

THE DEPARTMENT OF DEFENSE

DAY 1

September 19, 2007

San Antonio, Texas

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

2 (9:07 a.m.)

3 DR. POLAND: Good morning, everybody.
4 Welcome to this meeting of the Defense Health
5 Board here in San Antonio, Texas. We have a large
6 number of topics to discuss today and tomorrow,
7 particularly those related to treatment of wounded
8 warriors; both while they're under the
9 department's care and then when they transition to
10 the VA when they're no longer fit for duty.

11 I first want to thank Brooke Army
12 Medical Center (BAMC) for hosting this meeting and in
13 particular Brigadier General James Gilmore, to my
14 left, the Brooke Arm Medical Center Commander for
15 being here to welcome us. I know you're very busy
16 taking time out of your day to come and see us and
17 inform us about the mission is a treat for us.

18 Dr. Kilpatrick, would you call the
19 meeting to order, please.

20 DR. KILPATRICK: Thank you, Dr. Poland.
21 As the duly appointed alternate designated federal
22 official for the Defense Health Board, which is a

1 federal advisory committee to the Secretary of
2 Defense, and serving as a continuing independent
3 scientific advisory body to the Secretary of
4 Defense via the Assistant Secretary of Defense for
5 Health Affairs and the Surgeons General of the
6 military departments, I hereby call this meeting
7 of the Defense Health Board to order.

8 DR. POLAND: Thank you. Following the
9 tradition that we started at the beginning of my
10 tenure, could I ask all in the room to stand for a
11 minute of silence to honor the men and women who
12 are serving our country?

13 (MINUTE OF SILENCE OBSERVED)

14 DR. POLAND: Thank you. I want to go
15 around and have members of the Board introduce
16 themselves. We'll start first with some of the
17 distinguished guests that we have visiting us
18 today.

19 The first is the Honorable Bill Carr,
20 undersecretary of defense for military personnel
21 policy.

22 Mr. Tom Pamperin, the Department of

1 Veterans Affairs.

2 Mr. Arnold Fisher, I don't see him yet.
3 You'll get to meet him, of Fisher House Foundation
4 and also a member of IRG on rehab care and
5 administrative processes of Walter Reed Army
6 Medical Center.

7 Dr. Chip Roadman, retired Air Force
8 surgeon general and also a member of the IRG.

9 Dr. Charles Rice, Dean of the Uniformed
10 Services University. I don't see him here either.

11 Major General Michael Tucker. Actually,
12 he'll be with us tomorrow.

13 Colonel Jim Neville, Commander of the
14 Air Force Institute for Occupational Health.

15 Colonel Michael Bunning, Chief of Public
16 Health Air Force Surgeon General's office.

17 So if we could, I'll ask Dr. Kilpatrick
18 to start and we'll go around the Board and then in
19 the back and along the sides to introduce
20 ourselves.

21 (INTRODUCTIONS MADE)

22 DR. POLAND: I think we have everybody.

1 Colonel Gibson has some administrative remarks
2 before we begin the morning.

3 COL GIBSON: Very quickly. Make sure
4 you sign the attendance roster. It's one of the
5 Federal Advisory Committee requirements. We need
6 to keep track of everybody who attends. Because
7 this is an open session it is being transcribed,
8 so if you come to the mics, please speak clearly,
9 speak into the microphones and state your name
10 before you speak. Turn your cell phones and
11 Blackberry's to off, vibrate or stun whichever you
12 want. Try to keep the Blackberry's below the
13 table, if you will, sometimes they'll interfere
14 with the microphones. Refreshments will be
15 available for both morning and afternoon sessions.
16 We'll have a catered working lunch for the Board
17 members, preventive medicine officers, speakers
18 and distinguished guests. For others attending
19 there is a wealth of very fine restaurants nearby.
20 We're getting two Continuing Medical Education CME credits.
21 We would have more, but folks need to get the paperwork
22 into us so we can provide more -- early enough so we can

1 provide CME credits for this meeting. For the
2 Board members your paperwork is inside your
3 notebooks. For others we have additional
4 paperwork, see Karen that you'll have to fill out
5 to get credit for that. Finally, the next meeting
6 of the Board is the 11th and 12th of December in
7 Washington, D.C. We haven't quite nailed down the
8 hotel, so please check our website and we'll be
9 sending out invitations as well to that meeting.
10 This meeting we will receive and deliberate the
11 report from the Task Force on the Future of
12 Military Healthcare. That report is due to the
13 Secretary of Defense by the 20th of December, so
14 we will deliberate it before that and we'll
15 address a number of other issues that come before
16 the Board. Finally, I want to thank Karen and
17 Britt Triplett, who are here, and Ms. Jarrett and
18 Ms. Ward, who are back home, for their assistance
19 in putting this meeting together. Again, thank
20 you to Brigadier General Gilman, who used to be my
21 boss when I was at OTSG, for being here with us
22 today.

1 DR. POLAND: Very good. It is my
2 pleasure now to introduce Brigadier General Jim
3 Gilman. General Gilman is a 1974 graduate of the
4 Rose-Hulman Institute of Technology, with a degree
5 in biological engineering. He received his M.D.
6 Degree from Indiana University School of Medicine
7 in 1978. He's board certified in both internal
8 medicine and cardiovascular diseases. As a career
9 Army doc, he served in a number of locations
10 including Darnell Army Community Hospital, Fort
11 Hood, Texas, Madigan Army Medical Center, Fort
12 Lewis, Washington, Bassett Army Community
13 Hospital, Fort Wainwright, Alaska; and the Office
14 of the Surgeon General. He is currently Commander
15 Brooke Army Medical Center in Great Plains
16 Regional Medical Command. Brigadier General
17 Gilman has served as the commander of the Walter
18 Reed Healthcare System. His full bio is in your
19 briefing books. General Gilman, welcome.

20 BG GILMAN: Thanks. It is a pleasure
21 and an honor to number one, welcome you to San
22 Antonio. What Dr. Poland didn't tell you is that

1 I have spent an awful lot of my Army career here
2 and this is sort of our second home next to
3 Indiana. It's an honor -- first of all, Roger
4 said that I was his boss for a brief period of
5 time, and when I arrived at the surgeon general
6 office and I looked around at all the things that
7 I was supposed to know something about, there was
8 this cat called the Armed Forces Epidemiology
9 Board and the then executive director, I made him
10 come talk to me three or four or five times just
11 so I could begin to understand what the AFEB was
12 about. That was really still early in this global
13 war on terrorism, so this -- my impression from
14 what I see in the topics that are being addressed
15 here is that it's gone from being a deliberative
16 laid-back body to a body that really presumes to
17 tackle some of the most difficult issues that we
18 face on a day-to-day basis at the macro level.
19 And the approach that's taken is the one that's
20 taken many, many times, and that is: You take a
21 bunch of busy people and you give them one more
22 thing to do because they can't just keep adding to

1 their plate, they really do have to get some
2 things done. So I commend you for your service to
3 the country through this forum and now I'll just
4 sort of tell you a little bit about this place
5 where we work and that we care a great deal about
6 called Brooke Army Medical Center. Next slide.

7 This video doesn't launch, you'll have
8 to trust me, this was going to be a great video
9 clip that lasts two or three minutes that really
10 shows you the young men and women we take care of.
11 About half the patients were from Walter Reed and
12 about half the patients are from Brooke Army
13 Medical Center. It was actually put together by
14 the recruiters for us. They never show it,
15 because they don't like to show people that get
16 hurt. I still think that for recruiting
17 healthcare professionals it's a great video
18 because everybody wants to take care of patients
19 like we get to take care of. Next slide.

20 My mission statements are all short.
21 They almost always say "We". They say warrior
22 instead of soldier. And because my mom is an

1 English teacher, they have a verb. The key here
2 -- and I was the one who saddled Walter Reed with
3 "We provide warrior care", by the way. I got
4 Walter Reed from 51 words to four. Brooke Army
5 Medical Center down to six. The goal here is not
6 to have a mission statement that only the colonels
7 in the organization can understand. This is meant
8 for every E-3, PFC (Private First Class) in the
9 organization to learn and understand. But we mean
10 this in very global and holistic way. We spent a lot
11 of time -- when I introduced this to new employees
12 regularly, it is talking about if you're taking care of
13 kids in the pediatric clinic, that's part of warrior
14 service. If you're taking care of the spouses of
15 soldier's down-range, then that's warrior service.
16 If you're taking care of people who are too old to
17 be active warriors anymore, but you're taking care
18 of them within the culture that they understand
19 and you understand the nature of their service,
20 that's part of warrior service. If you're taking
21 care of their medical records as an administrator.
22 If you're billing so that we can provide a few

1 more services to those that have other health
2 insurance, that's warrior service. The challenges
3 to every member, every new employee, is if you
4 can't figure how what you do relates to warrior
5 service, you get on my calendar and you come see
6 me. So far nobody has showed up, but that's not
7 too surprising either. Next slide.

8 This is a typical day at Brooke Army
9 Medical Center. In parentheses below the first
10 numbers are the number of those that involve
11 warriors in transition. I will tell you that the
12 admissions of warriors in transition to Brooke
13 Army Medical Center has gone up and you'll see --
14 so that this average, this slide average over a
15 while doesn't probably reflect this. But if you
16 look at what we do, it's not too much different
17 that you would see in any medium-sized civilian
18 hospital. It doesn't qualify as a large hospital
19 based on some of the institutions that many of you
20 represent. A couple of things I would note is at
21 Brooke Army Medical Center and Wilford Hall Air
22 Force Medical Center are both part of the San

1 Antonio City's emergency medical system. We do
2 take civilian trauma. Two ambulances to
3 University Hospital, one to Wilford Hall and one
4 to BAMC is sort of the way the emergency operation
5 center of the City and the County work that out.
6 Again, this -- taking care of civilian trauma is
7 especially important between wars because that's
8 really our combat casualty care battle lab. And
9 to stay involved in that mission, we think, is
10 very important. So important that as we start
11 talking about base realignment and closure, we
12 intend to take care of our share of the trauma and
13 Wilford Hall's share of the trauma, both at Brooke
14 Army Medical Center when that becomes the only
15 inpatient facility. We have a very busy emergency
16 room. We have a great dining facility. It's too
17 bad you won't get a chance to eat over there. A
18 couple of things are notable by their absence.
19 First of all, we don't do labor and delivery at
20 Brooke Army Medical Center. That's been done at
21 Wilford Hall for over 10 years. All of the OB
22 care is -- and we do clinic at Brooke Army Medical

1 Center, but all the deliveries, at least all those
2 that we can plan, take place at Wilford Hall Air
3 Force Medical Center. There have been a grand
4 total of two deliveries at BAMC, since I took
5 command over two years ago. One was a lady who
6 came to our emergency room, severely pre-eclamptic,
7 who required delivery in order to get ahead of her
8 medical problems. And the second one was a
9 delivery in our OR as a mother's life was ending a
10 baby -- an emergency C-section was done and the
11 baby's name is Andrea Isabella Escamilla and the
12 baby is doing just fine. She was delivered there
13 and taken to one of the city hospitals for care of
14 her prematurity. So two deliveries in a little
15 over two years. That makes us different from just
16 about every place else, except Walter Reed, which
17 sort of is in kind of the same boat. Next slide.

18 Brooke Army Medical Center is sort of at
19 the center of the Great Plains Regional Medical
20 Command. The Army is organized into geographic
21 regions for the delivery of medical care. The
22 Great Plains Regional Medical Command, as you can

1 see, is the -- as you could probably guess from
2 this slide, is the largest regional medical
3 command besides Brooke Army Medical Center, there
4 are nine other health centers or hospitals that
5 fall as part of the regional medical command. The
6 three largest are in Texas. And then we also have
7 a number of occupational health missions that take
8 around to places that we wouldn't otherwise get to
9 like out here in Utah. We do still provide the
10 National Guard support and the summer camp
11 support. The Minneapolis VA is part of -- liaison
12 with them is part of our responsibility within the
13 Great Plains. We just recently annexed Minnesota
14 from the North Atlantic Regional Medical Command,
15 and we've got our eyes on Wisconsin. We're going
16 to get them next. Next slide.

17 This illustrates the way patients come
18 back to us from Iraq or Afghanistan. Injury on
19 the battlefield and initial care is provided by a
20 combat medic or this 18-Delta would then be a
21 special-forces medic. They are trained, they are
22 well equipped. They have a tourniquet that works

1 that you guys know everything about. And probably
2 the biggest change in the Army medical department
3 between the first Gulf War and the current
4 conflict is the fact that General Peek almost
5 single-handedly transformed this MOS (Military
6 Occupational Specialty) from a kind of a nursing
7 assistant point of view to being a real emergency
8 medicine technician who can take care of trauma,
9 transforming the second largest MOS in the Army
10 was a Herculean task completed just in time. We
11 are in the final stages of this transformation.
12 From there they're taken by ground or by air to a
13 forged surgical team where life-sustaining
14 surgery, but not definitive surgery is done. They
15 go from there to some sort of in-theater combat
16 support hospital or the Air Force's hospital in
17 Balad where additional stabilization and
18 preparation for transport; more definitive, but
19 still not definitive. Taken from there then out
20 of theater to Landstuhl Regional Medical Center.
21 Jointly Army, Air Force staff hospital where
22 additional stabilization is done and then they are

1 loaded for the transport across the Atlantic
2 ocean, either to the east coast to Walter Reed or
3 Bethesda or on to us. I would say that the Air
4 Force in particular has done a remarkable job in
5 terms of providing care and safe transport and all
6 the en route care necessary to get -- almost
7 without a single loss in the air to the
8 continental United States. This, of course, is
9 us. There are some things that we don't know very
10 much about yet. We don't know very much about
11 taking care of the severe TBI patient. We don't
12 know -- we basically have no expertise in
13 spinal-cord injury patients. So we do send
14 patients to the VA for those kinds of things.
15 Some are taken care of here in San Antonio.
16 There's one Marine and one soldier at Audi Murphy
17 VA today. We have several that are getting
18 treated for TBI (Traumatic Brain Injury) up at the VA
19 M Polytrauma Center in inneapolis. Five years ago this
20 h arrow would only ave had one head and it would have
21 been from us to the VA. Now it's very common for us
22 to send patients to the VA. We get them stabilized; take

1 care of their acute problems. We send them to the
2 VA, they do the traumatic brain injury rehab and
3 then they come back to us for maybe another
4 surgery, maybe some cosmetic or reconstructive
5 surgery or for it's for more work on their
6 prosthetics and more rehabilitation. Next slide.

7 These are the numbers to date that we've
8 taken care of. Not as large as Bethesda or Walter
9 Reed, but probably third only to those two
10 organizations in terms of the numbers that we've
11 had. I'd say a little bit about burns. All the
12 en route care is provided by critical care and the
13 air transport teams and other Air Force assets
14 except for the burn patients. We usually have a
15 burn surgeon who is stationed in Landstuhl who
16 starts the care and then when we find out that
17 there are burn patients ready to come our way, we
18 launch, by commercial air, a burn subject-matter
19 expert team from the burn center at the part of
20 the Institute of Surgical Research. They go to
21 Landstuhl; they pick up the patients and with the
22 Air Force bring them directly to San Antonio.

1 That's' different for burns then for any other
2 category of casualty patients I know of. Next
3 slide.

4 You're going to hear from Mike Tucker
5 tomorrow and you're going to hear -- you've been
6 hearing a lot about the Army Medical Action Plan;
7 we are almost completely through the phased
8 implementation of this. And with a lot of support
9 from the Army and resources, I think we're well on
10 the way to accomplishing this mission. It has
11 been a difficult delivery for this new program,
12 but we are well into it. We briefed the acting
13 Surgeon General yesterday and we brief the vice
14 chief of staff of the Army again on the 1st of
15 October on our progress. We have the people that
16 we need to manage the warriors in transition and
17 everybody has come online across the Army to
18 support this program. Next slide. Go ahead, Next
19 slide.

20 This is our warrior transition unit. I
21 just got my new battalion commander this week, who
22 will command the warrior transition unit. This is

1 their job and this is what their mission essential
2 task list consists of. Next slide.

3 You're going to visit the Center for the
4 Intrepid later on today. One of the blessings of
5 being the commander of Brooke Army Medical Center
6 is having the oldest building that houses patients
7 or families at Brooke Army Medical Center was
8 built in 1992. The facilities have been very,
9 very well maintained. It doesn't mean that
10 there's not a little scum on the bathtub once in a
11 while, but it does mean that the facilities have
12 been very, very well maintained. The two Fisher
13 houses are actually the oldest building, built in
14 1992. And Mr. Fisher isn't here, but he will tell
15 you that he goes over there to check to make sure
16 that we take care of them pretty well. The
17 hospital itself, I was here in 1996 when we moved
18 into the hospital, into BAMC. Since then we've
19 added the guest house, which also houses the
20 warrior family support center. We dedicated the
21 new Center for the Intrepid on the 29th of January
22 this year. Our barracks opened in about 2000 and

1 our troop command barracks -- not our barracks,
2 but our office spaces are also of about that same
3 vintage. In execution of the Army Medical Action
4 Plan, one of the things that we've done is: The
5 soldiers who are assigned to Brooke Army Medical
6 Center actually moved out of these barracks up
7 onto Fort Sam Houston. It's astonishing me, but
8 we did it with nary a complaint. The soldiers
9 knew that it was more important for the patients
10 to be co-located with the hospital than it was for
11 them to be located close to the hospital. In
12 adding the new people the stand up the warrior
13 transition unit, our command and control, what we
14 call troop command, actually moved into a
15 temporary building that's not nearly as nice as
16 these, up on the main part of Fort Sam Houston,
17 also without a complaint, because they recognized
18 that it was more important for the warrior
19 transition unit cadre who are taking care of these
20 guys to be close to them than it was for the troop
21 command folks to be close to the people who work
22 over here in the hospital. That is, these people

1 can go up to Fort Sam Houston, take care of their
2 administrative issues. These people can come down
3 to BAMC when they need to, but having these people
4 as close together to make sure that we're taking
5 as good of care of the warriors in transition and
6 their families as possible. It was the right
7 thing to do. We broke ground on Saturday for a
8 new warrior family support center which will be
9 located right over here. That's also going to be
10 built with private money, \$4 million. Mr. Fisher
11 started something that some folks in San Antonio
12 are going to continue, it's a 12,500 square-foot
13 building. Next slide.

14 From my perspective, and you guys are
15 all aware of this and I noticed General Franks is
16 not here, but General Franks probably introduced
17 many of us to this topic. The biggest -- the
18 requirement fight a long war with an all-volunteer
19 force pushed us, immersed us really in the
20 business of rehabilitation, because you cannot
21 want people to volunteer for the Army, you can't
22 have moms and dads want to let their sons and

1 daughters join the Army if when they get hurt
2 there is the impression that they're not being
3 given the chance to rehabilitate and stay in the
4 military if they want to, or if they're sent out
5 of our system to any other system before they're
6 ready to go. So we are heavy duty into
7 rehabilitation medicine. I didn't know what a
8 physiatrist was five years ago. I'm getting
9 pretty smart on physiatry now and boy do we have
10 some good ones. Next slide.

11 Center for the Intrepid you're going to
12 visit. I'm not going to steal the tour guides
13 thunder, but they'll probably tell you my sound
14 bite. The essence of the Center for the Intrepid
15 is that it uses the current younger generation's
16 fascination with technology and extreme sports and
17 it leverages those in order to accelerate
18 rehabilitation. That's what it's all about and
19 you'll see some of the ways that that's done when
20 you're over there. Next slide.

21 65,000 square feet, 4.5-acre site. We
22 gave Mr. Fisher four or five sites when he came

1 down. He didn't like any of those. He picked the
2 one he wanted. We have two adjacent Fisher houses
3 east with 21 handicapped-accessible rooms. The
4 usual Fisher house configuration was set up for
5 families, but wasn't necessarily
6 handicap-accessible rooms. We went from start to
7 finish in 15 months and two weeks after we cut the
8 ribbon -- again, because Mr. Fisher is watching me
9 every day, two weeks after that happened we're
10 doing patient care in there, because I promised
11 him that if he built it that we would operate it.
12 He was over on Monday -- there's actually been a
13 conference at BAMC all week on care of the
14 military amputee and Mr. Fisher was there to give
15 a few remarks to open it up. Next slide.

16 These are the guys we get to take care
17 of. All I can tell you is that every doctor and
18 nurse I know, and every therapist would love to
19 have patients like we have. Next slide.

20 When you're not too far from Fort Hood
21 in the footprint of the 1st Cavalry Division
22 having a horse around is okay, too. Next slide.

1 We do have some challenges here. You
2 know, whoever -- when you think about handicapped
3 parking spots you're not usually thinking monster
4 truck, you know? Now, we don't necessarily
5 encourage this, but we did -- by the way this
6 parking spot is actually the one next to mine at
7 the hospital and I pulled in and I just -- this
8 was too cool. This young man is missing both legs
9 and he had given up an awful lot of other things
10 he enjoyed in life, but he didn't want to give up
11 his truck. We don't really encourage this,
12 because this really a fall from a two-story
13 building for him, but it's his choice, it's not
14 ours. We tried to talked to him, we counsel them
15 and we try to get them to do safe stuff, but every
16 once in a while they're going to do this. So I
17 had to go talk to people about widening our
18 handicapped parking spots. Those are some of the
19 new challenges. And they're good challenges.
20 These guys are not happy to ride down the hallway
21 in a wheelchair. They want to walk and soon as
22 they can walk they want to run, and once they can

1 do that, they want to climb stairs, and once they
2 can do that they want to climb mountains. Next
3 slide.

4 Just a little bit about the ISR. Again,
5 comprehensive trauma burn and surgical critical
6 care service run -- it's a separate command that
7 does not technically belong to me, but you can't
8 separate us from them in the eye of the public so
9 we wind up having a fairly complex relationship
10 that we somehow or another are able to make work.
11 Next slide.

12 Burn injuries are harder. Those of you
13 that have been Walter Reed or those of you who
14 have dealt with amputees the rehab is not as media
15 savvy, because it's small muscles. A lot of it is
16 stretching, a lot of it is contractures, a lot of
17 it is range of motion. Much of it is painful.
18 Technology does not have as much to offer in the
19 rehabilitation of the burn patient. It has had a
20 big role in the survival of the burn patient, but
21 it doesn't have a lot to offer in terms of the
22 rehab of the burn patient. It is just plain hard

1 work. And from our perspective -- for all those
2 reasons there's a little bit more in the way of
3 existential anger that we deal with in the burn
4 patients. And we tell people before they -- and
5 you will see burn patients this afternoon at the
6 CFI. Anybody who says that that was just for
7 amputees is wrong, that's never what it was meant
8 to be. Mr. Fisher made that very clear early on
9 and we moved burn patients into CFI (Center for
10 the Intrepid) very, very early on and they're doing
11 there.great out They're with us longer. They are
12 with us even longer than the amputees. Next slide.

13 Just a slide or two about BRAC.
14 Inpatient care at Wilford Hall closes, Wilford
15 Hall doesn't close, the 59th Medical wing does not
16 go away. We have to tell people that all the
17 time. Wilford Hall is going away, no that's
18 really wrong. There's going to be a lot of great
19 medical care provided at Wilford Hall, just people
20 aren't going to be spending the night down there.
21 And all that moves us to the, what we call SMMAC
22 North, which is what I've been calling Brooke Army

1 Medical Center all day. We are managing to work
2 our way through this pretty well. General Travis
3 now, before him Brigadier General Dave Young and I
4 have been working on this for two years. We have
5 already integrated a number of services. We have
6 a plan. We didn't need a lot of help to make our
7 own plan. We went up and briefed the senior
8 military medical advisory council a couple weeks
9 ago on the plan. They're comfortable with it. We
10 didn't ask for any additional senior oversight.
11 We have lots of help in getting this done and so
12 far we have the resources to keep it on track.
13 Next slide.

14 This is what the north campus sort of is
15 going to look like. We have to build a couple
16 parking garages here and there. We have to add on
17 because all the battlefield health research and
18 trauma research from all three services moves to
19 San Antonio so we have to build onto the Institute
20 of Surgical Research and change its name to
21 Battlefield Health and Trauma. I'm sorry, that's
22 that part. This hospital is built for 450 beds to

1 begin with so we can take those areas that we
2 converted into admin and clinic areas and convert
3 them back into wards and move the admin and clinic
4 stuff over into the new building. We have to have
5 a bigger ER, we have to have more ICU space, and
6 we have to have more OR's and that's over here.
7 These are the buildings that are already there,
8 The Center for the Intrepid and the two Fisher
9 houses. Next slide.

10 Down at Lackland, this is all
11 renovation. Next slide.

12 This is what we look like at end state
13 425-inpatient beds, this many ICU's, that many on
14 the wards, 31 OR's for inpatient ambulatory
15 surgery, doing the combined amount of trauma of
16 BAMC and Wilford Hall already and then SAMMC South
17 is largely primary care, but there is the Center
18 of Excellence for eye care down there and an awful
19 lot of sub-specialty clinics. Next slide.

20 That concludes my brief. Thanks for
21 letting me tell you a fair amount about Brooke
22 Army Medical Center and a bit about what the San

1 Antonio Military Medical Center is going to look
2 like. I have a little time, I'd be glad to take a
3 question or two if that's desired. Thank you.

4 DR. POLAND: Questions from the Board?
5 General Gilman, we want to thank you for coming
6 and present you with the brand new coin. You're
7 actually the first recipient of the new Defense
8 Health Board coin. Thank you very much.

