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**DEFENSE HEALTH BOARD MEETING**

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**Monday, August 8, 2011**

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**Hotel Murano  
Venice Ballroom 3-4  
1320 Broadway  
Tacoma, Washington 98402**

The above-entitled meeting was convened, pursuant to notice, at 9:32 a.m.

**PARTICIPANTS**

**DEFENSE HEALTH BOARD MEMBERS:**

MAJOR GENERAL (Ret.) GEORGE K. ANDERSON, M.D.

M. ROSS BULLOCK, M.D., Ph.D.

Vice Admiral (Ret.) RICHARD H. CARMONA, MD,  
MPH, FACS, Vice President

REVEREND ROBERT GLENN CERTAIN, Dmin

REAR ADMIRAL PETER J. DELANY, Ph.D.

NANCY W. DICKEY, MD, Chair

EVE HIGGINBOTHAM, M.D.

DAVID ALLEN HOVDA, Ph.D.

COLONEL (Ret.) DONALD JENKINS, M.D., FACS,  
DMCC

JAY A. JOHANNIGMAN, M.D., FACS, FCCM

GENERAL (Ret.) RICHARD MYERS, Vice

President

DENNIS S. O'LEARY, M.D.

HONORABLE TOGO WEST, JR.

PUBLIC ATTENDEES AND PRESENTERS:

SHARON AIELLO

CAPTAIN JOHN ALVITRE

RICHARD BECKER

CARRIE BERNARD

CAPTAIN REX BROADRICK

COLONEL TOMMY BROWN

DAVY BUSH

COLONEL RUSSELL COLEMAN

DR. LARRY KNAUSS

BRIGADIER GENERAL MARK A. EDIGER

JAY EBBESON

CAPTAIN PAUL HAMMER

MAJOR DAVID HARPER

COLONEL DALLAS HOMAS

CAPTAIN CLINT NOLD

CAPTAIN DAVE KORMAN

DR. KURT KROENKE (telephone)

MAJOR JASON LANE

BOB LEVIN

DR. GEORGE LUDWIG

COLONEL JULIA LYNCH

CAPTAIN TRISTAN MANNING

JOE MENES

CAROLINE MINER

MASTER SERGEANT HAROLD MONTGOMERY

DR. MICHAEL PARKINSON

DR. JOSEPH SILVA

MAJOR ANNE STERLING

CAPTAIN ADAM STOVER

COLONEL DAVID VETTER

MAJOR GENERAL PHILIP VOLPE

DEFENSE HEALTH BOARD STAFF:

ALLEN MIDDLETON, Designated Federal Official

CHRISTINE BADER, Director

COL WAYNE HACHEY, Executive Secretary

MARIANNE COATES

OLIVERA JOVANOVIC

JEN KLEVENOW

LIZ MARTIN

HILLARY PEABODY

SERVICE LIAISONS:

LIEUTENANT COLONEL PATRICK GARMAN, USA, MS

CAPTAIN PATRICK LARABY, MD, MPH, MS, MBA,

FACOEM

COMMANDER WILLIAM PADGETT, MC, USN

COMMANDER ERICA SCHWARTZ, USPHS

COLONEL SCOTT STANEK

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

2 9:32 a.m.

3 Welcome and Call to Order

4 CHAIR DICKEY: If everyone will  
5 please be seated. I'd like to welcome  
6 everyone to this meeting of the Defense Health  
7 Board. I'm Nancy Dickey, and I'm president of  
8 the Board, and we have several important  
9 topics on our agenda.

10 Before we get started, though, I'd  
11 like to remind everyone that we do have some  
12 Board members who are calling in, and in order  
13 for them to be able to hear you, you must use  
14 your microphone. So please be sure you turn  
15 your mic on and identify yourself, so they  
16 know who they're hearing. With that, Mr.  
17 Middleton, would you please call us to order.

18 MR. MIDDLETON: Thank you, Dr.  
19 Dickey. As the Designated Federal Officer for  
20 the Defense Health Board Federal Advisory  
21 Committee, and a continuing independent  
22 scientific advisory board to the Secretary of  
23 Defense, the Assistant Secretary of Defense

1 for Health Affairs, and the Surgeon Generals  
2 of the military departments, I hereby call  
3 this meeting of the Defense Health Board to  
4 order.

5 **Opening Remarks**

6 CHAIR DICKEY: Thank you, Mr.  
7 Middleton. Now carrying on the tradition of  
8 our board, I'd ask that we stand for one  
9 minute of silence, to honor the men and women  
10 who serve our country.

11 (Whereupon, a moment of silence was  
12 observed.)

13 **Introductions**

14 CHAIR DICKEY: Thank you. Since  
15 this is an open session, before we begin, I'd  
16 like to go around the table and have the Board  
17 and distinguished guests introduce themselves,  
18 and Colonel Hachey, shall we start in your  
19 direction?

20 COL HACHEY: Hi. Wayne Hachey,  
21 Executive Secretary, Defense Health Board.

22 COL HOMAS: I'm Colonel Dallas  
23 Homas. I'm the commander of Madigan Army

1 Medical Center, and the Director of Health  
2 Services at Joint Base Lewis-McChord.

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

5 REV. CERTAIN: Robert Certain, and  
6 I'm a retired Air Force chaplain, former  
7 combat aviator, prisoner of war in Vietnam and  
8 Episcopal priest.

9 DR. HOVDA: I'm David Hovda. I'm a  
10 Professor of Neurosurgery and Molecular and  
11 Medical Pharmacology at UCLA. I'm the  
12 Director of the UCLA Brain Injury Research  
13 Center.

14 BRIG GEN EDIGER: Hi. I'm Mark  
15 Ediger. I'm the Commander of the Air Force  
16 Medical Operations Agency, representing the  
17 Air Force Surgeon General, Lieutenant General  
18 Green.

19 CAPT HAMMER: I'm Captain Paul  
20 Hammer. I'm the Director of the Defense  
21 Centers of Excellence for Psychological Health  
22 and Traumatic Brain Injury.

23 COL STANEK: Colonel Scott Stanek,

1 Office of the Assistant Secretary of Defense  
2 for Health Affairs, Force Health Protection  
3 and Readiness.

4 CDR SCHWARTZ: Hi. I'm Erica  
5 Schwartz. I'm the Preventive Medicine Liaison  
6 for the Coast Guard.

7 CDR PADGETT: Commander Bill  
8 Padgett, Marine Corps Liaison.

9 LTC GARMAN: Lieutenant Colonel  
10 Patrick Garman. I'm the Director of the  
11 Military Vaccine Agency, and I'm representing  
12 the OTSG today also.

13 CAPT LARABY: I'm Captain Patrick  
14 Laraby. I'm the Director for Public Health at  
15 the Navy's Bureau of Medicine and Surgery.  
16 I'm serving as the Navy liaison today.

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

21 DR. PARKINSON: Mike Parkinson. I  
22 work with health care organizations and  
23 employers around innovations and financing in

1 the delivery of health care as a consultant.  
2 Former member of the Board and co-chair with  
3 Dr. Silva of the Psych Complementary  
4 Alternative Medicine Group, a guest today.

5 DR. JENKINS: Don Jenkins, Chief of  
6 Trauma, Mayo Clinic, Rochester, and the chair  
7 of the Trauma and Injury Subcommittee.

8 DR. HIGGINBOTHAM: Eve  
9 Higginbotham, Senior Vice President and  
10 Executive Dean for Health Sciences, Howard  
11 University in Washington, D.C.

12 DR. ANDERSON: George Anderson,  
13 Board Member, Executive Director of the  
14 Association of Military Surgeons of the U.S.  
15 and a retired Air Force medical officer.

16 MG VOLPE: Good morning. I'm  
17 Phil Volpe. I'm the commander of the Western  
18 Region Medical Command, the Army's Western  
19 Region Medical Command, and also the Senior  
20 Market Executive for the Multiservice Market  
21 Office, TRICARE Puget Sound.

22 DR. CARMONA: Good morning. I'm  
23 Richard Carmona, former Surgeon General and

1 Vice President, Defense Health Board.

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

5 MR. MIDDLETON: Good morning. I'm  
6 Allen Middleton. I'm the Deputy Assistant  
7 Secretary of Defense for Health Budgets and  
8 Financial Policy, and the Designated Federal  
9 Official for the Defense Health Board.

10 CHAIR DICKEY: And I'm Nancy  
11 Dickey. I'm the President of the Texas A&M  
12 Health Science Center, and President of the  
13 Defense Health Board. Thank you. Well, let's  
14 see. We usually want to go down. Have you  
15 got a microphone we can share?

16 MS. BERNARD: Good morning. I'm  
17 Carrie Bernard. I'm Madigan Army Medical  
18 Center's Media Relations Officer.

19 MR. EBBESON: Good morning. I'm  
20 Jay Ebbeson. I'm the Director of Strategic  
21 Communication for Madigan.

22 MS. AIELLO: Good morning. My name  
23 is Sharon Aiello. I'm the Public Affairs

1 Officer for the Western Regional Medical  
2 Command.

3 MR. LEVIN: Good morning. I'm Bob  
4 Levin with the city's Community and Economic  
5 Development Department, Private Capital  
6 Division Manager.

7 DR. KNAUSS: Good morning. I'm  
8 Larry Knauss, child psychologist at Madigan.

9 DR. LUDWIG: Good morning. I'm  
10 George Ludwig. I'm the Deputy Principal  
11 Assistant for Research and Technology at the  
12 U.S. Army Medical Research and Materiel  
13 Command.

14 COL COLEMAN: Good morning. Russ  
15 Coleman, Commander, U.S. Army Medical Materiel  
16 Development Activity, MRMC.

17 MR. BUSH: Good morning. I'm Davy  
18 Bush. I'm the regional analyst for the  
19 Military Vaccine Agency.

20 MSG MONTGOMERY: Harold Montgomery.  
21 I'm the senior medic with the Army 75th Ranger  
22 Regiment.

23 MAJ STERLING: Major Anne Sterling,

1 Executive Officer, Madigan Army Medical  
2 Center.

3 MAJ LANE: Major Jason Lane,  
4 Executive Officer from Madigan Army Medical  
5 Center.

6 CAPT (RET) BECKER: Good morning,  
7 Richard Becker, Service Area Director for  
8 Western Washington with TriWest Healthcare  
9 Alliance.

10 MR. MENES: Good morning. I'm Joe  
11 Menes, Public Affairs Officer for the National  
12 Center for Telehealth and Technology.

13 MS. COATES: Good morning.  
14 Marianne Coates, contracted consultant for the  
15 Defense Health Board in communications.

16 MS. KLEVENOW: Jen Klevenow, DHB  
17 support staff.

18 MS. JOVANOVIC: Good morning. I'm  
19 Olivera Jovanovic, Senior Analyst, DHB,  
20 contracted support staff.

21 MS. MARTIN: Good morning. I'm Liz  
22 Martin, analyst, DHB support staff,  
23 contracted.

1 MS. PEABODY: Good morning.  
2 Hillary Peabody, also an analyst with the DHB,  
3 contracted support staff.

4 CHAIR DICKEY: Thank you, everyone.  
5 We're delighted to have our guests with us  
6 today, and appreciate all of our liaisons as  
7 well. I think with that, Ms. Bader, would you  
8 like to provide some administrative remarks?

9 **Administrative Remarks**

10 MS. BADER: Sure. May I ask Dr.  
11 Delany and General Myers, are you on line?

12 (Chorus of yeses.)

13 MS. BADER: Fantastic. Is anybody  
14 else on the line?

15 HON. WEST: Togo West, good  
16 morning.

17 MS. BADER: Excellent. Good  
18 morning, sir. Thank you for joining us.

19 DR. JOHANNIGMAN: Jay Johannigman.

20 MS. BADER: Good morning, Jay.  
21 Thank you very much for joining as well.  
22 Okay. With that, I'd like to make some  
23 administrative remarks. Good morning and

1 welcome to this meeting of the Defense Health  
2 Board.

3 Of course, I'd like to thank the  
4 hotel for helping with the meeting  
5 arrangements, as well as some of the contract  
6 staff that have already introduced themselves,  
7 Jen Klevenow, Jessica Santos, Lisa Jarrett, as  
8 well as Liz Martin, Hillary Peabody and  
9 Olivera Jovanovic, who worked very, very hard  
10 to put these meetings together, as well as  
11 Jean Ward.

12 I'd also like to thank all of  
13 today's speakers, who also have worked  
14 diligently to prepare the briefings for the  
15 Defense Health Board this morning.

16 I will ask that everyone please  
17 sign the Board attendance sheets on the table  
18 outside, and kindly indicate any recent change  
19 to your contact information, if it is not  
20 accurately reflected on the roster.

21 For those who are not seated at the  
22 table here this morning, handouts are provided  
23 on the table in the back of the room.

1 Restrooms are located just outside of the  
2 meeting room, and for telephone, fax and  
3 messages, please see Jen Klevenow, who  
4 introduced herself earlier today.

5           Because this is an open session and  
6 the meeting is being transcribed, please  
7 ensure that you state your name clearly before  
8 you speak, and use the microphones so that our  
9 transcriber can accurately record your  
10 questions and your comments. I will also ask  
11 that specifically today, so that the folks who  
12 have so generously offered their time to dial  
13 in can hear you clearly. That would be very  
14 important today.

15           Refreshments will be available for  
16 both morning and afternoon sessions, and we  
17 will have a working lunch for Board Members,  
18 liaisons and invited guests. For others  
19 looking for lunch options, the hotel  
20 restaurant is open for lunch, and there are  
21 other dining options in the local area.

22           Please note that short biographies  
23 will be read for each of our speakers today,

1 and more detailed bios can be found in your  
2 meeting binders. With that, I will turn the  
3 meeting back over to Dr. Dickey. Thank you.

4 CHAIR DICKEY: Thank you, Ms.  
5 Bader. It's my pleasure to introduce the  
6 newly-elected Defense Health Board co-vice  
7 presidents. On the phone with us this  
8 morning, General Richard Myers. Dr. Myers or  
9 General Myers, we're glad you're with us, and  
10 here at the table, Dr. Richard Carmona.

11 By majority vote, the Board has  
12 elected General Myers to serve as First Vice  
13 President, and Dr. Carmona to serve as Second  
14 Vice President. The Board is grateful to both  
15 of you for your willingness and interest to  
16 serve in this capacity. I know we will  
17 benefit tremendously from your wisdom,  
18 experience and particularly in these roles,  
19 your leadership.

20 So I extend my heartfelt welcome,  
21 and look forward to working with both of you.

22 GEN MYERS: Nancy, Dick Myers.  
23 Thank you. It's an honor to serve, and I'm

1 just sorry I can't be there in person. As I  
2 heard all the local folks introduce  
3 themselves, we've got some great folks out  
4 there in Fort Lewis and McChord area, and I  
5 wish I was there to say thank you for their  
6 service.

7 **Welcoming Remarks**

8 CHAIR DICKEY: Thank you, General,  
9 for that, and again, we do appreciate you  
10 being on the phone. That's actually harder  
11 duty than being here. I thank all of you for  
12 participating in the nominations and the  
13 elections as well.

14 Without further ado, we have a  
15 number of extraordinarily important issues to  
16 come before us in the next two days, and so if  
17 we can, we'll begin our briefings. Under Tab  
18 5, for those of you who have your books in  
19 front of you, Major General Volpe is going to  
20 give us our first briefing.

21 He currently serves as the  
22 Commanding General of the Western Regional  
23 Medical Command, and Senior Market Executive

1 for TRICARE Puget Sound. He's a board-  
2 certified Family Physician, and was  
3 commissioned as a Captain in the Medical Corps  
4 in 1983, entering the Army through the Health  
5 Professions Scholarship Program.

6 Major General Volpe most recently  
7 served as the Deputy Commander, Joint Task  
8 Force, National Capital Region Medical at  
9 Bethesda Naval Base. That is a mouthful.

10 General Volpe also served as the  
11 co-chair of the Department of Defense Task  
12 Force on the Prevention of Suicide by members  
13 of the Armed Forces. Without further delay, I  
14 present General Philip Volpe, and we're  
15 looking forward to your remarks. General.

16 MG VOLPE: Thank you, Nancy.  
17 It's a pleasure to be here. Can everybody  
18 hear me okay?

19 Okay, great. Thank you. Welcome  
20 everybody to Tacoma, Washington, the great  
21 Pacific Northwest, Puget Sound area. It is  
22 indeed a pleasure to be able to give you an  
23 overview of the Western Region Medical Command

1 in this area. I'm joined by my colleague and  
2 friend, Colonel Dallas Homas over here, who's  
3 the commander of Madigan Army Medical Center  
4 and is the Director of Health Services for  
5 Joint Base Lewis-McChord, who is the  
6 sponsoring, hosting organization for the  
7 Defense Health Board.

8 So thanks for being here, and it's  
9 really a privilege and honor to be able to  
10 share with you what we're doing in Western  
11 Region Medical Command. Dallas will focus on  
12 Madigan specifically, and I know we've got a  
13 tour tomorrow that includes some of the  
14 initiatives and some of the great projects  
15 that are going on and his great team over  
16 there at Madigan Army Medical Center.

17 So without any further ado, let's  
18 go to the next slide. Western Region Medical  
19 Command. We don't start anything without  
20 remembering why we exist as a military health  
21 organization, what military medicine is and  
22 what operational medicine is.

23 We're here to serve soldiers,

1 sailors, airmen, Marines and their families  
2 anywhere in the world, and that includes our  
3 camps, posts and stations, installations  
4 wherever we are, and that's what we're about.

5 We don't start anything without  
6 remembering why we have military medicine, and  
7 the unique aspects of military medicine, both  
8 in deployment in austere locations around the  
9 world, and the unique demands on service  
10 members and their families. Let's go to the  
11 next slide.

12 Really quickly, here's what I'm  
13 going to cover. I'm going to cover the  
14 mission, our strategy map, which is very  
15 important for us. As you all know, there's  
16 always crises and things going on every day,  
17 and you could very easily as an organization  
18 be swallowed up by the crisis du jour and the  
19 hot issue of the day.

20 So if you don't have a strategic  
21 underpinning and a road map and a strategic  
22 charter, you could sort of get lost, jumping  
23 from crisis to crisis to crisis, and never

1 really get to the root causes and the long-  
2 term solutions that you need to have in place  
3 for being a continuously improving  
4 organization and team.

5 So we are going to spend a little  
6 time on the strategy map, show you our battle  
7 rhythm, our strategic battle rhythm, which is  
8 very important to us in Western Region. I'll  
9 give you an overview of the hospitals. I have  
10 11 medical treatment facilities in the 20  
11 state region in the West, and that's what we  
12 cover at our headquarters.

13 Then I'm also going to talk a  
14 little about the Puget Sound Multiservice  
15 Market Office, and all the players that are  
16 involved in that. We have a great team.

17 I've been here a year and a half  
18 now, just absolutely impressed on how all of  
19 the service leaders, Army, Navy, Air Force and  
20 the Coast Guard and the Washington National  
21 Guard and the VA come together in a quarterly  
22 meeting over here, and collaborate and help  
23 each other out and solve problems.

1           We partner very closely, all of us,  
2 with the managed care support contractor,  
3 TriWest, who provides a great service, and  
4 then the local hospitals and medical assets in  
5 Tacoma-Seattle area and Puget Sound on the  
6 civilian side that we partner with.

7           Then talk about the key  
8 initiatives, and then just some closing  
9 thoughts. Okay, next slide.

10           Okay. Our mission statement.  
11 Really clear right up front. This has changed  
12 recently. This has just been changed about  
13 three months ago, because we wanted to make  
14 sure that we included interdisciplinary, world  
15 class and patient-centered health care  
16 services. This is probably the biggest  
17 transformational change that's going on in  
18 military medicine.

19           Specifically in the Western Region,  
20 I know I could speak to for sure, is this  
21 patient-centered approach to health care, and  
22 including the patients on a lot of decision-  
23 making in their health and well-being, as well

1 as a team approach to their health care,  
2 rather than just the very stovepiped  
3 individual, patient-provider relationship, a  
4 more, a closer team approach to that.

5 So we are converting to a patient-  
6 centered medical home. I'll talk to you about  
7 that in a second. But we want to include that  
8 what we exist for is for our forces, and then  
9 those who serve at our installations and  
10 communities and everything.

11 But I want to make sure that it's  
12 Service members first, and then also their  
13 magnificent family members, who provide a  
14 tremendous amount of support, so that Service  
15 members can do what they love doing. Then we  
16 support the community, including retirees,  
17 veterans, et cetera.

18 What we really want to do is  
19 convert from being an intervention  
20 organization that just focuses on health care  
21 when people are sick, and move the curve  
22 towards prevention. We should be looking and  
23 using our health care resources to optimize

1 unit performance, prevent disease and injury,  
2 and enhance health and well-being.

3 So that's why you see that in that  
4 mission statement. We've always done  
5 intervention services, but moving that curve  
6 to the prevention side is really going to be  
7 the key to health and wellness in the future,  
8 while maintaining the quality for intervention  
9 services, using multiple modalities.

10 You can see our vision statement.  
11 We're a team of teams. I've got a lot of  
12 teams out here that we are partnered with in  
13 our Western Region, and we all work together  
14 and we all figure out the solutions and the  
15 way ahead and maneuver back and forth and  
16 share resources, et cetera.

17 We make sure that we understand the  
18 word "trust" in our vision is absolutely  
19 essential to everything we do in health care.  
20 Serving beyond the call of duty, strengthening  
21 the health of the force, preventing disease  
22 and caring for our wounded, ill and injured  
23 service members On the bottom is a command

1 philosophy that I have in Western Region, that  
2 all my MTF commanders have embraced, because  
3 not only are we a team of teams, but remember  
4 four key words, that we're ready for whatever  
5 comes at us today or tomorrow.

6           Relevant for the future means we're  
7 willing to change, look at ourselves hard and  
8 change for the future, being responsive to our  
9 stakeholders, and then of course making sure  
10 that we're responsible to our patients  
11 specifically, but to each other, too, as  
12 colleagues. Okay, next slide.

13           This is the strategy map that I was  
14 talking about. You could see it has a mission  
15 and vision at the top, and this is pretty  
16 complex and there's a lot of words in here.  
17 But let me talk to this just briefly here.

18           This is our means. It's a means,  
19 ways and ends model of looking strategically  
20 at yourself as an organization. So the  
21 mission and vision are at the top. We have  
22 some strategic themes that we look at every  
23 single week as we're operating, and this is

1 really what we're trying to achieve. These  
2 are the ends.

3           If we do these six things well,  
4 we're doing our mission well, and they are:  
5 ensure healthy warriors, families and  
6 communities; optimize care and transition of  
7 the wounded ill and injured warriors; provide  
8 ready, deployable medical warriors and  
9 capabilities.

10           I have about 16,000 staff  
11 throughout the Western Region Medical Command.  
12 Three-fourths of them are civilian personnel,  
13 being DoD civilians and contractors, Army  
14 civilians and contractors, and the other one-  
15 fourth are uniform people just like myself,  
16 who have to be prepared.

17           I mean their job is to be prepared  
18 to be deployed and support our forces  
19 everywhere in the world. We deploy a lot,  
20 just about everyone, throughout, that's on  
21 active duty, throughout our region has  
22 deployed at least once and many have deployed  
23 multiple times.

1           So we take that very seriously.  
2           Sustain a confident, competent, resilient  
3           medical force. That's very important.  
4           Provider resiliency is very important, and  
5           we're doing pretty well on that around Western  
6           Regional Medical Command. Create enthusiastic  
7           and engaged patients. We're not satisfied  
8           with satisfied patients. We want raving fans,  
9           and that's what we're trying to build at our  
10          installations.

11           It's about building this trust in  
12          Army medicine, but also making sure that we're  
13          attending to what we need to do with patients  
14          and changing the model, again for prevention  
15          and well-being. The goal there is that our  
16          patients make appointments when they feel  
17          great, and they want to stay that way; not  
18          just when they become ill and injured.

19           This is our strategic charter for the  
20          future. Behind this is a slew of pages that  
21          have a whole bunch of metrics to see how we're  
22          doing and measure ourselves with in each of  
23          these areas.

1           But the key to this is that we keep  
2 one eye on today and one eye on tomorrow. The  
3 eye today is how are we using today's  
4 resources to accomplish these ends and this  
5 mission? It's using today's resources to  
6 accomplish today's mission.

7           That's what we do every single day.  
8 That's what all the commanders do at all the  
9 MTFs and all of our staffs. We have the  
10 mission today and we have to accomplish that  
11 with the resources we have, with priorities,  
12 et cetera, et cetera that we have.

13           Then we also have to do an  
14 assessment of ourselves. How well are we  
15 doing at reaching these ends and accomplishing  
16 our mission, and what do we need to change for  
17 the future? Facilities, materials, training,  
18 leader development, organizational design,  
19 funding personnel, the mix of personnel,  
20 policies, legislative change. I mean all of  
21 those kinds of things.

22           And that's how we assess ourselves.  
23 So again, one eye on today, one eye on

1 tomorrow. So we're in this continual cycle  
2 that sort of never ends, on how we're  
3 executing our mission. Okay, next slide.

4 This is important too. Because of  
5 that balanced score card I showed you, we have  
6 to have a battle rhythm to look at. We can't  
7 just do it one time and never look at it  
8 again. So here's our battle rhythm. If you  
9 follow the scale at the bottom here, this is  
10 one fiscal year, starting 1 October ending 30  
11 September.

12 We start off every year by doing a  
13 Balanced Scorecard Review, our strategic  
14 imperatives and initiatives, what's coming up  
15 in the horizon the next year that we know  
16 about, et cetera, and do we have the right  
17 initiatives in place and are we on the right  
18 path for the future.

19 We try to look out anywhere from  
20 two to three to five years. It's very hard to  
21 look out beyond that, because there's a lot of  
22 unknown out there, and there's just too many  
23 assumptions that just are not clear enough to

1 look beyond that, at my level in the Western  
2 Region.

3 So we took a hard look at the  
4 Balanced Scorecard. Then we get all of our  
5 commanders together. We review those  
6 strategic initiatives and they brief back how  
7 they're going to implement them at their  
8 locations, and what their challenges are to  
9 implement them.

10 Part of that is what's called the  
11 SAMB, the Semi-Annual Mission Brief. It's a  
12 slide packet of about 40 slides. It's nothing  
13 but metrics that look at everything like  
14 quality of care, readiness and access to care.  
15 It looks at, you know, a whole host of things,  
16 implementing the initiatives from last year,  
17 where we are. Just a lot of metrics. Budget  
18 execution, performance.

19 Because what we're trying to do  
20 here is tie strategy, business planning,  
21 resources and performance. Those four areas  
22 we're trying to tie together, because they're  
23 all linked. They're intricately linked, okay.

1 So then we do the semi-annual mission briefs.  
2 What the semi-annual mission briefs do is they  
3 give me a snapshot on where I am today at each  
4 hospital.

5 Each hospital does one of those,  
6 and we're in the midst of doing those right  
7 now. I just had half the MTFs do it last  
8 week; the other half are doing it this week.  
9 It's about a two and a half, three hour  
10 briefing with every MTF commander and they do  
11 it twice a year. It's a snapshot of the  
12 organization.

13 It gives us a common operating  
14 picture on where they are today. Then we  
15 design our business plans around how we've  
16 been performing and what we need to do to  
17 change, because those business plans that get  
18 approved are for the upcoming year.

19 Then we look in the summertime.  
20 This is where we are right now in the summer  
21 time here, doing these semi-annual mission  
22 briefs. We do another snapshot. So in a  
23 complete year, we meet about four times with

1 all the commanders at a strategic level.

2 This gives us a good battle rhythm for  
3 staying focused on the long-term, mid-term  
4 things that we need to do in the organization.  
5 This has been very handy. I'm absolutely  
6 surprised on the difference between the briefs  
7 on this year versus a year ago, and where  
8 we've gone.

9 Quality of care and access to care  
10 is up. Enrollment is up. Patient  
11 satisfaction is up. I mean there's a whole  
12 bunch of things that we're doing really,  
13 really well So I'm really thrilled about this  
14 and where we are right now. Okay, next slide.

15 So here's Western Region Medical  
16 Command in the green that you see here. This  
17 is the whole Army Medical Command you see, and  
18 you can see the MEDCOM, the three-star,  
19 Lieutenant General Schoomaker's headquarters  
20 in San Antonio, the AMEDD Center and School is  
21 one command; DENTCOM is another command.

22 Medical Research Materiel Command,  
23 General Dillman is there. Public Health

1 Command we have at Aberdeen Proving Ground,  
2 and the Warrior Transition Command in Crystal  
3 City. These are other commands.

4 All the other commands are the five  
5 regional commands. So we have our European  
6 Regional Command, commanded by Brigadier  
7 General Nigel West; we have a Pacific Regional  
8 Medical Command, commanded by Brigadier  
9 General Keith Gallagher. Tripler Army Medical  
10 Center is a hub hospital there, and obviously  
11 Landstuhl Medical Center is the hub there in  
12 European Command.

13 Then CONUS is split into three  
14 regions. This is a transformation. We used  
15 to be four regions, but we split into three  
16 regions. About a year and a half, two years  
17 ago we started executing this, and lined up  
18 with the TRICARE regions is what we did in the  
19 Army.

20 So there's Northern Region,  
21 Southern Region and Western Region, and  
22 although the size is much larger for surface  
23 area-wise in Western Region, they're about the

1 same enrolled population, each of those  
2 regions. But it just requires that I have  
3 to travel longer distances to get out to the  
4 hospitals than my fellow commanders here.

5 This is Brigadier General Joe  
6 Carvalho in command of the Northern Region.  
7 Major General Ted Wong is in command of the  
8 Southern Region. I've been in command about a  
9 year and a half here. The hub hospital for --  
10 well, we're not really using hub hospitals so  
11 much, because we have such diverse hospitals  
12 in here.

13 But you can see Northern Region and  
14 Southern Region here, and for us, the major  
15 medical center is Madigan Army Medical Center,  
16 which you'll get to see tomorrow, get a  
17 briefing from Dallas here shortly. That's  
18 really the hub, the most advanced Army  
19 teaching hospital the most staff, the most  
20 capabilities and specialty care and  
21 subspecialty care that we have.

22 Then we have another medical center  
23 in El Paso, William Beaumont Army Medical

1 Center, which is growing large because Fort  
2 Bliss is the largest growing installation.  
3 It's three times the size as what it was ten  
4 years ago, population-wise. So we're growing  
5 that medical center leaps and bounds right  
6 now.

7 If you go on Fort Bliss, there's  
8 construction all over the place. They also  
9 have had a significant transformation. Then I  
10 have other MTFs I'll show you on the next  
11 slide. But that gives you a snapshot. My  
12 headquarters is at Joint Base Lewis-McChord in  
13 a separate building on the other side of the  
14 installation from where Madigan is.

15 Then I have a portion of my  
16 headquarters down at Fort Bliss called the  
17 Readiness Division. Everybody in this  
18 division links with all the reserve units and  
19 National Guard units. It's my connection as  
20 the Western Region commander to all of the  
21 Reserve and National Guard that's out there,  
22 and they follow the Patch chart for the R4 gen  
23 cycle, what units are going to mobilize and

1 demobilize, when we've got deployments.

2 We also monitor the active duty  
3 units, the active component units that are  
4 also in the region, when they're going to  
5 deploy and come back, and we look at medical  
6 readiness and IDES, the Integrated Disability  
7 Evaluation System, the medically non-ready and  
8 the medical management cells that I'll talk  
9 about in a second, and the Warrior Transition  
10 operations. So that's what that Readiness  
11 Division monitors. It's our connection to the  
12 line side, if you will, the FORCECOM side in  
13 the Army.

14 Now the thing about Western Region,  
15 one of the nice things is that it's fairly  
16 new. Western Region was only four states two  
17 years ago. It was Alaska, Washington, Oregon  
18 and California, and it was embedded into  
19 Madigan, and everyone was dual-hatted. They  
20 had a job in Madigan and a job in Western  
21 Region, and that was Western Region.

22 So what we've done in the past  
23 really year and a half, two years, is we

1 separated out, created a brand new  
2 headquarters on Joint Base Lewis-McChord for  
3 Western Region, and then expanded and included  
4 the other 16 states.

5 Then we're also growing, because  
6 with BRAC, growing the Army, global  
7 repositioning, all of the changes from the  
8 last ten years, the Western Region is the only  
9 growing region in the Army. All the others  
10 have shrunk.

11 Our biggest challenge is keeping up  
12 with the growth, because as you know,  
13 facilities lags a little bit and the manning  
14 documents lag a little bit and all of that.  
15 So that's been our biggest challenge, but  
16 we're doing pretty well in that area. Next  
17 slide.

18 Okay. So here is a day in Western  
19 Region. I'll go through the hospitals on the  
20 next slide. There's Fort Wainwright up in  
21 Fairbanks. We support them. We have a  
22 hospital there, Bassett Army Community  
23 Hospital, and we have a clinic that's under

1 that hospital in Anchorage at Joint Base  
2 Elmendorf-Richardson, for the soldiers.

3 We have a BCT, a brigade combat  
4 team at Wainwright, a brigade combat team at  
5 Richardson. Then the hospital that supports  
6 us is the Air Force Hospital, Elmendorf Air  
7 Force Hospital. They do a great job  
8 supporting all our family members. Those  
9 assigned in Anchorage are enrolled to the Air  
10 Force Hospital down there, and the Service  
11 members Active Duty are enrolled through our  
12 clinic.

13 So we work very closely as a team,  
14 and they have a VA clinic that's built into  
15 that Air Force Hospital at Elmendorf. So it's  
16 great teamwork, great support that we get at  
17 both locations. Then we provide support to  
18 Eielson Air Force Base up in the Fairbanks  
19 area. It's a great partnership.

20 Every time I travel to either one,  
21 I always visit the Air Force base, the Air  
22 Force commander and staff, make sure that  
23 we're all talking and communicating and we're

1 all in this together.

2 We also support a small clinic way  
3 out on the border here at Fort Greeley,  
4 Alaska. I went and visited in December of  
5 last year, minus 44 degrees. It was a really  
6 religious experience.

7 Okay. Joint Base Lewis-McChord,  
8 this is a great location up here. We're going  
9 to talk more about that. Dallas is going to  
10 really talk about what Madigan does, as the  
11 Director of Health Services. But we have a  
12 great partnership and I'll talk a little bit  
13 about the Multiservice Market Office in a  
14 second there.

15 But that's the largest installation  
16 we have. Overall it's the second largest. At  
17 the end of all the moves and modularity, it  
18 will be the second largest installation active  
19 duty-wise, in the Army behind Fort Bragg,  
20 North Carolina. So Madigan is pretty much  
21 engulfed in a lot of the initiatives that are  
22 going on in that area.

23 At our hospital out in Fort Irwin,

1 California, we own a community hospital in the  
2 desert. Really, in the desert, the National  
3 Training Center, is where we bring all our  
4 brigade combat teams to train. There is no  
5 network out there. There's no community out  
6 there. It's in the desert, but we have to run  
7 a hospital.

8           What's unique about that is there's  
9 a minimum staffing you need to run a  
10 hospital. So even though it's inefficient  
11 because there's not enough patients to run the  
12 hospital, you still have to have that  
13 staffing. I mean there's a minimum number of  
14 run it. So we are not as productive on paper  
15 at that location as you would see in a  
16 hospital in another area.

17           You need two general surgeons to  
18 keep the operating room available, someone on  
19 call every other night to be able to respond.  
20 Even though the ORs aren't being used every  
21 night and every day, you know, that kind of OR  
22 utilization inefficiency and stuff.

23           We have a clinic out at the

1 Presidio/Monterey that falls under Madigan.  
2 Madigan and Dallas Homas provides oversight  
3 for that out in the Presidio, and it provides  
4 support to the Naval Postgraduate School and  
5 other things in the area, active duty. We  
6 have a pediatric clinic out there for kids.  
7 Then we enroll to the network family. Most of  
8 the family members are enrolled through the  
9 network out there.

10 Fort Carson, Colorado has a large  
11 hospital out there. It's a troop base,  
12 FORCECOM installation, multiple brigade combat  
13 teams out there, very heavily engaged.  
14 They're in Colorado Springs, right near the  
15 Air Force Academy. It's also a Multiservice  
16 Market Office, and it's run by the Air Force  
17 in that Multiservice Market Office, and the  
18 commander at the clinic up at the Air Force  
19 Academy runs that market area.

20 We have Peterson Air Force Base  
21 also that we support. You can do Purchase  
22 Care pretty easily out there. It's a great  
23 location.

1           Then we've got Fort Riley, which is  
2 about the same size as Fort Carson. But  
3 Manhattan, Kansas and Junction City, Kansas  
4 does not have as much network and resources as  
5 Fort Carson has. So it's a different kind of  
6 an organization, and we have to approach  
7 things a little different. The VA in Fort  
8 Carson is located mostly in Denver, but they  
9 have resources down in Colorado Springs. But  
10 in the Fort Riley area, the VHA is in Topeka,  
11 and the VDA is in Wichita, Kansas. The same VA  
12 helps support the area around Fort  
13 Leavenworth, where I have a health clinic.  
14 That health clinic supports our combined Arms  
15 Schoolhouse training, our doctrine center

16           So there's a lot of things going on  
17 at Fort Leavenworth. We have a health clinic.  
18 They use capabilities in Kansas City and in  
19 and around community hospitals, to get the  
20 specialty and subspecialty support.

21           Then Fort Leonard Wood, this area out in  
22 the middle of Missouri, is one of our basic  
23 training sites. So they don't have a large

1 enrolled population. They have a large  
2 population, but most of their health care is  
3 due to transient personnel that are rotating  
4 through there, and it's very hard to maintain  
5 continuity of care when someone's only on the  
6 ground for four to five months, and then the  
7 whole population changes over. But it's a  
8 basic training site. It's also an advanced  
9 individual training site. Not a lot of  
10 training, it's a TRADOC installation, not a  
11 FORCECOM installation. So it's a different  
12 model of delivering health care there.

13 Then we have Fort Bliss. I told  
14 you about that. That converted. It was a  
15 TRADOC installation. It converted to a  
16 FORCECOM installation. It used to be where we  
17 trained our air defense artillery folks, but  
18 now there's brigade combat teams there, and we  
19 support that. That's growing, the largest  
20 growing installation in the Army, and we're  
21 getting a new hospital that has been designed.  
22 I think ground breaking is this month That's  
23 an interesting market area too out there,

1 because it's an under-served area of the  
2 country, El Paso, Texas. Ninety-eight percent  
3 of all the civilian providers are signed up in  
4 the TRICARE network. So there's not a lot of  
5 ways to expand the network, other than  
6 bringing people in from the outside in that  
7 market area, and that's what we're trying to  
8 do there. It's also a hard place for us to  
9 hire personnel. They support White Sands  
10 Missile Range, a very unique post. We have a  
11 clinic that's up there. Then we also have  
12 Fort Huachuca, which has a health center. But  
13 we use Tucson and other surrounding community  
14 support for our patients in there. But that's  
15 also a schoolhouse. That's our intelligence  
16 school, where the intelligence enlisted get  
17 training.

18 So that's just a quick snapshot to  
19 show you our area. I'm physically at Joint  
20 Base Lewis-McChord about five or six days a  
21 month. I spend most of my time on the road,  
22 visiting these various sites and making sure  
23 we're staying on track and enjoying all the

1 great things that they're doing out there to  
2 serve their senior commanders in the  
3 communities, and the units that are out there.

4 Next slide.

5 That's just a snapshot, showing you  
6 all these. William Beaumont at Fort Bliss, I  
7 talked about a little bit. Bassett up in  
8 Alaska, a great -- a new hospital. We're  
9 building the new William Beaumont right now,  
10 ground breaking. Bassett was just occupied,  
11 just built and occupied. Just about two and  
12 half, three years ago, we started occupying a  
13 brand new hospital. A very nice hospital up  
14 there.

15 Madigan Army Medical Center, you'll  
16 see tomorrow. A phenomenal Army medical  
17 center built in the early 1990's, and is just  
18 a magnificent facility, and it's also  
19 undergoing change as we speak with new  
20 initiatives, and Dallas will talk about those.

21 Evans Army Community Hospital,  
22 right by Cheyenne Mountain out at Fort Carson,  
23 Colorado. It's the only military hospital in

1 that market area. But it supports Peterson  
2 and the Air Force Academy, and we work  
3 together in the Multiservice Market Office  
4 there.

5 Then Irwin Army Community Hospital  
6 at Fort Riley, Kansas I told you about.  
7 That's a very old hospital in the 1950's, and  
8 it's got its new hospital is halfway built.  
9 New design, new hospital, and is being built  
10 with the patient-centered medical home in  
11 mind, because there's some unique facility  
12 attributes to those facilities with the  
13 patient-centered medical home. So that's  
14 going up, and they'll occupy that probably in  
15 about two and a half years from now. That new  
16 hospital that's being built right next door.  
17 Then this will be leveled most likely.

18 Raymond Bliss Army Health Clinic at  
19 Fort Huachuca. Incident back in June. That's  
20 where the fires came. The Arizona fires that  
21 were going on actually reached the  
22 installation, the border of the installation,  
23 and the commander there got their medical

1 personnel together and quickly designed a plan  
2 to do tailgate medicine and move everything to  
3 a remote site. They did a great job and great  
4 planning on that. We were able to move  
5 anywhere in Arizona. We could have set up in  
6 any parking lot and still done emergency  
7 services, urgent care services and a lot of  
8 other services out there. So they did a great  
9 job on that.

