

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Arlington, Virginia

Tuesday, June 8, 2010

1 PARTICIPANTS:
2 Board Members:
3 WAYNE LEDNAR, M.D., Co-Vice President
4 GREGORY POLAND, M.D., Co-Vice President
5 COLONEL (Ret.) ROBERT CERTAIN
6 JOHN CLEMENTS, Ph.D.
7 EDWARD KAPLAN, M.D.
8 JAMES LOCKEY, M.D.
9 RUSSELL LUEPKER, M.D.
10 THOMAS MASON, Ph.D.
11 DENNIS O'LEARY, M.D.
12 MICHAEL OXMAN, M.D.
13 MICHAEL PARKINSON, M.D.
14 ADIL SHAMOO, Ph.D.
15 JOSEPH SILVA JR., M.D.
16 DAVID WALKER, M.D.
17 Other Attendees:
18 COMMANDER LINDA BELTRA
19 COLONEL CHESTER BUCKENMAIER III
20 BONNIE CARROLL
21 BRIGADIER GENERAL JAMES CARROLL
22 LIEUTENANT COLONEL STEVEN CERSOVSKY
23 CAPTAIN D.W. CHEN

1 PARTICIPANTS (CONT'D):
2 COLONEL NANCY DEZELL
3 RICK ERDTMANN, M.
4 D. BERNARDINE FENTON
5 CHARLES FOGELMAN, Ph.D.
6 LIEUTENANT COLONEL PHILIP GOULD
7 COLONEL WAYNE HACHEY
8 STEVE HIGGINS
9 KURT KROENKE, M.D.
10 COLONEL MICHAEL KRUKAR
11 COMMANDER MONICA KUENY
12 CLIFFORD LANE, M.D.
13 BRETT LITZ, Ph.D.
14 COMMANDER THOMAS LUKE
15 COLONEL JOANNE MCPHERSON
16 MARK MILLER, M.D.
17 CAPTAIN NEAL NAITO
18 COLONEL DONALD NOAH
19 MAJOR SCOTT O'NEAL
20 LIEUTENANT COLONEL KATHRINE PONDER
21 LIEUTENANT COLONEL WILLIAM SAMES
22 COMMANDER CATHERINE SLAUNWHITE

1 PARTICIPANTS (CONT'D):
2 LIEUTENANT COMMANDER JULIA SPRINGS
3 COLONEL SCOTT STANEK
4 BRIGADIER GENERAL LOREE SUTTON
5 WILLIAM UMHAU, M.D.
6 CAPTAIN JAMES WARE
7 MAJOR GENERAL PHILIP VOLPE
8 PHOEBE KUESTERS
9 Staff:
10 CHRISTINA CAIN
11 MARIANNE COATES
12 ELIZABETH GRAHAM
13 LISA JARRETT
14 OLIVERA JOVANOVIC
15 JEN KLEVENOW

16
17
18
19
20
21
22
23

* * * * *

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

2 (9:27 a.m.)

3 DR. LEDNAR: My name is Wayne Lednar.

4 I'm one of the Vice Presidents of the Defense
5 Health Board and would like to welcome everyone to
6 this meeting of the Defense Health Board. We have
7 several important topics on our agenda today and
8 we'd like to formally get started by asking our
9 Designated Federal Officer, Colonel Don Noah, if
10 he would please call the meeting to order.

11 Colonel Noah?

12 Col NOAH: Thank you, Dr. Lednar.

13 As the Designated Federal Officer for the Defense
14 Health Board, a federal advisory committee and a
15 continuing independent scientific advisory body to
16 the Secretary of Defense via the Assistant
17 Secretary of Defense for Health Affairs and the
18 Surgeons General of the Military Departments, I
19 hereby call this meeting of the Defense Health
20 Board to order.

21 DR. LEDNAR: Thank you, Colonel Noah.

22 In keeping with our tradition at the Defense

1 Health Board, we like to begin as our first order
2 of business to all stand and have a moment of
3 silence to remember the service of our warriors to
4 us and to our country.

5 (Moment of silence.)

6 DR. LEDNAR: Thank you. Please be
7 seated. This meeting of the Defense Health Board
8 is a public meeting open session and to support
9 our exchange of information and ideas, it's helpful
10 that we all know who's here and some of our
11 backgrounds. I would ask if we can go around the
12 table starting first with the Board and
13 distinguished guests and then those in the
14 audience. Please mention your name and the group
15 that you are with and representing here at this
16 meeting. So if we can start with Colonel Noah and
17 we'll go around this way.

18 Col NOAH: Good morning. I'm Don
19 Noah. I'm the Acting Deputy Assistance Secretary
20 of Defense for Force Health Protection and
21 Readiness within OSD Health Affairs.

22 CDR FEEKS: Good morning.

1 Commander Ed Feeks, Executive Secretary of the
2 Defense Health Board.

3 DR. OXMAN: Mike Oxman, Professor of
4 Medicine and Pathology at the University of
5 California and Board member.

6 DR. CLEMENTS: John Clements. I'm the
7 Chairman of Microbiology and Immunology at Tulane
8 University School of Medicine in New Orleans and a
9 member of the Core Board.

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

13 DR. WALKER: David Walker, Chair of the
14 Department of Pathology at the University of Texas
15 Medical Branch at Galveston and member of the
16 Board.

17 DR. SILVA: Joseph Silva, member of the
18 Board and Professor of Internal Medicine at the
19 University of California-Davis School of Medicine
20 and also Dean Emeritus.

21 Col MCPHERSON: Colonel Joanne
22 McPherson, the Executive Secretary for the DoD

1 Task Force on the Prevention of Suicide by Members
2 of the Armed Forces, a Subcommittee of the Defense
3 Health Board.

4 DR. FOGELMAN: I'm Charlie Fogelman.
5 I'm Chair of the Psychological Health Committee of
6 the Board.

7 CAPTAIN NAITO: Neal Naito, Navy liaison
8 to the Defense Health Board, Director of Clinical
9 Care and Public Health at Bureau of Medicine and
10 Surgery.

11 COMMANDER SLAUNWHITE: Good morning.
12 I'm Commander Cathy Slaunwhite, Canadian Forces
13 Medical Officer in a liaison role at the Embassy
14 in Washington, D.C.

15 DR. ERDTMANN: Good morning. My name is
16 Rick Erdtmann. I'm a member of the staff at the
17 Institute of Medicine, former military, and I'm
18 not officio, I'm an ex-officio member of this
19 esteemed board.

20 DR. LEDNAR: And we appreciate, Rick,
21 your being here and being part of the group. I'm
22 Wayne Lednar. I'm the Global Chief Medical

1 Officer of the DuPont Company and Vice President
2 of the Defense Health Board.

3 MS. BADER: Good morning. Christine
4 Bader, Director for the Defense Health Board.

5 Rev CERTAIN: Robert Certain. I'm a
6 retired Air Force chaplain and active Episcopal
7 priest, member of the Defense Health Board, the
8 Task Force on Suicide Prevention, the Medical
9 Ethics Subcommittee,
10 and Psychological Health Subcommittee.

11 DR. LUEPKER: I'm Russell Luepker and
12 I'm Professor of Epidemiology and Medicine at the
13 University of Minnesota and I'm a Core Board
14 member.

15 DR. MASON: I'm Tom Mason, Professor of
16 Environmental and Occupational Health, College of
17 Public Health, the University of South
18 Florida-Tampa.

19 DR. KAPLAN: Good morning. I'm Ed
20 Kaplan, Professor of Pediatrics, University of
21 Minnesota, and a Core Board member.

22 DR. PARKINSON: Mike Parkinson, past

1 President of the American College of Preventive
2 Medicine and Core Board member.

3 DR. SHAMOO: Adil Shamoo, member of the
4 Board and Professor and former Chair, University
5 of Maryland School of Medicine.

6 BG CARROLL: Brigadier
7 General Jim Carroll. I'm the Assistant Surgeon
8 General for Acquisitions and Research, and I'm also
9 here representing the Air Force Surgeon General,
10 General Green.

11 COL KRUKAR: Good morning, Colonel
12 Michael Krukar, Director of the Military Vaccine
13 Agency.

14 COL HACHEY: Wayne Hachey, Director
15 of Preventive Medicine, Office of the Assistant
16 Secretary of Defense, Health Affairs, Force Health
17 Protection and Readiness.

18 COL STANEK: Good
19 morning. I'm Colonel Scott Stanek. I'm the
20 Deputy Functional Proponent for Preventive
21 Medicine in the Office of the Army Surgeon General
22 and I'm the Army service liaison to the Board.

1 CDR KUENY: Good morning,
2 Commander Monica Kueny with the Coast Guard's
3 Office of Health Affairs.

4 Lt Col GOULD: Good morning,
5 Lieutenant Colonel Gould, Air Force Medical
6 Support Agency.

7 LCDR SPRINGS: Good
8 morning, Lieutenant Commander Springs, Health
9 Services, Headquarters, Marine Corps.

10 MS. CAIN: I'm Christina Cain. I'm a
11 DHB analyst.

12 LTC PONDER: Lieutenant
13 Colonel Kathy Ponder, Assistant Director, Reserve
14 and Medical Manpower, OSD.

15 LTC SAMES: Lieutenant
16 Colonel Bill Sames representing the Armed Forces
17 Pest Management Board.

18 Col DEZELL: I'm Colonel Nancy
19 Dezell, Force Health Protection and Readiness in
20 the Office of the Assistant Secretary of Defense
21 for Health Affairs.

22 LTC CERSOVSKY: Lieutenant

1 Colonel Steve Cersovsky. I'm the Director,
2 Epidemiology and Disease Surveillance at the U.S.
3 Army Public Health Command.

4 DR. HIGGINS: I'm Dr. Steve Higgins and
5 I'm a retired professor out of the State of
6 Indiana, and I am the father of the Executive
7 Secretary.

8 DR. UMHAU: My name is Dr. William
9 "Biff" Umhau. I'm a Family Medicine Doctor with
10 Occupational Health and Environmental Safety
11 Services with the NSA at Fort Meade.

12 DR. KROENKE: Kurt Kroenke, Professor of
13 Medicine, Indiana University, and a member of the
14 Psychological Health Subcommittee.

15 MS. KUESTERS: Hi. I'm Phoebe Kuesters,
16 and I'm a USUHS graduate student interning at the
17 Defense Health Board.

18 DR. MILLER: I'm Mark Miller, NIH,
19 Fogerty International Center Scientific Director
20 and former member of the DHB on the Steering --
21 Subcommittee on Infectious Diseases.

22 DR. LANE: Cliff Lane, National

1 Institute of Allergy and Infectious Diseases at
2 the NIH and Infectious Diseases Subcommittee.

3 CDR BELTRA: Commander Linda
4 Beltra, Bureau of Medicine and Surgery and I work
5 for Captain Naito.

6 MS. FENTON: Bernadine Fenton, Joint
7 Requirements Office for CBR and Defense.

8 DR. LITZ: Brett Litz, Professor of
9 Psychology and Psychiatry at Boston University,
10 and I'm at the National Center for PTSD in Boston
11 and a member of the Psychological Health
12 Subcommittee.

13 MAJ O'NEAL: I'm Major Scott O'Neal,
14 Joint Staff, Deputy Director for Regional
15 Operations.

16 MS. COATES: Good morning. I'm Marianne
17 Coates. I'm the communications advisor to the
18 Defense Health Board.

19 MS. JARRETT: Lisa Jarrett, Defense
20 Health Board contractor.

21 MS. JOVANOVIC: I'm Olivera Jovanovic,
22 senior analyst for the DHB.

1 MS. GRAHAM: Good morning. I'm
2 Elizabeth Graham, DHB support staff.

3 DR. LEDNAR: Thank you to everyone. I
4 would ask during the day if there is someone you
5 don't know, please take the step and walk up and
6 introduce yourself, and especially for the Core
7 Board members, please let's be sure to make all of
8 our guests feel welcome as part of our
9 deliberations here today. Thank you.

10 Next we're going to ask Ms. Bader and
11 Commander Feeks to share some remarks they have
12 before we begin this morning's session. Ms.
13 Bader?

14 MS. BADER: Thank you, Dr. Lednar. I'd
15 like to welcome everyone here today to the meeting
16 of the Defense Health Board and to thank the staff
17 of the Sheraton National Hotel for helping with
18 the arrangements for this meeting as well as all
19 of the speakers who have worked very hard to
20 prepare their briefings and getting your briefings
21 in in a timely manner. In addition, I'd like to
22 thank the Defense Health Board's staff. They work

1 very hard behind the scenes to make sure that we
2 have a very good meeting, and if you have the
3 opportunity, many of them are sitting along the
4 back wall so kudos to Elizabeth Graham, Jen
5 Klevenow, Lisa Jarrett, Olivera Jovanovic,
6 Christina Cain, and Jean Ward. At this time I
7 believe Commander Feeks has some announcements
8 he'd like to make. Thank you.

9 CDR FEEKS: Good morning and
10 welcome. I'd like to add my thanks to those of
11 Ms. Bader for Mr. Young on sound and Christine
12 Allen our transcriptionist. I'd like to remind
13 everyone that there is a legal requirement for us
14 to keep an accurate record of who attends our
15 meetings and therefore I'd like to ask you to make
16 sure that you sign the general attendance roster
17 on the table outside if you have not already done
18 so. For those of you who are not seated at the
19 tables, handouts are provided on the table off my
20 left shoulder. For telephone, fax, copy or
21 message services, please see Jen Klevenow or Lisa
22 Jarrett. Because the open session is being

1 transcribed by Christine Allen, please make sure
2 that you state your name before speaking and use
3 the microphones so that she can accurately report
4 your remarks.

5 In addition, the people on my left are
6 sitting with your backs to her and so you
7 especially I ask to be careful to say your name
8 when you begin to speak because she cannot read
9 your table tent. Refreshments will be available
10 for both morning and afternoon sessions. We will
11 have a catered working lunch here for Board
12 members, ex-officio members, service liaisons and
13 DHB staff, as well as for your speakers and
14 distinguished guests. For those looking for
15 options, the hotel restaurant is open for lunch.
16 In addition, there are several alternatives
17 located in Pentagon Row which is less than half a
18 mile from this hotel including Lebanese Taverna,
19 Subway, Champs, and Baja Fresh. If you need
20 further information, please see the hotel staff at
21 the front desk.

22 Again regarding transcription, I

1 neglected to mention that if your name is
2 difficult to spell, please give your name to
3 Christine on a piece of paper. If you use
4 technical terms that are likely to be misspelled,
5 likewise please provide those to her on a piece of
6 paper.

7 The group dinner tonight will be held at
8 Cucina Vivace located at 509 23rd Street, South,
9 in Arlington. A shuttle service will be provided
10 for those staying at the hotel and will leave the
11 hotel for the restaurant at 6:00 p.m. Return
12 transportation from Cucina Vivace to the hotel
13 will also be provided. If you have not RSVP'd for
14 the dinner, please do so with Jen Klevenow. The
15 cost for dinner is \$36 per person and in order to
16 facilitate payment, you are kindly request to
17 provide the exact amount in cash to Jen Klevenow
18 either during the day together or before entering
19 the restaurant tonight as our ability to provide
20 change is very limited. You will then be provided
21 a dinner ticket for the dinner tonight.

22 Tomorrow's session will be held at the

1 Industrial College of the Armed Forces at Fort
2 McNair, Washington, D.C. Only those with active
3 secret clearance will be permitted to attend this
4 session. A bus will depart from this hotel at
5 7:00 a.m. tomorrow morning for Fort McNair. If
6 you're planning to drive to Fort McNair, please
7 make sure that you bring a photo I.D. with you and
8 be prepared to go undergo a vehicle inspection
9 upon arrival at Fort McNair. Please inform the
10 security guards at the gate that you are there for
11 a meeting at ICAF. Limited parking is available
12 in the parking lot behind the ICAF building,
13 although as I understand it, classes are not
14 currently in session. They're preparing for their
15 commencement and so parking may be easier than we
16 fear. Those arriving by taxi, and this is
17 important, you should enter Fort McNair by the
18 pedestrian gate at the intersection of 2nd and V
19 Streets, Southwest, and that pedestrian gate is
20 right in the back of ICAF which is very, very
21 easy. So please if you take a cab, have them drop
22 you off at 2nd and V Streets, Southwest.

1 The next meeting of the Defense Health
2 Board will be held on July 14, 2010, at the
3 Bethesda Marriott on Pooks Hill Road, Bethesda,
4 during which the Board will receive a brief
5 regarding the findings of the DoD Task Force for
6 the Prevention of Suicide by Members of the Armed
7 Forces. In addition, the Board will hear an
8 information brief regarding the Joint Theater
9 Trauma System and the Joint Theater Trauma
10 Registry.

11 Finally, please put all portable
12 electronic devices in a silent mode. That
13 concludes my remarks.

14 DR. LEDNAR: Thank you, Commander Feeks
15 and Ms. Bader.

16 We'll move to our first item on the
17 agenda in terms of business today and this is an
18 item that will conclude with a vote by the Core
19 Board. Our first speaker is Dr. Adil Shamoo who
20 is the Chair of the Medical Ethics Subcommittee of
21 the Defense Health Board, as well as the Chair of
22 the DHB Bylaws Work Group. Dr. Shamoo is

1 currently a Professor and former Chairman of the
2 Department of Biochemistry and Molecular Biology,
3 Professor of Epidemiology and Preventive Medicine
4 and a member of the Graduate Faculty of Applied
5 Professional Ethics. He is affiliated with the
6 Center for Biomedical Ethics at the University of
7 Maryland, Baltimore, and serves as guest faculty
8 at the Applied Research Ethics Program at Sarah
9 Lawrence College.

10 The DHB Bylaws Work Group has reviewed
11 the current Bylaws of the Defense Health Board and
12 proposed several changes to reflect recent changes
13 in the Board and to assure compliance with
14 applicable federal laws and regulations, as well as
15 the Defense Health Board Charter. The Board has
16 been provided a draft of the DHB Bylaws
17 incorporating these recommendations of the Work
18 Group in preparation for the deliberation and vote
19 scheduled for today. The presentation slides may
20 be found under Tab 2 of the meeting binder. Dr.
21 Shamoo?

22 DR. SHAMOO: Thank you, Dr. Lednar. I'm

1 going to go rather quickly. Members of the
2 Working Group, Dr. Dennis O'Leary and Dr. Ed
3 Kaplan, with input occasionally from Dr. Lednar
4 and at the very end Dr. Gregory Poland, gave us a
5 series of questions we addressed. Many thanks to
6 Ms. Bader who was present in all the
7 communications and the staff, Olivera Jovanovic,
8 was really the one who did all the work and we get
9 all the credit. So thank you very, very much.

10 These are some of the teleconferences
11 and meetings with the Washington Headquarters
12 Services and we've had many, many emails. The
13 version you have of the document of the Bylaws is
14 version 19, so you can see how many changes we
15 have made. I'm not going to go through these.
16 Let me just go to the most important part. The
17 Board may suggest nominees for Board and
18 Subcommittee members to be forwarded to the ASD(HA)
19 for consideration. Nominations and appointments
20 to the Board and its Subcommittees are conducted
21 in accordance with FACA. Just briefly to those of
22 you who haven't heard this yet before, that is,

1 our Bylaws are the operational rules for us as a
2 Board. The Charter is the governing rules. The
3 DoD has a charter for us like all other boards.
4 Then there is the FACA law which governs all the
5 boards so that whatever we do has to be consistent
6 and not contradictory to these two documents.

7 In terms of audits, I don't think that's
8 important. This is the one which was contentious.
9 The Secretary of Defense based on the
10 recommendation of the Under Secretary of Defense
11 for Personnel shall appoint the President of the
12 Board from Board members. The USD(P&R) prior to his
13 recommendation may consult the Board for
14 membership. No Board member shall serve more than
15 two consecutive 2-year terms of service as Board
16 President. This was one of the issues we
17 discussed in detail and this is very close to the
18 Charter language. We added the one highlighted in
19 red that prior to his recommendation may consult
20 the Board membership. The Board really likes to
21 have the ability to recommend a potential Board
22 member. The Secretary of Defense has the final

1 authority, but we can presumably recommend some
2 names to him.

3 The Board shall select from within its
4 membership -- this is not controversial. I'm not
5 going to read it. This was approved by the Board
6 almost a year ago and we just inserted it in the
7 Bylaws. The Executive Committee, we have
8 something that needs to be looked at. Following
9 DFO approval, the Board President upon
10 consultation with the Executive will accept or
11 reject an item presented to the Board for
12 examination. These are Board members' duties.
13 The code of conduct didn't exist in the old
14 Bylaws. We wrote much stricter Bylaws than what
15 is in the Charter or FACA rules for example or the
16 ethics training we just received this morning.
17 Everybody up higher than the DHB likes it and they
18 suggested no changes and I think my attitude is
19 this code of conduct should be given whenever
20 there is ethics training, a printed copy should be
21 given to all Board members because it's much
22 stricter than the current ethics requirements.

1 Also Subcommittee members will serve no
2 more than 4 years. That's the same thing that is
3 true for Board members. This is very important.
4 The Board insisted that we have the ability to
5 discuss some issues which emanate from the Board.
6 One example is the discussion of TBI and the
7 recommendations for TBI, the Board made them a
8 year in advance before it hit in the media and our
9 recommendation I think played a major role in
10 supporting TBI research. The second paragraph,
11 paragraph B, members of the Board and its
12 Subcommittees may bring issues or topics to the
13 attention of the DHB President for the Board's
14 potential consideration. Of course the DFO and
15 the ASD(HA) have to approve what we do especially if
16 there is expenditure of federal money.

17 The Board can initiate an examination of
18 DoD health-related issues without committing
19 government funds. Members may bring an issue to
20 the attention of the Board through the President
21 and request information from DoD to facilitate its
22 deliberation of approved topics for examination.

1 Consistent with other Board business, the Board
2 President may refer and approve the issue to an
3 existing Subcommittee for further research and
4 investigation. If the Board deems the matter
5 under consideration appropriate and within the
6 scope of its charter, it may issue recommendations
7 or a report to the DoD. The key is that the Board
8 wants to provide independent advice to the DoD.
9 That is in the Charter. And at the same time we
10 want to be effective and the only way we will be
11 effective is if we are intellectually independent.
12 I think with these Bylaws consistent with the
13 Charter, we will be independent.

14 I'll be glad to answer any questions and
15 hopefully after the questions we will vote on the
16 Bylaws.

17 DR. LEDNAR: Are there any questions or
18 comments for Dr. Shamoo and the Working Group?
19 Again, as Commander Feeks has reminded us, if you
20 would please start by mentioning your name and
21 then any questions or comments for Dr. Shamoo.

22 DR. CLEMENTS: I apologize for not

1 having this sooner, but we seem to have a
2 contradiction here where it says under Section 3,
3 paragraph 8, Subcommittee members may serve
4 renewable 1-year terms without limit to the total
5 number of terms they may serve, and then in
6 Article 4, Section 2, it says Subcommittee members
7 shall serve no more than 4 years. Which of those
8 would be correct?

9 DR. SHAMOO: Four years is operative.
10 We will make sure to edit that point just to
11 clarify it. Thank you for bringing it up.

12 DR. LEDNAR: I might make one point
13 here. As a matter of historical reminder, the
14 Defense Health Board was stood up in December
15 2006. Prior to that time it did not exist. So as
16 a new Board, the Assistant Secretary of Defense
17 for Health Affairs at the time prepared a document
18 which chartered this new Board serving the
19 Department of Defense. That Board established and
20 a Board membership was named and we are in
21 December of this year reaching a 4-year point
22 since that initial Board was established. Given

1 the question that Dr. Clements just asked and Dr.
2 Shamoo reminded us about the term of 4 years, you
3 might ask does that mean that all of the Board
4 that started in December 2006 must rotate off
5 because they've reached 4 years. We have had
6 discussions that Ms. Bader has helped to
7 facilitate with Dr. Rice who realizes that it
8 really helps the Department of Defense to have a
9 transition and a smooth way to move into a future
10 and not to have an abrupt loss of an awful lot of
11 institutional memory. So there will be the
12 development of a transition plan to move through
13 this time period of December 2010 so that not
14 every member of the existing Board will be leaving.
15 We'll have some more discussion
16 about that at the lunchtime discussion because I
17 know there's a lot of interest in that. But it's
18 important that we do have a smooth and consistent
19 support to the Department as a Board going forward
20 but to also get position for the future so that
21 there can be a following of the Bylaws consistent
22 with the Charter and that's a 4-year term of

1 service.

2 DR. SHAMOO: I just want to add one more
3 thing. Dr. Silva gave us a few editorial changes
4 since he's been an editor for a long time of
5 things and these will not change the meaning of
6 the Bylaws whatsoever. So whatever we approve,
7 those are related to the and thus if we've added
8 too many of them, so they will be removed. I move
9 the report of the Working Group for approval and
10 it does not need a second because it's a Working
11 Group- Subcommittee recommendation.

12 DR. LEDNAR: Is there any additional
13 discussion or question about the recommended
14 changes to the Bylaws that's come to us from the
15 Bylaws Working Group?

16 DR. WALKER: Wayne, I'd like to go back
17 to the question of John Clements. If a person has
18 been serving simultaneously on the Core Board and
19 a Subcommittee for 4 years, then they go off of
20 all of them altogether?

21 DR. LEDNAR: The answer is yes, unless
22 there is a waiver or special exception because of

1 this historical standing up of everyone at the
2 same time. But the answer to your question,
3 David, is yes.

4 DR. SHAMOO: Dr. Oxman?

5 DR. OXMAN: In certain circumstances can
6 someone in that position remain functional as a
7 consultant?

8 DR. SHAMOO: I think this is above my
9 pay grade. I'll ask Ms. Bader.

10 MS. BADER: I'd have to get
11 clarification from Washington Headquarters
12 Services on that. I honestly don't have the
13 answer because it's not an appointment per se, but
14 I'll ask the folks at Washington Headquarters
15 Services and get back to you.

16 DR. SHAMOO: I'll butt in and give an
17 answer of my personal opinion. I think the
18 consultantship is totally different than the Board
19 and Subcommittees and the DoD can hire consultants
20 at any time.

21 MS. BADER: That's true they can. I
22 need to talk to Washington Headquarters Services

1 and then give you the legal answer.

2 DR. SHAMOO: The reason I know is that
3 because I was a consultant and it didn't count.

4 DR. LEDNAR: I think we're all learning
5 a lot, for example, of the FACA requirements as we
6 operate and we write down what in our Bylaws is
7 our rules of how we will operate. It has been a
8 reminder though that the appointments are made by
9 DoD and the appointments are for a 12-month
10 period, a 1-year period, so even though terms of
11 service may extend to as long as 4 years, there is
12 an annual review of each of us by DoD for the
13 acceptability to continue. So while there is an
14 allowed term of service, it really is up to DoD
15 whether or not it chooses to wish to ask for that
16 individual service or not.

17 DR. SHAMOO: I think I will call for the
18 vote and you, Dr. Lednar, should lead the voting
19 mechanism.

20 DR. LEDNAR: Do I have a motion?

21 DR. SHAMOO: No, you don't need a
22 motion. We already have a report and it is only

1 now voted on. Since I'm the Bylaws Chair I should
2 know these rules.

3 DR. LEDNAR: I'm not sure whether these
4 are Roberta's rules.

5 DR. SHAMOO: No, any rules. The logic
6 behind it is any working group or subcommittee
7 that a membership of more than two people,
8 therefore the two people must have agreed to
9 present the report and that's the motion and a
10 second.

11 DR. LEDNAR: For the Core Board, the
12 voting members, the question will be those who are
13 in favor raise your hand and say aye.

14 GROUP: Aye.

15 DR. LEDNAR: For the Core Board, those
16 who are opposed please raise your hand and say
17 nay.

18 DR. SHAMOO: And you have to take the
19 vote for abstentions. I'm sorry.

20 DR. LEDNAR: Are there by a show of
21 hands individually, those who choose to abstain,
22 who can and should vote but choose to abstain?

1 None. The vote is passed. Thanks to Dr. Shamoo,
2 Dr. Kaplan, and Dr. O'Leary in particular for a
3 very fine piece of work which is going to help us
4 perform at a very high level.

5 DR. SHAMOO: I will call for a round of
6 applause to Olivera. Than you very much, Olivera.

7 DR. LEDNAR: And thanks to Olivera.

8 (Applause) Thank you, Dr. Shamoo. We'll now move
9 to the next item on our agenda. Since we are here
10 to serve the men and women who defend our country,
11 our next brief this morning is an information
12 brief. Major O'Neal is currently assigned to the
13 Joint Staff, Joint Operations Directorate, Europe
14 and NATO Division. A career Armor officer, Major
15 O'Neal has served in a variety of operational
16 armor and cavalry assignments from platoon through
17 regiment in numerous locations including Fort
18 Polk, Fort Knox, Fort Hood, and Germany. His
19 operational deployments include tours in Bosnia
20 and Iraq. Major O'Neal's education includes a
21 bachelor of science from the United States
22 Military Academy in international and strategic

1 history, and a master's in military operational
2 art and science from the Air University at Maxwell
3 Air Force Base in Alabama. Major O'Neal will
4 provide an overview of U.S. military operations
5 worldwide. His presentation slides may be found
6 under Tab 3.

7 MAJ O'NEAL: Good morning. My name is
8 Major Scott O'Neal from the Joint Staff, and I
9 appreciate the introduction, sir. On behalf of
10 Admiral Mullen, the Chairman of the Joint Chiefs,
11 and Lieutenant General Paxton, Director for
12 Operations, thank you for the opportunity to come
13 and talk to you today about global operations.
14 Actually, any chance to get out of the Pentagon
15 for anybody who's served there is a welcome
16 distraction to say the least. I'm replacing
17 Colonel Chris Coke, "Mongo," who has been I think
18 several rotations of briefing this brief. He is
19 my direct boss. I won't make any comments on the
20 ability for an Army Major to replace a Marine
21 Colonel. I'll leave that up to you to decide. I
22 have my own thoughts on it personally, but I'll

1 leave it there.

2 I work at the National Military Command
3 Center and as part of the Deputy Director for
4 Regional Operations where we monitor the
5 intelligence and operations around the world in
6 order to provide the Chairman and the Secretary of
7 Defense the best possible information and advice
8 on their roles as advisors to the President. In
9 this capacity we keep track of specifics
10 associated with countless operations, intelligence
11 and in truth we could spend 2 days just talking
12 global operations without even beginning to
13 address specifics, both the ones that we face now
14 and of course I think the ones that we will face
15 in the near future.

16 If you would allow me, I would like to
17 depart from a somewhat stale approach of charts,
18 graphs, and bulletized briefing points and perhaps
19 the associated spin that we might all see on
20 various news cycles, and introduce you to the
21 Americans who are serving today in what I call the
22 frontier of freedom. It is my hope that you leave

1 here today with a more refined understanding of
2 the texture and the problems facing our nation as
3 seen through the experiences of the soldiers,
4 sailors, airmen and Marines serving on those
5 frontiers.

6 As our agenda, I thought about what my
7 boss, Admiral Mullen, has said are his priorities.
8 I'll talk a little bit about Iraq and Afghanistan,
9 obviously at the forefront of national
10 consciousness, maybe from a different perspective
11 than what you've seen before, and introduce you to
12 some very special Americans in operations that
13 don't always make the news. My objective today is
14 not to add to the overall slide count. I'm sure
15 there will be plenty of slides in the next several
16 days. But I would like to begin with a slide
17 recently briefed to Commander of ISAF, General
18 McChrystal, as a blueprint to winning the war.
19 It's not classified, but I'm sure it's
20 self-explanatory, and if I think you can figure
21 this slide out among such a distinguished body, we
22 need to have a plane ready for you to go to

1 Afghanistan tonight. This is not quite the most
2 easy slide and it was actually the butt of a joke
3 recently in a *New York Times* article. I did not
4 see on the agenda any reference to death by
5 PowerPoint in the medical community or at least
6 facilitating that and if we could add that to the
7 next discussion, trust me, living and breathing in
8 the Pentagon, death by PowerPoint is a specific
9 problem we face every day. So this represents a
10 viewpoint of the insurgency when we talk about
11 Afghanistan and although it's a complicated slide,
12 I'm not going to begin to explain it, I would like
13 you to draw population, popular support, and
14 government capacity. We're going to talk a little
15 bit about that as we go through this probably not
16 contextually, but I'm going to show you some
17 slides that will help bring that into focus.

18 I think this chart is commonly called
19 the kudzu chart. For anyone who has ever tried to
20 get rid of kudzu you can understand the associated
21 issues with that and easily see how a tangled mess
22 a counterinsurgency can become. The first thing

1 I'd like to do is talk about my boss' priorities
2 and he has three. Recently, in late 2009, he laid
3 out his priorities, defending our vital interests,
4 health of the force, and properly balancing global
5 strategic risk. As he describes our main effort
6 and I'm sure you've heard this before, it's to
7 disrupt, dismantle, and defeat al-Qaeda in Pakistan
8 and Afghanistan in that order and to prevent its
9 capacity to threaten America and its allies in the
10 future.

11 What this means is geographically we
12 have to understand a lot more than those two
13 countries. The Pacific Rim, Africa, our own
14 hemisphere, monitor the spread of technology and
15 appreciate the fundamentals needed to source the
16 global common sea, airspace, and cyberspace being
17 of note. The challenge of the peaceful use of
18 this is from activities such as terrorism,
19 proliferation, natural disasters, piracy, and cyber
20 attacks. We must address and develop the
21 capabilities to address threats of change in the
22 future. What you might now know though, the first

1 two sound very what you might be able to call
2 chairmanish, it might surprise this group or maybe
3 not of relevance to this audience is the emphasis
4 that the Chairman places on the health of the
5 force and it's not really defined as simply a
6 medical condition. The Chairman goes beyond that
7 with physical well-being by stating our core
8 responsibility is to win the war while caring for
9 our people and our families. For those who
10 haven't seen this picture, this is Admiral Mullen.
11 He's testing a robotic wheelchair, an endurance
12 and skill prototype at the University of
13 Pittsburgh's Center of Excellence for Wheelchair
14 and Related Technology in Pittsburgh,
15 Pennsylvania. He and his wife, Deborah, have
16 embarked in a conversation with the country
17 designed to facilitate and elicit support from
18 America's universities in helping the Department
19 of Defense.

20 I think it's easy to draw conclusions on
21 the health of the force, but the health of the
22 force directly impacts our ability to meet global

1 friction and global friction points around the
2 world. Today's global friction points in the
3 forefront of the national consciousness are in
4 places like Iraq and Afghanistan along with
5 emerging problems that you might hear in the news
6 in Korea and the Eastern Mediterranean and Israel.
7 Our national leaders must balance the long-term
8 requirements of places like Iraq and Afghanistan
9 with potential requirements for emerging
10 conflicts, both the ones we are predicting and the
11 ones that we have not predicted yet.

12 As I stated at the beginning of the
13 brief, my intent was to show you as we go along a
14 little bit of what goes on behind the scenes, and I
15 think this picture does a fantastic job of
16 introducing you to today's global friction points.
17 When I first arrived in Iraq in March 2003, I rode
18 around Baghdad in a light-skinned about half the
19 size of this truck with no armor protection at all
20 with an 18-year-old kid sitting on top of it with
21 a 50-caliber machinegun out front and unafraid,
22 not knowing what we didn't know, but that was what

1 we had. Here what you see in front of you is a
2 daylight picture in Iraq through a stand storm and
3 search lights in an ambush-protected vehicle
4 assigned to the 573rd Clearance Company, a team
5 preparing for departure on a convoy route-clearing
6 mission on a contingency operation Spiker in
7 Tikrit, Iraq. This will be the lead vehicle on
8 that convoy facing the most direct threat aware of
9 IEDs, probably what you could describe as the most
10 dangerous job in the world for a lot of different
11 reasons. And on a day like today when you don't
12 have air support and the ability to look ahead of
13 you it's even more dangerous. The insurgents like
14 days like this. Soldiers in that truck right
15 there will do that job every day for a year and
16 some of them multiple years. It obviously takes a
17 physical and mental toll.

18 Conflicts in Iraq and Afghanistan are
19 really just a portion of what we do and I think
20 this slide has been briefed before. It's been
21 updated. If you could think of this as a more
22 cleaned-up version of the kudzu chart I showed you

1 earlier. This sort of shows the balls that are in
2 the air for the Department of Defense,
3 specifically current operations as we go through
4 it. The ones in red are obviously the most
5 important and I won't spend a lot of time on this
6 because I think we could go through a lot of
7 different issues and go into specifics. But what
8 this is meant to do is illustrate the scope and
9 the complexity of what's facing our military
10 today, disaster relief, missile defense, pandemic
11 flu outbreaks, counterpiracy, unknown intentions
12 of hostile states. All of this has to transition
13 from the President's guidance down to a single
14 Service member to execute. So when you try to put
15 this into scope and scale, what is it? It's about
16 341,600 people deployed as of right now on that
17 frontier of freedom as I discussed in the
18 beginning. What does that mean? It's about
19 equivalent to the population of Belize, about 340
20 filled Cowboys Stadium. I know I just lost about
21 two-thirds of the audience when I mentioned the
22 Dallas Cowboys in Washington, D.C. However, I

1 happen to be a fan so don't hold that against me,
2 but it does help you get a scale for it. It is
3 also is about 80 percent of the battle at
4 Normandy, not necessarily D-Day, but the recent
5 anniversary, 540,000 casualties associated with
6 the Battle of Normandy that puts it into a little
7 bit into scope and scale of what's going on right
8 now around the world.