9 (PRESENTATION MADE)

10 DR. POLAND: Our next speaker this
11 morning is Colonel John Kugler, Deputy Medical
12 Director of TRICARE management activity. He will
13 give us a briefing regarding TRICARE's healthy
14 lifestyles and disease management campaign. These
15 are areas that the Board's legacy committee on
16 health promotion and maintenance under the AFEB
17 addressed through a number of recommendations in
18 the past, so it's good to see progress being made
19 by the department in these areas. Welcome
20 Colonel. The briefing slides are under tab 4 for
21 the Board members.

22 COL KUGLER: Good morning everybody it's

1 my pleasure this morning to give the Board and
2 overview of two very important programs for the
3 MHS. It's a little bit different than what I
4 think you'll hear the rest of your couple of days
5 here, but it's -- I think there are some
6 connections. Hopefully, I'll try and make that
7 clear to our warrior care. These are major
8 programs which I think are very close to the
9 overall mission of the MHS (Military Health System).

10 We'll talk about the case management and
11 the healthy lifestyle initiatives that are going
12 on. The overall MHS mission, of course, is
13 fourfold, is to preserve patient care, training
14 and sustain skills and direct support of the
15 deployed forces as well as the peacetime forces
16 and their dependents and to promote and deploy a
17 ready- medical force. In direct support of this
18 mission is a continuum of care, which I know
19 you're all familiar with, anywhere from health
20 until impairment in this care. In this continuum
21 of care is the case management model and the
22 disease management model as well as a focus of

1 wellness and health promotion all that contribute
2 to addressing the patient at their level of need
3 to facilitate optimal outcomes.

4 The first area we'll talk about is the
5 disease management program. The direct goals of
6 the disease management program are to optimize
7 patient outcomes through a patient centered model
8 of care utilizing evidence-based medicine and
9 patient partnerships, use the best practices to
10 promote optimal outcomes. Increase provider and
11 patient satisfaction in the process and at the
12 same time appropriately utilize scarce medical
13 resources.

14 A bit of background on this: In
15 September of '05, two years ago, ASD/HA, Dr.
16 Winkenwerder at the time, charged MHS with going
17 over the current status of disease management
18 programs and to develop an action plan for system-
19 wide coordinated approach to disease management.
20 As a direct result of that summit two years ago,
21 the department devised the unified approach that
22 is meant to tie the efforts of the three

1 contractors opposed to the purchase care section
2 as well as the services into a cohesive,
3 comprehensive approach to disease management.

4 Details first initiate the concentration
5 on three major diagnostic conditions and
6 implemented a year ago was concentration on
7 congestive heart failure and asthma and then the
8 condition of diabetes which was implemented this
9 past June. It's directed at both the purchase and
10 the direct care system and includes primarily
11 prime beneficiaries, but also there is a
12 demonstration project which will include standards
13 in extra patients as well. The government's role
14 in this is the identification of high-risk
15 patients as well as the uses of a methodology to
16 access the outcome of the program. It's left up
17 to the contractors to design a program and to
18 initiate their protocols. For example: How often
19 to call the patients, or what type of technology
20 to use. They are to provide us with the details
21 of that and that's all part of the evaluation
22 process.

1 Again, as I mentioned the major role of
2 the government is the identification of at-risk
3 patients that would be identified as being -- to
4 benefit from disease management. Primarily use
5 administrative data to basically target patients
6 that are high utilizers or high-cost patients
7 particularly CHF (Congestive Health Failure
8 and asthma. We get data runs on a monthly basis from
9 Kennell & Associates. The patients are stratified in
10 one of four levels by these criteria of utilization and
11 cost and levels three and four are targeted specifically
12 for disease management intervention.

13 As I mentioned the purpose is to assess
14 what works best for these populations. Who should
15 be targeted for disease management? What sort of
16 services should be provided? How can the program
17 be improved? And how do we compare with other
18 nation-wide disease management efforts? The
19 purpose of the evaluation is to quantify the
20 impact on patient health status and clinical
21 outcomes including quality of life. And also
22 secondarily to look at healthcare utilization and

1 expenditures.

2 The first report is due this December
3 and again the three major focuses will be on
4 clinical outcomes as measured as the changes in
5 the clinical processes; such as percent of
6 diabetics with A1C's done in the past year, a
7 common HEDIS measure. A measure of utilization or
8 the appropriate consumption of resources; for
9 example, emergency department visits for CHF or
10 asthma patients. And then finally, connected to
11 utilization are financial outcome measures,
12 changes in costs. And with this an assessment on
13 the return on investment of the disease management
14 program.

15 Some baseline data that was gathered for
16 fiscal year 2006 for CHF patients, this is to kind
17 of give you an example of the patients that are
18 being targeted. These are level 3 and level 4
19 patients. Again, these were patients that were
20 specifically chosen as high-cost, high-utilizer
21 groups. You can see that over \$69 million in
22 annual total costs were connected with these

1 patients. Primarily 80 percent of these had to do
2 with emergency and inpatient care. This is a
3 little different than the other two conditions
4 that we'll talk about. This is why CHF for a long
5 time has been recognized as very -- as a condition
6 it could respond very well to disease management
7 approaches. Again, it's estimated that almost 14,000
8 PMPY (per member per year) related costs out of the
9 36,000 total TRICARE costs are direct on these patients.

10 For asthma, again, looking at the
11 higher- cost patients at level 3 and 4, most of
12 the costs here is in pharmaceuticals and that's
13 likely not going to go down, in fact, that will
14 probably go up, but the area that's being targeted
15 for reduction is emergency care and hospital
16 inpatient care. While a small cut of the pie,
17 certainly is not an insignificant one.

18 This is an example of the outcomes card
19 or the draft score card for DM (Disease Management).
20 Again, you can see it's looking at the three main
21 areas we talked about, the utilization and those are
22 the metrics that are currently being utilized. So it's

1 financial and clinical measures. You can see each
2 of these are weighted, an evaluation score will be
3 done by the contractor that's doing the
4 evaluation.

5 In 2007, the NDAA (National Defense Authorization
6 Act) had some very specific requirements that they want
7 DoD to attend to with regard to disease management. And
8 our office the Office of Chief Medical Office, the office
9 that we work in and we are working with the service
10 subject matter experts and the TROs (Tricare Regional
11 Offices) to meet these requirements. And there are five
12 basic ones, we're well on our way, I think, to doing
13 this, but it's important that we specify what they are.
14 One is that Congress wants to specifically address
15 very specific disease conditions, not only
16 diabetes, heart disease management, but also
17 cancer in general as well as COPD (chronic obstructive
18 pulmonary disease and depression and anxiety disorders.
19 They would like us to make sure we meet nationally recognized
20 accreditation standards as defined by the DMMA, Disease
21 Management Association of America. That basically
22 has to do with population identification processes

1 and evidence- based guidelines as a guide.

2 They want to make sure that we specify
3 outcome measures and objectives which we've been
4 doing. Specifically to capture and report the
5 data across the services and the purchased care
6 arenas and to give Congress a report of how we are
7 evaluating this in an integrated fashion. Also to
8 include strategies which also include Medicare
9 beneficiaries or dual-eligible. And in the
10 process to make sure we are conforming with
11 current HIPPA laws and regulations. The report on
12 a design and the development and the
13 implementation on these conditions is due to
14 Congress March 2008.

15 I think the main challenge with meeting
16 this is making sure that we are providing
17 consistent DM services and a uniformed program
18 evaluations, not only within the services, but
19 within the three managed care support contractors.
20 That we avoid duplication of services and increase
21 in costs in our complex systems. At the same time
22 that we allow flexibility and creativity among the

1 -- not only the services but among the contractors
2 to address the needs of the patients under their
3 areas of responsibility to make sure that we're
4 not losing any of that in the process of having
5 the uniform -- the ability in producing the
6 duplications. So it's a balancing act, but an
7 important one. And that we manage the complexity,
8 which has probably the greatest challenge of
9 identifying the at-risk patients, especially when
10 you use administrative data, it's a difficult
11 chore and it's a fair amount of validation of that
12 data to make sure we are truly targeting the
13 patients that will benefit. The other problem
14 with administrative data is that it lacks some
15 clinical information particularly when we're
16 dealing with managed care support contract would
17 allow you to evaluate it, so we could identify
18 those who have had A1C tests done but we can't
19 capture what the A1C levels are. So there are
20 some built in barriers, basically to be able to do
21 that with the inherent nature of the data.

22 However, as I mentioned, significant

1 parts of the 2007 NDAA requirements have been met
2 by what we're doing basically now. We're trying
3 to put the uniform processes in place and refine
4 these processes as best we can and as I mentioned
5 we were identifying the patients and risk
6 stratifying them and having a uniform method of
7 evaluation. We're well on our way to defining a
8 cohort of beneficiaries. Certainly with three of
9 those conditions we're working on identifying
10 those with the other conditions as well. We're
11 tapped into the expert clinicians and the
12 subject-matter experts in both the services and in
13 managed case support contractors to get them
14 involved in developing interventions and
15 state-of-the-art educational materials. Taping on
16 the resources in the MHS particularly with regard
17 to the VA/DoD clinical practice guidelines, the
18 population health portal which is a data system
19 that captures both network and direct care system
20 data to some extent on these conditions and in the
21 well-refined dashboard and evaluation method for
22 quality measures that's being used fairly

1 extensively within the direct-care system and to
2 some extent in the purchased-care system.

3 Now there's a system-wide approach
4 requiring collaboration and coordination that's
5 kind of been the main focus and main work that's
6 going on in our office with managed care support
7 contractors as well as the services and I think
8 our big challenge is to continue that and to
9 refine it, and to make sure that the programs that
10 are developed as the end result of this are
11 complimentary for the existing programs within the
12 services and that they meld well with the efforts
13 from the managed care support contractors. Any
14 questions before I go on to healthy lifestyles
15 about these -- Yes, sir.

16 DR. KAPLAN: This is perhaps peripheral,
17 but it just dawned on me, are there differences
18 between how HIPPA laws are applied in the military
19 and how they're applied in civilian (off mike)?

20 COL KUGLER: Not that I'm aware of.
21 There all the same regulations.

22 DR. KAPLAN: The same?

1 COL KUGLER: Yes, sir.

2 DR. KAPLAN: Thank you.

3 DR. POLAND: Mike. State your names
4 first, please when you speak.

5 DR. PARKINSON: Thank you Colonel
6 Kugler, I'm delighted that the DoD has been more
7 involved in disease management, but I will tell
8 you as someone who has been deeply involved with
9 this for the last seven years and kind of turned,
10 what I think is the entire paradigm on its end,
11 which is rather than being provider centric to
12 being truly consumer centric and to actually look
13 for competent incentives for immediate and early
14 self referrals. Our DM programs traditionally
15 tend to be, I got you through claims
16 identification, which this is. It is the state of
17 the art unfortunately, but what are the provisions
18 -- or are you thinking about, if I've got those
19 five conditions, how do I self- identify as soon
20 as I'm enrolled in TRICARE, how do I self-identify
21 by being taken care of at BAMC that I would love
22 an educational program to understand the seven

1 things for my diabetes. That's one question.

2 The second thing is: What are your
3 plans of going forward to maybe perhaps spend less
4 money on ROI evaluation, because as you know the
5 GAO and others find no costs savings for these
6 program, at least as their currently practiced as
7 opposed to redesigning the program so they do
8 demonstrate cost savings. Every single one of us
9 believes in this room that patient behavior
10 modification saves money, but the program, as
11 currently put together, there is no standard
12 methodology to evaluate them, as you know, AMA has
13 not come out with that, so how are you going
14 beyond the current industry? Because the current
15 industry, I will tell you, needs your leadership
16 with new self-referral models and new engagement
17 model for the much deeper than post cards and
18 phone calls because they really, by and large,
19 don't work that well. Just your reaction to some
20 of those to go on, but I appreciate that and I
21 wanted to get it on the table. This Board, by the
22 way, gets very much -- this is probably the first

1 briefing, I'll note for the Board, obviously, that
2 deals with these issues in our new hat as working
3 with the department in the healthcare operations
4 as opposed to our historical charge. So thank you
5 for being here and that's just some early
6 reflection.

7 COL KUGLER: Well, I think those are
8 great reflections and I hope we're going to be
9 doing those things. I didn't mean to be overly
10 rigid in the presentation of the methodology;
11 other than we are required to have methodology and
12 to get the job done, but you are absolutely
13 correct, it should be much more patient directed.
14 We should be much more open to self-care models
15 and it's really a partnership with the patients.
16 I apologize for maybe not emphasizing that
17 component of it. And also don't want to lose the
18 flexibility and creativity of the individual
19 services as well as managed care support
20 contractors in tapping into their patient
21 population. We purposely don't want to lose that.
22 It's kind of a balancing act between trying to

1 make sure we meet the mail on what the standards
2 are for evaluating these programs, but in this
3 process we want to basically tune into best
4 practices and I think you're right on target
5 identifying those best practices. They are the
6 ones that are most directed to the patient. Most
7 of these is the relationship between the provider
8 and the patient, particularly the patient with the
9 initiative to recognize when they are getting into
10 trouble and getting the help that they need to get
11 control of their life. And I think any program
12 that does that is going to be successful. I hope
13 we don't lose that process. The folks are very
14 much aware of that and very much share your
15 philosophy about that. I can't show you a metric
16 other than ensure you that is definitely
17 considered and will be promoted as we go. Yes,
18 sir.

19 DR. LEDNAR: I'd like to also, like Dr.
20 Parkinson, applaud you for bringing this topic. I
21 think this is a good example of where we are
22 moving to and that's population health management

1 as opposed to individual patient treatment quality
2 assessments, both of which are important, but this
3 is really where we will get ahead of the macro-
4 forces on cost control in terms of healthcare.

5 I'd share an observation that we have
6 had looking again at populations across the
7 strata. You used the strata of one to four, in
8 terms of what to do about it. It's a different
9 intervention for a different strata. For those
10 who are at the more severe end of the disease
11 spectrum, clearly each patient's care, like the
12 CHF admissions, will each be costly. But when you
13 look across that set, clinical variability is a
14 very, very big and costly dynamic. Now, one of
15 the criticisms of course to evidence-based
16 medicine is that my patient is different, and
17 therefore, I should tailor the care nonstandard
18 work. So I think in terms of understanding this
19 population health experience in that more severe
20 end, clinical variability will be the issue. In
21 the earlier end, the earlier risk factor
22 identification and early disease, it's much more

1 utilization issue. If you look at the actual
2 costs that will be a group, the early asthmatics,
3 for example, who will be your big spend as a
4 group. So our natural inclination is to go to the
5 individual high-cost event area, the ICU, and
6 missing the fact that unless we deal in the
7 outpatient setting in earlier stage and do that
8 very effectively, we're missing a tremendous
9 opportunity, not only for costs but it to just
10 sort of slow down that disease progression.

11 So I think you have the ability for all
12 of us in the nation to develop a very sound
13 population-based methodology and we cannot get to
14 a standardized way to evaluate disease management
15 fast enough. So if you come onto any insights I'd
16 really encourage -- and I hope that the Board
17 would have an opportunity to hear some of these
18 methodologic thoughts that we all could help to
19 drive for adoption.

20 COL KUGLER: Yes, sir.

21 COL GIBSON: I've got a couple of
22 hopefully simple questions. I noticed in your

1 disease management goals, you talked about
2 provider satisfaction.

3 COL KUGLER: Yes.

4 COL GIBSON: And certainly in this time
5 of stress, a lot of stress on our providers, that
6 is a certainly important goal. We're hearing
7 stories about because folks are deployed the in
8 garrison people are under a certain amount of
9 stress. TRICARE, because of its nature of having
10 network providers, they have a little less
11 hands-on control with those folks.

12 I also noticed that in your outcome
13 measures, I didn't see any way to assess the
14 impact that these disease management interventions
15 on provider satisfaction. So how are you planning
16 on doing that? Is there some sort of survey
17 approach to this? What's the way of collecting
18 the data on them?

19 COL KUGLER: There is actually going to
20 be a provider satisfaction query or survey on
21 select providers. I don't know the details on the
22 managed care's side of that, other than that they

1 are going to be doing it. I don't think that's
2 necessarily worked out yet, but it is part of the
3 data collection. It's very important -- we've
4 certainly got a lot of feedback from places in the
5 direct care system of doing just in disease
6 management. They're concerned that we're going to
7 be messing with their program or driving a wedge
8 between patients and providers and that's why
9 we're tending to that. It's not the intent to do
10 that. It's actually the intent to enhance that
11 and the focus of the provider satisfaction and
12 patient satisfaction evaluation is to make sure
13 that's happening and that we're not making matters
14 worse, we're in fact, enhancing that relationship
15 and that's primarily the focus.

16 DR. POLAND: Yesterday the Board
17 established a new subcommittee on healthcare
18 delivery so I think both the disease management
19 evaluation report and the comprehensive report on
20 pain management, chronic pain management, that you
21 mentioned, will be of interest to that
22 subcommittee. We need to finish up this part in

1 about 15 minutes. You've got a lot of slides
2 left. If it's okay, we'll move ahead and grab
3 your question at the end.

4 COL KUGLER: I'm going to talk next
5 about the current healthy lifestyles initiatives
6 that have been going on for a couple years through
7 our office; basically focusing on the conditions
8 of tobacco use and alcohol abuse or alcohol
9 inappropriate use as well as obesity and
10 overweight issues.

11 The vision is that we make efforts as a
12 system to reverse the negative health trends that
13 have been identified throughout the country as
14 well as among our active duty population and their
15 dependents, the military family populations, to
16 look at a proactive process that will coordinate
17 with commands and communities to support healthy
18 lifestyle choices by our beneficiaries.

19 I'm sure you're all familiar with this
20 slide. There are variations of it. It basically
21 illustrates the cost connection between healthy
22 lifestyles that not smoking, having a healthy

1 diet, exercising, using alcohol in moderation and
2 avoiding risky behaviors, you live longer and you
3 don't cost the system as much. And the
4 consequences are very well documented that the
5 more these lifestyle risk factors come into play
6 the less you live and the more you cost. I mean,
7 that's the cold fact of life that's been
8 particularly dramatic for tobacco use.

9 If awarded, contracts in a program known
10 as TOBESAHOL, coined by our department, to
11 specifically look at initiatives, MHS-wide
12 initiatives, to deal with tobacco, alcohol and
13 obesity concerns. There have been some studies in
14 a health behavior survey that, for the past couple
15 of surveys, showing that there is a trend upward
16 in lifestyle issues and that we've been tagged
17 with basically making sure we are trying to do
18 something that will help reverse this trend.

19 First talk about the tobacco cessation
20 efforts. There's very good studies, many of them
21 done by military providers, documenting the
22 negative impact of tobacco and readiness. Overall

1 it's estimated that in 2004 the cost to DoD was
2 \$1.6 billion per year in additional medical care.
3 But beyond that our -- very documented that
4 impacts on military training, increased injury,
5 decreased night vision ability, exacerbation of
6 noise-induced trauma, increased surgical risks,
7 poor wound healing and so on and so forth.
8 There's a very much direct link, and we make this
9 case to the line commanders, a direct link between
10 tobacco problems and mission accomplishment.

11 The demonstration program running right
12 now is the tobacco-free me demonstration program
13 that has been subcontracted to Lockheed Martin and
14 it's basically a demo project that tests the
15 participation in the tobacco quitline program
16 which targeted in four states that have a large
17 population that are not followed by MHS programs.
18 This is basically to test the benefits of making
19 availability to a quitline and to pharmacotherapy
20 basically and nicotine replacement therapy and
21 bubpropion. So as a web component, behavioral
22 counseling via telephone quitline and well as

1 personalized "quit kits" as well as
2 pharmacotherapy. As of August about almost 400
3 beneficiaries were enrolled. The demonstration is
4 set to end next September. The primary metric is
5 looking how much this is utilized, how successful
6 the program is and the purpose is whether what the
7 costs and the impact would be if we could change
8 the benefit that would allow coverage for this
9 service.

10 Another portion of the tobacco program
11 and probably more, I think, germane to the issue
12 for the active duty is the tobacco counter-
13 marketing campaign called "Make everyone proud".

14 Basically it was a result of very
15 intensive focus-group efforts of the younger
16 enlisted. This is precisely the group of
17 beneficiaries where smoking has actually increased
18 over the -- and has stayed at an unacceptably high
19 level over the past several years. This is a
20 group we asked, Well, what is it about tobacco and
21 the military; and got some interesting feedback.
22 First off these groups thought it was prevalent

1 than it actually was, but they perceived it as
2 normative, that it was consistent with the
3 military image, that they saw some barriers even
4 though the smoking cessation classes and the
5 pharmacotherapy that was available that there were
6 some scheduling issues and some barriers that they
7 perceived. They thought that indirectly, even
8 though there was a message to not smoke, that
9 there was indirect support of it by the having
10 smoke breaks or the fact that tobacco sales are
11 less expensive than a civilian marketplace.

12 These findings were basically evaluated
13 by the marketing contractor and crafted into a
14 campaign including both print materials, radio
15 messages and a website that's been rolled out just
16 basically this past year at some target market
17 areas. As of July 2007, we had over 100,000 hits
18 on their website and average time about 10 minutes
19 per site, which isn't bad for a smoking cessation
20 website. Most of it comes from Pendleton and I
21 would say that was, of course, a Marine Corps
22 base. There was a lot of command emphasis to --

1 on the program there and that's probably the
2 reason why there was a fair amount of traffic.
3 The other aspect that's not on here is a program
4 that our office is promoting in terms of seeing if
5 we can get a change in the pricing of tobacco
6 products in commissaries and PXs. Also promoting
7 advertising -- a ban on advertising from post
8 media as well as engaging some more of the line
9 and other senior leaders in the anti-tobacco
10 message.

11 Alcohol abuse prevention. Notice in the
12 past healthy survey overall alcohol use has
13 decreased. Binge drinking has increased
14 particular to the Army and Marine Corps. It's
15 identified as a concern. Impact of inappropriate
16 use or heavy alcohol use is not insignificant.
17 Estimated medical cost for active duty about \$360
18 million per year. It contributes to about
19 one-fourth of private motor vehicle accidents.
20 Over 700 admin separations per year and a loss of
21 productivity almost 1,700 FTEs per year.

22 The program that's being has been rolled

1 out has been an off the shelf type of program for
2 educational online product targeted at young
3 people, similar to what's been used at college
4 campuses been modified for the active duty. It's
5 called PATROL, Program for Alcohol Training
6 Research and Online Learning.

7 It's targeted at these facilities of the
8 Air Force, Marine, Navy and Army. The pilot
9 project is winding up about now and can report
10 that actually has surprised us, but actually has
11 had an impact of sustained self-report behavior in
12 binge drinking.

13 The red line basically reflects self-
14 report in amount of alcohol consumption and it
15 reflects intervention group for the intervention.
16 Not only do we see a change at one month in those
17 we were able to obtain follow-up on, about 859 of
18 the participants, the change was sustained at six
19 months. So right now we're going to assessing the
20 next steps and see if we want to roll this out on
21 a wider basis or target specific groups or
22 whatever, but there's definitely a sustained

1 impact from an educational intervention for young
2 people, which is news in and of itself, I think.
3 We're very hopeful about it.

4 Another major program that many of you
5 may have heard about is the "That Guy" campaign.
6 Again, we looked at target groups to come up with
7 this theme.

8 It basically looks at the negative
9 effects, from a young person's perspective of
10 alcohol overuse; and basically identified the
11 caricature of an individual who, while in control
12 and may be a regular guy and together when they
13 have alcohol on board really become a laughing
14 stock and folks being laughing at them not with
15 them. Everybody could relate to that. This
16 really struck a chord among young folks and the
17 program was kind of developed around that with the
18 "That Guy" image. I ask you Google "That Guy"
19 sometime, it will take you to the website and I
20 think you'll see why this has been successful.

21 Again, a targeted audience young
22 enlisted primarily males. Secondary group is the

1 commanders and the chain of command. I would say
2 that this program has been highly successful in
3 both target groups. The young folks a very
4 popular website. It's also been popular with --
5 because I think this interest in the young people
6 it's popular with post commanders and line
7 commanders. They're responsible for the lives of
8 these young folks, particular the safety issues,
9 anything that can get their attention and behavior
10 they're interested in and they so far have been
11 quite enthusiastic in support of this program.

12 This is just a little bit about the
13 targeting process for the "That Guy" program.

14 It was launched last December and this
15 is just an advertisement of how widely it's been
16 used already.

17 The last one I'll briefly talk about,
18 about 30 seconds is the overweight program. The
19 military is not immune to this. This is a health
20 survey showing an increasing in self-report of BMI
21 over the past several years reflecting the
22 American population.

1 The link between overweight and the
2 readiness issues particularly with injuries and
3 medical conditions.

4 The costs associated with -- this is in
5 active duty, you're not supposed to get by (off
6 mike) and be on active duty but it does happen on
7 occasion, but for our beneficiaries the escalation
8 and costs in bypass surgery is pretty significant,
9 not only in a direct-care system, but particularly
10 in the purchased-care area.

11 The demo is a program called HEALTH,
12 Healthy Eating and Active Living in TRICARE
13 Households. It's basically an interactive program
14 that utilizes both an online and telephonic
15 nutritional counseling as well as some access to
16 pharmacotherapy. It's targeted at states and
17 residence, beneficiaries in Illinois, Indiana,
18 Michigan and Ohio. So far it's been highly
19 successful enrolling folks as opposed to the
20 tobacco program; it's got almost 2,500 enrollees
21 that are participating.

22 Other areas of focus: The folks with

1 the commissary agency is a program where they scan
2 labels on shelves indicating nutritional values of
3 products. With the Navy exchanges. There's a
4 DoD/VA CPG (clinical practice guideline) that was
5 rolled out recently on obesity. And then there's the
6 overweight and obesity metric is monitored on the MHS
7 score card at the senior level.