10 Weed Army Community Hospital.  
11 We're right in the design of a new hospital  
12 for that. That's the one that's at Fort Irwin  
13 in the desert, sits by itself out there, and  
14 they're doing an absolutely magnificent job  
15 there too. The continuity of care that's  
16 provided is phenomenal there, too, and the  
17 quality of care, of course. But it's tough to  
18 run a hospital when you've got two general  
19 surgeons, one orthopedic surgeon and a couple  
20 of OB/GYNs as your surgical specialties, and  
21 you're running operating rooms, and then you  
22 have your step-down unit and your wards and  
23 those kind of things out there. But we do it.

1 Now it has to be ready for trauma, because  
2 there's high risk training going on there all  
3 the time. So there's always an OR open and  
4 available while the other one is being used  
5 for routine cases. We have a trauma system in  
6 place where we can send patients to a trauma  
7 center in Los Angeles, or Las Vegas. Then  
8 there's Munson Army Community Hospital, excuse  
9 me, Health Center, at Fort Leavenworth.  
10 That's what that looks like, and I'll talk to  
11 you about a new design here in a second. Then  
12 here's Leonard Wood Army Community Hospital at  
13 Fort Leonard Wood, Missouri. Again, this is a  
14 TRADOC hospital. It has a construction  
15 project going on to expand its outpatient  
16 facilities. We're doing more and more stuff  
17 as outpatients, less and less inpatient care.

18 Our staffing is based on our  
19 occupancy rate. But we're seeing our in  
20 patient census slowly dropping despite  
21 increasing enrollment and a greater patient  
22 population to capture, that would potentially  
23 be inpatients. So we're relooking at that in

1 our balanced scorecard, and look to see do we  
2 need to convert inpatient space to outpatient  
3 space, and do we need to start decreasing our  
4 inpatient staffing.

5 We do hospitalize a lot of the VA's  
6 patients in our facilities. That's a win-win  
7 for all of us, especially in our graduate  
8 medical education centers, William Beaumont  
9 and at Madigan. Okay, next slide.

10 TRICARE Puget Sound. Just  
11 absolutely phenomenal. I am so impressed by  
12 the teamwork and partnership. We support  
13 Naval Hospital Oak Harbor. We support the  
14 Naval Hospital at Bremerton out there. I just  
15 went to the Bremerton change of command last  
16 week. It was great being there.

17 We support the 62nd Medical  
18 Squadron at McChord Field, part of Joint Base  
19 Lewis-McChord, and we help provide a clinic  
20 and support for Madigan for all the airmen and  
21 their families that are at Joint Base Lewis-  
22 McChord. That's working really, really well.

23 What's really impressive about the

1 medical squadron there, they have a 90 percent  
2 PCM continuity. I'm trying to replicate them  
3 all over Western Region right now, because  
4 it's one of the highest I've seen. They do a  
5 great job out there.

6           Then we also support and have  
7 included, even though they're outside of Puget  
8 Sound, is Fairchild. Fairchild Air Force Base  
9 is out in Spokane. I just visited there two  
10 months ago. I went out there to visit, meet  
11 with the commander and the VA in Spokane to  
12 make sure we're partnering. They're part of  
13 our TRICARE Puget Sound. We include them as a  
14 team member, and we provide some support to  
15 them too out there. The VA Puget Sound is a  
16 partner here, as well as the Coast Guard in  
17 Seattle is a partner. They're sitting members  
18 on our Multiservice Market Office meetings,  
19 quarterly meetings that we have. Of course,  
20 Madigan is at the hub, and provides a lot of  
21 support, because it's the major medical center  
22 that's out there.

23           We send consultants and experts in

1 their field at the beck and call of any of  
2 these facilities, if they need professional  
3 development, consultation, quality assurance  
4 or a staff assistance visit. Madigan provides  
5 those capabilities to all of these folks,  
6 regardless.

7 The Washington National Guard also  
8 sits on there. So we're connected to the  
9 Washington National Guard. Then of course  
10 TriWest is also a sitting member on our  
11 council for the Puget Sound area, and Humana  
12 provides services as well to our area.

13 Great teamwork, absolutely  
14 phenomenal. It's one of the most cooperative  
15 and advanced market areas, I think, in DoD.  
16 It's just, you know, really looking at  
17 mission. Okay, next slide.

18 Okay. This is how they're aligned  
19 in the Puget Sound. We're sitting right down  
20 here at Tacoma right now, right on the A there  
21 on Tacoma. You can see Joint Base Lewis-  
22 McChord and the VA in Seattle, the American  
23 Lakes Club right across the highway from Joint

1 Base Lewis-McChord.

2           The 62nd is there. Madigan,  
3 Bremerton, Oak Harbor, you can see that  
4 they're all over the other, and then 300 miles  
5 to the east is Fairchild Air Force Base, and  
6 we include them in there. They have a great  
7 team out there, too, in their facility.  
8 Everett, you know, is there. Okay, next  
9 slide.

10           Okay. Key issues. I'm not going  
11 to go into a lot of detail, but hopefully it  
12 will spawn some questions. I know Dallas will  
13 talk specifically about Madigan. So let's  
14 talk about pain management. We are heavily  
15 embracing pain management. We know that pain  
16 management in the United States of America has  
17 not been done well in our nation, and is  
18 becoming more and more of a specialty in and  
19 of itself.

20           We are moving forward with pain  
21 management. We are establishing an Integrated  
22 Pain Management Center at Madigan Army Medical  
23 Center. That's going to be the hub for the

1 region, and we also have a council that we are  
2 just now starting in the Puget Sound area. It  
3 includes the Multiservice Market Office  
4 partners, the VA and Bastyr University, which  
5 are experts in using complementary and  
6 alternative medicine up in Seattle. So we've  
7 included them, and we're trying to leverage a  
8 lot of the knowledge and experience, research  
9 and academics out there, to bring in a lot of  
10 those other modalities that historically have  
11 not been part of our military health system,  
12 because we believe using these other  
13 modalities will decrease the use and overuse  
14 of pharmaceuticals, quite frankly, for chronic  
15 pain management, opiate pharmaceuticals in  
16 particular.

17 We're establishing a consortium, a  
18 council in Puget Sound, and we are putting in  
19 telemedicine units so we can do  
20 teleconsultation from any of the hospitals I  
21 have in Western Region, right into Madigan,  
22 for to get expert advice on pain management,  
23 better pain management using various

1 modalities.

2           Okay. TBI, concussive injury. We  
3 know Service members are going to be exposed  
4 to explosive devices, and those concussive  
5 injuries, either penetrating or non-  
6 penetrating, are something we're learning  
7 every day more and more about.

8           I know the Defense Centers of  
9 Excellence is established and working towards  
10 protocols and research and leveraging  
11 academia. We've got the National Intrepid  
12 Center of Excellence for Traumatic Brain  
13 Injury and Psychological Health at Bethesda  
14 that we use for a referral basis.

15           We have, I'm going to show you a  
16 slide. We have a center, if you will, at  
17 Madigan, that provides a full scope of  
18 services, inpatient and outpatient, for all  
19 levels of traumatic brain injury. So we're  
20 moving ahead on that, and more and more I  
21 think we're starting to collaborate and use  
22 the knowledge that other people have learned  
23 out there, to get this thing rolling.

1           There's a move right now, too, to  
2 set up a collaborative council effort here,  
3 through the Madigan Foundation and some of the  
4 other bodies that are out here. The VA is  
5 very interested in creating some sort of TBI  
6 Center West, if you will, like the one out  
7 east in Bethesda, at this location. The VA is  
8 very concerned about the number of veterans  
9 and retirees out there that have been exposed,  
10 past and present, and new coming on the  
11 horizon, and ongoing care and doing this  
12 collaborative effort with our academic  
13 partners on the west coast, eight clinical  
14 partners on the west coast.

15           Readiness, Soldier Services, I'll  
16 show you a slide on that. I'll show you a  
17 slide on comprehensive behavioral health, and  
18 partnerships are collaborative efforts. As  
19 you can tell, one of our strategic directives  
20 is to establish partnerships, because we can't  
21 do this ourselves alone.

22           So we, whether we partner with the  
23 other Services in their areas or the VA,

1 TriWest or the local community, we are always  
2 looking to establish partnerships and  
3 collaborative efforts.

4 I'll talk about patient-centered  
5 medical home. Next slide. Okay. So patient-  
6 centered medical home. We are implementing  
7 those. We should be done in about another two  
8 years. It's a long process to convert our  
9 historical way of delivering primary care  
10 services at enrollment sites to the new way,  
11 which is a patient-centered medical home team  
12 approach to health care.

13 Here's us doing our ribbon-cutting  
14 ceremony over by Fort Leonard Wood. We're  
15 starting to set up some clinics off-post in  
16 communities where Service member families  
17 live, and we have one here. We did a ribbon-  
18 cutting in Puyallup, outside of Joint Base  
19 Lewis-McChord, because we had a lot of Service  
20 members there, and in that market area, we  
21 could serve them closer to their homes.

22 We have plans for doing future ones  
23 too, depending on business case analysis, and

1 market analysis of where our families live.  
2 We're also doing Soldier Service Medical Home  
3 that Colonel Dallas Homas will talk about.  
4 How do you enroll Service members to sites  
5 where they also get the benefit of continuity  
6 and a collaborative approach? Because our  
7 Service members, believe it or not, have less  
8 continuity of care than our family members,  
9 and we have to reverse that and fix that. So  
10 Colonel Homas will talk about an initiative on  
11 what they're doing at Joint Base Lewis-McChord  
12 on that.

13           So this is a great news story.  
14 We're going to march forward. We have  
15 strategic plans in place, and we have a whole  
16 line of operations list and a common operating  
17 picture month to month on how much progress  
18 that we're making. We're going to get  
19 certified, NCQA certified, at each of the  
20 locations as we go through. The civilian  
21 organization that certifies patient-centered  
22 medical homes sites, using the same standards  
23 that any civilian community has. Next slide.

1           Comprehensive pain management. I  
2 already talked about this, and I'll talk about  
3 it right at the end. One of our challenges is  
4 including complementary alternative medicine  
5 modalities into mainstream medicine.  
6 Historically, we have not done that well. But  
7 we have a lot of the academics and the  
8 research that shows the benefit. We have  
9 tools that do a measurement based with  
10 patients that are functionally better using  
11 certain modalities, and it decreases their  
12 requirement for chronic opiate use and other  
13 things. So this is good news, and we are  
14 moving forward on this. This is using, you  
15 know, yoga and medical massage and acupuncture  
16 and biofeedback, all of those kinds of  
17 modalities, that we have to build those  
18 capabilities more in our system. Next slide.

19           Readiness. This is huge. I mean,  
20 Soldier Readiness Services, making sure  
21 soldiers are fit, healthy, ready to perform.  
22 When I say soldiers, I really mean all Service  
23 members, because we always operate in a joint

1 environment when we're deployed. But that  
2 they're also resilient and resistant to injury  
3 and sickness by the immunizations we give  
4 them, the training techniques, both physically  
5 and psychologically. So this is a big part.

6 Then we also do soldier readiness  
7 processing for mobilizing and demobilizing  
8 units. We have learned a great deal. You  
9 know, we don't have a long history, because  
10 the Reserve Component was a strategic Reserve,  
11 and when they became an operational Reserve  
12 and we used them more frequently, we didn't  
13 have everything in lockstep like we have with  
14 the active component. We've learned a  
15 tremendous amount by mobilizing and  
16 demobilizing Service members in the Reserve  
17 component, and I feel really good, because we  
18 did a number of reviews of our SRP sites, not  
19 only at Joint Base Lewis-McChord but around  
20 the region, and we helped influence the Army  
21 EXORD that changed policy and procedure, so  
22 that Service members are better taken care of.

23 Because the most important part for

1 any Reserve component soldier, the most  
2 important part of any deployment, is the  
3 demobilization point, because that's where  
4 they get their DD Form 214, and that's where  
5 all their future benefits and all of those  
6 things. That's the part we didn't focus on.

7 We thought that they would want,  
8 and they do want, that getting them home to  
9 their families is more important first than  
10 doing the paperwork, and we were wrong.  
11 You've got to do the paperwork right first,  
12 and then you can get them home to their  
13 families, because it is so important.

14 It gives them all their benefits,  
15 their knowledge of where to go, all the  
16 different benefits programs, and how to  
17 leverage the system if they're having a  
18 problem.

19 So we spent a lot more time doing  
20 that and slowed down the demobilization  
21 process now to 14 days. It was five to seven  
22 days a year ago. We got the Army to change it  
23 to 14 days, so we could spend more time with

1 them at our installations. That's a good news  
2 story for our Reserve Component soldiers.

3 Integrated Disability Evaluation  
4 System. I'm not going to talk a lot about  
5 that, but it was implemented. We have a  
6 challenge with that. We have a challenge  
7 today. That's my biggest challenge today, is  
8 a smooth, operating Integrated Disability  
9 Evaluation System. It's because we're  
10 learning as we go.

11 We changed from a legacy system to  
12 the new system. We converted half our MTFs  
13 around the new system, the integrated system  
14 with the VA, and the other half are just  
15 converting now. It will take us another year  
16 or two to get to a steady state. But we are  
17 learning a lot of lessons and applying those  
18 throughout the enterprise.

19 This is a system that's made for  
20 soldiers. It's not made for readiness, it's  
21 not made for units. It's not made for the  
22 Defense Department. It's made for the  
23 soldier, the sailor, the airman, Marine, for

1 their due benefits due to disability by  
2 serving our nation, soldiers, sailors, airmen,  
3 Marines. So it's built around them, and it's  
4 very complex, as you could imagine. I mean  
5 doing their entire physicals, all of the  
6 medical conditions we evaluate. They have  
7 claimed conditions. They have the rights to  
8 seek legal rebuttal and appeals and those  
9 things. So it's a pretty methodical, long  
10 process, because at the end, we want to be  
11 separating them with some certainty about  
12 their disability, and making sure they're  
13 getting their due benefit from that, and that  
14 it's a fair and open system.

15 The Warrior Transition Units, we're  
16 doing great in Warrior Transition Units.  
17 That's phenomenal. I mean, anyone who's had a  
18 chance where, you know, we had it by Fort  
19 Carson there, the Warrior Games this past May,  
20 where all the soldiers, sailors, airmen,  
21 Marines came in, wounded warriors, Purple  
22 Heart folks, severely injured and stuff, and  
23 it was just fantastic.

1           We provided some support out of  
2 Evans Army Community Hospital there. But the  
3 Olympic Committee helps us run that at the  
4 Olympic training site, and that is one of the  
5 most inspirational things you will ever see  
6 and ever witness in your life.

7           We are really doing well in helping  
8 them regain their life back, and reorient  
9 their lives and set them up for success in the  
10 future, before we transition them either back  
11 to duty or, if they elect to transition out of  
12 the Service, on that. We have made phenomenal  
13 strides and we're going to continue to make  
14 phenomenal strides. Okay, next slide.

15           This is the traumatic brain injury  
16 program site that we have in Western Region  
17 across the hub. Category 1 is Joint Base  
18 Lewis-McChord, inpatient and outpatient care.  
19 Full spectrum traumatic brain injuries,  
20 severity there. At other sites, I have a  
21 combination of Category 2 and 3, which is some  
22 services for mild -- mild and some moderate  
23 kind of cases out there, and mostly outpatient

1 cases at these locations.

2 Madigan is our referral site and  
3 hub for our particular region. Then there's  
4 some other ones that have Category 4, which  
5 are very, very mild traumatic brain injury  
6 patients, one-time concussion, concussive  
7 injury, where their symptoms have resolved and  
8 we track them and follow them, and we have  
9 some centers at these locations that monitor  
10 them, see how they're doing and those kind of  
11 things, before we put them back in action and  
12 those kind of things.

13 We're doing well, given the  
14 knowledge and the extent of where we are. But  
15 we certainly need to do better in this, and  
16 this collaborative effort in DoD, with all of  
17 our research and academic partners in the  
18 United States, I think, is going to be great.  
19 We're doing better on this year after year.

20 What we really need to continue  
21 doing is a lot of these clinical practice  
22 guidelines, protocols, algorithms, and get the  
23 benefits of some of the new research that's

1 coming out in certain areas, that give us a  
2 more definitive understanding of traumatic  
3 brain injury and execution. Next slide.

4 Comprehensive behavioral system of  
5 care. Complex slide, don't bother reading it.  
6 There's five touchpoints. That's all you need  
7 to know. We're trying to take behavioral  
8 health and pull it into mainstream health  
9 care. There should be no difference between  
10 behavioral health and physical health, and  
11 we're trying to make it part of our health  
12 care system and reduce the stigma.

13 We believe if everybody gets it as  
14 part of their evaluation, it will help reduce  
15 the stigma in our area. So everybody gets a  
16 touchpoint. Before they get deployed, they  
17 get a behavioral health screen. They get it  
18 while they're deployed, before they come back.  
19 They get another behavioral health screen with  
20 some screening tools that we're using, and we  
21 keep honing them more and more, when they  
22 redeploy, within the first 30 days.

23 Then we do it again, after their

1 reintegration period, when they do their PDHRA  
2 90 to 180 days. Then the fifth touchpoint is  
3 once annually, or at the periodic health  
4 assessment that we give. So everybody gets  
5 some sort of behavioral health exam. If you  
6 deploy, you get a little more, before, during  
7 and after the deployment.

8 Every soldier gets it. All  
9 officers, all non-commissioned officers, all  
10 junior enlisted. We're getting more and more  
11 data out of this, and more and more  
12 understanding of how to apportion risk level,  
13 low risk, medium risk, high risk, and then  
14 what are our actions that we take at those  
15 risk levels. Next slide.

16 Partnerships and collaborations. I  
17 told you about the joint bases that we're  
18 operating. The VA community clinics you see  
19 here, Fort Bliss, Fort Wainwright. We have  
20 the VA embedded into these hospitals. That's  
21 an example of that, and then these are  
22 projects that are going on, to see if we're  
23 going to embed our DoD facilities into the VA,

1 when they build their next hospital in those  
2 areas. So we're working with the VA on the  
3 future, too.

4 I told you about the Integrated  
5 Disability Evaluation System. The two ideal,  
6 best practice locations are at Fort Riley and  
7 Fort Carson, where the VA has placed their  
8 assets in our hospital. One-stop shopping;  
9 all VDA and VHA assets are sitting right  
10 there, DoD and VA, for Service members going  
11 through the disability evaluation system.

12 Electronic health records, we're  
13 supporting that. We developed a network care  
14 tracker here between TriWest and Madigan, and  
15 we're trying to socialize that up through TMA,  
16 to be used. That is a referral authorization  
17 system, when we send people out on referrals,  
18 to get better appointments and tracking.

19 It will be part of the tracking  
20 system and the enterprise that we're  
21 implementing now, which does very good  
22 tracking. This does the appointing, though,  
23 the initial appointing really quickly. Like

1 in minutes, the patient can have their  
2 appointment and the institution can know, and  
3 it's all paperless. No faxing or anything  
4 like that, which is great.

5 Then the Virtual Lifetime  
6 Electronic Record. The VLER does it out in  
7 Spokane. They're using it out there at  
8 Fairchild, and we're starting to use it now at  
9 Madigan and in the Puget Sound area, and we're  
10 hoping that that will show some benefit in  
11 integrating DoD-VA health records. Then at  
12 Puget Sound, I talked about the Pain  
13 Management Council. Next slide.

14 Okay. Here's our challenges, final  
15 thoughts. Complementary alternative medicine  
16 is a challenge, because we don't have a lot of  
17 business processes for including those  
18 modalities into mainstream medicine. So where  
19 we keep pushing up the chain of command, and  
20 trying to make sure that we're building those  
21 things the right way.

22 How do you code for these things?  
23 How do you get personnel accountability? How

1 do you write the job description? All of  
2 those things for modalities that we  
3 historically have not had in military medicine  
4 before.

5 Our adjudication system for  
6 disability is where we believe we need to  
7 move. We currently have a dual adjudication  
8 system, IES, and what we feel is that we  
9 should be moving towards one adjudication  
10 system. It will be better for the soldier,  
11 better for everybody, better for DoD. It's a  
12 win-win right across the line.

13 Web-based personal health record.  
14 We've got to do that, where patients can  
15 access their own health record on a web-based  
16 program. But we have an enormous amount of  
17 patients that are coming into our facilities,  
18 just to get a copy of their record. Then we  
19 print it out or photocopy it and give it to  
20 them, because they have a right to it.

21 We've got to go to a web-based  
22 system, where they could just go in, just like  
23 we do with our financial accounts and banks

1 and everything else, and download it and even  
2 send it to someone if we want, like a second  
3 opinion or send it to a civilian provider or  
4 something, and email it on some sort of web-  
5 based system.

6           Shift to prevention. We need to do  
7 business process shifts, where we're getting  
8 credit for doing prevention. Historically,  
9 medicine in America has been very good for  
10 intervention services; has not paid well and  
11 credited well for taking time to do prevention  
12 and wellness and health. We need to do more  
13 of that.

14           Inpatient over structure. I told  
15 you about that already. By the trends I'm  
16 seeing, we've got to really consider hard  
17 whether we need to decrease our inpatient beds  
18 at some point, our inpatient staffing, because  
19 it's really hard to pay for that staff and not  
20 fill the beds with patients.

21           Virtual behavior. We're using a  
22 lot of virtual care in the Western Region. We  
23 are really moving out. We'll probably use it

1 more than anybody else. We're doing virtual  
2 behavioral health care, where providers at one  
3 installation could do behavioral health  
4 screening through Service members at another  
5 installation, and we think that's the way of  
6 the future.

7           It's very difficult to do that from  
8 state to state, though, because the states run  
9 medical licensures and all that stuff. It's  
10 amazing now that a patient could go to a  
11 doctor in one state and get care, but the  
12 doctor can't come to the patient to get care,  
13 because they're licensed in the other state,  
14 and they've got to -- you know, it's too  
15 complex for me.

16           But anyway, we've got to break down  
17 those barriers, so we can better leverage the  
18 resources and assets across state lines, to do  
19 what we need to do. Then Unified Medical  
20 Command, we think that that's a good thing,  
21 because it's really because of  
22 standardization, integration and unity of  
23 effort. We always feel in Western Region that

1 we could still do it by components; the  
2 Service medical structures stay in place.

3 But we got it to a point where  
4 we're doing joint business planning at certain  
5 market areas and stuff, and not individual  
6 service business planning. We've got to work  
7 closely together, be more integrated.  
8 Standardization, you know, the same physical  
9 exam forms and PHA, put the same -- the data  
10 in the same readiness forms. We're all  
11 measuring dental readiness the same way, but  
12 there's separate service systems that have to  
13 be used.

14 There's a whole bunch of things  
15 that we could leverage that would make us more  
16 efficient and better serve all Service  
17 members, soldiers, sailors, airmen and  
18 Marines, and really get unity of effort, and  
19 really make it a health care system on there.  
20 Okay, next slide.

21 I think I'm out of time. I don't  
22 have a lot of time for questions. I'll wait  
23 until Dallas is done, and then we can answer

1 questions then. Are there any hot questions  
2 that anybody has for me?

3 (No response.)

4 MG VOLPE: Okay. Thank you all  
5 very much. Appreciate it.

6 CHAIR DICKEY: Thank you very much,  
7 General Volpe. Wow. A lot of information, a  
8 great deal of useful information. I want to  
9 express our gratitude for your hospitality  
10 here, and providing an opportunity for us to  
11 become better acquainted with the Western  
12 Regional Medical Command.

13 I know somebody had an awful lot of  
14 geography, and they said yeah, but there's not  
15 a lot of people there. I'm familiar with  
16 that. West Texas is like that. So it doesn't  
17 make managing it any easier, though, when  
18 you've got that much space, and we're looking  
19 forward to learning more about the Command  
20 while we're here.

21 We're also honored to have with us  
22 Colonel Dallas Homas. He's serving as the  
23 commander of Madigan Health Care. His

1 previous assignment was the Chief of Clinical  
2 Operations, Western Regional Medical Command,  
3 Joint Base Lewis-McChord, Washington.

4 He's a graduate of the U.S.  
5 Military Academy at West Point, and was  
6 deployed to Afghanistan in support of  
7 Operation Enduring Freedom, serving the  
8 combined Joint Task Force 76th Command  
9 Surgeon, and to Iraq in support of Operation  
10 Iraqi Freedom, serving as the Multinational  
11 Forces and Corps Iraq Command Surgeon.

12 His Postgraduate training includes  
13 general surgery and plastic surgery  
14 residencies at Fitzsimmons in Aurora,  
15 Colorado, as well as a hand surgery fellowship  
16 at Walter Reed Army Medical Center in  
17 Washington, D.C. His information is also  
18 under Tab 5, just behind the material that you  
19 just were following with General Volpe, and  
20 without further delay, although I can keep  
21 talking until I get this microphone plugged  
22 in, we are delighted to hear about the Western  
23 Medical Command. Colonel Homas.

## Commander's Overview

1  
2 COL HOMAS: Ladies and gentlemen,  
3 thank you so much for the opportunity to brief  
4 you this morning, and share with you some  
5 insights into my command at Madigan. As she  
6 said, I'm the commander of Madigan and the  
7 Director of Health Services for Joint Base  
8 Lewis-McChord. Next slide, please.

9 My itinerary or agenda is very  
10 similar to General Volpe's, and for the sake  
11 of time, we'll just walk through the brief.  
12 Next slide.

13 The first thing I want to do is  
14 just quickly look at the itinerary for  
15 tomorrow. I know the Defense Health Board is  
16 going to be coming out and visiting us at  
17 Madigan. We're very pleased to receive you  
18 there. These are the six sites. You have a  
19 hard copy with the time line and the formal  
20 itinerary.

21 But please, as you review this, if  
22 there's any place that you don't think is  
23 worth your time, or if there's something on

1 this list that you, you know, in addition you  
2 would like to see, please let me know. We'll  
3 certainly accommodate and make that happen for  
4 you tomorrow.

5 I want to offer my apologies in  
6 advance tomorrow when you actually come to  
7 Madigan. I will not receive you personally,  
8 but Colonel Karen O'Brien, my deputy  
9 commander, will receive you, because I will be  
10 tied up with the Joint Commission, who is  
11 coming to Madigan tomorrow to survey us. So  
12 that's a pleasant opportunity to spend time  
13 with them.

14 (Laughter.)

15 COL HOMAS: But I will. I will  
16 break away from the Joint Commission as  
17 possible, to come and interface with the  
18 Defense Health Board, based on your agenda  
19 tomorrow. Next slide, please.

20 So, Madigan. To cut to the chase,  
21 on this slide I would just say that we think  
22 values are at the heart of everything we do,  
23 and as you see at the bottom here, I believe

1 that we are a values-based and standards-  
2 driven team, that delivers the highest quality  
3 health care possible to all of our  
4 beneficiaries, as we execute our variety of  
5 missions, which I'll get into.

6 Our team is mostly civilian, 70  
7 percent civilian as General Volpe stated for  
8 the region. So combining the efforts of our  
9 uniformed personnel and our civilian personnel  
10 in one collaborative team is such an important  
11 aspect of what we do. Next slide, please.

12 Similarly, I'm not going to walk  
13 through the balanced scorecard. But we at  
14 Madigan also have a balanced scorecard, again,  
15 trying to be strategically focused, while  
16 dealing with the crises every day and the  
17 delivery of health care on a day-to-day basis.

18 Our scorecard is very nicely nested  
19 with General Volpe's scorecard at the region,  
20 and is nested with the AMEDD balanced  
21 scorecard as well. Next slide, please.

22 So a little bit about Madigan.  
23 Madigan started out during World War II as a

1 field hospital. You can see the picture  
2 there. It was some three and a half miles'  
3 worth of corridor, and it was designed  
4 intentionally that way to protect the  
5 hospital's operations against air attack from  
6 Japan.

7 We still utilize very much of that  
8 facility today. It was renamed after Colonel  
9 Patrick Madigan, who was the father of Army  
10 Neuropsychiatry in 1973. He was a career Army  
11 officer and veteran of both world wars, World  
12 War I and World War II. Next slide, please.

13 This is what the nursing tower at  
14 Madigan looks like today, and the inpatient  
15 tower. You can see it's shadowed by the  
16 Medical Mall, where the outpatient clinics are  
17 located. We're currently the second largest  
18 medical treatment facility in the Army's  
19 inventory.

20 We sort of -- we are tied for first  
21 place with Womack Medical Center out at Fort  
22 Bragg. That's based on enrollment. We  
23 currently have approximately 109, 110 thousand

1 enrollees, moving to a target state of 122,000  
2 enrollees, and Womack is sort of neck and neck  
3 with us, or we're neck and neck with them.

4 We are honored, truly honored to  
5 serve 36,000 soldiers and airmen that are  
6 stationed at Joint Base Lewis-McChord, and I'm  
7 going to take you into some detail on who  
8 those individuals are in just a bit. We have  
9 five facilities currently in Washington, in  
10 the form of Madigan Medical Center here. Then  
11 we have four outpatient clinics, satellites,  
12 that we'll get to in a future slide.

13 We also have health care support  
14 responsibilities at Umatilla Chemical  
15 Munitions Depot in Oregon. We have two  
16 facilities in California, the  
17 Presidio/Monterey Clinic that you already  
18 heard spoken about, as well as the community-  
19 based Warrior Transition Unit, which is based  
20 out of Sacramento, California.

21 We are a certified Level 2 trauma  
22 center. We recently had a survey by the  
23 National Trauma Committee, and I'm very proud

1 to say that during the outbrief, the reviewer  
2 said that we were the epitome of a Level 2  
3 trauma center, and that their biggest  
4 challenge was to find anything that we could  
5 improve upon for the outbrief. So I'm very  
6 proud of that.

7 We have 243 staffed beds, inpatient  
8 beds that we need to fill more of, as General  
9 Volpe spoke to. Our capacity is 259 beds, if  
10 we needed to surge with inpatient capability.  
11 We are a leader in support for the war effort,  
12 deployment and readiness of the force.

13 We remain a nation at war, and with  
14 36,000 troops on Joint Base Lewis-McChord, we  
15 have our mission of deploying and redeploying,  
16 reintegrating the Active Component force. In  
17 addition to that, we're also a mobilization  
18 and demobilization platform for both National  
19 Guard Units and Army Reserve Units. So  
20 they're all flowing through Joint Base Lewis-  
21 McChord as a dominant power projection  
22 platform for our nation during this time of  
23 war.

1                   We are connected with our  
2 community. Lieutenant General Scaparrotti,  
3 the I Corps commander, very actively engaged  
4 in the Community Connector Program. Every  
5 brigade-size element has a designated city, to  
6 which they are connected, and our city happens  
7 to be Tacoma, Madigan City, and we are engaged  
8 in. One of the ways we're engaged is through  
9 continued participation in the Tacoma Trauma  
10 Trust, where we take civilian trauma, car  
11 accidents off of I-5, gunshots, stabbings,  
12 what have you from the city, and then treat  
13 them at Madigan on a rotating basis, with two  
14 other hospitals that are part of that Trust.  
15 We employ a lot of people from the area. Next  
16 slide, please.

17                   So here we are. You can see our  
18 current enrollment is about approaching  
19 110,000. The target enrollment for this  
20 community-based medical home in Puyallup, that  
21 you heard General Volpe speak of, the target  
22 enrollment is 8,200. We have a second  
23 community-based medical home that will open in

1 the South Sound area, in Olympia, Washington,  
2 which will open in the next month or two, with  
3 the same targeted enrollment.

4 So we will push up above 120,000  
5 total enrolled. We have more than 5,200 staff  
6 to provide services to that enrolled  
7 population, and you can see our annual  
8 operating budget approaches \$450 million a  
9 year. Next slide, please.

10 And so this is a day in the life of  
11 Madigan. If you can remember the numbers from  
12 General Volpe's slides for the region, these  
13 numbers represent anywhere, you know,  
14 typically one-fourth to one-third of the  
15 workload that's being performed in the Western  
16 Region is done right here at Madigan.

17 I'll draw your attention to the  
18 4,500 clinic visits a day, 39 admissions, 40,  
19 we got as high as 53, 55 surgical procedures  
20 in a day, and you can see we have 243 staffed  
21 beds, and again, our inpatient census is a  
22 little low.

23 We have a huge training mission.

1 I'm going to have a slide dedicated to that,  
2 you know, coming up soon. But on any given  
3 day, we have nearly 550 people in training.  
4 Nurses, docs, medics, all comers. So we have  
5 a very large training mission. Next slide,  
6 please.

7 This is who we serve. This is, I  
8 think, such a source of pride for me, because  
9 on Joint Base Lewis-McChord, we have some 13  
10 brigade equivalents. Thirteen. That's a huge  
11 amount of combat power that is located right  
12 down the street from this hotel, to include 50  
13 percent, three of six active component Stryker  
14 brigade combat teams are right here in Tacoma.

15 We have a Fires brigade, former  
16 artillery. We have engineers. We have combat  
17 aviation, an attack aviation brigade. We've  
18 got a Special Forces group based out of here.  
19 We've got Special Ops aviation based out of  
20 here, a Ranger battalion based out here, and  
21 on and on, all married to a C-17 Wing.

22 So when we talk about the ability  
23 to project combat power for this nation during

1 a time of war, this is why I say we are a  
2 dominant power projection platform for this  
3 nation, right here, just a few miles down the  
4 road.

5 The other thing, I'll draw your  
6 attention to this ROTC patch. Every year,  
7 every ROTC cadet in the nation trains, does  
8 their summer training rotation right here at  
9 Joint Base Lewis-McChord. So we are building  
10 the bench, preparing the next generation of  
11 officers, right here, and Madigan has the  
12 privilege of providing the health care for all  
13 of this.

14 So what an honor that is,  
15 particularly during a time of war, where  
16 defense of our nation is so critical. Next  
17 slide, please.

18 We really enjoy a tradition of  
19 excellence. You can see here, as far as the  
20 personnel piece, we have a lot of accolades  
21 that we can speak to. Sixteen specialty care  
22 consultants through the Army Surgeon General,  
23 and you can just read the list here. For the

1       sake of time, I won't go through those.

2                   And on any given day, we have  
3 nearly 100 people, soldiers, deployed forward  
4 in either Afghanistan or Iraq, in support of  
5 the war effort, which provides a challenge for  
6 us, as far as continuity of care and  
7 stability. All of this adds turbulence to our  
8 day-to-day operation certainly.

9                   Uniquely, we have a headquarters  
10 for the Army Central Simulation Committee, and  
11 we want to talk about that a little bit. We  
12 do have the da Vinci® Robotic Surgical System  
13 here, being used by a number of our operative  
14 services. We have a very active refractive  
15 eye surgery program.

16                   Again, our target population served  
17 there is the Warfighter. So that warriors do  
18 not have to go into combat with eyeglasses,  
19 which get dusty and scratched up and impair  
20 vision. So we offer a lot of refractive eye  
21 surgery to troops that are getting ready to go  
22 out the door to combat.

23                   We are the hub for the region's

1 Interdisciplinary Pain Management Service, and  
2 you can come visit that tomorrow, if you think  
3 that's of value to you. Additionally, in this  
4 area, a sort of decreasing number and scale of  
5 Warrior Transition Units.

6 We have a very large Warrior  
7 Transition Battalion, which pretty much steady  
8 state is about 700 warriors in transition, 450  
9 of which are located right here at Joint Base  
10 Lewis-McChord, and then 250 are in that  
11 community based Warrior Transition Unit, based  
12 out of Sacramento, California. So those are  
13 the warriors that are living in their homes,  
14 and we manage out of that headquarters in  
15 California. Next slide, please.

16 Continuing with our tradition of  
17 excellence, we had a bunch of originals that  
18 came out here, TeamSTEPPS, if you've heard of  
19 that, is a method of communications that  
20 mandates communications amongst team members,  
21 whether it be on the inpatient ward, the labor  
22 deck, serving ORs, where it's mandated that  
23 there's a pause.

1           The operating surgeon will say  
2 we're all in agreement we're doing a left knee  
3 arthroscopy today. Everybody agrees, and  
4 anybody in the chain can stop what they  
5 perceive to be an unsafe action, to include,  
6 you know, the E-4 scrub tech, if need be. So  
7 we're tracking that. We've rolled that out  
8 across our organization, with more than 3,000  
9 members of our team trained in that,  
10 TeamSTEPPS.

11           We have the Safe Patient Handling,  
12 with the recent installation of some 124  
13 hydraulic lifts, to prevent employee injuries.  
14 We have the simulators, and we are a national  
15 leader in simulation, which we'll get to. The  
16 electronic referral management process, that  
17 General Volpe spoke to, is very, very  
18 effective.

19           You can see our organizational  
20 awards; recognized by the Heart and Stroke  
21 Association, repeatedly recognized as one of  
22 the 100 most wired hospitals in the nation.  
23 The award for our Medical Military Simulation

1 Training Center, where we train our combat  
2 medics before they deploy into theater, which  
3 is also on your tour itinerary for tomorrow,  
4 was unanimously voted as best in the nation  
5 out of 214 sites that were considered. We  
6 also are pleased that we're so environmentally  
7 friendly, and you can see we have a LEED Gold  
8 clinic in our new WTB, and you can see that.  
9 You can just read that. You don't need me to  
10 read that for you. Next slide, please.

11 As far as education, I spoke  
12 briefly about that. We have 34 graduate  
13 medical education training programs that are  
14 continuously operating at Madigan. You can  
15 see that we have interns, residents, fellows,  
16 LPN students, nurse anesthetist students,  
17 scrub tech students. We host some 550 medical  
18 students and their clerkships throughout the  
19 course of the year, and on and on.

20 We're very proud of this statistic,  
21 which I think rivals any training institution  
22 in the country, with a 94 percent first time  
23 board examination pass rate. Recently, our

1 emergency medicine training program was ranked  
2 number one in the country, beating out  
3 programs across the nation, civilian and  
4 military, based on its performance on the  
5 annual In-service Training Exam, number one in  
6 the nation. Next slide please.

7           So here we go with the simulation.  
8 We were just reaccredited at the highest level  
9 by the American College of Surgeons, and we  
10 are the first and only simulation center in  
11 the Department of Defense to receive such a  
12 high level of accreditation, and we are only  
13 one of less than 20 such centers across the  
14 nation, and that's part of your tour as well  
15 tomorrow. We're very proud of this center.  
16 Next slide.

17           So some of our key initiatives.  
18 General Volpe spoke to you about the patient-  
19 centered medical home. I'm going to speak to  
20 you a little bit about the soldier-centered  
21 medical home and my initiative there, our  
22 initiative. I want to share this program with  
23 you, of how, as the Director of Health

1 Services for the installation, not just  
2 running my hospital, how we get after wellness  
3 in the community here at Joint Base Lewis-  
4 McChord.

5 They do that through this thing  
6 called the HARP, which I'm going to talk  
7 about. I want to share with you a little bit  
8 about behavioral health, and what we're doing  
9 here in Tacoma, and perhaps get your thoughts  
10 on that as well.

11 The pain management piece we'll  
12 review, and then the Virtual Lifetime  
13 Electronic Record, the partnership sharing of  
14 the electronic medical records with the VA.  
15 We are a pilot site here at Madigan to get the  
16 kinks worked out of that system. Next slide,  
17 please.

18 So here are two of our community-  
19 based medical homes. Similarly, we're  
20 transforming all of our clinic areas in the  
21 hospital building to be more patient-centered,  
22 to get after this approach. But here are two  
23 of the sites. Again, this one's already open

1 in Puyallup; this one will open soon, with a  
2 targeted enrollment of 8,200 beneficiaries  
3 each.

4 This one, currently the  
5 enrollment's up to about 2,000, and absolute  
6 rave reviews across the board from those  
7 beneficiaries receiving care there. It's  
8 where they live, it's where they shop. They  
9 can go, grab lunch, see the doctor, go to the  
10 bank, go pick up their prescriptions and go  
11 home, all within 10-15 minutes of where they  
12 live. What a great concept, and again, it's  
13 very well-received. Next slide.

14 So my thought was that boy, we have  
15 36,000 troops on Joint Base Lewis-McChord, and  
16 I'll tell you that where they receive their  
17 care is basically through their battalion aid  
18 stations. Anybody that's ever served  
19 understands that reality. Those battalion aid  
20 stations are typically run by a physician's  
21 assistant, with occasional oversight by the  
22 staff surgeon belonging to that brigade.

23 They don't want to send their

1 soldiers to Madigan. I came from that side.  
2 I know that to send a soldier to Madigan to  
3 get an appointment, to have an appointment  
4 with a doc, shuts down half a day or a day.  
5 They have to fight to find parking and the  
6 whole thing.

7 So the same concept of taking  
8 healthcare out to where our beneficiaries live  
9 and work and have lunch and all that, same  
10 concept. Why don't we do that and take  
11 healthcare right to the brigade areas. At  
12 Fort Lewis, they call that the "banana belt,"  
13 where all these brigade combat team  
14 headquarters are located.

15 Why don't we establish soldier-  
16 centered medical homes in the brigade area, so  
17 that if they need to go from the motor pool  
18 and see the doc, it's right there. It's the  
19 building next door, and we take our doctors,  
20 our providers, the ones in blue, behavioral  
21 health providers, physical therapy, PEBLOs, to  
22 help work through the disability process.

