

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

BOARD MEETING

Arlington, Virginia

Tuesday, June 14, 2011

1 PARTICIPANTS:  
2 Board Members:  
3 MAJOR GENERAL (Ret.) GEORGE K. ANDERSON, M.D.  
4 M. ROSS BULLOCK, M.D., Ph.D.  
5 VICE ADMIRAL (Ret.) RICHARD H. CARMONA, M.D.  
6 ROBERT GLENN CERTAIN, Ph.D.  
7 NANCY W. DICKEY, M.D.  
8 ROBERT FRANK, Ph.D.  
9 GENERAL (Ret.) FREDERICK FRANKS  
10 JOHN V. GANDY, III, M.D.  
11 EVE HIGGINBOTHAM, M.D.  
12 DAVID ALLEN HOVDA, Ph.D.  
13 JAY A. JOHANNIGMAN, M.D.  
14 GENERAL (Ret.) RICHARD MYERS  
15 DENNIS S. O'LEARY, M.D.  
16 Service Liaison Officers:  
17 LIEUTENANT COLONEL PATRICK GARMAN  
18 COLONEL PHILIP GOULD  
19 MAJOR ROGER LEE  
20 COLONEL ROBERT L. MOTT  
21 COMMANDER WILLIAM PADGETT  
22 COMMANDER ERICA SCHWARTZ

1       CAPTAIN PATRICK LARABY  
2       Additional Attendees:  
3       PARTICIPANTS (CONT'D):  
4       MAJOR GENERAL KIM SINISCALCHI  
5       ERIC ALLELY, M.D.  
6       CAPTAIN (Ret.) KATHY BEASLEY  
7       COLONEL PETER BENSON  
8       FRANK K. BUTLER, JR., M.D.  
9       LIEUTENANT COLONEL GREG CANTY  
10       SALVATORE CIRONE  
11       JOHN DAVID CLEMENTS, Ph.D.  
12       RANDY CULPEPPER  
13       DANIELLE DAVIS  
14       MICHAEL DINNEEN, M.D.  
15       CHARLES FOGELMAN, Ph.D.  
16       SLOAN GIBSON  
17       CAPTAIN KURT HENRY  
18       LIEUTENANT COLONEL RUSS S. KOTWAL  
19       KURT KROENKE, M.D.  
20       CLIFFORD LANE, M.D.  
21  
22

1 PARTICIPANTS (CONT'D):  
2 LEONARD G. LITTON  
3 WARREN LOCKETTE, M.D.  
4 VICE ADMIRAL JOHN MATECZUN  
5 MICHAEL D. PARKINSON, M.D.  
6 CHARMAINE RICHMAN, Ph.D.  
7 MAJOR BRANDI RITTER  
8 COLONEL COLLEEN SHULL  
9 JOSEPH SILVA, JR., M.D.  
10 COLONEL HARRY SLIFE  
11 WILLIAM UMHAU, M.D.  
12 JONATHAN WOODSON, M.D.  
13 DHB Staff:  
14 ALLEN MIDDLETON, Designated Federal Officer  
15 CHRISTINE E. BADER, Director  
16 COLONEL WAYNE E. HACHEY, Executive Secretary  
17 CAMILLE GAVIOLA, Deputy Director  
18 MARIANNE COATES  
19 OLIVERA JOVANOVIC  
20 JEN KLEVENOW  
21 ELIZABETH MARTIN  
22 HILLARY PEABODY

1 PARTICIPANTS (CONT'D):

2 JESSICA SANTOS

3 KAREN TRIPLETT

4 Court Reporter:

5 STEVE GARLAND

6 \* \* \* \* \*

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

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

(9:33 a.m.)

DR. DICKEY: I'd like to welcome everyone to this meeting of the Defense Health Board. We have several important topics on the agenda for today so let's get started. Mr. Middleton, if you'd call the meeting to order.

MR. MIDDLETON: Thank you, Dr. Dickey. As the Designated Federal Officer for the Defense Health Board, a Federal Advisory Committee and a Continuing Independent Scientific Advisory Board to the Secretary of Defense via the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the Military Departments, I hereby call this meeting of the Defense Health Board to order.

DR. DICKEY: Thank you, Mr. Middleton. Now carrying on the tradition of our Board, I ask that we stand for a minute of silence to honor those we are to serve, the men and women who serve our country.

(Moment of silence.)

1 DR. DICKEY: Thank you. Since this is  
2 an open session, before we begin I'd like to go  
3 around the table and have the Board and  
4 distinguished guests introduce themselves. I'm  
5 Nancy Dickey. I am a family physician by  
6 training, President of the Texas A&M Health  
7 Science Center and Chair of your Defense Health  
8 Board.

9 DR. WOODSON: Jonathan Woodson,  
10 Assistant Secretary of Defense for Health Affairs.

11 MS. BADER: Christine Bader, Director of  
12 the Defense Health Board.

13 DR. LOCKETTE: Warren Lockette, Deputy  
14 Assistant Secretary for Health Affairs.

15 GEN MYERS: Dick Myers, Core Board  
16 Member.

17 DR. FRANK: Good morning. I'm Bob  
18 Frank. I'm Provost and Senior Vice President for  
19 Academic Affairs at Kent State University.

20 DR. CARMONA: Rich Carmona, Board  
21 Member, former Surgeon General.

22 DR. JOHANNIGMAN: Jay Johannigman,

1 Trauma Surgeon, Cincinnati, Ohio.

2 DR. O'LEARY: Dennis O'Leary, Board  
3 Member, President Emeritus of the Joint  
4 Commission.

5 DR. HOVDA: Dave Hovda, Board Member.  
6 I'm a Professor of Neurosurgery and Molecular  
7 Pharmacology and Director of UCLA's Brain Injury  
8 Research Center.

9 DR. FOGELMAN: Charlie Fogelman. I'm  
10 Chair of the Psychological Health Subcommittee of  
11 the Board.

12 DR. LANE: Cliff Lane, National  
13 Institute of Allergy and Infectious Diseases at  
14 the National Institutes of Health.

15 DR. CLEMENTS: John Clements, Tulane  
16 University School of Medicine in New Orleans, and  
17 I'm on the Infectious Disease Subcommittee.

18 CAPT LARABY: Captain Patrick Laraby,  
19 Director for Public Health for the U.S. Navy's  
20 Bureau of Medicine and Surgery.

21 CDR PADGETT: Bill Padgett,  
22 Headquarters, Marine Corps Health Services.

1 COL MOTT: Bob Mott, Preventive  
2 Medicine, Army OTSG.

3 DR. ALLELY: Eric Allely, Joint  
4 Surgeon's Office over at the National Guard Bureau  
5 here representing Major General Martin.

6 MAJ LEE: Major Roger Lee, representing  
7 the Joint Staff Surgeon, and I'm the Joint Staff  
8 Liaison.

9 DR. PARKINSON: Mike Parkinson, former  
10 Board Member, and here to present one of the  
11 reports to the Board today.

12 DR. SILVA: Joe Silva, former Board  
13 Member and will present one of the reports today.  
14 I'm Dean Emeritus at UC-Davis School of Medicine  
15 and Professor of International Medicine and  
16 Immunology.

17 DR. BUTLER: Frank Butler, former  
18 Command Surgeon at the U.S. Special Operations  
19 Command and Chair of the Committee on Tactical  
20 Combat Casualty Care.

21 DR. BULLOCK: Ross Bullock, Professor of  
22 Neurosurgery, University of Miami and Core Board

1 Member.

2 DR. CERTAIN: Robert Certain, retired  
3 Air Force Chaplain and Member of the Defense  
4 Health Board.

5 DR. HIGGENBOTHAM: I'm Eve Higgenbotham,  
6 Senior Vice President and Executive Dean for  
7 Health Sciences at Howard University. I'm an  
8 Ophthalmologist and a Glaucoma Specialist.

9 DR. GANDY: I'm John Gandy. I'm an  
10 Emergency Medicine Physician retired from the Air  
11 Force and also a Member of the TCCC Committee.

12 DR. ANDERSON: George Anderson, Board  
13 Member, retired Air Force Medical Officer.

14 GEN FRANKS: Fred Franks, Board Member,  
15 U.S. Army retired.

16 MG SINISCALCHI: Good morning. Kim  
17 Siniscalchi representing the Air Force Surgeon  
18 General, General Bruce Green.

19 COL HACHEY: Wayne Hachey, Executive  
20 Secretary of the Defense Health Board.

21 MR. MIDDLETON: I'm Allen Middleton, the  
22 Designated Federal Official for the Defense Health

1 Board and the Deputy Assistant Secretary for  
2 Health Budgets and Financial Policy.

3 COL BENSON: Colonel Peter Benson. I'm  
4 the Deputy Chief of Staff Surgeon for the U.S.  
5 Army Special Operations Command at Fort Bragg.

6 MS. DAVIS: Danielle Davis. I'm the  
7 Administrative Secretary for the Committee on  
8 Tactical Combat Casualty Care.

9 COL SHULL: My name is Colonel Colleen  
10 Shull. I from the Defense Materiel Program Office  
11 at Fort Detrick. I'm the Chief of Staff there.

12 MAJ RITTER: Major Brandi Ritter. I'm  
13 with the Defense Medical Materiel Program Office,  
14 Head of Joint Medical Test and Evaluation.

15 CAPT BEASLEY: Kathy Beasley, Retired  
16 Navy Captain, Military Officer's Association and  
17 Deputy Director of Government Relations.

18 MR. CIRONE: I'm Sal Cirone. I'm a  
19 Staff Officer in the Office of the Assistant  
20 Secretary of Defense for Health Affairs.

21 DR. RICHMAN: I'm Charmaine Richman.  
22 I'm a Product Manager at the United States Army

1 Medical Materiel Development Activity.

2 LTC CANTY: Lieutenant Colonel Greg  
3 Canty, Office of the Surgeon General, also Health  
4 Promotion and Risk Reduction Task Force.

5 DR. UMHAU: William Biff Umhau, Family  
6 Medicine, Occupational Health Environmental Safety  
7 Services at NSA, Fort Meade.

8 CAPT HENRY: Captain Kurt Henry,  
9 Director, Clinical Operations BUMED.

10 COL SLIFE: Colonel Harry Slife, Deputy  
11 for Research and Technology, Fort Detrick, Medical  
12 Research and Materiel Command.

13 MS. PEABODY: Hillary Peabody, Support  
14 Staff of the Defense Health Board.

15 MS. MARTIN: Elizabeth Martin, also DHB  
16 Support Staff.

17 MS. JOVANOVIC: Olivera Jovanovic.

18 MS. GAVIOLA: Camille Gaviola.

19 DR. DICKEY: Thank you. Before we  
20 continue the morning session, Ms. Bader would like  
21 to provide some administrative remarks.

22 MS. BADER: Good morning, everyone, and

1       thank you very much for your attendance here today  
2       at this meeting of the Defense Health Board. I  
3       would like to start by introducing, although she  
4       had already introduced herself, a new member of  
5       our staff, Camille Gaviola, who is a retired Air  
6       Force Lieutenant Colonel and we welcome her to the  
7       Defense Health Board. I would also like to thank  
8       the Renaissance Arlington Capitol View Hotel for  
9       helping with these meeting arrangements and for  
10      all of the speakers who have worked very hard to  
11      prepare their briefings for the Board as well as  
12      the Defense Health Board Staff.

13                   Please sign the Board attendance sheets  
14      on the table outside of this room if you have not  
15      already done so and kindly indicate any recent  
16      change to your contact information if it is not  
17      reflected on the roster. For those who are not  
18      seated at the tables, handouts are provided on the  
19      table in the back of the room so that everyone can  
20      have the handouts and follow along if they choose.  
21      Rest rooms are located just outside of the meeting  
22      rooms, and for telephone, fax, copies or messages,

1 please see Jen Klevenow or Jessica Santos.  
2 Jessica is in the front of the room there in the  
3 black suit. Jen is outside at the table, and they  
4 can assist you with any logistical needs that you  
5 may have.

6 Because this is an open session in  
7 accordance with FACA and it is being transcribed,  
8 please state your name before you speak and use  
9 the microphones so that the transcriptionist can  
10 accurately record what you are saying.

11 Refreshments will be available for both the  
12 morning and the afternoon sessions and we will  
13 have a working lunch here for Board members,  
14 Federal Agency Liaisons, Service Liaisons, DHB  
15 staff and special guests.

16 For those who are looking for lunch  
17 options, the hotel restaurant is open for lunch  
18 and there are several dining options all within a  
19 short walking distance of the hotel. If you need  
20 further information, please either see either Jen  
21 Klevenow or the front desk hotel staff. Please  
22 note that short biographies will be read for each

1 of our speakers today and more detailed bios can  
2 be found in your meeting binders under Tab 3.  
3 Thank you very much.

4 DR. DICKEY: Thank you, Ms. Bader. We  
5 have a lot of work to do and a lot of interesting  
6 work to do. We appreciate all of you being here  
7 and sharing your time with us. Our first briefing  
8 today is going to be delivered by Dr. Charles  
9 Fogelman, Chair of the Psychological Health  
10 External Advisory Subcommittee, Dr. Joseph Silva,  
11 and Dr. Michael Parkinson.

12 Dr. Fogelman is the Executive Coach in  
13 Leadership Development and Management Consultant  
14 of Paladin Coaching Services where he advises  
15 professionals from various fields on issues  
16 pertaining to leadership and organizational  
17 development as well as strategic planning and  
18 implementation.

19 Dr. Silva serves as Professor of  
20 Internal Medicine within the Division of  
21 Infectious Diseases and Immunology at the  
22 University of California-Davis School of Medicine,

1 previously having served as Dean of the Medical  
2 School and Chair of Internal Medicine. In  
3 addition to academic positions, Dr. Silva's prior  
4 appointments include serving as a consultant for  
5 Kaiser Permanente Hospital and the U.S. Air Force  
6 Medical Corps at Wilford Hall Medical Center and  
7 subsequently in the Air Force Reserves.

8 Dr. Parkinson serves as President of the  
9 American College of Preventive Medicine. His  
10 previous positions include Executive Vice  
11 President and Chief Health and Medical Officer of  
12 Lumenos, a pioneer of consumer-driven health plans  
13 and a subsidiary of WellPoint where he was  
14 responsible for the development and implementation  
15 of an integrated, incentivized health improvement  
16 strategy employing evidence-based prevention, care  
17 management, account-based benefit designs,  
18 employer partnership and consumer engagement. A  
19 retired Air Force Colonel, Dr. Parkinson also  
20 served as the Deputy Director of Air Force Medical  
21 Operations and Chief of Preventive Medicine.

22 Dr. Fogelman is going to provide an

1 overview of the subcommittee's findings and  
2 proposed recommendations that were included in its  
3 draft report pertaining to psychotropic medication  
4 and complementary and alternative medicine. Board  
5 Members may find the presentation slides under Tab  
6 5. Dr. Fogelman, welcome, and we look forward to  
7 hearing from you.

8 DR. FOGELMAN: I'm quite loud, as you  
9 know. I'm perfectly happy to speak loudly and I  
10 guess I'll do that. When you asked me if I needed  
11 a microphone, I thought you meant did I need a  
12 lapel microphone.

13 Happy Flag Day, everybody. I'm wearing  
14 one of my flag ties for this purpose. And  
15 although I'm not going to do what I was briefly  
16 intending to do because of what are soon to be the  
17 pressures of time, I have something that I'd be  
18 happy to share with people if you want to come  
19 over to where I'm sitting or perhaps I can show it  
20 to you later if you want it read. This is a one  
21 and a half page article by Isaac Asimov, the  
22 science-fiction writer. It's a speech he gave in

1 1991 about "The Star-Spangled Banner" and it is  
2 really one of my favorite things on the subject of  
3 flags and so on.

4 We have an hour and 15 minutes. Is that  
5 right?

6 DR. DICKEY: Yes, sir. That includes  
7 not only the presentation, but questions and  
8 answers, Dr. Fogelman.

9 DR. FOGELMAN: I understand. Also I  
10 think we have somebody calling in at 10:00. Think  
11 Dr. Kroenke is going to call in at 10:00. So if  
12 we hear ding-a-lings up there, it's welcoming him  
13 because he was one of the active people on the  
14 committee.

15 Let's see. What have we got here?  
16 That's me. I'm the first guy, Mike Parkinson has  
17 been identified, and Joe Silva. That just tells  
18 you what slides are coming. This tells you what  
19 is the big thing we're going to be talking about.  
20 I'll come back to this. That's continuing about  
21 the big thing we're going to talk about. You may  
22 know some of us. Some of us are in the room.

1                   This is the current membership of the  
2 committee. We have recently been enlarged in all  
3 senses of the word by the addition of Dr. Bullock  
4 and Dr. Hovda, who make us more of a TBI Committee  
5 as well even though we're not.

6                   Don't point that thing at me. Now it's  
7 on after I was practicing my outside voice and  
8 everything?

9                   I'll tell you about this. The question  
10 which was at the beginning which I'll come back to  
11 before I go forward was presented to the Board now  
12 about a year ago. The previous administration of  
13 the Board decided that the best way to deal with  
14 what was a very large and very complicated  
15 question was to create two specific work groups,  
16 one for each half of the question: One on the use  
17 of complementary and alternative medicine in  
18 theater, and the other on the use of psychotropic  
19 drugs. The first meeting of -- was that really  
20 our first meeting in November, Mike? The first  
21 meeting of the work groups actually took place  
22 together and some members of the Psychological

1 Health Subcommittee attended that as well. As  
2 time progressed, both Dr. Parkinson's and Dr.  
3 Silva's appointments on the Board expired so that  
4 the work was then transferred as a whole to the  
5 Psychological Health Subcommittee, but all the  
6 people previously involved continued to be  
7 involved. I'm sorry that on that list we don't  
8 have the other members of the work group. I'd  
9 like to acknowledge them, but since I can't  
10 remember all of their names, maybe Mike, you have  
11 a better memory than I, when you get up here if  
12 you can do it.

13           Since Dr. Silva and Dr. Parkinson were  
14 really the Chairs of the work groups and moved  
15 most of the work forward enough though it was  
16 formally placed within the Psychological Health  
17 Subcommittee, in a few moments I'm going to ask  
18 Dr. Parkinson and Dr. Silva to come up and give an  
19 overview and present the report, which may be the  
20 real reason I skipped through there. We don't  
21 have a slide that tells us what else. Is there an  
22 ANAM slide now? Will I find an ANAM slide? No?

1           I'll tell you what we're going to do  
2 next and then we'll do this. The next task of our  
3 subcommittee, we're meeting on Thursday to begin  
4 to tackle this, we have been presented a question  
5 a numbers of years ago even before we were stood  
6 up about the ANAM, which is the Automated  
7 Neurocognitive -- somebody help me here. Well, I  
8 apologize for the frailty of my memory at my  
9 advanced age, but it's an automated neurocognitive  
10 instrument, which is used, I think, currently  
11 before and after deployment, maybe just before.  
12 We have a question about that and about its  
13 efficacy, and we're going to start to wrestle with  
14 that on Thursday with the hope and expectation  
15 that it will just take us several months to finish  
16 it because I know it's a matter of some importance  
17 that the Department get our recommendations about  
18 it.

19           To the task at hand, I'm not going to  
20 make you read the slides or your handouts. A very  
21 long series of questions was asked about the  
22 questions of the use of psychotropic medication

1 and the use of complementary and alternative  
2 medicine. Over the course of the meetings we  
3 decided to try to make something that we could put  
4 our hands and heads around rather than to try to  
5 answer everything. As Dr. Parkinson will talk  
6 about, we did try to focus it a little more  
7 because in the end we decided that to try to  
8 respond to the entire formal question would have  
9 been difficult to say the least. So you'll hear a  
10 report which is based on focusing everything down  
11 and trying to come up with, please do not laugh  
12 when I say this, a few findings and  
13 recommendations.

14 This is an interim report. These are  
15 not our final recommendations for the Board to  
16 vote on, but they will almost surely be 98 percent  
17 concordant with what the eventual wording will be.  
18 I doubt that we'll have any other findings or  
19 conclusions and we may reword some, but that also  
20 depends on what the guidance of the Board might be  
21 over the course of the morning.

22 Dr. Dickey, I don't know what the

1 formality is about requesting a vote on an interim  
2 report, so if you'd just have in mind whatever it  
3 is you want when we're done, we can proceed.

4 I'd like now to turn the lectern over to  
5 Dr. Parkinson with some comments from Dr. Silva.  
6 Dr. Parkinson will walk us through the rest of  
7 this.

8 DR. PARKINSON: Thank you. Thanks, Dr.  
9 Fogelman, very much.

10 Good morning, everybody, Dr. Woodson,  
11 Dr. Dickey, and all the distinguished Members of  
12 the Board. Thank you very much for your support  
13 of this initiative and we hope that what we bring  
14 you today in an interim report is useful for early  
15 action by the Department in some key areas that we  
16 on the committee felt were low-hanging fruit and  
17 some areas where we can build on the considerable  
18 success of the Department already in improving the  
19 psychological health and the response to  
20 psychological health among our troops.

21 Let me say at the outset I want to thank  
22 also the tremendous support from DoD Staff, from

1 the Services, both the consultants and the various  
2 agencies, and TMA that over the last duration of  
3 months has generated a tremendous volume of  
4 information which had led to a very comprehensive  
5 and we hope very useful report for the Department.  
6 But because of the volume of that material and  
7 because of the way in which it's organized, we  
8 want to make sure that we did an excellent job on  
9 the editing and the final preparation of that  
10 report. And as Dr. Fogelman indicated, we wanted  
11 nonetheless to bring you the findings and  
12 recommendations for consideration and discussion  
13 with the Board today.

14 The scoping of the issue, which is  
15 really what we spent a lot of our time on very  
16 early because we were given many, many questions  
17 and concerns in both the broad area of  
18 psychotropic medications and the broad area of  
19 complementary and alternative medicine which  
20 together would make up a textbook of DSM-IV, and  
21 so we scoped it in such a way that we could give  
22 practical advice around what issues we saw to be

1 of near-term concerns to the Department. The  
2 blending under Dr. Fogelman's leadership, last  
3 process comment, was a real credit to him in  
4 bringing together the expertise of the  
5 Psychological Health Subcommittee with those of us  
6 who were former Members of the previous Board who  
7 were designated to co-lead, myself and Dr. Silva.  
8 So from a systems point of view it was a  
9 challenge, but it worked very well and I'm very  
10 pleased to report that.

11 You can see here that the charge to the  
12 Board was essentially these four elements, and as  
13 we scoped it we said we wanted to have a priority  
14 on the in-theater operational aspects of this  
15 issue. We wanted to talk a little bit about the  
16 transitions, realizing that much of the  
17 Department's work recently has been about  
18 transitions of care and what happens after the  
19 troops come home. We wanted to get a broader  
20 understanding of the most common mental health  
21 conditions seen in theater and the status of  
22 optimal-based, evidence-based therapies being

1        deployed in the Department for the treatment of  
2        those conditions.

3                    We know there was a lot of emphasis on  
4        clinical practice guideline development and the  
5        Board was very interested in looking at what's  
6        happened to those guidelines since they've been  
7        developed, and who's providing what type of care  
8        to whom, where, scope of practice issues. None of  
9        these issues, by the way, are unique to military  
10       medicine. Those of us who wear civilian hats see  
11       these in our institutions in the practice of  
12       medicine every day.

13                   A lot of discussion both on the question  
14        about the role of primary care, about medical  
15        technicians, about the use of psychiatrists in  
16        theater, what's the most appropriate scope for  
17        these various people to add to their expertise and  
18        improvement? What is the in-theater availability  
19        of the recordkeeping systems so that bodies such  
20        as ours or the public at large or DoD policymakers  
21        and clinical leaders can know how to improve the  
22        system? What is a framework, a systematic

1 framework, that can be used or should be used to  
2 disseminate in a timely fashion operational  
3 breakthroughs, whether it be in research or  
4 practice in teaching? Is it there so that we're  
5 able to do that? And peripherally to look at the  
6 ongoing issues around mental health and stigma,  
7 which was secondary.

8 I mentioned before that we blended the  
9 two work groups. It worked out very well. You  
10 saw the series of meetings that we conducted. And  
11 as I mentioned, Dr. Kurt Kroenke, who did a lot of  
12 our work on evidence-based health care or  
13 evidence-based practice versus evidence-informed  
14 practice, this is an issue that's come up in the  
15 media somewhat, it was critical in that regard,  
16 Kurt's going to be joining us by phone here in a  
17 few minutes.

18 What I'm going to do is we tried to boil  
19 this down into five categories of findings and  
20 recommendations. Those categories are: The  
21 prevalence of psychological health conditions, the  
22 prevalence of psychotropic drug use, complementary

1 and alternative medicine, clinical practice  
2 guidelines, and, finally, education and training  
3 related to all these issues. I'm going to just  
4 make a brief comment. Dr. Silva will provide  
5 comments to kind of frame the context of our work  
6 and the challenges that we see in the report and  
7 going forward.

8           Not surprisingly, psychological stress  
9 from 10 years' worth of war, repeated deployments,  
10 is not something new or something that is  
11 unanticipated. It should be predicted and it was  
12 predictable. It was important to note and the  
13 committee felt strongly that we had to say despite  
14 these multiple repeated and perhaps in many ways  
15 unprecedented stressors, the majority of military  
16 members and their families have weathered it well.  
17 They have not suffered adverse psychological  
18 effects requiring medical or mental health care on  
19 an ongoing basis. However, the precise prevalence  
20 and treatment of psychological health problems  
21 among Service members particularly in theater is  
22 difficult to estimate due to inadequate data

1 collection. We'll have some recommendations  
2 around that area.

3           Number four, we are aware that across  
4 the Department there are efforts underway to  
5 improve psychological health screening and to  
6 foster psychological health and resiliency as  
7 assets that need to be developed and sustained.  
8 Indeed, many of the efforts that Dr. Fogelman  
9 mentioned that the Department has been engaged in  
10 over the last three to five years specifically  
11 have been targeted toward these concerns, so it's  
12 not as if our report is done in a vacuum.  
13 Hopefully it's informed with a lot of contextual  
14 material in the report itself that individuals  
15 will be able to see the level of effort.

16           Specifically, since 2009, the committee  
17 noted that psychological health staffing has  
18 doubled and troops have reported better access to  
19 care, particularly in theater. Nonetheless,  
20 improvements can be made in both initial military  
21 training and continuing operationally relevant --  
22 the key here is "operationally relevant" --

1 professional development. We'll talk more about  
2 that in the recommendations.

3           Number six, the importance of sleep  
4 problems is reflected in pharmacy data indicating  
5 that sleep medications are the predominate  
6 prescription psychotropic drug used in theater.  
7 We'll have some recommendations regarding sleep as  
8 kind of a sentinel indicator, if you will, that  
9 should be triggering certain types of reactions,  
10 particularly in military populations perhaps going  
11 forward. There was some suggestion about the  
12 overuse of pain medications in some of the lay and  
13 civilian media that we might have seen in reports  
14 that led up to this report. What the committee  
15 found was that pain is among the most common  
16 problems reported by Service members as it is  
17 among the civilian population. Pain increases the  
18 risk of psychological conditions such as PTSD and  
19 depression and can make such conditions more  
20 difficult to treat, and obviously that there is an  
21 appropriate use for pain medications, including  
22 opioids, in the right setting.

1                   So our recommendations related to the  
2 prevalence of these psychological health  
3 conditions is that the DoD --

4                   MS. BADER: Excuse me, Dr. Parkinson?

5                   DR. PARKINSON: Yes?

6                   MS. BADER: General Myers has a  
7 question.

8                   DR. PARKINSON: General Myers? Yes,  
9 sir.

10                  GEN MYERS: Dr. Parkinson, before we  
11 leave the preliminary findings, under 2, "Despite  
12 these exposures, the majority of military  
13 members," is that a data-driven finding? I mean,  
14 how did you determine that the majority  
15 (inaudible)?

16                  DR. PARKINSON: Right. I'd welcome Dr.  
17 Fogelman and others to join in here.

18                  DR. FOGELMAN: The short is yes and also  
19 something else. We had lots of firsthand reports,  
20 including from people who treated lots of folks in  
21 theater and also who treated families, but there  
22 were data which will appear in the full report

1       which you'll get, I guess, over the course -- one  
2       hopes over the course of the summer to support  
3       that. There may be 15, 18, 20 appendices of data,  
4       but the short answer is yes.

5                 GEN MYERS: I guess the question is,  
6       this is hard to get -- my guess is it's hard to  
7       get good data here because people aren't willing  
8       to come forward in many cases.

9                 DR. FOGELMAN: Yes.

10                GEN MYERS: And then maybe a secondary  
11       question is did you determine any difference  
12       Active Duty and Guard and Reserve in this area?  
13       Because again, my guess is the Guard and Reserve  
14       data is really difficult to access.

15                DR. FOGELMAN: That's absolutely  
16       correct.

17                GEN MYERS: And if it is, should we  
18       mention it in the report if we think we have a  
19       incomplete piece here?

20                DR. FOGELMAN: Well, I think that's  
21       correct, and I think we were actually surprised  
22       that we found some data which were about Guard and

1 Reserve which were able to be wrestled with. It  
2 was certainly not complete in any way. As Dr.  
3 Parkinson said, overall the data were way less  
4 than perfect, way less than complete, and way less  
5 than satisfactory in many ways, for many reasons,  
6 all of which you can imagine: The means of data  
7 collection, the different sets of people and  
8 organizations which are collecting data, different  
9 methods of reporting, different periods of  
10 reporting. I don't think that we would assert  
11 that it was an easy conclusion to reach or one  
12 which one would stake one's life, but we were  
13 pretty comfortable with the statement about a  
14 majority, meaning more than half. We would have  
15 liked to have made statements much more precise  
16 than that, but we were really quite comfortable by  
17 saying more than half.

18 DR. PARKINSON: General Myers, there are  
19 really three sources of information that from the  
20 outset we looked for: One is traditional clinical  
21 diagnostic information that you might get from a  
22 medical encounter; one is surveys both in-theater

1 and post-theater; and third is the wide body of  
2 work related to what the Department's already done  
3 in psychological health, PTSD, et cetera; and the  
4 fourth is actually psychotropic medication use,  
5 which obviously could be an indicator to the  
6 degree that people have access to medical care  
7 that's related to that. In the report we go into  
8 considerable detail in each case contrasting what  
9 we found in the departmental data sources. Was  
10 the information adequate from a methodological  
11 standpoint? Was it benchmarked against where we  
12 could find good civilian data of its equivalent or  
13 even civilian data of people in like stressor  
14 conditions?

15 A classic example would be the use of  
16 psychotropic medication. There has been an  
17 epidemic in the civilian sector of psychotropic  
18 medications, many of whom probably are young  
19 members who are coming in with those types of  
20 medications out of adolescence. So in other  
21 words, in every case we use that framework of  
22 looking at the DoD source where it existed,

1 benchmarking it against the civilian source and  
2 benchmarking it against a subset of civilian  
3 source if there was something that looked like a  
4 stressed population similar. So again, based on  
5 all of that and dialogue with the committee, they  
6 felt that we don't want to lose the message here  
7 that for the vast majority, at least greater than  
8 50 percent, a majority of individuals, despite the  
9 stressors, despite the repeated deployments,  
10 despite the duration, that the numbers that we see  
11 do not give evidence to the fact that there is a  
12 significantly increased prevalence of these  
13 conditions in the population that require medical  
14 or mental health treatment.

15           Now, again, the way it's worded, "that  
16 require medical and mental health treatment," we  
17 get a lot of issues. The report heard a lot about  
18 the stigma, about people afraid to come forward.  
19 The stigma is reflected in other things -- please,  
20 Dr. Silva, weigh in here -- but about coding  
21 issues, how something is coded in a medical  
22 record. The use of V-codes versus ICD-9 or CPT

1 codes. You know, these are all issues that are  
2 not new to military medicine, but they are in  
3 military medicine just as they are in the civilian  
4 sector.

5 So there's a little color commentary and  
6 I apologize that you don't have the whole report  
7 in front of you, but that's methodologically  
8 what's behind that dialogue at the committee  
9 level.

10 DR. SILVA: I liked the way my two  
11 colleagues summarized it. General Franks, you hit  
12 it right on the head. We felt comfortable getting  
13 data from the last 2.5 years, that the data was  
14 far more robust than what we had in the beginning  
15 of both theaters. It's a very complicated  
16 question you ask. Comparing it to some civilian  
17 similar like situations on the use of these  
18 agents, we don't believe there's been an increase  
19 and that we feel fairly comfortable with. But  
20 there is a sub rosa problem here that exists in  
21 our society: Drugs they get at the PX, the highly  
22 caffeinated drinks, the family sends them drugs,

1       they can purchase things on the local scene. So  
2       there are a lot of things we can't get a handle  
3       on. But in our final report I suspect we'll be  
4       developing very strong language that the  
5       Department of Defense continue to improve its  
6       systems to monitor or at least know what's in the  
7       pipeline pre-deployment, deployment and  
8       post-deployment.

9                   DR. DICKEY: Are there other questions  
10       before Dr. Parkinson moves on to recommendations?  
11       Dr. Frank?

12                   DR. FRANK: Why would you compare it to  
13       civilian populations that are stressed? Why  
14       aren't you just comparing it to community  
15       populations? I'm not quite sure I understand that  
16       point.

17                   DR. PARKINSON: Well, again, the members  
18       of our committee, if you were to go over kind of  
19       the folks we had on it and in terms of the access  
20       to the databases that they were aware of, and, as  
21       you might imagine, there's not necessarily a good  
22       match for either one of those data sets that

1     you're talking about, so a lot of it came on like  
2     one of these things, you know.  If there was data  
3     like that that we had available and a member of  
4     the committee was aware of it, we brought in folks  
5     and the NIH and other places, that would have been  
6     another population.  But again, the nature of  
7     wartime versus post-traumatic events, someone was  
8     in a fire, whatever could be the numbers, we  
9     looked for whatever sources we could.  And even at  
10    this stage if you're aware of or you think of a  
11    relevant, comprehensive, useful database that you  
12    think that we might not have been able to access,  
13    please let us know.  I mean, that's -- again, this  
14    is an interim report.  As I said, we spent on  
15    [sic] a very fast track looking at large amounts  
16    of data, but if there's one that you think that  
17    we've overlooked when you see the final report,  
18    please let us know.

19                   GEN FRANKS:  Excuse me.  Not to prolong  
20    this, but something General Myers said, is it not  
21    possible that there is a population, though, that  
22    is suffering from adverse psychological effects,

1 but does not currently require medical or mental  
2 health care?

3 DR. PARKINSON: Absolutely.

4 GEN FRANKS: That they haven't either  
5 come forward yet or it hasn't gotten severe enough  
6 yet, and that these effects sometimes take a while  
7 to manifest themselves depending on numbers of  
8 deployments, time after deployments, a family  
9 situation, that sort of thing?

10 DR. PARKINSON: Right. Yes, sir,  
11 General Franks. I don't want the committee or the  
12 Board to misread the scope of this particular  
13 finding. What we are not saying is there's not  
14 significant psychological health problems among  
15 certain subsets or members who've been in the  
16 military for the last 10 years with frequent  
17 deployments. What we're saying, as a population  
18 group as a whole that looking -- that we're not  
19 seeing that in terms of the ways that we're asked  
20 to look at that, which is the traditional way, you  
21 look at the prevalence of psychological conditions  
22 in a population. So we have studies that look at

1 PTSD in theater. I think the number is 3 to 6  
2 percent. We have self-reported data of 17 percent  
3 from the MHAT survey of people think that they are  
4 stressed out or that they self-report medication  
5 use of 10 to 17 percent. We look at DoD databases  
6 that suggest that the number's only 4 percent in  
7 the actual clinical interactions that are  
8 prescribed. So somewhere between 4 and 17 percent  
9 using traditional measures of medical epidemiology  
10 and survey methodology, with all of the mess,  
11 frankly, that comes with comparing different  
12 populations in different settings, is the right  
13 number as it relates to traditionally defined  
14 psychological stress.

15           And so you're absolutely right, there  
16 are subsets; a lot of the work by the Army looking  
17 at the Mental Health Advisory Team data.  
18 Depending on your MOS they have higher levels of  
19 stress related to other people. People were  
20 forward deployed in infantry units had a higher  
21 level of stress than those who were supply. I  
22 mean, again, I'm not an Army person, but we looked

1 at those; there are subsets within that. Clearly  
2 there are subsets in terms of care-seeking  
3 behavior in the Guard and Reserve, access issues,  
4 stigma issues, coding issues. All of those are  
5 explored in the report. I don't want to indicate  
6 that because this recommendation at the macro  
7 level suggests that the highest level where we  
8 look at these things that we don't see large  
9 numbers in the way that we'd expect for a duration  
10 of this type that there aren't issues. And that's  
11 a lot of the work that has happened in other DoD  
12 reports which are, frankly, very well described  
13 for particular subsets.