8 In summary, we're funding basically
9 evidenced-based demo projects that address the
10 major causes of preventable death and morbidity.
11 We're looking at ways that we can go forward.
12 What kind of feasibility and effectiveness of
13 these interventions. Maybe change a benefit if
14 that makes sense; anything that will encourage
15 healthier lifestyles and will move us along. We
16 think that we see a strong link to readiness and
17 definitely strong links to preventing chronic
18 disease and reducing healthcare costs in the long
19 term. Sorry for running through that. Any
20 questions?

21 DR. POLAND: Thank you. Bill, you had a
22 question, first.

1 DR. HALPERIN: Very briefly. I think
2 you demonstrate in the presentation that you're
3 using prevention all the way from primary
4 prevention to tertiary prevention in clinical
5 care, detection medical errors, collection of
6 data, et cetera, et cetera, the whole spectrum.

7 But you know it's interesting in your
8 early model population health and medical
9 management model it's actually -- prevention is
10 limited to a little corner called primary
11 prevention. It's kind of an old model. So it
12 might be, to make your model consistent with the
13 very impressive work you're doing, you might want
14 to change the model.

15 COL KUGLER: I'll bring that back to the
16 -- I think that's a valid point.

17 DR. PARKINSON: Again, wonderful that
18 the DoD is looking systematically at four of the
19 factors that drive 90 percent of the healthcare
20 costs. But a couple of points.

21 Personally, and I know that this is not
22 the charge of the DHB, anytime you mention the

1 benefit word, that is a retention and accession
2 issue brought within DoD. I can assure you that
3 cutting-edge employers are no longer doing demo
4 projects as to whether or not they should pay
5 tobacco cessation. No co pay, no deductible, 100
6 percent payment with additional incentives for
7 program completion. So please don't interpret,
8 again, from my perspective, we have to demonstrate
9 whether or not tobacco cessation without economic
10 barriers saves costs to the employers in the first
11 18 months. Kaiser has published an excellent
12 study on that. It saves the health plan itself,
13 medical care dollars in 18 months. So please
14 press on, look at the data, but talk to real
15 employers, 100 of which I can give you the names
16 of who are paying for it.

17 Additionally then getting differentials
18 based on smoking stats, which again is a benefit
19 decision, but until and unless you get that we're
20 not going to get going the other things.

21 Weight management, as you know, the
22 evidence is getting better. Finally coping skills

1 and stress management, which gets back to
2 something that General Roadman worked on years ago
3 called resiliency training. Don't underestimate
4 peer-to- peer relationships that don't exist on
5 the phone. This is an emerging area and we're
6 delighted that you're doing it and look forward on
7 these committees through the DHB to work you
8 ongoing.

9 COL KUGLER: If I can just respond.
10 Again, I agree completely with your points and
11 certainly would not argue with them at all.
12 They're certainly valid. The demo is not any
13 proof. The demo is because we have to convince
14 Congress to change it. We have to do a demo. We
15 can't just change it without, because it involves
16 CFR change and so forth, because the way the
17 benefit has been written from statutes through CFR
18 for tobacco specifically and to some extent for
19 obesity. We don't have coverage right now. Yes,
20 sir.

21 DR. BROWN: First of all, I want to echo
22 Mike's comments about tobacco cessation programs.

1 The VA has a variety of programs that we feel are
2 core programs that you might want to take a look
3 at.

4 COL KUGLER: We have actually.

5 DR. BROWN: The second thing, I have two
6 quick questions that I should probably know the
7 answer to, but in terms of our deployed troops,
8 deployed to Iraq today, for example, my impression
9 is that their access to alcohol is very limited.

10 My second question has to do with
11 tobacco cessation and why -- I've heard this
12 before, I've never understood it completely, why
13 is tobacco cheaper on military bases? Is it just
14 because of the difference in federal taxes is
15 there some other reasons?

16 COL KUGLER: That's a complex one. It
17 has to do with the commissaries, PX system and the
18 pricing regard to that. Again, tied to the laws
19 that set up that system and so forth.

20 DR. BROWN: But if it's just an obvious
21 -- why not just raise the prices?

22 COL KUGLER: We're trying to do that.

1 DR. POLAND: Let's keep moving on. Dr.
2 Silva and then Dr. Lednar.

3 DR. SILVA: A lot of campaigns for
4 smoking have also incorporated the family
5 particularly if you look at upper respiratory
6 infection rates otitis media in children of
7 smokers in the house. Have you used that in your
8 campaign?

9 COL KUGLER: Yes, sir. Absolutely.
10 That's a big focus. You'll see a lot of the
11 pictures in the campaign are of folks with kids
12 and the impact upon children and the family,
13 particularly with regard to trying to have a model
14 of a warrior that is healthy, making their family
15 proud of licking tobacco and keeping them healthy
16 as well.

17 The question about the deployed troops
18 there has been an increase in smokeless tobacco
19 use. There's not as much access, but tobacco
20 is a concern. We've gotten NRTs (nicotine replacement
21 therapy) in theater and so forth and are looking at
22 other ways to try to address that issue. It's tough

1 though. The war is tough with regard to those kind of
2 behaviors. There's some effort, particularly is doing it
3 and many other places we're looking at targeting folks
4 when they come back to make sure that issue is
5 addressed and focus on that group and like to see
6 more of that happen. That's a very important
7 area, extremely important.

8 DR. LEDNAR: As we're trying to manage
9 this clinical activity from one that's been
10 focused on acute and episodic care to the needs of
11 chronic management of patient conditions. One of
12 the interesting thoughts that TRICARE proposed is
13 taking advantage of the very high impact
14 doctor/patient relationship, the credibility that
15 the doctor has with their patient even in a brief
16 encounter and perhaps expanding our thoughts on
17 vital signs. It's traditionally been temperature,
18 blood pressure, heart rate and added to that what
19 are vital signs critical for today's health needs.
20 And perhaps that, do you smoke or do you use
21 tobacco? What is your BMI? A short depression
22 screen. Really in the process starting that

1 conversation we obviously have to equip our
2 clinicians with what you do with the answers you
3 get, because I don't think they're ready for that
4 and the programs that would support them. But in
5 the end to sort of bake that into what we use to
6 judge is clinical care of appropriate quality to
7 meet today's needs. So I just thought for that as
8 a thought as you're thinking about how to take
9 advantage of the one-on-one patient encounters to
10 compliment what you're trying to do at a
11 programmatic level.

12 COL KUGLER: That's an excellent
13 suggestion; actually get the entire team in the
14 process as well, the medics and the nurses. That
15 has been in many areas -- and with the new AHLTA
16 electronic record facilitates that and I think
17 they're working to try to help that even more, but
18 it's an extremely important point.

19 DR. POLAND: We have time for one more
20 comment. General Roadman.

21 GEN ROADMAN: Dr. Kugler, thank you.
22 I'm Chip Roadman, I really appreciate all your

1 comments. I would tell you I feel a little bit
2 like Rip Van Winkle. The question I've really got
3 is that with the number of people that are
4 enrolled, 5,004 as the numerator and you put the
5 denominator, you have about 5/10,000ths of the
6 population enrolled in a disease management
7 program, which I think would tell us that although
8 making progress there is a force field here that I
9 would really like to see what are the
10 disincentives that we have, whether it's policy,
11 whether it's centralization, whether it's behavior
12 on medical doctrine. Because I think if we
13 continue just beating the drum on once they have
14 the disease we enroll them, if we don't go after
15 the pre-disposing lifestyle issues, we will really
16 never make a dent in the monetary or quality of
17 life issues. I will, in full disclosure, I sit
18 with some of the TRICARE contractors and listen to
19 the inability to enroll because there's a
20 centralized requirement for TMA to allow somebody
21 to come into the program which puts an unnecessary
22 do-loop into the program. Have you done that

1 force field analysis and do you have a systematic
2 way to approach the policies and the practices to
3 get a fundamental change in how we do this?

4 COL KUGLER: I think hopefully this will
5 -- what we're trying to do is to get at that. The
6 methodology we hope is open enough to tease that
7 out and I agree, I think that the more we can do
8 at the front end on this before it gets too far
9 down the road -- it makes sense, certainly the
10 long term makes sense, but we had to start
11 somewhere. To get the easiest group to identify
12 quickly and to get return on investment easily and
13 to identify and have a program for was the higher
14 end group. But I fully agree that I think it
15 can't stop there and that's not our intent. To
16 look to the experience with this and to move onto
17 what's the next logical step I'm thinking probably
18 more in line with what you're saying, sir.

19 DR. POLAND: Thank you, very much. I'll
20 be the next speaker this morning. The Pandemic
21 Flu Preparedness subcommittee has been very active
22 over the last several months addressing a number

1 of questions that were presented to the Board by
2 Ms. Embry, the deputy assistant secretary for
3 force health protection and readiness and also our
4 usual DFO. The subcommittee has developed a
5 series of recommendations in response to these
6 questions. As the members know the
7 recommendations of the subcommittees are brought
8 to the full Board for deliberation and vetting and
9 then become products of the Board forward to the
10 Department for their consideration and action. Do
11 you have copies of these recommendations? I'll
12 take you through them.

13 There were three primary questions
14 addressed to it. One was to comment on the
15 disposition of the current stockpile of Clade 1
16 avian influenza vaccine and the option of offering
17 the vaccine to service members prior to the
18 vaccine's scheduled expiration date in December of
19 2007.

20 We were also asked to provide
21 recommendations on the Department's overall
22 pandemic influenza vaccine procurement strategy,

1 particularly as it related to ensuring affective
2 vaccine stockpiles to protect the armed forces.

3 Thirdly to comment on the possible
4 procurement and expanded use of additional
5 supplies of antiviral medications in the event of
6 an influenza pandemic. So if we go to the next
7 page, what would be recommendation 4.1. So it
8 would be the second page, top of the second page.

9 To go through our recommendations and
10 then we'll take questions or discussion at the
11 end. The first was that we supported efforts to
12 extend the shelf life of the currently stockpiled
13 Clade 1 vaccine.

14 4.1.1 we reaffirmed that the Clade 1
15 vaccine, now that it's FDA approved, should be
16 offered to persons within DoD who are at the
17 highest risk of occupational exposure to H5N1,
18 which we generously estimated at about 1,500
19 individuals and that the DoD should collect
20 follow- up safety and immunogenicity data on the
21 recipients. We also said in the next paragraph,
22 given the limited data about Clade 1 vaccine's

1 effectiveness as a potential primer, we advised
2 against offering Clade 1 vaccine's to service
3 members outside of those at the highest risk of
4 exposure at the current time. If additional
5 safety and immunogenicity information became
6 available or if the threat of pandemic increase,
7 we would reconsider that position.

8 4.1.2 we recommended that DoD pursue the
9 extension of the vaccine shelf life even if that
10 needed to retrospective and that DoD and DHHS
11 immediately engage in discussion with FDA
12 regarding what data is currently available and
13 what data would be required in order to meet the
14 criteria necessary to extend the expiration date.
15 Again, with the clock ticking and December 2007
16 being the expiration date there was urgency in
17 this.

18 4.2. Given the subcommittee's
19 recommendation to pursue an extension, we
20 recommended that DoD not dispose of vaccine even
21 were it to become expired, because of the
22 possibility of retroactive extension of the

1 expiration date by FDA.

2 4.3. We supported increasing the pre-
3 pandemic antiviral stockpile to allow DoD to
4 expand prophylactic strategies which included
5 purchasing 2 million additional treatment courses
6 of Oseltamivir, so that would be 20 million
7 tablets effectively doubling the stockpile. It
8 would then contain over four million treatment
9 courses of Oseltamivir.

10 4.4 we recommended further discussion
11 and modeling efforts in order to achieve consensus
12 regarding the optimum balance of treatment, which
13 we've defined there. Post-exposure prophylaxis
14 also defined and pre-exposure prophylaxis also
15 defined. And the most appropriate target
16 populations given a supply of antivirals.

17 4.5 we recommended a strategy or at
18 least developing a strategy for the long-term plan
19 for acquisition of protective pandemic vaccines.
20 We specifically reiterated a number of key
21 recommendations that we had made in 2006, which
22 has already been approved and forwarded to the

1 Board, but I'll briefly, very briefly review them.
2 One was that, for a number of reasons, we felt
3 strongly that DoD had to be a full working partner
4 at the table with the other federal agencies
5 because there was a number of studies and other
6 issues that were more DoD specific and less likely
7 to come up in discussion of civilian agencies.

8 4.5.1.1 was that data regarding the
9 antigenic and genetic analysis of influenza
10 isolates to be submitted to DoD for analysis; and
11 that data regarding clinical trials involving
12 investigational vaccines for H5N1 and other
13 potential pandemic viruses be made available. I
14 won't go through all the sub details on that.

15 Recommendation 5 on the following page.
16 This is where we got into a little more detail
17 about a procurement business model. The fact of
18 the matter is that multiple industry partners are
19 rapidly coming up with candidate vaccines. We
20 didn't think the DoD should be leveraged on well,
21 okay, this is the next one available; let's spend
22 all of our money on that one, but rather a rolling

1 procurement model that took into consideration
2 advances of vaccine technology.

3 No. 6, we recommended that this strategy
4 ensure the broadest possible influenza subtype
5 coverage and yet remain economically feasible.

6 No. 7 that DoD in particular actively
7 develop, fund and sustain a PI/AI research and
8 development focus in order to have content experts
9 who would be so acknowledged and could most
10 effectively participate in interagency efforts and
11 planning efforts. The Board noted that this was
12 traditionally and historically true of DoD up
13 until the last decade or two.

14 No. 8, we remained concerned that DHHS
15 and hence all of the agencies leveraged against
16 them had relied on inactivated split or subunit
17 vaccines as the primary vaccines being developed.
18 The past history had suggested the superiority of
19 inactivated whole virus vaccines other than a live
20 attenuated vaccine. There are no manufacturers of
21 whole virus vaccine anymore and new data
22 suggesting that adjuvanted split virus vaccines

1 might be equally or more immunogenic. Nonetheless
2 there's some controversy and we were quite
3 concerned that rather than serial development,
4 that is make a vaccine, okay, that one didn't
5 work, make another one; that parallel development
6 of multiple candidates be considered and tested
7 and that's basically what 8.1, 8.2 involve. So I
8 won't spend more time on those.

9 No. 9 was an issue that the committee
10 had heard about earlier and that is the idea of
11 further considering development of guidelines for
12 the use of convalescent and immune plasma for PI
13 and other military-relevant disease threats. We
14 felt the most practical way to do that would be to
15 convene a working group of subject-matter experts
16 in the immune plasma and blood banking fields.

17 So that's an overview of the draft
18 recommendations that we would like to forward on
19 to the Department. I open it up for questions,
20 after which Dr. Hachey will brief us on responses
21 and updates to these recommendations. Comments?
22 Questions?

1 DR. LUEPKER: Greg, as you talked about
2 the vaccine facing expiration, you talked about
3 extending that. Two questions.

4 One, what are the rules in technology
5 that set these dates and allow that?

6 Second, are there perception and public
7 relations issues associated with that?

8 DR. POLAND: Yeah, that would have to be
9 managed and obviously we would not want to give
10 vaccine that had expired. But the current vaccine
11 that we're talking about is an FDA-approved
12 vaccine. Manufacturers typically have a one-year
13 expiration date. In part that derives from the
14 idea that they don't want old vaccine still
15 sitting on the shelves when the next season's
16 vaccine becomes available and then mix-ups as a
17 result of that. But the vaccines are immunogenic
18 and safe past the year, but that's just been a
19 traditional expiration date for practical reasons.
20 Does that answer your question?

21 DR. LUEPKER: You hope that you get some
22 relief from the FDA eventually?

1 DR. POLAND: Correct. I mean, we've got
2 a lot of vaccine sitting there.

3 COL ANDERSON: I just wanted to also
4 clarify that Department of Defense went back to
5 the manufacturer, they're continuing the stability
6 data and they will do the request for that
7 extension so that will be a normal process and we
8 want it approved before it expires.

9 The other thing is that we have taken
10 possession of some of those vials for the use that
11 has been recommended by this subcommittee and
12 those are being kept separate from any seasonal
13 vaccines for those reasons, too.

14 DR. LEDNAR: Greg, you mentioned that
15 the vaccine remains immunogenic even past the
16 one-year date. Is there some additional testing
17 that the manufacturer should do and make available
18 to the decision makers like DoD just to allay some
19 of the concerns that -- while they say there is
20 immunogenicity and efficacy that persists past the
21 end date that there really is testing at some of
22 those lots to confirm it is true.

1 DR. POLAND: In fact what happens is
2 there is -- and I can't speak to the sub-details
3 of that, but there is a protocolized and
4 standardized set of criteria that FDA requires and
5 they have to test sterility, purity, stability,
6 immunogenicity and maybe its safety, I think. So
7 there's a set of data that has to be collected and
8 recorded in a standardized way in order for FDA to
9 grant that extension. Is that what you're getting
10 at Wayne?

11 DR. LEDNAR: I guess one other question.
12 In times past there was some concern about sort of
13 a U.S. national security concern that there be
14 sufficient capacity perhaps within United States
15 the manufacturer of vaccines as well as
16 antivirals. Are we getting to a different place
17 in terms of U.S. capacity?

18 DR. POLAND: That's a good question. I
19 think the answer is -- will be yes with antivirals
20 and will be no for vaccines at least with current
21 approved technology. With the egg-based
22 platforms, it is simply not possible to make

1 enough vaccine for the U.S. or the world. Now,
2 with (off mike) reverse genetics and other
3 technologies and perhaps the live attenuated
4 vaccines that will be a different story.

5 DR. WALKER: What's the nature of the
6 occupational exposure for whom the individuals
7 would be recommended to?

8 DR. POLAND: These were individuals that
9 were in the field. A number of them were
10 veterinarians or laboratorians that would have
11 exposure to the -- would have a high risk of
12 exposure to the virus.

13 DR. SILVA: Greg, I think that's a
14 really good summary of our many phone calls, so
15 congratulations. For those of you that don't know
16 about vaccine production, the egg platform, many
17 of these companies are using 100,000 eggs a day.
18 There is an industry out there of chickens that
19 you can't believe.

20 DR. POLAND: Sometimes which came first.
21 I think the egg might. And I invite other members
22 of the subcommittee who have any comments or

1 elaborations that they might want to make on my
2 summary.

3 DR. OXMAN: With respect to a homegrown
4 capacity to produce influenza vaccine in the
5 amounts we would need, there are, I think,
6 contracts already for tissue culture grown
7 vaccine. If the tissue culture platform is
8 classical, normal, nothing fancy. Tissue culture
9 platforms themselves will permit us to have that
10 capacity of homegrown, but as Greg pointed out,
11 not eggs.

12 COL GIBSON: We were privileged; Dr.
13 Silva, Dr. Oxman and I were privileged to go to a
14 meeting with HHS where they brought the vendors in
15 that are working under these contracts to
16 establish new vaccines; seasonal vaccines as well
17 as PI. What we found interesting, there's a lot
18 of money being thrown against them. They're
19 talking about building infrastructure in the
20 United States to do the -- as part of the funding
21 mechanism to test these vaccines. Consequently
22 the long-term end is more robust productions

1 facilities to meet epidemic/pandemic needs in the
2 United States. So we're getting there. There's a
3 down select process involved in that, but there's
4 a lot of work being done in that area.

5 DR. POLAND: Just to give the committee
6 an order of magnitude; well over a billion dollars
7 has been released by the government to get us to
8 the cell culture technology. Bill.

9 DR. HALPERIN: If I recall in WWI, it
10 was President Wilson who went full steam ahead on
11 keeping the military operations going while other
12 people were arguing other social (off mike). And
13 I wonder whether it's in the curfew here -- it's
14 another chapter basically this is vaccine related
15 as far as preparedness of DoD as far as social
16 distance in the presence of the start of a
17 pandemic whether they're plans -- we've heard from
18 time to time reports of various corporations who
19 have looked at school children and primary care
20 and --

21 DR. POLAND: Very good question. And
22 the Board previously in the July 2006

1 recommendations included things about distancing,
2 quarantine, use of (off mike) there may have been
3 one other non- pharmacologic intervention, but,
4 yes.

5 DR. HALPERIN: School closings?

6 DR. POLAND: Yeah, school closings.

7 COL ROADMAN: Greg, as the conversation
8 went about shelf-life extension programs (SLEP), for
9 those of us who have been stockpiling, whether
10 it's pharmaceuticals or anything else for surge
11 requirements the SLEP program is not an unusual
12 issue but it does have the public relations
13 requirement of when that becomes obvious. Clearly
14 the manufacturers are not interested in that. Us
15 as the users are, but that's a common program that
16 is employed.

17 DR. POLAND: Colonel Hachey, let's let
18 you get on to your briefing. Is there a comment
19 while he goes up?

20 COL NEVILLE: With all those resources
21 going towards improving vaccine production
22 capacity, is there any similar effort going

1 towards improving the vaccine component
2 recommendations, predictions and so forth?
3 Anybody know?

4 DR. POLAND: Actually I would say that
5 is the area where the government has made the most
6 rapid advances and that's in the -- let me just
7 call it the surveillance activities in terms of
8 understanding what's out there, what the
9 resistance patterns are, et cetera. There's been
10 a big political problem though and occasionally it
11 erupts into public view and that is the
12 willingness of those foreign governments to share
13 that information or to let isolates out, so
14 there's more work to do there. Go ahead, Wayne.

15 LTC HACHEY: I can't see what I'm
16 talking about from here.

17 DR. POLAND: Just do it from memory.

18 LTC HACHEY: I'm happy to say that most
19 of the subcommittee's recommendations as far as
20 pandemic influenza we've already done and we'll
21 see some evidence of that in the subsequent
22 slides.

1 But to start out with H5N1 continues to
2 mutate. It's persistence in wild and domestic
3 bird populations, at least since 1987 is actually
4 both worrisome and reassuring. Worrisome in that
5 it just doesn't seem to want to go away, but
6 reassuring in that it's had ample time to make
7 that leap to be able to facilitate human-to-human
8 transmission and that's why it has not taken that
9 opportunity. There's now four distinct strains
10 causing human disease, two clades and three
11 subclades. The Indonesian subclade, 2.1, at least
12 over the past year has had the highest mortality,
13 around 80 percent; the largest number of cases and
14 the smallest geographic distribution. Whereas the
15 strain affecting Europe, Africa and the Middle
16 East has the lowest mortality, about 30 percent,
17 it's a little disconcerting to say the lowest
18 mortality and 30 percent in the same sentence, but
19 it has the next to the highest number of cases, at
20 least over the past year. The largest geographic
21 location and coincides with the majority of our
22 deployed forces.

1 Staying with birds, the geographic
2 spread is consistent with domestic and wild bird
3 distribution. There's been no significant change
4 in human-to-human transmission. Sporadic cases do
5 continue to occur. The birds remain the primary
6 hosts. Cats, dogs and other mammals have
7 developed a disease without effective transmission
8 and there's no evidence of transmission to humans
9 other than via an avian or human root, so we still
10 can't catch avian flu from Fluffy.

11 The next three slides are WHO maps that
12 will cone done what's been happening with AI at
13 least in the bird population since 2003 to the
14 current time. This one chart depicts what's been
15 happening since 2003 to date. The red colored is
16 the areas reporting incidents in poultry and the
17 tan -- those areas with just disease in wild
18 birds. Coning it down a little bit since January
19 of this year, we can see some hot spots in
20 Indonesia, China, Vietnam and then in Africa.
21 Coning it down even further just since July of
22 this year, again, Indonesia remains a hot spot a

1 little bit of activity in Vietnam and China and
2 some activity in Egypt.

3 Shifting gears to human disease Clade 1
4 had its hay day a few years ago, but over the past
5 months we've seen less than a handful of cases.
6 Clade 2.1, again, primarily in Indonesia. 2.2,
7 most of the cases there are coming from Egypt.
8 2.3 seen primarily in China, Laos and Vietnam.
9 There is some concern that the 2.3 may be
10 underreported just due to the rather large
11 geography they're trying to represent and some
12 problems in reporting in more austere environments
13 there.

14 Looking at, again, a WHO map now with
15 human disease, we can see Clade 2.1 again in
16 Indonesia with 30 cases since January of this
17 year. 2.2 the lion's share of those cases
18 occurring in Egypt and 2.3 in the China/Vietnam
19 area. Recently Vietnam has reported an additional
20 five cases there.

21 When we met last the concern of sample
22 sharing came up and it's still an active problem.

1 Indonesia is demanding guaranteed access to
2 benefits stemming from samples and this
3 potentially will threaten the global influence of
4 surveillance network. The good news is that there
5 are ongoing negotiations and Indonesia has resumed
6 sample sharing on at least a limited basis;
7 however, some recent events do question the
8 government in Indonesia's level of transparency
9 particularly in light of their Minister of
10 Health's denial of previously confirmed limited
11 human-to-human transmission within the Indonesian
12 border.

13 The next two slides are just more about
14 what's new potpourri. First of all the WHO has
15 recently changed its criteria for diagnosis of
16 cases by in-country labs. This will improve more
17 real time reporting of positive cases. Right
18 after this change went into affect that's when we
19 had the additional five cases reported from
20 Vietnam. Also the good news is that the disease
21 we see is probably the disease that's there. That
22 they're more than likely or not a whole lot of

1 cases of either mildly symptomatic or asymptomatic
2 diseases. Out of seven seroprevalence studies,
3 our studies in Vietnam, Thailand, Cambodia and
4 Russia all with negative findings. The only one
5 with positive results is in Korea, four folks
6 tested positive out of 2,000 poultry workers and
7 all of these were without clinical disease. Some
8 other news is that the mutations required for
9 shipping from an avian bindings site to a human
10 binding site have been identified and we're just
11 two mutations away from that, which is a little
12 scary until you find out that after that change
13 the virus is still incapable of decent
14 human-to-human transmission. So there seems to be
15 much more to the story that has to happen than
16 rather just these two mutations and binding sites.