23 Primary care partnered up. The key

1 to this concept is a partnering between the  
2 brigade, the MTOE, the war-fighting side of  
3 the medical department, and the brick and  
4 mortar, stay at home, post-based health care,  
5 right. So I've got all the guys who are in  
6 the journal club, and publishing in peer-  
7 reviewed journals, and are sort of on the  
8 cutting edge of knowledge in the field.

9           Sending them down to the points  
10 where the war fighters live and work, and  
11 delivering healthcare. They are partnering  
12 with their providers, who are, by nature of  
13 the business, more removed from academia, and  
14 provide that.

15           Regarding physical therapy, during  
16 my time as a division surgeon, as a Corps  
17 surgeon, you know, I saw that most of the  
18 traumatic injuries that our troops get or are  
19 suffering from, and they don't want to go to  
20 the medical center, because it takes too much  
21 time. So what if we were able to bring that  
22 to them, in a soldier-centered approach?

23           I think it would enhance readiness;

1 it would enhance collaboration between the TDA  
2 side and the MTOE side. It would promote a  
3 sharing of those cultures with one another, so  
4 that we understand better what each is going  
5 through, and ultimately it will enhance unit  
6 readiness to fight. Next slide.

7 So as far as taking wellness  
8 initiatives out to the community, across Joint  
9 Base Lewis-McChord, one of my biggest things  
10 is, you know, how do you make sure, how do you  
11 enhance a 19 year-old, newly-married dependent  
12 spouse living in a remote set of quarters on  
13 Joint Base Lewis-McChord? How does she have  
14 any idea of the myriad of programs that exist?  
15 You know, literally more than 100 programs  
16 that exist to serve her, the children, the  
17 soldier, they don't know about. So how do you  
18 do it?

19 So the way we do it is through this  
20 thing called the HARP, the Health and  
21 Resiliency Board, which is nested under the  
22 same verbiage and concept as the Comprehensive  
23 Soldier Fitness Program put out by the Army.

1 It came out of the 357, BA 357 in the  
2 Pentagon.

3 So we have the same LOOs. Lines of  
4 Operation physical, spiritual, behavioral,  
5 social, and family. Those are the five  
6 pillars of comprehensive soldier fitness.  
7 Then as we looked at it, we said we really  
8 should have something on environmental health,  
9 and then we should have something on the  
10 wellness multipliers, like the Safety Office,  
11 EO, EEO, things like that.

12 They're all set up in these Lines  
13 of Operation, and it's chaired by a general  
14 officer, on a monthly basis, where all the  
15 players come, to include all the brigade  
16 commanders and brigade command sergeants  
17 major.

18 So that leadership is being  
19 educated on the myriad programs that exist out  
20 there in a very systematic way. Every month,  
21 they're getting laid out, so that they can  
22 then take that information, that knowledge, to  
23 their formations, and hopefully get that word

1 out on how people can access the programs.  
2 Next slide.

3 Now that leaves three of these  
4 lines of effort. We have the physical, the  
5 environmental health, and the behavioral  
6 health Lines of Operations. So we brief the  
7 programs, the various programs. We educate  
8 people, pass out cards, pass out refrigerator  
9 magnets, whatever it is, so that commanders  
10 and command sergeants major know what assets,  
11 what programs exist for their people.

12 Then they are then held responsible  
13 for getting that data percolated down through  
14 their ranks. Ultimately, the goal of this,  
15 here it is, is to communicate services and  
16 programs to commanders and command teams, with  
17 the goal of improving the overall health and  
18 resiliency of the community at large, right,  
19 through those approaches, through that  
20 approach. Okay. Next slide, please.

21 So a little bit about behavioral  
22 health. We have a very, very active  
23 behavioral health program, and you can see

1 here that we have 168 total credentialed  
2 licensed providers of different types,  
3 psychiatrists, psychologists, social workers,  
4 and licensed counselors. We have liaisons  
5 that we push out to each brigade on Joint Base  
6 Lewis-McChord, establishing that habitual  
7 relationship.

8           They know that when Dr. Jones comes  
9 down, you know, he's their doc when it comes  
10 to behavioral health, establishing those  
11 habitual relationships. We have a walk-in  
12 clinic with kiosks where you can just come in.  
13 You don't have to have an appointment, sign in  
14 and you're seen same day, which is very well  
15 utilized.

16           A number of programs here that are  
17 targeting both soldiers and family members, to  
18 enhance wellness from a behavioral health  
19 perspective. Madigan developed this thing  
20 called the D-RAT or the Down-Range Assessment  
21 Tool for behavioral health. What that is is a  
22 -- it's a one sheet that is sent to the unit  
23 in-theater, and 90 days -- you cannot fill it

1 out before you hit the 90 days, before  
2 redeployment mark.

3 So in that final one to three  
4 months that you're in combat, the first-line  
5 leadership, your platoon leader, your platoon  
6 sergeant, goes through and says Specialist  
7 Homas. Okay, yes. He got Article 15'd while  
8 we were here. We know he's having trouble at  
9 home with his relationship. Specialist  
10 Johnson, he's repeatedly shown up late for  
11 work. We think he's got drug abuse problems.

12 It is a commander's tool to assess  
13 risk down range, Down-Range Assessment Tool,  
14 performed by leadership in combat, which is  
15 then communicated back to us and my behavior  
16 health team at Madigan. So that when we  
17 receive these guys off the plane, we already  
18 know who the chain of command is tracking as  
19 having a higher level of risk.

20 They're immediately embraced,  
21 pulled in and assessed by a licensed  
22 professional then, right, to see what level of  
23 intervention is or is not needed. So this is

1 one thing that was an innovation that came out  
2 of Madigan.

3 We also conduct platoon level  
4 debriefings. So if a platoon's 30 or 40 men  
5 and women, we go to them shortly after they've  
6 redeployed, and we debrief them from a  
7 behavioral health perspective, face to face,  
8 and then a number of other initiatives, the  
9 five touchpoints that General Volpe spoke of.

10 We're tracking all of those. We're  
11 executing with all those touchpoints, and  
12 we're innovating. Again, we came up with this  
13 one. This is Touchpoint 2 on that big  
14 complicated chart that's hard to read.

15 This past year, we've had nearly  
16 93,000 behavioral health encounters at Madigan  
17 and that is way up from the year before. But  
18 what happened is 18,000 troops came back from  
19 combat. I was one of them. I came back. I  
20 got home in March of 2010, and 18,000 of my  
21 brothers and sisters from 1st Corps came home  
22 over the summer months there of 2010.

23 So we've had this huge spike, and

1 now what we're doing is we're tracking, to see  
2 what that volume does. So they've been back  
3 for a year, getting a lot of behavioral  
4 healthcare. Let's see what happens, now that  
5 they're in dwell, right. They're not on a  
6 patch chart for the most part, and we're going  
7 to see what happens to this demand on the  
8 behavior health system.

9 So yes, we've seen an increased  
10 utilization. We'll follow that trend line.  
11 We have seen a reduction overall in stigma. I  
12 don't think we'd get 93,000 encounters if  
13 stigma was alive and well. We have  
14 interviewed over 4,000 soldiers with regards  
15 to stigma, and it is alive and well in some  
16 ranks.

17 The most prevalent, you've got to  
18 remember, was company grade officers. Let me  
19 make sure. Somebody's nodding yes. Am I  
20 recalling that correctly? Right. Company  
21 grade officers, some captains.

22 We encountered some captains that  
23 are still concerned about their career, if

1 they seek behavioral health for a need that  
2 they have. So we will have to come up with a  
3 way of targeting them, so that they don't feel  
4 compelled to not seek care for that concern.  
5 Next slide, please.

6 Pain management. Again, you're  
7 going to see it tomorrow. These are the list  
8 of disciplines that we are going to put into  
9 our interdisciplinary pain management clinic.  
10 I thought CNN just released, in fact, I  
11 watched it on an airplane flying back from  
12 Kansas City just this past weekend, a  
13 compelling documentary on drug use. Drug  
14 abuse of prescription drugs in America,  
15 specifically oxycontin, which you know, is at  
16 everybody's pen tip as far as writing a  
17 prescription for pain meds. The street value  
18 of ten Percocet, unbelievable.

19 So we're really -- we are -- of all  
20 new initiatives, this is my number one new  
21 initiative to get after, and we'll show you  
22 how we're doing that tomorrow when you visit  
23 us. We basically cleaned out one entire deck

1 for the -- that's for the Navy guys in the  
2 room --

3 (Laughter.)

4 COL HOMAS: One entire deck of our  
5 inpatient tower that's going to be dealt with,  
6 to this initiative, pain management. Then  
7 we're going to monitor the outcomes, with a  
8 focus on what is the individual's functional  
9 status, the quality of life, the incidence of  
10 depression, anxiety, and their opioid use, and  
11 we have a software package called CPAIN, to  
12 help us monitor the outcomes of all these  
13 modalities, and again, trying to get after one  
14 of those challenges that General Volpe spoke  
15 of, you know, because we're not reimbursed for  
16 these alternative modalities.

17 So if we could document outcomes  
18 showing benefit, then I think that's the first  
19 step in changing that problem in America.  
20 Next slide, please.

21 So the challenges. You've already  
22 heard them. General Volpe spoke to them.  
23 Basically, facilities, you know. A lot of

1 growth has occurred on Joint Base Lewis-  
2 McChord. Madigan hasn't changed in size, you  
3 know. There are -- we are ever working on  
4 optimizing our use of space, and utilizing all  
5 those corridors in old Madigan or the Madigan  
6 Annex, the World War II building.

7           There are two MILCON projects on  
8 the books that are being actively worked by  
9 the Health Facilities Planning Agency, which I  
10 believe to be of huge benefit to Madigan,  
11 should they get put into the POM cycle. IDES  
12 spoke about that briefly.

13           We want to accelerate that process.  
14 IDES is not a readiness process. It's not  
15 about getting units ready. Its focus is  
16 taking care of soldiers, and making sure that  
17 their needs are met.

18           So by virtue of that, by virtue of  
19 the fact that soldiers can appeal and request  
20 second opinions and, you know, every step of  
21 the path is focused on maximal benefit to the  
22 soldier, it's not a speedy process. We're  
23 looking at, always looking at ways to move

1 that through.

2 We're really looking at enhancing  
3 partnerships with the VA here. We have a very  
4 collaborative relationship. Again, of all the  
5 places I've been stationed, second to none. I  
6 mean, the desire of agencies in this Puget  
7 Sound area to work together is unprecedented  
8 in my experience.

9 As far as my low inpatient census,  
10 problematic. I mean, I've got a lot of staff  
11 beds and how am I working to fill them? Well  
12 again, through increasing that partnership  
13 with the VA, increasing our enrollment to  
14 retirees. You know, the usage of military  
15 healthcare by soldiers is up about 400 percent  
16 from a decade ago.

17 So soldiers tend to be young,  
18 healthy guys, who need a limited amount of  
19 care. Not a whole lot of complex, inpatient  
20 healthcare is needed by soldiers, sailors,  
21 airmen, marines, coastguardsmen. So you know,  
22 we're trying to open up enrollment to  
23 retirees.

1           We will continue to participate in  
2 this Tacoma Trauma Trust, which costs us a  
3 significant amount of money to deliver trauma  
4 care, acute care, to civilian victims, that  
5 don't always pay. But we will continue,  
6 because the value of doing that is so much  
7 greater. The educational benefit that our  
8 residents get, our surgical residents get in  
9 management of trauma, as well as the  
10 partnership with Tacoma and the healthcare  
11 community in this area. We will continue to  
12 participate in that Trust.

13           We're actively looking at the  
14 potential of returning open heart surgery to  
15 the operating rooms at Madigan. Currently,  
16 the vast majority of our open hearts are done  
17 at Tacoma General for a number of reasons, and  
18 we're looking at that and dissecting that, and  
19 trying to facilitate or work a way to bring  
20 open heart surgery back to Madigan, again to  
21 help get after that challenge. Next slide,  
22 please.

23           I think our healthcare has caught

1 up to some degree. Do we have a minute or two  
2 for questions?

3 CHAIR DICKEY: Let me, while you're  
4 thinking of some questions; ask if any of our  
5 Board Members on the phone have any questions.

6 GEN MYERS: General Myers. I don't  
7 have any.

8 CHAIR DICKEY: How about anybody  
9 here at the table, for either General Volpe or  
10 for the Colonel? Amazing amounts of  
11 information, and I'm looking forward to seeing  
12 some of the simulated training. Several of us  
13 around the table are involved in medical  
14 education, and I think that the military was  
15 the initiator of a lot of the activities we  
16 now do in simulators. So it would be fun to  
17 see some of the world class facilities I know  
18 you have. If there are not comments or  
19 questions, allow me to thank both of you for  
20 your presentations. I know we are eager and  
21 excited to actually see the facilities and  
22 meet some of your team tomorrow.

23 I want to thank you for speaking

1 with the Board today. A tremendous amount of  
2 information you've provided for us, and again,  
3 comment that we will look forward to seeing  
4 you tomorrow, and in between your Joint  
5 Commission visits. But we did bring the  
6 President Emeritus. That ought to be worth  
7 something.

8 (Laughter.)

9 COL HOMAS: I did ask him to call  
10 his friends and maybe help us out a little  
11 bit.

12 (Laughter.)

13 COL HOMAS: We will be interested  
14 in complying with that request.

15 CHAIR DICKEY: It doesn't sound  
16 like you're going to need much help. Thank  
17 you, gentlemen, and thank you for hosting us  
18 here in the Washington area. I know we're  
19 going to learn a lot tomorrow, and thank you  
20 for the briefing this morning.

21 COL HOMAS: Thank you.

22 (Applause.)

23 CHAIR DICKEY: Well, you do --

1 extra thanks to both these gentlemen. They've  
2 given us a phenomenal amount of material, but  
3 kept us on time. Let's take a short break.  
4 We are due to start back at 11:30, and because  
5 we do have several Board Members on the phone,  
6 I'll ask us to please be timely about that  
7 restart. But it gives us about ten minutes  
8 for a quick break. Thank you.

9 (Whereupon, the above-entitled  
10 matter went off the record at 11:20 a.m., and  
11 resumed at 11:34 a.m.)

12 CHAIR DICKEY: If I can encourage  
13 you to take your seats, so that we can begin.  
14 As we're getting ready to welcome back our  
15 next -- welcome our next briefing, can I check  
16 and see which of our Board Members remain on  
17 the line?

18 DR. JOHANNIGMAN: Jay Johannigman  
19 on line.

20 CHAIR DICKEY: Jay, thank you.  
21 General Myers, Dr. Delany? Okay, okay. Jay,  
22 we appreciate you being there, and I know a  
23 couple of the others are probably returning,

1 even as we return from the break. Welcome  
2 back.

3 Our next briefing is going to be  
4 given by Dr. Donald Jenkins, and by -- so you  
5 guys need to give me lessons here. MSG,  
6 Master Sergeant?

7 MSG MONTGOMERY: Yes.

8 CHAIR DICKEY: How about that?

9 (Simultaneous speaking.)

10 CHAIR DICKEY: I told them when  
11 they asked me to take this job, I hadn't been  
12 in the military. Mr. Montgomery, I apologize.  
13 Dr. Jenkins is the Chair of the Trauma and  
14 Injury Subcommittee. I'll get to you, Dave --  
15 and a Board Member of the Defense Health  
16 Board. He serves as the Chief of Trauma at  
17 the Mayo Clinic and Foundation.

18 Prior to retiring as an Air Force  
19 colonel, Dr. Jenkins served as the founding  
20 Director of the Joint Theater Trauma System,  
21 which was developed by the Department of  
22 Defense, to improve the care provided to our  
23 wounded servicemen and women in Iraq and

1 Afghanistan.

2 He's been honored by the Chairman  
3 of the Joint Chiefs of Staff Award as the  
4 Physician of the Year in the U.S. Air Force,  
5 the Physician of the Year Award at Wilford  
6 Hall Medical Center, the Bronze star medal and  
7 the Paul Meyers Physician of the Year Award  
8 presented by the Air Force Association.

9 Also participating in the briefing  
10 is Master Sergeant Montgomery, currently  
11 regimental senior medic for the 75th Ranger  
12 Regiment, and has served in the Rangers for  
13 over 20 years.

14 His previous positions include  
15 Medical Operations non-commissioned officer,  
16 battalion aid station, non-commissioned  
17 officer in charge, company senior medic in the  
18 1st Battalion, 75th Ranger Regiment and  
19 company senior medic.

20 He has participated in multiple  
21 deployments in Operation ENDURING FREEDOM,  
22 Operation IRAQI FREEDOM, Operation UPHOLD  
23 DEMOCRACY and Operation DESERT STORM IRISH

1 GOLD with the 75th Ranger Regiment. We  
2 welcome both of you, and Dr. Jenkins, if you  
3 would like to start with the Trauma  
4 Subcommittee report.

5 Information Brief: Trauma and Injury  
6 Subcommittee/ Committee on Tactical Combat  
7 Casualty Care Update

8 DR. JENKINS: Thank you, Dr.  
9 Dickey, and thanks for the privilege of  
10 presenting this work. This is a work product  
11 that's produced out of the Committee on  
12 Tactical Combat Casualty Care, and then vetted  
13 through the Trauma and Injury Subcommittee,  
14 and I'm here as a spokesperson to talk about  
15 some potential advances we can make, and ask  
16 for your endorsement.

17 Briefly, what we'll talk about is  
18 resetting our frame and making sure we're all  
19 thinking about this from the same perspective,  
20 about the potential deaths in-theater that  
21 could be prevented and talk about a couple of  
22 ways of doing that.

23 Historically, up to 25 percent of

1 deaths in the current combat are felt to be  
2 potentially preventable. The vast majority of  
3 those potentially preventable deaths are due  
4 to hemorrhage, and unfortunately, there's  
5 quite a few of those deaths, the majority due  
6 to hemorrhage, that are not able to be treated  
7 with a tourniquet.

8           When we look at what's in the  
9 literature, Journal of Trauma Surgery had a  
10 study looking at Armed Forces Medical  
11 Examiners Office during two time periods. The  
12 first time period was early in the war, '03-  
13 '04, and then in 2006.

14           Again, what you see is that the  
15 prevalent cause of death was hemorrhage in  
16 about 85 percent, across both time periods,  
17 with a non-compressible hemorrhage of the  
18 torso coming in right at 50 percent of those  
19 deaths, and those at the junction, if you  
20 will, in the axilla or at the groin, coming in  
21 right at 20 percent.

22           More recent findings. Colonel  
23 Brian Eastridge has just worked, as a part of

1 his role in Joint Theater Trauma System, as  
2 the consultant for trauma to the Surgeon  
3 General, has done an update for us. What we  
4 see is the term used today is junctional  
5 hemorrhage, that's caused the majority of  
6 these potentially preventable deaths from  
7 hemorrhage.

8 Those junctional areas, as you see  
9 here are in, above the extremities, and  
10 apparently include the groin and axilla. This  
11 is one of the things that Monty is  
12 specifically going to discuss. Additionally,  
13 you may recall back in the March meeting, Dr.  
14 Holcomb came and presented his experience at  
15 Landstuhl, with the significant increase in  
16 complex blast injury in the dismounted troops.

17 Those cases resulted in a  
18 significant amount of injuries not amenable to  
19 a tourniquet application, and they didn't have  
20 a great answer for any of these things. That  
21 presentation included this uptake in these  
22 cases, where there are multiple amputations.  
23 Also, that there are a large increase in

1 urogenital injuries seen in that patient  
2 population.

3           So at the June meeting, it was  
4 recommended that further study of hemorrhage  
5 control mechanisms, particularly that of this  
6 non-compressible hemorrhage should take  
7 priority, and that we are looking for answers  
8 to how we could best put these new  
9 innovations. What are the innovations being  
10 identified that potentially could help us to  
11 control some of this most difficult  
12 hemorrhage?

13           So based upon work done with the  
14 Committee on Tactical Combat Casualty Care, we  
15 think that in fact there may be a few things  
16 we can do to address this gap. The treatment  
17 options for non-compressible junctional  
18 hemorrhage to date really comes down to a  
19 combat gauze and direct pressure, which in a  
20 lot of these cases can't be accomplished  
21 successfully, but because of the transport of  
22 those casualties out of the field setting, and  
23 through the evacuation chain, and just

1 sometimes that these injuries are not amenable  
2 to any type of care that we have available to  
3 us to date.

4 We think there are a couple of  
5 options that can be of benefit, and in fact,  
6 when the Committee on Tactical Combat Casualty  
7 Care met, the vote to support both of these  
8 endeavors was 39 for and 2 against, which is  
9 pretty consistent for that group when they get  
10 behind something. It's the vast, vast  
11 majority of those folks, and at the Trauma  
12 Injury Subcommittee level, the voting was  
13 unanimous to support both of these endeavors.

14  
15 **VOTE: Combat Ready Clamp™**

16 So at this point, I'll turn this  
17 over to Master Sergeant Montgomery, to talk  
18 about the Combat Ready Clamp™, and I'll come  
19 up and talk about the tranexamic acid when  
20 he's done.

21 MSG MONTGOMERY: Good morning. So  
22 I'm glad to speak with you here this morning,  
23 and one key thing is we're still defining that

1 junctional area, as it's depicted in the other  
2 slide there. Next slide, please.

3 So this has been a consistent  
4 problem for Tactical Combat Casualty Care  
5 across the board from the initial development  
6 of TC3 back in the mid- to early 90's, and one  
7 of the key things was the Corporal Smith  
8 injury from the Rangers in Mogadishu.

9 That's leading all the way up to  
10 present day, where this is a recent injury  
11 submitted from Colonel Kragh, depicting the  
12 same kind of injuries, high, inguinal high  
13 groin injuries, things that are not amenable  
14 to tourniquets at all.

15 A quote from a Marine battalion  
16 surgeon forward. Just in six months, over  
17 1,000 IEDs by the 3rd and the 5th Marines,  
18 many of these, over 200 casualties and 29 KIA,  
19 and many of these Marines had severe  
20 amputations that could have benefitted from  
21 some sort of proximal tourniquet device.

22 Also, U.S. Army Medical Research  
23 and Materiel Command posted a requirement back

1 in 2009 for a device of this nature, or  
2 something of this nature, looking at  
3 compressible hemorrhage that's not amenable to  
4 tourniquet location. Essentially, the clamp  
5 device that I'll discuss kind of meets all  
6 these requirements as well.

7 The key premise that we ought to  
8 look at with Tactical Combat Casualty Care is  
9 asking the medic or corpsman to do something  
10 that is going to be beneficial to the  
11 casualty, and where we're confident that it's  
12 going to be beneficial. But then also, that  
13 anything that we find that he can use, that  
14 it's relatively easy to equip him with it, and  
15 easy to train him with.

16 All right. So I'll go into the  
17 Combat Ready Clamp™ here itself. Essentially,  
18 the concept, not a new concept. The C-clamp  
19 device or some sort of pressure device in a  
20 clamping measure like this dates back to Dr.  
21 Lister with the Civil War, and several  
22 different surgical devices even used today.  
23 So it's really not a new idea, but what the

1 Combat Ready Clamp™ or the CRoC™ does is makes  
2 those devices more amenable to us in combat,  
3 right, and to work in an aid bag.

4 So just the basic set up of it  
5 assembled, and then in a small bag, and that's  
6 basically meeting Army requirements kind of  
7 thing. Most of us manage to fold it over  
8 pretty easily within the aid bag and it fits  
9 with no problem.

10 All right. So it's FDA-approved  
11 for these two locations. So inguinal, direct  
12 pressure over a packed inguinal injury site.  
13 So right where a wound is, a gunshot wound or  
14 heavy shrapnel or an IED-type injury, directly  
15 onto the site and then also in the pelvic  
16 manner, that includes the external iliac  
17 artery. So that's the two FDA sites approved  
18 at this point.

19 The unapproved but theoretical  
20 locations that the manufacturer's looking at  
21 down the road, and we've tested ourselves but  
22 we're not quite ready to make that leap,  
23 unless a true casualty presents it and it's

1 our only option, is abdominal that's on the  
2 descending aorta. That's basically occluding  
3 all the lower extremity arteries, and then  
4 conceptually, an axillary application.

5 This is going to take some serious  
6 development by the manufacturer, because it's  
7 going to require turning of the device and a  
8 little bit easier application in some ways.  
9 Just it's not quite ready for that yet. But  
10 theoretically, it could be applied in such a  
11 way as well.

12 All right. So the current fielding  
13 is essentially just three units. So the Army  
14 Special Mission Unit, the Ranger Regiment and  
15 the Navy Special Mission Unit, and then  
16 civilian-wise, just the Life Flight® down at  
17 Houston.

18 Human use at this point. Honestly,  
19 we have one reported human use, and that was  
20 on a local national that was wounded on one of  
21 our objectives about two months ago, but we  
22 don't have the follow-on data. So we don't  
23 really know whether survival or outcome or

1 anything like that, just because the way the  
2 system works, we don't maintain control of  
3 those kind of casualties over time.

4 All right. So equipment  
5 maintaining, definitely a medic or corpsman  
6 carried device, aid bag. It can be partially  
7 broken down, as you can see right here. It  
8 breaks down pretty easily within our aid bags  
9 at the M-9 type we have there, and fairly  
10 light. So pound and a half, about the size of  
11 an IV bag or something like that, which we try  
12 to pare those down anyway.

13 All right. So the testing for the  
14 most part has been on perfused cadavers, fresh  
15 human cadavers at Wake Forest, and then  
16 there's a publication pending there. In fact,  
17 we use this for all of our Train the Trainers.  
18 All the senior medics and docs that we're  
19 training the device with and training our  
20 medics with, all went and did the actual  
21 cadaver study training at Wake Forest.

22 To be honest, for many of us, it  
23 was an eye-opening experience, in the sense

1 that we had, we had doubts of this concept  
2 beforehand. But when we went in there,  
3 honestly it was along the lines of it's this  
4 simple, really? It's this simple, and this is  
5 all we have to do and we can fix this problem.

6 Some of the proposed testing, this  
7 is really more on the training side of the  
8 house, is -- things are dropping off already.  
9 Training side of the house, where Marine  
10 Readiness is looking at the actual corpsmen,  
11 training them and evaluating their training,  
12 but then also using the Doppler ultrasound to  
13 evaluate their effectiveness as a -- through  
14 the training and the effectiveness of the  
15 device in general.

16 All right. So potential issues  
17 that we have with it. Honestly, stabilization  
18 during transport, and the way it looks, your  
19 first thought is, is this thing is going to be  
20 very difficult to keep in place, especially on  
21 a litter or something like that.

22 Surprisingly, even with the strap  
23 on there as well, but surprisingly, once it's

1 clamped down and with the large metal plate  
2 under the buttocks, it actually is fairly  
3 stable within itself. It can be additionally  
4 stabilized with litter straps or some of the  
5 other devices.

6           So you figure most casualties  
7 certainly would be receiving this kind of  
8 treatment. We're going to be wrapping them in  
9 hypothermic prevention blankets and things of  
10 that sort. So I mean, generally the  
11 stabilization has not proven the problem that  
12 we thought it would in ourselves.

13           Device impact on pelvic fracture.  
14 It's very easy to suspect a pelvic fracture in  
15 the field; very difficult to diagnose one for  
16 our means. That's one of the concerns, but  
17 actually also we're almost thinking along the  
18 lines that this could actually help stabilize  
19 a pelvic fracture, just don't know yet. So I  
20 mean, that's just one of those things. It's  
21 out there, out there floating.

22           Then as with any device or tool or  
23 training or whatever, just the clinical

1 decision-making at the right time, the right  
2 place, right patient and all that sort of  
3 thing, to apply this. The way we think of  
4 this, this is not exclusive to this.

5 Basically, everything we're asking  
6 these medics to do, from the fluid  
7 resuscitation to the hemostatics, whatever,  
8 there's some sort of clinical decision-making  
9 that we're asking them to think about along  
10 the way.

11 So bottom line, this is an FDA-  
12 approved product. It's currently fielded by  
13 the small, limited number of units there, and  
14 we essentially have no other option. The  
15 other devices that are similar to this are not  
16 amenable to our aid bags at all. I mean we  
17 could potentially put something like that on  
18 vehicles or aircraft. But by the time you get  
19 a patient to that level, he may have bled out  
20 already.

21 My other problem with the current  
22 fielding is the small number of units you see  
23 there, we aren't seeing these kind of

1 injuries, all right. We're strike forces  
2 going in and straight onto the target and that  
3 kind of thing. So we're not patrolling long  
4 ranges, and through IED alleys and that kind  
5 of thing that many of the other units,  
6 especially the marines out in Western  
7 Afghanistan are seeing.

8 They're the ones seeing those kind  
9 of injury patterns. So it's definitely got to  
10 get in the hands of the right people, and not  
11 so much to get that human use, but to save  
12 lives out there, all right. Many of the  
13 discussions went down the route of not wanting  
14 to approve something like this until we do  
15 have actual human use.

16 Well, I don't really want to  
17 volunteer one of my rangers for that first  
18 human use at all. So it seems to work,  
19 doesn't seem to have problems, and the key  
20 thing is we don't have any other solution for  
21 this.

22 So looking at the Tactical Field  
23 Care section of the Tactical Combat Casualty

1 Care guidelines, no real changes to the  
2 existing text. All we did essentially was  
3 just add this portion in Section B for  
4 bleeding. So I'll let you read along there.

5 Kept it, we did keep it relatively  
6 generic in the sense that if another device  
7 similar to the CRoC comes out any time soon,  
8 then we can essentially just evaluate it and  
9 add. We don't have to rewrite the entire  
10 guideline or anything. So but basically,  
11 whenever tourniquets aren't amenable and you  
12 can't apply the tourniquets and the  
13 hemostatics or bandaging in general isn't  
14 working, then this is something to consider.

15 Then basically it's on the medic  
16 and his level of training and clinical  
17 understanding, I think, as to what extent we  
18 would want to go further with some of the non-  
19 approved, non-FDA approved type things. So I  
20 mean, that's something for our docs and PAs in  
21 the unit to think about, on what they would  
22 teach and let their medics do.

23 So barring any questions, I'll turn

1 it back over to Dr. Jenkins.

2 CHAIR DICKEY: Any questions?

3 DR. HOVDA: (off mic) I have one.  
4 This is Dave Hovda from UCLA. I read the  
5 report, and looking at the apparatus, we're  
6 talking about the external iliac artery. So,  
7 we're talking about the placement of this  
8 tourniquet above the inguinal ligament?

9 MSG MONTGOMERY: I'll let you do  
10 this one. This was a heated discussion --

11 (Simultaneous speaking.)

12 DR. JENKINS: Sure. So the  
13 discussion was quite lengthy and animated,  
14 Howard Champion and Norm McSwain, discussing  
15 you know, the exact placement of the device.  
16 You can see by the size of that cone that it's  
17 going to sit at -- the way it's designed and  
18 how it lays, it sits right at the inguinal  
19 ligament.

20 So there will be some component of  
21 femoral artery compression. There will be  
22 some component of external iliac artery  
23 compression, like just on the other side of

1 the inguinal ligament.

2 DR. HOVDA: Okay, thank you.

3 CHAIR DICKEY: Are there any  
4 additional questions? How about any questions  
5 from our members on the phone?

6 PARTICIPANT: You were cut off, so  
7 I couldn't hear it.

8 CHAIR DICKEY: I'm sorry. One more  
9 time?

10 PARTICIPANT: You were cut off.  
11 What was your question please?

12 CHAIR DICKEY: Do any of you on the  
13 phone have any questions for Master Sergeant  
14 Montgomery?

15 PARTICIPANT: I have none, thank  
16 you.

17 GEN MYERS: I have none.

18 DR. JOHANNIGMAN: None from Jay  
19 Johannigman.

20 CHAIR DICKEY: Okay. Thank you very  
21 much, and Dr. Jenkins, then, do you want to -  
22 - you have two votes. Do you want to  
23 separate these and do the votes on each

1 individual piece?

2 DR. JENKINS: I think it's wise if  
3 we just vote on this right now, and then --  
4 because we're going to switch gears a little  
5 bit.

6 CHAIR DICKEY: Right. The  
7 recommendation coming to you from the TC3  
8 then is to support the implementation of the  
9 compression tourniquet. It's not a  
10 tourniquet -- device for the use of  
11 hemorrhage control. Is there discussion or a  
12 motion on the floor?

13 DR. CARMONA: So moved.

14 DR. HOVDA: Second.

15 CHAIR DICKEY: It is moved and  
16 seconded by Dr. Hovda, that we approve the  
17 recommendation coming forward from TC3. Is  
18 there further discussion?

19 (No response.)

20 CHAIR DICKEY: Hearing none, all in  
21 favor say aye?

22 (Chorus of ayes.)

23 CHAIR DICKEY: Opposed, no?

1 (No response.)

2 CHAIR DICKEY: And I would assume,  
3 because this is part of the solution, but  
4 careful follow-up and so forth, that we can  
5 perhaps look for some additional information  
6 as this thing becomes activated in far more  
7 units, and we get some data about the impact.

8 DR. JENKINS: Absolutely, ma'am.  
9 Speaking with some of the folks that are  
10 keeping a close eye on this in human use down  
11 in Houston, and one of the suggestions I had  
12 for them personally is why don't you have a  
13 little postcard in the kit, so that every  
14 medic that is using this, you know, just ask  
15 him four or five questions, check a couple of  
16 blocks, and then throw it in the mail.

17 Go back to, you know, central  
18 repository, so we can get the words right  
19 from the medic themselves, did it work and  
20 how well did it work, difficulties they  
21 encountered, issues they might have had.  
22 They said in fact they have that postcard in  
23 the civilian version of the device, that

1 they're collecting that info.

2           So I suspect by the time we meet  
3 again, there will be several opportunities  
4 for this to have it in use and for us to get  
5 a report back.

6           CHAIR DICKEY: Excellent. Thank you  
7 very much. Yes, Dr. Parkinson.

8           DR. PARKINSON: If I may, Dr.  
9 Dickey, just a non-surgeon's curiosity for  
10 Don. The simple elegance of the anti-trauma  
11 trousers, which are using air and balloons, a  
12 technology that has advanced tremendously  
13 over the last decade or two, I'm wondering if  
14 any of the device manufacturers are looking  
15 at selective air balloon pressure, rather  
16 than --

17           My first reaction with this clamp is  
18 it's kind of 1890's technology, nuts and  
19 bolts and you screw it on. I'm just  
20 wondering if there's some next generation  
21 stuff out there that could use a masked type  
22 of technology or something like that.

23           DR. JENKINS: Unfortunately, in the

1 interest of time, we didn't give Monty's  
2 entire presentation. There are several other  
3 commercially available devices, some of which  
4 are pneumatic in nature. Given the field  
5 limitations and constraints, et cetera, it  
6 was determined by the group that they were  
7 not feasible for use.

8 Yes. But they're used routinely in  
9 hospitals, in cardiac cath labs,  
10 interventional radiology labs, et cetera for  
11 femoral punctures on a regular basis.

12 CHAIR DICKEY: Okay.

13 **Vote: Tranexamic Acid Use in Theater**

14 DR. JENKINS: Moving on now to  
15 tranexamic acid, so if we just go back to the  
16 intro comments, actually about 20 percent of  
17 the casualties that we talk about bleeding to  
18 death from this junctional hemorrhage might  
19 have their lives impacted by that Combat  
20 Ready Clamp™, there's an entirely other group  
21 that has no ability to apply compression to,  
22 in what is the equivalent of a torso  
23 tourniquet, if you will.

1           So there are a couple of studies,  
2           and I think the information has been floated  
3           out for folks to review. Hillary Peabody in  
4           the back in the room has every article ever  
5           written on tranexamic acid at her disposal.  
6           So again, I remind you that we reviewed this  
7           topic at length. Each of these discussions  
8           was about two hours in length, to get the  
9           wording right, et cetera, and it was an  
10          interesting discussion all the way around.

11           I'll try to summarize that as best I  
12          can here. The evidence comes from two big  
13          trials, well two trials; one big trial and  
14          one very convincing trial. So the CRASH-2  
15          information came out late last summer-early  
16          fall. There were several meetings held  
17          amongst trauma experts and military trauma  
18          experts, and we had the discussion at the  
19          Committee on Tactical Combat Casualty Care  
20          and the Trauma Injury Subcommittee.

21           And as of June, we were not  
22          convinced that TXA was the way to go. We are  
23          now convinced of that. The CRASH-2 study,

1 published in Lancet in 2010; 20,000 patients  
2 all cause mortality to decrease, as you can  
3 see from 16 percent to less than 15 percent,  
4 with a decrease in the risk of bleeding from  
5 5.7 to 4.9 percent.

6 In a subgroup analysis of those  
7 trauma patients, looking at specifically  
8 timing, there were about 3,000 deaths and  
9 about 1,000 of those deaths were due to  
10 bleeding. The risk of death due to bleeding  
11 was reduced to 5.3 percent if TXA was given  
12 within one hour, and down to 4.8 in that one  
13 to three hour time frame. So the one to  
14 three hour time frame becomes important in  
15 our discussion.

16 The MATTERS study, this is where it  
17 really made the difference to us, because  
18 this is care rendered actually to, in this  
19 group of patients, I think it's about 1,000  
20 overall. There were dozens and dozens of  
21 U.S. soldiers who were injured and cared for  
22 by these teams, who received TXA.

23 So really what it comes down to is

1 patients who got blood and got or did not get  
2 TXA and what were the results. That is,  
3 cared for by the same teams, have a similar  
4 concept, transfusion strategies, et cetera,  
5 all at one hospital in Bastion. Here you go.  
6 There's that, like I said, it's about 900  
7 patients overall. 600 got TXA, I'm sorry.  
8 600 did not get TXA; 300 did get TXA.

9 Massive transfusion numbers,  
10 actually more. Massive transfusion  
11 represented in this TXA group, and they got  
12 about 2.3 grams of TXA in that study. The  
13 overall mortality analysis, when you look at  
14 this, is that the 24 hour mortality,  
15 interestingly, is not affected by the use of  
16 TXA.

17 The result seems to come out at the  
18 28 day mortality and where there is a  
19 statistically significant improvement in  
20 overall survival. That is borne out  
21 especially in patients receiving massive  
22 transfusion. So patients requiring massive  
23 transfusions, similar mortality rate on Day

1 1, but half the mortality at Day 28.

2           So we suspect that there's something  
3 more to TXA than its anti-fibrinolytic  
4 properties afoot that lend its mortality  
5 benefit. Another way of looking at that is  
6 that within the -- you start to see the  
7 difference really come up at about Day 3, is  
8 where this begins. So it's substantial, and  
9 this is for the overall cohort. Similarly,  
10 at about Day 3 is the breakpoint where you  
11 start to see the significant improvement in  
12 mortality overall.

13           And so this was now the concluding  
14 statement, based on the framework we've laid  
15 out here and the substantial number of these  
16 casualties that are dying of unchecked  
17 hemorrhage. We have now a drug that appears,  
18 you know, quite safe, given in an appropriate  
19 timeframe, that it can make a substantial  
20 difference, especially for those casualties  
21 who are bleeding to death.

22           It shouldn't be administered outside  
23 of the three hour time period, it doesn't

1 seem to have that benefit. If you look into  
2 that CRASH-2 study published in Lancet, it  
3 does not have the benefit if administered  
4 beyond the three hours. The way that it was  
5 dosed in the CRASH-2 trial, was one gram  
6 given immediately and one gram over eight  
7 hours.

8           The Bastion experience is somewhat  
9 different than that, such that the two doses  
10 are given within a very short timeframe,  
11 within just a couple of hours of one another.  
12 So these have been underway quite some time,  
13 and these are the changes that we have  
14 proposed, that this section will be added to  
15 each of the sections for field care and  
16 evacuation care, administering one gram of  
17 tranexamic acid as recommended per the  
18 manufacturer, in 100 cc's of a crystalloid  
19 solution as soon as possible following the  
20 injury, but not later than three hours after  
21 injury.

22           Then after fluid treatment, give the  
23 second gram of TXA to those casualties. So

1 our recommendation is that the Defense Health  
2 Board view this favorably, and have a vote to  
3 support that change in the Tactical Combat  
4 Casualty Care or the Tactical Combat Casualty  
5 Care guidelines, as well as in the  
6 opportunity to begin the use of this  
7 immediately.

8 CHAIR DICKEY: Thank you, Dr.  
9 Jenkins, for that presentation. Quick  
10 question. Is there an object or a numeric  
11 number for massive transfusions, so that if -  
12 - or is it really those subjective  
13 descriptors that you just went over?

14 DR. JENKINS: So for the massive  
15 transfusion cohort in the MATTERS study,  
16 that's ten units in less than 24 hours.

17 CHAIR DICKEY: Okay. Dr. Silva.

18 DR. SILVA: Silva, UC-Davis. I know  
19 this is a hot topic for a lot of compounds  
20 now are temperature variability, and this  
21 drug has to be preserved at a lower  
22 temperature. How is that handled in the  
23 field, where you maybe have an ambient

1 temperature over 110 degrees? The solution's  
2 the mystery.

3 DR. JENKINS: Yes sir. Every medic,  
4 and Monty showed an example of his aid bag,  
5 where there are numerous medications that are  
6 to be kept in the temperature range of the  
7 manufacturer. In fact, I pulled, I can do it  
8 right now, pulled the little Motrin bottle  
9 out of my computer bag, which has a very  
10 tight temperature range in which it's  
11 supposed to be stored to maintain its  
12 efficacy.

