

DEFENSE HEALTH BOARD
WALTER REED ARMY INSTITUTE OF RESEARCH
WALTER REED ARMY MEDICAL CENTER

DEFENSE HEALTH BOARD MEETING

Washington, D.C.

Wednesday, April 11, 2007

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

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

2 DR. POLAND: Good morning, everybody.
3 Welcome to the second day of the Defense Health
4 Board Meeting.

5 This is another first for the Board in
6 that we are meeting in a different location for
7 the second day of our meeting. Yesterday, we were
8 at Walter Reed Army Institute of Research, but in
9 some ways for the Board, this is like coming home.
10 As the predecessor Board, the Armed Forces
11 Epidemiological Board, we met at Walter Reed
12 Medical Center many times. Two of our
13 subcommittees, the Scientific Advisory Board for
14 Pathology and Laboratory Services and the Panel on
15 the Care of Individuals with Amputations and
16 Functional Limb Loss are co-located on this
17 campus.

18 So, Ms. Embry, would you please call the
19 session to order?

20 MS. EMBRY: Be happy to. As the
21 designated federal official for the Defense Health
22 Board, a federal advisory committee to the

1 Secretary of Defense, which serves as a continuing
2 scientific advisory body to the Assistant
3 Secretary of Defense for Health Affairs and the
4 Surgeons General of each of the military
5 departments, I hereby call this meeting to order.

6 DR. POLAND: Thank you. If I can ask
7 all in attendance that can to please rise for a
8 moment of silence, particularly cognizant at this
9 premier medical institution, many sacrifices and
10 obvious sacrifices that people have made on behalf
11 of our country.

12 (Moment of silence.)

13 DR. POLAND: Thank you and a thank you
14 to the active duty reserve and veterans and their
15 families who have sacrificed so much on this
16 country's behalf.

17 I want to introduce two distinguished
18 guests with us this morning. The first is Dr.
19 Charles Rice at the end to my right, President of
20 the Uniformed Services University Health Sciences,
21 and Colonel Chuck Scoville -- if you could raise
22 your hand so the people can identify you -- the

1 Executive Secretary for the Panel on the Care of
2 Individuals with Amputations and Functional Limb
3 Loss.

4 In addition, if we could go around as
5 this is an open session, go around the table and
6 have the Board Members introduce themselves.
7 Also, a special welcome to Dr. Ali Khan, our new
8 CDC Liaison, and Mr. John Kraemer who is
9 representing the VA today as Dr. Mark Brown had a
10 conflicting meeting.

11 MS. EMBRY: So, Ms. Embry, could I ask
12 to start with you?

13 MS. EMBRY: I'm Ellen Embry. I'm the
14 Deputy Assistant Secretary of Defense for Force
15 Health Protection and Readiness and the designated
16 federal official for this Board.

17 DR. RICE: Charles Rice, Uniformed
18 Service University.

19 DR. GARDNER: Pierce Gardner, State
20 University of New York Medical School at Stony
21 Brook.

22 MS. ROSSBACH: I'm Patty Rossbach. I'm

1 on the Subpanel for Amputations and Functional
2 Limb Loss.

3 COL. SCOVILLE: I'm Chuck Scoville with
4 the Amputations.

5 DR. CATTANI: Jackie Cattani, the
6 University of South Florida College of Public
7 Health and the Center for Biological Defense at
8 the University of South Florida.

9 DR. MASON: I'm Tom Mason, professor of
10 Epidemiology, University of South Florida, College
11 of Public Health and the Director of the Global
12 Center for Disaster Management, Humanitarian
13 Action.

14 DR. HALPRIN: Bill Halprin, I'm Chair of
15 Preventive Medicine at the New Jersey Medical
16 School and Chair of Quantitative Methods at the
17 School of Public Health of the University of
18 Medicine and Dentistry of New Jersey.

19 DR. LAUDER: Tamara Lauder, Physical
20 Medicine and Rehabilitation, Minocqua, Wisconsin.

21 DR. LUEPKER: I'm Russ Luepker from the
22 University of Minnesota School of Public Health.

1 DR. SILVA: I'm Joseph Silva, Professor
2 of Internal Medicine, University of
3 California-Davis.

4 DR. MILLER: Mark Miller, I'm the
5 Associate Director for Research at the Fogarty
6 International Center, National Institutes of
7 Health.

8 DR. PRONK: Nico Pronk, Health and
9 Disease Management at Health Partners,
10 Minneapolis.

11 DR. LOCKEY: Jim Lockey, Professor of
12 Pulmonary Medicine and Occupational Medicine,
13 University of Cincinnati.

14 DR. WALKER: David Walker, Chair of the
15 Department of Pathology, Director of the Center
16 for Biodefense, Emerging Infectious Diseases,
17 University of Texas Medical Branch at Galveston.

18 DR. PARKINSON: Mike Parkinson, Chief
19 Health and Medical Officer of Luminos which is a
20 part of WellPoint, a health insurance plan.

21 DR. KAPLAN: Edward Kaplan, Professor of
22 Pediatrics, University of Minnesota Medical School

1 in Minneapolis.

2 DR. OXMAN: Mike Oxman, Professor of
3 Medicine and Pathology at the University of
4 California-San Diego School of Medicine.

5 DR. CLEMENTS: John Clements, Chair of
6 Microbiology and Immunology, Tulane University
7 School of Medicine in New Orleans.

8 DR. MCNEILL: Mills McNeill, I'm
9 Director of the Mississippi Public Health
10 Laboratory at the Mississippi Department of
11 Health.

12 DR. SHAMOO: Adil Shamoo, Bioethicist,
13 University of Maryland School of Medicine.

14 COL. GIBSON: Roger Gibson, Executive
15 Secretary, Defense Health Board.

16 DR. POLAND: I'm Greg Poland, Professor
17 of Medicine and Infectious Disease at the Mayo
18 Clinic College of Medicine in Rochester,
19 Minnesota.

20 One other comment for any members of the
21 public that would like to make comments at the end
22 of the afternoon session, could I ask you to

1 please register or sign in with Lisa Jarrod --
2 Lisa, could you raise your hand so people can see
3 you -- so that we can try to accommodate those?

4 Otherwise, Colonel Gibson has some
5 administrative remarks before we begin this
6 morning's session.

7 Also, I would like to -- I see that he
8 is here -- introduce Major General Eric Schoomaker
9 of the Walter Reed Army Medical Center, who also
10 wanted to welcome the Board.

11 MAJ. GEN. SCHOOMAKER: Well, good
12 morning. My name is Eric Schoomaker. I'm the
13 Commanding General of the North Atlantic Regional
14 Medical Command in the Walter Reed Army Medical
15 Center, an internist by training and until about
16 five weeks ago, I was a Commanding General of the
17 United States Army Medical Research and Materiel
18 Command which is a command at Ft. Detrick,
19 Maryland that is very heavily involved in
20 biodefense and protection of the joint force
21 against emerging and existing health threats and
22 the Center of Medical Logistics for much of the

1 joint force.

2 I want to tell you how pleased we are
3 that you have chosen our campus here at Walter
4 Reed.

5 Mike, it's great to see you and good to
6 see so many old friends and to see so many
7 distinguished colleagues who have chosen our
8 campus as a site for your meeting of the Defense
9 Health Board.

10 For those who aren't familiar with
11 Walter Reed and the Walter Reed campus, Walter
12 Reed is one of the pivotal academic medical
13 centers and casualty receiving hospitals for the
14 joint medical force. We do this in partnership
15 with our tri-service medical community partners,
16 the Air Force and the Navy. In fact, we're part
17 of a consortium of medical facilities, clinics,
18 hospitals, community hospitals and academic
19 medical centers here in the National Capital
20 Region that have responsibility for the care and
21 health promotion, health maintenance, health
22 improvement and ultimately health care for over

1 500,000 beneficiaries of federal medicine in the
2 greater metropolitan Washington, D.C. area.

3 We are also privileged to be one of the
4 principal casualty receiving hospitals for
5 casualties of the Global War on Terrorism and have
6 been very active as a site for that. You're going
7 to hear something about that. I think Chuck is
8 going to give us an update today about the program
9 that he is privileged to lead.

10 We couldn't be happier then to have you
11 here today. Frankly, we respect so much the
12 contributions that our academic and federal and
13 interagency partners make to improvements of the
14 health system of the Uniformed Services and
15 federal medicine in general.

16 I welcome you all here today. I hope
17 this is a profitable and a productive two days for
18 you. I'm personally looking forward to hearing
19 the report of the Independent Review Group that
20 we've hosted here and with whom we've interacted
21 over the last several weeks since I arrived in
22 command.

1 So, welcome. Don't hesitate to call
2 upon me or my staff. Regrettably, I'm personally
3 going to have to come and go if that's okay with
4 you, Ms. Embry and Dr. Poland, but we want to
5 make ourselves open and available to you for any
6 and all needs that you might have.

7 Thanks very much.

8 (Applause.)

9 DR. POLAND: We'd like to present a
10 certificate of appreciation to Major General
11 Schoomaker to recognize his superb leadership,
12 excellent organizational skills and outstanding
13 professional knowledge and willingness to assist
14 and cooperate with the Board and its work. Thank
15 you very much.

16 MAJ. GEN. SCHOOMAKER: That's very kind
17 of you. Thank you very much.

18 (Applause.)

19 MAJ. GEN. SCHOOMAKER: We in the Army
20 have this tradition that when you do good things
21 for us, we reciprocate. We package all of our
22 respect for you in a coin. This is the coin of

1 what some would argue the most esteemed name in
2 Army medicine, Walter Reed. This is the coin of
3 the Walter Reed Army Medical Center -- a man who
4 changed the lives of hundreds of millions of
5 people worldwide.

6 DR. POLAND: Yes, indeed. Thank you
7 very much.

8 MAJ. GEN. SCHOOMAKER: I'm happy to give
9 that to you.

10 COL. GIBSON: For those of you attending
11 the meeting, please make sure that you sign in.
12 One of the requirements of the Federal Advisory
13 Committee Act is that we record the names of all
14 attendees. So we would appreciate it if you would
15 sign the rosters as you come in, make sure. Also,
16 to remind you of what Dr. Poland said, if you wish
17 to make comments towards the end of the afternoon
18 session, if time is available, we'll try to
19 accommodate that, but you need to sign in for that
20 as well.

21 Because this is an open session, it's
22 being transcribed. Please make sure you state

1 your names clearly so our transcriber can
2 accurately record your questions and comments.
3 This is for the Board Members and the speakers.

4 The next meeting of the Defense Health
5 Board will be May 3rd. At that meeting, we will
6 receive briefings on the military vaccine program
7 for the Department of Defense, the vaccine health
8 care centers, a briefing on the influenza
9 surveillance program and a deliberative session, a
10 deliberation of the draft report from the Mental
11 Health Taskforce. That meeting will be at the
12 National Transportation and Safety Board Center in
13 downtown Washington, D.C.

14 Finally, I want to thank my staff, Ms.
15 Jarrod and Ms. Bennett, for their help in putting
16 this meeting together and a special thank you to
17 the Walter Reed Medical and Garrison staff.
18 General Schoomaker, thank you very much. Your
19 folks did an outstanding job of supporting us for
20 this meeting. Thank you.

21 DR. POLAND: All right, our first
22 speaker this morning will be Dr. Tom Burke. Dr.

1 Burke will provide an update on the activities of
2 the Mental Health Taskforce. His slides are under
3 Tab 3.

4 Tom, the floor is yours.

5 DR. BURKE: Thank you. Thank you, Dr.
6 Poland. I'm Thomas Burke. I'm the Executive
7 Secretary of the DoD Taskforce on Mental Health.
8 On behalf of Vice Admiral Donald Arthur and Dr.
9 Shelley McDermid, I would like to thank Ms. Embry
10 and Dr. Poland and Colonel Gibson and the members
11 of the Board for this opportunity to provide an
12 update on the progress that the Mental Health
13 Taskforce has made to date.

14 The first issue that I would like to
15 address is the change in membership that we had as
16 a result of the retirement of Lieutenant General
17 Kiley who was the Department of Defense Co-Chair
18 for the taskforce. General Kiley has been
19 replaced by Vice Admiral Donald Arthur, the
20 Surgeon General of the Navy who was appointed as
21 the DoD Co-Chair on March 27th, 2007. We would
22 like to thank General Kiley for his support and

1 his input and welcome Admiral Arthur. We look
2 forward to equally finding support from Admiral
3 Arthur.

4 The activities of the taskforce can be
5 grouped into three general categories:
6 Information gathering, deliberation of findings
7 and recommendations, then administrative tasks and
8 writing and editing the report.

9 So far, in the information gathering
10 process, we have held eight full taskforce
11 meetings approximately once a month since the
12 taskforce was appointed on the 15th of May of
13 2006. During these taskforce meetings, we have
14 had a number of informational briefings on a wide
15 variety of topics from subject matter experts
16 inside and outside of the Department of Defense.
17 We've also had open town hall format sessions at
18 each of the meetings at which time the public had
19 an opportunity to address the taskforce and to
20 give testimony. We also, during one of the
21 meetings, invited the military service
22 organizations and the veterans service

1 organizations to come and provide statements, and
2 those were very helpful to the taskforce.

3 We've made approximately 38 site visits
4 to military installations in CONUS, Europe and the
5 Far East. We did not do this as a full taskforce,
6 but we sent delegations of two to five members.
7 We tried to have a civilian and a military person
8 on each of the teams that went out. We completed
9 our final site visit in February of 2007.

10 During these site visits, we tried to
11 see all of the interested parties that could
12 provide input to the taskforce about the mental
13 health system and how it was functioning. We were
14 sure to visit the installation commander partly
15 out of an information gathering role and partly to
16 reassure the commanders and the units that this
17 was not an inspection, that this was an
18 assessment. It was part of a federal advisory
19 committee taskforce and that we were not there to
20 find fault or to identify problems other than in a
21 very general sense. We were not the inspector
22 general.

1 We had posts town hall at which time,
2 like the full taskforce meetings, we had an
3 opportunity for the public to address the site
4 visit team. This was an opportunity. This was
5 just an open invitation. We did not try to select
6 a representative sample of the community in a
7 scientific way. This was an opportunity for
8 people with concerns to come and make statements
9 to the taskforce.

10 We visited with resident military units,
11 whatever type of post. We tried to see the full
12 spectrum of military installations. We visited
13 all four services. We tried to get large posts,
14 small posts, geographically isolated posts, posts
15 with high turnovers due to deployment, posts with
16 large units that were being deployed and posts
17 with perhaps small military contingencies. So we
18 tried to see the full spectrum and to get input
19 from the various military units, and we were very
20 gratified with the support that we got from the
21 commanders of the installations and the commanders
22 of the units in providing soldiers, sailors,

1 airmen and marines for us to talk to.

2 We visited the medical treatment
3 facilities on base to see, to get their input on
4 how they believe the mental health care system was
5 working in the MTFs on post.

6 We also visited with the non-medical
7 behavioral health support personnel. Behavioral
8 health is more than just mental health care. It
9 involves all of the groups and organizations that
10 feed people with problems and concerns into the
11 mental health care system and also that handle
12 various programs that are intimately involved with
13 mental health care but are not directly managed by
14 the medical system such as the family advocacy
15 program, the drug and alcohol program.

16 We also went off post to talk to the
17 medical care providers in the local communities
18 because especially in the geographically isolated
19 locations, in places that have a lot of military
20 providers deployed, a lot of the family care is
21 being shifted to the Tricare Network, and we
22 wanted to see if there were any problems

1 identified or any model programs that were being
2 developed by the network providers to address that
3 increased need.

4 As we went through the site visits, we
5 had a standard list of questions that we tried to
6 ask. We tried to touch on all of those questions,
7 but it wasn't a rigid, formal structure. We tried
8 to allow the people who were talking to the
9 taskforce as much latitude as possible to express
10 themselves in their own way and still cover all of
11 the topics that we considered important. We
12 wanted to look for problems, but we also wanted to
13 look for things that were going well, model
14 programs, especially innovative ways of
15 approaching the problems associated with
16 deployment, with returning troops, with families.

17 The exact agenda for each of the site
18 visits varied. We negotiated that with each of
19 the sites because we saw the full spectrum of
20 types of military installation. Each one was a
21 little bit different, and so we allowed the
22 installation to provide a significant amount of

1 input on what was available there and on setting
2 the exact agenda.

3 We also made a data call. The taskforce
4 members assembled a long list of questions that
5 they wanted information on. This data call was
6 sent to the responding organizations by the
7 Assistant Secretary of Defense for Health Affairs,
8 Dr. Winkenwerder. The organizations that we sent
9 the questions to were the Deputy Undersecretary of
10 Defense for Military Community and Family Policy,
11 Assistant Secretary of Defense for Health Affairs,
12 the Tricare management activity and the Surgeons
13 General of the military departments.

14 We also had information. We tried to
15 gather information directly from individuals. We
16 set up a web site, a web page on the Defense
17 Health Board web site that was available for
18 individuals to provide statements. We felt that
19 that was important particularly because it dealt
20 with mental health care issues, and the full
21 taskforce meetings, where we took similar
22 statements, were in an open session like this.

1 Everything was transcribed. It was going to
2 become a part of the public record, and we didn't
3 want to provide a disincentive to people who were
4 uncomfortable with speaking about their problems
5 and issues in an open, publicized format where it
6 would all be recorded, and we provided them with
7 this more private avenue to make statements.

8 The web page for taking these statements
9 was closed on March 9th, but the web site for
10 providing information to the public about the
11 Mental Health Taskforce agendas and activities is
12 still up on the Defense Health Board web site.

13 We have had an ongoing literature
14 review. Because this was a very broad scope as
15 part of the Congressional tasking, we broke up the
16 work into pieces and assigned that to subgroups of
17 the taskforce to get the actual work done and the
18 report written, and they have done their
19 literature review on an ongoing basis in
20 addressing their individual taskings.

21 We set up a web site separate from the
22 Defense Health Board web site on Army Knowledge

1 Online that was accessible. It was password
2 protected. It was secure and was available only
3 to the taskforce members and the staff that we
4 could use as a virtual bookshelf to put all of the
5 information that was being gathered by the various
6 working groups up where all of the taskforce
7 members could get it without having to ask and
8 have it emailed to them. That web site is still
9 functioning.

10 As we've moved out of the information
11 gathering phase and into the deliberation of
12 findings and recommendations, we've had sessions,
13 open sessions, at the Washington meeting in
14 February, and we'll have another one at the San
15 Antonio meeting in April, where we deliberate the
16 findings, recommendations, issues that have been
17 discovered during the site visits and brought up
18 by the working groups in an open session. In
19 compliance with the Federal Advisory Committee
20 rules, deliberation is to be held in open session,
21 and we have done so, and it is part of the
22 transcribed records of those meetings.

1 We also will submit the draft of the
2 report for the Defense Health Board to deliberate
3 in session on the 3rd of May of 2007.

4 Our remaining activities are the update
5 briefing at today's meeting.

6 We have a full taskforce meeting from
7 April 16th to the 18th at which we will have an
8 open deliberative session and the remaining
9 opportunity for the full taskforce to get together
10 to work on finishing the draft of the report.

11 On May 3rd, we will deliver a draft. A
12 draft of the report will be available for
13 deliberation by the Defense Health Board. On May
14 15th, we plan to deliver the report to the
15 Secretary of Defense on time.

16 Any questions?

17 DR. POLAND: Thank you, Tom. I attended
18 one of your early meetings and was impressed with
19 the amount of energy and diligence your taskforce
20 has put into this. It's very much appreciated and
21 is a tremendous effort. We look forward to
22 receiving the draft in early May, I guess it will

1 be.

2 Comments or discussion from members of
3 the Board?

4 Dr. Shamoo?

5 DR. SHAMOO: Cancer in the fifties was a
6 taboo subject; breast cancer, still half and half.
7 Mental illness remains really a taboo subject.
8 There is a whole population whether in the
9 civilian sector or in the military that don't come
10 forward, and sometimes it's too late. Suicides,
11 we have literally thousands and thousands of
12 suicides in this country that are preventable, and
13 most of them are due to mental illness, and there
14 is a much larger number of injuries due to those
15 unsuccessful suicides.

16 My question is have you planned to
17 outreach to those silent individuals which are in
18 the hundreds of thousands and how the Mental
19 Health Taskforce is going to deal with it for
20 future recommendations?

21 DR. BURKE: Certainly the issue of
22 stigma, of access to care, of the availability of

1 care and of this unwillingness for people to come
2 forward and unwillingness for people to talk about
3 have all been issues that the taskforce has
4 considered. We have discussed those issues at
5 length, and I believe that all of those issues
6 will be addressed in the report when it's
7 delivered in May.

8 DR. POLAND: Mark, before you start, it
9 did dawn on me. Tom, could I ask you to just very
10 briefly recapitulate the tasking that you were
11 given for this taskforce because we do have
12 several new members of the Board who may not be
13 familiar with that, just a brief recap?

14 DR. BURKE: Yes. In the FY 2006
15 National Defense Authorization Act, there was a
16 Congressional direction for the Secretary of
17 Defense to establish a Mental Health Taskforce to
18 assess the mental health care and services
19 provided to members of the Armed Forces and their
20 families and make recommendations for improvements
21 in that system.

22 The taskforce was to consist of 14

1 members -- 7 DoD and 7 non-DoD members --
2 representing all of the services, representing a
3 wide variety of skill sets within the health care
4 field: Research, academia, clinical care. One of
5 the members was to be a Surgeon General of one of
6 the armed services. There was to be a member that
7 represented families.

8 Colonel Gibson led the effort to select
9 the taskforce, and there were seven DoD, seven
10 non-DoD. Lieutenant General Kiley, Surgeon
11 General of the Army was the Surgeon General member
12 and was appointed as the DoD Co-Chair. The
13 membership elected Dr. Shelley McDermid, who is a
14 Professor of Family Studies at Purdue University,
15 as the non-DoD Co-Chair.

16 We have representation from all of the
17 military services, the four military services:
18 Army, Navy, Air Force and Marines. Because the
19 Navy provides medical care for the Marines, our
20 Marine Corps representative is a personnel officer
21 and an aviator.

22 We have seven non-DoD members. Dr.

1 McDermid, as I said, and Dr. Blazer, who is the
2 Defense Health Board Liaison, he's also a member
3 of the Defense Health Board. We have a member
4 from Health and Human Services, Ms. Kathryn
5 Power. We have Dr. Tony Zeiss from the VA. We
6 have Dr. McCormick who spent 30 years with the VA
7 in Ohio and is now retired and is in academic
8 medicine. Dr. Layton McCurdy who is a Professor
9 Emeritus at the Medical University of South
10 Carolina. We have Ms. Deb Fryar who is with the
11 National Military Family Association. She's the
12 family advocate member of the taskforce.

13 DR. POLAND: Thank you. Dr. Miller?

14 DR. MILLER: Thank you, Dr. Burke.

15 Given the scope of the disease burden and long-

16 Term nature of mental health problems,

17 can you speak about the mandate and how inclusive

18 the mandate includes in terms of do you include,

19 for example, VA facilities and long-term nature of

20 problems in mental health such as post traumatic

21 stress syndrome? For example, what is the

22 representation of the 38 sites that you have

1 chosen? What percentage of all the long-term
2 military facilities that that represents, does it
3 include, for example, the VA facilities?

4 The second question is can the Board get
5 a copy of the questionnaires that were actually
6 administered?

7 DR. BURKE: To answer the second
8 question first, yes, I could provide Colonel
9 Gibson with copies of the questionnaires.

10 Certainly, the long-term care issues
11 were a major issue for the taskforce to look at.
12 The tasking in the Congressional language had 15
13 elements plus a 16th element that said anything
14 that the taskforce considered important was within
15 the scope of their charter. So our examination of
16 the issue has been very broad.