9 The bottom line is someone has to
10 transition policy and concepts into reality on the
11 ground. That person is the American Service
12 member on that frontier of freedom, and I'd like
13 to introduce you to several in moments perhaps to
14 define global operations as something other than a
15 statistic or slide, probably translating a little
16 more to a more personal level. This picture is a
17 soldier with the 200th Military Police Company
18 speaks to local Haitians at an internally
19 displaced persons' camp near Port-au-Prince, Haiti.
20 I think there's a brief on Haiti later on today so
21 I won't spend too much time on the Department's
22 commitment to that. What I would like to do is

1 put yourselves into the boots of the Service
2 member at a displaced persons' camp in
3 Port-au-Prince there for an indefinite amount of
4 time with the mission of "saving lives,
5 alleviating human suffering and mitigating the ill
6 effects of the weather," designed to assist in
7 those efforts to the Haitian government's efforts
8 at providing security. A military police
9 officer's success is measured and will continue to
10 be measured on those things that he has done there
11 and how the Haitian people remember him. He is a
12 police officer charged with alleviating human
13 suffering which is tough in our own country, not
14 to mention one devastated by an earthquake. Often
15 in situations like these, the only face seen by
16 populations is from the U.S. military, a theme
17 that will carry throughout this brief.

18 From one earthquake to another.
19 However, in this case U.S. soldiers in
20 coordination with Chilean soldiers erect a
21 hospital tent in Angle, Chile, following an 8.8
22 magnitude earthquake in March. As I'm sure it's

1 commonly understood in this audience, the
2 expeditionary resources of the U.S. health care
3 system or health care capability is necessary in
4 both disaster response and conflict resolution.
5 This particular tent is being erected to expand
6 the Air Force's Expeditionary Medical Support
7 Team's mobile hospital that will meet the needs of
8 the local population. It's that ability to
9 provide those essential services to a population
10 that is critical to what I try to do as is to
11 accomplish security.

12 In much the same capacity as seen in
13 Haiti and Chile, villagers wait to see health
14 professionals during a medical/civil action
15 program in the village of Garmin, Ethiopia. The
16 U.S. military are health professionals assigned to
17 Joint Task Force Horn of Africa providing medical
18 assistance and services to villagers who would
19 otherwise not have that. Why are we in the Horn
20 of Africa? By providing this service in a
21 critical part of this world, a potential terrorist
22 safe haven, a hotbed of insurgency potentially,

1 the government is really bridging the gap between
2 its people and governance and thereby establishing
3 a degree of trust that often times can only be
4 gained or is best gained through the use of
5 medical aid. I often did medical in two tours to
6 Iraq. We used the medical aid we provided local
7 civilians to help build that personal confidence,
8 and we often found some of our best intelligence
9 about where the bad guys were coming from that
10 very simple interaction.

11 But we're not doing everything in just
12 Third World countries or in areas struck by
13 natural disasters. Sometimes we're not quite as
14 visible and most like the Haitian and Chilean
15 earthquakes are something you've heard about and
16 you're familiar with the national struggles in
17 Yemen and Ethiopia. But did you know that the
18 United States recently participated in the
19 sixty-fifth commemoration of Victory Day in
20 Russia, the victory from World War II? Did you
21 know what American Service members did beyond the
22 march? U.S. Navy logistics specialist Seaman

1 Sergio Torres here is pictured with a sailor.
2 He's a sailor about the 7th Fleet command ship the
3 Blue Ridge. He's drawn pictures of a child in
4 Vladivostok's children's cancer ward in
5 Vladivostok, Russia. It's often I think at times
6 like this, moments that are never seen in public
7 or on the news, that are the most rewarding and
8 make you the most proud of what our Service
9 members do. In much the same sense, the moments
10 that are never seen, are the moments where wars
11 are won.

12 This is Iraq and to me having done this
13 for close to 3 years, this is counterinsurgency in
14 action. This is not what you see on news cycles.
15 This is not people shooting at each other. This
16 is the rebuilding of a country. Pictured here is
17 the interaction between the people and the
18 government at the local level. It is probably a
19 young Captain or a young Lieutenant talking to
20 local civilians and local leaders solving
21 problems, problems that Captain may or may not
22 have any ideas to help. It could be medical. It

1 could be essential services. It could be
2 plumbing. It could be jobs. It could be
3 security. The bottom line is that's being
4 discussed right there and our ability to
5 accomplish what that government needs to have
6 accomplished or to assist that government in
7 meeting the essential needs of those people if
8 done right can change the tide of a conflict.
9 Obviously things in Iraq are on the good side of
10 that conflict.

11 Sometimes official interactions which we
12 just saw are not as important as the personal
13 ones. This is my favorite picture from Iraq. I
14 think the beauty of the picture is in the contrast
15 of the picture. If you could just hear what that
16 old man is telling that young soldier, you have
17 old and young, armed and unarmed, their dress,
18 their experiences, their futures, the past between
19 those two individuals. Probably what you're
20 seeing here is the only interaction that gentleman
21 will ever have with a U.S. military member. If
22 our job as we talked about in that first kudzu

1 slide is to elicit popular support and bridge that
2 gap between the population and the government,
3 this is happening right there. How effectively
4 that young soldier is able to communicate that to
5 that man is counterinsurgency.

6 Here PFC Skyler Rosenberry is speaking
7 with an elderly man while visiting an elderly home
8 in Katameya, Iraq. He's with 4th Platoon, Delta
9 Company, 1st Battalion, 502nd Brigade Combat Team,
10 101st Airborne. As in Iraq, Afghanistan is facing
11 much the same issues. They're both
12 counterinsurgency actions we're taking. Here a
13 U.S. Navy machinist mate in Afghanistan, First
14 Class Katherine Matai, from the Civilian Affairs
15 Unit in Kazni's Provincial Reconstruction Team is
16 playing volleyball in Sarda Baba Village in Ghazni
17 Province. Civilian affairs personnel is what she
18 does and the PRT and security forces from the
19 Texas Agribusiness Development Team patrol to
20 interact with Afghan villagers. As in the
21 previous slide, this picture's contrasts are
22 interesting, a U.S. female in an all-male

1 environment playing volley ball in a soccer
2 culture, yet they're supposed to talk and
3 communicate. You have to bridge that gap in
4 culture, in gender and experiences. Her job and
5 her team's job which is a Department of State-
6 sponsored organization is to provide essential
7 services and assist in the government in an area
8 about the size of Delaware. No one else is there
9 to do it. That's her job.

10 Combat is an environment of extremes
11 which I'm sure many here are familiar with. It's
12 one of extreme mental boredom, obviously with
13 physical extremes as well. You combine those with
14 stark terror and vast contrasts in cultures and
15 experiences and objectives and the emotional
16 rollercoaster is hard, and perhaps no picture in
17 my opinion depicts it better than this. Here U.S.
18 Air Force Captain Susan Marciano, a flight doctor
19 assigned to the 79th Expeditionary Rescue
20 Squadron, is sleeping. She's on her way to pick
21 up a severely wounded service member this past
22 April in Afghanistan. She's going to care for

1 that patient as he's transported to the hospital
2 aboard an HC-130 Hercules aircraft. It's the
3 proverbial calm before the storm.

4 As I talked about in the beginning the
5 global commons on those areas of sea, cyberspace
6 and other areas that are considered global
7 responsibilities often don't have a lot of people
8 around to assist in securing them. We're involved
9 in a vast counterpiracy effort in areas like the
10 Horn of Africa and the Gulf of Aden. Here what
11 you see are two U.S. Navy members, Sonar
12 Technician First Class Anthony Bince and
13 Electrician's Mate Brian Chance, not with what you
14 might call security backgrounds. However, they're
15 on a visit board search and seizure team from the
16 Arleigh Burke Class Missile Destroyer the
17 Farragut. What they're doing is they're helping
18 Somali mariners restore power to their vessel in
19 the Gulf of Aden. They're part of Combined Task
20 Force 151 which is a counterpiracy effort led by
21 the United States. It's efforts like these along
22 the global commons where we have most of our trade

1 routes moving through to help facilitate daily
2 life around the world.

3 At first glance this might not look
4 necessarily like a frontier of freedom as I spoke
5 about in the beginning. However, here U.S. Navy
6 Lieutenant Lora Bollinger, who's the Deputy Public
7 Affairs Officer from Joint Special Operations Task
8 Force Philippines, is giving a seminar on
9 photo-captioning to photo journalism students at
10 Western Medano Command in Zamboanga, the
11 Philippines. Its partnership with representatives
12 from the Peace and Conflict Network personnel are
13 teaching local high school students the basics of
14 photography. What might go unnoticed is that the
15 Philippines is a source for al-Qaeda activity. It
16 may or may not be widely known but is commonly
17 understood that there is a base of that activity
18 and terrorism out of the Philippines, and Joint
19 Special Operations Task Force Philippines is
20 established to combat that.

21 This is not necessarily what you might
22 think of combating terrorism. However, bringing a

1 responsible journalist into the equation rife with
2 misinformation and spin cycles resulting from
3 misinformation campaigns is an effective way to
4 produce information designed to be pro-government
5 which helps again bridging that gap.

6 Here at home, Service members from the
7 Louisiana Army National Guard lower oil spill
8 booms onto local fishing boats in Brenton Sound
9 Marina. I think the Deepwater Horizon oil spill
10 is obviously is at the forefront of what's at
11 least the national discussion at this point, but
12 the Department of Defense has been heavily
13 involved in the beginning, most notably the
14 call-up of the National Guard.

15 I began this briefing with the desire to
16 provide a more refined understanding of the
17 texture of the problems facing our nation today as
18 seen through the experiences of the soldiers,
19 sailors, airmen, and Marines conducting global
20 operations probably not exactly how you have seen
21 it before or maybe how you might see it again.
22 However, I'm sure that you're well aware of the

1 heavy toll from not only Service members but their
2 families as well, and they do so willingly, which
3 does not go unnoticed here. It's organizations
4 like this that make a difference, and I appreciate
5 your personal time and effort to take care of our
6 troops, your troops.

7 I would like to close from a quote from
8 my boss, Admiral Mullen: "How we take care of
9 those who are wounded and their families and the
10 families of the fallen is right at the center of
11 my life. They've done exactly what we've asked
12 them to do. They put themselves in harm's way and
13 many of them have not come back."

14 Admiral Mullen seen here is greeting a
15 child of a Service member who's been killed this
16 past September at the Fourth Annual Time for
17 Remembrance Ceremony honoring America's fallen
18 heroes. It's a case in point of the price being
19 paid by American Service members.

20 I'd like to thank you for the
21 opportunity to brief you today. It's been my
22 pleasure. And like I said to start with, I didn't

1 quite know that there was a sun in the sky after
2 spending months upon months in the basement of the
3 Pentagon and it's nice to have a chance to see
4 that again. I'd love to answer any questions you
5 may have. With that, thank you for your time.

6 (Applause)

7 DR. LEDNAR: Thank you, Major O'Neal,
8 for that brief. I'll start with the first
9 question. Building on Admiral Mullen's
10 understanding and the importance he is bringing to
11 health for the force, if you can describe for us
12 if you know, how are we incorporating health as a
13 force multiplier and clearly an important lever
14 for combat success in the training in our senior
15 military educational system, the Army War College,
16 ICAF, and other kinds of educational programs
17 preparing our senior leaders for combat? How is
18 health being emphasized to them as an important
19 responsibility which they have?

20 MAJ O'NEAL: I can't talk necessarily
21 to the senior Service colleges. Obviously I
22 haven't necessarily had a chance to do that yet.

1 However, I can talk to you about things that might
2 be a little more pertinent to a unit that's
3 getting ready to deploy to an environment such as
4 Iraq or Afghanistan. Prevalent prior to that is
5 an understanding of psychological impact and I
6 think there now is a breadth of experience of
7 those who have gone through this cycle several
8 times both personally and with their families
9 culturally, it is now I think a lot more
10 acceptable to understand the effects of traumatic
11 brain injury.

12 There's a lot of discussion on how to
13 recognize the signs and symptoms of that, that is a
14 prevalent discussion and prevalent conversation
15 and there's a lot of training for both young
16 medical corpsmen or medics who can help recognize
17 that, the doctors and physician's assistants all
18 are trained in helping us establish that. The
19 most common, of course, physical effect results
20 from IEDs and the shock resulting from the
21 blunt-force trauma associated with that, so that's
22 I think a portion of it.

1 However, the best way to probably
2 describe it is an increase in the overall
3 awareness of those issues and then an increase in
4 the overall acceptance of addressing issues such
5 as those within a military culture which is
6 heretofore been very reluctant to admit a level of
7 weakness individually or socially.

8 DR. LEDNAR: Thank you. Are there other
9 questions or comments for Major O'Neal? Dr.
10 Parkinson?

11 DR. PARKINSON: Thanks, Major O'Neal,
12 very much. I actually really appreciate this kind
13 of personal qualitative view rather than the
14 typical J-3, J-4, J-6 approach to the world. It's
15 very, very telling when you see those pictures.
16 The Army recently fundamentally redefined its
17 leadership doctrine. They kind of wiped the slate
18 clean and they said that essentially, you're in
19 the Army so you know better than I do, said that
20 leadership is executed by every person in uniform
21 at every level and it's around influence. How do
22 you influence all of those scenarios and all of

1 those people in a way that advances the strategic
2 interests and the national interests of the
3 country and much to the good of the people in the
4 pictures as well?

5 It occurs to me I do a lot of my work
6 right now with large major employers and large
7 health care institutions. The 18- to 21-year-olds
8 in those pictures have to execute more leadership
9 than most executives I meet 99 percent of the time,
10 and they do it day-in and day-out with a skill set
11 which is really largely around passion that they
12 have for service and kind of an understanding of the
13 geopolitics but I'm not always sure. Frankly,
14 when I see and talk to a lot of them, it's like I
15 do my job and I do it well. I can see in that
16 picture. But if you could speak a little bit,
17 it's going to get into Dr. Fogelman's presentation
18 a little bit as we look at this in-depth report on
19 resilience and clinical and preclinical,
20 increasingly what major corporations are doing is
21 saying that resilience is defined not by the
22 medical world. And it's really not defined in the

1 Chairman's quote, it's defined in the line
2 leadership just like influence is now training for
3 Army and they're looking at simulations just like
4 they simulate firing a gun or flying an F-16 in
5 the Air Force.

6 Perhaps we can continue this dialogue
7 about how does the leadership look at training the
8 skills and the personality traits and the
9 influencing of those 341,000 people who at a
10 moment's notice have got more of a challenge than
11 any of the CEO of any company I've ever met? I
12 don't think we have a good enough understanding
13 yet of how we do that. I think the resilience we
14 talked about here today is good, but I'm just
15 struck by the magnitude of the job these people do
16 and ask ourselves all the time at the DHB, can't we
17 do a better job preparing them to be
18 high-performing resilient individuals beyond
19 period lectures or briefings or assessment tools
20 which are all medical, if you will? Does that
21 make sense a little bit? Just a thought.

22 MAJ O'NEAL: It does and I think that

1 there's no better leader in the military than a
2 noncommissioned officer of a small unit regardless
3 of service. I think that they are the ones who
4 lead the small units from the very front. They
5 are the ones who deal with the most personal
6 issues on a regular basis. The officers are
7 somewhat separated at times just by proximity and
8 function, but the noncommissioned officers are the
9 ones who have the most daily contact with those
10 soldiers and daily contact in this case
11 populations.

12 I think prior to the last 8 or so years,
13 we had more of a top-heavy decision-making and
14 top-heavy leadership culture and that a lot more
15 decisions were made at a much higher level than
16 they probably are now, and the role and the
17 function of those junior leaders has increased
18 because their capacity to execute has also
19 increased at the same time based on their
20 experiences, their level of experience, their
21 level of knowledge. There are always outliers,
22 but the ability for those individuals to draw from

1 most experience, most of them 3-plus years worth
2 of experience in an environment that demands and
3 creates a much faster learning tempo than it might
4 necessarily through sitting in a garrison
5 environment looking at a simulation or something
6 like that, those are all experiences drawn.
7 However, there are training experiences that help
8 you sort of prepare a fundamental understanding of
9 the problem and there are real-world experiences
10 and often those two are related but are very, very
11 different. Time and time again you see units come
12 into theater thinking they understand the problems
13 and how they're going to execute them, and find
14 immediately, maybe we don't. And you find
15 immediately that maybe you don't know your
16 personnel as well as you did once they're put
17 under that environment of stress which really is
18 that breeding ground for leadership. This is an
19 expansion of the discussion.

20 DR. LEDNAR: Are there other questions
21 or comments for Major O'Neal? Commander Feeks?

22 CDR FEEKS: I am looking at slide

1 number 3, what you called the kudzu slide, the
2 Afghan stability and counterinsurgency dynamics
3 slide. I think it's a marvelous slide because of
4 what it depicts which is the incredible complexity
5 of what we are trying to accomplish in Afghanistan
6 and that speaks immediately to just how hard it
7 is. I think that this is a slide that is worthy
8 of study and meditation by any American who wants
9 to appreciate what men and women in uniform are
10 doing far away from home. This is just amazing.
11 Thank you for providing that slide.

12 MAJ O'NEAL: Sir, if you could figure
13 it out. But you are correct. I think it is a
14 very telling slide once you start to really
15 understand the intricacies behind each of those
16 arrows and how they connect or don't connect or
17 what they connect through. It's a very
18 complicated process.

19 DR. LEDNAR: We have time for one more
20 question or comment for Major O'Neal. If not,
21 Major O'Neal, thank you very much for this brief
22 and thank you again as Dr. Parkinson said for

1 really putting a face, really adding the personal
2 touch about what this means to our men and women
3 in service.

4 MAJ O'NEAL: My pleasure, sir. Thank
5 you.

6 DR. LEDNAR: Thank you. (Applause)

7 DR. LEDNAR: Our next speaker is Dr.
8 Charles Fogelman who currently serves as Executive
9 Coach in Leadership Development and Management
10 Consultant as a Principal at Paladin Coaching
11 Services. Dr. Fogelman chairs the Psychological
12 Health External Advisory Subcommittee of the
13 Defense Health Board and will provide a summary of
14 the Subcommittee's recent activities including its
15 examination of a question addressed to the Board
16 regarding a review of evidence-based metrics used
17 by the Department to measure the effectiveness of
18 preclinical programs that support resilience,
19 education, and counseling as well as those that
20 measure clinical mental health program outcomes.

21 Dr. Fogelman's presentation may be found
22 under Tab 4 of our meeting binder. Dr. Fogelman?

1 DR. FOGELMAN: Thank you. A few scripts
2 are always much better than mine. I write mine
3 out right before and have notes and I always get
4 up here and I've written too small and I have
5 lousy handwriting. So to the extent that I'm
6 rambling and incoherent, blame it on my
7 second-grade teacher.

8 The big item for us will come at the end
9 of what I'm about to do. We have a report that we
10 submitted in draft form for the Board to look at
11 and I presume people have looked at it and then
12 we'll discuss that, so I'm just going to very
13 quickly go through the plain part of the slides
14 and then we'll move into the substantive
15 presentation. If you don't mind, Wayne, I'd like
16 to acknowledge the recent arrival of General Loree
17 Sutton who's the Director of the Defense Centers
18 of Excellence on Traumatic Brain Injury and
19 Psychological Health.

20 DR. LEDNAR: Welcome General Sutton.
21 Please join us up here at the table. Thank you
22 for coming.

1 DR. FOGELMAN: And that person walking
2 over there, Eric Carbone is a member of her staff
3 and is a psychologist.

4 These are the kinds of things I'll talk
5 about. I used to have a much larger set of slides
6 and I figured by now you've seen them enough.
7 These are the people who are on the committee.
8 You've seen this slide before but it's now
9 organized in a different way. As you'll hear me
10 say later, the work that resulted in the report
11 that's in front of you was done by two Subgroups
12 of the Subcommittee as a whole and that's how
13 they're divided up this time through.

14 This will tell you what we did at our
15 last meeting which was mostly paying attention to
16 how to get this report done so that we could get
17 it to this meeting. This will tell you a little
18 bit about what went on outside of the direct
19 face-to-face meetings we had in order to put the
20 report together. That's what we're going to do as
21 time marches on. This is the unanswered question
22 for us. We've not done anything on this question

1 because we decided together with the Traumatic
2 Brain Injury Subcommittee of the Board to work
3 together with them on this question because it
4 makes the most sense to do that. However, since
5 most of them had not been reappointed or have not
6 been reappointed, that work has not gone forward,
7 or not been appointed yet I guess.

8 Here's the big part of what we need to
9 do today. The report that you've received in
10 draft form is the result of trying to respond to
11 these two questions which were put to us last
12 December. An enormous amount of work has been put
13 into this by everybody on the committee, everybody
14 on the Subcommittee but me. All I had to do was
15 run the meetings and ask people if they were
16 proceeding, but the real hard work was done by the
17 individual members of the Subgroups and the two
18 leads of the Subgroups who I'll introduce later,
19 and especially members of the staff, Christina
20 Cain, who's back there some place, and the able
21 intern on the staff, Phoebe Kuesters.

22 When we looked at these questions we

1 thought about are they two pieces of the same
2 question, two different questions, or is there some
3 other way we should look at it. As we began to
4 think about it, we decided it made the most sense
5 to put half of us to work at the first and half of
6 us to work at the second and then see what
7 resulted as the process went on. As it turns out,
8 the people who were trying to respond to or think
9 about the first question wound up thinking more
10 about the theoretical issues, the conceptual
11 issues, the general design issues of how do you
12 figure out what the value is of the programs that
13 the Department has in place, programs for
14 preclinical care which is mostly resilience in
15 getting people ready for theater kinds of things,
16 and about clinical care.

17 The first group talked about what does
18 it mean to do this, what are the definitions, how
19 do you structure it, what advice can we give the
20 Department in evaluating programs generally? And
21 the second group paid much more attention to the
22 specifics of measuring clinical psychological and

1 psychiatric outcomes and how they relate to the
2 designs and intents of the Department, so that's
3 what that's about. Let me ask the two Subgroup
4 leads to come up now. Kurt, Brett, come on up.
5 These are respectively, first, Dr. Brett Litz who
6 is a psychologist. He is a Professor of
7 Psychology at the Boston University School of
8 Medicine in Psychiatry and Psychology. He is also
9 a Clinical Psychologist with the National Center
10 for PTSD. And Kurt Kroenke is a Professor at
11 Indiana University School of Medicine and wants
12 everybody to be sure to know that he's an
13 internist who does mental-health research and is
14 very interested in the delivery of services. He
15 is not a psychiatrist so don't treat him like that
16 is what he asked me. I'm going to ask each of
17 them to say a little bit about the process, but
18 really the substance and what were the major
19 issues each of their Subgroups dealt with, and then
20 I'll turn it over to Wayne or Wayne and I will
21 together put the whole set of recommendations
22 before you. Brett, do you want to go first?

1 DR. LITZ: Good morning. Our
2 sub-Subcommittee had quite a task in front of us
3 to come up with some recommendations about how to
4 guide the DoD to evaluate the full complement of
5 basically everything to the left of an actual
6 clinical intervention, which is the preclinical
7 spectrum from pre-deployment training to targeted
8 interventions of any sort, counseling, or what have
9 you across the spectrum. I think it was tallied
10 to be 800 and 900 programs that exist. The report
11 is very detailed and I think it's a very excellent
12 document. Because we were not actually privy to a
13 description of all the programs that exist which
14 would have taken months to discern, and without
15 knowing what the programs are, we can't really
16 make recommendations about metrics so that our
17 recommendations are conceptual about how to guide
18 the DoD to obtain uniformity in evaluation of
19 these programs. Let me just highlight a couple of
20 things, and they come in the form of a what, a
21 where, a when, a how and a why and it kind of
22 underscores for me the key issues about evaluating

1 preclinical programs.

2 The what is what are we evaluating? I
3 applaud the DoD for going about the task currently
4 of cataloging all the 800 to 900 programs that
5 exist, the preclinical resilience training
6 programs. That's a really important task and a
7 necessary one, but it's not sufficient. We need
8 to know what these programs are about and we
9 should really force the programs to delineate in
10 very clear terms their assumptions, their guiding
11 framework, they conceptual model, what they target
12 and why. And more importantly, whether their
13 program is designed to inform what happens to
14 Service members and families when they are faced
15 with extraordinary stress, trauma and loss. Do
16 their programs actually affect behaviors,
17 cognitions and so on and so forth when it comes to
18 actual coping with severe trauma especially in
19 theater? That has not been done and that needs to
20 be done. What will flow from that is a ready
21 cataloging of metrics and evaluation design
22 because once you know what the model is and what

1 the targets are and why these things are targeted,
2 then you could come up with a program evaluation
3 framework so that is the what.

4 The where for me is where are the holes
5 or where does most of the work that needs to be
6 done with respect to program development and
7 evaluation? For us it appears that there has not
8 been enough attention paid to what happens in
9 theater to help Service members with actual
10 preclinical states of stress injury to prevent
11 disorder or mental health problems. So what is
12 going on in theater with respect to prevention of
13 PTSD and other mental health problems as a result
14 of combat and operational stress, trauma, and loss?
15 It is unclear to us what is going on. There are
16 initiatives but I think that this is one of the
17 vacuums that exists with respect to cataloging
18 what the practice and determining what is going on
19 and evaluating them. I think it's a critically
20 important aspect to the tools of the DoD in terms
21 of prevention. The reason why it's critical is
22 that the literature, particularly with respect to

1 preventing PTSD, suggests that the best evidence is
2 for what is known as indicated prevention, helping
3 individuals in the throes of a preclinical state
4 as a result of exposure to trauma. The best
5 evidence suggests that that is what should happen.

6 Currently the Army in their doctrine has
7 methods of doing indicated prevention in theater.
8 It's unclear how those will be carried out and
9 whether they will be uniform, but that's a good
10 start. For us, the Navy and the Marine Corps
11 model is a particularly attractive model because
12 it's the only model and doctrine that actually
13 specifies a preclinical state, and the preclinical
14 state is called Orange Zone Stress Injury and it's
15 a heuristic guide that is used to identify people
16 in need so that that is the where, where do things
17 need to do?

18 The when is an issue of timing.
19 Resilience is fundamentally about bouncing back or
20 bouncing forward in the best case. It's about
21 change and reaction to, in the case of Service
22 members, combat and operational stress, trauma, and

1 loss so that evaluations have to be unfolding and
2 over time. And evaluations have to take into
3 account exposure to serious combat and operational
4 experiences or family stress for that matter
5 because without an evaluation of things that
6 happen, really our determination of resilience is
7 confounded by exposure. A lot of what we think is
8 the resilience of the force is somewhat confounded
9 by the fact that not everyone is exposed to trauma
10 so that that is the when, timing and repeated
11 assessment is critical.

12 The how. I'm a clinical scientist. I
13 do clinical trials. We could impose a heavy
14 scientific burden on the metrics and make
15 recommendations for clinical trials in the field
16 and that would not a good idea. Not only is it
17 not feasible, but the reality is that most
18 clinical trials actually don't inform practice and
19 we have 800 to 900 programs that already exist.
20 So what we need is a program evaluation framework.
21 The great thing about a program evaluation
22 framework is that if it is done properly and done

1 in a state-of-the-art way, it is very much in tune
2 with culture and all stakeholders are involved,
3 it's an unfolding process and it's about quality
4 improvement, and that's what we need is quality
5 improvement.

6 The last issue is why, and the why is
7 chiefly obvious, that we want to make sure that we
8 have programs that work, that we're not wasting
9 the time of family members and Service members,
10 that we're not giving them the false impression
11 that what we're providing to them is going to help
12 them per se. We want to know what works. I think
13 we also want to sure that we have resilience
14 training programs that will inform what actually
15 happens in theater when Service members in
16 particular are exposed to the hells of war.

17 DR. KROENKE: So our group focused on
18 the clinical piece which I think actually was a
19 bit easier than the preclinical piece for a couple
20 of reasons. First, I think what we're dealing
21 with is more circumscribed. I think the
22 preclinical is dealing with the whole Service

1 population and the clinical focuses on that
2 subgroup that already has overt manifestations in
3 terms of symptoms or functioning. Second, I think
4 the evidence base for the limited number of
5 conditions that are common is fairly strong in
6 terms of clinical metrics, so I think in the task
7 we had we were able to be more prescriptive and
8 less conceptual, not that conceptual is not
9 critical, but I think our job was a bit easier.

10 I think underlying, clinical was when
11 people already overt symptoms or functional
12 impairment. The two compartments of that end up
13 being looking at the whole population to screen,
14 and that's largely done now with what we found out
15 with the four P's which are the Periodic Health
16 Assessments and then whatever is done
17 pre-deployment and at several points
18 post-deployment, so we spent some time looking at
19 what's currently being done. I can say on that
20 aspect that our recommendations ended up being
21 modest modifications rather than substantive,
22 major additions except for a few items.

1 In terms of the clinical piece which is
2 not the whole population but when people present
3 for clinical care for psychological and psychiatric
4 disorders, there actually our biggest
5 recommendation ends up being to routinize
6 measurement because although evidence-based
7 measures exist and are fairly brief. They're not
8 routinely used, they are used more in some
9 settings than others, but that would be a strong
10 recommendation.

11 Finally, undergirding our principle was
12 to be pragmatic so measures ideally are brief and
13 evidence-based focusing on the big disorders which
14 ends up being depression, PTSD, and substance and
15 the actual recommendations are made are itemized
16 in the report.

17 DR. FOGELMAN: I hope that's a
18 sufficient overview. I suspect if any of you like
19 the folks over here who haven't read all the
20 background stuff are maybe not quite so able to
21 follow and for that I apologize.

22 I'm just going to whip through once so

1 you know what the sets of recommendations are
2 about and then I'll ask Wayne how he wants to
3 proceed. This set of recommendations regarding
4 preclinical program effectiveness, the person who
5 will ask questions about that is Brett but maybe
6 me, and surveillance of psychological health
7 indicators, either Brett or Kurt may answer. I
8 should say each of them came up with a written
9 report and I had to squeeze them together so any
10 bad editing is my fault and anything which doesn't
11 look good is my fault, blame me, and any of the
12 substance which is good is not due to me.

13 Then explicitly in regard to programs
14 intending to have an impact on clinical care, that
15 would be Kurt so that we have these three big sets
16 of recommendations. There aren't 76 of them. In
17 the nature of these reports apparently you have to
18 number them from the very beginning so all of the
19 things which went before, findings and the like,
20 got up to 56 so that it's only 20 recommendations.
21 Wayne?

22 DR. LEDNAR: First thank you to the

1 Psychological Health Subcommittee for all the work
2 that you did in this area. It's a real challenge
3 and really complex. What I propose is that I read
4 for the Board the questions that came to the
5 Board. Let's start with the goal of trying to
6 answer the mail and that is what were the
7 questions that came to the Board, and then we'll
8 open it up for any questions or comments about the
9 recommendations in the Subcommittee's report.

10 I'll just read from the document that we
11 have from Dr. Rice. Paragraph 2 reads, "Following
12 23 December, 2009, the Assistant Secretary of
13 Defense for Health Affairs requested the Defense
14 Health Board examine the following," and there are
15 two questions. "First, identify any evidence-
16 based metrics that the Department of Defense might
17 use to measure the effectiveness of preclinical
18 programs supporting resilience, education, and
19 counseling." Second question, "Advise the
20 Department on specific evidence-based metrics to
21 measure Department of Defense clinical
22 mental health program outcomes."

1 So those are really the two questions
2 that we would then hope that in the committee's
3 deliberations and its recommendations are
4 answering back to Dr. Rice that important advice.
5 With that I'll call for any questions or comments.
6 Dr. Parkinson?

7 DR. PARKINSON: First again to Charles,
8 Brett, Kurt and everybody on the committee, I
9 think you've done a yeoman's job and something
10 that frankly I think will inform not only the
11 military but civilian practice. These things as
12 you know better than I do are very ill-formed in
13 the civilian sector. Many large employers are
14 dealing just with these issues because they know
15 that health is not the absence of disease, it
16 really is the ability to bounce back, the global
17 economy, 24/7, the whole nine years, so this is
18 groundbreaking work I think and applaud you.

19 Number two, on a personal note, Kurt, it's
20 good to reconnect with you. He has been a
21 tremendous contributor to helping to understand
22 the natural history of symptoms, to illness, to

1 care-seeking behavior, that was the cornerstone of
2 a lot of our work in Persian Gulf Syndrome and
3 other things early on, so thanks again.

4 But my concern here is the
5 medicalization of something that is inherently not
6 medical. This is something we lived back in my
7 time in the Air Force with the Suicide Prevention
8 Task Force and I really think the recommendations
9 are excellent. There are some 20. I think the
10 committee's ongoing work will be helping the
11 Department to prioritize what needs to be done in
12 the next 6 months versus 60 years. And frankly,
13 what we need to do is to say where now do we need
14 to get this demedicalized? I realize when the
15 question came to us as preclinical versus
16 clinical, I think that was an unfortunate turn of
17 phrase, preclinical, as opposed to line- or mission-
18 oriented or population-based or public health
19 because it immediately puts program in our mind on
20 a preclinical thing and we've got that in programs
21 with 900 different programs out there that are
22 just running rampant which again is not too

1 dissimilar from the civilian sector with
2 foundations that fund programs that don't work and
3 10 years later find that they should have asked
4 for an evaluation framework.

5 So my challenge to the committee would
6 be as we continue with our work, what are the
7 one-page take-homes for every single Service
8 member and their families to define what is
9 high-performance, resilience behaviors for them
10 and their families with verbs and how they can
11 self-identify early and simply when things are a
12 little off-track? This is what leading employers
13 want to do. I think there are wonderful tools
14 that have come online in the last year. The
15 Healthways/Gallup Well-Being Index which now has
16 ZIP code level, we can actually take the ZIP codes
17 of military members who come in and look at their
18 ZIP codes and the populations that come from and
19 risk adjust with the demographics to say here's
20 the profile of the well-being index of people who
21 came in last year to the tune of 200,000 new
22 recruits. What is that baseline and incorporate

1 that. It's already available and paid for.

2 Those are the types of innovations in
3 the nonmedical world that we can hopefully
4 incorporate and then get them back to the line
5 because at the end of the day I shiver when I see
6 things like mandating face-to-face interviews.
7 It's classic catch-22. You got to be crazy to go
8 to war in Vietnam so you say you're crazy and you
9 can't get out. If we're not careful, this
10 medicalization will be great for universities and
11 researchers but it won't really get us to the
12 impact we have.

13 So again an excellent job and a
14 phenomenal team and wonderful stuff. Our job is
15 to translate it quickly to the end user who is the
16 Service member and the NCOs that we heard from
17 JCS.

18 DR. FOGELMAN: Thank you for your kind
19 words, Mike. I'm guessing that most of the people
20 on the Subcommittee would be happy to
21 demedicalize, but as you say, we have to deal with
22 what we're asked. In terms of the follow-up, I

1 have the same thing to say about that. If the
2 Board directs us and asks us to do some of that
3 follow-up then we'll surely do it, or if the
4 Department asks us to do it we'll surely do it,
5 but we need to be asked or told to do in that
6 regard. Do either of you have anything to say?

7 DR. KROENKE: Yes. I think where the
8 risk of the over-medicalization is actually more
9 in the preclinical side than in the clinical side,
10 so I think that's where the risk exists, and the
11 second area that it exists on the clinical side is
12 when we're doing this population screening. I
13 think we're pretty robust in terms of, let's use
14 evidence-based metrics once people are actually
15 being treated clinically. But on the four P's
16 where we're doing periodic and then pre-
17 deployment and post-deployment, one thing I think
18 with this new law in October where they mandated
19 even more screening, in particular pre-deployment,
20 including face to face, we talk about it in the
21 report, there's a positive side to that, but then
22 there's a potential thing that's going to have to

1 be monitored particularly in terms of resources.
2 Not only resources in conduct all those
3 face-to-faces, but also resources to provide the
4 care if things are detected, to not to
5 over-diagnose, particularly in the pre-deployment
6 setting because with people being frequently
7 deployed, if we overburden the system with
8 screening, we have to have the resources so that
9 we don't affect the operations and over-
10 medicalize things.

11 DR. LITZ: Thank you for you comments
12 and your kind words. There's a tension that
13 exists in this area in the preclinical realm about
14 whether to assume what is seen regardless of the
15 reaction as normal and will basically go down on
16 its own and there will be a resilience trajectory
17 or even a recovery trajectory, and if you call too
18 much attention to it that maybe there would be a
19 kind of iatrogenic -- and that's probably your
20 concern about this over-medicalizing, that there
21 may be this kind of iatrogenic kind of phenomenon
22 that occurs where you call attention to something

1 and then Service members are focused on that
2 problem that they may be having. That's intention
3 with I think what I have come to realize as the
4 realities of war and that everyone has a threshold
5 that can be crossed into a non- normal state but
6 it's not disorder per se. If we shy away from
7 that because of excessive concern about over-
8 medicalizing, I think we're doing Service members
9 and family members a disservice.

10 DR. PARKINSON: Brett, I think I just
11 want to clarify. My concern isn't at all about
12 iatrogenesis. My concern is that unless we have a
13 baseline understanding of what is this thing we're
14 trying to measure called psychological resilience,
15 family resilience, coping skills, that are
16 demedicalized in the lines of our main audience,
17 if anything I want a massive communication
18 campaign of what is healthy mental resilience in
19 the military population just as they're trying to
20 define a GSK with Bob Carr who was formerly Air
21 Force, by the way. So in other words, what does
22 resilience look at a global pharmaceutical company

1 for an employee and their family? That's what
2 they're working on. But it's at the level of the
3 employee and the family. I agree with you. I
4 totally don't think there's any problem. We need
5 to elevate the issue and civilianize it, if you
6 will, while we back it with the medical. So just a
7 clarification that I'm right with you.

8 DR. LITZ: One last comment. I think
9 that there is some rhetoric out there in our
10 combined fields that sort of intimates that
11 resilience is non-response, that it's like an
12 uber-adaptation to the hells of war and I think
13 that that is not ethical or responsive and not
14 appropriate actually. So I don't think you'd
15 disagree with that. It's about recovery.