13 Those soldiers, those medics are  
14 carrying numerous medications on their person  
15 in those packs, that have the same  
16 temperature constraints to it. And these  
17 medics are the same medics that administer IV  
18 morphine and other IV antibiotics. So they  
19 have the training to do that.

20 Medics know this is about the proper  
21 training and education, et cetera, and in  
22 fact these medications are being tracked very  
23 carefully, certainly those in Bastion would

1 become one of the items to be reported  
2 through the Joint Trauma System in the  
3 theater and captured in the Joint Trauma  
4 Registry, so that we could look at the  
5 success of this as time goes by.

6 CHAIR DICKEY: Other questions from  
7 around the table?

8 DR. CARMONA: Rich Carmona. Don,  
9 great work. Thank you. Just one question.  
10 Any thoughts on the positive or negative  
11 effects with concomitant blunt head trauma,  
12 TBI?

13 DR. JENKINS: Well again,  
14 unfortunately in the interest of time, I  
15 didn't present all of Colonel Warren Dorlac's  
16 slides here. That is clearly one of the  
17 intended benefits, is for those patients who  
18 sustain significant brain injury, the  
19 development of coagulopathy and the need for  
20 massive transfusion portends a poorer outcome  
21 for them.

22 The hope is that we would  
23 potentially see some benefit in that brain

1 injury patient population as well. Again, we  
2 don't have another answer for this day. This  
3 is a drug that has been available. It  
4 literally is taken over the counter in pill  
5 form by thousands and thousands of women in  
6 the United States on an every day or every --  
7 annual basis, and has a long and safe  
8 profile.

9           Unfortunately, as with any  
10 medication or transfusion one might  
11 administer to promote clotting, invariably  
12 patients have clotting. Sometimes that  
13 clotting is not of benefit to them, in terms  
14 of pulmonary embolis, you know, deep venous  
15 thrombosis, et cetera.

16           It's aimed at this group of patients  
17 that's exsanguinated before they can get to  
18 medical treatment by a surgeon, you know, the  
19 OR-based facility, which is what they need.  
20 This is, we think, one of the few tools that  
21 we can actually put in the aid bag, that  
22 might make a difference for those casualties.

23           DR. CARMONA: Thank you.

1 CHAIR DICKEY: Any questions from  
2 our members on the phone?

3 GEN MYERS: Not here for Myers.

4 DR. JOHANNIGMAN: Not from Jay  
5 Johannigman.

6 PARTICIPANT: No, the discussion's  
7 been very helpful. Thank you.

8 CHAIR DICKEY: Seeing no further  
9 discussion around the table, it is the  
10 recommendation of TC3 that the Board approve  
11 the proposed addition to the guidelines that  
12 are presented in slide 27, and I would  
13 entertain a motion for whatever action you  
14 choose.

15 DR. O'LEARY: So moved.

16 DR. CARMONA: Rich Carmona, so  
17 moved.

18 CHAIR DICKEY: Okay. It's been  
19 moved by Dr. O'Leary and seconded, if I may,  
20 Dr. Carmona. If there's no further  
21 discussion, all in favor of the motion to  
22 approve the recommendation of the changes  
23 present on Slide 27, please say aye?

1 (Chorus of ayes.)

2 CHAIR DICKEY: Opposed, no?

3 (No response.)

4 CHAIR DICKEY: Thank you very much,  
5 and I believe, sir, you have one more.

6 DR. JENKINS: With your permission,  
7 ma'am, and the indulgence of the Board --

8 CHAIR DICKEY: Absolutely.

9 **Vote: Needle Decompression**

10 DR. JENKINS: There's really not  
11 much literature to go on here, and if this is  
12 -- so this next proposed change is actually  
13 in keeping with current practice. At this  
14 point in time, what's in the Combat Casualty  
15 Care guidelines is a note that CPR is futile  
16 in that tactical field care setting.

17 In fact, what we have found is that  
18 there's some potential to save a life or two.  
19 This has been reported through to us. These  
20 are also things seen in autopsy, where at the  
21 Armed Forces Medical Examiner's office, they  
22 have seen some autopsies of casualties who  
23 are KIA, who have tension pneumothorax

1 physiology in their chest.

2           So the proposed change, and really  
3 this was the shortest of our discussions,  
4 would add the statement in the tactical field  
5 care phase, "Casualties with torso trauma  
6 with no pulse or respiration should have  
7 needle decompression performed, to be sure  
8 they don't have tension pneumothorax, prior  
9 to discontinuing care." So that was step  
10 one.

11           Step two goes to the evacuation  
12 care, and we have seen numerous survivors  
13 arrive in helicopters, in the back of Humvees  
14 with CPR in progress, who have moved through  
15 their period of arrest.

16           So the proposed change to the  
17 tactical evacuation care is along the same  
18 exact line, that don't give up until you've  
19 needle decompressed the chest, and then give  
20 permission to perform CPR prior to arrival at  
21 the medical treatment facility, not at the  
22 expense of compromising the mission or  
23 denying life-saving care to other casualties.

1           So again, this was voted on 39 to  
2 two by that group, and we would indulge your  
3 endorsement of that, those proposed changes.

4           CHAIR DICKEY: You have a  
5 recommendation from the Committee before you.  
6 Do you have any questions or comments, and if  
7 not, I would entertain a recommendation for  
8 action. While they're thinking, Dr. Jenkins,  
9 can I assume that -- I'm trying to figure out  
10 how to ask the question.

11           Obviously, part of the information  
12 is the tracking, to see whether or not this  
13 has made a difference. We've also talked  
14 here some about the combat casualty  
15 information sheet, and sometimes it's totally  
16 from that and sometimes it's not.

17           So is there a mechanism like leaving  
18 in place the needle if this is attempted, so  
19 that if the soldier does not have a  
20 successful resuscitation, we'll have data a  
21 year from now that says this was attempted X  
22 times, successfully Y times?

23           DR. JENKINS: Yes ma'am. The

1 statement of practice by the medic is once  
2 they place that needle, is to leave it in  
3 place, then it can become dislodged. This is  
4 one of the situations where at the Office of  
5 the Armed Forces Medical Examiner, they are  
6 very, very detail-oriented, and they capture  
7 every one. They know if someone has  
8 attempted to do this or not, even if there's  
9 no device left in place.

10 But the standard would be to leave  
11 it in place. There is a place on the medic  
12 card, I don't know if you happen to have  
13 those with you, Monty. There is a place on  
14 the card to specifically cite that you've  
15 performed this measure. It is one of the  
16 things captured in the Joint Trauma Registry.

17 CHAIR DICKEY: Other questions for  
18 Dr. Jenkins or any recommendation? This is a  
19 committee recommendation to the Board.

20 DR. CARMONA: Move to accept.

21 CHAIR DICKEY: A motion by Dr.  
22 Carmona to accept the recommendations present  
23 on page 33.

1 DR. CARMONA: And 32.

2 CHAIR DICKEY: I'm sorry, page 32  
3 and 33. You're right. Thank you, sir. I  
4 have a motion. Do I have a second?

5 REV. CERTAIN: Second.

6 CHAIR DICKEY: Moved and seconded.  
7 Is there further discussion on the  
8 recommendation?

9 (No response.)

10 CHAIR DICKEY: Hearing none, all in  
11 favor of the motion to approve the changes to  
12 the Trauma Cardiac Arrest Guidelines, those  
13 changes are present on Slides 32 and 33. All  
14 in favor, please say aye?

15 (Chorus of ayes.)

16 CHAIR DICKEY: Opposed, no.

17 (No response.)

18 CHAIR DICKEY: Thank you very much,  
19 Dr. Jenkins. Work well done, sir. Thank you  
20 for your presentation.

21 DR. JENKINS: Thank you.

22 CHAIR DICKEY: And Sergeant  
23 Montgomery, thank you very much as well for

1 your valuable contributions and your  
2 presentation today. Am I correct, Ms. Bader,  
3 we are

4 MS. BADER: Ahead of schedule.

5 DR. JENKINS: I apologize for that.

6 CHAIR DICKEY: It's just like a  
7 surgeon. He's ahead of schedule.

8 (Laughter.)

9 CHAIR DICKEY: We're now going to  
10 break for a working lunch in Venice 2, to  
11 include Board members and Service Liaison  
12 Officers and the DHB staff, as well as  
13 invited guests, lunch -- and speakers as  
14 well. We will reconvene promptly at 1:30 to  
15 resume the working session of the meeting.

16 I want to thank all the Board  
17 members who have so conscientiously been with  
18 us on the phone, and look forward to  
19 welcoming you back this afternoon at 1:30  
20 Pacific Time. You are adjourned for lunch.

21 GEN MYERS: See you at 1:30.

22 CHAIR DICKEY: Thank you, sir.

23 GEN MYERS: Thank you.

1                   (Whereupon, at 12:14 p.m., the  
2 above-entitled matter went off the record and  
3 resumed at 1:29 p.m.)



1 important when we have people on  
2 telephonically.

3 So welcome back from lunch, and our  
4 next briefing of the day is going to be  
5 delivered by our guests, Dr. Michael Parkinson  
6 and Dr. Silva. Dr. Parkinson is Principal of  
7 P3 Health, which assists employers health and  
8 health care organizations in optimizing  
9 prevention, performance and productivity.

10 Prior to his current gig, Dr.  
11 Parkinson was the Executive Vice President,  
12 Chief Health and Medical Officer of Luminos, a  
13 pioneer of consumer-driven health plans and a  
14 subsidiary of Wellpoint, where he was  
15 responsible for the development and  
16 implementation of an integrated, incentivized  
17 health improvement strategy, employing  
18 evidence-based prevention, care management,  
19 account-based benefit designs, employer  
20 partnership and consumer engagement.

21 A retired Air Force colonel, Dr.  
22 Parkinson also served as the Deputy Director  
23 of Air Force Medical Operations and Chief of

1 Preventive Medicine. If I can present your  
2 partner in crime, Dr. Parkinson, and then  
3 we'll let you take off.

4 Dr. Silva currently serves as a  
5 Professor of Internal Medicine within the  
6 Division of Infectious Diseases and Immunology  
7 at the University of California Davis School  
8 of Medicine. He previously served as Dean of  
9 the medical school and Chair of Internal  
10 Medicine, and he's currently the Dean  
11 Emeritus, I believe.

12 In addition to academic positions,  
13 Dr. Silva's prior appointments include serving  
14 as a consultant for Kaiser Permanente  
15 Hospital, the U.S. Air Force Medical Corps at  
16 Wilford Hall Medical Center, and in the Air  
17 Force Reserves.

18 Dr. Parkinson and Dr. Silva will  
19 provide an overview of the Psychological  
20 Health External Advisory Subcommittee's  
21 findings and their proposed recommendations,  
22 included in the draft report pertaining to  
23 psychotropic medication and complementary and

1 alternative medicine. Their slides are under  
2 Tab 7. Dr. Parkinson, it's all yours.

3 **VOTE: Psychotropic Medication and**  
4 **Complementary Alternative Medicine Use Draft**  
5 **Report**

6 DR. PARKINSON: Thank you, Dr.  
7 Dickey, and there are days when going to work  
8 I think what I do is a gig.

9 (Laughter.)

10 DR. PARKINSON: That's a personal  
11 characterization. That's very good. On  
12 behalf of Dr. Silva and myself, we're  
13 delighted to be back with you. As you recall  
14 at your last meeting, we presented the  
15 executive summary of the Psychological Health  
16 Subcommittee CAM report. At this meeting, you  
17 have the entire report in your binder.

18 I hope you can see by the breadth,  
19 the scope and the intensity of the effort,  
20 that the Committee took about nine months. I  
21 look back at the date, Joe, and it was really  
22 about this time last year we got charged with  
23 it.

1           We wanted to get the findings and  
2 recommendations to the Board, frankly, for  
3 early transmittal to the Department, to begin  
4 to think about acting on some of them, as well  
5 as to refine them and get the Board's input,  
6 which we had done in this report.

7           So we had a very constructive  
8 dialogue at the last meeting. All of your  
9 edits have been included in the current draft  
10 of the report, and following a very brief  
11 summary again at a high level of findings and  
12 recommendations, Dr. Silva makes some closing  
13 comments, and then we'll open it up for a  
14 further discussion and a vote, Dr. Dickey.

15           Okay. In the last week, there were  
16 two other -- two significant studies that  
17 caught my attention, that absolutely are  
18 aligned with the findings and recommendations  
19 of our Committee. The first was this week's  
20 *JAMA*, which has a study done by the VA on the  
21 use of Risperdal, in addition to anti-  
22 depressants for people with PTSD.

23           It was done at the VA Hospital, and

1 lo and behold, despite the fact that 20  
2 percent of VA patients are found to be on  
3 agents like Risperdal and Seroquel and things  
4 like that for anti-depressant resistant PTSD,  
5 they found no effect.

6 Just as an example of this, in the  
7 editorial that is by Colonel Hoge in the same  
8 issue, who goes on to say that the military  
9 must begin to understand the military-unique  
10 aspects of stress, and its management across  
11 the whole continuum, which is pretty much our  
12 finding and recommendation in our report.

13 No one else will do these studies  
14 except the military. Pfizer will not do the  
15 study, and just as we heard in the TC3 report  
16 earlier about the military-linked research and  
17 the rapid prototyping application of four of  
18 the techniques, the summary of our work is at  
19 the same intensity and depth of knowledge  
20 around common combat stressors that can  
21 accelerate to things like PTSD and need to be  
22 a focus.

23 The second major study came out in

1 *Health Affairs* this week, and basically shows,  
2 as we wrote in our report, that the national  
3 epidemic of prescription of anti-depressants  
4 continues to accelerate, including so much  
5 that 70 percent of now all anti-depressants  
6 are now prescribed by primary care physicians,  
7 and as much as seven percent of all the  
8 prescriptions have absolutely no psychological  
9 diagnosis anywhere to be found.

10           So they're increasingly being given  
11 out in primary care venues, to people with  
12 uncertain diagnoses for unspecified reasons.  
13 The reason I say this is relevant is again,  
14 the military reflects, both on the provider  
15 side and on the member side or the military  
16 member, we come from this universe of over-  
17 reliance and over-prescription, to a large  
18 degree, on psychotropic medications that are  
19 generally being increasingly encouraged at the  
20 consumer level and the primary care provider  
21 level.

22           So I just thought the timely  
23 issuance of those two studies was absolutely

1 aligned with our findings and recommendations.

2           Very briefly, I'm going to go --  
3 you've already heard these once, but I just  
4 want to show the changes. We focused on these  
5 areas as the rest of the report, given an  
6 entire laundry list of concerns to the DoD.  
7 Our emphasis was on in-theater deployed in  
8 operational settings. We focused on the most  
9 common mental health conditions in-theater.

10           What is the evidence of the  
11 prevalence? What is the evidence of the use  
12 of evidence-based treatments as best we know  
13 evidence? What is the current status of DoD  
14 and other related clinical practice  
15 guidelines, and what are major educational  
16 training and competency issues as it relates  
17 to military health professionals in both  
18 psychotropic medication, CAM and the broader  
19 control management of stress-related  
20 conditions?

21           Certainly underlying this is the use  
22 and access to medical records in-theater,  
23 analysis of those medical records to inform

1 our work. We spend a considerable amount of  
2 time, you'll see it in the full report, all  
3 the analyses that we compiled over this period  
4 of time.

5 What are, looking forward, some of  
6 the things that we would recommend the  
7 Department be able to do? One of the  
8 philosophical positions we took is where we  
9 identified gaps or deficiencies, rather than  
10 shoot the messenger, what are the things we  
11 can do in a constructive way now, to build a  
12 better outcome going forward?

13 Our membership of the Committee,  
14 again was the entire gamut. We had  
15 psychiatrists, we had the Service  
16 psychiatrists, we had psychologists, we had  
17 internal medicine/primary care, preventive  
18 medicine, public health represented, to give  
19 the broadest possible perspective relating to  
20 this.

21 Dr. Kroenke, who's joining us in a  
22 few minutes. I don't know if Kurt's on the  
23 phone, but he was a member of our committee.

1 He's doing work on the ANAM, among other  
2 things. Four days of meetings, a lot of  
3 dialogue at the last meeting for DHB.

4 One of the areas we discussed at  
5 length, and I know, General Myers, you're on  
6 the phone, is that we did revise the finding,  
7 limited primarily to the acute findings around  
8 stress-related conditions that require medical  
9 treatment, as opposed to the broader finding  
10 that was probably overstated, that the  
11 prevalence of post-deployment and other  
12 chronic-related stressors was not a problem.

13 It clearly is. Ten to twenty  
14 percent of those in infantry units are found  
15 to have PTSD. That's a number cited by  
16 Colonel Hoge in his article in *JAMA* and  
17 others. But we wanted to distinguish the  
18 acute treatment in-theater versus more chronic  
19 treatment related to that. So that finding  
20 was revised in this report.

21 There was considerable discussion  
22 that he wanted us to have and included in this  
23 report on what was not a primary thrust of

1       ours, given the charge.       It was the  
2       differential access to and ability of the  
3       Guard and Reserve members to get treatment for  
4       the conditions and broader issues.   So that's  
5       emphasized in the report, as well as the  
6       stigma issues.

7               Dr. Hoge, and I just -- again,  
8       there's a stigma at two levels.   One is I'm  
9       stigmatized because I have this condition, or  
10      am I stigmatized because I went to see a  
11      mental health professional.   Those two are  
12      related, but they're different.

13              So he calls in his editorial, as we  
14      called in the report, for better understanding  
15      about what are the values and the thinking and  
16      the systems that we might be able to get to,  
17      essentially destigmatize it on multiple  
18      levels.   That is emphasized here again.

19              The third major principle we  
20      incorporated from the discussion was the  
21      ongoing and continuing need for better DoD  
22      collaboration and integration.   We heard a lot  
23      of that this morning from General Volpe, in

1 terms of the multiple facilities where those  
2 things happen, the need to have an integrated  
3 EMR.

4 All these things are steps in the  
5 right direction, to make it seamless to our  
6 service members, whether they're Active Duty,  
7 retired, deployed, non-employed, so that it's  
8 readily available and they get the care they  
9 need.

10 Again, we have four of these  
11 categories of findings. I won't read these  
12 verbatim. You can read them here in the  
13 report. We've talked about them before. I'll  
14 highlight one or two things. One is we should  
15 not mistake the tremendous efforts that DoD  
16 has made on multiple fronts over a long period  
17 of time, to address many of these deficiencies  
18 as it relates to unprecedented, prolonged ten  
19 years' worth of combat, in a way that now  
20 probably doubles the amount of time we spent  
21 in World War II.

22 The nature of the conflict, the  
23 duration of the conflict, the uncertainty of

1 the battlefield and types of weapons that are  
2 being used is really kind of unprecedented.  
3 With that, there's been tremendous efforts  
4 made, and much progress made towards improving  
5 access to and coordination of services for  
6 those in need.

7 The staffing, both in-field and back  
8 home, you heard today from General Volpe.  
9 It's very good to hear some of the roles that  
10 you led at Madigan and other places, in terms  
11 of increasing the number of mental health  
12 professionals.

13 A lot of our report says even with  
14 that, we have a better job we have to do, in  
15 terms of standardizing the competencies by  
16 level of professional, in terms of what we  
17 expect them to be able to do, and on the  
18 Service members' side, in terms of what is  
19 truly our step therapy approach, if you will.  
20 Some was in line guidance, some was in medical  
21 guidance, to really make it come together in a  
22 uniform way across the DoD.

23 So we medicalize only those things

1 that need to be medicalized, and we really  
2 make militarily relevant coping skills, which  
3 happens in war time, something that's just  
4 inherent to our soldiers.

5 We did find that what we really  
6 need, and I keep coming back to this in the  
7 report, is the notion of an integrated,  
8 bottoms-up model, that begins with self care,  
9 buddy care, line integration, line medical  
10 support, triage levels of seeing health  
11 professionals, so that we frankly don't get  
12 into the national trend of primary care docs  
13 reaching for a prescription every time they  
14 see somebody who's got a stress-related issue,  
15 which is largely what we see in some of the  
16 Health Affairs data, among other things.

17 We think those models are already in  
18 the military; we just don't apply them to  
19 stress in a systematic way. It lives in  
20 certain guidance that you can find in some of  
21 the appendices in our report. But it's not  
22 been systematized, if you will, in a way that  
23 we organize, train and equip our troops,

1 whether Army, Navy, Air Force, Marines.

2           Even now, the Marines have a great  
3 initiative going on. It would be wonderful if  
4 that was the same type of initiative we saw  
5 going on in the Air Force, as it relates to  
6 people. Stress is stress is stress, and  
7 having four different versions of the same  
8 program probably does not really help us, at  
9 the other end, be able to do that.

10           So certainly the use of our EMRs in-  
11 theater, whether or not we can capture  
12 accurately both the CPT ICD-9 type codes, and  
13 can we link those to pharmacologic or  
14 cognitive interventions or others. It would  
15 be very useful to improve that in-theater.  
16 There's a lot of findings, there's a lot of  
17 discussion in your report that talks about the  
18 current capabilities of DoD, versus what we'd  
19 like to see going forward.

20           We do think that there's promising  
21 use of EMRs in-theater, but unless those EMRs  
22 have been embedded decision support, with  
23 reminders about step therapy, which is what

1 EMRs are all about. It's not just to record  
2 information; they're to be decision support  
3 tools. So we've got CPGs. How can we get  
4 them into the EMR?

5 So that at the point of care, they  
6 become the quality assurance vehicle that we  
7 want to be able to have. We do think that  
8 sleep is a sentinel marker for psychologically  
9 related conditions, and the DoD should convene  
10 a group on sleep disorders as it relates to  
11 military and combat.

12 That's a sentinel event, and we see  
13 the wide use of Ambien, for example, as just  
14 treating sleep disorders. What are other non-  
15 pharmacologic ways that we might be able to  
16 deal with that? Again, just recommendations.

17 The issue of what are the exact  
18 problems of use of psychotropic medications  
19 in-theater. The committee spent a very long  
20 time doing that. We found that there has been  
21 a trend over the last three years to the  
22 increased use of psychotropics. It probably  
23 is no greater than what we've just see in the

1 *Health Affairs* article nationally, where  
2 there's a rampant increase in the use of these  
3 drugs across the civilian practice.

4 Two are professional need. There  
5 does not have to be an inappropriate use of  
6 these drugs, as it relates to the common way  
7 that these types of conditions are treated.  
8 At least in the civilian sector, but it begs  
9 the question of, is there a better military-  
10 specific model that we need to build, and  
11 that's really where we want to go with this.

12 We do know that Service members can  
13 receive medications from multiple routes, with  
14 varying degrees of documentation. That is  
15 known in the Department, and the Department is  
16 working on that as we speak.

17 The use of polypharmacy is a term  
18 that is not well-defined in a standardized way  
19 across the health care industry. Polypharmacy  
20 and the multiple use of drugs may be  
21 clinically appropriate in some settings. So  
22 just labeling something "polypharmacy" doesn't  
23 tell you much about it.

1           We do think that there could be some  
2 better standardization of the use of the term  
3 and some more descriptive use of the term in a  
4 way that would be useful internal to the  
5 Department. We do believe, as was noted  
6 probably in this particular article in *JAMA*  
7 this week about the off label use of some  
8 drugs.

9           It may be appropriate in certain  
10 settings, but we do think that for one  
11 particular drug, Seroquel in particular, we  
12 might look at the DoD's use of Seroquel as it  
13 relates to that, and certainly the finding in  
14 *JAMA* about Risperdal, which is in the same  
15 category of drugs, being not any more  
16 effective for PTSD. That's the type of  
17 information that buttresses the committee's  
18 findings in that regard.

19           We wanted to remind the Department,  
20 not that they needed to be reminded, that the  
21 cornerstone of healthy coping skills is  
22 healthy lifestyles, and the ability to  
23 basically use nutrition, sleep, you know,

1 moderate use or no use of alcohol, even  
2 tobacco cessation. All those things are the  
3 cornerstone, and increasingly in corporate  
4 America, what you're essentially seeing is  
5 that healthy living leads to better  
6 operational outcomes.

7 We clearly are calling for better  
8 use of tracking of prescription drug data, off  
9 label use. Going quickly to CAM, you saw in  
10 the slides again this morning that we called  
11 for, particularly in two areas, which is  
12 acupuncture and in mindfulness training.  
13 Whether you call it the Relaxation Response by  
14 Benson or yoga or prayer or meditation, it is  
15 very effective, can be a very effective coping  
16 skill or maybe a buddy skill.

17 To be able to help people to acquire  
18 in-theater, we should be doing pilots,  
19 demonstrations of theater-applied mindfulness,  
20 in much the same way as we would do for TC3.  
21 That's the type of thing we thought, and  
22 certainly at the transition point,  
23 particularly for Guard and Reserve, if there

1 is CAM modality that works for an individual  
2 and needs to be assisted by a provider, we  
3 need to make sure that's aligned with the  
4 TRICARE benefit, so that we have consistency  
5 across the thing.

6           Again, we do think that every  
7 service should have a CAM consultant, and that  
8 CAM consultants shouldn't be peripheral; it  
9 should be embedded. The Department, and  
10 particularly in areas of pain management in  
11 its clinical practice guideline, has done a  
12 very good job in creating an incorporated CAM  
13 philosophy and approach. It needs to be  
14 broadly applied, to the broad area of stress.

15           Your full report has a number of  
16 relevant clinical practice guidelines that the  
17 Department and the VA have jointly  
18 collaborated on. Many of them are very  
19 promising and are excellent, like the pain  
20 management CPG.

21           It's not clear to the committee,  
22 however, how these are practically  
23 disseminated, standardized, baked into EMRs

1 and deployed into training of professionals.

2           That's not unique to the military.  
3 I can tell you in the civilian sector, the  
4 fact that you've got a CPG doesn't mean that  
5 anybody follows it. So again, this is an area  
6 for work for the Department, and the  
7 military's very good at implementing things  
8 and standardizing, once they get their minds  
9 around it. So I think that's very important.

10           Provide training alone without the  
11 embedding in the systems of care. Again, it's  
12 that failsafe, what we know about, whether  
13 it's preventive services or chronic care  
14 disease management. It's got to be baked into  
15 the full blown process of care, not just given  
16 as a one-off course in San Antonio for people  
17 there.

18           We talked largely about this. DoD  
19 should develop a framework for determining the  
20 effectiveness and utility of all  
21 interventions, rapid dissemination. I mean we  
22 should -- I'm a little off the report here,  
23 but we should have an expected cycle time for

1 problem, rapid prototyping, evaluation,  
2 deploy.

3 I think that's pretty much in the  
4 work that we saw today from the TC3. Again,  
5 they have de facto developed a cycle time  
6 expectation for things like this. So it might  
7 be something useful to talk about. Because  
8 it's happening out there in pixels, but it's  
9 not happening in a systematic way.

10 We found a variety of very excellent  
11 training courses by level of health care  
12 specialization, whether it's primary care  
13 docs, psychiatrists, mental health  
14 technicians, IDMTs, by service across service.  
15 But we don't find a consistent way that's  
16 combat-related stress and the use of  
17 psychotropics, and the use of CAM are embedded  
18 in a systematic way across those courses.

19 Hopefully, the framing of this  
20 report will help the Department to do that.  
21 So for all military providers, if I just come  
22 in from UCLA, I was in Family Practice. I go  
23 to Fort Bragg. I'm at Pope Air Force Base.

1 What's different about treating stress there  
2 than it was in a clinic overlooking the  
3 Pacific Ocean with a lovely academic medical  
4 center?

5 A lot. Is that in my basic training  
6 courses? I don't think so. So again, it's  
7 there. It's up here. It might be in the CPG  
8 somewhere, but translating it into that fresh  
9 captain who comes out in the Family Medicine  
10 Program who do train in that system and they  
11 do go through the military, which is the bulk  
12 of our docs.

13 What does that look like, and what  
14 we found is that step approach, that type of -  
15 - probably needs to be done. The way you do  
16 that, putting on my hat in GME, is to find the  
17 competencies. What does an IDMT need to be  
18 able to know, do and act upon, in order to  
19 their job up to the level of scope of  
20 practice.

21 So developing competencies by career  
22 fields should be developed, deployed and  
23 updated, based on the data and informed by

1 things like a TC3 model, for psychological  
2 health. And of course, what are they -- so  
3 it's a lot.

4           Increasingly, it's about what can I  
5 do for myself, what can I do for my buddy,  
6 what can I do for my small unit before I have  
7 to go out and find somebody who's got a  
8 caduceus on their chest, because that  
9 immediately hits that stigma button, no matter  
10 what we do.

11           I was just talking to Dr.  
12 Higginbotham at lunch. These things die hard.  
13 I'm really talking about stigmas for probably  
14 hundreds and hundreds of years, and it's a  
15 difficult thing to do. So let's personalize  
16 and internalize as much as we can going  
17 forward.

18           As I said, we spent more time  
19 revising the report since we last met with you  
20 about the way ahead, and I captured those  
21 thoughts here on this slide. But they're  
22 fleshed out much more in the report, and I  
23 think that's it. Dr. Silva?

1 DR. SILVA: Silva, UC-Davis. Mike,  
2 you did a hell of a job, much better than I  
3 would have done. I was just thinking, and  
4 that we've had discussions with some of you  
5 around the table about this report.

6 Obviously these items have to have  
7 ownership to move it along. I was thinking  
8 that we, unfortunately, had no surgeon on the  
9 committee. I think if we had a surgeon, we  
10 could have been done in half the time.

11 (Laughter.)

12 (Off mic comment.)

13 DR. SILVA: That's your opinion.  
14 But no, it's my real entree, that we have a  
15 poster child here that we can reduplicate.  
16 What's occurring in trauma, the components of  
17 self-analysis, establishing guidelines,  
18 monitoring progress, should be done for this  
19 important problem.

20 We took on the issues of where  
21 research is going, and the military has bought  
22 into this with the new chain of command. The  
23 research pumps are being primed, not only

1 within the military but within the civilian  
2 community. So I hopefully will have far  
3 better signs of how to treat in the future.

4 Then we spent a lot of time talking  
5 about how you disseminate these data out to  
6 the troops, people in the line, in the field,  
7 because it has to be embedded. A lot of  
8 things we've recommended are not really high  
9 science.

10 I mean the whole concept of  
11 readiness and resiliency, and then taking  
12 responsibility for personal health, which are  
13 growth themes that the Army and the other  
14 armed services are buying into, to build in a  
15 better resiliency.

16 We still believe that the whole area  
17 of complementary alternative medicine could be  
18 explored very, very quickly, even in the  
19 field. Those trials should be encouraged, as  
20 we wind down in Afghanistan. So there's a lot  
21 for the Department to consider, but someone's  
22 going to have to show ownership, or several  
23 people, on these items, chip it out and say

1 okay, let's take this on. I don't think it  
2 will be very expensive.

3 The only other thing I want to  
4 comment, and then we'll entertain questions,  
5 Madam Chair, is that the people that came to  
6 the military, to this sort of fuzzy set of  
7 committees, are very good people. They gave  
8 us tremendous insights, very, very devoted to  
9 their discipline, either psychology or  
10 psychiatry. They are equipped to deal with a  
11 lot of issues. They understand it. But how  
12 do you bring it across all service lines is  
13 going to be a real chore for the Department.  
14 Thank you.

15 CHAIR DICKEY: Thank you very much,  
16 Dr. Parkinson, Dr. Silva. I'll remind the  
17 Board that you heard a good bit of this report  
18 at the last meeting, and we had a couple of  
19 issues that the Committee agreed to take back  
20 and address our concerns. But these are, in  
21 essence, the recommendations that we heard a  
22 couple of months ago.

23 The recommendations are on --

1 they're in several formats in front of you.  
2 But slides 13, 14, 17, 19, 21 and 23, are  
3 recommendations in several different subsets.  
4 Are there questions or comments, and actually,  
5 I'm going to invite Dr. Carmona to take over  
6 the Chair for a few minutes, because I  
7 actually have a proposed amendment.

8 DR. CARMONA: So as Dr. Dickey said,  
9 any comments, questions, concerns to be  
10 reflected? Dr. Dickey?

11 CHAIR DICKEY: As we heard Dr.  
12 O'Leary discuss this morning, first an  
13 excellent report and covering an immense  
14 amount of ground in under a year's time. You  
15 are to be complimented, and I particularly  
16 like the direction of rapid cycle evaluation,  
17 assessment, modification, following after the  
18 TC3.

19 However, and again, because you've  
20 got both the PowerPoint and the reports in  
21 front of you, let me reference. On slide 11,  
22 number two, or if it's easier for you to get  
23 to it, I'm trying to figure out where it is,

1 in the report itself -- I may not be able to  
2 get to it there.

3 Well, the Executive Summary on page  
4 two, number two, I think I know what you're  
5 trying -- I hope I know what you're trying to  
6 say. But the bullet point that says "Despite  
7 these exposures, the majority of military  
8 members and their families do not appear to  
9 have experienced immediate adverse  
10 psychological effects," just doesn't seem to  
11 be consistent with other things that are in  
12 the report.

13 If what I think you're saying is  
14 they have not experienced adverse effects,  
15 which have turned into increased or excessive  
16 medical or mental health care, I can support  
17 it. So I have some language, but I don't know  
18 whether this language meets what you want to  
19 say.

20 I think what I've been trying to  
21 read into it is despite these exposures, the  
22 majority of military members and their  
23 families do not appear to have experienced

1 excessive or disproportionate adverse  
2 psychological effects, leading them to seek  
3 out medical or mental health care.

4 It's a relatively subtle change, I  
5 suppose, but I just found that it was  
6 uncomfortable saying they hadn't had any  
7 increase in psychological effects, and yet  
8 we're going to run a long paper here that's  
9 based on the fact they have increased  
10 psychological effects.

11 DR. SILVA: We both agree.

12 CHAIR DICKEY: Okay.

13 DR. SILVA: We agree that it's more  
14 with the tone of the point of the report.

15 CHAIR DICKEY: Thank you, sir. Then  
16 I would move that we amend the report in that  
17 fashion. I can re-read that language, if  
18 anybody needs it.

19 PARTICIPANT: Repeat your amendment  
20 again for those of us on the phone.

21 CHAIR DICKEY: The amendment is to  
22 bullet two on page two of the report -- of the  
23 Executive Summary or slide 11. "Despite these

1 exposures, the majority of military members  
2 and their families do not appear to have  
3 experienced excessive or disproportionate  
4 adverse psychological effects, leading them to  
5 seek out medical and/or mental health care."

6 PARTICIPANT: Okay. So the essence  
7 of your amendment, it's to modify it --?

8 CHAIR DICKEY: Yes sir.

9 PARTICIPANT: Okay, thank you.

10 DR. CARMONA: All right. With those  
11 changes reconsidered, is there any further  
12 discussion on that specific -- yes, please.

13 DR. O'LEARY: I think this is an  
14 improvement in language. This is a statement  
15 that I raised some concern about this morning,  
16 and the question, when we started getting  
17 peppered with questions by reporters about  
18 this. Is this, is there data to back this up?  
19 How do we know that this is true, even with  
20 the amended language?

21 DR. PARKINSON: Well Dr. O'Leary,  
22 part of this is -- I think it's on, and Joe,  
23 please weigh in here. In looking at the

1 traditional data sources that one would look  
2 at, which again, albeit they're not perfect,  
3 but then rarely are they. Also, just the  
4 statement itself. I hope people are reading  
5 the statement. It says "the majority of,"  
6 okay. It doesn't say that it's not a problem.  
7 There is PTSD in 10 to 20 percent of people,  
8 infantry units. It's lower in other types of  
9 units.

10 The use of drugs that we saw in-  
11 theater, which is four percent, although in  
12 other selected units, we found the number to  
13 be 11 to 17 percent, which the MHAT survey,  
14 which Dr. Hoge led and others, looking at the  
15 highest most intensity units.

16 But what the Committee wanted to say  
17 at that point, and correct me if I'm wrong,  
18 because you were on the Committee, Dennis, is  
19 the vast majority of individuals who have gone  
20 off to theater and gone off to these  
21 conflicts, are not seeking immediate mental  
22 health care, and there's not evidence that  
23 they're psychologically disabled, much along

1 the lines that Dr. Dickey just said,  
2 disproportionate or excessive.

3 The Committee did not want to say  
4 that the majority of individuals who've got  
5 psychological conditions requiring either  
6 psychotropic medications, CAM or medical care  
7 as a result of their service in either one of  
8 these conflicts. So as it reads, it doesn't  
9 say that it doesn't exist; it says "the  
10 majority of."

11 When we look at numbers of four and  
12 17 percent, that's kind of the intent of what  
13 the Committee wanted to say. I don't know if  
14 Dr. Kroenke's on here now to look at that, but  
15 that was the spirit of that particular  
16 recommendation.

17 DR. ANDERSON: So George Anderson  
18 with a follow-on question to that. Did you  
19 attempt to quantify or to work out a  
20 numerator/denominator on expected --  
21 seriously, there could be an estimate done  
22 here on how many troops were deployed, you  
23 know, family member expectations.

1           What did you actually see in the  
2 data? You know, I agree with what you're  
3 saying exactly, because I'm quite sure you're  
4 right. But you know, back to Dr. O'Leary's  
5 question. It would be nice if you had a  
6 numerator and a denominator.

7           DR. PARKINSON: Well Dr. Anderson,  
8 as you know George, this was -- the number one  
9 question was what is the no kidding prevalence  
10 for these conditions?

11          DR. HOVDA: What was the no --  
12 sorry?

13          DR. PARKINSON: What is the no  
14 kidding prevalence? How big is the bread  
15 basket? How big is the issue?

16          DR. HOVDA: Right.

17          DR. PARKINSON: The Department is  
18 challenged by having anything that looks like  
19 a rate, because we don't have a good  
20 denominator, and the numerators have irregular  
21 data capture as it relates to the coding and  
22 the coding itself, which is irregular, which  
23 again is not too dissimilar from the civilian

1 sector.

2 But whether you use CPT codes or V  
3 codes, which we were told are actually used so  
4 you don't have specific codes. Then there's  
5 also the issue of access to the AHLTA  
6 Electronic Medical Record System, which in  
7 forward deployed conditions they don't have.

8 So both on the numerator front and  
9 the denominator front, we could not get  
10 anything that looked like a real rate to say  
11 over time, and we also don't have anything  
12 really that's hard numbers since 2008.

13 So the scope of this question, which  
14 goes back to really 2000, is limited to 2008  
15 to 2011, and we have done approximations as  
16 best we can, given the data sources they did  
17 with this, to say this kind of looks like a  
18 numerator. This is a study and all of which  
19 are detailed in the full body of the report.

20 But also from the Service  
21 psychiatrists and the other folks on our  
22 committee, on balance, given what we've had,  
23 it's not perfect. That's what led to number

1 two essentially there. So yes, we don't have  
2 smoking gun evidence. But based on the  
3 clinical judgment of the people who are in-  
4 theater as well as the people who are not, and  
5 the people who are in this field in terms of  
6 public health psychology, if you will, that's  
7 kind of where they're comfortable with that  
8 finding, I think.

9 DR. CARMONA: Dr. Certain.

10 REV. CERTAIN: Thank you both for  
11 including this kind of a statement. In the  
12 Task Force for the Prevention of Suicide, we  
13 were very concerned in the DoD about the 20  
14 per 100,000 suicide rate overall, which is  
15 probably equivalent to the civilian rate.

16 But DoD's the only employer in  
17 America that really chases that stuff down and  
18 keeps current data on it. I think in this  
19 case, and these other psychological health  
20 concerns, we probably have something similar  
21 to that, and to remind the public,  
22 particularly the Congress and the media, that  
23 while we are very, very concerned about people

1 who are having psychological effects from  
2 their participation in combat in defense of  
3 this country, it is not a brush fire.

4 We need to be concerned about this  
5 minority of people who come out, who  
6 experience post-traumatic stress disorder and  
7 other adverse effects that are long-lasting  
8 from combat experience, and to do something  
9 about it if we possibly can. But to say it's,  
10 to make this kind of a statement is, to my  
11 perspective, is a reminder that we don't need  
12 to get our hair on fire because of it.

13 But we do need to face it in a  
14 methodical way, in a public health direction,  
15 in order to care for those people who have had  
16 these effects. So I appreciate the wording of  
17 it, and you know, the additional phrase of it  
18 doesn't lead them to seek help, because they  
19 don't necessarily perceive that they need  
20 help, which is the understatement there.

21 But they may. They may, five or ten  
22 years or 20 years from now, discover that the  
23 Ghost of Christmas Past continues to haunt

1 them, and will continue to need or call for  
2 services of civilian sector, VA, or others, to  
3 come to terms with the lingering past. So I'm  
4 very satisfied with this statement, and  
5 believe that it does not minimize the problem,  
6 nor does it make it worse.

7 But it keeps us aware that -- also,  
8 it doesn't stigmatize the 95 percent who don't  
9 have it, and you know, as a Vietnam veteran,  
10 when the sniper at the University of Texas  
11 Tower came about, that stigmatized every  
12 Vietnam veteran in the country, because so  
13 many people were looking at Vietnam veterans  
14 as people who were dangerous to the  
15 population.

16 We need to avoid that here if we  
17 possibly can. I think this statement helps.

18 DR. SILVA: Silva. Thank you, Bob.  
19 I would agree with you. I was going to  
20 reinforce your comment, but you did it just  
21 great. I will point out to the Board that  
22 there are data in one study where they looked  
23 at the duration of post-traumatic disease

1 syndromes in the civilian community, who had  
2 suffered non, you know, combatant kind of  
3 relationships versus the military. The  
4 duration in the military of having that  
5 syndrome were tracked, was much shorter than  
6 what it was in the civilian community.

