UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Arlington, Virginia

Tuesday, November 2, 2010

PARTICIPANTS:

Core Board Members:

WAYNE LEDNAR, M.D., Ph.D.

GREGORY POLAND, M.D.

CHRISTINE BADER

COLONEL (Ret.) ROBERT CERTAIN

JOHN CLEMENTS, Ph.D.

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FRANCIS A. ENNIS, M.D.

WILLIAM HALPERIN, M.D.

EDWARD KAPLAN, M.D.

JAMES LOCKEY, M.D.

RUSSELL LUEPKER, M.D.

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GENERAL (Ret.) RICHARD MYERS

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JOSEPH E. PARISI, M.D.

MICHAEL PARKINSON, M.D.

ADIL E. SHAMOO, Ph.D.

JOSEPH SILVA, M.D.

DAVID WALKER, M.D.

HONORABLE TOGO WEST

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FLORABEL MULLICK, M.D., Sc.D.

RIDGELY RABOLD

KENNETH W. KIZER, M.D.

CHARLES FOGELMAN, Ph.D.

THOMAS W. UHDE, M.D.

FRANK K. BUTLER, JR., M.D.

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ELDESIA GRANGER

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LARRY NISENOFF

PAUL REPACI

ALMA RICO

STEPHEN SCANGO

COMMANDER CYNTHIA SIKORSKI

PORTIA SULLIVAN

PAUL WILSON

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DHB Staff:

CHRISTINE E. BADER
Director and Designated Federal Official

COLONEL JOANNE McPHERSON
Executive Secretary

CCSI Contractors:

MARIANNE COATES

JEN KLEVENOW

LISA JARRETT

OLIVERA JOVANIC

ELIZABETH MARTIN

HILLARY PEABODY

BRITTNEY SCHNESSLER

KAREN TRIPLETT

Presenters:

COLONEL THOMAS BAKER

WILLIAM HALPERIN, M.D.

DR. JAMES KELLY

CAPTAIN JEFF TIMBY

Court Reporter:

CHRISTINE ALLEN

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P R O C E E D I N G S

(8:59 a.m.)

DR. LEDNAR: Good morning everyone. I'd like to welcome everyone to day two of the Defense Health Board. We have several important topics on our agenda today. But before we begin we'd ask if General Robb would share with us an article that has appeared in today's local newspaper that would be of interest to the Board. General Robb?

MAJOR GENERAL ROBB: First off, I'd like to thank everybody on behalf of the Chairman for what you all do each and every day. I think it was rather timely that there was an article in today's Washington Post that was spot on about what we were talking about yesterday. In case you haven't seen it, it's called "The Well-Armed Medic" and was talking about what they carry in their backpack, to talk specifically about Hextend in here and the discussions that we had yesterday. If you read the article which is very timely, you'd think that you were reading about the briefing we got yesterday about the pros and cons

of whole blood and component therapy and why we use Hextend or that type of material because it's about weight and cube. Sixty pounds these young medics have on their backs. Sixty pounds of life-saving equipment. When we're debating here the efficacy of a liter of something versus a half a liter of something, it makes a difference. So these are very, very important and very, very timely discussions that we are having here.

Again, on behalf of the chairman and the entire Department of Defense, thank you all for what you do each and every day to make the quality and the quantity of life for our soldiers, sailors, airmen, Marines, coalition forces and civilians as we go out and support the war fight.

The second thing I'd like to share with you is that I had the opportunity last week to view the premier of an HBO special called War-Torn. It's done by the same group that did Band of Brothers and Baghdad E.R. What it talks about is posttraumatic stress or posttraumatic stress disorder, in other words, when it makes

your life dysfunctional. It's fascinating and it will premier on November 11, Veterans Day. I share with you all that I believe it's a must-see for the men and women I believe on this Board because it captures the essence of what we're trying to put our arms around with this entity of psychological health and posttraumatic stress.

What it does, it does a chronology from the Civil War up to the current conflict, the Civil War, then it goes to World War I, World War II, Vietnam and the current conflict. It tells the story through letters in the Civil War and then footage and testimonials in World War I, footage and testimonials in World War II, but in World War II which is really the oldest surviving group of veterans that we have, it's a group of them in a room talking about how they just weren't quite right when they came back and what they had to put up with and what their families and the burden that societies has with how do we deal with these men and women who have this posttraumatic stress and it really captures it. Then of course

it talks about the current conflict. In fact, we had in our audience two of the families of folks who had committed suicide and they tell the story as you'll see in this documentary about what their sons and their daughters went through when they came back from this conflict.

Again it's well worth seeing. It captures the essence of posttraumatic stress, but really it captures what it means to society and then the families and you'll see there's a really special part at the end about a family that's sticking with their soldier and how they get through daily life. I think it will if nothing else energize us on what our end state is and what your target is and where we need to go to support these men and women.

Again, on behalf of the chairman -- I have to leave this morning. I'm actually moving today. But again, on behalf of the chairman and our entire staff, thank you all for what you do each and every day. I don't know if we say that enough. We probably don't. Again, good luck for

the rest of the conference. Thank you.

DR. BUTLER: I have to add one quick postscript to that. FYI, the first person to start to push the modern generation of lifesaving things out onto the battlefield specifically tourniquets and hemostatic agents was the CENTCOM Surgeon in 2005, Colonel Doug Robb.

DR. LEDNAR: Thank you, General Robb for telling us about the article today in The Washington Post and the upcoming documentary. We will get the reminder out to everyone in case you can't remember next week when it is November 11.

I'd ask at this time Ms. Bader as our designated federal officer if she would please call this meeting of the Defense Health Board to order. Ms. Bader?

MS. BADER: Thank you. As the designated federal officer for the Defense Health Board, a federal advisory committee and a continuing independent scientific advisory body to the Secretary of Defense via the Assistant Secretary of Defense for Health Affairs and the

surgeons general of the military departments, I hereby call this meeting of the Defense Health Board to order.

DR. LEDNAR: Thank you, Ms. Bader. In keeping with our practice of the Defense Health Board, we'd like to begin our meeting by please standing and let's spend a moment of silence in honor of the men and women who serve our country and keep us free.

(Moment of silence)

DR. LEDNAR: Thank you. Please be seated. This is an open session of the Defense Health Board. What we would like to do is to begin by being sure that everyone has an idea of who's here, so we'd like to please start with introductions and if you'd give your name and your affiliation. If we can start, we'll start in the opposite direction from yesterday. Mr. Bader, if you would begin and we'll go around the table and then we'll ask our guests to introduce themselves. Ms. Bader?

MS. BADER: Good morning. Christine

Bader, director, Defense Health Board.

VICE ADMIRAL MATECZUN: Vice Admiral John Mateczun, commander, Joint Task Force, National Capital Region.

FATHER CERTAIN: Robert Certain, member of the core board and retired Air Force chaplain.

DR. LOCKEY: Jim Lockey, occupational and pulmonary physician at the University of Cincinnati and member of the Board.

DR. CLEMENTS: John Clements, chair of Microbiology and Immunology, director of the Tulane University Center for Infectious Diseases and member of the core board.

DR. PARKINSON: Mike Parkinson, past president of the American College of Preventive Medicine working with health care organizations and employers today about performance.

DR. SHAMOO: Adil Shamoo, University of Maryland School of Medicine and member of the Board. There is no such thing as core board.

DR. KAPLAN: Ed Kaplan, professor, pediatrics at the University of Minnesota Medical

School and member of the Board.

DR. BUTLER: Frank Butler, chair of the Committee on Tactical Combat Casualty Care.

COLONEL MOTT: Bob Mott. I'm with the Army Surgeon General's Office and the Army liaison.

COMMANDER SCHWARTZ: Erica Schwartz, Coast Guard liaison.

CAPTAIN NAITO: Neal Naito, Navy liaison.

LIEUTENANT COLONEL GOULD: Phil Gould, Air Force liaison.

COLONEL HACHEY: Wayne Hachey, ODS Health Affairs liaison.

COMMANDER PADGETT: Bill Padgett, Marine Corps liaison.

COMMANDER SLAUNWHITE: Commander Cathy Slaunwhite, Canadian Forces medical officer in liaison at the embassy in Washington, D.C.

GROUP CAPTAIN COWAN: Alan Cowen, British liaison officer to the Department of Defense.

DR. MULLICK: Florabel Mullick, director, AFIB, soon to be nonexistent, and also executive secretary of the Subcommittee Laboratory and Pathology for the Defense Health Board.

DR. KIZER: Ken Kizer, chairman, Medsphere Systems.

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

DR. MASON: I'm Tom Mason, professor of environmental and occupational health at the University of South Florida and a member of the Board.

DR. DICKEY: Nancy Dickey, president of the Texas A&M Health Science Center and a member of the Board.

DR. WALKER: David Walker, professor and chair of pathology at the University of Texas Medical Branch at Galveston and member of the Board.

DR. SILVA: Joe Silva, professor of internal medicine and infectious diseases, University of California- Davis, Dean Emeritus,

member of the Board.

DR. PARISI: I'm Joseph Parisi, professor of pathology at the Mayo Clinic College of Medicine in Rochester, Minnesota, also chair of the Subcommittee on Pathology and Laboratory Services for the Defense Health Board and a member of the Board.

DR. ENNIS: I'm Frank Ennis, professor of medicine, Molecular Genetics and Microbiology at the University of Massachusetts Medical School and a member of the Board.

MAJOR GENERAL ROBB: Dr. Doug Robb. I'm Joint Staff surgeon and a member of the Pentagon.

GENERAL MYERS: Dick Myers, retired military and member of the Board.

DR. POLAND: Greg Poland, professor of medicine and infectious diseases at the Mayo Clinic, Rochester, Minnesota and one of the co-VPs.

DR. LEDNAR: Wayne Lednar, global chief medical officer of the DuPont Company and along with Dr. Poland co-vice president of the Defense

Health Board.

MS. KLEVENOW: Jen Klevenow, DHB support staff.

DR. LUDWIG: I'm George Ludwig. I'm the deputy principal assistant for research and technology at the Army Medical Research and Materiel Command.

COLONEL DINIEGA: Ben Diniega, Health Affairs.

COLONEL BAKER: Colonel Tom Baker, I'm the interim director of the Joint Pathology Center.

COLONEL WARDELL: Scott Wardell, executive director, Administrative Operations JTF CapMed.

DR. ERDTMANN: Rick Erdtmann, staff director, Institute of Medicine, ex officio member of the Board, former Army Medical Corps Officer.

COMMANDER SIKORSKY: Good morning. Cindy Sikorsky, preventive medicine resident, Uniformed Services University.

MR. HAILE: Jason Haile with Scitor

Corporation.

DR. BARTON: Joel Barton, pathologist and deputy chairman of the Urinary Department AFIP.

DR. SESTERHENN: Isabel Sesterhenn, Chairman, Urinary Department at the AFIP and future member of the JPC.

MR. APACHI: Pomer Apachi, Army Surgeon General's Office.

MR. MILLER: Good morning. I'm Gene Miller and I'm with Batel.

MS. COATES: Marianne Coates, communications advisor to the Defense Health Board, and one postscript if I can. The article by David Brown is one of several. David Brown is a physician with The Washington Post. Frank Butler has given him an education before he embedded for 1 month with the troops over in Afghanistan and the articles are continuing to come out. I think they're really good articles. Thank you for bringing it up today.

LIEUTENANT COLONEL FAGAN: Nancy Fagan

from Health Affairs.

DR. GRANGER: Eldesia Granger, resident, internal medicine, pediatrics, University of North Carolina-Chapel Hill.

DR. UMHAU: I'm Dr. Bill Umhau, a family medicine doctor, Occupational Health Environmental Safety Services at NSA Fort Meade.

DR. CRON: I'm Kevin Cron. I'm a preventive medicine resident.

MR. PERRY: Michael Perry, American Registry of Pathology.

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

MAJOR LEE: I'm Major Roger Lee from Joint Staff at the Pentagon with the Joint Staff Surgeon and the J-4 Health Service Support Division.

MS. JOVANIC: Hood morning. I'm Olivera Jovanic, DHB support staff.

MS. MARTIN: I'm Liz Martin, DHB support staff.

MS. PEABODY: Good morning. Hillary Peabody, also DHB support staff.

COLONEL GRIMES: Good morning. I'm Jamie Grimes and I'm the national director, Defense and Veterans Brain Injury Center.

DR. LEDNAR: Thank you everyone for those introductions. Before we begin our formal agenda, Ms. Bader has a few administrative remarks that she would like to share with us. Ms. Bader?

MS. BADER: Thank you. Good morning again and welcome. Please sign the general attendance roster on the table outside of the room if you have not already done so. Additionally, for those not seated at the U-shaped table, there are handouts that are provided at the sign-in table right outside the door. This is an open session. It is being transcribed. Please ensure that you state your name and speak into the microphone so that our transcriber can accurately record your comments.

We will be finishing earlier than originally scheduled today. Our plan is to finish

around noon. When we finish the formal session we will then have an administrative session and we'll have a working lunch for the Board members, ex-officio members, service liaisons and DHB staff. It's good news that we're finishing a little bit ahead of schedule. For those of you who are local and were not able to get out and vote before the meeting, please vote this afternoon. Thank you and we look forward to a great meeting.

DR. LEDNAR: Thank you, Ms. Bader. We'd like to start the meeting, and the Board is grateful to have with us today Vice Admiral John Mateczun, commander, 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, was U.S. Delegate to the NATO Committee of Chief of Medical Services, as well as on the Joint Staff during Operations Noble Eagle, Enduring Freedom and Iraqi Freedom. Vice Admiral Mateczun today will share with us a progress report on the Walter

Reed National Military Medical Center. Admiral Mateczun's slides may be found in the binders under Tab 8. For our guests, copies of the handouts have been available outside the room. Thank you. Admiral Mateczun?

VICE ADMIRAL MATECZUN: Thank you, Dr. Lednar, Dr. Poland, Ms. Bader, General Myers, my old boss on the Joint Staff who really headed up all those projects that Dr. Lednar was just reading. I'm here today to update you on our progress in enhancing the world-class health care capabilities in the National Capital Region. I'm going to tell you some of the background. I think many of you have been through these briefings before. We've been at this for 3 years now, going on four, and tell you what the components are of the Comprehensive Master Plan that will achieve the last of the world-class capabilities or attributes and then tell you something about how we're doing on some other projects as well.

It seems like just yesterday but here we are and there's under a year left to go, 321 days

I think until September 15, 2011, when the statute requires that we complete the BRAC projects. We were formed in 2007, the Joint Task Force, to execute the BRAC projects while continuing to provide casualty care in the capital region. Then in October 2008, the fiscal year 2001, NDAA required an independent review of the BRAC plans for Walter Reed and Fort Belvoir. Actually that was the fiscal year 2009 NDAA. In July 2009, there was a panel of the Defense Health Board that completed the independent review. Dr. Ken Kizer headed up that panel. That came to the department in July and went over to the Hill. The department endorsed those recommendations in October, and then a few weeks later the fiscal year 2010 NDAA codified the DHB definition of world class so it's now a statute and required a Comprehensive Master Plan for the National Capital Region on how we were going to achieve that status at the Walter Reed National Military Medical Center-Bethesda.

The Comprehensive Master Plan mandated was provided on April 23 this year to Congress as

a roadmap to get to those additional world-class attributes that were identified by the Defense Health Board. And then DOD also approved a supplement to that Comprehensive Master Plan which was also mandated by the fiscal year 2010 NDAA.