16 DR. PARKINSON: And I think if we define
17 just what you said, what is a healthy response to
18 stresses --

19 DR. FOGELMAN: Not necessarily suck it
20 up.

21 DR. PARKINSON: You got it. Right.

22 DR. LITZ: Not only what is healthy but

1 what is abnormal and what needs care. Thanks.

2 DR. LEDNAR: Dr. Kaplan and then Dr.
3 Mason. Dr. Kaplan?

4 DR. KAPLAN: This is directed to you,
5 Wayne. Why was the question asked to us? Maybe I
6 slept through that part.

7 DR. LEDNAR: I'm going to be looking for
8 some help maybe from Commander Feeks or Ms. Bader
9 in terms of the background as to how did this
10 question come to the Board.

11 DR. KAPLAN: In other words, what I'm
12 asking is, I missed why we were asked the question.
13 What is the ASD going to do with the information
14 that he got or what was the problem that
15 stimulated asking us?

16 MS. BADER: When Ms. Embrey was
17 performing the duties of the ASD(HA), and Dr.
18 Sutton, you can chime in if you'd like, the powers
19 to be were saying basically we have all these
20 programs, we're very interested in the resiliency
21 of our military members, we're interested in the
22 mental health of our military members and our

1 beneficiaries, and how do we know that the
2 programs that we're putting in place are working?
3 So these questions were posed. They were asked of
4 Ms. Embrey and then she asked the Defense Health
5 Board based on all of your expertise what metrics
6 are out there or how can we go about developing
7 metrics to show that the programs we have in place
8 and the work that we're doing is in fact
9 effective.

10 DR. KAPLAN: If I can just follow-up on
11 that, the action item to that would be
12 consideration for revision of the present
13 approach?

14 MS. BADER: It could be based on the
15 recommendations, and just like any other committee
16 that provides recommendations back to the ASD(HA),
17 they are exactly that. So the recommendations
18 will go back and they'll be read and they'll be
19 analyzed if you will by the experts within the
20 Department of Defense and then a plan will move
21 forward based on the recommendations.

22 DR. FOGELMAN: Let me say something to

1 that, too. Along the way we had the very able
2 assistance and participation of several people
3 from Health Affairs which helped us shape what we
4 were doing to be sure that we were being
5 responsive to what they perceived as their needs.
6 As Brett just said to me in an aside, in point of
7 fact there really isn't an "approach" now
8 that is to be revised. It may well be the case
9 that this is the first time within Health Affairs
10 that thinking about it systematically has occurred
11 at all.

12 DR. LEDNAR: I'd ask if General Sutton
13 has a comment she'd like to make.

14 BG SUTTON: Yes, thank
15 you very much. First of all, let me just thank
16 Dr. Fogelman, Dr. Litz, and Dr. Kroenke, for your
17 work on this report. I look forward to reviewing
18 it in detail, and I also appreciate the opportunity
19 to respond to this question.

20 We know that when we started this
21 journey, if you can think of it in terms of a
22 timeline, prior to the issues that came forward

1 during February 2007 with respect to Walter Reed
2 and the shortcomings of our treatment and
3 disability evaluation system as we well will
4 recall, there was a tremendous galvanizing of
5 leadership attention and resources both within the
6 military as well as nationally toward addressing
7 those issues. I think of that period up toward
8 2007 as being a period of relative scarcity with
9 respect to the issues we're addressing this
10 morning, psychological health and traumatic brain
11 injury. As a Department, we were focused forward
12 on savings the lives of troops that never would
13 have survived previous conflicts and the events at
14 Walter Reed actually proved in my estimation to be
15 really a blessing in disguise as riveting as they
16 were at the time, but to be able to really direct
17 our refocused attention toward this set of issues.

18 As you know, the strong support of
19 Congress led to very generous funding and support
20 for a proliferation of programs with respect to
21 traumatic brain injury and psychological health
22 and when you put over a billion dollars against a

1 set of issues you do then go into a period of
2 proliferation. When you think about the timeline,
3 those programs were for the most part contracted
4 for in the latter stage, the fourth quarter of
5 Fiscal Year 2008 so they've just been in existence
6 for about 18 months now. Many of them are
7 starting to near maturity. We're very excited
8 about that because we've known from the very
9 beginning whether it be the Service-specific
10 executed programs that came out of the Red Cell
11 work from June 2007 through November when the Red
12 Cell disbanded and handed off those programs, to
13 the Defense Centers of Excellence which was just
14 standing up at that time, we have been working
15 with the Services to be able to track the
16 development and the implementation of those
17 programs which has included from the very
18 beginning a recognition that this would be the
19 time that we could absolutely transform our
20 culture by going to an evidence-based,
21 outcome-directed program.

22 To that end, we have reached out not

1 only to the Defense Health Board for your thoughts
2 on this and certainly the recommendations that
3 have come out of this work will go into what we
4 are currently doing in terms of our work with the
5 RAND Corporation. We have a promising practices
6 contract that we've been able to gain with the
7 RAND Corporation this year to be able to think
8 through how do we put outcome metrics as Dr. Litz
9 said? What is the program or evaluation framework
10 for such public health initiatives, as an example,
11 the Theater of War Program? RAND Corporation is
12 looking at that right now to put together that
13 program evaluation framework. Or for the Real
14 Warriors Campaign which is a public health
15 national education campaign designed to eliminate
16 stigma?

17 We have also been working with the
18 Chairman, Admiral Mullen, who convened a group
19 last November at the Uniformed Services University
20 to develop a total fitness framework. This
21 incorporates eight domains of fitness. It can be
22 thought of as really the first time that the

1 Department has developed a framework that
2 incorporates the leading science, the leading
3 knowledge, from this burgeoning field of
4 resilience. We have recognized from the beginning
5 that resilience is a command-led endeavor. With
6 the Defense Centers of Excellence when we started
7 our efforts we developed a three R continuum which
8 is resilience, recovery, and reintegration,
9 recognizing that this challenge is much broader
10 than the medical model of recovery. Yes, we lead
11 that and command supports. To left of that
12 resilience, command supports through the
13 development and execution of tough operational
14 training that starts from the very first day of a
15 session and that has started now within all of the
16 Services in terms of even acquainting troops and
17 their family members with what are the normal
18 human responses to trauma.

19 What does resilience mean? How can we
20 think of it as a dynamic process as has been
21 mentioned earlier? We're at the leading edge of
22 those efforts to be sure, but what is coming out

1 of now this total fitness framework that has the
2 Chairman's absolute support and unflagging
3 leadership is that we are now working with
4 Samueli Institute to develop the program
5 evaluation and comparative effectiveness framework
6 that will allow us to then populate a model
7 template working with Gallup, I think it was
8 mentioned a moment ago, in terms of the Gallup
9 Healthways Alliance.

10 Some folks may not know, but since
11 January 2008, the Gallup team has collected a
12 minimum of 1,000 health and well-being surveys
13 from Americans every single day, and just about 2
14 or 3 weeks ago we were invited by Jim Clipton and
15 his team to get a presentation of their data so
16 far. It's rudimentary analysis at this point, but
17 the exciting part of this is that the Gallup team
18 has engaged us in this journey and we have
19 contracted to implement a resilience composite
20 pilot study which is in the process of being
21 implemented right now.

22 Let me explain what that means. That

1 means that as you know the Army has moved forward
2 with its Comprehensive Soldier Fitness Program
3 which trains master resilience fitness trainers on
4 the NCO side and a number of efforts related to
5 that. As part of this program, each of the other
6 Services will be given the opportunity to select
7 one of a number of evidence-based resilience
8 programs whether it be Gallup's Strength Finder's
9 2.0 Program or the Human Performance Institute
10 Program, there are several choices there, but the
11 baseline measures that will initiate the study
12 come from the Gallup Q12 Engagement and Well-Being
13 Index. Their research has found that the
14 engagement question which goes something like
15 this, Are you able to give your best at work every
16 day? That has become the most powerful predictor
17 for, if answered in the affirmative, very positive
18 outcomes, if answered in the negative, really not
19 so positive.

20 So we're looking forward to both
21 benefiting from the work that's been done here to
22 advise the Department and now with the other

1 efforts that I've described to be able to
2 incorporate this into a coherent framework and
3 plan that will allow us then over these next 1 to
4 3 years to synchronize this proliferation of
5 programs all of which were well intended of
6 course. But we know that now our challenge is to
7 be able to apply the program evaluation framework
8 and the outcome metrics and to be able to simplify
9 our ability to support warriors and their families
10 where they need to help, how they need the help
11 and to help them determine really what is the
12 tool, what is the approach that will help them
13 with a given issue or concern.

14 So that's where we're headed, sir. I
15 hope that helps.

16 DR. LEDNAR: Thank you, General Sutton,
17 for that.

18 DR. KAPLAN: Yes. Thank you for putting
19 that in perspective.

20 DR. LEDNAR: First, Colonel Noah has a
21 comment, then Dr. Mason and then Dr. Silva.

22 Col NOAH: Doctor, thank you. Dr.

1 Kaplan's question kind of brought me out of my
2 reverie and made me remember when, Dr. Fogelman,
3 your group met at Health Affairs a year ago
4 perhaps, you asked me what kept me up at night
5 regarding these psychological health issues, and I
6 remember specifically asking you, and maybe this
7 is where these came from, to help provide us with
8 specific outcomes and metrics regarding
9 resiliency. Knowing what I know about both
10 institutions, I think the Boy Scouts do a way
11 better job of instilling resiliency than the
12 Department of Defense and they don't have a
13 billion dollars. So I would like for the
14 Department to take resiliency from being a go
15 forth, do good type of an effort to specific
16 outcomes, and that I think was what I had in mind
17 at least when I asked this question. Not that I
18 want you or that we should expect you to come up
19 with a specific plan. That's not it. If you tell
20 us what the sucked egg looks like, we'll go suck
21 it, but we are fairly broad spectrum in our
22 efforts so far. I want resiliency to climb out of

1 the late 1990s concept of biological defense.
2 Everybody knew it was good and all you had to do
3 was put that in a grant proposal and you were
4 going to get money, but it didn't tie you to
5 anything positive at the outcome.

6 DR. FOGELMAN: Thank you for reminding
7 me. You are a younger man than I am and therefore
8 have a much better memory, but that sounds right
9 to me. One thing I want to say about that though,
10 is remember that our job, and I think if I'm not
11 speaking out of turn at large the Board's role,
12 when asked questions like this is not particularly
13 to suggest policy or to have an impact on policy
14 and the things that you're talking about are one
15 step beyond or already into the policy arena. We
16 had, I assure, lots of policy recommendations we
17 wanted to make but didn't seem like they fit.

18 DR. LEDNAR: Dr. Mason?

19 DR. MASON: This is Tom Mason from the
20 University of South Florida. Thank you very much,
21 Brigadier, for your comments and clarification.
22 To any one of you on the team, if I look at your

1 slide and your point 67 and points A and B, the
2 epidemiologist in me suggests that you say a
3 compound self-report item currently used for
4 assessing global psychological functioning should
5 be modified, and B says include several additional
6 questions. Does that suggest, and this is a
7 follow-up to many discussions this Board has had,
8 with regard to the lack of if you will utility,
9 I'm being polite, of information that's collected
10 in the Post-Deployment Health Assessment which
11 basically then required a Post-Deployment
12 Reassessment or Health Reassessment? Are there,
13 in your considered professional opinions, specific
14 components of the Pre-Deployment Health Assessment
15 that addresses at present resilience?

16 Are you proposing apropos this
17 particular slide that there are certain components
18 of any one of a number of the reports which you
19 have very nicely articulated for us that could
20 well inform a modified Pre-Deployment, would
21 definitely inform a Pre-Deployment Health
22 Reassessment and recognize that it is not always

1 in the Serviceman or -woman's best interest to be
2 perfectly honest and frank, when the Post-
3 Deployment Health Assessment if it impairs the
4 time or adds additional time before they get home?
5 I would welcome your comments.

6 DR. FOGELMAN: Kurt, I'm sure you have
7 stuff to say about that or maybe you don't.

8 DR. KROENKE: The Pre-Deployment
9 Assessment had been very, very thin in terms of
10 psychological assessment and with the new
11 Congressional law and so forth, that will be
12 thicker so it will be more like the
13 Post-Deployment. And this first item here is to
14 say not only look at symptoms, but let's look at
15 functioning because symptoms, you need to combine
16 them with is there functional impairment. In
17 terms of I think your question about the
18 Pre-Deployment so that it's going to be more
19 extensive now, what was the other part of your
20 question?

21 DR. MASON: What I'm concerned with is
22 in any program, to evaluate the efficiency or

1 efficacy of interventions, you have to have a good
2 baseline and my concerns have always come back to
3 how well-prepared are they before they are indeed
4 exposed to challenges, so how resilient might
5 they be at day one or day zero? Then your
6 interventions are going to move forward and you
7 will be able to track them. You'll know what
8 training they've attended. You'll admit that you
9 may well not get all the information that you want
10 at a particular critical point in time but you're
11 going to go after it at a later point in time.
12 All I'm interested in is, are there specific plans
13 as part of this to incorporate in your expanded
14 Pre-Deployment and Post-Deployment Health
15 Reassessment ways in which to evaluate the
16 efficiency of these respective programs across the
17 board?

18 DR. KROENKE: One last comment and then
19 Brett may have a comment. Even though the
20 Pre-Deployment is going to end up being thicker
21 now, it's still largely focused on symptoms and so
22 it doesn't focus on resilience. Brett, you may

1 comment on the resilience piece.

2 DR. LITZ: We're not there yet and I'm
3 sorry to say that because we had so much work to
4 do to get clarity about how to make sense of
5 what's going on and move forward in terms of
6 ensuring sense making that we didn't tackle the
7 issue, a great issue, which is what metrics should
8 we know was our original question but we couldn't
9 answer it, what metrics should we use to actually
10 index outcomes over time? This is going to be a
11 tough issue because feasibility and doability and
12 time constraints and subject burden are huge
13 issues, but we can do it if there's a mandate to
14 do it. But we certainly could. It's an
15 answerable question, some small numbers of items
16 to index, where you stand at baseline and how
17 these things affect you over time.

18 DR. LEDNAR: General Sutton, did you
19 have a comment you'd like to make?

20 BG SUTTON: This is
21 exactly the imperative in terms of where we are
22 going. I would say that underway right now,

1 really in the final stages of staffing, is the
2 revised set of Pre-Deployment and Post-Deployment
3 Health Assessments including then the
4 Post-Deployment Health Reassessment and the aim
5 for these revisions has been to incorporate more
6 of a functional approach and to clarify the
7 questions. We've done extensive focus group
8 testing with Service members to be able to make
9 sure that the questions as we have framed them
10 actually are interpreted as intended.

11 Also with the recent events of this last
12 year at Fort Hood there's been a concerted effort
13 on the part of the Department to learn everything
14 that we possibly can reaching out to the best
15 experts in the area of violence and risk
16 assessment and to be able to incorporate that into
17 these revised questionnaires and the surveys. We
18 also know to get to your baseline question, how
19 important that is, and I would point to the Army's
20 with the Comprehensive Soldier Fitness Program and
21 the Global Assessment Tool that does for the first
22 time and it's in its first year of implementation

1 so to be sure there's much work to be done, but
2 this program really does provide a baseline across
3 the various domains of resilience and I think over
4 time we will be able to learn so much from this in
5 addition to the other efforts I've talked about,
6 the overarching framework for which is the
7 Chairman's Total Fitness construct.

8 We've just recently submitted an article
9 to *Military Medicine* that outlines the Total
10 Fitness construct, as well as we are submitting an
11 article to the *Joint Forces Quarterly*, we've
12 been able to benefit from the Institute of
13 Medicine and their recent reports and thanks so
14 much, Rick, for your work to that end. And has
15 been said by Dr. Litz, we are on a journey, we
16 have a long ways to go but that's exactly our
17 desired endpoint and outcome so that with your
18 help we'll continue our progress. Thank you.

19 DR. FOGELMAN: Brett?

20 DR. LITZ: Just a brief comment about
21 the total fitness measure that's being deployed.
22 It's a great opportunity because it's a universal

1 prevention strategy and the Army has mandated that
2 every Service member fill this questionnaire out
3 over time and that's terrific. What I would say
4 is that we looked at it and someone came and
5 talked to us about it and I think that we could
6 use a critical eye on that as well in terms of
7 what constructs are being evaluated and how are
8 they. We'd be happy to consult with you about
9 that, but that's a great opportunity because it's
10 universal, everybody gets it, it's repeated over
11 time, so let's get it right.

12 BG SUTTON: I think as
13 has been said, we really do see this as an
14 opportunity for us to lead the nation with respect
15 to these issues of resilience and recovery and
16 reintegration, so I think it's one of those
17 moments in military medical history where really
18 what we are learning with respect to the human
19 brain and all those various domains of functioning
20 that we can benefit the nation and the world more
21 largely. Thank you.

22 DR. FOGELMAN: I think it really was our

1 intent among other things to have an impact on the
2 things that you were talking about being rolled
3 out now and that's why we had people from Health
4 Affairs work with us and I believe some of what we
5 talked about has already been incorporated on a
6 kind of background and substantive level. That's
7 one of the reasons we have a reference here to
8 efforts that Health Affairs has already engaged in
9 because we want to help move those forward and to
10 the extent that what we do in our help with the
11 things that General Sutton was talking about, so
12 much the better.

13 DR. LEDNAR: Dr. Silva?

14 DR. SILVA: I don't know if I should
15 comment or what. I started out here turning to
16 Dr. Walker when you began. I said I didn't
17 understand a damn thing about this document and I
18 read it twice.

19 But if I could just frame a few
20 sentences. Let me know if I'm off-track. I'll
21 keep it short, Mr. Chairman. You're really
22 proposing two studies here, one, let's see what

1 makes people resilient. And then by the way,
2 there are lot of people who have nervous problems.
3 That's the second question.

4 You then go to the end of the
5 presentation where you have documents that the
6 Subcommittee reviewed, and there must be eight or
7 10 different test tools that are being employed to
8 define either one or both of these. And in the
9 second set of documents are the various timelines
10 in which people are being studied. So at some
11 point in time, is there going to be an invention of
12 more studies, better ones, a coalescence of the
13 studies? I just don't know where the endpoint is
14 going to be out there because this is very
15 complicated work being proposed and some of it is
16 going to be innovative and some may even involve
17 human use experimentation protocols.

18 I know Dr. Kroenke's work. I've been an
19 admirer of his for years. I think it has to be
20 done, but this is a big, enormous project. Thank
21 you. That's all. I'll just express my
22 frustrations and ignorance.

1 DR. FOGELMAN: Aside from apologizing
2 for the jargon, we really did try to put it into
3 English, but not brief English I concede. We were
4 keenly aware of the enormity of the effort and the
5 possible enormous implications or the implications
6 of enormity of what we were recommending, but I
7 think it's really in Colonel Noah's shop to talk
8 about it.

9 DR. LEDNAR: Dr. Oxman? This will be
10 the last comment.

11 DR. OXMAN: It's really a very broad
12 question. For a simple-minded infectious disease
13 urologist, I wonder honestly if I understand the
14 analogy. We don't know why some people who get
15 infected with a particular virus get sick and why
16 some people don't and there are many, many things
17 we can measure in advance to try to learn what the
18 important ones are that measure resilience or
19 resistance to disease having been infected. Then
20 we want to assess those and see which ones are
21 relevant, and then having done that, we want to
22 base prevention or improving resilience on the

1 basis of that information. Is that kind of an
2 analogy of what you're trying to do?

3 DR. FOGELMAN: Yes.

4 DR. LEDNAR: Thus the benefit of
5 cross-discipline perspectives in the Defense
6 Health Board. Thank you, Dr. Oxman. The
7 intention of this agenda item was both to
8 understand the Subcommittee's work and its
9 recommendation, but for the Core Board to vote on
10 whether to accept the Subcommittee's
11 recommendation and send forward to the Department
12 for its consideration. At this point I will
13 entertain a motion for a vote. Does anyone move
14 to vote to accept the Subcommittee's report and
15 recommendations?

16 DR. SILVA: So moved.

17 DR. MASON: Second.

18 DR. LEDNAR: Seconded? Is there any
19 further discussion? I think as a comment as
20 General Sutton said, this is a journey. It's
21 complex. We certainly heard the importance of
22 baselining and metrics, and there are at least two

1 comments. First, Dr. Walker and then Dr. Luepker.

2 DR. WALKER: It seems to me that it's
3 just the beginning, so does this continue? Does
4 this work continue? Does this group continue to
5 meet as they continue to address the questions?

6 DR. LEDNAR: I would say this
7 communication if accepted and sent forward to the
8 Assistant Secretary of Defense for Health Affairs
9 will be reviewed and considered by the Department
10 and then they will advise what if anything they
11 would like to pursue. I think what the Subcommittee
12 has teed up as something important for their
13 consideration. So the answer to the question, will
14 there be more, is a question asked and the
15 Department will deliberate in its usual way and
16 let us know. General Sutton?

17 BG SUTTON: Mr. Chairman,
18 if I could just say I absolutely agree that if I
19 could invoke the wisdom of Churchill when he said,
20 "This is not the end, this is not the beginning of
21 the end," it is perhaps the end of the beginning.
22 So I look forward to continue to work. You're

1 exactly right that we've got much further to go.

2 Thank you.

3 DR. LEDNAR: Dr. Luepker?

4 DR. LUEPKER: You may have just answered
5 this, General, but I see 10 slides of
6 recommendations and I don't think we're prepared
7 to debate each one of them nor should we. But I
8 wonder is this meeting the needs of the original
9 request? Are the recommendations whether the
10 beginning or the end of the beginning are what you
11 folks need to evaluate these multiple programs
12 that have grown up in the last couple of years?

13 BG SUTTON: Sir, from the
14 discussion here this morning, it certainly sounds
15 promising. I have not reviewed the report to this
16 point, but I look forward to reviewing that and
17 learning from the work of the committee. So, yes,
18 I would say that the work as it's been described
19 this morning absolutely sounds like it is aiming
20 at the point that were really looking to gain more
21 insight and more knowledge. As Secretary Gates
22 has said repeatedly, we are in unchartered

1 territory at year number nine of this conflict and so
2 we are absolutely open to whatever ideas, whatever
3 is the best wisdom and the best emerging
4 knowledge. I would point to the fact that of the
5 over \$600 million in research that we have
6 invested in over these last three years, this year is
7 really the first year where we'll start to get the
8 leading edge of the returns on that enormous
9 investment and that is an exciting prospect and it
10 will continue to inform our way ahead as we
11 synchronize not only our research investment but
12 also as we've mentioned today our programmatic
13 investment that extends across the continuum of
14 resilience, recovery, and reintegration.

15 DR. FOGELMAN: Let me be clear though.
16 We were responding to questions from the Assistant
17 Secretary for Health Affairs. We have a separate
18 advisory role for the Defense Centers of
19 Excellence. I'm never sure about the exact chain
20 of command or lines of authority but I think there
21 is a piece of what your shop does which is -- I
22 don't want to step on any toes and use the wrong

1 terms because I don't know if I have the terms
2 right, part of you do is report to Health Affairs,
3 part of what you reports to the Joint Chiefs. Is
4 that roughly right? Or to the Surgeons General?
5 But what we were doing was not aimed for General
6 Sutton's shop in any direct way, but if it was
7 aimed there, it was aimed to go through Health
8 Affairs and then over.

9 BG SUTTON: Dr. Fogelman,
10 you're exactly correct. This is a much broader
11 effort than is what is contained within the
12 Defense Centers of Excellence. Dr. Noah, if
13 you'd like to add to that, thank you.

14 Col NOAH: They way you described
15 the relationship is exactly correct. I guess the
16 comment that I would make is that the
17 recommendations or the work that's been done to
18 date certainly is useful but it doesn't completely
19 answer the mail which was articulated by Ms.
20 Embrey regarding specific metrics and outcomes.

21 DR. FOGELMAN: I have to say something
22 about that. We met with Mr. Middleton when he was

1 acting in that role and we had a not terribly
2 brief discussion with him about what the best ways
3 to focus our energies would be. He was quite
4 clear about if you can't do everything, we really
5 want to have the conceptual framework first and
6 maybe an example or two rather than struggle to
7 come up with a list of items. So there was
8 guidance from your shop that moved us in that
9 direction.

10 Col NOAH: If you met with him in
11 his capacity as the Acting ASD at the time, then
12 his guidance would certainly guide what we're
13 asking of you and it does sound like you've been
14 given two directions, one which is outcome and
15 metric focused and the other is framework
16 directed. I guess if I were given the choice
17 between the two or between the three, the third
18 being do both which I would not recommend at
19 least, is I would go to the original request of
20 helping us define outcomes and metrics and putting
21 the onus of defining the framework to achieve
22 those back on us. That would be my druthers on

1 that if that means anything.

2 DR. LEDNAR: One thought I guess I might
3 offer at this point is the Assistant Secretary of
4 Defense for Health Affairs did pose two questions
5 in their communication to the Board. Clearly the
6 Subcommittee in its discussion with ASD Health
7 Affairs to better understand the question and what
8 might be the best ways to focus energies on this
9 put a lot of thought into thinking to this point.
10 I think it can be informative for the Department
11 to have this understanding available to the
12 Department to understand the Department can
13 reflect on the questions as asked in December 2009
14 and think about what might best help the
15 Department going forward, and clearly there has
16 been a lot of important pre-work around the metrics
17 and outcomes piece, both resilience and the
18 medical treatment that probably is now positioned
19 for a pretty focused next step if the Department
20 wishes that to happen.

21 Col NOAH: I think that's good and
22 the reason I answered the way I did just a moment

1 ago is that asking you to focus on those
2 relatively objective pieces of metrics and
3 outcomes hopefully plays to the strengths of your
4 scientific acumen to come up with a framework
5 would presume an in-depth knowledge of the way we
6 are structured which may or may not be
7 appropriate.

8 DR. FOGELMAN: No, I don't think it has
9 to do with the way it's structured. The framework
10 has to do with how you think about evaluating
11 programs and that's quite independent of the
12 structure of the organization which creates the
13 programs.

14 Col NOAH: That's different than my
15 understanding of how we would implement rather
16 than how we would examine.

17 DR. FOGELMAN: The idea of the first
18 part is to help you think about the specific
19 things that you want to do and the idea of the
20 second part was pretty much to give an example in
21 the most measurable way which was currently
22 available to us. Does that help?

1 Col NOAH: And I don't see that as
2 being counter or being excluded from the metrics
3 and outcomes. So then I'm falling back to option
4 three, do both.

5 DR. FOGELMAN: Kurt?

6 DR. KROENKE: Just one comment. In
7 terms of what you said, on the clinical piece, we
8 are done on that. I mean, we are really quite
9 concrete and prescriptive from 67 on. In other
10 words, I think it's before 67 and I think that's
11 because of the scope of the work and the number of
12 programs that are going on. So if our group were
13 to do anything more, I think it would be if you
14 wanted concrete metrics on resilience, that would
15 probably be some additional work. Would you
16 agree?

17 DR. LITZ: Yes.

18 DR. LEDNAR: Just to remind everyone
19 where we are, we had a motion for a vote. There
20 has been some additional discussion. Are there
21 any other comments before we call for a vote to
22 accept the Subcommittee's report and

1 recommendations?

2 DR. SHAMOO: Dr. Lednar, I don't know
3 what I'm voting. I all the time like to know what
4 I'm voting for. Because this is amorphous now
5 after all the discussion. It's amorphous. Maybe
6 we could have a one-paragraph motion with the
7 documents behind it as an attachment and vote on
8 the motion so we know what we are endorsing
9 because the discussion I heard, one, two, or three
10 and one is already done, I'd be willing to vote
11 for one, but I don't know what two and three
12 exactly are. I know we'd like to vote and get it
13 over with.

14 DR. FOGELMAN: I can't imagine a way to
15 do that which gives sufficient depth and texture
16 to what we're talking about. I understand that
17 it's closer to opaque than transparent, but I
18 can't think of a way to make it briefer. I'll
19 have to defer to Wayne's judgment on that. There
20 were originally many more than this I should tell
21 you.

22 DR. LEDNAR: I think, Dr. Shamoo, your

1 suggestion is really a good one because I'm sure
2 there's some ambiguity about what is it more
3 specifically that we are voting on. I think the
4 idea of a short paragraph of clarity with the
5 Subcommittee's report as an attachment, if that
6 short, brief wording can be developed later day,
7 we can come back and review that extra wording
8 later today and then have the vote on whether that
9 wording and the attached report is satisfactory.
10 Dr. Walker?

11 DR. WALKER: It's my understanding that
12 we're voting on these recommendations.

13 DR. LEDNAR: But I think that part of
14 the voting on the recommendations is to put a
15 framework and a context to it and I think that
16 that clarity is probably close but isn't quite
17 pulled together yet and could be very helpful to
18 the Board which I could hope we can do before the
19 end of the day today.

20 DR. PARKINSON: At first despite my
21 neighbor here, when I say down, Dr. Shamo I don't
22 see it, but I will tell you I think it would be a

1 service to the Department. This really is a
2 wonderful document. It's a tremendous broad-view
3 roadmap with 20 recommendations as far as I can
4 tell. But what's the bottom line for the
5 Department? The bottom line is clinical metrics
6 are well formed and they're delivered. Number
7 two, the area of resilience is a moving target and
8 we didn't have time to look at it. The evidence
9 base is lacking. We need to work on it. There
10 are promising developments. Number three, attach
11 21 recommendations and begin to chart a course for
12 the Department to follow, all approved, aye or
13 something like that.

14 DR. FOGELMAN: I can certainly live with
15 that language.

16 DR. PARKINSON: The SECDEF, if they got
17 this, to Colonel Noah's point, is oh my God,
18 seriously. And we want to be effective. That's the
19 bottom line for General Sutton and her team and
20 all the wonderful things. But the color
21 commentary that we received in the last 45 minutes
22 has got to be up front because whoever gets this

1 way above our pay grade is not going to read pages
2 14 through 25. Do you know what I mean? So what
3 do they need to do? And I think that's what we
4 can probably help with.

5 DR. LEDNAR: I think that what Dr.
6 Shamoo and Dr. Parkinson have recommended will in
7 fact make it easier for the Department to both
8 understand and then use the hard work of the
9 Subcommittee so that I think it's worth the extra
10 effort.

11 DR. FOGELMAN: I understand that. Part
12 of what is happening for us is since we were
13 working with Health Affairs people all the way
14 through, we were kind of surrounded by what we
15 were doing more than we were on the outside of
16 what we were doing in looking at it so this makes
17 sense to me.

18 DR. LEDNAR: I'm going to ask if Dr.
19 Shamoo and Dr. Parkinson would work with Dr.
20 Fogelman later today and propose some language. I
21 think, Mike, as you had outlined and probably our
22 transcriptionist can help remind you of your

1 thoughts because I think they were very
2 articulate. At this point I'm going to bring this
3 agenda item and its discussion to a close. I'd
4 like to thank Dr. Fogelman and the Subcommittee
5 for all the hard work that they've done. This was
6 clearly a big challenge to try to address and as
7 General Sutton said, this is a journey and
8 important to get as much focus and clarity on as
9 we can.

10 What we'll do now is to take a 15-minute
11 break because it's been a while since everyone has
12 had a chance to get up. Let's reconvene in 15
13 minutes, please. Thank you.

14 (Recess)

15 DR. LEDNAR: The Defense Health Board is
16 reconvened. Our next speaker this morning is
17 Captain D.W. Chen. Captain is an active duty
18 Medical Officer with the U.S. Public Health
19 Service currently assigned to the Department of
20 Defense Office of the Assistant Secretary of
21 Defense for Health Affairs where he serves as
22 Director of Civil Military Medicine. In this

1 capacity, he oversees DoD health policies and
2 programs governing support of homeland defense,
3 defense support of civilian authorities, emergency
4 preparedness and response including coordinating
5 pandemic influenza preparedness, operational
6 laboratory and analytic capabilities and coalition
7 and non-DoD beneficiary health care. Captain Chen
8 has responsibilities that touch every one of our
9 Subcommittees of the Defense Health Board.

10 Captain Chen is board-certified in
11 preventive medicine and is a fellow of the
12 American College of Preventive Medicine. He will
13 provide an information brief regarding public
14 health emergency management within the Department
15 of Defense. Captain Chen's slides may be found
16 under Tab 5 of our meeting binders. Thank you,
17 Captain Chen.

18 CAPTAIN CHEN: Thank you very much, Mr.
19 Chairman and Defense Health Board members. I
20 guess it's good afternoon now. My name is Captain
21 D.W. Chen and as was mentioned by the chair, I
22 currently serve as the Director of the Civil

1 Military Medicine Division, Force Health
2 Protection Readiness, at Health Affairs. As was
3 mentioned, my team helps to coordinate policies
4 and programs governing Military Health Systems in
5 support of homeland defense, defense support to
6 civil authorities, emergency preparedness response,
7 and coalition and non-beneficiary health care. It
8 is my pleasure this afternoon to visit with you
9 and provide an informational update briefing on an
10 important new DoD policy titled DoDD 6200.3,
11 Public Health Emergency Management within the
12 Department of Defense.

13 This policy provides a contemporaneous
14 framework for all DoD components with respect to
15 preparing for, recovering from, and responding to
16 public health emergencies of all etiologies and
17 all hazards. This policy or this issuance was
18 shaped by a number of very recent events up to and
19 including some last-minute modifications of the
20 issuance from lessons learned in the H1N1 outbreak
21 and evolution this last year.

22 As a side note, when I first started my

1 assignment at Health Affairs, then Deputy
2 Assistant Secretary of Defense Embrey asked me to
3 provide an informational brief to the then Armed
4 Forces Epi Board on the then DoD Directive 6200.3
5 titled "Emergency Health Powers on Military
6 Installations." During that time I informed the
7 then Board members of the game plan at Health
8 Affairs to both update that DoD Directive and to
9 provide detailed implementing instructions for
10 that. So here we are some 4-1/2 years later, I'm
11 still at Health Affairs and the issuance is the
12 outcome of 4-1/2 years worth of, I think a lot of
13 coordination and work within DoD, with the
14 Services, the combatant commands, and the Joint
15 Staff, as well as the federal interagencies. I
16 think the longish period for getting this out the
17 door reflects in many ways some of the
18 complexities and moving parts and breadth and
19 depth of this particular topical domain.

20 I think we're running a little behind
21 schedule, I'll plan to try to breeze a little bit
22 quickly through the briefing slides, you have the

1 slides as was mentioned in your briefing books,
2 and save some time at the end for some questions.

3 A brief history of this policy series.

4 As I mentioned, DoDD 6200.3 which was published in
5 May 2003, closely following the SARS evolution and
6 the anthrax attacks of 2001 and 2004,
7 respectively, was titled "Emergency Health Powers
8 on Military Installations." That DoDD was very
9 biologically focused. It was the first time in
10 policy that the position of the public health
11 emergency officer, or PHEO, was established and that
12 DoDD identified emergency health powers that can
13 be exercised by an installation commander during a
14 public health emergency.

15 The purpose of the DoDI 6200.03 was to,
16 number one, rescind, update, and provide
17 implementing instructions for the original DoDD,
18 establish guidance to protect installation
19 facilities, personnel and other assets and it
20 provided an all-hazard incidents there. Very,
21 very importantly, this DoDI is the companion
22 health policy to the line document titled DoDI

1 6055.17 which is known as the DoD Installation
2 Emergency Management Program that was issued by
3 AT&L and the installations and environment. This
4 DoDI also establishes a NIMS or National Incident
5 Management System framework, clarifies roles and
6 responsibilities of MTF commanders during
7 public health emergencies, it clarifies roles and
8 responsibilities and training requirements for
9 PHEOs. Very importantly it creates a new role and
10 responsibility of the MTF Emergency Manager or
11 MEM. It very, very importantly under the civil
12 support umbrella authorizes DoD installations to
13 assist the states and the CDC in the Strategic
14 National Stockpile of the SNS activities and for
15 our laboratories to legally and formally
16 participate in CDC's Laboratory Response Network.

17 There were a number of new statutes,
18 regulations, and directives that were considered in
19 writing the DoDI and in many instances, language
20 had to be harmonized with these. These include
21 the international health regulations that were
22 signed by the U.S. Government to the World

1 Assembly back in 2005. CDC was updating, or is
2 updating their quarantine regulations. Obviously
3 the NIMS is the state of art in terms of how we
4 manage incidents. There's a whole slew or skein
5 of Homeland Security presidential directives that
6 were issued during the Bush administration, 5, 8,
7 9, 10 and 21 which range from good and ag to
8 biodefense to NIMS. PHAPA legislation was signed
9 out by Congress in 2006 and the CDC in
10 collaboration with Johns Hopkins developed model
11 state emergency powers acts that each of the 50
12 state legislatures could use to model state
13 legislation governing public health emergency
14 management so that there are a number of different
15 documents that we had to take into consideration
16 in updating our own policy issuance.

17 I mentioned 6055.17. This was actually
18 signed out by the Under Secretary of AT&L in 2007
19 as part of the Installation Protection Program.
20 I'm sorry, it was signed out in 2009. What we did
21 is Health Affairs worked very closely with the
22 installations and environment group to make sure

1 that line document had adequate or sufficient
2 medical and public health hooks and links so that
3 would link up to our new DoDI that eventually
4 would follow this particular 6055.17. Also many
5 of you may be familiar with another DoD issuance
6 called DoDI 2000.18 which has to do with sea
7 burning, preparedness for installations, and what
8 the 6200.03 does is it also updates the medical
9 and public health requirements for this issuance
10 as well.

