

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

OPEN MEETING

Arlington, Virginia

Tuesday, December 11, 2007

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

2 (9:10 a.m.)

3 DR. POLAND: Good morning, everybody.

4 Welcome to this meeting of the Defense Health  
5 Board. My name is Dr. Poland. I am President of  
6 the Board. We have a variety of extremely  
7 important topics to discuss today, so we'll go  
8 ahead and get started, and I'll ask Ms. Embrey to  
9 call the meeting to order.

10 MS. EMBREY: Thank you, Dr. Poland. As  
11 the Delayed Designated Federal Official for the  
12 Defense Health Board which is a federal advisory  
13 committee to the Secretary of Defense, the  
14 Surgeons General, and the Assistant Secretary of  
15 Defense for Health Affairs, I hereby call this  
16 meeting of the Defense Health Board to order.

17 DR. POLAND: Thank you, Ms. Embrey. A  
18 tradition that we have established with the board  
19 is a moment of silence to honor and remember those  
20 who have served and those who particularly during  
21 this season are away from their families and are  
22 sacrificing on our behalf. So if all in the room

1 would please stand and observe a moment of  
2 silence.

3 (Moment of silence.)

4 DR. POLAND: Thank you very much. I  
5 particularly want to welcome Dr. Ward Cassells who  
6 is the Assistant Secretary of Defense for Health  
7 Affairs. It's an honor to have you here with us  
8 today, and we want to thank you for your support  
9 of the board and interest in the board's  
10 activities and joining us today. I understand you  
11 have some welcome remarks, but let us greet you  
12 formally.

13 SEC CASSELLS: Dr. Poland, I don't have  
14 any prepared remarks. I'd just like to thank you,  
15 Ellen Embrey, and Roger Gibson, for your service  
16 here and all the board. This is a tremendous  
17 turnout and testament to the importance of what we  
18 all collectively are doing. And Gail Wilensky,  
19 there aren't words to thank you for the work that  
20 you did on the other task force and this task  
21 force which you had led. This is the final of the  
22 six major task forces. It is keenly awaited, and

1       you will find not just me but the whole defense  
2       department taking notes and working toward  
3       implementation of these results. So we thank you  
4       for the tremendous numbers of hours you've put  
5       into this working long and working hard and  
6       working smart. And I am sure that the board will  
7       be able to add their perspectives too and they are  
8       very, very welcome. So Dr. Poland, thank you so  
9       much for doing this.

10                 DR. POLAND: Colonel Gibson will have  
11       some administrative remarks I think and then we'll  
12       begin.

13                 COL GIBSON: I want to thank the staff  
14       at the Crystal City Sheraton for helping make the  
15       arrangements for the board members and also thanks  
16       to my staff, Karen Triplett and Lisa Gerrett for  
17       all their hard work in preparing for this, and Ms.  
18       Ward back home.

19                 If you haven't done so, please sign the  
20       attendance roster that is on the table outside the  
21       room. There are also rosters for those folks who  
22       want to make statements, and there is a roster for

1 the press.

2 For those who are not seated at the  
3 tables, for this afternoon's sessions we'll have  
4 handouts available for the briefings that are  
5 given at that time. Restrooms are around the  
6 corner outside to your left when you leave this  
7 room. And if you need telephone, fax, copies, et  
8 cetera, see Ms. Triplett. The next meeting of the  
9 board will be April 23rd and 24th in Tacoma,  
10 Washington. Our host will be Mattigan Army  
11 Regional Medical Center at Fort Lewis. At this  
12 meeting we'll complete deliberations on a number  
13 of open board business items.

14 Through the Uniform Services University  
15 we have been able to get 2.6 continuing education  
16 credits for this meeting. To receive the credits  
17 you need to sign the CME attendance roster and  
18 complete the evaluation form and attestation  
19 statement for the meeting and hand it in to Ms.  
20 Gerrett or Ms. Triplett. For board members, your  
21 evaluation forms are in your notebooks. We will  
22 mail out the CME certificates when we receive them

1 USU. Refreshments are available for both the  
2 morning and afternoon sessions. We will have a  
3 catered working lunch for the board members,  
4 preventative medicine officers, distinguished  
5 guests, and speakers. There are a number of  
6 hotels right around here for others who will be  
7 breaking for lunch.

8 Finally as a reminder, this meeting is  
9 being transcribed so please speak clearly into the  
10 microphones and state your name before you begin.  
11 And please turn off your pagers, Blackberries, and  
12 cell phones. The Blackberries, for the board  
13 members, keep them below the table. They do  
14 interfere with the microphones from what I am  
15 told.

16 DR. POLAND: Our first order of business  
17 today is the deliberation of the draft findings  
18 and recommendations of the task force on the  
19 future of military health care. As the board  
20 members will recall, the task force was formed  
21 last year at the direction of Congress and charged  
22 with examining matters related to the future of

1 health care with the Department of Defense. The  
2 task force was to make assessment of and  
3 recommendations for sustaining the health care  
4 services being provided to members of the armed  
5 forces, retirees, and their families. A copy of  
6 the congressional language is at Tab 2 of your  
7 briefing books.

