do with production which then in turn falls back on my budget. Some of it has to with data quality, you know, that I have to report each month back up through my chain of command up through the system.

But the comment I'd like to just also add is that sometimes the efficiency -- don't equate efficiency with quality of care. So I just want to make sure that we don't lose that because, again, you have, you know, outcomes which are important, but you also have objective and subjective matters on the patient's behalf about whether what you encounter with that provider, that physician, that nurse practitioner, whoever. It was a quality one, and they walked away better before it as opposed to be frustrated by a system that, although it was more efficient, was not humanistic caring holistic in its approach.

DR. LEDNAR: Thank you, sir. And thank you, Mr. Campbell. Thank you. Our last

presentation today is going to be given by Dr. Charles Fogelman. Dr. Fogelman currently serves as Executive Coach and Leadership Development and Management Consulting as a principal at Paladin Coaching services. Dr. Fogelman's current volunteer activities include providing clinical services at the Adult Outpatient Behavioral Health Clinic at the National Naval Medical Center, Bethesda.

His previous positions include serving as President and CEO of Atlantic Coast Behavioral Health Services Incorporated as well as service on the Federal Council on the Aging, senior program evaluator at ACTION, the Federal Volunteer Agency, and Director of an Interagency Task Force on Long Term Care and Volunteerism.

Dr. Fogelman also chairs the Defense Health Board's Psychological Health External Advisory Subcommittee and will provide for us today a summary of the Subcommittee's recent activities. Dr. Fogelman's presentation material may be found under Tab 9. Dr. Fogelman?

DR. FOGELMAN: Thanks, Wayne. I'm keenly aware that I'm fundamentally all that's between you and a little bit of time in the sun, so I'm going to try to make my presentation shorter than Wayne's introduction.

(Laughter)

DR. FOGELMAN: I didn't want to be the one at the end because that limits the number of words that I can say. Some people think that psychologists are mind readers so I can do this. I have some data about that. I want to tell very briefly what we're doing. I want to do the Subcommittee membership first. You will see as we go along.

The two major things that we're doing, two major questions that we're working on, and the dominant substance of the two meetings since the last Defense Health Board meeting are these two. The questions are fundamentally. What are the evaluation measures and principles behind the evaluation measures for understanding the efficacy and effectiveness of preclinical, those are the things that come roughly

under the heading of resilience and building kinds of issues on the one hand and clinical mental health programs on the other. Those are the things that we're working on.

It is as you might imagine not a small task for we have an ambitious goal of trying to bring at least an interim report on each of these questions if not a full report to the Board at its June meetings, when I hope not to be at the end of the day, unless we don't have anything to report in which case I'll send somebody else.

Those are the people. We've divided ourselves into one group to deal with. This is not an experimental design. It's not preclinicals, it's not clinicals, it's just these are the people on the Committee working on the various things.

In addition to the meetings we've had face to face as a whole Subcommittee, each of these groups had a series of teleconferences. And I think we have a list of those in the backup slides. And there are several more scheduled for the immediate future.

Let me whip through the last two meetings we've had.

The one of that date was the first set of people we had coming in to tell us what they thought was actually already going on in and about the Department on the two questions of what are the measures of preclinical in clinical work. And a little bit about programs in each.

And the meeting we had just last week, we tried to accomplish a couple of things. One thing which we thought was very important was to have people come in who actually had recently served. We had a young sergeant, and a young captain come in. The captain has the additional benefit -- additional experience benefit, not only of having recently served in, I think, both Iraq and Afghanistan, but being a Ph.D. Psychology student at the University of Michigan -- where I got my degree so I thought that was nice, and I was pleased to see that we are still teaching people well because he was a smart and engaged fellow, Captain Erwin.

A lot of what we also do is try to get more of a sense from people wearing uniforms, not just people who've recently served but people who are on the uniform side

of our lives, about how they're seeing things. We've spent a lot of time talking to and listening to policy folks. So it was kind of more of an interest in what those people had to say.

And then we went on a tour to the Pentagon because -- I don't know how this is for most of the Subcommittees that you folks are involved with, but most of the folks on my Subcommittee hadn't been in the Pentagon before, much less toured around it, much less had a very interesting private tour led by Ms. Bader to take us down some very interesting and lovely corridors. And people like that a lot, especially since for the general tour we were attached to a group of high school kids, which was interesting I have to say.