17 It has certainly included the issue of
18 care for service members after they separate from
19 the service, particularly as that involves the VA.
20 We had a VA member, Dr. Zeiss, and Dr. McCormick
21 who had long experience with the VA. So we had a
22 lot of very well informed VA input to the

1 taskforce's deliberations.

2 We also spent one of our full meetings.
3 In San Francisco, we saw the National Center for
4 PTSD at Palo Alto, and we went to the VA Medical
5 Center there in San Francisco.

6 DR. POLAND: Dr. Luepker?

7 DR. LUEPKER: Yes, thank you, Dr. Burke.
8 Just a question I may have missed, are you
9 quantifying the resources available, i.e., the
10 number of mental health professionals on one hand
11 available to do this and, on the other hand, the
12 patient or potential patient as we look long-term
13 load? Are those numbers being collected and will
14 they be presented?

15 DR. BURKE: Yes, those numbers were part
16 of the data call that we put out to the services
17 and to Tricare, the Tricare management activity,
18 and those numbers and the findings and
19 recommendations that are based on those numbers
20 will be a part of the report.

21 DR. POLAND: Dr. Lauder?

22 DR. LAUDER: Thank you, Dr. Burke, for

1 your input. A question I have is I know a lot of
2 the focus is on PTSD, but is the taskforce also
3 taking into account the probable number of
4 traumatic brain injury patients that will
5 eventually probably end up in a mental health
6 system?

7 DR. BURKE: We're certainly looking at
8 that as a part of the overall burden of mental
9 health, of mental illness. We met recently with
10 the TBI Taskforce, and Vice Admiral Arthur has had
11 a lot of experience and interest in that. So he's
12 bringing an additional emphasis. As the new
13 member, he's bringing an additional emphasis on
14 TBI and the overlap and the interconnection
15 between mental illness and traumatic brain injury.

16 DR. POLAND: Captain Ludwig?

17 CAPT. LUDWIG: Good to see you again.

18 DR. BURKE: Nice to see you.

19 CAPT. LUDWIG: You had a very broad
20 presentation on your group. I just wonder if I
21 missed it or if you included the fifth armed
22 service, Coast Guard, in any way on the taskforce

1 and, if not, can we talk about getting some
2 representation on the group?

3 DR. BURKE: We did not have a Coast
4 Guard member on the taskforce, and this was not an
5 attempt to slight the fifth armed service. We
6 also did not look at any of the other uniformed
7 services, but the representation on the taskforce
8 was limited to the military departments.

9 I would certainly be more than happy to
10 discuss with Colonel Gibson and yourself about
11 making sure that we have Coast Guard input.

12 CAPT. LUDWIG: Thank you.

13 DR. BURKE: Thank you.

14 MS. EMBRY: The Department would
15 officially endorse that.

16 DR. BURKE: Yes, ma'am.

17 DR. POLAND: Dr. Lockey?

18 DR. LOCKEY: Dr. Burke, will your report
19 identify where there are knowledge gaps in
20 relationship to causation pathophysiology,
21 treatment modalities in regard to military related
22 mental health issues?

1 DR. BURKE: Yes, we will. The report
2 will not go into great depth on the basic science
3 of mental illness and mental health. It's more of
4 a look at the care system and the resource system.
5 But that has been considered and that will be a
6 part of the report.

7 DR. POLAND: Dr. Oxman?

8 DR. OXMAN: Dr. Burke, has the taskforce
9 considered or will it consider the issue of the
10 ability of the VA to provide support for families
11 of veterans with mental health issues?

12 DR. BURKE: That has certainly been part
13 of the discussion. The taskforce was not asked to
14 specifically recommend changes to the VA, but
15 inasmuch as the mental health care system is
16 indeed a system and the Department of Defense is
17 only one part of that system and that part of the
18 mandate, part of the emphasis that Congress placed
19 on us was to look at care for families, certainly
20 the way those systems, those parts of the system
21 interact to care for families will be a part of
22 the report.

1 DR. OXMAN: Thank you.

2 DR. POLAND: Dr. Pronk?

3 DR. PRONK: Dr. Burke, I was wondering
4 if you could speak to the notion of integration of
5 mental health services in the context of primary
6 care type services. Does, for example, the
7 taskforce address the issue of screening in those
8 type of settings for mental health and then
9 address the issue of continuity of care?

10 DR. BURKE: We have. We had a work
11 group that was specifically looking at issues of
12 continuity of care. The issue of mental health
13 care in primary care has been thoroughly examined,
14 I believe, by the taskforce. We've had subject
15 matter experts. We saw, I personally was on one
16 of the site visits at Robins Air Force Base where
17 we talked about the way they were integrating
18 mental health services into primary care. So,
19 yes, that is being looked at.

20 COL. GIBSON: I just wanted to make one
21 comment. The Mental Health Taskforce, what Dr.
22 Burke is here doing today is just basically

1 providing us with an update of the activities that
2 are going on.

3 The taskforce report, once its
4 delivered, the taskforce will basically stand down
5 within about 60 days after the delivery of the
6 report. Their charge is to provide
7 recommendations to the Department that are
8 actionable and that the Department will respond
9 to, so the taskforce itself is not going to run
10 future programs, et cetera. They will do their
11 due diligence in their report and then turn it
12 over to the Secretary for his consideration.

13 Once that report is turned over, the
14 Secretary has a period of time to then respond to
15 Congress with his response to the taskforce
16 recommendations.

17 DR. POLAND: Tom, thank you. Let me
18 just ask two closing questions: One, anything
19 further the Board can do that would facilitate the
20 taskforce work and, two, any barriers that you're
21 encountering that we can help with?

22 DR. BURKE: No. The Defense Health

1 Board has been very helpful and very cooperative
2 as far as scheduling briefings and meetings. Our
3 taskforce is 14 members with other full-time jobs,
4 and they're scattered all over the United States.
5 So bringing them together in one place can be a
6 little problematic, and you've been very helpful
7 as far as helping us coordinate those meetings
8 between the Defense Health Board and the
9 taskforce.

10 The barriers, certainly with a topic
11 this broad, we could use years more of work, but
12 we're on a schedule.

13 DR. POLAND: Be careful what you wish
14 for.

15 DR. BURKE: Thank you.

16 DR. POLAND: Thank you, Tom. We look
17 forward to your report.

18 Before we move on to the next topic,
19 there are some members of the Board that weren't
20 here when we did introductions as well as some of
21 the liaisons and preventive medicine officers that
22 I'd like to introduce themselves, so if we could

1 start on this side.

2 COL. BADER: Good morning. Colonel
3 Christine Bader, the Executive Secretary for the
4 Taskforce on the Future of Military Health Care.

5 DR. MULLICK: Good morning. Dr.
6 Florabel Mullick, Principal Deputy Director of the
7 Armed Forces Institute of Pathology and Executive
8 Secretary of the Subcommittee of the Defense
9 Health Board on Pathology and Laboratories.

10 DR. PARISI: I'm Dr. Joe Parisi, and I'm
11 the Chair of the Defense Health Board Subcommittee
12 on Pathology and Laboratory Services.

13 LT. COL. WERBEL: Lieutenant Colonel
14 Aaron Werbel of the Joint Staff.

15 CDR. FEEKS: Good morning. Commander Ed
16 Feeks, Preventive Medicine Officer, Headquarters,
17 Marine Corps.

18 COL. GUNTER: Good morning. Colonel
19 Phil Gunter, Bridge Liaison Officer to the Office
20 of the Army Surgeon General.

21 CAPT. JOHNSTON: Good morning. Surgeon
22 Captain Richard Johnston, British Liaison Officer.

1 CAPT. NAITO: Good morning. Captain
2 Neil Naito, Preventive Medicine Officer, Bureau of
3 Medicine and Surgery for the Navy.

4 COL. SNEDECOR: Colonel Mike Snedecor,
5 Air Force Preventive Medicine Officer, Air Force
6 Surgeon General's Office.

7 CAPT. LUDWIG: Captain Sharon Ludwig,
8 U.S. Coast Guard Headquarters.

9 COL. STANEK: Colonel Scott Stanek,
10 Preventive Medicine Staff Officer, Army OTSG.

11 DR. KHAN: Good morning. Ali Khan, CDC,
12 Atlanta, Georgia.

13 DR. POLAND: Thank you. Our next
14 speaker will be Colonel Christine Bader. She will
15 update the Board on the Taskforce on the Future of
16 Military Health Care. This is the first meeting
17 at which the work of this Board will be discussed,
18 and Dr. Bader's slides are under Tab 4.

19 COL. BADER: Good morning. Good
20 morning, General Schoomaker, Ms. Embry, Dr. Poland
21 and Colonel Gibson.

22 One quick note for the record, I am a

1 nurse. I am not a doctor. So I just want to make
2 sure that I'm not inappropriately titled.

3 Good morning. Again, this is our first
4 activities update for the Taskforce on the Future
5 of Military Health Care. What I'd like to do
6 first is just have a quick overview of our
7 purpose, our Congressional charge, introduce you
8 to our taskforce members, update you on our
9 activities, our public meetings, talk about our
10 next public meetings and our upcoming milestones.

11 Again, I'm here to update you on our
12 activities to date from December when we had our
13 first administrative meeting, when our members
14 were appointed up to this point, the end of March,
15 2007.

16 Our Congressional charge came out of the
17 Fiscal Year 2005 National Defense Authorization
18 Act. We are to make assessments of and
19 recommendations for sustaining the military health
20 care services being provided to members of the
21 Armed Forces, retirees and their families.

22 We had 10 elements for study. Our

1 charge is very broad. We are looking at wellness
2 and disease management initiatives, education
3 programs focused on prevention awareness and
4 patient initiated health care, the ability to
5 account for true and accurate costs of military
6 health care, alternative health care initiatives
7 to manage patient behavior costs including options
8 and cost and benefits of the Universal Enrollment
9 System for all Tricare users, appropriate command
10 and control structure with DoD, the adequacy of
11 military health care procurement systems, the
12 appropriate mix of military and civilian personnel
13 to meet readiness requirements and the high
14 quality service requirements, beneficiary and
15 government cost-sharing structure to sustain
16 military health benefits over the long term,
17 programs focused on managing the health care needs
18 of Medicare eligible military beneficiaries, and
19 efficient cost and effective contracts for health
20 care support and staffing services including
21 performance-based requirements for health care
22 provider reimbursements.

1 So you can see that our charge is very
2 broad. The members of our taskforce: We have 14
3 members. Half of are Department of Defense
4 members, and the other half are non-Department
5 members. General John Corley is a Co-Chair. He's
6 the Vice Chief of Staff, Headquarters, U.S. Air
7 Force.

8 Major General Nancy Adams is U.S. Army
9 retired former Commander, Tripler Army Medical
10 Center and former Acting Director, Tricare
11 Regional Office, North.

12 We also have Rear Admiral John Mateczun,
13 U.S. Navy Deputy Surgeon General; Lieutenant
14 General James Roudebush, U.S. Air Force Surgeon
15 General; Major General Joseph Kelley, U.S. Air
16 Force, he's the Joint Staff Surgeon; Shay Assad,
17 the Director of Defense Procurement and
18 Acquisition Policy, Office of the Undersecretary
19 for Acquisition Technology and Logistics; General
20 Richard Myers, U.S. Air Force retired, former
21 Chairman of the Joint Chiefs of Staff.

22 Our non-Department of Defense members:

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190

1 Dr. Gail Wilensky was elected at our first session
2 in December as the non-DoD Co-Chair. She's a
3 senior fellow at Project HOPE.

4 Robert Henke is the Assistant Secretary
5 for Management, the Department of Veterans
6 Affairs.

7 Dr. Carolyn Clancy is the Director of
8 the Agency for Health Care Research and Quality
9 Department of Health and Human Services.

10 Robert Hale is the senior fellow at the
11 Logistics Management Institute and member of the
12 Defense Business Board, formerly the Assistant
13 Secretary of the Air Force for Financial
14 Management and Comptroller.

15 Major General Smith, U.S. Army Reserve
16 retired, is the past President of the Reserves
17 Officers Association and former Global Controller,
18 Ford Motor Company.

19 We have Larry Lewin, founder of the
20 Lewin Group and currently Executive Consultant on
21 Clinical and Technology Effectiveness, Health
22 Promotions, and Dr. Robert Galvin, Director of

1 Global Health Care, General Electric.

2 So you can see that we have a very broad
3 range of expertise on our taskforce, and we're
4 very fortunate.

5 Our activities to date: We will review
6 our meetings. We've had quite a few open
7 meetings. We have direct and written testimony,
8 subject matter expert briefings, and we have the
9 review of reports and studies which is ongoing.
10 We are constantly doing research, pulling up
11 reports that are relevant to our task, pulling out
12 necessary information and gathering that to
13 collate it and put it into our interim and final
14 reports. Of course, we have to draft and submit
15 our interim report which is due at the end of May.

16 Up to this point, our taskforce has
17 decided to act in a plenary manner. Everyone is
18 meeting together. We haven't broken down into
19 subgroups. Perhaps we will do that after the
20 interim report, but at this point we are pretty
21 much all meeting together in open sessions.

22 We have developed a web site where we

1 have an open side and a password protected side
2 just as the Mental Health Taskforce has done. On
3 the password protected side is where we can put up
4 our materials, begin to review drafts of our
5 interim report, the taskforce members can provide
6 comments without everything. At this point,
7 there's no deliberation involved, so it's not open
8 to the public, but it's where we can kind of make
9 our edits and scratch out our work.

10 Again, we had our first administrative
11 meeting on the 21st of December. That is where
12 Dr. Wilensky was elected Co-Chair. It was purely
13 administrative.

14 We've had public meetings. We've had
15 five up to this point. We also had one
16 information visit where we went to the United Mine
17 Workers of America and talked to them about their
18 health plan, their outreach programs and their
19 mail order pharmacy.

20 Our first open session was held on the
21 16th of January, where we received input from Dr.
22 Winkenwerder and Dr. Chu. Dr. Winkenwerder

1 briefed on the overview of the Defense Health
2 Program, gave his system impressions and talked
3 about management issues. Dr. Chu briefed on the
4 military health care, gave a long view, talked to
5 us about some recent developments and what he saw
6 in the immediate future.

7 We also received information briefings.
8 Mr. Middleton briefed on how the military health
9 system is currently financed and Mr. Kokulis
10 briefed on the military health care system cost
11 drivers and legislation that was proposed last
12 year to sustain the benefits. Much of that
13 legislation is what brought us to the development
14 of the taskforce.

15 On the 6th of February, we had
16 additional information briefings talking about the
17 pharmacy benefits program. We had Rear Admiral
18 Tom McGinnis, the Chief of Pharmaceutical
19 Operations Directorate, brief us on beneficiary
20 and government cost-sharing structure that is
21 required to sustain military health benefits over
22 the long term. We also received information from

1 Captain Patricia Buss on cost-sharing under the
2 pharmacy benefits program, and we were briefed by
3 Jean Storck, Chief of Health Plan Operations, on
4 our managed care contracts.

5 Major General Smith, who is on our
6 taskforce, represents advocacy groups. He's been
7 out and, of course, he has meetings with them and
8 can bring back to us some of their concerns. So,
9 during that meeting, we also had a short back
10 brief from him on meetings that he had with
11 advocacy groups.

12 On the 20th of February, we had the
13 Surgeons General and the Joint Staff Surgeon brief
14 us on the direct care system as well as General
15 Kelley briefed in an unclassified manner on the
16 deployment aspects of our military system.

17 We also received a back brief from
18 General Corley and Dr. Wilensky on their meetings
19 when we went to the Hill and spoke briefly to
20 members of the Senate Armed Services Committee and
21 the House Armed Services Committee exactly on what
22 they are looking for us to do with this task. We

1 are going to continue to stay in touch with them
2 to make sure that we are on track, so that we can
3 provide back to the Secretary of Defense and to
4 Congress what they're asking us to do.

5 On the 7th of March, we had
6 presentations from industry experts. We heard
7 from United Health Care and the Association of
8 Retail Chain Drugstores. We also heard from
9 beneficiary group representatives. Major General
10 Smith coordinated with some of the advocacy
11 groups, with NOAA, the Reserve Officers
12 Association, family organizations. They came in
13 and compiled responses and testimony, read them to
14 us on what they see for the future of military
15 health care.

16 For those advocacy groups that could not
17 attend the meeting or perhaps there wasn't time
18 enough to hear from everybody, they provided
19 written statements. We did pretty much hear from
20 everybody who asked to present. Those that wanted
21 to provide a written statement, obviously we have
22 those statements, and we are taking them into

1 consideration.

2 On the 28th of March, we heard from our
3 managed care support contractors. We heard from
4 Dave McIntyre representing TriWest, Dave Baker
5 representing Humana and Steve Tough representing
6 HealthNet.

7 Again, on the 20th of March was the
8 first time we had a small group meeting. This was
9 not a public meeting. It was just more of an
10 informational meeting at which time we heard from
11 United Mine Workers Association about their
12 outreach programs and their pharmacy program for
13 their retired beneficiaries. They will be
14 presenting in open session at our meeting next
15 week on April 18th.

16 Late last night, I returned home from
17 our first road trip. We went out to San Antonio.
18 We had a briefing from the commanders of Brooke
19 Army Medical Center and Wilford Hall Medical
20 Center. They talked to us about the market share.
21 They talked to us about what they're doing in
22 their facilities. We went through their burn

1 center and then had a tour of the Intrepid Center.

2 After our meetings with the commanders,
3 we went to Sam Houston Club and had a town hall
4 meeting, and that was our first town hall meeting.
5 It was very informative.

6 Then yesterday, we had hearings outside
7 of San Antonio. We heard from spouses, retirees,
8 Guard and Reserve, young officers, junior officers
9 and enlisted members.

10 It was a good two-day trip. Again, it
11 was our first road trip, and we wanted to hear
12 from folks outside of the Beltway. We wanted to
13 get out and talk to a wide range of the population
14 who receive the benefit of our military health
15 care and to receive their input, their
16 recommendations. We were obviously there as
17 students. We were there to learn, and it was a
18 very, very eventful two days.

19 So, with that, our next big milestone
20 outside of meetings is our interim report which we
21 will deliver to the SecDef, the Senate Armed
22 Services Committee and the House Armed Services

1 Committee by the 31st of May.

2 Thank you for your time. Are there any
3 questions?

4 DR. POLAND: Thank you, Colonel Bader.
5 Dr. Kaplan?

6 DR. KAPLAN: I may be getting ahead of
7 the story, but is there any liaison at all between
8 the group that you're reporting on and the
9 independent review group which we will hear more
10 from this afternoon?

11 You're much more inclusive, as I
12 understand it, but it seems to me there are areas
13 of overlap, and I wonder if there's been any
14 liaison.

15 COL. BADER: Thank you for your
16 question, sir. Actually, Secretary Marsh,
17 Secretary West and Arthur Fisher met with our
18 Co-Chairs Dr. Wilensky and General Corley just
19 last week to discuss issues of overlap. We
20 recognize that there's overlap in the groups, and
21 we are very hopeful that we can share information,
22 obviously leverage off of each other's work and

1 collaborate.

2 Thank you.

3 DR. KAPLAN: Thank you.

4 DR. POLAND: Dr. Mason?

5 DR. MASON: Thank you, Colonel Bader.

6 COL. BADER: Yes, sir.

7 DR. MASON: I would appreciate some
8 discussion, if you could, on points one and two
9 that you articulated for us, specifically risk
10 tracking and rewards and educational programs.
11 Could you just share with us some of your
12 thoughts?

13 In the civilian sector, rewards are a
14 two-edged sword. So I'm really interested in the
15 military setting and definitely active duty
16 military. What is the thinking of the taskforce
17 right now in terms of tracking which, to me, as an
18 epidemiologist, is the established cohorts that
19 you're going to follow for life and that you're
20 somehow going to intervene and intercede with
21 their practices, their behavioral practices, and
22 in some of the issues with regard to wellness and

1 educational programs, please?

2 COL. BADER: Thank you, sir. We
3 actually, our interim report asks us to be focused
4 on cost-sharing and the pharmacy benefit. So, to
5 be perfectly honest with you, sir, that's what
6 we've been looking at for the first couple of
7 months. That is not to say that wellness is off
8 of our radar screen. However, at this point, I
9 will tell you that I will be better prepared to
10 answer the questions of the vector the taskforce
11 is taking at the next update.

12 DR. MASON: Thank you.

13 DR. POLAND: Dr. Pronk?

14 DR. PRONK: Yes, Colonel, I was
15 wondering if the subcommittee is considering the
16 identification of best practices or benchmarks.
17 And in that context is looking across that
18 continuum of services that you have in your task
19 for wellness all the way down the continuum of
20 care, if you will. So, are you also including
21 sort of industry benchmarks that are identified
22 through the National Business Coalition on Health

1 -- for example, its evaluation -- evaluate tool or
2 AHIP, the Alliance of Community Health Plans,
3 those kinds of approaches?

4 COL BADER: Yes, actually, we have
5 talked about that, especially some of -- the --
6 Dr. Galvin has brought that up a lot, Larry Lewin,
7 in looking at industry benchmarks and how we can
8 incorporate them into the way ahead for our
9 reports and for the recommendations for the task
10 force, yes, sir. Thank you.

11 DR. POLAND: Col. Gibson and then --

12 COL GIBSON: Just for the Board again,
13 COL Bader's providing an update on their
14 activities to date. Substantive questions with
15 respect to the report should probably wait until
16 the full Board gets a chance to talk to us in a
17 deliberative session. So, the questions are fair;
18 it's just that there are limited things that COL
19 Bader can really address on behalf of the task
20 force at this point.

21 DR. POLAND: Dr. Parkinson?

22 DR. PARKINSON: Yes, thank you. A

1 couple of questions. Why -- I'm curious -- the
2 choice of United Mine Workers relevant to White
3 Ride or other organizations out there -- what's --
4 what was the rationale with them? It would just
5 be informative for me.

6 Second would be has the task force had
7 the opportunity to dust off something that the
8 Milbank Foundation thought was noteworthy for
9 studying and publishing, and that was the Military
10 Health System Optimization Plan -- it was crafted
11 by a number of us here -- that frankly had some
12 policy barriers put in place but it started with a
13 readiness-based model and then said how do you
14 move from that. It would be historically
15 informative for the committee as well as to look
16 at Dan Fox and David Kindig's assessment of that
17 in 2001. It was published by Milbank Foundation.

18 And the third piece is the term "patient
19 driven" -- I think there was a term in the charge
20 about patient driven. As you know, the main --
21 one of the major transformations of all health
22 care purchasing in the last five years has been

1 around consumer-focused or consumer-driven health
2 care, and I would just offer as a point of contact
3 myself or other people in that sector, which is
4 still about 10 million Americans are there. We
5 have major new lessons to learn. I know Bob
6 Galvin knows of it. G.E. has not been an early
7 promoter or adopter of some of the models but may
8 be informative for your committee and I would
9 offer that to you -- not just myself but some
10 other people.

11 COL BADER: Great. Thank you very much.
12 We'll certainly look up the optimization plan, and
13 we can talk offline about your third point.

14 DR. PARKINSON: Okay.

15 COL BADER: Regarding the United Mine
16 Workers of America, we are always looking for, you
17 know, a good plan, a good practice, something
18 that's been used and has worked. A member of our
19 task force was aware of what -- the retiree funds
20 and their benefits and that it's been successful
21 and that is how that was brought forward to us.
22 Thank you.

1 DR. PARKINSON: Thank you.

2 DR. POLAND: Dr. Gardner?

3 DR. GARDNER: Pierce Gardner. One of
4 the themes of the day is the transitions of the
5 care of the service member from inpatient to
6 outpatient and from outpatient DoD to the VA
7 system or the private sector, and I wondered if --
8 I don't see any focus of sort of the systems
9 management and the need for assistant
10 recordkeeping and hopefully electronic records
11 that would facilitate those I think identified
12 glitches in the current system.