11 Just a quick word about public health
12 emergencies. National emergencies or
13 public health emergencies can be declared as you
14 know by a number of different authorities. The
15 POTUS can obviously declare a national emergency
16 usually through the Stafford Act. The Secretary
17 of HHS can declare a national public health
18 emergency through the Public Health Service Act.
19 Governors can declare emergencies within their own
20 jurisdictions, as well as well as military
21 commanders. Just a quick word about a little bit
22 of tension that arose between these two

1 authorities last year. We had some difficulties
2 in the DoD with respect to providing civil support
3 to governors in states because President Obama in
4 light of H1N1 chose not to declare a national
5 emergency through the Stafford Act, but the
6 Secretary of HHS did declare a national
7 public health emergency. There were different
8 ramifications, but the key issue there is that it
9 had some differences in terms of what can be
10 harnessed and what can be implemented depending on
11 what principal declares the national emergency.
12 I'll also add that the SECDEF and the SECDCS can
13 also declare national emergencies within their own
14 authorities as well.

15 The public health emergency definition I
16 mentioned in the DoDD was very biologically
17 focused. This DoDI has a much broader all-hazards
18 definition and you see here that it's pretty
19 broadly defined, bio, national disaster, chem,
20 rad-nuke, zoonotic disease. Also we added in
21 other circumstances or exigencies or scenarios
22 which can be considered a public health emergency.

1 This includes things like a significant number of
2 deaths, disabilities, health care needs that
3 exceed available resources. And very importantly
4 I'll just highlight this as I'll talk about it
5 momentarily, any event that may require World
6 Health Organization notification as a potential
7 PHEIC, public health emergency of international
8 concern, in accordance with the international
9 health regs. I mentioned the IHRs a little bit
10 earlier and I'll go through that a little later in
11 the talk.

12 As with many DoD issuances, there are
13 roles and responsibilities outlined for each party
14 or entity or proponent within the Department. The
15 ASDHA's responsibilities including obviously
16 policy program planning, et cetera, serving as a
17 principal advisor to the SECDEF regarding
18 public health emergencies, issuing any
19 implementing guidance or regulations, serving as a
20 main point of contact for interagency
21 coordination, and very importantly, ensuring
22 training and education requirements of which there

1 are many are met as a result of this DoDI.

2 What are the Service responsibilities?
3 Ensuring that military line commanders work with
4 local and host nation authorities. Of course we
5 are asking the Services to help us maintain intra-
6 and inter-Service collaborative networks, PHEOs,
7 obviously budget estimates and POM requirements,
8 coordinating with TRICARE Management on
9 public health emergencies, making sure resources
10 and capabilities are identified. And again as a
11 recurring theme, providing authorization to
12 military installations to serve as RSS sites and
13 closed pods for SNS assets, the Strategic National
14 Stockpile.

15 The COCOMs and the GEOCOCOMs also have
16 responsibilities outlined. COCOM commanders were
17 directed to designate an individual at each level
18 of their organizational structure, local,
19 regional, theater, to facilitate coordinated
20 planning among PHEOs and MEMs knowing that there
21 are many Service MEMs that come from many
22 different installations and how do you coordinate

1 a single face, if you will, in terms of a state or a
2 host nation?

3 I'll talk about this at the end. The
4 combatant commanders are tasked to work in
5 collaboration with the ambassadors and the chiefs
6 of mission in each of the host nations to talk
7 about the importance of who is going to report a
8 PHEIC to the WHO, and I'll talk at the very end
9 about a real-life fire exercise that happened last
10 May and June time period when the index cases of
11 H1N1 appeared in Kuwait on the Saudi Peninsula
12 among U.S. active duty forces and the question
13 came as to who was going to report this to the
14 WHO, the government of Kuwait or the U.S.
15 Government.

16 The National Guard has a piece in terms
17 of working with their local installation PHEOs in
18 their catchment area. Military commanders, these
19 are the line commanders, whether they're
20 installation or nonfixed installation commanders,
21 their responsibilities include appointing a PHEO
22 and an alternate PHEO, making sure resources are

1 available, very importantly, integrating
2 public health emergency management into their
3 overarching installation emergency management
4 plans. There are many, many plans, many, many
5 requirements. What we try to do with the
6 Installation Protection Program is to help
7 installation commanders tie all that together into
8 one rather than having 50 or 60 different separate
9 plans.

10 Also negotiated agreements with state
11 and local jurisdictions to serve as SNS
12 coordinators, assuring that ESSENCE, which is our
13 prodromic or syndromic surveillance tool, is
14 monitored, obviously cooperating with local law
15 enforcement if there is an intentional or
16 terrorist act and declare a public health
17 emergency when warranted and making sure those
18 risks are communicated.

19 MTF commanders who are not necessarily
20 installation commanders or nonfixed installation
21 commanders also have responsibilities outlined in
22 this issuance, including making sure that each

1 military hospital has a NIMS-compliant emergency
2 management program, they're supposed to designate
3 it as a newly created creature called a MEM.
4 Looking at authorizing licensed but
5 noncredentialed health care providers provide
6 care. I'm going to talk about this momentarily as
7 part of the altered standards of care research
8 capacity. Directing all MTF staff to report any
9 circumstances suggesting a potential public health
10 emergency to the cognizant PHEO. Ensuring that
11 MTF emergency management is integrated similarly
12 into plans. And once again, a shout-out here to
13 ESSENCE.

14 What are some of the emergency health
15 powers that can be exercised by a military line
16 commander? This is a cut and paste directly from
17 the original DoD Directive from 2003. You can see
18 here some of the many emergency powers. I'll just
19 hone in on closing, evacuating, decontamination,
20 destroying a facility, controlling ingress and
21 egress, restriction of movement, taking measures
22 to safely contain and dispose of infectious

1 wastes, distributing health care supplies as
2 needed, directing U.S. military personnel to
3 submit to medical examination or testing. This is
4 especially true if they are going to be able to be
5 released from a quarantine situation. The same
6 thing about restriction of movement. The
7 isolation, quarantine, or restriction of movement
8 has to be done in coordination with the local CDC
9 quarantine officer. There are CDC quarantine
10 officers that cover all of the continental U.S.
11 and its territories.

12 Here are some general procedures. Again
13 many of these are cuts and pastes from the
14 original DoDD. Circumstances suggesting a
15 public health emergency should be immediately
16 reported through appropriate Service combatant
17 commander or military channels and you'll see at
18 the very end a notification routing chart that
19 depicts this in great gory detail. PHEOs shall do
20 a number of things. A lot of these things are in
21 the epidemiological public health realm. PHEOs
22 can take the following actions as directed by the

1 military commander: identifying individuals who
2 may be exposed, counseling and interviewing them,
3 examinations. And very importantly, sharing
4 information with civilian public health officials.
5 This is a recurring theme in this DoDI about the
6 importance of really working very, very tightly
7 with civilian health and emergency management
8 authorities. Again there is that piece about
9 notifying law enforcement if there is an
10 intentional act, a criminal act or terrorism.

11 Public health emergencies can be
12 declared and can last up to 30 days, then they
13 have to be renewed. The last piece there
14 obviously is a shout out to making sure that our
15 veterinarians are adequately and fully informed of
16 veterinary diseases that have potential for
17 transmission to humans.

18 This is an outline of some of the
19 restriction of movement procedures. Much of it
20 again was copied and pasted from the original
21 DoDD. Again this is balancing public good versus
22 individual rights and making sure there is due

1 process even in the extenuating circumstances of a
2 strict restriction of movement, and you can see
3 here a number of those things that carefully
4 delineate and assure that.

5 Obviously we have some overseas
6 limitations on a lot of the things we just
7 mentioned. We have host nations that we must work
8 with and so scopes of authority may be limited,
9 and obviously working with host nations as part of
10 implementing this DoDI is very, very important.
11 We added in a lot more language in this DoDI about
12 qualifications for PHEOs. They have to be a
13 government employee. They have to be a clinician.
14 The original was a physician and then in
15 negotiation and discussions with the Services, we
16 chose the word clinician. The reason that is
17 there is because PHEOs may be called upon to
18 provide advice to a line commander on issues
19 related to diagnosis and treatment, so some
20 clinical training of some sort is very, very
21 needed, an MPH or four years experience in public
22 health and training in NIMS.

1 We listed 10 core PHEO responsibilities
2 in this DoDI. This, of course, gives an
3 explanation of what we expect PHEOs to do and
4 training and education obviously emanate from
5 these core responsibilities. As you see here,
6 I'll just go through them real quickly, they
7 really need to do a good job of collaborating with
8 the line installation emergency management team.
9 We expect that they would be the medical
10 representative on the installation emergency
11 management team. Maintaining assay or
12 public health threats to a variety of different
13 sources whether they're intel, population-based,
14 surveillance systems, et cetera, both open source
15 and closed source. Their main thing is to provide
16 advice to the military commander when to declare a
17 public health emergency and when to implement
18 some of those emergency health powers. Ensuring
19 epidemiological investigations are conducted.

20 They're not necessarily doing the shoe
21 leather public health, but they're at least
22 ensuring and understanding what the outcomes of

1 those assessments and how to translate that into
2 measures to prevent for example further exposure.
3 Recommending appropriate action on diagnosis,
4 treatment, and prophylaxis.

5 The next five, to support integration of
6 public health emergency management again into the
7 overall installation emergency management plan. I
8 want to say that that other DoDI on installation
9 emergency management mandates that there is an
10 installation emergency management plan for all
11 installations. Making sure that they're up to
12 speed and a very big part of the planning and
13 implementation of surge capacity, risk
14 communication, there's a public affairs shop and
15 PR group and a strategic communications shop at
16 most every command and installation.

17 The PHEO really needs to be there giving
18 them advice on how to craft the messaging to make
19 sure it's accurate and scientifically and
20 medically on the money. This came out during the
21 H1N1 outbreak, and that is a lot of questions
22 arose about workplace or return-to-work issues and

1 PHEOs received many of those questions. So we
2 wanted to make sure that PHEOs did play a big part
3 of this and got trained and were honed up on some
4 of the contractual civil service or government or
5 other kinds of issues related to workplace. And
6 finally, again a recurring theme, coordinate with
7 appropriate civilian authorities.

8 The MEMs I told you was newly created in
9 this issuance. Here are some of their
10 qualifications. Again it has to be a U.S.
11 government employee and the big thing here is they
12 really, really, really need to be experts in NIMS
13 and ICS. Main responsibilities, instead of 10
14 PHEOs, there are only five for MEMs. Here you see
15 that MEMs serve as the primary MTF point of
16 contact with respect to installation emergency
17 management and civilian authorities, ensuring that
18 appropriate information is addressed in the
19 management plans, making sure that those plans are
20 integrated with overarching or overall
21 installation plans, supporting the MTF commander
22 in all training and exercise activities, and very

1 importantly, serving as a primary resource
2 ombudsman to ensure that in the budgeting process
3 in the MTF that the issue of emergency management
4 is addressed.

5 I talked about a shout out to the
6 veterinarian community. We felt this was very
7 important to be very explicit about making sure
8 that as of public health emergency planning that
9 the veterinarian community and veterinary
10 professionals were fully engaged, directed to
11 report any circumstances suggesting a
12 public health emergency to the appropriate PHEO.
13 It could be something as simple as a dead bird
14 during a period of time when we may be looking at
15 high path AI on an installation.

16 The last two or three slides here are
17 there is a separate annex in the DoDI itself that
18 was specially dedicated to the topic of search
19 capacity and procedures for health care in
20 public health emergencies. This originally called
21 authored standards of care which got changed to
22 the more contemporaneous term of situational

1 standards of care, and now the buzz is crisis
2 standards of care. Whatever we call them, we have
3 something in the issuance that speaks to the issue
4 and provides some very broad guidance to
5 especially the Services and COCOMs on what to do
6 when you are faced with this situation. A lot of
7 guidance came out of HHS and the Agency for
8 Research and Quality who issued a series of
9 monographs on altered standards of care and care
10 to allocation of care under fixed resources.

11 You see here that that annex which we
12 received help from, some ethicists here from the
13 Defense Health Board, a number of attorneys, HHS
14 and many others, Colonel Hachey was very well
15 involved in this as well, outlining the framework
16 that the HHS will use for delivered care in the
17 circumstances. Allocation of resources can be
18 based on operational or other national security
19 objectives as well as medical necessity and risk.
20 When resources are inadequate, these standards of
21 care may be required. These things may include
22 expanding the scope of practice, suspending

1 certain procedures for specialty referrals, use of
2 equipment, health documentation under HIPPA,
3 establish alternate or supplemental sites of care.

4 Some other statements, the MHS shall use
5 limited resources to achieve the greatest good for
6 the greatest number. MTF commanders may
7 supplement staff with Reservists and volunteers.
8 Risk commutation is very, very important. These
9 privileges can be initiated only when the MTF
10 emergency management plan is activated and will be
11 terminated once the emergency plan is no longer
12 active, so very, very unusual and special
13 circumstances.

14 The last two slides here, I mentioned
15 that there was a fairly complicated what we
16 affectionately call a spaghetti chart. What this
17 does is it lays out, and I will tell you that this
18 took three years in the making to make sure that
19 everybody was on the same page, on how we would do
20 this within the Department of Defense, within the
21 interagency, with state and local governments and
22 with the World Health Organization and host

1 nations. What it says is, it's a busy slide but
2 if you just follow through, here is a patient who
3 may have a potential diagnosis or may present with
4 H1N1 or pandemic influenza with ILI and a really
5 strong epi history of exposure.

6 What this chart does is it lays down
7 that the patient may go to downtown care or the
8 patient may go through an MTF, and it goes through
9 how there is some laboratory piece to make some
10 confirmation, that could happen both on the
11 civilian side and the military side, but
12 ultimately the PHEO needs to be informed of this
13 and the PHEO ultimately makes sure that civilian
14 local providers and the CDC gets notified. But
15 the PHEO also has to inform the line commanders,
16 the Service public health centers, the Armed
17 Forces Health Surveillance Centers you see down
18 here, and a whole gaggle and group of folks up the
19 chain ultimately ending up with the HHS EOC who is
20 the reporting node for the entire U.S. government
21 for reporting PHEICs, public health emergencies of
22 international concern, to the WHO.

1 The next slide is a drilldown that
2 includes the line commander and overseas
3 complexities or vagaries or idiosyncrasies, the
4 PHEO going to the military commander, and then you
5 see here that ultimately the word gets to HHS
6 through the National Military Command Center.
7 That's the EOC that's managed by the Joint Staff.
8 Then ultimately there's some relationship that
9 exists between the chief of mission, the host
10 national government, and the combatant command
11 overseas.

12 So this chart pretty much outlines that
13 and I will tell you that a memo is being drafted
14 and being prepared for signature by either the USD,
15 Under Secretary of Defense for Policy or the Under
16 Secretary of Defense for Personnel and Readiness that
17 further codifies a lot of the taskings to the
18 geographic commanders and combatant commanders to
19 work with chiefs of mission and host nations to
20 define who is going to do the report. We don't
21 want to do it at the last minute. We want to
22 think through this thing eagerly.

1 All of this stems from the difficult
2 challenge we experienced at a U.S. government when
3 we had our index cases of H1N1 appear on the Saudi
4 Peninsula among our active duty troops in Kuwait
5 and the government of Kuwait was very hesitant to
6 report these to the WHO for a number of
7 understandable reasons. There were differing
8 opinions ranging from the ambassador to Kuwait to
9 Foggy Bottom, Secretary Sebelius, General
10 Petraeus, and everyone had an opinion of whether
11 or not we needed to report the case. At the end
12 of the day the decision was made by the DEPSECDEF
13 that we really needed to report this and we did
14 and lo and behold those cases did appear in the
15 WHO count cases about two days later. What that did
16 highlight or illuminate is the importance of
17 making sure that we talk to the host nations well
18 ahead of time about who's going to be reporting
19 what and among who, State Department personnel,
20 active duty military, their families, people
21 attached to the embassy, so on and so forth and
22 not wanting to wait to the last minute when it's

1 hair on fire.

2 The last slide here is we borrowed very,
3 very lately the algorithm that was in the
4 international health regs that help countries to
5 make determinations on what qualifies for a
6 public health emergency of international concern
7 that warrants reporting to the WHO and we adapted
8 it to reflect some of the DoD-unique contingencies
9 and issues. This is a tool that we wanted to
10 provide to PHEOs and MEMs in helping them make a
11 determination of whether or not something that
12 happened could be something that bells and
13 whistles need to go off and a lot of things are
14 going to happen.

15 A summary here or takeaways,
16 public health emergency or line emergency
17 management programs are now integrated. I'll also
18 mention that 6055.17 which is that installation
19 emergency management DoDI is going to be revised
20 in the near future in large part because of what
21 happened at Fort Hood and the recognition that
22 they needed to amplify and enhance some of the

1 requirements in clarifying the roles of military
2 MTF commanders. That notification routing
3 procedures, that big chart I showed you,
4 identified standing PHEO responsibilities,
5 creating the position of the MEM. The Services
6 said we really, really, really need these
7 situational standards of care so we added those,
8 updated some of our quarantine and isolation
9 procedures. Again SNS and LRN authorizations were
10 explicitly provided and algorithms for determining
11 a public health emergency, the last slide I showed
12 you, was there.

13 Way ahead, we had our first
14 implementation meeting on March 3, 2010. We're
15 having our second one in July. This was one of
16 the more easily coordinated issuances that I can
17 remember because we involved the entire DoD and
18 interagency constituencies at all points of
19 writing the draft so that they really felt
20 ownership and these are some issues that came up
21 as part of implementation. The joint training
22 piece is actively being looked at with the Defense

1 Medical Readiness Training Institute.

2 Is there a thing called a contingency
3 PHEO? That question came up during the Haiti
4 response. With joint-basing situations, we have
5 multiple PHEOs who may be tenants. Who is the
6 uber PHEO of record, I guess to call it, looking to
7 TRANSCOM to perhaps provide a little more detailed
8 guidance on quarantine and isolation? Lastly,
9 that PHEIC notification piece, that spaghetti
10 chart, is complex enough that it really warrants
11 having some tabletop exercises of some sort to try
12 to drill through that.

13 I thank you for your attention and I
14 think I have just a few minutes for any questions
15 that the Board members may have.

16 DR. LEDNAR: Captain Chen, thank you
17 very much for that brief. If I can ask the first
18 question, and it's really if you've had a chance
19 to assess the capability within DoD for PHEOs and
20 MEMs. Do we have enough? Are they skilled to be
21 able to do their part in this DoDI? And given the
22 fact that three years from now many of them will be in

1 different jobs and some may no longer be in the
2 Service, do we have a thought on sustainability so
3 that we have a continuous supply of the needed
4 expertise?

5 CAPTAIN CHEN: That's a very good
6 question. I think following the DoDD, the
7 original DoDD, that required the establishment of
8 PHEOs, the Services were very diligent insofar as
9 identifying individuals to serve as PHEOs. The
10 problem was that in many instances it was the
11 fifth collateral duty. So what we did in this
12 DoDI is to really try to hammer home the point
13 that a PHEO has a lot to do and so does a MEM and
14 their time and effort that needs to be spent on
15 planning and making the kind of connectivity they
16 need to civilian governments and knowing what
17 they're supposed to do is actually fairly time
18 consuming and can't be the fifth collateral duty.
19 To that end, I think the Services have taken this
20 additional guidance and we've also left a little
21 bit of wiggle room.

22 The original DoDD said every

1 installation shall assign a PHEO. What we allowed
2 the Services to do is to have a little bit of
3 flexibility in saying you can define at what level
4 you need to have a cognizant PHEO with all those
5 questions that we put down there, a clinician, an
6 MPH degree, NIMS training and so on and so forth
7 so that at least you have someone who has those
8 skills that you can go to. Then we can focus and
9 invest the effort that we need to do in up front
10 joint training and continuing training and also
11 very importantly, creating some kind of vehicle to
12 allow networking among PHEOs so they can help
13 another sort of like how EIS graduates help each
14 other and work through.

15 So my answer to your question is, I think
16 that capability is there. The Services have
17 already moved to creating the MEMs so I think our
18 tasking is to make sure that we provide the
19 training and the infrastructure to allow the
20 cohort of them to do their jobs. We haven't heard
21 yet of a dearth or scarcity of PHEOs. I think the
22 Services have really tried hard to balance finding

1 the right people in the right area.

2 The importance of PHEOs was focused and
3 reinforced during H1N1. When we worked on H1N1
4 preparedness especially with the COCOMs, each of
5 the COCOMs have assigned PHEOs. We have one belly
6 button who we can talk to who worked all these
7 issues and a lot of the training and education
8 requirements that are emanating now that we're
9 working on were things that we found out during
10 the H1N1 that the PHEOs really needed to know.

11 So, sir, I think we're on the right
12 track. We haven't heard anything yet about a lack
13 of PHEOs, but I guess we'll find out as we continue
14 to implement the DoDI. There are many, many
15 exhortations in the issuance that talk about
16 resourcing. It's directed at the line command
17 level and others. I'm not sure if I answered your
18 question completely, but we're trying our best to
19 do that.

20 DR. LEDNAR: Thank you. Are there other
21 questions? Dr. Shamoo?

22 DR. SHAMOO: Thank you. If a PHEO is

1 central to your operation, I'm not an
2 epidemiologist and I'm not a clinician so I don't
3 know, but still to me the qualifications sound not
4 sufficient to such a central role of this whole
5 operation.

6 CAPTAIN CHEN: Sir, we looked very
7 minimally at the training and qualifications of a
8 PHEO and MEM. You can imagine that when we first
9 started we had a pretty big menu and it got
10 whittled down as we said, what is the real core
11 bottom line? So we came up with the clinician
12 issue, we came up with some MPH and public health
13 experience for the PHEO, and for the MEM similarly
14 being on top of NIMS and ICS. Above and beyond
15 that, I think the onus is on us as the DoD to make
16 sure that the up front training and the continuing
17 education is there so that the PHEOs are
18 adequately prepared to do what they're called on
19 to do.

20 I think in a way the medical model of
21 PHEOs and MEMs to be a little bit
22 anesthesiologists because anesthesiologists are

1 very, very, very, very, exquisitely well-trained
2 and it's kind of the going joke in the medical
3 community that a lot of the things that
4 anesthesiologists do are fairly routine, but you
5 come across those instances where a patient
6 becomes truly hemodynamically instable and all
7 things break loose and that's where that training
8 really, really becomes important.

9 So I think for PHEOs and MEMs similarly,
10 trying to make sure that there is up front
11 training and we touch on topics that you wouldn't
12 even think about and then putting that on top of
13 the basic qualifications allows us to get to a
14 place where PHEOs and MEMs are capable of doing
15 the things they need to do. I think it's not
16 going to happen overnight, we're going to adjust
17 this a little bit, but one thing is important in
18 improvement.

19 The original DoDD said that every
20 installation commander shall appoint a PHEO and I
21 think the expectation was that it was going to be
22 the MTF commander. I think what this issuance did

1 was to revisit or reassess that approach and say,
2 you really need to try to find an individual who
3 can devote a lot more time and energy into the
4 study and the updating and keeping up to speed
5 with the kinds of things so they can do the job.
6 So we don't see actually the MTF commander in many
7 instances serving as a PHEO. A lot of the PHEOs
8 who we've heard of are those who have been
9 designated as such. In some of the Services
10 they're either three-quarter time, half-time,
11 three-quarter time, almost full-time, so I think
12 that's good news to our ears because I think that
13 was our intention. We couldn't direct the
14 Services to do that but that's what they're doing.

15 DR. SHAMOO: But you're requiring MPH or
16 four years of experience and that's it for such a
17 central role. They don't have to be an MD. You
18 gave the example of an anesthesiologist and an
19 anesthesiologist is a MD who goes into a
20 subspecialty called anesthesiology, plus he goes
21 through an internship and then he becomes an
22 anesthesiologist. So it's a huge difference and

1 I'm either not understanding what you're saying or
2 I'm seeing a huge deficit for such a central role
3 in public health in an emergency for a very young
4 man if he has only four years of experience out of
5 college. That's a very young 25-year-old deciding
6 the lives of tens of thousands of people.

7 CAPTAIN CHEN: Sir, I think at least for
8 the PHEO side, the minimum qualification is being
9 a clinician, so you're a nurse, you're a doctor,
10 you're a veterinarian, you're a physician, et
11 cetera. At least you have some background in
12 clinical training. That's some part of training
13 that is very important to your understanding of
14 clinical medicine. The additional public health
15 piece gives you some level of competence I guess
16 and awareness of public health principles. That
17 in and of itself is not sufficient. There's a lot
18 of extra training in orientation that you need to
19 hone in your skills as a PHEO, taking what you've
20 known and adding on the training so I'm not going
21 to say education. The training piece and the
22 joint training piece, we have a series of

1 workshops that have occurred over the last year
2 trying to really get to what are the most
3 important framing facets or dimensions for PHEOs,
4 initial training and continuing training, to make
5 sure that they are up to speed.

6 There was talk at the start of this
7 process was this going to be a separate MOS? Is
8 this a full-time job? The Air Force went as far
9 as to say it has to be a physician. But when we
10 came to the table and talked to the other Services
11 and they all have different approaches, the common
12 ground approach was everyone at least has to have
13 a clinical background. If you as the Air Force
14 want to make it a physician, go for it. If you're
15 the Navy and you're the Army and the Coast Guard
16 and you don't want to do that, but you at least
17 have to be a clinician. So there was some give
18 and take as part of the staffing coordination
19 process. But I think one thing is, we will revisit
20 this issue down range a bit and hopefully if there
21 are some adjustments or revisions that we need to
22 make including input and feedback and advice and

1 counsel from you here at the Board, we'd greatly
2 appreciate that.

3 DR. LEDNAR: Dr. O'Leary?

4 DR. O'LEARY: I was a little surprised
5 on your issue of surge capabilities, I agree with
6 the resource allocation issue in what we would
7 call the graceful degradation of care, but it
8 doesn't seem to speak to job one which is to the
9 enhancement of surge capabilities. I know your
10 slide directs itself to the macro picture, but
11 there are important issues like discharging
12 patients who don't really need to be there or
13 putting them at a different level of care,
14 mobilizing off-duty personnel, making sure you
15 have access to additional beds and respirators, et
16 cetera, and it seems like more explicit attention
17 to what is really a surge capability in the things
18 that you list would be more appropriate.

19 CAPTAIN CHEN: I think the annex on
20 surge capabilities was more or less sort of rules
21 of the road because that was what the Services and
22 the combatant commands were very hungry for

1 especially as part of their pandemic influenza
2 preparedness planning. The part about the actual
3 nuts and bolts of what you need to do to ensure
4 you have adequate surge capacity looking at your
5 bed planning and triage, looking at alternate care
6 sites, making sure you have adequate stockpiled
7 material and equipment, we put in as one of the
8 core responsibilities of the PHEOs making sure you
9 address the surge capability issue. We didn't go
10 into a lot more detail about the specific for
11 that.

12 What we did is in the training part that
13 we're looking at, we took that surge capability
14 piece and identified specific elements of the
15 kinds of things you need to think about in the
16 planning process as a PHEO when you want to think
17 about surge capability and how you go about
18 executing that, here are some of the things. We
19 didn't want to overburden the verbiage in the
20 issuance but, rather, try to attend to it in the
21 training piece and provide some overarching sort
22 of rules of the road or roadmap on how we handle

1 things in general.

2 That's a good point, though. There are
3 a lot of things that you have to think about in
4 surge capability. Maybe many of you know that HHS
5 has sponsored the Institute of Medicine to look at
6 some of the issues of surge capability. A lot of
7 those things are very germane to our fixed MTF
8 facilities. Surge capability is an issue we have
9 to look at forward care as well. But at least in
10 the fixed facility setting, a lot of those things
11 too we're also working with HHS and seeing how
12 best to approach that issue.

13 The tenets we did say about how you make
14 priorities on care, beneficiaries, active duty
15 personnel and so on and so forth, were some really
16 tough kinds of things that we had to take into
17 consideration but we felt we really needed to
18 articulate those things in some fashion knowing
19 that the individual commander, the individual
20 provider on the ground is often going to be making
21 these very, very, very difficult kinds of
22 decisions if there is a fixed allocation of

1 resources.

2 DR. LEDNAR: Dr. Mason?

3 DR. MASON: We're painfully familiar
4 with our disasters. My question to you is how
5 integrated are the individual PHEOs into their
6 local emergency OPS centers and what role or roles
7 do they play with our exercises? How actively
8 engaged are they in what we do on a regular basis?

9 CAPTAIN CHEN: The ground truth is that
10 over the last 3 or 4 years, PHEOs especially but
11 MEMs too have become progressively and inexorably
12 woven into and integrated into a lot of the
13 municipality, city, county and even state-level
14 planning. The taskings for PHEOs to reach out to
15 civilians is there. Civilians often want to know
16 who do we reach out and touch on the military
17 installation side of the house and there are many
18 examples of very fruitful and successful
19 interactions inside and outside the gate. There
20 are other instances where that relationship could
21 be better.

22 Our utopia if you will, our end state,

1 would be of course as you said, sir, where PHEOs
2 are an important part of civilian government
3 planning in emergency operations, that they
4 consult with each other, that there are MOUs in
5 place, that they share information. There are
6 many MOUs across the country and we're trying to
7 replicate those. One of the things there is at
8 least in the continental U.S. and you can take
9 this model overseas as well, is that NORTHCOM and
10 PACOM have a very big role in making sure that the
11 PHEOs within their responsibility are working well
12 with states and with FEMA regions. So I think
13 we're moving more toward a state of having that
14 happen. There are many instances where we've
15 gotten data calls or requests from both ends, the
16 military side of the house and the civilian side
17 of the house about who do you touch and we've made
18 the connection. So I think that relationship is
19 only going to get better.

20 This issuance really tries to put a big
21 shot in the arm for that and we really want to see
22 that civilian/military closeness get even better

1 and better and better.

2 DR. LEDNAR: Dr. Erdtmann?

3 DR. ERDTMANN: I think that's quite a
4 piece of work. That's really impressive. I think
5 that you partly answered my question, but I just
6 want you elaborate a little bit. I would imagine
7 there are times when a Service member who is
8 living off post is getting guidance from the field
9 that might be different or conflicting with a
10 local public health authority. How does that get
11 resolved and who makes the final decision?

12 CAPTAIN CHEN: That's a little bit of a
13 tricky slope. Sir, we did address that and we had
14 a conversation about how to handle active duty
15 members and families who live off post, who may
16 live pretty close to the post but literally off
17 post, and there are two things. One is there's
18 language in the DoDI that speaks to installations
19 and they're covered or responsible parties or
20 populations. So there are some instances where
21 installations consider as part of their
22 responsible population beneficiaries who live

1 outside the gate. There are others who do not,
2 and those who do not say if you do live off the
3 gate and you don't come back on base, you are now
4 under jurisdiction of the local health department
5 or state health department rules.

6 The hope is that when there is a
7 disconnect or a conflict that the PHEO or the
8 installation or installations and the local health
9 authorities have gotten together to talk about how
10 best to handle that kind of situation because that
11 happens a lot. You can't really address that
12 without sitting down and talking through how would
13 we do that. So that issue is in the DoDI as part
14 of the training process and it is one of those
15 kinds of sticky wicket issue that surfaced because
16 of the SNS piece, when SNS comes and who gets them
17 first and who doesn't and that issue did come up,
18 but it's a very good question. We left it up to
19 the Services and we carefully crafted the language
20 to say the Service installation and how they
21 define their covered population is what we used.

22 DR. LEDNAR: I'd like to thank Captain

1 Chen for this brief and the presentation. It's
2 obviously very important work going forward, and
3 thank you for sharing that with us.

4 CAPTAIN CHEN: Thank you having me, Mr.
5 Chair.

6 DR. LEDNAR: Thank you. What we will do
7 now is with Captain Naito's indulgence we are
8 going to flex the agenda and break for lunch at
9 this point and Captain Naito's agenda will be the
10 first one when we reconvene in 45 minutes from
11 now. Ms. Bader has some information for us to
12 help us as we move off to lunch. Ms. Bader?

13 MS. BADER: Lunch will be provided for
14 the Board members, ex-officio members, Service
15 liaisons as always. The staff, our distinguished
16 guests and our speakers and all others, please
17 avail yourselves to the suggestions offered by
18 Commander Feeks at the beginning of the meeting.
19 Thank you very much.

20 DR. LEDNAR: Thank you.

21 (Recess)

22 DR. LEDNAR: Okay. We would like to

1 reopen our afternoon session of the Defense Health
2 Board. Again, with Captain Naito's flexibility,
3 what we're going to do is, begin the afternoon
4 session with the report of the DoD Task Force on
5 the Prevention of Suicide by Members of the Armed
6 Forces.

7 We've been joined since we opened this
8 morning by General Volpe and Ms. Bonnie Carroll,
9 and I can read a few bio points here, then ask
10 General Volpe and Ms. Carroll to say a few extra
11 words if you'd like to the Board about your
12 background and anything that you think would help
13 introduce the topic that we're about to go into.

14 Major General Volpe serves currently as
15 the Commanding General of the Western Regional
16 Medical Command and Senior Marketing Executive for
17 TRICARE Puget Sound. He's a board certified
18 family medicine physician, and is a fellow of the
19 American Academy of Family Physicians, and a
20 diplomat of the American Board of Family Medicine.

21 Major General Volpe most recently served
22 as the Deputy Commander, Joint Task Force,

1 National Capital Region, Medical. General Volpe's
2 numerous awards and declarations include the
3 Defense Superior Service Medal, Legion of Merit
4 with Four Oak Leaf Clusters, the Bronze Star Medal,
5 the Purple Heart Medal, and a number of other
6 distinguished awards. In addition, General Volpe
7 possesses the Surgeon General's A Proficiency
8 Designator in the field of family medicine. We
9 all know that there's a critical shortage of
10 primary care physicians, and it's nice to have in
11 command the primary care perspective as we think
12 about the Military Health System.

13 Ms. Bonnie Carroll serves as the
14 National Director of the Tragedy Assistance
15 Program for Survivors, Inc. called TAPS. TAPS is
16 a national non-profit veteran service organization
17 addressing the emotional, psychological, and
18 administrative problems that arise from the loss
19 of a loved one in military service to America.

20 Previously, Ms. Carroll has served as
21 the Deputy Senior Advisor for Programs, Ministry
22 of Communications, Coalition Provisional Authority

1 in Baghdad, Iraq, and Deputy White House Liaison,
2 Department of Veterans Affairs. Ms. Carroll's
3 military experience includes Chief Casualty
4 Operation in the United States Air Force Reserve
5 and Air and Space Operations, Air Reserve
6 Component Advisor at the Pentagon.

7 Major General Volpe and Ms. Carroll will
8 brief the Board on the recent activities of the
9 Congressionally mandated DoD Task Force on Suicide
10 Prevention by Members of the Armed Forces. I'll
11 mention that at the next meeting of the Defense
12 Health Board on the 14th of July, as the Task
13 Force continues its deliberations and brings its
14 thoughts to a full report, the Board will have an
15 opportunity again in July for a brief on the
16 findings and recommendations of the Task Force.
17 So General Volpe and Ms. Carroll, thank you for
18 joining us. Would you like to say a few words,
19 anything in addition before we begin?

20 MS. CARROLL: Certainly it's an honor to
21 be here, and thank you very much for having us.
22 The Task Force has been fortunate to have a broad

1 based experience and expertise, and they've
2 included the standpoint of the surviving families,
3 which has added a tremendous perspective, looking
4 at postvention as clues to prevention.

5 TAPS now has over 1,000 surviving family
6 members who have lost a loved one to suicide, and
7 that wealth of experience has added tremendously
8 to the insights that we've been able to gain.
9 General Volpe.

10 MG VOLPE: Yeah, it's an honor to
11 be here and to be able to brief the Board on where
12 we are on the Task Force Prevention of Suicide by
13 Members of the Armed Forces. It's been an
14 eye-opening experience for me up until now. We
15 started the Task Force at the end of last summer,
16 beginning of the fall, and have a sunset clause
17 coming at the end of this summer, beginning of the
18 fall, to provide our report.

19 We've had considerable briefings, which
20 I'll discuss some of the stuff in here that --
21 where we are, but we have a number of
22 deliberations to do over the next few weeks in

1 actually writing the report and discussions on
2 what our exact findings and recommendations will
3 be. But I'll be able to give you a status today.
4 But again, it's a privilege and honor to be able
5 to be here and share where we are on that at this
6 point.

7 DR. LEDNAR: As General Volpe is heading
8 to the podium, his presentation slides may be
9 found under Tab 7 of our binders.

10 MG VOLPE: Okay, good afternoon.
11 Again, I'm going to brief on where the Task Force
12 is, give you a quick little update, and it's for
13 the members of the Defense Health Board. Colonel
14 Joanne McPherson, raise your hand, Joanne, right
15 there, is the Executive Secretary, and Bonnie and
16 I had the wonderful opportunity to be the
17 Co-Chairs of a very distinguished group of
18 individuals, truly experts in the field. Next
19 slide, or is that up to me? This could be
20 dangerous. Okay. Here's what I'm going to cover
21 real quick, just talk about the Task Force
22 membership. The charter, we don't really have a

1 charter, per se, we're using the language from the
2 National Defense Authorization Act of '09 that was
3 done by Congress as our charter, and that has some
4 specified tasks in it.

5 But really the charter has been the
6 wide, broad aspect of looking at suicide
7 prevention and making recommendations to the
8 Secretary of Defense really on the policy side and
9 what other recommendations we can make, all for
10 the purpose of preventing suicides, saving lives,
11 and that's really been our guiding focus for the
12 Suicide Prevention Task Force, preventing
13 suicides, saving lives.