14 DR. FOGELMAN: Charles Fogelman. We  
15 decided fairly early on to try to focus mostly on  
16 what we knew about theater or immediately before  
17 or immediately after deployment, which was a  
18 massive enough set of data and number of people to  
19 go through as it was. We didn't go as far as  
20 talking to the VA, for example, because that was a  
21 much later thing. I think you're both absolutely  
22 right that there is unquestionably a set of the

1 population who are going to show up with symptoms  
2 later. In some ways, the current clinical  
3 definition of PTSD might indicate that some people  
4 aren't diagnosable or don't meet the criteria  
5 until after they're out. The concern is real. We  
6 focused a little bit more narrowly.

7 DR. PARKINSON: Yeah, I want to  
8 reemphasize again what Dr. Fogelman just said is  
9 we did not specifically look at long-term effects  
10 related -- in the VA system or in the civilian  
11 sector related to the treatment of these  
12 disorders. And the focus of our report in  
13 dialogue back with the defense leadership was,  
14 yes, let's begin to focus on the operational  
15 setting and the ecology around the operational  
16 setting. In that regard, that's what this report  
17 reflects.

18 DR. WOODSON: Jon Woodson.

19 DR. PARKINSON: Yes, sir?

20 DR. WOODSON: I would make a  
21 recommendation then since this is an interim  
22 report that you do look at the VA and here's the

1 reason why, particularly as it relates to the  
2 Guard and Reserve. We know that there are Guard  
3 and Reserve personnel who come back and have  
4 behavioral health issues and seek treatment at the  
5 Veterans Administration. Remember, Guard and  
6 Reserve are interesting folks. When they get that  
7 DD-214 they become veterans and, in fact, they can  
8 receive care for military Service-associated  
9 mental health and physical health issues, and they  
10 do go to the VA. The issue is, and we're trying  
11 to solve this problem, is getting the information  
12 from the VA back to DoD, particularly when they  
13 may be remobilized.

14 The point I'm making is that I think  
15 particularly for the Guard and Reserve you need to  
16 contact the Veterans Administration and see what  
17 kind of information you can get because that may  
18 be a population that would be excluded from your  
19 data analysis if you don't do that.

20 DR. PARKINSON: Yes, sir. Related to  
21 this section of the report, we felt that what  
22 would be very useful is essentially a bottoms-up,

1 systematic, and comprehensive review of an  
2 integrated functional model around appropriate  
3 psychological health, particularly in the  
4 operational setting, and the model is both  
5 integrated with line and medical in a traditional  
6 military sense, a prevention, self-care, buddy  
7 care, unit care, field echelon care moving up to  
8 someone who might be considered for psychotropic  
9 medication rather than jumping right into a  
10 clinical model with psychotropic medication. And  
11 we think the creation of that model, which exists  
12 in various places around the Department, but has  
13 not been standardized or integrated or deployed,  
14 would be very, very important in a prevention,  
15 detection, and treatment mode. Certainly we've  
16 done a lot of work over the last 5 to 10 years,  
17 but we could not identify where that model exists  
18 or where it's currently deployed in any systematic  
19 way.

20 The second recommendation is that much  
21 the way we treat basic first-aid for trainees,  
22 psychological first-aid for predictable combat

1 stress may be best provided at the self- and  
2 buddy-care level. Operationalizing self- and  
3 buddy-care models for predictable stressors that  
4 occur at predictable times either around events or  
5 periods during deployment should be standardized,  
6 formatted, and deployed. Peer-to-peer training  
7 prior to deployment should augment personal  
8 resiliency training. Use the same models we know  
9 work in the military for other things and use it  
10 for psychological health.

11 Uniform coding practices, particularly  
12 in the medical record, for the diagnosis and  
13 treatment of psychological health disorders with a  
14 particular emphasis on in-theater practical  
15 deployment, surveillance, and quality improvement  
16 purposes. The committee heard multiple times from  
17 multiple people that coding practices are non-  
18 standardized in theater and that, not  
19 surprisingly, access to the automated medical  
20 record -- AHLTA -- is not uniform. And,  
21 therefore, the lack of uniformity both in the  
22 practices themselves and in the technology to be

1 able to capture data create de novo problems in  
2 getting a good picture of what's happening real  
3 time in theater.

4           Number four, DoD should incorporate  
5 point-of-care guidelines, decision support tools,  
6 and guidance that could be integrated into the  
7 medical and mental health care workflow. Training  
8 remains essential, particularly to providers in  
9 theater who may not have ready access to those  
10 automated decision support tools. Many of us on  
11 the committee work in the quality improvement  
12 area, and what's been shown again and again and  
13 again is that training with embedded decision  
14 support and electronic health records does not  
15 work very well. And so what we did not see is  
16 embedded decision support tools when there is  
17 access to an electronic medical record,  
18 particularly for such a prevalent and common group  
19 of disorders like sleep, stress, anxiety,  
20 depression, PTSD, et cetera. There is work toward  
21 that, but we think that that can be accelerated.

22           Number five, analogous to the Task Force

1 on Pain, DoD should establish a Task Force on  
2 Sleep to identify emerging scientific findings and  
3 define best operational and medical practices to  
4 optimize performance and readiness. There are  
5 many things that the military does uniquely in the  
6 military and even more uniquely in operational  
7 settings. If sleep -- and Ambien® is the most  
8 prevalent psychologic medication used in theater  
9 and it's, frankly, given out many times just  
10 reflexively, at least through anecdotes. We need  
11 a Sleep Task Force that looks at what is the role  
12 of sleep, circadian rhythm, and ways that we can  
13 operationalize that among troops that feel  
14 constantly under stress. The committee felt there  
15 are other models yet again that DoD has deployed  
16 in other areas that could be deployed in this  
17 area.

18 In the area of psychotropic medication  
19 drug use itself, the findings were the following:  
20 That DoD lacks a unified pharmacy database that  
21 reflects medication from pre-deployment,  
22 deployment and post-deployment settings, as Dr.

1       Silva mentioned; MHS data systems are inadequate  
2       to detect important clinical and pharmacy data in  
3       a timely fashion. Let me explain that it's not  
4       that MHS hasn't invested considerable resources  
5       into data systems, absolutely, and they are  
6       commended for it. But the timeliness of that  
7       information and the accuracy of that information  
8       for meaningful quality improvement -- and you'll  
9       hear us refer again and again to the TC3 model  
10       where the surveillance is real-time, rapidly  
11       reviewed studies, then brought into a quality  
12       improvement model to dramatically impact a widely  
13       prevalent condition -- we saw as a very promising  
14       model that to date we have not deployed in the  
15       area of mental health and resiliency.

16               The AHLTA system is not sufficiently  
17       linked with pharmacy information. It was very  
18       difficult to track for all the diagnoses in  
19       theater what were the drugs prescribed for a given  
20       ICD-9 or CPT diagnosis. The MHS Pharmacoeconomic  
21       Center has identified these areas as limiting and  
22       is working to identify data structure for improved

1 in-theater data collection. Again, a theme. What  
2 the committee found was not necessarily new. It  
3 was known to many people and we're working on it.  
4 But again, if we need an exclamation point,  
5 linking the clinical information with the  
6 pharmaceutical, the psychotherapy, and CAM  
7 interventions where they're appropriate, and we'll  
8 talk more about that in a minute as it is very  
9 important, to improve quality of care and  
10 outcomes.

11           Number two, there has been a trend  
12 toward increased use of psychotropic drugs in  
13 theater over the past three years. Dr. Silva  
14 mentioned that from 2008 on, the data has been  
15 better than prior to 2008, and when we look at  
16 that data, this is all detailed in exhausting  
17 detail in the report, there has been an increase  
18 in the use of common psychotropic drugs  
19 operationally in theater -- sleep,  
20 antidepressants, sedative hypnotics,  
21 antidepressants [sic], antianxiolytic agents, et  
22 cetera, et cetera -- in much the same way they're

1 being, frankly, prescribed an awful lot in the  
2 civilian sector, and there's much discussion in  
3 there as well. Not surprisingly, clinical  
4 practice patterns in the military come from  
5 clinical practice patterns we learned in the  
6 civilian sector. So parsing out what is  
7 appropriate and what is not given, in my case  
8 looking at employer data in the civilian sector  
9 where these drugs are always the number one or two  
10 in the employer's drug spend, is difficult. But  
11 this trend has been noted. It is real. The  
12 question is whether or not we believe it's  
13 appropriate or not.

14 Finding number three. There does not  
15 appear to be an inappropriate increase in the use  
16 of psychotropic medication given the detection of  
17 the stressors that we've seen and the increase in  
18 the prevalence of the conditions these drugs are  
19 designed to treat.

20 Number four, we noted that Service  
21 members can receive medications through multiple  
22 routes with varying degrees of documentation. We

1 identified at least four routes of medication  
2 access in in-theater, some of which are documented  
3 through the PEC and through DoD systems, others  
4 are not. We discussed it in much more detail, but  
5 it needs to be better clarified and documented.

6           Number five, on the issue of  
7 polypharmacy, the use of multiple psychotropic  
8 medications may be appropriate in select  
9 individuals. Polypharmacy is by itself not  
10 necessarily a bad thing. It can constitute a  
11 balanced approach to optimize functioning. Close  
12 monitoring, however, is required with multiple  
13 drugs to optimize treatment and minimize side  
14 effects. Individual clinical and population level  
15 MHS data systems currently do not comprehensively  
16 detect polypharmacy, adverse drug-drug  
17 interactions, or potential for abuse, particularly  
18 in theater.

19           Number six, some off-label use of  
20 psychotropic medications is appropriate based on  
21 available information and evidence. However, DoD  
22 lacks a consistent policy or approach for

1 off-label use of drugs.

2 Dr. Kroenke, I don't know if Kurt is on  
3 the phone now, but Dr. Kroenke has done an awful  
4 lot of work and there is a tremendous amount of  
5 information about the appropriate use of off-label  
6 FDA drugs, if you will, using a hierarchy of  
7 evidence and informed methodologies, and that  
8 discussion is in the report for DoD's review.

9 Number seven, there may be -- and this  
10 may be understated in my personal view -- an  
11 underuse of alternative treatment strategies,  
12 particularly in the area of mindfulness and  
13 mindfulness training, acupuncture both self and  
14 other ways of administering acupuncture, perhaps  
15 even deploying it in a field setting. There may  
16 be opportunities that can underemphasize the use  
17 of psychotropic medications and increase more  
18 self-reliance.

19 And number eight, there is a lack of  
20 uniform access to medications in theater. We  
21 oftentimes heard that depending on what theater  
22 you're in that they may have not had access to a

1 particular drug because while it may have been on  
2 formulary, it wasn't available, or because the  
3 Service psychiatrist who had come in put one drug  
4 on it versus another.

5           The recommendations in this section are  
6 the following. The committee wanted to make the  
7 point that healthy lifestyles even in wartime,  
8 proper nutrition, sleep hygiene, are at the  
9 cornerstone of any important psychological health  
10 and resiliency strategy and, again, need to be  
11 reemphasized. DoD should review and modify  
12 existing policies and practices for capturing,  
13 tracking, and monitoring prescription drug data --  
14 we talked about that -- as well as sources of  
15 untracked drugs. Drugs can be sent, prescription  
16 drugs, by well-meaning family members or other  
17 individuals. After going through the PEC process to  
18 make sure that they're on the right drugs and they  
19 have 180-day supply, they can bring additional  
20 supplies with them in theater. If they're coming  
21 in from the civilian sector they may have seen  
22 multiple doctors that we don't have access to the

1 medical records. There certainly may be certain  
2 types of nutrition and supplement stores available  
3 in theater that have agents in them that may have  
4 psychotropics. So a wide variety of sources,  
5 although we think we're capturing it, we have no  
6 idea of the capture, what proportion that is, of  
7 total drug use in theater. DoD should standardize  
8 and ensure that it's definition of polypharmacy is  
9 consistent with general use in civilian practice  
10 and, again, a little more enlightened use of the  
11 term.

12 Why don't I stop there, Dr. Dickey, for  
13 comments or questions about that general section  
14 and prevalence of psychotropic drugs? And I  
15 welcome from Dr. Silva, Dr. Fogelman, or Dr.  
16 O'Leary any comments in this section.

17 DR. DICKEY: Dr. Anderson?

18 DR. ANDERSON: George Anderson. I  
19 noticed on a couple of slides and particularly in  
20 this last recommendation you talk about the  
21 importance of sleep and sleep hygiene. I wonder  
22 if you could expand a little on that and if you

1 actually looked at rest in the concept of crew  
2 rest in addition to sleep.

3 DR. PARKINSON: One of the discussions  
4 that we had, General Anderson, was on taking a  
5 military operational perspective. As many of you  
6 know, Dr. Anderson served in the Air Force. We  
7 talked about circadian rhythm and sleep/rest  
8 cycles, peak performance, much of what was done at  
9 the School of Aerospace Medicine. That type of  
10 broader perspective for operational issues  
11 relating to rest, cognitive functioning, sleep,  
12 sleep therapy, early return, we did not see that  
13 effort and that's why the answer is no, we didn't  
14 see that and we're recommending that. Is that  
15 fair?

16 DR. ANDERSON: We might come back to  
17 that issue. You'd better look at it.

18 DR. FOGELMAN: Right. That's why we  
19 recommended a Task Force on Sleep, but really that  
20 was just a marker for those types of things. And  
21 while we have a lot of good work in the Department  
22 that's going on, again, distilling that down in

1 the context of the current conflicts, what can I  
2 operationally do rather than reaching for an  
3 Ambien® or a TMC where basically that's the most  
4 prevalent medication just because that's what we  
5 do? You go to see a provider, what do you get?  
6 Your provider's going to write you a prescription.  
7 We're trying to get out of that mode and, again,  
8 not saying that that's -- we don't have whole  
9 documentation, but if you look at the macro  
10 picture, prevalence of sleep, sleep medications  
11 are way up there. Is that the best model? And  
12 the operational focus. And, again, I'll come back  
13 to TC3 again because there's a lot of ways that  
14 you treat trauma in the civilian sector in terms  
15 of the operational tempo and the operational  
16 framework. What is it about trauma treatment  
17 that's different in the military? What about  
18 sleep treatment should be different in the  
19 military?

20 DR. DICKEY: Before I go on to other  
21 questions, let me ask you if any of the other  
22 members, Dr. Fogelman or Dr. Silva, have quick

1       comments you want to make that might actually  
2       offset any of the questions that are about to  
3       come?  If not, we'll open it up to questions from  
4       the group.

5                   DR. SILVA:  Chairwoman Dickey, I don't  
6       have any.  I think the questions fleshed out some  
7       of the things I was interested in.

8                   But as a sidebar, we were very impressed  
9       with the new research coming out of the NIH in  
10      terms of the Institute of Alternative Medicine and  
11      are now starting to take a very complicated set of  
12      modalities and picking them off, trying to do  
13      randomized double-blind, duh, duh, duh.  And I  
14      think there is a huge role for the military to  
15      continue on this path to stress warrior  
16      resistance, mindfulness, the buddy system.  These  
17      are very powerful techniques.  Of course, in their  
18      Basic Training they're taught how to act under  
19      stress, incredible stresses.  You know, in some  
20      ways we have a very successful Army.  The failure  
21      rate is very low.  So that's only my sidebar  
22      comment.

1 DR. DICKEY: Charles?

2 DR. FOGELMAN: In response to what  
3 General Anderson said, were you referring to the  
4 recent development and expansion of, I forget the  
5 full name, respite centers that exist in theater  
6 which have just begun to be deployed and utilized  
7 in the last year? There are no hard data about  
8 that, and that's not just about sleep. It is  
9 largely about sleep, but if there were hard data  
10 about that, we would have reported it. Rather, we  
11 chose to reflect the need for that and the  
12 possible activities about that in, one, the  
13 recommendation about having a Task Force on Sleep  
14 so that it can be more comprehensive and thorough,  
15 and also when we talk about healthy lifestyles  
16 it's embedded in that as well. I'm not talking  
17 about this specific operational activity, but we  
18 would hope that a Task Force on Sleep would  
19 address that.

20 DR. ANDERSON: That all fits together  
21 beautifully. I was really aiming for what Dr.  
22 Parkinson responded, there's a rather broad body

1 of knowledge that's been in the scientific  
2 literature on human performance and that should be  
3 the reason for doing some of these things that  
4 you're talking about in an operational  
5 environment. So I hope it all comes with  
6 appropriate proof eventually.

7 DR. DICKEY: Dr. Higgenbotham?

8 DR. HIGGENBOTHAM: Eve Higgenbotham.  
9 I'm sure it's embedded, but certainly I would  
10 imagine that adherence is certainly challenged in  
11 the theater compared to the private sector and  
12 certainly when you consider polypharmacy it would  
13 be enormously challenged. And to what extent are  
14 you focusing on adherence in your analysis and to  
15 what extent that's going to be one of your actions  
16 that you're going to pay some attention to?

17 DR. PARKINSON: That's an excellent  
18 question and clinically very appropriate. And  
19 from our current review of the data systems it  
20 would be very hard to review the data and  
21 determine. And I'll tell you, we do the civilian  
22 sector, too. It's hard also in the civilian

1 sector. The fact that something is prescribed  
2 doesn't mean it's picked up and it doesn't mean  
3 it's taken.

4 But having said that, that's another  
5 effort that probably in our amended report we need  
6 to speak a little more to. The adherence issue is  
7 almost a second-order issue and we didn't get to  
8 it that much. I think it was because of the  
9 limitations of the data system that we saw  
10 originally to link a diagnosis to a treatment, and  
11 then to follow on that treatment for adherence  
12 over a longer period of time was almost a  
13 second-order question, but it's important and we  
14 appreciate that comment.

15 DR. DICKEY: Dr. Woodson?

16 DR. WOODSON: Thank you very much. Jon  
17 Woodson. A comment and a question. The comment  
18 is that since we began activities in Afghanistan  
19 and Iraq, a lot of things have changed.  
20 Currently, we do significant screening before  
21 Servicemen and women go overseas for psychological  
22 health and medication to, hopefully, prevent

1 issues downrange. The question I have is whether  
2 or not the panel is really examining  
3 appropriateness of applying civilian standards of  
4 practice as it relates to medication use to the  
5 military. Some of it is unproven. It's kind of  
6 the best practice, but it's unproven in terms of  
7 which psychotropic agents to use or which  
8 combinations to use. One of the observations I've  
9 made, and I recently returned from theater, is  
10 that we need to ask the hard question as to  
11 whether or not the standard of practice as it's  
12 done in the civilian world is appropriate for the  
13 military, and then what's the best evidence for  
14 that practice. Could you comment on that?

15 DR. PARKINSON: Excellent, excellent  
16 comment and very, very thoughtful, extended  
17 dialogue in our committee about this issue. Those  
18 of you around the table know better than anybody  
19 outside this room probably, the use, abuse, and the  
20 hope of terms like "evidence-based medicine."

21 And to your point, Dr. Woodson, whose  
22 evidence based on what patients, in what setting

1 for what? And I'm saying this as a primary care  
2 physician, not as a psychiatrist, but when you  
3 actually look at the data, for example, of how  
4 well do psychotropic drugs actually work for the  
5 conditions they're prescribed for versus a lot of  
6 the good work of Dr. Kroenke and others versus, A,  
7 watchful waiting, B, supportive care, cognitive  
8 behavioral therapy, which still basically is the  
9 cornerstone of how we do resiliency and coping  
10 skills -- which, by the way, the panel felt  
11 strongly -- what is the operational equivalent in  
12 a military setting of focused, impactful cognitive  
13 behavioral therapy/psychotherapy? Where is that  
14 work being done?

15 So you're spot on the target here in  
16 saying that we were empowered but also crippled by  
17 the level of what is civilian standard of care.  
18 And as long as there is a military department that  
19 is overseen by civilians, as we should be, that  
20 becomes informative, but it's certainly not  
21 prescriptive. Again, I'm going to come back to  
22 TC3. What they treat trauma with at George

1 Washington Hospital may not be the way that you  
2 need to treat it in theater. It's a baseline, but  
3 it's not the ceiling. So that that level of  
4 effort when we talk about a systematic, bottoms-up  
5 review of what we currently do end-to-end about I  
6 can't sleep in theater, I'm restless, all of which  
7 go back to the Civil War and beyond as common  
8 conditions in combat, do we have that focus in a  
9 very linear, progressive, stepwise manner at all  
10 levels to look at what is a militarily relevant  
11 and impactful clinical practice parameter as  
12 opposed to stealing it out of what DSM-IV says? I  
13 couldn't agree with you more and we talked at  
14 length about that. I'd encourage anybody, Dr.  
15 O'Leary or anyone, to comment on that. We had the  
16 right people around the table talk to this issue,  
17 sir, but you're absolutely right.

18 DR. DICKEY: I believe we have Dr.  
19 Kroenke on the phone. Dr. Kroenke, do you care to  
20 add anything to the comments you've heard?

21 DR. KROENKE: I couldn't really hear  
22 most of what's been said, so I'd be happy to

1 answer if there's any questions. The audio's not  
2 very good.

3 DR. DICKEY: And our apologies for that.  
4 If there are specific questions, we'll try to  
5 relay them to Dr. Kroenke.

6 I think that the reference to TC3 is  
7 important in that it's less that TC3 bases its  
8 recommendations for care on what we do here than  
9 what we're finding is the steps forward in the  
10 military have tremendous lessons for what we do in  
11 the civilian sector, and perhaps that's the same  
12 directionality that we ought to have in  
13 psychological health and in some of the CAM  
14 interventions.

15 DR. FOGELMAN: That's absolutely  
16 correct. And in my personal view, the two major  
17 things that we say out of all the findings are,  
18 one, to try to create a psychological analogue to  
19 TC3 in the sense that there is activity,  
20 treatment, and intervention in theater or  
21 wherever, but in theater for the purpose of this  
22 conversation, data gathered from that, data looked

1 at, processed, understood, published in one  
2 direction and put into some data store, like the  
3 Trauma Registry, as an analogue, and then put back  
4 into theater very quickly and then emphasized as a  
5 lead, as a model for the community at large.  
6 That's one. I guess maybe three. And  
7 establishing a panel on sleep disorders is, in my  
8 view, the second most important thing. And third  
9 is having in each Service who are responsible for  
10 complementary and alternative medicine just as  
11 there are psychological consultants.

12 DR. DICKEY: Are there any other  
13 questions before Dr. Parkinson moves on to  
14 complementary and alternative medicine?

15 DR. PARKINSON: We'll now summarize the  
16 entirety of complementary and alternative medicine  
17 in two slides. I'm just kidding. But that was  
18 the scope issues that we dealt with on the  
19 committee, but we took the charge with relish.

20 The findings there, there is growing  
21 evidence of the effectiveness of selected  
22 complementary and alternative medicine modalities

1       which may be a practical alternative treatment  
2       choice or an adjunct to prescription medications.  
3       Those specifically are mindfulness, mind-body  
4       training, as well as acupuncture. And, again,  
5       it's not that the Department is not doing anything  
6       in these areas, but they're doing it selectively,  
7       local sites, certain individuals, but not a  
8       full-scale commitment and deployment.

9               Number two, on a transition issue CAM  
10       modalities are typically not a covered benefit  
11       under TRICARE despite some being available in  
12       varying degrees at multiple military treatment  
13       facilities. Again, it's dependent on the facility  
14       whether or not you can access these services. If  
15       they were successful for you in theater or were  
16       successful for you in a location, it's unclear  
17       whether or not you could continue them in another  
18       setting under the current TRICARE benefit.

19               The recommendations in this section  
20       again include DoD should conduct and support  
21       militarily relevant studies to measure the  
22       effectiveness of CAM approaches.

1           To Dr. Woodson, the fact that I did it  
2           in a controlled trial at the University of  
3           Pittsburgh is interesting, but it may not be at  
4           all useful to the level of need that DoD has and  
5           the information and the resources you have versus  
6           psychotropic medications or in combination with  
7           psychotropic medications for the management of  
8           common psychological symptoms and conditions with  
9           either high prevalence and/or operational  
10          concerns.

11                 Number two [sic], DoD should encourage  
12          the Services to create complementary and  
13          alternative medicine consultants just as they  
14          currently have in other more traditional  
15          specialties of medicine.

16                 Number three, DoD should ensure that any  
17          CAM treatments that are recommended in "The  
18          Clinical Practice Guidelines" are part of the  
19          TRICARE benefit and that uniformed providers are  
20          trained in these techniques where appropriate.

21                 Why don't I stop there, Dr. Dickey, for  
22          any questions or comments?

1 DR. DICKEY: Are there questions or  
2 comments regarding that before he moves on to  
3 findings and clinical practice guidelines.

4 DR. PARKINSON: Dr. Dickey, can I ask  
5 you to ask Dr. Kroenke just for any comments  
6 generally about the interface between psychotropic  
7 medications and CAM? He probably is one of the  
8 more informed people in this area and I'd like the  
9 richness of his expertise to be shared with the  
10 Board.

11 DR. DICKEY: Dr. Kroenke, the question  
12 is if you could share a few comments about the  
13 interface between CAM and psychotropic  
14 interventions in the arena that was studied by the  
15 committee.

16 DR. KROENKE: In terms of psychologic  
17 disorders, the ones that require treatment, the  
18 two most prevalent and relevant are depression and  
19 PTSD. So if you look at currently available  
20 treatments, the strongest evidence base is for  
21 both antidepressants or certain types of  
22 psychotherapies, like cognitive behavioral

1 therapy. If you look at the role of complementary  
2 and alternative medicine and what the evidence is  
3 for psychological disorders, there is some  
4 preliminary data for mindfulness-based types of  
5 interventions. Obviously the strength is not as  
6 great as for either cognitive behavioral therapies  
7 or antidepressants.

8 In terms of herbal sorts of treatments,  
9 which is an important issue because that's what's  
10 also widely available to individuals through  
11 stores and so forth, the evidence base again tends  
12 to be modest for a couple types of medications for  
13 depression, which is like St. John's Wort, SAM-e,  
14 and omega-3 fatty acids. However, they haven't  
15 been tested head to head with standard kinds of  
16 treatments and they obviously don't have to go  
17 through FDA regulations. So, in summary, for  
18 depression that is modest evidence for both  
19 mindfulness treatment and several types of herbal  
20 treatments, although it's not as strong as either  
21 antidepressants or psychotropic treatments.

22 As far as PTSD, which is the other

1 disorder, to date there is much less evidence for  
2 these complementary and alternative medicines for  
3 PTSD than studies that have been done for  
4 depression. So all we can say for PTSD is that  
5 probably in terms of either herbal medications  
6 there would be not enough evidence for it in terms  
7 of things like mindfulness-based treatments.  
8 Whatever there is it's preliminary and has not  
9 been as well studied for depression.

10 And then finally, in terms of the other  
11 complementary and alternative medicines like  
12 acupuncture, that's been better studied for pain,  
13 so there you wouldn't be competing with  
14 psychotropic medicines, but you'd say what's the  
15 role of acupuncture versus things like analgesics  
16 and opiates?

17 DR. PARKINSON: Thank you, Kurt, for  
18 that. This is Mike. The reason that I asked for  
19 him to give some color to this section of the  
20 report, I could identify six or seven timely,  
21 topical research issues that the Department could  
22 be doing today to look at the use of these

1 modalities either in a self-administered, buddy-  
2 administered field setting. And what we find is  
3 there's a lot of activity going on in this area,  
4 but it's typically outside of theater at the  
5 center at NICoE with one or two individuals. And  
6 it's a kind of commitment, but pushing this  
7 forward in an operational concern and looking at  
8 practical applied research and deployment  
9 methodologies, because it's not going to be done  
10 by Pfizer and it's not going to be done by NIH.  
11 So there is a niche here going back to General  
12 Anderson's concern that that type of approach,  
13 which is what we've heard from TC3, we should be  
14 picking off three or four or five of those issues  
15 and putting them right front and center for a  
16 military model to ask is there a bigger role for  
17 mindfulness training in theater that a buddy can  
18 help somebody else to do in a kind of peer-to-peer  
19 cognitive behavioral therapy, a peer-to-peer  
20 self-administered or a personally administered  
21 acupuncture methodology? It might be interesting.  
22 At any rate, that's why I wanted the color. Thank

1       you very much for that.

2                   On clinical practice guidelines, believe  
3       me, folks, we're coming toward the end here so  
4       bear with us. The DoD has initiated some  
5       promising integrated line and medical protocols  
6       for identifying and rapidly addressing  
7       psychological health issues in theater. We don't  
8       have time to go into it today, but this TEAMS  
9       concept and the TEAMS work which is still in  
10      development, we came to it relatively late,  
11      probably my omission, but that is very promising  
12      and reflective of the type of recommendation that  
13      the committee made about an integrated line  
14      leadership, line-level operational and medical  
15      collaboration to address these issues. Again, the  
16      message here is good work, stay the course,  
17      accelerate.

18                   The 2010 DoD and VA Clinical Practice  
19      Guidelines for PTSD is a significant contribution  
20      to the acute psychological health of Service  
21      members. However, a systematic means to evaluate  
22      and readjust the Guidelines' practicability and

1       usefulness in theater does not appear to be in  
2       place. Again, from experience in the civilian  
3       sector, it takes a lot of work, in many cases two  
4       to three years, to form a clinical practice  
5       guideline. Then what? Unless it's embedded in  
6       AHLTA, unless it's got a systematic update,  
7       review, operational research piece that informs it  
8       along military lines, it will be of limited  
9       effectiveness. It is uncertain how well these  
10      Guidelines are disseminated and implemented  
11      currently. And, again, to be fair, some of them  
12      have just been developed relatively recently.

13                 The next point the committee wanted to  
14      make is that provider training alone is absolutely  
15      insufficient for ensuring that CPGs are deployed  
16      and utilized appropriately. Policy, line, and  
17      in-field systems and support are required to  
18      ensure optimization of care.

19                 Based on those findings, the  
20      recommendations are made. Better integration of  
21      line and medical approaches, again a recurring  
22      theme. We saw some promising signs of that in the

1 TEAMS concept. In-context description of  
2 appropriate clinical pathways for common  
3 psychological health issues should be made  
4 available at point of care. What do we mean by  
5 "in context?" Dr. Woodson, to your point exactly,  
6 seeing somebody in an outpatient clinic who says  
7 they're stressed at the University of Pittsburgh  
8 is not contextually useful for somebody who was  
9 forward deployed in Afghanistan. What are the  
10 sentinel events we should be looking for in that  
11 individual be they common or be they different  
12 from the types of things we expect to see in  
13 someone who can't sleep in Pittsburgh? That's the  
14 type of issue we're trying to get at within  
15 context.

16           Number three -- and, again, could be  
17 very well modeled by scenarios and simulation  
18 training. It's the Pareto rule [sic], 80 percent  
19 of what you're going to see of these things, let's  
20 train for it.

21           Number three, DoD should prioritize the  
22 Psychological Health Research and Practice

1 Guidelines so that they're evidence-informed as  
2 they're actually conducted in applied field  
3 operations in garrison care. This should include  
4 systematic application of quality improvement  
5 techniques. DoD should develop a framework for  
6 determining the effectiveness and utility of all  
7 interventions, rapid dissemination of these data,  
8 and rapid turnaround. Again, it's not original  
9 with us. We're stealing the thunder from the TC3.

10 I'll stop there, Dr. Dickey, for this  
11 section. Again, I hope you're following in the  
12 play book here, which is the interim report in  
13 your guidelines, with more color commentary.

14 DR. DICKEY: Questions or comments about  
15 the Clinical Practice Guidelines section? General  
16 Franks?

17 GEN FRANKS: Fred Franks. I'll go back  
18 to the Reserve Component issue that was mentioned  
19 in Dr. Woodson's recommendation to include that  
20 dimension in the overall report. I know from the  
21 United States Army well over half of the total  
22 Army, when the Reserve Component is released from

1 Active Duty, they do not have access to a military  
2 treatment facility. Most oftentimes their  
3 treatment is either in the VA or a civilian health  
4 care provider. And if it's not covered under  
5 TRICARE, they don't even go because they can't  
6 afford it possibly. And sometimes they have  
7 difficulty connecting psychological issues to  
8 their Active Duty time if there's a time lapse in  
9 manifestation of the issues.

10 I really believe that throughout the  
11 report here we ought to have a recognition of the  
12 different health care systems available to members  
13 of the Services' Reserve Components after they're  
14 released from Active Duty and what that might say  
15 to us about the psychological health issues.

16 DR. PARKINSON: General Franks, I'd  
17 agree with you. The committee discussed these  
18 issues. We're aware of the varying levels of  
19 access to care and concerns, and we can highlight  
20 it more in the findings and recommendations. It's  
21 not that we didn't discuss it, but we would  
22 basically, again, use this feedback to strengthen

1 that aspect of the report.

2 Let me tell you, however, that we did  
3 specifically address how does good practice that  
4 begins if I'm deployed in Afghanistan, that  
5 continues when I come to Fort Bragg, that when I  
6 go back to my home in Peoria, Illinois, how are  
7 those disseminated? That's called a Clinical  
8 Practice Guideline that started in the military,  
9 just as many good medical practices start in the  
10 military, that diffuses in terms of the clinical  
11 and the health care system and there's a  
12 wraparound to make sure that in the TRICARE  
13 benefit that those are allowed and encouraged. So  
14 we speak to the TRICARE benefits standardization,  
15 particularly in areas where it's a little weak, in  
16 evidence-based or evidence-informed complementary  
17 and alternative medicine techniques in  
18 psychological health. We speak about the DoD/VA  
19 CPGs, those were deliberate that they're across  
20 the whole system. But the issue of how you  
21 disseminate those through the civilian standards  
22 or civilian practices, and, again, that's another

1 issue, if these are effective, if we've done the  
2 upfront studies that show that they work, if we  
3 made a CPG and embedded it in our EMR, it should  
4 be embedded at UPMC when I go back to Pittsburgh  
5 so that anybody in that system who uses EPIC is  
6 able to access the same CPGs. There is a system  
7 to do this if we kind of get behind it. But I  
8 just wanted to say we talked about these things.  
9 They're in the report in pixels, but we need to  
10 pull it out specifically (inaudible) the Guard and  
11 Reserve.

12 DR. FOGELMAN: Yes, yes, a thousand  
13 times, yes.

14 DR. WOODSON: If I could make one  
15 comment, Jon Woodson again, actually a couple of  
16 things. Number one, you may know that we have  
17 added probably in excess of 2,800 behavioral  
18 health specialists to the TRICARE network to, in  
19 fact, meet the mental health needs of not only  
20 Servicemen and women, but other beneficiaries,  
21 families as well. And that says one thing, and,  
22 of course, we've doubled the budget related to

1 this. But the one thing that we clearly need to  
2 do and spend more time on is mentoring, advising,  
3 and coaching the civilian behavioral health  
4 specialists in the culturally relevant delivery of  
5 services to Servicemen and women. So what I'm  
6 saying is that, you know, like most of the  
7 civilian population, they're disconnected from the  
8 military and they don't understand actually what  
9 goes on. What was it like to be in the combat  
10 zone and what were the real stressors,  
11 particularly if Servicemen and women are having  
12 delayed reaction? So we've developed outreach  
13 mechanisms to behavioral health specialists who  
14 would deliver services to Servicemen and women and  
15 their families, which, again, are a unique  
16 community to try and help them understand what the  
17 particular stressors are, what they should be  
18 asking about and probing for in order to get to  
19 the point of making the right diagnosis, and  
20 trying to develop the right therapies.

21 This is difficult because you can't  
22 force them to do it. We've got incentivize them

1 to do it, but that is an area where we're trying  
2 to put a lot of effort to make sure that we have  
3 the right behavioral health specialists trained in  
4 the appropriate way to treat our community.

5 DR. PARKINSON: Yes, sir. As if on cue,  
6 you led into the training section, and we know in  
7 the first finding -- yes, Dr. Dickey, go ahead.

8 DR. DICKEY: We have another question  
9 from Dr. Higgenbotham.

10 DR. PARKINSON: Oh, I'm sorry. I'm  
11 sorry.

12 DR. HIGGENBOTHAM: Yes. This is Eve  
13 Higgenbotham. I was actually thinking along the  
14 same path, and as a medical educator, I mean, it  
15 would be great if we could have military medicine  
16 embedded more in our educational process because  
17 these young primary care providers are graduating  
18 with really no understanding of military medicine.  
19 I know this is probably tangential to the  
20 conversation, but I think we have so many of our  
21 Wounded Warriors coming back and our veterans that  
22 I think it's time that we really formally embed

1       this information into our educational programs.

2                   DR. DICKEY: I think the other place  
3       that you can formally outreach, and it certainly  
4       doesn't approach 100 percent, but you can probably  
5       identify the organizations that represent the  
6       majority in both primary care and behavioral  
7       health organizations so these topics formally and  
8       repeatedly go on their curricula. We also know,  
9       physicians at least, that if you tell us it's on  
10      the test, we spend a little more time looking at  
11      it. So those are all ways that we may be able to  
12      have some impact in terms of enhancing that flow  
13      of information back and forth.

14                   DR. PARKINSON: Dr. O'Leary and Dr.  
15      Dickey will know that the increasing emphasis on  
16      maintenance and certification, this could become a  
17      vehicle where modules built for MOC at least for  
18      the physician segment, and you could do it for  
19      psychologists and continuing education, could just  
20      be shrink-wrapped essentially and plugged in every  
21      couple of years to bridge that cultural gap.