13 COL BADER: Well, our charge does talk
14 about -- you know, you talk about the records
15 system and, you know, we do talk about, you know,
16 technology and the record system that's not
17 hardcopy --

18 DR. GARDNER: Electronic?

19 MS. EMBRY: Electronic.

20 COL BADER: Thank you, ma'am.

21 Electronic record system.

22 I'm looking over at Ms. Embry because we

1 talked about this quite a bit last week in a
2 number of meetings.

3 So, although our task force is not
4 directed to your second point to look at, you
5 know, specifically transitions from inpatient to
6 outpatient. That's all part of our overarching
7 sustaining the benefit and care of the patients
8 and care of the beneficiaries. Our charge is
9 very, very broad, so we're going to touch on a lot
10 of different areas.

11 DR. GARDNER: Thank you.

12 DR. POLAND: GEN Schoomaker.

13 MGEN SHOOMAKER: If I could just exploit
14 the fact I'm sort of the mayor of Walter Reed, and
15 the Board is meeting here. I'm not a Board
16 member, I recognize, but I just wanted to follow
17 on two comments at least -- the last one and what
18 Dr. Parkinson talked about.

19 First of all, I wonder if the Board is
20 aware or is looking into some of the efforts that
21 GEN Kiley instituted before his announced
22 retirement that look at changing the way we do

1 budgeting of our healthcare system that links
2 rewards and reduction in risk factors for cohorts
3 of patients and looks at clinical outcomes as a
4 driver rather than pure productivity. I think
5 we've all had the benefit of talking to Dr.
6 Parkinson and others like him in the past and are
7 looking at a radical revision in the way we do
8 budgeting, and since fiscal drivers are so
9 important in this particular task force -- task
10 force attention -- I'm hopeful that that work will
11 not be lost or be overlooked.

12 And I guess a follow-on to Dr. Gardner's
13 points -- many of us who have been around the
14 military medical system, as I have for almost
15 three decades now, have looked at the events of
16 the last two months or so as being perhaps the
17 most dramatic ones that we've ever observed and
18 have never seen, from the public through the DoD
19 right down through my parent service, the Army, as
20 much attention focused on interagency cooperation,
21 the transitions, the focus on how we are going to
22 take care of the whole person and the whole

1 family; and I'm more than idly curious as to how
2 much of the work that's going to be reported out
3 of multiple review groups, commissions, and active
4 working groups, even within the Army alone, is
5 going to be a part of your report or a part of
6 your scrutiny as a task force.

7 COL BADER: Well, I know that we're
8 going to collaborate, obviously with everybody's
9 work, but we came into this with, you know, no
10 preconceived notions, absolutely a clean slate.
11 We have talked about incentives. We have the
12 surgeons general. I know GEN Kiley brought up,
13 when he briefed, some of the issues that you spoke
14 about, and I can tell you that our task force
15 members are open to all recommendations. I cannot
16 tell you now exactly what they will recommend and
17 what will come out in the report. I can tell you
18 that they're looking at everything.

19 MGEN SHOOMAKER: To include all of the
20 current recommendations that are coming forward --

21 COL BADER: Yes.

22 MGEN SHOOMAKER: -- from an independent

1 review group --

2 COL BADER: Yes. Yes. Yes.

3 MGEN SHOOMAKER: -- and the Shalala/Dole
4 Commission and --

5 COL BADER: Our co-chair, Dr. Wilinsky,
6 is also on the Dole/Shalala Commission. We have
7 contacts with all the other groups. I've actually
8 heard from their executive secretary. We are all
9 collaborating. We are continuing to gather
10 information. At this point, I cannot tell you
11 what we will put in our interim report, obviously,
12 or our final report. We're still deliberating.
13 We're listening, we're learning, and we are
14 considering all the information we received.

15 MGEN SHOOMAKER: Well, it's a very
16 fertile -- it's a time of great opportunity for us
17 in the uniformed services to get this right, so.

18 COL BADER: Yes, sir. Yes, sir.

19 DR. POLAND: Dr. Halperin.

20 DR. HALPERIN: Yes, Bill Halperin. Your
21 mandate does sound very broad, and the meetings
22 with the United Mine Workers health folks sets the

1 stage for my question. Does your mandate really
2 address itself it to, for example, healthcare of
3 miners per se, as in clinical care, or we all
4 understand that a lot of the health of miners has
5 to do with appropriate ceiling bolting so that the
6 roof doesn't fall in and protection of miners
7 against coal dust exposure -- both of these things
8 mandated by the Mine Safety and Health Act of
9 1972. So, in fact, the health of miners depends a
10 lot on preventive medicine, as well as clinical
11 care. So, my question is, using the mine workers
12 as the example but then in reference to the
13 military in general, is your focus also on the
14 infrastructure of preventive medicine, or is it
15 basically healthcare as in healthcare and
16 wellness?

17 COL BADER: We can actually -- as I had
18 stated earlier, the initial charge for us for the
19 interim report was the cost sharing and the
20 pharmacy benefit. The second half we will now
21 start getting more into the wellness and the
22 prevention, and we can at that point choose

1 whatever avenue -- because we are so broad that we
2 -- whatever path we would want to take. My
3 thought right now is that we will take -- you
4 know, we will look at, you know, obviously all
5 aspects of preventive medicine and all aspects of
6 wellness, and we're not -- you know, we're very
7 broad. We have that latitude, and so I believe
8 that we will look at all aspects.

9 DR. POLAND: Thank you. Let me see, Dr.
10 Luepker and then Dr. Silva.

11 DR. LUEPKER: Yes, thank you. COL
12 Bader, as I'm listening to this, I have a broad
13 question, some of which has been touched on
14 already. It seems like there are three areas.
15 One is providing the highest quality care --
16 always a goal; second is a complex system and how
17 it might be made better; but, third, and really
18 the points here talk about costs which are driving
19 many concerns in healthcare in this country. So,
20 as you see the breakdown, is your primary push
21 here to deal with the cost crisis, or is it
22 reorganization, or is it how to provide better

1 care? And then what -- given all or probably
2 goals -- in what proportion?

3 COL BADER: We are looking equally at
4 everything, and I'm being very sincere. I mean,
5 we're looking at efficiencies; we're looking at
6 quality of care; we're recognizing that, you know,
7 our goal is to maintain a healthy and fit force;
8 we are, you know, looking at cost share -- we're
9 looking at -- so, we're still looking at
10 everything. We really are, and I'm being very
11 sincere.

12 DR. POLAND: Dr. Silva?

13 DR. SILVA: Yes, I suspect by your
14 previous answer that you'll be looking at errors
15 in medicine, too, which is a great concern.

16 MGEN SHOOMAKER: I'm sorry, sir?

17 DR. SILVA: Errors in medicine. The
18 Institute of Medicine highlighted this years ago,
19 and in the public sector there are a lot of
20 benchmarks that are driven off now, prevention of
21 errors by healthcare systems and practitioners
22 therein, and I guess that could fit under your

1 category of prevention as a broad topic.

2 DR. POLAND: Dr. Miller?

3 DR. MILLER: As a follow-up to Dr.
4 Halperin's question, when you mentioned that you
5 are looking at prevention services, I can see that
6 this represents a potentially slippery slope in
7 terms of does it also extend to potentially
8 looked-at prevention services during combat
9 situations -- for example, to ensure that there is
10 adequate protection for military forces during
11 combat protections?

12 COL BADER: Are you -- sir, you're
13 talking about hardware? Are you talking about
14 vaccines? Or when you --

15 DR. MILLER: Well, vaccines are implicit
16 in terms of --

17 COL BADER: Right.

18 DR. MILLER: -- health services
19 protection, but there are other types of combat
20 protections as well, so does your remit include
21 those types of prevention services as well?

22 COL BADER: We have not looked at that

1 at this point. We have not considered that. I'll
2 take that as a note, thank you.

3 DR. POLAND: Dr. Parkinson?

4 DR. PARKINSON: Yes. Apologies for a
5 second comment, but in the vein of Dr. Pronk's
6 comments concerning best practices, another
7 relatively hot-off-the-presses document that was
8 produced by the Institute of Medicine on a
9 committee that both Nico, myself, and several
10 people like Martine (off mike) of IBM, and Pam
11 Hymel, formerly of Lockheed, are on, and it really
12 addresses the entire continuum issue: If you have
13 a population of employees and family members, how
14 do you optimize their health status with a primary
15 prevention strategy all the way through to
16 purchasing quality healthcare? It's called the
17 Integrating Employee Health Report by NASA, and
18 it's also been translated into a monograph for
19 employers to apply in their worksite, so, again, I
20 think both Nico, myself, and others would be
21 resources because every employer in America is
22 dealing with this list, as Bob Galvin knows. The

1 difference -- the nuance here, of course, is we
2 run our own system within the macro dysfunction,
3 frankly, of the U.S. health care system. So, how
4 do you sort it out? That might be another
5 document for you to pore over and try to apply.

6 COL BADER: Thank you.

7 DR. PARKINSON: They actually have that
8 document.

9 DR. POLAND: Dr. Parisi?

10 DR. PARISI: Thank you for your report,
11 COL Bader. Just a quick question. Has the task
12 force made any recommendations or had any
13 considerations for the handling of pathology
14 specimens, especially vis-à-vis the BRAC closing
15 of the AFIP? Do you have any -- have you given
16 any thought to how things will be handled there?

17 COL BADER: No, we have not made any
18 recommendations on that issue. I can certainly
19 take that back. Thank you.

20 DR. POLAND: No other comments? COL
21 Bader, thank you very much for your interim
22 report. We will move on now to Dr. Joseph Parisi.

1 He will discuss the mission and vision of the
2 Scientific Advisory Board for Pathology and
3 Laboratory Services. This was a handout that
4 Board members received a moment ago.

5 DR. PARISI: Good morning. Thank you,
6 Dr. Poland, COL Gibson, Ms. Embry, and Board
7 members and guests. I'm Dr. Joseph Parisi. I'm
8 Chair of the Defense Health Board Subcommittee on
9 Pathology and Laboratory Services. I'm a
10 pathologist, and I have subspecialty expertise in
11 neuropathology and have spent most of my
12 professional career doing that. I was privileged
13 to be a staff neuropathologist and then chair of
14 the Neuropathology Section at the AFIP from 1981
15 through 1990 and was a member and then recent
16 Chair of the AFIP Scientific Advisory Board.

17 As a pathologist, I am at a bit of a
18 disadvantage this morning, because we're very
19 visual people and I like to have slides up and
20 things so that I can point to them. So, the best
21 we could do is provide you with a handout that I
22 hope will be somewhat satisfactory.

1 If we look at the expanded mission of
2 the new Defense Health Board, as it's been
3 defined, it includes the word "treatment," and I
4 think this is a very important inclusion.
5 Appropriate treatment, and an effective treatment
6 in fact, requires pathology input, and it requires
7 accurate and timely diagnoses be made, so
8 excellence in pathology is really a central key to
9 excellence in medicine, and it's a key component I
10 think in many -- potentially all -- issues that
11 will be considered by the Defense Health Board.

12 I think this -- the importance of
13 pathology actually has been recognized. If you
14 look at the logo of the new health board, you'll
15 see that it includes a microscope, which is sort
16 of the universal association -- universal symbol
17 of pathology or the practice of pathology
18 throughout the world. So, I think it's already
19 been recognized as a key component.

20 If you look at the subcommittee, this is
21 really an extension of the earlier AFIP Scientific
22 Advisory Board, and it's -- so it has very close

1 ties to the Armed Forces Institute of Pathology
2 and we'll detail some of those in a moment.

3 A proposed mission -- and again this is
4 still an evolution, but as I see it the proposed
5 mission of the subcommittee is to provide the
6 Department of Defense with timely scientific and
7 professional advice and guidance, and that is
8 pertaining to all aspects of pathology including
9 consultation for practice of pathology, education,
10 and research; and we hope to do this through
11 several means. We hope to collaborate with other
12 civilian and DoD institutions and agencies;
13 emphasize state-of-the-art diagnostics; promote
14 quality assurance and best practices; monitor
15 events with hard pathologic data; and promote
16 excellence in medical practice through the AFIP's
17 core strengths, which include consultation,
18 education, and the very advanced tissue repository
19 of carefully categorized and studied cases.

20 So, basically, as I see it, the mission
21 of the subcommittee is to be a resource on all
22 things pathology to the Defense Health Board.

1 However, there are several unknowns. The current
2 mission of the DHB is being -- is in evolution,
3 and I think the -- it's obviously been expanded
4 beyond what the former committee's charge was.

5 Also, there are considerable unknowns
6 regarding the fate of the AFIP with the recent
7 BRAC recommendations.

8 The AFIP, as a bit of background, has
9 served as the center of military pathology for
10 decades. It's provided pathology expertise for
11 the military and civilian medical communities
12 worldwide. It's also been very important in the
13 training of military pathologists by providing
14 educational courses, as well as first-hand
15 experience for trainees and new people into the --
16 in the subspecialty areas of pathology. It's
17 always been the go-to place for difficult and
18 unusual cases, and it has a vast repository of
19 these cases that are available for future study.

20 The AFIP really has had a major,
21 positive impact on the practice and science of
22 pathology -- the practice and science of pathology

1 and medicine to both the military medicine and
2 civilian medicine worlds, not only nationally but
3 also internationally, and actually I know of no
4 pathologist who's in practice today who hasn't
5 been somehow directly or indirectly influenced by
6 the AFIP through its courses, its consultations,
7 or its publications. So, it's really been a major
8 role in defining pathology.

9 On the next page, I just put a couple of
10 the important AFIP activities. A primary mission,
11 of course, is to provide accurate diagnoses, and I
12 think when patients come to physicians they want
13 to know "what do I have?" and that's really the
14 basis of all treatment strategies.

15 The AFIP also maintains this very active
16 national tissue repository that contains over
17 three million cases that have been carefully
18 categorized and studied, and these are under
19 active investigation and really require and are
20 best served by practicing active pathologists who
21 can provide continual input into the cases.

22 As a bit of background, the AFIP

1 actually was established in 19 -- I'm sorry, it
2 was established in 1862 as the Army Medical Museum
3 as a repository for injuries and disease specimens
4 of Civil War soldiers. It was expanded in 1888,
5 and in 1946 the Scientific Advisory Board was
6 established. This was the precursor to the
7 current subcommittee. The Scientific Advisory
8 Board was established to provide guidance and
9 advice to the DoD and the director of the AFIP.

10 However, the AFIP became a victim of the
11 recent BRAC recommendations. This again is
12 background. I've included some of the details.
13 In May of 2005 the Secretary of Defense announced
14 recommendations to close or realign military
15 facilities and, yes, as part of the base
16 realignment and closure, and part of this of
17 course was to close Walter Reed Army Medical
18 Center. But also a corollary to this was to
19 disestablish the AFIP, and the recommendations at
20 that time were the Medical Examiner's office and
21 the DNA registries would move to Dover Air Force
22 Base in Dover, Delaware; some of the educational

1 services would move to Fort Sam Houston in Texas;
2 the museum and repository would remain in DoD; and
3 other services provided by the AFIP would be
4 discontinued, transferred to other parts of DoD,
5 or contracted. However, the details and the plans
6 were really not provided for what would happen.

7 The -- this announcement actually was
8 followed by a relatively vigorous grassroots
9 groundswell of support for the AFIP from
10 individual pathologists, individual practitioners,
11 professional pathology organizations, and other
12 medical organizations who all strongly felt that
13 the AFIP should be kept in tact. However, the
14 BRAC Commission recommendations went forward in
15 September. President Bush signed this on
16 September 15th, and Congress approved the BRAC
17 report in its entirety on November 9th.

18 So, the BRAC is really a law now and
19 we're under -- we're assuming the -- we're under
20 the assumption that things will go forward as have
21 been defined in the BRAC law. However, there are
22 some wrinkles and uncertainties that have been

1 thrown into the equation. For example, even as
2 early as last week or as recently as last week,
3 the Kennedy Amendment to the Emergency
4 Supplemental Appropriations Bill that was passed
5 by both the House and Senate recognized and
6 stipulated that none of the funds in this or any
7 other action be used to reorganize or relocate
8 functions of the AFIP. What impact this will have
9 is still uncertain and remains to be seen.

10 In summary, I think that the
11 Subcommittee of Pathology and Laboratory Services
12 -- their vision of our subcommittee is really
13 still in evolution. This is a coolly -- a
14 changing environment. We have evolving missions
15 at multiple levels. I think the AFIP activities
16 have been and they are key factors in military
17 pathology excellence and we would like to continue
18 to build on the existing AFIP stress. However,
19 because of the uncertainties, we really don't
20 where all these will lead.

21 Dr. Florigal Mullick, who is the
22 Executive Secretary for our subcommittee, actually

1 has been appointed the new AFIP director, and I'm
2 very glad that Dr. Mullick could be here today.
3 That appointment will become effective on June
4 29th. I can really think of no other individual
5 more capable to guide the AFIP during these times
6 than Dr. Mullick.

7 I wanted to reassure the Defense Health
8 Board that the Pathology Subcommittee is committed
9 to supporting the activities and the missions of
10 the Defense Health Board in every manner possible.

11 I'll be happy to entertain any
12 questions.

13 DR. POLAND: Thank you, Dr. Parisi. Dr.
14 Oxman?

15 DR. OXMAN: The museum and collection of
16 pathology materials is immensely valuable, and
17 they've been valuable to a large extent because of
18 the intimate association of expert pathologists
19 with them both physically and intellectually, and
20 it appears that that linkage is going to be broken
21 under the new organization plan. Can you comment
22 on what you think the impact of that loss will be

1 on the utility and, in the long run, the
2 preservation of that irreplaceable collection?

3 DR. PARISI: I think you've hit upon a
4 very important point, Dr. Oxman. It's very
5 important to keep the registry alive. It's very
6 important to keep active input by practicing
7 pathologists -- young people, older people,
8 doesn't matter -- by practicing people who have
9 important questions to answer that the repository
10 can provide answers to, especially as newer
11 techniques become available. These tissues are a
12 really irreplaceable and invaluable source, so I
13 see the separation from active pathology providing
14 input to the repository. If that link is lost,
15 it's going to be a real tragedy because it'll
16 basically become a warehouse and we'll have very
17 little say in what comes in and goes out and how
18 that is intellectually used.

19 The repository, as you know, has been
20 the very rich resource that has been the basis of
21 much of our understanding of diseases. If you
22 look at our understanding of disease processes,

1 much of it comes from very (off mike) papers and
2 reports that originated at the AFIP --
3 observations that originated at the AFIP -- and to
4 lose that would be a real tragedy not only
5 nationally but internationally.

6 DR. POLAND: Any comments or questions,
7 Dr. Silva?

8 DR. SILVA: Thank you for your report.
9 Are there any plans to set up a digitalization
10 process to help maintain the collection of all
11 over the long haul?

12 DR. PARISI: The digitalization of
13 slides -- first of all, we're talking about
14 millions and millions of slides. It's very
15 costly. It's time consuming at this point, and
16 most pathologists till like to have the glass in
17 their hand and to look at the images under the
18 microscope themselves, so there has been talk
19 about that. I think it's a possible evolutionary
20 step. It's certainly not ready at this time. I
21 think as the technologies improve and the
22 digitization algorithms improve, that's probably

1 going to become more reasonable, but I think at
2 the current state-of-the- art, it's really not
3 practical.

4 DR. POLAND: Dr. Luepker?

5 DR. LUEPKER: Yes. Thank you, Dr.
6 Parisi. I'm curious -- being not very familiar
7 with the AFIP other than its rather substantial
8 history -- how are activities currently broken
9 down? How much is the museum and maintaining the
10 museum? How much is education and training? How
11 much is active pathology for inpatients our
12 outpatients?

13 DR. PARISI: Well, I'll be happy to
14 answer some of these and Dr. Mullick perhaps would
15 like to come in as well. Educationally it
16 provides courses that are really not available
17 anywhere else on the planet -- very rich,
18 well-taught courses taught by experts in the
19 field, very detailed, that are attended year after
20 year after year by thousands of physicians that
21 are both actively practicing physicians, as well
22 as trainees.

1 The museum has been very, very active.
2 They have several traveling exhibits. I think
3 they've become better known in recent years, and
4 again Dr. Mullick can probably provide more of the
5 details, but I think the museum activities have
6 certainly increased the awareness of the museum
7 and the importance of these sorts of collections.

8 The consultation services -- the AFIP
9 still maintains a subspecialty kind of
10 organization so that if you have a soft tissue
11 case it goes to a soft tissue specialist. If you
12 have a brain tumor, it goes to the
13 neuropathologist, and those activities are still
14 continued. So --

15 DR. LUEPKER: Do you continue to add to
16 the collection in the museum?

17 DR. PARISI: The repository is
18 continually added so that when a case is
19 accessioned to the AFIP, it actually becomes part
20 of the registries, part of the repository.

21 The collections -- there have been
22 several additions to the collections over the

1 years. I don't have a list of those specifically,
2 but there have been several important collections
3 that have come to the AFIP.

4 The museum has also been very active in
5 developing some traveling exhibits having to do
6 with health care, as well as attracting school
7 tours and more individuals coming on campus to
8 actually see the museum in person.

9 DR. LUEPKER: Thank you.

10 DR. POLAND: Maybe Dr. Mullick would
11 like to say something?

12 DR. MULLICK: Yeah. First of all, I
13 would like to emphasize that neither Dr. Parisi
14 nor I are here to lobby for AFIP or any such
15 thing. The BRAC law is the BRAC law, and we are
16 following it. We have a plan. We have timelines,
17 so that is one issue.

18 The reason that Dr. Parisi said he had
19 to discuss some of these and I concurred is
20 because the AFIP for hundreds of years has been
21 tied very closely to the Department of Defense,
22 military pathology, Veterans Administration

1 pathology, and civilian pathology. So in making
2 plans for a charter or anything of that sort for a
3 Pathology and Laboratory Subcommittee for the
4 Department of Defense, these factors we felt
5 needed to be in the question because there are
6 still many uncertainties as of training of
7 military residents.

8 The second opinion of military cases --
9 they will be contracted out, but then that brings
10 a number of other uncertainties. Where will these
11 placements be? If I send the case from a military
12 placement to Dr. Parisi, he is definitely not
13 going to return it to me to put it in my
14 repository.

15 So, those are uncertainties that I think
16 we can address at the task force, but at the
17 moment it is kind of like in flux. The BRAC plan
18 probably will not be implemented for another two
19 years, so we have, like, the status quo kind of
20 thing for two years, but major changes have to be
21 addressed. There is a measurement of a Pathology
22 Management Office I think, but that will be a

1 virtual office to manage and quality control
2 contracts, the contracts that will go to the
3 civilian (off mike). So, is it a composite of
4 issues that are very uncertain. The level of
5 training of the military pathology is another
6 issue and so on and so on.

7 At the moment, the AFIP is functioning
8 as always. To our big surprise, despite the fact
9 that the BRAC law is final and we are in the
10 process of maybe this week or next week sometime
11 starting to implement some of the timelines, the
12 staff is mostly in place, very dedicated. Not too
13 many talks about we are leaving nothing unmasked,
14 but of course the number of cases have been
15 reduced -- they're civilian -- even though the
16 military cases have increased, so it's kind of
17 like business as usual. Less cases, relatively
18 speaking, because of the civilian portion, but the
19 VA sends us almost 20,000 cases a year and the
20 military is increasing their second opinion.

21 Then I emphasized that the museum, which
22 is the National Museum of Health and Medicine,

1 with thousands of artifacts, the best microscope
2 collection, the (off mike) collection worth
3 millions of dollars, or that remains in DoD, that
4 remains and the plan is to go out to Bethesda. I
5 think a new building will be built. The plans are
6 like that.

7 The repository, which is where all the
8 slides and gross tissue and actual fixed organs
9 are housed -- that will also remain, and in the
10 discussions that we've had, it has been emphasized
11 that it needs to remain an active, not a warehouse
12 type of system with -- then involving many talks
13 with Dr. Winkenwerder's office, Dr. Jones (off
14 mike), and all of agreed that it should be an
15 active repository with some pathology stuff and so
16 on, because it should not be a warehouse or -- we
17 are already aware and concerned about that, and I
18 think it would probably (off mike), but, again,
19 uncertainties. We still don't know who is going
20 to see the contract for evaluation of the status
21 of the specimens. The value has been determined,
22 but we need to know exactly what is fixed, what is

1 not fixed.