Here are the primary components of what went into the Comprehensive Master Plan, world-class construction projects at Bethesda, and I'll go into some detail about that; the National Capital Region organizational and budget authorities; how are we handling IMIT; and our civilian personnel. Here's an update on the construction projects. I have a lot of pictures that I'll be showing you as well on how the new construction projects are going and some of the renovations. The Comprehensive Master Plan that was submitted to Congress in April and reiterated in August identifies $829 million in facility projects on the Bethesda campus that includes the design of temporary facilities, additional parking, outfitting, transitional costs and the base infrastructure upgrades needed to meet the

attributes. In sum, there will be new construction of 560,000 square feet, 325,000 square feet, and I'll show you a picture, are in poor or failing condition and they will be demolished and it would also renovate an additional 120,000 square feet of clinical space. The primary drivers of the space requirements are the identified attributes of single-patient rooms to be in a world-class standard. So at the end state of the BRAC there will still be 50 double-patient rooms at Bethesda and in order to achieve the new standard we have to convert those 50 double-patient rooms into 100 single-patient rooms. We're already in the process of renovating the operating rooms to reach the size required to be world class, but that has also edged some of the logistical infrastructure out from around the O.R.s and so we have to go back and add some more space to do that. That and a simulation center and the space required for simulation are the primary drivers of the space that we need.

Right now the department is estimating

that these projects will begin in fiscal year 2012 and be completed by fiscal year 2018. Right now there is a saturation of construction and that certainly includes construction workers coming on to the Bethesda campus and that will last through the end of BRAC. We have a lot of projects that we've got to finish up. The Navy has determined that a new environmental impact statement will be required before this construction can begin so that we're going to have to do a lot more coordination with community organizations before we can get to that environmental impact statement.

Costs will continue to be refined. If there's one thing I've learned it's that construction costs are always an estimate even when you're through. We're going to complete the planning for all of the facilities on the campus by the end of this year and then design will get underway.

This is the current campus on Bethesda. For those of you who are familiar, Wisconsin Avenue is right out here down at the bottom of the

slide. This is the new outpatient building, Building A, and this is the new Building B which has a lot of intensive care units, some operating rooms and some other infrastructure. These are the existing clinic buildings and inpatient buildings on the campus and this is some of the historic part of the campus back in here. We have within the department a facilities condition index which the Under Secretary for Acquisition Technology and Logistics has updated. This FCI index which you'll see over here scores the buildings based on this new scoring system that we're using within AT&L. You'll see what the Defense Health Board subcommittee and Dr. Kizer's committee saw in particular. This is all red so this is poor or failing infrastructure based on facilities' conditions which is exactly what the Defense Health Board said and is exactly what we need to work with. This is where the inpatients are and so we're going to have to build and move functions out of here so we can get all of the beds that we need to into this space and some into

this space. Then the plan right now would really be to do new construction of all of this. This would all come out, that's the 325,000 square feet that needs square feet that needs to be demolished and build 560,000 square feet in there.

This is a very telling slide in terms of the projects. The MILCON projects are going on. These are the most current MILCON projects in Buildings A and B, MILCON military construction funding. Then there wasn't any previous military construction funding going on on the campus after 1971 when these buildings were built so that we have a lot of facility restoration and modernization that we need to do.

This is the campus as it exists today. There is a lot of building going on. The last time I was here I didn't have these slides. You'll see that this is the outpatient building now complete. It is actually getting turned over. It is in the process now of outfitting. There is a parking garage here. This is Building B which is going to start being outfitted very soon as

well. This will be completed in outfitting by December as will this so that all of the equipment will come in and be installed, tested and it will be ready for people to move out of these current clinic buildings over into the clinic space over here. The green is what was phase one. There is some medical swing space over here where orthopedics and O.T. Are now, but they won't be needed right away for anything else.

This is the NICOE. I saw that you had an update. The NICOE saw their first patients 3 weeks ago and now are starting to sequence patients through and over the next 2 weeks we'll get up to a patient census of 10 next week in there and then we'll ramp down for the Thanksgiving holiday and then back up in December. Staff is coming in at a very good pace. These three Fisher Houses are 20-unit Fisher Houses and this was donated by the Intrepid Foundation. This is donated by the Fisher Foundation.

And Building 3 has been accepted by the Navy now and they are doing some modifications to

make sure that it meets code and then it will be ready to primarily house patients and families that will be coming in to the NICOE and the other two will be turned over shortly. They are very beautiful houses, 20-unit houses each so that that's 60 new units for family housing coming onto the campus. This is a new parking garage. We've just torn out this part of the old campus and are starting construction on that now. This is a massive parking garage with almost 1,300 parking spaces. It will be done by the time the BRAC is finished.

Then on phase two we have the wounded warrior lodging. I'll show you a slide on that. We have an admin building, a 70,000 square foot workout facility and pool and a parking garage going back into this part of the campus right here. This of course is the university if you want to get oriented to that. When I say that we're saturated with construction, I mean we're saturated with construction right now.

This is a back look at the campus

looking at it from the other side. This is Wisconsin Avenue out front. Right now many of you may know that there's a Medical Center Metro stop and the National Institute is right across the street. The Washington Metropolitan Area Transit Association has done a study on how we can pedestrian traffic across Wisconsin Avenue which is not an easy thing to do. The three most crowded intersections in Montgomery County surround the Medical Center: One up here on Wisconsin Avenue, one kind of back over here to the bottom on Connecticut which you can't see and then on Jones Bridge Road over on this side at Jones Bridge and Connecticut. So there are massive amounts of traffic coming through there. It is hard to get across Wisconsin Avenue.

They've come back with a proposal for either a short tunnel or shallow tunnel under Wisconsin Avenue, a deep tunnel with an elevator coming under Wisconsin Avenue or we thought they were going to go for a bridge, but they think that that impairs the site picture so they're proposing

an underpass that would actually divert Wisconsin Avenue under something that goes across there. That of course would be a very expensive option. The department has $20 million committed to working with them on whatever it is they choose to do in working with that traffic mitigation.

We also have a proposal in to mitigate traffic through business processes. We have a million refills a year that we do and trying to divert that traffic and not have people have to drive to our places but taking a look at mail order refill is one way that we can not have traffic come on to the traffic campus. It's a very busy campus.

This is the admin building. Let me go back and show you were that is just so you can see. That's this building right over here, this large complex so that this is all administrative. This is the end state down here with the green roof. This was an historic building. Some of you may have actually worked in this building. It used to be the Navy Medical R&D Command. It was

completed by the same architect who's done the tower. They call it a curved façade. It's actually an angled façade. It's not curved. But it's historic and so we had to maintain the façade. They decided to maintain the whole building. It had asbestos that's all mitigated and they're renovating inside there now. You'll have these other two floors that will come down with a green roof and then a gymnasium and parking complex so that this will be a very environmentally friendly part of the campus.

Tower cranes are my friends. I see new tower cranes popping up all the time, but these tower cranes are constantly working. They were working until dark the other night. They have to stay synchronized as they turn. They turn across each other. It's kind of interesting to watch. Our building, the building where we work out of is right over here. Luckily we are in what is called a no-fly zone so they can't turn these over our building which gives us a little bit of confidence in what's going on.

This is the completed part of the outpatient building, just a couple of shots. You can see here this is one of the lobbies what it looks like. It's really an extraordinary building. This is looking into a skylight tunnel that comes all the way from the center of the roof, down all the way through the floors of the complex to bring light into each of the floors so they have this central corridor. This is what the bottom of it looks like with the very nice Zen garden and mosaic that has been put in down there. These are also very near where the new MATC, the amputee and prosthetics care center will be.

This is the new wounded warrior lodging that is going up. This is the concept with two towers and an admin building and dining hall. These are each of the towers as they're going up and the admin building will be across back here. This is the concept. We've now moved into a new business and that is rehabilitation. Before Operation Iraqi Freedom we really didn't rehabilitate patients, prosthetics and amputee

patients in particular and return them to active duty. Now, however, we do and so that requires that we adjust. Previously we didn't have to have room for people to return to activities of daily living and we didn't need to train in that, they would be discharged to go to a VA and transition there. Now we do need to discharge patients from the hospital not completely ready to assume activities of daily living, particularly the amputees.

We have a lot of people in limb salvage and/or traumatic brain injuries and they may need a nonmedical attendant which is an evolving concept for us as well. A nonmedical attendant many of you is a construct under the Joint Federal Travel regulation which allows us to pay for sending one family member with a casualty some place, but now they've turned it into a functional entity and that is that they actually are a nonmedical attendant who helps people in these circumstances. The Army uses this concept extensively, the Marines and the other services to

a lesser degree.

This is what one of the suites would look like. All of the rooms in these towers are constructed as suites of two bedrooms, a bedroom on either side with a common living area in the middle which has a small laundry, a kitchenette and the other things that we need to ease people in transitioning to their new outpatient environment. This has been very successful. People usually don't want to leave the campus. We've been helping many of them transition into apartments in the local community. They usually don't want to, and then once they're there they never want to leave those apartments. As they gain independence and confidence at being able to navigate in that world, they're very happy to be moving through the steps that it takes to readjust back into the community. These are going to be extraordinary. There are 300 of these rooms, 150 suites. If necessary we can put a person and a nonmedical attendant in there or two outpatients if we need to. These are completely ADA compliant

rooms and meet every standard that we can for taking care of our folks.

Here is the concept. This is just a conceptual drawing on how we would achieve the world-class standard. I showed you that area that we needed to take out the buildings and this is what would go in there. It's still very conceptual. You can see that this arranges the campus on axes which will be much easier for patient and staff navigation and puts a tower back in here. We're still looking through the possibilities for aligning behind the tower because the site picture when you look up a slope from Wisconsin Avenue it's important to the National Capital Planning Commission that has to approve the plan, but that would be the idea right now.

Let me switch to Fort Belvoir. The Fort Belvoir Community Hospital plans were seen to be world class. In fact, this is the leading exponent of evidence-based design in the country right now. It's moving right along. The plan is

a parking garage on either side and there's nothing parking and south parking. Those are up and functional. There are two clinic buildings on either side. You see these clinic buildings which are now finished and the skin is on. This is a thermal skin which recreates the look of brick or terracotta but has much better properties and is easily replaceable. Should they become damaged there is an air gap behind that terracotta-looking skin as well and so it's very environmentally friendly. These scoops which are sort of the signature as you look at the campus from outside are rainwater collectors. They serve a double function in that they air conditioners and air handlers and other equipment are underneath them and covered so that you don't see the air handlers on top of the buildings. They collect rainwater and put it down into cisterns underground. Ultimately they'll water these gardens that are in between the projects.

This is nine holes of a golf course. It's about the size of the Springfield Mall for

those of you who know Northern Virginia. It's about an aircraft carrier in length from here to here and another aircraft carrier from there to there so that this is an extraordinarily large medical campus. This is 7-story tower which is the inpatient building and will be the last to completed with 120 beds, 10 O.R. and 30 E.R. spaces to put in there. This is the central utility plant which will feed the energy needs, and this is all going to be parking out in the front at the end so that there will be a lot of parking. There's good way finding. Coming in you'll see each of them has a name. This is the Meadows, the Sunrise, the Oaks, the Eagle and the River so that these buildings are themed as you walk through them and walk through the building you'll be able to find where it is that you're going. We're trying to make sure that people who are going to one of these buildings park over here instead of here because it's kind of a long ways.

These are some of the current pictures from the outside. It's an extraordinarily looking

facility. This is the back of the inpatient tower. You can see the skin is almost finished on it. The towers are coming up. They're working on finishing the interior of that now and we are moving to start outfitting in the clinic buildings. The clinic buildings is that swoop I told you about. We're going to start outfitting in those clinic buildings here this month and we'll have those clinic buildings ready but we're not going to be ready to move out of Fort Belvoir until we get parts of the tower completed because we have to have ancillary services available before we can move some of the other services.

This is what some of the interiors look like. I didn't hear anybody say that they were a pediatrician. This is clearly a PEDs ward with turtles and duckies as you walk down the way. This is the concept of what it looks like as you come in. The idea is that you walk into a foyer and then move into these fairly quiet spaces that will then move you back into the clinic rooms very much like the Disney on-stage/off-stage concept.

Support, supply and logistics will not be on stage if you will where the patients are waiting. People carrying blood and doing other things will be back in the back moving through the back part of the clinic that will be back there in those corridors along the back. The staff rooms are in the back and all of the patient rooms are along the side. It's a very nice concept. This is the P.T., physical therapy, pool. It's an extraordinary pool. These are connectors between the buildings. Ultimately there will be gardens here. You can see the light. There's light everywhere. This is one of the murals. I don't know. This is one of those things where you delegate a lot of things to people and they pick murals. This is in the PEDs ward and I didn't know if it was a scary tree or a friendly tree. You can decide when you got. But it does have bold, distracting colors is what the design people were looking for.

Also going up out at Fort Belvoir to support the wounded warrior lodging is a brand new

complex of completely ADA-compliant rooms which are going to be built something like along the lines of what you saw at Bethesda in these towers and with the admin building. This will be primarily a warrior transition unit as it's an Army base and the vast bulk of the casualties that we handle in the capital region are soldiers at the moment. All of that is changing as the current conflict changes and I'll be glad to update you on how we're doing there. That's some of the pictures of the construction and how we're getting to world class and in particular how we're going to take care of the wounded, ill and injured coming back.

Budgetary authorities. One of the things that the Defense Health Board panel recommended was that you have to have an alignment of organizational and budgetary authorities in order to be able to achieve world class. I am in complete agreement with that and this is what we've done. I now have what's known as operational control over the Walter Reed Army

Medical Center, the National Naval Medical Center and DeWitt Army Community Hospital. Those are the hospitals that are going to collapse into the new Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital. I have the authorities necessary to reorganize, realign and direct moves with those folks. It's kind of a daunting task. There are about 9,000 people in those facilities so that's a lot of people relying on us to get this done correctly.

Post-BRAC the Joint Task Force will maintain operational control over the Walter Reed and Fort Belvoir complexes. There is a move to call this Walter Reed National Military Medical Center-Bethesda and put a B on the end. If you think about it, it incorporates both the Walter Reed and Bethesda parts of the past and so although it's not in the law, that may be something that comes into common usage over time. Of the other outpatient clinics, there are about 37 other clinics in the region. I still have what's known as tactical control over them but not

OPCON. The Chairman of the Joint Chiefs has directed that we look at that after the BRAC and that we get through the BRAC before we move any further.

We have single organizational and budgetary authority so that we get synergies for more effective and efficient operation that aligns with the Defense Health Board's recommendations which they called foundational that somebody has to be empowered with singular authority. We have worked with Health Affairs to get all of the budget aligned. This year we've got all of the budget for these three hospitals aligned and that is an operations and maintenance budget of around a billion dollars and will be directing the operations in those three hospitals in the funds flow.

IMIT. I'd like to say I'm a lot smarter about smart suites, but smart suites are always surprising. We do have smart beds that we've put in. We've got the electronic clinical dashboard which we're getting the infrastructure to put in

and real-time location system technology. You can never tell. People always have questions. Technology can be misused. I'm not a Luddite and I'm not going to trash technology, but you have to be careful.