17 Some bad news as far as Neuraminidase
18 resistance. Previously there were only two
19 mutations that were identified that were
20 associated with resistance. Now there are a total
21 of four and Oseltamivir is no longer alone. With
22 at least Clade 2.1 and one of these mutations,

1 which is quite rare, fortunately, we have
2 potential Oseltamivir, Zanamivir and Peramivir
3 resistance. Also in vitro it turns out that
4 Zanamivir resistance hemagglutinin mutants are
5 much easier to generate than Oseltamivir is. So
6 as we start using Zanamivir more for at least H5N1
7 its resistance pattern may blossom.

8 So this is some of the DoD activities at
9 least in regards to antiviral. We recently
10 released our new antiviral guidance, guidance for
11 use that's based on a variable supply and disease
12 severity. We use the National Pandemic Severity
13 categories for disease severity. It reinforces
14 the need for early and consistent implementation
15 of the non-pharmacologic mitigation measures that
16 the Board was just talking about a few moments
17 ago. It also introduces the post-exposure
18 prophylaxis strategy as an additional treatment
19 modality or strategy for mitigation.

20 Shifting gears to vaccine. If we look
21 at the National Strategy for Pandemic Influenza
22 implementation plan, HHS and DoD have a kind of

1 common task. First of all, HHS is required to be
2 able to immunize 20 million people against
3 influenza strains that present a pandemic threat.
4 DoD is required to establish stockpiles of H5N1
5 vaccine and other influenza subtypes determined to
6 represent a pandemic threat adequate to immunize
7 1.3 million people. So translating that to
8 doses, you need to double those amounts.

9 How much do we have as far as meeting
10 that goal? Nationally we're just shy of 15
11 million doses of a variety of H5N1 vaccines. The
12 DoD portion is about 1.2 million. The vaccine
13 started being produced in 2004 and continued
14 through 2007 and represent products from three
15 manufacturers. The products use different
16 reference strains reflecting the evolution of H5N1
17 virus as both in birds and humans. And only one
18 of these products is licensed, which happens to be
19 the product that DoD has in place. Most of the
20 HHS stockpile is stored in bulk by the
21 manufacturers and most of the DoD stockpile at the
22 present time is in vials with the December '07

1 expiration date. We're actively pursuing
2 shelf-life extension of that which appears to be
3 going well. Additional vaccine contracts are
4 being completed for 2007 and 2008, which will
5 include vaccines to new H5N1 viral strains from
6 Clades 2.1, 2.2 and 2.3 for the next vaccine run.

7 What are the current strategies for
8 civilian for the pre-pandemic vaccine? Well,
9 they're planning on vaccinating laboratory
10 personnel who work with H5N1 and pandemic response
11 teams. Then, vaccination of defined target
12 groups, which are yet to be fully developed when
13 the pandemic is imminent, each person getting two
14 doses of pre-pandemic vaccine and the level of
15 protection of course depending on how close of a
16 match it is.

17 The DoD policy which was recently
18 released mimics the national law strategy while
19 offering the FDA-approved vaccine to lab personnel
20 and teams with direct contact with high path H5N1.
21 Within the policy we've also established a
22 tracking, effectiveness and adverse event

1 monitoring as well as immunologic
2 serosurveillance. Then with the imminent onset of
3 a pandemic then the joint staff in cooperation
4 with NORTHCOM as the synchronizer will determine
5 the priorities based on risk, ability to receive
6 two doses and critical role of DoD personnel,
7 with, again the goal of preserving operational
8 effectiveness.

9 Well the DoD and national strategies may
10 actually change over time especially if we get a
11 better vaccine, whether it be a universal vaccine
12 or improved cross protection, across clades and
13 subtypes or if production could be substantially
14 increased and long term-wise that means either
15 bigger or more facilities, non-egg based
16 production as an intermediate goal. And the
17 short-term fix is the use of adjuvanted vaccine.

18 So the current H5N1 vaccine studies that
19 are underway include split virion and whole cell
20 vaccines, adjuvants, different routes, intradermal
21 versus IM, a mix and match adjuvant study and data
22 on cross immunogenicity between clades and

1 subclades. I'll be presenting, at least, some
2 preliminary data that touches on most of these
3 aspects.

4 The first one is immunogenicity of whole
5 cell Clade 1 H5N1 vaccine across clades. This is
6 a Baxter seroderived whole cell Clade 1 vaccine
7 dose of 7.5 ug unadjuvanted in people 18 to 44 who
8 received doses on day zero and day 21. You can
9 see that the response isn't bad. At 21 days 40.5
10 percent, at 42 days 76.2 percent, and then,
11 looking at cross protection, again, better than
12 what we currently have now with our unadjuvanted
13 split vaccine at 42 days 45.2 percent. Now this
14 is a number by percent with microneutralization
15 titers greater than 1 to 20. The problem is that
16 the microneutralization test is not standardized
17 and we don't know whether a titer greater than 1
18 to 20 will actually correlate with protection.

19 This next study is some older data that
20 ties in with the next study, which is newer data.
21 This is immune priming and cross-immunogenicity
22 after a booster dose. Subjects received two doses

1 at a 21-day interval of a plain or adjuvanted H5N3
2 vaccine. Sixteen months later, 26 subjects
3 received a third dose of the same vaccine.

4 You can see that the adjuvanted vaccine
5 had a much more pronounced yield whereas the
6 unadjuvanted the results are rather dismal. Then
7 cross protection from the H5N3 reference strain to
8 an H5N1 strain really were dependent on the
9 specific strain with some being rather robust and
10 others somewhat lackluster. Again, all of the
11 unadjuvanted had rather dismal results.

12 The next study was looking at booster
13 immune response following priming with an
14 antigenic variant. Thirty-seven individuals
15 vaccinated in 1998 with two doses of a 90 ug
16 unadjuvanted Clade 3 vaccine, then they were
17 vaccinated eight years later with one dose of a 90
18 ug unadjuvanted Clade 1 vaccine. Antibody
19 responses were compared with H5 naïve subjects who
20 received a single 90 ug dose of the latter
21 vaccine. You can see that the primed response is
22 substantially better than those who are unprimed.

1 The good news is that if this holds true for our
2 current Clade 1 vaccine, even though it's not a
3 good match to the current threat, may actually be
4 a very good primer for a pandemic- specific
5 vaccine.

6 The next study looks at adjuvanted Clade
7 vaccine safety and efficacy data in a human trial.
8 This is essentially the GSK adjuvanted vaccine.
9 As an observer blind randomized trial, two doses
10 inactivated split Clade 1 vaccine. Doses were
11 administered 21 days apart, 400 subjects, eight
12 groups of 50, with an age range from 18 to 60 with
13 four antigen doses ranging from 3.8 to 30 ug. The
14 vaccine was compared with and without adjuvant.

15 This is just a chart looking at the
16 demographics. Mean age was mid-30s, pretty much
17 an even gender split with a couple outliers in two
18 of the groups and ethnicity was primarily a white
19 population. The results were fairly impressive.
20 After just one dose there was a substantial bump.
21 This axis is the percent with HA titers greater
22 than 1 to 40, so at just 7.5 ug and one dose,

1 we're looking at 50 percent coverage. After two
2 doses we're in the 80 to 90 percent range.

3 This next slide just looks at some of
4 the same data. The HI antibody response to
5 homologous vaccine strains using the
6 non-adjuvanted vaccine. Using the non-adjuvanted
7 vaccine you see that the response is much less
8 robust although it's reassuring even with the
9 non-adjuvanted. 43 percent that's what we were
10 looking at with the response from our 90 ug
11 currently held and FDA- approved vaccine.

12 If we move on to the adjuvanted vaccine,
13 I can see that the response is much more
14 impressive with after the second booster dose
15 seroprotection titers in the 80 to 90 percent
16 range. More importantly if supplies are rather
17 tight, even with one dose using 7.5 ug we're
18 protecting 50 percent of the vaccines.

19 So the results that all eight vaccine
20 formulations in this particular study had a good
21 safety profile with no serious adverse events.
22 And the adjuvanted vaccine induced, as expected,

1 more injection sites and general symptoms. They
2 were mostly mild to moderate, and all were
3 transient. All of the adjuvanted formulations had
4 significantly more immunogenicity at all doses.

5 Now I couldn't leave without talking
6 about ferrets at least once. Again, ferret data;
7 this is looking at immunization with a low-dose
8 adjuvanted split H5N1 vaccine demonstrating
9 protection in ferrets against both homologous and
10 heterologous challenges. Again this is using the
11 current GSK adjuvanted vaccine. So ferrets were
12 immunized with a Clade 1 adjuvanted vaccine and
13 then challenged with a Clade 1 challenge and a
14 Clade 2.1 challenge the Indonesian 5/05 strain.

15 Looking at the results from the
16 homologous challenge, you know, if you get just
17 the adjuvant, well, you die. If you get the
18 unadjuvanted vaccine you're still likely to die if
19 you're a ferret. But even with fairly low doses
20 of antigen, have substantial protection with as
21 little as 5 ug with 100 percent survival.

22 Shifting to a heterologous challenge,

1 again, the Clade 2.1 Indonesian 5/05 strain with
2 doses as low as 3.8 ug universal survival. So
3 pretty good cross protection across clades.

4 In summary, the H5N1 pre-pandemic
5 vaccine studies, the adjuvants, short-term-wise
6 appear to be the way to go in increasing
7 immunogenicity and cross immunogenicity of H5N1
8 vaccine, and, in fact, a single dose of the GSK
9 adjuvanted vaccine could protect now half of the
10 vaccine recipients. Priming with one or two
11 vaccine doses leads to a booster response to a
12 subsequent dose of the same or even a different
13 H5N1 vaccine. Some pending studies currently are
14 mix-and-match studies using the GSK adjuvant with
15 other companies' influenza antigens. That is
16 currently under way. Also further trials on
17 cross-immunogenicity and priming which I hope to
18 present in greater detail the next time we meet.

19 That was a bunch of posters about our
20 pandemic exercise, which you won't have the
21 pleasure of seeing.

22 But we did have an exercise involving

1 the OSD P&R. It was to ensure preparedness and
2 continue the mission essential operations with a
3 diminished force and could safeguard its staff
4 during a pandemic influenza. The exercise was
5 designed to assess the overall preparedness, to
6 identify vulnerabilities, identify strengths,
7 capture lessons learned and identify a way forward
8 for improvement.

9 The exercise goals, first was the
10 ability to work at home, so trying to stress the
11 IT connectivity and server capacity. Also to
12 examine the capability of the communications
13 systems designed for pandemic to include our 800
14 number for people to call in to report their
15 status as well as telephone trees. The ability to
16 employ social distancing at work and the ability
17 to execute a sample of mission essential functions
18 with a diminished workforce. Also to look at the
19 flow of order of succession and delegation of
20 authority and the ability to muster using a
21 web-based tool.

22 The exercise accomplishments at

1 in-state, the overall readiness rating for P&R was
2 96 percent. Total number of participants, for
3 this kind of pilot exercise was just 1500. Total
4 on- site employees, about 1200. Total number of
5 teleworkers representing about 17 percent of our
6 population number 251. And the total number of
7 incapacitations 54. We did find that teleworking
8 does take some practice on the first day of the
9 exercise the help desk got 32 calls and by the
10 second day that dropped down to 14 calls. That
11 was similar that we found from our satellite
12 organization.

13 Some decisions that have to be made
14 based on the results of this exercise is that we
15 have to continue with readiness preparations to
16 resolve some identified vulnerabilities. And PI
17 weight four should be incorporated in the P & R
18 coop plan. Geotrex exercises should more fully
19 stress the IT capacity until we know exactly what
20 the breaking point it. Also the exercise included
21 folks in uniform and DoD employees, but had a
22 fairly low representation as far as our

1 contractors and Geotrex decides who want to bring
2 those in. Also need to assess the impact of
3 pandemic influenza on Pentagon parking and food
4 service for some of the ancillary services and to
5 test the office of Secretary of Defense and
6 interagency integration during a pandemic.
7 There's also consideration of appointment of a
8 full-time P & R emergency preparedness program
9 manager who is going to oversee all of these
10 activities.

11 So just in closing with the next update
12 I hope to share the results of expanded PI
13 exercise results. Also some policy adjustments
14 after we increase our antiviral stockpile. The
15 recommendations of the Board were taken and we're
16 currently purchasing that additional 2 million
17 doses of Oseltamivir and developing revisions in
18 our policy to reflect a more expanded prophylactic
19 role particular with post-exposure prophylaxis
20 being an option consistent with the HHS community
21 mitigation guidelines. Also some more data on
22 pre- pandemic vaccines as those preliminary

1 studies get a little meatier and we have more to
2 report, I'll have to share that information with
3 you, as well as our acquisition plans. And, then,
4 finally the results of vaccine modeling.

5 This, too, was a nifty picture of a
6 women sucking on a pigeon head, which is in your
7 handouts.

8 DR. POLAND: Thank you. We have just a
9 couple minutes for questions. Wayne.

10 DR. LEDNAR: Wayne, very nice
11 presentation. I've got really two questions or
12 reactions coming out of the preparation, the
13 exercise work you did. One was the teleworking
14 information technology and the other with
15 personnel issues.

16 The private sector assessment of the
17 ability of telecommuting being a viable way to
18 continue operations, in the most assessments I've
19 seen, is that we are vastly overstating our
20 capacity in working remotely during a pandemic,
21 especially for operations that are very broad band
22 dependent. I don't know whether the Department of

1 Defense has the ability of sort of getting a
2 certain defined amount of capacity in a pandemic
3 situation to support critical military operations.
4 But what's entirely possible is all the rest of
5 the country sucking off the capacity limiting what
6 he has available to it. So I would be just a
7 little careful about how much dependence on an IT
8 solution.

9 The other is a challenge that we've seen
10 several times and that's in the personnel area,
11 dealing with the fact that if there is a
12 morbidity, let's say an absence rate of -- pick a
13 number, 30 percent, how, in fact, critical
14 functions will be sustained because it may require
15 the reallocation of people from one MOS to work in
16 a different MOS in a different location. So it's
17 just not finding a solution to work with one-third
18 of your people in your office. It's how do you
19 reallocate flexibly people who are cross-trained
20 in multiple military specialties and apply them
21 flexibly where you need them. If you had a
22 personnel policy and implementation that's that

1 quick and adept. We don't see it in the private
2 sector. We're not there yet.

3 LTC HACHEY: Well, I don't know how
4 quick and adept we'll be, but the civilian
5 personnel office did recognize that that what they
6 need to do is have a good idea of where the
7 talents are within the organization and to
8 essentially move people around. So as holes
9 become vacated that are critical that you can take
10 someone who doesn't normally do that, but does
11 have that skill set and plug him in. So in their
12 personnel accountability they want to know where
13 their people are, whether the people are sick or
14 not or whether they're staying home for other --
15 pandemic is just scaring the bejeezes out of them
16 or whether they're actually quarantined, but also
17 what skill set they have so they have an inventory
18 of what resources are available on a day-to-day
19 basis. Now whether moving from that data to
20 actual operations will be as facile as we hope,
21 we'll have to wait and see. But the organization
22 has considered those issues and is, at least,

1 collecting the data to potentially be able to do
2 those kinds of switches.

3 DR. POLAND: Dr. Clements.

4 DR. CLEMENTS: In the Department of
5 Defense Implementation Plans for Pandemic
6 Influenza that was published in August of '06.
7 There are 20- some odd preparedness and response
8 matrixes of which vaccine acquisition and PI
9 exercises there are only two. So who's monitoring
10 the progress? These all have timelines of three
11 to 18 months after publication of August '06, so
12 we should be nearing the end of these. So who is
13 monitoring the progress of these? And is there --
14 who's got the big picture here?

15 LTC HACHEY: Each -- for the -- at least
16 the National Implementation Plan, which is
17 reflected in the DoD plan, DoD has, I believe, a
18 little over 300 tasks representing about a third
19 of all of the tasks. Of those -- actually all of
20 the tasks are being monitored by the Department of
21 -- not the Department of Homeland Security, the --
22 yes, the Department of Homeland Security. So

1 they're the kind of the larger watchdog as far as
2 all of the interagencies completing the task on
3 time. You also have quarterly updates that each
4 agency is required to submit outlining their
5 progress in meeting those tasks so there is a fair
6 amount of oversight. Now as far as meeting our
7 two tasks, as far as antivirals and vaccines,
8 we've met the antiviral requirement, gosh, before
9 the task was actually written. So we've been in
10 compliance with that one for quite some time.
11 Meeting the 1.35 million capability of immunizing
12 DoD personnel, we're somewhat limited; one,
13 fiscally, just having the money to buy that much
14 vaccine. And the other real rate-limiting step is
15 there isn't enough vaccine to buy to meet that
16 goal. So our acquisition plan is spread over the
17 next couple years that we'll be able to be a
18 position of omitting that individual task.

19 DR. CLEMENTS: But would the Board ever
20 be able to see from a DoD perspective how the DoD
21 is meeting these different tasks?

22 LTC HACHEY: Yes. In fact, let's see,

1 about two Board meetings ago, one of the PI
2 updates included exactly which tasks we were
3 assigned. Which ones fell under the medical arena
4 and what our status was for each of those tasks?
5 But we can easily include that in future updates.

6 DR. LUEPKER: Just to mention about the
7 ferret experiment. It seems apparent from your
8 data that protection is not only adjuvant
9 dependent, but dose dependent. But it looks like
10 the ferrets, which are much smaller than humans,
11 are getting dosages similar to humans. Is that --
12 my perception true?

13 DR. POLAND: In their experiment they
14 got ug and that's what you're commenting on is
15 that in some of the human studies they go down as
16 low as 3.8.

17 LTC HACHEY: Yes, I believe that is true
18 that the ferrets are receiving essentially the
19 equivalent of the human data switch would be, I
20 guess, per unit of weight much more substantial.

21 DR. LUEPKER: Yeah, the question is:
22 Are the dosages body-size adjusted somehow or are

1 they actually getting --

2 LTC HACHEY: No, they're getting 3.8 or
3 the.5 ug.

4 DR. LUEPKER: And that's actually not
5 uncommon to find that in small animal models you
6 frequently have to use the same dosage that you
7 use in humans because that observation is not out
8 of the ordinary for these types of studies.

9 DR. POLAND: Okay. What I'd like to do
10 now is ask for any last comments or concerns
11 anybody has on the pandemic recommendations;
12 otherwise, if I don't hear any I'll assume
13 consensus and then we'll forward them on as an
14 approved Board product. Good. Okay. We are
15 going to take a ten-minute break here and
16 reconvene at precisely ten minutes. Just one
17 think that Colonel Anderson just passed on to me:
18 The FDA just announced that they have approved the
19 new formulation of flu mist for an expanded
20 population, so basically down to age 2. So that's
21 very good news.

22 COL GIBSON: Quick administrative point.

1 Those of you going on the tour this afternoon need
2 a picture ID and we have 57 seats on the bus to
3 take us over there. So if that's going to be a
4 problem, we need to work on it. Thank you.

5 DR. POLAND: Okay. Ten-minute break.

6 (Recess)

7 DR. POLAND: We've got a pretty tight
8 schedule to try to adhere to. We're going to look
9 at the Southern Hemisphere recommendations from
10 the subcommittee on pandemic preparedness. Then
11 we have a bit of a change in schedule. We'll then
12 go to the disability evaluation system plan. We
13 need to do that done before lunch. And we'll do
14 the adenovirus stuff right afterwards. Can we
15 bring up the Southern Hemisphere or how are we
16 doing that? Is that in the packet? Just go to
17 tab 6. You have the material there.

18 We had been asked by the joint staff
19 about the issue of southern hemisphere vaccine and
20 whether our troops were at risk, and if so, should
21 we do anything about it. We came up -- we had a
22 number of teleconferences, had a number of

1 presentations during that, a number of pieces of
2 data reviewed. Mark, in fact, presented an
3 analysis that he had done looking at the different
4 seasons and what the results of that were. And
5 the basic summary of it, what I can tell you is
6 that in general there appears to relatively little
7 impact on U.S. troops by southern hemisphere
8 strains that are so different from northern
9 hemisphere vaccine that they cause widespread
10 illness. There's a proviso to that, and the
11 proviso is that we don't always have the best of
12 surveillance, particularly in areas where we have
13 a growing commitment but not yet robust
14 surveillance activity. So for example there's
15 more and more sustainment in Africa and there will
16 be -- a command that will stand out, but we don't
17 necessarily have great surveillance in Africa.

18 The other thing is traditionally the way
19 people have thought about this it's fairly
20 simplistic. The virus doesn't respect a border or
21 an equator and yet we sort of think of well,
22 there's a northern hemisphere season strain

1 circulating and there's a southern hemisphere and
2 there's not much mixing. In fact, this is sort of
3 a rolling time-dependent, sliding scale of these
4 quasi-species of viruses. So it's an ever
5 changing, complex issue contaminated now by the
6 immense amount of global mobility that occurs
7 every day of the week all through the year. So it
8 really requires a real time, highly dynamic,
9 comprehensive surveillance system; components of
10 which are in place, but not all.

11 So if you skip down to No. 6, and maybe
12 I'll make a comment about 5. The issue is whether
13 troops should get southern hemisphere vaccine and
14 those are not licensed to the United States. But
15 there are a couple -- were there to be a unique
16 strain that we thought was of issue, there are
17 some fallback provisions for the military, for the
18 country and that is IND or emergency use
19 authorization, approval that would allow the use
20 of the vaccine. So with those fallbacks, then,
21 our recommendations come under No. 6.

22 We did not recommend the use of a

1 southern hemisphere influenza vaccine for U.S.
2 Forces at the present time. If FDA licensure of
3 the vaccine became available, obviously we would
4 reconsider that issue. Apart from rare outbreaks,
5 there didn't seem to be an overall impact that we
6 could discern with the data available on mission
7 from southern hemisphere influenza and an unclear
8 association between what's in a southern
9 hemisphere vaccine and what's circulating in areas
10 where our troops actually are stationed.

11 We recommended that the Department have
12 discussions with manufacturers and urged them to
13 seek U.S. licensure. We believe one company is
14 doing so. It was the fallback mechanism for DoD
15 of the IND or EUA mechanism.

16 Then we recommended enhanced
17 surveillance strategies, including collaboration
18 with other agencies and other personnel in the
19 southern hemisphere. Primarily because of our
20 belief that even within the southern hemisphere
21 what surveillance we had reflected assets in more
22 highly developed areas of the southern hemisphere.

1 That may or may not be where our troops are
2 actually committed.

3 There's a brief overview of it. Any
4 comments, thoughts, et cetera?

5 DR. WALKER: If I recall, do we not need
6 detection of appearance of a new HN type in the
7 southern hemisphere, because they really appeared
8 in the northern hemisphere, the change of it
9 appeared first in the northern hemisphere from
10 what we detected.

11 DR. POLAND: I think that's right.
12 Mark, do you want to comment? Kevin.

13 DR. McNEILL: I was privileged to serve
14 on an IOM committee that actually will be
15 releasing a report next week on the DoD GIS, the
16 global influenza surveillance program, and I think
17 the recommendations in that report and some of the
18 status update in that report that address your
19 last issue on surveillance. They'd be a partner
20 for this committee to review once it's released
21 next week.

22 DR. POLAND: Okay. Good. We'll get a

1 copy of that and look at that.

2 COL GIBSON: There's a couple other
3 dynamics that this subcommittee dealt with. One
4 is that there's an issue of tropical or
5 subtropical, year-round influenza (off mike) low
6 incidence, but completely different from this
7 seasonal thing that happens further down in the
8 southern hemisphere.

9 The other is that other agencies, and if
10 you remember when we discussed this, we had CDC
11 there and HHS and others, State Department, Health
12 and Human Services, Peace Corps, there's a
13 boatload of folks that are interested in our
14 comments on this and whether they feel as though
15 it's important to vaccinate their folks. Now
16 they're usually down there longer because a
17 permanent tour where a lot of what we do are
18 deployments. But they're interested in us
19 finishing this up.

20 DR. POLAND: Okay. I'll take as
21 consensus an approval, then. There are no other
22 comments? Okay. Thank you.

1 We're honored to have the Honorable Mr.
2 Bill Carr, deputy undersecretary of defense for
3 military personnel policy with us today as the
4 next speaker. Mr. Carr oversees the recruiting,
5 retention, compensation and related human resource
6 management for the 1.4 million active duty
7 military members of the armed services. He's a
8 graduate of the United States Military Academy and
9 holds a Master of Science in systems management
10 from the University of Southern California and has
11 completed post-graduate work at the Kennedy school
12 of government Harvard University. Mr. Carr's
13 20-year military career was performed in the field
14 of military personnel management including service
15 as chief of enlisted management for Army forces in
16 Korea. He also served with the U.S. Army Military
17 Personnel Center as the enlisted strength and
18 readiness manager for the Pacific, Korea, Panama,
19 Hawaii, and an officer accession manager for the
20 Department of the Army. He's worked with the
21 armed forces recruiting as the commander of the
22 defense activity management recruit eligibility

1 screening for the Pacific regions. His bio is in
2 your briefing book. One other thing. With Mr.
3 Carr today are Lieutenant Colonel Nancy Fagan,
4 program director of military public health. Mr.
5 Tom Pamperin from the Department of Veteran's
6 Affair. Mr. Paul Williamson with Creative
7 Computing Solutions and I think that's it, right?