2 Everything is automated as far as the
3 slides but not the gross -- I heard -- they were
4 talking about imaging. We were fortunate to
5 receive congressional money, and we've had a
6 contract in place for the last two years where all
7 of the specimens are being imaged, including the
8 radiology pathology collection and the (off mike)
9 medicine (off mike), so that is going well, and
10 the contract was renewed so that I think the
11 repository is going to be great state with all the
12 actuals that still ongoing. So, so far nothing
13 has died, even though we are in the process of
14 still providing service.

15 But, again, this is not lobbying for
16 AFIP. We understand the law, and we have a plan,
17 and we are going by the national capital area
18 business plan that's in place. But because
19 pathology at the AFIP has been so tied with the
20 military pathology, the VA, and the civilians, we
21 feel that the task for this committee, the
22 mission, the vision has to include all those plans

1 which are in flux.

2 And I finish there.

3 DR. POLAND: Thank you. Ms. Embry? I
4 represent the Department at these meetings, and
5 one of the things that I think would be
6 extraordinarily helpful is for you and for Dr.
7 Parisi to perhaps since now you're moving from an
8 operational role to an advisory role that it would
9 be most constructive for you to make
10 recommendations or provide some guiding principles
11 that you believe are essential that the Department
12 needs to continue to perform at a certain level
13 that we need to incorporate into our departmental
14 plans, because it is kind of an awkward situation
15 because you are currently running our capability
16 and now you're also supposed to be advising us on
17 it. So, for the next two years I think while we
18 are trying to shape those plans, when you're
19 wearing your hat as an advisor as part of this
20 Board, I think it would be very helpful to advise
21 through the Board what it is that we absolutely
22 need to preserve in terms of capability and

1 services.

2 DR. MULLICK: Right, and the committee
3 is composed of a wide variety of experts --
4 national pathologists who are experts in their own
5 field. Also we -- I have contacted the three
6 military consortiums for pathology to be on the
7 committee -- as well as the Veterans
8 Administration director of the laboratory -- so
9 that all of us when we have our first meeting we
10 will all be thinking along those lines and we will
11 definitely take up your recommendation, Dr. Embry.

12 MS. EMBRY: Well, I think we need to be
13 able to use that. We do have a change in
14 leadership, as you know --

15 DR. MULLICK: Right.

16 MS. EMBRY: Dr. Winkenwerder is leaving
17 and departing very soon, and Dr. Casscells, who
18 will be the new Assistant Secretary, will be
19 arriving on board very soon. Dr. Tornberg, who
20 was the other Deputy for Clinical Plans and
21 Policy, who had oversight over the AFIP, has
22 departed.

1 DR. MULLICK: Right.

2 MS. EMBRY: So, I -- if there's anything
3 that you could do to convene your committee and
4 make your recommendations as early as possible so
5 that the new team is informed without a whole lot
6 of background --

7 DR. MULLICK: Um-hmm.

8 MS. EMBRY: -- and is aware of the
9 requirements that we need to incorporate in our
10 plan by this December.

11 DR. MULLICK: Right.

12 DR. POLAND: Dr. Mason?

13 DR. MASON: I'm Tom Mason at the
14 University of South Florida. There's another
15 dimension. It's the intersection epidemiology and
16 pathology, and as a visiting scientist to the AFIP
17 I very proudly sent my graduate students to the
18 AFIP to work with unique pathologic information --
19 not necessarily the slides but the information on
20 cases that get sent to the AFIP worldwide for
21 referral for review, and that has led to graduate
22 degrees, and I would argue that many of us who are

1 presently educating the next generation of public
2 health practitioners would be very interested in
3 and very concerned about the maintenance of all of
4 these data on individuals from whom pathologic
5 specimens have been sent to AFIP but with adequate
6 information on the persons themselves to
7 facilitate research into ideology.

8 DR. POLAND: Thank you. Other --Dr.
9 Walker.

10 DR. WALKER: I agree wholeheartedly with
11 Dr. Paris is about the key issues of pathology and
12 driving the diagnosis and monitoring the patients
13 with disease in the military certainly as well as
14 civilian world. But beyond the issues of the
15 AFIP, which has served (off mike) referral,
16 anatomic pathology function, is the anatomic
17 pathology practice outside in the hospitals that
18 needs to be addressed by this subcommittee? And
19 there's all the laboratory medicine, microbiology,
20 clinical chemistry, blood banking, hematology,
21 molecular diagnostics -- which I think really are
22 what also need to be included in the emphasis and

1 advice given, because those are just as key to
2 care of the patient as the anatomic pathology.

3 DR. POLAND: Um-hmm. Dr. Oxman.

4 DR. OXMAN: I would request that in
5 advising the Department of Defense and the Defense
6 Health Board that the subcommittee attempt to
7 address this concern, and that is what has made
8 the AFIP and the collection of monumental value
9 has been the fact that people have referred their
10 cases for second opinions to a group that provides
11 internationally recognized expertise. If that
12 expertise is contracted out and is no longer
13 available in close association with the
14 collection, then those consultations will stop
15 coming and the collection will stop growing and
16 stop being useful. I think it's also important to
17 recognize that when one goes back to look at
18 issues like pandemic influenza and current
19 concerns one goes back and uses new techniques and
20 new ways of looking at the old and invaluable
21 cases. I'm very concerned that with what has
22 happened that whole process and that whole value

1 will be lost. So, I would like to request that
2 the subcommittee address this or attempt to
3 address this very directly and very
4 undiplomatically perhaps in its report, because
5 that's the only way it's going to be a useful
6 report.

7 DR. POLAND: Thank you. Any other
8 comments? None, okay. Thank you very much, Joe,
9 for your report. Our next speaker and last
10 speaker before we break for the morning session is
11 COL Skoville. He's the Executive Secretary for
12 the Panel on the Care of Individuals with
13 Amputations and Functional Limb Loss. This is,
14 again, our first interactions as we evolve into
15 the Defense Health Board with this panel.

16 So, COL Scoville?

17 COL SCOVILLE: Thank you. Ms. Embry,
18 Dr. Poland, distinguished Board members. The
19 Panel on Care for Individuals with Amputations and
20 Functional Limb Loss is looking at a population
21 currently at the total of 572 individuals with
22 major limb loss across all four services. Twenty-

1 three percent of these have upper extremity
2 involvement, 20 percent have multiple limb
3 involvement. We established the Board of
4 Directors of Amputee Patient Care back in
5 September of '03 to provide oversight to the newly
6 developing pattern of care we'll be providing to
7 the individuals coming back from Afghanistan and
8 Iraq with limb loss.

9 We had several preparatory meetings
10 where you establish the missions, goals -- well,
11 visions and priorities of the panel, and then we
12 became a subcommittee of the Defense Health Board
13 in October of 2006.

14 The Board membership was selected based
15 on their training and experience in the field of
16 amputee patient care and included GEN Fred Franks,
17 retired; GEN Baloney, amputee, who had navigated
18 the military system to return to duty and (off
19 mike) Vietnam era wound; Dr. Alcide LaNoue, former
20 Surgeon General, who had run one of the amputee
21 care centers during the Vietnam war era; GEN Fox,
22 who had been the commander at Brooke Army Medical

1 Center; Dr. Doug Smith, a distinguished civilian
2 orthopedic surgeon, one of the most renown in
3 amputee care in our country; Pedish(?) Shinseki to
4 represent the family members of individuals with
5 limb loss; Doug McCormick who is an above-knee
6 amputee who has expertise in legal and legislative
7 issues related to amputee patient care and
8 services for individuals with disabilities. Patty
9 Rossbach, is sitting with me, the president of the
10 Amputee Coalition of America, an advocacy group
11 looking into issues related to amputee care. Two
12 members which were originally working with us,
13 Judge Jack Farley got recalled to his position as
14 the judge on the Court of Veterans Appeals and
15 with the recall was unable to ethically be on our
16 Board and make decisions which would affect
17 activities he may have to rule on in the courts;
18 and Dr. Cussman with the VA with his advancement
19 and increased responsibilities. We are looking to
20 add a member to the Board to represent San Diego
21 and the Navy, as we have expanded services to that
22 area, and again to gain additional representation

1 for the Veterans Administration on the Board.

2 The charter that the Board developed was
3 to provide infinite advice and recommendations on
4 matters pertaining to the care and treatment of
5 patients with amputations or functional limb loss
6 within the Department of Defense. Our vision is
7 to do a collaboration of a multidisciplinary team
8 to provide world renowned amputee care, assisting
9 our patients as they return to the highest levels
10 of physical, psychological, and emotional
11 function.

12 Originally we focused just on the
13 individuals with major limb loss, and we realized
14 that there were a large number of individuals also
15 with functional limb loss, that have had knee
16 fusions, multiple fractures, nerve damage, and
17 (off mike), ultimately resulting in amputation but
18 even if they did not result in amputation severely
19 limited the individual, so we've expanded our
20 scope to look at how we're providing care for that
21 population as well.

22 The main issues that the panel has been

1 looking at -- early on we looked at the extent of
2 care. When we first started, the focus was on
3 should we get the individuals basically functional
4 and discharge them from the service and return
5 them to the community and let them fend with the
6 Veterans Administration with local care provided
7 through veterans benefits, or should we work to
8 return them to the warrior/athlete level,
9 realizing that they were tactical athletes prior
10 to injury and that was kind of their goal -- to
11 return to that level. With the Board's Guidance,
12 we've gone to that warrior/athlete. We've been
13 successful in having 63 individuals return to
14 active duty; 8 have deployed back into theater for
15 a second or third rotation.

16 The next issue is location of care and
17 number of sites. We started initially with care
18 provided just at Walter Reed. Questions about is
19 it better to provide care close to home and have
20 the patients scattered across the country or
21 develop a focus of care? The (off mike) from
22 Vietnam that the members of the Board brought

1 stated that it was probably best to provide a
2 central focus of care, and we're doing research
3 efforts to look at, to validate that, but that
4 seemed to be the best plan, and as Walter Reeds
5 capacity was reached, we were approaching the
6 capacity -- we just opened Brooke Army Medical
7 Center as a second center for care, and with the
8 Navy's desire to be involve and patients coming
9 from the West Coast, we've opened the center out
10 at San Diego as a third center for care,
11 resources, long-term sustainment for the program.

12 Amputee care in the military in the past
13 was designed to provide initial care and discharge
14 the patient into the VA health care system. As we
15 have individuals returning to service with major
16 limb loss and we're working to bring them to that
17 level, that warrior/athlete level where they can
18 make a decision of returning to service or
19 returning to the civilian community based on items
20 other than limb loss, the requirements for the
21 program, physical requirements and the long-term
22 requirements for the program are an issue that

1 we're starting to look at and how do we program
2 for this and plan to -- how can we sustain this
3 program long term, because limb loss is a
4 life-long condition to deal with.

5 Facilities -- we have had -- the
6 facilities were designed initially for the
7 short-term care. We have made renovations to
8 facilities, and we have developed new facilities
9 to provide the care.

10 The panel very early walked through,
11 looked at our facilities that exist in (off mike)
12 made recommendations on items we could do to
13 improve our capabilities within existing
14 facilities in the development of future goals or
15 facilities.

16 Return to duty -- MEB/PEB. This has
17 been evidenced more recently, but we looked at
18 this very early in our meetings, and the issue was
19 one of timing of the MEB/PEB. You wanted to keep
20 the patient on active duty and within the system
21 to get the maximum benefit of care without them
22 feeling that they were being forced out. They

1 pushed me out early. I didn't get everything I
2 needed. And at the same time, you wanted to
3 program the Board so that they were getting their
4 Board completed as they were nearing that maximum
5 benefit of care.

6 So, they didn't feel like they were
7 trapped in a system and couldn't leave and trying
8 to decide first -- you know, it went back to the
9 how long are we going to keep them? Are we going
10 to return them to a high level of function? Are
11 we going to send them to other systems using
12 TRICARE within the military system or others? So,
13 that became one that I think we're still looking
14 at and working with to come up with what is the
15 optimal solution. Much of it's individualized and
16 working with the individual patients on what their
17 goals and expectations.

18 DoD -- the VA DoD joint efforts to
19 transition care into the VA system. We have the
20 accessibility to the newest, greatest technologies
21 for our patients. We work with the appropriate
22 technology for the patient. Sometimes, you know,

1 the high-end microprocessor knee is not the
2 appropriate technology for the task, so it's
3 providing the appropriate technology. But as the
4 prosthetic companies provide us with new
5 componentry, no one else in the country has that.
6 And the VA is working with us, so they are ready
7 to provide this continuation of care. We have --
8 with members of the Board working with VA, we've
9 been able to establish a training program where VA
10 prosthetists and therapists come and spent a week
11 with Walter Reed or Brooke Army Medical Center
12 looking at what we're doing, and we do ongoing
13 training and education programs.

14 Research focus -- again, we've discussed
15 this with the Board members, looking at the wide
16 spectrum of where we should head with our
17 research. We have DARPA that is getting
18 congressional funding for research. We don't want
19 to duplicate what they're doing. We have the VA
20 that is getting funding for research. We don't
21 want to duplicate what they're doing, so looking
22 at focusing the research on short-term achievable

1 goals that are aimed at the young, healthy
2 individual that is looking to return the highest
3 level of activity is kind of the guidance we're
4 getting from our Board on that.

5 Command and control is an issue that I
6 don't think we've come to a resolution yet on.
7 The amputee care started at Walter Reed, kind of
8 Army centric early on. The Department of Navy is
9 now being involved with San Diego. With the
10 Center for Intrepid opening in San Antonio, we
11 have a number of groups that are now moving
12 forward and trying to make sure that we aren't
13 developing differences in care, differences in
14 philosophy at multiple sites where patients go
15 (off mike). "I didn't get to go there, so I
16 didn't get this" is an issue, and it's one of the
17 topics that our next meeting is going to be
18 looking at and addressing.

19 The facilities -- the Center for
20 Intrepid down in San Antonio, is an incredible
21 facility. We've had over 600,000 Americans
22 contributed to it. It is a monumental structure

1 to provide world class care. The same
2 capabilities will be available here at the
3 Military Advanced Training Center at Walter Reed.
4 Our building -- they put up structural steel. It
5 started going up in December of 2006. We have a
6 ribbon cutting we're looking at planning right now
7 for 13 September. The contract completion date is
8 22 November for joint occupancy, so we're well
9 ahead of schedule on the contract side. We will
10 have very similar capabilities to the Center for
11 Intrepid. The Center for Intrepid was designed
12 off of our plans for the Center here at Walter
13 Reed.

14 And San Diego is developing the
15 comprehensive Combat Casualty Care Center, making
16 modifications to their existing facilities to be
17 able to provide, again, a comprehensive program.

18 One point about the centers that we're
19 creating is in the center here at Walter Reed, for
20 example, we will have the -- the psychologists
21 will be housed near the veterans benefits
22 counselor; the vocational ed and rehab counselor;

1 the VA social workers; the MEB/PEB counselor; the
2 physical therapists, occupational therapists; the
3 physiatrist; the physician that is the lead for
4 the program. We're bringing all of the
5 individuals the patient has to interact with on a
6 daily basis into one central location, and by
7 bringing the MEB/PEB individuals into the same
8 building, as we work the Medical Board process the
9 patient doesn't have to go running all over or the
10 MEB counselor does not have to go running all over
11 to say this is the last piece of paper I need and
12 get delayed in the process. So, our Board -- now
13 panel -- has been moving, providing guidance to us
14 as we've evolved from an initial care program to a
15 fully evolved advanced rehabilitation program for
16 our individuals with limb loss.

17 The panel is, again, a subcommittee of
18 the Defense Health Board and will exist at the
19 pleasure of the Board and as long as we need to.

20 Any questions at this time?

21 DR. POLAND: Thank you. Thank you, COL
22 Scoville. We're anxious to engage with you on

1 this very important work. It ties in obviously
2 with a number of themes that we've talked about
3 this morning and this afternoon.

4 Any comments or questions from the Board
5 members?

6 Dr. Lauder.

7 DR. LAUDER: Thank you very much, Dr.
8 Scoville. That was an excellent presentation, and
9 a very well thought out task for us, and I commend
10 you on it, particularly with your expansion of
11 patients with, shall we say, "relative
12 amputations," and so I commend you on that.

13 I have a couple of questions, and one is
14 you seem to have everything well thought out
15 looking at a lot of different issues. Are you
16 looking at the number of staff to do this immense
17 amount of work, and by that I mean you did mention
18 physiatrists, but I know there's a small number of
19 physiatrists within the military system as well as
20 therapists and prosthetists. Are there enough
21 people to do the job, question number 1?

22 COL SCOVILLE: I believe we do have

1 enough staff. At this point we've been able to
2 use a variety of approaches to providing staff.
3 Some of the staff is involved with research with
4 the patients, so as we're treating and using
5 advanced technologies, we're researching that
6 advanced technology so we're able to use some of
7 the research dollars for some of that staffing.
8 Some of the staff is provided through core
9 dollars, because it has always been our mission to
10 provide care for limb loss, albeit at a lower
11 level. Some of the staffing is provided through
12 Dollars for the Global War on Terrorism, and some
13 of the dollars have been provided through
14 congressional add-ins, so we've been able to
15 maintain the appropriate staff level for the
16 patient population, and if you look at our
17 population, if you ask most individuals how many
18 individuals there have been with major limb loss
19 from Iraq and Afghanistan, you usually get a
20 number much higher than the 572 that we have.

21 Amputation is the most visible of
22 wounds; and other issues, like TBI and mental

1 health issues, aren't visible. If you look at
2 their numbers, they're probably higher, and if you
3 look at the resources that we have, I believe
4 we're probably well resourced for the population
5 that we're serving.

6 DR. POLAND: Please.

7 DR. LAUDER: Can I just follow up with
8 this same issue?

9 DR. POLAND: Yes.

10 DR. LAUDER: The same people that are
11 working with the amputee population are also going
12 to be working with the traumatic brain injury
13 population, and so that's the same core of
14 therapists and psychiatrists and mental health
15 staff that are going to have to work with both
16 sets of patients, and I guess that's where some of
17 my concern comes in.

18 COL. SCOVILLE: Yes, and a number -- by
19 virtue of the injury, most of our individuals'
20 limb loss has been the result of some form of
21 blast trauma, and many have at least a mild
22 traumatic brain injury, so there is overlap

1 between the two very closely. We have recently --
2 I know at Walter Reed we've been expanding the
3 number of individuals we have to deal with -- the
4 traumatic brain injury population as well. We've
5 created a weekly clinic where we're bringing in --
6 we've always had a weekly clinic for our amputee
7 patients where we bring in all of the
8 subspecialties once a week and bring the patients
9 in for an assessment -- how are they doing -- and
10 making sure we're touching base with the patients,
11 knowing where they're going, and that everyone
12 involved on the team knows where they're going.

13 We've been doing the same with the
14 traumatic brain injury. We created a weekly
15 clinic every Wednesday in physical medicine with
16 our physiatrists, and because Walter Reed has the
17 physiatry residency program, we're able to really
18 meet the need right now. We're working, again, to
19 gain staff as we expand the TBI mission and role.

20 Yes.

21 DR. POLAND: Dr. Oxman and then Dr.
22 Luepker.

1 DR. OXMAN: I would like to also commend
2 the subcommittee for really approaching the whole
3 comprehensive care of these individuals. I wonder
4 -- because the combination of severe traumatic
5 brain injury and limb function loss escalates the
6 challenge, I wonder how many of the individuals
7 have been able to look at and are caring for now
8 are in that category and what you think about the
9 capacity to deal with the increasing number of
10 those that will be flowing into the system.

11 COL SCOVILLE: I think we've been
12 fortunate that the number of people with the
13 severe traumatic brain injury and with limb loss
14 has been relatively low. For that population, the
15 traumatic brain injury is the most significant
16 wound. The ability to manipulate prosthetic
17 devices, the ability to plan for moving with the
18 prostheses is paramount to being able to do the
19 therapy for the amputation, so it's been -- the
20 emphasis has been -- with that population, the
21 emphasis has been more on the traumatic brain
22 injury and resolution of that and working with

1 very simple prosthetic componentry and evolving
2 the prosthetic componentry as a traumatic brain
3 injury resolves.

4 We've had, unfortunately, several
5 individuals that have had loss of eye sight as
6 well as loss of upper limb, which makes that a
7 catastrophic injury. So, there are those issues,
8 and those we work very closely with the VA with
9 their traumatic -- with their polytrauma centers
10 that they've established where they're doing the
11 traumatic brain injury -- the blind rehab, the
12 prosthetic rehab -- and we work the patients back
13 and forth, so they'll go with the VA and spend
14 some time focusing on certain issues there.
15 They'll come back to us and we'll focus on issues,
16 and it's a very close tie for those patients. But
17 we can always do -- you know, we can always do
18 more.

19 DR. POLAND: Dr. Luepker.

20 DR. LUEPKER: Yes. Thank you for an
21 excellent report. I wonder if I'm effectively
22 reading between the lines or over- interpreting

1 something you said. You know, it's apparent that
2 the ways we now have to deal with limb loss -- the
3 technology is extraordinary, and enormous advances
4 have been made -- but I wonder if you set goals of
5 return to active duty, and you mentioned eight
6 people who have done that, you know, where does
7 that leave the large number of people who will be
8 discharged to the VA as opposed to --

9 COL SCOVILLE: Well, the goal is not to
10 return to active duty. The goal is to get them to
11 a level of capabilities where they can make a
12 decision of "do I return to active duty or do I go
13 and do other things?" I've had a large number of
14 individuals that have been capable of returning to
15 active duty that have participated on our 10-miler
16 team, that have run marathons, that because of the
17 benefits they join the military to get the GI
18 Bill, to get educational benefits. They have
19 those educational benefits; they also have the
20 veterans benefits related to the disability.

21 And it is -- we've even counseled
22 individuals that returning to duty is not the

1 right choice for them, that they need to move into
2 the civilian sector because the benefits of
3 staying on active duty versus taking a medical
4 discharge -- it's much more advantageous for them
5 to return to the civilian sector. An example --
6 we had an individual who was a reserve service
7 member that wanted to go back into the active
8 reserve. His wife was pregnant, his unit was
9 ready to demobilize in two months. He wanted to
10 be back with his unit when they demobilized. He
11 would have gotten continual care for his limb loss
12 because of the medical connection there, but the
13 health care benefits for his wife during the
14 pregnancy would cease once the unit demobilized
15 and he was no longer active reserve. So, we have
16 to work with them more frequently on what is the
17 right decision for the individual. But the goal
18 is not to say "you need to go back to duty." The
19 goal for us is to try to achieve with each patient
20 -- and we will not achieve it -- but our goal is
21 to get each patient to a level where they can make
22 an educated decision on whether they return to

1 active duty or don't return to active duty based
2 on things other than limb loss.

3 DR. POLAND: Dr. Lauder?

4 DR. LAUDER: This is Dr. Lauder. I have
5 another question. I guess I need further
6 information from you or perhaps there is a
7 question in this as well. I'm not sure best how
8 to term it, but my question focuses around the
9 most appropriate prosthesis versus the best
10 prosthesis, and for each individual there's an
11 appropriate prosthesis for their level of
12 activity.

13 COL SCOVILLE: Yes.

14 DR. LAUDER: And that stems down a long
15 line of cost containment from where that
16 individual goes after active duty and where he can
17 get his prosthesis, because most private
18 insurances do not pay for most prosthetics. So, I
19 guess I'm trying to find out where is this
20 individual if he doesn't have a high level of
21 disability or -- I mean, is he going to continue
22 to get it through the VA system, or is he going to

1 be left out on his own then later to have to pay
2 for a very expensive high-level prosthesis or
3 what's kind of the result?