I received a question up on the Hill about this one that utilizes real-time location system technology. Part of putting things in was we wanted to make sure that our staff had RFID tags. When you walk into a patient room the patient has a right to know who you are, what you're doing there and what your job is. The idea is that this would flash up on the screen and they could see who you are and what your job is. The question I got on the Hill was are we going to use this to monitor staff, in particular nursing staff? I said no we're not, but now I have to go back with assurances that we're not going to use this to see who's taking breaks or doing other kinds of things. Interesting questions about technology.

The Joint Medical Network. Part of the

difficulty that we have in moving into the future is that the DeWitt and Fort Belvoir complexes are linked back to Walter Reed as their hub for servers and other IT so that we have to transition that platform to another hub. We've got the funding and we're putting together the fiber which is another one of the things we need to do to lay down this new network. We're still working through some of the questions about how we move images. This is not just us in the capital region. How can we make sure that images are accessible in a timely way wherever they need to be? We don't have completely uniform ways of storing and moving all images. We're getting closer. In particular these things you see, cardiology, ophthalmology, endocrinology and nuclear medicine are going to have arrive at some standards.

Civilian personnel are key to what goes on. We have about 4,200 civilians who work in the hospitals that we're talking about at the medical centers. This has been a key part of the

department's effort. We needed to retain that workforce at Walter Reed so that they didn't attrite because we're taking care of casualties while we're doing this transformation so that we needed that capability. Then we need them to staff these Medical Centers of the Future. They are an experienced and skilled workforce and we can't afford to have to go out and recruit all of them again.

This is the first guaranteed placement program for a BRAC site of this size. It's been tried in the department and in particular it is these 2,200 employees are Walter Reed that we're focusing on with the guaranteed placement program. We worked very hard for 2 years at identifying the spaces, that is the jobs that were going to be in each of these new hospitals, then we matched faces to those spaces and then we notified them in June of this year about where it is that they were projected to be in the future state. We sent out all those letters. They didn't have to send back a letter if they were happy with where they were

going. Nevertheless, you'll see that we got back a tremendous number of responses particularly from this 2,200, but from everybody else saying yes I am happy with what's happening here. We certainly have 209 people here who didn't like the location and we're working on that every day.

We've got another year to go before we have to move people so that we're working to try to make sure that in as many cases as we can people are working at the location that they want to work out of. That's an extraordinary acceptance rate we thought and in a program of this size with that many people, I can tell you it's a testament to the commitment of our workforce to stick with us, and as long as we keep our covenant with them to try to provide a job and have it be in the place that they want to be we think we can continue to work this. We do our moving to one single DOD civilian personnel agency. These people work in at least two and sometimes three or four different civilian resource organizations, Army, Navy and others so

that we're combining them into one and we're just finishing up the coordination on the authorities that it will take to do that. Then our plan is to transition them into that new support structure in April, make sure that their pay is all right and that they don't have any problems before we begin the move in the summer of 2011.

In conclusion DOD is committed to enhancing and improving the world-class health care capabilities of the NCR. We're working on this integrated health care delivery system and understand that it will provide more efficient and effective health care. Casualty care will always be our top priority. We express our appreciation to the Defense Health Board for support through the transformation of military medicine in the NCR. It's been a 3-year journey. We have another year to go before the end of BRAC and we certainly have a lot to do in that period of time. People ask me often about risk, what's the risk of finishing the BRAC? I think that people tend to see just what's left in front of them to do and it

looks like a lot of daunting tasks.

However, my risk assessment is that the majority of risk is in the past, that is, before steel went up on these buildings, before they were outfitted, before we bought the furniture and had the equipment lists to put all of the equipment that we need into them and before we had the money. That was when there was a lot more risk so that the risk is more finite today although in some ways that makes it more visible to people and we need to make sure that our people internally and all of the folks who work in oversight with us understand where it is that we're going.

That concludes the presentation that I have. I do want to tell you just a little bit about what we're doing today. We have a lot of casualties coming back from Afghanistan. The number of amputees has increased coming back. During the Iraq conflict we had a number of IED and complex orthopedic trauma cases coming back and a number of burn patients. The number of burn patients has diminished dramatically. We don't

have very many burn patients coming out of Afghanistan.

We do have a lot of amputees coming out so that the proportion of critical care air transport patients who come back in as amputees has risen. Also the numbers of multiple amputations have grown as well. In Iraq they were running under 25 percent, generally around 19. They're up above 25 now and on a given day maybe more. In fact, we have four quadruple amputees that we're caring for now so that the number of double amputees and triple amputees is also increasing. We're working on a model to try to understand resource consumption and requirements for those amputees. There is really very little study on how much it takes to take care of a double amputee. Is it one-and-a- half times as much or is it three times as much as it takes for a single amputee? We're working with that very diligently.

We're also working on a model that tries to identify modeling for the capacity that we'll

have in the O.R., the I.C.U. and med surg beds and we've just presented that to the Joint Staff and to the Under Secretary for Personnel and Readiness to take a look at during the transition and see if we're going to have the capability to take care of that. In addition these complex orthopedic trauma cases are something that we've come to understand that we have to keep a much closer eye on. We have a team at Bethesda of four orthopedic trauma surgeons at Walter Reed and four at Bethesda. Right now we think that they're comfortable handling eight amputees a month. Ten stretches them and 12 is probably too much. They can't continue to see both the outpatients do their washouts in the O.R. and the other things that they have to do and handle the inpatients and incoming load at some point and we're working diligently to try to define what that point is. There's no work on it and so we think that we're coming to understand that more and we'll certainly be happy to share that information as it becomes available. You'd be proud of all of the great

staff there that are working to take care of these casualties who come back and the great staff that are working diligently to make sure that they have the best in facilities as they come back. That concludes my presentation and I'm ready for any questions that you might have.

DR. LEDNAR: Admiral Mateczun, thank you for that brief. I think for a number of us on the Board who've been following the progress of this issue, a lot has been accomplished so thank you for that. I might ask if Dr. Kizer might start if you have any comments or questions, Dr. Kizer, that you'd like to ask.

DR. KIZER: Thank you, and thank you Admiral Mateczun. That's a great overview. I think it's been gratifying to see the response to the committee's report and I think the general acceptance of what was put forth and I certainly commend Admiral Mateczun for his leadership in operationalizing many of the recommendations. Since the subcommittee has not met since I believe March 2009, and has not had the opportunity to

review the Comprehensive Master Plan or anything, I don't think that the subcommittee can weigh in officially on any of that. But again I think it's gratifying to see the progress that is being made.

I have one caveat that I would put forth. The report I think was quite clear that the majority of what is required to achieve world class is unrelated to construction and facility design. As important and as visible as those things are, the majority of what will actually achieve world class is what was described as the invisible architecture, the culture, the processes of care and other things and I'm not sure where any of that stands at the moment. There were a number of specific recommendations in that regard and perhaps at a future meeting we can hear more about how those things are being addressed.

DR. LEDNAR: Thank you. Are there other questions and comments? Dr. Kaplan?

DR. KAPLAN: Thank you for a very nice report. I wanted to clarify one thing that you said at the end of you report and I'm not sure I

understood it correctly. You said that the number of IED injuries had increased, that the number of patients coming back had increased if I understood you correctly from 19 to 25 percent. Does that take into consideration the denominator, the number of troops on the ground?

VICE ADMIRAL MATECZUN: Let me clarify that the number of casualties coming back from Afghanistan has increased. The number of casualties coming back from Iraq has decreased. The number of people from either war who have come back with multiple amputations has increased from 19 percent to more than 25 percent.

DR. KAPLAN: That's an absolute number and not relative to the number of troops on the ground?

VICE ADMIRAL MATECZUN: That's correct. The number of amputees is the denominator.

DR. KAPLAN: Thank you.

DR. LEDNAR: General Myers?

GENERAL MYERS: Thank you, Admiral Mateczun. That's a great brief. Could you

comment on the USO and where they're going to put their centers? I assume you know a lot about that. I also know a lot about it.

VICE ADMIRAL MATECZUN: Yes, sir. We're still working through that. The USO has proffered a building, an extraordinary new USO building to the Navy. The Navy has still not finalized the site. They're planning on accepting the proffer and have not finalized the site. Right now it looks like that construction would begin after the BRAC is completed.

GENERAL MYERS: Just for the group, and you may want to get the USO to brief it because while it's nonmedical we think it's essential to the health and well- being of the patients out there. What the USO has committed to do is a capital campaign to raise $100 million to build two buildings -- one at Bethesda and one at Fort Belvoir -- that would hopefully be close to where the wounded warriors are housed. They will be nonmedical, but the kind of place where you can go with your family, there will be food services and

other things available, entertainment sorts of things, really a departure from what the USO has done in the past. But given the fact that we've been at war for 10 years, this whole notion of enduring care came up and with our new leadership at the USO they want to move in this direction. It's going to be a huge commitment.

The construction companies, Turner and Clark, we'll try to get them to provide in-kind services to build these. I don't know how much they're going to do, but they're both very receptive to that, so it's a huge deal. The one criteria we set for this whole thing is that when an injured soldier or his family walks in that there's a wow factor like they've never seen before. I've already seen the art and they're going to be beautiful. They will be a good adjunct and a place to go which is a nonmedical setting where they can enjoy their family and friends, entertainment and other things and be a hub where all the other veteran's services that are out there through the hundreds of

organizations that help wounded warriors and other veterans will have a place to be so that that is the concept. You may want to get a pitch on it. It's a big deal for the USO. A $100 million campaign is a big deal.

DR. LEDNAR: What I hear in General Myers' concept is consistent with what Dr. Kizer was talking about, the invisible architecture. Part of the culture of care for our wounded warriors and their families is in part what happens in the medical spaces and the medical processes and part of it is what happens in the whole process of getting care, getting to a campus, housing, how the family supported and these other things so that I see it as part of a connected whole. We look forward to learning more about the USO's activities. Dr. Parisi and then Dr. Silva?

DR. PARISI: I had a question for you regarding pathology services for Fort Belvoir and DeWitt Hospitals. Are those going to be independent, free-standing pathology units or are

they going to be tied to the main Bethesda campus and to the JPC or how do you envision that?

VICE ADMIRAL MATECZUN: Laboratory services at Fort Belvoir are separate. There will be some integration between them in terms of services, the Joint Pathology Center for instance will be providing subspecialty consultation primarily through the Bethesda campus and we will keep it administratively organized to do that. Otherwise they'll have their own separate laboratory down at Fort Belvoir.

DR. LEDNAR: Dr. Silva?

DR. SILVA: Admiral, thank you for an update. I have two questions. One, if everything goes as planned, you're done in 2018 when everything is done?

VICE ADMIRAL MATECZUN: Yes. The middle portion of the campus would be started in 2012 and done in 2018. These BRAC projects will be done in 2011.

DR. SILVA: Correct. When you're finally done, what is the big number for the cost

of everything that we could hang our hat on? I know you're going to have overruns and that's common.

VICE ADMIRAL MATECZUN: Right now it's about $1.4 billion for the current projects on the Bethesda campus and that would add right now $829 million.

DR. SILVA: The second thing is I'm in the part of the world where we have what's called California crazies. They can tie up projects related to environmental studies like you can't believe. Are you sniffing at tea leaves and do you expect much trouble there?

VICE ADMIRAL MATECZUN: The Montgomery County population and the Bethesda population are very sensitive to traffic and that is their primary concern. There's not much else that they ever bring up. So with the National Institutes across the street they're vigilant after those projects were built and keeping a very close eye on traffic coming in. If we can divert refill pharmacy traffic off of our campus we'll be able

to move 8 percent of the total traffic that will be coming on to the campus so we think that that's an extraordinary measure. It's certainly going to be a better traffic mitigation than anything else we can do just by our own actions so that we're trying to work with that very carefully with the local Bethesda folks. There is the saying that all it takes to stop a project is a postage stamp and a request for an injunction but we've been very fortunate in our relations and we've tried to make sure that we're as transparent as we can be with the Bethesda campus.

DR. SILVA: Thank you.

DR. WALKER: Admiral Mateczun, this is an outstanding facility for the needs of the current war. How much flexibility is there? I don't have in my own mind what the needs of the next war are going to be.

VICE ADMIRAL MATECZUN: I was walking around the campus yesterday and looking at Buildings 9 and 10 which came out of the Vietnam War and they came right at the end of the Vietnam

War and now we're building the capability. Buildings 9 and 10 have certainly have had extraordinary use over the last 35 years so that I'm not too concerned. We've done five studies now in the National Capital Region taking a look at the beneficiary population. We have in excess of 500,000 beneficiaries here in the local area almost 300,000 of whom are enrolled in the TRICARE system so that there is plenty of patient population out there to fill the beds. There is not going to be an excess of beds. In fact, what's happening now as the casualties are coming in is that people are deferred out into private-sector care so that our private-sector care bill is over $500 million now in the National Capital Region. We'll be able to bring most of those cases back in. We have 40 percent of the Army's Graduate Medical Education Training Programs and over a third of the Navy's Graduate Medical Education Training Programs that we have to support between those two facilities. So there are plenty of patients out there and the patient

demand will be there.

In addition, we're doing some new things that we think will turn into a referral center for many of our patients. We're working to partner with the National Cancer Institute in the Comprehensive Cancer Center that we're standing up for the first time. This will be the first Comprehensive Cancer Center in the military health system. The number of cancer patients and the number of Centers of Excellence that we have will certainly I think be able to bring in patients or recruit them. We do transplants and we do some of the other referral business that will need to come in so that I don't think we're overbuilding infrastructure in any sense right now.

DR. LEDNAR: We have time for one more question. Dr. Lockey?

DR. LOCKEY: I wanted to build on the Disney on- stage/off-stage concept in relationship to this fairly comprehensive and large medical center. Who is addressing ease of access for visitors and for patients in regard to finding

locations they need to go and not getting frustrated? Are you going to follow the Disney concept for that are is somebody else looking at that issue?

VICE ADMIRAL MATECZUN: Dr. Kizer's panel actually listed those concerns as part of the attributes that you had to get to to get to world class. In getting to the Comprehensive Master Plan for instance we have architects, patients, a lot of folks looking at how we can get to ease of way finding, what makes it friendly for patients and how can we do that. At the Fort Belvoir complex they've gone to extraordinary lengths to adjust to that with the themes that they've got like how people will flow into the parking garages and out of the parking garages. It's been a team effort. There is no single entity or individual that I can think of that's focused on that, but it is one of the concerns that we've had.

DR. KIZER: Wayne, could I perhaps make two comments in response to a couple of questions?

Central to a number of the recommendations that were made was the need to design flexibility into the design and in response to the question that was asked here, the recognition that whatever is designed and built to deal with the current casualties is likely to change in 10 to 15 years or the next conflict and that should be recognized in how the facilities are designed so they can be fairly adaptable to future needs, and that's certainly the mantra in private hospital construction today.

The other point I would make with regard to filing prescriptions and being cognizant of Secretary Gates's comments about the need to reduce DOD health care spending, this is one opportunity that is a -- opportunity. I don't recall the exact numbers but I believe the DOD handles about 10 percent of its prescriptions on a mail-out basis in contrast to the VA where about 85 percent of prescriptions are done on a mail-out basis. It's also perhaps one of the very few or only process in health care anywhere that

consistently operates at a Six Sigma level of performance so that that is an area perhaps to keep in mind as a cost-saving strategy that also increases the effectiveness of the system in looking at broader use of mail order prescriptions.