8 MR. CARR: Hi. I'm Bill Carr, I am (off
9 mike) military personnel policy -- Mr. Tom
10 Pamperin is my co-chair for the interagency group
11 that's looking at this. Nancy Fagan, of course,
12 from Health Affairs, and Paul Williamson who is
13 over there on the wall who ran the Navy physical
14 evaluation board for a number of years and is very
15 familiar with it. As a baseline, let me describe
16 a disability disposition, so that I can have
17 baseline against which to talk about improvements.
18 Let's assume that I've had a bad parachute landing
19 and my right knee mobility and range of motion is
20 severely limited and there's a definition for
21 that. I go to the hospital and upon realizing
22 just how serious it is, I probably will find my

1 way within that military treatment facility to the
2 medical evaluation Board. They're looking at that
3 injury in the context of my capacity to continue
4 this career. If they concluded that I could not,
5 even after considering job retraining, then that
6 medical evaluation board will prepare a narrative
7 summary and it will go forward to a centralized
8 physical evaluation board. Army's in Washington
9 area, Navy is Washington area. Army has some
10 other active areas as well. And Air Force is at
11 Randolph Air Force Base. It goes to that
12 activity. They look at the facts and they notice
13 that Carr has a bad knee. They will probably rate
14 me 30-percent disabled because there is a book, a
15 reference book that both DoD and VA use that say
16 when the range of motion is this, then the
17 percentage disability is that. It is 30 percent.
18 A separate judgment; am I fit to continue in the
19 Army? And if the answer is no, that I am unfit,
20 and because I reached the 30-percent threshold, I
21 will be medically retired. Had it been 20 percent
22 or less, then you receive severance pay. That

1 very simply is the process. There is due process
2 appeal. If you've reviewed my records and told me
3 that I'm 30-percent medically retired, but I have
4 some reason to say I think it should be 40
5 percent, then I would have a formal opportunity to
6 talk to that Board.

7 So what does Carr do that has to do with
8 VA? I've just settled it up -- squared it up with
9 DoD on my knee, but I had certain other things
10 that were not unfitted, hypertension and sleep
11 apnea. So those, after I've left active duty, I
12 would report to the Veteran's Administration as a
13 service aggravated condition. If the VA felt that
14 they were, then I would be awarded percentage
15 disability for that. So often we hear, Well, VA
16 gives higher percentages. Well, of course they
17 do, because they are looking at a wider range of
18 things. The military's interest is only in your
19 fitness and whether an unfitting condition is upon
20 on; that was my knee, not the sleep apnea and not
21 hypertension that's controlled with medication.
22 So, therefore, I'm 30 percent. When I came out of

1 VA I could have been at a much higher percent
2 because they consider those other things. Why?
3 Because they're making a judgment about your
4 quality of life and your capacity to work and earn
5 that you would have been at, absent that medical
6 condition.

7 So when one says they're different,
8 that's often overplayed. The issue is: Are they
9 different on the same thing? Do they look at that
10 knee, remember I mentioned we're looking at the
11 same book, so if we look at that same knee against
12 that same book, are we different? We went through
13 a very disciplined one-week exercise a couple of
14 weeks ago with a very strong performers and
15 supervisors from VA and from DoD. And I'd report
16 to you that when we look at the same knee against
17 the same standard, we come out with about the same
18 rating. There was a variance of up to 10
19 percentage points and that's not much. And these
20 were in complex cases and they were usually
21 because of a mental disorder, which is the
22 trickiest of all to capture and categorize its

1 impact upon your job and duty performance and job
2 performance.

3 So at the end of the day, well-trained
4 people looking at the same condition against a
5 common standard, come up with about the same
6 answer for a specific problem like a leg, but if
7 they are going out of that scope and looking at
8 things that don't limit their capacity to serve in
9 the military, naturally they'll come up with other
10 factors they properly may consider under law, do
11 consider, and, therefore, arrived at a higher
12 rating. It's no more complicated than that. So
13 that's the baseline program and if I could put up
14 the first slide, I'd like to describe from the
15 baseline the changes that we'll have coming our
16 way and I'll describe the schedule for that in
17 just a moment.

18 Remember I mentioned the MEB, or the
19 Medical Evaluation Board? That's the local
20 hospital, Madigan at Fort Lewis. Ultimately if I
21 have this serious problem with my leg, a narrative
22 summary, that's the little folder to the right in

1 Step 1, is sent forward to the Physical Evaluation
2 Board in Washington. And they'll look at it and
3 decide what my disability is and so forth. I
4 mention that for the baseline system. Now how are
5 we going to change it?

6 Remember that under the old system, I
7 had a physical from DoD; I had a rating from DoD
8 against the Cook book. Then after I retired, I
9 went over to VA, I had another physical, probably,
10 and another rating. So that's two physicals, two
11 ratings each different and arguably redundant. So
12 the first change we make to accelerate and
13 simplify the process is to say this is going to be
14 a joint endeavor of DoD and VA and we can do this
15 under present law. Congress doesn't do a darn
16 thing, we could do this and we'll probably start
17 doing it within the next few months. We would
18 take Carr with the bad knee and say, Carr; tell me
19 all the things that are wrong with you. Remember
20 out here the VA is interested in a lot more
21 besides my unfitting knee. They're interested in
22 my hypertension or whatever could affect my

1 quality of life and my work. So I will fill out a
2 form that will describe whatever maladies I
3 believe I present with and capture those for the
4 doctor. In just a minute I'll come to Tom,
5 because he's going to talk about template and step
6 4. That DoD -- this says question mark, that's
7 pretty much getting settled in DoD. That
8 physician, probably at the same hospital, is going
9 to say, Carr came in with a bad knee, he told me
10 about hypertension. I scheduled him for a
11 physical and before that physical occurred, there
12 were things we wanted to discover systematically
13 about Carr so that the disability could be rated
14 and those are in the form of a template. I'll
15 turn over to Tom and he'll talk about the template
16 and the rating panel and then I'll come back when
17 we get to this stage.

18 MR. PAMPERIN: All right. We don't have
19 the template slide, do we?

20 MR. CARR: No, we don't.

21 MR. PAMPERIN: Good morning everyone.
22 I'm the deputy director of the compensation and

1 pension service, and as Bill said, the co-lead on
2 the line of action for this. And our approach has
3 been that to have it as an integrated but plug and
4 play, VA comes in, does its thing and gets out and
5 DoD does what they need to do. When a person is
6 identified for an MEB we have developed a new one-
7 page application for compensation that will be
8 completed both by the member and by the MEB doc
9 who is deciding this. The MEB doc will identify
10 what disabilities or disabilities are
11 disqualifying. Then we'll -- the veteran will --
12 or the service person will identify what other
13 issues they have concerns with. An important
14 concept here is that at this stage, we are living
15 in two completely different cultures. In DoD it
16 is the Department of Defense that decides what is
17 to be examined. In VA it is the veteran who
18 decides what is to be examined, based upon his
19 claim. In our environment, typically the DoD will
20 examine one- and-a-half disabilities per
21 separating service person who goes through the MEB
22 process. We will process about 220,000 original

1 claims this year. About 50,000 of those claims
2 will be from veterans who are claiming eight or
3 more disabilities. So the level of complexity of
4 the new exam will be significantly higher.

5 We have a series of about 90 templates
6 or exam worksheets. The exam worksheets are paper
7 documents that are parallel to the ratings
8 schedule attempting to elicit from the physician
9 the information needed so that rating specialist
10 can apply them to the rating schedule.

11 VA is deploying in a pilot format a
12 template, kind of, almost TurboTax if then sort of
13 thing that will ensure that all pertinent
14 information is provided. This is particularly
15 important, particularly when you get into
16 specialty and subspecialties outside of
17 psychiatry, ophthalmology and audiology, because
18 frequently the individuals who examine there
19 aren't familiar with our requirements and have a
20 tendency to generate exams that are more like a
21 progress note and might not fully address every
22 issue. So we have deployed templates inside VA.

1 They are not mandatory yet, but when they do
2 become mandatory they have been demonstrated to
3 significantly improve overall quality of exams
4 although they do take longer. But we will do the
5 examinations for most veterans who, if they have
6 uncomplicated exams, a simple general, medical
7 examination is sufficient to evaluate their
8 disability. However, we do require
9 specialist-type examinations in ophthalmology,
10 audiology and psychiatry. Beyond that it really
11 depends on -- an examiner may be, if I claim
12 several things, might be presented with two or
13 three worksheets that they would have to answer
14 the specific questions relating to that
15 disability. The exam is produced and will be
16 provided both to the PEB Board and to, for
17 purposes of our pilot, a centralized rating
18 activity in St. Petersburg, Florida. Once this
19 thing is fully implemented it appears that we will
20 have two centralized rating panels, one in St.
21 Petersburg and one in Seattle. VA would then
22 rate, in our standard protocol, all of the

1 conditions that the veteran has claimed. Our
2 rating decision is typically about seven or eight
3 pages long, because it takes each contention and
4 discusses, I am claiming service connection for
5 post-traumatic stress disorder. What is the
6 evidence to support that? What is the evidence
7 that is missing? Okay. It is service connected.
8 The rating criteria we assign 30 percent for the
9 PTSD. The rating criteria for 30 percent are
10 this. The evidence that supports this are that.
11 The rating criteria for 50 percent is this and we
12 fail to see the following evidence. So for each
13 condition -- because we go through a detailed
14 explanation like that a typical rating decision is
15 six or seven pages long.

16 MR. CARR: So what we've established to
17 this point is under the change, DoD will keep
18 doing like it's done at the hospital, but this
19 will change because a new form is going to have to
20 filled out and this will change because the DoD
21 physician is going to have to do a ballet with the
22 A forms that they're unaccustomed to doing in the

1 past, which are fairly straightforward, simple,
2 and doable so the physician shouldn't have
3 difficulty with them at all. That will go to a
4 rating panel. Let's say, coming back to Carr,
5 this says 30 percent bad right knee, 10 percent
6 hypertension. Now it's back in the hands of the
7 services. And in that context the services look
8 at that document that's come in and they have to
9 decide right here which of the items are
10 authentic. And so they might say, Well the knee
11 is unfitting, but nothing else is. They would put
12 an asterisk next to the knee, the asterisk is
13 notional. So now we know that Carr has a bad knee
14 and hypertension. Only the knee is unfitting.
15 They'll write to Carr and say -- remember, I'm
16 talking about under current law capacity. I'll
17 come to Dole-Shalala in a minute. They'll say,
18 There's the deal. And I'd say, Okay. Fair
19 enough. I agree that I'm unfit. DoD would be
20 done with it at that point. The member might say,
21 and this is a little different, I don't like that
22 rating. I think I'm 40 percent. I've read the

1 Cook book and I think I'm a 40 percent not a 30
2 percent. That would be handled by VA who indeed
3 did it. And VA would have a decision-review
4 official, which a normal part of VA disability,
5 it's the first step in the appellate, and that
6 person would hear and respond. At that point, if
7 the member wasn't satisfied because we are
8 appealing a VA action, then there's other things
9 provided for in the VA system; the Board of
10 Veteran's Appeals and so forth. The person would
11 be told all about that when he got this letter in
12 terms of what the options are and if they did
13 chose to pursue that and this person looked at it
14 and said I've looked at it, it's 30 not 40 and the
15 member still thought it was 40, they'll take that
16 up out here with VA in their processes. Should it
17 become the case, for the military crowd, this may
18 be interesting, that 30 becomes 40 a year later.
19 Then it goes to the Board for correction of
20 appeals. The service boards will say, Make it 40
21 effective the date it would have been and we can
22 (off mike) from that point. So if later on the VA

1 makes the decision the member will be held
2 harmless.

3 MR. PAMPERIN: Just a couple of things
4 about the review process. Again, in the current
5 DoD environment, a service member has the ability
6 to rebut, or attempt to rebut a decision by an
7 informal board and request and informal board.
8 Everything to the left of that line, the
9 separation line, is internal DoD. VA has not yet
10 made a formal decision for VA purposes. We will
11 have complied with our legal requirements up
12 front, when we take that claim, we have to send
13 the letter from hell to veterans, called the
14 Veteran's Claims Assistance Act, which explains
15 everybody's legal obligations. But -- and we do
16 that up there because our decision is invalid if
17 we don't provide that VCA notice prior to our
18 decision. As long as the member is still to the
19 left of that line, they are an active duty person,
20 they are not a veteran. For purposes of
21 compensation they have no standing, but we will do
22 -- our decision review officer process where that

1 individual has the authority to change a decision
2 based not only on new evidence, but on difference
3 of opinion. If two people look at the same
4 evidence and I think it could be rated higher,
5 they can change it. That would feed back to the
6 PEB Board as our final best offer in terms of what
7 the disability evaluation is. When the member
8 becomes separated, they will receive a formal
9 award letter from us together with a copy of the
10 rating that fully explains -- I fully believe they
11 will have one prior to that as well, but they will
12 fully explain how we arrived at our decision. At
13 that point they have one year from the date of
14 that letter to file a notice of disagreement with
15 us about our decision, either as to effective
16 date, evaluation or whether or not a particular
17 condition is service connected. From there we
18 enter our appeals process.

19 DR. POLAND: Before we leave that, from
20 the left of the slide up to the red line, what's
21 the mean amount of time and the range of time to
22 traverse those processes?

1 MR. CARR: About 180 to 380. It's going
2 to settle in at 140 to 240 and it may sound like a
3 lot.

4 DR. POLAND: Is the mean?

5 MR. CARR: That's the range. I don't
6 know the mean. I'm sorry. I knew it and I don't
7 recall it.

8 DR. POLAND: It doesn't take longer than
9 about a year?

10 MR. CARR: It does not take longer than
11 about a year, but remember we talked only about
12 this side of the line. Remember in the old days,
13 in the current day, I have to after I've finished
14 with DoD trudge over to VA and start all over
15 again. Because we bought that, let's call that
16 180, so we have shoved that back here and achieved
17 it within the 140 to 240 I mentioned. So we made
18 it faster while burdening it more, but it can be
19 done and we're not over promising.

20 So we have taken what is really a 500-
21 and-some-day system, if you consider DoD doing it,
22 trudging to VA going through their physical and

1 their rating and so forth. And we turned a
2 540-day thing into a little under a year with the
3 possibility of hitting it in 140 days. But the
4 mean is going to be somewhat closer to that.

5 DR. POLAND: One other question I have
6 in that regard and I mean these terms in sort of
7 the legal -- the way the legal system uses them.
8 Is the culture or this process facilitative or
9 adversarial?

10 MR. CARR: Well, I'd love to say it
11 facilitative. There's an inescapable adversarial
12 component to it because there is a debate about
13 this condition and it meriting more. I wish I
14 could say that debates like that are not
15 adversarial, but I would say to defense
16 leadership, I know you asked us -- and we'll have
17 this discussion with them very soon -- to make
18 this less adversarial. We can make it
19 informative, well understood, transparent,
20 compassionate, but when it comes to the decision,
21 and if I am dissatisfied with that decision, I
22 don't know how we label it other than adversarial.

1 It doesn't mean it's mean spirited, but it is
2 adversarial. Again, adversarial processes can be
3 conducted with great collegiality and they would
4 be certainly under this. I hope that answers it.

5 MR. PAMPERIN: I'd like to supplement
6 that a little bit. I tend to think and this is
7 not a criticism, and please don't take it that
8 way, but the stuff to the left of the line is
9 basically workmen's' comp, whereas -- and we have
10 characteristics of adversarial or there's a
11 perception of adversarial to the right of the line
12 as well. What is different about what is to the
13 right of the line are really a couple of very,
14 very, significant things.

15 First, we will be applying the approach
16 that's mandated by title 38. Title 38 is fairly
17 unique in the federal government in that in
18 addition to being deciders, we are also advocates.
19 And as a result, we have a duty to assist the
20 veteran in proving their claim. Additionally, our
21 standard of proof is the lowest standard of proof
22 possible in a legal system in that it is

1 equipoise. If the evidence is balanced, you must
2 provide the higher evaluation.

3 Finally once you get to the right of the
4 system, until there is a final Board of Veteran's
5 appeals decision, as long as a veteran keeps their
6 claim active, there is no such claim as a closed
7 record. The veteran can continue to supplement
8 the record with additional medical evidence that
9 must be viewed in context so that if an appeal
10 takes two years and you see this steady stream of
11 additional evidence, even though when we made the
12 decision originally, it may have appeared to be
13 correct. We will consider all that subsequent
14 evidence and may very well go back and change it
15 from the beginning.

16 DR. POLAND: I don't want to get too
17 deep into discussion, but this is sufficiently
18 complex that if there are questions or
19 clarifications for this specific part. I think
20 General Roadman you had your hand up and then Dr.
21 Luepker.

22 LT GEN ROADMAN: Secretary, it's good to

1 see you again. I'm Chip Roadman. I come from it
2 from having served on the IRG.

3 MR. CARR: Indeed.

4 LT GEN ROADMAN: It looks to me like you
5 have the service still deciding fit for duty,
6 yes/no; the VA determining the disability rating,
7 and then coming back to a PEB that makes a
8 determination to finally about fitness. What we
9 found was that there was variation from service to
10 venue and that was manifest most in the barracks
11 in rehab with people from Guard reserve, different
12 services, same injuries, different results. Where
13 you have "Joint" question mark, that seems to be a
14 pivotal decision on actually fixing predictability
15 and accuracy. Where are you coming down on that?

16 MR. CARR: It's a decision that will go
17 to -- in order to deal with this disability stuff
18 and get it done with great participation,
19 ultimately it came under what's called the Senior
20 oversight Council. The co-chairs are Deputy
21 Secretary of Defense England and Deputy Secretary
22 of VA Mansfield, down the sides are the

1 secretaries of the military departments, Army,
2 Navy and Air Force and usually the vice-chiefs,
3 sometimes the chiefs. So that's the crowd.
4 That's about as Pentagonish as you get when you're
5 trying to review a matter. So they make the
6 meetings, it's real -- stuff.

7 Now the question that will be facing
8 them next Tuesday is what shall we do with that
9 question mark? We tried various options in the
10 tabletop. One was to say, let's make this a
11 purple activity that is production. In other
12 words, it's making decisions, as well as migrating
13 off to different services, if you couldn't make it
14 work out in the Army perhaps you could go to the
15 Air Force. And that's really a false hypothesis
16 as it proved out there, because Air Force doesn't
17 have a lot of room for, as much as we might think,
18 for circumstances, because they have so many
19 non-deployables now and their chief is concerned
20 about that.

21 So one is production. Second is
22 appellate. That really proved to be a problem.

1 It was time consuming. It always had the service
2 looking like the Grinch and purple daddy looking
3 like the hero. The third is to say quality
4 assurance and that's probably where it ends up
5 because the General's right, there are
6 differences, systematic differences between the
7 way one service systematically rates a condition
8 and another does as well as DoD and VA. As I
9 mentioned earlier, they're small, but when they
10 come up they can be reduced. So I think that this
11 thing is going to end up being -- my preference, I
12 don't know where it's going to end up. It's fair
13 to say I think it will end up that the services
14 will do the PEB as they have in the past. The
15 results will be audited as will the results from
16 the DVA rating panel and when we see systematic
17 behavior away from the central tendency or the
18 expected pattern, then we have to hold a Pow-wow,
19 do training, or whatever is necessary to achieve
20 convergence, because that does remain as a problem
21 and it does have to be addressed, this matter of
22 services waiting in identical condition in a

1 wholly different way. None of us likes it, but
2 none of us knows how to get at it unless there's a
3 purple activity. And when those happen everybody
4 figures out a way to converge to --

5 DR. POLAND: Dr. Luepker. And unless
6 it's very focused on this, let's get through the
7 rest of the presentation.

8 DR. LUEPKER: Two quick questions. One,
9 you said 220,000 cases this year. Are those all
10 people asking for disability ratings?

11 MR. PAMPERIN: Those are original
12 disability claims. We projected for this year
13 806,000 disability claims that's from the 2.9
14 million people who think that their conditions
15 have gotten worse, plus 220,000 originals. We're
16 going to finish this year at 835,000 --

17 MR. CARR: Well, let me help put that in
18 context because I think I -- we're talking about
19 the people who matriculate each year through the
20 DoD system as a wounded in war, a motorcycle
21 accident at Fort Campbell; that number is 22,000.
22 So the number that's going to be running through

1 this, all services combined, in any given year, is
2 22,000 of whom some, many, are going to be
3 returned to duty. They'll never be disabled and
4 separated. Now Tom is talking about -- there are
5 many who progress through their career, they
6 retire normally for longevity; it doesn't have
7 anything to do with disability. And then, as they
8 are fully entitled to do, report the conditions
9 that they believe qualify on the long policy and
10 this nation's wishes, to recognize financially and
11 medically, the hypertension, the diabetes, or
12 other things that occurred over their life that
13 are presumed to be service connected. All of
14 those things. So that's a big number, but it
15 doesn't mean they were disabled for a day while
16 they were on active duty. It simply is they left,
17 there are some things -- it didn't have to do with
18 fitness, but it does have to do with future
19 quality of life and employability.

20 DR. LUEPKER: That's helpful. We are of
21 course most worried, at the moment, about the
22 22,000.

1 The second question is the timing
2 question. You said, well, we're hoping to get it
3 down to 140, 240 days. Why does it take that
4 long?

5 MR. CARR: Yeah, you're right. And
6 we're going to have that broken out. It is --
7 generally the answer is the following: First the
8 generality. That Army's longer than the Marine
9 Corps; going to different services, I'll use those
10 two poles to illustrate the case. The Marine
11 Corps is a young force. It retains carefully in
12 its career force because it has a mission, an
13 organization, a grade structure where the pyramid
14 is wider at the base. The Army, on the other
15 hand, would be more inclined to remediate and to
16 spend considerable time and effort remediating.
17 Now the Marines could do that, but if the Marine
18 were interested in departing, could be cared for
19 on departure, and make room for another more fully
20 utilizable, capable Marine then I think the
21 commandant would say, That's what we should have
22 the Marine Corps do.

1 The Army on the other hand will go
2 through a lot more remediation. As a consequence
3 the time spent in medical remediation is what eats
4 at those 240, it's not administrative. More
5 remediation, more work, trying to optimize so that
6 they might be found fit and retained.

7 DR. LUEPKER: So part of this is -- you
8 say "remediation" and I think rehabilitation. Is
9 that what we're talking about here?

10 MR. CARR: Well, I don't know -- you're
11 all better at this than I, not being a physician.
12 But I meant by that that it could be a corrective
13 procedure just as easily as it could be -- I don't
14 know, maybe that is what rehabilitation means.
15 Anyway it is: To make what is present and making
16 it awkward to do your job, more conducive to doing
17 your job by whatever medical procedures would be
18 apt. I'm going as far as I can with the English
19 language in the presence of so many physicians.

20 This really -- to this point -- and in a
21 moment I'll call upon Paul, but to review what
22 we've summarized so far, we have taken a sequential

1 process and made it concurrent. We've taken two
2 physicals and made it one, albeit a little heavier
3 burden, because it's got the VA stuff to it. We
4 have taken two ratings and turned it into one and
5 DoD will subscribe to this and they're not very
6 different. Therefore, we will have saved time,
7 generated something more simple and that is the
8 system that we'll migrate toward.

9 I think we'll start -- we can start it
10 around Thanksgiving, to start moving -- we're
11 going to switch D.C. hospitals, Walter Reed,
12 Malcolm Grow, Bethesda onto this system and Army
13 leadership was a little bit reluctant like, I know
14 you got it on paper, I know you've run it through
15 a tabletop, I know you've rehearsed it, I want to
16 see a proof of concept with about half a dozen or
17 a dozen people going through it. So fine. We'll
18 probably go to perfect concept from Thanksgiving
19 into January and then January take the D.C.
20 medical evaluation Boards, Malcolm Grow, Bethesda
21 and Walter Reed and have them matriculate through
22 this process.

1 DR. POLAND: There's -- I'm going to ask
2 for very limited, succinct and focused questions
3 as they pertain to this slide in process,
4 otherwise let's hold --

5 MR. CARR: This, by the way, is the only
6 slide.

7 DR. POLAND: Oh, it is? Okay.

8 MR. CARR: For that purpose.

9 DR. POLAND: Then I'm still right.

10 DR. KAPLAN: Your instructions were
11 longer than my question is going to be.

12 MR. CARR: But precautionary, a
13 prophylactic measure.

14 DR. POLAND: Touché.

15 DR. KAPLAN: Important to this is could
16 you tell us about the qualifications of the people
17 in these Boards that make this decision. You, for
18 example, mentioned that you needed ophthalmology
19 and psychiatry and I can't remember what the third
20 one was, at some points along the way. What are
21 the qualifications for the people in these Boards?

22 MR. CARR: Tell me turn to Paul for

1 that, because Paul has a very direct experience.

2 MR. WILLIAMSON: Thank you, Mr. Carr.
3 Are you, sir, speaking directly to the
4 qualifications of those who are on the physical
5 evaluation board who are making the
6 fitness/unfitness determination rating, was that
7 your question?

8 DR. KAPLAN: I think all of the above.
9 The MEB and PEB outfit, yeah.

10 MR. WILLIAMSON: Well, the MEB process,
11 as Mr. Carr pointed out and we'll look at these
12 slides here that I brought along. You know you
13 have your patient source who come from the combat
14 field or just the general population who end up
15 going into medical. Now this is back to the
16 question of how long does this process take? It
17 depends upon where do you drop the chalk to start
18 counting? Is it from the time that he first walks
19 through medical and makes a presentation for
20 medical condition until he walks out the service
21 back door? Then Mr. Carr is correct in how long
22 does it take if you're isolating it down to the

1 point of when the individual is referred to the
2 PEB from the medical evaluation board process.
3 That time frame is considerably reduced. It's
4 done in a matter of 30 days in most cases.