4 COL SCOVILLE: The individuals are -- as
5 they -- if they remain in the military and their
6 care is provided through the military, if they are
7 medically discharged from the military, they have
8 dual eligibility both through the VA system and
9 through the military, either, you know, through
10 the TRICARE system whether they are close to a
11 military base in the TRICARE prime or they are
12 remote and they've got TRICARE standard. There
13 are still the benefits and the links to the
14 military system into the VA. I work very closely
15 with Fred Downs, who is the lead for Veterans
16 Affairs with the durable medical equipment, which
17 includes prosthetic devices, wheelchairs, the
18 racing bikes that are specially designed for
19 individuals with limb loss, and our goal is to
20 make sure we don't let the guys slip through the
21 cracks. And as I said earlier, we make sure we
22 provide the appropriate technology. We look at

1 what the individual wants to do. You know, if
2 they're going to be out hunting and slopping
3 through the woods, you don't want to give them a
4 computer chip in their prosthesis because it's
5 going to malfunction out in the middle of the
6 woods and they're kind of stuck there. So, we may
7 give the individual three, four, five different
8 prosthetic devices for various activities based on
9 what their returning to, or they may get one
10 because that's what their goals are, what they're
11 functional needs are. It's meeting the individual
12 needs of the patient, and it's a combination of
13 the military, the VA, and the VA contracts or
14 works with civilian prosthetists across the
15 country. They have a network of providers, and
16 they will move the patients to the appropriate
17 site for the care that's needed.

18 DR. LAUDER: And has that been paid for?

19 COL SCOVILLE: Yes.

20 DR. LAUDER: Completely for the patient.

21 COL SCOVILLE: That -- there are a
22 couple of issues where is not completely paid for,

1 and we're working those right now through various
2 channels.

3 DR. POLAND: Dr. Walker.

4 DR. WALKER: Could you explain to me the
5 system for a long-term, hopefully long follow-up
6 for the outcomes and complications if they occur?

7 COL SCOVILLE: We have a database we've
8 developed, which we're getting each of the
9 patients to either agree to be a member of or not
10 or bringing them back for research related to
11 long-term outcomes. We are doing phone contacts
12 with them. Definitely they're calling us. They
13 see something on the news about a new foot that's
14 out or a new ankle that's out or a new hand that's
15 out and we get five or six phone calls right --
16 you know, when there's something on the news,
17 because the patients want to know what it is and
18 if it is a significant enough improvement that
19 would warrant replacing their current prosthetic
20 device. Some of the knees were just upgraded, and
21 it's inappropriate to give them, you know, the new
22 model, because it's not significantly different

1 except in very specific patient situations, and
2 we'll have the patients' records and history and
3 skill sets evaluated by our team of, now, OT/PT,
4 social worker, physiatrist and determine is this
5 an appropriate device for this patient and then
6 work with the patient to either educate them as to
7 "it really doesn't make a difference in the
8 activities you're doing" or "this is really
9 important" and work through the system to get them
10 the updates. But we have a number of research
11 protocols looking at long-term follow-up with the
12 patients.

13 DR. POLAND: Dr. Cattani?

14 DR. CATTANI: Jackie Cattani -- sorry.
15 Are there differences in benefits that are
16 available in the long term based on whether
17 someone is active or a reservist in terms of the
18 new technology that we develop follow-up for
19 amputees that were reservists?

20 COL SCOVILLE: No, none that I'm aware
21 of.

22 DR. CATTANI: They're all eligible.

1 COL SCOVILLE: They're eligible.
2 They're medically retired or they're continuing on
3 active duty and we're providing the same care to
4 all groups.

5 DR. POLAND: Did you have something?

6 MS. ROSSBACH: No, I just wanted to
7 reaffirm that nobody was going to go back into the
8 civilian sector and depend upon third-party payers
9 within civilians to pay for their prostheses,
10 because we all know they don't pay, so I wanted to
11 make sure but --

12 DR. POLAND: Okay. Thank you very much.
13 COL Gibson has some comments.

14 COL GIBSON: Today's presentations will
15 be available on the Defense Health Board website
16 by the end of the week. The transcripts for this
17 morning's session will also be available through
18 the Defense Health Board website in about seven
19 days. The website is www.ha.osd.mil/dhb.

20 DR. POLAND: Okay, this concludes the
21 morning session of this meeting. We will break
22 for lunch. We will return at 2 p.m. to deliberate

1 the draft findings and recommendations of the
2 independent review group.

3 Ms. Embry, would you adjourn us, please?

4 MS. EMBRY: This morning session is
5 hereby adjourned.

6 (Whereupon, a luncheon recess was
7 taken.)

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

1 A F T E R N O O N S E S S I O N

2 DR. POLAND: If I could have people take
3 their seats, please, we'll begin the Afternoon
4 Session.

5 Good afternoon, to everybody. And
6 welcome to this session of the Defense Health
7 Board.

8 Ms. Embrey, would you like to call this
9 Open Session of the DHB to order?

10 MS. EMBREY: Yes, Dr. Poland, I
11 certainly would.

12 As the designated Fellow Official for
13 the Defense Health Board, a Federal Advisory
14 Committee to the Secretary of Defense, which
15 serves as a continuing Scientific Advisory Body to
16 the Assistant Secretary of Defense for Health
17 Affairs and the Surgeons General of each of their
18 Military Departments, I hereby call this
19 afternoon's meeting to order.

20 Dr. Poland.

21 DR. POLAND: Thank you. The tradition
22 we have at the Defense Health Board, we usually do

1 it at the very opening of the first day, but given
2 the significance of this afternoon's meeting, I'd
3 like to do the same today, and, that is, to ask
4 all that can to stand for one minute of silence to
5 honor those that we are here to serve, men and
6 women, who served our country.

7 (Moment of Silence.)

8 DR. POLAND: Thank you. You may be
9 seated. Before we begin our deliberations, I
10 would like to welcome the co-chairman and members
11 of the Independent Review Group who the Secretary
12 of Defense charged to report on rehabilitative
13 care and administrative processes at Walter Reed
14 Medical Center and the National Naval Medical
15 Center.

16 Since its establishment by Secretary
17 Gates as a Defense Health Board Subcommittee on
18 March 1st of this year, the group is fully engaged
19 in gathering information on the issues at these
20 two medical centers, as well as identifying the
21 underlying issues challenging the provision of
22 high quality care and treatment for our military

1 members and their families.

2 I would like to personally, on behalf of
3 the Board, commend the efforts of the group and
4 their staff for all their hard work. I speak for
5 the entire Board when I say our service members
6 deserve the finest medical care available and to
7 be treated with the dignity due to anyone who
8 places him or herself in harm's way to protect
9 this nation and our freedom.

10 I also want to say a personal "hello" to
11 a number of distinguished guests who are with us
12 today.

13 RADM Brusick Core (?) is here with us;
14 RADM John Mateczun. I'm not sure if he actually
15 made it or not. Okay. Dr. Charles Rice,
16 President of UCIS; RADM Adam Robinson; Major
17 General Eric Schoomaker; and, RADM Mark Tedesco.
18 Before we begin, I would also like the Board and
19 IRG members to introduce themselves, and I'll
20 start by asking the Assembly, and we'll work our
21 way around both sides of the table.

22 MS. EMBREY: I'm Ellen Embrey. I work

1 for the Department of Defense. I'm the Designated
2 Federal Official for the Board and for the IRG.
3 And my official duties in the Department is as the
4 Deputy Assistant Secretary of Defense for Force
5 Protection and Readiness.

6 SECRETARY WEST: I'm Togo West, and I'm
7 one of the two co-chairs of the IRG.

8 SECRETARY MARSH: My name is Jag Marsh.
9 I am the other co-chair. I'm former (off mike) of
10 Virginia, former Secretary of Army, as was Mr.
11 West.

12 MR. BACCHUS: My name is Jim Bacchus,
13 and I'm one of the members of the Independent
14 Review Group.

15 MR. SCHWARZ: I'm Joe Schwarz, former
16 member of Congress, practicing physician, and
17 member of the IRG.

18 MR. ROADMAN: I'm Chip Roadman. I'm the
19 former Surgeon General of the United States Air
20 Force, retired in 1999, and member of the IRG.

21 MS. MARTIN: I'm Cathy Martin, retired
22 Navy Admiral, and I'm a member of the IRG.

1 MR. FISHER: I'm Arnold Fisher, and I'm
2 a member of the IRG.

3 MR. HOLLAND: I'm Commander Major
4 Holland, retired, from -- the last assignment was
5 the Senior Most Advisor to the Assistant Secretary
6 of Defense for Reserve Affairs.

7 MS. ROSSBACH: I'm Patty Rossbach, and
8 I'm a member of the Panel on the care of
9 Individuals with Amputations and Functional Limb
10 Loss.

11 DR. GARDNER: Louis Gardner, a Board
12 member and Professor of Medicine and Public Health
13 at the State University of New York at
14 Stonybrook.

15 MS. KITTANI: Jacqueline Kittani. I'm a
16 consultant to the Defense Health Board and
17 Professor of Public Health at the University of
18 South Florida, College of Public Health.

19 DR. MASON: I'm Tom Mason, Professor of
20 Epidemiology, University of South Florida, College
21 of Public health, and also the director of the
22 Global Center for Disaster Management and Managing

1 Assistant.

2 DR. HALPERIN: Bill Halperin. I'm Chair
3 of the Department of Preventive Medicine at the
4 New Jersey Medical School and Chair of the
5 Department of Quantitative Methods in the School
6 of Public Health, both in Newark, New Jersey.

7 MS. ROTTER: Tanya Rotter (?), Board
8 Member, Physical Medicine/Rehabilitation,
9 Minneapolis, Wisconsin.

10 DR. RUSSELL: Kissan Russell (?),
11 Rutgers, Board Member, and I'm Professor of the
12 Epidemiology in Medicine at the University of
13 Minnesota.

14 DR. SILVA: Joe Silva (?), Board member,
15 Professor of Medicine, University of
16 California-Davis.

17 DR. MILLER: Mark Miller, Board member
18 and Associate Director for Research at the Fogarty
19 International Center, National Institute of
20 Health.

21 DR. BRONCK: Nico Bronck (?), Board
22 member, Vice President for Health and Disease

1 Management, Health Partners, Minneapolis.

2 DR. ROCKIE: Jim Rockie (?), Board
3 member, Professor of Pulmonary Medicine,
4 Environmental Health, University of Cincinnati,
5 College of Medicine.

6 DR. TEIR: (off mike) Teir (?),
7 Pathology, Director of the Center for Bio-Defense,
8 Emerging Infectious Diseases, University of Texas
9 Medical Branch at Galveston, and Board member.

10 DR. PARKINSON: Mike Parkinson, Board
11 member, Chief Health and Medical Officer of
12 Luminos (?), a consumer-driven plan, which is a
13 subsidiary of Well Plan(?).

14 DR. CAPLAN: Edward Caplan, a Board
15 member, Professor of Pediatrics, University of
16 Minnesota Medical School, Minneapolis.

17 DR. OXMAN: Mike Oxman, Board member,
18 Professor of Medicine and Pathology, at the
19 University of School of Medicine, in San Diego.

20 DR. CLEMONS: John Clemons, Board
21 Member/Chairman of Microbiology and Immunology, at
22 Tulane University School of Medicine, in New

1 Orleans.

2 DR. McNEIL: Neils McNeil (?), Director
3 of Mississippi Public Health Laboratory, in
4 Jackson, Mississippi.

5 DR. RISSI: Jeff Rissi (?), a Board
6 member and Professor of Pathology at Mineo (?)
7 Clinic, Rochester, Minnesota.

8 DR. NIGEL: Nigel (?), Board member,
9 Bio-Emphasis, Professor at University of Maryland,
10 School of Medicine.

11 DR. GIBSON: Roger Gibson, Executive
12 Secretary, Defense Health Board.

13 DR. POLAND: I'm Greg Poland. I'm
14 President of the Defense Health Board and
15 Professor of Medicine and Infectious Diseases at
16 the Mayo Clinic, College of Medicine, in
17 Rochester, Minnesota.

18 For those in attendance today, this
19 session of the Defense Health Board provides the
20 Independent Review Group an opportunity to
21 deliberate their draft findings and
22 recommendations in a forum open to the public.

1 The discussions will remain between the
2 members of the Defense Health Board and the
3 members of the IRG.

4 If time allows, at the end of the
5 session we will hear from those who submitted
6 statements prior to the meeting.

7 If you wish to speak, we ask that you
8 register at the desk just outside the doors to the
9 members right.

10 Everyone has the opportunity to submit
11 written statements to the Defense Health Board.
12 Statements may be submitted today at the
13 Registration desk, outside the double doors, or by
14 e-mail, to the following address: Dhb@ha.osd.mil,
15 or they may be mailed to the Defense Health Board.
16 The address is also available on flyers located at
17 the Registration table.

18 I'll ask now if Secretary Marsh and then
19 -- I'm sorry Secretary West and then Secretary
20 Marsh would like to make any opening remarks, and
21 then I will make a set of opening remarks.

22 SECRETARY WEST: Secretary Marks is a

1 veteran of World War II. His service far -- to
2 the nation far proceeds mine, and so I am going to
3 ask him to go first, and then I'll follow.

4 SECRETARY MARSH: I was going to let you
5 go first.

6 (Laughter)

7 SECRETARY MARSH: As I indicated
8 earlier, my name is Jack Marsh, and I had the
9 opportunity to co-chair with a very distinguished
10 American, to my left, Togo West.

11 A couple opening comments. First, Mr.
12 Chairman, I thank you for this opportunity to
13 appear before your Board and appeal the members of
14 your Board to consider as a another role these
15 suggestions and recommendations that our Panel
16 makes, because we think they'll make a
17 contribution to the medical/health community of
18 our great nation.

19 You know that there's always been an
20 American ethic, and the American ethic is -- as
21 Togo said, I'm said a veteran of World War II.
22 The American ethic is America always takes care of

1 its wounded, and that's -- we've gotten to be
2 certain that we continue to emphasize that ethic.

3 And what we're endeavoring to do in this
4 report is to bring to your attention a number of
5 things to improve and strengthen and correct some
6 of the deficiencies that we've observed in the
7 medical system as it relates, principally, to
8 Walter Reed and to Bethesda, although our
9 observations about Bethesda were not as deep or as
10 concerned as about Walter Reed. But there's a
11 difference between the two hospitals.

12 But I would point to you that we have on
13 this Board, and I would suggest in your questions,
14 that you direct many of your questions to the
15 members of the Board who have skill and expertise
16 in medicine and in nursing.

17 And there are a whole range of things
18 that contributed to this report, and they were
19 major contributors to the report.

20 We place a great emphasis on families.
21 We place an emphasis on the Guard and on the
22 Reserve. In doing that, we do not diminish our

1 emphasis on the active force and recognize it, but
2 we do emphasize families, and families impact on
3 the active and the guard and reserve.

4 As a father who had a severely wounded
5 son, I can emphasize with the concerns that people
6 have about medical treatments and how they are
7 treated.

8 And I think you are going to find that
9 the trauma care that exists for those who are
10 wounded and injured is outstanding. And, yet,
11 it's after the hospitalization and stabilization
12 and the outpatient status that would emerge you
13 begin to see so many of these problems occur.

14 Now, we are on the view -- and I need to
15 emphasis -- first, re-solicit the help of the
16 Board. Your expertise and background could carry
17 great weight, not just in the Department of
18 Defense, but in our country, because of your
19 recognized leadership.

20 But we're going to need, in order to
21 implement this, the help and support from the
22 other services of the Department of Defense.

1 We're going to need the help of the
2 Department of Defense, the Veterans
3 Administration, OMB, OPM, and, above all, we're
4 going to need the help of the Congress of the
5 United States that has ultimate responsibility for
6 the creation, maintaining and support, of our
7 medical system, and our Armed Forces.

8 We have reason to think that some of the
9 observations that we make here are systemic.
10 Although we were charged to look at Walter Reed
11 and, to a lesser extent, Bethesda, we did
12 encounter indications that some of the problems
13 that we addressed principally here at Walter Reed
14 do exist in other military medical facilities of
15 our Armed Forces.

16 We did not pursue that, but we point out
17 the fact that that could be the case.

18 I think you will find what we call in
19 our report the confluence of the circumstances
20 that led to the perfect storm here at Walter Reed.

21 One: The increased flow of casualties
22 from the War, significantly, above what they had

1 anticipated. The implementation of A-76, a
2 federal government-wide program, begun in the
3 1960s, administered OMB, that impacted adversely
4 at this time of confluence; BRAQ (?), the decision
5 that was made to close the Army's hospital at this
6 time, was another circumstance.

7 And then the large number of soldiers,
8 who would go into the status of "whole-ropers",
9 would place an enormous requirement on the
10 facility.

11 So these are the things that we will lay
12 out. We invite you to look at it and read it, but
13 we, more importantly invite you to give your
14 support to redeem these things, in the Department
15 of Defense, in the Congress of the United States.
16 We think that it can be done. We're confident
17 that people will respond to that.

18 I think you for attendance here today.

19 DR. POLAND: Secretary West.

20 SECRETARY WEST: Thank you, Dr. Poland,
21 as always.

22 Secretary Marsh, thank you for giving

1 eloquent and thorough coverage to what we on the
2 IRG have been concerned with.

3 There is, of course, a wealth of good
4 news about these two facilities, Walter Reed Army
5 Medical Center, the National Naval Medical Center,
6 Bethesda. But we were not called in to being, to
7 search out the good news.

8 The fact is, if you listen to Talk Radio
9 and hear what's going on, you hear people calling
10 in all over the place, saying how much they admire
11 what has happened to them at Walter Reed, how
12 grateful they are for it.

13 By the same token, when I had a chance
14 to just sit in the lobby and talk to patients
15 coming in, every one of them -- the outpatients
16 who were coming here, who are true outpatients,
17 who are coming out from far outside the area, for
18 care at Walter Reed, spoke glowingly of the care
19 they received here.

20 So having mention those two balancing
21 items, one that we were not called in to find the
22 good news, we were called in to find out what, if

1 anything, there needed to be done, let me say
2 this: Walter Reed Army Medical Center bears the
3 motion distinguished name in American military
4 medicine.

5 It, and its colleague to the North, the
6 National Naval Medical Center in Bethesda, set the
7 standard for health care in DoD.

8 Recent reports, the activities that have
9 called us into being for our review suggest,
10 however, that, although Walter Reed's rich
11 tradition of flawlessly rendered medical care of
12 the highest quality, remains to this day
13 unchallenged, its highly-prized reputation does
14 not remain unchallenged.

15 Fractions fractures in its continuum of
16 care, especially as it pertains to care and
17 support for its outpatient service members have
18 been reported by being reviewed not only by us but
19 by veritable, I don't know, cavalcade, of panels,
20 organizations, officials, and, yes, even those who
21 report upon the daily national life, either
22 electronically, or in daily, or periodic

1 publications. And justly so.

2 Failures of leadership. Virtually
3 incomprehensible inattention to maintenance of
4 non-medical facilities, and a repeatedly, almost
5 palpable disdain for the necessity of continuing
6 support for recovering patients and their families
7 have led the growing list of indictments of this
8 once, and still proud, medical facility.

9 Our report is likely to be replete with
10 findings and recommendations covering a wide range
11 of issues and circumstances that have been brought
12 to our attention. They appear to converge,
13 however, around four core concerns, and my
14 co-chair touched on them so I will try not to be
15 redundant. Let me pose them, then, as questions.

16 First: Who are we? The country, in the
17 case of Walter Reed as an Army, in the case of
18 both medical centers, as centers of medical
19 assistance and support.

20 Unfortunately, if one considers the
21 reports we have heard in the IRG, as we've gone
22 about our business, from service members and their

1 families, about the lapses and support of them
2 during their rehabilitation phase of care at
3 Walter Reed, we would conclude that we may be
4 answering that question in ways that are not
5 attractive to us, as a nation or as services.

6 We say so much about ourselves as a
7 nation and about military services, about
8 attitudes we displayed towards those who look to
9 the nation for support during the most vulnerable
10 times of their lives. And we, on the IRG, in view
11 of that, are considering a number of
12 recommendations and findings involving the
13 assignment and training of case workers, increases
14 in the number of case numbers, and adjustment to
15 the case worker to patient ratio, assignments of
16 primary care physicians. All the questions about
17 how do we demonstrate our attitude about those who
18 have served and suffered.

19 Secondly: Who are we, and what are we
20 to become? That is actually my question that
21 frames Secretary Marsh's reference to the BRAQ and
22 A-76 procedures, and the potential difficulties;

1 in fact, the difficulties they've inflicted on
2 Walter Reed, and may inflict on both institutions.
3 I won't touch on that further. The point is that
4 is our second concern.

5 The one thing that I would point out is
6 that we will have a recommendation about BRAQ and
7 about the need for proper transition.

8 Thirdly: How are our service members
9 doing? At every turn the IRG has encountered
10 service members and families, health care
11 professionals, and thoughtful observers, who point
12 out how challenging the traumas associated with
13 TBI, traumatic brain injury, and PTSD,
14 post-traumatic stress disorder, have become, and
15 how further challenging they have been in terms of
16 both DoD and Department of Veteran Affairs
17 diagnosis and treatment.

18 We believe, and are likely to conclude,
19 that there is need for greater and better
20 coordinated research in this area. We anticipate
21 a substantial recommendation with respect to
22 Centers of Excellence.

1 And, fourth -- now, this is the last
2 one, so let me just tell you that I had a little
3 disagreement with the person assisting me in
4 typing this up, although it's been -- it's a
5 question.

6 The question says: How long? I
7 originally had it say, "How long, oh, Lord, how
8 long?" It refers to the Disability Review
9 process.

10 If there is one issue that has generated
11 unanimity on the IRG, and we have proceeded with
12 remarkable unanimity and consensus, I would virtue
13 to say -- but, Dr. Poland, you'll hear from our
14 members shortly whether I'm right or not -- I
15 would virtue to say, on this, we are as unified as
16 any organization will be, and that's very unified.

17 And our belief that the horrors that are
18 inflicted on our wounded service persons and their
19 families, in the name of Physical Disability
20 Review, known as Department of Defense, as the
21 MEBPE process, simply must be faced.

22 It is, I'm sure, no surprise to the

1 members of the Defense Health Board, as it was no
2 surprise to us in the IRG, that each part of the
3 governmental process can make sound arguments to
4 defend and explain why three, and in the case of
5 the Army, four separate Board proceedings, with
6 associated paperwork demands on the wounded
7 service member and family, accompanied by delays
8 and economic dislocation for assisting family
9 members, and characterized prominently by
10 inexplicable, to the service men, differences in
11 standards and results are justified.

12 We, however, are a nation that values
13 the good sense of common men and women. That's
14 why we call it common sense. And common sense
15 says that, from our service members and family's
16 point of view, this must seem a wildly
17 incomprehensible way to settle for service members
18 and families the question of whether the member
19 must leave the service and, if so, under what
20 circumstances.

21 We will, undoubtedly, have a
22 recommendation of some consequence. Well, it

1 certainly is some sense of unanimity from us on
2 how that system might need to be combined and
3 consolidated into a reasonable process from the
4 service member's point of view.

5 Thus, virtually every finding and
6 recommendation we will make can be traced back to
7 these four concerns:

8 One: Leadership and attitude. That's
9 the first two. Transition from Walter Reed Army
10 Medical Center to Walter Reed National Medical
11 Center.

12 Three: The extraordinary use of IED,
13 devices in the current wars, and their impacts on
14 the brains and psyches of our service members, and
15 how we should deal with that.

16 And, four: The longstanding and
17 seemingly intractable problem of reforming the
18 disability review process.

19 To be sure, it was the degradation and
20 facilities that first caught the eye of media
21 reporters. Important as that is, we believe that
22 there is far more to be dealt with here in

1 applying painting rooms or crawling around
2 basements to finally deal with electrical
3 problems.