VICE ADMIRAL MATECZUN: Yes, and we are fans of the VA's central mail order pharmacy system. It is extraordinarily Six Sigma in those operations so that we understand completely that that is a road to quality. There are some built-ins into the plans. There is room to expand on the clinic buildings. You'll see that their room has been left behind these. Part of Dr. Kizer's panel's recommendations were that you have to look to the future and be able to expand. Remember that the BRAC required that we not build any more capability than existed during the baseline year so that we were capped if you will at the number of beds that we've got and we distributed them. However, in these clinic buildings down at Fort Belvoir which is now where

the majority of our population is moving, down south on the 95 corridor there's room to expand out and there is also room to expand out the back of these inpatient towers so that we can add inpatient capability as well.

We kept that in mind when we took a look at the Bethesda campus. Here this is going to be built and what they're working on is a concept that goes beyond this building so that if you take a look at Bethesda 2040, this is 2018, then you will see that it starts to flow into the rest of the campus in terms of being able to increase capacity if you need to. Nobody talks about decreasing capacity and certainly in these large complexes that seems to be the way that it's going. But yes, these were great recommendations from the panel and we've been happy to incorporate them into our planning.

DR. LEDNAR: Admiral Mateczun, on behalf of the Board we really appreciate first this brief today, but I think we could all see the complexity of this project and it wouldn't come together

without extraordinary leadership and we really appreciate what you've done to make this all happen. Care doesn't stop. You are flying an airplane and fixing it as you go and we really appreciate the leadership that you've brought not just in terms of the medical aspects of this but you've got a lot of work with Health Affairs, with Congress, with communities like Montgomery County and a lot of balls in the air. So from all of us and our wounded warriors, thank you for your leadership. The Board continues to stay available to you in any way that you would find helpful. Thank you.

VICE ADMIRAL MATECZUN: Thank you.

DR. LEDNAR: Our next speaker is Colonel Thomas Baker. Colonel Baker serves as 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. Period to his selection as interim director, Colonel Baker served as chief of the Integrated Department of Pathology at Walter

Reed Army Medical Center and the National Naval Medical Center and was associate chair of pathology at the Uniformed Services University of the Health Sciences. In addition, Colonel Baker currently serves as faculty member of the National Capital Region Pathology Residency Program and Nephrology Fellowship Program. Colonel Baker today will provide a progress report on the Joint Pathology Center. Colonel Baker's briefing slides may be found in our binders under Tab 9. Colonel Baker, thank you for joining us.

COLONEL BAKER: Thank you, sir. I appreciate it and I appreciate the opportunity to update the Defense Health Board. If you'll look at the slides, what you'll see is this is a little bit different than the briefing we had last time so that hopefully I'm assuming that there's a little bit of baseline knowledge and my apologies if I lose anybody. I'm happy to backtrack and explain things.

A little bit of background. We discussed this at the March meeting. As of BRAC

2005, the Armed Forces Institute of Pathology must be disestablished by September 2011. The National Defense Authorization Act of 2008, Section 722, outlines the establishment of the Joint Pathology Center within DOD in a manner that's consistent with BRAC law. The components of the Joint Pathology Center as outlined in law is that it will serve as the Pathology Federal Reference Center, the reference center for the federal government, will provide pathology consultation, education including continuing medical education and graduate medical education, pathology research and then the Tissue Repository that's currently part of the Armed Forces Institute of Pathology, maintenance modernization and utilization of the repository. The mission was delegated officially to the Department of Defense in April 2009 and delegated to the Joint Task Force National Capital Region Medical in December 2009 so that we've had the mission for about 11 months.

In anticipation of delegation, we lean forward in the foxhole. The JTF CapMed put

together an implementation team in summer 2009 that includes the members who are listed from the three services, from the VA, USUHS, the Armed Forces Institute of Pathology as well as JTF Army Executive Agent and Health Affairs. Our goal then was to take the original CONOPs that I briefed back in 2008 and perform a gap analysis on it and identify the things that were missing in our initial plan. We did a very thorough gap analysis and from that developed the detailed concept of operations and drafted an establishment plan. With the official delegation of the mission in December 2009 we changed the team to a transition team. The activities were we were developing an operation plan, assisting in personnel, equipment, budget facility issues and this is still an ongoing process as members of this team are still involved in the establishment of the Joint Pathology Center.

The Joint Pathology Center Office of the Director was established on October 1 so that we have an official presence now. As I go through

we'll talk a little bit about the differences from the previous presentation that I did in March. This slide you saw at the last briefing outlines the five pillars of the Joint Pathology Center. Four of them you'll recognize as being from NDAA 2008 that's a part of the law, pathology consultation, maintenance utilization and modernization of the Tissue Repository, pathology research and pathology education. The last piece there is strategic partnerships and we consider this a critical pillar or critical piece to the Joint Pathology Center as we move forward and as we mature as an organization in developing those. Not only will it argument and enhance our capabilities, but it really provides a force multiplier for the Joint Pathology Center.

There were some changes from the previous presentation that I made in March of this year. What we had discussed back then was that we were going to phase in the mission of the Joint Pathology Center in coordination with the AFIP as they just established and we were going to phase

it in over a 6-month period. After working this through in careful coordination with the Armed Forces Institute of Pathology we decided that probably the best approach would be to transfer this on one day and that would be April 1, 2011. The AFIP will continue their mission of providing consultation, education, research and repository services up until April 1 and we'll assume it on that date. Obviously as we get down to the work of doing this there is going to be a little bit of overlap, but that's the official date for the transfer of the mission from the AFIP to the JPC. Even after establishment, the AFIP will continue to support the JPC through summer 2011 and we've worked out a lot of those details and will be working on more of those details, but they will be supporting us through the establishment. Our goal is full operating capability by September 2011. As I said, the Office of the Director was established in October 2010 and on October 1, 60 people were transferred to the Joint Pathology Center from the AFIP as a part of the transfer

function that occurred and 45 of those we detailed back to the AFIP to continue their important mission since we won't assume the mission until April 1.

As for the Office of the Director, as I said, that was officially established on October 1. It consists of 15 personnel that were transferred over. We're in the process of hiring five additional personnel as well. For the most part this is information technology, quality, administrative folks, histotechs as well as a laboratory manager. What we're doing right now with the Office of the Director is developing the administrative structure for the JPC. This includes how do you handle personnel issues, how do you deal with contracts, how do you deal with budget, all the things that you need that are running in the background of a successful organization. As we talked about in the past, one of the key elements of the Joint Pathology Center is the quality management plan and having an overarching quality management plan to allow the

JPC to function. We do have three quality folks on board, three positions, and we're going to be developing their quality plan so that we can apply for CAP accreditation.

Other things include we're finalizing a lot of the transferring of equipment from the AFIP. Somebody brought up in the past that why would you want all the equipment? The fact is if you look at the equipment at the AFIP, it's state-of-the-art. It's new, it's state-of-the-art, it's the equipment we need and purchasing new equipment, there is really no added benefit to doing that. We're being selective but it turns out to be about 500-plus pieces of equipment that we're going to be transferring over from the AFIP. In addition to that we're also purchasing the equipment that perhaps is not available at the AFIP or that we do want to modernize. We're also implementing contracts. There are contracts that are currently at the AFIP that we're transferring over. Other ones include new contracts that we have that we're implementing for the JPC.

Information technology is one of the key pieces of the Joint Pathology Center and one of the key pieces that needs to be in place for us to assume the mission on April 1. We have five IT folks who came over as a result of transfer function from the AFIP and the big project that they're working on, there are a couple of big projects, but the biggest project that they're working on is taking the AFIP laboratory information system called PIMS and converting that to the joint pathology version of PIMS or what we call JPIMS. This is applying the JPC business rules to that model and modifying it so that it can function as a part of the JPC. A piece of that that goes with that is at the bottom there where I've listed obtaining DIACAPS approval. That's security approval and it's a rather lengthy process for security approval for this information system to be on the network so that that is one of the pieces that we're looking at.

The other big piece that we're looking at is developing a JPC website. One of the pieces

of that is, number one, you have the JPC website, the JPC presence with the information and contact information and all that, but there are also several other things that we're going to have as a part of the JPC website. The third piece there is the education module and we'll talk about that as a little bit. The other two include we want to do online specimen accessioning and we're already working on that in how to move that forward as well as how do you get your consultative reports to your customers. You can fax them and you can do things like that, but what we'd like to do is have consultative reports available to the providers who refer cases to us for consultation and have them online so that they can view them online.

The Office of the Director is also developing the budget requirements for fiscal year 2012 and beyond. We're working very closely with the Resource Management shop at the Joint Task Force to do this. We're also working on our strategic communication, that is, working with our

federal stakeholders, our customers to ensure a smooth transition of clinical services from the AFIP to the JPC. There was also a small blurb in CAP's "Statline" talking about the Joint Pathology Center as well as an article in CAP Today, which in more detail describes what the Joint Pathology Center is. These are not only for the federal stakeholders that we're talking about but also for the pathology community in general.

The pathology consultative service. In terms of personnel, 10 AFIP pathologists transferred to the Joint Pathology Center on October 1 and they were detailed back to the AFIP so that they're still working at the AFIP and will do so until the mission transfers to the Joint Pathology Center. We're bringing two additional subspecialty pathologists on board in December as the result of a transfer from the VA. We have an active-duty oral pathologist coming to the Joint Pathology Center in November. We have just completed hiring actions on four pathologists and we have recruitment actions pending for multiple

other pathology positions. We have about nine recruitment actions going at this point.

One of the issues I think that was brought up at the last Defense Health Board was difficulty in recruiting. We've had absolutely no difficulty in recruiting. I have lots of applicants for the positions, very, very well-qualified applicants for the positions. With maybe one or two exceptions I think we're going to have no problem in filling all the positions for the pathologists at the JPC. The other thing that we're doing as a part of consultative services is developing the process of specimen accessioning, specimen control and courier system, recognizing that that's a critical piece to the Joint Pathology Center working well. We're working on that and we should have that finalized in the next month to month and a half.

In terms of histology as we discussed before, the histology lab for the nonpathologists who will cut the slides, do the special stains for the slides and things like that, part of our plan

was to have a histology lab for the entire joint area of operation for the JTF that would serve Fort Belvoir, the new Walter Reed as well as JPC. We're moving forward with that. Understanding that there are concerns and risks to this obviously since all the pathology will be done at one place and will be separate from the Joint Pathology Center, there is some risk and we looked at what do we need to do to mitigate that risk. Number one, having a robust courier system in place and having good communication between the two campuses is one piece so we're looking at how to do that.

I think the benefits of doing all histology in one location, number one, we can focus on high quality and good turnaround time. We're looking at a 24/6 operation with expected turnaround time for all cases to be next shift. As I tell pathologists, you order special stains at 4:00 at night, you go home and they're on your desk the next morning so that we have that piece in place as well. We're also focusing on

automation of our special stains in our histochemistry and our folks are working very closely with the JPC pathologists, the ones at the AFIP and others, to help us to ensure that the quality of the stains that we're automating are acceptable. We want the highest quality so that we're involving the pathologists in helping us to determine that what we're doing is the right thing to do.

Molecular laboratories. We had talked a little bit about molecular laboratory capabilities that are going to assume AFIP's functioning molecular laboratory en bloc block moving it over to the Joint Pathology Center. It will be in Building 17 that Admiral Mateczun had pointed out on one of his slides. It won't be available until August 2011, so the AFIP will continue that function in support of the JPC until we can assume that in August 2011.

The Environmental/Biophysical Toxicology Lab. This is the depleted uranium and embedded fragment lab. We're looking at several sites.

We're very aggressively pursuing opportunities for locations for this laboratory. We have some good prospects that should come to fruition hopefully in the next month or so. Until we assume we assume that function at the Joint Pathology Center, the AFIP will be continuing to provide that function for the JPC and for the federal government.

There are two pieces to education. Number one is continuing medical education and number two is graduate medical education. Our continuing medical education focus is online and that's what we're putting into place using the Ask AFIP education module. When you go on their website you'll see that there is a pretty robust educational module called Ask AFIP. We're going to use that as the backbone for our JPC online offerings with webinars, online lectures as well as digitized slide repositories for continuing medical education credit. What this allows us to do is it opens up the aperture in terms of our end users being able to us it and whether it's at a

one-person facility or somebody who's deployed or whatever, it allows greater participation in the educational process.

The second thing is that by doing online offerings this allows us to be much more responsive to our customers in terms of their needs for educational opportunities. Although we won't be providing live courses, we of course will support live courses that are brought to us, appropriately vetted but brought to us and there are a couple of them that are still working their way through the system that we anticipate supporting once we see their final proposal on this. Continuing medical educational credit for our online presence will be provided by USUHS, by the university. At least initially that's going to be the extent of their involvement in our continuing medical education but as the JPC matures we see a significant opportunity for working across that organization to improve the offerings for continuing medical education.

In terms of graduate medical education,

we'll be offering fellowship rotations as well as residency rotations for federal government fellowships and residencies and we're putting MOUs in place to allow this to happen with federal facilities right now. We anticipate being able to accept residents on rotation in July 2011 so we have about a 3-month period from the time that we start the mission on April 1 to July 1 to allow us to be able to get up to speed to appropriately train residents. The other thing that we're supporting is the Navy Oral Pathology Residency Program. This is a 3-year residency program and the AFIP currently does one full year of that 3-year residency program and we've committed to doing the same thing for the program with the Joint Pathology Center so that we'll be assuming that on April 1.

Additionally, it's not on this slide, but as of course for the Veterinary Pathology Residency Program that's currently at the AFIP, we will be assuming that mission as well and as we discuss veterinary pathology in a few slides, that

will be coming over a little later form this but our goal is to be able to provide that residency education as soon as that mission is taken by the Joint Pathology Center.

There are two pieces to the research piece here. Number one is pathologist-driven research and then number two is the Tissue Repository and we'll talk about opportunities with the Tissue Repository I believe with the next side. In terms of pathology-driven research, what we're looking at is transferring up to 85 current active protocols from the AFIP to the Joint Pathology Center. We're not sure what the final number will be. It will depend somewhat on where they are in terms of research, but that's what we're looking at right now.

The second bullet I mentioned for a reason. The Comprehensive Cancer Center, and it should be Cancer Center and not Cancer Treatment Center, is an NCI designation and Admiral Mateczun referred to this. It's an initiative at the JTF to achieve NCI designation. When you look at that

program, one of the things that they allow is for this to be done as a consortium. So we've been brought that into the discussion on this and this is a great opportunity from a research perspective.

If you look at the NCI requirements for Comprehensive Cancer Center designation, one of the big pieces is research. It's not just clinical trials. It's all the way from basic science to clinical trails so that it's a whole spectrum of research opportunities for that designation. Looking at the Cancer Centers of Excellence that are going to be a part of this, UHUHS, the NCI, all the players in this consortium and looking at the capabilities and the opportunities that there are with all of these, it's phenomenal. As this develops I see this as being one of the key pieces at least initially to the JPC being able to conduct pathologist-driven research.

In the third bullet, we're working very closely with the Associate Chief of Research for

Headquarters VA to identify opportunities for collaboration and support. We've already identified several potential opportunities over the next couple of years that we're going to look at as the JPC matures. I'll talk about the Tissue Repository later.

As for other federal stakeholders, as you'll see there is a lot of interest in the Tissue Repository in utilizing that for research. But the other piece is for us to develop the partnerships appropriate or necessary for collaborative efforts not only within the Department of Defense but also with other federal agencies, with the NIH and with the CDC and others. The opportunities for research are not going to be just in the JTF CapMed or in the new Walter Reed or with UHUHS. Our goal as the JPC matures is to bring in the other federal stakeholders and look for research opportunities.