7 So we do have some analogous data  
8 that part of our mission, our education, et  
9 cetera, is to deal with stress and to deal  
10 with tragedy. There are mechanisms, whether  
11 part of a written curriculum or not, it's a  
12 silent part of the curriculum, being a  
13 military person on Active Duty in theater.

14 DR. CARMONA: Thank you. Christine.

15 MS. BADER: Hi, this is Christine  
16 Bader. I just have an administrative comment  
17 for the folks who have been so gracious as to  
18 dial in. Either one or more of you has your  
19 phone open, the lines open. You're not on  
20 mute, and the other members on the phone line  
21 are getting a lot of feedback. So if you can  
22 all please place your phones on mute until  
23 you're ready to speak, that would be greatly

1 appreciated. Thank you.

2 DR. CARMONA: Okay. On this  
3 particular issue, it appears to me that there  
4 is general agreement that what the intent of  
5 Dr. Silva and Dr. Parkinson was the issue was  
6 the semantics and how it should be reflected,  
7 and I think the record will demonstrate that  
8 there was general agreement, and we struggled  
9 a little bit with how to articulate that  
10 specifically, so that the receivers on this  
11 report would fully understand the intent of  
12 the Committee.

13 Is there any further discussion  
14 about this specific issue?

15 (No response.)

16 DR. CARMONA: If not, then we have a  
17 motion by the doctors to accept the change,  
18 based on what Dr. Dickey had presented to us.  
19 Any further discussion?

20 (No response.)

21 DR. CARMONA: If not, then I would  
22 entertain a motion to accept.

23 REV. CERTAIN: Moved.

1 DR. CARMONA: Second please.

2 DR. HIGGINBOTHAM: Second.

3 DR. CARMONA: All in favor?

4 (Chorus of ayes.)

5 DR. CARMONA: Any opposed?

6 (No response.)

7 DR. CARMONA: All right. The motion  
8 passed as stands then. Now we'll move on to  
9 the other recommendations of the doctors, and  
10 I would ask the Board's preference. Do we  
11 want to take these in aggregate, or would you  
12 like to take each one separately?

13 DR. O'LEARY: Aggregate. I do have  
14 an amendment.

15 DR. CARMONA: Yes sir, okay. Hold  
16 on to it for just one second, Dr. O'Leary.  
17 Was there anybody that wanted to opine  
18 differently? So we'll take these in  
19 aggregate, and now we'll go to Dr. O'Leary, to  
20 tell us what his amendment might be.

21 DR. O'LEARY: This is an issue that  
22 the Subcommittee agreed on, and which I spoke  
23 to at the last meeting of the Board, and still

1 is absent from the report. This is the  
2 expectation with regard to training. If you  
3 want to look at page 33, and excuse me, page  
4 32 of the report, or slide 24. It's  
5 Recommendation 2 in either case.

6 We spoke about the importance of  
7 actual assessment of competency of  
8 practitioners. When I brought this up, again  
9 at the last meeting of the Defense Health  
10 Board, there was a lot of head nodding. I  
11 submitted specific language when I got the  
12 report, and this, we're seeming to have a lot  
13 of trouble getting some traction around this.

14 So I would like to move that the  
15 specific language that I submitted, which  
16 would be to insert the words right after where  
17 it says "Professional competencies must be,"  
18 insert the words "initially assessed and  
19 periodically reassessed," so that the whole  
20 sentence would read "Professional competencies  
21 must be initially assessed and periodically  
22 reassessed, consistently maintained and  
23 updated, as appropriate to reflect best

1 evidence, and continued professional  
2 supervision should be available."

3 DR. CARMONA: Okay. We have a  
4 recommendation from Dr. O'Leary. Further  
5 discussion?

6 DR. PARKINSON: I have three  
7 observations: mea culpa, mea culpa, mea culpa.  
8 So actually I totally agree, and between the  
9 transcript and some of my reediting, I just  
10 probably dropped the ball, Dr. O'Leary. But I  
11 totally agree. I think everybody agreed. We  
12 agreed in the Committee. It was just an  
13 oversight.

14 DR. CARMONA: Okay. Any further  
15 discussion on the changes that Dr. O'Leary has  
16 brought to our attention?

17 (No response.)

18 DR. CARMONA: No. If not, then I  
19 would entertain the motion to accept them as  
20 stated by Dr. O'Leary.

21 DR. ANDERSON: So moved by George  
22 Anderson.

23 DR. CARMONA: Can we have a second

1 please?

2 REV. CERTAIN: Second.

3 DR. CARMONA: That's seconded by Dr.  
4 Certain. All in favor?

5 (Chorus of ayes.)

6 DR. CARMONA: Any opposed?

7 (No response.)

8 DR. CARMONA: Okay. Let me know one  
9 more time. Was there any opposed?

10 (No response.)

11 DR. CARMONA: Okay, so no  
12 opposition, so we have a unanimous vote.  
13 Okay. So absent any further discussion on any  
14 amendments, we will entertain an aggregate  
15 vote for the recommendations of Dr. Silva and  
16 Dr. Parkinson regarding the issues on  
17 psychotropic medication, complementary and  
18 alternative medicine.

19 DR. ANDERSON: So I move approval.

20 DR. CARMONA: Do I have a second?

21 DR. HIGGINBOTHAM: Second.

22 DR. CARMONA: Okay. Any further  
23 discussion on any of the motions?

1 (No response.)

2 DR. CARMONA: Okay. If no further  
3 discussion, then all in favor?

4 (Chorus of ayes.)

5 DR. CARMONA: Any opposed?

6 (No response.)

7 DR. CARMONA: Okay, thank you all.  
8 The motion's passed. Dr. Dickey, I will turn  
9 the gavel back to you.

10 CHAIR DICKEY: Thank you very much,  
11 Dr. Carmona, and thank you Dr. Parkinson, Dr.  
12 Silva and to your entire Subcommittee, for the  
13 work that you have done our behalf. Now our  
14 next briefing, I believe, is by Dr. Kurt  
15 Kroenke, who is on the phone with us. Dr.  
16 Kroenke, have you joined us?

17 DR. KROENKE: Yes, I have.

18 **VOTE: Automated Neurological Assessment**  
19 **Metrics Question**

20 CHAIR DICKEY: Let me give you a  
21 brief introduction, and then we'll turn it  
22 over to you. Dr. Kroenke is Chancellor's  
23 Professor of Medicine in the Division of

1 General Internal Medicine at Indiana  
2 University, and a research scientist at the  
3 Regenstrief Institute, as well as the  
4 Roudebush VA Center for Implementing Evidence-  
5 Based Practice. He also directs the Master of  
6 Science and Clinical Research degree program.  
7 His principle research interests include  
8 physical and psychological symptoms in medical  
9 patients, including pain, depression, anxiety  
10 and somatization.

11 He co-developed the Prime MD Patient  
12 Health Questionnaire, which has become a  
13 widely used clinical and research measure for  
14 diagnosing and monitoring common mental  
15 disorders in primary care. Dr. Kroenke has  
16 authored more than 270 peer-reviewed  
17 publications, and is the recipient of numerous  
18 teaching awards as well as sustained research  
19 funding from NIH and other federal agencies,  
20 foundations and industry organizations.

21 He's participating via  
22 teleconference to provide an overview of the  
23 Psychological Health External Advisory

1 Subcommittee's findings and proposed  
2 recommendations that are included in the draft  
3 report pertaining to the automated  
4 neuropsychological assessment matrix known as  
5 ANAM. Board members will find the  
6 presentation under Tab 8. Dr. Kroenke, we're  
7 delighted to have you join us, and look  
8 forward to your briefing.

9 DR. KROENKE: Thank you. Just one  
10 question. I'm going to be going through the  
11 PowerPoint, and the question I have is will  
12 people be looking for PowerPoints as they go  
13 through in their folder or on the screen?

14 CHAIR DICKEY: We have both of them,  
15 Dr. Kroenke, and if you would like to say  
16 "advance," we'll advance the slides.

17 DR. KROENKE: Yes, okay. So the  
18 first slide you've already seen what the  
19 report's on to. You can move to the second  
20 slide. The second slide's the overview, and I  
21 won't repeat for some of the slides, but I'll  
22 be able to walk you through this fairly  
23 efficiently, so there should and will be time

1 for discussion as well.

2 On the third slide, this is the  
3 three bullets of our charge, which was to  
4 assess the effectiveness of baseline pre-  
5 deployment neurocognitive testing using ANAM  
6 as the short term tool, to determine  
7 neurologic deficits and functions following a  
8 traumatic brain injury.

9 Second, determine the added value of  
10 supplemental sections. So there was a  
11 question on whether something needed to be  
12 added to the current ANAM, and then a third  
13 bullet added to that, examine the value  
14 between symptoms and patient history,  
15 sleepiness scales, as well as measures of  
16 response inhibition and effort.

17 Now I'll actually start at the end.  
18 The bottom line are recommendations, and then  
19 as this unfolds over the next ten minutes, I  
20 think it will be clear, or basically can be  
21 expressed in one sentence, which is continue  
22 to do what we're doing with the ANAM, but  
23 don't do more at this point. So that's going

1 to be the theme and the conclusions we came  
2 to.

3 Specifically, in relation to: do not  
4 do more at this point. Three key areas would  
5 be: should we replace the ANAM with a  
6 different tool, and at this point, the answer  
7 would be no. Second, should we expand the  
8 ANAM by adding other domains onto it, and the  
9 answer would be currently no.

10 The third is should we expand beyond  
11 what we're doing with ANAM, which is routine  
12 pre-deployment screening, for example, some  
13 type of routine post-appointment screening,  
14 and the answer would be no at this point.

15 So continue to do what we're doing,  
16 but neither at this point replace the ANAM  
17 with a different tool, make ANAM longer, or  
18 expand the use of ANAM, and that would be what  
19 you'll see in the several slides that will be  
20 shown from our report.

21 Membership of the Committee is  
22 number four. These members are well-known to  
23 the Board so we can move on. So basically, I

1 think this was a charge that came to our  
2 committee a little while ago, and it was put  
3 on hold because of the expiration of the TBI  
4 External Advisory Subcommittee. It probably  
5 would have been optimally addressed by working  
6 together with their committee and ours, but  
7 that committee has expired.

8           However, in the spring, we were  
9 asked to readdress it. So we did convene for  
10 one day meeting on May 9th, and that is where  
11 this draft report emanated from.

12           Next slide, slide 6, which is  
13 basically the key people, other than committee  
14 members who are at -- or excuse me, yes. Yes,  
15 we developed the draft on May 9th, but we met  
16 on June 16th.

17           So the meeting from which this  
18 report emanated from was June 16th, and Dr.  
19 Kane, who's an expert on ANAM was there, as  
20 well as Ms. Helmick from the Defense Center of  
21 Excellence, as well as Ms. Fudge from Office  
22 of the Assistant Secretary of Defense for  
23 Health Affairs, and they made presentations to

1 us.

2 Next slide. First, it's important  
3 to realize TBI is not limited to deployment,  
4 that there's a lot of cases in the U.S. each  
5 year. Military populations are simply at  
6 higher risk, due to this often happens in  
7 younger age groups in certain behaviors,  
8 sometimes risky as well as high risk  
9 occupations.

10 It was estimated in 2010 they had  
11 30,000 cases. There are some drastically  
12 higher estimates. But the key is most are  
13 mild TBI, which is on the next slide. But the  
14 important point is it's not just limited to  
15 deployment, in fact, it's probably many more  
16 cases due to training, vehicular accidents,  
17 force-related injuries among Service members  
18 due to combat exposure, but that's a fact.  
19 Most is mild TBI.

20 If you look at the next slide,  
21 number 8, it divides TBI rates over the last  
22 decade by mild, moderate and severe. Ignore  
23 the yellow bar for now, because that's

1 unclassifiable. If you look at those three  
2 categories, there's two important points.

3 One is it again emphasizes most of  
4 the cases of TBI are mild, and second, if  
5 anything, the moderate to severe cases have  
6 either declined or remained stable, and most  
7 of the increase has been in mild TBI.

8 So that epidemiology is important,  
9 but it also has limitations in the performance  
10 of any measure, which may have often been  
11 developed for any measures often better in  
12 assessing more moderate cases than those very  
13 mild cases. That's from any lab tests or any  
14 tests we do.

15 Next slide, which is -- the main  
16 point of the this slide is the first two  
17 bullets, there are some acute and recurring  
18 consequences potentially of concussion, and  
19 that one current use and probably practical  
20 use of a measure like ANAM is an assessment  
21 after injury of determining when it may be  
22 safe for Service members to return to duty, as  
23 one of the tools clinicians might use.

1           On slide 10, ANAM was developed by  
2 this DoD Joint Working Group. A couple of  
3 features is (a), it's brief, second, it's  
4 repeatable, which it could be used serially in  
5 assessing people. It's automated, okay. Now  
6 in 2008, there was the National Defense  
7 Authorization Act which mandated pre-  
8 deployment neurocognitive testing of Service  
9 members, and ANAM was chosen as the  
10 neurocognitive assessment tool.

11           So let me just comment on these two  
12 acronyms. One is ANAM and one is NCAT, and  
13 these terms are commonly used. The way to  
14 look at it is NCAT is any tool that can be  
15 used to assess neurocognitive assessment, and  
16 ANAM is not the only one. So it would be like  
17 saying we have post-traumatic stress disorder  
18 assessment tools, and a PC of 17 is one, and  
19 it's the one we currently use in the military,  
20 but it's not the only one.

21           So basically, as far as brain  
22 imaging, you could have a CAT scan or MRI, and  
23 you choose which to use. So NCAT is any tool

1 that could be used to assess neurocognitive  
2 functioning, and is the tool we're talking  
3 about.

4 Now the other point is a huge number  
5 of Service members have received ANAM. So  
6 what the bottom line of that is there's a  
7 large reservoir or repository of normative  
8 data, and that just has to be taken into  
9 account in decisions to replace ANAM, that  
10 there is this large normative data on service  
11 members.

12 Next slide. So this talks a little  
13 bit about its current use, and one is because  
14 there is this repository, baseline ANAMs are  
15 available to assist providers to determine  
16 change in neurocognitive status, because it's  
17 probably the change of the measure that's more  
18 valuable than the absolute performance,  
19 because there can be a lot of individual  
20 factors.

21 It's really analogous to having a  
22 baseline EKG and someone who comes in with  
23 chest pain for a baseline serum creatinine or

1 someone started on nephrotoxic drugs. So in  
2 that case, baseline ANAMs are like having any  
3 other baseline laboratory test.

4 There have been a marked number of  
5 requests since, well actually since 2011.  
6 That's actually quite a few, more than 10,000,  
7 and a quarter of those are in-theater.  
8 Although pre-post changes are the most useful  
9 and sensitive, there is this huge population  
10 of baseline norms, and we mention those  
11 865,000 patients.

12 So in the absence of a baseline, a  
13 clinician can still get ANAM after a  
14 concussion or injury, and second best would be  
15 concurrent to sort of baseline norms, just  
16 like we all have baseline norms on  
17 creatinines. If one's elevated, you can say  
18 well it's normally what a normal creatinine  
19 is.

20 Next slide. So ANAM's being used  
21 in-theater. You have to determine recovery  
22 from TBI and return to duty. There is paucity  
23 of data on other types of NCAT instruments,

1 and there is approval to begin comparing other  
2 instruments. Our recommendation would be  
3 before replacing an ANAM, one would need some  
4 comparative data, because any new measure that  
5 you brought in would not have the normative  
6 data.

7 Slide 13. So here's our findings,  
8 and I'll selectively make some points. Number  
9 one, ANAM is not intended to be a diagnostic  
10 instrument, and should not be used as a screen  
11 or diagnostic tool for a Service member prior  
12 to diagnosis. Let me amplify that. ANAM is a  
13 test. So we dual-diagnose a heart attack,  
14 with a EKG only. We take an EKG along with  
15 signs and symptoms, and that's the way ANAMs  
16 should be used.

17 You've already diagnosed. It's a  
18 neurocognitive dysfunction without clinical  
19 examination. So it's a useful complementary  
20 tool. Second, because of that, you wouldn't  
21 want to start screening asymptomatic Service  
22 members to look for subtle changes in an ANAM,  
23 because that's not a disease. So that's why

1 it's okay to get baselines, but one must be  
2 cautious about determining a test in  
3 isolation. In fact, there could even be risks  
4 in widespread post-deployment ANAM testing  
5 only.

6 Point two I can summarize quite  
7 frankly, is there's been a question of whether  
8 to add sleepiness scales, or the PEEK scales,  
9 because they may affect neurocognitive  
10 performance. Actually currently, these tend  
11 to be captured by ANAM, but they're not  
12 incorporated in the results, and in fact it's  
13 not really clear how they're incorporated in  
14 other test results. They may be incorporated  
15 clinically. But there is some adjustment of  
16 that in ANAM now.

17 Slide 14. The other issue is  
18 language, and the big thing about language  
19 problems is two points. One, language --  
20 hello? Okay. Language problems are typically  
21 not affected following mild TBI, and cannot be  
22 well-evaluated by a computerized self-  
23 assessment instrument. So bringing language

1 into a self-administered brief measure would  
2 be beyond what those measures can usually  
3 capture.

4 The fourth point, since the majority  
5 of mild TBI events are not related to  
6 deployment, these findings and recommendations  
7 could go beyond and be relevant to Service  
8 members throughout their term of service.

9 So that if someone had ANAM at one  
10 time point, if they had an injury or  
11 concussion from a motorcycle accident or a  
12 football injury or in training, that same ANAM  
13 could be used in conjunction with the clinical  
14 assessment.

15 Now slide 15, I'm going to let you  
16 just pause here, because sometimes phone  
17 service goes out. Has everybody been able to  
18 hear what I've said so far?

19 CHAIR DICKEY: Yes, Dr. Kroenke.  
20 Thank you.

21 DR. KROENKE: Okay. So we only have  
22 about five slides left. The fifth finding is  
23 -- so it reiterates that the ANAM may be an

1 effective pre-deployment tool for establishing  
2 baseline. So it's like a baseline test, which  
3 could then be a comparison standard following  
4 individual exposure to events.

5 So the bottom line is a baseline  
6 test is fine, but you would then get a certain  
7 test based upon either some injury, or some  
8 signs and symptoms that an individual Service  
9 member was reporting.

10 Finally, the other question besides  
11 language had come up, one about memory,  
12 attention and effort, and they do appear to be  
13 embedded and measured by the current ANAM.

14 I think seven, it reiterates again  
15 that using it after an event, either in-  
16 theater or in-garrison, can be useful in the  
17 injury assessment, and that you couple any  
18 ANAM for abnormalities with a clinical  
19 evaluation. That's really where it should be  
20 used in clinical assessments.

21 Point two is there's been minimal  
22 comparisons of brief neuropsychological  
23 measures against one another. So it means

1 there's a substantial amount going into the  
2 military data regarding ANAM, and then some  
3 differences which have been suggested seem to  
4 be small to modest at this point. But  
5 certainly we would need head-to-head  
6 comparisons to make that decision, and right  
7 now we don't have those head-to-head  
8 comparisons of competing instruments.

9 So on the last several slides, our  
10 recommendations are number one, your personal  
11 post-deployment NCAT for all Service members  
12 is not recommended at this point. Instead, it  
13 should be used selectively for those, as I  
14 said, who have experienced symptoms or signs.  
15 So that's kind of a scope, at this point, in  
16 terms of a recommendation.

17 Number two is whatever kind of  
18 neurocognitive assessment tool you use, which  
19 is currently ANAM, it's best used as a  
20 targeted instrument, to increase the data  
21 available for individual level assessment  
22 compared to baseline. So it shouldn't be used  
23 as a stand-alone diagnostic tool.

1           So if I was to summarize number one  
2 and two, what are the don'ts in there at this  
3 point, one is don't start universal post-  
4 deployment neurocognitive assessment. Number  
5 two, don't use any kind of NCAT measure like  
6 ANAM as diagnosing a disease in isolation.  
7 Number three, and that it's reiterated in  
8 point number three, even changes in scores.

9           So if someone inadvertently got  
10 another ANAM after they had a pre-deployment,  
11 and there was some change on it, that in  
12 itself shouldn't diagnose a disease, but it  
13 should be considered together with events,  
14 symptoms and clinical findings.

15           Number four, we should also  
16 interpret NCAT findings along with other  
17 information we routinely obtain on Service  
18 members, which could have been cognitive  
19 testing, including in particular depression  
20 and PTSD, because that's the very important  
21 measure.

22           So since we gather those, we would  
23 not only want to look at their clinical

1 findings related to possible TBI, they would  
2 have to interpret NCAT results, in this case  
3 with ANAM, by knowing whether or not they have  
4 these other factors.

5 Likewise NCATs should not be used  
6 alone to determine fitness for duty or  
7 deployment. So if you had an isolated  
8 abnormal NCAT, that shouldn't be used alone to  
9 say you're not fit for duty. It would have to  
10 be coupled with something on clinical exam or  
11 history by a clinician, that suggested that  
12 there was something clinical there as well.

13 On page 19, number six, because of  
14 the huge normative data, we do not recommend  
15 changing from ANAM at this point. If there  
16 are other batteries that provide a significant  
17 advantage in the future, it should be, could  
18 be reconsidered.

19 Number seven, there does not appear  
20 to be an urgent need to add additional domains  
21 to ANAM at this point, and in the future, we  
22 should see what the effects of sleep  
23 deprivation may be on test results.

1 Currently, there are questions asked about it  
2 in ANAM, and the clinician can use it. But  
3 they're not reflected in changing the scores  
4 and the norms on the measures.

5 Finally, given the limitations of  
6 NCAT in general, especially testing complex  
7 domains, because the final question is what  
8 about executive function, they tend to be  
9 beyond -- it's kind of like language. Testing  
10 language and executive function are more  
11 complex domains, also interestingly tend to be  
12 more moderate severity TBI. But they're  
13 probably beyond the domains of a brief self-  
14 administered measure.

15 So that's all of my points, and then  
16 I think obviously there may be some  
17 discussion.

18 CHAIR DICKEY: Thank you, Dr.  
19 Kroenke, for an excellent presentation. Are  
20 there questions or comments about the  
21 briefing? Dr. Anderson.

22 DR. ANDERSON: Question from George  
23 Anderson. You've, the report is great, and

1 really nicely laid out.

2 DR. KROENKE: Just there's some  
3 competition on the phone. Someone else is  
4 talking.

5 (Pause.)

6 CHAIR DICKEY: I think we have  
7 someone on the phone who's got your line open.  
8 If you're having a side conversation, if you  
9 can mute your phone for us, please. I'm  
10 sorry, Dr. Anderson.

11 DR. ANDERSON: Yes, a question from  
12 George Anderson. A great report. It's been  
13 presented, of course, as you were asked, in  
14 the context of pre-deployment baseline and  
15 then ANAM is a tool, with clinical power  
16 later. The obvious question to me is is it a  
17 good idea to do a baseline ANAM on all  
18 military members, given that you have mild TBI  
19 incidents across the military population?

20 CHAIR DICKEY: Dr. Kroenke, did you  
21 hear the question?

22 DR. KROENKE: Well again, there was  
23 the competition. So maybe I think briefly,

1 and then you can sort of expand on it. I  
2 think the question was there's routine pre-  
3 deployment now, and so the question -- could  
4 you repeat the question? Should we do  
5 something more than?

6 DR. ANDERSON: Yes, Kurt. The  
7 simple question is should we have an across  
8 the military population baseline ANAM test  
9 done, so that you could use it as a clinical  
10 tool, if there is TBI from other causes than  
11 combat?

12 DR. KROENKE: Well, my own opinion  
13 is that it makes sense, so this is not the  
14 committee talking, this is me talking, it  
15 makes sense. On the other hand, any time you  
16 incorporate some new measure into a  
17 population, you know, you would sort of have  
18 to argue, you know, what's the evidence,  
19 what's the cause?

20 I think the pre-deployment was  
21 mandated. So I think that happened. That's  
22 probably -- I mean just my opinion would be  
23 it's unlikely, and to make that go away, we

1 would be in violation of something. So I  
2 think that happens, and we don't see any  
3 reason to -- we're not recommending to stop  
4 that.

5 I guess my own opinion would be  
6 despite what you said, I'd be cautious about  
7 expanding it to the whole population at this  
8 point. Although interestingly, some school  
9 systems, I understand, like for Maryland now,  
10 are mandating some neurocognitive testing  
11 before sports, you know. So that had been  
12 moved by legislation in states.

13 So I tend to have a conservative  
14 view. So before I start to mandate things  
15 routinely, I also worry about the down side.  
16 In other words, on deployment now we have a  
17 mechanism for measuring Service members.  
18 Otherwise, we'd have to institute a new  
19 mechanism service-wide of getting it.

20 So to me, that might be in advance  
21 of what we're doing, and the Committee didn't  
22 discuss it. So my view would be I probably  
23 wouldn't recommend it. But it's not something

1 that shouldn't be considered.

2 DR. ANDERSON: Just a follow-on  
3 comment to that. Kurt picked up quickly on  
4 the reason for the question, that is that this  
5 is going to become a population-wide concern,  
6 particularly for high school and college  
7 sports. So this is a place where this  
8 normative data that's being collected by the  
9 DoD could be extremely valuable for the  
10 nation.

11 DR. KROENKE: So I think that's  
12 something that could be considered for the  
13 future quite probably. I mean the Board could  
14 decide. I'm personally probably still  
15 reluctant to make it in this report, unless  
16 one might put it in a bullet, you know. DoD  
17 might consider the value of expanding it to  
18 every Service member have one ANAM.

19 DR. ANDERSON: Yes. It's not part  
20 of your recommendation. I understand that.  
21 It was really a follow-up question and  
22 comment. But I think this might come on our  
23 future action list.

1 DR. KROENKE: Yes.

2 CHAIR DICKEY: Dr. Hovda.

3 DR. HOVDA: This is Dave Hovda.  
4 Kurt, great job. It's very hard to give a  
5 briefing, I know, from a telephone and not  
6 being in the room. So I want to congratulate  
7 you on that. I also apologize for not being  
8 able to make the last meeting, given my other  
9 responsibilities in Washington at the time.

10 I think there's a distinction that  
11 the report should try to emphasize, and that  
12 is that there is a distinct difference between  
13 trying to assess individuals at a return from  
14 theater, and whether they have, they're  
15 suffering from symptoms associated with repeat  
16 mild traumatic brain injury, and doing  
17 something in-theater to determine or back  
18 home, for that matter, given the excellent  
19 data that you reported, that this isn't just a  
20 theater event that can occur, in terms of mild  
21 traumatic brain injury, like determining when  
22 an individual is safe to return to duty,  
23 either for active duty or for returning to

1 whatever duty he was doing.

2           So those are two different  
3 questions, I think, and I was not part of the  
4 development of the ANAM or of IMPACT, but a  
5 lot of these tests for athletic endeavors were  
6 primarily return to play issues. They weren't  
7 issues in terms of trying to determine long-  
8 term problems.

9           We know that about, from the  
10 scientific literature, we know that about 80  
11 to 85 percent of the individuals that have  
12 mild traumatic brain injury are going to clear  
13 within seven days, or seven to ten days, and  
14 as long as they don't receive a second injury  
15 or a second problem during the time that  
16 they're trying to clear, there's really no  
17 scientific evidence that I'm aware of that  
18 that brain is going to be any more susceptible  
19 to problems.

20           I know that if they get repeated  
21 head injuries, or they have symptoms and are  
22 still allowed to either conduct themselves in  
23 theater or be exposed to a second stress, that

1 they're more likely to acquire lots of  
2 different problems besides those associated  
3 with mild traumatic brain injury. That data's  
4 very strong right now.

5 So the distinction in the report  
6 should probably read some way to differentiate  
7 this from acute determination of whether to,  
8 for lack of a better term, return to play,  
9 return to Active Duty, and those that are  
10 going to be post-deployment that are assessed  
11 for longer-term problems and traumatic brain  
12 injury.

13 I completely agree, that it should  
14 not be -- there is no gold standard for this,  
15 and I think that the way that the report's  
16 crafted to address this is very appropriate  
17 and makes perfect scientific sense.

18 But there is a distinction between  
19 the two, in terms of acute and chronic, and I  
20 don't want to get them folded in, because  
21 that's not, what I don't -- I think we're  
22 trying to maybe employ a tool for the right  
23 problem at the wrong time, if that makes sense

1 to people.

2 I'd be very interested to hear what  
3 Dr. Ross Bullock, if he's still on the line,  
4 what his comments are. So that would be the  
5 only distinction that I would make in the  
6 report. I'm happy to craft up some verbiage  
7 for that, as an amendment, if you want me to.  
8 But that would be my only distinction.

9 DR. BULLOCK: Dave, this is Russ  
10 Bullock. Yes, you know, I echo your comments  
11 there. I think that the -- it's so difficult  
12 to hear, because of this other side  
13 conversation that we're having.

14 Hello? In any case, Dave, I really  
15 agree with your comments there. But I think  
16 that the report is very conservative, and does  
17 take those, take that kind of overall tenet.

18 CHAIR DICKEY: Thank you. I'm not  
19 sure that the interrupting phone  
20 conversation's actually one of our people.  
21 Sometimes you just bleed in.

22 DR. BULLOCK: That seems to be the  
23 case, and my guess is that it's just something

1 that's just bleeding into the call. So we'll  
2 probably have to deal with it. Maybe what  
3 would be helpful is if you could please say  
4 again what -- you don't have to wordsmith it,  
5 but what might be one measure, changed or  
6 tweaked that you might make in the report,  
7 based upon what you said?

8 CHAIR DICKEY: I think we've heard  
9 some excellent comments. Correct me if I'm  
10 wrong, Board members, but I don't know that  
11 I've heard any amendments to the report.  
12 Rather, some future opportunities, as we  
13 continue to track the evidence-gathering and  
14 the potential application. Are there any  
15 Board members who are suggesting an amendment  
16 or addition to the recommendations before you?

17 DR. BULLOCK: Well B- go ahead on  
18 that.

19 CHAIR DICKEY: Okay. Then I would -  
20 - Dr. Kroenke, I think you've done a better  
21 job than you gave yourself credit for. I  
22 think people are just looking forward to the  
23 potential benefits to an even larger platform

1 than the one that is currently being served,  
2 and perhaps data collection over time will  
3 tell us whether that larger platform is a  
4 useful application.

5 I would be happy to entertain an  
6 action. This report is before you with  
7 recommendations today, and the Subcommittee  
8 would ask that we consider approving those  
9 recommendations as a Board, and forwarding  
10 them to the Department. Yes sir.

11 BRIG GEN EDIGER: Dr. Dickey, could  
12 I ask one question?

13 CHAIR DICKEY: Yes sir.

14 BRIG GEN EDIGER: This is Mark  
15 Ediger from the Air Force. I know in talking  
16 with our specialists, one of the things  
17 they've been anxious to see is evidence, in  
18 terms of how well the ANAM actually is  
19 specific and sensitive to the cognitive  
20 effects of traumatic brain injury.

21 I noticed the recommendations in the  
22 report. Really, I don't see a recommendation  
23 recommending further study, and I wondered if

1 that might be because the emerging evidence  
2 referenced in Item No. 5 is from an ongoing  
3 study, and the group thought the study in  
4 progress was sufficient, or is it because  
5 perhaps they think we've already got  
6 sufficient evidence?

7 CHAIR DICKEY: Dr. Kroenke, were you  
8 able to hear the question?

9 DR. KROENKE: Yes. I mean I think  
10 the question spoke to where more research  
11 might be needed. So how good is the ANAM, and  
12 in parceling out cognitive injury? We did get  
13 a series of slides presented at the meeting,  
14 and frankly, some was stronger than others,  
15 some was in process, and some of it's  
16 population-dependent.

17 So not being able to sort of  
18 remember that all of this time, it felt like  
19 it's -- to be honest with you, we still want  
20 the data, but it's currently very bad ability  
21 in different disease states, which leads to  
22 the cautious recommendation that it should  
23 never be used alone. It's probably emerging.

1 It's a lab test that is going to be coupled  
2 with neuropsychologic and clinical  
3 examination.

4 So maybe that's one way to deal with  
5 the fact more work is needed, in terms of its  
6 sensitivity in detecting certain things, and  
7 certainly there could be an amendment that  
8 talked to that, you know, more research is  
9 needed regarding that specifically. But  
10 that's probably why we couched everything into  
11 saying never use it as a stand-alone.

12 CHAIR DICKEY: Doctor, General  
13 Ediger, are you suggesting that at least some  
14 of the Services might welcome specifically  
15 addressing additional research or continued  
16 monitoring and additional research using ANAM  
17 and potentially other cognitive measures?

18 BG EDIGER: Well, Captain Hammer was  
19 just, you know, telling me that there are at  
20 least two studies in progress. I knew there  
21 was some study in progress, but I know when I  
22 talked with our clinicians, they believe that  
23 more information is needed, because from time

1 to time there are various instruments out  
2 there and questions are raised about whether  
3 or not we've selected the best instrument.

4 CHAIR DICKEY: Okay. So Dr. Hovda.

5 DR. HOVDA: This is Dave Hovda  
6 again. Perhaps maybe a way we could address  
7 this would just be to add an addendum to the  
8 recommendation, saying that even though we are  
9 approving these recommendations, we are  
10 encouraging that ANAM validity and reliability  
11 be continually tested and upgraded as we see  
12 fit.

13 CHAIR DICKEY: Okay. Would you  
14 actually add a tenth recommendation to that  
15 effect?

16 DR. HOVDA: Yes.

17 CHAIR DICKEY: Is that a motion,  
18 sir?

19 DR. HOVDA: Yes, it is.

20 CHAIR DICKEY: Does that address  
21 some of the concerns?

22 DR. HOVDA: Yes. I think -- I'm  
23 sorry. This is Dave Hovda again. Yes, I

1 just think that to lay down as sort of the  
2 only -- by couching it the way it is in the  
3 report, it certainly isn't the gold standard  
4 and it's certain that crafting of the report  
5 addresses that quite easily.

6 But I wanted -- I think, from a  
7 scientific point of view, it makes sense to  
8 continue to review it, to see if things have  
9 changed. One of the things that's the  
10 elephant in the room that nobody wants to  
11 address when we're talking about ANAM or other  
12 assessments of concussion, is that a lot of us  
13 are treating these blast concussions as if  
14 they are the same thing as athletic  
15 concussions.

16 They may be, and there are a lot of  
17 people that say that they're the same thing.  
18 There are other people that think that they're  
19 a completely different type of disease. I  
20 think we need to stay open scientifically to  
21 that sort of analysis, and that way maybe the  
22 ANAMs will need to be altered or change, as we  
23 learn more and more and more about the

1 biomechanics and the physiology of blast  
2 concussions.

3 CHAIR DICKEY: So I've heard a  
4 recommendation for adding a tenth  
5 recommendation, which would essentially say  
6 we'll continue to monitor, follow and evaluate  
7 other possible tools, in a living fashion or  
8 an ongoing fashion.

9 DR. HOVDA: That's correct. I'd  
10 move that. Thank you.

11 CHAIR DICKEY: Okay. So you have an  
12 amendment before you. I would need a second  
13 for that amendment, and a recommendation for  
14 action on all of the recommendations, with or  
15 without the amendment that's proposed.

16 DR. CARMONA: Second.

17 CHAIR DICKEY: I just got a second  
18 for the amendment, all right. The amendment  
19 would be that we would have ongoing evaluation  
20 and possible consideration of other evaluation  
21 tools. Is there further discussion of the  
22 amendment?

23 (No response.)

1 CHAIR DICKEY: If not, all in favor  
2 of the amendment say aye?

3 (Chorus of ayes.)

4 CHAIR DICKEY: Opposed, no?

5 (No response.)

6 CHAIR DICKEY: All right. Now we  
7 still have in front of us then the now ten  
8 recommendations from the Subcommittee.

9 DR. HOVDA: I propose acceptance.

10 CHAIR DICKEY: We have a motion to  
11 approve the ten recommendations from the  
12 Subcommittee, and move them forward. Is there  
13 further --

14 DR. JENKINS: Second.

15 CHAIR DICKEY: A second to the  
16 motion from Dr. Jenkins. Is there discussion  
17 about the motion?

18 (No response.)

19 CHAIR DICKEY: If not, all in favor  
20 of approving the ten recommendations in front  
21 of us, please say aye?

22 (Chorus of ayes.)

23 CHAIR DICKEY: Opposed, no?

1 (No response.)

2 CHAIR DICKY: Dr. Kroenke,  
3 excellent work. Thank you very much, and  
4 we'll actually look forward to continuing to  
5 follow this issue, not only this but  
6 potentially additional tools that might be  
7 added. Thank you for joining us this  
8 afternoon. It is a challenge to do so  
9 telephonically, and so we appreciate the extra  
10 work on your half.

11 All right. We are a touch behind.  
12 If we could make it a short break of ten  
13 minutes and resume here at three o'clock,  
14 we'll try to catch back up and continue the  
15 work that's before us. So it's currently ten  
16 minutes of 3:00. We'll resume at three  
17 o'clock.

18 MS. BADER: Hi. This is Christine  
19 Bader. For the folks on the line, we're going  
20 to hang up on our end. If you can all the do  
21 the same, and then dial back in, and then  
22 perhaps that way we'll be able to solve the --

23 (Whereupon, at 2:48 p.m., the above-

1 entitled matter went off the record and  
2 resumed at 3:04 p.m.)

3 **Information Brief: Military Infectious Disease**

4 **Research Program**

5 CHAIR DICKEY: Welcome back, and  
6 we'll hope the rest of our colleagues will  
7 join us in just a few moments. Our next  
8 presentation's going to be delivered by  
9 Colonel Julia Lynch. Colonel Lynch currently  
10 serves as the Director of Military Infectious  
11 Disease Research Program at Fort Detrick,  
12 Maryland.

13 She completed her medical education  
14 at Columbia in New York on a U.S. Army  
15 scholarship, with follow-on pediatric  
16 residency at Walter Reed Army Medical Center,  
17 a fellowship in basic science research at  
18 Walter Reed and a fellowship in Infectious  
19 Disease at the Uniformed Services University  
20 of the Health Sciences.

21 She's board-certified in Pediatrics  
22 and Infectious Disease, and holds a  
23 Certificate of Knowledge in Tropical Medicine

1 and Traveler's Health from the American  
2 Society of Tropical Medicine and Hygiene.  
3 She's worked as a clinical pediatrician for  
4 over 20 years, both in the U.S. and abroad,  
5 including Europe, the Middle East and Central  
6 America.

7 She's providing an informational  
8 brief regarding MIDRP and her slides are found  
9 behind Tab 9. Colonel Lynch, welcome. We're  
10 delighted to have you.

11 COL LYNCH: Great, thank you. Oh, I  
12 think this isn't on perhaps. Is it? Can you  
13 hear me? Oh, okay. All right. Well, I  
14 really appreciate this opportunity. It's been  
15 some time since the Military Infectious  
16 Disease Research Program, which we call MIDRP,  
17 has had an opportunity to give sort of a  
18 status update to the Defense Health Board.

19 So I'm going to take the time I  
20 spend this afternoon is going to be in two  
21 parts. The first is a very broad overview,  
22 because I know we're time-limited about the  
23 work going on in the program. At the end, I

1 want to spend some time and hopefully engage  
2 you in some discussion about what I see is  
3 really the significant problems and challenges  
4 that we're facing in continuing to deliver  
5 force health protection products for  
6 infectious disease to the force.

7 So any overview, I've got to make  
8 sure I get the right buttons -- any overview --  
9 - there we go. We start off understanding our  
10 parent organization. The MIDRP is part of the  
11 Medical Research and Materiel Command. It's  
12 one of the program offices, and you can see  
13 our mission and vision statement there.

14 I don't want to put you to sleep  
15 with an organizational chart. This is simply  
16 to point out that the Medical Research and  
17 Materiel Command is led by Major General  
18 Gilman, and he has, as part of this  
19 organization, both my office and other  
20 research area directorates, which you see  
21 here, as well as ownership of the medical  
22 research labs, at least in the Army.

23 The principle labs that carry out

1 the infectious disease research are the Walter  
2 Reed Army Institute of Research for the Army,  
3 some work at UCLA, the U.S. Army Medical  
4 Research Institute for Infectious Disease,  
5 although they have primarily a biowarfare  
6 program there, and some work at ISR, in  
7 relation to our Wound Infection Program.

8 Now important to this is the Army's  
9 the lead agency, and we do the planning,  
10 programming and budgeting. But we also fund  
11 research that goes on at the Navy research  
12 labs, and I have some slides which will  
13 address that in more detail later.

14 We have in the organization both the  
15 tech base, 61 through 63 funding, research and  
16 discovery, early development, and partner or  
17 really our sister organization, which is our  
18 advanced developers in the same command, which  
19 I think gives us a great strength, in being  
20 able to transition our products from early  
21 discovery through development.

22 I just shut everything off, because  
23 I pushed the wrong buttons. I was afraid that

1 would happen. They have a big button here  
2 with a white square, but it's not the one you  
3 should push. Okay. There are some more  
4 details here about the various research area  
5 directorates I won't go into, but you can look  
6 at.