Past and not an exact list of the future teleconferences. There are a couple of reasons we're going to West Point. One is we've never met anyplace -- well, not really met anyplace -- outside of the Washington region, and I thought it would be nice to have a small different place for folks to go. And there is currently a resilience program, an early form, at West Point. It may or may not continue, but

that's one of the things that we wanted to see and understand what it's about. What's good and what's not good about it, how it measures itself and the like. The rest of that is pretty straightforward.

Now, this is a question which is going no where. There is -- you may be aware -- supposed to be a TBI Subcommittee. It has a distinguished and wonderful chairman, our colleague, Dr. Bullock, but unfortunately none of the members of the Committee, if I understand it, has a currently valid appointment; is that correct? So therefore that Committee has not met.

And we have a working group -- or normally we have a working group -- together with that Committee to deal with this question since the ANAM covers both of our realms. So as a result -- I'm embarrassed to say -- this question sits out there unanswered. Now, it was also sitting out there before we stood up so that may be information or not.

And that brings us to this. I'm sorry, it was a little bit longer than Wayne's introduction, but if anybody would rather ask a question or make an

observation and give Wayne a chance to close up and Don a chance to hit the gavel so we can go outside for a little while, I'm happy to entertain, at least, to really wonderful questions or comments.

DR. LEDNAR: Dr. Fogelman's brief was a whole lot more informative than my introduction. Thank you. Questions or comments for Dr. Fogelman?

Thank you, Dr. Fogelman, for that brief and for all the energy that you're bringing to this important aspect of the health and effectiveness of our force.

What we'd like to do at this point is to ask Commander Feeks to share with us closing administrative remarks and information which we will need for tonight and for tomorrow. Commander Feeks?

CDR FEEKS: Thank you, Dr. Lednar. This is Commander Ed Feeks. And for those of you who are -- since we're not going to reconvene in this room and we won't be needing the contents of these binders in this room anymore, I invite you to make

use of the manila folder that's in the back of your binder as a compact way to take it with you if you want to. It's more economical than having us FedEx it to you once we all get home. So please avail yourself to this manila envelope in the back of your binder if you'd like to take the contents of your binder with you.

Secondly, if like me when you checked in you forgot to turn in the Federal Employee's Certificate in order to obtain an exemption from Florida sales tax for your hotel room, there is a copy of that form in the back or in the left envelope of your binder. It saves -- again, it saves the Government if you fill this out and turn it in.

Some of you may have received an e-mail copy of one that's sort of prefilled out, and unfortunately we don't have copies of that here, but if you would please turn in your certificate, the front desk should still accept it and associate it with your stay and exempt you from sales tax.

And for Board members, ex-officio members, service liaisons, and invited guests, bus transportation will leave from the hotel at 7 a.m. tomorrow morning to take us to site visits. We will begin at an old Navy see plane base called Naval Air Station Banana River, but it's been better known to the younger locals here since 1950 as Patrick Air Force Base. We will then also go to Canaveral Air Force Station and the Kennedy Space Center.

Please note that you must travel on the provided transportation due to security measures. You're not able to follow the buses in your rental cars.

We anticipate that we will conclude at 1:30 p.m. tomorrow and arrive back here at the Double Tree by 2 p.m.

Now, the installations that we will visit have communicated the following dress code: Flat closed-toe shoes must be worn. So no heels, peep toes, slingbacks, et cetera, are permitted. I don't know what I'm going to wear.

(Laughter)

CDR FEEKS: Long pants must also be worn. No skirts, shorts, or capri pants are permitted. Backpacks and coolers are also prohibited. We will be looking at static display aircraft tomorrow. We'll be climbing ladders an that sort of stuff, and so that's the reason for that.

For those of you joining us for the dinner tonight, please convene in the lobby by 6 p.m. The shuttle service is being provided and will leave from the hotel at 6. And return transportation from Milliken's Reef to the hotel will also be provided.

And, again, if you've not RSVP'ed for the dinner, please see Jen Klevenow who's seated next to Andrew, our sound man.

And this concludes my remarks. Dr. Poland?

DR. POLAND: Well, I don't think we have any other business to adjudicate this afternoon unless there are any questions. We've gotten

through a tremendous amount of important issues. No other questions? I think we can adjourn.

Col NOAH: Thanks, everyone, for attending. On behalf of Dr. Rice now -- I've got to keep this up to date -- myself, and the rest of the Office of the Assistant Secretary of Defense for Health affairs, I do appreciate what you do for us, with us, and to us. It does help us to do what we do that much better.

And I was actually the one who asked for those evidence-based metrics because it is incumbent upon me, and hopefully all of us, to measure our impact on what we do. So thank you for helping us do that.

The meeting of the Defense Health Board is adjourned. Thanks very much.

(Applause)

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

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

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