22                   DR. DICKEY: No pun intended, right,

1 shrink-wrapped?

2 DR. PARKINSON: Exactly right. Thank  
3 you.

4 DR. DICKEY: Okay. Move on to training.

5 DR. PARKINSON: That leads us into the  
6 training module. And, again, I'll wrap this up  
7 and then turn it over to Dr. Silva for some  
8 closing comments.

9 We noted a variety of increase in the  
10 number and quality of trained psychological  
11 behavioral health personnel, Dr. Woodson mentioned  
12 2,800, as well as the training of psychological  
13 behavioral health personnel has really increased  
14 along two major axes -- three major axes really,  
15 which is [sic] independent duty technicians and  
16 corpsmen, primary care providers, and also  
17 psychiatric providers. However, once again the  
18 education is not standardized across Services,  
19 it's not standardized by profession or scope of  
20 practice. And standardization, given what we  
21 know, we would recommend that that be something to  
22 be pursued posthaste essentially.



1 supervision should be available. Specific  
2 training with defined specialty-specific scope of  
3 practice for the treatment of psychological  
4 conditions in theater should be developed,  
5 deployed, and updated based on new evidence  
6 derived from civilian and militarily focused  
7 operational studies.

8 TC3, what happens with TC3? It goes  
9 back where? It goes to the corpsman or the  
10 technician right back into the field, short cycle  
11 time, small closed loop. DoD should optimize the  
12 use of existing educational tools,  
13 teletechnologies, and mobile apps for training all  
14 levels of care. These tools are there. It's  
15 embedding and really shooting out the information  
16 we need along with the systems of support care.  
17 And again, web-based self-management tools and  
18 strategies to educate and guide Service members.

19 A little aside here. What can we use  
20 about mobile applications [sic]? The average troop or  
21 soldier today has got a lot of electronics on  
22 them. What are the things that employers are

1       deploying for the release of stress and  
2       productivity and resiliency around mindfulness  
3       training that is embodied and enabled with  
4       technical applications? The early versions of  
5       this were looking on the computer, monitoring your  
6       own respirations, and inducing the relaxation  
7       response. These are things that can be very much  
8       done in a military operational way with the  
9       resources and the thinkers that you've got in DoD.  
10      So we were out there a bit, but we're trying to be  
11      constructive in a way to think what are scalable  
12      solutions here that aside from getting more mental  
13      health providers looking face-to-face to a  
14      soldier?

15                     Yes, Dr. Fogelman?

16                     DR. FOGELMAN: Mike's last comment is  
17      important. We're looking at this from a very high  
18      and broad perspective at the 100,000-foot level,  
19      trying nonetheless to have an impact on what might  
20      happen on theground. It's not that there aren't  
21      many programs, like there's the Center for  
22      Deployment Psychology [sic], for example, which

1 provides these things, but that somehow it didn't  
2 seem systematic, tied together, or linked to the  
3 civilian world, and that's why we tried to be very  
4 large about it rather than talk about particular  
5 kinds of things.

6 DR. PARKINSON: Is there discussion on  
7 this section, Dr. Dickey? Dennis?

8 DR. O'LEARY: One of the issues that was  
9 discussed on the committee is not reflected here  
10 and that is in Recommendation 2 where it says,  
11 "Professional competencies must be consistently  
12 maintained and updated." We need to insert the  
13 word "assessed, maintained, and updated." This,  
14 you know, gets really to the heart of maintenance  
15 and certification which is under the aegis of the  
16 American Board of Medical Specialties. You have  
17 to measure, you know, to make sure whatever it is  
18 you want to maintain and update over time.

19 DR. PARKINSON: Thank you. General  
20 Myers?

21 GEN MYERS: On your interim finding on  
22 Training Number 1, where you talked about the

1       increased number and quality of trained providers,  
2       did the work group make any judgment on the  
3       adequacy of the numbers of providers?

4               DR. PARKINSON: No, we didn't, sir, and  
5       a couple of reasons. I think that's kind of an  
6       obvious question. Why? Because, and, again, I  
7       could be -- I don't want to misspeak for the  
8       group, but whatever the metrics used for adequacy  
9       are, anything from a professional to population  
10      ratio type of stuff, it certainly is dependent on  
11      mode of practice. Is it something that's enabled  
12      by technologies versus the traditional  
13      face-to-face visit? But it speaks directly to  
14      what we think the Department should be doing:  
15      looking at systemic models to leverage the  
16      providers they do have to perhaps be more  
17      effective in the interactions and engagements that  
18      they do have. That's something we didn't look at,  
19      again, in terms of aggregate numbers, but it  
20      assumes that we have a preferred model to which we  
21      would apply that. Again, more is generally  
22      better, but to the degree that we've not been able

1 to access for all the reasons we outlined in the  
2 other sections, we didn't really have the time to  
3 look at that in any detail.

4           You have one slide on the way forward  
5 and I'll let that speak for itself. Again,  
6 because of the timeliness of this report and the  
7 importance of it, we wanted to bring it to you  
8 today in an interim fashion. I want to turn it  
9 over to Dr. Silva for some global context and  
10 comments related to the overall effort.

11           DR. SILVA: Thank you, Mike, and thank  
12 you to the Board. Joe Silva. I'm not going to  
13 make a lot of comments. I'll just make a few.

14           I looked at this when I went to the  
15 meetings, and I had some family issues this year  
16 so I haven't made all of them and both Charles and  
17 Michael have done the heavy lifting, so I could  
18 look back at this report. I have no ownership  
19 except for a few lines. But I think for this  
20 audience it's a very simple equation. You have  
21 the numerator and it's stress in whatever form.  
22 You have interdominators, three or four things that

1 we can influence as a committee, how to reduce the  
2 stress, sleep studies, very important. Are we  
3 allowing access to health care providers? Who are  
4 they? Are they all equipped? Are we giving these  
5 providers the agents necessary to reduce that  
6 stress and get a better performing warrior? I  
7 mean, that's the denominator.

8           And then that equals what? It equals  
9 success. And we don't have a lot of good data  
10 systems to know where we're failing and how we can  
11 improve them. But this is the start of tackling a  
12 very difficult issue and we really have a lot of  
13 writing to do yet, so thank you.

14           DR. DICKEY: First, I think we have to  
15 thank this group for an extraordinary amount of  
16 work that was done over a relatively short period  
17 of time as they have outlined for you. The  
18 extraordinary amount of work is really just kind  
19 of outlined. There is a huge amount of work yet  
20 to be done. The Board does need to act upon the  
21 recommendations, the preliminary report of the  
22 subcommittee, in order for that report to move

1 forward. And it is extraordinarily detailed so  
2 I'm going to open it up. My guess is we can do  
3 everything from simply recommending the acceptance  
4 of the report which you have both in written copy  
5 and nicely condensed onto your PowerPoints or we  
6 can try to go through page by page if you have  
7 suggestions or changes you wanted to make before  
8 this group takes action. So what are your wishes?  
9 And doing something with this report stands  
10 between you and the break.

11 Dr. Carmona.

12 DR. CARMONA: Richard Carmona. One  
13 question, prior to answering your question is one  
14 of the things that has become apparent to me in  
15 all of this work, which I think is extraordinary  
16 that we are getting as granular as we need to be.  
17 But even if we eventually move and identify the  
18 absolute best practices in military medicine for  
19 dealing with psychological problems, the other  
20 side of the issue is the change of the culture,  
21 acceptance, destigmatization. Because the problem  
22 is, even if we lay this all out and it's perfect,

1       and I've had these discussions with George Casey  
2       before I left, with Mike Mullen when I got  
3       involved a few years ago, with General Franks, and  
4       I sat on a group that Admiral Mullen and General  
5       Casey brought together, the thing that really  
6       perplexed me most is even with these best  
7       practices, how do we change the culture in uniform  
8       that allows acceptance of this? I mean, right  
9       down to the company level where it was my opinion  
10      we need to make a recommendation that possibly  
11      even in the OERs we hold officers accountable for  
12      battle readiness for their troops, which usually  
13      is physical readiness, but we don't do anything  
14      for mental readiness.

15                   And possibly we need to be thinking  
16      about how can we begin to change the culture and,  
17      if you will, empower right down to the squad  
18      leader, company commander, and right up to the  
19      division battalion, all of the levels, that this  
20      has to be taken seriously and is part of their  
21      evaluative process as well? So I filled it out as  
22      well because I really do think that unless we

1 focus on that as well, we'll be wasting our time  
2 with all these best practices because it will take  
3 generations before it permeates and really is  
4 acted upon.

5 DR. DICKEY: Excellent. Excellent  
6 comment. And I'm going to jot that down as I  
7 think one of the things that may come about even  
8 as we take action on this report would be  
9 additional arenas that we believe this  
10 subcommittee or some working group will be  
11 continually reporting back to us. I think the  
12 references we heard throughout the discussion this  
13 morning are that this is in many ways a mirror of  
14 TC3, and we certainly don't think a single report  
15 from TC3 is the be-all and end-all. It's a  
16 continuous update of we've identified this, we've  
17 changed that, here's the impact, and we'll be back  
18 next time you're here. So I think addressing the  
19 stigmatization issue within the military  
20 infrastructure and how to change that culture is  
21 clearly one of the issues that needs to be on the  
22 yet to be addressed concerns.

1           What is your desire? Do you have enough  
2 concerns that you'd like to go back to the  
3 beginning and kind of flip page by page? Or are  
4 you satisfied that the report generally identifies  
5 what you want to have done and are prepared to  
6 adopt it with the knowledge that this group would  
7 see this back repeatedly?

8           General Anderson and General Myers,  
9 please.

10           DR. ANDERSON: I would move that we  
11 accept the report as an interim report as it is  
12 described. I would like to add a footnote,  
13 though. I had one other series of thought as we  
14 went through this. There were comments about line  
15 programs and the chaplain was mentioned. I would  
16 not want us to go through and discuss this  
17 anymore, but I think those areas need to be very  
18 clearly included in the report so that we  
19 understand. When you have a section on Clinical  
20 Practice Guidelines and it mentions line programs  
21 and you're talking about training, there are some  
22 things -- there are some implications of this that

1       need to be very clearly stated. So with that  
2       footnote, as I said, I would move acceptance of  
3       this as an interim report with the understanding  
4       that you had some very good feedback here today.

5                 DR. DICKEY: I have a motion. Is there  
6       a second to the report as presented?

7                 DR. O'LEARY: I agree with George.

8                 DR. DICKEY: Seconded by Dr. O'Leary.  
9       General Myers.

10                GEN MYERS: Dick Myers. I think I'm  
11       just going to agree with George on his couple of  
12       points there. I would also add that I would think  
13       the work group would like any editorial comments  
14       we have on the report if they're nonsubstantial.  
15       If they're substantial we ought to debate it right  
16       now; otherwise, we ought to adopt the report.  
17       That would be my recommendation.

18                DR. DICKEY: Okay. So you have before  
19       you a motion and a second and word of support to  
20       approve the report as presented to you. Editorial  
21       comments can be forwarded on, but substantial  
22       changes should be debated now. So now is your

1 time.

2           Since I don't have Vice Chairs yet I'm  
3 going to perhaps wander off of Robert's Rules for  
4 just a moment. I want to go back to something  
5 General Myers -- I think it was General Myers --  
6 brought up earlier, very early in the report where  
7 you conclude that -- sorry, I'm looking for it.  
8 It's Interim Findings, Prevalence of Psychological  
9 Health Conditions: "Despite these exposures, the  
10 majority of military members and likely their  
11 families have not suffered adverse psychological  
12 effects requiring medical or mental health care."

13           Yes, I'm very concerned about that  
14 statement. Perhaps what we heard verbally was,  
15 "have not suffered substantially greater  
16 psychological effects than comparable civilian  
17 populations," but I just -- and I, unlike most of  
18 you around the table, have not been in uniform and  
19 have not been in combat. But from my minimal  
20 exposure in my practice, I don't think I can  
21 support that statement. I think they certainly  
22 have psychological impact.

1                   Now, whether we know how to identify  
2                   them, whether we know how to treat them, or  
3                   whether they are any worse than policemen and  
4                   firemen and EMTs, I'm not sure. But I think the  
5                   majority of military members and families, in  
6                   fact, have adverse psychological effects. And the  
7                   question is how to identify them, how to  
8                   appropriately treat them, and how to make sure  
9                   that they don't negatively impact their ability to  
10                  move forward in life.

11                  Am I being nitpicky?

12                  DR. ANDERSON: George Anderson. Dr.  
13                  Dickey, I absolutely support what you're saying  
14                  there. And I think that that one needs to be  
15                  reordered and I don't think the group, this study  
16                  group can, you know, get the exact right wording  
17                  today. But that's one thing that should be looked  
18                  at.

19                  Also, just that word "suffer." "Suffer"  
20                  is by and large an undefined word. So my counsel  
21                  would be just don't use that word. Find better  
22                  words for this. And I think the group can do



1 a phrase here that might help us because my  
2 experience, personal experience, which is  
3 anecdotal, I admit, is that the adverse effects  
4 show up years down the line. So I would suggest  
5 that it read -- that line perhaps would read  
6 better this way, "Despite these exposures, the  
7 majority of military members and their families do  
8 not appear to have experienced immediate, adverse  
9 psychological effects requiring medical and mental  
10 health care." And that leaves it open for further  
11 investigation down the road through the VA system  
12 probably and civilian medical care.

13 DR. DICKEY: I find that (inaudible) my  
14 concern.

15 DR. PARKINSON: I think it's fine.  
16 Yeah, I like it, also. Again, finding number two  
17 follows on finding number one. I'll just tell you  
18 it basically says yes, there is a broad prevalence  
19 of predictable -- and that's what we wanted to  
20 say. So the two were meant to kind of travel  
21 together, but I think the very helpful comments  
22 made by the Board are extremely constructive and

1 actually closer to what I think we meant to say.

2 Is that fair, Joe?

3 DR. SILVA: Yeah, I agree.

4 DR. DICKEY: Okay. You have a motion  
5 and a second to approve the interim report with  
6 one amendment to which I heard general support.  
7 Are there other specific issues anyone wants to  
8 raise?

9 GEN FRANKS: I don't know where to  
10 insert this, but the discussion on Reserve  
11 Component, I think I would feel better or more  
12 comfortable anyway if there were to be some  
13 visibility that perhaps these issues may manifest  
14 themselves differently in their Reserve Component.  
15 Members of the Armed Forces, after they're  
16 released from Active Duty and they fall into a  
17 health care system that is quite different than  
18 the one available to active members, I'm not quite  
19 sure where to put that.

20 DR. FOGELMAN: We can certainly say  
21 that, but we tried to be as circumscribed as we  
22 could because as soon as we started talking about

1 larger things and longer things, a whole world  
2 opened up that would have prevented us from  
3 reporting anything. So what you say is exactly  
4 correct and we were certainly talking about Guard  
5 and Reserve. We can put in a sentence. We can  
6 put in a sentence about how there's an  
7 insufficiency of providers in rural areas. We can  
8 put in a sentence about telemental health. We can  
9 put in all sorts of things, but each of those is  
10 an independent item which deserves independent  
11 presentation and may or may not be worked on in  
12 the department generally and is not necessarily  
13 directly in the scope of the report as we put it.  
14 I don't mean to say you're wrong; you're right.  
15 But I think we're limited and I would not want it  
16 to have -- not want the report to have an  
17 extremely large and increasing list of things.  
18 Not to dismiss anything that you're saying but the  
19 question is how does it fit within the boundaries  
20 of this report?

21 DR. DICKEY: A suggestion has been made  
22 by Ms. Bader that if you look to the last page of

1 the report, "The Way Ahead," there are some  
2 changes that will probably need to be made to that  
3 paragraph anyway, and that would be an appropriate  
4 place to include the issue of wanting to assure  
5 that we look at any differences that may exist  
6 between Guard, Reservist, and Active Duty. It's  
7 also a good place to include the stigmatization  
8 and culture issues that Dr. Carmona raised and  
9 possibly the issues of the line training that  
10 might need to be there.

11 GEN FRANKS: Perfect.

12 DR. DICKEY: And if we say, "for example,"  
13 then this doesn't have to be an exhausting list --  
14 exhaustive list. Rather, we realize as you study  
15 an issue, other issues will arise. So that would  
16 be a place, General Franks, to put that in place.

17 Anybody on the committee have a concern  
18 with that?

19 All right. Motion and a second to  
20 approve the report, an amendment made to the  
21 summary of prevalence, and some suggestions for  
22 minor modifications to "The Way Ahead" with those

1 changes in place. All in favor say aye.

2 GROUP: Aye.

3 DR. DICKEY: Oppose, no. Any  
4 abstentions? Again, I hope you will take back to  
5 your work groups and subcommittees our thanks for  
6 a tremendous amount of work done to get this  
7 going. And the references to TC3 suggest that we  
8 will probably see multiple reports back on this  
9 issue and, hopefully, the same immense advances  
10 that we've seen in combat casualty care.

11 It is, according to my schedule, time  
12 for a short break. We should resume at 11:30, if  
13 possible.

14 (Recess)

15 DR. DICKEY: I want to welcome everybody  
16 back. While we gather people back to the table,  
17 General Frank tells me that -- I'll get this  
18 straight, Dr. Frank, General Franks (Laughter) --  
19 today is the Army's 236th birthday.

20 (Applause)

21 DR. DICKEY: I asked him if that meant  
22 he was providing cake but he said no. (Laughter)

1 Our next briefing is going to be given by Dr.  
2 Frank Butler. Dr. Butler is the Chair of the  
3 Tactical Combat Casualty Care (TC3) that we heard  
4 a lot about in the last session. It's a work  
5 group of the Trauma and Injury Subcommittee. A  
6 former Navy SEAL, he helped develop many of the  
7 diving techniques and procedures used by Navy  
8 SEALs today, including closed-circuit oxygen  
9 diving exposure limits and decompression  
10 procedures for complex multi-level, mixed gas  
11 diving operations conducted for submarines. I  
12 would contend if you can say all of that without  
13 having to take a breath you're probably halfway  
14 there. Right? (Laughter)

15 Dr. Butler has previously served as the  
16 Director of Biomedical Research for the Naval  
17 Special Warfare Command, the Task Force Surgeon for  
18 a Joint Special Operations Counterterrorist Task  
19 Force in Afghanistan, and was the first Navy  
20 Medical Officer selected to be the Command Surgeon  
21 of the U.S. Special Operations Command. He's going  
22 to give us an information update regarding

1 potential changes to the Tactical Combat Casualty  
2 Care Guidelines concerning tranexamic acid. Dr.  
3 Butler will--- I'm a family doc, Dr. Butler. I  
4 don't think we use that.

5 (Laughter)

6 Dr. Butler will also present two topics  
7 for a vote in regard to tactical evacuation care,  
8 the guidelines, and the in-theater use of dried  
9 plasma. His slides will be found under Tab 6. Dr.  
10 Butler, it's all yours. I hope you can say those  
11 words better than I just did. (Laughter)

12 DR. BUTLER: Thanks, Dr. Dickey. It is  
13 a pleasure, as always, to be back with the Board.

14 I would like to take a second to  
15 introduce two additional members of the audience.  
16 Colonel Tom Deal, stand up. In the back is the  
17 U.S. Special Operations Command Surgeon. He is  
18 one of our great leaders in Special Operations  
19 Medicine. He is retiring tomorrow, and he came up  
20 to be with the Defense Health Board today because  
21 he feels so strongly about these points.

22 (Applause)

1                   So, also, Dr. Tony Pusateri is here.  
2           Tony runs the Hemorrhage Control arm of the Army  
3           Medical Research and Material Command. Tony was  
4           one of the very early researchers on haemostatic  
5           agents, so we owe him a lot. And he's here to  
6           help keep me straight during these two  
7           discussions.

8                   Thanks also to Dr. Parkinson and the  
9           Psychological Health Group for the positive  
10          feedback there. I will pass those comments on to  
11          the group.

12                   I'd like to start out with a discussion  
13          of TACEVAC care. And to delineate in this context  
14          I am speaking specifically about point of injury  
15          to first medical treatment facility. There is a  
16          lot of variation in the terminology for en route  
17          care, but for our purposes today, so that you  
18          don't get confused and I don't get confused,  
19          MEDEVAC is a designated air ambulance. It's got a  
20          Red Cross. It does not have offensive weaponry  
21          and it doesn't have much armor. A CASEVAC  
22          platform is a technical aircraft. It does not

1 have a Red Cross. It does have big guns and it  
2 does have armor. In those contexts today we're  
3 going to be speaking of both of those types of  
4 evacuation.

5           So you'll be interested to learn that  
6 there are three very distinct paradigms for  
7 evacuation care right now in theatre. The Army  
8 model is called "DustOff," and it uses an HH-60.  
9 Think medium-sized helicopter and one EMT basic  
10 flight medic. The Air Force model is call sign  
11 "Pedro." They also use HH-60s largely, although  
12 they do have some 53s. Think bigger helicopter.  
13 Relatively new to the scene, but important to the  
14 discussion, is our British Allies showing up with  
15 the MERT model, Medical Emergency Response Team,  
16 and this was at the initiative of the Emergency  
17 Medicine Advisor for the British Defense Minister.  
18 This is a remarkable platform. They work off of a  
19 47. Think big helicopter.

20           The team is headed by an emergency  
21 medicine or a critical care physician. They have  
22 two EMT paramedic attendants and a critical care

1 nurse. Routinely they give plasma and packed red  
2 cells in flight when needed. Routinely they do  
3 advanced airways, rapid sequence intubation,  
4 ketamine analgesia when needed. They will put in  
5 a chest tube while you're flying. Multiple times  
6 they have opened chests and cross-clamped aortas  
7 in flight; pretty amazing capability. They were  
8 the first people in-theater to be using  
9 tranexamic acid. But point of emphasis is there  
10 is only one of these. There's only one team in-  
11 theater the last I heard. Maybe that's changed.  
12 But point of agreement, I have not heard anybody  
13 dispute this, if there is a critical casualty and  
14 you have the MERT available, you send the MERT. I  
15 have not talked to anybody in-theater who has been  
16 making decisions about how to pick these  
17 casualties up that doesn't use the MERT if it's  
18 available.

19           So I'm going to bring this a little  
20 closer to home for you. These are two cases out  
21 of the recent every-Thursday video  
22 teleconference. You've heard me speak of this

1 many times. These are very recent cases. A  
2 21-year-old male, dismounted IED blast. His  
3 injuries included a lacerated spleen, a transected  
4 colon, a lacerated liver, a pancreatic contusion,  
5 a perforation of his diaphragm, multiple rib  
6 fractures, a scapula fracture, and bilateral upper  
7 extremity injuries. He had a C-A-T® tourniquet to  
8 his right arm by the ground medic. He was in  
9 severe pain and agitation during the flight. When  
10 he showed up at Bastion, he was in shock. He had  
11 a blood pressure of 70 palpable. His base excess  
12 was 8, pretty significant shock. His  
13 postoperative course was complicated by anuric  
14 renal failure and a mucormycosis infection. And  
15 when he was last discussed by the group he was  
16 undergoing dialysis at Walter Reed.

17 The care provided to this injured  
18 warrior in the air was this: He was flown by the  
19 Army MEDEVAC system. He had one EMT basic  
20 qualified medic for all these injuries. And Bob  
21 Mabry makes the point that a patient like this  
22 would overwhelm a community emergency room, you

1 know, much less an EMT basic. So during his  
2 flight, 20 to 30 minutes possibly, he got no IV.  
3 He got no interosseous access. He was given no  
4 plasma. He was given no blood. He was given no  
5 Hextend®. He got no analgesia. There was no  
6 documentation of how long he was in flight. There  
7 was no documentation of whether or not he was  
8 treated to prevent hypothermia or given  
9 antibiotics.

10 In contrast, a 24-year-old male,  
11 slightly later than the first patient, was in a  
12 dismounted IED blast. He lost both lower  
13 extremities. He had severe injuries to his right  
14 hand. He had significant groin injuries, shrapnel  
15 peppering of the face. The ground medic put two  
16 tourniquets on his right leg. He was picked up by  
17 the MERT. They put a C-A-T® tourniquet on his other  
18 leg. He was intubated with rapid sequence  
19 intubation. He got three interosseous lines  
20 started. He was given three units of fresh frozen  
21 plasma, three units of packed red cells, and a  
22 gram of tranexamic acid. Stunning disparity in

1 the care.

2           And I will tell you that there were  
3 really three things that coalesced to bring this  
4 to the committee so that we could bring it to you.  
5 One was a recurring number of these cases with  
6 this type of disparity in care. Second was the  
7 Army Surgeon General's Task Force on Dismounted  
8 Complex Blast Injuries. That group looked at this  
9 issue and I think that you will see this  
10 represented in General Schoomaker's report when it  
11 comes out. The third thing was Bob Mabry, a  
12 member of the committee. The pre-hospital guy at  
13 the Joint Theatre Trauma System went over to do a  
14 three-month tour as the Director of Evacuation  
15 Care in Theatre. And he came back with a  
16 comprehensive and amazing report that I would  
17 commend for your reading if you haven't had a  
18 chance to look at it.

19           So that precipitated a meeting. Our  
20 meeting in Dallas was largely focused on TACEVAC  
21 issues. And we went over all of these aspects of  
22 care with the Committee and the Trauma and Injury

1 Subcommittee and these were the recommendations  
2 that emerged. The first is for the U.S. to  
3 develop an advanced TACEVAC capability and we'll  
4 just come right out and say patterned after the  
5 British MERT. If the Brits leave, we have no  
6 MERT. Not one right now. It should be manned  
7 with critical care trained and experienced  
8 personnel. We should use the most capable  
9 aircraft available for these evacuations for the  
10 critical patients, routinely give red blood cells  
11 and plasma in flight, advanced airways as  
12 indicated, IV medications, whatever other advanced  
13 interventions.

14 What we're not doing is recommending any  
15 changes to the system. What the Brits don't have  
16 is any data that shows improved outcomes from the  
17 MERT. It's compelling and we have addressed that  
18 with our British colleagues. There may be some  
19 forthcoming in the future, but we don't -- it's  
20 too soon to change the system, but it's time to  
21 start taking a look at the model.

22 When we look at the outcomes it will be

1 important to look at the injury severity subgroups  
2 because when you look at the MERT, always bear in  
3 mind that they are sent for the worst casualties.  
4 So if their mortality is the same as DustOff,  
5 that's a huge win for that model when you adjust  
6 it for severity. And again, we have to think  
7 beyond Afghanistan. That's a mature theatre. The  
8 Special Ops folks that these individuals represent  
9 are operating all over the planet in 60 countries  
10 right now. So think beyond Afghanistan.

11 You know, there is just no question that  
12 you'd like to have a larger air frame if possible.  
13 A 45 would be great. A 53 would be great. Now  
14 the CV-22s. We have a squadron of these guys  
15 right down the road from me at Hurlburt now.  
16 These are incredibly capable aircraft and they  
17 would be good as well.

18 So who has said we think this is a good  
19 idea? There is an urgent need statement that was  
20 submitted by one of the surgeons supporting the  
21 Marine Corps that was submitted that said that  
22 they recommended the -- they used a MERT-like

1 platform as their terminology. I will say that  
2 that has not made it up to the command level at  
3 the Headquarters of the Marine Corps. It  
4 apparently did not get approved by the in-theatre  
5 chain of command, so I don't know the politics  
6 behind that, but I have the original document and  
7 we know that it was at least initiated. Dr. Mabry  
8 came back from his tour as the Deployed Evacuation  
9 Care Director and said, hey, we need to take a  
10 look at this model. We don't need to change the  
11 system yet, but we need to take a look at this  
12 model. The Surgeon General's Task Force echoed  
13 that. And most recently the TC3 Committee and the  
14 Trauma and Injury Subcommittee have echoed that as  
15 well.

16           So those preceding recommendations speak  
17 to a special team that would go on a special  
18 aircraft. The comments that I'm going to make now  
19 apply more generally to the TACEVAC system. So  
20 SecDef has directed a 60-minute max for TACEVAC  
21 time from point of entry to the hospital. Is that  
22 going to be enough to save your life? It depends

1 on how badly you're injured. I think we should  
2 take that as a maximum, but it doesn't mean that  
3 if there's not -- if there's a way to get you to  
4 the hospital in 20 minutes we should try to get  
5 you to the hospital in 20 minutes. And again,  
6 think beyond Afghanistan. Some of the places that  
7 the Special Ops guys are, TACEVAC is a dramatic  
8 challenge, Africa, other places in the Middle  
9 East.

10 So what if you have multiple casualties  
11 and there is still hostile fire at the location  
12 where the casualty is? Will the air ambulance  
13 with the big Red Cross fly in to get that  
14 casualty? With some exceptions, possibly;  
15 generally, no. Terrific book, "We Were Soldiers  
16 Once and Young" written by General Moore, a  
17 dramatic depiction of that type of a problem. So  
18 if you are supporting forces out there, you always  
19 want to try to have an air ambulance, a MEDEVAC  
20 chopper on call, but you've got plan B and plan C,  
21 too, right? I mean, if there's a gunfight going  
22 on and you need an aircraft to go in and get your

1       injured soldiers out, then you need to have a  
2       plan. And it may mean tapping into another unit  
3       or another agency, but those kinds of things are  
4       imminently doable.

5                       We did this when I was with the Task  
6       Force in 2003. We had a whole planning matrix and  
7       depending on condition A -- gunfight, no gunfight,  
8       altitude, weather, day, night -- you know, we knew  
9       right which aircraft to go to. So we need to  
10      improve the planning for adverse conditions.

11                      In-flight care providers that meet or  
12      exceed the civilian standard, and Bob Mabry has  
13      championed this amazingly well. He defines that  
14      primarily as a critical care flight-trained  
15      paramedic. But there's no reason that a nurse,  
16      physician, or P.A. with the same training couldn't  
17      do it. But the critical part is the critical care  
18      and the flight trained. You can't take a vanilla  
19      corpsman or a vanilla doctor, put them on a  
20      helicopter, and expect him to do a good job for  
21      your casualty. It's not necessarily what their  
22      background trains them to do.

1           There should be at least two of these  
2 per platform if you are transporting a critical  
3 casualty. The MERT has four. We're not sure if  
4 there's good data to say you need four, but maybe  
5 two, and at least one per critical casualty. I  
6 will add as a point here General Schoomaker just  
7 bought off on that to -- it's a very expensive  
8 proposition to say we're going to go from EMT  
9 basic to EMT paramedic on all of our platforms,  
10 but he just rogered up for that. The program is  
11 in development, but this is a great, great step  
12 forward for the Army.

13           Routine availability of packed red cells  
14 and plasma. We're going to talk a lot more about  
15 crystalloid and plasma in the next session so I  
16 won't dwell on this except to say this is what  
17 they do for you when you get to the hospital. It  
18 is definitive care of hemorrhagic shock and  
19 there's no reason you can't do it on the  
20 helicopter. The MERT team is doing it all the  
21 time.

22           Pre-deployment trauma experience for

1 TACEVAC providers. So you're a Ranger medic.  
2 You've got a million things to learn. You've got  
3 to be a member of the unit. You've got to learn  
4 to assault objectives. It's all you can do to  
5 learn basic TC3. But if you are a person whose  
6 main job is trauma care in the air, you should  
7 have a much more intense focus on trauma care in  
8 the air. Spend some time at C-STARS. You know,  
9 spend some time with Dr. Johannigman. Go to MIMS.  
10 I mean, there are remarkable opportunities out  
11 there and everybody that flies in those  
12 helicopters with critical patients ought to be in  
13 those trauma centers all the time pre-deployment.  
14 I mean, that is their job. And as the psych  
15 health folks were talking about, we need to start  
16 tracking this as part of the unit's report card.  
17 This is a critical thing.

18           The standard protocol for TACEVAC care.  
19 It is wildly variable the care that you will  
20 receive from one unit to another unit to another  
21 unit in theater now. We have a tactical  
22 evacuation section in the TC3 guidelines. I won't

1 tell you that we have all the answers, but we're  
2 looking for them all the time. And if there is  
3 going to be another group that Health Affairs or  
4 CENTCOM or whoever decides should have ownership  
5 of that, that's great. But there needs to be a  
6 group that has ownership of it and does  
7 evidence-based updates all the time because this  
8 is changing rapidly as we'll talk about in the  
9 next couple of sessions.

10 Oversight of TACEVAC care in theater,  
11 one of Bob Mabry's big points. You wouldn't have  
12 somebody who wasn't qualified to run your  
13 Neurological ICU. You wouldn't have somebody that  
14 wasn't qualified to run your Cardiac Critical Care  
15 Unit. Why would you have somebody who doesn't  
16 have EMS experience running your EMS system in  
17 theater? We need an EMS cell both in theater and  
18 as part of the home team for the Joint Theatre  
19 Trauma System. This group has heard way too much  
20 about the importance of documenting care. Again,  
21 if you don't know what you did, then you can't  
22 tell what you need to do better. So all of these

1 things you have heard on numerous occasions.

2 Physician oversight in TACEVAC units.

3 This speaks to the memo that this group approved  
4 at the last meeting. It is unbelievable that  
5 right now in theater we have a team where the  
6 offensive tackles know the plays and the coaches  
7 don't. Doctors do not routinely get TC3 in  
8 theater, and we're going to talk about one of the  
9 negative things that has happened as a result of  
10 that in the next session. But if you're going to  
11 be out there in theater and you're going to be  
12 supervising people who care for trauma patients,  
13 then you need to know how to care for trauma  
14 patients. It doesn't seem like a big jump.

15 There should be a standardization of  
16 care in TACEVAC and our Air Force reps at the  
17 meeting brought this out. Nobody is saying that  
18 each Service has to recreate this capability, but  
19 somebody needs to have ownership of it and it  
20 needs to be standardized across the board. You  
21 know, a Marine should not get care that is not  
22 just as good as a Special Ops person over here or

1 an 82nd Airborne guy over there.

2 Process improvement. It's really tough  
3 to do process improvement if there are no records.  
4 And over and over again on the Thursday  
5 conferences there's no pre-hospital data. That  
6 should be a flag and that should be something that  
7 goes back to the Unit Commander to say, hey, guys,  
8 let's do this better.

9 So in summary, you know, what we would  
10 do is take these recommendations and offer them  
11 for your consideration. They were made by the TC3  
12 Committee and unanimously endorsed by the Trauma  
13 and Injury Subcommittee. And I will take some  
14 questions.

15 I have to show you this picture. Master  
16 Sergeant Montgomery called me to task for showing  
17 too many SEAL pictures and not enough Ranger  
18 pictures. So I will emphasize that this brief is  
19 replete with Ranger pictures thanks to Master  
20 Sergeant Montgomery.

21 And questions, please.

22 DR. DICKEY: You're too good, Frank.

1 You just got it all.

2 Dr. Carmona.

3 DR. CARMONA: Frank, Rich Carmona. You  
4 and the TCCC really have done an extraordinary job  
5 of coordinating a lot of science and moving it  
6 forward in a quick fashion. One of the additional  
7 benefits, of course, of what you're doing is that  
8 this information will also eventually permeate  
9 into the civilian system, which is why we have the  
10 best EMS system in the world today because it's  
11 based on military medicine beginning with the  
12 Second World War, Korea, and especially Vietnam.

13 I think it's interesting that many of  
14 the things that you're pointing out, like how we  
15 resuscitate and some of the fluids that we use,  
16 for instance, which are still used widely in the  
17 United States, you have to counter to what Canon  
18 spoke about 100 years ago, for instance, in how we  
19 resuscitate. And you know, now we're getting a  
20 better understanding of this hypotensive  
21 resuscitation.

22 One of the things I specifically want to

1 comment on, though, is the MERT program, which I  
2 think is good, but I think it's important that you  
3 pointed out that we don't have the evidence yet,  
4 but that intuitively it seems that way. But it  
5 goes back to parallels that I learned after  
6 Vietnam when we were putting together the U.S. EMS  
7 system, that in the beginning when we had mobile  
8 intensive care units, everybody thought there has  
9 to be a physician on every one of those things.  
10 And we actually found that physicians were  
11 counterproductive in the field and they actually  
12 were more of an impediment than an assistance. So  
13 I think it's good that we lead with this  
14 information, that we don't have all the  
15 information, and as good as the British system  
16 seems to be, the bottom line is, are the outcomes  
17 going to be improved based on the configuration  
18 that they're using? Could we do it just with  
19 well-trained, you know, advanced medical persons  
20 in the field? And those questions are still  
21 before us. And the second part of that, of  
22 course, is if we don't have the data, we'll never

1 be able to make the decision, so making sure we  
2 have all of those reports.

3 DR. BUTLER: Yes, sir. A couple of  
4 comments. The paramedic part, I mean, Bob Mabry  
5 has a paper that's not out yet. I look forward to  
6 sending it to you when it does come out. It was a  
7 natural study where a group that flew critical  
8 care flight paramedics replaced a group that did  
9 EMT basics. Mortality doubled. Doubled with the  
10 EMT basics. So that gives us EMT basic-EMT  
11 paramedic contrast in 48-hour survival.