The Tissue Repository is obviously a big piece to the Joint Pathology Center and I have a couple of things. If you go down and you look at

the Tissue Repository, it is a national treasure in terms of what they have. It's a one-of-a-kind repository of pathology specimens. You won't see anything else like that in the world. I applaud the AFIP for bringing the Tissue Repository to this point over the last couple of decades. It's a great opportunity. There are a couple of questions we raised.

Number one, as a part of our plan early on we want to open up the repository to allow it to be utilized for research but how do you do it in a careful and considered manner? How do you do it so that it ensure sustainability of the repository? And how do you do it to ensure that appropriate priorities between perhaps competing entities or agencies is taken into consideration?

It's quite a complex process if you want to open this up. What we're doing is a two-pronged study of the Tissue Repository. The first phase of that study is we recently completed a contract with the Institute of Medicine which is one of the arms of the National Academy of

Sciences to conduct a study and inform us to help make recommendations in terms of the Tissue Repository. What should the mission and vision of the Tissue Repository be in a way obviously that's consistent with the mission and vision of the JPC? Who should have access to the Tissue Repository? Should it just be DOD? Should it be the federal government? Should it be broader? They're going to help us answer those questions.

What technology should be considered when we look at the repository and we officially stand that up for utilization? An offshoot of that is what business model should the repository use for research? I think a lot of these actually cover the Defense Health Board's original recommendations in terms of ensuring that we have the right process in place to utilize the Tissue Repository. The business model as I mentioned is an offshoot of technology so that the technologies will be a part of what drives the business model. I can tell you that there are several different business models that you could think of if you had

to think about how you would run a tissue repository, but how do you do it to ensure sustainability and that it's used correctly?

What materials should the Tissue Repository store? Right now it's about 32,000 square feet of tissue that includes glass slides and paraffin-embedded tissue blocks which are the blocks that slides are cut from. There are also about 500,000 wet specimens, that is, specimens in formalin. There are 18 freezers' worth of frozen tissue and there are a lot of documents as well, radiographs and other documents. The AFIP currently right now is digitizing a lot of that, but in terms of as a part of the mission and vision, what materials should be maintained in the Tissue Repository? We've asked the IOM to help inform us on that as well.

Then of course when you look at the Tissue Repository, there are a lot of unique collections. There are larger collections of specific malignancies and other nonmalignant diseases that you won't see anywhere else. There

are also unique and very rare tumors and unique and very rare infectious cases that if you gave over to research you wouldn't have any more in the Tissue Repository. What is the balance there? What do you do with those unique collections? Do you not use them or do you find a way to use them and allow it to be done without depleting those rare collections, and we've asked the Institute of Medicine also to help us with that. The Institute of Medicine deliverable is June 2012, about 17 months.

The second phase of the study, as I said, this is a two-pronged study, we plan on overlapping this with the IOM study. This is the nug work for the Tissue Repository such as developing a process for utilization of material in the repository. What are the regulatory requirements or what is the approval process? Should you have a scientific advisory board that approves and so on, really getting those pieces into place. Then how do we appropriately resource the repository? What personnel do we need? That

really depends on the technologies we have in place. What IT requirements do we need to fully utilize the repository and appropriately utilize the repository? Then as I alluded to, the organizational structure to oversee the repository utilization, and as we talked about earlier with technologies, technologies obviously drive the ability of the repository to be appropriately utilized so that we have to look at that. Then space requirements. What space do we need to do this?

We anticipate 2-plus years or probably 2 years to complete these portions of the study. During the study we'll continue to use the Tissue Repository in support of the consultative mission and for education. Those typically don't deplete the repository so that those are sustainable. Then of course we talked about the fact that there are 85 active ongoing protocols coming to the Joint Pathology Center potentially. A lot of those are retrospective studies that rely on material in the repository so that we'll continue

to support those. Then we are going to have 29 pathologists at the Joint Pathology Center, many who would like to use the repository for research even in that 2-year interim so we're going to do that on a case-by-case basis but we want to be able to support the JPC pathologists' research. The bottom line with this is that opening this up beyond the JPC at least initially will not occur until after our studies are done and everything is in place for us to do this appropriately.

As we talked about as the last brief on veterinary pathology, the AFIP right now has a Veterinary Pathology Program that's unique and there's really nothing like it. In terms of pathology consultation there are really no veterinary pathologists that you can go to to formally consult in the world so that this is a unique group. In addition, they also have the only Veterinary Pathology Residency Program in the Department of Defense and they also are actively involved in research. The veterinary pathology residents are trained in part to support research

efforts once they graduate so that we're taking that mission to the Joint Pathology Center. We anticipate being able to assume that function by June 1 and our limiting factor on this is space available and we'll talk a little bit about space. The 85-P will continue to provide this service until it's transferred.

DR. LEDNAR: Colonel Baker, in the interests of time can we ask for the remainder of your material if you can draw out the highlights for us and then we'll have some time for questions with you?

COLONEL BAKER: Certainly, sir. In support of stakeholders, I'll just get down to the federal agencies. Obviously support of our federal stakeholders is one of the key things for the Joint Pathology Center and we did put out a survey in the spring. We do have some responses from our major stakeholders or from our federal stakeholders. What we have to do with that is we have to loop around and close the loop on the ones that didn't respond. For example, Homeland

Security, the State Department, Justice and the FBI, we really need to loop around and close that and be able to identify what can we do to support those missions. I've already started closing the loop. I've already talked to the FDA on one of them that's not listed and they're going to be getting me a final report hopefully this month. I think the bottom line here is that our organization allows for sufficient flexibility to address stakeholders' current and future needs as we identify these things and this discussion with our stakeholders is an ongoing process. It's not a static process so that we'll see opportunities as new things come up that our stakeholders would like us to do.

As I said, a formal survey went to other federal agencies and we received responses from a portion of Health and Human Services and I've listed the things from Indian Health Services and then several divisions of the CDC. Then of course as I said we need to loop around with other federal agencies and close the loop on this so

that we know what type of support federal agencies need. Of course, the VA has always been a big part of our discussion and we have ongoing discussions with them in terms of how we can support them and I've listed things. There are a couple of new things on there. This is like I said an ongoing discussion. These are facilities and nothing has changed. Our consultation service will be in Building 606. The renovation is complete. I know one of the concerns that was brought up was pathologists being in cubicles. We already have plans in place to reconfigure the space for private offices so that there will be private offices for all of the pathologists. The Tissue Repository is in Buildings 606 and 510. Building 510 is undergoing life safety renovation which will be completed this next summer. Veterinary pathology will be up on the Forest Glen campus as well and that space is being renovated and should be done by about April 2011.

As we talked about, histology is going to be performed for the Joint Area of Operations

at the new Walter Reed. The new space is renovated. The space is occupied right now. It's 6,000 square feet of very high- tech lab. Molecular laboratories will be in Building 17 on the Bethesda campus and renovations should be completed by August 2011. Then with the depleted uranium and embedded fragment laboratory we're still look for space but we hope to finalize that very shortly. As for our budget for Fiscal Year 2011, that's a mistake. It's $10.1 million, but if you include the 45 pathologists who ere detailed back to the AFIP it's actually $13.6 million and we're working on the fiscal year 2012 and beyond budgets.

Our way forward as we've talked about before as our top priority is to ensure continuity of clinical services during the establishment. We're going to continue our hiring process. We've been very successful so far. We'll refine and submit our budget for Fiscal Year 2010, finalize the requirements for DU testing, refine and finalize logistical and IT requirements, continue

with our Strategic Communication Plan and develop policies and procedures. This includes the accessioning process, transferring of contracts and our goal is to be CAP accredited by September 2011 so that we have that as our end state for the Joint Pathology Center. One of the things that the Defense Health Board brought up was oversight. We've talked about a board of advisers being in place to provide advice to the Joint Pathology Center so that we need to define the function and structure of the board of advisers which will be made up of representatives from stakeholders and then implement that plan. The other thing is to select an inaugural director in summer 2011 for appointment after full operating capabilities after September 2011. The reason for this is that you don't want to change captains in the middle of the establishment here. I'll take this through establishment until the inaugural director comes on board.

Thank you. That's all I have. I appreciate the opportunity to brief. Are there

any questions?

DR. LEDNAR: Thank you, Colonel Baker. I'd ask Dr. Parisi, a member of the Board, if he would like to first an opportunity to make any comments or ask any questions. Dr. Parisi?

DR. PARISI: Thank you, Colonel Baker, for your update. I'd like to preface my comments by reasserting that the Defense Health Board is committed to assisting you in designing a JPC that is going to succeed, satisfy the spirit and requirements of the law and continue to provide excellence in consultation, research and education that will advance our understanding of diseases. Having said that, I feel somewhat like a broken record because many of the comments I will offer have been iterated before in written reports as well as in public hearings and in private conversations.

My sense is that the JPC is evolving as a hospital-centric surgical pathology service with little emphasis on research and education and which in its current state anyway does not fulfill

the congressionally mandated requirements to function as the reference center in pathology for the federal government. If you look at pathology as a field, pathology is an evolving field just like everything else in medicine. Histologic diagnoses already are being augmented by molecular diagnostic techniques and there are more and more newer techniques coming down the road. The JPC really ought to embrace these new technologies and be the leader in the field if indeed it's going to be the Center of Excellence that has been demanded.

I've got some specific comments regarding the diagnostic services mission. I'm still concerned about the appropriate staffing of the JPC. Will the staff be mainly junior-level people or will it consist of senior-level people? Will those senior-level people be full-time or part-time? Mentoring is a very important part of the evolution of a pathologist and who will do this mentoring? I think these are very important considerations. I'm not sure what criteria are

being required for the hiring of new pathologists or what the process in place is for that. You mentioned that pathology support in the field will be provided by telepathology. I think that's great, but who is going to do the reading of the diagnoses? Is it going to be done again by junior staff or senior staff? And what kind of quality assurance of policies or activities will be in place to monitor that is the quality and correctness of diagnoses rendered by the JPC? I think the physical separation of pathologists from the accessioning area, the laboratories and the transcription areas is still a potential problem but I understand there are some constraints because of space limitations. However, I again reiterate that I would encourage you to look at ways to make a better marriage of those functions.

The laboratories being at the Walter Reed campus also raises questions of responsibility of the JPC pathologists for efficient interpretation and performance of special studies and diagnostic procedures and I'm

not sure who is going to direct the laboratory, who is going to be in charge of specialized procedures and pulling this all together may be problematic since the priorities for the hospital are clearly different from the subspecialty priorities of the JPC. You mentioned that state-of-the-art labs will be provided. I'm not sure what that means? What is menu of immunostains or in situ hybridization techniques that will be available? Where will new procedures be developed and validated as they become available? Will specialized immuno-EM, scanning EM and florescence microscopy be available and where will these occur? Will there be wet-tissue labs and where will those be located? Where will the environmental pathology and toxicology labs be located particularly with respect to analyses for drugs, toxins, polymers and other foreign materials that result in disease?

DR. LEDNAR: Dr. Parisi, may I make a suggestion? I think the kind of detailed thoughts you're having will be very useful to Colonel Baker

and the JPC. We're not asking, Colonel Baker, for you to respond to all of these but I think it's a sense of some of what Dr. Parisi and the Board sees as aspects to help the JPC succeed in its mission. As the Board in its position that continues to be supportive to you and to the department, I might offer that Dr. Parisi and anyone else from the Board who is interested to be available to elucidate these and discuss these and be sure that you understand the thoughts behind them as you consider your way ahead. Would that be okay, Dr. Parisi?

DR. PARISI: I think there is progress that's been made. I think that we have a ways to go. I think the development of the Comprehensive Cancer Center as you mentioned provides a real opportunity, but to really provide that opportunity is going to require dedicated laboratory basic kind of research, the sorts of things that you've already described in your briefing. I have a whole list of other suggestions here. I guess I had another question.

DR. LEDNAR: Dr. Parisi, here's a thought, and that is given the really detailed evaluation that you've given to this that we might ask you to prepare some written notes or written outline of your thoughts in completeness given the spirit of time here and then we can get these to Colonel Baker and to the staff of the JPC, and then we'd ask if the JPC would come back and share their thoughts to this listed of suggestions that you would have for them from the Board. Would that be an acceptable way ahead?

DR. PARISI: Sure.

DR. LEDNAR: Thank you, Dr. Parisi. Are there other questions or comments? Dr. Walker?

DR. WALKER: Twenty-nine pathologists is a lot and seems like it would be an opportunity to have a lot of subspecialists, but I'd be very interested in knowing what the subspecialties would be and how will recruitment assure that you get pathologists who are really committed to advanced investigation of disease further than just routinely looking at slides through a

microscope.

COLONEL BAKER: Absolutely, sir. We've outlined before the subspecialties that will be in the Joint Pathology Center and it really encompasses the entire spectrum. I think there are 11 or 12 of them. One of the things we won't be having is pediatric pathology, but we're really encompassing everything else. In terms of that I think we do have that covered.

DR. LEDNAR: Dr. Silva?

DR. SILVA: Wayne, I've had the opportunity to look Joe's shoulder and he has very extensive notes there and as a Board member I'd like to know what he's going to state, so I like your idea to put it in writing. But when they fill in the acrostic because we want to assure the quality of this lab, then I think we should put it on the next meeting to see what the blanks are on the chart. It's very extensive, but it's a detail we need to know about as in how good this lab is going to be and is it going to be world class. So I would ask for that review.

DR. LEDNAR: Yes, the Board will be copied on the notes and correspondence. Dr. Parisi will be preparing for the Board and will be shared with the Board to Colonel Baker and the JPC and then we can schedule at an upcoming meeting another touch point to these points. Good suggestions.

DR. SHAMOO: Dr. Lednar?

DR. LEDNAR: Dr. Shamoo?

DR. SHAMOO: Very, very quickly. I think it would be more appropriate to have a small ad hoc committee of Dr. Parisi, Dr. Silver since he is knowledgeable and interested in this subject and one more person and then bring a more distilled report to the Board. Otherwise, I think we are having one individual speaking for the Board and we don't have a clue what the content is and that to me would be much more in line with the structure of the Board.

DR. LEDNAR: I would say yes and yes. I would say that probably the most useful way to understand these points is in a small group

discussion with members of the Board and with Colonel Baker and his staff and to process that and then as the department makes decision on the basis of that input to bring a summary of some of those key points back as an agenda item to the Board by Colonel Baker. Dr. Parkinson?

DR. PARKINSON: Just a clarification. Is the National Capital Region seeking to be a designated NCI cancer center, the NCR, or is that still being debated?

VICE ADMIRAL MATECZUN: We're engaged in discussions with Dr. Varmus on that. The end result of being an NCI-designated cancer center is grants. We don't need the grants necessarily and so what we're probably going to do is to work through the attributes of a Comprehensive Cancer Center, not necessarily apply for the grants and he'll have to make a decision about whether or not that would be an NCI designation or whether we're going to enter into a partnership with the NCI itself.