7 Now specifically, the mission of the  
8 Infectious Disease Program is to conduct a  
9 very focused, responsive, research and  
10 development for products that would be  
11 fielded, that are fielded and lead to improved  
12 means of protection or treatment, in order to  
13 maintain maximal global operational  
14 capabilities. So in terms of infectious  
15 disease, we have very much a global focus.

16 So it's inherently a force health  
17 protection mission. Again, we are limited to  
18 naturally-occurring infectious diseases, not  
19 those posed or that would be engendered by a  
20 malicious act. It is requirements-driven and  
21 as I already mentioned, the Army is the lead  
22 agent.

23 I call this our mothership. That's

1 the Walter Reed Army Institute of Research,  
2 which is in the same building as the Navy  
3 Medical Research Center. It's really the hub  
4 of the endemic disease research program, and  
5 of course their overseas labs.

6 These are -- this is our customer,  
7 and it's not projecting terribly well. I  
8 don't know how that looks in your handouts,  
9 and of course our forces, they're fierce and  
10 resilient in carrying out the mission of the  
11 U.S. government.

12 But as I think is what is so well  
13 depicted in this picture is also their  
14 vulnerability. They are vulnerable to  
15 naturally-occurring infectious diseases, those  
16 transmitted by vectors, those transmitted from  
17 the environment itself, those transmitted from  
18 person to person, living here at the tip of  
19 the spear in these very challenging  
20 environments.

21 Of course we know throughout  
22 history, there's really an abundance of  
23 documentation, that infectious diseases have

1 major impact on military operations, and can  
2 sometimes even be really definitive in terms  
3 of outcome.

4 So there are many examples where  
5 they've caused more casualties than enemy  
6 fire. They're present in really complex  
7 distributions around the globe, which of  
8 course we have to track and understand. There  
9 is almost always a requirement for new tools,  
10 because these pathogens are very dynamic and  
11 they change.

12 We know that if we don't attend to  
13 these, the result will be lost duty time,  
14 decreased combat effectiveness. And even when  
15 we have countermeasures, there are morbidities  
16 associated with them, that often make us want  
17 to improve the things that we have. And  
18 again, the end result, if we don't address  
19 these in terms of protecting, we know we're  
20 going to have significant medical logistic  
21 burden.

22 So this slide's a very broad-brush  
23 overview of the kinds of impacts DNBI, in some

1 cases infectious disease specifically have  
2 kind of wrought on various conflicts and  
3 operations over time. So given a very broad  
4 array of infectious diseases, how do we decide  
5 what to focus on?

6 Well, we do that through expert  
7 panels, and the most recent panel that we  
8 conducted was in April 2010, that built upon  
9 the prior panel, which was in early 2000. I  
10 won't go through the details. There will be  
11 some additional slides which are in your slide  
12 set. But I guess the bottom line is we  
13 convene panels of experts, both infectious  
14 disease, representing all the Services. We  
15 have external representatives. We bring in  
16 the users, that is the COCOM Surgeons'  
17 offices, the requirements writers at the AMEDD  
18 Center and School, and we really met for two  
19 days and go through a process that's very  
20 information-based, using analysis from the  
21 National Center of Medical Intelligence, and  
22 an iterative process to come to really a  
23 consensus threat list, which you see here.

1 It's our validated threat list as of 2010.

2 Now the point I'd like to make about  
3 this list are just a couple. One is in doing  
4 this panel, we used a decision support  
5 software, so that as we form a consensus, you  
6 have a lot of granularity as to how strong the  
7 consensus really was. Important in that is  
8 that the top three pathogens on this list,  
9 malaria, dengue and diarrheal bacterial  
10 pathogens, there's 100 percent consensus. 100  
11 percent, that those are the most important  
12 force health protection threats.

13 As you go down that list, I will  
14 tell you that the degree, the strength of the  
15 consensus starts to wobble. So I always, when  
16 I share this list, would tell people I would  
17 never stand before you and be able to hold an  
18 argument, effective argument that number 11 is  
19 really much more important than number 15.

20 The list shouldn't be used that way,  
21 other than focusing us on what's important is  
22 clearly at the top. We were fortunate to  
23 determine that they were actually the same

1 three pathogens that we had in our prior  
2 analysis, and they remain our biggest  
3 programs. So we are confident that we are  
4 still moving forward, focusing on the most  
5 important pathogens.

6 Now because some of these agents are  
7 not common to us in the U.S., I thought I'd  
8 just take a minute to show you or give you an  
9 understanding of how we perceive them in terms  
10 of the force health protection threats that  
11 they are.

12 The first is malaria, which clearly  
13 is a pathogen of great global public health  
14 importance, and you can see the numbers here  
15 with the millions, and you know it's big. But  
16 important in this, when you look at the  
17 biggest risk groups, particularly in terms of  
18 severe disease, you find, of course, infants  
19 and children, pregnant women and travelers.  
20 At DoD, we are among the biggest travelers in  
21 the world, and are extremely vulnerable going  
22 as immune naives into environments where there  
23 is malaria.

1           So historically this has been among  
2 the most feared and disabling of acute  
3 infections. There are legions of great  
4 stories, going back certainly before World War  
5 II but certainly in World War II, of the  
6 tremendous attack rates. Of course, there's  
7 better malaria control now than there was in  
8 that era.

9           Nonetheless, I'll show you in a  
10 moment, and you have in your slides, the  
11 National Center for Medical Intelligence,  
12 their best current estimates about attack  
13 rates. For large parts of the world, we still  
14 look at predicted attack rates of deployed  
15 forces of 11 to 50 percent per month from  
16 malaria, if we put boots on the ground in  
17 those areas. That's certainly a big potential  
18 problem.

19           So estimates per episode of malaria,  
20 about 10 to 14 lost duty days per episode.  
21 Now even though we are not and have not been  
22 heavily deployed in heavily endemic areas, we  
23 still see about 100 cases per year and one

1 death per year on average over the last ten  
2 years.

3           And significant costs when we have  
4 to MEDEVAC someone out who has acquired  
5 malaria during their deployment, and you're  
6 probably wondering well, what about our  
7 personal protective measures, which are very  
8 important and are numerous, the most important  
9 of which is actually chemoprophylaxis. Yes,  
10 we have chemoprophylaxis, and we believe that  
11 everyone knows about it, but not everyone  
12 still uses it. There are significant  
13 compliance issues, and I'll show you some  
14 examples in a moment.

15           So these are the heat maps.  
16 Obviously, Africa's a huge problem. The red  
17 is the 11 to 50 percent per month estimated  
18 attack rates to troops. The orange is 1 to  
19 10, and the yellow is the .1 to 1 percent.  
20 And just so you could see there, yes, there is  
21 some malaria in some current theaters of  
22 operation, and yes, we have seen cases,  
23 although this is primarily vivax, and not the

1 more severe form of malaria.

2           So again, we've not been heavily  
3 deployed in the hottest zones for malaria, but  
4 we still see these events, when we have even  
5 smaller units that go into the highly endemic  
6 zones. I'll point out just a couple of the  
7 examples here. I think the experience in  
8 Liberia in 2003 is really part of a civic  
9 assistance mission, in which 225 Marines were  
10 on the ground for just two weeks, and out of  
11 that came 80 cases of malaria, 44 evacuations,  
12 four of them severe and complicated, going  
13 right to ICUs.

14           So these are the kinds of events,  
15 when we put people in harm's way, malaria will  
16 rear its head and be really a huge potential  
17 problem, limiting combat effectiveness.  
18 Additional examples. Even early in  
19 Afghanistan operations, a U.S. Ranger 725-man  
20 force, I would say heavily, highly disciplined  
21 force, and yet for a four month period of  
22 time, 38 cases.

23           When that unit was subsequently

1 given an anonymous survey about their use of  
2 prophylaxis, we found that more than 50  
3 percent admitted they did not do the things  
4 that they were told. So yes, personal  
5 protective measures and chemoprophylaxis has  
6 its limits. It's still the best thing that we  
7 have. I'm in no way trying to say we  
8 shouldn't be doing these things. It's the  
9 best we have.

10 In our program, we continue to work  
11 on new anti-malarial drugs, because part of  
12 the compliance issue is the tolerability with  
13 the drugs that we have. So our program,  
14 again, looks to discover and develop new anti-  
15 malarial prophylactic drugs. Probably the  
16 more definitive solution but perhaps the more  
17 challenging one is actually a vaccine for  
18 malaria, which has been a multi-decade effort.

19 This is very complex. There are no  
20 licensed vaccines targeting parasites, so  
21 there's no road map like we have with viruses  
22 and bacteria. But the most successful vaccine  
23 for malaria to date, which is called the RTSS

1 vaccine, was developed by the Army with GSK,  
2 and is currently in Phase 3 trials in Africa.

3           Unfortunately, it appears up to the  
4 Phase 2 testing, that this product will only  
5 be about 50 percent protective. So not  
6 sufficient probably for DoD use, except for  
7 maybe very special populations. So we  
8 continue to work on building on the experience  
9 with RTSS, to develop a vaccine that is more  
10 protective, more broadly protective, and has  
11 better durability.

12           Briefly on dengue, our second most  
13 important pathogen, dengue's really four  
14 viruses. It has a different vector. It's the  
15 most prevalent vector-borne viral disease  
16 globally, and again, huge burden in terms of  
17 its public health impact globally. Currently,  
18 no U.S. FDA-approved vaccine or drug, so we  
19 have supportive care and estimates of 10 to 14  
20 lost duty days for each episode of dengue.

21           Prevention is entirely the personal  
22 protective measures, minus the  
23 chemoprophylaxis, since we don't have that.

1 Now dengue is a pathogen which has risen on  
2 our priority list steadily over the last  
3 couple of decades. This is what the  
4 distribution of dengue in the world looked  
5 like approximately in the 70's, and this much-  
6 used photograph, which is meant to illustrate  
7 not only air travel but in fact shipping and  
8 other ways in which we have moved, with  
9 considerable efficiency, material around the  
10 world, such that we now have a dengue global  
11 distribution which looks something like this.

12 So it's truly a pathogen, as I said,  
13 which has increased our sense of concern, and  
14 again, right now, neither areas of operations  
15 are endemic areas. So we're not seeing in the  
16 baseline much dengue, but we know from again,  
17 the threat assessments by the National Center,  
18 that there are significant hot zones in the  
19 world, and when we do put boots on the ground  
20 in those places, we typically see, among our  
21 febrile illness patients, 30 to 60 percent of  
22 them are in fact due to dengue.

23 Here's the heat map for the globe.

1 The hottest focus for dengue is actually in  
2 Asia, although there's significant dengue in  
3 South America. Just to point out this brown  
4 here, which is Africa. If you read the key,  
5 the brown is we're not sure. It's a very  
6 interesting pathogen. We know the vector  
7 exists. We know the virus is there. It's  
8 periodically isolated.

9 But for reasons that are unclear,  
10 the indigenous population there doesn't  
11 recognize or report dengue cases, whether it's  
12 buried in the mass of febrile illnesses in  
13 Africa, or there's a resistance in the  
14 population that's unknown. So we really don't  
15 know what the risk would be of us North  
16 Americans traversing into that area. There  
17 may in fact be a dengue risk there as well.

18 Just a closer-up picture of the real  
19 hot zone, which is Asia for dengue. Then  
20 briefly, the enteric pathogens we often forget  
21 about. These are not often a source of  
22 mortality, but are significant morbidity. A  
23 lot of epi studies in deployed forces

1 routinely show 30 percent per month attack  
2 rates for traveler's diarrhea, if you will.

3 The pathogens we focus most on, in  
4 terms of developing vaccines, are ETEC,  
5 Shigella and campylobacter. There's some  
6 description here. They're variable in their  
7 prevalence around the world. So it's a  
8 challenging target, because there are other  
9 pathogens besides those three.

10 But the conclusion of our analysis,  
11 in terms of which is the biggest bang for your  
12 buck, is if we could prevent those three  
13 pathogens, we would achieve probably 80 or 85  
14 percent reduction, certainly among the more  
15 serious cases of diarrhea and dysentery in  
16 populations.

17 This is real and current. If you  
18 look at these, this report, which was  
19 published in 2008, coming out of OIF and OEF  
20 again, it's not a mortality disease, but it's  
21 a grinding morbidity that affects combat  
22 effectiveness, and you can see really some of  
23 the staggering numbers. Out of two million

1 deployments, 3.8 million cases of diarrhea.  
2 Diarrhea days, 850,000 visits to Medical,  
3 17,000 hospitalizations and over a million  
4 lost duty days, essentially due to diarrhea,  
5 that we're unable to completely control. With  
6 our excellent field public health and  
7 preventive measures, it's just not quite  
8 sufficient.

9 All right. So I'll give you the  
10 highlights of the three big problem set. This  
11 is the solution set that we work on. Our  
12 program invests most heavily in vaccines,  
13 thinking prevention is the best thing you can  
14 do with the money that you have. In the area  
15 of drugs, which is really directed at malaria,  
16 and leishmaniasis, again we heavily focus more  
17 on preventive therapies, but sometimes direct  
18 therapy when prevention is not possible.

19 We work on diagnostics, specifically  
20 for the deployed setting. So at Role 3 or  
21 below, their ability to make a clinical  
22 diagnosis of one of these pathogens, and then  
23 we also work in vector control products.

1 Reduce the risk of exposure, at least to the  
2 vector-borne infectious diseases.

3           We have two main funding streams.  
4 What I call the Legacy Program, that's been  
5 around for decades, is Army funding, and these  
6 are the problem sets, which have dedicated to  
7 the Army funding dollars here that I've  
8 described. We also since FY '10 have had some  
9 funding from the Defense Health Program  
10 Enhancement, which has been focused primarily  
11 on new problems that have emerged out of OIF  
12 and OEF.

13           So you see here work related to the  
14 rapid screening of blood for field  
15 transfusions, wound infection-related research  
16 that's funded here, some additional work on  
17 diagnostics. A very, really a tech watch  
18 essentially in respiratory disease. Another  
19 way to sort of depict the portfolio, looking  
20 at costs, are points of use for the different  
21 countermeasures.

22           We work in prevention here, pre-  
23 exposure and pre-deployment, and if you work

1 your way down, these things which are in green  
2 are the Army-funded program, and in the field  
3 interventions you see here, as you change to  
4 red, these are the Defense Health Program  
5 Enhancement-funded activities, which focus  
6 again, field and then definitive care, which  
7 was an area we've really not been working much  
8 in before. I've largely been focused in the  
9 vaccine work of prevention.

10 All right. I'm not going to go  
11 through these. I wanted to give you a sense  
12 of what kind of dollars that are being  
13 invested in these programs. The one thing I  
14 would point out as a commentary is the amount  
15 of dollars that we invest, and these would be  
16 61 through 63 for each year.

17 So that's from discovery to early  
18 development, before we pass it on to advanced  
19 development, are significantly less than what  
20 industry would put on a similar problem.  
21 These are the Defense Health Program funds.  
22 So you can get an idea for that.

23 Now although there are some

1 differences in the management of both the Army  
2 and the Defense Health Program funds, these  
3 are the commonalities, which is that we  
4 execute our programs. We do it through  
5 steering committees, which are composed of our  
6 subject matter experts and our lab, but also  
7 external, as appropriate; stakeholders, like  
8 from the requirements-writing community.

9         Those groups develop the near, mid-  
10 term and long-term goals and objectives for  
11 the acquisition of a product. All of the  
12 funds themselves in each year are allocated  
13 based on peer review processes. PIs write  
14 proposals; they're reviewed both externally by  
15 panels, as well as our internal review, and  
16 that's how we award money each year.

17         To keep all of that on track, in  
18 terms of, as industry does, to actually  
19 working towards a product, we have strategic  
20 reviews of each of our programs every three  
21 years, where we bring in an additional panel  
22 that has a lot of representation, for example,  
23 from industry, and ask them to look at our

1 mid-term and long-term goals. Is this  
2 consistent with how industry, you know, best  
3 practices to approaching developing a product  
4 that will make it through FDA licensure?

5           Honestly, this process that we've  
6 had now, going back many decades, has been  
7 very successful. So what I show you here is  
8 what I sometimes call the "Glory Board," on  
9 both our success and our current activities,  
10 and this column of the fielded products. So  
11 these are in fact the FDA-approved products  
12 that have been developed through MIDRP.

13           Across here, these are anti-  
14 parasitic drugs, so primarily malaria is here.  
15 What you see in this box of fielded products  
16 are all of the FDA-approved anti-malarials,  
17 all of them. It is only the DoD investment  
18 that is developing drugs for malaria. There's  
19 no commercial market or significant commercial  
20 interest that would take on specifically for a  
21 prophylactic indication.

22           Another area of great success has  
23 been in our vaccines, and here you see a

1 number of the force health protection vaccines  
2 which are in use. I think this represents  
3 something like 30 or 40 percent of all of the  
4 FDA-approved vaccines for adults. So again,  
5 the DoD contribution has been significant  
6 overall to actually developing important force  
7 health protection products that would not be  
8 developed otherwise, because they generally  
9 lack a commercial market in the U.S.

10 We have, of course, diagnostics as  
11 well, vector control products. The ones which  
12 are highlighted in red are those which were  
13 just approved by the regulatory authority in  
14 this last year. So it's continuing to be  
15 active and actively successful.

16 So what makes us unique? Why can't  
17 we just be replaced by industry, by academia,  
18 by not-for-profits like the Gates Foundation?  
19 I get that question. We don't need to be  
20 doing this. The Gates Foundation is doing  
21 this. Well, they're not doing the same thing  
22 that we're doing. We have that eye on the  
23 target, which is that FDA approval, but for an

1 adult indication.

2 Those of the products which are  
3 being pursued by certainly non-profits and  
4 industry as well, as I'll elaborate on later,  
5 are for pediatric indication. To get the FDA  
6 approval for use in our soldiers, that same  
7 product has to be tested, demonstrated to be  
8 safe and efficacious in adults. That's the  
9 piece that we have to do and that we lead,  
10 even if there's also a companion pediatric  
11 indication and market.

12 So organization of the Medical  
13 Research and Materiel Command was organized in  
14 these efforts much like a pharmaceutical  
15 company. In terms of best practices, we have  
16 processes, something called Decision Gate,  
17 which again helps us shepherd products along  
18 and have that transfer from tech base into  
19 advanced development.

20 I think particularly important is  
21 that our core interest research program is  
22 actually embedded in military labs with  
23 uniformed researchers. So that the

1 researchers are wearing the same uniform as  
2 the individuals that they are protecting.  
3 They understand. They know what the problem  
4 set is, they know what the issues are.

5 We have a disciplined and mission  
6 focus to what we do, and we have this  
7 tremendous asset, which is our overseas  
8 research labs. Now there was recently a  
9 report published by the Center for Strategic  
10 and International Studies on the overseas  
11 labs. I don't know how many of you are aware  
12 of that, but I highly recommend that you get a  
13 copy. I'll be happy to send you a copy of the  
14 link on the website.

15 It was an independent study, not  
16 commissioned, to look at the role of the  
17 overseas labs, and I think it's very frank and  
18 honest, both in describing the tremendous  
19 asset they are to the nation, as well as the  
20 challenges that they also face in continuing  
21 to function essentially as the public health  
22 labs and the product developers for the  
23 products that we need, from a global

1 perspective.

2 I have some slides in there which is  
3 just highlighting one of the labs, just to  
4 give you a flavor for what they're like, in  
5 terms of not being really a single entity, but  
6 being a hub of activity in the region. So the  
7 Thailand lab is really the hub for research in  
8 Southeast Asia, and tremendous benefit.

9 It was because of this lab in  
10 particular and this particular community in  
11 which we've worked for decades now, that we  
12 were able to get the licensure of these  
13 important force health protection products.

14 You may be aware of the HIV vaccine  
15 trial that concluded about two years ago,  
16 which has really changed the whole field of  
17 HIV vaccine research. Done by the Army.  
18 Showed that limited, but success. The  
19 protection is possible. Again, it's been a  
20 game-changer in the field, and is part of  
21 really a network of our whole HIV vaccine  
22 program, and being able to conduct studies in  
23 various regions of the world, where the HIV

1 virus itself is quite different.

2 Now as highlighted in that Center  
3 for Strategic and International Studies  
4 report, there's a tremendous byproduct, if you  
5 will, of the work that is fundamentally  
6 focused on force health protection products.  
7 But as a result of what is done at those labs,  
8 we have tremendous global public health  
9 benefits.

10 These vaccines are not only used by  
11 us, but I can tell you the JE vaccine is a  
12 routine pediatric immunization for children  
13 living in endemic countries. As is Hepatitis  
14 A. We've all received that. Our children now  
15 all receive that. It was developed through  
16 this program.

17 Also, of course, there is capacity-  
18 building in the countries that we work.  
19 There's really a small corps of uniformed  
20 researchers, and are largely, most of the  
21 scientists there, are local nationals. So  
22 tremendous benefit to those local national  
23 partners, in terms of employment and

1 education, and of course, medical diplomacy.

2 All right. So now I've told you all  
3 the good stuff. Now come the problem set that  
4 we have. I've been at this job for about two  
5 years, and as I've tried to understand,  
6 certainly be very proud of what we've  
7 accomplished, but also look to the future and  
8 understand where our biggest challenge is.

9 These are the things that I've come  
10 up with. There's three of them I'm going to  
11 talk about in more detail. But just to lay  
12 them all out for you, to begin with, the first  
13 I've called changes in external partner  
14 dynamics, making it increasingly difficult to  
15 develop force health protection products in  
16 the future. I promise I'll explain that.  
17 It's enigmatic.

18 The second on the list is funding,  
19 which has essentially been shrinking over  
20 time, and I'm going to lay out a couple of the  
21 very specific ramifications of these  
22 constraints in funding. And thirdly is a  
23 topic entitled endangerment of the force

1 health protection mission, due to parallel and  
2 uncoordinated investments, coming from the  
3 chem biodefense community and their broadened  
4 scope into emerging infectious disease.

5           So to take each of those on in a  
6 little bit more detail, so as I've alluded to,  
7 we've been successful in the past because we  
8 partner with industry. We don't take products  
9 all the way to market, and certainly don't  
10 sustain them in market. We hope to be a  
11 consumer, DoD, and buy them, just as everyone  
12 else does.

13           That's been a very successful  
14 paradigm, even for products for which there's  
15 a limited market in the U.S. Part of the  
16 reason for that historically was the U.S. FDA  
17 was the only game in town. For any company  
18 who wanted to develop a product, it was  
19 logical to develop it and have it licensed  
20 through the FDA, even if they were going to go  
21 on and commercialize that outside of the U.S.  
22 Japanese encephalitis vaccine is a perfect  
23 example.

1           We get what we need, because we have  
2 to use products which are approved by the FDA,  
3 and the company eventually gets what it needs.  
4 So over the last couple of decades, there's  
5 been a change in that dynamic, in which  
6 industry has started to recalculate the cost  
7 and the benefit, and found that they had  
8 increasingly little interest in the pathogens  
9 that we care about, that there was little to  
10 no profit margins after development.

11           Both costs have gone up, in terms of  
12 the cost of developing, as well as kind of  
13 hindrances, as they see it, to development as  
14 occurred with the Helsinki Declaration, which  
15 essentially creates an ethical standard in  
16 which a company, GlaxoSmithKline, conducts a  
17 clinical trial in a resource-poor country  
18 where the problem is present, and then has to  
19 provide that product at costs affordable to  
20 that country.

21           So no profit margin; in fact, large  
22 losses. So as this was evolving over the last  
23 couple of decades, companies began to pull

1 away from these kinds of product development  
2 efforts. Enter the not-for-profits. The not-  
3 for-profits saw this happening, and said this  
4 is now we can help keep industry in the game.

5           So we now have very large  
6 investments from organizations like the Gates  
7 Foundation, Wellcome Trust. Of course, multi-  
8 lateral groups like GAVI, which helps to keep  
9 products in the marketplace, and what they're  
10 all doing is providing resources, to  
11 essentially change the equation for industry,  
12 keep them in the game, keep it viable that  
13 they could have some high volume, low profit  
14 margin, but still be successful.

15           So how is this a problem? Well the  
16 problem, as I indicated, is that what the not-  
17 for-profits and now industry is seeking,  
18 exclusive to us, is pediatric indications,  
19 because that's the commercial market for  
20 dengue, for malaria in endemic countries, are  
21 pediatric vaccines.

22           There have emerged in the last  
23 decade regulatory authorities outside of the

1 U.S. Not just Europe, but Brazil, Singapore.  
2 If you look, I have the BRIC countries in  
3 particular, if you're familiar with that term,  
4 Brazil, Russia, India, China. This is not a  
5 theoretical. I've laid out here a very  
6 specific example we're in the midst of right  
7 now, which is in our dengue vaccine  
8 development.

9 We're partnering with a company that  
10 has a vaccine in Phase 3 clinical trial. We  
11 are providing some resources, including our  
12 clinical research sites overseas to conduct  
13 trials, and at this point in time we have no  
14 promise from industry, none, that they will in  
15 fact bring that product back to the FDA.

16 We have so little leverage in the  
17 dynamic that all we can do is basically hope  
18 and pray, which is not, I think, a great  
19 strategy for DoD, to assure that it in fact  
20 has the force health protection products for  
21 its forces.

22 Furthermore, if they are successful  
23 and this vaccine works and they don't bring it

1 back to the FDA, which is I think highly  
2 probable, our adversaries or other countries  
3 around the world will have access to that  
4 dengue vaccine, while we do not.

5 So I fear that this is a dynamic  
6 which is going to increasingly occur, just as  
7 it is right now for dengue, with our other  
8 dengue vaccines in the future, with malaria  
9 products, because of this structural change.  
10 So, how do we combat that? Well, I'm going to  
11 move on to the funding slides, because this is  
12 fundamentally one of the problems.

13 Our best leverage when we partner  
14 with industry is when we have the IP, and we  
15 license essentially the technology to  
16 industry, as we did with the Hepatitis A  
17 vaccine, the Japanese encephalitis vaccine.  
18 It's another reason they have to go to the FDA  
19 first, or in a timely manner, is we make it  
20 part of the agreement.

21 When we don't have the IP, when  
22 we're in a purely assist role in this current  
23 dynamic, we don't have the influence that we

1 once had. So how is our funding looking in  
2 terms of generating IP, the leverage that we  
3 need to work in this arena? Well, it's not  
4 looking so good.

5 What I've shown you here is with a  
6 2,000-year baseline, if our funding in these  
7 product development areas have kept up purely  
8 with the biomedical inflation rate, the rate  
9 that's used by the NIH, this would be our  
10 funding over this last decade. But in fact  
11 this is what our actual funding is.

12 This is '11, the year we're in now.  
13 This is the projection from '12, '13, '14. So  
14 those are all quite notional, because in fact  
15 there are no Congressional appropriations for  
16 those years yet, and everything that's on the  
17 horizon says cuts, cuts, cuts.

18 So we're in that precarious and  
19 certainly not improving position, to be in the  
20 power position in terms of our dynamics with  
21 industry, in developing these products in the  
22 future. This bottom curve is the HIV vaccine  
23 program, which has its own funding lines, and

1 really is in a similar sort of flatline  
2 situation.

3 Another way that funding impairs us  
4 is in just a narrow pipeline in general. So  
5 this graphic I show to you here actually comes  
6 from industry. It was done by industry, to  
7 sort of lay out how they view product  
8 development. It's kind of a nifty graph. You  
9 look across the top, it has the phases of  
10 product development here.

11 Down here we have the typical time  
12 industry expects to spend at each phase of  
13 development. Here you have the industry  
14 estimates of how much money they would need to  
15 put aside to support each of those efforts,  
16 and down here, the probability of success to  
17 licensure, which of course is generally low.  
18 Developing products, particularly vaccines and  
19 drugs, is a high risk business.

20 Across the middle here you have this  
21 notional idea that when you're in the  
22 discovery phase, you have a bunch of ideas,  
23 some of which will prove to work and go all

1 the way to licensure, and some of which will  
2 die somewhere along the path. The red ones  
3 are the winners; the blue ones are the losers.

4           Unfortunately, you don't know which  
5 is red and blue. You create a pipeline to  
6 test ideas and have these kind of milestones,  
7 these down selections, where you decide which  
8 looks the best to move on, and then move on.  
9 Because you can see, it's increasingly costly  
10 as you move on.

11           So this is how industry models  
12 product development. What happens when you  
13 significantly cut a budget, this is supposed  
14 to be -- there it goes -- say in half, is you  
15 limit your pipeline. You can only bring fewer  
16 things forward. It's very logical.

17           The problem is if you end up on this  
18 top half, in terms of your down selections,  
19 you get pretty far along before you discover  
20 the thing you have is a loser, and you've got  
21 to go much farther back.

22           So what does this do? Do you get  
23 there eventually? Yes. But it takes much

1 longer. Industry has worked this out. They  
2 understand the kinds of investments you need  
3 to make, so that you can in a timely manner  
4 get to the conclusion that you need, and then  
5 move on to another problem.

6 Well, we spend a long time in the do  
7 loop, because with the funds that we have, we  
8 have very few things that we can put emphasis  
9 on and move forward in an expeditious way.

10 Also with our funding constraints  
11 comes a lack of responsiveness to new threats  
12 or returning threats. A great example is what  
13 happened with leishmaniasis. So leishmaniasis  
14 is kind of an exotic infection, but one we had  
15 significant problems with in the first Gulf  
16 War. It's native, endemic in a lot of desert  
17 areas.

18 But because of funding constraints,  
19 something had to be cut in 2000-2001, and  
20 leishmaniasis, people forgot about, said let's  
21 cut that one. Well, we also know what else  
22 happened in 2001. We went back to the desert,  
23 and within a few years, we had several

1 thousand cases of cutaneous leishmaniasis. In  
2 2004, we're told to stand back up that  
3 leishmaniasis program. Again, we never wanted  
4 to cut it. It was just something that what  
5 can you do?

6 Well, it was stood up with no  
7 additional funding. It's been very effective.  
8 Two licensed diagnostics for leishmaniasis,  
9 the only FDA-approved, the only approved  
10 diagnostics in the world for leishmaniasis  
11 have come out of this program, and we're in  
12 the midst of clinical testing of topical  
13 treatments.

14 So we can do it. It's very  
15 inefficient, and again, when you have to  
16 close, dismantle things and then restart them  
17 a few years later, I'm sure, for those of you  
18 who've been engaged in science, you know this  
19 is very challenging and again inefficient.

20 All right. So those are my funding  
21 woes that I worry about. These are the things  
22 that keep me up at night, by the way. This  
23 last one is a complex one also, and again,

1 I've sort of entitled it endangerment of the  
2 force health protection mission due to these  
3 parallel investments that have emerged in the  
4 last two years from the chem biodefense  
5 program.

6 Let me take you through this. I  
7 previously alluded to the fact that the Army  
8 is the lead agent for programming and  
9 budgeting infectious disease, naturally-  
10 occurring infectious disease research. They  
11 had also been the lead agent for biowarfare  
12 until a public law was passed a couple of  
13 decades ago, which separately established a  
14 chem biodefense program.

15 The law was pretty clear in putting  
16 it in a law. It says what's in the chem  
17 biodefense program shall not be in the  
18 naturally-occurring infectious disease  
19 program, and that has existed and been in  
20 place now for some time.

21 What's changed here -- oh, I should  
22 mention that that program has traditionally  
23 focused on both threat reduction with regards

1 to WMDs, as well as development of  
2 countermeasures. So force health protection  
3 measures for the troops as countermeasures to  
4 specifically biowarfare agents.

5 So what changed in 2009 is a  
6 broadening of the scope essentially, that came  
7 from the lead office for the Chem Biodefense  
8 Program, that sent out a memo to the  
9 Secretaries of the departments and said  
10 emerging infectious diseases are now part of  
11 the chem biodefense mission.

12 Following that, there were attempts  
13 to use chem biodefense dollars, specifically  
14 to fund the addition of these assays targeting  
15 these pathogens, which were relevant at the  
16 time, onto the chem biodefense diagnostic  
17 platform, which is called the JBATES  
18 (phonetic).

19 Those were blocked, largely because  
20 lawyers looked at it and said the public law  
21 says you can't use chem biodefense dollars for  
22 non-biowarfare pathogens. These, while  
23 relevant and important pathogens, are not

1 biowarfare agents. They're acts of nature,  
2 not of malicious intent by man.

3           Since that time, there has been in  
4 the Congressional appropriation language,  
5 beginning in FY '11, within the chem  
6 biodefense appropriation emerging infectious  
7 disease has come into their language as  
8 something within their program. I'm told that  
9 the draft for FY '12 includes that as well.

10           Well, what is an emerging infectious  
11 disease? I'm an ID doc here to tell you that  
12 it can be a lot of things. Most people would  
13 classify it possibly as like SARS, a  
14 surprising event, a new, novel pathogen. But  
15 others would consider pandemics, though  
16 they're not a surprise that there is a  
17 pandemic, only you'd never know exactly when  
18 or where that's going to happen.

19           But there certainly are folks who  
20 would consider Chikungunya and dengue as  
21 emerging pathogens, because their prevalence  
22 is changing. It's a dynamic process. Most  
23 would not consider man-made bioengineered, but

1 maybe. That's a potentially emerging  
2 pathogen.

3 The problem is it lacks a  
4 definition, and therefore it becomes unclear.  
5 What is in the chem biodefense program now,  
6 relative to what's in the Military Infectious  
7 Disease Research Program, since we know they  
8 can't co-exist? You can't have them in both  
9 places.

10 The chem biodefense program, in sort  
11 of moving from a countermeasure focus on  
12 biowarfare agents into EID, is actually  
13 pursuing influenza therapeutics, to the tune  
14 of about 200 billion. There's an RFP going on  
15 right now. I have subject matter experts from  
16 our labs who are helping them. I mean, we're  
17 reaching out and trying to interact and say  
18 what is this that you're doing? Yes, we'll  
19 help, but it becomes very murky and unclear as  
20 to how a therapeutic focused on H1N1 is a  
21 biowarfare countermeasure, particularly when  
22 it's a therapeutic.

23 It again seems questionable as to

1 its force health protection value. It's not a  
2 prophylactic, it's not a vaccine. It's  
3 something after the soldier, sailor, or airman  
4 has been removed from the battlefield and is  
5 in a hospital, that you would use. So it's  
6 very murky and unclear.

7 I would say with regard to the  
8 threat reduction activities, there's a similar  
9 murkiness in that they're now pursuing not  
10 just threat reduction, in terms of traditional  
11 agents, but EID, whatever that is, with a big  
12 emphasis in biosurveillance. The CSIS report  
13 takes some time to describe how this is  
14 bearing out as a problem for our overseas  
15 labs, in taking on a threat reduction, perhaps  
16 even intelligence collection mission, from  
17 what these labs have done, which is  
18 traditional public health labs.

19 So I think the net result of all of  
20 that is a concern about this blurring of  
21 programmatic lines, what's in their program,  
22 what's in our program, a risk of duplication  
23 of effort. I guess at the bottom of my

1 concern is both the loss of focus, in terms of  
2 being focused on force health protection as  
3 opposed to homeland defense or other important  
4 things, but not inherently force health  
5 protection things.

6 Frankly, the loss of funding for  
7 what we consider are the top pathogens, in  
8 terms of their force health protection threat.  
9 So, I think that's my last slide, and I'll  
10 leave that there, and happy to entertain  
11 discussion or questions, and hope you can help  
12 in some way me resolve these issues or  
13 challenges that I think are significant.

14 CHAIR DICKEY: Wow. That's a lot of  
15 information. Are there questions or comments  
16 for the Colonel? Yes, Dr. Jenkins.

17 DR. JENKINS: Two questions, Don  
18 Jenkins here. One is there any joint activity  
19 between your group and the program office,  
20 looking into nucleic acid, testing rapid  
21 nucleic acid, testing for dengue as it is  
22 endemic on the Texas border? There's cases,  
23 you know, that are being brought back from

1 deployment, in terms of screening the blood  
2 supply, the way it's been done in the past for  
3 other emerging diseases.

4 The second question has to do with  
5 wound and mucor. There seems to be a dramatic  
6 uptick in the amount of mucor being seen in  
7 the wounds in the last 120 days in-theater.  
8 Is that something that your group is aware of  
9 and is working on?

10 COL LYNCH: Yes, so the dengue  
11 question first. So the diagnostics, the space  
12 that we work in is for field diagnostics, Rule  
13 3 and below. The limitations that we have, in  
14 terms of fielding assays to that level is that  
15 if they're nucleic acid testing, right now  
16 they have to be on the JBATES system.

17 So we are actively right now  
18 working, or fairly advanced in working on a  
19 dengue diagnostic assay, that's nucleic acid  
20 testing, that is for the JBATES platform, and  
21 that's what would seek FDA approval. We do  
22 have rapid dengue tests also actually in the  
23 definitive clinical studies right now, which

1 are immunochromatographic tests.

2 But again, they are for the  
3 indication of diagnostics, which is a little  
4 different than blood screening. The blood  
5 screening that we're working on is  
6 specifically for HIV, Hepatitis B and  
7 Hepatitis C, again for Rule 3 and below, in  
8 particular below, because the real deficiency  
9 is in those walking blood banks at forward  
10 fast teams, which are outside of the cache,  
11 where they don't have any really kind of lab.

12 So they really need some low  
13 complexity tests that can be done, to make the  
14 blood supply at that level safer than it is  
15 today. But again the focus right now has just  
16 been on those HIV, Hepatitis B and C.

17 DR. JENKINS: And that goes  
18 specifically to my concern, is dengue can be  
19 such an innocuous disease when first  
20 contracted, as to go unnoticed. Who's not  
21 tired and achy, as Monty and I were talking  
22 about earlier, when you're in a deployed  
23 setting? There's a window before the big

1 symptoms develop. Surely, you could be  
2 transmitting this in that setting.

3 It caused me, you know, significant  
4 concern. It should be one of the things that  
5 we're actively engaged in.

6 COL LYNCH: No, that's a good point,  
7 and it is something that I'm going to address  
8 with the blood safety scientists, who work as  
9 part of the blood, those other assays. I'm  
10 going to bring it up to them as to how much  
11 consideration they've given for the risk  
12 that's posed by dengue in blood.

13 Your second question was about wound  
14 infections. I don't have time to go into  
15 details. I'd be happy to come back and talk  
16 about the wound infection research in  
17 particular. It's received considerable  
18 funding since FY '10. We had about \$30  
19 million in FY '10, and we have about \$30  
20 million in FY '11.

21 It's both an intramural and  
22 extramural activity, you know. At least it's  
23 the one program, unlike the Army funding,

1 which is all intramural. The DHP funding, we  
2 do both extramural solicitations. So we have  
3 a broad portfolio right now, that includes  
4 biotechnology groups, universities, as well as  
5 our intramural labs.

6 We are very cognizant of the change  
7 in the epidemiology, which is moving now with  
8 more combat actions in Afghanistan, where the  
9 terrain, frankly it's a different environment,  
10 and we're seeing more fungal infections in the  
11 wounds. So there's a pretty active concern  
12 and shift in all of our announcements now,  
13 specific to include the development of drugs  
14 and wound infection management tools for  
15 invasive fungal infections. Not Candida, but  
16 invasive fungal infections as the molds.

17 CHAIR DICKEY: Dr. Carmona.

18 DR. CARMONA: Rich Carmona.  
19 Colonel, thanks for the outstanding  
20 presentation. A couple of questions also.  
21 You recall a number of years ago we started  
22 running into problems with vaccines, and we  
23 had talked with the Hill about the so-called

1 GOCO end that the government owned, and taking  
2 over some of these processes.

3 Of course, this is probably the  
4 worst time financially, economically for these  
5 challenges to happen, when everybody's budget  
6 is being cut. My question in this regard is  
7 what are you hearing from your legislative  
8 liaisons on the Hill, for the willingness to  
9 engage in this particular area?

10 Because what we're seeing, not just  
11 in infectious disease or emerging infectious  
12 diseases, but as you know in oncology and some  
13 of the other areas, if the patents run out or  
14 if there's not a projection that significant  
15 monetary gain can be made from going into the  
16 area, the drug companies are moving away from  
17 all of those things, and yet there's still a  
18 great need for the nation.

19 I know when I used to argue these  
20 things, I found that it is very difficult to  
21 argue on substantive scientific discussion in  
22 a very political environment. Often, you have  
23 to raise this to the level of a national

1 security issue, to get some traction  
2 sometimes.

3 So I'm wondering your thoughts in  
4 that area, and second, how is the  
5 collaboration going with CDC and NIH on some  
6 of these projects?

7 COL LYNCH: To your first question  
8 or comment about broader government  
9 activities, and trying to sort of  
10 countermovement of industry away from a lot of  
11 things that we're interested in, there's a big  
12 program actually that's multi-agency, the  
13 Medical Countermeasure Initiative, which is in  
14 fact seeking to stand up manufacturing  
15 capabilities for, I think, in '10, to try to  
16 fill a hole, where industry doesn't really  
17 want to step in, where we've got products  
18 broadly that the population needs or the DoD  
19 needs, in which it's difficult to engage  
20 industry.

21 Having said that, we are aware of  
22 it. We're not deeply engaged in it. It's  
23 still, I think, as we tried to look at how

1 could this help us, is still kind of  
2 problematic, because as opposed to  
3 manufacturing and stockpiling, I'm not sure  
4 that dynamic works for everything.