12 Now, that doesn't answer the question  
13 about physicians. And in fact, as you point out,  
14 we have the study from the Canadians. The  
15 Lieberman study said, hey, put docs on there.  
16 They do worse. Well, we're going to talk in the  
17 next session. If the docs are in there, jumping  
18 in there and starting IVs and giving them large  
19 volume crystalloid, we know exactly why they're  
20 doing worse. You know, the doctors are doing what  
21 doctors are taught to do in ATLS, which is to some  
22 extent wrong. And we're going to get into that

1 significantly in the next session.

2           So I think probably the best thing that  
3 the MERT team does, I mean, I heard Don Jenkins  
4 say multiple times these MERT patients are showing  
5 up at the E.R. with normal blood pressure and a  
6 base excess of zero. These guys are resuscitated,  
7 you know, pre-hospital. So, you know, it may be  
8 the blood and not the person giving it.

9           DR. CARMONA: Frank, I think the other  
10 thing that was pointed out in some of the earlier  
11 things we discussed this morning with  
12 psychological aspects, the best practices for  
13 military medicine may, in fact, be very different  
14 than what we do in the civilian world. Most of  
15 the people that we're dealing with that are  
16 injured in theater are young, healthy people who  
17 are able to physiologically compensate under  
18 extraordinary circumstances, whereas we look at  
19 the trauma population outside from the very young  
20 to the very old, it's really a very different  
21 population with a different set of variables  
22 imposed upon them. And I think that in the past

1 we always adopted the civilian standards and said,  
2 okay, this works, let's take it to the combat  
3 theater. I think now we may be finding that this  
4 is a different cohort under different  
5 circumstances and that military medicine may need,  
6 in fact, a different set of protocols that are  
7 optimally efficient and effective in reducing  
8 morbidity and mortality.

9 DR. BUTLER: Right.

10 DR. DICKEY: Frank, you mentioned that  
11 we talked about data gathering a great deal. Are  
12 we making any progress in terms of having data in  
13 a meaningful manner? I guess there are two or  
14 three or four competing systems out there. Worst,  
15 of course, is simply not collecting any and some  
16 variations thereon. So are we making progress?

17 DR. BUTLER: It is a real honor to have  
18 Lieutenant Colonel Russ Kotwal, who is the person  
19 who has done more than anybody else to push the  
20 pre-hospital data collection forward, here with  
21 us. He can probably answer that question better  
22 than I can.

1 LTC KOTWAL: Russ Kotwal, (inaudible)  
2 U.S. Army, Special Operations Command.

3 DR. DICKEY: Could we get you to come to  
4 one of the microphones, sir?

5 LTC KOTWAL: Ma'am, as you know, I've  
6 been working with Ms. Meckler and her staff at the  
7 Rural and Community Health Institute there at  
8 Texas A&M in developing our pre-hospital trauma  
9 registry over the last few years. So initially  
10 what we had was we had a very rudimentary database  
11 that we implemented prior to this conflict back in  
12 2000, just collecting data on training exercises.  
13 Then once 2001 came about, we still collected the  
14 things that we had before battle injuries  
15 specifically. From 2001 until now, we've  
16 collected all the battle injuries that we've had  
17 and gone back and retrieved all the autopsies as  
18 well from most of our guys or all of our guys.  
19 With it, what was very notable, and the paper will  
20 come out in August, August 15th, but pretty much  
21 what we had was we had no died of wounds and no  
22 killed in action as a result of not taking action

1 at the point of injury. And so there was also no  
2 died of wounds from infection and there was only  
3 one died of wounds from something that occurred at  
4 level two that could have been preventable.

5 And so from our standpoint what we did  
6 and what was kind of interesting is that there are  
7 a few of us that were followers of TC3 from the  
8 onset back in 1996. I was a medical student at  
9 the time that John Hagmann was up at USUHS at the  
10 time, but then went off to the unit. We  
11 implemented TC3 in detail and so had that  
12 knowledge base. And I think one of the keys was  
13 actually small unit leadership. And I heard  
14 several folks talking about that in reference to  
15 the psychological applications as well. Small  
16 unit leaders is what made TC3 what it was  
17 throughout the U.S. Army Special Operations  
18 Command.

19 And so as physicians, we can make  
20 recommendations, but it's not until the Commanders  
21 take that program and make it their own. And so  
22 my goal back in the '90s was to sell this to the

1 Commanders to make it their program. And one of  
2 the key parts, and I say this in the paper as  
3 well, is a guy by the name of McChrystal, who was  
4 the original Commander at that time back in the  
5 1990s. And what he did was he came up with a  
6 basic big four and one of those four was actually  
7 medical training. And so by doing that what he  
8 did was he enabled his subordinate Commanders to  
9 then emphasize TC3. By doing all of that before  
10 the conflict occurred and by taking the lessons  
11 from Somalia and from what Captain Butler wrote in  
12 TC3, I think that, yes, Rangers sacrificed in  
13 Somalia, but I think that sacrifice generated a  
14 greater savings in OEF and OIF over the last  
15 decade, which was proven with our data with the  
16 PHDR.

17           So what we're doing with the PHDR as far  
18 as the long term is I'm still trying to push that  
19 globally throughout the military. We did a  
20 supplementary program with the 101st through 2nd  
21 PCT. Went out and over the last year gathered  
22 data and Colonel Mike Wort is the Brigade Surgeon.

1 We're going to be going over that data later on  
2 this week. As a matter of fact, I also met with  
3 Sierra Nevada Corporation just recently as they  
4 are very interested in looking at electronic and  
5 telemedicine fixes for this as well. And so I've  
6 got a meeting right now that's going to be  
7 occurring in College Station actually on Thursday  
8 as we talk with folks from RT and also from Sierra  
9 Nevada Corporation. Then on Friday, we have a  
10 meeting with representatives from OTSG as well as  
11 MEDCOM as we're talking about the way ahead and  
12 possibly spiral development to the PHDR.

13 And I apologize, that was a long answer  
14 to your question.

15 DR. BUTLER: Nope.

16 DR. DICKEY: Dr. Woodson.

17 DR. WOODSON: Thank you very much for  
18 both of those reports. As I mentioned before, I  
19 recently came back from theater and had an  
20 opportunity to look at and assess the TACEVAC  
21 strategy and examine sort of our legacy system  
22 against Pedro and MERT. And I must admit I've had

1 an interest in this topic for some time dating  
2 back to when I was trained in CCATT and deployed  
3 forward in OIF 1. And I knew that there were some  
4 changes that need to be made.

5 Just a couple of comments. Number one,  
6 I fully endorse and have talked with the Surgeon  
7 Generals about the upgrading of the skills of the  
8 forward-deployed medics in regards to medical  
9 evacuation, TACEVAC. I think, though, that what  
10 we need to understand is that not all kinetic  
11 situations and theaters are the same. And so we  
12 have to be careful about developing a strategy  
13 which provides our basic upgraded capabilities for  
14 tactical evacuation without over committing in  
15 some sense to specific platforms. What I mean by  
16 this is that if you take Afghanistan for now, we  
17 can talk about point of injury to first echelon of  
18 care and then there's also a requirement for  
19 transport of very sick, ill, and injured  
20 Servicemen and women between facilities, which is  
21 also a part of that TACEVAC as far as I'm  
22 concerned. And then there's the strategic

1 evacuation set of issues.

2           You take a platform like MERT on a  
3 CH-47. That can't land everywhere and certainly  
4 the Osprey can't land everywhere under all of the  
5 tactical situations. So we have to create a  
6 platform and a strategy, which I think uses  
7 currently the Blackhawk in the inventory as the  
8 basic aircraft because it's just a lot more agile.  
9 And then you have to build on that. Well, what  
10 are you trying to achieve? To send an advanced  
11 medical team where pickup and bringing to  
12 definitive care may be more appropriate than  
13 spending time in the field, particularly under  
14 certain tactical situations trying to resuscitate  
15 an individual is probably a better strategy to get  
16 them out of there. So every situation isn't  
17 right. But having said that, I wholeheartedly  
18 endorse the need to upgrade the skills because  
19 that natural experiment with that National Guard  
20 Unit that was deployed really did show that we  
21 could have improved outcomes.

22           The final piece that I think needs the

1 discussion is, again, what are the right  
2 personnel? I wholeheartedly think that we need  
3 better medical control, meaning that we have to  
4 have people who understand pre-hospital systems  
5 and can give directions to either intensive care,  
6 critical care, nurses, and paramedics. I don't  
7 know that you always will have enough physicians  
8 to deploy in that manner. And so the issue is  
9 about medical control is very important.

10           The last piece is when I went to theater  
11 I took my IT person with me. And the reason I  
12 took my IT person with me is I know we need to do  
13 a better job of capturing that pre-hospital data,  
14 that very important data from the point of injury  
15 to inform what we do and transform what we do as  
16 we try and improve care. So we're working on that  
17 very hard right now.

18           DR. BUTLER: Yes, sir. And to follow up  
19 with what you're saying, I didn't mention and  
20 should have, that the MERT has primarily flown out  
21 of Bastion, which, as things would have it, is  
22 where the Marines are currently experiencing this

1 significant increase in dismounted IED blasts. So  
2 it's absolutely right that, you know, most trauma  
3 patients will do well no matter what helicopter  
4 picks them up. But the MERT has flown out of  
5 Bastion and has picked up a lot of the Marines who  
6 have gotten into these dismounted complex blast  
7 injuries.

8 DR. DICKEY: Other questions? Dr.  
9 Johannigman.

10 DR. JOHANNIGMAN: Combining on those  
11 last two comments, the flexibility of the platform  
12 having been there, the MERT currently is focused  
13 on pre-hospital, but there are times when we would  
14 have loved to have had the MERT make that trip  
15 from Bastion to Bagram. And now, you know, the  
16 Air Force does have the tactic teams that are  
17 flowing in to try to do that mission. But as the  
18 Secretary said, it's really -- is it the  
19 intervention or the provider, which interventions,  
20 and timeliness? Because the other thing that we  
21 saw with the MERT teams is sometimes because they  
22 were only a single platform, because they were

1 CH-47, sometimes there would be a delay holding  
2 that casualty out there waiting for a MERT team to  
3 get there rather than to immediately transport  
4 them to a level three. So the other piece of data  
5 that's going to be critical, just as it is in the  
6 U.S. EMS system, is what are the times and times  
7 to intervention that are going to make the  
8 difference? Is it the doc or the timing of those  
9 interventions?

10 DR. BUTLER: Right. And not to jump  
11 ahead too far into our tranexamic acid discussion,  
12 but if you look at the results of the CRASH 2 Part  
13 B, I mean, it is critical to get tranexamic  
14 onboard. And we'll talk about those data shortly.

15 DR. DICKEY: Other questions? Go ahead.

16 DR. BUTLER: Okay. So let me jump into  
17 dry plasma. And to set the stage, I think we all  
18 know here that hemorrhage is the leading cause of  
19 potentially preventable death in combat. I think  
20 we would all agree that if your blood is not  
21 clotting well that that increases the risk of  
22 hemorrhagic death. I hope that soon, if not now,

1     you'll all agree that crystalloids and colloids  
2     dilute the existing clotting factors that you have  
3     current or have presently in your blood and that  
4     plasma replaces clotting factors lost through  
5     hemorrhage. Packed red cells do not, crystalloids  
6     do not, colloids do not. I think those are  
7     statements of fact.

8             I think it's important, and we're going  
9     to look at some data shortly, but as focused as we  
10    are in TBI, I will tell you that the literature is  
11    growing that says coagulopathy worsens outcomes in  
12    TBI casualties as well as those with uncontrolled  
13    hemorrhage. And we're going to look at some  
14    metrics shortly.

15            So these are not sick people. Why would  
16    they be coagulopathic on the battlefield? Well,  
17    because perhaps you have allowed them to get  
18    hypothermic and when you get hypothermic your  
19    clotting enzymes don't work as well. Perhaps  
20    you've given them two liters of lactated ringers  
21    and diluted the clotting factors that they have  
22    left in their intravascular system. Perhaps they

1       took aspirin or Motrin® before they went out on the  
2       mission and now their platelets are all  
3       ineffective. Perhaps they're acidotic if they're  
4       already in shock. And it's important to note that  
5       there is an intrinsic coagulopathy as well,  
6       probably caused by tissue markers or the body's  
7       own system. There is something about being  
8       injured that kicks the fibrinolytic system into  
9       hyper drive in some patients.

10                So one of the dramatic advances in care  
11       of trauma patients realized from the U.S.  
12       experience in Afghanistan and Iraq has been the  
13       use of higher ratios of plasma to red blood cells  
14       in casualties requiring massive transfusions. And  
15       in some papers lately, even if they don't need  
16       massive transfusions, the outcomes are better.  
17       And this has, as they say, gone viral. It went  
18       straight from the military to the civilian sector.  
19       They're doing it all over the place now. This is  
20       a great example of how things have -- how our  
21       experience in the war is helping our civilian  
22       colleagues as well.

1                   I want to take a second and talk about  
2           large volume crystalloids. I talked to Colonel  
3           Deal, who took ATLS last week and they're still  
4           teaching 2 liters of lactated ringers. I will  
5           tell you that this is a dying standard of care.  
6           There is a growing body of evidence that I am  
7           about to show you, some of that says that  
8           pre-hospital fluid resuscitation with large volume  
9           crystalloid worsens outcomes. There have been no  
10          randomized control trials of lactated ringers or  
11          normal saline that have shown benefits in  
12          outcomes. And I'll pause here for somebody to  
13          correct me on that point.

14                   So why are the outcomes worse? Well, if  
15          you read the literature they'll hold up several  
16          theories. You're on scene longer because you  
17          stopped to start an IV. You dilute clotting  
18          factors, as we talked about, or you pump up the  
19          blood pressure in somebody who still has an  
20          unrepaired vascular injury and you cause more  
21          blood to become extravasated and you finish  
22          bleeding to death. In contrast, if you give

1 pre-hospital plasma that is just an extension of  
2 the definitive resuscitation you're going to get  
3 when you show up at the hospital.

4 All right. So why is this a big deal?  
5 Well, we had Major Julio Lairer from the ISR come  
6 and talk about the study that is ongoing at the  
7 Institute of Surgical Research. Would you be  
8 interested to know that of the people that show up  
9 at a military hospital in theater right now, if  
10 they have an IV 87 percent of them have large  
11 volume crystalloid resuscitation? I'll pause  
12 again for anybody to argue that point. I mean, it  
13 is the first time it has ever been really well  
14 documented. You know, why is that happening?  
15 Probably because the coaches tell the players no,  
16 no, no, no, no. Don't use those techniques; use  
17 the large volume crystalloid like it teaches in  
18 ATLS.

19 Okay. Data driven. This is the first  
20 time I've ever shown these next two slides and I  
21 do want to give you guys a walk through some of  
22 the data. So let's say that you are severely

1 injured and this is your baseline chance of  
2 survival. So what are the modifiers of your  
3 chances of living through your injury? Well, if  
4 you have a coagulopathy, you have a 600 percent  
5 increase in your chance of dying, Niles' paper.  
6 If you live in a remote area -- this is a paper  
7 from Australia where they've got some serious  
8 remote areas -- a remote area alone causes a 428  
9 percent increase in your chance of mortality.

10 Now, think for a second about our  
11 Special Ops brothers here who are out operating  
12 somewhere in Africa. Remote area? Yeah. So they  
13 know that their soldiers have a higher chance of  
14 dying because they are in a remote area. This is  
15 just a way to document it from the civilian  
16 sector.

17 If you have polytrauma and you have  
18 blunt head trauma with coagulopathy, you have a  
19 291 percent increased mortality. If you look  
20 specifically at early deaths, as Mitra did, if you  
21 have a coagulopathy you have a 245 percent chance  
22 of increased mortality in the early period. If

1 you look just at large volume crystalloid, and in  
2 this case they actually used predetermined cutoffs  
3 for their levels of crystalloid -- this is a Ley  
4 paper from this year -- just the fact that you've  
5 got 1.5 liters of crystalloid doubles your chances  
6 of dying. Wow. So isn't it good that we're  
7 teaching all these guys to start IVs and running  
8 all this fluid?

9           The Haut paper found that the act of  
10 starting an IV and running in any fluids caused a  
11 44 percent increase in mortality, and the Bickell  
12 paper, going back to '94, found that if you did  
13 large volume crystalloid in patients with  
14 penetrating trauma that you increase their chances  
15 of dying by 29 percent. So where are the papers  
16 that show the benefit of large volume crystalloid?  
17 I promise you if I had them I would put them up  
18 here as a counter, but I don't.

19           So this we've known and been talking  
20 about for a long time. This next slide is sort of  
21 an awakening for our group as well. With the  
22 emphasis on traumatic brain injury, as we were

1 preparing to do the Freeze Dried Plasma talk for this group  
2 and going through the literature, it was amazing  
3 the association between coagulopathy and traumatic  
4 brain injury outcomes. So we mentioned that if  
5 you have blunt head trauma and a coagulopathy you  
6 almost triple your chances of dying. If you've  
7 been taking anti-platelet agents you have an  
8 almost triple increase and a Grade III or IV  
9 intracranial hemorrhage. If you're taking aspirin  
10 or ibuprofen as we tell our soldiers not to do --  
11 but we don't kid ourselves, there are some guys  
12 out there doing it -- you almost triple your  
13 chances of an intracranial bleed. In this study,  
14 if you have a coagulopathy you have a 41 percent  
15 chance of increasing the progression of  
16 intracranial hemorrhage. Wow. Wow.

17           So let's sum it up. Large volume  
18 crystalloids increase mortality, worsen  
19 coagulopathy of trauma and outcomes in traumatic  
20 brain injury. Other than that they're great.

21           And that, again, is what your troops are  
22 carrying right now. Hypotensive resuscitation

1 with Hextend®, better logistically. It reduces the  
2 weight a lot. But I will tell you that we don't  
3 have hard data that says the survival is improved  
4 over lactated ringers. We've got the Ogilvie  
5 study and the Proctor studies which say it may be  
6 a little bit better, but it's pretty soft and  
7 those are very well-criticized studies. It does  
8 not treat coagulopathy. We do know that it  
9 doesn't cause coagulopathy in the dose that we  
10 recommend. That did come out of the Proctor and  
11 Ogilvie studies.

12           So liquid plasma. No question about it,  
13 it is the standard of care for treating  
14 coagulopathy and it increases survival  
15 unquestionably as part of damage control  
16 resuscitation when given with red blood cells.

17           Okay, so that's some background. Is  
18 there anybody that agrees with the concept of  
19 let's give people plasma instead of large volume  
20 crystalloids pre-hospital? Well, yeah, a few.  
21 We'll start off with the Mayo Clinic. They're  
22 doing it right now. We'll start off with Memorial

1       Hermann in Houston, John Holcomb's hospital.  
2       They're doing it right now. We'll add the U.S.  
3       Special Operations Command. They'd like to be  
4       doing it very soon. The U.S. Special Operations  
5       Command, the Army Surgeon General's DCBI Task  
6       Force has endorsed this concept. The Army Special  
7       Missions Unit, the Navy Special Missions Unit,  
8       these are the gentlemen that rounded up Mr. bin  
9       Laden here last month. Those guys would very much  
10      like to have dry plasma and are on record as  
11      saying that. The Army Institute of Surgical  
12      Research, the TC3 Committee, the Trauma and Injury  
13      Subcommittee, and, by the way, the French, German,  
14      and British militaries who are already doing it.

15                So some quotes here that will place this  
16      in perspective for you. This is a quote from an  
17      abstract that's been accepted for ATACCC, Advanced  
18      Technology Applications for Combat Casualty Care.  
19      That is a conference that comes up in August.  
20      Great conference if you have a chance to go. He  
21      is describing the Houston experience of putting  
22      thawed plasma in the ED. So you don't have to

1 dial 1-800-BLOODBANK and wait for it to show up.  
2 Forty-two minutes instead of 83 minutes for  
3 infusion and they showed an increase in their  
4 30-day survival: 86 percent versus 75 percent.

5 The Mayo Clinic. I stole these slides  
6 from Dr. Jenkins. They say that the current  
7 evidence supports increased ratio of plasma PRBCs  
8 and early use of plasma and trauma. They have  
9 successfully implemented pre-hospital thawed  
10 plasma into our rural Level I trauma system. The  
11 initial results, and they only had about 15, 20  
12 patients when they presented at the meeting, what  
13 they've not shown is an increase in survival yet.  
14 What they have observed is a pretty consistent  
15 improvement in their coagulation status. And for  
16 those of you who speak coagulation, INR 2.7 at  
17 point of injury, 1.7 at the ED. That's good if it  
18 holds up through the study.

19 So why aren't we doing it already?  
20 Well, because liquid plasma is not logistically  
21 feasible for Ranger medics or Special Forces  
22 medics. It has to be handled appropriately.

1 Dried plasma, though, is an option. And it's  
2 probably the best option for groups that can't --  
3 that don't have access to blood banking and can't  
4 carry liquid plasma. Dried plasma contains  
5 approximately the same levels of clotting proteins  
6 as liquid proteins. It depends to some extent on  
7 how you dilute it, but there are some papers out  
8 that talk about how you can do that and preserve  
9 the clotting factors. Again, the French, the  
10 German, and the Brits are doing it now. I'll tell  
11 you, I have not seen any data from their  
12 experience. There is some data that has been  
13 submitted for publication with the French product,  
14 but I have not been given access to it yet.

15           So is the U.S. doing anything to come up  
16 with an FDA-approved dry plasma product? You bet.  
17 We don't have one now, but HemCon is supported by  
18 the Army Medical Research and Materiel Command.  
19 They have a product called LYP for lyophilized  
20 plasma. It is currently in Phase I trials. They  
21 are supposed to finish up in a few months. The  
22 Entegriion product -- Entegriion is supported by

1 Office of Naval Research. It is a spray dried  
2 product which they advertise as being better.  
3 They have an IND that's about completed. They  
4 have not yet entered Phase I. Essentially, the  
5 same thing for Velico, which is significantly  
6 different in that they are trying to sell the  
7 system. So if Commander Padgett has a hospital,  
8 they would sell him their system and you would  
9 then go on and make your own freeze-dried plasma  
10 as opposed to buying it off the shelf.

11 FDA approval is not imminent. We think  
12 we're talking 2015 or beyond. We need a solution  
13 now. Again, think beyond Afghanistan. Short  
14 transport to the hospital there, we could give it.  
15 And most of our platforms, if we had liquid plasma  
16 and made the logistic effort to give it, but think  
17 about those guys in other places.

18 A quick look at the foreign products.  
19 The French freeze-dried plasma has been around  
20 since '94. One downside for that is that it's  
21 pool plasma. In general, the blood bankers don't  
22 like pooled anything. And they did hold it for

1 eight weeks to retest before releasing it, but now  
2 they have a pathogen intercept technology and they  
3 have suspended the quarantine. Notable that the  
4 price for this stuff is \$800 a unit. That might  
5 put it out of reach for the military, depending.

6 The German freeze-dried plasma is a  
7 product called LyoPlas; different in that it is  
8 single donor. It's quarantined for four months  
9 until the donor is retested after four months. It  
10 is very alkaline as supplied and it's much cheaper  
11 at \$100 a unit.

12 So how can we represent the Line  
13 Commander's interest in freeze-dried plasma?  
14 Where is it on their radar screen? This is a  
15 letter from Admiral Eric Olson to Dr. Rice when he  
16 was Acting Health Affairs. "I am requesting a  
17 waiver to the health care policy regarding non-FDA  
18 approved blood products." Basically, it says we  
19 need German freeze-dried plasma now. And this is  
20 the handwritten note from Admiral Olson to Dr.  
21 Rice, "Thank you for your full consideration of  
22 this request. This is a real lifesaver with very

1 low risk."

2           The Army Surgeon General's quote on  
3 this, note the letters in red, basically he says:  
4 I fully support your request from a clinical  
5 perspective. Medically, this is the right thing  
6 to do. However, I have no easy way around the  
7 regulatory considerations. He points out that  
8 neither of these products are necessarily going to  
9 bring their products to market in the U.S. and  
10 that's a real problem.

11           A quote from Mike Dubick at the  
12 Institute of Surgical Research, this was from the  
13 conference that was held a year and a half ago in  
14 Dallas, "The consensus of discussants at the  
15 USAISR-sponsored symposium on pre-hospital fluid  
16 resuscitation overwhelmingly favored the  
17 development of a dried plasma product."

18           Don Jenkins: If I had FDP,  
19 logistically, I would use it. I would put it on  
20 the helicopters and I'd put it on my ALS  
21 ambulances.

22           So the recommendation from the committee

1 and the Trauma and Injury Subcommittee was that  
2 the Department take all necessary steps to  
3 expedite the fielding of a dried plasma product to  
4 ground medics and to air medical evacuation  
5 platforms that don't have liquid plasma and packed  
6 red blood cells. Not everybody has access to  
7 blood banks.

8           So what are steps that could be taken?  
9 Well, first, we could conduct expedited studies in  
10 trauma systems using pre-hospital liquid plasma as  
11 the primary resuscitation fluid. Potential  
12 question from you to me: Hey, Frank, show me the  
13 data that says if you use plasma alone as a  
14 pre-hospital resuscitation fluid, show me that's  
15 been proven to improve outcomes. I will tell you  
16 there is no data like that. But there should be.  
17 One way or the other we should know.

18           The next thing is we need to just not  
19 think about mortality. We need to look at  
20 indicators such as improvement of coagulation  
21 status, improvement in their reduction and their  
22 shock, as well as TBI outcome markers as outcome

1 measures. Coagulopathy is incredibly important in  
2 TBI and we need to capture that as part of our  
3 metrics. So kudos to both MRMC and ONR for  
4 supporting the development and fielding of an  
5 FDA-approved dried plasma product. I think we  
6 need to tell them that that's important and to  
7 please continue.

8           The top slide here or this top bullet is  
9 probably the most important bullet in the dried  
10 plasma presentation. A lot of argument back and  
11 forth about how do we go forward? How do we get a  
12 presidential waiver to use foreign products? How  
13 about this? And I will give credit to an  
14 individual on Colonel Deal's staff for suggesting  
15 this particular route. We have a U.S. product  
16 that has an IND in place, an investigational new  
17 drug request in place that has just finished Phase  
18 I of their trials. So the next step, assuming  
19 that they did well, and as far as we know they  
20 have, why don't we have a military arm of the  
21 Phase II trials where we take this drug with full  
22 consent? We don't have to get a waiver of

1 informed consent. I think we should get informed  
2 consent. From units that want to use this, we  
3 should explain to them. You know, we give you a  
4 large volume of crystalloid. Do you want to take  
5 a look at those slides again? Or we give you  
6 dried plasma.

7           So that is a real option. I don't see  
8 why we couldn't do that. It is completely  
9 coloring within the lines. I think we need to  
10 gather data on the French and German products.  
11 They've been out there for a long time. We need  
12 to know what their experience is and we don't  
13 right now. And there may be other options for the  
14 use of freeze-dried plasma that might include an  
15 exception to policy if none of the other options  
16 work out so that we could go out and buy these  
17 European dried plasma products.

18           I know there are some questions now.  
19 Sir.

20           DR. BULLOCK: Thanks so much for a  
21 really clear expose. I mean, it seems like it's a  
22 huge unmet need that you put the finger on here.

1       So two things that come into my mind. So the  
2       first is that, you know, the issue of freeze-dried  
3       plasma, surely that's an FDA -- FDA is a big  
4       limiting factor in all this. They've been  
5       involved in a dialogue with trying to move this  
6       forward. What's their view about how to move this  
7       forward as quickly as possible?

8                 DR. BUTLER: You know, the FDA is not  
9       really in the business of moving things forward as  
10      quickly as possible.

11                DR. JOHANNIGMAN: They are incredibly --  
12      I'm sorry to interrupt, but right now they are  
13      incredibly conservative in anything. In the last  
14      5 years there has been an almost 180-degree  
15      turnabout of the FDA's approach. They are so risk  
16      aversive right now in any of these trials, but I  
17      think what my counter is going to be is, Frank,  
18      you provided that data. How strong is that lay  
19      study? Because what we actually need -- what  
20      needs to be part of this discussion is now the  
21      objective evidence that the current standard of  
22      care has been documented to lead to increased

1 risk. Two hundred-fold increased risk in  
2 mortality so that that would prompt a look at  
3 alternative agents. And if you base your look and  
4 your IND in soldiers based upon, well, yeah, it's  
5 a risk business we're in, but right now a 200  
6 percent increase using our current operational  
7 standards is probably something that we might be  
8 able to ameliorate.

9 DR. ANDERSON: I'm not familiar with Ley's  
10 paper.

11 DR. BUTLER: So Ley's paper, the  
12 Bickell paper I thought was compelling way back  
13 when. Large volume crystalloids has never been  
14 part of TC3, both because we don't want the medic  
15 to have -- literally, these guys were carrying 20  
16 pounds of lactated ringers in their packs back in  
17 the day. You know, some of you guys might  
18 remember that. And we've had medics come to the  
19 meeting and say the best thing TC3 ever did was  
20 tourniquets. Second best was getting rid of that  
21 20 pounds of lactated ringers in my bag. It's a  
22 huge thing when you're talking maneuver elements.

1                   So large volume crystalloids have never  
2                   been part of TC3. Starch continues to be accepted  
3                   by everybody who has looked at this seriously, but  
4                   not taught to anybody who takes advanced trauma  
5                   life support as their basis for trauma. And what  
6                   course do we send all of our military physicians  
7                   to as their basis for trauma care? ATLS.

8                   DR. ANDERSON: So to follow up on Dr.  
9                   Johannigman's question. I haven't read these papers  
10                  either, but sometimes the intent of the paper is an  
11                  association as opposed to a risk analysis. And I  
12                  think, again, if you look at what IOM -- you guys  
13                  have been briefing at the IOM as well -- this is  
14                  an area where another scientific approach is  
15                  probably necessary. I mean, the question I would  
16                  have here is what's the power of proof in this  
17                  area? And it sounds to me like there is a major  
18                  lack of data right now supporting a risk analysis  
19                  kind of an approach in the medical literature. So  
20                  one idea here is if you're not actually doing the  
21                  scientific research yourself, is to call for that  
22                  research. This might be a place where going to

1 the IOM would be a good idea.

2 Do you have a comment on that, Frank?

3 DR. BUTLER: Yes, sir. With your help  
4 we've done that. That was in our research  
5 recommendations that the Board looked at six  
6 months ago, to look at pre-hospital resuscitation.  
7 Anything that you want to do pre-hospital is not  
8 well supported by the data if you're looking for  
9 improvements in outcomes. So, and initially, the  
10 answer in TC3 was to do nothing. To do nothing.  
11 And that was shot down by the trauma community.  
12 No, we're going to do something. But again, there  
13 is no data that supports strongly any pre-hospital  
14 fluid strategy right now.

15 DR. CARMONA: Frank, just a quick  
16 comment. Historically, unfortunately, I've been  
17 around long enough to have seen these things  
18 change. If you remember in the 18 Deltas during  
19 Vietnam, Special Operations Forces in general, we  
20 actually tried colloid resuscitation in the field  
21 back then. We were carrying albumin and anything  
22 else that we could find and we put in. And if you

1 remember, back then, as it is today, most of what  
2 we did was anecdotal. It really wasn't based on  
3 science. It was based on somebody's idea that  
4 this was the best thing. That worked well for a  
5 while. Unfortunately, then we had the concept of  
6 shock lung or Da Nang lung and then increased  
7 cerebral edema. So people said, well, we better  
8 not do that anymore because it appears that using  
9 colloid too early is causing unintended  
10 consequences that ultimately increase morbidity  
11 and mortality. So we stopped doing it again. But  
12 there was no data. There really wasn't a lot of  
13 cumulative data that helped us.

14           And I think the point that you made is  
15 we really need to drive this. Right now we have  
16 anecdotal information that freeze-dried and other  
17 methods of resuscitation maintain hypotensive  
18 resuscitation and so on are good. But that's not  
19 new either. Canon reported that back in 1903 and  
20 we kind of ignored them for all the years. So I  
21 think it's time that we do gather the data once  
22 and for all and vigorously use that data to

1 demonstrate that there are better ways to do these  
2 resuscitations. And I believe that as opposed to  
3 what I said earlier about a different military  
4 standard, I think this standard would be  
5 applicable across the board for all resuscitation  
6 once it's adopted because the civilian world is  
7 still struggling with this as well.

8 DR. BUTLER: One of the things that is  
9 -- I mean, as we rush toward freeze-dried plasma,  
10 as important as the agent may be, how much of the  
11 agent that we give. And I have not seen any good  
12 data in humans that addresses that issue. There  
13 is emerging some data from Mass General and from  
14 Harvard that looks at swine models. But humans?  
15 I mean, in the hospital you get plasma and red  
16 blood cells as much as you need. They're watching  
17 your blood pressure and you just keep pumping it  
18 in. I don't think we can extrapolate from that  
19 practice to saying that we can do the same thing  
20 with plasma.

21 DR. PUSATERI: On your last slide you  
22 talked about the lack of evidence on pre-hospital

1 use of plasma. This doesn't give us any  
2 information now, but I just want to let you know  
3 that two weeks ago we closed a program  
4 announcement under the MRMC (inaudible) for  
5 pre-hospital plasma and got nine responses. So  
6 we're expecting full proposals very soon.

7 DR. BUTLER: That's great news. MRMC  
8 has --

9 DR. DICKEY: Dr. Bullock? Oh, I'm  
10 sorry.

11 DR. BULLOCK: I just want to make one  
12 other point about recombinant factor VII because  
13 the military, in particular during the height of  
14 the Iraq campaigns, have more experience than  
15 anybody using pre-hospital factor VII in TBI  
16 patients specifically, these types of patients  
17 that you're mentioning here with the multiple  
18 injuries and shock. And that data hasn't really  
19 been written. Do you know when we can expect to  
20 see that? Because that's a game changer, is the  
21 use of recombinant factor VII.

22 DR. BUTLER: The press had a field day

1 with recombinant factor VIIa and it was because it  
2 was an off-label use. So let's take a step back.  
3 This group is sophisticated enough to know the FDA  
4 licensing process. Number of drugs in the U.S.  
5 market that are approved by the FDA specifically  
6 for the use of treating combat trauma on the  
7 battlefield, zero. So everything we do out there  
8 is off-label. So more to the question is -- and  
9 that's what the press focused on, but it's not the  
10 real question. The real question is does it cause  
11 an increase in venous occlusive events? And it  
12 would take an anecdote event or two and say look  
13 at this, this is awful.

14 From a practical standpoint, factor  
15 VIIa, if you're going to use it in the field,  
16 costs \$7,000 a pop and has to be refrigerated.

17 DR. DICKEY: The interchange is hard to  
18 keep up with.

19 DR. BUTLER: If we could use your  
20 comment, Dr. Bullock, to look quickly at  
21 tranexamic acid, there is no vote on this issue,  
22 but we hope that there may be for the next

1 meeting. And I wanted to just show you some of  
2 the background data.

3 As opposed to factor VIIa, which is a  
4 procoagulant, it makes you clot when you're not  
5 clotting. This is an anti-fibrinolytic, which in  
6 the natural process of clot formation and clot  
7 dissolution. This stops the clot dissolution.

8 So CRASH-2 came out last summer, a  
9 prospective, randomized trial using this agent in  
10 trauma patients, over 20,000 patients in 40  
11 countries. And it was found to significantly  
12 reduce mortality, all causes of mortality from 16  
13 percent to 14.5 percent. It reduced death from  
14 bleeding from 5.7 to 4.9 percent. So the DoD took  
15 its first look at tranexamic acid in the aftermath  
16 of the first CRASH-2 paper, and this is from the  
17 Army Institute of Surgical Research information  
18 paper. They note that the loading dose was 1 gram  
19 over 10 minutes IV. It's FDA approved for dental  
20 procedures in hemophiliacs, not exactly combat  
21 trauma. Also approved for hypermenorrhea. It has  
22 been noted to increase cerebral ischemia and

1       subarachnoid hemorrhage.

2                       They did note that this was a  
3       randomized, double-blinded placebo-controlled  
4       trial, the highest level of clinical evidence and  
5       a quite large one at that. They did no subgroup  
6       analysis in the original paper for patients  
7       requiring massive transfusion or TBI -- or  
8       patients with TBI. The price was right. Instead  
9       of \$7,000 we're talking \$80. Now we're talking.  
10      It's been used for a year by the U.K. forces. By  
11      their math it might have saved 23 of 1,500  
12      preventable deaths in OIF and OEF. I would argue  
13      with that number, but we're going to talk about it  
14      some more.

15                      Comments about the paper? You know,  
16      John Holcomb noted that in a drug that was  
17      supposed to decrease bleeding, 50 percent of the  
18      people didn't even need a transfusion. The  
19      inclusion criteria were "patients with significant  
20      hemorrhage or at risk of significant hemorrhage."  
21      Wow. Well, you know, that's anybody on the  
22      battlefield, right? Yeah. So it was a

1       problematic inclusion criteria.

2                   The rate of transfusion was the same  
3       between the two groups. Only 48 percent of these  
4       individuals had any surgery at all. The  
5       difference in mortality due to bleeding was small,  
6       0.8 percent. John notes that hours one through  
7       three after injury is where all the benefit was.  
8       And we're going to come back to that.