DR. PARKINSON: Thank you, sir. The

reason I asked that is that again whether or not that is an essential attribute of so-called world class to Dr. Kizer's work or not, it certainly is a brand and a standard that we know. As for the emerging explosive change to medical practice from genomics and proteomics and all of these things which I hopefully will see in the IOM report, I don't know if there's any possibility that Dr. Erdtmann without violating IOM processes could arrange for a subset of IOM staff to meet with the DHB in advance of the report release or something. Because I think that certainly world class in the context of all the money we're putting into brick and mortar should mean the capabilities are absolutely cutting edge as a national resource and I would hate to see the slip between the vision and the practicality. It's not necessarily pathology with all due respect to this discussion. It really is the glue, the culture, the transition processes, the art indeed of patient care and we need stay in touch with all of that somehow. I'm delighted that the IOM report is moving forward

and if there's a way that we might even at least see a little bit of that of work with the IOM committee it might be useful as well in the sense of true federal collaboration.

DR. LEDNAR: Perhaps we can pursue what is possible within the bounds of the IOM process or not. We can do that offline. In the interests of time what I'm going to ask is we adjourn this discussion. I'd like to thank Colonel Baker for your brief and your update.

COLONEL BAKER: Thank you, sir.

DR. LEDNAR: An image that I'm having in my mind is the GPC is about to take the active runway. You're going to begin your takeoff roll and it's less than 12 months from now that you'll be standing up and fully operational. Again the Board stands committed and ready to be helpful to you for success on the mission as Congress has charged. So thank you.

COLONEL BAKER: I appreciate it and I appreciate the input from the Board. Thank you.

DR. LEDNAR: We're going to take a

15-minute break.

(Recess)

DR. LEDNAR: I'd like to reconvene our meeting. We are going into the last segment of today's Defense Health Board meeting and what we are about to do is something that the Board in the past has found very, very useful, and that's to have short report-backs from the service liaisons to the Defense Health Board sharing with us some of the health issues that they find as priority from their service perspective and their service point of view.

We will have short briefings by Colonel Bob Mott for the Army, Lieutenant Phil Gould from the Air Force and Captain Neal Naito from the Navy. At our next meeting we will also hear similar kinds of briefs from the Coast Guard and from the U.S. Public Health Service and we intend to rotate through our meetings going forward in terms of updates. Of course, if the services at any time in between have issues that they would like to bring up, those through the right channels

can be brought to the Board. Dr. Butler?

DR. BUTLER: Wayne, just a quick suggestion. It would be great to add the U.S. Special Operations Command to that. They are really a separate entity and have their own four-star and a different set of problems.

DR. LEDNAR: That's a great suggestion. Thanks, Frank. We can add that into the cycle. With that I'll ask Colonel Mott if you'd begin. Thank you, please.

COLONEL MOTT: I certainly appreciate the opportunity to speak today. I've been coming to what was the AFEB since 1993, so almost 20 years ago. It's been a real privilege to serve as liaison in the last couple of years and it's really interesting to see how the Board has evolved. It's certainly expanded my horizons. I'm a preventive medicine physician and when we first got the request to speak we kicked it up the chain of command to see what the issues were and a lot of the issues have already been addressed or are being addressed by the Board, suicides,

traumatic brain injury and all these. Unfortunately they left it up to me to select the topic, so like my throwback uniform today I decided to go back to the AFEB days and talk about some current thinking on tuberculosis. There has been a fair amount of activity lately and a fair amount of discussion and we decided it would be a nice idea to you up to date on some of the thinking.

I do want to point out that this is an update. It's really not a formal question to the Board. If we get to that point we'll ask that. One of the reasons that we decided to talk about this is Lieutenant Colonel Jamie Mancuso has been doing a DRPH thesis on tuberculosis so I'd like to whet your appetite and maybe get him to come in to one of the Infectious Disease Subcommittee meetings to give you an update on his work. Here are some of the other information sources. Information for this brief was taken from Captain Jerry Mazurek. He's at CDC's Division of Tuberculosis.

The reason this has been brought up is the CDC in June of this year released some guidelines on the use of interferon gamma release assays or IGRAs. There was also a fairly detailed session at the Army Force Health Protection Conference in Phoenix this year that talked about a lot of these issues. They talked about IGRAs, talked a little bit about post-appointment TB screening questions and a discussion of appropriate screening approaches which I'll get into in a little bit. Then last month Lieutenant Colonel Mancuso did his DRPF defense and then we had a JPM meeting, a Joint Preventive Medicine Policy Group meeting just last week with a lot of the liaisons in attendance to talk about a lot of these issues.

To emphasize that these are not questions to the Board, I thought it would be better to say ponderings. This is thinking within our group, the Subcommittee on Preventive Medicine, infectious disease and lab communities. One question we've been getting since the IGRAs

have come out from our folks out in the field is should we start moving away from a tuberculin skin test toward the IGRA test? I wanted to get a little bit into what these tests are in case the Board hasn't heard about this but I'm sure a lot of you have. There are currently four FDA-approved IGRAs. QuantiFERON-TB started off back in 2001 although that's not currently available; QuantiFERON-TB Gold in 2005, QuantiFERON-TB Gold In Tube in 2007 and the T-spot that was approved in 2008. You can think of IGRAs as a skin test in a test tube. It's measuring similar things to what you have in vivo in the body but it's going it in a test tube. It measures interferon gamma released from lymphocytes in whole blood samples so that it is a blood test. It is a little bit more specific. It uses antigens specific to MTB so it does not have as many issues as the tuberculin skin test with nontuberculous microbacteria in BCG strains. I did want to point out that I don't like the NTM terminology or acronym. It used to be called

microbacteria rather than TB which is MOTTs so that it would be in some infectious disease textbooks.

It has sensitivity similar to the tuberculin skin test. Specificity is one of its strengths since it does not have the antigens from the nontuberculous bacteria in the BCG strains with a greater than 99 percent specificity in subjects who have low risk for TB -- they're 89 to 99.6 percent. So if you compare it to TST using the 15- millimeter cut-off it's similar specificity. If you go down to the 10-millimeter cut-off it may be more specific than the tuberculin skin test especially after BCG vaccine or with nontuberculous disease. A lot of people think that you have a blood test and it's easy, but it's really not a panacea. There are a number of steps in the test. I think it was 77. It was pretty dramatic the number of things you'd have to do to get a result of this test so it's a lot more complex than just doing a PPD. It's very lab intensive unless you automate it and the Air Force

has been doing a lot of work trying to get robotics to do this test and have had some success doing that.

It is more costly. Estimates by Dr. Mazurek are $86 versus $18 for the TST and those are Medicare data. This is a cartoon. The top right is the interferon gamma being released in the skin to give you the classic wheel for PPD, and then the bottom one is the cells in the tube releasing the interferon gamma and that's what's picked up by the test. Considerations that we're thinking about, essentially IGRAs and TSTs, are both FDA-approved. They're both fine tests with their limitations. The nice thing about the IGRAs is they only require one patient visit. They come in and get the blood test and then it's resolved like any other test, whereas with TST you have to come back within a time-specified period which is a pain in the neck. For anybody who's been in basic training you have to bring the folks back to get it read. Again, the IGRAs cost more and certainly are not a panacea. There is a lot of

variability within those steps. One of the issues is volume in the tubes that has to be very specific. There is a fair amount of variability during the blood into those tubes. There are issues with altitude. If you try to draw it in Denver it's going to be a lot different than if you draw it out here in Washington, D.C.

Our current approach at least in the Army is to allow the use of either the tuberculin skin test or the IGRA, but even in policy we've pointed out some of the nuances and some of the difficulties with the tests so that it shouldn't be just one person making the decision to do it. It really should be a decision with the command group, the lab, clinicians, Public Health folks and logisticians. We've had a few MTFs. Tripler is doing it, but it hasn't been adopted quite as quickly as I though it would be to be honest with you. Some of the other bit issues that we continue to struggle with is should we move toward more targeted TB testing in accessions and during predeployment periods.

This is a slide from Dr. Mancuso's DRPH defense. What I want to point out here is you have active TB in the U.S. population showing a fairly steady decline. When I did my MPH up at Johns Hopkins it was right about here. We had that little hockey stick phenomenon that had a lot of people concerned, but since then it's sort of trending down again. I also have active TB in the Navy or the triangles here again trending down. Then if you look at TST reactors, it's turning down but then coming back up. It's possibly because of nontuberculous microbacterium exposure, but I points out the fact that even with prevalence decreasing, we're having increases in TST positivity so that's a little bit of a concern.

Targeted testing has been recommended by the CDC. This is a quote from the MWR in 2000, "A targeted testing program should be conducted only among groups at high risk and discouraged in those at low risk." There are some high-risk populations that have been pretty well described,

but of note, the U.S. military is not really considered high risk and even though we do deploy to areas that have high incidence of TB, in general we're not considered a high-risk population. Current testing. We currently to all accessions and this is all services. We do all predeployments. We have moved to targeted testing for postdeployment although the question that we're using to decide whether to test somebody or not has not been all that successful so that those need to be tweaked a little bit. Then high risk. If you do have a contact with an active TB case if you're a health care worker who's serving in a high-risk clinic or if you're working at a prison and those kinds of things, we still recommending testing for that.

Should we move toward targeted testing and accessions during predeployment? One of the major considerations is is it appropriate to screen at a low- prevalence population. We're going to have a number of false positives and it's not like you're going to have a week of therapy.

These are folks are signing up for 9 months of INH. Then the question is is it possible to develop a targeted testing approach for accessions in particular and also predeployment?

Another consideration is if we move to a questionnaire-based program, we've had issues with postdeployment, is it possible to develop a questionnaire and have that serve as a proxy for a negative-screening test during accession or basic training? Then ultimately if we do go to a much more targeted approach is that going to lead to an increase in active TB cases?

There was also some discussion last week about whether we should move away from doing TB questionnaires on the postdeployment health assessment or the postdeployment health reassessments. Then instead of doing that, add it to the periodic health assessment which we're doing annually. The thought there would be when you redeploy there's a period anyway that you wait to get that TB test unless you have a known exposure to an active case perhaps. Does it make

more sense to put it on the PDHA where you can spend more time with the provider. Having come back from Iraq in June, I can tell you the PDHA is a very quick event. People don't want to answer yes to very many things. They just want to get through and get out. So I think moving it to the PDHA makes some sense.

One consideration is maybe you may not want to do this with the National Guard or the Reserves if we're having issues with their PDHA if it's not going to be as rapidly as we do annually in the active component. Another consideration is there may be a longer timeframe between when you redeploy and when you get your PDHA. It should be less than a year for some people and if you're even deployed for 6 months it should be within that 6-month period but it's going to be longer than 90 to 120 days probably. Will that delay cause somebody to potentially activate and get active disease?

A real quick rundown. There are reports of active TB cases by service from 2005 to 2010.

One thing to note is there's really not a whole lot of active disease out there. In fact, the Coast Guard was doing really well up until 2010. I'm not sure what happened there, Erica. You guys are slipping. We did have a blip in 2009, again very, very small numbers for this population so it's probably not statistically significant.

As far as the way ahead for us, we're going to continue to look at courses of action for doing a screening questionnaire. We're going to look at those active cases and try to better characterize what the risk factors are. Was it truly deployment associated or was it foreign-born people who would have activated anyway? I do think it would be a good idea to have Dr. Mancuso and the Air Force folks who have done a look at the IGRAs to come to the Infectious Disease Subcommittee and give you an update.

There's really a lot of nice analysis that's been doing over the last couple of years. If you have time to get that on the agenda, I think it would be very useful even in the absence

of a formal question, although if we get it through me may ask a question about targeted testing and accessions and for predeployment. That's the last bullet and go up through our leadership either on the Army side or as a joint community to ask some more specific questions to the Board. That's all I have.

DR. LEDNAR: Thank you, Colonel Mott. We have time for some questions. Dr. Poland?

DR. POLAND: Thanks, Colonel Mott. In fact, your briefing once again proves the value of doing what we're reinstating, so thank you. We'd welcome that discourse with the ID subcommittee. One quick question. Do you happen to know if any of the cases were MDR TB or XDR TB?

COLONEL MOTT: I do not. I'm sure that we would have heard about that. I don't remember that happening either.

DR. POLAND: Olivera, you can add this to our list.

LIEUTENANT COLONEL GOULD: My only other comment related to that is that most of those

cases while they may have deployed they have in their past one of the typical screening questions positives such as they were foreign born or they have a first-degree relative who was foreign born from a country of high prevalence.

DR. LEDNAR: Dr. Kaplan?

DR. KAPLAN: In the counts in that table that you have with the counts, you don't have denominators. Is there any great difference in rates among services?

COLONEL MOTT: I think the Army until recently has been fairly stable as far as rates and I think the other services are similar.

DR. KAPLAN: The total number in the number of cases would be different because each service has a different total number, and my question is by just seeing the numbers suggests there are not many, but you wonder if there's any difference between them if you calculate rates.

COLONEL MOTT: I think we'll do that. This is just a quick poll from our meeting that we had last Wednesday so that we didn't have a chance

to do rates. It's a quick snapshot to give us the burden of disease overall to see how many cases we have, but that's certainly easily done.

DR. KAPLAN: Yes, it shouldn't be hard to do. Thank you.

DR. LEDNAR: Dr. Walker?

DR. WALKER: Could you tell me how foreign-born service members with a positive test and history of BCG vaccination is managed?

COLONEL MOTT: Did you ask how many?

DR. WALKER: How are they managed if they've got a positive test and they tell you had a BCG vaccination. How do you manage these individuals?

COLONEL MOTT: With the PPG or the PPD. I'm sorry.

DR. WALKER: Do you treat them for 9 months with INH or not?

COLONEL MOTT: If they're above 15 millimeters.

DR. LEDNAR: Dr. Parkinson?

DR. PARKINSON: Thank you, Bob. I think

that was a good update. I too way back when looked at the epidemiology of this and it hasn't changed in 20-plus years that foreign born is a risk. What I think in a time of more and more demands on basic training and what we do, if you do an approach or an analysis of this it shouldn't be just PPD versus full force versus targeted or the new assay full force versus targeted. It might also be in the context of what is blood drawn for in general for all new recruits and could you piggyback this draw on something else and do a true cost-effectiveness analysis in terms of direct and indirect costs in terms of training time and the second visit. That's a way an employer increasing would look at instituting a corporate fitness program with my downtime because the world has changed a lot.

COLONEL MOTT: Absolutely. Dr. Mancuso did a cost-effectiveness analysis as part of his thesis. One thing that the Air Force has looked at is drawing into a heparin tube instead of doing it in each of the three QuantiFERON Gold In Tube

test which does not really impact the results of the test that much, just pop on another Vacutainer tube, putting it into smaller tubes in the lab, but again there's a little bit of a manpower issue there. I think Jamie did take into consideration the time it takes to put on the TST, bring it back and read it and those kinds of issues.

DR. LEDNAR: Dr. Kaplan?

DR. KAPLAN: One more question. Do you have any data for dependents?

COLONEL MOTT: I do not. Data on how many LTBI positives we have, it's very hard to capture. That's one nice thing about the IGRA test is that you do have a lab result which is queriable so that it makes it a little bit easier to define what that LTBI positive population is.

DR. KAPLAN: Thank you.

DR. LEDNAR: If I can ask while the CDC's overall assessment is the military is not a high-risk group when we think of testing, I recall in some of our operational briefs that have been given to the Defense Health Board there have been

humanitarian operations and there has been military support offered into parts of the world where tuberculosis is prevalent. I think this is a story of low frequency but high potential consequence particularly as we get MDR and XDR so that when we think about some of these new technologies it will be useful to know how some of these testing technologies perform across the treatment- resistance patterns of these organisms as they change. It's a pretty complex area but clearly an important one.