4 We have experts of every sort assigned
5 to us, to our staff. And we've got, as you heard,
6 members of the health community on the IRG, with
7 experience and expertise.

8 And, yet, none of these concerns is our
9 bottom line. Not break, not failings, not
10 breakdowns, and not culprits. This is, I would
11 suggest, our bottom line: We are the United
12 States of America. These are our sons and
13 daughters, and brothers and sisters, and maybe an
14 uncle and aunt, even a grandparent or two, who
15 sit, if they can, who lie, who find themselves
16 before us, in the car as it is in the rooms, if
17 they are fortunate, walking along the pathways
18 here at Walter Reed and at Bethesda.

19 Their families are our families, and we
20 are their neighbors, their fellow citizens, their
21 anguish is ours. We can and must do better.

22 Thank you.

1 DR. POLAND: I'd also like to make a few
2 remarks on behalf of the Defense Health Board and
3 then open it up for individual Board comments and
4 questions. To start with, we very much want to
5 thank the Independent Review Group for
6 rehabilitative care and administrative processes
7 at Walter Reed Army Medical Center and National
8 Naval Medical Center for the serious and focused
9 attention they have given the matters before us
10 today.

11 I personally attended one of their
12 meetings on behalf of the Defense Health Board and
13 was impressed with their engagement and their own
14 frustrations at the current system and resulting
15 issues. Let me assure everybody in attendance
16 here today that I observed what I would call a
17 let's roll up our sleeves and fix these problems
18 and let's do it now attitude.

19 So we thank Secretaries West and Marsh,
20 as well as the other IRG members for providing the
21 DHB with preliminary information despite a very,
22 very tight and accelerated time line.

1 Now, there are soldiers sitting before
2 me, and sailors, and air men, and their family
3 members, and I want to speak to you, and this is a
4 little personal. Up until a few months ago, for
5 the last 52 years, direct members -- immediate
6 members of my family have served in the Marine
7 Corps, they have been wounded in combat, and I
8 know the frustrations first hand of what that
9 means.

10 I have a son hoping to enter the Air
11 Force, and I, myself, served as a VA physician for
12 two years and saw first hand the kind of care
13 we're capable of giving when it's called upon. So
14 these issues for me today that we're going to talk
15 about are not academic, these are personal. I
16 also want to start with what is perhaps an obvious
17 statement, that the willingness of our citizens to
18 participate in the future defense of our country
19 is in direct proportion to how they see us treat
20 the current members of our military.

21 What might not be obvious is that these
22 words were first spoken by General George

1 Washington in the 1700's. But General
2 Washington's words had historical precedent. In
3 1636, the pilgrims of Plymouth Colony passed a law
4 which stated that soldiers disabled during war
5 with the Indians would be supported by the Colony.
6 It's instructive to listen to how the law read.
7 If any man shall be sent forth as a soldier and
8 shall return maimed, he shall be maintained
9 competently by the Colony during the rest of his
10 life. Later, the first U.S. Congress in 1789 also
11 recognized the country's responsibility toward
12 wounded and disabled veterans and passed a law to
13 provide pensions to disabled veterans and their
14 dependents. The Continental Congress of 1776
15 encouraged enlistments during the Revolutionary
16 War, how, by providing pensions for soldiers who
17 were disabled.

18 It's further instructive to recall the
19 last words of President Abraham Lincoln's second
20 inaugural address in 1865, after the bloody Civil
21 War, when he stated, "Let us strive on to finish
22 the work we are in, to bind up the nation's

1 wounds, to care for him who shall have born the
2 battle, and for his widow and his orphan." In
3 1811, the first domiciliary and medical facility
4 for veterans was authorized by the federal
5 government progenitor of the modern day VA system,
6 whose mission is, and it's important that we say
7 these words, to serve Americans, veterans, and
8 their families with dignity, with compassion, and
9 be their principal advocate in ensuring that they
10 receive medical care, benefits, social support,
11 and lasting memorials promoting the health,
12 welfare, and dignity of all veterans in
13 recognition of their service to this nation; to
14 care for him who shall have born the battle, and
15 for his widow and his orphan.

16 One hundred and forty-two years later,
17 we must hear this call to do what is right and to
18 reaffirm our duty to provide what we must to our
19 wounded warriors and their families.

20 The problems we are here to discuss
21 today do not represent the failings of any one
22 person or any one entity, as Secretary West

1 alluded to. To believe otherwise is to prove the
2 old saw that for every complex problem, there is a
3 simple, but wrong solution.

4 Rather, this is a systems failure, a
5 complex tangle of chronic, acute, anticipated, and
6 even unanticipated problems that have come to
7 light. For some of these issues, the causes are
8 clear and the solutions immediate. There is no
9 need for debate or hesitation; these are issues
10 for which standards of care and standards of
11 management already exist, we need only implement
12 them. For other issues, we need to be clear that
13 simple solutions don't exist. For example, an
14 unanticipated result of the current Gulf War is
15 that of the severely multiply wounded soldier who,
16 because of modern medicine and the unparalleled
17 ability of our nation's military medical system to
18 provide immediate outstanding quality medical
19 care, that soldier now survives, but also now
20 requires significant medical and rehabilitative
21 medical support further exacerbated by a new type
22 of injury, at least in terms of the magnitude of

1 cases, that of concussive blast injuries leading
2 to traumatic brain injury or TBI that requires
3 life long care and support.

4 Thus, while there are some immediate
5 administrative solutions to the current set of
6 problems, there are other issues whose solutions
7 will not be simple, which will not be immediate,
8 that will not be inexpensive, and that will not be
9 one time fixes. This is exemplified by the
10 findings and recommendations of the Department of
11 Veteran Affairs OIG report on medical treatment of
12 veterans after a traumatic brain injury.

13 Finally, the DHB has carefully reviewed
14 the terms of reference for the IRG, they are
15 specific, yet broad in scope, certainly broader
16 than what can be addressed, much less data
17 collected and understood within the time lines
18 allowed to the IRG.

19 But it is important to point out that
20 the IRG has put its finger on the key pressing and
21 compelling issues that deserve both immediate and
22 sustained attention. With that, what I would like

1 to do is now open up the floor for the board
2 members to ask questions and have dialogue with
3 the IRG members. Thank you. Doctor Silva.

4 DR. SILVA: Joe Silva; within the board,
5 were there data that there's a stacking up of
6 patients awaiting processing? Should there be a
7 fast track system set up, if so, for those that
8 have had unusual waits or unusual family and
9 personal circumstances?

10 SECRETARY MARSH: Mr. Chairman, I would
11 suggest that someone with particular expertise in
12 that area might respond that either -- Congressman
13 Schwarz, do you want to take that?

14 MR. SCHWARZ: The short answer, Doctor
15 Silva, is yes and yes, but we were able to track,
16 and I'd like to say Sergeant Major Holland, Doctor
17 Roadman, and myself, but other members, as well,
18 Congressman Bacchus, as well, tracked numbers of
19 people who were medical holds and holdovers.
20 There is a distinction in the definition there
21 that we'll let Doctor Roadman get into.

22 But the answer is yes, and that, indeed,

1 is one of the problems, much more a problem here
2 than at Bethesda, because of the numbers of
3 wounded here at Walter Reed are far greater than
4 those at Bethesda. And the problem is the fact
5 that the administrative wheels turn slowly. And
6 then there are problems with domiciling these
7 people, because there certainly wasn't room here,
8 some of them living on the economy. We can give
9 you specific cases where we have been involved in
10 trying to resolve some of these problems. And I
11 must say, after pointed out to the command here at
12 Walter Reed, they acted rapidly and I think quite
13 appropriately to try to alleviate some of the
14 problems. But the answer to your question, short
15 form, yes and yes.

16 DR. SILVA: Thank you.

17 SECRETARY MARSH: Chip, do you want to
18 add?

19 DR. ROADMAN: No, sir. Well, since
20 Congressman Schwarz decided I was going to talk
21 about hold and holdover, the hold is active duty
22 people waiting for their boards, holdover is

1 guard, or reserve components, guard and reserve in
2 holdover. There probably have been in the past
3 administrative reasons for doing that because of
4 administrative reasons.

5 It produces a significant problem, and
6 there is a perception that within the treatment
7 facilities, there is a stratification based on
8 whether you're active duty or whether you're guard
9 reserve, and we believe that the hold/holdover
10 separation actually reinforces that what we have,
11 in short hand, called a caste system, and believe
12 that that should be corrected.

13 I understand that that is being
14 corrected at the local level, however, it is still
15 in the Army Regulations that those are there, and
16 this is illustrative of the point that I think is
17 important, and that is, local commanders struggle
18 to try to do the best they can with policies that
19 are given to them, there are unattended
20 consequences of policies, and as those policies
21 become non-functional or actually have a negative
22 impact, we need to have a good way to very rapidly

1 get those out of the regulations and change the
2 system, because we can't afford to have guard
3 reserve component members thinking they have a
4 different standard or a different administrative
5 standard of care.

6 MR. HOLLAND: Mr. Secretary, let me
7 follow up on that. We do not want anyone to
8 perceive that we also want our service men and
9 women to be looked at a number, they're not a
10 number, they're very important entities. Their
11 situation should be looked upon as such, and then
12 the length of their time to complete the process,
13 whether it is both for their rehab care or their
14 MEB PEB process should be looked at as an
15 individual and take into consideration their
16 situation.

17 So we want to make sure that no one
18 thinks, okay, let's speed the process up and churn
19 them out like you do widgets in a plant. These
20 are not widgets, these are our great men and women
21 that are fighting our war today for freedom and
22 that's very important.

1 DR. POLAND: Doctor Mason.

2 DR. MASON: A follow-up command,
3 Sergeant Major. In the report as we have seen it,
4 you make reference to case management and case
5 managers and improved training and sort of the
6 nurturing and availability of case managers; could
7 you or any other member of the IRG share with us
8 some of the specific ways in which to improve on
9 that set of circumstances?

10 MS. MARTIN: You hit it right on as far
11 as case management. We discovered that one of the
12 issues was essentially the number of case managers
13 that were dealing with many, many, many injured
14 warriors. And I believe some action has already
15 been taken to hire more case managers.

16 But it's more than just hiring people
17 and throwing people at it, it's, number one,
18 looking at the entire process and how individuals
19 are actually taken care of, how their cases are
20 managed, if they have a primary care manager to
21 really assess the case, as well as how the case
22 managers are trained. And so many of our

1 recommendations are based on case management and
2 some real good solid recommendations on how this
3 can be addressed.

4 DR. MASON: Thank you.

5 DR. ROADMAN: This gets us into some of
6 the conversation that we had in our closed
7 session. When we say case manager or we say
8 primary care provider, those have a very specific
9 meaning to each of us who grew up in our medical
10 silos. What we are talking about here is the fact
11 that the system is confusing enough if we're
12 seeing multiple providers, and let me go on and
13 develop this.

14 Our problem that we've seen is that many
15 patients are treated with their diagnosis in
16 series rather than in parallel, and what really
17 means is, the most obvious injuries are treated
18 immediately, which is, in medical triaging, is an
19 appropriate way to be going after that. However,
20 at the same time, there has to be a holistic
21 approach to the patient, because although there
22 may be a traumatic amputation, there also may be

1 supratentorial damage that's not obvious, and
2 we're talking about a brain injury, TBI, mild to
3 moderate, non-penetrating type of injury, and that
4 might be treated later, and a delay in diagnosis
5 and treatment is actually detrimental to the
6 ultimate recovery of that patient.

7 So when we talk about case management,
8 we're really talking about a shepherd. Now, there
9 is no -- there's actually no personnel number for
10 shepherds. But somebody needs to shepherd the
11 patients through this terribly confusing system,
12 both in clinical care and in recovery, that is
13 actually their advocate, that is actually looking
14 out for them.

15 So when we say case manager, when we say
16 all of those issues, we're not talking about a
17 personnelist approach, we are talking about an
18 individual who can lead somebody through and
19 explain the ramifications of their decisions and
20 explain how to engage in an appointment system and
21 explain how to get to their treatment. So we need
22 to pull it out of the bureaucratic definitions.

1 As you think about our point, our point was,
2 individuals need help, and so we have to have a
3 structure that does that.

4 DR. POLAND: Congressman.

5 MR. BACCHUS: Two points, first of all,
6 following up on what Doctor Roadman just said,
7 pervasive in all we saw throughout our
8 investigation was the impression that the wounded
9 service men and women are expected to take the
10 initiative in trying to deal with the system,
11 they're expected to initiate any actions
12 themselves.

13 It seems to us that they have a hard
14 enough time being wounded and trying to recover
15 without having to work their way through that
16 bureaucratic process. So as General Roadman said,
17 we want case management to be a matter of taking
18 the initiative for the wounded service man or
19 woman and being their advocate.

20 Second, I wanted to follow-up on another
21 point he made a moment ago about the reserve and
22 the guard. Now, I may have a certain point of

1 view here, at one time I was an enlisted man in
2 both the guard and the reserve, but it seems to
3 me, and I think it seems to all of us that both
4 the reserve and guard, on the one hand, and the
5 regular forces on the other are all at risk of
6 their life and limb for our country in the Middle
7 East, and they should all be treated equally in
8 the way that they are treated when they return
9 home when they are wounded in the service of their
10 country.

11 And we would like to underscore that
12 fact going forward as others respond to our
13 recommendation.

14 DR. POLAND: Doctor Lauder.

15 DR. LAUDER: Following along with this
16 conversation, in the case management, I might
17 suggest that we start thinking of military
18 medicine in a different light given the unique
19 subset of patients that we have particularly from
20 this war, i.e., traumatic brain injury and the
21 multiple wounded, and that is that we think of a
22 transitional step between acute in-patient and

1 out-patient care. And we need this transitional
2 step, and whether you call it a transitional unit
3 or a step down unit, what it is, it's a continuum
4 of rehabilitative care, which is really I thin
5 crucial to the subset of patients.

6 And that might be within -- well,
7 typically, an example is, typically that is a unit
8 that's within the medical treatment facility or
9 the hospital if it's in the civilian world, where
10 they go from being an acute in-patient to this
11 secondary area before they become an out-patient,
12 where this case management can take place, and
13 it's a transition of having to function on their
14 own and get to an appointment on their own, and I
15 think it's very crucially important for this
16 subset of patients.

17 DR. ROADMAN: I represented nursing
18 homes and assisted living after my extended active
19 duty, and one thing that is clear is that rehab
20 medicine is different than acute medicine, and
21 actually the approaches to it are different, so
22 what you're saying is right.

1 What we have in the civilian sector is
2 really almost a geriatric model with a few
3 exceptions of young people. And actually, with
4 the military now, with the number of survivals
5 with very serious wounds, what we're starting to
6 see is a younger population, and as you know, in
7 our payment systems, in our bureaucracy, in health
8 care in general in our country, we aren't prepared
9 to deal with the young rehab nearly as well as we
10 are the geriatric rehab.

11 So I think there's a learning curve here
12 for us that actually we need to be defining what
13 is right rather than taking what experience we
14 have with the geriatric patients and superimposing
15 that, because the needs are different, and I think
16 a lot of thought has to go into how we do that,
17 but the point being, we need to take people from
18 very serious injuries in the acute and recognize
19 that they're going to have to deal with these
20 injuries for the rest of their lives, and we need
21 to prepare them to be able to do that.

22 DR. LAUDER: And again, just to refer to

1 the OIG report from the VA, I think that they
2 utilize a set of measurement outcome criteria for
3 traumatic brain injury, but the subset of
4 measurements that they use come from facilities
5 that have a lot of experience in dealing with the
6 continuum of rehabilitative care and particular
7 with traumatic brain injury, and we may use those
8 as model systems to look to for assistance.

9 DR. ROADMAN: You know, it sounds like
10 you and I are going to have a dialogue all
11 afternoon. And this gets to the same point I was
12 trying to make, and that is, a traumatic head
13 injury and the acceleration/deceleration type
14 injuries that we see in the civilian sector, from
15 motorcycles and automobile accidents and those
16 types of issues. The data is coming out that
17 those are pathophysiologically and neurologically
18 different than what we see with
19 acceleration/deceleration, and so although I think
20 we have a model for that, I think we need to be
21 very careful.

22 And it gets us into one other area where

1 the military will once again be defining leap
2 forward in clinical medicine, and that is with TBI
3 and PTSD, as being different types of rehab than
4 what we see in the civilian sector. So once
5 again, I think there's a learning curve, that's a
6 start, but there are absolutely large differences,
7 and so we need to be amenable to change rather
8 than a cookie cutter.

9 DR. POLAND: Doctor Luepker.

10 SECRETARY MARSH: I might mention on the
11 case managers, the ratios are way, way too high.
12 There are not enough case managers and that needs
13 to be addressed, and I believe that steps are
14 being taken to do that. One of the reasons I
15 think we found at Bethesda, their case manager
16 ratios were lower, the number of wounded patients
17 were lower, but nevertheless, getting those ratios
18 into a better relationship is a must, and I hope
19 that that's happening in the Army, I believe it's
20 happening here at Reed.

21 DR. POLAND: Doctor Luepker.

22 DR. LUEPKER: I just wanted to follow on

1 something Doctor Roadman said about PTSD and TBI.
2 I mean that is, in many ways, I think the looming
3 burden here and as yet isn't confronted both with
4 the short and long term need, and research is
5 needed to better understand these.

6 But the impact on the individual service
7 person and their families is enormous. And the
8 treatments that are frequently needed are
9 emotional and behavioral, not traditional
10 treatments. And the question is, have you thought
11 or discussed the need for mental health
12 professionals to deal with this problem currently
13 and potentially in the future?

14 MR. SCHWARZ: If I might address that
15 partially. I was impressed with the expertise the
16 mental health professionals here at Walter Reed
17 had in dealing with PTSD. Much thought has gone
18 into it, I believe much serious research, much
19 detailed following of patients, going all the way
20 back to my war, to Vietnam, and I believe that
21 both in-house here, clinically and research,
22 Doctor Hogue has done superb work in PTSD.

1 I don't feel that the boat is being
2 missed there. The boat is being missed with
3 traumatic brain injury, and the reason is that
4 there was no realization going into this war that
5 somewhere in the neighborhood of 75 to 80 percent
6 of the injuries, the wounds, were going to be
7 blast. But people sitting inside a Humvee 1114 or
8 a Bradley or a Cougar vehicle, Cougars are better
9 because the bottom is triangular, and what happens
10 are different than what has happened in other
11 wars, and we're behind the curve on that. And one
12 of the things that we will do in this report, in
13 its final iteration, is strongly encourage all
14 branches of the service, all the medical services,
15 to get up to speed on precisely what is the
16 pathophysiology of the closed head injury due to
17 blast. And if I might defer to our good friend,
18 Mr. Fisher, here has some ideas about what we
19 might do and a way to house a facility that deals
20 precisely with that issue.

21 MR. FISHER: My idea, although it's
22 still under investigation because I need to know

1 more about it, is that I think we need a center in
2 which research and diagnosis comes from one
3 particular place before we send these TBI patients
4 out to be worked on either at Richmond, or at Palo
5 Alto, or Tampa, or Minnesota.

6 We need to bring in civilian
7 neurologists to work with the military medical
8 field. We need to have a center for research. We
9 need to follow these victims of TBI to where they
10 go next and to keep track of them and not to just
11 send them out and let them fend for themselves.
12 It's something that I would like to investigate
13 more.

14 There is a civilian army out there that
15 is willing to build a center for traumatic brain
16 injury, just like the army of intrepid foreign
17 heroes fund that built the center for the intrepid
18 in San Antonio. And I would like any help I can
19 get to further this investigation of a center for
20 TBI.

21 MR. SCHWARZ: May I make one more
22 comment, and that is, at the National Naval

1 Medical Center, Doctor Moritides, and I believe,
2 Admiral Robinson, am I properly correctly
3 pronouncing her name? Maria Moritides is doing
4 some superb work precisely on traumatic brain
5 injury. And I spent an afternoon in her lab doing
6 what needs to be done. Much more needs to be
7 done, but they're doing superb work there, and I
8 saw some of the work done with some patients and
9 ongoing with some patients on cognitive
10 rehabilitation with this injury.

11 And so I think both the Army and the
12 Navy, and the Air Force, I'm sure, as well,
13 General Roadman, know what need to be done here,
14 but we're a little behind because there was no
15 anticipation going into this war that this, using
16 the phrase that we use in our report, this would
17 be one of the signature injuries, one of the
18 signature wounds of this war.

19 MR. HOLLAND: Excuse me, sir. I'd like
20 to follow up on that and take it to the
21 non-medical piece to this, is the idea that we
22 must be able to evaluate our men and women on the

1 battlefield and know what kind of blast they were
2 involved in. To ask an individual that has just
3 had a traumatic event happen to them in their
4 platoon what went on, you need to ask everyone,
5 because you'll get, if there's ten still standing,
6 ten different stories. So we must be able to
7 evaluate it, whether it's putting a device on
8 their helmet, on their uniform, whatever, but this
9 is the only way we're going to be able to truly
10 track this and we must get this started from the
11 very beginning and not the back end of the
12 process.

13 SECRETARY MARSH: Chip.

14 DR. ROADMAN: If I can jump in, and I
15 think what I heard was, we need to do research on
16 this, and so you all are going to have to forgive
17 me. I think of myself as an operator, not an
18 academic, I don't have a ph.d. What we need is
19 the relative right answer.

20 Actually, the operators don't need a
21 double blind study over 20 years to determine
22 what's going on. We need very quickly evolving

1 research on the types of injuries, the types of
2 therapy.

3 And let me tell you how really difficult
4 the problem is that the practitioners are facing.

5 We've got a lot of good people doing a
6 lot of good work. The problem is, it's not
7 coordinated, it doesn't have a common definition.
8 If you take the VA and you take the defense VA
9 system, they have a different definition from what
10 is being worked in a lot of different facilities,
11 so no wonder it's confusing, the definition for
12 the community is not the same.

13 In addition to that, when you go and do
14 a medical record, there is no code in the ICD 9 or
15 10, or coming back into the what is it for, the
16 other coding book. I'm just an obstetrician,
17 okay, I may not know all these numbers, as a
18 matter of fact, I've read more regs lately than
19 I've ever wanted to read, but the fact of the
20 matter is, there's not a number that goes on a
21 medical record that says mild traumatic brain
22 injury, even though that's the diagnosis. And if

1 you put the ICD 9 in there and you finally work it
2 through the system, it comes out with a
3 psychiatric diagnosis.

4 Now, no researcher can prospectively or
5 retrospectively gather data if there's not a
6 number that identifies what they are.

7 There are about 20 different things that
8 could be TBI. It is imperative that tomorrow we
9 put a number on TBI so that we can prospectively
10 track that, so that Mr. Fisher's group can
11 actually put these people into a prospective
12 longitudinal study in order for us to know what
13 happens with the natural disease of the course
14 with treatment of the course, but also what
15 happens, that we can track them and make sure that
16 they're getting the therapy that they need.

17 Now, that may be a rambling issue, but
18 there are systemic issues that need to be fixed
19 today in order to be able to take care of these
20 patients today.

21 DR. POLAND: Doctor Kaplan.

22 DR. KAPLAN: This brings up a point that

1 maybe has been talked around, but I'm not sure
2 that I've got an answer for it, and that is the
3 point of uniformity which you just referred to.
4 We've heard about the difference between Bethesda
5 and Walter Reed, we've talked and heard about the
6 difference, or postulated differences between
7 active duty reserve and national guard. In your
8 report, are you going to come across as a
9 uniformed set of suggestions that will cut across
10 services, that will cut across all these --
11 dislack of uniformity, or did I misunderstand?