9                   Bryan Cotton mentioned, among other  
10       things, that he wasn't surprised to see that the  
11       drug would not have a dramatic effect in the  
12       number of units transfused in such a general  
13       population. You know, we're not focusing on  
14       patients with massive hemorrhage. This is at risk  
15       of hemorrhage. I thought a good criticism was  
16       there is no subgroup analysis on patients arriving  
17       in shock. Here's a trauma patient without any  
18       mention of injury severity score, base deficit, or  
19       lactate. That's a little tough to add up. And he  
20       also notes that we're not talking about big  
21       numbers.

22                   Important, though, if you look at the

1 TXA in the overall study, it was administered 2.8  
2 to 2.9 hours after the injury, given to those at  
3 risk of hemorrhage. Most people were not in  
4 shock. There was really no -- I mean, they didn't  
5 delineate what the protocol should be for use  
6 after this study. And so last July, the Joint  
7 Theater Trauma System Director's Conference looked  
8 at this, reviewed the data, and decided to not  
9 decide.

10 So fast forward to about three months  
11 ago. They went back and did a subgroup analysis  
12 of the 20,000+ patients and looked at timing and  
13 focused just on deaths from bleeding. And they  
14 found that there was a significant reduction in  
15 death due to bleeding if tranexamic acid was given  
16 within one hour. It's a 30 percent reduction in  
17 mortality -- 32 percent reduction in mortality.  
18 If it's given between 1 and 3 hours, it's a 20  
19 percent reduction in mortality. Those are nice  
20 numbers.

21 Question 2, Part B, quotes a Cochrane  
22 review and the Cochrane review said that

1       tranexamic acid safely reduces mortality in  
2       bleeding trauma patients without increasing the  
3       risk of adverse events. So hopefully that will  
4       address all of the concerns about increase in  
5       venous thromboembolism.

6                   The conclusion of the authors was our  
7       results strongly endorse the importance of early  
8       administration of tranexamic acid in bleeding  
9       trauma patients and suggests that trauma systems  
10      be configured to facilitate this recommendation.  
11      And I will tell you that there is a CPG that has  
12      been crafted and should be approved soon for in-  
13      hospital use of tranexamic acid. So when the TC3  
14      Committee looked at it, our perspective was a  
15      little bit different. We're asking should medics  
16      be using it on the helicopters, you know, in  
17      Africa, you know? Is there a pre-hospital place  
18      for this?

19                   And Joe DuBose came in. He is an Air  
20      Force Trauma Surgeon currently at Maryland at the  
21      Shock Trauma Center there. This is a study that  
22      will be breaking soon that I want for you all to

1 know about. It's the MATATERS study, and I always  
2 get this wrong: Military Application of  
3 Tranexamic Acid in Traumatic and Emergency and  
4 Resuscitative Surgery. Joe would be proud.

5 So basically, they're looking at it in  
6 combat and they're working out of Bastion. And  
7 they looked from January 9 to December 10, and  
8 looked at 24-hour mortality and 28-day mortality,  
9 blood product use, and complications. They had  
10 411 patients picked up by the MERT, 8 from Dwyer,  
11 477 from other locations. In all, they had 293  
12 patients that got tranexamic acid and 603 that did  
13 not. Those are pretty good size numbers.

14 And I'll just show you this bottom  
15 figure. If you look at the mass of transfusion  
16 patients, so think of these as the patients in  
17 shock pre-hospital, the 28-day improvement and  
18 survival, if you got tranexamic acid your  
19 mortality was 13.6; if you didn't, your mortality  
20 was 27.6; significant at the.003 level.

21 So Joe has been one of the real leaders,  
22 along with our British colleagues, in looking at

1       this. I think this is a rigorous analysis. And  
2       we are hopefully going to be having a vote on this  
3       and some other related issues at the August  
4       meeting. And I just have to say -- I had to show  
5       one SEAL picture. (Laughter)

6                 So the moral is, yes, you can run and,  
7       yes, you can hide. Just not forever.

8                 So questions about tranexamic acid or  
9       any of the previous things?

10                DR. DICKEY: Dr. Butler has presented  
11       three separate topics for us, two of which require  
12       some action on our part. So let me repeat his  
13       question. Are there any questions or comments  
14       regarding tranexamic acid discussion which does  
15       not require action on our part?

16                Okay. Then I'll ask you if you have  
17       really good bifocals, in the right-hand corner of  
18       the slides they're numbered. And in Slides 9  
19       through 23 there's a series of recommendations on  
20       TACEVAC. Frank, do these sum up to a  
21       recommendation or do we need to kind of go through  
22       these one at a time?

1 DR. BUTLER: I have tried to capture the  
2 essence of the recommendation and the bolded text  
3 at the start. And what is underneath is meant to  
4 be descriptive.

5 DR. DICKEY: So I would take that to say  
6 the first recommendation is that the U.S. develop  
7 an advanced TACEVAC capability. There are then  
8 several slides that discuss what that means. I'm  
9 going to suggest that takes us through -- up to  
10 optimizing TACEVAC response time.

11 DR. BUTLER: Yes, ma'am.

12 DR. DICKEY: The recommendation before  
13 you is that the U.S. begin to develop an advanced  
14 TACEVAC capability based on the MERT model insofar  
15 as possible, though not necessarily exact copy of  
16 that.

17 DR. CARMONA: So moved.

18 DR. DICKEY: It is moved. Do you want  
19 to do these one at a time? It may be the easiest.  
20 Okay. It has been moved that we accept that  
21 recommendation. Is there a second?

22 GEN MYERS: Second.

1 DR. DICKEY: It's been seconded by Dr.  
2 Myers -- Colonel Myers -- General Myers. I'm  
3 sorry, I'll get this title right yet, General. Is  
4 there further discussion?

5 If not, all in favor of that  
6 recommendation, please say aye.

7 GROUP: Aye.

8 DR. DICKEY: Opposed, no. Any  
9 abstentions? All right. Frank, the next one  
10 would then be that we optimize TACEVAC response  
11 time. And does that carry us -- does that include  
12 the in-flight care providers and hostile fire  
13 evacuation or are those separate?

14 DR. BUTLER: No, ma'am. Those are  
15 separate.

16 DR. CERTAIN: This is on page 7 of the  
17 verbiage report?

18 DR. DICKEY: I'm looking. Well, it  
19 might be easier to look at --

20 DR. CERTAIN: (inaudible) on page 7, it  
21 might be easier to keep track.

22 SPEAKER: Slide 13.

1 DR. DICKEY: Slide 13 or page 7 of the  
2 -- that might be easier, Dr. Certain. So  
3 optimizing TACEVAC response times. Note the  
4 SecDef has directed 60-minute response times and  
5 it's my understanding that currently we're  
6 averaging closer to 40 minutes. Is there any  
7 discussion about the recommendation to optimize  
8 TACEVAC response times?

9 DR. CARMONA: Rich Carmona.

10 REPORTER: I'm sorry. Can you put your  
11 microphone on?

12 DR. CARMONA: Yeah. Rich Carmona.  
13 Frank, you know, we've always gone by the tenet of  
14 the golden hour. So SecDef says 60 minutes, also.  
15 What's your thought on timing?

16 DR. BUTLER: I think that the golden  
17 hour is an interesting statistic. I think it  
18 might not have relevance for a specific critical  
19 patient. I think if you can get them to the  
20 hospital in 20 minutes you should do that.

21 DR. CARMONA: So, in fact, I mean, I'm  
22 agreeing with you. But rather than some arbitrary

1 time limit, as quickly as possible?

2 DR. BUTLER: Yes, sir.

3 DR. CARMONA: Okay.

4 DR. DICKEY: Question with that regard.

5 Dr. Woodson and I were having an aside here. Part  
6 of the concern is as you take that first  
7 recommendation we just adopted, which is to move  
8 towards an advanced capability, sometimes the less  
9 advanced capability will shorten your response  
10 time whereas somebody's got to write the  
11 algorithm, if you will, that says if I can get him  
12 out of here on a less advanced platform quicker, I  
13 may not -- I probably shouldn't wait on the  
14 advanced capability. So is that balanced in here  
15 at someplace?

16 DR. BUTLER: I think that is a great  
17 point. That's where you want Dr. Benson or Dr.  
18 Kotwal making that decision for you. It's  
19 something that we train our medics to do to look  
20 at the different response times.

21 For example, if you had a patient who  
22 had both legs blown off, but had tourniquets in

1 place and was not actively bleeding and was  
2 talking to you, maybe you do have time for a --  
3 maybe you wouldn't have to send in the MERT team.  
4 It is very situationally dependent. As I  
5 mentioned, we had a big matrix that looked at all  
6 of the factors that might impact on CASEVAC  
7 circumstances and worked off of that matrix. So I  
8 would say that it's situationally dependent.

9 DR. DICKEY: Dr. Carmona.

10 DR. CARMONA: Rich Carmona. An  
11 additional comment on that. What was interesting  
12 post-Vietnam as we started to roll out both ALS  
13 providers and advanced practice providers in the  
14 military and as they learned more, the time in the  
15 field went up and mortality went up as well even  
16 though you've got smarter people taking care. And  
17 so we recognize now that really in almost all  
18 cases, notwithstanding what Frank said, is that no  
19 matter what your level of sophistication, even if  
20 you're the trauma surgeon in the field, once you  
21 have an airway and hemorrhage control, you've got  
22 to get them moving quickly. And if you can do

1       that en route, that's even better.

2                   DR. DICKEY: We made the comment that we  
3 haven't fixed this in the civilian sector either.  
4 Scoop and go versus hang out and see how long you  
5 can take to stabilize.

6                   General.

7                   DR. ANDERSON: So, Dr. Butler, if you  
8 take the SecDef 60-minute max just as it is  
9 stated, that can be viewed as a resource  
10 statement. In other words, that's -- he wants to  
11 have the resources in place to make sure that you  
12 can respond in 60 minutes. I'm sure that the  
13 SecDef would agree that as quick as possible would  
14 be the right thing to do. So your wording should  
15 be like that, I think. The problem is, you know,  
16 with Dr. Woodson's statement about airframes as  
17 well, you have to be real careful about how you  
18 build in a huge resource requirement into this.  
19 In other words, if you said it's 20 minutes, then  
20 you have to think about helicopter basing and all  
21 of that. So from your operational experience it  
22 would be nice to be sure that the wording is

1 appropriate to allow reasonable resourcing.

2 DR. BUTLER: Yeah. General, I  
3 understand. Maybe that would be -- maybe it would  
4 be more acceptable if we added optimized TACEVAC  
5 response time and mission planning because we  
6 understand that there are always going to be  
7 restraints on resources.

8 DR. ANDERSON: Yeah.

9 DR. BUTLER: Constraints on resources.

10 DR. ANDERSON: Yeah.

11 DR. BUTLER: And the important thing is,  
12 is that you look at all the resources that you  
13 have and figure out how I can do this best. In  
14 other words, you shouldn't say, okay, I've got a  
15 6-by here. I can drive this guy to the hospital  
16 and make it in 55 minutes when I could have him  
17 evacuated by helicopter in 20 minutes.

18 DR. ANDERSON: The immediate comeback --  
19 George Anderson -- is you've got it, Frank. But  
20 that's the kind of wording that you need --

21 DR. BUTLER: Yes, sir.

22 DR. ANDERSON: -- in the report and the

1 motion here.

2 DR. DICKEY: So can I take that as a  
3 motion to approve this recommendation with some  
4 editing to suggest that there has to be a balance  
5 between resource requirements and time  
6 maximization?

7 DR. CARMONA: So moved.

8 DR. DICKEY: It's been moved by Dr.  
9 Carmona.

10 DR. ANDERSON: Right. And just to  
11 further that, the key there was optimize in  
12 mission planning. And there are resource  
13 implications to that, but the operational thing is  
14 the mission planning.

15 DR. DICKEY: Okay. Is there a second to  
16 that?

17 GEN FRANKS: Second.

18 DR. DICKEY: Seconded by General Franks.  
19 Is there discussion?

20 All in favor say aye.

21 GROUP: Aye.

22 DR. DICKEY: Opposed, no. Any

1        abstentions? Okay. The third recommendation,  
2        hostile fire evacuation option with a number of  
3        subsets here. Are there any questions or a motion  
4        to accept?

5                    DR. CARMONA: So moved.

6                    DR. DICKEY: It's been moved by Dr.  
7        Carmona.

8                    DR. O'LEARY: Second.

9                    DR. DICKEY: Seconded by Dr. O'Leary.  
10       Any further discussion?

11                   All in favor say aye.

12                   GROUP: Aye.

13                   DR. DICKEY: Opposed, no. Any  
14       abstentions? Thank you.

15                   Fourth recommendation, in-flight care  
16       providers that meet or exceed the civilian  
17       standard.

18                   Dr. Butler, I think I heard you say that  
19       you already have the verbal go-ahead to move in  
20       the direction of at least the paramedic. Is this  
21       recommendation is still important for being able  
22       to --

1 DR. BUTLER: It is because I think it  
2 reinforces General Schoomaker's recommendation. I  
3 think it also sets the bar for the other Services.  
4 Right now it's Army-specific.

5 DR. DICKEY: Okay. So your  
6 recommendation is to -- in-flight care providers  
7 that meet or exceed civilian standard with several  
8 bullets to specifically define that and at least  
9 one per critical casualty.

10 Do I hear a recommendation?

11 DR. CARMONA: Rich Carmona. Just for  
12 discussion. Frank, on the issue of meet or  
13 exceeds the civilian, I know where you're trying  
14 to go with this, but being that we know that the  
15 military medicine standard may turn out to be  
16 different than civilian, do we want to include  
17 some wording to include that also so that we're  
18 not directly tied into what the civilians have  
19 come up with? Again, not that that's necessarily  
20 bad, but just that in our discussion it's come out  
21 that it may be that there's a different standard  
22 for military medicine.

1 DR. BUTLER: That's a great point. You  
2 could incorporate the first three bullets into the  
3 recommendation and just say specifically a  
4 critical care flight-trained paramedic nurse or  
5 doctor.

6 DR. DICKEY: I think that's much more  
7 defined, and I think as often as possible I prefer  
8 not to find us trying to create conflict between  
9 whose standards are higher or lower. So to the  
10 degree that that is truly the goal you're going  
11 after, I think that's much more defensible and  
12 definable.

13 DR. BUTLER: And I don't want to leave  
14 the physician assistants out. But I don't know of  
15 many places that use physician assistants as  
16 medical attendants in CASEVAC platforms.

17 GEN FRANKS: You're after increasing  
18 battlefield survivability as opposed to meeting  
19 civilian standards. I mean --

20 DR. DICKEY: Correct.

21 DR. BUTLER: Yes, sir.

22 DR. DICKEY: Doctor?

1                   GEN FRANKS:  And unique requirements of  
2     the battlefield and the trauma and the treatment  
3     by adding these types of qualified medical  
4     personnel on a medical or TACEVAC flight.

5                   DR. BUTLER:  Yes, sir.  And I will --

6                   GEN FRANKS:  To increase survivability,  
7     not necessarily to meet a civilian standard.

8                   DR. BUTLER:  I get those words from Bob  
9     Mabry, and I think his point was the civilians are  
10    sending these critical care flight paramedics to  
11    pick up relatively mildly injured people who have  
12    been in a car crash.  We're sending an EMT-B to  
13    pick up somebody who has had three arms blown --  
14    or two arms and a leg blown off and has traumatic  
15    brain injury and a big hole in his chest.  So, his  
16    point is our casualties are much worse.  We should  
17    have at least meet and probably exceed the  
18    civilian standard.

19                   But, you know, maybe it would be better,  
20    rather than say civilian standards, just put those  
21    three bullets, you know?  To have either a  
22    critical care flight-trained paramedic, doctor, or

1 nurse on the platform.

2 DR. DICKEY: So, why not just leave that  
3 civilian? So it says, "that meet or exceed the  
4 standard of critical care-trained flight  
5 paramedic, critical care-trained flight nurse, or  
6 critical care-capable flight-trained physician."  
7 Then you have actually given yourself some  
8 options. So as long as they bring the skill set  
9 of those people, you're not necessarily looking  
10 for the initials after their name, you're looking  
11 for a skill set.

12 DR. CARMONA: Rich Carmona again.

13 DR. DICKEY: You're --

14 DR. CARMONA: What about a more general  
15 term not excluding what you said, but based --  
16 evidence-based optimal configuration of personnel?  
17 That doesn't limit us. Because what if we wanted  
18 to use PAs in the future and they're not listed  
19 today? So again, I'm trying to make it as a wide  
20 an option as possible for our military medical  
21 commanders to make that decision. And yet, as  
22 Nancy pointed out earlier, not appear that we're

1 competing with the civilian sector as far as a  
2 standard.

3 DR. DICKEY: Check your mic there  
4 because your red light's not coming on.

5 DR. CARMONA: It's kind of flashing on  
6 and off.

7 DR. DICKEY: You've burned it out.

8 DR. CARMONA: Yeah. (Laughter)

9 DR. ANDERSON: (inaudible) put another  
10 quarter in.

11 DR. DICKEY: Okay. Doctor?

12 DR. ALLELY: Yeah, Dr. Eric Allely.  
13 Hey, Frank, this was great. I appreciate the  
14 presentation. I've got a question, though, and  
15 that's just because I'm an Army flight surgeon.

16 Do you mean everybody? I mean, when you  
17 say CASEVAC -- you said CASEVAC, somebody says  
18 CASEVAC. In flight. I mean, this would be  
19 fabulous. If I could make this happen, if I was  
20 God and all these positions appeared and we could  
21 actually populate all of our flight medics, I  
22 mean, and put all of our UH 60s with this kind of

1       capability. I mean, is your recommendation is  
2       that no patient should be moved in the air with a  
3       -- with medical treatment capability short of  
4       this? Because I think that's a great limiting  
5       problem for me.

6               DR. BUTLER: See, I think that's a great  
7       point. And it's important to realize that there's  
8       patient movement that occurs on aircraft or  
9       vehicles or boats of opportunity. I think that  
10      maybe at the start of this, we should pin that  
11      down by saying, "designated MEDEVAC units," to  
12      exclude groups like the 160th, you know? I mean,  
13      these guys are tactical, they're doing what  
14      they're doing, and it's not necessarily picking up  
15      casualties. But if we're talking the 48th Air  
16      Ambulance Company, yes, that is what they do,  
17      trauma care in the air is their mission. So, I  
18      would maybe -- designated MEDEVAC units would be  
19      the right way to qualify that.

20             DR. ALLELY: I -- again, Dr. Allely. I  
21      think that would be great, again, to get to. But  
22      I just -- again, I'm not familiar with how this is

1 going to move forward and where it moves for this  
2 system. But I think there is, at least from the  
3 Army's perspective, a huge manpower problem when  
4 that comes -- if that comes to be. You know, we  
5 need to explore what the consequences are of that.

6           And my suggestion would be rather than  
7 getting into the weeds about trying to describe  
8 what those capabilities are exactly, that maybe  
9 the recommendation would be from this Board to  
10 have a manpower study done, the goal being to  
11 optimize -- to maximize this kind of care, and to  
12 try to determine what that means exactly in terms  
13 of which platforms get it, which platforms don't.  
14 And then it goes into the whole toolkit we have in  
15 terms of air evacuation, you know, what we use and  
16 when we use it. Because obviously you're not  
17 going to do the MERT everyplace either, right?  
18 You're not going to have that everywhere. But we  
19 have to figure out a way to elegantly scale the  
20 system and the capabilities to meet the  
21 operational requirements and the manpower  
22 capabilities that we have. Does that make sense?

1           DR. BUTLER: I think that our group was  
2           convinced by Bob Mabry's study which, again,  
3           apologies to this group. I hope that it was sent  
4           out in your read-ahead package. It was certainly  
5           referenced in the position paper. But that study  
6           has been done. The answer is in, again, comparing  
7           paramedic versus EMT-B. General Schoomaker was  
8           convinced enough to already green-light it as an  
9           Army program. It is compelling data.

10           DR. ALLELY: Oh, that's great. I mean,  
11           I just -- one I haven't seen. I'm convinced of  
12           the data, that it's better. But that is, you  
13           know, I woke up and -- believing that. I just --  
14           it will be interesting to see how that plays out  
15           in manpower having been on the other end of the  
16           problem. And I look forward to my being smarter  
17           about the issue. So, thanks.

18           DR. DICKEY: I think I hear the concern  
19           being raised. I'm not sure how to change the  
20           language, and I don't believe I yet have a motion  
21           on the table. The concern is that the data  
22           suggests that it needs to be critical care-trained

1 flight paramedic or higher level of training. But  
2 we may or may not have the personnel, the  
3 workforce to be able to actually meet that  
4 standard. Is that what I'm hearing you say?

5 DR. ALLELY: Well, this is Dr. Allely  
6 again. We certainly don't now. That doesn't mean  
7 we don't develop a training program that gets us  
8 there. I know that's the intent. And I'm just  
9 concerned about language coming out of the Board  
10 that isn't at least -- doesn't at least tip the  
11 hat to the concept that there is a timeline that  
12 has to be figured out here, that it's obviously  
13 not going to happen tomorrow, and it may not  
14 happen next year. But -- so that's the kind of  
15 stuff that has to be worked out, you know, into  
16 the system.

17 I mean, I just came back from deployment  
18 two months ago, and working very closely with my  
19 MEDEVAC group, I mean, we had folks over there who  
20 were just barely EMT-B. I mean, I wish I could say  
21 it was better than that, but it's not. And so --  
22 and we're struggling even to get there. And so

1       notwithstanding the Army Surgeon General's  
2       recommendation, reality has a role as well.

3               And so, all I'm looking for, I guess, is  
4       maybe some language that says we're not smart  
5       enough yet to know exactly how to employ this, to  
6       make this happen. We know it's a better idea, and  
7       we need to just not put the stamp of the Defense  
8       Health Board on something that may not be as  
9       easily reached as maybe an interim position.  
10      That's all. That would be my -- the minority  
11      report from this end of the table.

12             DR. DICKEY: Dr. Anderson?

13             DR. ANDERSON: Actually, if you look  
14      forward to some of your other recommendations,  
15      sir, I think we're going to run into the same trap  
16      on some of those. And that is, you know,  
17      personally I'm eager to -- and by the way, this is  
18      George Anderson speaking. I'm eager to be  
19      supportive of this improvement in clinical care.  
20      But we have to worry, I think, a little bit from a  
21      process standpoint about the Defense Health Board  
22      appearing to set a standard of care when we don't

1 have the full science for it.

2 I'm looking ahead. I mean, there are  
3 resource implications as well, but particularly  
4 when we get to the next one on the cells and the  
5 plasma. You know, I would certainly support  
6 what's been presented in terms of your report, the  
7 same thing on the professionals and the commitment  
8 to train better, and so on. But I don't think we  
9 have the full data set at this point to be sure  
10 that we're on a rational ground for having a  
11 Defense Health Board position on it.

12 So, we may want to find some other way  
13 of supporting you than one-by-one recommendation  
14 support on these areas that may need a little more  
15 work.

16 DR. BUTLER: Right. If I could answer  
17 that.

18 DR. DICKEY: Yes.

19 DR. BUTLER: I don't know how many of  
20 these papers were sent out to the Board as  
21 read-aheads, but we do have a good study on the  
22 relative impact on outcomes from paramedics versus

1 EMT basics. It's there, the study has been done,  
2 it's not going to get any better. It's really not  
3 going to get any better.

4 With respect to the red cells, I think  
5 that there is remarkable data on the in-hospital  
6 experience. This is the standard of care when you  
7 get to our hospital. What we're doing is moving  
8 that standard of care forward a little bit. And  
9 there is no argument in the military, if you look  
10 at the CPG right now for theater trauma care it  
11 says packed red cells and plasma one-to-one.  
12 That's all we're saying.

13 DR. ANDERSON: Yeah, I guess to just  
14 come back from that -- George Anderson again --  
15 I'm compelled to say we may get wrapped around the  
16 axle a little bit on trying to approve all this.  
17 I would like to see something like a Defense  
18 Health Board statement that says we fully accept  
19 this report and would encourage steps aimed at  
20 assuring that these standards are met as soon as  
21 possible. You understand what I'm trying to say  
22 here is, I think there is some pretty severe

1 resource implications here that deserve some more  
2 study.

3 DR. DICKEY: Let me give you an option  
4 here because you're currently on item number 4 of  
5 12, and we know several of these are going to have  
6 the same sort of implications.

7 We have another meeting on the books for  
8 not quite eight weeks from now, not quite two  
9 months from now. It may be exactly eight weeks.  
10 So, one of the things we could ask is if you want  
11 to go through and see if there are select ones of  
12 these that you're very comfortable with and want  
13 to vote today versus select ones of these you'd  
14 like to ask Dr. Butler to go back and say can you  
15 massage the language a bit to come back with the  
16 goal being what you have said here, but some  
17 interim that allows us to appear to be responsible  
18 in our recommendations. And it would -- I mean,  
19 by mid-August you will have a second crack at  
20 this. So that would be one way to address that,  
21 George.

22 You're -- oh, good. And TC3 has another

1 meeting before our August meeting, really. Bless  
2 your hearts. And they have one with our August  
3 meeting? No, it's with our November meeting.  
4 Okay, I was going to say. Man, you are a meeting  
5 group.

6 DR. BUTLER: And we don't want to be  
7 time hogs, but we have four recommendations for  
8 you potentially to vote on coming up from our next  
9 meeting, so this would be in addition to those.

10 DR. DICKEY: We understand, but we also  
11 understand that we want our recommendations to  
12 carry weight. If we go forward irresponsibly and  
13 there's no way that they can honestly be carried  
14 out, then that invites people to sift through what  
15 we do and decide they'll pick this one and not  
16 that one.

17 On the other hand, if we've got a day  
18 and a half here, we can continue to craft the  
19 language if you want to try to get that done here  
20 today. So, ladies and gentlemen, it's your Board.  
21 Do you want to send this back and ask that they  
22 take Recommendations 4 and some of the others and

1 try to come back to us with goals and interim  
2 steps? Do you want to continue to try to craft  
3 language here? What are your wishes?

4 DR. BULLOCK: Well, I just want to, you  
5 know, endorse your view. I think we have to be  
6 careful. We have to keep our powder dry. We have  
7 to not get down into the nitty-gritty detail that  
8 might embarrass logisticians, you know, when it  
9 comes to providing this level of expertise on each  
10 and every MEDEVAC, CASEVAC mission. So I mean, I  
11 think the broad principles we absolutely agree  
12 with that, but we have to get the wording better,  
13 in my view.

14 DR. DICKEY: Okay. I'm interpreting  
15 both George and Dr. Bullock as saying the same  
16 thing. If I don't hear any objection, I will take  
17 that as a recommendation to Dr. Butler to take  
18 back the actions -- the recommendations we don't  
19 take action on.

20 Let me ask the question differently  
21 then. Are there any of the remaining  
22 recommendations that you are comfortable that you

1 would like to pull out and take action on today, 4  
2 through 12?

3 Question, Frank, while people are  
4 looking through. Number 7, standard protocols for  
5 TACEVAC care, do those currently exist and the  
6 issue is recommending that all Services embrace  
7 those? Or are those things that need yet to be  
8 developed?

9 DR. BUTLER: Right. In the sense that  
10 the Board has looked at the TC3 recommendations  
11 and endorsed those in prior meetings, they're out  
12 there. They're just not being followed.

13 DR. DICKEY: And number 9, the TCCC card  
14 and the NATO card and the Joint Trauma Registry  
15 all currently exist. Again, they simply are hit  
16 or miss in terms of who follows them, correct?

17 DR. BUTLER: Correct. And the lack of a  
18 central strong statement has led to some things.  
19 I will use as an example, last week I got a phone  
20 call from a lady from the Air Force Surgeon  
21 General's office saying, I want to use the TC3  
22 card, but it's an Army form and the Army says I

1       can't use it for my Air Force people because it's  
2       an Army form. So I said, huh, how about we do  
3       this? So I took the original card that the  
4       Rangers had sent me and I said, okay, this has no  
5       Army form stamp on it. This is the Rangers, can  
6       you use this? Yes, thank you very much.

7                 So, we did that. But, again, it is hard  
8       to change the military culture on all levels.  
9       And, you know, to the extent that this group makes  
10      a strong statement, we have a chance at doing it.  
11      And don't kid yourselves, because we tell the  
12      military they've got to do this, it's still not  
13      going to get done unless somebody drives the point  
14      home, unless we have Line Commanders that execute  
15      it.

16                DR. DICKEY: George?

17                DR. ANDERSON: Well, as I look through  
18      those, that one would be one that would be very  
19      easy to approve, number 9. It would approve  
20      documentation of the TACEVAC card. And certainly  
21      that's something we would like to do in the  
22      context of gathering the data and forwarding the

1 studies.

2 But, again, the implications of that, it  
3 goes back through the Commanders and the  
4 operational organizations. I just wonder how we  
5 can be most effective in helping you achieve what  
6 you want to achieve with that, Frank. So, you  
7 know, I mean, I'd be very quick to approve number  
8 9. But then I don't understand exactly how that's  
9 going to be operationalized and how the Defense  
10 Health Board itself enters into that.

11 DR. DICKEY: Dr. Butler?

12 DR. BUTLER: You know, I think, sir,  
13 your comment leads us back to the issue of who  
14 owns level 1 trauma care. And the Line Commanders  
15 will tell you, they own level 1 trauma care. So,  
16 if you want to change ALTA, you can talk to the  
17 Service Surgeons General.

18 If you want to get a pre-hospital  
19 unit-based trauma registry, you have to be talking  
20 to the heads of the Services. And, you know, we  
21 have actually worked through this process with the  
22 Army. The other Services, not yet, to my

1 knowledge.

2 DR. GANDY: You know, just looking  
3 through all this together, if you just look at all  
4 the recommendations, you know, it all comes back  
5 to the first recommendation, which is we need to  
6 develop an advanced TACEVAC care capability. In  
7 other words, an EMTB standard is not good enough  
8 for our guys when they've got polytrauma. We need  
9 guys out there that can take care of people better  
10 than that.

11 And if you look at everything else,  
12 under it, it's basically guys who've already  
13 thought about this, how to fix it and how to  
14 develop a system. So what they're doing is saying  
15 we need this and this is the blueprint, you know,  
16 of things that need to change to make that system  
17 work. So you can't just have highly skilled  
18 providers without the training and the oversight  
19 and the equipment and the tools to do it with, you  
20 know.

21 So I guess, you know, a lot of these  
22 recommendations come because Dr. Mabry's already

1 thought about this a lot of hours. And he already  
2 has a plan to get enough paramedic-trained guys in  
3 the next five years and the funding and how it's  
4 going to work and where they're going to go and  
5 who is going to do the oversight, et cetera. So a  
6 lot of these come because they've already thought  
7 about it. But the real recommendation is to, you  
8 know -- do we want to endorse an advanced TACEVAC  
9 capability because we know from that study that it  
10 saves lives?

11 DR. BUTLER: To echo what John's saying,  
12 the Joint Theater Trauma System sent Bob Mabry  
13 into theater to look at the tactical evacuation  
14 care issue. So he was their designated person to  
15 go in and fix this. He came back and spoke to not  
16 just the Joint Theater Trauma System, but to the  
17 TC3 group, which includes the trauma consultants  
18 for all three Surgeons General. And these  
19 recommendations passed unanimously through all the  
20 trauma consultants.

21 So, I don't know how much better the  
22 look is going to get. I would say that the



1       qualifier that states, you know, that these  
2       standards are in evolution, they're not fixed, and  
3       that we're continuing to look for best evidence as  
4       we move forward, and there can be changes in the  
5       future. But I think what Frank has presented  
6       certainly is a very good point of departure. If  
7       we qualify it then, then I think it meets some of  
8       the concerns that my colleagues have expressed  
9       already.

10               DR. DICKEY: I don't want to put words  
11       in your mouth --

12               DR. CARMONA: Please.

13               DR. DICKEY: -- but are you recommending  
14       then that we approve all of the existing  
15       recommendations with a qualifying statement that  
16       this is a work in progress and the goal is X and  
17       that the following appear to be current best  
18       practices, which will be under continuous  
19       evaluation?

20               DR. CARMONA: Yes, that's true. And add  
21       in the logistical part as well so that nobody  
22       feels something is being imposed on them acutely

1 to ramp up, you know, a bunch of 18 Deltas and new  
2 medics at any level or nurses or docs. And  
3 because as Frank has pointed out, I think this has  
4 been fairly well vetted by the Service Chiefs,  
5 Surgeon Generals, and so on.

6 So I think that the platform is a good  
7 one, but I think what we're doing is footnoting  
8 this and giving a little more granularity to our  
9 thought process. So that when somebody looks at  
10 it in six months or a year, they see that we've  
11 done our due diligence and that we recognize that  
12 some challenges still remain, but we want to move  
13 forward.

14 DR. DICKEY: And I will simply add a  
15 comment to that and say there are some of these  
16 things that I personally do want to see mandated.  
17 I've been on the Board, this is now the beginning  
18 of my third year. We've been talking about  
19 documentation since my very first meeting.  
20 There's good data from some of the branches, but  
21 not all. And so, at some point it's time to say  
22 get with the program. Okay? It should no longer

1 be optional. So, I'm not sure we get that flavor  
2 in there.

3 General Myers?

4 GEN MYERS: I have a question as --  
5 maybe it's for Dr. Butler. But are we actually  
6 mandating something or are we just recommending  
7 something?

8 DR. DICKEY: Recommending.

9 GEN MYERS: If we're recommending, then  
10 I'm not so worried about how the logisticians feel  
11 about it. I don't think it -- in my view, that's  
12 irrelevant. We're the Defense Health Board. We  
13 make recommendations. How it's implemented is the  
14 Services' problem. Let them deal with it.

15 DR. DICKEY: Okay.

16 GEN MYERS: I mean, we give them our  
17 best judgment and we -- and then we leave.

18 DR. DICKEY: Dr. O'Leary.

19 DR. O'LEARY: I am certainly happy with  
20 Mr. Carmona's[sic] suggestion, but if we are still  
21 debating in some fashion the who question out of  
22 these recommendations, then that's 4, 6, 8, and

1       10. And everything else, I think, seems to be  
2       perfectly all right with everybody.

3                So I think we should either move them  
4       all or move them all with the exception of those  
5       four.

6                DR. DICKEY: Four, 6, 8, and 10, take  
7       your pick. I'm looking for a definitive motion.

8                GEN MYERS: I move to adopt them all.

9                DR. DICKEY: All right, you have a  
10       motion --

11               SPEAKER: Second that.

12               DR. DICKEY: You have a motion and a  
13       second to adopt the 12 recommendations --  
14       actually, 4 through 12 because you've already  
15       taken action on the first 3 as recommendations to  
16       move forward. Is there further discussion? It's  
17       amazing if you have people who get hungry enough,  
18       what they'll do. (Laughter)

19                Okay. It was actually a lunch that was  
20       timed very specifically, and so it's going to be a  
21       little over-dried -- no. Motion and second  
22       before you to adopt recommendations 4 through 12.

1 Is there further discussion? If not, all in favor  
2 say aye.

3 GROUP: Aye.

4 DR. DICKEY: Opposed, no? And we'll  
5 even take a shot at some language that lets them  
6 know we understand that these are goals to get to,  
7 not to do tomorrow. Recommendations, absolutely.  
8 Except if they keep ignoring us, we're going to  
9 come out with stronger language, right?  
10 We have one more --

11 DR. JOHANNIGMAN: They do so at their  
12 own peril.

13 DR. DICKEY: All right. On page -- oh,  
14 okay. Now the last recommendation from TCCC is on  
15 the freeze-dried plasma. It's on page 8 of the  
16 written material -- position paper and it's just  
17 before the references.

18 This recommendation is that we should --  
19 Department of Defense should take all necessary  
20 steps to expedite the fielding of dried plasma to  
21 Ground Medic Corpsman, Pararescuemen, and Air  
22 Medical Evacuation Platforms with a number of

1       bullets setting forth how that might be done.

2                   DR. CARMONA:   So moved.

3                   DR. DICKEY:   It's moved by Dr. Carmona,  
4       who has got his mic -- no, he doesn't.   Seconded  
5       by Dr. O'Leary.   Is there further discussion?

6                   All in favor, please say, aye.

7                   GROUP:   Aye.

8                   DR. DICKEY:   Opposed, no?   All right,  
9       take a deep breath.   You have got a huge amount of  
10      work done this morning.   Dr. Butler, thank you.  
11      You covered an immense amount of material and  
12      educated a few of us.

13                   Now, we are going to break for a working  
14      lunch in Studio E.   The lunch includes Board  
15      Members, Federal Agency Liaisons, Service  
16      Liaisons, and DHB Staff.   For all of the others,  
17      recommendations were made for where you could  
18      check availability in the area.   The Board will  
19      reconvene at 2:45?   It's now 1:45.