5 DR. POLAND: But the qualifications of
6 the individual --

7 MR. WILLIAMSON: Yes, I'm going to get
8 to that. The qualification of the individuals who
9 sit on the physical evaluation board -- let's go
10 back to the medical evaluation board. You have
11 specialists who are the orthopedist,
12 ophthalmologist, specific to the condition that's
13 being presented and they're the ones who develop
14 the narrative summary that is presented to the
15 medical evaluation board that makes the initial
16 determination as to whether or not this case
17 should be referred to the physical evaluation
18 board because there's a question about the
19 individuals being able to meet medical retention
20 standards for that service or their fitness for
21 continued medical service is in question. That's
22 then referred to the physical evaluation board.

1 The qualifications of the physical evaluation
2 board physicians, we're talking about 05s and 06'
3 who have years of clinical experience as well as
4 specialty experience. When I was president of the
5 department of Navy physical evaluation board, I
6 had six different positions; psychiatrist, family
7 practice, aeronautics, internal medicine, a wide
8 spectrum of specialties that considered those
9 cases.

10 DR. POLAND: I think the issue may be --
11 I mean many of us are practicing physicians on the
12 board, but we're not trained in disability
13 evaluation, which has really almost become a
14 science or a specialty unto itself. So do they
15 have specific disability rating training?

16 MR. WILLIAMSON: Each of the services
17 has a training program to bring those specialists
18 into the occupational medicine rating process.

19 DR. KAPLAN: Are they members of the
20 board, is my question?

21 MR. WILLIAMSON: No, sir, they're not.

22 MR. CARR: By the way on the board is --

1 it's not all on the physician. On the board are
2 also line officers so the usual dialogue you'll
3 see at a MEB and by design at the PEB, is here's
4 the limit on range of motion. That's the
5 physician's responsibility, and then the line
6 officer says, Boy with that range of motion, it's
7 not quite (off mike.) I believe that the capacity
8 to do the work is limited. Really a disability
9 determination is emerging in both, but in our
10 case, in neither of these is it all on the
11 physician. There is someone there saying give me
12 the range of motion, the diastolic/systolic,
13 whatever, you give me that and I will share with
14 you information and between us we'll decide if
15 this medical condition is a fit against a
16 promising career. So it is a collaborative
17 decision with neither party fully responsible, but
18 both swapping information to try and get close to
19 the right --

20 DR. POLAND: Half the parties at the
21 table, then, have no training in disability
22 evaluation?

1 MR. CARR: Well, if you were at the
2 hospital, not much. If you are at the physical
3 evaluation board, I think they're full-time
4 professional. So if you are at the place over on
5 the left, the local hospital saying do I have to
6 refer it for a decision, they're not as hip in
7 disability processing, which really means they're
8 not familiar with the retention medical standards
9 as would be the person of the centralized board,
10 but they're the ones firing the real bullets. So
11 when you get to a board that's making real
12 determinations as opposed referral, they're full-
13 time professionals. And you would not have it
14 systematically the specialty representative unless
15 it's psychiatrist. So if it's a psychological or
16 mental, a psychiatrist has to sit on that -- has
17 to present for the physical evaluation board, but
18 for the other ones the specialties are fungible.

19 MR. MCKNIGHT: I have a concern about
20 your model. I think it's a great idea to combine
21 the physical exams into one opportunity; however,
22 my concern -- because Monday morning I'll be

1 seeing active duty troops and once a month I get
2 my MEB list and I'm supposed to go through it.
3 I'm concerned that the person who is now a
4 warrior/vet is not going to get the comprehensive
5 evaluation that they deserve, because in reality
6 what I'll face Monday morning is is this Sergeant
7 no go or go? I mean the line says we've got a guy
8 who's got a bum knee, are they going to go under
9 deployment two months or not? So we're going to
10 be evaluating that issue for is this a warrior who
11 can go off to deployment. If he says, Oh, I've
12 got this arm thing and I've got this back thing,
13 I've got this blood pressure, my concern is that
14 we're going to say, Okay, we've got all this
15 comprehensive stuff to go after; however, the
16 orthopedics gone deployed or the cardiologist is
17 now gone, things that really are not germane to
18 the mission to get the troop going or not going on
19 the deployment are going through the MEB process.
20 So you said, Oh, by the way, we're going to dump a
21 little bit more into primary care comprehensive
22 evaluation, when in fact the ops tempo is so great

1 and the resources are so fluid that you really --
2 I'm afraid are not going to give that person the
3 total evaluation that they deserve.

4 MR. CARR: And yet we cannot change the
5 environment. So that's a environmental
6 constraint.

7 MR. McKNIGHT: Well, I would say the
8 VA's side of the coin would have a more stable
9 environment to give that comprehensive evaluation.

10 MR. CARR: I'll tell you to that point
11 how government decisions sometimes are made.
12 Would Tom and I have viewed it the way you're
13 suggesting? I always viewed it would be a VA
14 physician doing the exam. Their templates, they
15 do it already. They're doing the rating panel and
16 that's the way it would be. Along comes
17 Dole-Shalala. Fine commission, great leadership
18 and they determine that it should be done by DoD.
19 So I talk to the staff, how did you arrive at
20 that, because it makes, to me, all the sense in
21 the world that it would be VA. Workload-wise for
22 reasons you mention and also that their rating

1 panel is making it or breaking it on the basis of
2 that product. Why should they rely on DoD for
3 that? Another agency an extra learning curve
4 among a busy agency? Well, I tell you why that
5 was, Mr. Carr, because the PEBs really want to
6 hear from their own doctors. It was about as thin
7 as that. I said, no, no, no, change that thing
8 and at least leave it optional. No, no, no, no.
9 Now part of that is that there are 58 cooks in the
10 kitchen, so whenever there's a crisis they all go
11 in there and start bumping into each other and so
12 we have lots of self-appointed experts giving out
13 lots of binding decisions and writing them into
14 law. So that's how that one happens.

15 Will we visit it? Fine we're going to
16 get stuck with it for a while, we'll revisit it,
17 we'll come back to it, because you're exactly
18 right and I'm where you are. That's how it
19 happened, my apologies.

20 MR. PAMPERIN: But Bill, aren't we also
21 saying that to the extent to which -- because I
22 happen to agree with you. I think at the end of

1 the day this is going to be a VA exam, but right
2 now it's DoD administered, which could be a DoD
3 professional or a TRICARE provider and to the
4 extent to which VA is a TRICARE provider in the
5 area, they would have right of first refusal. And
6 even where we're not a TRICARE provider. At
7 McConnell Air Force Base where the VA medical
8 center is a mile and a half away and the Air Force
9 goes there every day anyway, it's going to
10 probably end up being VA.

11 MR. CARR: I think that's exactly right.

12 CDR FEEKS: First of all, if I can
13 oversimplify for the sake of clarification. The
14 MEB is a medical process done by medical people in
15 the medical treatment facility? The PEB is a
16 personnel process done centrally and each case is
17 reviewed by a board consisting of one physician
18 and several line officers?

19 MR. CARR: You are correct in the
20 context of the Marine Corps. If you go to an Army
21 MEB they have an engagement with reclassification
22 and they -- but, fair enough, for simplicity let's

1 go with that. MEB physical, PEB administrative,
2 fair enough.

3 CDR FEEKS: My question to you, sir
4 about this diagram, I promised you a question
5 about the diagram. You don't go from step one to
6 step two, and with step one it's going to
7 recommend a finding of unfitness; is that correct?

8 MR. CARR: Correct.

9 LT COL DOMINGUEZ: If I could make one
10 question. You have the step six there where the
11 service determines whether they're fit or unfit
12 after they've gone through the VA rating scheme.
13 If the service member is determined fit and we can
14 return him to duty, wouldn't we want to do that
15 before we go through the lengthy VA rating
16 process?

17 MR. CARR: We could do it. The thing
18 I'd suggest is, our knowledge is most complete --
19 anything we did, anything we know here is going to
20 be expanded here, so you could do it based on
21 this, but why should we? Because we're going to
22 have better information there and we should make

1 one binding decision because we're going to make
2 it stick. It should stick and if -- we don't want
3 to have a lot of this going on, but the member has
4 to believe that every fact was known. There might
5 be new evidence introduced up here, there could be
6 a late breaking thing flying in here from the MEB
7 to the PEB. So that's the reason we did that.
8 Your point is a good one. The fitness could be
9 adjudicated early. I'm not sure that we would
10 write in a way that would prevent it, because if
11 there's compelling, logical, you've got to be
12 kidding me we're waiting, then I think we would
13 leave room for that decision to go forward to the
14 benefit of everybody involved. But as a general
15 rule, we'd like to have the information expanded
16 where possible. Does that satisfy?

17 DR. POLAND: Dr. Parkinson and then Dr.
18 Shamoo.

19 DR. PARKINSON: Can I ask, Britt, go
20 back to other slide? Because this will inform.
21 The macro goal that I keep coming back to is the
22 elimination of undesirable variation, that's every

1 step of the process. It's that undesirable
2 variation that is literally causing a lot of
3 problems.

4 MR. CARR: Credibility and everything
5 else.

6 DR. PARKINSON: So every time I hear a
7 stepping away of the opportunity to eliminate
8 undesirable variation, we are compromising our
9 opportunity to fix the whole thing. You'll hear a
10 little later this afternoon that the Board has
11 been asked the issue of evidence-based accession,
12 retention and deployment standards. That lives on
13 this diagram in that box right up above, dot, dot,
14 dot, based on medical evidence, DoD instruction
15 and military department regulation. So this
16 subcommittee that will speak to that, on our
17 approach this afternoon, that's where we live, but
18 we can't have that be at all effective. My point
19 at this juncture is to say if that then goes into
20 a distributed, Well, maybe we'll implement it or
21 not architecture, it's a huge undesirable
22 variation that will undermine any effort, even in

1 defining principles to fill in that box up there.
2 So listen up this afternoon when we talk a little
3 more about what we're going to do today. This has
4 been extremely helpful, but I would hypothesis
5 it's not answering the mail for the opportunity to
6 eliminate undesirable variation. It is answering
7 the mail to reduce some of the redundancy,
8 shifting of resources, as we've heard, if not
9 solving the resource problem and I think it's yet
10 to be determined about the capabilities of people
11 at both the MEB and the PEB level. This is -- in
12 the private sector and I look at Dr. Wagner at Dow
13 and the companies I deal with, this is a very,
14 very -- you have to have good quality people doing
15 this. So that's just the context of where that
16 box is and I wanted everybody on the full board to
17 hear where that box is and what we'll talk about
18 this afternoon.

19 MR. CARR: We will be -- we're in the
20 business of smart, correct, compassionate, so I'll
21 be listening up and if there's something in there
22 for us we'll use it.

1 I did want to mention, by the way, so
2 I'd be sure I get them in. Thus far, I haven't
3 talked about Dole-Shalala, that was that
4 commission. The president may make an
5 announcement today where he's going to perhaps
6 commit the administration to Dole- Shalala really
7 says one important thing. There's many; but it
8 says, You know, let's have DoD make a fitness and
9 if they're unfit they get an annuity. It matters
10 not if their 80 percent disabled or 10, they will
11 simply receive an annuity and that's the end of
12 it. All of the medical and so forth would go to
13 VA. It could go on for a long time, but that is
14 essentially the principal of it. DoD is fine with
15 that. If we can -- it would mean that the PEB
16 would look at the case, say this is unfit and from
17 that point, either a straightforward
18 administrative action to say what's your pay and
19 years of service, multiply it by 2.5 and you're
20 there on the percentage you get. So that would
21 simplify and it would divide agency role, moving
22 toward the core competency of DoD, I know if

1 you're fit or unfit ratings, I don't know if we're
2 supposed to be experts in that. So that's
3 Dole-Shalala.

4 The second part is the military
5 audience. I got an earful at Randolph yesterday
6 about something we've got to work out in house and
7 that is the matter of what happens if I'm fit, but
8 I'm non-deployable. So we are probably -- at
9 about the time Dole-Shalala comes in, if it comes
10 in, going to take a look and we may have to adjust
11 our stance to say if you're non-deployable maybe
12 we should look at the retention medical standards
13 and say you're also unfit. Absent an exception,
14 which could certainly be granted, as in the case
15 of prosthesis, as in the case of super Marine, as
16 in the case of whatever we wanted to make an
17 exception of the case of, but we're going to have
18 to take a look at this dichotomy because it's
19 killing us at the top. It's unexplainable to the
20 public that you're fit for duty, but you're not
21 deployable. And now feeling pressure from your
22 service to be administratively separated for being

1 non-deployable for what sounds like a medical
2 condition. It's just too confusing.

3 DR. POLAND: We've got about five
4 minutes left and there's a couple more comments.
5 Adil, I think you were first.

6 DR. SHAMOO: This is a just a
7 parenthetical. Do you mean they all get the same
8 annuity depending on their salary or is it percent
9 of their annuity?

10 MR. CARR: It's based on their
11 seniority. So the more senior would get --

12 DR. SHAMOO: That's it. Regardless of
13 the disability?

14 MR. CARR: Regardless of.

15 DR. SHAMOO: I'll go back now to my
16 original question and that is: If I'm the lonely
17 soldier come and face the system here, the power
18 differential and (off mike) is so huge it would be
19 petrified. The reason is the soldier really needs
20 money, basically, and medical care from the
21 government, whether it's VA or DoD. And that --
22 there's a conflict there. If the board, all the

1 time is going to give all the money to whoever
2 requested, I would say the government will go
3 bankrupt. So there is that huge conflict.
4 Moreover the power differential makes the soldier
5 really at a total disadvantage. All the people he
6 is facing are MDs, PhDs, MV PhDs, officers, line
7 officers they are all big shots. And I presume
8 the overwhelming majority of these numbers you
9 gave us, over 800,000 are soldiers, they are not
10 line officers. So that power differential, it's
11 there and --

12 MR. CARR: That's quite right.

13 DR. SHAMOO: No matter what system you
14 do. If you don't -- please give that soldier some
15 backbone to be able to face up to these Boards and
16 line officers and MDs. Those problems will
17 remain.

18 MR. CARR: We'll do more than that. Not
19 just backbone, we'll give an advocate for exactly
20 the reasons -- in other words what is the fullest
21 information we can present. Now let me talk
22 ethically, they are -- or in an ethical context,

1 which is exactly the context which you're
2 correctly talking about. We would say that the
3 people on the government end are out there to save
4 money. I would report -- I couldn't prove, I
5 rarely see that. Most don't think about that.
6 Even if it were true, it's also true that they
7 have to be mindful of the public resource that's
8 part of their public responsibility and the member
9 is not entirely pure here either or the patient
10 because they have an interest in maximizing in one
11 direction, even if that was true, you'd have a
12 natural tug and the right to counsel and so forth.
13 So in that context, the thing that gives me heart
14 is that I don't see that kind of behavior in those
15 who participate in the system there's certainly no
16 reward for stingy. I'm not sure you could do it
17 even if you wanted to, but to the extent it
18 exists, it is the nature of a government benefit
19 in which government officials, presumably with
20 good public purpose carry out their
21 responsibilities. But I don't think VA is
22 necessarily viewed as being a conservative -- this

1 can be done.

2 What I see, as far as injured, is this
3 incredible participation, compassion. You go to
4 meetings, here's the four stars. It says
5 something. For that crowd to show up, spend hours
6 be intimately familiar about the processing
7 details, the definition of traumatic brain injury,
8 all says to me that on the government side is
9 there interest is understanding, donating, making
10 better and so forth. I think we went that way
11 with motorcycle accidents and everything else.
12 The war changed some parts of DoD, for example,
13 the fact that we would retain one with a
14 prosthesis, we've never done that before, so we're
15 doing it now because they are far more
16 sympathetic. So you could see our ethos, you
17 could feel it as it was shifting. It's very much
18 pro war. I guess as time goes on it might soften
19 and become more jaded, because warriors are more
20 sympathetic than automobile accidents or more
21 loveable or more ethos. So we've got to watch
22 ourselves. But for right now it's at a zenith in

1 terms of --

2 DR. POLAND: I'm sorry, but we're going
3 to have to stop because our next speaker has a
4 time limited place in which they have to leave.

5 I'll just summarize by saying that this
6 is an issue the Board will continue to follow and
7 will request updates from the department.

8 Our next speaker is Lieutenant Colonel
9 Lorie Brosch. She's the chief of the trainee
10 health and preventive medicine. She'll brief the
11 Board on adenovirus at Lackland Air Force Base.
12 For background information adenovirus infection
13 and recruit training centers has been a legacy
14 concern, really, of the Board. It has
15 historically cost considerable morbidity and
16 occasional mortality among recruits while
17 adenovirus infection is not seen only in the
18 military, its high incidence appears to be
19 relatively unique to the basic training
20 environment. So, Lieutenant Colonel Brosch,
21 welcome. I'm sure the members are going to have
22 some questions for you after the briefing.

1 LCOL BROSCHE: Thank you for the
2 opportunity to come and -- what I think is a very
3 interesting adenovirus story at Lackland. I want
4 to say that on the panel there are some people
5 that work very closely with me. Colonel Bunning,
6 my prior commander, Colonel Neville from AFIOH and
7 Colonel Snedecor. They're very intimately
8 involved with a lot of my presentation. Next
9 slide.

10 I realize we're getting close to lunch
11 and I'm a realist so I'm going to try to keep this
12 as dynamic as I can and keep you interested. I
13 will probably slip over some slides I was going to
14 spend more time on. My slides are pretty
15 detailed, and one of the reasons I did that is if
16 I don't touch on everything you've got the
17 information there. I'm going to review a little
18 bit about the background on adenovirus, the
19 surveillance we're currently doing at Lackland,
20 talk about the outbreak itself, the response and
21 where we are currently. Next slide.

22 You kind of talked a little bit about

1 already the background on adenovirus and it's
2 really been a significant player in the training
3 population. Normally causes mild to moderate
4 respiratory disease. A severe disease is very
5 rare expect in immunocompromised people. There
6 are about 49, some people say 51 strains, distinct
7 strains of adenovirus and it's always been usually
8 4 and 7 that have caused most of the outbreaks in
9 military recruits. In 1971 an oral adenovirus
10 vaccine was developed against serotypes 4 and 7.
11 For financial reasons the production was stopped
12 in '96 and the stores were depleted by '99. Not
13 surprisingly, after that Lackland Air Force Base
14 had its most significant outbreak of adenovirus
15 which occurred -- I think it was actually stopped
16 being administered in July of '99. Sure enough by
17 November we see an outbreak of adenovirus. You
18 can see the numbers here, it was very significant,
19 we had a lot of hospitalization during that time
20 at a very high cost. Actually the adenovirus
21 persisted from '99 to 2004 and it's still causing
22 quite a bit of illness. I want you to focus a

1 little bit on this rate because I'm going to talk
2 a little bit more about where we are in terms of
3 that rate right now, 1.3 per hundred trainees.
4 And most of the illness is caused by Type 4 and
5 another significant point is that we did not
6 really have any life- threatening pneumonia, so
7 the severity was less. Next slide.

8 I stopped at 2004 on the last slide, so
9 what happened in 2005 and '06? Well, we're not
10 really sure why, there are some theories, where --
11 the yellow line represents adenovirus activity.
12 This is from NHRC, which I'll get into a little
13 more detail, they do our respiratory illness
14 surveillance, they help us with that. So they get
15 samples from the trainees and as you can see we
16 had almost no adenovirus in 2005 and 2006. You
17 can see the population varies a little bit. We
18 did have one dip in 2005, but we came back up in
19 2006. Next slide.

20 I want to switch a little bit and just
21 talk about surveillance because that is how we
22 kind of realized that we had a problem at Lackland

1 in terms of the adenovirus. In terms of active
2 surveillance, as I mentioned we used the febrile
3 respiratory illness, you'll hear me refer to it as
4 FRI, F-R-I, and that's a study -- I'll talk more
5 about that through NHRC. We have EOS, the
6 Epidemic Outbreak Surveillance organization that
7 works with us. In terms of passive surveillance
8 we look from population health, we get the DNBI
9 (Disease Non-Battle Injury) data which we look at.
10 And also I didn't add it on this slide, but we are
11 currently starting as a new medical surveillance a
12 system THOR, Training Health Online Reporting, which is
13 in its infancy, which will hopefully be an online easy
14 way to monitor our training population. Next slide.

15 This is a little bit about the FRI
16 study. Kevin Russell, he was here a little while
17 ago, he was in the back there, from NHRC, I
18 believe you were even PI (Principal Investigator) for
19 a while on this study along with your staff. It's a
20 tri-service study. It's on the high risk for the
21 trainee population only. It does surveillance only for
22 viral respiratory passages. I think there is one day

1 where do they do on (off mike) other than that
2 it's viral. You can see all the bases that are
3 involved in it and there we are. For those of you
4 who may not be familiar with Lackland, we are the
5 only training base for basic trainees for the Air
6 Force. We process in about 6 to 800 trainees a
7 week and we have a six-and-a-half week training
8 program at this time. Next slide.

9 The FRI study, it's purpose is to
10 determine the attack rate, which I alluded to
11 previously of FRI in this high-risk population, to
12 serve as an early warning system for respiratory
13 disease, which in fact it did, and I'll talk about
14 that; to see what pathogens are out there causing
15 disease in this population and since flu and
16 adenovirus have been the typically key players,
17 viral-wise, in this population they focus on that
18 and they're also working on some TCR testing that
19 they do on the samples. Next slide.

20 The FRI case definition, this is very
21 important because this is kind of the case
22 definition that we use clinically when we look at

1 the outbreak. It has to be on a trainee, fairly a
2 basic trainee; we expanded a little bit into the
3 tech trainee population. A FRI case is someone
4 who has to have a fever of 100.5 or greater and an
5 additional respiratory symptom. For the actual
6 study itself they use cough or sore throat. We
7 expanded that a little bit in the outbreak and we
8 included rhinorrhea and a few more
9 respiratory-type symptoms. Any trainee who has
10 pneumonia, clinical or radiological evidence is
11 automatically considered a FRI case. And
12 basically what happens is these trainees come into
13 our clinic, Reed Clinic on Lackland. They're seen
14 and the FRI study has people onsite ready to do
15 surveillance and culture these patients that meet
16 the criteria. The docs will call them and they're
17 right there and they'll do the testing. For the
18 FRI study they do a throat swab for viral culture
19 and also beside the sample being sent to NHRC and
20 that should be -- I guess it's been going on about
21 seven years. I didn't realize that. We've been
22 sending a sample to AFIOH simultaneously, so two

1 samples go out. This is a throat swab for viral
2 pathogens on the trainees. Next slide.

3 EOS is another organization that's there
4 with us. We're the real world test bed for EOS
5 and as you can see their mission there. And they
6 want to provide real time sample analysis and they
7 have nurses there that are also collecting
8 clinical samples now. The FRI nurses and the EOS
9 staff kind of work together and a lot of times
10 they are enrolled. Trainees have to be enrolled
11 in these studies and they'll be enrolled in both
12 of them simultaneously. EOS has an advanced
13 diagnostic lab right on Lackland. The reason this
14 is important is I'll talk about the PCR capability
15 that they brought to the outbreak instantly for
16 us. And they used a PRC and they're working on
17 other advanced molecular diagnostic technology.
18 Next slide.

19 The DNBI data comes from population
20 health support division at Brooke, and what's
21 interesting about it is that it has a unique
22 identifier for trainees. The trainees are not

1 really considered active duty yet until they
2 graduate, so they've kind of this unique
3 identifier that you have to look for to pick out
4 diseases and injuries and that's what we do. We
5 look at that as part of our surveillance. Next
6 slide.

7 So I thought I would review what the
8 definition of an outbreak is just to show you that
9 we really did have one. The definition the course
10 of any disease at a frequency that is unusual
11 compared with baseline or unexpected. So our FRI
12 rates 2005-2006 point to the .4 cases per hundred.
13 Actually when we look back at the data we had
14 maybe four, three or four adenovirus positive in
15 2006 total. Next slide.

16 This slide is from 2007, it starts in
17 February. I basically broke this up. I wanted to
18 take you a little bit into what I call the acute
19 portion of the outbreak, which was until the end
20 of June. As you can see, green represents
21 culture- positive adenovirus from NHRC. The red
22 represent pneumonia which I'll allude to a little

1 bit later, but you can see, this is a number one
2 here, counts for a day. You've already hit three
3 or four in a few weeks or a month. Actually at
4 the heart of the outbreak we had about 100
5 positives. Next slide.

6 This is what we started seeing. NHRC
7 puts out a weekly graph for us on the FRI study
8 and they do this for all the sites that I alluded
9 to before. As you can see, one might wonder what
10 was this. It was actually enterovirus, we saw
11 some coxsackievirus last year. It was not
12 adenovirus that caused this little blip here. But
13 as you can see starting about the end of March we
14 started climbing. Now, as I said, we had been at
15 such low levels that this was really a big change
16 for us. The red represents substantially elevated
17 above the expected rate. Next slide.