12 DR. ROADMAN: No, you hit it on the
13 head.

14 MR. SCHWARZ: Yes.

15 DR. KAPLAN: Yes to which one?

16 MR. SCHWARZ: Yes to uniformity.

17 DR. POLAND: Doctor Oxman.

18 DR. OXMAN: I'd like to go back to
19 something that Secretary West said. He pointed
20 out that one of the important issues was the
21 continuity of care. I think it's important to
22 recognize that these seriously wounded warriors

1 will have wounds that will effect all the rest of
2 their lives and that their families are seriously
3 wounded and will remain seriously wounded for the
4 rest of their lives.

5 And so I think it's crucial that we
6 provide for a continuity of care that extends
7 between the acute care and the out-patient care at
8 Walter Reed or the Navy, but also into the VA.

9 And one of the problems that I have when
10 I take care of patients at the VA is, it's against
11 the law for me to take care of the patient's wife.
12 And for the seriously wounded warriors, I think
13 it's essential that, and that may take a
14 congressional action, but it's essential that we
15 provide the ability to take care of them and to
16 provide care for their families for the rest of
17 their lives, in a setting in which they're put
18 first on the list. And so I hope that the IRG
19 will add that item to its final report.

20 SECRETARY WEST: You know, I'd like to
21 respond to that, but I'm not sure I could put it
22 any better than you just did. I don't think

1 there's anybody on the IRG that would disagree
2 with you, or anybody who worries about the effects
3 of war on our service members and their families
4 that wouldn't. And, yes, we're going to have to
5 exert whatever muscle we can find, whether it's
6 legislative or intellectual or just shouting at
7 the top of our voices to try to get that done.

8 It's an important part; if you circle
9 back, the patient's recovery does not just depend
10 on the patient, it depends on the family member,
11 which, in turn, comes back and effects the
12 patient. So you're right, I think we are alert to
13 it.

14 I would also remind us that all of these
15 considerations, as we talk about the chemical and
16 the medical considerations, all tie back to other
17 parts of what is effecting our service members and
18 their families as they find themselves in that
19 unique place that we're calling rehabilitation or
20 that part of the continuum, where they have had
21 the crucial work done and they're now going
22 through rehabilitation, or, and I hate to mention

1 these dreaded words, going through the physical
2 disability review process. Now, I'm going to try
3 not to mention it every single time that I get the
4 microphone, but everything eventually relates back
5 to that process, as well, its impact on the morale
6 and the thinking and the psyche of the families,
7 but also it's important to know to get the number,
8 to know how we are dealing with TBI, to know how
9 our review boards are going to deal with it and
10 how that's going to effect what happens. And we
11 call them patients, and that's a fair term, a lot
12 of clinicians here, wounded service members, and
13 how that's going to effect them for the rest of
14 their lives.

15 So even as I listen to us talk, I also
16 reflect on the fact that at least, I won't say a
17 percentage, but a significant part of the process
18 here that is effecting mindsets, recovery, how
19 people feel has to do with the uncertainty of it
20 all, not just the uncertainty of life, the
21 uncertainty of their lives and what's going to
22 happen.

1 I should be leaving this to the Sergeant
2 Major to say, but I do want to add this in. It is
3 common to hear commanders and others say, well,
4 you know, I talked to the service member who's
5 there and who was in the process, in
6 rehabilitation, and I asked them what do they
7 want, sir, I want to go back to my unit, I want to
8 go back, I don't want to go on to civilian life, I
9 don't want to go to VA, and you can attribute all
10 sorts of things to that statement, don't want to
11 be part of VA, don't want to have to face the fact
12 that they cannot return to their unit and do what
13 they were doing, that they're not going to be the
14 same again, and they're hoping that they will, and
15 our purpose is to get as many back to active duty
16 as possible. But the fact is, the uncertainty of
17 it all has as much an impact in terms of what we
18 are hearing from members and their family as
19 anything else. They're not complaining to us by
20 and large, although some do, don't misunderstand,
21 some do, that they're not getting good medical
22 care in the rehabilitation part.

1 The reason I say some do is, we've got
2 some stories. One service member whose doctors
3 told him several different things, he didn't know
4 what to do. But the real concern that seems to
5 effect them as much as anything is, they don't
6 know what's going to happen and they don't know
7 what is happening.

8 We spoke about complex solutions to
9 complex problems. There are some solutions here
10 that at least to our members and their families
11 don't seem all that hard to figure out. Tell us
12 what's happening, tell us where we're going, let
13 us know what's happening with the process and how
14 it works, and please, don't besiege us with all
15 the paperwork that goes with it.

16 SECRETARY MARSH: To add to what
17 Secretary West mentioned on the families, you'll
18 find in this report significant emphasis on the
19 families, because it perceive -- and they do play
20 a very valuable role in recovery. But they don't
21 know what's available to them. There can be
22 transportation, there can be certain assistance in

1 remuneration, they don't know that, and the
2 process breaks down in trying to get them that
3 assistance. There needs to be greater instruction
4 for families on benefits and assistance. There
5 are rules in this. As I understand the rule, if
6 the attending physician makes the determination
7 that a family member should come to the bedside of
8 a wounded soldier, or a marine, or air man, or
9 navy, that's what is required.

10 But many times families, and we know we
11 had instances where they pick up, they come up
12 here, they sustain significant financial hardships
13 in travel and rooming and lodging, it is a very,
14 very difficult situation.

15 And the question was asked, something
16 about regs, not only do you get to -- need the
17 service regs in sync, you've got to get the DOD
18 regs in sync, and how you can have a situation
19 where the DOD regs and the service Army, Navy, and
20 Air Force regs are out of sync, it seems to me
21 Defense should take the lead and get that
22 straightened out. And I think we're going to have

1 to have Defense take the lead to get the family
2 situation straight also.

3 DR. POLAND: Doctor Shamoo.

4 DR. SHAMOO: This comment, question is
5 really for everyone, including the advocacy and
6 families of service men. I'm concerned that the
7 IRG will be out of business in a few weeks, the
8 immediate attention will fade in a few months
9 maybe, and who's going to sustain that these
10 serious reforms, we could differ here and there,
11 but to me, what's important are these serious
12 reforms which will take some of them a few months,
13 some of them up to a few years, to sustain them to
14 get done. We shouldn't be back here in three,
15 four, five years and we're discussing the whole
16 thing all over again, not that we will do all of
17 them 100 percent, but at least to sustain it. How
18 we go about to do that?

19 MS. EMBREY: I can speak to that. I'm
20 the designated federal official at this board, I
21 represent the Department, I'm here at the pleasure
22 of the Assistant Secretary, Doctor Chu, and the

1 Secretary of Defense, and he is most concerned
2 with these issues, he established this Independent
3 Review Group to make recommendations to him, he's
4 quite serious about the outcomes and the
5 recommendations, he will weigh these
6 recommendations, along with those of other ongoing
7 studies that should conclude within the next
8 several weeks, and I believe that he has reform on
9 his mind, and he will hold all those who have
10 accountability in the system responsible for
11 making those changes.

12 SECRETARY MARSH: Jim.

13 MR. BACCHUS: Let me add a word if I
14 might, Mr. Secretary. I think it's probably
15 apparent to all here that there is a strong
16 consensus among all the members of the IRG about
17 the recommendations we'll be making. We have no
18 political acts to grind, none whatsoever. Our
19 sole goal has been to help secure and ensure the
20 very highest standard of treatment for our
21 returning wounded service men and women. We have
22 received strong support from the Department of

1 Defense, from the Secretary, from our great staff,
2 and from everyone at Walter Reed and at Bethesda.
3 We expect the same strong support going forward.
4 You have just heard from the administration. We
5 assume that the administration will take our
6 recommendations, implement those that can be
7 implemented through the executive branch
8 administratively, and recommend that the rest be
9 approved by the Congress.

10 We assume that the Congress, on a
11 bipartisan basis, will want to do their very best
12 for our wounded service men and women. It is true
13 that we will cease to exist here in a week or so,
14 but I think you can count on each and every one of
15 us to be relentless in voicing these views going
16 forward.

17 DR. POLAND: I'd like to ask a question
18 that -- because I had a chance to chat a little
19 bit about it with Admiral Martin, she might be
20 best poised to illuminate us about this. I found
21 one of the findings and recommendations
22 particularly insightful and not necessarily

1 anticipated, and that is, when there are
2 inadequate facilities, difficulties, particularly
3 with hiring and retaining nurses, although other
4 categories of health care providers are involved,
5 and a sense of an overwhelming number of really
6 horrific wounds, that there begin to play a
7 compassion fatigue, I think was the word that was
8 used, which means that this is having an effect
9 not only on the wounded service member and their
10 families, but also the care givers, and in turn,
11 when they're effected, it further effects the
12 wounded service member and their families. Can
13 you talk a little bit about the issues that
14 contribute to this compassion fatigue?

15 MS. MARTIN: Well, I think, as Secretary
16 Marsh started out by saying this all created what
17 we call a perfect storm, and it's layered onto the
18 compassion fatigue as the shortage of staffing,
19 whether it be because of a 76 study, whether it be
20 because of military to civilian conversions,
21 whether it be because of the announcement of BRAC
22 and individuals leaving the system, or whether it

1 is because individuals have been treating wounded
2 warriors for such a long period of time and very
3 stressed, this all has a tremendous, tremendous
4 impact on the staff.

5 And we saw that from the very beginning,
6 and it's not just the physician, the nurse, the
7 technician, or the hospital coreman taking care of
8 the wounded warrior, I believe it goes throughout
9 the facility.

10 And that begins to grow and to feed, so
11 it might start at a certain point, but it travels
12 throughout the laboratory, x- ray, and all of a
13 sudden you have this uncontrollable, more or less,
14 culture that is brewing.

15 And individuals, especially here at
16 Walter Reed, also know that eventually they're
17 going to be moving from this great facility to
18 another unknown facility that they might not have
19 worked at or never even passed by. So all of
20 those pressures have been building up here at
21 Walter Reed, and perhaps to some extent at the
22 National Naval Medical Center, but within the

1 National Capital area for several years now. And
2 certainly, we put compassion fatigue, that label,
3 on the pressures and the stressors that the health
4 care providers are feeling. But I think it's much
5 more than just those at the bedside, I think it
6 extends throughout the entire compound or campus
7 here, perhaps not just in the hospital.

8 But that's something that leadership,
9 starting from the Secretary of Defense all the way
10 down has to look at and really address, because in
11 order to relieve that, we're going to have to
12 start looking at the culture, both the Army
13 culture and the Navy culture, and looking at how
14 we're going to blend that, and most importantly,
15 how we're going to communicate that message that
16 sends a positive signal all the way through our
17 entire organization, both at Reed, as well as at
18 the National Naval Medical Center.

19 And that's going to be very, very tough,
20 that's going to take, I think, a lot of emphasis
21 and an awful lot of work, and it's more than just,
22 as I kind of mentioned with case manages, more

1 than just throwing bodies and people at it.

2 DR. POLAND: Congressman Bacchus, would
3 you like to make a comment?

4 MR. BACCHUS: Just very briefly. I
5 agree with every word that Admiral Martin just
6 said, but I want to underscore something that
7 we'll be addressing our recommendations. If we're
8 going to keep nurses, if we're going to hire
9 nurses, especially in this part of the country,
10 we're going to need to pay nurses a whole lot
11 more, and I believe that the United States of
12 America can find the money to do that.

13 DR. POLAND: Doctor Parkinson.

14 DR. PARKINSON: Thank you, Doctor
15 Poland. You know what, a comment and then a
16 question. The military and, by extension of the
17 VA, have so much more than the civilian sector in
18 terms of our culture, teamwork, (off mike)
19 capitalizing on that and really making both care
20 we deliver and care we purchase uniquely tailored
21 to the needs of that special population of service
22 members is something that I would suggest your

1 group is now focusing us on.

2 What is different about getting rehab to
3 a service member who comes back with signature
4 injuries of the war versus rehab? And your report
5 has helped focus, at least this board member, on
6 what is the cultural and historical benefit of the
7 military to the country.

8 So when you look at military medicine,
9 we have preventative medicine at Walter Reed
10 because of the tradition of Walter Reed, and
11 preventative medicine and a healthy fighting
12 force, immunizations, hygiene, personal protective
13 equipment. We have state-of-the-art combat
14 casualty care that advances surgical practice all
15 throughout the United States. Unfortunately, we
16 advance surgical care every time we go to war.
17 But the third major area, if you put preventative
18 medicine, critical care, and combat surgical
19 support is re-entry, recovery, and rehab. We have
20 not committed ourselves in a systematic way to the
21 third leg, if you will, of a comprehensive health
22 system. And the report and the ways that you've

1 looked -- the term that just captured my read, and
2 maybe it's been used elsewhere and I just missed
3 it, signature injuries of the war, if you create
4 best practice models that are military unique and
5 VOV -- DOD VA friendly, then we have something to
6 shoot for, and then all of us can sit down and
7 say, what's the legislative barriers we have to
8 stop or build, what's the regulations and policies
9 we've got to get rid of yesterday which we
10 control, what are the attitudes that we've got to
11 inculturate (?) in our people, in our care
12 providers, you've got it.

13 So I think -- this is a comment just to
14 get some response, because your report
15 crystallized it for the board in a very real way,
16 and the first way I've seen it with that signature
17 issue.

18 MR. SCHWARZ: Let me start and then pass
19 it to Doctor Roadman. Understanding, as I look at
20 this table of, in great part, medical academics
21 across the way, but superb clinicians, you know,
22 the bench research that I do is mostly with a

1 number 10 bog parker (?) blade, and I expect --
2 that's a surgical, that's a scalpel for those of
3 you who -- and Doctor Roadman the same. But
4 nevertheless, we did address this. And one of the
5 things, a given, and had you gone on a minute
6 longer, I think you would have stated it very
7 clearly, that rehabilitation for the wounded
8 warriors in this conflict, in every conflict, but
9 perhaps more particularly in this conflict, is
10 different. This is not civilian rehabilitation,
11 the injuries are different.

12 As an example, I had it pointed out to
13 me today, something I knew, but it was appropriate
14 to point out to me that in the civilian world,
15 only about two percent of amputees are upper
16 appendage amputees, whereas military injuries,
17 it's 20 percent. So looking at what you do with
18 amputees, people have lost arms and hands, the
19 rehabilitation for the closed head injuries, for
20 the TBI, which we know is going to be different,
21 and as the research goes on, the rehabilitation
22 will continue to focus on how different it is.

1 But we have pointed out in our report,
2 and I know Doctor Roadman will put the code (?) on
3 this for me very nicely, that this is a different
4 type of rehabilitation and there's no reason that
5 the military cannot and I think probably does
6 recognize it and bring it right up to speed where
7 it ought to be.

8 But it is different than rehabilitation
9 in the civilian world, the injuries are different,
10 the wounds are different, the magnitude of the
11 soft tissue injuries are different, more
12 amputations, more closed head injuries, and that's
13 something that needs to be concentrated on; Chip.

14 DR. ROADMAN: Yeah; it's more
15 amputations of young people. I mean a below the
16 knee amputation for a diabetic is not an unusual
17 thing, and you know, we know how to do that,
18 that's been done for a long time, but these are
19 young people that are going to return to a very
20 active life and they've got to be able to have
21 good prosthetic care, as well as rehab.

22 Now, Mike, Doctor Parkinson, you asked a

1 specific question, like what kind of regulations
2 do we need to go and fix.

3 Doctor Schwarz and I walked in today and
4 we saw the most amazing thing down in the
5 prosthetic lab. We saw a young man that had lost
6 his arm about mid-forearm, he was being fitted
7 with a prosthesis that was computer activated from
8 his flexor and his extensor muscles in his arms,
9 and he could grab with an imposing thumb objects.

10 Now, that will return him to a
11 relatively useful life of using his hands. We
12 thought we understood that. Let me tell you about
13 what we learned. If somebody, a guard or reserve
14 has an amputation, most likely they will get a 30
15 percent retirement and go out and be eligible for
16 care. And I have always been using East Moose
17 Breath, Idaho as where the retiree goes.

18 Now, in East Moose Breath, there is one
19 primary care doctor, and that's for 60 miles
20 around, and so this individual actually, by
21 regulation, is not eligible to sign up for Tricare
22 Prime, it is not in the geographic span with

1 coverage of providers. Now, here's the deal;
2 Tricare Standard will not pay for per diem and
3 travel for a prosthetic patient to go and get the
4 care that they need, whether they need to go to
5 Florida or they need to come here or somewhere
6 else; if they're in Tricare Prime, they will. But
7 because of geography, they can't sign up for
8 Prime, and because they are who they are, where
9 they're injured, the type of injury they have,
10 they don't get equality of care, which is the
11 conformity and consistency that we talked about,
12 because of bad luck, that's not acceptable.

13 And so the rules have to be changed for
14 people that need the type of ongoing care, and it
15 can't be determined by living in East Moose Breath
16 versus living some place near Chicago.

17 That doesn't meet the who are we test as
18 Americans for our fighting forces; does that make
19 sense to you?

20 And so I believe that instead of waiting
21 around to figure out what these loop holes are for
22 the people in these emerging diseases, our

1 bureaucracy needs to actually do it prospectively
2 and say, and what's the worst case that can occur,
3 and do that before the problem rather than after
4 the problem; does that answer your question?

5 MR. SCHWARZ: Yes, sir.

6 DR. POLAND: Doctor Halperin.

7 DR. HALPERIN: Thank you. Bill

8 Halperin; these are obviously complex systems that
9 we're talking about, and sometimes structural
10 changes have to be made because there's a new
11 phenomenon and we have to keep pace with the new
12 phenomenon. But in order to improve quality in
13 complex processes and improve satisfaction,
14 decrease errors, I think modern management would
15 suggest continuous collection of appropriate data.

16 And I wonder whether that is an issue
17 which needs improvement in this situation, whether
18 it's been one that's been focused on by the IRG,
19 whether continuous quality improvement needs data
20 looking at centennials or indicators that would
21 tell us whether, you know, the vacancy rate for
22 essential people we need, like nurses going up, or

1 the delay time towards resolution of a claim is
2 too long, or whether, when you go to a restaurant,
3 you know, were you happy with the meal, were you
4 happy with the process, what's the satisfaction
5 level of the clients. So my question is, what do
6 we know about the collection of continuous quality
7 data and are we -- do we need to improve it?

8 MR. SCHWARZ: I believe that the IRG
9 agrees with your premise, which, of course,
10 because we agree with it, it makes it correct, and
11 we have addressed that in a general way in our
12 report. But, you know, I certainly agree with
13 your premise, and I would expect the rest of the
14 group does, as well.

15 And it's not something that has gone
16 unnoticed, that we do need to collect every single
17 shard of information that we can, especially
18 about, as we have coined the phrase, the signature
19 wounds, the signature injuries of this war, which
20 are different than those of previous wars.

21 DR. ROADMAN: Well, you know, I have to
22 tell you, I get angry every time I go through a

1 grocery store and I watch them ring up a can of
2 peas and it automatically reorders and we can't
3 get x-rays from one facility to another.

4 Now, that's not an accurate comparison,
5 but in today's environment where we have "a
6 digital world", we have a Giant that can run an
7 empire out of Bentonville, Arkansas, and we have
8 problems getting electronic records from -- or we
9 have trouble getting physical exams from
10 retirement to the VA, that makes absolutely no
11 sense at all.

12 And I will tell you that we have been
13 working on that as far back as when I was a young
14 colonel, emphasis on young, and we hit
15 administrative road blocks, and we hit leadership
16 road blocks, and this isn't a technical problem,
17 this is a decision to get on with doing it.

18 And hopefully we can spur that type of
19 activity. And everybody has their individual
20 interest in doing their form versus somebody
21 else's form, and leadership has to say noted, fix
22 it, and then we will make progress. But it's a

1 leadership issue, not a technical one, and it can
2 be done, but it's not.

3 SECRETARY WEST: We were asked a
4 question earlier about whether the large number of
5 service members returning from the two war zones,
6 whether there was a stacking effect, and the
7 answer was yes. Let me say, sometimes systems and
8 processes that seem to work just fine, that
9 contribute to a perfectly well functioning
10 organization, organizations with great prestige,
11 don't show their flaws until they are stressed to
12 such an extent as every system in American
13 military medicine and perhaps in all of DOD is
14 being stressed by the fact of war.

15 I made a comment, one of the lines in my
16 opening statement, which I am sure was hurtful to
17 some of the professionals who heard it, about a
18 perceived disdain for the importance of support
19 during the rehabilitation period is undoubtedly
20 driven by a kind of compassion fatigue.

21 Now, I might say, compassion fatigue was
22 voiced at Bethesda Naval, where, in fact, as you

1 pointed out, the real stressors which are showing
2 the actual effect and relationships as perceived
3 by patients are being shown up here at Walter
4 Reed, because there is no doubt about it, health
5 care professionals don't go into the business
6 because they want to be mean to people, they go in
7 because they are moved by a concern for what
8 they're going to be doing.

9 So every single health care
10 professional, we can assume, here at Walter Reed
11 or anywhere else around the country, around the
12 world, who wears a uniform, or even those who
13 don't, is in the business to make our service
14 members feel better, to do good things for (off
15 mike) -- and their families. So when there is a
16 perception of a reaction or an attitude from a
17 deliverer of services, you can look for the
18 reasons. It doesn't make it any better for the
19 receiving service members, but I think a lot of it
20 is driven by the lack of staffing, by the stress
21 that our systems are being put to and our people
22 are being put to. That's one example, the example

1 you mentioned is another.

2 You're right, Doctor, we have been
3 working on the, and this is an important part of
4 the hand off, on the interface between VA and DOD,
5 so that records can be transmitted to help service
6 members, who will become veterans for as long as
7 the memory of man and woman runs. Certainly, back
8 when I was Secretary of VA, and even before then
9 when I was Secretary of the Army, there was a big
10 piece in the paper about how proud VA is of their
11 electronic record system, so what.

12 They can't get the records in their
13 interface with DOD, and moreover, within DOD there
14 are so many different systems, we will be working
15 at it for a long time. This time, when all of us
16 are being stressed by war, is when those failures,
17 or those that lack, will show itself up most
18 clearly. What will we do about it?

19 We will write our report, we will put
20 out our recommendations, we will have the support
21 of DOD, the Congress has already indicated it's
22 going to hear our report and then start asking

1 questions right away, there is another review
2 group looming, a panel by the President, who will
3 look at it all; these issues and the resolutions
4 that we propose, and the issues that have been
5 brought up by family members are not going to go
6 away this time, because there is so much attention
7 being focused on.

8 DR. POLAND: Dr. Lauder.

9 DR. LAUDER: I've heard several times
10 about the differences in the rehabilitation care
11 for this war, being the traumatic brain injuries
12 from IED's and multiple traumatic injuries,
13 especially upper extremity injuries, and that is
14 true, and I think that we all recognize that. The
15 basis, however, for good rehabilitative care and
16 the continuum of care standards for the rehab
17 patient is not different despite the diagnosis and
18 the etiology of the problem, meaning that there is
19 a standard of continuum of care that should occur,
20 regardless of the diagnosis. What happens in
21 their therapy or what happens within their
22 doctor's office will be different because of the

1 diagnosis, but there still needs to be this smooth
2 transition.

3 Having said that, what I might -- a
4 suggestion, you make a nice comment and it's
5 completely appropriate, and noting the declining
6 numbers of mental and behavioral health staff, and
7 the need to look into that, I might suggest
8 broadening that to looking into the providers that
9 are needed within a rehabilitation team, to
10 include but not limited to, physical medicine and
11 rehabilitation doctors, therapists, social
12 workers, and as we have already mentioned, nurses.
13 So that would broaden that and go with, I think
14 what we're trying to achieve.

15 DR. POLAND: Any other comments or
16 questions from the Board; Doctor Shamoo?

17 DR. SHAMOO: This may not be within the
18 pervial (?) for the IRG (?) or us, but some of you
19 have contact maybe with the Presidential
20 Commission. Pre-college -- there is a great deal
21 of help for disabled individuals, whether they are
22 veterans or not, and I'm emphasizing here issues

1 of education and training, that is vocations
2 training, because we want our veterans to become
3 independent and productive citizens.