20                   MS. BADER:   I think 2:10.   Can everyone  
21      make it for a half of an hour lunch?

22                   DR. DICKEY:   2:10?

1                   MS. BADER:  Is that okay?  So we can  
2 start to catch up?

3                   DR. DICKEY:  We'll make it easy on you,  
4 2:15 will give you 35 minutes.  2:15, and we'll  
5 try to talk faster.

6                                 (Whereupon, at 1:36 p.m., a  
7 luncheon recess was 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 (2:20 p.m.)

3 DR. DICKEY: Welcome back, those of us  
4 who made it back anyway, right? Our next  
5 presentation of the day will be from Mr. Sloan  
6 Gibson. Mr. Gibson. Here he comes. We've kept  
7 him waiting a while.

8 Mr. Gibson currently serves as the  
9 United Service Organization, USO's, 22nd  
10 President. He was selected by the U.S. Board of  
11 Governors in September of 2008. Prior to joining  
12 the USO, Mr. Gibson spent more than 20 years in  
13 the banking sector in Charlotte, North Carolina;  
14 Atlanta, Georgia; Nashville, Tennessee; and  
15 Birmingham, Alabama. That means you should talk  
16 nice and slow so we can understand you.

17 (Laughter)

18 Mr. Gibson is also a 1975 graduate of  
19 the United States Military Academy at West Point,  
20 and his slides are under Tab 7 of your meeting  
21 binders. Welcome, Mr. Gibson. And it says here,  
22 without further delay. I think we've probably

1 already imposed enough delay on you. So, we  
2 appreciate you being here and being patient with  
3 us.

4 MR. GIBSON: Well, thank you very much.  
5 Everybody hear me all right? Maybe other reasons  
6 to talk real slow from me today, I find this a  
7 little intimidating to be on the program with  
8 speakers talking about topics I can't even  
9 pronounce much less do I know what they are. So,  
10 a little different experience for me, a little  
11 different audience than normal.

12 Our mission at the USO is to lift the  
13 spirits of America's troops and families. We do  
14 that around the world every single day, everywhere  
15 we serve troops. But we ask ourselves a simple  
16 question, who needs us most? And we recognize  
17 that the answer to that question is different  
18 today than it would have been, say, a decade ago.

19 So, on our short list of who needs us  
20 most: Our troops that are foreign deployed  
21 serving in harm's way; their families back home  
22 that are going through this, all the stresses

1 associated with repeated deployments. They're on  
2 that short list. And, of course, our Wounded  
3 Warriors and their families and our families of  
4 the fallen.

5           USO is with our Wounded Warriors and  
6 families, really, almost from the moment they  
7 arrive in the hospital in Afghanistan. They're in  
8 Bagram or Kandahar or Balad. Have been, although  
9 we won't be there much longer. We're at Landstuhl  
10 with a major presence, where we're welcoming these  
11 Wounded Warriors and their families. We visit  
12 them at their bedside, help them if they're  
13 outpatients. And then when they arrive back home  
14 for further treatment and further rehabilitation,  
15 we're there at the majority of the military  
16 hospitals around the country, as well as here in  
17 the National Capitol Region.

18           So, you think about the USO and it's  
19 changing. It's changing to meet some very  
20 different and very urgent needs that our Wounded  
21 Warriors and our troops and their families face  
22 today. It's clear that our Wounded Warriors and

1       their families have some of the most pressing  
2       needs, not just for the outstanding health care  
3       and rehabilitation services that they receive from  
4       the military's medical facilities. But they also  
5       need help and support getting ready for what comes  
6       next.

7                   Our outreach to Wounded Warriors and  
8       families led us to take a look at the broader  
9       process of healing, which includes efforts to help  
10      keep families strong, to help these men and women  
11      get their heads back into life, to help these  
12      troops test their new physical bounds that they  
13      have and personal capability. We've seen some of  
14      that at the second of the most -- the two Warrior  
15      Games we've helped sponsor with the U.S. Olympic  
16      Committee out in Colorado Springs. Some amazing  
17      scenes there where men and women are accomplishing  
18      physical feats you never would have dreamed, that  
19      they never would have dreamed they could have  
20      accomplished. Helping them with their next steps  
21      to find and sustain hope and maintain resilience  
22      what, for many of them, is a very long and arduous

1 recovery, helping them to make plans and helping  
2 them build support network for the future. We are  
3 well-positioned, as are our partners, to help  
4 build some of these early steps in the  
5 readjustment process that they will face as they  
6 return back home.

7           To be clear, we are not clinicians. We  
8 are not behavior health counselors. We're not  
9 family counselors. We're not job placement  
10 specialists. But we are and can be conveners  
11 building partnerships that help provide the kind  
12 of support that our Wounded Warriors and their  
13 families need outside of hospitals and  
14 rehabilitation facilities.

15           That's very much in our DNA. If you  
16 think back years ago when President Roosevelt  
17 created the USO, it was all about bringing  
18 together the disparate efforts of six different  
19 nonprofit organizations. Over the course of our  
20 history, we've continued to build new partnerships  
21 as the needs of troops and families change.

22           Our original bylaws mandate that we

1 provide "specialized types of related work which  
2 may be needed to adequately meet the particular  
3 needs of the Members of the Armed Forces." Not  
4 exactly eloquent prose, but it makes it pretty  
5 clear that the idea is to bring together different  
6 organizations to help meet the needs of our troops  
7 and families.

8           We reach out and try to build  
9 partnerships with best in class organizations to  
10 meet very specific needs. Examples: We will work  
11 this summer with the National Military Family  
12 Association to deliver family retreats for Wounded  
13 Warrior families. We've been partnering for quite  
14 some time with Sesame Workshop on programs that  
15 are geared specifically to families with young  
16 children, families where parents are typically  
17 deploying often. We've sent Sesame Street  
18 characters around the world to help very young  
19 children learn that it's okay to miss mom or dad  
20 when they're away. We do other things with Sesame  
21 Workshop helping kids cope with changes in their  
22 parents when they come home from a deployment or,

1 in the worst case, when parents don't come home at  
2 all; helping to teach these children, give these  
3 children coping skills, and to help build  
4 resilience and encourage even the youngest of our  
5 dependents to talk about how they feel.

6 We have a great partnership with United  
7 Through Reading. Service member walks into a USO  
8 center somewhere, selects an age-appropriate  
9 children's book, we video record them reading that  
10 book to their children back home. And then we get  
11 the cards and letters and e-mails from the  
12 families talking about how the kids have watched  
13 that video 10 times a day every single day for 3  
14 months -- excuse me, for 3 months. It becomes  
15 such a powerful connection to their deployed loved  
16 one. We did 70,000 of those and we're up to about  
17 200,000 since we started the program. Powerful  
18 way to keep families connected.

19 We work with the Wounded Warrior Project  
20 at Landstuhl. And a very robust partnership here  
21 in the states, two very important partners of ours  
22 -- new partners -- Hire Heroes U.S.A. and the U.S.

1 Chamber of Commerce. And in the future we'll be  
2 working with the American Management Association  
3 and Georgetown University. All of those entities  
4 helping us prepare Wounded Warriors, helping them  
5 build the skills that they're going to need in the  
6 civilian workplace and making the connections for  
7 future employment. And I'll talk about that some  
8 more in just a moment.

9 We're not the only group that's out  
10 there trying to offer some of this assistance, but  
11 I would tell you that at least I think that we're  
12 probably taking it several steps beyond what you  
13 oftentimes find. There's a pretty intensive focus  
14 on outcomes and what we do. We're not necessarily  
15 interested in activity. We're not necessarily  
16 interested in inputs or throughput. We're  
17 interested in outcomes.

18 This year we'll work with Hire Heroes  
19 U.S.A. on about a dozen transition workshops that  
20 we'll conduct around the country for Wounded  
21 Warriors and family members, helping them get  
22 ready: resume writing skills, interviewing

1 skills, some of the things that they need to know  
2 as they prepare to enter the civilian workplace,  
3 how to translate their experience into experience  
4 that's relevant to potential civilian employees.  
5 All these programs are taught by Wounded Warriors  
6 that can relate very, very closely with these  
7 participants.

8           We augment the workshop, we come in  
9 behind the workshop with what we call a Career  
10 Opportunity Day we partner with the U.S. Chamber  
11 of Commerce on. Tom Donahue and I visited now  
12 almost a year ago and agreed that we would partner  
13 up to place as many Wounded Warriors or spouses as  
14 we possibly could. And not just in good jobs, but  
15 in careers. And so we've now done our first few  
16 Career Opportunity Days. It's not -- again, not  
17 the idea just to help them find work, but to help  
18 them find a career. We did our most recent Career  
19 Opportunity Day here at Fort Belvoir just last  
20 week. We had 42 wounded or injured troops that  
21 attended. One-fourth of those left that day with  
22 a job offer in their hand. We try to tailor the

1 types of companies that are participating in the  
2 job -- this is not held in a cavernous convention  
3 center with hundreds of people, everyone wearing  
4 their new Joseph Banks suit. It's a much more  
5 intimate kind of affair. The employers that  
6 participate are required to bring specific  
7 opportunities, specific jobs that they're actually  
8 hiring for. This isn't about, you know, just  
9 having casual conversations. And you know, so far  
10 we're seeing 25 to 35 percent of the participants  
11 are walking out the door with a job offer in their  
12 hand.

13 The many -- about a third of the 42 that  
14 participation at Fort Belvoir this past week came  
15 from the Wounded Warrior Regimen at Quantico. We  
16 had 21 employers represented in the group, many of  
17 those recruited by the Chamber. A handful of  
18 those are USO corporate partners that we've  
19 enlisted to participate as well.

20 Our next Career Opportunity Day will be  
21 out at Fort Carson, Colorado, working with the  
22 Warrior Transition Unit out there. I tell you,

1 the first Career Opportunity Day we had there, we  
2 had 40 participants. A third received job offers  
3 on the spot, and 10 of the 40 accepted their offer  
4 on the spot. So 25 percent of the participants  
5 walked out the door having accepted a job.

6 We'll do another half a dozen of these  
7 Career Opportunity Days complementing the  
8 transition workshops between now and the end of  
9 the year. And we'll continue to survey  
10 participants, both coming right out of the  
11 workshop, right out of the Career Opportunity  
12 Days, but then 6 months later, 12 months later,  
13 because, again, what we're focused on here are  
14 outcomes. It's not seeing how many people we can  
15 run through a classroom. It's how many can we  
16 place in jobs that they stay in and that become  
17 careers for them?

18 We ask a lot of our partners, including  
19 measuring outputs, because we really think that  
20 that's what matters. Our mission is to lift  
21 spirits, and if we're going to accomplish that we  
22 better be measuring what we're doing to make sure

1       that we're accomplishing it. Then we can use that  
2       as feedback to fix or discard programs that don't  
3       work. We've -- you know, one of the essential  
4       ingredients in all of this, we've learned, is  
5       mentoring. And we've been through one or two  
6       mentoring partners thus far and we haven't found  
7       the right partner yet. So we're looking for the  
8       right organization to work with us on training  
9       mentors so that we can assign mentors for these  
10      men and women and family members as well.

11                As we looked at all the needs of Wounded  
12      Warriors and their families and the magnitude of  
13      those needs, we recognized that it was pretty much  
14      above and beyond the scope of the USO's normal  
15      resourcing capabilities. And so we watched a  
16      campaign that we call Operation Enduring Care.  
17      The goal there is to raise \$100 million over a  
18      5-year period; \$25 million to build 2 centers. In  
19      fact, we're going to break ground -- it was a  
20      treat for me to see Admiral John Mateszun.

21                It was just over two years ago that I  
22      went and paid the first visit on Admiral Mateszun

1 with this idea. I had been to visit BAMC and been  
2 inspired by what I'd seen there, and realized what  
3 we were doing here in the National Capitol Region.  
4 And thought if somebody's already committed to  
5 doing something like that, like we have at the  
6 Warrior and Family Support Center at BAMC, if  
7 they're already committed to do that, you're  
8 great. We'll work with them and help. If not, we  
9 should raise our hand. And with a lot of support  
10 from my Board, and including my Board Chair down  
11 here at the end of the table, we have committed  
12 that and we'll actually break ground on the 27th  
13 of June down at Fort Belvoir on the first of the  
14 two locations. The second location will be at the  
15 Naval Medical Center in Bethesda, and really  
16 special. And I think some of you have picked up  
17 the magazine on the way in, or you've got in front  
18 of you, which has got a feature article on these  
19 two centers that we're going to build. So you can  
20 learn a little bit more about those.

21                   These will be the largest USO centers  
22 anywhere in the world: 25,000 square feet in

1 round numbers, guided very much by evidence-based  
2 design principles, much like the hospital next  
3 door. The idea is to allow Wounded Warriors and  
4 their families to be together outside the hospital  
5 as a family, a place of respite, a place of  
6 recovery, a place for reintegration.

7           Before building the centers we went out  
8 and actually surveyed Wounded Warriors and family  
9 members. We surveyed medical professionals and  
10 staff and caregivers to make sure we knew what  
11 needed to be designed into these centers. Some of  
12 the things that we heard: They had to relate back  
13 to daily life. These men and women are anxious  
14 for some little touch of normalcy. There needed  
15 to be a social center, a social outlet, because  
16 that's so much an important part of their complete  
17 healing process.

18           Concerns that many of these troops had  
19 with their families, you think about taking care  
20 of the Wounded Warriors, their first thought is  
21 taking care of their family members, so being able  
22 to take care of the families that are there. The

1 average amputee, as all of you know, spends about  
2 18 months at Walter Reed. You know, that's a long  
3 time. I tell people, audiences, when I'm talking  
4 about this, think about the last time you had a  
5 family member that spent three days in the  
6 hospital. How emotionally and physically taxing  
7 was that? Now imagine 18 months. That's a real  
8 challenge, and we want to make sure that we're  
9 focused on taking care of those family members.

10           So we want the centers to provide some  
11 sense of normalcy. Free access to the Internet  
12 without some of the restrictions that DoD provides  
13 on Internet access, Facebook and all that kind of  
14 stuff, which is what these kids want to do.  
15 Continuing education, a top priority. In fact, it  
16 was number one. A place to take some college  
17 courses and other personal development classes. A  
18 place to deal with the administration associated  
19 either with their condition and their recovery and  
20 their either return to their units or transition  
21 to a military -- to the civilian community or the  
22 administration associated with just life that

1 continues to go on even though they're there.

2 Access to seminars to transition for --  
3 to prepare them for their post-military life. A  
4 welcoming place after hours, because one of the  
5 things that we heard is the nighttime is  
6 oftentimes a very difficult time for these men and  
7 women. We even got input on lighting and color  
8 schemes and things like that, so, to make sure  
9 that these were the kind of relaxing places.

10 We fed all that to our architects to  
11 make sure that we've designed the kind of warm and  
12 inviting places that can be the very special place  
13 for their recovery, a place where families can be  
14 together as families, where children can play,  
15 meditation gardens, and where they can prepare for  
16 what's next in life.

17 Behind these two centers, we're reaching  
18 out to families. I mentioned caregivers just a  
19 second ago. Usually mom or dad, brother or  
20 sister, husband or wife. We did our first  
21 Caregivers Conference down at Fort Bliss, Texas,  
22 last year. Our next caregivers -- we had more

1       than 200 caregivers there from around the country.  
2       Our next Caregivers Conference will be at Fort  
3       Bragg, North Carolina. We're expecting about 500  
4       participants in that conference from both Fort  
5       Bragg and from Camp Lejeune nearby, drawing on  
6       experts from across the country and creating the  
7       opportunity for caregivers to share their own  
8       experiences and working to help keep that family  
9       strong so that they can be there for their loved  
10      one.

11                 Along with work like this and Caregivers  
12      Conferences, work with the National Military  
13      Family Association, there are a number of other  
14      programs that we deliver that are designed to help  
15      really restore and sustain the enthusiasm for  
16      life. To provide a break from daily routine, to  
17      build that resilience that they're going to need  
18      for the recovery. A number of these are  
19      physically arduous. We've partnered for three  
20      years now with Ride to Recovery, a great  
21      organization, 300- to 400-mile bike rides for  
22      Wounded Warriors. We've had quadruple amputees

1 out on these rides before.

2 I've been out on day one of six-day  
3 rides, and I would tell you that it really kicked  
4 my butt. These aren't easy. This is hard stuff.  
5 And people hear about things like Ride to Recovery  
6 and they think, well, that's great physical  
7 rehabilitation. But I'm here to tell you, the  
8 best place where it works is up here. Because  
9 these men and women complete one of these rides  
10 and they realize, if I can do this I can do  
11 anything. Now that's a powerful lesson for a  
12 young Wounded Warrior to carry with them for the  
13 rest of their lives.

14 Rehabbing With the Troops, another  
15 program where we connect by Internet through with  
16 Wii™ gaming, and we'll get professional sports  
17 stars to engage in different Wii™ physical athletic  
18 -- physical activity games with Wounded Warriors  
19 to encourage them to be active and involved. And  
20 they've got programs where they keep track of  
21 their hours and their scores and all of those  
22 kinds of things as an encouragement to be more

1 physically active. Team River Runner, a new  
2 partnership to get guys and gals out on the  
3 whitewater. Warrior Games, I mentioned earlier,  
4 220 Wounded Warriors from all branches of the  
5 Service from all over the country, you're familiar  
6 with that. That we've partnered with the U.S.  
7 Olympic Committee and the Department of Defense,  
8 really, since inception.

9           There are some other programs -- even  
10 though all of these, I think, have a lot of  
11 emotional wellness component to them, others that  
12 target it really more directly. Operation Proper  
13 Exit, another partnership of ours, where we send  
14 dramatically injured Wounded Warriors back to Iraq  
15 to the -- as close as possible to the scene of  
16 their injury to get emotional closure around that  
17 traumatic experience. And we've all read about  
18 men and women going back to Vietnam 30 years  
19 later. Well, we're sending Iraq war veterans back  
20 18 months later. And they are life-changing  
21 experiences for them.

22           We work very closely with our great

1 friend Gary Sinise, Lieutenant Dan Band, and our  
2 friends at TriWest Healthcare in the Marine Corps.  
3 We've got Gary doing concerts all over the  
4 country, where we've been able to fold in a  
5 message about emotional wellness and mental health  
6 and getting some help if you need it.

7 We also work with TriWest, have trained  
8 many of our staff and volunteers in our centers to  
9 recognize the signs that a Service member or  
10 family member may not be coping well with stress  
11 and how to have a non-threatening conversation  
12 with that Service member about getting some help  
13 and having a resource to be able to put in their  
14 hand and say, there's somebody at this number  
15 right now to talk with you.

16 We've also been there for families of  
17 the fallen. We've supported -- many of you  
18 probably know the USO has two centers at Dover Air  
19 Force Base. We supported every dignified transfer  
20 since before 9-11, no matter what time of day or  
21 night. We have recently expanded our support  
22 there at Dover as many more families come to

1       observe the final return of their loved ones.  
2       We're working with Fisher House Organization and  
3       with the command there to provide more support to  
4       families.

5                   Also providing some support during the  
6       journey. You know, you stop and think about it.  
7       Well, the USO happens to be located at the vast  
8       majority of the airports that these people are  
9       flying out of or through. The first one of those  
10      happened as I was standing out on the tarmac with  
11      a family one evening. And I handed my business  
12      card to the Army Sergeant that was the Casualty  
13      Assistance Officer, and I told him, I said, if you  
14      -- this family needs any help, you let me know.  
15      And I had driven back home during the middle of  
16      the night, and the next morning about 6:30 I got  
17      out of the shower and my cell phone was ringing  
18      and it was that Sergeant. And he said, sir, I've  
19      got the family at the airport in Philadelphia. If  
20      I take them to the USO, can they go in? And I  
21      said, they'll be waiting for you. And that was  
22      the germ of the idea, and we've now put in place a

1 mechanism where we help as many families as we  
2 possibly can as they're making that journey. It's  
3 not a big thing. It's a little thing. But  
4 anything that we can do to help make that journey  
5 go a little bit better is plenty.

6 We work very closely with our good  
7 friends at TAPS. I know you all are familiar with  
8 that organization, Bonnie Carroll, great friend.  
9 We partner with them on Good Grief Camps. This  
10 summer, we've got a new venture that we've  
11 actually pulled TAPS into. The Warrior Foundation  
12 approached us last year. They've been doing camps  
13 for children -- primarily inner city children that  
14 have lost a parent -- for quite some time.  
15 They're called Camp Aaron. And they approached us  
16 and said, we'd really like to do some Camp Aarons  
17 just for military kids. And so we asked TAPS to  
18 come in because of their deep specialty in the  
19 military space, and the three of us are partnering  
20 together to do four Camp Aarons this summer: Fort  
21 Campbell, Fort Hood, Joint Base Lewis-McChord, and  
22 Camp Lejeune. So, helping our families of the

1       fallen as well.

2                       These Wounded Warriors and their  
3 families and the families of the fallen, they need  
4 us right now. They'll continue to need the  
5 support of the American people for many years to  
6 come. I was visiting just yesterday with the head  
7 of a foundation. And she was expressing her  
8 concern about the sustainability of her work,  
9 because she knows -- she's primarily focused --  
10 her foundation is primarily focused in the  
11 physical healing and emotional wellness space for  
12 troops. And she understands how long this tale is  
13 going to be that we have to deal with as a  
14 society. This is going to be a challenge for us  
15 for a long time. It's a concern for us in terms  
16 of sustaining that mission and it's a concern for  
17 others.

18                      Just before Memorial Day, Admiral Mullen  
19 was urging the nation to remember the service and  
20 sacrifice of the 1 to 2 percent of the population  
21 that have served our country here these last 10  
22 years. This is very much a logical extension of

1       our mission, helping to build this community of  
2       care. But it's going to require the attention of  
3       good people all over the country to ensure that  
4       our troops and their families are given the chance  
5       to succeed in life.

6                   I know from my own experience, these men  
7       and women don't want the world. They just want a  
8       little bit of what you and I have the opportunity  
9       to enjoy. And they deserve every bit of it and  
10      much more.

11                  So, even though we delivered some 700  
12      performances and events last year with  
13      celebrities, we're not just about entertainment.  
14      Even though we hosted at our roughly 160 USO  
15      centers around the world some 8 million visits by  
16      troops and family members, we're more than just  
17      the local USO center down the street or in the  
18      local airport. Much more to today's USO.

19                  Proud of the staff and volunteers that  
20      make it possible for us to do all the things we  
21      do, and the donors that make it possible. Almost  
22      2 million individual donors to the USO, and dozens

1 and dozens of corporations that help us. Our  
2 mission is to lift the spirits of America's troops  
3 and families. Our goal is to meet the most  
4 important and urgent needs of those men and women  
5 and family members that need us the most.

6 Let me thank you for giving me this  
7 opportunity. I really do appreciate the chance to  
8 be here. Thank General Myers for helping make the  
9 opportunity possible, and for all the passion and  
10 wisdom that he brings to the USO organization.

11 And thank all of you individually for  
12 what you do, the service that you continue to  
13 provide to help take care of our troops and  
14 families. Thank you very much. I'd be glad to  
15 answer a question or two, if we've got time,  
16 ma'am.

17 DR. DICKEY: Thank you so much for the  
18 presentation, Mr. Gibson. Questions or comments  
19 from any of you regarding the presentation or  
20 about the USO in general?

21 I think as we plan our trips it might be  
22 useful to include one of the USO facilities he's

1       describing for us. Surely we'll either get back  
2       to BAMC or to the National Center again.

3               SPEAKER: Sure, fantastic.

4               MR. GIBSON: Thank you all very much.

5               DR. DICKEY: Thank you for what you do  
6       for us. Our next speaker is Vice Admiral John  
7       Mateczun.

8               He serves as the Commander of the Joint  
9       Task Force National Capital Region Medical Center,  
10      JTF CapMed. I've accused some others of having  
11      some long titles, but.

12              Previously, he's held the positions of  
13      Joint Staff Surgeon and the Medical Advisor to the  
14      Chairman of the Joint Chiefs of Staff, as well as  
15      U.S. Delegate to the NATO Committee of Chiefs of  
16      Medical Services. Present in the Pentagon on  
17      9-11-01, he subsequently served on the Joint Staff  
18      during Operations Noble Eagle, Enduring Freedom,  
19      and Iraqi Freedom.

20              Vice Admiral Mateczun's ensuing flag  
21      assignments were as Chief of Staff, Bureau of  
22      Medicine and Surgery; Commander of the Naval

1 Medical Center, San Diego; and Deputy Surgeon  
2 General of the Navy. He also served as Director  
3 of the Military Health System Office of  
4 Transformation, and is a member of the  
5 congressionally mandated Task Force on the Future  
6 of Military Health Care.

7 John Mateczun's awards include the Navy  
8 Distinguished Service Medal, Defense Superior  
9 Service Medal with Oak Leaf Cluster, Legion of  
10 Merit with three Gold Stars, Bronze Star, Defense  
11 Meritorious Service Medal, Meritorious Service  
12 Medal with Gold Star, Navy Marine Corps  
13 Commendation Medal, Army Commendation Medal, and  
14 Navy Marine Corps Achievement Medal.

15 John Mateczun will present an  
16 information brief regarding the integration of the  
17 health care services of the National Capitol  
18 Region. Admiral, we are honored to have you with  
19 us and look forward to your remarks.

20 VADM MATECZUN: Thank you, it's a real  
21 pleasure to be here. Sorry Mr. Gibson left, I  
22 wanted to give him a thanks. And I already have,

1 but just publicly for the great work that the USO  
2 has done.

3           And I'll tell you, it's not hard to give  
4 -- it's very hard to give something to the  
5 government, believe it or not. And we don't make  
6 it easy. He stuck with it and they're going to  
7 break ground on this beautiful USO that you see on  
8 the cover of that magazine there down at Fort  
9 Belvoir. And then soon they're going to break  
10 ground on the one out at Bethesda.

11           Right now, as you'll see, the Bethesda  
12 campus is saturated with construction. And so  
13 we've sort of had to hold off there, even though  
14 it'd be great to have it ready by the time that we  
15 opened up.

16           You know, I was trying to count up the  
17 number of times that I've been here over the last  
18 three years in this job. I lost count. But this  
19 will be, I believe, the last presentation that  
20 I'll give to you before the BRAC is over. And so,  
21 been focused on the BRAC now for three and a half  
22 years and certainly a lot has been accomplished,

1 but we'll be able to move on into the post-BRAC  
2 period here pretty soon.

3 I want to update you on what's going on  
4 in the NSCR, what's happening with the BRAC, talk  
5 a little bit about the comprehensive master plan  
6 and world-class that you've worked so much on, and  
7 then tell you a couple of other things that I know  
8 you'll be interested in, and answer any questions  
9 you might have.

10 Background. Gosh, just looking around I  
11 don't know how many of you have seen this how many  
12 times before. But BRAC -- you know, BRAC, five  
13 and a half years ago, you know, the BRAC law, six  
14 years is the deadline. And today we are 49 days  
15 away from actually starting to move out of Walter  
16 Reed -- start the moves out of Walter Reed. So,  
17 it's getting pretty close.

18 The Washington Post articles on Walter  
19 Reed in February, Dole-Shalala, the Independent  
20 Review Group, met -- had recommendations. And  
21 then the Joint Task Force was established in  
22 September.

1           A lot of decisions have been made.  
2       Walter Reed and Fort Belvoir will be joined  
3       hospitals, a civilian-manning model for both  
4       hospitals. And then a lot of emotion about Walter  
5       Reed. Walter Reed just had its 100th anniversary  
6       a few months back. And it has a very storied and  
7       extraordinary history, and there are certainly  
8       those that would like to keep it open, would have  
9       liked to have kept it open. Some of those were in  
10      Congress over on Capitol Hill. And so they  
11      proposed some language in the FY09 NDAA that  
12      basically said, hey, we're going to say, why don't  
13      you just stop for a while and then we'll take a  
14      look at it later on?

15           Well, BRAC is a package, and if you open  
16      up one piece of the BRAC package it all opens up.  
17      And so, god, I think there were 268 or something  
18      BRAC projects, an extraordinary number. And so  
19      the administration said, no, can't open up one  
20      piece of it. And there was a threat of a  
21      Presidential veto. And so, Congress came back and  
22      said, okay, you said it was going to be

1 world-class, prove it. And so they said there was  
2 going to be a congressionally mandated committee  
3 to take a look at that. The Defense Health Board  
4 hosted that committee as a subcommittee. They  
5 came back, reviewed everything, came back with  
6 their recommendations.

7           The Department reviewed those  
8 recommendations, endorsed what the Defense Health  
9 Board Subcommittee had said, sent it back over to  
10 Congress and Congress said, okay, codified into  
11 law, into statute, the meaning of a world-class  
12 medical facility. So when I say we're going on a  
13 journey to world-class, I'm required by law to get  
14 there. That's not just an inspirational journey,  
15 boy, we'd really like to be world-class. We  
16 actually have to meet the definition.

17           And so, last year we -- in '10, about a  
18 year ago, we submitted two reports to Congress --  
19 one in April, one in August -- saying this is how  
20 we're going to achieve that goal. And then in  
21 February, the President's budget included the  
22 funding to get to those projects, which I'll talk

1       about in a little bit.

2                       This is the BRAC kind of update. This  
3       is the largest infrastructure investment ever made  
4       in the military health system. Right now, \$2.4  
5       billion into these two facilities. On the bottom  
6       left there you'll see the Walter Reed National  
7       Military Medical Center, and it looks like a bunch  
8       of buildings. You had a patient that came in the  
9       other day and was looking at some of the  
10      statistics and said this many square feet, this  
11      many dollars. They said, oh, you know, that  
12      number of square feet, that's the Mall of the  
13      Americas. And so the footprint of that medical  
14      center is the Mall of the Americas. It's not just  
15      a hospital, it is a monster hospital and it's  
16      very, very big.

17                      And you know, it's grown so much,  
18      actually, that we're seeing patients at it now.  
19      All of these new buildings that are there. But  
20      you really have to think about emergencies and the  
21      hospital in a whole different way than you did  
22      before when you got the Mall of the Americas

1       instead of a Navy hospital that's there.

2                   Over on the right-hand side you see the  
3       Fort Belvoir Community Hospital.  It's got the  
4       footprint of the Springfield Mall, for those of  
5       you who know something about Northern Virginia.  
6       It's an aircraft carrier from a parking garage  
7       into the middle of the center tower, there, and  
8       another one going back out the other way.

9                   Both of them are built on golf courses,  
10       if that means anything to you.  So, if you want to  
11       invest in medical construction in the future, find  
12       a golf course today.  (Laughter)  It may be a good  
13       time to purchase.

14                   So, 1.52 million square feet of new  
15       construction on the Bethesda campus.  And a  
16       certain amount of renovation that goes on top of  
17       that.  Fort Belvoir, 1.47 square feet of new green  
18       field construction down there.

19                   So, going really, really well.  The  
20       outfitting --I can't tell you how many line items  
21       we got, how many pieces of equipment it takes to  
22       fill out a hospital.  So, I think we manage an

1 inventory of about 125-, 130,000 stock numbers  
2 now. It's pretty busy outfitting these places.

3 Good news is, we are on track to be able  
4 to consolidate the four hospitals here in the  
5 National Capitol Region into two and to move into  
6 them by the BRAC deadline, the 15th of September.

7 This gives you a picture of the  
8 saturation construction that's on the Bethesda  
9 campus. You'll see you're looking at Wisconsin  
10 Avenue, the iconic tower there in the middle, and  
11 new construction that's on the outside of that.

12 Those things that are in green are kind  
13 of on the front part of the campus, and were part  
14 of what we call RFP1. The blue back in the back,  
15 they are Warrior Transition and Administration  
16 buildings, and I'll talk about each one of these  
17 buildings. Over on the right, we see gates,  
18 Fisher Houses, and a new Intrepid Center. And so,  
19 we are sort of peaked out in terms of the number  
20 of construction workers on campus. They are busy  
21 finishing the insides of these buildings right  
22 now.

1                   That's the medical center, per se. You  
2 know, it's not just that we are building new  
3 buildings, we're actually fitting new capabilities  
4 into this building. We are reorganizing and  
5 taking best practice as we go, and we have a  
6 certain number of congressionally mandated Centers  
7 of Excellence that have to go in there. One of  
8 the biggest changes is that we are consolidating  
9 the Cancer Centers of Excellence from Walter Reed  
10 into a Comprehensive Cancer Center that will be  
11 the first Comprehensive Cancer Center within the  
12 Department of Defense.

13                   We're working with the National Cancer  
14 Institute, which is -- and if you take a look at  
15 that front left building, you know, it is  
16 literally across the street, across Wisconsin  
17 Avenue from that building. So, we have an  
18 extraordinary opportunity to partner with the  
19 National Institutes of Health. We also have a  
20 medical school on this campus, and so the future,  
21 I think, of academic medical center collaboration  
22 in terms of research and development is very, very

1 bright along this corridor.

2 Dr. Varmus, Dr. Harold Varmus, is over  
3 at the NCI now. Very interested in working with  
4 our patients, being able to -- we're very  
5 interested in being able to work with them, so  
6 that we have the latest protocols. In fact, in  
7 that tower all of the lung cancer protocols that  
8 are in use basically today across America were  
9 developed in collaboration between the National  
10 Naval Medical Center and the NCI. And so, this is  
11 a longstanding collaboration which we look forward  
12 to building on in the future.

13 This is that new outpatient building.  
14 It's the largest outpatient clinic building now in  
15 the military health system. It's extraordinarily  
16 large, and you can see some of the capabilities  
17 that are there. A lot of it, of course, is about  
18 the prosthetics rehabilitation and prosthetic  
19 mission that transfers over from Walter Reed.  
20 Bethesda doesn't do any of that today. We have at  
21 Walter Reed, the MATC, Military Advanced Training  
22 Center. This is MATC 2.0. Chuck Scoville who

1 runs that facility came over. We incorporated all  
2 the changes that he's learned in the last two  
3 years since they opened up that MATC. And so,  
4 it's an extraordinary facility.

5           You can see that prosthetics lab up in  
6 the upper left-hand corner. You don't see on the  
7 left-hand side, those are all benches where they  
8 can do adjustments. But there's actually a  
9 ceramics kiln, a whole area for manufacture that  
10 comes just off to the left of that. So, this is  
11 probably the leading prosthetics laboratory in the  
12 world right now once it opens up.

13           Right now, the MATC is still running  
14 over at Walter Reed. It will pick up its patients  
15 and everybody will come over to this new facility  
16 when we begin the moves.

17           So, an extraordinary new capability. It  
18 doesn't look like it's very tall. It's actually  
19 six stories tall, you know, coming up to the top.  
20 It's got a lot of environmental features. We were  
21 shooting for LEED Silver, and we achieved LEED  
22 Gold with a lot of work. So it's a very

1 environmentally-friendly building, you know, as we  
2 went.

3           There is no re-circulated air in this  
4 building. It is all fresh air circulating. That  
5 sky well, that skylight well that you see in the  
6 middle of the top of the building is where all of  
7 the fresh air comes in. The vents are down at the  
8 bottom, draws air in, heats it in a heating wheel,  
9 and supplies it to the whole building all the  
10 time. So, a very good building. That light well  
11 also brings in light, so no matter where you are  
12 in the building, coming out of a clinic, you can  
13 orient yourself by that light well. So, it's a --  
14 has a lot of evidence-based design features.  
15 Truly an extraordinary facility.

16           Across the way -- this is on the one  
17 that's on the right-hand side of the tower and  
18 this is attached to the inpatient side. It has 50  
19 intensive care unit beds, 3 new operating rooms,  
20 catheterization labs, trauma suites, and where the  
21 new emergency room is. This is -- huge  
22 capability.

1           One of the things we've learned is that  
2           you have to be able to adjust constantly to meet  
3           these schedules. As we were getting ready to move  
4           into the ICUs and open them up, we found that we  
5           were seeing an increasing number of patients with  
6           multiple amputations. And so, in the ICU rather  
7           than having wound V.A.C.s, you know, all over the  
8           floor we had three suction ports on the booms that  
9           are there in the ICU. You can see them kind of on  
10          the left-hand side of the critical care picture  
11          on the bottom left.

12                 We went back and put in five and six  
13          ports. So, manufacture was able to come and  
14          adjust that so that we would be able to meet that  
15          capability. And so, it is a constant adjustment  
16          as you go. You order something and by the time it  
17          gets there, you pretty much need to think about  
18          can I modify it or will it be ready to go?

19                 So some of the differences between Fort  
20          Belvoir and here. This is 50 ICU beds here,  
21          there's 10 ICU beds down at Fort Belvoir. Fort  
22          Belvoir truly is built as a community hospital and

1 not a medical center nor would we want to do that.  
2 If we want to run an integrated delivery system,  
3 there's no need to have medical centers within the  
4 same area -- a regional area of health care  
5 delivery. The renovations that are going on  
6 inside, part of what the Defense Health Board  
7 said, and is codified now in a statute, is that  
8 single patient rooms are world-class. In fact,  
9 every hospital of any significance in the region  
10 is moving to single-patient rooms, including Johns  
11 Hopkins. We get a lot of questions, you know,  
12 sometimes saying, well, isn't Johns Hopkins  
13 world-class? You know, can't -- hey, their  
14 facility isn't all that great, I've been in it.  
15 I've walked around there and I got great care.  
16 Well, hey, they're moving to single-patient rooms,  
17 I can tell you. They're in an extraordinary  
18 expansion mode in terms of their inpatient side.  
19 So, that's the standard now. And that's what we  
20 have to meet.