8 As a subcommittee of the Defense Health  
9 Board, the task force and board are required by  
10 federal advisory committee statutes to deliberate  
11 task force findings and recommendations in an open  
12 session before they are finalized. The task force  
13 will deliver the final report to the Secretary of  
14 Defense in the very near future. The report is a  
15 product of the task force. The board as a part of  
16 the committee will provide any comments regarding  
17 the task force report in a separate document.

18 All of the members have received a copy  
19 of the task force draft findings and  
20 recommendations. I remind you that this document  
21 is a draft and not yet a public document. Our  
22 discussions today will center on primarily the

1 general findings and recommendations and not on  
2 for example specific numbers recommended by the  
3 task force.

4 For those in attendance, the discussions  
5 today will be between the members of the Defense  
6 Health board and the Task Force on the Future of  
7 Military Health Care. If time allows, at the end  
8 we'll take questions and statements from the  
9 public. We ask that you register to speak at the  
10 desk right outside this room. Everyone however  
11 has the opportunity to submit written statements  
12 to the board. Those statements can be submitted  
13 today at the registration desk or by email at  
14 dhb@ha.osd.mil, or they mailed to the Defense  
15 Health Board office. The address is also  
16 available on fliers located at the registration  
17 table.

18 I'd like for us now to go around the  
19 table and introduce ourselves, and I'd like to  
20 start by having our newest member, Colonel Retired  
21 Reverend Robert Certain introduce himself.

22 COL CERTAIN: I think you just did, sir,

1 but I'm Robert Certain, retired Air Force  
2 Chaplain, Colonel. During Vietnam I was a B-25  
3 crew member POW.

4 DR. POLAND: Thank you and welcome.  
5 Other distinguished guests today include Dr.  
6 Floabel Mullick, principal director of AFIP,  
7 Brigadier General William Fox, a member of the  
8 Board's Panel for the Care of Individuals with  
9 Amputations and Functional Limb Loss, Major  
10 General Retired Mary Ann Matthewson, Chaplain for  
11 the V.A., and Mr. Larry Leitner from USAMRID here  
12 representing Mr. Bill Howell.

13 So if we could, we'll go around and  
14 introduce ourselves and I'll turn to Ms. Embrey  
15 and then Dr. Wilensky.

16 MS. EMBREY: I'm Ellen Embrey. I am the  
17 Designated Federal Official for the board, and in  
18 my real job I am the Deputy Assistant Secretary  
19 for Force Self- Protection Medical Readiness.

20 MS. WILENSKY: I'm Gail Wilensky. I'm  
21 Co-Chair of the Task Force on the Future of  
22 Military Health Care. And since Bill Fox is here,

1 I'd better also indicate I have a real day job  
2 which is a Senior Fellow at Project HOPE, although  
3 for the last year I have thought my day job is  
4 actually worrying about military health care.

5 RADM SMITH: I'm Dave Smith. I'm the  
6 Joint Staff Surgeon and a member of the task  
7 force, and I am also a customer of the Defense  
8 Health Board.

9 MS. BADER: Good morning. Christine  
10 Bader, Executive Secretary.

11 MR. HALE: I'm Bob Hale, task force  
12 member, former Comptroller of the Air Force.

13 MR. HENKE: Bob Henke, task force  
14 member, CFO to V.A.

15 MG ADAMS: Nancy Adams, Major General,  
16 U.S. Army Retired, task force member.

17 RADM MATECZUM: John Mateczum, task  
18 force member.

19 GEN MYERS: Dick Myers, General Retired,  
20 task force member.

21 LTG ROUDEBUSH: Jim Roudebush, task  
22 force member, Surgeon General of the Air Force.

1                   MG SMITH: Bob Smith, Major General  
2 Retired Reserves, and task force member and former  
3 international controller of Ford Motor Company.

4                   MG KELLEY: Joe Kelley, task force  
5 adviser and retired Major General.

6                   MR. GARDNER: Pierce Gardner, Defense  
7 Health Board member and a professor of medicine  
8 and public health at the State University of New  
9 York at Stony Brook.

10                  DR. WALKER: David Walker, Defense  
11 Health Board member, chair of pathology,  
12 University of Texas Medical Branch at Galveston.

13                  BG FOX: Bill Fox, subcommittee member  
14 for the Amputee Care and Functional Limb Loss  
15 Subcommittee, and Chief Operating Officer for  
16 Project HOPE.

17                  DR. SILVA: I'm Joe Silva, professor of  
18 internal medicine, dean emeritus, University of  
19 California at Davis School of Medicine.

20                  DR. SHAMOO: Adil Shamoo, professor of  
21 bioethics, University of Maryland School of  
22 Medicine.

1 DR. PARKINSON: Mike Parkinson,  
2 president, American College of Preventive  
3 Medicine, member of the Defense Health Board.

4 DR. PARISI: Joe Parisi, member of the  
5 Defense Health Board, Chair of the Subcommittee  
6 for Pathology and Laboratory Services, and  
7 professor of pathology at the Mayo Clinic.