14 I'll update you on March, April, May
15 meetings real quick, show you some site visits we
16 made, we made a number of site visits, and then I
17 really want to get into a little about general
18 observations and general findings from which we
19 might generate some questions or a discussion or
20 suggestions and recommendations to us, especially
21 during this critical time that we are deliberating
22 and actually writing the report, and then talk

1 about future sessions here, and then garner any
2 other feedback that you may have. Next slide.
3 These are the members of the Task Force, 14
4 members, 7 military, 7 civilian. You can see it's
5 a pretty wide group of folks. I mentioned Bonnie
6 and I are the Co-Chairs of this. We have three
7 enlisted advisors, senior noncommissioned
8 officers, and a whole bunch of other experts from
9 around the field in academia, research, and
10 clinical services in the area and field of
11 suicide, representation from the VA on here, and
12 from all of the Services, Army, Navy, Air Force,
13 and Marine Corps. Next slide.

14 Now, these are some -- I mentioned it's
15 a pretty -- our purpose is pretty wide scope,
16 prevent suicide, save lives, but in NDAA language,
17 it had some specific things that they wanted us to
18 address in our report, from which we are still
19 deliberating on, but I have an opportunity to
20 speak to those right here.

21 And the next two pages, this page and
22 the one after it, will list what's actually in the

1 language. Methods to identify trends and causal
2 factors in suicides, you know, the methods to
3 identify trends and causal factors, and there
4 actually are some methods that are already in
5 place that the Department of Defense has already
6 made under the Defense Centers of Excellence and at
7 Health Affairs and stuff, and some of that is like
8 the DODSER Report, the DoD Suicide Event Report,
9 and those kind of things. And we'll be making
10 some recommendations specific about that report
11 and the system and method used that will identify
12 trends and causal factors in suicides.

13 You can see the second bullet here is,
14 well, you know, once you've identified trends and
15 causal factors, how do you use that information to
16 inform suicide prevention programs? And that is a
17 large part that the Task Force is looking at. And
18 we believe in our initial findings, this is one of
19 the major areas of which we see needs some
20 significant improvement, it is how are we actually
21 using the information.

22 We're gathering a lot of information,

1 the Services are doing a ton of great work out
2 there, but we don't really have a solid system for
3 how we methodically transform what we're gathering
4 into useful information that has an impact on the
5 actual programs that we are developing.

6 Now, I say that, but each Service has
7 theirs, but DoD-wide, we're not all linked in
8 uniformity there. So there's going to be some
9 specific recommendations there, you know, how do
10 we take the information from the DODSER, how do we
11 take information from the Services, how do we take
12 information from investigations of actual
13 suicides, from research and from families and
14 feedback from those impacted, and how do we have a
15 fusion cell of that information that then has the
16 analysis behind it to inform programs? So this is
17 real important and we'll be spending a lot of
18 time, actually tomorrow our Task Force is meeting
19 the rest of this week and we'll be discussing
20 that, an assessment of the current suicide
21 education and prevention programs.

22 Now, understand that besides the DoD

1 Task Force on the Prevention of Suicide, there's a
2 number of other things that are already going on
3 out there that are going to be much more in depth
4 than what the Suicide Prevention Task Force looks
5 like, and what I'm talking about specifically is
6 research that's going on in this area.

7 As you know, the reason why we have so
8 many experts on the Suicide Prevention Task Force
9 is because there's not a lot of research and
10 evidence based information in this field, and so
11 most of the stuff in our report is going to be
12 expert opinion, consensus opinion from the members
13 on our Task Force report. But we do know that
14 there are some unbelievable great efforts going
15 on. The RAND Study will be published on suicide
16 prevention program. They are looking at an
17 assessment of current suicide education and
18 prevention programs among the Services.

19 There's also the National Institute of
20 Mental Health, ongoing multi-year study at
21 multiple -- University of Michigan, I think
22 Cornell and some other locations under the Uniformed

1 Services University of Health Sciences; Dr.
2 Ursano is leading that effort. And that's going
3 to deliver us a lot of the evidence based
4 information that we need to help guide. So, you
5 know, we'll probably make some comments in our
6 report about that, but that is ongoing.

7 The biggest challenge for us, assessing
8 the Services suicide prevention programs is,
9 there's no certified assessment tool, there really
10 is not a certified assessment tool for anyone to
11 be judging another Services' program.

12 But what we have determined through
13 experts in the field and other programs out there,
14 there are certain domains that need to be covered
15 in a suicide prevention program, and so we're
16 looking at it with the Services program, are they
17 doing things to cover each of those domains, those
18 domains like resiliency, community support,
19 training, awareness, positive psychology, crisis
20 intervention, behavioral health services, all of
21 those things are domain areas that need to be
22 covered in a comprehensive suicide prevention

1 program.

2 So again, we'll be making specific
3 recommendations in that area. But I really think
4 the real meat and impact of this will come out of
5 that research, the research studies that are
6 currently ongoing, finally devoting the resources
7 to the field of suicideology to get the research
8 behind and evidence based in what we're doing.

9 The other problem with the suicide
10 prevention programs in evaluating and judging them
11 is something that our Task Force has identified,
12 which I think we've realized this in a lot of the
13 programs, the Services all have a lot of good
14 programs -- a lot of programs that are going on.
15 A lot of energy is being spent to suicide
16 prevention.

17 One of the difficulties is, when we do
18 programs, we haven't necessarily put in program
19 evaluation into a program before -- as it's being
20 designed and implemented. So there's a lot of
21 programs going on, but we really don't know which
22 programs are having an impact and which ones

1 aren't, but we're doing a lot of programs out
2 there. So we're trying to tease that out, but one
3 of the things that's going to be a recommendation
4 is that no program gets instituted without a
5 program evaluation portion of that to see if it's
6 truly delivering the outcomes that it was intended
7 to do when we implemented the program.

8 Assessment of suicide incidents by
9 military occupation, we are looking at this. Now,
10 this is very important to understand, that it
11 appears, and I'll share this with you right here,
12 because it appears to our Task Force, based on the
13 briefings we have, that a lot of certain MOS',
14 Military Occupational Specialties, if you will, in
15 areas of concentration, areas of occupational
16 concentration, have a higher risk based on the
17 numbers, so have a greater number, a greater rate
18 of suicide, but the problem is that when we've had
19 these briefings, and this gets back to the
20 research again, they're not normalized out for all
21 the other factors that are causal factors that
22 lead to suicide.

1 And so for me to sit here and tell you
2 that infantrymen or riflemen have a higher
3 incidence of suicide, while the numbers in rate
4 show that, there are other factors that haven't
5 been normalized out in there. So I'm not certain
6 I could make that conclusion without seeing that
7 data first and normalizing out those other
8 factors. Age, male, young, lower -- junior
9 ranking, single, married, marital relationship,
10 all of these other things have to be looked at,
11 education level, because there is a relationship
12 with suicide, and those factors have not been
13 normalized out in most of the briefings that we've
14 gotten that could really make us conclude on that.

15 So we're going to try to iron that out
16 in the next few weeks here, see if we can actually
17 make a clear recommendation or a finding related
18 to occupation, military occupation specialty.

19 The appropriate type and method of
20 investigation, now this bullet here that was in
21 the NDAA '09, along with all the bullets on the
22 next page, and we can go to the next page now, all

1 have to do with the investigation process.
2 Clearly, Congress has recognized, probably based
3 on constituent feedback, surviving members of
4 suicide -- and from what they have garnered, that
5 each Service investigates suicide a different way,
6 and even within Services, there's not a set
7 standard to do a suicide investigation.

8 Sometimes it's criminal investigation,
9 if they think that it might be homicide, but the
10 purpose of that is to rule out a felony or a
11 crime, not to look at suicide from the prevention
12 standpoint and how to prevent future suicides. So
13 there's a lot of things going on, there's a lot of
14 types of investigations that go on, but there's
15 not a standardized one, and we're going to be
16 making a recommendation, what we think is a way
17 ahead for a standardized approach to that
18 investigation.

19 And I will share a lot of that with you.
20 We think that one of the -- some of the models for
21 this are what they do in the aviation community
22 for accident investigations, a non-attribution

1 accident investigation board that looks at
2 aircraft incidents, and their whole purpose is not
3 attribution, but their whole purpose is to prevent
4 future accidents, future aviation accidents.

5 So we think the area of safety, of
6 aircraft accident investigations may be a good
7 model to adopt for suicide prevention in order to
8 look for the trends and causal factors and find
9 out when someone commits suicide, how does it
10 inform future -- preventing future suicide, so I
11 wanted to share that with you. Next slide.

12 These next series of slides, I'll go
13 back just to show you, we had a whole bunch of
14 formal briefings in March from a number of folks
15 from around the country. The VA has been involved
16 pretty heavily on this, the U.S. Army Reserves,
17 the National Guard. I will tell you, the numbers
18 for the National Guard this year appear to be
19 going up and the rate appears to be going up just
20 in the first five months of this year. And on the
21 active component side, they appear to be going
22 slightly down.

1 Now, that's just a little snapshot in
2 time. This needs to be looked at over time. I
3 don't think you could draw any conclusions. I can
4 just tell you that the numbers so far this year
5 are either up or down in a certain thing, but I
6 can't tell you why, and I can't tell you it's
7 because of our efforts or our suicide prevention
8 programs that that is the case, but that's what it
9 appears to be at this point.

10 This here is done by the Air Force
11 model. We're looking at different Service models
12 and different -- what you could call best
13 practices in Service. So each Service gets to
14 brief us on what they're doing, and their
15 programs, and why are they doing these programs,
16 and why they think it's beneficial, and that's
17 been ongoing back and forth, so we're looking.

18 And we're also looking -- we may be
19 spending a lot of time in behavioral health and
20 mental health side of suicide and not enough in
21 primary care side, in the prevention side and well-
22 being side of preventing suicides. We also had

1 the Army brief us a little on their Warrior
2 Resiliency Program research. Next slide.

3 You can see the April meeting. A couple
4 of things in the National Guard Bureau; we had two
5 briefings, one from Michigan National Guard called
6 the Buddy to Buddy Support Program, and one in the
7 New Jersey National Guard that's called a Vet to
8 Vet Program, which is a peer to peer program for
9 Service members after demobilization or after a
10 crisis or event or a deployment or something, of
11 which they have an opportunity to reach out to
12 peers, other vets that have been through the
13 experiences they have, and they're showing some
14 promise.

15 Again, the rigors of research and
16 evidence based need to be applied. But we did get
17 some briefings again along best practices on peer
18 to peer programs. Next slide. Oh, go back one.
19 I did want to mention this. The role of
20 messaging, this is a big area, and we're going to
21 be making some specific recommendations in this
22 area on the Task Force, and what the messaging --

1 what we're talking about, we're not talking about
2 text messaging here, we're talking about messages,
3 strategic communications.

4 We appear to focus a little too much on
5 the negative side of suicide. Of course, it's
6 tragic, and there's a negative side, and there's
7 loved ones that are affected by all of this, but
8 it seems like a lot of the strategic messaging is
9 focused on what went wrong and all the negatives
10 about a suicide case. And every day there are
11 saves being made out there. There are people that
12 are identifying risk, someone in crisis, taking
13 action, getting them to help, and help works, and
14 we don't seem to be getting that message out
15 there, that humans have problems, it's okay to
16 seek help, there's plenty of resources out there,
17 and help works.

18 Simple messaging like that I think would
19 go a very long way, positive psychology, if you've
20 heard that term before, positive psychology. So
21 we're going to have some specific recommendations
22 through the Secretary of Defense on a greater use

1 of strategic communications on the great -- on
2 services that are out there and things that we can
3 do to let people know. And we also think it will
4 help attack the stigma associated with that. Next
5 slide.

6 Then there's that New Jersey program I
7 talked about. And the anti-stigma programs, we
8 had a briefing on various anti -- on what
9 different folks are trying to do to reduce the
10 stigma for help-seeking behavior, okay. There is
11 a stigma associated with suicide, but then there's
12 another stigma that's associated with seeking
13 help, for people who need help, from which
14 resources are available, that's the stigma that
15 we're trying to really tackle, is this help-
16 seeking behavior. And that might not be a good
17 term, because when you use the term "help" with
18 young Service members, they don't like that. I
19 mean you can just talk to soldiers, sailors,
20 airmen, marines, the way our Task Force has, it
21 may not be a good term, help, it's sort of like
22 there's something wrong, you need help type of

1 attitude and -- amount there, so that needs to be
2 looked at.

3 The Army Behavioral Health Integrated
4 Data Environment, ABHIDE, database, this is sort
5 of -- individual briefed us on this, Dr. Kenneth
6 Cox, on what the Army is doing to connect the dots
7 and look at -- there's so many things going on.
8 The problem we have is, we don't really have a
9 registry that connects the dots in the military.
10 And this Task Force is just looking at Service
11 members, by the way, I did want to make sure I
12 made that point clear.

13 It is DoD Task Force on the Prevention of
14 Suicide by Members of the Armed Forces. It is not
15 concentrated on other populations of people that
16 are at risk for suicide. But one of the
17 difficulties is, we always hold commanders
18 responsible for the health and welfare of their
19 troops, Army, Navy, Air Force, Marines. The chain
20 of command is very important, leaders are in
21 charge in everything, but they have very few tools
22 that really connect the dots for them, that allow

1 them to have a common operating picture on an
2 individual.

3 So that commander that calls in a
4 soldier or a marine that did something wrong
5 doesn't necessarily know that that soldier is
6 having a family problem or is recently divorced,
7 or, you know, is having a financial problem, or
8 has creditors coming after them.

9 That commander may be reducing the
10 person in rank or pulling money from the person at
11 a critical time when this person is just getting
12 over some other financial difficulty or burden
13 that's going on. They may not have visibility of
14 that. So how do we connect the dots? How does a
15 commander know who's getting treatment for alcohol
16 and substance abuse at the time that they're
17 seeing a soldier so that they can make better
18 decisions and understand the common operating
19 picture on soldiers, sailors, airmen, marines out
20 there? So we're looking at a way -- databases
21 that could connect the dots. I'm not sure if
22 we'll have an answer, but we think that there's a

1 need for a tool that sort of brings all of these
2 things in there.

3 One of the other points with this that
4 makes it very difficult, as you all are aware, we
5 have a number of things we do, because of the
6 stigma that currently exist, we provide programs
7 that allow people to seek mental health care
8 anonymously, off post, out of the direct care
9 system, and go seek, but that's good, we need them
10 to seek help, and if there is a stigma and this
11 allows them to go seek help to get over the
12 stigma, that needs to be there.

13 The difficulty with that is, it adds to
14 the stigma. There must be something that could
15 affect my career if I seek help in the direct care
16 system, and so that's why they're making this
17 available for me to go. Not only that, it's a lot
18 harder to connect the dots.

19 Who knows what a civilian provider where
20 someone is seen anonymously has done with a
21 particular Service member, or their state, or
22 their diagnosis, or where they are in their

1 treatment, or group therapy or counseling? That
2 information doesn't necessarily get fed back to a
3 commander and leaders who are charged with the
4 health and well-being of individuals. So that's
5 an area that needs significant improvement on
6 that. Okay, next slide. These are site visits we
7 made, Army, Navy, Air Force, Marine installations
8 in order to talk with groups of young soldiers,
9 leaders, NCOs, officers, family members, and
10 community services and behavior health personnel
11 on installations. Next slide.

12 General observations, Services are
13 heavily engaged in suicide prevention, that is for
14 sure, they're devoting a lot of energy to that,
15 and leadership is involved at all levels.

16 There's no shortage of effort, and the
17 problem is that we don't have good program
18 evaluation, so we don't know if our efforts are --
19 how good our efforts are really doing.

20 And it gets back to this third bullet.
21 We cannot know for sure just how many lives we are
22 saving day to day because of the programs we have.

1 But I think most of the members on the Task Force
2 think there's a lot of good things that are going
3 on out there that are saving lives, and we're
4 looking at what recommendation do we make to even
5 bring that to another level and make this better.

6 Relationship, there is a relationship.
7 Members of the Task Force believe, based on the
8 briefings they've gotten and the data that's been
9 provided, that there is a relationship between
10 increased OP tempo, deployments, frequent
11 separations from families, on the overall stress
12 of the force, and, subsequently, behavioral health
13 diagnosis and treatment, and, subsequently,
14 suicide, the whole area of suicide, the number and
15 rate of suicides.

16 We don't know what the relationship is,
17 but there is some sort of relationship, because
18 when you chart it all out and the data is clearly
19 some sort of relationship in there. We believe a
20 lot of these studies, the National Institute of
21 Mental Health, will provide those sources, but I
22 believe the Army is particularly dissecting this

1 out right now, and we'll have to meet soon with
2 the Vice Chiefs of Staffs of the Services and some
3 of the Service leadership on what they found from
4 just digging in within their own data on that.

5 Next slide.

6 I just wanted to share this with you
7 quickly, prevention, intervention, postvention,
8 we're sort of looking at it from that aspect with
9 general findings. There are primary prevention
10 things that we could do, intervention or secondary
11 tertiary prevention things that could be done, and
12 then postvention, what are things that we could do
13 better in the postvention. Not only someone who's
14 attempted suicide, because they're at higher risk
15 for attempting suicide again, but even people that
16 experience a tragedy, a lost buddy from an
17 accident, lost buddies in the streets of
18 Afghanistan or Iraq and those things, do we need
19 to do critical event debriefings and do those
20 sorts of things with units and Service members,
21 that's all going to be within our recommendations
22 and those type of things.

1 I did want to talk about stigma and
2 culture. Clearly, stigma kills, and the culture
3 of the military adds to the stigma, it's the
4 intensity of the stigma. And what I'm talking
5 about there is, everybody in the military has been
6 taught, mentored, and coached to get the mission
7 done, suck it up and drive up, I will succeed at
8 all costs, we'll solve the problem, we'll tackle
9 it head on, I can do it myself, I don't need help,
10 it sort of goes with the military culture.

11 Now, this is an area we've got to be
12 very careful with, because these are the same
13 skills that allow you to win in combat and survive
14 on a battlefield in an austere dangerous
15 environment. But they may be also damaging on
16 those people who need help from seeking help, that
17 culture, so that's really what I'm talking about
18 there.

19 Deployment/dwell time we think is
20 important, not only the length of deployment,
21 excuse me, the length of the dwell time, which has
22 been mentioned recently, but the quality of the

1 dwell time, how we're reintegrating people, the
2 human dimension of resetting people after a long
3 deployment for a year, six months, a year,
4 whatever it is that they're gone, separated from
5 their family. It's not like turning a switch when
6 you come back and everything is back to normal.
7 Anyone that's deployed knows what I'm talking
8 about. What is the right process to get people
9 back to balance again as they're coming back? So
10 that's important.

11 OP tempo -- leadership, there are some --
12 and when you dissect some of the suicide -- the
13 suicides that have occurred, there are incidents,
14 particularly feedback from family members that we
15 have gotten where there has been toxic leadership,
16 leaders who are perceived -- and I'm really
17 talking about first line supervisors here, the
18 immediate leader, your first line supervisor
19 really is the person that I'm talking about when
20 you look at suicide, that junior leadership.

21 Are we really taking the time to train
22 junior leaders on how to handle the difficult

1 human tragedies and dynamics that get experienced
2 by every human being in a lifetime and how to help
3 manage that? We know young NCOs, when they become
4 noncommissioned officers from the junior ranks, we
5 know they know drilling ceremony, combat
6 operations, how to lead their team into combat,
7 how to get the mission done and all that stuff,
8 but are they really trained on how to deal with
9 their soldier that may be the outcast in the unit,
10 the guy or -- the man or woman who hasn't been --
11 doesn't fit into the rest of the team that well?

12 How do you get them to fit into the team
13 well? What is your training on that as a leader?
14 How do you identify it, how do you know that could
15 be a problem? Because, clearly, some of the
16 suicides are individuals that have felt that they
17 didn't fit in with the rest of the unit, they
18 weren't accepted by the rest of the unit as an
19 equal player or an equal member, not all, but
20 there are some -- a number of cases in there, that
21 becomes very important.

22 Are leaders trained on how to deal with

1 financial problems of their Service member that
2 they're charged to overcome? Or what happens if
3 there's a marital crisis, there's a difficulty in
4 somebody's marriage? Are junior leaders, 24-, 25-
5 year-old noncommissioned officers ready and
6 prepared to assist Service members that are having
7 marital problems and guide them through resolving
8 those problems, or do they, because they don't
9 have the skills, ignore it and put it aside? And
10 as most of us know, usually problems like that
11 don't get better on their own without some sort of
12 intervention or someone going into it.

13 Training is important. We have a lot of
14 suicide awareness and education, but we believe we
15 have very little training in suicide. Now, I
16 can't -- I mean there is some training going on,
17 but training is a demonstration of skills. When
18 you show a PowerPoint briefing, that's just an
19 education, you're not demonstrating any skills.

20 The example I like to use is, when you
21 go to the range and use your -- qualify for your
22 weapon, you don't get a briefing on how to use

1 your weapon and then they mark qualified on it,
2 you've got to go to the range and fire the weapon
3 and it's got to hit a target, okay, that's what
4 qualifies you.

5 The same thing with identifying risk
6 factors in suicide. Service members should be
7 able to demonstrate they know what to do and how
8 to recognize somebody and demonstrate they know
9 how to get them help. We don't seem to follow up
10 on that a lot in our suicide prevention programs.
11 Most of it is awareness and education. Peer to
12 peer programs work very well. The Marine Corps,
13 my accolades in the Marine Corps are doing a lot
14 of peer to peer programs. Service members are
15 more comfortable talking to peers about their
16 problems than they are their leaders or outside
17 people coming in, or behavioral health people.
18 And if those peers are trained properly that
19 they're talking to, could get them in to take
20 action on what they need.

21 Crisis intervention is all over the map.
22 There's no standardized crisis intervention method

1 that we could find. There are numerous hotlines
2 to call. Bonnie here calls just about every
3 single hotline and mimics a suicidal patient in
4 crisis, and almost every single one is fairly
5 unhelpful from what we could identify, okay.

6 And the question really is, how do we
7 develop the 911 system for suicide crisis? That's
8 really the question we're trying to answer, how do
9 we -- when you dial 911, you know what you're
10 going to get, and you know what happens, and
11 there's a reliable person on the other end that
12 orchestrates and gets resources and advises you
13 what to do in a situation. Is it perfect? No,
14 it'll never be perfect. We don't have the
15 equivalent for suicide crisis. Usually you get
16 other phone numbers to call when you call a
17 hotline, or, you know, take them to an emergency
18 room or something like that is the answer that you
19 get. It's very haphazard. So we need to hone it
20 down, one uniform crisis intervention process,
21 hotline process. Resiliency is important, I'll
22 talk more about that next time. Behavioral health

1 resources and utilization is important, but
2 remember, that's at the far end of the scale,
3 because what we're really talking about is well-
4 being, resiliency, well-being, and taking care of
5 people.

6 The behavioral health is at the far end
7 of the scale. That's not the solution to suicide
8 prevention. That will prevent some suicides with
9 crisis intervention, good behavioral health care,
10 but the majority of it needs to be in the up front
11 end in the prevention on well-being and taking
12 care of people, and the investigations process,
13 which I already talked about. Next slide.

14 These are future sessions that we're
15 having here. Of course, this week, a week in
16 June, a week in July we will finalize the report.
17 And we have some actions going on in between those
18 weeks, too. And then we will have to close out in
19 the month of August. Next slide.

20 I know I spoke a lot, I tried to just
21 give you a lay down on where we are on the
22 prevention Task Force. Again, it's been an eye

1 opening experience for me. I learned more about
2 this field, not being an expert in suicide
3 prevention, per se, coming into this, being a
4 Co-Chair, and it's great working with Bonnie and
5 all the members of the Task Force on this. But
6 any questions? Do we have time for questions or
7 whatever?

8 DR. LEDNAR: Thank you, General Volpe.
9 Dr. Kaplan, a question?

10 DR. KAPLAN: Thank you for the brief, it
11 was very informative. I have two brief questions.
12 The first one is, is your Task Force also involved
13 with people after separation who commit suicide?

14 BG VOLPE: Yes and no. What we're
15 looking at is suicide prevention, and what we have
16 found is an inconsistency in reporting. So
17 different Services have different information, and
18 it's particularly important for the Reserve
19 component who demobilize and are out there in
20 civilian jobs. And what we're -- I could tell
21 you, in previous years, we were not capturing
22 folks after ETSing or separating or where they

1 were in civilian status and not on active duty
2 status. It is a lot better now, but we only track
3 to a certain number of days, I believe, and each
4 Service is different. And I don't have the
5 numbers off the top of my head, but we don't go
6 out and -- I do not have a confidence level that
7 someone that commits suicide in five years from
8 now that may have been related to their service
9 today in Iraq and Afghanistan, if we will actually
10 capture that in five years from now in our current
11 system.

12 DR. KAPLAN: Kaplan again, so do you
13 think you miss a lot that way? In other words, is
14 that a major -- or what percent of the problem is
15 that and is it large enough to think about? And
16 the second question that I have after that is,
17 maybe I missed it, but do -- are there official --
18 that's not the right word, but are there official
19 representatives of the various Services?

20 You've told us that the various Services
21 tend to take different approaches to how they deal
22 with this. Are there representatives of the

1 various Services represented directly on your Task
2 Force? I know you've gone out and interviewed
3 them. And if not, do you think that would be
4 helpful in terms of trying to get more uniformity
5 or equalized strengths among the three --

6 BG VOLPE: There's a representative
7 from every Service on the Task Force, yes, sir.

8 DR. KAPLAN: And the other part of that
9 was, what percentage of post-separation do you
10 think there might be?

11 BG VOLPE: I think there's a
12 significant percentage. I think there's a
13 significant percentage out there of people that
14 have separated from the Services. I think right
15 now people that separate, we have a better ability
16 to track. I know on the Army side, they're
17 tracking them very much closely, so is the
18 National Guard and Reserve -- U.S. Army Reserves.

19 But individuals that separated back in
20 2002, 2003, 2004 and before that time, I don't
21 know, I don't have -- I don't really have a good
22 feel or number, but I believe that we are missing

1 people that separate from the Service, not
2 everyone, it's better today, but I still believe
3 we are still missing people.

4 DR. KAPLAN: Thank you.

5 DR. LEDNAR: Dr. Certain.

6 DR. CERTAIN: Just to follow up on that,
7 part of the issue is, for us, is that, on the Task
8 Force is a charter from Congress limits our scope
9 to members of the Armed Forces, so we're not -- we
10 are not charged with investigating those who are
11 in the VA system. And the other issue is, when
12 somebody leaves active Services, whether it's
13 Guard Reserve or full-time active service, and
14 they go out into the community, then it's up to
15 the local coroner, local law enforcement to
16 determine whether or not it's a suicide or a
17 single car accident or whatever else is going on,
18 death by cop or death by train.

19 That's a ragged operation out in the
20 counties of America, and we don't get -- the CDC
21 takes three years before they will report back
22 numbers in the civilian population, and whether or

1 not the question gets asked of a civilian suicide
2 whether or not that person was ever in the Armed
3 Forces is not a standard question to be asked out
4 in the local areas. So that whole area is way
5 beyond the scope of this small investigation.

6 And so we're very limited. And those
7 who are currently on active duty or within it,
8 basically within that 180 day separation,
9 post-deployment for the Guard and Reserve.

10 DR. KAPLAN: Excuse me, just to follow
11 up, Kaplan again. Is it -- have you discussed, is
12 it the responsibility of maybe not this Task
13 Force, but some Task Force in the future to look
14 at that issue, particularly if there's a
15 significant percentage of the total number of
16 suicides that may be involved?

17 DR. CERTAIN: Certain grabbing the
18 floor, the VA follows, VA has its own set of
19 studies in this regard for veterans, and I'm not
20 sure. The full scope of the RAND Study, I've seen
21 the draft report, but I'm not clear about how far
22 they've taken their study.

1 The whole question is out there that the
2 -- you can look at -- online at the suicide
3 numbers in this country and see what the trends
4 are among various age groups, race, and ethnic
5 groups and what have you. The military rate,
6 which has got us all very concerned in DoD, has
7 been climbing for five years, the civilian rate
8 has not been climbing in those same five years,
9 however, last year, as best we can tell, the
10 military rate reached the civilian rate for the
11 first time in history.

12 But we don't know what the civilian rate
13 -- we only have 2007 is the latest numbers we have
14 there, but it -- in the target demographic that's
15 in the military on a nationalized basis, it's
16 approximately 20 per 100,000 per year, and that's
17 where DoD was last year approximately, and we
18 assume the civilian rate was about that. Earlier
19 -- before it started climbing, the DoD rate was
20 around 16 per 100,000. The Army and the Marine
21 Corps lead that, with the Navy and the Air Force
22 being way below that. And, you know, the

1 ethnicity is remarkable. Anglo-Saxon males commit
2 suicide at twice the rate of any other ethnic
3 group other than Native Americans.

4 BG VOLPE: On that topic, we would
5 have to ask ourselves two questions, one is, what
6 difference would it make in identifying those
7 individuals on preventing suicides, number one,
8 and the other one is, do we need to recommend some
9 sort of legislation where local community and
10 county medical examiners who have a suicide in a
11 veteran have to report that to some central
12 registry of which the VA and DoD collaborate on to
13 collect that information?

14 I mean the Task Force will look at that,
15 and we may make that recommendation, I'm not sure
16 yet, but that's one of the discussions that has
17 been -- that's come out in our deliberations.

18 DR. LEDNAR: Dr. Luepker.

19 DR. LUEPKER: Russ Luepker. Thank you,
20 interesting report. You said a couple things that
21 caught my ear when you started talking about
22 normalization or things I might call adjustment

1 factors, and one of them might be occupation,
2 highly likely, but you don't want to adjust that
3 away. I mean there's certain occupations, whether
4 it's rifleman or computer programmers that have a
5 higher rate of suicide, that's a very important
6 bit of information of where you're going to target
7 your interventions.

8 I would say, as well, to Dr. Certain and
9 others, you know, I think in the public eye,
10 people that are discharged, and suicide, whether
11 it's one month or five years later, still are
12 connected with the Service when that happens, and
13 we somehow need to learn about that group which is
14 an equally important group of people to lose.

15 DR. LEDNAR: The Task Force will be
16 coming back in about five weeks. As General Volpe
17 said, there's a lot of work yet ahead to process
18 the inputs and put it all together and think about
19 what they found and what to recommend. And on
20 July 14th, at the next meeting of the Defense
21 Health Board, General Volpe and Ms. Carroll will
22 be sharing with us really how this all comes

1 together in a package, so we'll have more
2 opportunity at that point to --

3 BG VOLPE: Thanks. (Applause)

4 DR. LEDNAR: Agility is becoming the
5 middle name of the Defense Health Board. And with
6 the indulgence of our speakers, we're really going
7 to be sure that Captain Ware can attend his
8 daughter's graduation, as I understand it, which
9 is later today, and he's not going to be late
10 because of us. So what we're going to do is hear
11 from Captain Ware, but before we do, there is a
12 video that he had asked that we show which will
13 sort of prepare us for the comments he's then
14 about to make. So if we can show the video.

15 (Video played)

16 DR. LEDNAR: I think you can see why
17 Captain Ware suggested we see this video first
18 before he speaks. And it's really our privilege
19 to have with us today Captain James Ware, who
20 serves as the Commanding Officer of the USNS
21 Comfort Medical Treatment Facility, home port is
22 in Baltimore, Maryland.

1 Since assuming command, Captain Ware has
2 led over 2,000 medical providers and humanitarian
3 volunteers to include over 600 civilian and
4 international doctors and nurses on eight
5 international humanitarian medical missions.
6 Following the Haiti earthquake in January of this
7 year, the Comfort responded in record time in
8 support to the earthquake victims in Port-au-
9 Prince. So please -- we appreciate, Captain Ware,
10 your joining us, and we look forward to your
11 brief.

12 CAPTAIN WARE: Thank you very much.
13 General, distinguished guests, thank you for
14 having me. My presentation today is really one of
15 -- more of an emotional overtone of the things
16 that our nation, doctors, nurses, not only from
17 the Department of Defense, but also civilians.
18 Humanitarian volunteers stepped forward on the day
19 after the earthquake in Haiti to support the
20 Haitian people. And I had the opportunity to be a
21 teammate of those individuals.

22 There were over 1,400 medical

1 individuals who supported the Comfort's mission.
2 And I'm going to try to tell you a little bit of
3 the story and a little bit of the information on
4 that, so bear with me.

5 The Comfort itself is a hospital ship.
6 How many folks here have been on the Comfort? So
7 maybe about 40 percent of you. It's a big ship.
8 I had my in-laws out yesterday to show them the
9 ship; as mentioned, I have a daughter who's
10 graduating tonight. And the typical notion of the
11 ship is, it's 14 feet longer than the Titanic and
12 ten feet wider, it's a very, very large ship. The
13 staff on board is 1,200 beds for medical staff,
14 and we have 1,000 beds that can be used for other
15 members besides the medical staff. We talked
16 about patients, but we also need beds for
17 translators, or escorts and other types. So
18 there's 2,200 beds aboard the ship.

19 As everyone here knows, the earthquake
20 occurred on the 12th of January. It wasn't truly
21 a significantly huge earthquake compared to others
22 that we've had, the 8.8 in Chile, but

1 unfortunately, the structures in Haiti that were
2 built there were not built very well. And the
3 city of Port-au-Prince really collapsed around
4 itself that day.

5 The city of Port-au-Prince is about
6 three million people. It's been estimated that
7 there were 230 people ultimately who died from
8 injuries from that earthquake, 300,000 people who
9 were injured, and another million plus who were
10 displaced or homeless, certainly the biggest event
11 in this hemisphere probably since the time of
12 Christ as far as human tragedy.

13 I'll talk a little bit about the medical
14 aspects of the mission and some of the team work
15 and the team building that has occurred on the
16 Comfort. Some of my comments may reflect back to
17 my other mission that I completed, which was
18 called Continuing Promise, which is something the
19 Southern Command does on a yearly basis down in
20 the Caribbean to support international relations
21 in that area. And the Comfort was down there in
22 2009, then into Haiti. We had worked with the

1 Haitian government, I had personally worked with
2 the Minister of Health, worked for the Minister of
3 Health in a sense, kind of the way I see when we
4 go into our neighbor countries, we really support
5 and uplift the Minister of Health in these
6 countries, as we did in this disaster relief
7 mission.

8 On the 13th, on the morning of the 13th
9 of January, it was obvious to me that if the
10 Comfort could be sent down to Haiti, we could have
11 a great impact. However, the ship was in a state
12 of maintenance cycle. We didn't have steam, we
13 didn't have water, we didn't have electricity in
14 many areas of the ship. There were a lot of
15 actionaries that were required to get the ship up
16 to speed.

17 We had been down for about 45 days,
18 which was a planned evolution, so I didn't know if
19 we would get the call. But at 11:00 on the next
20 morning, we got the call that we needed to prepare
21 to activate. And the ship should be able to
22 activate in five days when it's ready to go, and

1 we were not ready to go. At that moment, a couple
2 of things occurred. I began to make phone calls
3 to outside agencies, NGOs, if you will, to find
4 personnel who could support us in translation and
5 other areas. The supply officer began to make
6 calls for food. We needed at least 30 days of
7 food, which was going to require somewhat of about
8 250 pallets, and we needed manpower from the
9 Department of Defense, specifically the Navy.

10 All of those things occurred over the
11 next 48 hours. We identified a manning document
12 that was probably not the perfect manning
13 document, but something we could get started with,
14 560 individuals from the Department of the Navy,
15 medical side of the house, along with other NGOs
16 that could provide translator skills.

17 And specifically the American Red Cross,
18 thank goodness, stepped to the plate, identified
19 100 individuals out of Baltimore, when we left
20 Baltimore at the 76-hour mark, they provided 67 of
21 the 100 they ultimately provided, and they were
22 lifesavers in themselves.

1 Even though they were not medical types,
2 and they were each American Haitians who had an
3 American passport, that was the only requirement
4 that we asked of them, and they came from cities
5 from Chicago, New York, Miami, all over the
6 country, just Haitian Americans who stepped
7 forward and said they would serve and joined us on
8 the ship. The ship, in two days, was able to get
9 underway. From a medical perspective, we had
10 ordered additional medical supplies. The combat
11 hazard care mission of the ship, which is in
12 Baltimore, where our main focus is, does not have
13 an excessive amount of pediatric medical supplies,
14 so that's one area that we focused in on, along
15 with other supplies so that we could provide the
16 casualty care mission that we thought we'd be
17 involved with.

18 The Comfort was part of a large
19 international mission, quite frankly. And I know
20 we have a Canadian here, the Canadian Surgeon
21 General, you'll see his picture in a minute, but
22 the Canadians were part of the overall mission.

1 The French, the Italians had ships
2 there, the Mexicans, there were Cuban doctors, and
3 in the sense of supporting the patients for the
4 Minister of Health in Haiti, in supporting the
5 overall World Health Organization and the PAHO, as
6 well as the Joint Task Force Commander, General
7 Keen, as well as the American ambassador, we
8 really understood ourselves to be part of a much
9 larger medical organization. And our mission as
10 part of that larger organization was to accept the
11 worst of the worst earthquake victims who were
12 injured the day of the earthquake. If you can
13 imagine 300,000 people who were injured in an area
14 that has a circumference of about 20 kilometers.
15 In that circumference area, which we were within
16 that circle, there was about 300,000 people,
17 probably more when we got there, some people
18 obviously continued to die, but in our -- was, we
19 would accept the worst of the worst if we could
20 triage those individuals to save life and limb.

21 When we arrived, the Israelis had
22 arrived very, very quickly. They brought a

1 medical component team that I think was very
2 successful in the patients that they could see.
3 However, they ran out of supplies fairly quickly
4 for the mass casualties that were presented to
5 them, and we accepted some of their patients, the
6 worst of their worst, so that they could continue
7 on with medical care. However, in about three of
8 four days, they ended up rolling up and leaving,
9 as well, because they had really taxed themselves
10 out.