4 That is the ultimate goal, it's really
5 not making them (off mike), and however, post high
6 school, there is very little help for the disabled
7 in terms of helping them in their disability,
8 whether it's a cognitive or visual, whatever it
9 is, in helping them get that education and
10 training, whether it's a community college, or
11 four year college, to become productive citizens.

12 Is there any way, shape, or form we
13 could insert something there so there will be at
14 least some kind of a long range attention to
15 either give to colleges some incentives or the VA
16 System can, you know, like the GI Bill is
17 different, of course, to help them in post high
18 school education?

19 MR. MARSH: I don't know of any specific
20 recommendation. It appears in the report in
21 reference to that, although, I think the
22 observation that you're making about some type of

1 GI Bill benefits for them would be exceptionally
2 helpful. Of course, there are certain GI Bill
3 benefits now administered somewhat differently in
4 the Armed Forces, but what you're suggesting is
5 something, I think is worthy of consideration.

6 DR. POLAND: Okay. What I would like to
7 do now is several things so that you know the flow
8 of what we're planning. I'll ask Ms. Jared (?) to
9 assist us in having the, I think it's two members
10 of the public who have registered to make
11 comments. I'd then like to ask some of our
12 distinguished guests if they would like to make
13 some comments. I'll then ask Secretaries Marsh
14 and West for any closing comments they have, and
15 then I will finish with a closing comment on
16 behalf of the Board, with the name for us to
17 finish roughly around 4:00 or so. For the members
18 of the public and for the others that we'll ask to
19 make statements, if we could keep that to under
20 five minutes, please; Ms. Jared?

21 MS. JARED: Kathy Moakler?

22 DR. POLAND: Welcome, Ms. Moakler.

1 MS. MOAKLER: Good afternoon. My name
2 is Kathy Moakler, I'm the Director of Government
3 Relations for the National Military Family
4 Association, and I'd first like to thank the Board
5 for providing a forum for the IRG to present their
6 findings, and I would like to thank the members of
7 the Independent Review Group for the timely and
8 efficient study, and especially, as you can tell
9 because of the families in our name, for your
10 concern for the families of the wounded, because
11 we believe behind every wounded service member is
12 a wounded family, and we are concerned of about
13 the care for the caregivers, to make sure that
14 they have access to the resources and training
15 that they need. We will provide a statement to
16 the IRG with some of our concerns in the future,
17 but we appreciate the concern that you have for
18 families, thank you.

19 DR. POLAND: Thank you, and thank you
20 for coming.

21 MS. JARED: M.A. Parker -- just signed
22 in.

1 DR. POLAND: Okay; no other -- Ms.
2 Jared, no other members of the public? Okay. Any
3 of our distinguished guests that would like to
4 make a comment, and I might specifically see
5 General Schoomaker, if you might, given your
6 previous command, like to make a comment about the
7 TBI research that we know is going on. Thank you.

8 MAJ. GEN. SCHOOMAKER: Yes, I'm Major
9 General Schoomaker, I'm the Commanding General of
10 the North Atlantic Regional Medical Command in
11 Walter Reed, and as I mentioned this morning,
12 until about six weeks ago, I was the Commanding
13 General of the United States Army Medical Research
14 and Material Command at Fort Detroit. Is this
15 okay?

16 SPEAKER: Yeah.

17 MAJ. GEN. SCHOOMAKER: I have a couple
18 of comments. First of all, I'd like to thank the
19 group too. I was sitting and listening to you,
20 and having interacted with the Review Group over
21 the last few weeks, I was impressed that you got
22 right to the heart of so many of the problems that

1 many of us have recognized and have recognized for
2 some time about our system, and have been, as it
3 is so well outlined at the local command level or
4 at the provider level, hamstrung to do anything
5 about, because these are our system's issues, many
6 of them.

7 So I'm please and impressed that you
8 have found so many of the things that we have to
9 go after, and I can tell you since, certainly
10 since taking command here in the Army, has thrown
11 the full rate of the Army behind us. I've never
12 been in a situation, in my professional like, and
13 in my career, in which the Army has leaned so far
14 forward to help us so aggressively, and has sent
15 the message repeatedly that don't wait until the
16 last report of the last paragraph, start to solve
17 problems that you see can be solved on the ground,
18 across the region, across the entire medical
19 department, if necessary, and has given me a very
20 very good staff and to assist me, to include a
21 (off mike) General Armor Officer taken out of the
22 Armor Center to help me.

1 And so to answer the question that was
2 posed earlier, what reassurances do we have that
3 we're going to continue on this, and to know that
4 we're not going to be here three to five years
5 from now asking why didn't we solve it back then.

6 I can tell you that for this soldier --
7 we're going to solve this problem, and I think the
8 Army has told us, and the Department of Defense
9 says that we will not rest until these problems
10 are settled. Included in there, I think are some
11 of the great insights here that have been brought
12 out about the need for us to focus on primary
13 care, and what we're developing here is the triad,
14 of a primary manager, a case manager, and a
15 command and control element through the Warrior
16 Transition Brigade, and before I go any further on
17 that, I'd just like to explain that one of the
18 things that I think we've all struggled with is
19 terms, is definitions.

20 We use the word wounded warrior, for
21 example, in the Army, in association with a
22 specific kind of a severely injured soldier who

1 has 30 percent or more disability, may have lost a
2 limb, or eyesight, and yet the majority of the
3 people that we're talking about here, frankly, are
4 not battle injuries.

5 We have a large number of soldiers, just
6 as any conflict, who don't battle injuries, they
7 have non-battle injuries, they have illnesses or
8 injuries that are a part of training, that are a
9 part of deployment, and that are a part of life,
10 frankly.

11 We have a soldier with a severe
12 cerebellar neurologic disease that is unassociated
13 with Blast, and he asked the question, am I no
14 less a wounded warrior than someone who's been
15 subject to Blast, I raised my hand to defend the
16 nation, I've gone on deployment, and a
17 degenerative neurologic disease has caught me,
18 don't I have the same kind of priority for care,
19 and the answer for us is absolutely.

20 So what we've begun to call these is
21 warriors in transition, they're in transition back
22 to active duty because the vast majority of our

1 soldiers to go back to active duty and we're very
2 please with that, of those brought back from fears
3 (?) of operation, the vast majority as in (off
4 mike), have returned to active duty; that's the
5 motto of the Army Medical Department, "to conserve
6 the fighting strength."

7 And those that can't go back, we've put
8 them into a single category, addressed earlier,
9 the med hold med holder, over segregation, as
10 General Roadman has said, has created this
11 impression of two classes of care, which was
12 initially addressed -- developed for
13 administrative reasons and we said there's no
14 reason to do that any longer, and so we are making
15 those changes as we go, and I don't want to go
16 into all of the details, but I wanted to assure
17 the Board and the Independent Review Group that we
18 are aggressively going after everything we can do
19 as we see the solutions.

20 Let me talk briefly about TBI and
21 traumatic brain injury and post traumatic stress
22 disorder. I talked offline before the meeting

1 with several of the Board members, just to share a
2 little bit of what I'm beginning to grasp better.

3 I'm an internist, I'm not a neurologist,
4 I certainly am not a nurse surgeon, I have not
5 been directly involved in the treatment of these
6 folks, as many of our staff have, both in the Navy
7 and the Army here, and what I think we've got at
8 this point, is an emerging science that we don't
9 fully understand yet, both around post traumatic
10 stress like symptoms and the post traumatic stress
11 syndrome fully expressed, and here the Army has
12 taken a very aggressive lead in trying to
13 understand through cohort (?) studies and
14 longitudinal studies as to how post traumatic
15 stress like symptoms emerge and then how they
16 become fully expressed post traumatic stress
17 syndrome, if not symptomatically managed, and the
18 milder forms of traumatic brain injury where we
19 might have a diffuse neuronal dysfunction that
20 results from some aspect of Blast to include
21 concussive injury, but has a gross overlap of
22 symptoms between the two, and at this point, not

1 having a goal standard or a biomarker that we can
2 say, they have no way right now of putting a
3 thermometer into someone's brain and say you've
4 got a Blast induced neuronal dysfunction that
5 results from concussive injury or non-concussive
6 injury, and you have an emotional response -- our
7 blunt instruments are just that, they're blunt and
8 they can't separate these two syndromic kinds of
9 categories yet, and we need good, hard, basic
10 science and longitudinal studies that have been
11 referred to.

12 I think we have an instrument for that
13 right now. The Congress and the National Defense
14 Authorization Act of '06 created language that
15 said to the Department of Defense, coordinate,
16 integrate all of your Blast related injury
17 prevention, mitigation, and treatment programs
18 into one executive agent. That executive agency
19 was passed through the Secretary of Defense, the
20 Deputy Secretary of Defense to the Army, the
21 Secretary of the Army passed that to the Army
22 Surgeon General, who then passed it to the United

1 States Army Medical Research and Material Command
2 at Fort Detroit, and they have spent the last year
3 working closely with Health Affairs and the other
4 services to bring together a comprehensive review
5 of all of the research in Blast, from adequate
6 brain injury, eye, traumatic amputation, hearing,
7 all aspects of Blast.

8 So we have a great instrument right now,
9 we have a great vehicle for that in the MRMC, and
10 I would very strongly submit, Mr. Fisher, that
11 that's a place that you could focus some of the
12 energy for building centers of excellence.

13 My counterpart Commander for the
14 National Naval Medical Center is sitting right
15 behind me here, and Admiral Adam Robinson, and
16 I've talked about the fact that the new Walter
17 Reed National Medical Center, I think is an
18 excellent venue for a center of warrior care in
19 which we place research and clinical trials,
20 programs like around traumatic brain injury, and
21 other aspects of warrior care, and that becomes
22 the center, and Mike, I have to commend you for, I

1 think a really tremendous insight into heretofore
2 ignored area for us, or at least undervalued area
3 for us, and that's in the rehabilitation area.

4 Ma'am, we have essentially what you
5 described as a step down unit, it's called a
6 malone house; it's exactly what the malone house
7 is, and we don't understand it the way that you
8 just described it, but it's an intermediate or a
9 halfway house of sorts, in which families and
10 soldiers together recovering, and it's beyond this
11 campus in proximity to the hospital, in proximity
12 to life support services, and get that
13 intermediate step down kind of approach, but we
14 didn't do it prospectively, and we didn't do it
15 coherently, and we didn't do it as intelligently
16 as we probably needed to, and what we need to
17 better understand, Mike, is what you pointed out,
18 is what are the essential natures of
19 rehabilitation, especially within the military
20 context.

21 What makes the soldier who has been
22 injured, him or herself or the marine, and I use

1 that as a generic term for all of the injured or
2 ill warriors, what makes them so bound to their
3 colleagues and their comrades who have gone
4 through this that they want to get back and help
5 so actively in that rehabilitation process, and
6 they're vital to that? It's not the same thing;
7 it's not like the rehabilitation that many of us
8 have seen for other categories of injury element.

9 So I'll close by just saying how
10 profoundly pleased we all are that the group has
11 done as thorough a job as they have in such a
12 short period and contract a telescope kind of
13 study time, but I think it's giving us some
14 tremendous tools and insights for making
15 improvements.

16 DR. POLAND: Thank you. In just a
17 moment I'm going to ask Secretary Marsh and West
18 to make closing comments and then I will. First,
19 though, may I ask our -- do we have any wounded
20 soldiers or veterans here with us today? If so,
21 would you please stand or raise your arm, and if
22 your family members are with you, would they also

1 stand that we might recognize you? Thank you,
2 thank you very much. Did you want to make a
3 comment?

4 MAS. SGT. CHENARD: (off mike)

5 DR. POLAND: Please, there's a
6 microphone right there.

7 MAS. SGT. CHENARD: Thank you very much
8 one and all. Master sergeant Chenard, I've been
9 here almost a year. My injuries are nothing
10 compared to some of my colleagues. Everything
11 that you've said here is resonating very deeply
12 into our hearts and our minds, and we thank you.
13 I didn't hear anything about TSDLI, for some of
14 the troops, it's becoming really hard to apply the
15 administrative requirements.

16 The requirements will become more and
17 more difficult. I can't think of anything more
18 adversarial than a soldier being told by a PDB he
19 or she got 20 percent, and oh, by the way, if you
20 disagree with that and want to contest that, you
21 know, we can turn around and give you nothing.
22 I'm going to leave that sentence open.

1 I want to thank the Marine Corp
2 yesterday for putting in the newspapers that
3 they've started their own brigade, and they
4 mention the term Ombudsman, and in the earlier
5 discussion that we heard, we have case managers,
6 we have platoon sergeants, we have primary care,
7 they all seem to have a track or lane that they
8 have to follow. The Ombudsman, on the other hand,
9 he or she appears to have more leeway, as in
10 crossing lanes, the whole purpose being to assist
11 the soldier, he or she, in obtaining documents
12 they need to help the medical staff do what they
13 have to do, the (off mike) to properly diagnose
14 clinically and otherwise in putting the narrative
15 summary, the data that needs to be in there, so --
16 and that needs to be in there, and I might add,
17 needs to stay in there without any changes until
18 it reaches the hands of the PEB (?) individuals,
19 so that they can properly evaluate the soldiers;
20 all right.

21 If you need more details on that at some
22 other time, I'll be glad to give it, but I think

1 you all know what I'm talking about. An Ombudsman
2 might be the solution to that.

3 I'd like to be able to encourage
4 everybody to understand it's been talked about in
5 a circular way here with very good intention, I
6 just want to reiterate when you're all pumped up
7 and you're in a combat zone, and all of a sudden
8 you get injured, one moment you were talking to
9 your troops or aiming a weapon or communicating on
10 a radio, the next thing you know, you're so doped
11 up at some local hospital because your colleagues
12 were able to transport you there in lightning
13 speed, a big difference between now and Vietnam,
14 as brought up by Doctor Schwarz, and now you're in
15 (off mike), you're semi-conscious, you're told a
16 few things, and low and behold, you're back state
17 side in one of our medical treatment facilities
18 being very appropriately and warm and cared for by
19 our staffs, who can not get enough credit for
20 everything that they do; all right.

21 I had an operation at the Navy and I'm
22 here to tell you that the cohesion, the

1 integration to everything -- thank you Admiral
2 Robinson, and your staff was just phenomenal. I
3 couldn't tell what uniforms were treating me, but
4 they did a fantastic job, and I thank them, and I
5 may speak for a lot of others that I might add.

6 So coming back to -- you're wounded, you
7 get back state side, and you're kind of groggy,
8 and then all of a sudden you go from being a
9 healthy service member to gosh, I got to take how
10 many pills a day, and then you're asked to be --
11 you have to make some decisions, and this may take
12 a long time for your body to wean itself off the
13 effects of the medication, some -- most of the
14 effects will help you, and as we all know, there
15 are side effects and some of us react very
16 differently, and all of this is going very fast,
17 even though weeks and months and a lot of
18 appointments are going by, and then the family
19 never, of course, comes into the picture and he or
20 she is totally unfamiliar with how the system
21 works, let alone the medical environment.

22 So there's a lot of dynamics going on,

1 and in spite of all of that, we seem to make it
2 through the process. But just please think about
3 the soldier and how he or she feels with all of
4 these chemicals in the body and all of these
5 emotions bubbling up, that's the part that we
6 often, I think occasionally lose track of, not
7 intentionally, but it happens and it effects a lot
8 of people, and I ran out of thoughts, I'm sorry.

9 DR. POLAND: Thank you, thank you for
10 your comments. Admiral Robinson, any comments
11 that you'd like to make?

12 ADM. ROBINSON: Good afternoon to
13 everyone. I'm Adam Robinson, the Commander to
14 National Naval Medical Center, and I think that
15 General Schoomaker summed up a lot of the issues
16 that we talked about. I'd like first, to thank
17 the IRG for all of their help, and for their
18 discussions, and also everything that they've done
19 to bring many issues forward. With traumatic
20 brain injury, it is a very interesting injury.

21 The comment that I'd like to make is
22 that at National Naval Medical Center, with our

1 continue of our care, trauma service, which
2 includes traumatic brain injury, we're dealing
3 with new diagnoses and new treatments, and instead
4 of being able to do the typical studies that will
5 take years and that will have prospective or have
6 a very controlled situation, we're finding that we
7 are actually making enrolleds (?) and defining new
8 areas that we're going to need to get out to
9 everyone much sooner.

10 This is akin, and I'm sure that this
11 isn't exactly right, but it's akin to having a new
12 treatment for a bad illness, in which half way
13 through the study you realize that the treatment
14 works so well, you can't continue to study it any
15 longer, you really just have to make your findings
16 known and you can get out. So with traumatic
17 brain injuries, I'm in no way saying that National
18 Naval Medical Center leads the way, but with
19 the -- because of how we have done care and
20 because we're getting all of the penetrating head
21 injury and most of the concussive head injuries at
22 National Naval Medical Center, we've actually

1 concentrated in this area. We need to get that
2 information out to the line, to the line
3 hospitals, to the Veterans' Administration,
4 because we need to do that, and I think it will
5 make it different.

6 The issue that I'd like to also talk
7 about is, the rehab issue, which I think is an
8 incredibly important issue and the sustainment of
9 care issue, which goes with that, and the two
10 areas that we have been credited with doing it
11 remarkably well by several members of the Defense
12 Health Board, have been the preventive medicine
13 and the combat surgical support, and then the
14 third part that we haven't done as well is the
15 rehab care, and I'd only like to comment that in
16 military health system, the rehabilitative care
17 has usually been not done as much.

18 We're not really set to do that, and I'm
19 speaking from the Navy point of view,
20 particularly, but the systematic rehabilitative
21 services have traditionally been the purview of
22 Veterans' Affairs, and Veterans' Affairs has been

1 resourced to do that.

2 I'm not suggesting to you that we don't
3 need to do that now on the military health systems
4 side, but I think that's a tremendous change in
5 the model, and as we do that, we need to do it
6 with our eyes open, we need to understand what
7 we're doing, we need to be resourced
8 appropriately, and we then need to make sure that
9 we change many of the laws and many of the other
10 things so that we can give the sustainment of the
11 care to the member once they may have transitioned
12 from an active status or reserve status to a
13 retired status, and I think that's very important
14 and we need to discuss that openly, and we need to
15 make sure that we clarify that.

16 I think that we need to partner with
17 Veterans' Affairs, and Veterans' Affairs'
18 hospitals, and we need to partner with them on a
19 daily basis with every injury in our poly trauma
20 centers, and in our traumatic brain injuries, and
21 I would suggest that we're doing that, in no way
22 we're not, and VA is very receptive, but we need

1 to do it even more robustly.

2 And then lastly, just in the national
3 capital area, and I think that General Schoomaker,
4 again, would agree, we absolutely do need to go
5 ahead with the integration of Walter Reed and
6 Bethesda, both of the institutions, essentially,
7 will close, they will come back as the Walter Reed
8 National Military Medical Center, that is
9 absolutely the thing we should do. General
10 Schoomaker and I are absolutely locked in arm and
11 arm with that.

12 In order to do it correctly, I'll just
13 leave with this one thought, and that is it needs
14 to be integrated health care system, it needs to
15 have the robust med center, research, graduate
16 medical education at the Walter Reed National
17 Military Medical Center, and we need to partner
18 with Navy, with Army, with the Air Force, and with
19 Uniformed Services University, President Rice is
20 behind me also, in order to have the integrated
21 health care system that will actually give the
22 care and then give the sustainment to that care to

1 the beneficiaries in the national capital area.
2 I'd like to end by just thanking the Defense
3 Health Board and also the IRG for all of the work
4 that they've done and for bringing this front and
5 center to not only DOD's attention, but also the
6 American public. Thank you very much.

7 DR. POLAND: Thank you. Secretary
8 Marsh, would you like to make any closing
9 comments?

10 SECRETARY MARSH: Just a few; Secretary
11 Togo West talked with me, and I said I would -- he
12 suggests that I close, but I'm doing this on his
13 behalf, as well as my own. First, an
14 administrative announcement; the lady who
15 represented the family group, who wanted to make a
16 statement, if -- we need to get that statement
17 within the next 48 hours because -- our report is
18 going to be completed and we will not be able to
19 print it unless we do. I would like to thank
20 General Schoomaker, it was a month ago, Eric, that
21 we were out here, when you just assumed the
22 command, and the Admiral, Admiral Robinson, for

1 everything you all have done to help us. If I
2 could mention to the members of the Board, the
3 Health Board, you people enjoy enormous prestige
4 in a very critical field (off mike), and you have
5 great influence, and you can help through your
6 member of Congress, when you leave the (off mike)
7 and go back home, and let me suggest that you
8 bring to their attention, because it'll have great
9 weight because of your background, this effort
10 that we're trying to do here on behalf of our
11 government.

12 I might mention to the Health Board, you
13 need to look at enlistment of doctors. We are
14 having problems getting doctors in the National
15 Guard and the Reserve, and there's a capability
16 that you could use to take in older doctors in
17 their 50's, but they have to sign an eight year
18 obligation, and that's counted productive.

19 Finally, I would thank two groups of
20 people, two different groups. You saw the
21 tremendous abilities and expertise of why this
22 committee was able to draw on great talents, and

1 I'm referring to the members here seated to my
2 right. They have done -- really worked
3 unbelievably hard, and this report reflects in
4 large measure their inputs, and the second group
5 that I would like to cite, are those who worked as
6 staff members for the IRG. They too have done a
7 yeomen (?) service. Both of these reports and
8 efforts are a reflection of their efforts and also
9 the input of my colleagues here on the IRG, and my
10 good friend Togo West. Thank you very much.

11 DR. POLAND: Thank you, sir. Secretary
12 West? Well, I will again thank the IRG and the
13 Secretary's Co- chairs for the work that they did.
14 We did have a few comments as a Board, one was to
15 consider in the -- as we go forward, development
16 of a set of guiding principles, many of which
17 we've talked about that would be transparent in
18 public as to what the ultimate solution to the
19 current issues would look like, and some of those
20 might include principles requiring that the
21 eventual solutions be patient centric, that they
22 adhere, of course, to the highest standards of

1 clinical care, that they be evolutionary over
2 time, cost effective, and actionable.

3 The other idea that we had was the
4 development of a road map or a pathway of the
5 ideal medical care and support pathway from the
6 point of acute injury all the way through chronic
7 rehabilitative care that would involve both
8 patients and their families, and again, this
9 pathway or road map should be patient centric.

10 We also look forward to the development
11 of metrics, measures, and timelines for this
12 medical care and support road map. A definition
13 of the personnel resources and ancillary services
14 need to achieve the road map, and finally, as is
15 endorsed in your report, the idea that someone, a
16 specific individual, must be in charge of this
17 process and have definable authority and
18 accountability for -- and the sustainability of
19 this process.

20 I'll summarize by saying that the bottom
21 line is that we develop solutions that get the
22 right people delivering the right services at the

1 right time and at the right locations to the right
2 consumers. In this regard, the IRG has
3 appropriately titled its report rebuilding the
4 trust, and I think it's an appropriate one.

5 Finally, it's absolutely clear that the
6 root solution here to the many issues is
7 legislative appropriations. The military,
8 medical, and VA systems must be sufficiently
9 resourced to enable them to provide the health
10 care, acute and chronic, that our wounded warriors
11 and their families deserve. It is part of the
12 cost of war. These individuals and their families
13 have paid a high price. It is our country, you
14 and I that are in debt to these heroes, and it is
15 time we paid our debt; to care for him who shall
16 have born the battle and for his widow and his
17 orphan. It is a moral imperative from which we
18 dare not shrink, and just as we don't leave our
19 acutely wounded soldiers behind battle lines, we
20 can not leave them medically behind the lines
21 either. Thank you all very much for you
22 attention. Ms. Embrey, would you adjourn the

1 meeting?

2 MS. EMBREY: This meeting is officially
3 adjourned.

4 (Whereupon, at 4:09 p.m. the
5 PROCEEDINGS were adjourned.)

6 * * * * *

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