21                   And there are a number of rooms that  
22 we're renovating, you can see that on the upper

1 left. That's one of the single-patient rooms.  
2 These are also going to be configured with Smart  
3 Suite technology, so that these will be the first  
4 hospitals -- Fort Belvoir will have it completely  
5 incorporated and we'll phase it in on the Bethesda  
6 campus.

7           So, an integrated IM/IT structure in the  
8 room. If a patient walks into the room, an RFID  
9 nametag, you walk into their room, it will on  
10 their screen tell them who you are and what you  
11 do, which is a patient's right to know. Who are  
12 you and what are you doing in their room?

13           It will also be able to have a screen up  
14 at the head of the bed, no charts down at the  
15 bottom. So clinicians, everybody else coming in  
16 will actually walk to the head of the bed to  
17 discuss the records with the patients. They will  
18 have extraordinary amount of information  
19 available. The beds are smart beds. If they fall  
20 out of the bed, it's going to send a signal to  
21 somebody. There are lifts in many of these rooms  
22 now, not just to assist patients in ambulating

1       into the bathroom, but also to assist staff in  
2       lifting them. Our largest occupational injury is  
3       back strain from lifting and turning patients that  
4       can't do that for themselves.

5               So, we've incorporated -- and once  
6       again, just a huge amount of redesign as we go;  
7       340,000 square feet here being reconfigured. So,  
8       a lot of construction going on.

9               This is the Admin Center. You'll see on  
10       the left it's an Olympic-size pool, a 50-meter  
11       pool. Everything in the Department is funded  
12       through some funding stream or another. And  
13       there's, you know, opportunities for people to  
14       say, somebody else should pay the bill for that.  
15       This is one of the great discussions that we had  
16       that I think turned out in a very productive way.  
17       So, usually an installation is responsible for  
18       building the gym on the installation. And usually  
19       it's the staff that uses the gym and the pool.

20               And there was some sentiment that said,  
21       you know, those Wounded Warriors, they probably  
22       don't want to be seen out there in public and they

1 would probably, you know, be better off working  
2 out in the physical therapy spaces. So we went  
3 and talked to two Wounded Warriors. And they  
4 said, whoa, not so fast. What's different, you  
5 know, from me and any other soldier or Marine? I  
6 want to work out with everybody else. In fact,  
7 that's what I do half of my day, if I'm not doing  
8 anything else. And I want to do it in a great  
9 facility. And so we were able to get the funding  
10 here.

11           This is part of the Healing Campus.  
12 It's not solely directed at patients or staff, and  
13 we are adjusting to this whole concept of having  
14 people that are on our campus for a year or more  
15 to go through those phases of intermediate  
16 rehabilitation that we never used to do for them.

17           So, we're adjusting, and that's one of  
18 the adjustments, I think, that was really  
19 fabulous. It's got an indoor track. You wouldn't  
20 believe how much time our Wounded Warriors spend  
21 working out. It's one of their resiliency  
22 mechanisms and it works as a lot of stress relief.

1                   This is also, for those of you  
2 interested in history, that front façade of the  
3 building you see in the upper right was the old  
4 Naval Research Command. And that's where all of  
5 the diving tables, including the saturation diving  
6 tables in use today, were developed over the  
7 years. So, a lot of history was sitting there as  
8 an empty building. It was a historic building,  
9 and so we had to preserve the façade. But they've  
10 added -- see on that left-hand upper picture --  
11 all of the things that come off of the back of  
12 that building.

13                   This is that new Wounded Warrior lodging  
14 and this whole concept of intermediate  
15 rehabilitation. Part of what we do now is to put  
16 people into basically a hotel room, and you live  
17 in a hotel room with whoever you're living with  
18 for a year. That gets tired pretty quick and --  
19 without pretty committed people. And so you'll  
20 see on the bottom right that these are done as 152  
21 suites. So, these are two-bedroom suites with a  
22 completely ADA-compliant design.

1           We also found out that ADA is not one  
2 size that fits all. And so, once again, we  
3 brought the Wounded Warriors over, and if you'll  
4 take a look at that bed that's, you know, on the  
5 right-hand side, that upper-left picture there,  
6 just a bed. Wounded Warriors -- if you're a  
7 Wounded Warrior with a prosthetic, you probably  
8 want a higher bed. If you're a Wounded Warrior  
9 who is in a wheelchair undergoing limb salvage,  
10 you want a lower bed. If you're a Wounded Warrior  
11 that has a spouse, you probably want a bigger bed,  
12 a wider bed. And so, we are accommodating all of  
13 those requirements, trying to put them in.

14           But it's not just the ADA rules, it's  
15 how you apply them in the individual case. So,  
16 you know, as people come out of the inpatient  
17 facility and move in here as they try to return to  
18 activities of daily living, we will be able to  
19 accommodate their needs.

20           But also, they may have a need for a  
21 non-medical attendant. And you know, this is  
22 something that we are still working with very

1 much, but that non-medical attendant, should they  
2 not be a spouse, will also have the opportunity to  
3 live in this suite and be with them. Because just  
4 because we did discharge somebody from inpatient  
5 doesn't mean that they're ready to go be on their  
6 own out here, necessarily.

7           And so this is an adjustment. We are  
8 going to have some of these rehab patients that  
9 are on Active Duty for the rest of their career.  
10 Just because they have a prosthetic doesn't mean,  
11 now, that they're getting out of the Army or the  
12 Marine Corps. And so, they're going to be our  
13 patients for some time. It's going to take us a  
14 while to rehab them, and this is how we're doing  
15 it. So I think that this is an extraordinary  
16 achievement to that mission. It's really going to  
17 be a great place.

18           Parking, parking, parking. Wow. On the  
19 campus, you know, we are actually -- off of the  
20 back of our campus is a tangent of the Beltway.  
21 So, we live inside the Beltway, which means we're  
22 subject to the National Capitol Planning

1 Commission rules. And we have also got the State  
2 Historic Preservation Office for Maryland and a  
3 lot of other folks to work through. But they have  
4 ratios -- parking ratios that they put up.

5 We're also right across the street from  
6 a Metro station. And so, just let me say, parking  
7 is always, you know, an issue. But we're building  
8 a lot of parking and we're building more. And  
9 we're still probably going to need more parking.

10 This is what's going on out there at  
11 Fort Belvoir. Parking garages on either end.  
12 Clinic buildings with those swoops on top, and  
13 those swoops are also water collectors. They also  
14 cover the heating and cooling equipment that's on  
15 the roof. But they collect rainwater, put it into  
16 cisterns down in-between the buildings, and we  
17 water green spaces with that water that are  
18 in-between the buildings. Another one of those  
19 evidence-based design features.

20 This is a beautiful hospital. If you're  
21 driving by and you drive by there, you would never  
22 think that this is a military hospital in any way,

1 shape, or form. This is the leading exponent --  
2 proponent of evidence-based design as a hospital  
3 in the country. If there was a proven  
4 evidence-based design feature at the time, it was  
5 included into this design. So this shows you how  
6 fitting going on [sic]. It has a number of  
7 capabilities, which are not at Fort Belvoir now:  
8 specialty care, including radiation oncology. You  
9 can see a linear accelerator there and a lot of  
10 other new community hospital types of services.

11 This is the inpatient tower, Building C,  
12 so you have those outpatient buildings where all  
13 the clinics are and then this inpatient tower. On  
14 the inpatient tower, we're really working to  
15 finish this. In fact, we've learned from private  
16 sector -- we didn't build any hospitals in the  
17 military health system for 10 years. We came in  
18 with this one.

19 What we found out is that private sector  
20 time is money. We interpret that as time is  
21 mission and so in order to finish these projects,  
22 we have overlapped things. It used to be we'd do

1 design for two years and then we'd have a  
2 blueprint and, you know, as soon as we finished  
3 the blueprint it would be out of date in less than  
4 a year. But then we would be beginning  
5 construction and we'd have to go back and modify  
6 the blueprint. So here we overlapped the design  
7 and building and now, at the end, we've learned to  
8 overlap construction outfitting and training as we  
9 go in order to meet the timelines.

10 This is a lodging that's going to go in  
11 for Wounded Warriors down at Fort Belvoir, 288  
12 rooms. These are not completely -- all of these  
13 rooms are not built as ADA-compliant rooms. A lot  
14 of ambulatory patients will be here who don't need  
15 ADA-compliant rooms and so this is built primarily  
16 to accommodate their needs, although there are  
17 sufficient ADA rooms should we need them.

18 These are some of the things that we're  
19 doing to get ready for transition. This is a  
20 pretty big transition, we've got 9,000 people that  
21 work amongst these hospitals and all of them are  
22 moving at one point in time. Many of them have

1 already moved within the Bethesda campus, but  
2 we've got about 5,000 people moving out of Walter  
3 Reed into these other 2 campuses yet to go.

4 So we're taking a hard look at the  
5 MEDEVACs, how we do that. There will come a point  
6 in time when we'll divert the casualty flow, all  
7 those C-17s that are coming into Andrews. They  
8 will go to Bethesda. We'll begin clinic  
9 relocations and then we'll relocate the Wounded  
10 Warriors and, lastly, we'll relocate the  
11 inpatients.

12 We've taken a hard look. We've taken a  
13 look at casualty estimates, classified casualty  
14 estimates from CENTCOM, and we anticipate no  
15 detriment to casualty care during the transition.

16 We had an exercise on Sunday on how to  
17 move patients. There's no lack of interest, so  
18 for an exercise we had CBS, National Public Radio,  
19 and various others show up and watch us, you know,  
20 work through the exercise. Best practice out  
21 there, we're working with the same people that did  
22 the relocation at UCLA. And so, they moved about

1 350 patients there in 5 hours and so here we  
2 anticipate relocating 150 inpatients. Keeping it  
3 simple, they'll all move from Walter Reed to  
4 Bethesda and we've got a whole plan on the way to  
5 do that. So, it's kind of neat.

6           Okay, that's a lot about the BRAC, so  
7 what happens, you know, after the BRAC? Just as a  
8 reminder, those things that are in kind of in red,  
9 those things that were the older part of the  
10 chassis on the medical center, so we're working  
11 through what needs to be done with the rest of  
12 that.

13           So we had the comprehensive master plan.  
14 It identified the facility projects. Basically,  
15 we needed to construct 560,000 square feet while  
16 we demolished 325. This adds no new capability or  
17 functions, it just provides the space that we  
18 needed to, number one, relocate those things out  
19 of the inpatient building that we have to, to get  
20 to single-patient rooms there, and to get up to  
21 current space standards on those things that are  
22 already existing.

1           The Navy's begun the NEPA process. The  
2 funding is in the President's budget, and so the  
3 projects would begin in '12, they'd be completed  
4 by Fiscal Year '18. So that's more work within  
5 our working hospital, within a very large working  
6 medical center. The good news is we have a way to  
7 do it.

8           We have objectives I've talked to you  
9 about before that we're going to work with. A  
10 schedule -- this is a little bit about the design  
11 concept. You'll see the tower there in the  
12 middle, all those things that are behind the tower  
13 would basically be demolished and we have to  
14 reconstruct that part. It's grown in no  
15 necessarily coherent way over the years, so  
16 demolish it, take it out, and then put in a  
17 building behind it.

18           National Capitol Planning Commission --  
19 you'll see that the tower building in the middle  
20 -- in those two shoulders just off to the left and  
21 the right of the tower, from the architectural  
22 perspective there's a view shed so that nothing

1       should exceed the height of those shoulders, so  
2       that that new outpatient building and the new  
3       inpatient additions are the height of that  
4       shoulder, so that it maintains the picture. But  
5       as you look up from Wisconsin Avenue, there's a  
6       little bit of room back there, but nothing can  
7       peek up, if you will, behind those shoulders in  
8       this new construction. So it's built to have a  
9       portion that stays behind the tower that's a  
10      little bit higher, but the rest of the building  
11      would be behind those shoulders. So, a very  
12      challenging concept, but that's how to finish up.

13                 And what it means for circulation in the  
14      Mall of the Americas-size building is basically  
15      there's a right-hand side -- you'll see it starts  
16      to rationalize the North/South and East/West  
17      approaches, so that you're able to get across the  
18      campus in a coherent way, and provide patient  
19      amenities as we go.

20                 Okay, a couple of other items I wanted  
21      to update you on. The National Intrepid Center of  
22      Excellence had opened. It's now achieved its full

1 clinical caseload as of February, so they have at  
2 any given point in time 20 patients that are in  
3 there. They've worked out their schedule so that  
4 each patient and family is now there for just  
5 about two and a half weeks as they undergo  
6 extensive evaluation and education protocols.  
7 Joint Pathology Center became operational on the  
8 1st of April and began its clinical mission. And  
9 so AFIP is providing support until the JCP reaches  
10 full operating capability. Basically, the staff  
11 crosses over between these two until AFIP closes  
12 and then there's the transfer of work over to the  
13 Joint Pathology Center.

14 We have Manning Documents approved now  
15 for the new hospitals. We're working on finishing  
16 the world class operating rooms at Bethesda and  
17 the renovations and we are going to have a joint  
18 medical network that allows us to, particularly,  
19 move images, but it will also provide a common  
20 desktop, single log-on, universal directory, all  
21 of the other things that we can't do right now.  
22 If you're at Walter Reed and you want to look up

1 somebody in Bethesda, you can't do it. You have  
2 to call them and ask them what their e-mail  
3 address is.

4           If you want to move an image from  
5 Bethesda to either Andrews or Fort Belvoir, it  
6 takes about two hours. I can actually drive an  
7 X-ray right now around the region faster than I  
8 can move it. Why? It's because you've got a bump  
9 across a lot of different protocols, security  
10 protocols. You've got to get in to the NIPRNet  
11 and compete for broadband space, and then you have  
12 to have an assistant administrator pull it out of  
13 the other side. It's pretty hard.

14           So the Joint Medical Network will allow  
15 us to actually just look at the image. It's going  
16 to be a great improvement. So the BRAC is going  
17 on. We're currently on schedule to complete the  
18 transition. Casualty care, patient safety remain  
19 our top priorities and I tell everyone, I am under  
20 no compulsion from my boss, the Deputy Secretary,  
21 to do anything that would put casualty care or  
22 patient safety at any risk at all.

1           So we do have a legal obligation to  
2 complete the BRAC. However, if casualty care or  
3 patient safety were at risk, we would certainly  
4 weigh, you know, on the side of maintaining  
5 casualty care and patient safety. However, that  
6 said, these are such great facilities that we want  
7 to get into them as quick as we can. Nobody likes  
8 to move. Nobody likes change, but we've all got  
9 to and it's going to be much better for our  
10 patients after we do it.

11           We're committed to fulfilling the  
12 requirements of the NDAA mandate to make this a  
13 world class facility and we are committed to  
14 making sure we have the most effective and  
15 efficient health care system that we can, after  
16 the BRAC is over.

17           So, that's a lot of update for you.  
18 It's been a long journey for the last three and a  
19 half years. It's unbelievable to me that there  
20 was no steel up on any of these projects three and  
21 a half years ago and here we are today. It's been  
22 an extraordinary journey and we appreciate all of

1 the support that you've had. I'd love to answer  
2 any questions that you might have about any of  
3 these projects.

4 I see Dr. O'Leary there. You know, Dr.  
5 O'Leary, this was --

6 DR. O'LEARY: This is amazing.

7 VADM MATECZUN: The Joint Commission --  
8 actually, in the last two months the Joint  
9 Commission has been at every one of the MCR  
10 hospitals. So they've been to Walter Reed --

11 DR. O'LEARY: Good.

12 VADM MATECZUN: -- they've been to  
13 Bethesda, and they've come back to look at the new  
14 facilities at Bethesda. They were just out at  
15 Andrews Air Force Base and last year they were at  
16 Fort Belvoir-DeWitt. So they were very laudatory  
17 and each of those hospitals got the best marks  
18 that its ever had. And so I think sometimes we  
19 worry -- we'll lose focus, they'll lose focus.  
20 They won't be able to do it. You know, patient  
21 safety is at risk. What we found is, you know, it  
22 has actually focused us in an extraordinary way as

1 we move from place to place on those things that  
2 are routine. Where's the crash cart? Where all  
3 of the other things? How are we taking care of  
4 this patient? You know, we've become intensely  
5 focused, so we're pretty proud of that.

6 DR. O'LEARY: Well, the whole idea was  
7 to take this organization well beyond what the  
8 Joint Commission expected and I think what you  
9 have achieved in this relatively brief timeframe  
10 is really extraordinary. Of course, there's more  
11 work to do, but this is really a very uplifting  
12 presentation. We really appreciate it.

13 DR. HOVDA: Yes, Dave Hovda from UCLA.  
14 I can -- having lived through this, I can't tell  
15 you what to expect from the perspective of moving  
16 down the street, but I can tell you the enthusiasm  
17 of the staff of moving patients into a brand new  
18 facility. It actually improved the quality of  
19 care, we believe, because everybody got excited  
20 about making this work and they were going to make  
21 this work. And I commend you and your office and  
22 you personally for this dedication to make this

1       happen. This is wonderful.

2                   VADM MATECZUN: Thanks. You know, when  
3       we talked with -- when we went out to UCLA and  
4       talked to a lot of folks out there, one of our  
5       questions was, so is it hard to change a unit, you  
6       know, while you're doing this?

7                   And they said, you better change before  
8       -- you know, while you're doing it and before  
9       because afterwards it gets really hard.

10                  DR. O'LEARY: Yeah, we took it as an  
11       opportunity to break some old ruts that were in a  
12       lot of departments and a lot of medical services.  
13       And we said, you know something? Not only are we  
14       going to change buildings, we're going to change  
15       the way we provide care for people. And for some  
16       of my colleagues who were resistant -- I'm trying  
17       to be diplomatic. This was really nice, clean-cut  
18       and it was like starting a whole new relationship,  
19       so you have a wonderful opportunity.

20                  DR. BULLOCK: What will be the net  
21       change in the number of beds with the move?

22                  VADM MATECZUN: The BRAC law kept the

1 number of beds constant, and so it is 345 beds  
2 across the facilities. That's constant. About  
3 345, plus 120. I'm sorry.

4 DR. DICKEY: Admiral, I apologize. You  
5 may have told us, is this a single record between  
6 the two hospitals, and the entire Capitol Region?  
7 So you talked about the current difficulty of  
8 transporting images, what about the medical record  
9 itself?

10 VADM MATECZUN: Well, we already -- we  
11 send our electronic health record information to  
12 AHLTA servers that have one common repository. So  
13 our problem is reaching it in a consistent way.  
14 If it depends on where it is in the network and  
15 what enclave you have to try to get to, to get to  
16 it. What this does is to consolidate all of the  
17 data, if you will, in an accessible way.

18 DR. DICKEY: What about the ability of  
19 the veterans versus the military hospitals to talk  
20 back and forth?

21 VADM MATECZUN: The secretaries --  
22 Secretary Shinseki and Secretary Gates -- have

1 personal initiatives on this. They're getting  
2 ready to meet again, with an electronic health  
3 record way ahead for both departments.

4 DR. DICKEY: That will be nationwide?

5 VADM MATECZUN: Nationwide for the DoD  
6 and the DVA.

7 DR. DICKEY: Great, great. Other  
8 questions or comments?

9 GEN FRANKS: I just want to comment. I  
10 echo what the Admiral said. I've had the  
11 opportunity to make a kind of a stealth visit up  
12 there last Thursday, into the Amputee Care  
13 Facility, escorted by Chuck Scoville. The Admiral  
14 mentioned it. And I applaud what they've done.  
15 Listening to the best what you call evidence-based  
16 design for amputee rehab, prosthetic lab  
17 computer-assisted rehab environment, firearms  
18 training simulator, a pool, probably the best from  
19 the prosthetists themselves, glad to build  
20 prosthetic devices of anywhere in the country, so  
21 I really applaud what they've done.

22 And from someone who dug the first

1 shovel full of dirt for that MATC at Walter Reed,  
2 I applaud what you all have done up there,  
3 Admiral. Thanks a lot for all the amputees.

4 VADM MATECZUN: We think that we're  
5 keeping our covenant with America's sons and  
6 daughters that have put their lives at risk for  
7 us.

8 DR. DICKEY: We thank you very much, not  
9 only for the presentation, but for the  
10 extraordinary leadership you've provided to get  
11 through this. Obviously, a huge amount of work  
12 has occurred in a very short period of time.

13 VADM MATECZUN: Thank you. And thank  
14 you for the support of the Board. (Applause)

15 DR. DICKEY: Now let me disappoint you.  
16 I would recommend that we forego our break and let  
17 each of you to get up and refresh your coffee or  
18 tea as you need to. We're still a little behind  
19 schedule. If we do that, we'll be a little  
20 closer, so if we can go immediately to our next  
21 briefing by Mr. Leonard Litton.

22 Mr. Litton serves as an Operations

1 Research Analyst for the Director of Operational  
2 Readiness and Safety at the office of the  
3 Secretary of Defense. In this capacity he  
4 provides analyses on various issues pertaining to  
5 the Department of Defense's safety and operational  
6 readiness programs, including aviation and ground  
7 safety programs, as well as enhancement  
8 initiatives.

9 He's currently leading a Department-wide  
10 effort to respond to the congressionally mandated  
11 final report of the DoD Task Force on the  
12 Prevention of Suicide by Members of the Armed  
13 Forces. Previously, Mr. Litton served 25 years on  
14 Active Duty in the United States Air Force and  
15 retired as a Colonel in October 2010. He's going  
16 to provide an information brief regarding the  
17 Department's response and implementation of the  
18 recommendations from the DoD Task Force on  
19 Prevention of Suicide by Members of the Armed  
20 Forces and his slides are under Tab 9 of your  
21 meeting binders.

22 Mr. Litton, we're delighted to have you

1 with us and look forward to your update. Thank  
2 you.

3 MR. LITTON: Okay, I'm here just to give  
4 you an update on the Department's response to the  
5 DoD Task Force Report on Suicide Prevention. Just  
6 to familiarize yourselves with the language that  
7 came from Congress in the '09 NDAA, if you're not  
8 that familiar with it, was that the Secretary of  
9 Defense shall establish the Task Force to examine  
10 this matter and, 12 months later, the Task Force's  
11 task, if you will, was to produce a report on that  
12 subject.

13 OSD Personnel Readiness has been  
14 delegated the responsibility to follow through on  
15 the back end of this and transmit the report to  
16 Congress, which has been done. And then the  
17 second bullet there is develop a plan based on  
18 those recommendations, basically, if you will, to  
19 answer the matter.

20 The Department feels that the report  
21 provided an excellent overview of the suicide  
22 issue. It was very comprehensive and really it

1 has served as a catalyst for a comprehensive  
2 review across the Department of all policies and  
3 programs that deal with the suicide prevention  
4 issue. It can take 49 findings, 13 foundational  
5 recommendations, and 76 targeted or more detailed  
6 recommendations. The Department felt like this  
7 very comprehensive report required a very  
8 comprehensive review process.

9           We didn't feel like we could do this  
10 quickly and do it justice, so we devised a charter  
11 to regulate the response process and really took  
12 it in a phased approach. An initial response to  
13 Congress was transmitted on March 2011 that really  
14 dealt at a pretty high level -- the 13  
15 foundational recommendations -- and really what we  
16 tried to do there was set a vector on whether the  
17 Department would look further for improvements.

18           We're targeting 30 September for our  
19 final implementation plan based on those 76 detailed  
20 recommendations. And then, if you're familiar  
21 with the report, you know that it really talks  
22 about a lack of a governance entity -- or

1 governance structure at the OSD level to provide  
2 that strategic direction and oversight for suicide  
3 prevention on the Department. And we're targeting  
4 the 1st of October to begin that process.

5 As far as the review process, we have a  
6 Tier 1 working group. It's made up of a core  
7 group that has seven individuals, six others that  
8 advised myself, and a matrix group, really, that  
9 comprises stakeholders across the Services and the  
10 Department that provide input.

11 Tier 2, a General Officer's Steering  
12 Committee in which we take recommendations to  
13 discuss as far as how we're going to move forward  
14 on those 76 target recommendations. And then at  
15 Tier 3, an executive group chaired by Dr. Stanley  
16 the USD(P&R).

17 Phase I was basically to give a general  
18 overview of the report and comment on those 13  
19 foundational recommendations, and provide that to  
20 the congressional committees as directed to give  
21 them just an overview and, really, a sense that we  
22 were working this report and that we were working



1 really further investigate those targeted  
2 recommendations that were related to 2, 3, and 4.  
3 However, for the rest of them, we would continue  
4 the investigation.

5           For Phase II, that's the process we're  
6 in now. We're taking each one of those targeted  
7 recommendations and vetting them across the core  
8 group and the Job Steering Committee to bend them,  
9 really, into one of four categories: "Accept For  
10 Action," which means the Department believes we  
11 don't meet the full intent of that recommendation  
12 and we believe there's more work to be done; "No  
13 Further Action Required," which we believe we've  
14 got it down, either the actions we have in place  
15 or are going to have in place very soon, are going  
16 to meet the intent of that recommendation;  
17 category number 3, being "Deferred To Another  
18 Department," which either we didn't fill out -- it  
19 was within DoD's purview or it was better executed  
20 by another department, we haven't found any of  
21 those yet; and category number 4, would being "No  
22 Action Directed," which will be for whatever

1 reason, resources, whatever the reason may be,  
2 we're not going to take any action on that  
3 recommendation.

4 The end state of Phase II, again, will  
5 be, hopefully, twofold: An internal Department  
6 document that will be in a lot of detail on  
7 basically who's doing what, how much it's going to  
8 cost, and when we're going to have it done; and  
9 then a report to Congress, to congressional  
10 committees, as the NDA language requires to let  
11 them know where we're moving forward. And it will  
12 probably not have as much detail because it's just  
13 not needed.

14 And then, Phase III, the 1st of October  
15 to -- you know, if you've read the report, it does  
16 recommend an OSD Suicide Prevention Policy  
17 Division or Office. To tell you the truth, that  
18 concept is really still taking form, but there is  
19 going to be a phased oversight entity to meet the  
20 intent of that recommendation. Exactly what it's  
21 going to be, I can't tell you yet.

22 As far as the current progress, the

1 Working Group -- core group -- has met multiple  
2 times. The General Steering Committee has met six  
3 times to review these recommendations. We've  
4 reviewed all the 13 foundational recommendations.  
5 At this point, we've reviewed 39 or the 76 target  
6 recommendations.

7 As just kind of an overview, general  
8 consensus is emerging on that entity focused on  
9 suicide prevention at the OSD level. I think most  
10 stakeholders believe that is something that would  
11 add value provided that we do it right. I know  
12 the Services do have some concerns about getting in  
13 too much detail and not infringing upon the unique  
14 culture of the four Services and I think most  
15 people agree that that's the right approach to  
16 take.

17 A strategic communication effort that  
18 would really get at I call it two sides of the  
19 coin: one the stigma piece and the other side the  
20 wellness piece, so we're attacking that from both  
21 sides. Data collection and standardization, we've  
22 made a lot of progress there, but there's still a

1 long way to go -- particularly on a lot of seams  
2 and, in particular, between us and the VA.

3           And then a comprehensive training  
4 strategy and plan. The Services moved out smartly  
5 as far as training goes, but there are a lot of  
6 subgroups that the Task Force report identified  
7 that we still need to make sure we're focused on:  
8 that they have the right training, that they have  
9 the right objectives, and that we make sure that  
10 we provide it in the medium that best achieves  
11 those objectives and how adults learn. So we  
12 think there's some more work to do there.

13           As a quick overview of where we are with  
14 responding to that report, I'd be happy to take  
15 your questions, ma'am.

16           DR. DICKEY: Thank you for that  
17 excellent update. Questions, comments? I think  
18 we've worn them out.

19           MR. LITTON: I put everybody to sleep.  
20 All right. (Laughter)

21           DR. DICKEY: I know that most of them  
22 are very familiar with the report, so surely that

1       can't mean they have no concerns about it moving  
2       forward? I presume we will continue to get  
3       updated reports as you continue moving through the  
4       recommendations, as well as the number of them  
5       that are in the "Accept For Action," meaning you're  
6       going to continue to develop those. We'll get  
7       follow-ups on those?

8                 MR. LITTON: Yes, ma'am.

9                 DR. DICKEY: Dr. Certain.

10                DR. CERTAIN: I appreciate your  
11       response. I was on the Task Force and the Army  
12       came out with its report just weeks before ours,  
13       and the RAND report's out now. Are they fairly  
14       consistent across the board and are able to expand  
15       on what you're doing by using the other two  
16       reports at the same time?

17                MR. LITTON: Yes, sir. I have read both  
18       reports and there are a number of consistencies,  
19       if you will. The findings that your Board, the  
20       Task Force found, resonates with the Army report  
21       and with RAND's report as well. So we have a  
22       matrix that tracks those recommendations as well

1 and so several of them will be right across the  
2 board.

3 DR. CERTAIN: God bless.

4 DR. DICKEY: Thank you. Any other  
5 questions or comments? Again, we thank you for  
6 the work and we recognize that it's a long path  
7 ahead.

8 MR. LITTON: Yes, ma'am. Thank you.

9 DR. DICKEY: Thank you.

10 SPEAKER: Dr. Dinneen is not here yet,  
11 so we'll have to take a break.

12 DR. DICKEY: I know I'm going to break  
13 your heart. Dr. Dinneen is not here yet --

14 SPEAKER: There he is.

15 DR. DICKEY: No, no. We don't have to  
16 take a break. (Laughter) So, if you'll stay  
17 close so that when he gets here we can convene  
18 relatively quickly, let's look at maybe a  
19 10-minute break. Don't go too far.

20 SPEAKER: Yeah, he's right around the  
21 corner.

22 (Recess)

1                   DR. DICKEY: I want to welcome our last  
2 speaker of the day, Dr. Michael Dinneen. Dr.  
3 Dinneen, I think we're going to end on an  
4 energetic high note, right?

5                   We are going to have the pleasure of  
6 hearing from Dr. Dinneen, who is currently serving  
7 as the Director of the Office of Strategic  
8 Management for Military Health System, a position  
9 he assumed after retiring from the U.S. Navy in  
10 January of '05. He's responsible for developing  
11 and monitoring the implementation of the Strategic  
12 Plan for the Military Health System. And as a  
13 participant in health policy development, Dr.  
14 Dinneen serves on various committees, including  
15 those under the Institute of Medicine, the Harvard  
16 Health Care Delivery Program, and the Center for  
17 the Study of the Presidency and Congress.

18                   He's going to give us an information  
19 brief regarding DoD's response to evidence-based  
20 metrics established to monitor and improve the  
21 performance of the military health system. His  
22 slides can be found under Slide 10 in your meeting

1 binders. We're delighted to have you and look  
2 forward to your comments. Thank you.

3 DR. DINNEEN: So, first of all, there  
4 are no slides in Slide 10, but I gave out just two  
5 pieces --

6 DR. DICKEY: But they're all right here.

7 DR. DINNEEN: -- just two pieces of  
8 paper.

9 DR. DICKEY: See, you guys like him  
10 already. There's just two pieces of paper there,  
11 right?

12 DR. DINNEEN: And if folks would like  
13 the full set of slides I show you today, I'll be  
14 happy to forward those.

15 It's a great pleasure to be here and I'm  
16 so glad Mr. Middleton's here because what I'm  
17 going to talk about today, the first section is,  
18 really thanks to him, an idea that he had a  
19 couple of years ago now, to be able to describe  
20 the strategy of the military health system of a  
21 single page. And so that page is what you see in  
22 your handout and also what you see on the slide up

1 here.

2           We've adopted as a vision something we  
3 call the "Quadruple Aim." It defines where we're  
4 trying to go as an organization over the next  
5 several years. It's adapted from the model that  
6 was published by Dr. Don Berwick in Health Affairs  
7 in 2007, called the "Triple Aim." And now, if you  
8 read a lot of what's coming out in terms of the  
9 national strategy in health, a lot of the Triple  
10 Aim concept is throughout many of the writings  
11 that are coming out of HHS now. So we feel that  
12 that gives us a good alignment with other federal  
13 partners as well as where health care is going.

14           The components of the Quadruple Aim for  
15 us, our readiness, which is at the core of our  
16 mission. And then it's -- the easy way to  
17 remember it is better health, better health care,  
18 and lower per capita costs. What I'd like to talk  
19 about today is how we're attempting to measure our  
20 success in reaching the Quadruple Aim,  
21 particularly I'd like to focus in on, in the  
22 second and third portion of this, population

1 health. Because I think that one of the areas  
2 that there's been the most dialogue around in the  
3 last six months is how do we understand our major  
4 transformation from going from health care to  
5 health or some would even say sick care to health?

6           That right now the focus of measurement  
7 and the focus of dollars is on taking care of  
8 people with severe illness, and yet the focus of  
9 being able to keep people healthy and reduce the  
10 burden of illness is a harder thing to get our  
11 heads around. So I think most of the effort that  
12 you'll see in our measures development currently  
13 is around measuring population health,  
14 particularly psychological health.

15           And I think that's because it is  
16 reflective of the difficulty everybody has in  
17 understanding how to measure and improve  
18 population health. Now this may be no new news to  
19 all the people in the room that are in the field  
20 of public health, but for us it's been a real  
21 interesting challenge. So I'd like to orient you  
22 to this chart. First of all, how many of you have

1       seen this before?

2                   A few. Okay, so it's all right to  
3 orient you. Let me just walk you from left to  
4 right on this. On the left you'll see that the  
5 very left-hand column is the four elements of the  
6 Quadruple Aim: readiness, population health,  
7 experience of care, and per capita cost. You'll  
8 also see a section called "Learning and Growth,"  
9 which is about our ability to have sustainable  
10 success.

11                   The next column is called strategic  
12 imperative, and where that came from is over the  
13 last couple of years the Surgeons General have  
14 been meeting with the senior policy leaders -- the  
15 Assistant Secretary as well as the DASD  
16 -- in quarterly meetings to update our strategic  
17 plan and out of that work came a set of strategic  
18 imperatives that said, these are the key areas  
19 where we need to see significant improvement.

20                   So, in that large area that you would  
21 call, for instance, population health, right now  
22 we believe the biggest challenge we've got is to

1 engage patients in healthy behaviors. There are  
2 other things we could do in population health, but  
3 right now engaging patients in healthy behaviors,  
4 particularly increasing activity, reducing rates  
5 of obesity, and addressing things like alcohol use  
6 and risky behaviors.

7 In the area of experience of care we  
8 felt there was a need to focus in on delivering  
9 evidence. Base care, addressing specifically the  
10 needs of wounded, ill, and injured, particularly  
11 fixing the disability evaluation system,  
12 optimizing access to care, and promoting patient  
13 centeredness. So, of all the things we could do,  
14 the imperatives are those few that actually will  
15 get, we believe, the greatest movement towards  
16 achieving the Quadruple Aim.

17 You'll see down at the bottom, we don't  
18 talk about the electronic health record directly,  
19 we talk about enabling better decisions. Enabling  
20 better decisions, physicians and caregivers  
21 enabling better decisions on the part of patients.  
22 And then fostering innovation and developing our

1 people.

2           The next column over is executive  
3 sponsor and this has been important. You'll  
4 notice that those acronyms stand for committees  
5 that are at the two-star level, that are chaired  
6 by one of the senior policy people in the  
7 organization. So, for instance, Dr. Lockette, who  
8 is here, is chairing the Clinical Proponency  
9 Steering Committee, the CPSC. That committee has  
10 responsibility for oversight of the measures that  
11 are beside the CPSC -- monitoring, and then  
12 ensuring that there are programs in place to  
13 achieve the targets that have been set.

14           The next column over -- and we'll spend  
15 some time on this, hopefully in response to your  
16 thoughts -- are the performance measures. The  
17 challenge in any organization is to get a set of  
18 measures that are somewhat comprehensive, but not  
19 overwhelming in number. And we think we're sort  
20 of at the limit of what is a reasonable number of  
21 measures right now. The measures with the arrows  
22 are the ones that were presented just this past

1 April to the senior leadership for approval to  
2 either take the place of a prior measure or fill  
3 in a blank, because what we started with,  
4 actually, is what we want to accomplish and then  
5 we said, how would we measure it.

6           So we actually went to the imperatives  
7 first, developed the measures second, and then  
8 this sort of Verizon bars that you see in the  
9 middle is how far along are we in the development  
10 of each of those measures. If all of the bars are  
11 completed, that means we have the concept, we have  
12 an algorithm, we have performance data from at  
13 least 2 or 3 years, and we have targets set for  
14 Fiscal Year '11, '12, and '14.

15           And then, finally, you'll see -- moving  
16 across you'll see what our previous performance  
17 was. That was the quarter before April, the  
18 current performance and either improvement or  
19 decline in performance. Then we have targets set  
20 for -- well, the tenor there because we had sort  
21 of graded ourselves on last year, but then '11,  
22 '12, and '14. And most recently, in response to a

1 Strategy Management Initiative from the  
2 Undersecretary for Personnel and Readiness, we now  
3 have a portfolio of initiatives. So, in order to  
4 achieve those targets, on the very right hand side  
5 of this chart you'll see the set of initiatives  
6 that are in place that are intended to move the  
7 organization in the direction of achieving these  
8 performance targets.