11 The United States military, specifically
12 Military Sealift Command, which orchestrates the
13 logistic ships in the United States Navy, had
14 anywhere from ten to 20 ships in the area. Some
15 of those were logistics for fuel, food, water,
16 medicine, transport, as well as the Seabees, and
17 so that was a big part of our contingency. The
18 Army had medical folks there, the 82nd Airborne,
19 and I see some of my Army colleagues here, that
20 provided security around the airport and also
21 outstanding medical care on ground.

22 The Air Force had flown in an e-med

1 fairly quickly and provided outstanding medical
2 support, as well. And we were all part of a
3 larger network. I must admit that that network
4 was fairly immature when we arrived, and the whole
5 idea was to begin the communication process,
6 doctor to doctor information, transfer patients to
7 the ship, treatment, recovery in four to five
8 days, six days, seven days, the average patient
9 stayed aboard seven days, many with escorts, and
10 then transfer back into country, best possible
11 scenario, to a facility that could offer the
12 capability and the continuum of care that was
13 appropriate for that level of needed care, as well
14 as proximity to family if we could find that.

15 Besides the medical operation, we also
16 had just general operations. Security was an
17 element. We needed security forces for the
18 medical teams that went ashore. We had triage
19 teams ashore. In a sense, I had two trauma
20 surgeons, and quite frankly, both of them have
21 been to Iraq and Afghanistan, the verbiage from
22 them was, this was five times more intense than

1 anything they had ever experienced in their prior
2 combat experience. But we utilized them as our
3 triage officers on ground. On the first three
4 days, one of the individuals, through a DART team,
5 had triaged over 1,200 individuals, and probably
6 only about 15 percent of those could come to the
7 ship. They would have been the worst of the worst
8 who could have had survival or we could have saved
9 limb for those individuals. A very intense first
10 couple of days during the -- right after our
11 arrival.

12 We were able to arrive seven days after
13 the earthquake. It took us three days to get out
14 of Baltimore once we got the manning order and
15 then another three and a half days to get to
16 Haiti.

17 I had the benefit of having an
18 operational commander or a line commander in the
19 United States Navy in a supporting status with me,
20 and he was able to coordinate the helicopter, the
21 medical regulation piece, as well as security, and
22 also the operational slant from high authority,

1 from the JTF level, which was very important,
2 because with all of the different activities going
3 on, the medical aspect, the Minister of Health's
4 intent for us, as well as the operational sources,
5 Commodore Laco was a fine partner in that regard.
6 In addition, as I spoke of, we saw ourselves
7 really as part of a much larger team. The Joint
8 Task Force, which was the military component in
9 theater, answered directly to our American
10 ambassador, and Major General Keen, that was his
11 responsibility.

12 But as a disaster relief effort, really
13 the United States military works in concert with
14 the State Department, as well as USAID, and so I
15 was fortunate enough to have two USAID members on
16 board the ship when we left Baltimore, as well as
17 a few NGOs in a planning cycle.

18 Ultimately, we ended up having 240
19 civilian Americans, humanitarians, who joined the
20 mission on board the ship in support of this.

21 The first 36 hours I would say were
22 very, very intense. It's been described that the

1 first day was 40 hours. And our surgeons and our
2 anesthesiologists and our nurses and our core men
3 really saw the bulk and realized that first 40
4 hours, what the next four weeks would be like.

5 We were taking patients on via
6 helicopter about every ten minutes, two to three
7 patients in a helicopter, and that continued from
8 sun up on the very first day until sun down, and
9 that was a little under 100 patients. The next
10 day was about the same. The morning when we
11 arrived, on the 20th of January, as I looked
12 outside, I could see about 50 helicopters ready to
13 land on our deck, and that was from the
14 helicopters on board the other ships, the USS Carl
15 Vinson, the USS Baton, as well as the Canadian
16 forces who were there in support, the French, and
17 the Italian. So we all worked very well together.

18 There was some massaging of
19 understanding how things should work, but quite
20 frankly, everyone was focused on saving lives, and
21 that was never lost to any of us, and I think
22 because of that, medical experts can come together

1 quickly and predict the right course of action and
2 take those courses of action.

3 The staffing on the ship, as I
4 mentioned, we have 1,200 staff beds, and we really
5 went above that. From the standpoint of mass
6 casualty, what I relearned in this scenario was
7 that surgeons -- how many surgeons do we have in
8 here? We've got a few surgeons? No surgeons?
9 Surgeons can take care of a patient and their
10 anxiety is alleviated because they've done their
11 job, and they can really dust their hands off.
12 But it's the nursing care, the 24/7 nursing care
13 that's the most difficult on critical care
14 patients. And I had 153 nurses aboard, but the
15 first four days of an emergency like this, what my
16 observation was, is we all have enough adrenaline
17 to get us through the first four days. The next four
18 days, days five, six, seven and eight, it's a
19 certain amount of passion and endurance and
20 physical capability of individuals.

21 But I will tell you, on day eight, when
22 you're maxed out, you have more patients than your

1 resources can provide you, people will hit the
2 wall, and it was the nursing staff. The patient
3 safety moment of nursing staff, where we were
4 really at that maximum limit of seeing as many
5 patients as we could to relieve the hospitals on
6 shore, and yet to put the nursing staff in a
7 situation that those 18 hour days were just too
8 long, and we took it to that limit because we knew
9 that for every man, woman, child that we didn't
10 take aboard, that they could die or that they
11 would lose a limb, and so we had to take it to
12 that limit and we did.

13 But for future planning purposes, I'm
14 hoping that the ship can find more nurses,
15 therefore, more beds, if we ever need to use our
16 national asset, either the USNS Comfort or the
17 USNS Mercy in our own back yard.

18 Most of the injuries were obviously
19 traumatic injuries, crushing injuries. About a
20 little less than 700 of the operations that were
21 performed were orthopedic injuries that were
22 stabilized. Once again, there's no surgeons in

1 the audience? If you could imagine in the first
2 four days, we had 122 femur fractures. And I
3 don't -- I've never worked in a hospital in the
4 private sector, but I think the average even
5 trauma hospital, the trauma hospital in Baltimore
6 here in Washington, they'd be taxed to see that
7 many in a year, and we saw that in the first 96
8 hours, so it was very, very intense.

9 We talked a little bit about the
10 volunteers and the Red Cross and what they brought
11 to the team, the translation skills. These were
12 not medical individuals, but they really brought a
13 lifesaving translation.

14 If you can imagine a patient, an escort
15 with a seven-year-old child, and the child needed
16 to be, through the mother, needed to talk a little
17 bit about what their injuries were, it was the
18 Haitian translators that were able to translate
19 that information in Creole. And some of them had
20 very difficult jobs.

21 There were, it's estimated 5,000
22 amputations on shore done. We ended up doing 37

1 amputations. But our focus and our mantra was
2 really to save limb. But some of those
3 translators had to be the translators to mother or
4 to patient to give the acceptance to do that and
5 that was very, very difficult.

6 The Orthopedic Trauma Association of
7 America stepped forward and was in touch with the
8 Navy Bureau of Medicine and offered their
9 services, and they were able to send ten trauma
10 surgeons to the Comfort in about six days after
11 our arrival, and that was really a godsend.

12 At one point we had 23 anesthesiologists
13 and 38 surgeons operating out of ten operating
14 rooms, and the orthopedic surgeons that came were
15 the best of the best in our country from all over
16 the country. Most of them did not have a military
17 affiliation, but were able to step right up to the
18 plate and jump in and really do a great job.

19 We also see that the American College of
20 Surgeons also sent surgeons. Johns Hopkins sent
21 doctors and nurses. The National Nursing United
22 out of the West Coast was also a player.

1 Operation Smile, Project HOPE, who had about 70
2 people I think that came out, physicians and
3 nurses who had actually served on board other Navy
4 vessels, and they were quite good because they
5 knew our environment and they had served with us
6 before, and I really appreciate their time.
7 University of Michigan, UCLA, and as I mentioned,
8 USAID. This is just a schematic of the NGOs that
9 were aboard. In the red is the Red Cross who left
10 with us out of Baltimore, Project HOPE and others.
11 But they really did provide lifesaving skill sets.

12 The Navy doesn't have pediatric NICU or
13 PICU nurses, and so we needed to go to the private
14 sector for those individuals, as well as pediatric
15 intensivists, which they provided.

16 How many folks here have done
17 humanitarian service in other countries? A
18 couple. So you know that language skill set is
19 very, very important. I mean many Americans speak
20 Spanish, so if we're in the Caribbean, most of the
21 countries there speak Spanish, but in Haiti it's
22 Creole, and so the U.S. Navy was able to, on the

1 13th, go out and ask for additional Navy
2 individuals who had Creole language skills, and
3 they were able to also send 66, and we really
4 needed every one of those individuals. There's
5 something about compassionate care when you have
6 somebody who knows the cultural significance, so
7 the individuals not only having the skill set of
8 the language, but also a cultural understanding.

9 From the medical operations, the focus
10 really from the very first day was taking care of
11 the individual patient needs and not losing sight
12 of how important that was, even in the mass
13 casualty, once they arrived to the Comfort. The
14 triage that had to be done on ground had to be
15 very direct, and there were patients who needed to
16 be triaged into an expectant category, as well as
17 individuals who had injuries that could not come
18 to the ship because really their injuries were
19 either more chronic or could be solved at one of
20 the ashore facilities, and I think a very, very
21 difficult issue. But compassion and understanding
22 were always our focus.

1 This just shows a sense of admissions
2 and our discharges. One of the things we did not
3 start with a good intent, or I did not start, was
4 an understanding of where I could discharge my
5 patients on the day of arrival. But within the
6 first 24 hours, it became very obvious that we
7 were going to have to discharge as many patients
8 as we were taking on, some steady state.

9 And thankfully we knew the environment,
10 we had been to Haiti, I had worked with the
11 Minister of Health, and I had individuals on board
12 that had also had those skill sets, and they were
13 able to find NGOs on ground, and there will be a
14 picture a little bit later on, on where we were
15 able to send those individuals. This slide
16 indicates -- the blue indicates the number of
17 earthquake victims that we took aboard, and then
18 the red on the bottom indicates non-earthquake
19 victims.

20 We did, in fact, take some patients off
21 from the shore who were not earthquake victims,
22 once again, to assist the Haitian medical staff so

1 that they could focus on more patients. And in
2 addition to that, we did take some Americans and
3 some Service members who actually were injured in
4 the rubble removal. And this is just another shot
5 of that in a different perspective. But 794 of
6 the individuals were earthquake victims.

7 Surgeries on board, we had ten operating
8 rooms, and we could work between anywhere from 30
9 to 50 operations a day. At one point we were
10 working in ORs 24/7. Most of these surgeries were
11 very complex crushing injuries, and many of the
12 rooms would have two to three surgeons in the room
13 facilitating the surgeries.

14 I'm not a pharmacist, but I do know that
15 when I look at these numbers, and I look at
16 in-patient care, it says 64,000. Well, I know
17 that that's over about a 35-day cycle, and that
18 equates to me a little under 2,000 prescriptions
19 in hospital a day. Well, I only had five
20 pharmacists, and I know that they worked very,
21 very hard. But the amount of X-rays, the amount
22 of pharmacy, the amount of lab work that we were

1 required to do over those first 30 -- 35 days, I
2 think was really monumental with really the small
3 staff. I mean it was a staff trying to manage a
4 large hospital, but with the types of patients
5 that we had and the critical care nature, it was
6 really -- they did a very good job.

7 We moved almost all of our patients
8 aboard to the ship by helicopter, probably about
9 96 percent. We ended up having to move some of
10 the patients back ashore by boat. That wasn't my
11 first option, but we needed to do that because the
12 helicopter workload was being moved to other
13 areas. Also, shelter and rubble removal were a
14 big priority for the government of Haiti, and we
15 wanted to support that, as well.

16 In addition to that, once the patients
17 got ashore, we needed to have ground
18 transportation, and USAID was a great partner in
19 that aspect, as well as the Minister of Health.

20 This slide indicates the different
21 facilities that accepted medical patients from us,
22 and we needed to go throughout country. Once

1 again, the capability of the facility, as well as
2 the geographic location for family was many times
3 a determining factor where we would end up sending
4 patients. But from the hospital, I needed to send
5 out physicians and nurses to begin the dialogue so
6 that they could accept the patients. And, if at
7 all possible, a doctor to doctor referral process
8 stayed in intact, and that was very important to
9 my staff, and so I supported that wholeheartedly.
10 And we did a lot of moving around of staff to move
11 these patients to the best possible locations.

12 When we initially arrived, we had not
13 seen this many NGOs on ground. We had been there
14 the year before and had worked just with the
15 Minister of Health and the hospitals, but the
16 hospitals were all truly destroyed, and most of
17 the patients that were gone to the national
18 hospitals were in the streets, just another
19 visualization.

20 Certainly it was a very intense period
21 of time for the staff members, as well as the
22 escorts and the patients. And I don't think it

1 can be under estimated, the importance of having,
2 from the military perspective, psychological
3 opportunities for psychologists and psychiatrists
4 to assist where needed, as well as spiritual
5 well-being. Because we had death and dying aboard,
6 patients, even though they were transferred to the
7 Comfort, still died of their wounds, and because
8 they were with escorts, and because some of our
9 staff became attached to those patients, it was
10 very important to go through a cycle of spiritual
11 recognition. And we would hold ceremonies on
12 board the ship with staff and escorts and family
13 members of the patient, and that really proved to
14 be a very positive type of a display I think for
15 all involved, because we were all very wrapped up
16 in the patients, and when we lost a patient, it
17 was a very sad thing, and the family members, as
18 well, but it really did serve a tremendous
19 positive purpose.

20 The supply chain was -- we were very
21 lucky. Quite frankly, if we have to use the
22 Comfort or the Mercy again in a tragedy like this,

1 we were lucky because we were in the same time
2 zone of Washington, D.C., and we were not that far
3 from Guantanamo Bay, which we used as a supply
4 hub, and so we were able to get supplies that we
5 needed in a 36 to 48 hour period.

6 We ordered sea arms, which are for the
7 operating rooms to take X-rays, to position
8 orthopedic appliances. We ordered quite a lot of
9 additional narcotics and medicine, in addition to
10 fresh blood supply. And we felt that our supply
11 systems were very, very effective for us in that
12 regard, but we realized that, because of location,
13 we did get lucky. We additionally had taken down
14 about 120 pallets of medical supplies which we
15 unloaded there, and in addition to that, we
16 brought back a field hospital that we initially
17 were going to use, but we ended up not putting
18 out, because the NGO community had blossomed to
19 such a degree that the medical capability on shore
20 was greater at the moment the Comfort left than
21 when we -- than pre-earthquake levels.

22 This is just a chart of our blood usage.

1 Anywhere between 15 and 20 units on average a day
2 for about the first 20 days.

3 We weren't there to help birth babies,
4 but we had nine women who were critically injured
5 who were pregnant, and we ended up having nine
6 births aboard. And it's interesting how one
7 single patient can galvanize in a very positive
8 way the crew.

9 This case here of Isabelle, she was --
10 the mother was in 26 weeks, and she had a crushed
11 pelvis, and the doctors were concerned to remove
12 the baby, we were worried about blood supply
13 issues, as well, if we had enough blood at the
14 time, and Isabelle was born prematurely and wasn't
15 thriving initially, and the intensivist
16 pediatrician who was from Chicago, was a civilian,
17 really felt that the baby did not have much of a
18 chance to live, and kind of pulled back the
19 support mechanisms, because we were still bringing
20 on dozens and dozens of patients a day to try to
21 save life and limb in those individuals.

22 But amazingly enough, Isabelle struggled

1 for life and overcame and began to thrive, even
2 without any additional medical focus on her. And
3 she really -- everyone on ship knew of Isabelle,
4 and everyone on ship really gained a great sense
5 of response from her survival, and she's still
6 alive today, thank goodness. But it showed the
7 resilience of the Haitian people from this
8 premature child.

9 We talked about orthopedic support a
10 little bit, under 700 orthopedic cases that were
11 done. Our focus was truly on saving limbs, and
12 the orthopedic surgeons did an outstanding job. I
13 think I mentioned the one time we had 13
14 orthopedic surgeons working really in unison.

15 Acinetobacter was one of our issues. In
16 2003, the ship, when it was over in Iraq, had a
17 few cases on board, and we again found this
18 bacterium, and one of the men -- the patient who
19 had meningitis who had been transferred from the
20 Israeli hospital on day number two, and so it was
21 an infectious disease focal point to try to make
22 sure that we isolated the patients who either had

1 the infection or had the skin pathogen, and that
2 was done very, very well. Dr. Todd Gleason was my
3 infectious control doctor and spent a great deal
4 of time the first ten days ensuring that the other
5 500 -- 600 patients were isolated and did not get
6 that bacterium.

7 So with that, just a little bit of
8 history. I'm here to take questions if anyone has
9 any, and thank you very much. Thank you for
10 letting me get for my graduation, as well. So any
11 questions?

12 Ms. BADER: Dr. Shamoo.

13 DR. SHAMOO: Adil Shamoo. Great work
14 and great resource for a country to do good will
15 across the world. You mentioned there were
16 230,000 death in Haiti. As a matter of fact this case
17 came up by teaching a spring course on medical ethics
18 at University of Maryland. And I had several
19 students, they were physicians, but they were
20 studying for a master in public health. And we do
21 a lot of case studies, and they forced me to talk
22 about this case as a map of Haiti. They had much

1 more information than I did, I only read the
2 newspaper, so I was at a disadvantage.

3 But one of the sort of crystallized
4 question that came up, and they sort of put me
5 across the blackboard and kept shooting arrows at
6 me, the work should be done to save more lives.
7 And public health measures such as amputations,
8 antibiotics, clean water have a greater output,
9 whereas surgery, for example, is much more time
10 consuming. And my question to you is, who makes
11 that ethical decision in deciding whether you will
12 spend resources on surgery versus public health
13 measures, and what kind of an ethical flow chart,
14 and who decide that, is it you, somebody else at
15 DoD?

16 CAPTAIN WARE: We ended up having an
17 ethical committee for the hospital, and the
18 Chairman of that actually was a Haitian born
19 neurologist, trained at Columbia University, but
20 as a Naval Officer, Dr. Etienne, and because he
21 knew the cultural understanding of the nation, his
22 family was from Haiti, and because he had had

1 training in ethics, as well as cultural ethics, he
2 was the team leader for my hospital and did an
3 outstanding job.

4 He did write a very good article soon
5 after that, I don't know if you've seen that
6 article specifically, but I can get you in touch
7 with that article. I don't know which journal it
8 was in.

9 He was also a neurologist, and we had
10 six cases of tetanus, not an ethical issue, but
11 very interesting to see tetanus alive and well in
12 these areas. So we had a team of physicians and
13 nurses, I don't know if we -- may have even had a
14 chaplain on there, and I think we did, we may have
15 had two chaplains on there, who really struggle
16 with some of the ethical issues, some of the death
17 and dying pieces, and we initiated that before we
18 arrived in Haiti, because we knew that that was
19 going to be some of the issues.

20 Many of the doctors from America really
21 didn't understand the cultural types of issues for
22 Haiti, and many -- from my perspective, I think

1 ethics is a cultural issue, as well, and so you
2 needed to understand those issues.

3 The Minister of Health was intimately
4 involved with -- when we started and throughout
5 our process of how we handled many of the issues.
6 Now, not that they would provide the ethical
7 direction specifically, but they could give
8 general guidance.

9 And because we were working for the
10 Minister of Health, in a sense, even though each
11 individual patient was of themselves very, very
12 important, we felt we had a good handle on some of
13 the difficult decisions that had to be made. So I
14 mean that's not a direct answer, but we had a team
15 of individuals who looked at these as a
16 collaborative effort and to try to make the tough
17 decisions not to get too bogged down, but to be
18 able to move on. So I hope that helps. And I
19 would recommend the article because it was a very,
20 very good article.

21 Any other questions? I'd like to thank
22 the Canadians for being available, and I've worked

1 with them on quite a lot of international medical
2 missions, and it's always great to have your
3 support here and in the field, so thank you.

4 DR. LEDNAR: Captain Ware, on behalf of
5 the Defense Health Board, thank you for the brief
6 today, and especially for the service that you and
7 the staff --

8 CAPTAIN WARE: Thank you.

9 DR. LEDNAR: Congratulations.

10 Ms. BADER: Okay. We'll take a
11 quick 15 minute break now and then we'll come on
12 back and then finish out the day. Thank you. So
13 please return to your seats by 3:25. Thank you.

14 (Recess)

15 DR. LEDNAR: Okay. If we can please
16 take our seats. Our next speaker is Colonel
17 Chester "Trip" Buckenmaier. Did I say that
18 correctly, sir?

19 COL BUCKENMAIER: Yes, sir.

20 DR. LEDNAR: And we appreciate your
21 flexibility with our schedule this afternoon. I
22 apologize for you being able to get on the podium

1 later than we had planned, but thank you for your
2 flexibility. Colonel Buckenmaier serves as the
3 Chief of Anesthesia and Operative Services, Chief
4 of Regional Anesthesia and Program Director of the
5 Defense and Veterans Pain Management Initiative at
6 Walter Reed Army Medical Center.

7 In addition, he's the President of the
8 Tri-Service Military Advanced Regional Anesthesia
9 and Analgesia Initiative, Anesthesia Consultant
10 Group. Colonel Buckenmaier also holds positions
11 as Assistant Professor at the Uniformed Services
12 University.

13 In September of 2003, he deployed to the
14 21st Combat Support Hospital in Balad, Iraq, and
15 demonstrated that the use of advanced regional
16 anesthesia can be accomplished on the battlefield.

17 Colonel Buckenmaier performed the first
18 successful application of continuous peripheral
19 nerve block for pain management in theater. In
20 collaboration with the Henry M. Jackson
21 Foundation for the Advancement of Military
22 Medicine and Telemedicine, an advanced technology

1 research center, he established the Army Regional
2 Anesthesia and Pain Management Initiative.
3 Colonel Buckenmaier will be providing an
4 information brief regarding the Defense and
5 Veterans Pain Management Initiative, and his
6 material and slides can be found under Tab 8 of
7 our binders. Colonel Buckenmaier, thank you.

8 COL BUCKENMAIER: Thank you very
9 much, sir. I appreciate the opportunity to speak
10 to the Board today. It's a lot to listen to, I
11 realize, so I'll try to get you a little bit back
12 on schedule if I can. I do go by Trip. Chester
13 is a cruel historical family joke that's been
14 played on three generations of the males in my
15 family. Fortunately, I have all daughters, so the
16 madness is finally going to end.

17 I am an anesthesiologist by training,
18 and I became an acute pain medicine physician sort
19 of because of this conflict that we've been
20 involved in for the last eight, going on nine
21 years. And I think it's important to begin by
22 looking where we came from. This is a mural

1 painting of General Stonewall Jackson during the
2 Battle of Chancellorsville. He was in the process
3 of actually routing the Union forces back to
4 Washington, D.C. And, of course, depending on
5 your point of view, north or south, you're either
6 excited or dismayed that he was wounded in the
7 process of ordering the front lines, because he
8 was going to do something that was very rarely
9 done at the time, he was going to fight at night.
10 And while he was out in the twilight, he was shot
11 by one of his own men, concerned that the
12 Union forces were approaching.

13 He was the recipient of a number of
14 battlefield innovations. We tend to leap forward
15 in medicine when we have these conflicts. He was
16 removed from the battlefield, for one thing;
17 believe it or not, that was not necessarily the
18 case in conflicts previous. You kind of relied on
19 family members or other members of your unit to
20 come look for you. And he was removed by a horse
21 and a cart that was designed specifically for that
22 purpose, to go get casualties and take them to

1 another innovation, a clearing station, which we
2 call a Combat Support Hospital now.

3 And he received some pain control from
4 his wounds during his travels in the form of
5 whiskey. I'm sure our soldiers wish we still did
6 that. But he also is quoted as saying, "What an
7 infinite blessing," referring to the pain control
8 he received during his amputation from chloroform.
9 He also received morphine, morphine, a drug that
10 Serturmer, a German physicist, developed in 1805,
11 and here 200 years later, the standard for pain
12 management on the battlefield remains morphine.

13 So what's changed? Why am I standing
14 here in front of you today to talk to you about
15 pain? Morphine has worked, it is the gold
16 standard, it's worked very well in the past.
17 What's changed in this conflict?

18 Well, for one thing, a very impressive
19 statistic is, less than ten percent died of wounds.
20 And, in fact, in Afghanistan, this time last year,
21 if you had a heart beat and you were breathing and
22 you were a coalition soldier and you arrived in

1 Bastion, where I was working, you had a 95 percent
2 survival rate, pretty impressive. So more people
3 are surviving than ever before.

4 I'm not suggesting to you that the metal
5 that's flying around out there, though it's flying
6 any slower, or I'm not suggesting that the wounds
7 that we're dealing with are any less horrific than
8 the wounds that we've seen in the past, indeed,
9 they're, in many cases, far more severe than we've
10 possibly had to deal with in the past.

11 Many of these soldiers that, in previous
12 conflicts, would not have survived are now
13 surviving. So we're having pain issues that we
14 never really had to deal with before. But one of
15 the success stories is that vehicle right there,
16 we've essentially built a 6,000 mile long ICU,
17 from point of injury back to th4e United States,
18 and it's made all the difference in survival, but
19 it's a very difficult environment to work in.

20 Now, imagine you're a nurse on this
21 flight, it vibrates, it's loud, you're dealing
22 with a bunch of amputees, not the greatest thing

1 to be vibrating in a loud environment when you've
2 just had your extremities blown off, and you're a
3 nurse, and the only tool that you have in your
4 armamentarium to manage pain is morphine.

5 Well, one of the side effects of
6 morphine is, it's a respiratory depressant. And
7 you don't have a lot of monitors on this aircraft.
8 In fact, for the nurse and the two technicians,
9 you may be dealing with upwards of 40 casualties
10 in some cases that you're responsible for, and
11 your tool for pain control is morphine.

12 So you have a soldier who is in agony.
13 In fact, my first deployment in 2003, by then
14 Surgeon General Peak was the result of an email he
15 sent to my boss saying the soldiers are arriving
16 in Landstuhl in agony, what are you going to do
17 about it, that's pretty strong language, agony,
18 our American Service members are in. So you're a
19 nurse on this flight, do you give them morphine?
20 And if he stops moaning, how do you know that this
21 soldier stopped breathing? Now, when I deployed
22 in 2003, I was not a pain physician, I went there

1 to do this sexy technique we called regional
2 anesthesia that technology had made more
3 accessible and available and we thought it was
4 being under utilized on the battlefield.

5 The relief of pain was sort of a
6 secondary gain. But I went there with
7 assumptions. We all know the first three letters
8 of that word. I went there assuming that the
9 things that I took for granted back in the world
10 would obviously be in this battlefield in 2003.

11 Certainly there was going to be epidural
12 catheters, and certainly there was going to be
13 patient-controlled analgesia, the morphine pumps,
14 and certainly there was going to be other pain
15 medications other than morphine that we could be
16 using for these soldiers, certainly, but the
17 reality in 2003 was something very different.

18 So I arrived in 2003 with a neat
19 technique, and it remains a really cool management
20 technique for pain, but I got an education at that
21 time that we had a lot of work to do. And it's
22 been a road that I'm going to describe for you

1 that, in many respects, many like-minded
2 physicians, realizing the same things that I did,
3 that got involved in our early organization that
4 was supported by now deceased Congressman Murtha,
5 helped create a situation where this Task Force
6 and the reasons for it could be clearly defined,
7 and that's what we're going to talk about, the
8 generation of this document right here.

9 So one of the things we figured out is,
10 there's a lot of technology out there that we
11 could have been utilizing, and the good news is
12 that some things, my organization has gotten out
13 there, we now have a military pain infusion
14 system, but there's a lot of things that we could
15 be doing that we're not necessarily doing because
16 we don't have the infrastructure to bring these
17 technologies to bear.

18 There's nobody responsible for pain
19 right now out on the battlefield. Now, you're
20 sitting there right now saying, well, I know
21 they're caring for pain, and yes, they are. And
22 if you picked up a phone right now and called any

1 commander out there and said, are you managing
2 pain in your soldiers, the answer is going to be,
3 absolutely, and I'm shocked that Colonel
4 Buckenmaier would suggest something otherwise.
5 But if you asked that same commander, who is
6 responsible in your unit for the management of
7 pain, who's responsible for making sure the
8 transfer of that soldier to the Air Force so that
9 that pain management continues, who's responsible
10 on the aircraft, who's responsible for the
11 transfer to Landstuhl, who's responsible at
12 Landstuhl, you get the picture, and the answer is,
13 you'll get the answer, well, everybody is
14 responsible for pain.

15 Well, that's warm and fluffy and that
16 makes us all feel good, but when everybody is
17 responsible for something, nobody is actually
18 getting anything done.

19 So why a pain management task force? It
20 was very informative listening to General Volpe
21 discuss some of the challenges and the things that
22 he found looking at suicide. Interestingly

1 enough, from a behavior health summit, pain was
2 recognized as one of the factors that's
3 contributing to those suicide issues.

4 We have legislation now, a Congressional
5 mandate that's recognizing, because family members
6 are telling our leadership, dad is on the couch in
7 the morning from a pain perspective, on his
8 medications, the kids go to school, and when he
9 comes back later that day, dad is still on the
10 couch; yes, he's pain free, but that's not dad.
11 There's got to be a system of managing this pain
12 that allows us to have the human back without just
13 relying on standard tried and true medications,
14 monotherapy, which has sort of been the history.
15 We're a reflection of civilian medicine. This
16 isn't a military problem, this is a United States
17 problem, a medical problem within this country
18 that both the civilian sector and the military is
19 trying to grapple with.

20 The issue for the military, though, is,
21 we don't have the option of really waiting, we
22 have to deal with these soldiers that are

1 traveling in this 6,000 mile long ICU today,
2 because the consequences of not managing this
3 pain, as I'm going to show you, have far reaching
4 consequences; suicide is just one that we
5 mentioned.

6 But there's lots of pain related
7 readiness issues, soldier medication issues, use,
8 abuse and misuse of these opioids that commanders
9 are having to grapple with every day.

10 So we were given a mission to provide
11 recommendations to the MEDCOM for a holistic multi-
12 disciplinary and multi-modal approach to pain
13 management, state of the art science, optimal
14 quality of life for soldiers, their families and
15 other patients we take care of in our system.
16 They gave us six months, it seemed like six
17 minutes, to accomplish that task. And our vision
18 statement is providing a standardized DoD and VA,
19 vision and approach to pain management to optimize
20 care for warriors and their families.

21 So some key elements happened right from
22 the beginning of the Task Force. First of all,

1 Brigadier General Richard Thomas was appointed as
2 our Chairperson for this Task Force, which is, in
3 my opinion, a very fortunate happenstance, and we
4 recognized right from the beginning with out first
5 meetings, in fact, the first meeting, I was
6 communicating on the phone during the meeting with
7 General Thomas, discussing the absolute necessity
8 that this be a Tri-Service and VA initiative right
9 from the beginning.

10 So the Task Force was made up of Army,
11 Navy, Air Force and VA proponents right from the
12 beginning. And you can see all the various
13 specialties. There is no Army pain, there is no
14 Navy pain, there's just pain. And pain is a
15 disease, which it is, a disease process permeates
16 all medical barriers. There's really no medical
17 specialty that you can name that doesn't have an
18 aspect of it that has a component of pain.

19 And one of the first things we set out
20 to do, just like General Volpe's theme, is to go
21 find out, what is the state of pain right now in
22 the military. And we visited a number of Army,

1 Navy, Marine, Air Force, civilian institutions
2 throughout the country, as you can see, in key
3 locations like Duke, and the University of
4 Washington, to find out what our civilian
5 colleagues were doing.

6 And the good news is, both in civilian
7 medicine and in the military, there were lots of
8 pockets of excellence. There were people that
9 were out there despite their lack of support,
10 making it happen every day. The problem was,
11 though, if you visited one DoD facility from a
12 pain perspective, you visited one DoD facility.
13 Everybody had their own view. There was no
14 optimization, no standardization to that
15 optimization of care.

16 So if a family member was getting
17 something at a Fort Lewis and ended up at a Walter
18 Reed, the care that they were expecting might not
19 even be available at that particular facility.
20 And there was really nobody owning pain in the
21 DoD.

22 So what types of pain are we talking

1 about? This is actually Brian Wilhelm, he's HIPAA
2 compliant, signed all the paperwork, he was the
3 first recipient of a continuous peripheral nerve
4 block, what we would consider advanced pain
5 management on the battlefield, the first recipient
6 of an acute pain service out on the battlefield.
7 He would go on to have five operations, enumerable
8 dressing changes, all on the anesthetic, the pain
9 anesthetic, the analgesia that we had started in
10 Balad, Iraq at the time. He would go on to lose
11 that extremity, but it is an N of 1, and I dislike
12 Ns of 1 as far as stories, but a year later, still
13 on active duty, with his prosthetic, not having
14 chronic pain issues, and he's the first of now
15 many hundreds, if not thousands of soldiers that
16 we've tried to impact on out of our Walter Reed
17 program.

18 But then there's the more common pain
19 that many of you might be familiar with, chronic
20 low back pain, muscular skeletal pain. These are
21 issues that plague our military and our primary
22 care providers every day, and they're looking for

1 answers within their communities on how to deal
2 with these situations. And unfortunately, the
3 answer that they're coming up to at each
4 institution tends to be different.

5 Our VA partners figured out this issue a
6 little bit sooner than we did and got started with
7 some ways of managing pain in the VA prior.
8 Probably one of the reasons is the single greatest
9 complaint of a soldier arriving at a VA facility
10 isn't PTSD, and it isn't TBI, and I'm not taking
11 anything away from those very important issues,
12 it's pain, that's why they show up in the VA, more
13 than 50 percent. So they really needed to
14 accomplish something. So a strategy was initiated
15 by the Under Secretary for Health in 1998. They
16 had a pain management directive, and they had
17 three top priorities; they wanted to implement a
18 step care plan, integration of the medical home,
19 and build a partnership with the DoD.

20 And these are some of the relationships
21 that my organization started with folk such as
22 Matt Gallagher working at the Philadelphia VA, to

1 try to begin discussing about the transition
2 problems we were having with soldiers in our
3 system transitioning to the civilian sector or the
4 VA, the complaint being, you're sending us these
5 soldiers, and they're pain free, but then we have
6 to spend the next month getting them off the
7 narcotics before we can start the rehabilitation
8 process, there's something wrong here.

9 So they actually developed a national
10 pain management office. You'll notice these
11 pillars right here, education, research, and these
12 businesses they call them, centralized throughout
13 the VA domain, areas where this sort of pain care
14 can be coordinated amongst all the very diverse
15 institutions. And, of course, it's a huge
16 problem. When you look at diseases and the
17 nervous system, this is just data from the VA,
18 diseases of the muscular skeletal system. In many
19 cases, the presenting symptom for many of these
20 large percentage issues are pain issues.

21 But then when -- let's just talk about
22 the polytrauma triad. We briefly mentioned TBI

1 and PTSD, some would suggest signature injuries, a
2 term I don't necessarily like. I don't really
3 know what a signature injury means, but that has
4 been used before as some very important issues
5 that have been seen in the current conflict.

6 Look at the overlap of these issues with
7 pain. There's a very interesting slide I don't
8 have right now from my colleague in the VA, Mike
9 Clark, who shows the symptom overlap between PTSD,
10 TBI and pain symptoms, and it's almost complete
11 across the board. How can you actually manage
12 these other very important issues well if you
13 don't have a really good handle on managing pain?
14 How are you going to deal with the behavior health
15 problems of a soldier or a soldier with suicide
16 issues or risk if you're not adequately managing
17 his pain? The reality is, we haven't really done
18 the study to show an if then loop between pain and
19 suicide, but pain has been a component of many of
20 the suicide investigations that have been done in
21 the DoD. So why is this a problem now? Well, as
22 clinicians, we're finally recognizing pain as the

1 disease process that it is and not just a symptom
2 of some other disease.

3 We're beginning to see the relationship
4 between acute injury and pain leading to
5 inflammation and peripheral sensitization that
6 goes on to a central nervous system sensitization.
7 You're beginning the disease process of pain that
8 has consequences in the pathophysiology of the
9 human -- as he's trying to recover, and that
10 contributes to the psychological issues that these
11 individuals begin to develop, and you begin to see
12 this vicious circle that starts to develop and
13 feed on itself, and then you start having unwanted
14 consequences from the fact that you didn't begin
15 managing this pain well throughout the continuum.

16 So key elements in the continuum of pain
17 care plan, primary prevention. Most of the pain
18 care happening right now out on the battlefield
19 and in our hospitals is with primary care. We'll
20 see in just a second one of their major complaints
21 is, they don't feel armed, they don't feel
22 educated, they don't feel they have the resources

1 they need to affect that mission. I've just
2 described to you that we don't have an acute pain
3 service today out on the battlefield, at all our
4 combat support hospitals. One of the
5 recommendations of our Task Force is to have those
6 folks out there starting this process of pain, and
7 not just beginning with narcotics, using all of
8 the other tools that are available to us, not sort
9 of anti-inflammatory drugs.

10 Our British colleagues use Paracetamol,
11 the IV form of acetaminophen to great effect. All
12 these things including regional anesthesia that we
13 could be doing to break that vicious circle, do
14 the appropriate acute pain medicine so that we can
15 avoid many of these chronic pain problems.

16 And certainly back with our muscular
17 skeletal injuries with troops just getting ready
18 to go to war, we can arm our primary care folks
19 with the tools and the consulting resources to
20 manage those very important issues also.

21 Second prevention is having that system,
22 having a tiered network within our DoD hospital

1 system so that primary care providers know where
2 to go, where we turn, what assets beyond just
3 narcotics that they have to provide their
4 soldiers, and then certain tertiary prevention.
5 We still need people that are able to do in base
6 of pain procedures for those individuals that,
7 despite our best efforts, still develop chronic
8 pain syndromes. This is actually out of the first
9 textbook that my organization created for pain
10 management on the battlefield. It's a simple
11 schematic showing the nervous system and all the
12 areas that we can impact as physicians and nurses
13 and health care providers on these pain pathways.
14 But to do that, you have to have people out there
15 that are responsible, tasked and resourced to do
16 that mission.