5 So I think there may be a solution  
6 in there. But we're certainly not there yet,  
7 as to figuring out exactly how would that  
8 work, that we would be able to sustain malaria  
9 vaccine or sustain the dengue vaccine of the  
10 future through that mechanism. It's certainly  
11 a huge government investment, and we've got to  
12 look at it better, to how we could actually  
13 make that work.

14 Your second question, I'm sorry  
15 remind me, was about?

16 DR. CARMONA: Collaboration with CDC  
17 and NIH.

18 COL LYNCH: Yes. The Walter Reed  
19 Institute of Research and Navy Medical  
20 Research Center have over 300 CRADAs,  
21 Collaborative Research and Development  
22 Agreements. They're broadly networked with  
23 anyone and everyone who has something to bring

1 to the table, whether it's biotechnology  
2 companies, you know, again industry certainly,  
3 academia, other groups like the CDC.

4 So I think where appropriate, we  
5 don't have a lot of barriers. Our scientists  
6 are very willing to say, "Come talk to us.  
7 What are you working on? How can we help  
8 you," because what we often bring to that is a  
9 real product development focus, which the CDC  
10 and NIH don't necessarily have.

11 So I think we're broadly integrated.  
12 Those are not barriers that are substantial.

13 CHAIR DICKEY: Thank you.  
14 Additional questions or comments?

15 (No response.)

16 CHAIR DICKEY: Well, we thank you  
17 for that excellent brief, and I feel sure we  
18 will find an opportunity to have you come back  
19 and either go into some detail on some of the  
20 subsets, or simply update us. I appreciate it  
21 very much.

22 COL LYNCH: I would be happy to,  
23 thank you.

1 Information Brief: Department of Defense  
2 Institutional Review Boards

3 CHAIR DICKEY: Our next speaker is  
4 Ms. Caroline Miner. Ms. Miner is the program  
5 manager for the Research Regulatory Oversight  
6 Office for the Office of the Under Secretary  
7 of Defense for Personnel and Readiness.

8 As the R202 program manager, she is  
9 responsible for developing, implementing,  
10 maintaining, and providing leadership and  
11 oversight for the Human Research Protection  
12 Program, the Animal Care and Use Program, and  
13 the Research Integrity and Misconduct Program  
14 for all organizations under the purview of  
15 Personnel and Readiness, including Health  
16 Affairs, Reserve Affairs, DoD's K through 12  
17 school system and numerous personnel policy  
18 offices, and in your spare time, right?

19 Ms. Miner is going to present an  
20 informational brief regarding the  
21 Institutional Review Boards for the DoD, and  
22 her slides are found under Tab 10. Thank you  
23 for being here, Ms. Miner.

1 MS. MINER: Thank you very much for  
2 the invitation. I'm actually very excited  
3 about this. As you've already mentioned, my  
4 name is Caroline Miner, and I am the program  
5 manager for the Research Regulatory Oversight  
6 Office, for all of the Undersecretary of  
7 Defense for Personnel Readiness. So I would  
8 like to spend a couple of minutes defining the  
9 scope of that and also the limitations of the  
10 scope, so that you understand what I'm  
11 responsible for and what I'm not responsible  
12 for.

13 So all of Research Regulatory  
14 Oversight, oh there it is, is under the  
15 purview of the Under Secretary for  
16 Acquisitions, Technology and Logistics, and  
17 the action office for AT&L is the ASD. It's  
18 the Assistant Secretary of Defense for  
19 Research and Engineering.

20 For those of you who are perhaps  
21 were around longer, the ASD B

22 PARTICIPANT: Old. The word is  
23 "old."

1 (Laughter.)

2 MS. MINER: The ASDRE used to be  
3 known as the Director of Defense Research and  
4 Engineering, so the title has recently  
5 changed. Now in 2005, AT&L reorganized the  
6 way they do their research regulatory  
7 oversight, and what they said is that each of  
8 the large components, Army, Navy, Air Force  
9 and P&R, needed to have their own oversight  
10 structure.

11 So they set up programs where Army,  
12 and the proponents for each of those programs,  
13 for each of the services, are the Surgeons  
14 General. For P&R, P&R says you may delegate  
15 this program down two levels. So the Under  
16 Secretary then was -- I've just forgotten his  
17 name -- Dr. Chu, thank you. He said okay, I'm  
18 going to delegate this to the DASD for Force  
19 Health Protection and Readiness. So that has  
20 been our location ever since.

21 So as you can see, in 2005, they  
22 implemented this new oversight structure, and  
23 it has really made a major improvement in the

1 way we conduct our oversight. However, you  
2 can also see, and as we'll talk about in a  
3 minute, we do have some problems within the  
4 regulatory arena, and one of the problems is  
5 that we're very stovepiped.

6 So Army has a program, Navy has a  
7 program, Air Force has a program, P&R has a  
8 program, and those programs, for the most  
9 part, don't really work together.

10 Okay. Now you invited me here to  
11 tell you about the IRB system. The IRB is  
12 simply, and most of you are probably in the  
13 field, IRB is -- whoops, wrong one -- is just  
14 one part of what we call the Human Research  
15 Protection Program. So the IRB is the group  
16 that does, is required by regulation to do the  
17 reviews of the research.

18 But the program itself is much  
19 broader, and we think of it as an integrated  
20 process for all the elements of an  
21 institution, supporting or conducting  
22 research, work together to make sure we're  
23 protecting the rights of our subjects.

1           And just as an example of the types  
2 of things we do within the Human Research  
3 Protection Program, it includes our QA and QI  
4 processes, a lot of training, just our  
5 institutional commitment to research  
6 integrity. I'm also the research misconduct  
7 and integrity officer, the communication and  
8 coordination, and we also spend a lot of time  
9 working on policies and procedures.

10           To give you an idea of the scope of  
11 the research that's going on within the  
12 Defense Department, this is just -- we had a  
13 data call earlier this year to put together  
14 all, a listing of all of the open human  
15 subjects protocols from FY '10, and so  
16 intramural, I think all of you know, that just  
17 means the stuff that we're conducting  
18 ourselves. Extramural is the research that  
19 we're paying somebody else to do for us.

20           You can see we have an incredibly  
21 large research portfolio. So intramural, DoD  
22 research. This is exempt versus non-exempt.  
23 The exempt are the ones that meet certain

1 regulatory criteria for very -- so they don't  
2 have to go the IRB for review. The non-exempt  
3 don't meet those criteria.

4 You can see that we have over 4,000  
5 non-exempt protocols and 1,000 exempt  
6 protocols intramurally being conducted within  
7 the DoD and almost 3,000 that we're funding  
8 outside. So it's a very large, I mean we have  
9 a very large program.

10 Now I wanted to spend the majority  
11 of the time talking about some of the  
12 initiatives that we are focusing on right now,  
13 in terms of, as I said, we know that there are  
14 some issues with the regulatory oversight  
15 structure.

16 So first of all, we're very  
17 stovepiped, and this causes problems in terms  
18 of if I'm a researcher and I'm working at a  
19 Navy site, an Army site, and an Air Force  
20 site, I have to go through -- not only do I  
21 have to go through each of those local sites'  
22 IRBs, but I also have to go through the Army  
23 system, the Navy system, the Air Force system.

1           So I can potentially have six or  
2 eight or twelve review systems that I have to  
3 go through, whereas if I was a non-DoD  
4 performer, I might only have maybe three. So  
5 that's a big issue for us. We also have a lot  
6 of DoD unique requirements. So Congress loves  
7 us. They like to give us extra rules. Some  
8 of them we deserved, but sometimes we don't.

9           Nevertheless, we do have additional  
10 DoD requirements, and we have a very unique  
11 environment. As you just saw in the previous  
12 presentation, that means that we're doing  
13 things that aren't really done elsewhere.

14           We also have component unique  
15 requirements. Now this we did ourselves. So  
16 as I said, you know, Army, Navy, Air Force,  
17 they each have their own process. That means  
18 that each has the authority to write their own  
19 requirements and they do.

20           Then the other issue is we have our  
21 compliance oversight, and this was written  
22 this way in the regulation. It is very  
23 institution-centric. The reason it was

1 written that way is because everybody wants  
2 the institution where the patient population  
3 or the subject population is at, everyone  
4 believes that that institution should have the  
5 final say in how the people at their  
6 institution are involved in research or not.

7 I mean, ethically and all other  
8 reasons, that's a very, very good, logical,  
9 sound argument, but it does make it difficult  
10 when you have very institution-specific  
11 requirements, to then conduct non-institution  
12 specific research.

13 Okay. However, as I said, we do  
14 recognize that we have problems, and we have  
15 been taking steps to try to address some of  
16 our problems. In the past, the past being the  
17 last three years, we have across the DoD we  
18 have harmonized -- oops, wrong button again --  
19 we have harmonized what are called our  
20 assurances.

21 So these are the formal contracts  
22 between the institutions and leadership  
23 basically, that say we will -- if you give us

1 money to spend on research, we promise that  
2 we'll follow the rules. So we now across the  
3 DoD all use this one document. That doesn't  
4 sound like much, but believe it or not, it  
5 took us a long time to come up with that one  
6 document.

7 We are also all across the  
8 Department now all use the same institutional  
9 agreement for IRB review. Again, it probably  
10 doesn't sound like much, but it was very -- it  
11 took us a while. We also have common  
12 requirements for training. Again, this is  
13 across the Department. We all accept that we  
14 all have endorsed and agreed upon the same  
15 training requirements for the Human Research  
16 Protection Program.

17 Then more recently, one of our past  
18 initiatives is that we have created a topic-  
19 specific central IRB, and I'm going to tell  
20 you a little bit more about that, because it's  
21 actually one of our initiatives within P&R.  
22 We kind of led the way on this one, and it's  
23 been incredibly successful.

1           So the topic-specific IRB is called  
2 the Infectious Disease IRB, and it was based  
3 out of the Infectious Disease Clinical  
4 Research Program, which is based at the  
5 Uniformed Services University. So to stand up  
6 this Central IRB, we have an agreement that we  
7 negotiated between all of the Surgeons General  
8 and the DASD for Force Health Protection  
9 Readiness.

10           So you remember back at the first  
11 slide, those were each of the proponents for  
12 the Human Research Protection Program, for  
13 their component. The IRB is located at the  
14 Uniformed Services University, but the  
15 representatives for the IRB are drawn locally  
16 from each of the institutions that are  
17 represented within that central IRB. This is  
18 a very key point.

19           There are administrative support  
20 provided centrally from the clinical research  
21 program out to the sites that are part of the  
22 network. So if you want to be on the network,  
23 number one, you have to agree to participate

1 within the confines of our MOA, but in return,  
2 you're given research support.

3 Then the other key factor here is we  
4 have a headquarters global oversight  
5 mechanism. So we have what's called a  
6 headquarters panel that has representatives of  
7 each Office of the Surgeon General, and we  
8 meet and what it does is it allows each of the  
9 Surgeon Generals' offices to have visibility  
10 into all of the protocols that are going on.

11 So the program has been highly  
12 successful in overcoming the stovepipe  
13 regulatory system. I recently did a site  
14 visit with them, and I sat down with the  
15 members, the clinical researchers, and the IRB  
16 staff, and they were saying -- I mean, the  
17 feedback was amazing. They were saying that  
18 they were able to accomplish research now that  
19 they would not have been able to accomplish  
20 two years ago.

21 We had essentially moved what it  
22 would take up to two years sometimes in  
23 getting approvals, down to maybe a four month

1 process. So it's just phenomenal how well  
2 it's worked. However, I will also point out  
3 it's very limited in scope. This is only for  
4 the Infectious Disease Clinical Research  
5 Program.

6 We are -- in fact, I didn't know  
7 Captain Hammer was going to be here when I put  
8 my slides together, but Captain Hammer now is  
9 actually leading up a working group, to see if  
10 there's a way for us to expand this model and  
11 this concept out to some of the other areas,  
12 or even -- may even make this one itself a  
13 little larger.

14 But I want to point out that the  
15 success itself is not because there is a  
16 central IRB. It's not just this central IRB  
17 that magically made it better. It's because  
18 of all different parts of the program we put  
19 into place. The clear relationship between  
20 the institutions and the IRB; the relationship  
21 between the headquarters level, the ability  
22 for all the surgeons to be able to look in and  
23 see every protocol that's going on, so that

1 nobody's worried that somebody's doing  
2 something that they don't know about.

3 Okay. So other projects that we're  
4 working on for harmonization in terms of what  
5 we're currently work on, is we just recently -  
6 - okay. So in 2008 and 2009, a group of  
7 researchers primarily at Eisenhower, got  
8 together and applied for a grant from TATRC,  
9 to see if they could demonstrate network, a  
10 central network that would work across IRBs in  
11 all the Services.

12 In the demonstration project, they  
13 included institutions from Army, Navy, Air  
14 Force, and they included Uniformed Services  
15 University, which is for P&R. What they found  
16 is that number one, yes, we could get a  
17 network that met the needs of all the  
18 Services, and the network worked.

19 So we in Health Affairs saw this and  
20 we said "Ahh, this is good." So we put our  
21 emphasis behind it, and in the intervening  
22 years since then, the network has now expanded  
23 to 19 institutions across CHMS, and just in

1 July of this year, the Force Health Protection  
2 Integrating Council approved the government's  
3 plan for this network, where we will begin to  
4 stand up a program office at Uniformed  
5 Services University, and the network itself  
6 will be funded proportionally by the various  
7 services that use it.

8 The other really exciting part about  
9 this network is that the Army is working with  
10 us to develop the business intelligence  
11 interface, which allows us to take the data -  
12 - because the network starts. You know, the  
13 PI inputs his study or her study into the  
14 network, and it's a work flow process.

15 So then it goes to whatever group  
16 needs to review it next, whether it's the IRB,  
17 Scientific Review, Radiation Committee,  
18 whatever. So it just funnels the protocol.  
19 Well, in the process we gain a whole lot of  
20 data, including searchable aspects, et cetera.  
21 So we're developing this business intelligence  
22 software, that will allow us to do searches.

23 So for example, if you want to know

1 how many studies we have going on on the topic  
2 of diabetes, we'll be able to tell you that.  
3 We'll be able to tell you that without doing a  
4 very large data call that takes months. We  
5 will tell you that within hours. We'll also  
6 be able to tell you how many protocols we  
7 have. Any data that is within the system, we  
8 will be able to mine.

9           Now just in terms of the kinds of  
10 efficiencies the service offers, you can see  
11 here -- now, this is metrics from within the  
12 system, from after the institutions have  
13 already implemented this electronic network.  
14 Apparently, from what I understand, if we were  
15 able to graph from pre-network, back when they  
16 were still using their individual paper-based  
17 systems, the time improvement, process  
18 improvement from that period to now, I  
19 understand went from like 100 days to do an  
20 expedited review, to somewhere around 40 or  
21 50.

22           So this is a year within the  
23 network, and you can see here we have three

1 different institutions plotted. We've gone  
2 from an average of 35 days for two of them  
3 down to 14 or 15 days, is the average time it  
4 takes to complete an expedited review. Walter  
5 Reed's a little bit slower, but even still  
6 they're down to approximately ten days.

7 So one of the strengths of the  
8 system is that we are able to map every single  
9 process, and as you know, probably from your  
10 Six Sigma training, if you can map it, you can  
11 improve it.

12 The other value that this is adding  
13 is so every step of the process can be  
14 measured, and again, if you can measure it,  
15 you can improve it. We can include any kind  
16 of protocols. So we have publications that  
17 are also able to join the network. We also  
18 have publication clearance as part of the  
19 network, not in all of our sites but at some  
20 sites, and at Walter Reed they reduced their  
21 processing time for publication clearance from  
22 30 days to 14 days.

23 Any committee or process requiring

1 coordination can be included on the network.  
2 Again, it's a work flow process, and HQL data  
3 mining. So enterprise-wide harmonization. So  
4 the plan is once we get everybody onto the  
5 system, then we will take even more steps  
6 towards harmonizing the processes, harmonizing  
7 the forms we use, trying to make it easier for  
8 the research community.

9 Okay. Now here's our strategic  
10 vision for the future. We just recently, and  
11 this is one of the reasons I was very excited  
12 to be here today, is because we actually have  
13 a strategic vision for the future, and we have  
14 just developed it recently.

15 So what we would like to do  
16 obviously is reduce our stovepipe process  
17 through, and we just -- so about six months  
18 ago, the ANC Health Affairs asked us to stand  
19 up a Tiger Team to see what we could do, to  
20 try to foster research within the military  
21 health system.

22 The white paper and the  
23 recommendations that came out of that were

1 presented to the SMMAC, the Senior Military  
2 Medical Advisory Council, in March of this  
3 year. The SMMAC endorsed our recommendations,  
4 including recommendations that number one,  
5 we'll expand the central IRB concept, in which  
6 we are moving forward on, to try to get the  
7 IRB out, the centralized process out, and that  
8 we also implement the electronic research  
9 management tool.

10 But the big thing is we have a  
11 number of Tiger Teams, well working groups,  
12 that are currently working with the clinical  
13 investigation program in the R&D community, to  
14 come up with processes for strengthening our  
15 research infrastructure, including the things  
16 that I mentioned here, like how do we expand  
17 that central IRB concept, so that we can make  
18 the research process easier? How do we get  
19 the research management tool out across a  
20 larger audience?

21 Protecting human subjects. We're  
22 all in this together. So any questions?

23 CHAIR DICKEY: Thank you very much,

1 Ms. Miner, for that presentation. Are there  
2 questions or comments?

3 DR. HIGGINBOTHAM: Eve Higginbotham.  
4 Well, congratulations on your process  
5 improvement. So my question may not be  
6 something that you may welcome, but given what  
7 we've heard earlier about, you know, the  
8 integration with the VA system, to what extent  
9 is your strategic plan extending to  
10 integrating with the VA, given the electronic  
11 health record expansion?

12 MS. MINER: We have had an  
13 incredibly difficult time integrating anything  
14 with the VA. Every time, so there have been  
15 multiple times in the past. So I started  
16 working for the DoD in 2005, and since that  
17 time, VA has come to me several times and said  
18 hey, we need to figure out how to do things  
19 better.

20 We have met, and every time we think  
21 we come up with an idea for how to do things  
22 better, it just -- I want to say every single  
23 time, it's the VA that hasn't been able to

1 come through on how to do things better. So  
2 for example, one time there was concern about  
3 how to do we share data better, and we came up  
4 with a plan. I took it to the DoD Privacy  
5 Office folks and the DoD Privacy Office folks  
6 said yes, we can do this, no problem.

7 Then the VA came back and said no,  
8 we can't do that because, you know, we don't  
9 want to give you this particular kind of data.  
10 So we have found the VA to be very difficult  
11 to work with, and when it comes -- for  
12 example, remember I showed you that form we  
13 had, the institutional agreement for IRB  
14 review. I told you about that.

15 All of the DoD institutions agreed  
16 we use the same form. If two institutional  
17 groups or two DoD groups are working together,  
18 we use that form. We have similar forms that  
19 we use with IRBs at universities, et cetera.  
20 But the VA absolutely refuses to use it. They  
21 will not enter into an agreement with us.  
22 They will not review for us, nor will they be  
23 responsible for us. So they just absolutely

1 refused. So we haven't done very much with  
2 the VA, but I don't think it's our fault.

3 (Laughter.)

4 CHAIR DICKY: Yes sir.

5 CDR PADGETT: Commander Bill  
6 Padgett. Is this DoD's -- or acquisition  
7 commands will fall under -- and concept  
8 involvement commands that have IRBs will fall  
9 into this as well, or is this just medical?

10 MS. MINER: That's an excellent  
11 question, because right now, because the money  
12 we're using to pay for the -- and I'm assuming  
13 you're talking about the electronic IRB  
14 system?

15 CDR PADGETT: Correct.

16 MS. MINER: Yes. Right now, the  
17 money we have is Defense Health Program money,  
18 and so for now, the network is limited to  
19 Defense Health Program sites. We are actively  
20 trying to find a way to find non-DHP money to  
21 help us expand the program outside of that,  
22 because the license we have to for the COTS  
23 product, I mean, the key part of the network

1 is an off-the-shelf product that we took and  
2 then expanded.

3 The license is unlimited. So we  
4 could, theoretically, we can use it anywhere,  
5 except that the color of money we used has  
6 narrowed our ability to expand it.

7 CDR PADGETT: Is that something that  
8 Defense Health Board can recommend back up to  
9 the Secretary of Defense, that this is a  
10 subject matter expert recommendation, that  
11 this program should go to all of our DoD IRBs?

12 CHAIR DICKEY: I'm looking at some  
13 of my staff around here. Is it possible that  
14 the Defense Health Board could look at the  
15 role of intramural and extramural research,  
16 and one of the areas of investigation and  
17 recommendation might in fact be the value of  
18 being able to cross the stovepipes, if you  
19 will?

20 MS. BADER: Right. I think that  
21 before the government, the Assistant Secretary  
22 would ask the Board to do something like this,  
23 we would have to go back to Dr. Woodson, and

1 then we would have to have a lot more  
2 information than we received in one briefing  
3 today, before the government would ask the  
4 Board to unilaterally make a decision or  
5 recommendation on that.

6 MS. MINER: Well, and also that  
7 limitation is a fiscal law issue. So I think  
8 it's a matter of finding different, finding  
9 money from another source, and we just don't  
10 have that yet.

11 CHAIR DICKEY: Captain Hammer.

12 CAPT HAMMER: I wanted to make a  
13 comment, and just say thanks for the shout out  
14 on our upcoming initiative to expand the idea  
15 of what's been done in infectious disease.  
16 But I do want to clarify though that what  
17 we're looking at is to try to develop a  
18 centralized IRB, again using the infectious  
19 disease model for specifically for  
20 psychological health and TBI sorts of things.

21 The challenge in that is that it may  
22 be much larger in terms of the numbers of  
23 studies than there are for the infectious

1 disease. But I mean, that's one of the  
2 questions that we have to look at. But  
3 that's, it was specific for that particular  
4 scope of studies.

5 I think if we're able to do that and  
6 find a home for it and figure out how to  
7 structure it, using the model I think we'll be  
8 able to answer a lot of questions very  
9 quickly, and I think it will really help in  
10 expanding a lot of the questions we're trying  
11 to answer.

12 MS. MINER: Well, and I'd like to,  
13 because one of the things I kind of had a  
14 little hiccup there, because I thought there  
15 was something I wanted on my slides that  
16 wasn't there, because one of the things I  
17 would like to see happen is you have your  
18 working group that's looking at well, how do  
19 we improve the process for our mental health  
20 research?

21 We have Dr. Rauch and the R&D  
22 community saying okay, how can we use the  
23 model that we see for the infectious disease

1 IRB? How can we use that to expand the  
2 clinical research capability just within the  
3 MHS? So what they are doing or what I am  
4 advocating for them to do, there's still a  
5 working group working on it, but if they do  
6 what I'm hoping they do, what they will do is  
7 is they will put their resources, their  
8 dollars into --

9 So remember I mentioned for the ID  
10 IRB, one of the key factors was that the  
11 clinical research program put research  
12 resources out at the sites. Okay, so that's  
13 what I'm trying to get the R&D community to  
14 do. They have some extra money that they're -  
15 - I won't say extra, but that will get me in  
16 trouble.

17 But there's some money right now  
18 that's been targeted towards building research  
19 infrastructure, and I'm hoping that they will  
20 do that, that they'll pick some sites where we  
21 have good research infrastructure, but we  
22 could have better, and put out there maybe a  
23 statistician or a clinical coordinator or

1 those types of resources that specifically are  
2 designed to help the researcher get from idea  
3 to finished research project, and then see if  
4 we can then coordinate it with your activity.  
5 Then I mean, I'm hoping that we can all work  
6 together to create something good.

7 CAPT HAMMER: Yes. It dovetails  
8 nicely with what we have, in terms of the  
9 capability within the DoD system, is an  
10 enormous volume of potential research subjects  
11 that we have to protect appropriately. But I  
12 think oftentimes, an unfocused sort of shotgun  
13 approach to research, that leaves us with  
14 duplicative studies on one side, and then not  
15 enough studies in another thing.

16 So maybe we should cover the broad  
17 area I think would really help. But I think  
18 that's a good synergy. I think it would work.

19 CHAIR DICKEY: Sounds like we have  
20 the opportunity, though, to continue to  
21 increase our understanding and maybe some  
22 directions that we can work across the entire  
23 protection spectrum. I think that in fact,

1 there's a fair amount of partnering  
2 extramurally, and I think that helped  
3 precipitate some of the questions that we  
4 invited you to come and answer today. So  
5 thank you very much.

6 MS. MINER: You're welcome.

7 CHAIR DICKEY: We appreciate your  
8 presentation, Ms. Miner, and look forward to  
9 opportunities to have you back. Now we have a  
10 treat in store for you. I don't think in my  
11 time on the Board we've seen a lot of panel  
12 discussions.

13 **Panel Discussion: Line Commanders**

14 CHAIR DICKEY: But we have a group  
15 of commanders from Joint Base Lewis-McChord  
16 here, who are going to share information with  
17 us. The format, and I guess that's what those  
18 high stools are over there.

19 So as they're getting ready to,  
20 getting prepared for it, I'd like to ask you  
21 to welcome Captain Adam Stover from HHC, 864th  
22 Engineer Battalion; Captain Clint Nold from  
23 FSC 864th Engineer Battalion; Captain Rex

1 Broadrick from the 565th Engineering Company;  
2 Captain David Korman from the 617th Engineer  
3 Company; and Captain Tristan Manning, HHC  
4 Madigan Health Care System.

5 As those individuals are joining us,  
6 perhaps they'll each do a brief introduction,  
7 and share with us, among the other things they  
8 may be prepared to share, what challenges they  
9 face as battalion commanders.

10 Some of the challenges, particularly  
11 you might share with us is how many  
12 deployments you've had and what challenges  
13 your battalions face, particularly from a  
14 health perspective, as you return from those  
15 deployments. We apologize. We're running a  
16 little behind time, but are open to hearing  
17 your insights and experiences this afternoon.

18 So welcome to the five captains, and  
19 I know they were talking while I was talking.  
20 So but I'm sure you guys can all multi-task,  
21 right? We welcome you. We look forward to  
22 hearing your insights into the work that  
23 you've done, particularly in terms of the

1 deployments and the challenges on returning  
2 with the battalion.

3           So we've heard five names, but we  
4 don't know who belongs to what. So maybe you  
5 might start by going through and telling us  
6 who's who, and along with that, perhaps your  
7 battalion deployment history, and then we can  
8 come back and talk about some of the  
9 challenges that you've met.

10           CPT STOVER:       I'm Captain Adam  
11 Stover. I'm the HHC 864th Engineer Battalion  
12 Commander. I deployed to Afghanistan in 2007  
13 and 2008 with the 173rd as a platoon leader,  
14 and I was in command throughout most of our  
15 deployment. So we deployed to Kandahar in  
16 April 2010, and just got back in late March  
17 2011.

18           I think one thing that's a challenge  
19 to us all is the soldiers we've got with our  
20 detachment, they deployed with some health  
21 issues. We had to send them right back. You  
22 know, that was quite a challenge for us,  
23 deployed with some kind of questionable

1 profiles.

2           And then since we've been back, a  
3 lot of soldiers are going through med boards.  
4 That's taking a long time. I think that's a  
5 challenge for most of us. I'll go ahead and  
6 pass it on to the next commander.

7           CPT    BROADRICK:           Captain    Rex  
8 Broadrick.       I'm    the    585th    Vertical  
9 Construction Company Commander, also in the  
10 864th Engineer Battalion.    Deployed five  
11 times. I've got both enlisted and officer  
12 experience. Most recently just came back. I  
13 joined the battalion about five months into  
14 the deployment, so I did seven months down  
15 range with them, and I like a lot of what  
16 Captain Stover just said about the issues that  
17 we've had.

18           CPT NOLD:    Good afternoon.    Captain  
19 Clint Nold. I'm the FSC commander with the  
20 864th Engineer Battalion. My deployment  
21 experience is 15 months in Iraq. I was there  
22 in 2007 to 2008. I deployed out of 12th Cav,  
23 from Germany to Iraq.

1 Same issues with the medical board  
2 as well, and I kind of question when you come  
3 back from a redeployment, the line of  
4 questions you get to assess your medical  
5 readiness. I'm not sure those questions  
6 really do accurately assess, you know, a  
7 unit's readiness or health issues.

8 CPT KORMAN: My name's Captain Dave  
9 Korman. I command the 617th Engineer Company  
10 horizontal, also part of 864th. My  
11 deployments, not counting my enlisted time, I  
12 did -- I was a platoon leader from '05 to '06.  
13 Then I joined the company for four months down  
14 range.

15 I agree with all the points that  
16 have been made so far about with soldiers and  
17 med boards, and the non-availability with the  
18 T3s. I mean, the biggest problem that that  
19 has for us is those soldiers are taking slots  
20 that we can't get new soldiers in that we can  
21 actually deploy down range. So I know we were  
22 force capped pretty well.

23 CAPT MANNING: I'm Captain Tristan

1 Manning. I guess I'm the only non-engineer  
2 here. Medical Service Corps Officer. I  
3 deployed in 2005 with 1st Brigade Combat Team  
4 Light Infantry out of Fort Drum, and then also  
5 deployed more recently in 2009-2010 with 1st  
6 Corps, under USFI Iraq, and currently right  
7 now I'm the HHC company commander for Madigan.

8 CHAIR DICKEY: I think we'll make  
9 this kind of a Q and A back and forth. So  
10 feel free to wave a hand and we'll try to do  
11 that. Since all of you kind of agreed on the  
12 challenges being both deploying with health  
13 issues, and then coming back and the kind of  
14 floating system, if you will, with the medical  
15 boards on return, I guess part of my question  
16 is do you think there's a process out there  
17 that we should be -- that we might implement,  
18 that would my first concern would be to help  
19 you not deploy with people who, within the  
20 first few weeks, they're discovered they're  
21 not medically ready and end up filling slots  
22 that should perhaps have been filled better by  
23 others?

1           CPT BROADRICK: I'll take a little  
2 bit of that one. I think part of the issue  
3 you might run into if you tried to improve  
4 upon the system that we have, is we have a lot  
5 of soldiers that will do just about anything  
6 to get out of a deployment. So there is a few  
7 that we find coming -- that we find once we  
8 get overseas, where they probably shouldn't  
9 have been over there.

10           But if you tamper with the system  
11 too much, I think you're going to run the risk  
12 of having a lot of those soldiers, if we try  
13 to improve the way for soldiers to get out of  
14 a deployment, that they're going to take  
15 advantage of that. So there's -- I think that  
16 the system, how we have it right now, it's not  
17 perfect, but I can see how -- I can see the  
18 way it's structured right now, why it was  
19 structured that way, and how we end up with  
20 the problems that we have down range.

21           DR. HOVDA: This is Dave Hovda from  
22 UCLA. Thanks very much for your service and  
23 for coming today. What do you feel was the

1 most common problem that individuals had, that  
2 necessitated them to come back or not be  
3 deployed?

4 CPT BROADRICK: I know one for us  
5 that seemed to happen more for the soldiers  
6 that wanted to come back was their behavioral  
7 health type issues. I know also on the going  
8 out there end, there was a lot of soldiers  
9 that actually wanted to deploy, who had some  
10 behavioral health issues that were not able to  
11 deploy, because of the 90-day medical  
12 stabilizations and those types of things.

13 So we saw it work both ways, both in  
14 the soldiers that wanted to get out of it.  
15 They figured out, especially about the time I  
16 got over there, that if you wanted to get home  
17 from a deployment real quick, you said, and  
18 there were definitely some legitimate ones as  
19 well. But there were some that were not so  
20 legitimate that would be the behavioral  
21 health.

22 There were, I had a couple of  
23 soldiers that had musculoskeletal things.

1 There's two in particular. One of them made  
2 it through the whole deployment; the other one  
3 made it about half the way through the  
4 deployment, before he had to come back. So  
5 there were some of those.

6 In both those cases, those guys  
7 wanted to deploy. Whether or not they should  
8 have, I think they probably stretched the  
9 truth a little bit when they were talking to  
10 the doctors, as far as trying to -- they  
11 wanted to deploy with us. So they made sure  
12 that happened.

13 But the behavioral health kind of  
14 cut both ways. We've had soldiers that wanted  
15 to deploy and when they finally were able to  
16 get out there, did a great job for us. But  
17 they weren't released to deploy with us,  
18 because of they had just changed a medication  
19 or something like that, and they didn't even  
20 realize that it was going to affect them that  
21 way. Then the other ones that came back  
22 early, because that was the best way for them  
23 to do so.

1           CHAIR DICKEY:   Were any of you in  
2 units that had mental health, behavioral  
3 health specialists? I think we heard that  
4 there's increasingly behavioral health  
5 specialists in the units, and they go along  
6 with you, hoping to enhance the availability  
7 and access and trust, I guess, in accessing  
8 care?

9           CPT MANNING:   Usually the combat  
10 service, the folks that deal with our  
11 behavioral health issues aren't really organic  
12 to line units as such. But they usually  
13 occupy a FOB or area, if you will, that kind  
14 of covers that. So if a soldier does have an  
15 issue, there's usually one available within, I  
16 don't know, within -- you know, at least  
17 within, speaking from the Iraq side, at least  
18 within helicopters right away.

19           But I know, seeing it from 2005 to  
20 2009, the increase of combat operational  
21 stress control units did increase  
22 significantly in the battlefield.

23           CAPT HAMMER:   I'm curious, as you're

1 all company level commanders, right? How  
2 comfortable do you think you are, as well as  
3 your subordinates, the company level NCOs and  
4 even lower, with what the platoon level NCOs,  
5 you know, sergeants and corporals and that  
6 sort of thing.

7 How comfortable do you think you all  
8 are with, and how often have you had this  
9 experience, where you've had a mental health  
10 professionals who is the area, the combat  
11 service support kind of area person, has gone  
12 out and just walked around and talked, and  
13 done sort of informal consultations?

14 How comfortable would you be going  
15 up hey doc, let me run this one by you? I've  
16 got this guy and I think he might be  
17 manipulating, but I'm not sure? How  
18 comfortable do you think you are, as well as  
19 the guys that you are commanding, with doing  
20 that?

21 CPT NOLD: I would like an  
22 opportunity, because that way you could kind  
23 of get some user-level discretion at the lower

1 leadership level, and I think that would make  
2 it a little less bureaucratic, because that  
3 way, your first line leaders and commanders  
4 would be able to discern whether somebody  
5 actually truly needs mental health, or might  
6 be kind of, you know, utilizing the system to  
7 his advantage.

8 CAPT HAMMER: Did you have that  
9 experience, though, of actually --

10 CPT NOLD: I never had that  
11 experience.

12 CPT BROADRICK: Okay. I actually  
13 interacted with several. To the question that  
14 you asked before about how available they  
15 were, I was on about nine different FOBs, and  
16 I'd say we had access on about half of them.

17 I question to what level, because a  
18 lot of -- as I was interacting with them, a  
19 lot of times they'd go well, we're going to  
20 push them back to KAF, to get a more  
21 definitive evaluation.

22 But I was pretty comfortable going  
23 to them, and our guys became comfortable too.

1 That was one of the things that we all knew,  
2 was where the mental health personnel were, if  
3 they were available on the FOB that we were  
4 at. So I was pretty comfortable going to  
5 them.

6 But there was, they were very  
7 hesitant to make any kind of definitive  
8 diagnosis on our guys. In one case in  
9 specific, it was a soldier that was definitely  
10 admittedly trying to get out of a deployment  
11 later on down the line.

12 It took having to push him all the  
13 way back to KAF, and then I had to sit down  
14 with that mental health provider at the Role 3  
15 there, before he kind of had a Come to Jesus  
16 moment and decided that he didn't want to end  
17 his career that way.

18 But they were available out there.  
19 I found that state-side, it's like pulling  
20 teeth, to be able to talk to behavioral health  
21 providers about a behavioral issue that our  
22 soldiers are having out here. I've had more  
23 behavioral health issues since we came back,

1 and especially since we got all our rear  
2 detachment personnel that came back to us.

3 I haven't been able to -- I've  
4 called and talked to multiple people in  
5 behavioral health clinics, and they haven't  
6 been able to give me any information, due to  
7 privacy concerns and those types of things.

8 That's been, as a company commander,  
9 it's been very frustrating. I understand the  
10 reasons behind it. They want those soldiers  
11 to feel like they can go talk to someone  
12 without any repercussions. But as a company  
13 commander, I found myself where I just want to  
14 make sure that I'm doing everything I can for  
15 a soldier, whether it's giving them a battle  
16 buddy or just, you know, keeping that extra  
17 supervision on them.

18 I can't even talk -- they can't give  
19 me anything. So in one case, I couldn't even  
20 get them to verify that they were seeing one  
21 of my soldiers.

22 CAPT HAMMER: Do you feel like the  
23 mental health professionals are not

1 comfortable with that command consultation  
2 kind of role?

3 CPT BROADRICK: No, they definitely  
4 were not comfortable at all with that. I'm  
5 still pending one where they said they had to  
6 consult with Legal, just to -- I've got a guy  
7 that I'm chaptering out of the Army, and they  
8 said they had to consult with Legal, just to -  
9 - I sent them to get that last mental health  
10 evaluation, because it wasn't in the regs as  
11 being needed for that particular chapter.

12 They wouldn't even give me the  
13 report back, after they had already completed  
14 it. They were waiting for advice from their  
15 lawyer, to make sure that it's okay to release  
16 that report to me.

17 CHAIR DICKEY: I'm curious, are  
18 those military mental health providers or  
19 contract?

20 CPT BROADRICK: I believe they're  
21 the contract ones. It's a problem with both.

22 CHAIR DICKEY: Is it? God love  
23 HIPAA, right?

1 CPT BROADRICK: It's very complex.

2 CPT KORMAN: Well, I'd just like to  
3 add one thing that Captain Broderick brought  
4 up, is sometimes it's more important -- I had  
5 a soldier that had suicidal ideations, and  
6 when we sent him to Behavioral Health, they  
7 wouldn't talk to me and tell me yes, we saw  
8 him and we released him.

9 But then I don't know if they --  
10 they said they cleared him, but then he comes  
11 back and does it again. They send him back  
12 over there, and it's the same. They clear him  
13 and then I can't talk to the Behavioral Health  
14 about him. So do I really take it that he's  
15 safe or do I have to do something else?

16 CAPT HAMMER: And that's an  
17 important part, I think, of what we have to  
18 do. We, you know, in the psychological health  
19 community have to do, is to be able to have  
20 that ability to have a conversation. One of  
21 the things I valued was when I was deployed,  
22 when people come up to me, I'm a psychiatrist,  
23 and say let me run this one by you, doc. I've

1 got a guy. He's got this and that. How do I  
2 handle that? What do I do with him? I'd say  
3 well, try this or try that, and I'd ask  
4 clarifying questions, and we'd have a  
5 conversation. I think that helped junior  
6 leaders who didn't have much experience  
7 handling people, get better at it, in dealing  
8 with the psychological stuff.

9 I think that's a failure or  
10 difficulty that we have, is that we're not, we  
11 get wrapped around the axle of rules and  
12 regulations and HIPAA violations and following  
13 the DoD Instruction on command mental health,  
14 and it's like we've lost the point what do we  
15 do to really help both the leadership and the  
16 individual? But that's just Paul Hammer's two  
17 cents.

18 CPT MANNING: I'd like to add in  
19 that I felt comfortable when -- I noticed the  
20 difference between the two, my two  
21 deployments. But not only do you have your  
22 behavioral health specialists that are  
23 presenting themselves as readily available for

1 soldiers; but I think as the stigma kind of  
2 goes away, company commanders at this level  
3 are more apt to approach those soldiers about  
4 the issue.

5 Not only that, but you do have unit  
6 chaplains are very, very proactive in this  
7 type of setting, and I personally have seen my  
8 chaplains very involved in this.

9 CHAIR DICKEY: I have Dr. Carmona  
10 and then Dr. Parkinson.

11 DR. CARMONA: Rich Carmona.  
12 Captains, thank you for your, this opportunity  
13 to share your experiences with us. I have two  
14 questions. One is your personal experience  
15 as company commanders. Clearly, you're held  
16 responsible for battle readiness of your  
17 troops, which usually means physical  
18 performance standards and so on.

19 How many of you are monitoring the  
20 mental health status as part of readiness, as  
21 it relates to your respective troops? And of  
22 course, I don't mean persons that have  
23 significant psychological breaks so that it's

1     apparent to everybody. But I mean,  
2     aberrancies in their mental health that affect  
3     performance. How many of you are really  
4     looking for that as part of overall ability to  
5     perform their jobs and being battle ready?

6             Then number two, I'd appreciate your  
7     comments on post-deployment assessment for all  
8     of you and your troops when you come home?  
9     Are we asking the right questions to be able  
10    to determine who may have problems?

11            CPT KORMAN: Well, I'd like to  
12    address your second one, and we just -- my  
13    company just went through self today, and the  
14    problem I had with it was we filled out a  
15    questionnaire. But if you answered "no" to  
16    all those questionnaires when you went to the  
17    provider, they looked over it and signed off  
18    on you.

19            There's no secondary questioning or  
20    any probing or any asking to the soldiers. So  
21    my soldiers could go through, say they had no  
22    problem. They got checked off from the mental  
23    health provider. They went to the physical

1 health provider. They said are you having any  
2 problems? They said no, they checked off,  
3 they left.