18 I want to kind of walk you through a
19 little bit of the thinking on what we did. We
20 realized that we had a problem. I am the local
21 co- investigator or the PI for the FRI study which
22 does go through our local IRB at Lackland Wilford

1 Hall and I get the culture results of any patient
2 that is enrolled in FRI. It has to be ordered
3 under a physician's name and they all come back to
4 me. So as you know, as we went along, I wasn't
5 seeing very much of any respiratory disease, very
6 low rates. Starting in March, end of March, I
7 started seeing our FRI rates go up and it looked
8 like, from the samples I was getting -- now these
9 samples that I was getting were actually from
10 AFIOH. Remember I mentioned that NHRC has a
11 sample and AFIOH has a sample. That's the one I
12 get in CHCS and that I could see readily and that
13 was from the AFIOH. So I started seeing we were
14 having adenovirus. I talked to the providers and
15 said we've got adenovirus. We didn't know what
16 serotype it was at the point. We hadn't seen it
17 before. Let's use our normal respiratory
18 precaution hygiene. We kind of dealt with it more
19 at a clinical level at that point. We have a very
20 good relationship with the Wilford Hall ID doc and
21 this is actually Dr. Mark Raznick who has been
22 separated from the Air Force. We started talking

1 to each other and he said, You know, we've been
2 seeing some odd pneumonias. And I say "odd"
3 because we can't figure out what the virology is.
4 And he said, We better talk about this, because we
5 hadn't really thought about adenovirus as a cause.
6 So we progressed, as a team, and I'll get into a
7 little more specifics and then we started our
8 interventions. Next slide.

9 Just want to review a little bit of the
10 lab testing capabilities. In May of 2007, which
11 is kind of at the heart of when we were seeing our
12 outbreak, all we could get was a viral culture
13 from AFIOH, a viral culture, serotype from NHRC
14 and a rapid adeno test from EOS. We had really --
15 like I said, NHRC had capabilities but it
16 wasn't real time. In June EOS obtained CCR
17 capabilities for adeno 14. I'll talk a little bit
18 more about why we wanted adeno 14 and AFIOH
19 started to do seroimmunization, in July AFIOH
20 obtained for adeno 14. Just want to point out
21 a little bit about the results. What happened was
22 we communicated with NHRC and we said we're seeing

1 this adeno, what strain is it? They said, It's
2 14. When you look back at the history of last
3 year, and we didn't know this until 2007, we did
4 not know this in 2006, we had one 14 as a
5 combination with 21. That's all we had at
6 Lackland. Some of the other bases had started
7 seeing 14 in low numbers. Mostly that's cold
8 infections. When we ask them to type or
9 adeno-positive cultures, 90 percent were adeno 14.
10 Next slide.

11 I won't spend a lot of time on this.
12 It's best to say that along with our clinical case
13 definition someone having to meet the FRI
14 criteria, they had to meet one of these laboratory
15 case definitions to be able to be called a case.
16 There are various ways we could have done that and
17 I'll let you read that a little bit on your own.
18 Next slide.

19 I'm going to spend just a minute on the
20 clinical. Mild, moderate, severe is how we
21 divided the case definitions because unfortunately
22 we started seeing moderate and severe cases where

1 it involved hospitalization. Just to give you an
2 idea, April to June, the same time period last
3 year, we had 14 pneumonias total and that's
4 looking at the DNBI. Only three were admitted at
5 that time. From the same time period this year,
6 51 pneumonias, 27 admitted. You might argue there
7 was some bias because we knew we had the disease
8 and maybe we admitted, but still that's quite --
9 we're talking over 50 percent admission rates and
10 that really was due to severity. A lot of these
11 kids were very sick. Next slide.

12 This represents our pneumonias. And you
13 can see in April is when we started seeing them
14 and we got a cluster here in May and we realized
15 that we really had some serious illness and it has
16 actually persisted on and I'll show some recent
17 slides as well. Next slide.

18 A little bit of epi about the
19 pneumonias. For time's sake I won't go into
20 details. I will say that the only patient who did
21 die had another disease going on at the same time.
22 She actually had mono first and then got the adeno

1 and she did succumb on August 7th. She's the only
2 death we had. But I might point out that these
3 are young healthy trainees, five ended up in the
4 ICU with pneumonia during this time period and
5 three needed to be intubated, so these were very
6 sick kids. They had a very classic clinical
7 picture; I'm actually going to be producing an
8 article about this, because there was a fairly
9 classic pneumonia presentation of these kids. And
10 you can see at the beginning our capability was
11 somewhat limited, but when we tested the ones that
12 were adeno positive, this is on the pneumonias 100
13 percent were 14. Next slide.

14 Local response. Well, I can't really
15 emphasize enough the team response that was
16 necessary for this. There I am the only
17 preventive medicine physician at Lackland. Public
18 health, I can't say enough about public health.
19 They did a fantastic job. You know it's an
20 outbreak and public health is a really big player.
21 Kudos to them. Like I said, the relationship with
22 ID, the clinic missions in the clinic and of

1 course one of which is colonel Bunning. I would
2 also say that we had a receptive line. They were
3 willing to listen to their medical people in terms
4 of our interventions, so that was very important.
5 The biggest recommendation we made initially was
6 that we segregated our isolated the sick trainees.
7 What we did is we created, depending on
8 determinology, a fever or a bed rest flights, the
9 line liked bed rest a little better than fever
10 flights, but basically these are the kids that met
11 the FRI criteria. What we did is instead of
12 sending them -- seeing them and knowing they
13 needed quarters for a couple of days, sending them
14 back to their flights, we segregated them, we
15 isolated them. We put them in a dorm and we let
16 them recover there. It helped in many ways
17 because they got rest that they might not have
18 gotten and basically it got them out of the
19 general population. The other thing of all these
20 public health measures, I won't go over these,
21 they're fairly standard. Local measures on the
22 trainees, cleaning, cleaning, cleaning, I can't

1 emphasize enough, everything, because this virus
2 can be everywhere. Next slide.

3 Just to give you -- the other thing we
4 did is just to show you some of the epi, some of
5 the stuff we looked at, like I said, we could
6 spend a whole day on this because there's so much
7 epidemiology you can do with it. You can look at
8 the individual squad unit to see if you had more
9 disease in one squadron, that's what we did.
10 Actually what we found out is that this would
11 change, these were the pneumonia patients, but it
12 depends on the month it seems to switch around.
13 If we did see somebody that looked like an outlier
14 we would go and investigate the squadron and see
15 if there was anything unusual. Next slide.

16 The other thing we found more in the
17 beginning, this goes up to September 3rd. In the
18 beginning of the outbreak almost all the trainees
19 were minimum of week four, so there was no
20 question that they were transmitting it while they
21 were there. Obviously somebody may have
22 introduced the virus but it was being transmitted

1 later in their training. Now as we get into the
2 effort we are seeing more cases a little bit
3 earlier. Next slide.

4 Also want to emphasize the interaction
5 we had with other agencies. AFIOH, AETC, the Army
6 was involved at CHPPM and WRAIR, Dr. Cushman was
7 doing the vaccine trials came down. We invited
8 the CDC and we were working very closely with the
9 Texas State Health Department all during this
10 time. Next slide.

11 Here's the initial result of our
12 response. This takes you to July and we're going
13 to take credit for this even though it may have
14 happened anyway, but our rates dropped. And what
15 we did is on May; right about here is when we
16 implemented all the measures that I showed you,
17 isolating the trainees, started doing some
18 aggressive measures. So our rates came down,
19 which is good. Next slide.

20 Current status, where are we now? Well,
21 I wish we could say this thing was over, but it
22 isn't. Our FRI rates are lower; we vary from.6

1 to.9. Considering our baselines were.2 to.4 we're
2 still elevated, but at that peak, we had hit two
3 per hundred. So we're definitely down. We're
4 still getting positive cultures for adenovirus;
5 we're still getting positive PCR adeno 14. The
6 majority are still adeno 14. We're still seeing
7 more, if you combine all the pneumonias, we're
8 still seeing a higher rate of about three times.
9 What we are seeing a little different is that we
10 -- our pneumonias where we had maybe 75 percent
11 confirmed with adeno, we're getting less of a
12 percentage of adeno-confirmed pneumonias so we're
13 starting to look for other etiologies,
14 mitochondria, Chlamydia, et cetera. We are
15 continuing segregation of the trainees. Our
16 threshold was when we hit less than ten in that
17 flight we would close it. We can't seem to get
18 there. We vary from 10 to 30 depending on the
19 week. Next slide.

20 Here's the fever slide, just to show you
21 or the bed rest slide. Trainees in and out and
22 we've had a lot. I believe we're up to about 600

1 this actually starts here in March and goes all
2 the way down. So trainees in, trainees out, still
3 disease.

4 We're still seeing pneumonia. Actually,
5 August, what was a little scary was we had kind of
6 come down in our rates and August it went up again
7 and so we again got public health out there. Some
8 of the squadrons had run out of their cleaning
9 product and we just have to stay on top of it at
10 all times. Next slide.

11 I think this is pretty much my last
12 slide. This is where we are right now. This is
13 NHRC slide. Now NHRC is adding the serotype of
14 the adenovirus in there for you to see. They
15 never used to do that, which is nice. You can see
16 this color represents 14, so basically still the
17 majority of our adenovirus is 14; we have a few 4s
18 in there and our new -- we've kind of new steady
19 state that we're hovering at, and it's here. Now
20 this is based on expected rates. NHRC calculates
21 the expected rate by looking retroactively a few
22 months. Now our expected rates are higher than

1 they were. So instead of looking at the color,
2 you almost need to look at more the raw number
3 because this would have previously probably have
4 been at least a yellow, maybe even a red for where
5 we were before. So we've reached a new steady
6 state. Next slide.

7 These are just my acknowledgements.
8 There were just a whole bunch of people who were
9 involved in this. I just wanted to make sure I
10 put their name on the list here to give them
11 credit. We're still doing some more studies on
12 the adenovirus. This is not over yet.

13 DR. POLAND: Thank you. I do want to --
14 just for members of the Board that aren't on the
15 ID panel, recall that this is serotype 14 vaccine
16 that's being devised as serotype 4 7. I don't
17 want to put him on the spot, but Commander Russell
18 is here and maybe he can give us a short summary
19 of the phase II and III study that's being done to
20 bring this to licensure.

21 CDR RUSSELL: Thank you very much. Fort
22 Jackson, Colonel Kuchner is the PI there and Great

1 Lakes. I'm the PI for the phase II, III studies
2 for the serotype 4 and 7 adenovirus vaccines.
3 We've been enrolling since October of 2006 and
4 we're currently about just under 300 shy of our
5 total and 4,000 for the two sides. At our current
6 enrollment rates we anticipate just two more
7 Saturdays of enrollment, we enrolled every
8 Saturday. We're very close to that. Then there's
9 the active follow up of those enrolled individuals
10 through the recruit training and then a six-month
11 follow up after that. I think we're just about
12 getting the trial over. Now, I'll mention, just
13 quickly, that the data monitoring board is meeting
14 now and the end of next week we will hear the
15 outcome of their preliminary unblinding of the
16 first 2,000 and to determine whether or not, based
17 on that unblinding, there will be a recommendation
18 for more enrolled or not.

19 DR. POLAND: Is Lackland one of the
20 areas where the vaccine trial is being carried
21 out?

22 CDR RUSSELL: Lackland is not. It's

1 being done at Fort Jackson and Great Lakes.
2 Lackland had such low levels that you saw of
3 adenovirus it wasn't a consideration for the
4 trials.

5 COL GIBSON: So, Kevin, you would say
6 that at least from the phase II, phase II study
7 things are going about as expected.

8 CDR RUSSELL: Agreed. Things have gone
9 well since we've started enrollment. We're on
10 timeline pretty much. There are a plethora of
11 other issues in the acquirement of the vaccine,
12 but currently it's scheduled for late 2009.

13 DR. POLAND: Comments or questions from
14 the Board? Ed and then Joe.

15 DR. KAPLAN: I was interested in two
16 things. Have you looked at any evidence of
17 seropositivity of new recruits coming to the base?

18 LCOL BROSCHE: We actually -- we have not
19 done that. We haven't gone through that step, but
20 that's a good idea. What we have done though is
21 we looked at slides that were fairly new, I think
22 at one point, maybe you can comment Colonel

1 Bunning, I think we did look, not recently, but in
2 the early part of the outbreak, I think we did
3 look at one slide that was fairly new.

4 DR. KAPLAN: The other question is in
5 this last handout that you just handed. It
6 suggests that there has been an increase in type
7 14 at the advanced training bases also.

8 LCOL BROSCH: Right.

9 DR. KAPLAN: Public health
10 implementation as you so nicely did at Lackland?

11 LCOL BROSCH: I didn't want to put that
12 on the slides for time's sake, but that's why I
13 just handed that out. That's the latest report
14 from AFIOH. And you can see, yes, the tech
15 training bases are also having problems. They're
16 in communication with us, their doing --

17 DR. KAPLAN: But all of those people
18 come from Lackland?

19 LCOL BROSCH: Correct.

20 DR. KAPLAN: I think this is an
21 important point that shouldn't be lost in this is
22 that oftentimes when we see recruit training bases

1 get it, people forget to look at the advanced
2 training bases and that's a very nice example of
3 that.

4 DR. POLAND: Let me ask, before you go,
5 because I think pertinent to the discussion, if
6 Commander Russell would just make a comment I just
7 asked him about.

8 CDR RUSSELL: Briefly, I just want to
9 point out that the adenovirus in this hemisphere
10 is adenovirus serotype 14 is a pretty new
11 occurrence or we haven't recognized that
12 previously. There are some older reports of some
13 adenovirus 14s in Eurasia. But in this hemisphere
14 it hasn't been associated with the respiratory
15 illnesses until some cases that we first
16 identified in early 2006 and some outbreaks in the
17 Pacific Northwest. So the question there comes,
18 Well what about the vaccines that we're currently
19 testing the adenovirus 4 and 7? Within the
20 adenovirus and the different serotypes that Lorie
21 discussed there are there are serogroups, A, B, C,
22 D. And in general there's reason to believe that

1 there's some antigenic protection among a group
2 and adenovirus serotype 14 is a serogroup B, as is
3 serotype 7, so the vaccine, including serotype 7.
4 The question is: Is that going to provide some
5 cross-protection for the adenovirus 14s that we're
6 seeing right now. Historically there is a report
7 that shows that the strain of adenovirus 14, I
8 believe, noted in the '70s, there was some
9 cross-protection of adenobodies produced toward 7
10 to that 14. So there's reason to believe there
11 might be, but I might point out quickly that this
12 14 is a little bit distinct from what we saw in
13 those years. We've done some pretty extensive
14 studies, both with genotyping and sequencing with
15 RARE and the Lovelace Institute, Dr. Cayonne that
16 shows it's unique 14. So those studies are
17 largely being headed up right now by Walter Reed
18 looking at this heterologous cross-protection and
19 whether or not it exists.

20 DR. POLAND: Sorry, Dr. Silva.

21 DR. SILVA: I was a young major when
22 type and 7 cycled at Wilford Hall. I have a lot

1 of memories with three of us rounding every six
2 hours through the Quonset huts and we felt
3 isolation was a key role. I was always impressed;
4 they carried the spivot pitchers of the ugliest
5 red exudative throats I've ever seen in dozens of
6 men. Did these lead to a lot of exudate, I mean
7 thick exudate, some I worried about --

8 LCOL BROSCHE: Some, but, no, not really.
9 I mean very sore throats but not necessarily
10 exudative.

11 DR. SILVA: And you answered my question
12 about 14.

13 DR. POLAND: Colonel Bunning.

14 COL BUNNING: I wanted to point out that
15 you noticed a lot of different people on that
16 slide. We have a whole series of studies that are
17 in the analysis phase following through -- we are
18 working with CDC. We have a cross-sectional
19 study. We had a nosocomial-hospital based study
20 as well. We have a whole series in working with
21 our other service partners in the state. There's
22 a lot more to come out of this.

1 DR. POLAND: Dr. Oxman.

2 DR. OXMAN: A question and a comment.

3 Comment: I believe that the cross protection
4 between 7 and 14 is really based on tissue-culture
5 serology and not clinical if I'm not mistaken.

6 CDR RUSSELL: That is correct.

7 DR. OXMAN: The other characteristic of
8 adenovirus infections is they have a very
9 prolonged period of shedding after the acute
10 illness and after sub-acute illness or
11 asymptomatic infection and that would certainly
12 affect the epidemiology when people move around
13 from one base to another.

14 LCOL BROSCHE: Right. What we're doing
15 is because of that and because we've also in just
16 some preliminary studies we did, we saw that there
17 are a lot of asymptomatic patients out there
18 carrying. So we know there's more out there than
19 we've been seeing. But what we do is we screen
20 our trainees the night before they leave, we get a
21 temperature and we interview them and we screen
22 them now before we let them go to the test agency;

1 for that reason, that they may be incubating and
2 they may still be having problems.

3 In terms of the shedding, we actually
4 have a study going on to try to delineate that,
5 but you're exactly right, it can shed for a week.

6 COL BUNNING: We've identified over 30
7 days so far.

8 DR. POLAND: Dr. Lednar.

9 DR. LEDNAR: A follow-up to Dr. Oxman's
10 point about the prolonged shedding. It was really
11 an eye opener to see just how sick some of these
12 young airmen were including ICU admissions. Is
13 there any evidence that there was transmission of
14 adenovirus from the patient to the hospital staff?

15 LCOL BROSCH: Yes. We did have --

16 DR. LEDNAR: Is there any evidence that
17 that is beginning to get seeded?

18 LCOL BROSCH: We did a healthcare worker
19 study which we haven't reported the results of,
20 but we did. We had a definite -- in fact, we had
21 one very sick resident, a resident that did get
22 sick during this time. Yeah, you're right. In

1 fact, most of us, I'll tell you personally that I
2 probably had it during this whole time. Not the
3 pneumonia level, but I was sick for a couple
4 weeks, a lot of us were ill from it, but not to
5 the degree of some of these men.

6 DR. POLAND: Any other comments? Okay.
7 Thank you very much.

8 COL GIBSON: Two very quick comments.
9 Those of you, who haven't registered, raise your
10 hand. Karen will bring around the sign-in. We do
11 have to keep track of registration.

12 Also, we need a show of hands who wish
13 to go on the Intrepid tour this afternoon. I
14 think we're going to be okay on the bus, but we
15 have two additional cars lined up to get us over
16 there. The critical -- the critical part is not
17 the Intrepid. They can take care of as many of us
18 that can get there, the issue is the bus. Karen,
19 which one do want raised first? Intrepid? Raise
20 your hand if you want to go on the Intrepid tour.
21 Now anybody who hasn't signed up, raise your hand
22 so Karen can bring that around.

1 DR. POLAND: We're going to break for
2 lunch and reconvene at 1:45. The Board members,
3 liaisons, preventive medicine officers,
4 distinguished guests and speakers can remain here
5 for a working lunch. For everybody else there are
6 several restaurants in the area. Do you need to
7 know about dinner tonight?

8 COL GIBSON: Oh, yeah. Let's mention
9 dinner tonight.

10 MS. TRIPLETT: I need a show of hands.

11 COL GIBSON: Dinner tonight is at County
12 Line. We'll be leaving from the hotel at 6:15.
13 This is a Texas barbeque. And we have enough
14 reservations for everybody. You want a show?

15 MS. TRIPLETT: Thank you.

16 DR. POLAND: We'll reconvene at 1:45.

17 (Whereupon, a luncheon recess was
18 taken.)

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

2 DR. POLAND: I want to thank again, Mr.
3 Carr and his team for coming and briefing us and
4 we would like to stay -- the Board would like to
5 stay engaged on this issue. It's obviously a hot
6 topic issue. So we'll be seeing more of each
7 other. Thank you very much. I also want to
8 introduce Colonel Chuck Scoville, who is actually
9 at the Military Advanced Training Center, which is
10 sort of a sister facility to CFI, which you'll see
11 today. And I hadn't realized it, but Chuck was
12 actually involved in the planning process of what
13 we're going to see. So welcome, Chuck.

14 COL GIBSON: He's also the executive
15 secretary for the panel on amputees and care for
16 patients with amputees and functional limb loss,
17 one of our subcommittees.

18 DR. POLAND: We've always tried to be
19 cognizant of the need to be knowledgeable and
20 recognize each other and I want to take a few
21 minutes now to recognize a departing member of the
22 DHB team. Commander Dave Carpenter, the Canadian

1 Liaison to the Board has been reassigned to
2 Ottawa. He is going on to presumably bigger and
3 better things. His replacement Commander
4 Catherine Sloan- White will be with us in December
5 at our Washington, D.C. meeting. So, Dave, can
6 you come forward and we have a plaque for you in
7 recognition of your service with DHB?

8 CDR CARPENTER: Which way is forward?

9 DR. POLAND: Thank you, Dave, and
10 Godspeed. We'll go, then to our first
11 presentation, Dr. Mike Parkinson, who is President
12 of the American College of Preventive Medicine.
13 He'll provide his subcommittee update, much like
14 we did with the pandemic questions on a question
15 that's before the board on evidence-based
16 accession, retention and deployment standards.
17 So, Mike, we'll turn it over to you. We have
18 about 15 minutes or so scheduled for this.

19 DR. PARKINSON: Okay. We may not need
20 that entire time, Mr. Chair, but I did want to
21 give the full committee an update, both the
22 question and the activities that the subcommittee

1 has engaged in since it was brought to our
2 attention.

3 The question to the DHB is to ask the
4 DHB to examine issues associated with the
5 establishment and modification of DoD medical
6 standards that span the career life cycle of
7 service members from accession through separation.
8 Here we're talking about accession, retention and
9 deployment standards. What tools or methods
10 should DoD use to establish and modify those
11 standards that will ensure a medically-ready force
12 to meet our nation's requirements while minimizing
13 the potential to cause or aggravate medical
14 conditions that could preclude continued military
15 service? We conducted a conference call thanks to
16 Colonel Gibson, Colonel Grieg and also I want to
17 thank Lieutenant Colonel Niebuhr, who, as you
18 recall in an earlier meeting, gave us an update on
19 evidence-based accession standards and DoD
20 considerable progress in that realm. We convened
21 a conference call, the subcommittee, with those
22 subject-matter experts and the first thing we

1 wanted to ascertain was essentially presented to
2 us before lunch, and that is in the midst of three
3 federal, extremely impactful reports, largely
4 critical of the disability evaluation system and
5 the interface between the DoD and VA, how big of a
6 problem and how big an impact could this committee
7 have answering these questions, because they're
8 integrally tied, as I pointed out in our
9 conversation before lunch, to that box that was
10 right up there. So we are the -- we are the
11 cerebrum, not the cerebellum, but the cerebrum the
12 drives what happens in those arrows. So while the
13 arrows look clean, what happens in those boxes is
14 what's in the intelligence of evidence-based
15 standards. We wanted to understand the current
16 status of that. I think the Board also probably
17 wants to monitor the progress of that and in that
18 context then we were able to better define the
19 scope of what this subcommittee can do to answer
20 this question. And I think that our group will be
21 very comfortable with doing the following, and we
22 already have a draft that Bill has begun to think

1 about.

2 What we clearly can't do is go over 180
3 conditions and determine the level of evidence
4 that the DoD currently uses times three different
5 services with different ways of determining
6 whether that retention standard, deployment
7 standard, fitness for duty standard is equivalent
8 or if it should be equivalent or should it be
9 standardized. What we can do, however, is
10 articulate through the answer to this question a
11 series of guiding principles that we would ask DoD
12 to pursue as it begins to standardize where
13 standardization is necessary with the fall back
14 being if it's not standardized across the
15 services, you better have a darn good reason to
16 say why it's not, rather than a default that says
17 we're all different and therefore we can't.

18 We would articulate a series of guiding
19 principles that would allow DoD to achieve its
20 goal in the context of the re-engineering of the
21 entire disability evaluation process. So we can't
22 do it outside of that, it has to be done inside of

1 it. Things that would be in those goals would
2 include such things as the use of a hierarchies of
3 evidence approach, similar to something like the
4 U.S. Preventive Services Task Force that could be
5 built upon but tailored to unique DoD needs. We
6 could then articulate the types of databases, case
7 studies or even Fentanyl events which DoD should
8 be looking for by type of standard as a way to
9 continually validate their existing standards and
10 (off mike) them accordingly. We certainly would
11 rely heavily on the experience of the accession
12 standardization project, which is evidence based
13 to inform that and ask how far we can apply
14 Colonel Niebuhr's group and their work to the area
15 of retention and deployment standards. It may or
16 may not be applicable. So in this way we would
17 begin to purvey guiding principles that should
18 then be translated by the relevant DoD and service
19 members into applications so that over time, year
20 over year, we get closer to a consistency of
21 evidence and a unanimity of approach where that
22 makes a lot of sense.

1 Areas that we would also consider in the
2 recommendation would be the use of these to inform
3 or perhaps, maybe, even create contractor and
4 accession and deployment standards. We have as
5 many contractors in theater today as we have
6 uniformed service members. Contractors create a
7 tremendous resource drain on our MTFs so that's
8 another consideration that perhaps we want to look
9 at in our principles.

10 NATO standards. We don't just fight
11 alongside our contractors, but we're right
12 alongside our NATO and NATO is looking at
13 standardization of NATO standards as it relates to
14 that. So certainly want to have some language in
15 there. Recently there was a study, Dr. McNeill
16 has served on with the Institute of Medicine
17 around the National Research Council on the whole
18 area of if you have that (off mike) Neil's you
19 probably don't, but a good work out of the NRC on
20 this area about accessions too, so we've already
21 got some good work in the area. So we us not
22 coming back with the "how-to" but the principles

1 that guide the "how-to" that could be very much
2 consistent with and I think useful to the
3 Department. So I'll open up for any comments from
4 the other subcommittee members, but that's what we
5 would bring you in relatively short order, Mr.
6 Chair, so I think we're there. But it took a
7 while for us to get a good problem definition, to
8 get some environmental assessment as to where this
9 TBE thing is because it's got to go in there right
10 away and then the hard decision has to be made why
11 don't we standardize.