17 So the VA has proposed this stepped care
18 plan which we're looking at very closely and are
19 recommending that we adopt this within the DoD,
20 where we attach primary care, secondary
21 consultation and tertiary care pain centers so
22 that we have a logical progression for our primary

1 care providers on where to send these patients
2 rather than just focusing on opioids and the
3 problems we've been having with that approach in
4 the past.

5 Some Task Force site findings, primary
6 care providers, as I mentioned earlier, feel that
7 they're ill prepared to handle these pain
8 patients. There's a lack of common orientation to
9 pain, meaning what resources are available, what
10 is the best therapy right now. General Volpe was
11 mentioning, we don't have a lot of evidence to
12 help guide us in our management of these suicide
13 issues. We don't have any more evidence now after
14 eight years of conflict on how to manage pain in
15 these soldiers than we did back in 2002, and
16 that's unconscionable to me, and that is because
17 we're not collecting the data consistently across
18 the continuum.

19 One of the primary findings of the Pain
20 Task Force is a program we're calling Pasture,
21 which is an outcomes driven database, so that we
22 can start to answer the questions, what is the

1 impact of acupuncture, what is the impact of other
2 complementary alternative medicine techniques,
3 what is the impact of using other medications
4 other than morphine on managing some of these pain
5 states, is spinal cord stimulation the best answer
6 for some of these back pain issues?

7 That's exquisitely expensive, but we
8 know no more about spinal cord stimulation and its
9 impact, whether it's good or bad, than we do with
10 acupuncture. So we need to start gathering the
11 data so that we can answer some of those very
12 difficult questions.

13 Current research is not up to snuff, up
14 to speed on pain management. We've really in some
15 respects missed an opportunity. I'm very
16 fortunate that my group had the support of
17 Congressman Murtha at the time, and we've done
18 some very good research, but it's been an
19 Army-specific program, it needs to branch out, it
20 needs to be part of the Navy, part of the Air
21 Force, we need our VA partners, and we need an
22 organization that's able to coordinate all of

1 those efforts.

2 Lack of predictable pain management
3 capabilities, we've already discussed, a lack of
4 standardization. It's not just standardization
5 for the sake of standardization, it's
6 standardizing to optimize the care no matter where
7 a patient goes in our system, and then a lack of
8 non-medication treatment modalities.

9 So our Task Force recommendations can be
10 boiled down into essentially four broad spectrum
11 recommendations, a focus on the war in the family,
12 sustaining the force, to synchronize a culture of
13 pain awareness, education and proactive
14 intervention, not just in our pain specialists,
15 but in all of our primary care and physician
16 population and nursing population.

17 We need to provide the tools and
18 infrastructure that support and encourage research
19 into these areas. We need the IT support, this
20 Pasture Program to make that a reality, and build
21 a full spectrum of best practices for the
22 continuum of acute and chronic pain care based on

1 the foundation of best available evidence. But we
2 can't do that until we start collecting the
3 evidence in our population.

4 This is a big task, there's a lot of
5 moving parts. Just the relationships between the
6 Army, Navy, and the Air Force, which some of those
7 early successes like that pain infusion system
8 only occurred because like-minded physicians,
9 despite their commands, within each of these
10 Services got together, Army, Navy, and Air Force
11 positions, and did it because it had to be done,
12 and we made it happen.

13 We need an organization where that same
14 sort of relationship can exist so that we can
15 create the standardization across the continuum of
16 care. We're calling it the Defensive Veterans
17 Pain Management Initiative. It focuses on both
18 the acute and chronic phases of pain. It's going
19 to have a military board of directors, somewhat
20 similar to this Board right here, made up of
21 Tri-Service members from all the various
22 specialties to provide policy guidance, not

1 providing policy, just guidance to the various
2 surgeons general on directions that the military
3 should be moving. You'll notice it has three
4 pillars. These pillars you've seen now multiple
5 times, a clinical piece, an education piece, and a
6 research and technology piece. And it's driven to
7 support in the Army the balanced scorecard. You
8 can't have a briefing with General Schoomaker and
9 not mention the balanced scorecard.

10 So that's all I have today. I
11 appreciate your indulgence. I hope that didn't
12 take too much time. I'd be happy to take any
13 questions. Thank you.

14 DR. LEDNAR: Colonel Buckenmaier, thank
15 you for that great -- do you have questions for
16 Colonel Buckenmaier? Dr. Walker.

17 DR. WALKER: Do you need anything from
18 us? It's a wonderful story, it sounds like a very
19 worthwhile enterprise. Is there anything that we
20 can do to help?

21 COL BUCKENMAIER: Well, part of our
22 role right now is trying to socialize this

1 throughout the various organizations so that this
2 document isn't a mystery to leaders such as this
3 Board, so that as we're doing the difficult tasks,
4 the Army is moving in this direction. We're
5 hoping that we'll be able to convince our Navy and
6 Air Force partners to move in the same direction
7 with us as a team. And that's where I think an
8 organization such as this and the influence that
9 you bring to bear within the system can be very
10 helpful. This is, as I mentioned very early on,
11 if there was one key statement, it's there is no
12 such thing as Army pain. The Army feels a real
13 need to move out on this because of what's going
14 on right now in the conflicts. But when I went to
15 Afghanistan, I wasn't taking care of Army
16 soldiers, I was taking care of Marines, and I was
17 using the exact same pain techniques that I was
18 using in 2003 on Army soldiers. So we need to get
19 together on this if we're going to be successful.

20 An Army only program, in my mind, is
21 almost certain to fail. And I know from my own
22 experience in succeeding in certain areas, the

1 only way we were able to succeed is by creating
2 that coordination amongst the Services.

3 You don't just give the Army an infusion
4 system and then hope that the Air Force is going
5 to accept it on their aircraft, they don't. The
6 reason our pump was able to move forward is, we
7 talked to the Air Force and said what do we need
8 to do to make this acceptable in your system, and
9 we also talked to the Navy at the same time,
10 that's what I think we're looking to this Board to
11 suggest to our leadership. A very good question,
12 thank you.

13 DR. LEDNAR: Colonel Buckenmaier, a
14 question that I would have is, are your pain
15 management principals getting implemented in the
16 Joint Theater Trauma System?

17 COL BUCKENMAIER: One of our
18 recommendations is to -- right now we ask the pain
19 question, are you in pain with what's called the
20 11 point scale. The 11 point scale has been used
21 for a very long time, it's a validated scale. One
22 of the things we found in our Task Force was that

1 it's universally disliked, it's universally given
2 inconsistently, and many patients don't really
3 understand what it means.

4 One of the things that we came up with
5 this Task Force is that DoD-VA pain rating scale,
6 that's rooted and functional language so that
7 we'll be able to ask that question consistently,
8 but more importantly, this is in a format that
9 would very easily fit into the JTTR, so that we
10 can start collecting this data on pain that we
11 traditionally have not been collecting.

12 We haven't really even been asking the
13 question for many years about pain. The JTTR is a
14 very important and vigorous database, but it did
15 not have anything on pain from its inception. So
16 that is one of our major findings.

17 DR. LEDNAR: Dr. Oxman.

18 DR. OXMAN: First of all, I'd like to
19 compliment you on the beginning of a heroic event.
20 My experience with pain is very narrow and it's
21 related to -- largely related to Herpes Zoster and
22 postherpetic neuralgia. But what's very impressive

1 about that is that there are major differences
2 between neuropathic pain and direct tissue damage
3 related pain. And also there are -- there's an
4 evolution of mechanisms which we don't understand
5 over time. There are lots of theories, but
6 there's a tremendous shortage of data upon which
7 to base anything.

8 The 11 point Likert scale, which is also
9 a visual analogue scale, if used right, doesn't
10 have -- has some detractors, but it can give you a
11 lot of very good data which can be integrated and
12 correlates pretty well with decrements and
13 activities of daily living and quality of life
14 answered by questions at the same time as the
15 Likert scale is involved.

16 So I think you've got -- you made a
17 tremendous start, I think it's obvious that you
18 need to have all of the Services approaching this
19 in a parallel or a joint fashion, including the
20 VA, and hopefully getting a lot of input from the
21 civilian community which has many of the same
22 problems. And I think that perhaps opioids have a

1 bad name because of the difficulty of getting
2 people off them and replacing them later on. But
3 what little laboratory data there is and some work
4 that's largely with rats suggests that very early
5 an aggressive treatment of pain, which in terms of
6 battlefield pain is, you know, unless you do
7 something physical for which there's very little
8 data, is opioid, is very important to prevent some
9 of the later consequences in the development of
10 neuropathic pain.

11 COL BUCKENMAIER: Absolutely; we
12 have not abandoned the 11 point scale, it's been
13 integrated into this new DoD scale, but we've
14 tried to make something that had things that a
15 battlefield medic, for example, who's not
16 interested in a number is interested in whether he
17 should treat or not, so we've given them a simple,
18 what the British are using, red, yellow, green,
19 which has the scale, the 11 point scale
20 incorporated it, so we've kind of combined those.

21 I am a -- I'm an anesthesiologist, it
22 would be ludicrous to suggest that I'm not a fan

1 of opioids, but I am not a fan of opioids when
2 they're used to the exclusion of all the other
3 medications, and that's the key with this multi-
4 modal approach. I think part of our historical
5 problem and our problem today is, we've been
6 looking for a silver bullet. If we could find
7 just that one drug that would make this issue go
8 away, but pain in some respects is like cancer,
9 it's such a fundamental part of your survival that
10 it's going to resist any one answer.

11 But opioids can certainly be a slice of
12 the pain management pie, and using opioids can be
13 used very effectively, particularly if you're
14 using them in concert with other medications,
15 other technologies, other things such as
16 acupuncture, for example. But to do that, you
17 have to have a coordinated system to be able to
18 provide that level of care. So I absolutely
19 agree. And all the things that you discussed are
20 actually in this document. Yes, sir.

21 DR. LEDNAR: Dr. Parkinson.

22 DR. PARKINSON: Yes, Mike Parkinson.

1 Thanks again, Dr. Buckenmaier. I just want to
2 make the observation that there are two or three
3 key areas, or four areas that the Defense Health
4 Board historically comes around to that I kind of
5 identify as military leadership competencies in
6 the area of medical practice. One of them was
7 clearly burns, and we have a long tradition of
8 burn care when that was a predominant modality of
9 injury and advanced the science. Another area is
10 increasingly the whole area of psychological
11 stress, trauma, closed head injury, and we are now
12 informing the civilian community as it relates to
13 closed head injury concussion, as we learned from
14 an iterative way.

15 Pain management is huge, and it's not
16 just in the setting of the traumatic, you know,
17 casualty, coming out of a war zone, but I would
18 suggest that it is a systematic and often times
19 unfortunate philosophical gap in all of our
20 medical and clinical training that we consistently
21 under estimate the amount of pain our patients are
22 in.

1 We are not trained systematically in how
2 to recognize and treat it in a way that is
3 responsible. Ironically, there's a national
4 veterinary hospital that my brother, full
5 disclosure as a veterinarian, is involved with,
6 and said their brand is going to be, your pet will
7 never experience discomfort. Can we say that
8 about our pediatric patients in a NICU? Can we
9 say that about our patients that we take care of
10 every day? No. As a matter of fact, we sometimes
11 say, I'm not going to treat him because I want to
12 see what -- it's a very perverse thing. So I
13 would suggest that you think very broadly and very
14 big about the whole philosophy of pain management
15 and how we learn it from the time we're a nursing
16 student or a pharmacy student or a first year
17 medical student, because I think you're onto
18 something really big here, and like so many things
19 in DoD, I think we can lead the way in a paradigm
20 shift in what needs to be done out there in
21 medical practice generally. So it's anatta boy,
22 but think broadly, and I encourage this discussion

1 and look forward to progress.

2 COL BUCKENMAIER: Thank you.

3 DR. LEDNAR: Any other questions or
4 comments?

5 (Applause)

6 DR. LEDNAR: Okay. Our next agenda item
7 is, with great patience, Captain Naito, has been
8 awaiting his opportunity at the podium, and
9 Captain Naito is a long time colleague and so
10 forth, and -- my notes.

11 CAPTAIN NAITO: Good afternoon, it's a
12 pleasure to be here. And the genesis of this
13 question to the Defense Health Board from our
14 Surgeon General actually came from one of our
15 pediatric infectious disease specialists in
16 regards to the recent mumps outbreaks in the
17 Midwest and recently up in the Northeast for the
18 past several years, and again, the question is,
19 these populations seem to be similar to our young
20 active duty population, is there something we
21 should be doing different in terms of where we now
22 have a Navy Accession Screening Program which we

1 just started this past year at Great Lakes.

2 So we followed the other Services in
3 starting a serological screening program for our
4 recruits in 2009. The Army started one at some of
5 their recruit sites back in approximately 2005,
6 and the Air Force has been doing it since the
7 1990's.

8 And in particular, although we screen
9 for Hepatitis A, Hepatitis B, and other serum
10 titers, the main question in terms of MMR is one
11 that has come up. So previously in 2009, we
12 routinely gave MMR vaccine. Since 2009, we've
13 been doing titers. And so the question is that,
14 there is no really good screening titer for mumps,
15 and so we use a surrogate of looking at measles
16 and rubella titers, and if both measles and
17 rubella titers show immunity, then immunity to
18 mumps is assumed, as well.

19 So as we all know, mumps can cause some
20 serious disease in our adult population in terms
21 of some more significant ones, in terms of hearing
22 loss, sterility, et cetera. For most folks it's

1 more of causing severe symptoms. But still, in
2 mass outbreaks, you can imagine the impact on
3 operational readiness if we had a mumps outbreak
4 among our active duty population. So the reason
5 why, again, the question come up to the Defense
6 Health Board is that the mumps vaccine part in
7 recent research days is not as effective as the
8 measles and rubella vaccine in inducing immunity
9 and preventing outbreaks.

10 Also, there is some good evidence that
11 mumps immunity does wane more rapidly than measles
12 and rubella immunity over time. And that, again,
13 in the two outbreaks that occurred over the recent
14 years, they've occurred despite seemingly high
15 reported vaccination rates in the population. So
16 again, getting at, you know, are these populations
17 similar to our populations, and should we be
18 concerned about it.

19 So in light of that information, the
20 Accession Screening and Immunization Programs have
21 been very successful for the other Services, and
22 for us, as well, just in the year that it's been

1 ongoing in saving us resources, and also, more
2 importantly, sparing the recruits unwarranted
3 vaccinations. So, as you know, we give our
4 recruit populations a lot of vaccines over a short
5 period of time, and so any way that we can be more
6 targeted with that is better for them, as well.
7 So in regards to the discussion, the Armed Forces
8 Health Surveillance Center back in 2007 published
9 data in their MSMR, and showed that measles and
10 rubella immune titers range between 80 and 85
11 percent, and so then in a recruit population, this
12 data was taken from 2000 to 2004, thus, about 15
13 to 20 percent of accessions would receive an MMR
14 vaccination.

15 They did some mumps titers, as well, and
16 the mumps immune rates were a bit lower, again, 74
17 to 80 percent. Now, again, a caveat with this
18 test is, there's -- some researchers show
19 potentially that, again, the titer data may not be
20 as accurate with the mumps as opposed to measles
21 and rubella.

22 So again, in the context of these other

1 outbreaks occurring in civilian populations that
2 on initial impression would be similar to our
3 population. As far as I know and in talking to
4 some of our Service reps here, there has been no,
5 you know, huge mumps outbreak occurring in any of
6 our Services recruit training centers. We do have
7 occasional incidents of mumps, but again, it's not
8 to a level of an outbreak. However, in discussing
9 this issue with Dr. Poland, there are a lot of
10 nuances to it, and again, the issue of waning
11 mumps immunity, vaccination immunity over time at
12 a much quicker -- relatively quicker rate than
13 measles and rubella, and also the question of
14 whether the measles and rubella titers are good
15 surrogates brings up the question that, given
16 these mumps outbreaks, should the Navy and
17 potentially the other Services give MMR
18 vaccination across the Board rather than
19 continuing on with this titer program?

20 So potentially as the Board considers
21 this issue, there are several courses of action
22 that probably one could consider in how to

1 approach this issue. So again, continuing on with
2 the ASIP Program as is, because again, and there's
3 a typo there, 15 to 20 percent of our recruits are
4 getting revaccinated, again, showing low titers,
5 and potentially that may be enough of a
6 revaccination that prevents any sort of outbreak
7 in our population, so we're different from the
8 college population in that sense with that
9 potential herd immunity there.

10 Or again, considering the research
11 evidence out there, should we just go back to
12 universal MMR vaccination for all our recruits?
13 Again, in terms of a cost benefit ratio, the MMR
14 vaccine is relatively cheap. And then there is no
15 good mumps screening test out there. We'll
16 continue with our program as is, but again, if
17 there is -- our increased surveillance picks up
18 any increased incidence of mumps, then go back and
19 restart universal MMR vaccination. So I forgot to
20 put in a recommendation slide, but in talking with
21 some of my colleagues here, probably consider this
22 last course of action the reasonable approach

1 pending input from the Defense Health Board. And
2 that concludes my presentation.

3 DR. LEDNAR: Okay. Thank you, Captain
4 Naito. We might first ask for any questions or
5 comments from the Board, and then I'll ask Colonel
6 Noah if he would just say a few words. But first
7 questions from the Board. Dr. Oxman.

8 DR. OXMAN: A couple of questions.
9 First of all, do you have pretty extensive data on
10 whether or not individuals who were positive for
11 measles and rubella antibody and therefore didn't
12 get MMR develop mumps, and how extensive is that
13 data?

14 CAPTAIN NAITO: I don't have any exact
15 data on that, I'd probably have to go back to the
16 Armed Forces Health Surveillance Center, but the
17 -- kind of the overall sense is that it's not
18 happening that often. So again, maybe an
19 occasional mumps case here and there, but nothing
20 to the extent of outbreaks like they're having --
21 like they had in the Midwest and the Northeast.
22 So there may be some of that occurring, there

1 probably is, but it's at such a low level that it
2 doesn't pose a threat to our force readiness. But
3 I don't have any exact data, so I'd have to --

4 DR. OXMAN: I think obviously the exact
5 data is important. Can I ask a couple more
6 questions? I'm always a little bit skeptical as a
7 virologist about extensive serologic testing as
8 evidence of, and particularly indirect evidence of
9 immunity, and I think it's -- what you said is
10 absolutely clear, that neither the quality or the
11 duration of immunity to mumps is comparable to
12 either measles or rubella components of the MMR.

13 So we know that people who are antibody
14 positive for the other two are susceptible, or
15 some of them may be susceptible to mumps. You
16 talked about cost benefit; serology isn't free,
17 and MMR is relatively cheap, and I recognize the
18 real problem of adding another shot to the
19 automated injection of recruits, but how much --
20 would the cost benefit -- what would the cost
21 difference be between giving everybody MMR versus
22 serologic testing of everybody and ended up giving

1 15 to 20 percent of them MMR, which you're doing
2 now?

3 CAPTAIN NAITO: The -- and the other
4 Service liaisons can chime in, but my
5 understanding is, and this is from also our
6 recruit training center, is that it is -- the
7 current program is cost effective with the
8 screening titer program as compared to giving MMR
9 straight across the Board.

10 DR. OXMAN: Again, it would be good to
11 see those numbers. And finally, from the Service
12 perspective, you've already mentioned that you'd
13 like to avoid adding another routine shot to the
14 other 80 percent who don't get it now, but, you
15 know, how big an issue is that? Again, I'm just
16 raising the question, not asking you to answer it,
17 and I'll stop there. But I think mumps is
18 potentially a very significant disease in a young
19 adult population.

20 CAPTAIN NAITO: Right, and so that,
21 again, that's the reason we're bringing this
22 question to the Defense Health Board, because it

1 was raised by one of our pediatric infectious
2 disease specialists who's Captain Miller down at
3 Portsmouth, so --

4 DR. LEDNAR: Dr. Luepker.

5 DR. LUEPKER: (inaudible)

6 Lt Col GOULD: I was going to provide some
7 -- back in 2003, when I looked at this question in
8 the context of all vaccine preventable diseases
9 for which we have a serologic test, and measles,
10 mumps and rubella, the serologic test is
11 approximately -- was approximately about \$6 at
12 that time, and the shot itself was somewhere
13 between \$10 and \$12. So for every, you know, so
14 if you're cutting that cost down to 20 percent
15 being at the \$10 to \$12 cost versus the \$6 cost,
16 you're saving money for the government.

17 DR. LEDNAR: Can you share what the Air
18 Force approach is in the basic training accessions
19 process around mumps currently?

20 Lt Col GOULD: Well, we briefly, in 2007,
21 following the outbreaks in the Midwest in 2006,
22 instituted mumps serologic testing. However, that

1 did not prove to be overly useful, there weren't
2 any outbreaks in the recruit setting, and thus,
3 that was discontinued in favor of the cheaper \$6
4 testing.

5 And in 2003, just for info, it was
6 approximately 15 percent were negative to either
7 mumps, or not mumps, measles or rubella, and
8 combined total was approximately 22 percent that
9 were negative to one or both.

10 DR. LEDNAR: And can the Army describe
11 what its approach is in the accessions process for
12 mumps?

13 COL STANEK: This is Colonel Stanek.
14 I know the Accession Screening Immunization
15 Program has certainly saved lots of money for the
16 Army, but I'll defer to Colonel Krukar from MILVAX
17 who can give a more exact answer than I have.

18 COL KRUKAR: Thank you, Scott.
19 Michael Krukar from MILVAX. The Army has at five
20 different sites the ASIP Program, and we've been
21 able to determine that with about 123,000 recruits
22 per year, we've been able to avert to almost

1 200,000 doses of vaccines, for a cost savings of
2 approximately 5- to \$6 million per year.

3 And with the Navy, I believe with their
4 recruit population, we expect that to be about 40-
5 to 45,000 per year. So if we do go with the
6 screening process, as Dr. Gould said, somewhere
7 between \$4 to \$6, I think there's some real cost
8 savings there.

9 DR. LEDNAR: Are there questions from
10 the Board? Dr. Kaplan.

11 DR. KAPLAN: I'm sorry, I'm still not
12 clear on how many cases of mumps are being seen.

13 Lt Col GOULD: It's not documented that I
14 know of in the Air Force.

15 DR. KAPLAN: In all three Services.

16 CAPTAIN NAITO: Yes, sir. So I'll have
17 to query the Armed Forces Health Surveillance
18 Center and see if they have any more numbers, but
19 it's very low, if any. And then, again, the
20 question is, in the backdrop of all these
21 outbreaks occurring in similar, you know,
22 populations, and going for this using the

1 screening program, is that the best way, you know,
2 to protect our population given all these other --

3 DR. KAPLAN: Do you know -- Kaplan. Do
4 you know when the last time there was a
5 significant outbreak of mumps in any of the
6 Services; has it been within ten years or 20 years
7 or 30 years or what, does anybody know those data?

8 CAPTAIN NAITO: Well, per the MSMR, it's
9 probably at least greater than 20 years ago or 30
10 years ago, because again, initially we started
11 giving MMR universally back in the '80's, so it
12 would be, you know, before that.

13 DR. KAPLAN: Thank you.

14 DR. LEDNAR: Any other questions for
15 Captain Naito? At which case I'd ask Colonel Noah
16 if he might advise us on the way ahead.

17 Col NOAH: One of my roles as the
18 DFO here, in addition to opening and closing the
19 meeting, is to act as the Assistant Secretary's
20 representative to help kind of advise and guide
21 us, you, that is, on your time, that is, the
22 Defense Health Board's time, and the resources,

1 our collective resources, both the Board's and the
2 Services. And I guess the thought that comes to
3 my mind on this is that, I don't want to say that
4 this question is necessarily too easy for the
5 Defense Health Board, but on the other hand, it is
6 lacking a bit of outrage in that in the absence of
7 morbidity and mortality on this issue, the answer
8 to the question seems a little bit less
9 scientifically related than it does resource
10 related.

11 So I have a recommendation here, it's
12 just kind of a thought, in that this question,
13 this issue seems pretty typical of those questions
14 that come up before either the Protection Council
15 or the Clinical Proponency Innovating Council, as
16 well.

17 So my recommendation on this would be to
18 bring this up through either the Joint
19 Preventative Medicine Working Group or directly to
20 one of the integrating councils, the two being --
21 Protection and Clinical Proponency, to resolve
22 this at that level unless there's folks that feel

1 strongly that this needs to be a Defense Health
2 Board issue.

3 DR. LEDNAR: Any thoughts from the
4 Defense Health Board, particularly on the
5 Infectious Disease Subcommittee? Dr. Kaplan.

6 DR. KAPLAN: Well, my understanding was
7 that these kinds of questions, if they did come to
8 the DHB, initially went through the appropriate
9 Subcommittee before it came to the Board. Is that
10 not correct? In other words, would this -- and
11 I'm not picking on this, but it was my
12 understanding that the Infectious Disease
13 Subcommittee would initially take up -- that such
14 questions were referred to the appropriate
15 Subcommittee, be it about mumps or ingrown
16 toenails. Is that correct?

17 CAPTAIN NAITO: I believe, sir, that is
18 correct. But I guess the -- when I was referring
19 to the Defense Health Board, I was referring
20 collectively to include the Subcommittee. So, you
21 know, I'm trying to walk that line between being a
22 good steward -- to include the Subcommittees, as

1 well as, you know, identifying potential other
2 ways of scratching this itch, as well.

3 DR. KAPLAN: My point was not that
4 inasmuch as that in the past, when those kinds of
5 questions came up, they would be sent to the
6 Subcommittee and then referred out or decided to
7 take under advisement. And my question is, is
8 that not the protocol? And, Wayne --

9 CAPTAIN NAITO: Can I --

10 DR. LEDNAR: I'm going to -- just a
11 second. I'm going to ask Dr. Shamoo to sort of
12 remind us, because our Bylaws, in fact, have some
13 information that helps inform that.

14 DR. SHAMOO: This is not just the
15 Bylaws. Like I said, I've been six years with the
16 Board and the previous organization, the questions
17 the DoD ask the Defense Health Board, doesn't ask
18 direct -- then the Defense Health Board, in their
19 judgment, I see the heads of Ed Feeks and Mike
20 Oxman, who deals with these issues, and then we
21 refer it to one of the Subcommittees, not the
22 other way around, not from the bottom up,

1 otherwise, we wouldn't know what the heck we are
2 spending government money on basically. So --

3 DR. LEDNAR: Neal, do you have a
4 comment? Then I have a --

5 CAPTAIN NAITO: Oh, yes.

6 DR. SHAMOO: That's in the chart there,
7 also.

8 CAPTAIN NAITO: I think, again, the
9 reason why we brought the issue, at least from the
10 Navy side, and our Surgeon General signed off on
11 it was, they did have discussions with Dr.
12 Poland, and I've had discussions with our Service
13 liaison, and since one of our, you know, well
14 respected pediatric infectious disease expert
15 really had this concern, and he's really well
16 versed in the issue, it seemed like something
17 that, again, to try to get ahead of the curve so
18 that if we, you know, in the sense of we don't
19 want to wait to have an outbreak, and so it's a
20 very nuanced issue, and so I thought given the
21 expertise of the Defense Health Board, especially
22 the Infectious Disease Subcommittee, I think it is

1 something worthwhile to look at and to see,
2 because again, for child protection, with all
3 these outbreaks occurring nationwide, although
4 it's not occurring in the military, I just -- I
5 think it's a worthwhile question to answer, are we
6 doing the right thing with continuing with this
7 titer program, to include mumps in there or not?

8 DR. OXMAN: Given Colonel Noah's advice,
9 I think that a couple of important questions were
10 asked, and one was how good is the data relating
11 the -- on the power, if you will, of the serologic
12 screening you're doing now, and how many cases of
13 mumps have occurred, which will give everybody who
14 looks at this some sense of the quality of the
15 negative information that we're getting and
16 reassurance that we're getting, because the --
17 will be very different if there were just a major
18 outbreak of mumps in a recruit unit, and the
19 politics would be totally different. So I have no
20 problem in not having this referred that the Board
21 provided.

22 We could, at least informally, and

1 whatever other groups are going to handle it
2 within the military, have that information in the
3 questions I asked about cases of mumps, the
4 questions that Ed Kaplan asked about, if we really
5 look at the data, how long has it been since there
6 has been an epidemic of mumps in a group of
7 recruits.

8 COL NOAH: Okay. The one piece of
9 information that you gave us that is very relevant
10 here is that you discussed this with Dr. Poland,
11 and that he seemed amenable to having the Board at
12 least take a look at this at some level. So I
13 think the thing to do here would be to go ahead
14 and let's submit this for the Board's
15 consideration and also for Dr. Rice's
16 consideration, and let Dr. Rice, you know, pass
17 official judgment on the fact that the Board
18 should be turned loose on this, and then let it be
19 assigned to, you know, the correct Subcommittee
20 for --

21 DR. LEDNAR: So what the Defense Health
22 Board will expect back is really Dr. Rice as ASD

1 Health Affairs will basically let us know. And
2 I'm confident without being inside of his head
3 that he will be supportive especially since Dr.
4 Poland, you know, sees a value, that we will hear
5 a go ahead, and then the Infectious Disease
6 Subcommittee can expect through the Defense Health
7 Board to receive this question. I think its
8 deliberations can be fairly quickly completed.
9 Dr. Luepker.

10 DR. LUEPKER: Thank you, I've been
11 waiting. I actually wanted to thank Captain
12 Naito. You know, we're presented with a lot of
13 things, and here a presenter came with a series of
14 specific questions and options, and I don't want
15 -- this may get referred to a different pathway,
16 but I don't want the message to be delivered that
17 we don't want people to bring us questions,
18 because that, in fact, I think is what most of us
19 want to see.

20 DR. LEDNAR: Just to build on what Dr.
21 Luepker said, what Captain Naito did is not only
22 to sort of help frame a question, but thought

1 about some of the solutions paths that might be
2 taken to that question, and I appreciate that
3 thoughtfulness of options going ahead rather than
4 just dropping a hot potato in the lap of someone.
5 Anything else, Captain Naito?

6 CAPTAIN NAITO: Oh, no, that would be
7 it. Thank you very much.

8 DR. LEDNAR: Okay. Thank you for your
9 brief and bringing us this question. Okay. Our
10 next presenter is Dr. Thomas Luke. And Dr. Luke
11 currently serves as a Clinical Trials Investigator
12 and Scientist with the Henry Jackson Foundation at
13 the Department of Virology and Rickettsial
14 Diseases, Naval Medical Research Service in Silver
15 Spring, Maryland.

16 Dr. Luke received his medical degree
17 from the Uniformed Services University, completed
18 his transitional internship at the National Naval
19 Medical Center, and his preventive medicine
20 residency at the Uniformed Services University.

21 Dr. Luke received his bachelor of
22 science degree from the United States Naval

1 Academy, and dual master's degrees in business and
2 management from Webster University and a master of
3 tropical medical and hygiene from the Uniformed
4 Services University. Dr. Luke retired as a
5 medical officer from the United States Navy in
6 2009. Previously, he was an infantry and a
7 logistics officer in the United States Marine
8 Corps. His presentation may be found under Tab
9 10, and it's an information brief about
10 convalescent plasma therapy. Dr. Luke.

11 DR. LUKE: Thank you very much, sir.
12 And this will be a follow-on presentation that
13 I've had the pleasure and opportunity to have had
14 previous discussions with the Defense Health Board
15 starting in 2006, and based upon some
16 recommendations, I think we've got an interesting
17 update.

18 So you can see that this is called an
19 update on convalescent plasma therapy. And I
20 think that, you know, those of us that were
21 involved with the pandemic planning efforts that
22 really began in 2005, we were all, you know,

1 trying to address the question, what to do.

2 You know, this was a national plan that
3 had never been conceived before, and you know,
4 that rolled down from the President through the
5 various different departments and agencies,
6 finally making its way to the Bureau of Medicine
7 and Surgery, where it blew up on Ed Kilbane in my
8 office, in the Director of Population Health. And
9 there are very specific questions from Admiral
10 Arthur and others about what is the Navy going to
11 do. So at the time, you know, there had been some
12 books that had been published, as we all know, but
13 the real question is, you know, what was the
14 experience, what could we learn about epidemics
15 that have occurred within the United States Navy.

16 So I went over and spoke to Dr. Jan
17 Herman, who is a PhD military historian there at
18 BUMED, and kind of on a dime he's maintained what
19 I would call a very interesting little reference
20 library about the history of the United States
21 Navy Bureau of Medicine and Surgery, and he
22 allowed me access to that, then we started going

1 through, and if you take a look at this slide
2 right here, this actually comes from the Surgeon
3 General's annual report of 1919.

4 Every year the Surgeon Generals of both
5 the Army and the Navy had to report to Congress
6 about what had happened within the military forces
7 at that point in time. That was stopped in 1957.
8 But I think that this graph is fantastic in
9 describing what it is that we're facing in regards
10 not only to influenza, but also a potential for
11 epidemic diseases, which are naturally or manmade.

12 And if you take a look at this, this is
13 the annual death rate per 1,000, United States
14 Navy, and we've got ten, 20, 30, 40, 100 here, and
15 in talking with Dr. Crosby about what he sees on
16 this, when I ask him about this, you know, this
17 could be an indication of the supposed fall wave
18 of Spanish influenza in 1918, followed by a
19 quiescent period, followed by this rather large
20 spike in deaths.

21 And I don't think that when we take a
22 look at what pandemic influenza has done this

1 year, I think we may find that this is going to be
2 similar, not in regards to the death rate, but
3 actually the attack rate.

4 I will say that one aspect of this is,
5 if you take a look at about a five or ten per 1,000
6 death rate per year, that would be considered to
7 be a major emergency by today's standards. And
8 one of the very interesting facts is, when we were
9 looking at resources and what could be done, we
10 found, to our surprise, that there were only 235
11 respirators in the United States Navy, 235, and
12 that wasn't the rate limiting step, the rate
13 limiting step was the personnel to operate them.

14 So obviously solutions had to be looked
15 at. And one of the things that -- let me just
16 give you this notification, these are my opinions
17 and no one else's, we started to come up with
18 looking at solutions, and we found that there had
19 been reports within Dr. Herman's library of the
20 use of convalescent plasma. And some of the
21 claims that were on these papers were really kind
22 of very interesting, and, you know, it purported

1 50 percent survival rate, that people were, after
2 being treated with convalescent plasma, were, you
3 know, were having a Lazarus-like effect in their
4 recovery.

5 And the question is, is that true? And
6 that was based upon a couple reports that they
7 were having in the Navy Medical Bulletin. So what
8 Dr. Kilbane asked me to do was seek and find. And
9 we decided to conduct, you know, a formal medical
10 analysis on these reports, and we worked with the
11 Uniformed Services University, their LRC --
12 Laboratory Research Center -- to essentially do as
13 wide a cast for a study, which I'll show you here,
14 and it became a very interesting process.

15 You know, the paper was later published,
16 and had an opportunity to brief the DHB on a
17 couple of occasions. And if I repeat some of
18 this, pardon me, but I know that there are some
19 new members here today.

20 So let me just start with the background
21 here. Convalescent plasma serum has been used in
22 the prophylaxis and treatment of pathogens in

1 humans and in animal models. This includes H5N1,
2 which we'll talk about, Spanish flu, SARS,
3 measles, Hepatitis A, South American hemorrhagic
4 fevers, Junin and Muchapo, where convalescent
5 plasma is the standard of care, reducing mortality
6 by about 90 percent if used within eight days of
7 symptoms, diphtheria, orthopox, variola vaccinia,
8 and many others.

9 And as we know, you know, this was the
10 treatment of care, standard of care, but with the
11 rise of Martin Pharmaceuticals, it has not had as
12 a prominent role in "modern treatment," but it is
13 still used occasionally throughout the world, and
14 primarily the United States now as specific
15 derivatives of convalescent plasma, such as
16 vaccinia immunoglobulin, rabies immunoglobulin,
17 and other products.

18 As we know, DoD personnel are at high risk
19 for epidemics of infectious disease, both natural
20 or bioterror. The Department of Defense currently
21 collects and produces large volumes of products
22 from military volunteers. And based upon some of

1 the work we did, on June 7, 2007, Admiral Arthur
2 requested the DHB evaluate and consider the use of
3 convalescent plasma for the treatment of H5N1
4 pandemic influenza and other infectious diseases
5 for which inadequate therapies exist, which in
6 regards to viral infections is all of them. We
7 don't have good therapies for most of the viral
8 diseases that we currently suffer from and those
9 which could arise. Based upon that, the DHB
10 hosted an international conference on convalescent
11 plasma therapy on May 5th and 6th of 2008, and
12 this was attended by representatives from the
13 World Health Organization, Department of Defense,
14 Department of Health and Human Services,
15 Department of Homeland Security, Centers for
16 Disease Control, National Institute of Health, the
17 Food and Drug Administration, the Center for
18 Biologics Evaluation of Research, Plasma Protein
19 Therapeutics Association, a number of individuals
20 from nonprofit blood bank centers, and
21 individuals, national and international
22 researchers, academicians, and clinical care

1 experts who have expertise in the use of
2 convalescent plasma.

3 Following that, the DHB made
4 recommendations on 14 May 2008. Now, these are
5 available, I don't want to spend a lot of time
6 going over those, but essentially the DHB made two
7 sets of recommendations, those which are national
8 level recommendations and those which were
9 specific for the DoD.