4 So even if they had them, if they  
5 didn't want to talk about them or they just  
6 wanted to get out of there in time. I think  
7 it would have been better if the providers  
8 actually took time to maybe ask some of the  
9 questions, or to do some kind of meeting where  
10 they actually talked to them, so they can get  
11 an idea, rather than just filling out a bubble  
12 sheet and turning it in.

13 CPT MANNING: There is an individual  
14 part to that. What he just said is that if  
15 I'm a soldier going through self as a pre-  
16 deployment, I check no, because I want to go  
17 home early. That's kind of on me as well. If  
18 I don't want to address my own issue with a  
19 provider, then the provider has no clue as  
20 what to ask me.

21 If I click yes on something, then a  
22 provider will make the time to sit with me  
23 afterwards, after that initial screenings.

1 But most soldiers will click no, just so they  
2 can get home on time or go do something else.

3 DR. CARMONA: And how about you all  
4 as company commanders, your responsibility for  
5 surveillance of mental health, as part of  
6 overall battle readiness of your troops?

7 CPT BROADRICK: I think that that's  
8 something that a lot of commanders will do,  
9 kind of just second naturedly, to make sure  
10 that we do it. But another thing that I think  
11 has helped with that is we've been  
12 implementing a wellness program within our  
13 brigade, I think, as part of the Army program  
14 with their FORCECOM risk assessment tool, and  
15 using some of those things.

16 Where we have, you know, a  
17 population of soldiers that we identified that  
18 are at a higher risk for some certain type of  
19 behavior. What I've noticed is without fail,  
20 those are the soldiers that you're more  
21 concerned with, that have their regular  
22 behavioral health appointments, or that you're  
23 more concerned about not being able to do

1 those.

2           So I think just kind of maybe by  
3 accident or maybe on purpose, the Army has  
4 come up with a system for us to be able to do  
5 that, and I know that at least us within the  
6 864th Engineer Battalion, from my perspective,  
7 it seems like we've got a good handle on a way  
8 to monitor that.

9           And then as far as it ties into  
10 readiness, I think those are usually those  
11 soldiers who are the ones that you can't wait  
12 to deploy, to get them away from whatever  
13 situations they're in state-side, or you  
14 really don't want to deploy, and you're  
15 looking at keeping them back on rear  
16 detachment, so that they can hopefully get out  
17 by the time you come back.

18           CHAIR DICKEY: Dr. Parkinson.

19           DR. PARKINSON: Yes. Thank you all  
20 for coming. Some would probably say that if  
21 you're crazy enough to enlist in the Army,  
22 that that's a behavioral health problem in  
23 itself. But thanks for all you do. But I

1 guess in the -- looking back, put yourself in  
2 one of your soldier's shoes, and then put  
3 yourself in your "if only I knew then what I  
4 know now" perspective.

5 So what are the competencies that  
6 the soldiers, the rank and file soldier needs,  
7 that you wish they had, to be able to deal  
8 with stress, combat, the anticipated and  
9 unanticipated things that they saw or would  
10 see? Similarly, what's the competency that  
11 you would like to have? Not to be a mental  
12 health professional, but what is the  
13 competency you would like as a commander that  
14 you just knew you didn't have, but you wish  
15 you would have had?

16 So from the soldier competency and  
17 from yours as a commander competency, just a  
18 high level, if you would describe "I wish I  
19 could have X," it would have made me a better  
20 commander, and for our soldier, I wish I could  
21 have Y. It would have made me be more  
22 effective or be more fulfilled, be more of a  
23 comrade, whatever. Does that make sense?

1 CPT BROADRICK: I'll go again.

2 (Laughter.)

3 CPT BROADRICK: Having been a  
4 soldier before, I think one of the first  
5 things I realized, as I started moving up the  
6 ranks on the officer side, was that being --  
7 just how important the role of that battle  
8 buddy was. You know, I had a few friends I  
9 was close to and then I had some other  
10 soldiers and leaders that I started with, that  
11 I watched kind of go off the wayward path,  
12 that you know, ended up in bad situations.

13 I think that just realizing the  
14 important role that I had as a battle buddy.  
15 I think that's one of the most important  
16 things, and at the leader level, that's really  
17 what we rely on our junior leaders, and even  
18 just in the unit, from soldier to soldier.  
19 Just the brand new soldiers coming in.

20 If they've got that, if they feel  
21 like they're a part of the team and they've  
22 got that battle buddy mentality where they're  
23 looking out for each other. That above

1 everything else will help soldiers get through  
2 whatever difficult times they're going  
3 through.

4 Because we know most of the soldiers  
5 don't have the legitimate medical problems.  
6 It's just having to figure out new ways to  
7 deal with new stresses that they maybe weren't  
8 expecting or just didn't know how to deal with  
9 before.

10 Then as far as the leader's  
11 perspective, I don't know. I'll pass that off  
12 to someone else.

13 DR. ANDERSON: If you don't want to  
14 talk about that, you know I really thank y'all  
15 for being here and talking. You're aware,  
16 right from the Chairman of the Joint Chiefs  
17 down, the issue of the stigma of psychological  
18 health has been a major issue. Could you just  
19 talk about that a little bit?

20 Are we addressing that properly? Is  
21 the problem going away, or is it something  
22 that can go away? I'm talking specifically  
23 about the stigma.

1           CPT NOLD:   Well, the psychological  
2 issues, I kind of wonder if it's -- the Army's  
3 been at war for ten years, and there's  
4 constant, you know, you're deployed 12 months,  
5 and you're back home for 12 months, and then  
6 two months you're in training. I just kind of  
7 think that the deployment cycle is the root  
8 cause of the issue.

9           Like I can't really -- I can't speak  
10 for statistics, but like the shorter  
11 deployments, like that the Air Force or that  
12 the Marines have. I just think it's too much  
13 of a cultural change or too much of a change.  
14 They're going from garrison, where you got all  
15 these million taskings that you do, and then  
16 you go down range to a mature theater, and you  
17 know, you're just doing strictly your mission.

18           Then, you know, you're away from  
19 civilization.    You're away from people.  
20 You're away from interaction and families. I  
21 just kind of think that's more of the issue or  
22 more of the psychological problem. I don't  
23 think there's enough time to let your brain

1 unwind down and become a normal human being  
2 again.

3 I mean when you take, like most of  
4 the people that come in the Army, they're in  
5 their 20's, and most people in their 20's, you  
6 know, all they think about is, you know,  
7 alcohol, adrenalin, sex and all the normal  
8 things that like college people experience, or  
9 just people out of high school.

10 I just think it's the extreme  
11 environment. I think that's the root cause of  
12 our problems, and I don't know how much  
13 documentation, when you read about like World  
14 War II or, you know, how did those people come  
15 back from World War II? You know, I don't  
16 know how much has been captured. How did they  
17 cope with it? They called it combat stress,  
18 and I think a lot of people just dealt with it  
19 internally.

20 Today, it just seems like we kind  
21 over-embellish. Or PTSD, like you know, I  
22 could on the questionnaires, after the post  
23 assessment, it seems like you can answer a

1 question in such a way, you can almost  
2 outsmart the questions, you know. Whether you  
3 just want to go home for the day or write the  
4 questions down that, you know, you're a mental  
5 case. It just kind of depends.

6 So I don't know if that helps you  
7 guys, with what you guys do.

8 CPT BROADRICK: Yes. I think also  
9 for part of the stigma, it's going away. It  
10 is definitely going away. I deployed the  
11 first time to Afghanistan right after  
12 September 11th, and it's a night and day  
13 difference as far as the stigma that there  
14 was, as to going and getting help afterwards.

15 In fact, right after that  
16 deployment, one of my squad leaders ended up  
17 killing himself, and it just -- I think that  
18 the difference between then and now is huge,  
19 for the -- we're encouraging our soldiers, and  
20 it's evident in the redeployment process.

21 Whether soldiers are just answering  
22 questions so they can go home for lunch a  
23 little bit sooner, or get home to their

1 families a little bit sooner or not, at least  
2 they know that the Army cares about that stuff  
3 enough.

4 And usually, and I think it's just  
5 now getting to the point where down at the  
6 lower levels of leadership, where they're  
7 encouraging soldiers to seek out that. At the  
8 same time, you know, it goes back to we deal  
9 with some of the same issues with soldiers  
10 jumping on board with that a little bit too  
11 much, looking for another way that they can  
12 get something for nothing or another ends to  
13 whatever means it is they think they're  
14 looking for.

15 But I think the stigma is definitely  
16 -- it's changed a ton in the last ten years.

17 COL STANEK: This is Colonel Stanek.  
18 Thank you guys for coming down here and  
19 sharing your thoughts. Just for the benefit  
20 of the group, could you just kind of let them  
21 know the size of the units that you're in  
22 command of, so they have a perspective of how  
23 many people you're taking care of?

1           CPT STOVER:    I've got 120 soldiers  
2 in my headquarters company.

3           CPT BROADRICK:  175 soldiers.

4           CPT NOLD:    108 people.

5           CPT KORMAN:   I have 161.

6           CPT MANNING:  I have 548.

7           CHAIR DICKEY:    Captain Broadrick,  
8 can we go back to the comment you just made in  
9 response to Dr. Anderson.  You talked about  
10 you think the stigma's improving, particularly  
11 for the soldiers.  What about those of you who  
12 may be looking to stay in for the full 20  
13 years, or the fellows in your battalions who  
14 want to move up?

15                    Is there a different perspective if  
16 you expect the Army to be your home for the  
17 next 20 years?

18           CPT BROADRICK:  It depends on where  
19 you're at.  The short answer is, yes, I think  
20 there is.  I think for us as company  
21 commanders up here, that it's -- that there's  
22 that extra burden of, you know, don't want to  
23 be seen as having to do something like that.

1 But at the same time, I think we all know it's  
2 there, and we all have the opportunity.

3 I mean the Army's there too. I  
4 don't think there's a stigma. There's people  
5 out there saying you won't do it. I think  
6 it's just part. To me, it just feels like  
7 it's just part of the job being in charge of  
8 soldiers.

9 It does -- I believe, I think it  
10 does show not so much weakness, but maybe a  
11 little bit of chink in your armor, that most  
12 leaders aren't going to want to show to their  
13 soldiers. So that's just me personally. I  
14 don't know if everyone else feels the same  
15 way.

16 CHAIR DICKY: Any other comments or  
17 questions for the group? Dr. Higginbotham.

18 DR. HIGGINBOTHAM: Thank you for  
19 coming to share your thoughts this afternoon.  
20 Can you comment on the problems of substance  
21 abuse, and your experience either in the  
22 theater or here at home or is it something  
23 that is actively dealt with, or is it under

1 the cover, if you will?

2 CPT KORMAN: We actually had an  
3 incident down range, when we had -- we had one  
4 soldier we found who was taking spice,  
5 artificial marijuana, and when NCOs questioned  
6 him, went back to his room and found out that  
7 there was a larger problem inside the unit.  
8 In total, there was ten soldiers we ended up  
9 chaptering out of the Army.

10 The issue was since it was a -- at  
11 the time, it was a legal substance in the  
12 state of Washington, even though it's illegal  
13 in the Army. His wife was mailing him that  
14 stuff down range and they were using it. When  
15 we came back, we still have incidents.  
16 Mostly, the only incident I had with my rear D  
17 soldiers, I mean it's still in the barracks.  
18 I think soldiers are going to be soldiers.

19 But also, more importantly, I guess  
20 what upset me with my unit is that some of the  
21 NCOs had the attitude of it's only marijuana,  
22 and I think that's more of a -- I don't know.  
23 Maybe you don't want to talk about it. I

1 think it's more of a younger generation.  
2 There's more acceptance, I think, in the lower  
3 enlisted of the use of certain types of drugs,  
4 and they see no reason why they can't use  
5 them, even if it's illegal.

6 That's only combated by actually the  
7 Army enforcing its policy of chaptering  
8 soldiers out that do that and punishing them,  
9 so everybody else sees that they get done.

10 CPT BROADRICK: Yes. I think that's  
11 one of the -- also one of the byproducts of  
12 the war and, you know, being home for 12  
13 months, 12 to 18 months before you go again  
14 for a year. I know within my own unit, I've  
15 seen -- I've got soldiers that shouldn't have  
16 been here, because they got caught with it.

17 But they, for one reason or another,  
18 were able to get over. But I agree with  
19 Captain Korman. I think that one of the  
20 biggest things that we have to do, and I think  
21 for the most part leaders are trying to do, is  
22 to chapter those soldiers and to pursue  
23 whatever punishments are there.

1           But also, having come back and  
2 having to deal with the few soldiers that have  
3 come up for drug charges since we came back,  
4 there are some things that I'm just figuring  
5 out right now. While we're sitting here  
6 waiting for months for a CID or MPI  
7 investigation to complete before we can even  
8 move on these things, meanwhile these  
9 soldiers, usually the ones that are doing it  
10 are the ones that are planning on getting out  
11 anyways.

12           So they're getting that much closer  
13 to their ETS date and those types of things,  
14 where, you know, it's just part of, I guess  
15 part of the process, waiting for the  
16 bureaucracy to catch up to it and in some  
17 cases, you know, those soldiers may reach  
18 their ETS date beforehand, or get off on some  
19 sort of technicality, and, you know, being  
20 here in Washington, along the I-5 drug belt,  
21 it doesn't help too much either, having --  
22 where soldiers are going out on the weekends  
23 and seeing the stuff all over the place.

1           So if they start seeing soldiers,  
2 where it looks like they're getting away with  
3 it, then it makes our job a little bit tougher  
4 to try to enforce those standards.

5           CHAIR DICKEY: Sorry about that. I  
6 want to thank you very much for being here and  
7 sharing your experiences with us, and  
8 providing some insight that perhaps bring back  
9 some memories for some of these guys, and  
10 educate those of us who haven't been in that  
11 position.

12           You're actually putting faces on the  
13 issues that we've been talking about. So if  
14 all of you would join me in thanking these  
15 gentlemen.

16           (Applause.)

17           **Panel Discussion: Physicians**

18           CHAIR DICKEY: I think we have to  
19 close today one more panel discussion. I'd  
20 like the next panel to come up, and we'll see  
21 if I can do a little better job of  
22 coordinating introductions and individuals,  
23 although it worked reasonably well last time,

1 right?

2 Today's second panel discussion is  
3 going to include a number of physicians from  
4 the Madigan Health Care System, and again,  
5 putting a face on the issues that this Board  
6 spends its time on.

7 So we have, and I'll just give the  
8 list of names, and then ask you to introduce  
9 yourselves briefly, and the same sorts of  
10 issues, I think, is to share with us some of  
11 the challenges that you face, and some of the  
12 constraints, perhaps, in doing your job.

13 Colonel David Vetter, an internist;  
14 Major David Harper, a pediatric subspecialist;  
15 Colonel Tommy Brown, a general surgeon; and  
16 Captain John -- I hope I'll say this right --  
17 Alvitre, physician assistant and flight  
18 surgeon.

19 So how about if you tell us which  
20 name fits with whom, tell us a little bit  
21 about yourselves, deployment history if you  
22 will, and then talk to us a little bit about  
23 the challenges of providing health care.

1 COL VETTER: My name is Colonel  
2 Vetter. I'm an internal medicine doctor at  
3 Madigan, the old man up here, I guess.  
4 Deployed about six times, most recently to  
5 Afghanistan.

6 CPT ALVITRE: And I'm Captain John  
7 Alvitre, the PA in the group. I have six  
8 deployments, 21 years in service at this time,  
9 and I come representing the FORCECOM, the  
10 other side.

11 COL BROWN: I'm Colonel Tommy  
12 Brown, the Western Region Consultant for  
13 General Surgery and the program director and  
14 the chief out here at Madigan for General  
15 Surgery. I deployed in 2005 -- 2006 -- or  
16 2004-2005 to Iraq. I did a turn at Ibn Sina-  
17 Balad and deployed with the split FST in  
18 Afghanistan, and then last year deployed as a  
19 contingent to the Spanish hospital in Herat.

20 MAJ HARPER: Major David Harper.  
21 I'm a pediatric subspecialist by trade. I did  
22 a pediatric residency in the Army and then  
23 went for a year to Afghanistan as a battalion

1 surgeon at the PROFIS system, with an infantry  
2 battalion.

3 Then went to Walter Reed and did  
4 pediatric subspecialty training, and nearly  
5 immediately turned around and went back to the  
6 theater, this time again as a battalion  
7 surgeon with a heavy brigade combat team. I  
8 am now at Madigan as a pediatric oncologist,  
9 working in the Medical Center there.

10 CHAIR DICKEY: And perhaps you can  
11 share with us -- you heard a little bit about,  
12 the last panel, some of the issues in terms of  
13 assuring readiness before our soldiers leave,  
14 dealing with issues as they come back, and I  
15 know there's particular interest in terms of  
16 the behavioral health and the stigma or lack  
17 thereof, in terms of people seeking care.

18 MAJ HARPER: As working down with  
19 the battalions, an infantry battalion or  
20 whatever, that's both getting ready to deploy  
21 and returning from deployment, and then seeing  
22 a battalion go in 2005 versus recently, 2010,  
23 some of those issues -- the readiness issues,

1 there's competing interests sometimes, and I  
2 think with the new system. But for getting a  
3 unit ready to deploy, taking care of the  
4 soldiers versus meeting the mission, being  
5 able to get soldiers to field, all of the  
6 different assignments that any team needs as  
7 they go, and whenever you're getting ready for  
8 deployment, identifying the soldiers that have  
9 medical issues, that maybe they need to stay  
10 at home, maybe they need to get out of the  
11 Army. Maybe that can be taken care of in-  
12 theater, what kind of medical resources are  
13 available in-theater to take care of them, is  
14 a difficult and challenging process.

15 It always comes down to the wire for  
16 some of those, to the point with the last  
17 deployment I went on, as I attached the unit  
18 ultimately in the last few weeks, helping the  
19 battalion brigade commanders to identify which  
20 soldiers need to stay and be able to go, and  
21 some of them literally weren't cleared to get  
22 on the aircraft to fly to theater, until the  
23 day they were able to go.

1           And for the most part, I think we do  
2 it right. But any brigade that goes, it's  
3 taking several thousand people, and there's  
4 going to be a few that get down range that  
5 probably shouldn't have gone. Likewise,  
6 there's going to be a few that were in the  
7 system and weren't able to go, because there  
8 were some medical issues.

9           But maybe they could have gone and  
10 could have been fine on the deployment and  
11 done their job, but they got left behind. I  
12 think those are individual cases. But when  
13 you look at the large number, I think we're  
14 doing that right. That's kind of that. I  
15 guess I'll see if other people have comments  
16 on that, and then I think answer some  
17 questions about the others.

18           CPT ALVITRE: One thing I did notice  
19 is, being that I'm an integrated provider,  
20 meaning that I'm with my unit 24-7. We go get  
21 deployed, we come back. I don't take off. I  
22 don't leave. I don't go back to a hospital.  
23 So since I belong to that unit, it's very

1 helpful, because I have eyes-on, you know,  
2 every day.

3 Any time these individuals need any  
4 kind of health care, they come to see me  
5 first. So I know I'm going to give that  
6 continuity of care. I would say if you look  
7 across the board, when you compare unit to  
8 unit, those with integrated providers do fare  
9 well. They fare much better, because they  
10 already have somebody who knows what's going  
11 on.

12 A lot of the previous commanders  
13 that are up here, they actually don't have  
14 integrated either PA, doctor, MD or DO. They  
15 don't have a nurse. They don't have somebody  
16 that's tracking that, somebody that says, yes,  
17 I'm giving you this medication, you know. I  
18 prescribed it. I know what's going on, and  
19 then I know about all the, be it 90-day  
20 medication, you've got to be on it 90 days.  
21 We've got to make sure you do well.

22 So I have, I guess, the wild card up  
23 my sleeve, in being able to know my people.

1 Now that we're not moving units as much, I  
2 actually was in my last brigade for five  
3 years. So I knew them pretty well. We were  
4 able to maintain a 90 percent deployability  
5 strength. Other units, you know, were down  
6 to, I would say 70 percent.

7 They didn't have somebody that was  
8 integrated with the unit, and when you're  
9 talking about 800 to 1,000 personnel, that's a  
10 lot of people. So I would say one of the keys  
11 we have noted was having a provider that's  
12 actually integrated in the unit from the  
13 start, and that made a big difference.

14 DR. JENKINS: Don Jenkins. Tommy,  
15 good to see you again. Tommy taught me how to  
16 debride IED wounds in 2004, before he left the  
17 Balad, went down to Ibn Sina. Good to see  
18 you. A question specifically for you.  
19 Colonel Homas really is exceptionally proud of  
20 the GME mission at Madigan. He told us all  
21 about that in great -- vivid detail this  
22 morning.

23 My question specifically to you, as

1 a program director, do you have protected time  
2 away from deployment, or are you going to be  
3 gone from the residency training program as a  
4 program director for a year or more, and how  
5 do you do that?

6 What's going on in the general  
7 surgery programs in the Army, with the program  
8 director specifically? How do you protect for  
9 that? What is the ROC thing to that, and is  
10 there anything that we can do from this end,  
11 to make sure that all missions are met?

12 In ACGME, it was a tough thing for  
13 us, because there was a credibility issue.  
14 How could you be teaching the military  
15 surgeons of the future if you weren't  
16 deploying? But at the same time, you're not  
17 there as a program director when those people,  
18 you miss out on an entire year of the training  
19 of your own trainees. Can you talk a little  
20 bit about that?

21 COL BROWN: Well, the ACGME has  
22 very specific guidelines for program  
23 directors. So a program director can only

1 deploy for three months at a time, boots on  
2 the ground. So you know, I deployed with you  
3 six plus months when I was gone before. But  
4 once I became program director, my deployments  
5 are only three months long.

6 The program directors, we don't --  
7 there's six of us in the Army General Surgery,  
8 and we don't follow the same tempo as everyone  
9 else. You know, I deploy every couple of  
10 years. The other general surgeons deploy for  
11 six month deployments now. Since 2005, the  
12 limit general surgeon deployments to six  
13 months at a time. The tempo right now, most  
14 of the guys who have been in since 2005 or so  
15 have deployed three to four times, and they  
16 generally have a dwell time of about 12 to 16  
17 months.

18 So there are some guidelines that  
19 have to be followed and that's helpful. Many  
20 of the programs, like Madigan, we have three  
21 civilian surgeons who help maintain a base for  
22 us when multiple providers are deployed.  
23 Certainly, you know, the deployment tempo is

1 very high for general surgeons. It's higher  
2 than most any other group, and you know, it  
3 takes its toll on your training staff.

4 But in general, having the program  
5 director deploy for a lesser period of time is  
6 helpful. If your hospital is able to support  
7 hiring a civilian or two to help maintain that  
8 base, that's helpful as well.

9 CHAIR DICKEY: Can any of you  
10 address a little bit, I think you may have  
11 just a bit, Colonel -- Captain, but the stigma  
12 of behavioral health, and whether you perceive  
13 that we're improving the problems. I  
14 appreciate what you said about being embedded.  
15 I think in fact that it must be a phenomenal,  
16 I'd say, ace up your sleeve, because of the  
17 capability of actually seeing the differences.  
18 So much of a power factor.

19 In fact, I am amazed that we don't  
20 just do that for every group. But talking a  
21 little bit about the changes you've seen in  
22 terms of behavioral health availability and  
23 stigma in the last five years or so.

1 CPT ALVITRE: Ma'am, the behavioral  
2 health has, I would say, definitely improved.  
3 We've gone from having a far off location to  
4 get a psychologist, psychiatrist. Now we have  
5 them every FOB, it seems, and in some cases we  
6 have up to five. Which has been great,  
7 because we bring in the Navy, the Air Force  
8 and the Army, everybody working together.

9 We've also done a lot of the  
10 respect.mil or RESPECT-Mil program. We've  
11 integrated my -- first it started with my  
12 squadron, the battalion level unit, then our  
13 brigade. What we did is once a month, we  
14 brought in all the commanders, all the company  
15 commanders and the first sergeant, because  
16 they were the ones doing the administrative  
17 part of it, and we talked to them one on one.

18 We had the chaplain there. We  
19 brought somebody from mental health, and then  
20 the medical providers for that unit, with the  
21 colonel or lieutenant colonel and the sergeant  
22 major, and then again, like I said, the  
23 commander and first sergeant.

1           So the commander or the commanding  
2 group knew everything going on at their level  
3 and below. By doing that, we would go case by  
4 case, because this program we developed we did  
5 internally, and everybody was doing it.  
6 Nobody was talking to anybody about it. Now  
7 it's become a standard.

8           What we do is we would say, hey, has  
9 anybody, you know, gone to see you, Chaplain?  
10 Has anybody come to the aid station to see  
11 you? And pretty soon, we noted that this  
12 individual with a minor problem over here, a  
13 minor problem over here. We put them together  
14 and he had a pretty outstanding issue going  
15 on.

16           You know, so we started piecing that  
17 together, and we stayed -- I would say we  
18 stayed pretty much a step ahead. We only had  
19 to send one individual back for mental health  
20 concerns. Other than that, we you know, just  
21 monthly talking about it. The commanders had  
22 less of a stigma, and everybody, the stigma, I  
23 would say, was decreased by having access, by

1 having that security, HIPAA in a sense, with  
2 it.

3           You as a commander could come talk  
4 to me, and I know what I'm supposed to do by  
5 HIPAA. I also know what the commander is  
6 entitled to, and that's where we get into that  
7 gray area. There's the regulation that covers  
8 it, and if you give the commander only what  
9 they need, they actually have a lot of -- a  
10 lot that they're armed with to make proper  
11 decisions.

12           So we started doing that program.  
13 It developed to the point that a commander  
14 could come see me 24-7 about any of his  
15 soldiers, and I would talk to him, and it was  
16 between us. If we had to bring it up to the  
17 bigger boss, the colonel, lieutenant colonel  
18 and sergeant major, we'd take it to him.

19           By offering that, we actually had a  
20 lot of field grades that would come see us for  
21 personal matters. So the doors started  
22 opening up. People were, you know, the stigma  
23 was gone. They knew that they were going to

1 be secure. They knew that we weren't out  
2 there just spreading all of the rumors and  
3 what's going on.

4 Once we felt there was a secure plan  
5 in place, we received a lot more, we took care  
6 of a lot more, we got a lot more people back  
7 to the mission.

8 CHAIR DICKEY: What would you have  
9 said to the captain that was describing it as  
10 a bit more problematic than that? Are we  
11 asking the wrong questions or just reassuring  
12 that if he seeks out the right piece of  
13 information, he should be able to get it?

14 CPT ALVITRE: Going back to that, I  
15 would say that, again, as an engineering unit,  
16 most of them do not have an internal medical  
17 provider who is with them. Since they get  
18 somebody, you know, it could be from this  
19 group, that shows up, doesn't know them from,  
20 you know, anybody else, day one, day 30, you  
21 know, of knowing these people.

22 They're deployed in another country,  
23 so they don't know historic background. They,

1 you know, have to build those bridges. By the  
2 time the building of that bridge is there,  
3 we're too far. So getting it at the  
4 beginning, getting the provider that's  
5 integrated. Those, and the chaplain. We  
6 integrated our chaplain extensively. We put  
7 him through, you know, medical training, EMT.  
8 So he was able to be with us. We were able to  
9 be with him, and everything worked together.

10 So it is there, it's available. I  
11 would say even if they sought it out. You  
12 know, I used to go from JCOP to JCOP, fly out,  
13 drive out or whatever, and I'd go out on  
14 patrols with individuals. My chaplain  
15 actually would go out to the JCOP as well, and  
16 so would our command group.

17 Everybody was integrated. Everybody  
18 went out to see what everybody's job was. The  
19 more we did that, the more they saw our  
20 presence, the less they worried. And then we  
21 integrated the medics as a form of counselor,  
22 that they could come see our senior medic, who  
23 in turn could come see us.

1           You know, we could get them to the  
2 mental health channel, and I believe the  
3 Army's developed a program for that as well.  
4 So now we're getting a wider net that we're  
5 throwing out.

6           MAJ HARPER: I was going to comment  
7 specifically on the other issue. Twice now  
8 I've been the provider who's been taken from  
9 other hospital and attached with a unit to go.  
10 There are some challenges developing trust  
11 within the unit, both within the leadership  
12 and within the soldiers and things.

13           But over time, you can definitely do  
14 that, and I appreciate the comments before,  
15 you know, about getting out there and talking  
16 to the commanders and talking to the soldiers.  
17 If you can do that, you can be there when the  
18 soldiers need that.

19           Sometimes, it's limited what you can  
20 do by just physical location. There are  
21 tremendous behavioral health resources that  
22 are now available in-theater. But companies  
23 and battalions and things are being broken up

1 on small basis throughout large areas, and  
2 there are units that will spend months at a  
3 time without being able to have behavioral  
4 health provider or a medical provider or a PA.

5 And I think sometimes they're at a  
6 little bit higher risk. The only way to get  
7 those kind of providers out to everybody would  
8 be basically to have one within each company  
9 or each platoon, and I think that's -- being  
10 in the right place at the right time for the  
11 right person is something that's difficult to  
12 do.

13 The stigma of people seeking health  
14 care has changed, or is better, certainly in  
15 2010 or 2011 than it was in 2005, where  
16 soldiers feel more comfortable coming and  
17 getting help. Leadership certainly knows more  
18 about it, and the higher level commanders  
19 recognize that they need to help their  
20 soldiers deal with it, and there's less  
21 pressure.

22 It in some ways seems to the point  
23 now where they expect so much, that the young

1 soldiers coming in are sometimes almost  
2 wondering why don't I have some of these  
3 problems? Or, you know, we talk about it so  
4 much that being normal or being healthy or not  
5 having a problem right now is maybe being seen  
6 as abnormal. I'm not sure that's a bad thing.  
7 That's definitely an improvement.

8 DR. ANDERSON: Please talk about the  
9 provider side a bit. It's been a long war,  
10 huge implications on the medical force  
11 structure, if you will, about retention and  
12 recruiting and morale in general, CONUS and  
13 down range.

14 COL BROWN: From a general surgery  
15 standpoint, you know, again we're a fairly  
16 highly deployed group, and you know, most of  
17 us have been deployed three or four times, and  
18 almost all of us will tell you it's the most  
19 professionally rewarding part of our careers.

20 But what is a problem for us right  
21 now, general surgery in particular, is we're  
22 losing mid-level providers, because, you know,  
23 we have a few guys like me who have been

1 around for a while and will stay in, and we  
2 have all the young, you know, docs who are  
3 still coming in.

4 But we're losing our mid-level  
5 providers, because of our deployment tempo,  
6 and, you know, when you -- I did a deployment,  
7 you know, PDS for this last year, and when you  
8 call the guys up and say you're going to  
9 Afghanistan, they're okay with that, because  
10 they're going to go and they're going to work.  
11 We're going to use our hands and do what we're  
12 trained to do.

13 But when we tell someone you're  
14 going to Iraq, where the surgical footprint is  
15 as big as it's ever been, and we're continuing  
16 to just sit there and do nothing for six  
17 months, you know, there's a lot of general  
18 unhappiness about that. That's driving our  
19 mid-level providers out. We're losing our  
20 mid-level surgeons at a high rate.

21 You know, I think everybody would be  
22 happy to see us downsize that footprint at  
23 places where we're not needed, and we're all

1 just sitting on our hands.

2 COL VETTER: It's important to  
3 realize that there's two patterns of  
4 deployments for medical folks, but also for  
5 the ordinary soldier. One is a pattern that's  
6 more traditional, where the mission is very  
7 intense, the unit's very cohesive, and, you  
8 know, I think those folks actually do pretty  
9 well.

10 But there's a modern deployment now  
11 where if the mission's not as intense, what  
12 ends up happening is you end up being plugged  
13 into two totally different worlds at the same  
14 time. You know, you can go through your day  
15 down range deployed with all the stresses of  
16 deployment, and then have internet access or  
17 Skype or phone access, and deal with all the  
18 things that happen with your family, you know,  
19 during that very same day.

20 Especially on the younger folks, you  
21 know, the stresses of those two very  
22 schizophrenic worlds really set them up for  
23 some challenges. That's the people, I think,

1 that need the most access to the mental health  
2 folks, and that probably generates, you know,  
3 a lot of the business. So the deployments  
4 I've been on, you know, have been more of the  
5 mission intense ones. They've been life-  
6 changing, very fulfilling experiences.

7 But there's also deployments where,  
8 you know, you very much are expected to be  
9 plugged into both worlds and, you know, making  
10 sure the electric bill's been paid and, you  
11 know, the oil tank's full and all that kind of  
12 stuff too.

13 So it's a challenge, but I think we  
14 also take a lot of pride in being able to meet  
15 those challenges. I don't think many people  
16 in the world can.

17 MAJ HARPER: So there's a big need  
18 for the Army to have, you know, general  
19 medical officers that can fit it any role and  
20 support any unit, and be the doc for that  
21 group. The pool of people who can fill that,  
22 it needs to be a big group, and there's a lot  
23 of subspecialty training there.

1           For example, I do pediatric  
2 oncology, and that's my interest. And yet I  
3 get pulled and for a year at a time become a  
4 general medical officer for a unit. That's  
5 rewarding, I think, but it's different, I  
6 think, than stepping out of doing general  
7 surgery here and general surgery in Iraq, or  
8 general surgery here and general surgery in  
9 Afghanistan.

10           And that certainly has taken a toll  
11 on some of my colleagues and their goals and  
12 their career interests and things like that,  
13 with staying in. It's hard to stay  
14 academically competitive in a career in  
15 research or academic medicine or GME or any of  
16 those things, where your career is punctuated  
17 by eight, nine, ten, twelve months coming out,  
18 and now 16 months sometimes, when we attach to  
19 the units and stay an extra 90 days to help  
20 with the mental health needs.

21           But balancing that into a  
22 specialized medical career is a challenge, and  
23 I know that it's, you know, affecting the way

1 some people think about their long-term goals.

2 CHAIR DICKEY: Dr. Jenkins.

3 DR. JENKINS: For you, Major, a  
4 quick couple of questions. I respect you  
5 tremendously as the father of a childhood  
6 leukemia survivor, cared for by a brilliant  
7 Air Force pediatric oncologist. I have  
8 friends as pediatricians who've deployed in  
9 this role, and it has to be tremendously  
10 challenging to care for a population of  
11 patients who you've never been trained to care  
12 for.

13 What specifically did you do or the  
14 Army, to be able to you -- to prepare you for  
15 that role, taking care of adults with adult  
16 problems and specifically some of these  
17 challenging mental health issues, number one?

18 Number two, it's my personal opinion  
19 that the only way to effect a change in field  
20 care, a la Tactical Combat Casualty Care, you  
21 have to engage the surgeons, because that's  
22 the point at which all medical care flows into  
23 the field. Did you specifically, or does the

1 Army have an update kind of program that, for  
2 instance, we voted today on the use of  
3 tranexamic acid at the combat medic level.

4 What training specifically would you  
5 receive, in terms of an update of the latest  
6 practices and such in-theater, before going?

7 MAJ HARPER: In 2005, nothing, no  
8 updates, and I'll talk about 2010 in just a  
9 minute. So the challenge of jumping to taking  
10 care of adult medicine, I think -- I don't  
11 want to say pediatricians can't. I think we  
12 do a very good job of taking care of soldiers,  
13 because we have training in adolescent  
14 medicine, and a lot of the behavior, the  
15 substance abuse and you know, just the way  
16 that young soldiers think and a lot of the  
17 problems they have, we have a lot of training  
18 in, and it's rewarding to apply that there.

19 But what we're not necessarily well-  
20 trained in or good at is trauma first aid, and  
21 yet at that level, at the PROFIS level, that's  
22 really, you know, where you end up. In 2005,  
23 there wasn't a lot. We went through kind of

1 what the brigade surgeon had organized down at  
2 the brigade level, and went through that  
3 training.

4 That's now standardized, and as I  
5 went in 2010, I had the opportunity to go down  
6 to Fort Sam Houston and take the Tactical  
7 Combat Casualty Care course for providers, and  
8 review. Not just getting my own hands back  
9 on, but that course is continuously updated  
10 from what we're learning from the field. So  
11 that's definitely something we've done well,  
12 and that's from both my experience and the  
13 experience of others.

14 The one downside to it, though, is  
15 that's another couple of weeks, you know. So  
16 you tack that on ahead of a deployment or  
17 whatever, and that's more time away from what  
18 you're trying to do.

19 CHAIR DICKEY: In a follow-up to  
20 that question, there's some evidence, and I  
21 think most of it, all of it perhaps going from  
22 the military, that on the flip side of that,  
23 where you've gone and been dealing with

1 advanced adolescent medicine, if you will, you  
2 step out of your specialty for a period of  
3 time, and for as long as a year or more, and  
4 then you're going to come back and jump into  
5 that.

6 So I guess the question is first, is  
7 there any retraining when you come back, and  
8 second, are there lessons that the military  
9 may have learned as we look at civilian  
10 medicine, where people are more commonly today  
11 stepping in and out of clinical practice than  
12 perhaps they did 20 years ago?

13 MAJ HARPER: There are opportunities  
14 for retraining. If you -- certainly within  
15 skilled things for surgical procedures and  
16 things like that, I know there are  
17 opportunities.

18 For my specialty, if I would have  
19 asked and said I need time, then, you know,  
20 time could have been provided. I had some  
21 good partners here and some mentors. So  
22 things that are maybe not as fresh, you have  
23 time to review and things like that.

1           But honestly to come back from that  
2 period of time, when you're gone away, it  
3 taxes the system that you came from, and you  
4 came back in and as you reintegrate, you  
5 integrate with your family and things, you  
6 start to get back in. Finally, whoever's been  
7 covering for you is, you know, they need a  
8 break too, to some degree.

9           And so to take -- you know, to  
10 answer that question honestly, to take a lot  
11 of time and say I need this time to retrain on  
12 things, is putting your friend, your  
13 colleague, the other person in the trench, you  
14 know, potentially in a difficult way.

15           But with that said, in my  
16 experience, I've had good colleagues and good  
17 mentors who were able to get back in, to  
18 review things, to work together as a team, and  
19 we've been able to do it and be okay. But --  
20 and I was offered the opportunity to do  
21 retraining if I felt like I needed it, but  
22 didn't, because of those other reasons.

23           CHAIR DICKEY:       Last thoughts or

1 other questions?

2 (No response.)

3 CHAIR DICKEY: Gentlemen, allow us  
4 to thank you for at the end of I'm sure a long  
5 day for all of you, coming over and sharing  
6 your insights with us. If you'll help thank  
7 the doctors for it.

8 (Applause.)

9 CHAIR DICKEY: I know what our  
10 civilian doctors would say if we asked them at  
11 the end of the day to please come over and  
12 brief a group of people. So we thank you very  
13 much for the additional time, and no extra  
14 pay, I suspect, right?

15 (Laughter.)

16 **Closing Remarks**

17 CHAIR DICKEY: Ms. Bader, a little  
18 late, but would you like to offer any  
19 administrative remarks before the meeting is  
20 adjourned?

21 MS. BADER: Sure. Just very  
22 briefly, I mean, there's a manila envelope for  
23 everyone around the table, for you to put your

1 materials from your binder in your manila  
2 envelope, and then you can take that home this  
3 evening.

4 As a reminder, the Board will be  
5 conducting a site visit tomorrow to Madigan.  
6 This site visit is not open to the public. We  
7 will at 6:45 meet in Venice 2 for an  
8 administrative session and breakfast, and  
9 lunch will be served at the McChord Club.

10 Members and invited guests are  
11 kindly requested to convene in the hotel lobby  
12 by 7:30 tomorrow morning. If you're not  
13 joining us for lunch -- I mean, excuse me, for  
14 breakfast -- and then at 7:30 we'll board the  
15 bus to Madigan.

16 For those who are joining us for  
17 dinner tonight, we will convene in the lobby  
18 by six to take a shuttle to the restaurant and  
19 a return shuttle will be provided as well.  
20 I'm going to ask Jen Klevenow to talk a little  
21 bit about the logistics tomorrow. I know  
22 folks have flight times that vary throughout  
23 the day. So she's going to give us a little

1 bit of information on shuttles.

2 MS. KLEVENOW: Hi. Okay, so like  
3 Ms. Bader said, 6:45 a.m. is breakfast next  
4 door. We are going to leave promptly at 7:30  
5 and head over to the base. For those of you  
6 that are going on the site visit but cannot  
7 stay until the end time, I guess, please let  
8 me know. We do have a vehicle on standby.

9 We will use that vehicle to either  
10 transport you back or possibly even the  
11 airport. We just need to know in advance.  
12 But we do have that one vehicle on standby.  
13 For dinner tonight, if you haven't RSVP'd,  
14 please let me know. We may need to change  
15 seating arrangements at the restaurant, and  
16 the same goes for tomorrow.

17 If you did not register for tomorrow  
18 but you plan to attend, please let me know, so  
19 that we can make the arrangements for you. I  
20 don't have anything else.

21 CHAIR DICKEY: All right, thank you  
22 very much, and let's see. This meeting of the  
23 Defense Health Board is adjourned. I want to

1 thank all of you for attending. Particularly,  
2 I want to thank all of you for coming, as we  
3 were going to have some challenges with quorum  
4 and I think we got a tremendous amount of work  
5 done.

6 We thank all of you who made  
7 presentations and helped us get through that  
8 as well, and this meeting is now adjourned.

9 (Whereupon, at 5:25 p.m., the above-  
10 entitled matter was adjourned.)  
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