9           So, for instance, one of these is the  
10 patient-centered medical home, which is about  
11 five up from the bottom. And you'll see there  
12 that it's got a full circle, so that means that if  
13 the circle is there it means the initiative has  
14 been designed, it's been approved by senior  
15 leadership, and it's been funding in the out years  
16 through the POM.

17           So, we're using this mechanism,  
18 actually, to align the budget with the strategy  
19 and ultimately what we want to show is that each  
20 of those initiatives is fully fleshed out and  
21 fully funded through the POM. The other thing  
22 that's happening as a result of having this

1 particular way to describe what we're working on,  
2 on strategy, is that it's allowing us to align the  
3 IM/IT portfolio with our strategic initiatives as  
4 well.

5           So do we have the IM/IT automation to  
6 support getting the outcomes we desire from each  
7 of these initiatives, which will then drive those  
8 improvements in performance? So, a complicated  
9 slide, but we've tried to use the design concepts  
10 of Dr. Tufte -- if anybody's familiar with that --  
11 so that you can actually reach your own  
12 conclusions by looking at this of how well are we  
13 doing in achieving our strategy and sort of where  
14 are we falling short? Where do we have a long way  
15 to go?

16           What I thought I would do now is  
17 actually see if any of you are interested in  
18 seeing the data that supports these measures. I  
19 know you might be interested in the psychological  
20 health measure, but if there are any other  
21 measures you'd like to see -- each of the measures  
22 is hyperlinked to the actual data which describes

1       how we're doing and how we've been doing, and how  
2       big a problem we've got.  If anybody has an idea,  
3       I'd be happy to go --

4                 DR. DICKEY:  Dr. Dinneen, I think it was  
5       maybe one or two meetings ago we heard a very nice  
6       presentation about population health, so maybe you  
7       can link us to the obesity documentation,  
8       particularly for, I presume, it would be the  
9       adults.

10                DR. DINNEEN:  Very good, so --

11                DR. DICKEY:  So we've heard about the  
12       new enlistees.

13                DR. DINNEEN:  So here is the data.  And  
14       this is actually an effort to come up with a  
15       measure that is actionable.  So the rate of  
16       obesity itself we had been showing for a couple of  
17       quarters, but people sort of said, well, what can  
18       you really do about that?  That doesn't change  
19       that quickly.

20                On the other hand, what this is showing  
21       is that on the left-hand side, what you'll see is  
22       folks with a BMI of 25 to 29.  And then what you

1 see for Army/Navy/Air Force under direct care --  
2 actually for all of direct care -- the question  
3 is, if somebody has a BMI of 25 to 29, do they  
4 have in their record a problem that says this  
5 person has a problem called overweight. And in 17  
6 percent of the cases, they have a problem listed.

7           And then on the other side it's where  
8 you have a BMI greater than 30. Do you have a  
9 problem in your problem list that says, this  
10 person has a problem with their weight? And so,  
11 in 54 percent of the cases, we have a problem in  
12 the problem list. And in terms of something being  
13 actionable, we think this is pretty actionable.  
14 So I was recently out at several of our MTFs and I  
15 mentioned this -- showed this data to a couple of  
16 the doctors and they said, of course, we don't  
17 write that down. And I said, how come? And they  
18 said, well, if we did we wouldn't know what to do  
19 about it and we don't want to insult the patients.  
20 And also it's-- you know, many of these people  
21 it's -- a BMI is a bad measure, so we really don't  
22 consider that a problem.

1           So we really think that this is actually  
2 a useful exercise to engage the dialogue between  
3 the health care professionals of whether we're  
4 serious about addressing this issue. We talk  
5 about the obesity epidemic, but are we going to  
6 have a personal conversation with people about  
7 whether that's a problem for them?

8           To give you an example, just to drive it  
9 home a little bit further, I was hospitalized  
10 about a year and a half ago with an arrhythmia and  
11 at that hospitalization, nobody talked to me about  
12 my weight. And at that time I was 204 pounds.  
13 I'm now about 186 and nobody said anything about  
14 my weight and I was pushing obesity at that point.  
15 I was 29 on the BMI and, you know, that's a great  
16 opportunity to get somebody when they have a  
17 life-threatening something to say, you know, you  
18 really have got to lose some weight. So we think  
19 this is useful and you'll notice that we've signed  
20 up for a target of 75 percent this year.

21           DR. DICKEY: That's not the target of  
22 getting you to reduce your weight, it's just the

1 target of getting the health care provider to list  
2 it as a problem?

3 DR. DINNEEN: Yes. Right. And it's  
4 definitely a process measure at this point in  
5 time.

6 DR. DICKEY: Dr. Anderson?

7 DR. ANDERSON: So, this reminds me of a  
8 recent discussion I got involved in on this very  
9 issue on obesity, and particularly on BMI.

10 DR. DINNEEN: Yes.

11 DR. ANDERSON: So what the experts  
12 informed me of is, well, that's not all that great  
13 a metric because it's a lagging indicator. What  
14 you want to do is drill down and start looking in  
15 nutrition and exercise and all the contributing  
16 factors. So the question is, you're tracking  
17 this, but this very well might be, you know, for  
18 you -- obviously you're intention was reached, but  
19 for those in the population whose attention isn't  
20 reached, you may need to be looking at some  
21 secondary indicators that might get you the  
22 information earlier.

1 DR. DINNEEN: Yes, I think that's such a  
2 good point. We're in an active collaboration with  
3 a number of the health care systems now and one of  
4 the ones that's been fascinating is our  
5 collaboration with Kaiser Permanente. They have  
6 this concept -- I think which, again, they stole  
7 from the Institute for Health Care Improvement --  
8 with what they call the "Big Dots" and the "Little  
9 Dots." So we do think that at the enterprise  
10 level, looking at a lagging indicator  
11 strategically makes sense. But then we have to  
12 connect it to the Little Dots, if you will, that  
13 are the drivers of those lagging indicators. And  
14 we're actually working fairly closely now with the  
15 folks at the Population Health Portal to be  
16 developing explicitly those cause-effect  
17 relationships, so we can actually test the  
18 hypothesis of whether the Little Dots actually  
19 drive the Big Dots.

20 DR. ANDERSON: Yeah, and again, George  
21 Anderson speaking, but to state the obvious here,  
22 your actual programmatic energy needs to go into

1 those Little Dots.

2 DR. DINNEEN: Absolutely. And I think  
3 that's where you'll see here -- I'd actually like  
4 to show you one so that we can show you some of  
5 that work applied to population health -- is the  
6 second portion of what I'd like to share today,  
7 but --

8 DR. DICKEY: But before you go on,  
9 because we've got several questions.

10 DR. DINNEEN: Sure.

11 DR. DICKEY: You've obviously wakened  
12 the group up. Dr. O'Leary?

13 DR. O'LEARY: Yeah, I may not be  
14 interpreting this correctly, but it seems like in  
15 a number of the target areas, the aspirations are  
16 quite modest. (Laughter)

17 DR. DINNEEN: Could you give me an  
18 example?

19 DR. O'LEARY: I mean, like, take the two  
20 under Promote Patient Centeredness. You know,  
21 where --

22 DR. DINNEEN: So let's look at

1 Percentage of Visits (inaudible), their primary  
2 care manager. Can I go to that?

3 DR. O'LEARY: And the satisfaction  
4 makeup.

5 DR. DINNEEN: Let's go to the data here.  
6 This has been an enormous effort on the part of  
7 the Services to get this to move to 51 percent  
8 from approximately 40 percent. And if you look  
9 over here where we're now looking at, we're  
10 looking at variation on the right-hand side of  
11 this. So, in the Army, there's still a number of  
12 places where the likelihood that you'll see your  
13 primary care provider, if you have an assigned  
14 primary care provider, is 20 percent or less.  
15 When we started, the numbers were down in the  
16 teens in a number of places, even close to  
17 Washington, D.C.

18 You'll notice that the Air Force, that's  
19 been working on this issue for longer. They have  
20 a number of places that are up in the 80s.  
21 They're 78 to 80 percent, so 4 out of 5 times if  
22 you come in for primary care, you'll see your

1 doctor. And the variation is significantly less.  
2 The lower cites are in the 40s, so while the  
3 enterprise target because it's an average, is  
4 modest perhaps, the opportunity exists for --  
5 because we have quite a bit of variation in the  
6 organization -- to really see significant change  
7 in those places that are very low. And lots of  
8 learning to occur between the places that are very  
9 high and the ones that are very low.

10 DR. O'LEARY: I would just observe that  
11 if you set your target higher, the opportunity is  
12 even greater.

13 DR. DINNEEN: Well, one of the issues --  
14 and I think it's a very, very good point -- one of  
15 the issues we run into, though, is disillusioning  
16 people. And that we have in the past set some  
17 high targets for things and they were just  
18 unobtainable. And people knew that and so at some  
19 level it -- I've coached soccer and one of the  
20 biggest things that you learn as a soccer coach --  
21 and I don't know if this applies directly, but I  
22 think of it on occasion -- is that you set up a

1 game for the players to play and if you make it  
2 too difficult, if it's above their capability,  
3 they won't work as hard. But if you make it so  
4 it's just out of their reach, they will want to  
5 get to that target. And our aspirational goals  
6 are very high, but the near-term goals have to be  
7 reasonable or we will lose the attention of our  
8 folks.

9 DR. O'LEARY: One last question. How  
10 often do you review these targets? And if you are  
11 trying to keep nudging people up, do you review  
12 the targets every year or every several years?

13 DR. DINNEEN: We review all the targets  
14 once a year and we review the performance once a  
15 quarter with the senior leadership. So the last  
16 review of the targets was this past November.

17 DR. DICKEY: Great.

18 DR. DINNEEN: Although some of the  
19 measures are somewhat new.

20 DR. DICKEY: Dr. Johannigman?

21 DR. DINNEEN: I was --

22 DR. DICKEY: Oh, you -- okay.

1 DR. DINNEEN: Oh, sorry.

2 DR. DICKEY: Great. Jay?

3 DR. JOHANNIGMAN: Yeah, it would seem  
4 like some of these are excellent opportunities to  
5 take it one step further and actually use the  
6 medical record and information technologies. I'm  
7 puzzled by the lack of reporting of obesity. If I  
8 understand correctly, when you report to an MTF  
9 you get vital signs, height and weight taken. If  
10 those were simply entered into your database, the  
11 BMI is calculated and, as a provider, when I come  
12 up and see my medical record and step into the  
13 room, obesity ought to be -- overweight ought to  
14 be flashing in yellow and obesity ought to be  
15 flashing in red. And if I'm not compliant, then I  
16 should have a red mark on my provider information  
17 set because I didn't do this.

18 I mean, it seems like we're only taking  
19 this half of the way and most of this is simply  
20 pushing information technology where the medical  
21 record is supposed to take us.

22 DR. DINNEEN: Right. And so, in the

1 meeting that Dr. Lockette chaired, where this was  
2 discussed at the Clinical Proponency Steering  
3 Committee, that exact issue came up -- and the CIO  
4 was in the room -- and the effort is now underway  
5 to do exactly that, to have the height and weight  
6 calculated BMI and present that to the provider  
7 when the provider sees the patient, so that the  
8 provider --

9 DR. JOHANNIGMAN: Not only that, but if  
10 I, as a patient, am in the obese BMI, then the  
11 database ought to be looking up my cholesterol.  
12 The database ought to be targeting my blood  
13 pressure. The database ought to be -- there's a  
14 bunch of triggers that ought to occur seamlessly.

15 You know, we have to take this down the  
16 full iteration and it would make it seamless. And  
17 I think you will find your providers will embrace  
18 that because it makes their life simpler and makes  
19 them a more thorough care provider.

20 DR. DINNEEN: We totally agree. It's  
21 all in the execution. Totally agree.

22 DR. DICKEY: Dr. Carmona?

1                   DR. CARMONA: Just a brief comment about  
2 this. Almost a decade ago, the Surgeon Generals  
3 and I started working on this issue and one of the  
4 things that we found that seems to be repetitive  
5 is this: I guess, what I jokingly used to say,  
6 the one degree that I needed to be more effective  
7 as a Surgeon General was really that of an  
8 anthropologist because, ultimately, it comes down  
9 to culture.

10                   And what I just heard today was not  
11 different than I heard almost a decade ago where  
12 -- both on the civilian side and the military  
13 side, where people didn't want to put that in. On  
14 the civilian side, well, I might get sued if I  
15 call somebody fat, plus this BMI doesn't work so  
16 well. On the military side it was more of, well,  
17 I'm worried about their careers. If I put this in  
18 there it could be a problem for promotion. It  
19 could be a problem for evaluation. So, again, as  
20 we spoke this morning, I see the barriers to entry  
21 of all of this good science, ultimately, is  
22 breaking a cultural barrier that doesn't allow us

1 to use the good science for the benefit of the  
2 troops.

3 DR. DICKEY: Interesting point. Good  
4 point. So, tell us how we overcome those  
5 barriers, Dr. Dinneen?

6 DR. DINNEEN: I do think your point is  
7 well taken. I have a daughter who's a sociologist  
8 and, particularly, she continues to remind me that  
9 quantitative information has to be linked with  
10 qualitative information. And one of the things  
11 that I was introduced to not long ago at Kaiser  
12 Permanente was they're trying to address this  
13 issue of readmissions, which, again, is one of our  
14 measures.

15 What they did at Kaiser Permanente, and  
16 they presented at our conference last year, was an  
17 ethnography of 600 admissions where what they did  
18 is they took the last 600 readmissions and they  
19 went to the homes of the patients with a video  
20 camera and video recorded what was going on in the  
21 home. And they learned that all the fancy  
22 discharge planning that was done was not nearly as

1 critical as what happened after the patient got  
2 home. And very specific things about  
3 reconciliation and medications, what telephone  
4 number they were given to call. And so the  
5 cultural barriers are not necessarily as high as  
6 you might think, if we get better at understanding  
7 at the one level -- at the individual level --  
8 what's going on that leads to some of these  
9 outcomes.

10 What changed me to lose the 20 pounds  
11 wasn't the doctor telling me, it was my daughter  
12 telling me she was embarrassed to be in public  
13 with me. So, I mean, we have to sort of think  
14 through what are those barriers.

15 DR. DICKEY: Ouch.

16 DR. CARMONA: If I might just make --  
17 Rich Carmona -- one more comment. We chased this  
18 for a number of years and until we started looking  
19 at the data and saw that one of the primary  
20 reasons young men and women were not retained on  
21 Active Duty had to do with obesity or the chronic  
22 disease associated with obesity, type 2 diabetes,

1 hypertension, hyperlipidemia, et cetera. So we  
2 found it is the most proficient accelerator or a  
3 cause of chronic disease.

4           It wasn't until we got wise, and then  
5 scheming with my fellow Surgeons General, that we  
6 figured science doesn't sell for science itself,  
7 but at the press conference when we spoke of  
8 obesity being a national security problem, it got  
9 traction. And then, of course, the questions  
10 followed.

11           What do you mean by this being a  
12 national security problem? Well, let's look at  
13 what's happening with recruitment and retention of  
14 both officers and enlisted personnel in the  
15 military. Let's look at workforce projections to  
16 the future. Let's look at cost of health care as  
17 it relates to obesity and chronic disease, both  
18 for the military and civilian. And then we  
19 started to get traction, but in the midst of two  
20 theaters of war, anthrax attacks, and everything  
21 else, it was really tough to get traction on this  
22 issue. Yet it may be one of the most important

1       that we have to move forward rapidly, both for  
2       cost and quality and care.

3               DR. DINNEEN:  Yes, sir.  The thing that  
4       comes to mind in that is the leadership we've had  
5       in the last few years in getting a much tighter  
6       relationship built between ourselves and Personnel  
7       and Readiness, and the fact that the partnerships  
8       that have to occur to address the population  
9       health issues are being built.

10              The other thing that's been  
11       extraordinary the last two years has just been the  
12       support we've gotten from Chairman Mullen and from  
13       the Secretary of Defense in addressing those  
14       issues.  But I think it's understanding us as  
15       employer that might help us turn that corner --  
16       that cultural corner you're talking about.

17              Perhaps I could -- if it would be all  
18       right if I could go to where we're going in the  
19       future, a little bit?

20              DR. DICKEY:  Please.

21              DR. DINNEEN:  And one thing -- this  
22       comes from some work we've been doing now with

1 Kaiser Permanente and what I'd like to show you is  
2 a few slides. This, again, is just reminding you  
3 of the Triple Aim.

4           These are measures now that are being  
5 proposed to really re-examine what we mean by  
6 population health and how we measure it. And this  
7 is Matt Stiefel's work from his work in IHI, as  
8 well as his work at Kaiser Permanente, so he would  
9 say that measuring population health -- and I  
10 haven't shown this before, so it's just open  
11 critique here, it's just an idea -- is that you  
12 really want to measure three different things to  
13 understand population health. You want to measure  
14 -- going from the bottom to the top -- a risk  
15 status, a health risk appraisal, and right now I  
16 think we do not in the military health system have  
17 a consistent health risk appraisal that we're  
18 getting on everybody.

19           We do the PDHA, PDHRA for Active Duty,  
20 but in terms of the total population we serve and  
21 then, the on-going measure of disease burden.  
22 So, last year we did a one-time look at the rate

1 of disease, but we should be measuring this on a  
2 regular basis so that population health is a  
3 combination of preventing illnesses from  
4 occurring, but also reducing the burden on the  
5 whole population by the diseases that do exist.

6           And then, third, it would be true  
7 outcomes. So are we measuring true outcomes in  
8 population health, both mortality and healthy life  
9 expectancy? And some of the work that some other  
10 systems are doing right now, they're actually  
11 getting at all of these measures. Not all at  
12 once, but in pieces. And so I'd like to show you  
13 a little bit of data about this, but also show you  
14 the model on a little bit more of a graphical  
15 format.

16           You'll just notice that experience of  
17 care and per capita cost are the other two  
18 elements of the Triple Aim, and for us it would  
19 add readiness as well.

20           So, what is population health? What  
21 influences? How do we measure it? How do we  
22 improve it?

1                   Now this is a little bit busy, but I  
2 think it is really a nice way to depict  
3 understanding population health, and please stop  
4 me if this is common sense to everybody. But it  
5 wasn't to me, especially as somebody who is trying  
6 to measure this. So, working from left to right,  
7 if I could?

8                   We know that we have to think about the  
9 genetic endowment, prevention and health  
10 promotion, socioeconomic factors, and physical  
11 environment as determinants. But then, in the  
12 middle, there are the main things that in some  
13 ways we can modify: resilience, hopefully;  
14 physiological risk factors; and behavioral risk  
15 factors. And I like it that we differentiate  
16 behavioral from physiological risks. So  
17 physiological risk being things like cholesterol.  
18 Behavioral things like unhealthy behaviors, people  
19 engaging in activities that could get them sick.

20                   And then, as you move across, that moves  
21 you into disease and injury which either can  
22 result from those things in your environment or

1 from your behaviors and your risks. We should be  
2 able to measure that as an intermediate outcome and  
3 then states of health become the true outcome.  
4 So, how are we doing in terms of function? And  
5 how are we doing in terms of mortality?

6           And then, finally, as was mentioned when  
7 this was presented to conference, the Holy Grail  
8 of well-being, well-being being the larger concept  
9 of a combination of how I understand my life, how  
10 I'm feeling today, if you will, my self  
11 evaluation, and then how I evaluate my life in the  
12 context of what I expected. So, how I'm  
13 experiencing my life, how I'm evaluating my life  
14 becomes well-being. A broader concept.

15           So what's exciting about this to me is  
16 that there is the opportunity for us to expand  
17 what we have. If you'll notice on your paper  
18 there, what we have in population health is really  
19 just risky behaviors and screenings. What we need  
20 to do, probably, is increase those measures to  
21 then look at this other area of disease burden and  
22 mortality and healthy life that we have in our

1 population.

2           So, years of potential life lost, life  
3 expectancy. And what's fascinating is you can  
4 actually get to that with Social Security data and  
5 there are organizations that are doing it. So  
6 what I'm hopefully going to be proposing is that  
7 in our population health section, that we expand  
8 our measures to include true health outcomes,  
9 disease burden, and risk status. And that that's  
10 a strategic direction we need to go in if we're  
11 really going to be reporting out how we're doing  
12 in population health.

13           So you'll see that it kind of sets up  
14 that way. Risk status on the left, disease burden  
15 in the middle, health outcomes on the right. And  
16 then health outcomes feeding this overarching  
17 concept of well-being, as what Matt Stiefel would  
18 call the Holy Grail.

19           And I'd like to talk a little bit about  
20 well-being because there's pretty good science in  
21 that as well. So, could I just ask if there's any  
22 reactions to this as a model? Yes, sir?

1 DR. CARMONA: I like the model, I just  
2 have a question for you. Rich Carmona.

3 DR. DINNEEN: Yes, sir?

4 DR. CARMONA: Is, as we look at going  
5 from risk status to disease burden, what would you  
6 think about including epigenetics between the two?  
7 That is, environment influencing the genetic  
8 predisposition, which we're finding more about  
9 every single day, that epigenetics may prove to be  
10 even a lot more important as it relates to the --  
11 you know, the genetic predisposition we know can  
12 be modified, but epigenetics is more or less the  
13 everyday tinkering of your genetic with on and off  
14 switches, and so on. Based on what you're  
15 breathing, what you're eating, what your exercise  
16 is, and so on.

17 DR. DINNEEN: That's a great idea,  
18 really.

19 DR. CARMONA: I'll pass that back to  
20 Matt today. Yes?

21 Dr. HIGGENBOTHAM: Eve Higgenbotham. To  
22 what extent -- because socioeconomic factors, we

1 know, is a significant driver in the private  
2 sector -- to what extent there is the endurance of  
3 those factors within the military health system.  
4 Since everyone has health care, are there some,  
5 you know, lingering impacters of socioeconomic  
6 status? And I guess that's one question.

7 The other question is whether or not  
8 we're minimizing that impact. I guess I'm  
9 assuming that it still is an impact if, you know,  
10 leaving it out of the individual risk factors in  
11 some ways?

12 DR. DINNEEN: Yes. In fact, in the  
13 third section I wanted to actually talk a little  
14 bit about that. So it may make sense -- it may  
15 introduce that concept right now and then we can  
16 come back to this if you want because I am  
17 respectful of your time.

18 So the third section is just the concept  
19 of well-being. If you haven't been introduced to  
20 this, it's a body of work that is also related to  
21 the positive psychology folks, so this is actually  
22 a model that is adapted from something Uwe

1 Reinhardt had -- the health care economist -- that  
2 goes from health care production processes leading  
3 to health care outcomes and then health being a  
4 contributor to well-being production processes,  
5 leading to well-being.

6           It's fairly simple at that level. And  
7 if we go to the next page -- I think I gave you  
8 this -- all the traditional things we focus on so  
9 heavily now that lead to health care production  
10 and health care outcomes, but I think we know from  
11 the work done by public health folks is that  
12 health care only contributes, in terms of health  
13 production, about 10 to 20 percent. And that, for  
14 instance, healthy behavior is 30 to 40 percent.  
15 Childhood development and education and the  
16 socioeconomic factors that you were mentioning are  
17 significant contributors to health outcomes.

18           But then, as you move up from -- and  
19 this would get so complicated if you tried to put  
20 all the feedback loops in, but basically -- so  
21 bear with me for a moment.

22           The folks, Dr. Diener and Dr. Keineman,

1 have been writing on this issue and have actually  
2 been studying for a number of years those things  
3 that contribute to or build well-being. And that  
4 literature suggests that although all of these  
5 contributors are important, it's actually your  
6 career, how you spend the majority of your day,  
7 that is the biggest contributor to overall  
8 well-being and whether you're satisfied and happy  
9 in going to work.

10           And the number that always comes out is  
11 that 20 percent of Americans will answer yes to  
12 the question, are you pleased about going to work  
13 today? The next social is the nature of your  
14 intimate relationships, so your family as well as  
15 your friends. Income and wealth, it's really  
16 about are you worrying about money? Do you have  
17 worries about your financial health? Health is  
18 the fourth and that's both psychological and  
19 physical. And then the fifth is community, and  
20 that's really about a sense of belonging to a  
21 bigger community that you contribute to.

22           And one of the things that's the biggest

1 driver, it turns out in this literature of  
2 well-being, is volunteerism. So do you volunteer  
3 your time? Do you play on a softball team? Do  
4 you contribute to a -- do you coach? Those kinds  
5 of -- as builders of well-being.

6 So, as we -- the reason I wanted to  
7 bring this up is that Dr. Stanley has actually  
8 published a strategic plan under Secretary of  
9 Defense for Personnel and Readiness. And the  
10 second of his five goals is actually improving the  
11 readiness and well-being of the force and their  
12 families. And we are a contributor to that, but  
13 now getting back to your question.

14 Do we have the right policies in place  
15 to maximize the well-being -- not the  
16 socioeconomic status -- of the force and their  
17 families? And so, there actually is some nice  
18 work done on this. Derek Bok, former President  
19 of Harvard, has written a book called, "The  
20 Politics of Happiness," where he looks at the  
21 policy implications of actually trying to increase  
22 the well-being -- or they use that synonymously

1 with "happiness" -- of a population.

2           And we have a real opportunity in the  
3 Department of Defense to say do we have the right  
4 alignment of programs, including health, that  
5 along with a benefit structure, along with our  
6 community programs, what we're doing in our  
7 commissaries, what we're doing in our schools to  
8 build the well-being of the force and their  
9 families?

10           And so I'm very pleased to say he has  
11 authorized the organization to go out and measure  
12 well-being, using the standard way it's being  
13 measured by Gallup. And Gallup is now involved in  
14 this program where they're measuring well-being  
15 every day. A thousand people in America, every  
16 day, for 25 years. So we'll have data on the  
17 Department of Defense probably in about four  
18 months. We don't know if we'll use Gallup, but  
19 we'll have some well-being measure within about  
20 four months.

21           So I just wanted to kind of put that in  
22 context. What we're measuring now: This concept

1 of population health as including risk factors,  
2 disease burden, and overall outcomes. And then,  
3 that we're in a broader context of as a health  
4 system promoting health to build well-being.

5 Yes, sir?

6 DR. CARMONA: Just a comment, and I'd  
7 like to hear your opinion. You know, about two  
8 years ago, our colleagues at WHO put out the  
9 report on the social determinants of health, which  
10 gets to what Eve was just mentioning. And  
11 although it's amazingly parallel to what you have  
12 here, I sense intuitively that the variables  
13 within the military are going to be different  
14 social determinants, although they would be skewed  
15 because most of the people do have a job, and do  
16 have an income, but some of the social factors may  
17 be different. And, of course, deployments become  
18 an issue, where you don't have that on the  
19 civilian side.

20 So, although remarkably similar  
21 platforms that you start from, I think there will  
22 be variability in the variables that we are going

1 to look at.

2 DR. DINNEEN: Right. What's so exciting  
3 about this is, if we do do this using the same  
4 methodology, we'll be able to benchmark and right  
5 now because a significant portion of the United  
6 States has had military experience, Gallup has  
7 surveyed about 18,000 -- something like that --  
8 military. So we already have some benchmark data,  
9 and we look pretty good.

10 But the more important question is how  
11 are we different? And what can we do to actually  
12 focus efforts to improve that even more?

13 DR. FOGELMAN: I want to tell you about  
14 something that I'm struck by. When you were  
15 talking about career and you said 20 percent of  
16 the people like going to work, there is a very  
17 powerful Gallup finding, which I use on a regular  
18 basis, that only 20 percent in the world answer  
19 yes to the following question: At work every day,  
20 do you have the opportunity to do what you do  
21 best?

22 DR. DINNEEN: Right. That's in the

1 survey.

2 DR. FOGELMAN: Which is -- and I'm  
3 really interested to see how that turns out in our  
4 population.

5 DR. ANDERSON: I think one of the things  
6 -- if I could just free associate with that for  
7 just a moment -- is that we're in the midst now of  
8 examining a lot of opportunities for pay for  
9 performance in health care. And I think one of  
10 the concerns that's raised by the folks that are  
11 looking at human motivation is that when you look  
12 at folks in the military, they have a real sense  
13 of purpose. And if you monetize that, do you risk  
14 losing that sense of purpose?

15 So one of the biggest drivers of saying  
16 yes to that question about do I like going to  
17 work, is whether the work that you do has purpose.  
18 And that's something we need to capitalize on in  
19 our organization because a lot of people feel that  
20 way that are in the military or the GS side of the  
21 house and we want to be careful not to lose that.  
22 So I think getting some of this data may help us



1       that's one of the joys of this job that I have, is  
2       that I am able to go out and visit with others.  
3       And so, Bellin Health presented some data just  
4       last week where they actually showed, this is --  
5       the blue is the Bellin Health risk assessment  
6       score and higher is better. So they've worked to  
7       get that number to go up. Wouldn't it be great if  
8       we in the Department of Defense could show some  
9       more sort of data?

10               DR. ANDERSON: Well, I'm talking about,  
11       you know, across the population.

12               DR. DINNEEN: Right.

13               DR. ANDERSON: Yeah.

14               DR. DINNEEN: Exactly. And yet, we've  
15       had difficulties because -- and it's been in  
16       execution. We didn't have a -- you know, I don't  
17       know all the details, but I did work on that for a  
18       number of years. But I think we have another  
19       opportunity now.

20               As we have said, one of our aims is  
21       population health. One of the aspects is health  
22       risk assessment, but let's look at that again and

1 see if we can get it right.

2 DR. ANDERSON: Yeah, and understand, I'm  
3 not a critic. I'm just saying, there were  
4 population health people advising the TRICARE  
5 designers 15 and more years ago. And so when you  
6 get the Quadruple Aim going, this is pretty  
7 fundamental.

8 DR. DINNEEN: Yes.

9 DR. ANDERSON: It's actually got to  
10 execute now. And, by the way, that's George  
11 Anderson speaking.

12 (Laughter)

13 DR. DINNEEN: And the other thing that's  
14 good now is that a lot of work has been done on  
15 health risk assessments by civilians, so there are  
16 nonproprietary surveys out there now that we could  
17 simply take advantage of and then have  
18 benchmarkable data. So, again --

19 DR. ANDERSON: I'm sorry, but I have to  
20 say this. One of the reasons that we could do  
21 that back two decades ago was the Services  
22 couldn't agree about what the standardized health

1 risk appraisal was going to be. And we worked  
2 real hard in the Air Force to have one and it was  
3 just hard to agree.

4 DR. DINNEEN: It's been very difficult  
5 to get almost any of these measures to be agreed  
6 across the three Services. (Laughter) But I  
7 think leadership is really doing a great job  
8 getting there because I couldn't have shown you  
9 anything like this three or four years ago.

10 DR. DICKEY: Dr. Dinneen, if you'll just  
11 choose the ones that I score high on, then I'll  
12 agree with him. (Laughter) And that's the  
13 problem. We all score differently on different  
14 ones.

15 DR. DINNEEN: So that's all I had. It's  
16 been a very enjoyable opportunity to dialogue.

17 DR. ANDERSON: Thank you.

18 DR. DICKEY: Excellent report and  
19 interesting information. We'll look forward to  
20 continue to hear updates on this as well.

21 DR. DINNEEN: And if anybody wants the  
22 full set, just ask me. I'll be happy to send it

1 along if Mr. Middleton says it's okay.

2 DR. DICKEY: Great. Thank you very  
3 much.

4 DR. FOGELMAN: I just want to say that  
5 one of the reasons that we get good attendance at  
6 the Psychological Health Subcommittee is because  
7 we've arranged for Dr. Dinneen to come every time.  
8 Because every time he talks to us, it's one of  
9 these wonderful things. So I would suggest that  
10 you just bring him back here all the time.

11 DR. DICKEY: There's about 30 of us  
12 around the table, do you suppose you can come give  
13 a pep talk at each of our sites? (Laughter) We  
14 may have to clone him.

15 I need to know, is there an overlap  
16 between the 20 percent you get to do something  
17 meaningful and the 20 percent who like going to  
18 work? Yeah. Almost total overlap, I bet.

19 SPEAKER: Thanks, Mike.

20 DR. DICKEY: Thank you very much. Well,  
21 you have put in a long and, hopefully, productive  
22 day. Before we close for the afternoon, Ms. Bader

1 would you like to give us an administrative  
2 comment?

3 MS. BADER: Sure. Thank you. Thank  
4 you, Dr. Dickey. And for those members that are  
5 departing today, there's a manila envelope inside  
6 your binder, so that you can remove the contents  
7 of your notebook and take it with you.

8 For those that are heading to the  
9 airport -- I know some folks have to leave this  
10 evening -- there is a shuttle here at the hotel.  
11 You can just go to the front desk. And for  
12 additional information, always Jen Klevenow is the  
13 queen of logistics for the Defense Health Board.

14 As a reminder, the Board will be meeting  
15 in closed session tomorrow to receive a series of  
16 classified briefings. Registration is, therefore,  
17 closed to the public. Board members and invited  
18 guests are kindly requested to convene, those that  
19 are staying here, in the lobby -- in the hotel  
20 lobby by 7:15 tomorrow morning, at which time we  
21 will board the shuttle to the Army National Guard  
22 Readiness Center. Registration will begin at 8:00

1 a.m. at the Center and the meeting will be called  
2 to order by 8:15. There will be breakfast in the  
3 room that will remain in the room until about  
4 8:35, and then that will be cleared out.

5 And the breakfast room and the  
6 registration room -- everything's being held in  
7 the same section of the Army Readiness Center.  
8 And I'm going to now turn it over to Jen because  
9 I'm sure folks have questions about luggage and  
10 taxis and things along those lines for tomorrow.

11 MS. KLEVENOW: Okay, as Ms. Bader  
12 mentioned, we're leaving here at 7:15 tomorrow  
13 morning. There is a separate room at the Guard  
14 Center for folks to store luggage, for those of  
15 you that are going to go to the airport after the  
16 meeting tomorrow. Those that do go to the airport  
17 as well, we will obtain taxis for you to get to  
18 the airport. There won't be a return shuttle back  
19 to the hotel for those staying an additional night  
20 only because there's just a few of you. For those  
21 few, we'll put you in a cab and then you'll be on  
22 your way.

1                   We do have lunch planned tomorrow as  
2 well. Lunch will be in a separate room on the  
3 first floor of the Guard Center. For those of you  
4 that are local and are driving in, I do have most  
5 of you on the list and reserved parking for you.  
6 If you wouldn't mind on your way out, if you could  
7 just tap me on the shoulder just to make sure that  
8 I have you on the list just to make sure there's  
9 no mishaps at the gate tomorrow, that would be  
10 appreciated for all of us.

11                   And any questions?

12                   SPEAKER: What if we want to have dinner  
13 tonight?

14                   MS. KLEVENOW: Dinner tonight? 6:30 at  
15 Café Italia, 21st Street, up about four blocks  
16 from here. There's also a shuttle leaving from  
17 the hotel lobby at 6:15. Cash payment, \$32 to me.  
18 Exact change is appreciated.

19                   MS. BADER: And the restaurant is less  
20 than a mile, if you choose to walk.

21                   MS. KLEVENOW: Yes. Nice day.

22                   MS. BADER: Yeah, it's a nice day. So

1       you would just depart the hotel and head towards  
2       Crystal City, 32nd Street.

3                   SPEAKER:  32nd or 21st?

4                   MS. BADER:  Oh, wait.  23rd, my apology.  
5       We'll walk you a little farther.  (Laughter)  We  
6       all need the exercise and we'll improve Mike's  
7       metrics.  23rd Street, I apologize.

8                   DR. DICKEY:  All right, so everybody's  
9       got the logistics for tonight?  Everybody's got  
10      the logistics for in the morning?  Any other  
11      questions of concerns?  Any other directions?

12                   MS. KLEVENOW:  Nope, that's it.

13                   DR. DICKEY:  All right.  We stand  
14      adjourned until tomorrow.

15                               (Whereupon, at 4:39 p.m., the  
16      PROCEEDINGS were adjourned.)

17                               \* \* \* \* \*

18

19

20

21

22

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

CERTIFICATE OF NOTARY PUBLIC

COMMONWEALTH OF VIRGINIA

I, Stephen K. Garland, notary public in  
and for the Commonwealth of Virginia, do hereby  
certify that the forgoing PROCEEDING was duly  
recorded and thereafter reduced to print under my  
direction; that the witnesses were sworn to tell  
the truth under penalty of perjury; that said  
transcript is a true record of the testimony given  
by witnesses; that I am neither counsel for,  
related to, nor employed by any of the parties to  
the action in which this proceeding was called;  
and, furthermore, that I am not a relative or  
employee of any attorney or counsel employed by the  
parties hereto, nor financially or otherwise  
interested in the outcome of this action.

-----

Notary Public, in and for the Commonwealth of  
Virginia

My Commission Expires: July 31, 2015

Notary Public Number 258192