10 And unofficially, you know, I and the
11 Naval Medical Research Center, the Department of
12 Virology have used those "DoD recommendations" as
13 a guideline for all our efforts. So again, once
14 this pandemic H1N1 broke out, the DHB Pandemic
15 Influenza Preparedness Sub Panel met on 8 May and
16 endorsed the previous recommendations. Based upon
17 this, the work of BUMED, and in particular,
18 Captain Neal Naito, funding was obtained for NMRC
19 to begin a collection, a process for individuals
20 who had recovered from or were vaccinated against
21 pandemic H1N1.

22 Now, this was a fairly significant

1 effort. It required an IRB. And we also
2 collaborated with the National Institute of
3 Allergies and Infectious Disease, which had had a
4 few efforts in the past to collect convalescent
5 plasma for various different infectious organisms,
6 and our collaboration is in support of a second
7 IND that the National Institute has developed for
8 a multi-centered clinical trial.

9 We have also been able to establish a
10 number of other collaborators with other DoD and
11 Navy institutions, one being the Navy Blood
12 Program Office with Commander Williamson, he's at
13 the Bureau of Medicine and Surgery; Armed Services
14 Blood Bank Center at the National Naval Medical
15 Center, which is Commander Graham; National
16 Medical Center, San Diego with Commander
17 Hollis-Perry; the Infectious Disease Clinical
18 Research Program of the Uniformed Services
19 University, and the Armed Services Blood Program,
20 ASBP, with Colonel Rentas.

21 So I had previously mentioned that a
22 paper -- I would just like to briefly discuss some

1 aspects of this as where they started. You know,
2 based for the analysis, there were essentially
3 about 50 to, if I remember, 40 to 50 reports that
4 were published on Spanish influenza, excuse me,
5 relating to the use of some type of convalescent
6 product.

7 Twenty-seven reports were further
8 identified as relating to the use of human plasma
9 for the treatment of influenza pneumonia. Based
10 upon our criteria, eight relevant studies involving
11 1,703 patients met inclusion criteria, and one of
12 the striking aspects of this is that the -- many
13 of the investigators reported that the patients
14 that were selected was because they were the most
15 severe patients within their hospital setting.

16 The most common laboratory finding was
17 leukopenia, which is very consistent with a viral
18 infection. The most common clinical finding was
19 cyanosis and dyspnea, which supports the idea that
20 these particular patients were suffering from not
21 necessarily pneumonia, but a SARS or AIDS type of
22 picture. Convalescent whole blood plasma or serum

1 was obtained from the donors one to six weeks
2 after recovery from influenza. This was primarily
3 from military volunteers. Patients typically
4 receive one or two treatments. The average amount
5 of plasma in the treatment product was 100 to 150
6 milliliters.

7 All studies, eight studies reported a
8 survival benefit. And according to the authors of
9 this, there was a rather marked improvement which
10 was not seen in other treatments or standard
11 patients.

12 When we looked at this, and based upon
13 these reports, which had, by modern standards,
14 many methodological limitations, we concluded that
15 the approach should be tested in well controlled
16 clinical trials.

17 Absolute risk differences, these are the
18 -- you can see that it reports that approximately
19 a 21 percent survival benefit for all cases
20 regardless of when they were treated, that is,
21 from day 0 out to day 30, and if the treatment was
22 used within four days, essentially a 43 percent

1 survival benefit at that time.

2 So following the publication of that
3 paper, there were three reports in the literature
4 of Chinese patients who had been treated with
5 convalescent plasma. I'd just like to briefly
6 talk about Dr. Zhou's patient here. If you'll
7 take a look at this graph, you'll see that there
8 are a series of green lines here, or a series of
9 lines. The green line that you see right here is
10 a temperature graph. You'll have an orange line
11 which indicates when Oseltamivir therapy was
12 initiated.

13 There is a blue line which shows the
14 viral load. And finally you'll see some time
15 points here being June 14th at 10:00 a.m., June
16 15th at 10:00 a.m., and June 16th at 10:00 a.m.
17 This was a 31-year-old patient who had a four day
18 period of cough and fever who reported to a
19 hospital in China, was noted to have bilateral
20 pneumonia, and was assessed for H5N1 by RTPCR, at
21 which case Oseltamivir therapy was initiated.

22 Quantitative RTPCR was also conducted,

1 and it was elected to use convalescent plasma with
2 a titer of one to 180 obtained from a female donor
3 who had survived H5N1 approximately one year
4 earlier.

5 Upon treatment on June 15th at 2:00
6 a.m., you can see a rather remarkable drop in the
7 viral -- the serum viral titers with additional
8 drop to 0 within a matter of about 36 hours. Now,
9 this is certainly not conclusive, but it is very
10 suggestive. And two other patients have also been
11 treated, one from a survivor of H5N1, as well as
12 another patient received convalescent plasma from
13 a patient that was previously vaccinated with an
14 H5N1 vaccine. So one of the recommendations that
15 the DHB had made was that there should be some
16 further work on the idea of convalescent plasma
17 and its use and H5N1 and other diseases for which
18 there is no good therapy.

19 And there has been a wealth of papers
20 that have recently come out. Myself, Dr.
21 Casadevall, Steve Watowich, Steve Hoffman, John
22 Beigel, and Timothy Burgess just published an

1 article in critical care medicine which I think is
2 actually fairly interesting and gives a lot of the
3 background and some recommendations that I think
4 are important for the Department of Defense to
5 consider.

6 I think that some of the representatives
7 that came to the conference for the World Health
8 Organization were very influential on having this
9 published. Other individuals which were not
10 listed here that attended the conference were
11 involved with some position papers that have come
12 out from the Wellcome Trust and other
13 organizations. And then we've had a series of
14 papers coming from Dr. Leider, et al.; Wu, et al.;
15 and Wong, et al., about the actual collection of
16 convalescent plasma, which was currently initiated
17 in a rather large way in Hong Kong and China early
18 last summer.

19 So let me just say that I think that if
20 convalescent plasma is ever going to be a
21 practical solution, the question is, how much can
22 we produce, and what can the Department of Defense

1 do?

2 So the Department of Defense produces --
3 has GNP licenses for only one group of products,
4 and that's blood products. And we do a pretty
5 good job of producing blood products in the
6 Department of Defense. It's either packed red
7 blood cells -- precipitate or plasma, that's
8 primarily what we do.

9 So let me just give you some statistics
10 here. The Department of Defense has 22 licensed
11 blood banks, mostly in the United States, but also
12 overseas. In 2009, they produced approximately
13 12,000 RBC units a month. In 2010, their monthly
14 average was a little bit less, but this works out
15 to be about 150,000 units per year.

16 The plasma which is produced is from
17 whole blood donations, but this could be
18 substantially expanded by plasmapheresis in which
19 plasma is drawn off from patients and the RBC's
20 and platelets are returned at the same time. Let
21 me just make an aside here that this could be
22 substantially, in an emergency situation, at least

1 in my opinion, based on my personal anecdotal
2 experience with the need for blood on certain
3 occasions, could be met during emergencies.

4 So when I was in the Marine Corps in
5 Camp Pendleton, California, a -- in the Naval
6 Hospital would say we need Type AB donors, we need
7 A, and that would go -- filter through the medical
8 network over to the line side in which the gunnery
9 sergeants would go out there at morning formation
10 and say, if you've got AB blood and you want to
11 donate, look at your dog tag and get in the truck
12 and we'll take you out there.

13 So, you know, and after 9-11,
14 immediately following 9- 11, at the National Naval
15 Medical Center, there were a line of approximately
16 200 to 300 individuals standing in line ready to
17 donate should it be necessary after the Pentagon
18 was hit and in New York.

19 So I think that we're all very aware
20 that, you know, military donors are more motivated
21 than others. So we certainly I think could have a
22 system in which we could substantially increase

1 the donation rate for a particular type of patient
2 and a particular type of donor should it be
3 necessary. Again, just in general, DoD has
4 approximately 1.1 million active duty personnel.
5 If two percent have severe influenza disease, then
6 20 to 40,000 units of convalescent plasma would be
7 required. One important aspect about this and why
8 I think the Department of Defense should think
9 about this is, the DoD is not dependent upon the
10 production, allocation and delivery by the
11 pharmaceutical industry on outside agency, we can
12 make this ourselves.

13 And it's very important, and I think
14 it's a substantial advantage that we have that we
15 may want to further explore. So let me just
16 briefly go over the investigation on new drug
17 applications that we have for pandemic H1N1 and
18 for other -- potentially for other infectious
19 agents.

20 Based upon the recommendation for the
21 DHB, indicated that they thought that DoD efforts
22 on this should be -- have collaboration. So NIAID

1 has an IND for the production of pandemic H1N1
2 convalescent plasma, and NMRC is closely
3 collaborating with the National Institute of
4 Infectious Disease to get the plasma.

5 NIAID also has the plasma therapy IND
6 for severe H1N1 disease slated for a multi-center
7 trial. We are in the process of identifying a
8 military medical treatment facility clinical site,
9 again, the IDCRP of the Uniformed Services
10 University. One aspect that has complicated this
11 is, currently the activity of H1N1 is very low,
12 but we expect that this will resume again in the
13 fall.

14 The collaborative team and IND's could
15 serve as a model for other military relevant
16 diseases such as anthrax, in which we have several
17 hundred thousand U.S. military personnel which are
18 being vaccinated for anthrax; orthopox, that is,
19 vaccinia for the prevention of variola or
20 smallpox, adenovirus, Crimean-Congo hemorrhagic
21 fever, in which for the first time in probably
22 four decades, we've had a death in the Department

1 of Defense from this bunyaviridae virus.

2 And other things that could potentially
3 be done like was done in the '30s, '40s, and '50s
4 was lyophilized convalescent plasma is an
5 application that could be explored.

6 So I just want to briefly talk about
7 adenovirus, since this was a specific
8 recommendation for the DoD by the Defense Health
9 Board. Adenovirus is a significant respiratory
10 disease in the recruit setting without adequate
11 treatment. It is an infrequent cause of severe
12 death and disease in our recruit training camps.
13 The Naval Health Research Center in San Diego has
14 well-defined assays to determine the serotype and
15 antibody titer for the following adenovirus
16 strains as part of their Federal Respiratory
17 Illness Surveillance Program: 3, 4, 7, 14, 21,
18 and C (1,2). Serotype 4 is by far the most
19 prominent strain, but also there are, you know,
20 significant rates of these others.

21 The Naval Medical Research Center has an
22 FDA approved methodology to label fresh frozen

1 plasma as a convalescent plasma product, and this
2 could be adapted to adenovirus or other infectious
3 agents as necessary.

4 So I just want to talk real briefly
5 about our current efforts in collecting plasma. I
6 think a little background on epidemic and seasonal
7 influence of vaccination at a particular Naval
8 facility is of interest. This facility has
9 approximately 4,400 students between the ages of
10 18 and 24 years of age, approximately 1,200
11 instructors and other support personnel.

12 On 23 May 2009, there was an index case
13 during graduation when all the parents and so
14 forth came. This created a lot of consternation
15 within the administration and others. And
16 immediately following graduation week, the
17 students departed for summer training. When they
18 returned, they had an accelerated influenza annual
19 seasonal vaccination program throughout the DoD,
20 but they got theirs in late August and early
21 September. On the 10th of September, the first
22 confirmed case among the students occurred, and

1 they had a fairly significant epidemic in
2 September and October, but that also extended
3 through the November time frame.

4 On the 7th and 8th of December, they
5 received the Novel H1N1 vaccination, which was the
6 injectable product, and working with the Navy
7 Blood Program Office and the Armed Services Blood
8 Bank Center at the National Naval Medical Center,
9 they retained fresh frozen plasma from both of
10 these runs for us.

11 And I want to show you some cross
12 sectional data on the 1st. This is 17 November,
13 this is immediately after they had had the height
14 of their epidemic, but before they had received
15 their novel H1N1 vaccination. And if we used the
16 data that came from Dr. Zhou as, you know, just a
17 baseline that 1:80 is an acceptable convalescent
18 product, you can see that 84 percent of these
19 samples had a titer of 80 to 1,280 or greater,
20 which is a fairly high proportion, which indicates
21 to me that, you know, had we started earlier and
22 identified individuals that were recovering, we

1 certainly could have had by the current
2 understanding of what -- HAI titer represents,
3 could have been producing a treatment product,
4 adequate treatment product far earlier.

5 Also, these were tested for the seasonal
6 H1N1 and H3N2, and though the maximum titers were
7 not as great, a substantial percentage, 22 percent
8 and 17 percent were also adequate for potential
9 use as a convalescent product for seasonal
10 influenza.

11 Now, it's very interesting because, you
12 know, Dr. Casscells, as we all know, has done a lot
13 of work and so forth, but if you take a look at,
14 you know, some of the estimates, you know, it's
15 anywhere from 30- to 50,000 cases a year in the
16 United States of influenza leading to severe
17 disease which are thought to be responsible for,
18 you know, high morbidity and mortality.

19 You know, clearly, our population has,
20 you know, "a lot of antibody." We followed this
21 up on the -- with a blood draw on the 20th of
22 April, and this is essentially the same story.

1 Now, this is following the epidemic, as well as
2 the injectable H1N1 vaccination, and still we have
3 rather high titers, and again, it seems to have
4 very significant titers for the other two strains,
5 as well. So this is just a graphic cross
6 sectional for both times in November and April.
7 We have very high titers against the novel H1N1,
8 with lesser titers against the other two, but
9 ostensibly are satisfactory for a potential
10 influenza convalescent plasma product.

11 So I just want to show you this. We
12 have a standard fresh frozen plasma product which
13 has an FDA approved label, and this is the box.
14 And one of the aspects that we wanted to do was,
15 we did not want to go down the pathway, at least
16 at this point in time, for reasons I can get into
17 later, but we wanted a relatively simple mechanism
18 for the blood banks to label a hyperimmune
19 influenza product without having to completely
20 revamp their computer systems for labeling.

21 So in consultation with NIAID and the
22 FDA, we've got a rather simple label which is

1 attached right to the plasma product. One could
2 invoke that instead of anti-influenza A, H1N1 2000
3 immune plasma, that could be an anti-anthrax
4 product, an anti-variola product, an
5 anti-adenovirus product, and other things for
6 which we don't have adequate therapies for in the
7 DoD or in the civilian community.

8 So let me just hit some summaries here.
9 Convalescent plasma could be a primary adjunct
10 therapy for multiple pathogens in the United
11 States. It currently is the standard of care for
12 the treatment of Argentine hemorrhagic fever. Dr.
13 -- was very kind to come up and give us a
14 briefing. I think the Argentineans have a very
15 reasonable model for how to handle an infectious
16 disease in their country. And collaborators have
17 developed and implemented a protocol to produce
18 anti-influenza A -- non-plasma under an IND. It
19 could also produce seasonal H1 and H3 convalescent
20 plasma now.

21 The H1N1 experience will be informative
22 for the evaluation and potential development of

1 convalescent plasma for other military relevant
2 diseases, and this is just a short list. But
3 adenovirus, I think we could do that relatively
4 quickly. Anthrax, I think we have the only
5 population in the United States.

6 And let me just say for anthrax
7 treatment, about three years ago, Cangene was
8 given \$150 million contract for the production of
9 a hyperimmune IVIG product, and that sounds very
10 nice, and it's very important, but it was only
11 10,000 doses, so that's \$15,000 a dose. And as
12 much as we need Anthrax products, that's not going
13 to solve the needs of the Department of Defense
14 with 1.1 million individuals. Orthopox, again,
15 the DOD is a highly vaccinated population,
16 Crimean-Congo and others. Most importantly, the
17 concept has been introduced to industry, DoD, FDA
18 and researchers, and that was a significant
19 hurdle, quite frankly, because this is something
20 which is coming up out of the past.

21 DoD already produces large volumes of
22 plasma. We have hundreds of individuals who are

1 working at this system. They have the
2 infrastructure there, they have the personnel,
3 they have the training, and they have the FDA
4 licenses for a number of GNP products. This
5 could be an extension of that mission, at least in
6 my opinion.

7 I just want to say that plasma
8 production is fast, that is, I get sick with
9 something new, I recover, and you know, they
10 kindly ask me would I donate some plasma because
11 someone else is ill. I think that's the concept.
12 We can do this within a very short period of time.
13 It is inexpensive and it is widely available.

14 IVIG production is slower and it is not
15 within our -- in the DOD capabilities, though DoD
16 should consider having collaborations with IVIG
17 manufacturers to, you know, develop experimental
18 IVIG products for diseases for which we do not
19 have a treatment for at this point in time. So at
20 the end of this, the question is, resources and
21 obviously funding, you know, becomes an issue,
22 but, you know, also direction. Right now we are

1 working because we're interested in it, but moving
2 from a project to a program is an entirely
3 different set of situations. And we are currently
4 seeking other collaborations with other
5 institutions other than the ones that I mentioned
6 here today. So thank you for the opportunity to
7 come and give you an update on our efforts, and
8 I'd be glad to answer any questions you have.

9 (Applause)

10 DR. LEDNAR: Questions for Dr. Luke?
11 Dr. Walker.

12 DR. WALKER: What's the evidence that
13 antibodies are effective against an established
14 case of adenovirus pneumonia, including --

15 DR. LUKE: Sir, there is none. It does
16 need to be worked out from an experimental
17 standpoint. The fundamental issue is that we have
18 the ability to produce that experimental product,
19 and moving it into well-defined clinical research
20 trials is the obvious next step.

21 DR. LEDNAR: Other questions for Dr.
22 Luke? If not, Dr. Luke, thank you for that very

1 helpful information update, and thank you for the
2 brief.

3 DR. LUKE: Thank you.

4 DR. LEDNAR: I will give a short status
5 report for Dr. Halperin and Dr. Lockey in terms
6 of the military occupational/environmental health
7 and medical surveillance. This brief is intended
8 as a status report of the Subcommittee's
9 activities of late. Okay. Which is the forward
10 here?

11 MS. JARRETT: Do you want me to --

12 DR. LEDNAR: Yeah, can you forward the
13 slides for me? So what we're -- okay. I think I
14 have control now. We'll talk about the current
15 membership of the Subcommittee. A charge which
16 the Subcommittee came to understand, which is an
17 important block of work for the Defense Health
18 Board, particularly the Subcommittee, and because
19 of that, some site visits and reports that are
20 underway that the Defense Health Board can expect
21 to receive a report on in the very near future.

22 First, the Subcommittee membership, Dr.

1 Bill Halperin is the Chair. He regrets he wasn't
2 able to be here today because the summer school
3 program at his medical school starts today. He
4 had sufficient enrollment in his course. Today
5 being day one, he didn't dare miss it, so he sends
6 his regrets that he couldn't give this brief.

7 Dr. Lockey, who was intending to be here
8 until Sunday, unfortunately, his spouse
9 experienced a very unfortunate injury and he's
10 elected, very appropriately, to stay home and be
11 sure that his wife is getting good care. So I'm
12 standing in to give the report for them.

13 This is the committee, and importantly,
14 Dr. Ed Kaplan and Dr. Mike Oxman have provided
15 some very important assistance to the work of this
16 particular Subcommittee around the topic you'll
17 hear in just a moment.

18 Now, back in 2002, then Assistant
19 Secretary of Defense for Health Affairs, Dr.
20 Winkenwerder, had discussions underway that
21 involve the DoD Centers for Deployment Health. I
22 emphasize the word "Centers" plural. It is not a

1 singular entity; it is, in fact, three entities,
2 centers. And we came to see that, if you read the
3 very bottom two lines of this slide, that the
4 Assistant Secretary of Defense for Health Affairs
5 wished the then AFEB, and it then became the
6 Defense Health Board later on, to serve as a
7 public health advisory board for the DoD Research
8 and Clinical Centers for Deployment Health.

9 So, in fact, the ASD was looking for
10 interaction between the then AFEB, now the Defense
11 Health Board, with these Deployment Health
12 Centers, serving as an advisory board. And that
13 started some activities, and those activities
14 included, in the fall of last year, in October,
15 Dr. Halperin and Commander Feeks made a visit to
16 San Diego to visit one of these Deployment
17 Centers, and that is the Deployment Health
18 Research Center in San Diego, and in the process
19 of meeting with the Center Director, came to
20 understand more the portfolio of activities and
21 where there were potential opportunities for
22 improvement.

1 The full committee then met virtually
2 just before Christmas and went over some of those
3 thoughts to try to prioritize some of the areas of
4 potential improvement as a prelude to a visit that
5 was conducted about a month ago, on May 11th and
6 12th, by a number of us in the room, Dr. Oxman,
7 Dr. Luepker, Dr. Kaplan, myself. Anyone here
8 that I'm missing that was part of that group? And
9 Ms. Bader as our DFO.

10 And it was a very informative visit.
11 And what will come back to the Defense Health
12 Board at the August meeting is, in fact, a report
13 of that visit and recommendations that the
14 Subcommittee will propose be endorsed by the
15 Defense Health Board back to the Defense Health
16 Research Center in San Diego.

17 Now, this particular activity will be
18 followed by visits and understanding of the other
19 two Centers. The visit next in the queue will be
20 the Deployment Health Clinical Center at Walter
21 Reed first, and one base site visit by Dr.
22 Halperin and a DFO, maybe Ms. Bader, we'll sort of

1 see who it is, and that kind of approach has
2 turned out to be very helpful to clarify what
3 information about the Center is going to be most
4 helpful for the Subcommittee to receive, what are
5 the areas of question that the Subcommittee should
6 begin to focus on so that in September,
7 tentatively, there will be a two-day Subcommittee
8 visit to that Deployment Center to better
9 understand their mission and where some of the
10 gaps are.

11 I might say initially that it appears as
12 though these Centers are operating somewhat
13 autonomously. There are opportunities for
14 connection and collaboration. But I think more of
15 the particulars about the -- recommendations we
16 can expect to begin to hear in the August meeting.
17 For that, I ask any of the other Defense Health
18 Board members who are here if there are other
19 comments or questions that you'd like to share at
20 this point about our visit to San Diego? Mike.

21 DR. OXMAN: You summarized it very well.

22 DR. LEDNAR: Okay. Ed, Ms. Bader.

1 Okay. So that is the status report. Expect to
2 hear more at our meeting in August. Now, with
3 that we come to our last agenda item, and thank
4 you for your persistence to stay with us until the
5 end, and that's a follow back to what we talked
6 about earlier in terms of the Psychological Health
7 report and moving forward. And if I can ask Dr.
8 Parkinson if -- we should all express our thanks
9 that they spent lunch working on trying to develop
10 an approach -- and some language to accompany the
11 Subcommittee's report for us to consider and then
12 vote. Mike.

13 DR. PARKINSON: Yeah, thank you, Wayne.
14 Just to summarize our activity, from the
15 Psychological Health Committee, we had Drs.
16 Fogelman as Chair and Dr. Kroenke who headed up
17 the clinical component of that activity. We had
18 Dr. Shamoo, myself, and we had occasional
19 insightful input from Dr. O'Leary. So we had 4.5
20 members represented.

21 The goal of the group was, coming out of
22 our discussion, was to capture the sense of the

1 Board discussion, if you will, in something that
2 represented kind of a summary, an overview memo,
3 not displacing, but complimenting the full report
4 from the Subcommittee. So what you have in front
5 of you is essentially a draft version of what
6 would appear on top with an attachment being the
7 full report of the Subcommittee's work. What we
8 essentially did is took items number one and two
9 verbatim off of the draft report we saw this
10 morning, and we replaced essentially 3, 4, A, B,
11 and C, to which then the rest of the report would
12 be attached.

13 You can read it for yourself. The two
14 issues that we discussed and how we came down at
15 that juncture was the use of the word
16 "prioritize," which would essentially be in 4C,
17 the use of the word prioritize as something --
18 department.

19 The feeling was that if we asked for a
20 plan in an ongoing basis with the Department, that
21 that would be inherent within it, the notion of
22 prioritization and some degree of a stage process.

1 And then the other issue that we
2 discussed was the need to specifically mention the
3 Psychological Health External Advisory Committee
4 in recommendation 4C as opposed to just saying the
5 Board.

6 So I think that what this does, it
7 reflects the major findings and kind of the broad
8 high level take homes while also saying in bullet
9 number three that the DHB reviewed the report, fully
10 endorses the report's findings and
11 recommendations, and then hopefully this expresses
12 the discussion of the full Board earlier, and I
13 leave it to you, Mr. Chairman, to discuss further
14 or otherwise move ahead.

15 DR. LEDNAR: Thank you, Mike, and Adil,
16 and Charlie for bringing this to the next step. I
17 guess one thought, one suggestion on paragraph C,
18 it's on the second page, it must be paragraph 4C,
19 a suggestion for alternative wording, the current
20 wording suggests the Board further propose that
21 the Department work with the Psychological Health
22 External Advisory Committee and the Board on an

1 ongoing basis.

2 I think what we want to do is convey the
3 important work the Subcommittee did. I think this
4 cover memo really captures some of that in a way
5 that helps it become more understandable and
6 actionable. But it really is up to the Department
7 to decide if it wishes to pursue some activity,
8 further activity beyond this.

9 So as an alternative, a suggestion might
10 be that -- is wording like this; the Board remains
11 prepared to assist the Department in identifying
12 evidence based metrics to measure the
13 effectiveness of pre-clinical programs and in
14 developing a plan for applying the
15 recommendations. But we heard this morning that
16 it clearly is a difficult challenge in the
17 pre-clinical area to develop metrics. But the
18 ASD's question to the Board, first question,
19 metrics for a pre-clinical program, we didn't
20 answer. We still remain available if the
21 Department wishes, and clearly, especially in the
22 clinical area where there are metrics, and if it

1 wishes to proceed to implementation, if there's
2 something the Board can do the Department feels is
3 helpful, stand ready at the Department's request
4 to do that. Charlie.

5 DR. FOGELMAN: Well, part of what we
6 were feeling is that it really is kind of
7 unanswerable at the moment. You know, there's a
8 sort of large swamp, and although some may think
9 that we added to the swamp, in fact, what we did
10 was, try to lay out a series of steps in order to
11 help everybody get out of the swamp.

12 I think the wording is okay, except
13 putting the emphasis on looking for additional
14 pre-clinical measures. It doesn't really capture
15 the idea that we're trying to help them put a
16 clarifying process in place rather than identify
17 -- necessarily identify specific things. I can
18 certainly live with it, and I'm sure the committee
19 could live with it the way it is, I just don't
20 think it fully captures it.

21 DR. LEDNAR: I guess what I was sensing
22 and what I believe was probably Ms. Embrey's

1 thoughts, which became this request, where the --
2 as we heard this morning, there was a lot of
3 activity and energy and money being spent in this
4 area, some of it on the clinical area, some of it
5 on the pre-clinical area, and we think for --

6 DR. FOGELMAN: And a lot of it in
7 training, not with --

8 DR. LEDNAR: And looking for some way to
9 evaluate, where was this high value activity, it
10 was making a difference, it was helping in some
11 measurable way, some sort of an approach to pick
12 out from the -- probably the shorter list of areas
13 that really were a high impact, were effective or
14 whatever, with a measurable kind of an approach to
15 it, realizing the challenge in the pre-clinical is
16 hard, but that was really the question that she
17 was looking for some help with, and for lots of
18 understandable reasons, this communication doesn't
19 answer that mail.

20 DR. FOGELMAN: Our argue is that we gave
21 beginning help for that, and that's really the way
22 to think about it is, is that if -- begin and

1 aiming in a direction, which is why I think Mike
2 wanted to put in language that says that we'll
3 continue to help with it, because just getting
4 started was such an enormous activity. You're
5 nodding like I'm not being clear.

6 DR. LEDNAR: Mike and then Adil.

7 DR. PARKINSON: I guess the -- I would
8 be fine with that, just hearing it -- I would be
9 fine in language personally. I do think that what
10 we incorporated for emphasis is specifically in
11 4A, which I kind of glossed over my summary, was
12 that the committee clearly said that these are not
13 available and that the first priority is to find
14 what the goal is, you know, which is essentially
15 what is the operational definition of resilience
16 in Service members, what is so called -- and by
17 the way, the use of -- I would have rather put
18 these in quotes, but because it was in the report
19 as this, in other words, what is pre-clinical
20 quotes, what is program supporting resilience
21 education counseling, that's what the committee is
22 saying is, we need case definitions here before we

1 go about metrics for a case definition we haven't
2 defined.

3 So I do think that the language you
4 proposed, Wayne, actually brings -- it's a nice,
5 full circle because it brings it back to the
6 request like we've got to get on with this, folks,
7 because Congress is breathing down our back,
8 frankly, an it re-emphasizes the fact that we're
9 ready to stand by even as we proceed, frankly, to
10 get the case definition of what those three things
11 are. So I think in a way it actually does what I
12 think our discussion was, keep us engaged, use us
13 to the best possible use of the Department, so I
14 like your language.

15 DR. LEDNAR: What I heard, Mike, in your
16 comments was, this communication back to the ASD
17 Health Affairs is basically saying we think you
18 have work to do, and that is defined, decide what
19 you're calling pre-clinical, decide what you're
20 calling training, and then there's some approach
21 that could be taken with that clarification on
22 options for measurements.

1 But first you decide how you want to
2 define it, and that is an important next step in
3 terms of moving it in. Dr. Shamoo.

4 DR. SHAMOO: Thank you. I like the
5 language, and it is consistent with the discussion
6 we had about the relationship of the Department
7 with the Board and Subcommittee. I had -- the
8 language says this is for item 4C. The Board
9 remains ready to assist the Department in
10 developing a plan for applying the
11 recommendations, which will -- I was emphasizing
12 --

13 DR. PARKINSON: Willingness.

14 DR. SHAMOO: -- willingness to work with
15 them in subsequent work.

16 DR. LEDNAR: And my addition perhaps is
17 unnecessary given, you know, the content of 4A,
18 right, so we can really go either way. But I
19 think, Adil, your wording was really good. Is
20 there any value in re-emphasizing that there is --

21 DR. SHAMOO: I have no objection, so you
22 choose, you're the Chair.

1 DR. OXMAN: Wayne?

2 DR. LEDNAR: Yes, Dr. Oxman.

3 DR. OXMAN: I think I heard the
4 committee itself state that their response in that
5 area, 4A, was incomplete for those obvious
6 reasons. And so wouldn't it be logical for the
7 Defense Health Board to acknowledge that and say
8 that, for the reasons noted in 4A, their response
9 was incomplete and we're ready or we're ready to
10 help complete that process?

11 DR. FOGELMAN: Mike, let me suggest,
12 that's really in the substance of the thing which
13 is now attached to it.

14 DR. OXMAN: Right.

15 DR. FOGELMAN: And, you know, bringing
16 more attention to it there just is adding words
17 when the objective of these few lines is to remove
18 words. And most people in Health Affairs really
19 have been working with a lot of them are quite
20 aware of the substance and what the next steps
21 might be -- availability in any event. So there's
22 -- in all of this, there's a kind of formality to

1 it which is beyond the substance of it.

2 DR. SHAMOO: (inaudible) I call the
3 question --

4 DR. LEDNAR: I had difficulty reading
5 and understanding the second sentence in 4A. Hey,
6 Mike, you spoke about it, I think I may understand
7 it. Are you putting quotation marks in there to
8 fix it? I could not figure out what pre- clinical
9 and programs were. Are they the object of --

10 DR. SHAMOO: (inaudible)

11 DR. WALKER: Well, that was to develop
12 --

13 DR. PARKINSON: With editorial
14 permission from the Chair, I would propose,
15 because what we did is, we tried to be as true to
16 the full report there, David, as we could, that's
17 the way it's grammatically laid out in that
18 report. But what I think really needs to be said,
19 the first priority is to develop a working
20 operational definition of: "resilience in Service
21 members and families," "pre-clinical," and
22 "program." In other words, it's case

1 definitional. And that would make it clear
2 because, right, and then maybe we could
3 editorially amend the cycle just so it's the same,
4 because it reads better. I agree, it was
5 confusing.

6 DR. LEDNAR: And just to help our
7 transcriptionist, these last comments were Dr.
8 Parkinson and Dr. Silva added his affirmation,
9 that was a good idea.

10 Okay. So with those grammatical
11 additions which really bring attention to DOD's
12 need to develop clarifying definitions, and then
13 the words in 4C, the Defense Health Board stands
14 ready to continue to support.

15 DR. SHAMOO: This is Shamoo. The 4C you
16 suggested, is that right?

17 DR. LEDNAR: Yeah.

18 DR. SHAMOO: Okay, thank you.

19 DR. LEDNAR: I'll propose that 4C, and
20 let me read it once again --

21 DR. SHAMOO: I move it, second it.

22 DR. LEDNAR: Some people want to go

1 home.

2 (Discussion off the record.)

3 DR. LEDNAR: Is there a microphone on?

4 Okay. So my microphone is on, Lednar. What I
5 hear is that, with the discussion we've had, and
6 we can share these notes with the staff, this
7 cover memo would be attached, would have an
8 attachment, which is the Subcommittee's report.
9 That package then is coming to a vote. Is it
10 acceptable -- for a moment. All those in favor of
11 sending this package forward, the governmental and
12 the attachment Subcommittee report, say -- raise
13 their hand and say aye.

14 GROUP: Aye.

15 DR. LEDNAR: Any opposed, say nay. Any
16 who wish to -- then this is approved, the
17 governmental and the Subcommittee's report.

18 Thank you to the group that spent their
19 lunch helping us this last step to the
20 Subcommittee for all of their work. Okay. But it
21 was part of your lunch. Okay.

22 As we move to close, we are not going to

1 adjourn just yet, we have some important
2 information that relates to this evening's event
3 and importantly tomorrow's activities. So with
4 that, if Ms. Bader or Commander Feeks, whoever is
5 best to speak to the information about the dinner
6 this evening and the plans for tomorrow's
7 meetings. Who's going to -- Commander Feeks?

8 CDR FEEKS: Thank you, Dr. Lednar,
9 this is Commander Feeks. All right then, for
10 those of you who are departing today, and really
11 since we're not coming back to this facility, each
12 of your binders should have a manila envelope in
13 which I suggest you put the contents of your
14 binder so that you can take them home in a nice
15 compact form rather than take the whole binder.
16 You're welcome to take the binder with you. We
17 can ship the binder to you if you don't want to
18 take it with you, but it's much easier and more
19 cost effective to the government if you empty the
20 contents of your binder into your manila envelope
21 and take that with you.

22 For Board members, ex-officio members,

1 Service liaisons, and invited guests, bus
2 transportation will depart from this hotel at 7:00
3 tomorrow morning to take us to the Industrial
4 College of the Armed Forces at Fort McNair in
5 Washington, D.C.

6 If you are staying in the hotel, you
7 should check out beforehand, you should take your
8 luggage with you, and there will be a place to
9 stow your luggage inside the facility at ICAF, as
10 we did last year. If, on the other hand, you are
11 driving, remember to bring a photo ID, and if you
12 do not have a DoD sticker on your car, your
13 vehicle may be subject to a vehicle inspection at
14 the gate. And again, if you're arriving by taxi,
15 remember that you want, and I'm going to get this
16 address right if I just try, you want the taxi to
17 drop you at the pedestrian gate on V Street and
18 2nd. What does it say? Pedestrian, it was from
19 this morning's announcement. Please forgive me
20 for not having it right here, hang on. Okay,
21 yeah, 2nd and V -- as in Victor -- Street,
22 Southwest. Have the taxi drop you there, and the

1 pedestrian gate right there will give you access
2 to Fort McNair, right in back of the building
3 where we're going to meet of ICAF.

4 Okay. The meeting is scheduled to
5 adjourn at 2:00 p.m. tomorrow and will be followed
6 by an Infectious Disease Subcommittee meeting.
7 For those of you who are joining us for dinner
8 tonight, please convene in the lobby of this hotel
9 by 6:00 p.m. Shuttle service is being provided
10 and will leave the hotel at 6:00 p.m., and return
11 transportation from Cucina Vivace to the hotel
12 will also be provided. If you've not RSVP'ed or
13 provided your payment to Jen, please see her to
14 make the necessary arrangements. She is standing
15 over with the staff.

16 And that concludes my remarks. Ms.
17 Bader.

18 MS. BADER: I'd just like to reiterate a
19 thank you to everybody for attending here today.
20 We covered a broad spectrum of health care topics.
21 The Defense Health Board does a lot of really good
22 work and we have a lot of work ahead of us. So

1 thanks for being here today, and I'll turn it over
2 now to Colonel Noah to adjourn the meeting.

3 DR. LEDNAR: If I can just make one
4 comment before Colonel Noah, and that is just to
5 call your attention to a really high impact
6 one-pager that Dr. Certain prepared. It's an
7 article, a very thought provoking article about
8 war time sacrifice. I think it's very, very
9 important reading for all of us, and thanks to Dr.
10 Certain for writing it and sharing it. Copies of
11 this were in front of everyone's place. And if we
12 could ask Colonel Noah to officially adjourn the
13 meeting, Colonel Noah.

14 Col NOAH: Okay. Unless anyone else
15 can think of any other reason to postpone the
16 adjournment, I'd like to thank everyone for your
17 participation. This has been a very good meeting,
18 both for the Board members and for the excellent
19 presentations and input by other attendees.

20 (Whereupon, at 5:33 p.m., the
21 PROCEEDINGS were adjourned.)

22 * * * * *

1 CERTIFICATE OF NOTARY PUBLIC

2 I, Carleton J. Anderson, III do hereby
3 certify that the forgoing electronic file when
4 originally transmitted was reduced to text at my
5 direction; that said transcript is a true record
6 of the proceedings therein referenced; that I am
7 neither counsel for, related to, nor employed by
8 any of the parties to the action in which these
9 proceedings were taken; and, furthermore, that I
10 am neither a relative or employee of any attorney
11 or counsel employed by the parties hereto, nor
12 financially or otherwise interested in the outcome
13 of this action.

14 /s/Carleton J. Anderson, III

15

16

17 Notary Public in and for the

18 Commonwealth of Virginia

19 Commission No. 351998

20 Expires: November 30, 2012

21

22