COLONEL MOTT: We've done TSTs for my whole career and it's hard to back off of that and not do them suddenly. I think what would make me more comfortable is that we do have very good surveillance in place and we have teams that can go out and investigate active cases. I know the Navy is a lot more reluctant to perhaps try this than we may be because of the tight experience on ships. There is a lot that goes into it but having deployed and gone on humanitarian operations, the exposure is really not that high

when you're in a deployed setting especially in the current environment where you're on the fob. Even people who are out patrolling don't necessarily have that close contact that you would think for a contact investigation. It's certainly not zero risk, but I'm not sure it's as high risk as you might think.

DR. LEDNAR: Dr. Ennis?

DR. ENNIS: I don't know this literature. It would seem to me one thing that might of interest since the sensitivity of the assay is similar to the skin test and the specificity is much higher, has it been done already by some group used as a secondary test, after a positive skin test do the IGRA and if it's negative don't necessarily put somebody on an INH for 9 months?

COLONEL MOTT: In fact, the current MMWR goes into many different scenarios about how to use the test and currently they are not recommending serial testing although some of the infectious disease physicians who were at our

meeting last week said that if you have a person with a positive skin test who really does not have any risk factors and you don't really believe the test or you want to convince them that if they truly are positive they need to take that 9 months of INH then they'll go ahead and get the IGRA. But in general the CDC is not recommending serial testing with TST followed by an IGRA test.

DR. LEDNAR: What we'll do is we'll conclude this brief. Thank you for bringing this topic to use and the Infectious Disease Subcommittee looks forward to an opportunity to hear some more.

COLONEL MOTT: Thank you.

DR. LEDNAR: Thank you, Colonel Mott. Our next speaker is Lieutenant Colonel Phil Gould. Colonel Gould serves as chief of preventive medicine operations at the Air Force Medical Support Agency Office of the Air Force Surgeon General where his principal focus in immunization policy development. We look forward, Colonel Gould, to hear your brief, please.

LIEUTENANT COLONEL GOULD: Thank you. I realize that this is a weighty topic and I don't really wish to add additional pounds to the Defense Health Board in terms of the number of subcommittees. I do think that it is an issue of long-term concern for the military health system as well as for the services. As an overview I'm going to talk a little bit about a document that was released earlier this year called "Too Fat to Fight," then present a little bit of some of the current and historic trends with obesity and then follow-up with the questions that the Air Force has put forward for the Board to consider addressing in the future.

In April 2010, a large body of retired generals and admirals as well as colonels and captains from the services got together and agreed to a document that was called "Too Fat to Fight." It was a hark back to a call to action that occurred in the 1940s and 1950s where the military services had identified that there were a lot of individuals who were called to service during

World War II who were inadequately sized thin and not fat and they put forward a large effort to convince Congress and the president that some kind of a school lunch program was in order and they used that model as a call to action for the opposite problem that we are having now. Important statistics that they included in their document were that 75 percent of young Americans between the ages of 17 and 24 were ineligible for entry into the armed services or other uniformed services. Of those, nearly half were ineligible because of their weight. They also point out that now 39 states report that 40 percent of their youth are overweight or obese and that 3 report that over 50 percent of their youth are overweight or obese which is a staggering statistic.

Between 1995 and 2008, 140,000 potential recruits, and these are not potential recruits who were rejected by the recruiter on gross visual inspection, these were ones who had passed some level of visual inspection by recruiters, were sent to be evaluated at the military entrance

processing stations and were then turned away because they were too heavy. Over time between that same time period the number of people who were rejected based on their physicals has grown over 70 percent.

Additionally, 1,200 individuals enter basic training, go through basic training but do not complete their first term of enlistment because of some issue related to weight that causes them to be discharged. That means in order to maintain the necessary number of personnel that you have to train a new person to fill that void which means that we spend approximately $60 million every year to replace those who do not complete their first enlistment because of their weight.

Their key recommendations were, first, to remove junk food and junk drink, soft drinks and sodas and so forth, out of schools. That, of course, is a difficult challenge for many school systems because it's net money generator. And to increase funding for school lunch programs and

also to consider increasing funding for school dinner programs for those children who clearly are not likely to receive a second meal for the day and to choose the types of foods that are healthiest. This, of course, may reinforce better eating habits if the choices that they're provided are healthier. And finally, to support the development, testing and deployment of proven public health interventions and that may be one of the questions for the Board.

This is data from the MSMR which is the military's version of the morbidity and mortality weekly report. This data comes from outpatient diagnoses. The reason why I want to highlight that is the scale clearly is not the true scale of the problem. At this top of this line is 6 percent. I know from just the Air Force data for the fitness program that this is probably about half of what the actual figures are. The point I wanted to emphasize is that if you look at the blue, almost black, triangles here, they are definitely on the increase over the last 5 years.

Then if you go for the 30- to 40-year- olds, all of the services, even slightly the Marine Corps, have shown an increase in the total percentage. Again these are outpatient diagnoses and that means that the somebody had to go to the clinic and be evaluated. In some cases that's because they were referred, but in other cases it may be voluntary. For over 40 the climb is even higher.

I point out the under-20s only because if you look at the last 5 years there is a steady increase for the Air Force and it's the only one where the Navy outdoes us. If you look at trends in overweight and obesity among applicants to service and this goes to some of the data that was presented in "Too Fat to Fight," we've increased in both the percentage who have a BMI of 25 to 30 from 22.8 back in 1993 to 27.1 in 2006, and for those with a BMI over 30, all the way from 2.8 to 6.8, a 4 percent increase over about 13 years so that that is a considerable change.

If we switch to the dependent perspective if you will, and this is from the

"Behavioral Risk Factor Surveillance Study," which is annual study performed throughout the United States and includes survey items as well as some data within the states themselves, and you look at the scale. This is self-reported data where people tell their height and tell their weight. If you'll notice, there is a fair amount of no data in 1985, but none of the states has more than 15 percent with a BMI that would be considered obesity. Then if you go to 1990, you pick up a lot more responses but you've also noticed that the colors are beginning to increase. Then if you go to 1995, and you actually have to add a new category of 15 to 19 percent and over half of them are now colored in the darker blue. Five years later, you have to add another category which is over 20 percent, and again over half of them are in the new category. In 2005, you have to add not just one but two more colors in order to capture the data. All total you have about 4 on there that are less than 20 percent. And that's 2009.

The questions for the Board, given the

trends in obesity in the U.S., how will the Defense Department and the Air Force's ability to recruit and retain active-duty Guard and Reserve military personnel be affected? And will we need to modify our accession standards in order to be able to utilize the personnel who are available? Perhaps we could have cyberforces who are seated most of the time in dark rooms playing video games and maybe they don't need to be quite as fit as our Special Forces, et cetera. Assuming we don't modify it, what are the best practices to attain appropriate body weight for those who are overweight in our active duty Guard and Reserve? Assuming that some of these will fail whatever methods that may be the best practices, do we discharge them? Do we give them some kind of waiver? What should we do with these people?

As for our dependents what is the optimal strategy to adopt regarding both our children as well as spouses and retirees? What might the long-term costs be to the DOD assuming these trends show no sign of decreasing? What

might be the best practices to address these? Then we have our sons and daughters of the military more likely to join the military. I think we have anecdotal suggestions that this is true. Ms. Bader's family might be representative. If so, is there something that we should be doing for those dependents to help them avoid going toward the trend that's the national trend? What other practices should the Defense Department advocate to influence children and adolescents along the lines of "Too Fat to Fight"? Thank you very much.

DR. LEDNAR: Thank you, Colonel Gould. This is obviously an issue of major national importance as well as to the DOD, and for those who are interested in health care and medical treatment issues, you can see where this leads in terms of diabetes for the future. This is a major, major issue and thank you for helping us get our sights up to look ahead and try to do something about this at this point. Dr. Fogelman?

DR. FOGELMAN: I want to note one thing.

Thank you for that. I think that was great. In the Psychological Health Subcommittee we often talk about how do we asses people and when do we assess them and we often raise the question of what happens on accession? Are we screening them adequately? What are the criteria? Everything we ask about is exactly parallel to what you're saying here.

In the last couple of days there was a new story about a joint NIMH-DOD study which was sparked by the issue of suicides and people who were engaged in high-risk behavior and the idea of what happens before accession and at accession is raised there and it's been raised for quite a number of issues. I'm struck at the analogy or analog between the two and I wonder because of that if there isn't some theme that we might as a collective group want to address or think about, that is, is there a way that we should offer advice about accession and accession standards generally and not just in the two realms we're talking about? I'm raising as a discussion point.

DR. LEDNAR: To build on what Dr. Fogelman said, our traditional medical armamentarium is diagnose and doctor treat. Colonel Gould, what you've raised up is this is about choice. This is about the individual making a choice and this is not a choice in a medical clinic office. I think our skill set to help persuade people, enlighten them, support them in their decisions outside of the whole medical treatment system, we've got to get a whole lot better and we'll probably need to engage some skills that are not traditional medical skills. Some of the areas that Dr. Fogelman and his subcommittee has expertise in I think we need to better engage and deploy. This is not coming up with a new positron. This is a whole different issue. Dr. Parkinson and Dr. Kaplan?

DR. PARKINSON: Phil, thank you very much for that. I think the Board goes back and forth between the macro and the micro and the macro and the micro and I think you've nailed the macro issue for affordability and sustainability

of not just health care, but the employed sector of this economy. I was sitting next to an HR director for a Fortune 500 company, she herself was based in Fresno and point blank said, "We have good, high-paying manufacturing jobs available today. Ninety percent of the applicants coming in our door cannot physically meet the requirements to do them and that's before the drug screen. I essentially can't hire anybody in the United States." I won't name the name of this company, but that's why they're outsourcing jobs. In many ways if there's anything that the DHB does going back to what Eisenhower sometimes said about using the military to essentially bring race relations into the 21st century, I think there is a role as Dr. Taylor and the department talks about and whatever next generation TRICARE is, he made it quite clear in his opening comments with the cameras off, frankly, that it's not about the contracts, it's about rethinking the contract about what are we doing for our people and how do we make it affordable and healthier.

I'll leave the group with another thought. Phil, you hit the nail on the head. The Robert Wood Johnson Foundation had a Building Healthy Communities Commission that did a report now about a year ago. The punch line is this, where and how we live, learn, work and play, those four areas, are bigger determinants of our health, longevity and our health care than medical care. A world- class medical facility notwithstanding, it is largely peripheral to what we're talking about. And when it gets to the point where we're actually talking about backing off on health standards, I love the fact that you asked the provocative question.

I wrote down CPA. With cyberforces of the future, CPA is going to stand for couch potato ace. Heaven forbid if we the military, and I love it because you're asking this question, should we back off on health standards because frankly we just can't do it and frankly we got to give up?

This week, at the other end of the spectrum in the New England Journal in a

randomized controlled trial, 40-plus BMI individuals who were given intensive lifestyle and behavioral changes, guess what? They all lost 10 percent plus of weight so that they're not going to bariatric surgery. Who better at both ends of the spectrum gets serious about this than the Department of Defense? I think the DHB through all of the tentacles that we have, from Dr. Taylor's charge, to Secretary Gates saying get this thing under control and now we can't recruit the people we need for the active-duty military? We've got a perfect storm and I think there's a lot we can contribute maybe not answering these questions per se but they put us on the path to do that in concert with the department.

DR. LEDNAR: Dr. Kaplan, Dr. O'Leary and then Dr. Poland.

DR. KAPLAN: I was sitting here looking at the graph, Phil.

LIEUTENANT COLONEL GOULD: Which graph, sir?

DR. KAPLAN: I'm sorry.

LIEUTENANT COLONEL GOULD: Do you have a slide number? The bottom right-hand corner.

DR. KAPLAN: The first graph, the 20- to 30-year- old obesity trends. There are two things that struck me and maybe they're totally wrong. There is no question about the increase in obesity. The first question is it's interesting if you look at this graph that the Marines are down at the bottom and show the least slope up. Is that because of preselection or is that because they are more active?

LIEUTENANT COLONEL GOULD: That's a great question. The interesting thing is of all the services, they have the most lenient entry requirements and yet they are able through their aggressive training as well as ongoing requirements to maintain their body weight. The answer is they're not the most stringent, in fact they're the least stringent of the services in their entry requirements, but they whip them into shape. At MCRD San Diego they'll tell you that the average diet of the Marines during training is

6,000 calories per day.

GENERAL MYERS: To follow-up on that, Phil, the thing that might skew that data is that 75 percent of Marines are on their first enlistment and I think that number still holds. They bring them in young probably under 20 and by 22 or 23 they're out. I don't know how that influences that data, but it's different than the Army model, the Navy model or the Air Force.

DR. SHAMOO: I have an informational question on the same graph just to attain further clarification.

DR. LEDNAR: Let's have Dr. Kaplan get to question two, then we'll have Dr. Shamoo, Dr. O'Leary and Dr. Poland.

DR. KAPLAN: The second question I have is in a way related to what General Myers just said. I was trying to figure this out and I don't know it. During this period of time, from 1998 to 2008, if I remember back there were periods of time in there where several of the services had trouble meeting recruitment expectations. Can one

speculate that maybe the qualifications changed in order to meet the recruitment expectations and that one ends up with a different breed of cat as an enlistee at that point?

LIEUTENANT COLONEL GOULD: I'm going to have to defer to AMSARA for that.

DR. LEDNAR: Dr. Shamoo?

DR. KAPLAN: AMSARA is the Accession Medical Standards Analysis and Research Activity for the record.

DR. LEDNAR: Dr. Shamoo?

DR. SHAMOO: You have here percent of service members with clinical diagnoses of overweight.

LIEUTENANT COLONEL GOULD: Yes. Those are outpatient diagnoses, sir.

DR. SHAMOO: These are self-referred? This is not a survey?

LIEUTENANT COLONEL GOULD: No, it is not a survey. It's not a perfect data point. I fully admit that.

DR. SHAMOO: That's what I'm saying.

LIEUTENANT COLONEL GOULD: Absolutely, sir.

DR. SHAMOO: That's very important. This data could be totally different because this is people who have been diagnosed when? How did they end up seeing a doctor about their obesity? This is not a survey so that I question the whole integrity of this data in terms of its accuracy reflecting through measure of obesity within the services.

LIEUTENANT COLONEL GOULD: I know that it's not accurate, but my point is I do think that the trend is probably close to the truth whether the actual number is not. I know for the 20 to 30s that it's half of what the actual data shows for the Air Force in terms of their fitness profiles. Recognizing that it's not a perfect data measure doesn't necessarily alter that.

DR. LEDNAR: I think Colonel Gould has tried to make clear to us the source of the data and what its limitations are. Directionally, this and other data point to the fact that we have a

real issue however we want to count the numbers and describe it. It doesn't take any energy out of the importance of this issue I believe. Dr. O'Leary?

DR. O'LEARY: I totally agree. I want to pick up on Mike Parkinson's point. This is bigger than the military and it is bigger than TRICARE. This is a national readiness issue, it's a public health issue and we seem not to have been able to capture the attention of the American public by saying this is a health issue that's going to drive up heath care costs, diabetes, et cetera. I think if you start talking about describing the broader impacts of obesity and the role that the military could play in driving this issue and unpopular things like restricting soda pop access and pushing family counseling and doing things that we know that work even though people may see this as some sort of Big Brother intervention, this is becoming a national risk issue and I think it is a leadership opportunity for the military.