12 DR. POLAND: Thank you, Mike. It's a
13 complex topic and we're fortunate to have somebody
14 who knows as much about the system as you do with
15 your skill sets. So thank you. Questions or
16 comments? Dr. Lednar.

17 DR. LEDNAR: I think one of the
18 challenges in this rework of the disability system
19 and its simplification; it seems like that there
20 are two separate questions that this consolidated
21 approach may be trying to address. One is a more
22 service specific one about is the

1 soldier/sailor/airman fit for service duty? Yes?
2 No? Or should they be separated.

3 Question two is: Is there some health
4 condition in this service member which may have a
5 connection to the service and is producing some
6 disability?

7 And I think trying to keep some clarity
8 in these two questions as they're both answered is
9 important. One of the unfortunate aspects of the
10 language that you used, and everyone using the
11 term "disability" "disability plan" "disability
12 programs" is the fact that there's a difference
13 between impairment and disability. Impairment is
14 more what it sounds like some of the rule sets
15 sort of get at in terms of range of motion and
16 these kind of -- what a doctor can observe,
17 describe and document versus what is the
18 servicemen's reaction to the change in their body
19 part. We've all seen people, who, with a similar
20 level of injury, some go right back to work and
21 others are out of work for the next six months.
22 So disability is really the personal, behavioral

1 reaction to the anatomical insult. So we're
2 calling this a disability system and yet it seems
3 like we're kind of impairment focused. So I guess
4 I'd just be a little careful about the confluence
5 of these questions for different purposes and it's
6 going to be a challenge to make this evidence
7 based.

8 DR. POLAND: Mike, any comments you want
9 to make in regards to that?

10 DR. PARKINSON: I agree. These were the
11 cautions, why we didn't want to find ourselves
12 with one leg in a La Brea tar pit that we could
13 not get out of and that we'd look ridiculous
14 because there's no evidence, but we need to inform
15 the mission as opposed to doing it and that's kind
16 of -- that type of consideration, Wayne is very
17 helpful, because you're right; impairment versus
18 disability and do we need to reframe the semantics
19 at some point? I don't know. Just something to
20 think about.

21 CAPT JOHNSTON: The other issue that I
22 think that's -- I'm not sure if you specifically

1 addressed it, it was raised this morning is the
2 difference between fitness for deployment and
3 fitness for duty. To me, to some extent, they
4 seem to be the same things as part of your duties
5 is to deploy, but clearly they're looked at
6 differently and I wonder if that ought to be
7 reflected in the way the regulation is assessed
8 and ought to be a separate issue, it ought to be
9 part of the same issue.

10 Perhaps, finally, one further way of
11 looking at it is whether or not (off mike) mission
12 makes you more vulnerable to the sorts of
13 environmental stresses in the military (off mike)
14 personal.

15 DR. PARKINSON: If I may just comment
16 just on that, because this is more historical
17 observation and evidence based. But I do think --
18 and we heard from Mr. Carr today that all science
19 always lives in the context of culture and history
20 and things that have happened. I think that the
21 pendulum in the culture of the military services
22 has swung from, in order to be on active duty

1 service, everybody must be deployable. We
2 initially had the desk jobs and then you had the
3 people at the point of the spear, to use that
4 acronym and then everybody was going to be a
5 warrior. Now we use the warrior term, which is an
6 interesting term to me having a little distance
7 from it. But now whether its compassion or the
8 fact that we really need these good people who are
9 amputees or they have disabilities, they're going
10 to be serving our country, but they may not at all
11 be deployable. So I think we want some time when
12 there was clear fitness for duty, fitness for
13 deploy like this, then we move together, whether
14 it was total 100 percent overlap. And I sense
15 that we are going like this again as a result of
16 need of compassion, functional need of services,
17 which is the right thing to do, so the people who
18 are compared are not disabled because they're back
19 at the job. So this a dynamic that's going on
20 here and the words deployment are constantly
21 changing. They are not static definitions,
22 they're dynamic. And the culture, to me now,

1 seems to be they're going like this again in terms
2 of how a person actually spends a duty time. It's
3 just a reflection.

4 MR. CARR: It would probably not be
5 unreasonable for the Defense Health Board to
6 observe that it is complicated to the point of
7 being impossible to say you are fit, but you
8 cannot be deployed. Now I would report, as one of
9 your representatives, doing the stuff we do, that
10 it's become increasingly tough. That we have to
11 someone who is non-deployable, but fit and in some
12 cases, in the case of the Air Force, there's quite
13 a concern about number of deployable and quite a
14 pressure about on those who are not deployable to
15 separate. That leads us to an impossible
16 position. It means you are fit, but I want you
17 out for a medical condition. You can see what I'm
18 getting at. So I think it's reasonable for the
19 Board to say this doesn't pass the giggle test;
20 that you can be fit, yet non-deployable and
21 therefore separated. If you're not fit for the
22 full range of your duties, including

1 deployability, then we question your ability to be
2 called fit in the first place. Now that wouldn't
3 alter our ability to waive that, to say, you're
4 right, if you can't deploy, you're unfit, but
5 we'll waive it when it suits us to do so. A
6 sympathetic person with prosthesis, if we thought
7 gaming was coming up in the system and wanted to
8 truncate the gaming, but the rule, the standard
9 would be if you're non-deployable, you are
10 presumptively unfit and then the service would
11 make a judge about the need for you to stay
12 avoiding the expectation of your staying.

13 DR. POLAND: Dr. Oxman.

14 DR. OXMAN: As someone at great distance
15 from this, it seems that the distinction between
16 impaired, which is a measure of difference between
17 the ideal or the perfect and where you are as a
18 result of an injury is a useful term and it's
19 quite different between being fit, because the
20 next thing, when you hear "fit", it's fit for
21 what? So a paratrooper, who has a minor knee
22 injury, may have a minor impairment, but he's no

1 longer fit to jump. He certainly is fit to do
2 other things.

3 DR. POLAND: Wayne, maybe one more
4 comment and then we'll move on.

5 DR. LEDNAR: There may be some
6 assistance in thinking through this, again, that
7 the civilian community would use and that is
8 understanding one's work and what are the
9 essential job functions? For those who are
10 familiar with the American's with Disabilities
11 Act, it really gets you to figure out what aspects
12 of the job are critical that one be able to do;
13 they are essential job functions. And for each
14 MOS in each of the services, that's an answerable
15 question. So if you're a paratrooper, if you
16 can't jump out of airplanes; that's an essential
17 job function. Now, if there's a service member
18 who has some inability, temporary or permanent, to
19 an essential job function, the question then
20 becomes, for the employer, is can we accommodate?
21 Can we deal with the fact that they may be
22 non-deployable, but still able to do a CONUS,

1 garrison-based important job? Then it's really up
2 to the employer to decide business necessity. Do
3 we have a business to run and we can't afford to
4 have so many non-deployables. If that logic is
5 applied consistently could be fair as you think
6 through this. So there isn't necessarily an
7 obligation to go one way or the other, but to
8 think through this in kind of a step-wise way.

9 DR. SHAMOO: Can I make a comment on
10 that?

11 DR. POLAND: Briefly.

12 DR. SHAMOO: With one caveat: And
13 that's in the civilian world the courts already
14 have decided "with reasonable accommodation" and I
15 guess the military has not reached that.

16 DR. POLAND: All right. Thank you,
17 Mike, very much for that body of work.

18 Our next speaker is Dr. Ed Kaplan,
19 Department of Pediatrics, University of Minnesota
20 School of Medicine. Dr. Kaplan will update the
21 Board on Group A beta streptococcal infection in
22 military recruits and the penicillin supplies. I

1 think you and Commander Russell are going to
2 jointly do this. We just need to be finished by
3 2:30 so that we have the capability of boarding on
4 the busses on time.

5 DR. KAPLAN: I was asked today to
6 briefly -- I emphasize briefly brief you on the
7 issue that we discussed once before the
8 streptococcal issue. Can I have the next slide,
9 please?

10 The problems that were brought before us
11 were Group A strep infections have always been a
12 medical and public health problem among military
13 recruits especially. Going back as far as one
14 would like to go. This will likely continue
15 unless or until a cost-effective vaccine is
16 available. The morbidity and mortality are not
17 insignificant. Then as we discussed previously,
18 there has been no uniform inter, and in some
19 cases, intra service approach to the issue. And
20 then the other issue that we'll refer to is the
21 supply of benzathine penicillin. Next please.

22 The current mainstay of streptococcal

1 prophylaxis among recruits is benzathine
2 penicillin G. Note that this is the new
3 manufacturer, and we'll talk about that in just a
4 moment. Next, please.

5 With the help of Colonel Gibson, reports
6 were sought from the various services and what I'm
7 going to show you is really a cut-and-paste job
8 from those of you who were kind enough to respond.
9 But please correct me if I've made errors. In
10 some cases I've corrected the spelling. Next,
11 please.

12 The Coast Guard recruiting center at
13 Cape May, New Jersey. Cape May does not have a
14 specific policy or practice regarding the
15 prevention, treatment and control of strep in the
16 recruit population. Recruits do not receive
17 intramuscular benzathine or oral Erythromycin as
18 prophylaxis. Historically, Cape May typically has
19 had sporadic and limited occurrences and they
20 treat it on a case-by-case basis. And as
21 Commander Russell will tell you in a little bit,
22 Cape May is involved with the program at the NHRC.

1 Next, please.

2 From the Marine Corps, let me give you a
3 very brief Navy instruction on the matter. You
4 know the Navy medical facilities at the Marine
5 Corps recruit training sites take care of this.
6 The short version is that every recruit gets
7 prophylaxis on arrival and that's benzathine and
8 thereafter it's guided by surveillance. I believe
9 there is local variation and you may want to
10 comment on that. So we have prophylaxis in the
11 Marine Corps with local variation. Next, please.

12 The Army has always had a problem with
13 this and we have a very detailed report for Fort
14 Leavenworth, Fort Benning and Fort Sill give
15 Bicillin. We have a very detailed report for --
16 Fort Leavenworth, Fort Benning and Fort Sill give
17 Bicillin to all soldiers in basic training and
18 have not had a shortage of Bicillin, which we
19 commented on the last time, since early 2007.
20 Fort Knox uses Bicillin on a limited basis to
21 those who have exudative pharyngitis or
22 peritonsillar abscesses and those with culture

1 positive. If a particular unit has a large number
2 of positive strep cases, the entire battalion may
3 be prophylaxed with Bicillin. This has happened
4 five times in the past year. Fort Jackson does
5 not give Bicillin its recruits. Only Fort Benning
6 and Fort Jackson have dedicated location as
7 hospital quarters or medical quarters for soldiers
8 with fever or illness not severe enough for
9 admission to the hospital. The policy document
10 from the Army respiratory disease surveillance
11 program was attached. Next, please.

12 This was effective June last year, and
13 it points out that there is a policy there. Of
14 interest to us, to me, and this is my note here,
15 was that this was sent from General Cates to
16 everywhere, as far as I can tell, the then AFEB
17 did not receive a copy. Next, please.

18 The Army's protocol is here and I'll
19 show you an example in a moment, but they do have
20 a way to calculate the ARD cases and the strep
21 recovery rates and have come up with what they
22 call a SASI index, which is a percentage of

1 streptococcal disease over the denominator of
2 acute respiratory disease. And if this is greater
3 than 25 for two consecutive weeks, it triggers a
4 response. These documents are available in case
5 anybody would like to read them further. Next,
6 please.

7 This is an example of July 2005 through
8 July 2007 from Army recruiting centers and you can
9 see the ARD and the SASI indexes are shown here
10 and the 25 is shown by the lines. These are the
11 various recruit training centers and you can see,
12 for example, at Fort Leonard Wood, which
13 historically has always had a problem. But you
14 can see there consecutive weeks where they do meet
15 the criteria. Fort Sill is also there and there
16 are other places like Fort Knox, which in this
17 period of time Fort Jackson, in which this did not
18 trigger a response. So this is a well-oiled
19 mechanism it seems to me at this point. Next,
20 please.

21 The recent information from the Air
22 Force shows that basic military trainees receive

1 prophylaxis during the first week of training. A
2 provider explains the medication which they will
3 receive. All trainees who are not allergic to
4 penicillin receive 1.2 million units of Bicillin.
5 Trainees who are allergic are given Azithromycin 1
6 gm weekly times four weeks instead of the
7 penicillin. In the past, they were using
8 Levaquin, but apparently for those who were
9 allergic to penicillin or could not take the
10 microlides were given Levaquin and I understand
11 that policy is under review. It's almost a little
12 bit like -- seems to me like swatting flies with
13 cannonballs here. The numbers not receiving any
14 prophylaxis are very small. It was felt that herd
15 immunity would be there. Of interest, and I think
16 something that I really never heard of before and
17 I called to the attention of the Board is they
18 have apparently had several cases of cellulitis
19 with MRSA at the site of the penicillin injection.
20 There were no serious side effects from the
21 penicillin itself and I've not seen this super
22 infection with staphylococci. Next, please.

1 The Navy policy, as I understand it is
2 Bicillin or Erythromycin at the Great Lakes and
3 then as part of the Navy's policy --

4 DR. POLAND: Could you use the
5 microphone, Ed?

6 DR. KAPLAN: I'm sorry. Would you like
7 to comment a little bit about the activities at
8 your laboratory and then I'll finish up.

9 CDR RUSSELL: Thank you, very much, Dr.
10 Kaplan. Dr. Kaplan asked me last week to update
11 some of the data that we provided to you all in
12 December of last year. So we put some updated
13 slides together for you and then he later said,
14 "It's your data, will you present it?" I said,
15 "Great." So I updated the slides. This morning I
16 said, "Ten minutes?" He goes, "No, five." So
17 we'll be real quick here. Some good points here
18 that we're just going to bring up real quickly.

19 So a reminder again that the Naval
20 Health Research Center does surveillance at nine
21 different military treatment facilities that are
22 associated with recruit training camps. So we

1 actually get Group A strep isolates that come from
2 the recruits themselves and we analyze those in
3 our lab in San Antonio for antibiotics,
4 susceptibility or resistance patterns as well as
5 emm types specifically. We don't follow rates,
6 like the SASI index. We really just get isolates
7 in and look at trends over time. Next.

8 Again, nine different sites. Next.
9 They are located throughout the United States, the
10 recruit training camps. Next. So, quickly, we
11 published in 2003 about some of the data up to
12 that point. At that point we noticed emm 75 was
13 significantly associated with Erythromycin
14 resistance seen at that time. Next.

15 Some of the conclusions of what I
16 presented to you in 2006 was that, again, emm type
17 associated with Erythromycin resistance as well as
18 this emm type 5 being associated with a lot of the
19 outbreaks that we've seen in recent years.

20 Here's the 75 and the resistance seen to
21 Erythromycin. Not much in other emm types. Next.

22 The important, interesting thing about

1 this is that 75, seen mostly at Lackland during
2 the years of that publication is the reason that
3 there was also an association between
4 Erythromycin- resistant and a particular site, and
5 that being Lackland at the time. The question is
6 what's happened and are we continuing to see more
7 Erythromycin resistance over time and the next few
8 slides will illustrate this a little bit. Next.

9 Here's at Parris Island, MCRD. You see
10 the Erythromycin resistance here in pink and you
11 see that in recent years there's just been very
12 little. This is a direct result, actually, of the
13 emm 75 type diminishing, because that's largely
14 associated with the emm 75. Next.

15 Here you see at Lackland a lot of the
16 Erythromycin resistance and there was that
17 geographic association at the time and that has
18 disappeared in recent years. Next.

19 Again, at Fort Leonard Wood the same
20 trend. Next.

21 This is a graph of all of the different
22 recruit training centers. I showed this to you

1 before. It's very busing but there's an awful lot
2 of information in it. What I'm just going to say
3 here briefly is all the sites do do
4 chemoprophylaxis differently. And you'll see here
5 at the MCRDs, San Diego for example, they do get a
6 second Bicillin injection unlike Parris Island,
7 but all the information is in there and we can
8 provide that to the Board. Do they give an
9 injection if they don't -- do they base other
10 prophylaxis on surveillance? Do they give any
11 kind of antibiotic to those that are Pen allergic?
12 All of that information is in here and what do
13 they use. Next.

14 A lot of outbreaks, but none since I
15 presented to you in December. Next.

16 This was briefly an outbreak that
17 occurred in 2003, which really demonstrated the
18 fact that the Bicillin injection was not providing
19 30 days of coverage. So that led to the question,
20 and Dr. Kaplan has been working with us for quite
21 a long time to try and get this study to happen,
22 and it has been financially supported by GEIS; and

1 that is the question of whether or not the current
2 Bicillin injection, what time frame that Bicillin
3 injection is providing to Group A strep. So the
4 concern is that maybe the current manufacturing
5 process for penicillin G are different from
6 historic when so many of the studies were done
7 that showed the duration of protection. We do
8 have outbreaks that continue to occur despite the
9 chemoprophylaxis that we use. The objective was
10 to, once again, determine the pharmacodynamics of
11 that injection at the serum penicillin level
12 following injection in the recruit population.
13 The recruit population is different. They are a
14 different population. That's important. So the
15 method is 200 trainees. We're going to do three
16 blood draws over four weeks. We're going to go
17 into the barracks nightly to do kind of a rolling
18 blood draw so that we're not impacting their
19 training very much, and then that serum is going
20 to be analyzed by Dr. Blumer, University Hospitals
21 in Cleveland to determine serum penicillin levels.
22 Status is we do have preliminary approval and we

1 plan on implementing this study around November.

2 Next.

3 So in summary, again, we continue to
4 follow surveillance for Group A strep. Now that
5 we do have the Bicillin product back we seem to
6 have a reduction in numbers. That sums it up.

7 Thank you.

8 DR. KAPLAN: So that basically is that.

9 Next, please.

10 This was, in part, the reason for doing
11 the study that Commander Russell has just pointed
12 out you and that was a study by Jim Bass in
13 Hawaii. And I took a quote directly from that.
14 In the studies that they did and published in CID
15 about 11 years ago, penicillin was detectable and
16 only 40 percent of 86 samples after seven days.
17 Detectable, it didn't say anything about levels.
18 And in only three samples after 14 days. Age,
19 height, weight and body surface area were not
20 significantly related to penicillin concentration
21 at one or seven days. These were Army recruits
22 and the mean weight was 75 kilos as I recall.

1 This, I think, has an important possible impact.

2 Next, please.

3 Currently, and to follow up, according
4 to the Food and Drug Administration -- well, first
5 of all, as you may know, the drug company which
6 was making Bicillin for many, many, many years was
7 Wyeth. They sold it to Monarch Pharmaceuticals
8 and there became a shortage as those of you who
9 have been involved with this know. I found out,
10 with a meeting with the FDA a month or two ago
11 that the FDA is only bound to determine whether
12 the manufacturing process has changed from that
13 used by the former producer. There appears to me
14 no way of finding out and made public whether
15 changes were made in the manufacturing process
16 before the process was sold or afterwards. And
17 the FDA does not require any biological levels or
18 testing at all. That's one of the reasons that I
19 think this study is going to prove useful. Next,
20 please.

21 So for discussion and consideration;
22 should there be, and we asked this question in the

1 past, a more uniform policy across the services or
2 as close to it as possible. Should there be a
3 uniform policy within the individual services? Is
4 monitoring and surveillance realistic or possible?
5 The policy regarding the adequacy of available
6 Bicillin is going to be addressed. And then the
7 issue regarding microlides. There were problems
8 as Commander Russell pointed out with microlides
9 resistance particularly in emm type 75. We don't
10 seem to see that at this point right now, but I
11 think it's just a matter of time before it comes
12 back. I think that's the last slide.

13 DR. POLAND: Thank you, Ed. Why don't
14 you stay there for questions. Let me start first
15 with any of the preventive medicine officers. I
16 think Ed, you were wanting to make a comment and
17 there might be other.

18 CDR FEEKS: Just by way of
19 clarification, it's interesting; I did pursue some
20 more details in this matter. At San Diego, the
21 practice is Bicillin prophylaxis on arrival and
22 then every four weeks and this is done year round.

1 At Parris Island, on the other hand, it's Bicillin
2 prophylaxis on arrival and then any further
3 prophylaxis is based upon surveillance, namely
4 indications of an outbreak would prompt another
5 round of prophylaxis with Bicillin. Obviously in
6 the penicillin allergic we use Azithromycin
7 regimen. Interestingly, the officer candidate
8 school at Quantico does not use a prophylaxis
9 program and strep has not been a problem there and
10 I don't know why that should be so. Maybe we in
11 the Coast Guard have the same luck in that regard.
12 I don't know.

13 DR. KAPLAN: It's always been in
14 recruits. Not only in the U.S., but if you look
15 at the literature around the world, it's in
16 recruits, and I think it's because it's an
17 epidemiologic phenomenon. People are coming from
18 different parts of the country with previous
19 exposure to various types and they bring new types
20 in and you mix them all together and you end up
21 with outbreaks.

22 CDR FEEKS: It's interesting to me.

1 During the summer in particular, at the officer
2 candidate school at Quantico, you have not only
3 those normal classes of college graduates who are
4 there as officer candidates, entering the Marine
5 Corps, you also have what they call a "Bull Dog,"
6 which is the name of the program of Marine officer
7 training given to the Marine Corps option, Navy
8 ROTC University students who come to Quantico for,
9 I forget how many weeks it is, for training. But
10 strep does not appear to be a problem in this
11 coming from all corners of the country group
12 either. I wonder what the difference is.

13 DR. KAPLAN: I don't know. I don't
14 know.

15 COL GIBSON: I've done some studies on
16 Group A beta strep too. Direct contact
17 transmission is the number one way that this thing
18 is spread. A lot has to do with the barracks
19 environment. The type of barracks they're in --
20 are your officers staying in two to a room? Three
21 to a room? Four to a room? Or are they in a
22 barrack with another 50 bunks?

1 CDR FEEKS: In officer candidate school,
2 they're in an open bay barracks, just like the
3 enlisted guys are. When they graduate from that
4 and go onto the "basic" school or TBS, then they
5 live more like gentlemen.

6 DR. KAPLAN: Both points well taken.

7 LCDR LUKE: Also the question of course
8 are the academies. Now at the naval academy the
9 men and women are much more civilized, they live
10 two to three to a room. But at WestPoint, of
11 course, they start with beast barracks, which is
12 tents and appropriate housing for those type of
13 folks. In any case the issue that I thought was
14 interesting was at Parris Island we were talking
15 -- I was talking to a preventative medicine
16 officer out there, they had been using
17 Azithromycin and one aspect that we had been
18 discussing was the fact that we had been
19 discussing was the fact that some of the evidence
20 that we can presented at this Board a few years
21 ago, it raised the issue of Chlamydia infections,
22 anywhere from three to nine percent, if I remember

1 correctly; whether or not Azithromycin was in some
2 way helpful for prophylaxis of that problem that
3 continues on now that we've gone back to Bicillin.
4 His question was Would it be worthwhile that we
5 should entertain using Azithromycin in our females
6 since it would prophylaxes against G, A, BHS as
7 well as Chlamydia and that's a question that he
8 had posed to me and I guess I'll pose that back to
9 DHB to consider that maybe there is a room to use
10 Azithromycin at least in our female recruits.

11 DR. KAPLAN: I don't know the answer to
12 that question, but someone will have to help me
13 with this. Is the treatment does for Chlamydia
14 the same? I mean, the doses that were used and it
15 was used at Lackland for a while was once a week
16 for four weeks at that point. I don't know what
17 the treatment dose --

18 BROSCH: If I can comment on that,
19 because that's what we did at Lackland when we
20 didn't have Bicillin. A gram, the one gram will
21 cover Chlamydia. That's it. You just need one
22 gram, one time. We screen for Chlamydia at

1 Lackland in our female population. What we did,
2 because we still wanted to know how prevalent is
3 Chlamydia, we made sure we did the Chlamydia test
4 before we gave (off mike).

5 DR. POLAND: Other comments from the
6 Board members?

7 DR. KAPLAN: If it is done I would
8 certainly keep watch on the resistance rate of the
9 Group A strep.

10 LCDR LUKE: Certainly, but the Bicillin
11 is not going to touch the -- you know, we already
12 know we've got five percent on average. Our
13 females are coming with Chlamydia. So I guess the
14 question is if we're going to hit them with an
15 antibiotic, perhaps we should be treating
16 presumptively for Chlamydia as well as
17 prophylaxing against the streptococcal disease.

18 COREPETER: I just had a quick comment.
19 Just want to make sure that as you're doing these
20 studies or evaluating the different posts, there
21 are three different preparations I'm aware of
22 Bicillin, BLA and CRN. I can't remember the

1 third, but depending on the amount of Procaine
2 penicillin mixed in, because when proceed is
3 mixed, it makes it less painful. So just ensuring
4 that you have a standardized (off mike) use.

5 DR. KAPLAN: I think everybody's using
6 the LA. The third used to be AP. They don't make
7 that anymore. That had crystalline as well. I
8 don't think that's made anymore.

9 DR. POLAND: Thank you, Ed. So we are
10 done with the first day's activities other than
11 meeting to go over to CFI. We are planning on
12 leaving the hotel at 3:00, so you'll have a bit of
13 a break. We'll meet in the lobby. What time
14 would you like us to assemble?

15 COL GIBSON: About ten 'til. For the
16 bus. About ten 'til.

17 DR. POLAND: Okay. Then can we have the
18 Board members just stay in place for a minute or
19 two, but everybody else is dismissed. Thank you.

20 (Whereupon, the PROCEEDINGS were
21 adjourned.)

22 * * * * *