DR. LEDNAR: Dr. Poland?

DR. POLAND: I agree with those sentiments. Also Charlie said this is very much a cross-cutting issue for the way we are currently organized as a Board and we'll have to think through how to address it.

I have a couple of thoughts. I would as you did distinguish between overweight and obese. The second point is that there are beginning to be reasonably evidence-based interventions that work. The third point is I think it deserves a lot of thought as to whether accession standards should be changed. For example, your example with the cyberforces.

In the case of obesity and not overweight, you begin to get into issues of presentism as well as a lot of issues related to follow-on medical problems. A closely aligned problem with that is sleep apnea for example. Depending on what you mean by cyberforces, I want that person awake, alert, et cetera. But the evidence is just barely beginning to accumulated

about decreased effectiveness of the obese, not the overweight but the obese, in the workforce. So there are a lot of issues that attend this and I commend you for raising it as an important issue.

DR. LEDNAR: Dr. Fogelman?

DR. FOGELMAN: Thinking about Mike's point I have a question which may be a policy question that's probably larger that the Board but since it's an issues which is always on my mind, thinking about the integration of the services and how that affected the country as a whole and several other things along the way, didn't all of those occur when there was a draft? That's my whole question.

DR. LEDNAR: We won't look for an answer at the moment to that question. I would like however to wrap up this discussion with a suggestion, Colonel Gould. Offline if you'd have a conversation with Ms. Bader, she can offer some advice on the way ahead. How do we take this issue? How do we work with it? How do we bring

it to the Board and get some forward motion going staying very cognizant of what Dr. Poland said that this is a very, very broad cross- cutting issue that's got more than health components and we want to thoughtful about how we go about this. So if you would have a conversation with Ms. Bader, she can advise on how to go ahead. Thank you for brining this issue and than you for preparing this brief to us. Thank you.

Our next brief will be given by Lieutenant Commander Brett-Major. Lieutenant Commander Major is a prior surface warfare officer now working in Navy medicine. As an internal medicine and infectious disease physician, his key areas of specialization are in tropical public health and blood-borne pathogens. He currently serves as program director for U.S. Military Tropical Medicine, a tri-service program led by Navy medicine, which educates and trains U.S. military physicians in the practice of medicine in developing areas. In addition, he is also acting head of the Navy's Central HIV Program and an

officer of the Armed Forces Infectious Disease Society. Should I have said Captain Naito?

CAPTAIN NAITO: I was going to introduce Lieutenant Commander Brett-Major.

DR. LEDNAR: Thank you. Captain Naito, please introduce.

CAPTAIN NAITO: The reason why I asked him to speak is in regard to giving you an update on HIV epidemiology in the Navy and given the topical interest at the Pentagon for certain issues, I thought it would be good for him to give you an update that he gave to our senior leadership in this regard.

LIEUTENANT COMMANDER BRETT-MAJOR: Thank you, Captain. Distinguished Board members, ladies and gentlemen, good afternoon. And thank you for this opportunity for me to brief our program to you and also to tell you about some of our recent activities. This is an informational brief.

The Navy's Central HIV Program is a Bureau of Medicine and Surgery activity that on October 1 administratively realigned under the

Navy-Marine Corps Public Health Center. We act as the Bureau of Medicine and Surgery's coordinating agent for Navy medicine's responsibility under our Secretary of the Navy Instruction which governs the way the Department of the Navy approaches HIV infection, screening, prevention, tracking, personnel management and so on. Fundamentally our job is to promote HIV-related force health protection and readiness.

You know Captain Naito already. He is our program's mentor at the Bureau of Medicine and Surgery and he's the gentleman who has to answer the telephone for all of my misdeeds. Also in the back, Dr. Scott, if you would stand up just for a moment, sir. He is the department head for epidemiology and threat assessment in the military's HIV Research Program which is an Army Executive Agency run out of the Division of Retrovirology, and why he is here will become apparent in a moment.

You may already be familiar with the state of HIV infection throughout the United

States. This is 2007 data from the Centers for Disease Control. I'm a Floridian, so I pick on Florida a lot, but generally in high-population areas in Florida in particular the rate is about 1 to 3 per 1,000 just to give you some context for the Navy-Marine Corps numbers I'm going to show you in a moment.

Another thing to notice is while this is AIDS and not HIV data, it does demonstrate density of disease around the United States and you can see in these high-population areas of regions of HIV intensity with bad clinical HIV. These are all areas where we heavily recruit and enlist, these are areas where we train our people both in intake and pipeline training and in a couple of particular areas they're areas where we have them operationally assigned.

The global HIV burden can be a bit more challenging to describe. Certainly there are regions that do not report robustly their HIV burden within their populace but you can appreciate quickly that areas of frequent

deployment of Department of the Navy personnel are areas with high transmission with the darker colors. Translating these potential domestic and global exposures can be challenging. However, the Navy's Central HIV Program screens the entire Navy-Marine Corps for the seroprevalence of HIV.

We evaluate every service member by DOD policy every 2 years. But in actuality we screen approximately 70 percent of the force each year and that's a consequence of peri-deployment requirements for theater entry for our service members. This is HIV incidence per 1,000 active-duty-tested sailors and Marines and our incidence is about 1 out of 3,000 for the Navy and about 1 out of 1,500 for the Marine Corps, so that these are individuals not known to be HIV positive who were evaluated by routine or other referred screening.

Prevalence is a little bit higher are you might expect with accumulation of service members. We routinely keep HIV-infected service members in the Navy and Marine Corps functioning.

Our results clinically with our service members and their return to duty are very good. But we have about 1 out of 1,000 sailors as HIV positive and 1 out of every 2,000 Marines as HIV positive. Like the force structure, the HIV population in the Navy and Marine Corps is predominantly overwhelmingly men. Among 2009 incidence of HIV infections which are almost completely among the enlisted ranks, we have a small smattering of officers who are infected each year, but the overwhelming number are among enlisted personnel, like the civilian pandemic of HIV in the communities which are troops encounter, it is predominantly among African Americans and Hispanics although certainly the rates among Caucasians is not trivial.

If you tried to translate our numbers into a unit and were to presume for a moment that there were gaps or if you were to try and transcribe those numbers into a unit size and get a sense for organizational population of HIV, this wouldn't actually be true, of course. Because we

reassign as policy in the Department of the Navy service members HIV positive into units where they're not deployed oversees about six to 10 out of a Marine division. The entire way that the Navy's Central HIV Program and I think indeed our counterpart activities in the Army and the Air Force are designed around an initial concern in the 1990s for stigma and protection of privacy which I think was an understandable construct.

But over the last year and a half or so we started getting some very reasonable questions. Our Navy Personnel Command started asking me in late 2009 about what they perceive of clusters of transmission in a couple of centers where individuals are trained. When I drilled down into their personnel data to see if that had credibility I wasn't able to validate their concern, but the question that sponsored their interest in us was very reasonable: There is the potential change in DOD policy.

Also Navy medicine got some good press down in the Tidewater area for the way that HIV

patients were being managed by one of our HIV Evaluation and Treatment Units at Navy Medical Center Portsmouth and then some very reasonable questions followed about the nature of infection in the population which we've retained with HIV following that. Theater commands are always struggling with the difficulties in timing various disease screening programs in order to limit deployment of those diseases in their areas of operation and dealing with those issues of timing and screening.

Everyone was asking what you might expect we ask ourselves all of the time which is who is getting infected, where is it happening, when is it happening, how is it happening and why is it happening. Our stakeholders range from personnel commands in the Navy and Marine Corps to the various medical entities that are responsible for providing a fit and ready force to our line stakeholders. Certainly the potential policy change for personal behavior is relevant. In the United States the epidemic while every group is

touched, it's predominantly a group of young men who have sex with men.

There is also the issue of whether or not the tests which we routinely employ in order to detect HIV when we think about firewalls and barriers of bringing HIV people in and detecting them early before we put HIV- infected service members in areas where we do not want them whether the fidelity is high enough to do what we want those tests to do, and there are limitations certainly with our screening tests.

This figure here shows the progression of detectable elements as a consequence of infection in someone's blood when they've been infected by HIV, and on the far left is RNA proceeding toward the early immunologic markers to the later immunologic markers and early on with testing with first- and second-generation enzyme-linked immunosorbent assays, typically someone had to be infected for 6 to 12 weeks before you'd detect it.

Interestingly, we had not switched to

more modern ELISAs until relatively recently and the third-generation ELISA which now starts to include antigenic epitopes that are recombined and put on the card for detection for higher detectability can detect within about a month, and recently the FDA approved a fourth-generation assay for the purpose of blood donation screening which employs also some antigens, some little bits of the virus itself rather than the immune response which shortens that to about 3 weeks and possibly down to 2 weeks, and then you have nucleic acid testing which is pretty good from 7 to 2 weeks, but those are normal distribution curves of response and so the window can be variable depending on your population and where and how those assays are performed.

The observation in preparation for thinking about a change in accession policy regarding Don't Ask, Don't Tell was that there really was insufficient evidence to say much about what would happen to the HIV burden and that this was an area that deserved monitoring. The last

substantive effort to have a close look at how HIV transmission toward our service members including their behavioral risk factors was published by Stephanie Brodine and her group out of Navy Medical Center San Diego as a part of the Department of Defense's Natural History Study now known as RV-168. It was a good study though it was restricted to research-inducted population west of the Mississippi.

The Army has recent experience which we benefited much from where they explored with Army leadership, the Army Public Health Command and the Military HIV Research Program, a little bit about HIV transmission dynamics associated with their force and those were informative for us for what I'm about to describe for you. The Navy's Central HIV Program with Captain Naito approached the Military HIV Research Program and we said we now want to start asking these questions in a systematic way that will inform we look prospectively at new individuals who are identified as HIV positive and also we can inform

our educational practices across our service and potentially provide operational and actionable public health intelligence. This is a quality assurance fundamentally activity for our program which as public health responsibilities under the Secretary of the Navy Instruction and it's descriptive epidemiology with potential exploratory analyses dependent on cluster identification.

We were trying to describe the timing, geography, mode and risks of contemporary seroincident HIV infections in the Navy and Marine Corps. We want to as we are able interrupt ongoing transmission networks. We want to optimize our strategies for detecting HIV in the force. We want to enhance our educational programs. The Navy and Marine Corps Public Health Center executes a program called the Sexual Health and Responsibility Program. We want to improve our understanding of the high-risk groups in order to target our interventions both screening and education appropriately. And we want to inform

our future decisions for how we handle screening as our population evolves.

We took a lot of lessons from the Army and we're trying to merge personnel health, diagnostic testing and molecular epidemiologic data in order to produce a geospatial temporal map. Our own data coupled with the Navy and Marine Corps Public Health Center, the Department of Defense Serum Repository with the Armed Forces Health Surveillance Center, the Military HIV Research Program, our personnel entities, Personnel Command Headquarters Marine Corps and the sailors and Marines themselves will all contribute to the construct of this map.

In the winter and spring of 2010, we organized our effort. We sought peer review through the Military Infectious Diseases Research Program and received a favorable rating. Then especially since we had a research element supporting our technical efforts went to the Walter Reed Army Institute of Research IRB to review our strategy and ensure that we were

operating within our role as a public health and quality assurance activity and we received a nonresearch determination from the WRAIR IRB. We approached our stakeholders, first the Navy Personnel Command and achieved personnel data pools from which we'll start our map of where people were over the course of their careers and compare that to serovalidated time windows of likely infection. Then we were also very fortunate in that we received a seed money grant award from MIDRIT that allowed us to get going. MHRP has unique skills in terms of firewalls between operational activities and research and privacy with that information both with their work with the Natural History Study and their recent activities with the Army and their EpiCON and we're utilizing that as they're building secure databases and data structure for us and we're beginning our laboratory exploration.

We finally have our last negative samples starting to get organized and we're going to begin testing and verifying our dates for our

infection window. Headquarters Marine Corps is pulling some data for us and we're progressing. Our collaborators across our communities and stakeholders have been extremely supportive and we have sufficient money to get our data structures together to begin analyzing held data and to begin validating the window of infection. The molecular epidemiology in such a project is quite expensive and we do not yet have that funding.

As we collect data and we are comfortable with its validity and relevance to stakeholders, we plan to brief them in an interim fashion. We're hopeful that our effort will also help inform through our process and through the Army's process also with HIV recently a force-wide HPV-HCV study which is on the horizon in the general rubric of blood-borne pathogens. We're also hopeful that our data collection in this fashion will help us in our current dialogue initiated this fall most robustly to start sharing roles and responsibilities to at least understand how our various service-specific HIV program

elements align and how we can support each other. Thank you very much. Questions?

DR. LEDNAR: Thank you, Lieutenant Commander Brett-Major. Are there questions for Lieutenant Commander Brett-Major? Dr. Silva?

DR. SILVA: It looks like a study and hopefully we'll learn a lot. The acronym MHRP, what is that?

LIEUTENANT COMMANDER BRETT-MAJOR: Yes, sir. That's the Military HIV Research Program. It's the DOD title for Walter Reed's Division of Retrovirology.

DR. LEDNAR: Are there other comments? Commander Brett-Major, thank you for this brief and to Captain Naito for bringing this brief to the Board and to each of our service liaisons, thank you for your considered thought about what topics to bring and for preparing these briefs. I think a number of us have been feeling this has been a very good decision by the Board to restart again this practice of regular briefs from the services, so I thank you for making this a very

successful session of the Defense Health Board.

As we move toward adjournment, I'll make a reflection before I turn the microphone over to Ms. Bader. When we think about the topics that we've talked about in the last 2 days, several words come to my mind: Priority, timeliness, urgency, relevance, and I think this is central to what the Defense Health Board can do with and for the Department of Defense. Again, we are able to best provide independent advice to the Department of Defense to the extent that we have good briefs that are coming on important topics to the Board.

I think I'll also reflect on the fact that efforts by Defense Health Board staff -- and I'm looking at Marianne Coates and the work that she's done -- in interacting with media to have them understand more about the Board and in fact to find a way to have success as we've seen with the recent Washington Post physician reporter and again with Dr. Butler's assistance and others have really provided some insight to the readership of The Washington Post which is broad about the

objective reality of our forces. And that wouldn't have happened if Marianne hadn't made that connection, if Frank Butler hadn't found a way to navigate through the realities of supporting a reporter to get embedded into a military unit to write a report that really describes the reality. This is really a team effort and a lot of success, Marianne, thanks to you and to Frank.

On that note, I would ask if Ms. Bader as our Designated Federal Official would share any administrative comments and then to officially bring our meeting to adjournment. Ms. Bader?

MS. BADER: Some good news: I don't have any administrative comments to make so I'm sure everybody is happy about that. Yes, applause all the way around. I'd like to thank everybody for their attendance today and of course for their tremendous support of the Defense Health Board, and with that I call this meeting adjourned. Thank you.

DR. LEDNAR: A reminder. If you haven't

already signed in today, including myself, please be sure to stop at the front desk sometime.

(Whereupon, the PROCEEDINGS were adjourned.)

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I, Christine Allen, notary public in and for the District of Columbia, do hereby certify that the forgoing PROCEEDING was duly recorded and thereafter reduced to print under my direction; that the witnesses were sworn to tell the truth under penalty of perjury; that said transcript is a true record of the testimony given by witnesses; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was called; and, furthermore, that I am not 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.

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