8 DR. OXMAN: Mike Oxman, member of the  
9 Defense Health Board and professor of medicine and  
10 pathology at the University of California at San  
11 Diego.

12 DR. MILLER: Mark Miller, member of the  
13 Defense Health Board and associate director for  
14 research at the Fogarty International Center,  
15 National Institutes of Health.

16 DR. MCNEILL: Mills McNeill, board  
17 member, and Director of the Public Health  
18 Laboratory at the Mississippi State Department of  
19 Health.

20 DR. LEUPKER: I'm Russell Leupker, and  
21 I'm a board member and a cardiologist and  
22 epidemiologist from the University of Minnesota.

1 DR. LOCKEY: Jim Lockey, professor of  
2 international medicine and environmental health at  
3 the University of Cincinnati and a board member.

4 DR. LEDNAR: Wayne Lednar, member of the  
5 Defense Board and global chief medical officer for  
6 Dupont.

7 DR. HALPERIN: Bill Halperin, member of  
8 the board, chair of preventive medicine, New  
9 Jersey Medical School, Newark, New Jersey, and  
10 chair of quantitative methods, School of Public  
11 Health, Newark, New Jersey.

12 DR. CLEMENTS: I'm John Clements. I'm a  
13 member of the health board. I am the chairman of  
14 microbiology and immunology at Tulane University  
15 School of Medicine in New Orleans.

16 COL GIBSON: I'm Colonel Roger Gibson.  
17 I'm the Executive Secretary for the Defense Health  
18 Board.

19 DR. POLAND: And I'm Greg Poland,  
20 professor of medicine and infectious disease and  
21 vice chair of the department of medicine at the  
22 Mayo Clinic, in Rochester, Minnesota. I am going

1 to read a statement I wrote, and it is better to  
2 come clean. I just flew in from Amsterdam last  
3 night so hopefully what I have to say is coherent,  
4 but we'll give it a try here.

5           It was of interest in that it gave me  
6 about 10 hours in a coach seat to read through  
7 this report in detail. I was amazed as I think  
8 you will be to learn that in fiscal year 2001 the  
9 cost of the military health mission was \$19  
10 billion, and by fiscal year 2007 it had increased  
11 by more than 100 percent to \$40 billion serving 9  
12 million beneficiaries. Pharmacy benefits have  
13 gone up from \$1.6 billion to \$6.5 billion in a  
14 7-year time period. And the task force has  
15 estimated that at its current rate of growth, the  
16 military health system costs will be \$64 billion  
17 by 2015 which will be 12 percent of the DOD  
18 budget. To give you a number or an anchor with  
19 which to understand that 12 percent, that number  
20 was 4-1/2 percent in 1990.

21           The military health system includes  
22 133,000 personnel, 86,000 military medical folks,

1 and 47,000 civilians, working at over a thousand  
2 geographic locations. This morning the DHB will  
3 as the parent board vet the report produced by the  
4 task force on the future of military health care.  
5 The task force you will recall delivered an  
6 interim report focusing primarily on pharmacy  
7 benefits in May 2007. The report before you is  
8 now the draft of their final report. It's obvious  
9 that much work and thought have gone into its  
10 formulation and we thank the co-chairs General  
11 Corley and Dr. Wilensky for such a deep dive into  
12 a complex topic as this one and the very honest  
13 assessment that came from it. Thank you very  
14 much.

15 I have read it with interest and indeed  
16 selfish interest. By way of disclosure, my family  
17 since 1955 have been beneficiaries of the military  
18 health care system, and 5 days ago my son Eric  
19 received his letter of acceptance from the Air  
20 Force Academy. So we are fully in this one. The  
21 changes proposed and the implications of it will  
22 affect him and all other beneficiaries long after

1 virtually every one of us in this room have  
2 retired. So this is an important step on the  
3 never-ending journey needed to provide for those  
4 who ensure our safety and security while being  
5 financially prudent.

6 I also want to just by overview talk a  
7 little bit about the recommendations of the task  
8 force. I was pleased that they started with a set  
9 of guiding principles, something you often do not  
10 see in a task force, and those included three  
11 overarching ones, that DOD must maintain a health  
12 care system that meets readiness needs, that they  
13 must make changes in business and health care  
14 practices aimed at improving effectiveness of the  
15 military health care system, and that veterans and  
16 their dependents, and I like the word they chose,  
17 deserve a generous health care benefit.

18 They had a series of specific  
19 recommendations, and I will just read the topics  
20 of those without going into detail of them. I  
21 guess maybe the co-chairs will read some of those.  
22 That's fine. The one area that the task force

1 addressed but did not give recommendations on for  
2 very good reasons is this issue of the DOD  
3 organizational structure and the committee noted  
4 that the lack of an integrated system here  
5 resulted in a "cumbersome disintegrated system  
6 with adverse effects primarily related to  
7 fragmentation, the inability to coordinate,  
8 manage, and implement best practices, and the lack  
9 of a uniform cost-accounting system."

10 I want to now move us as a board to  
11 discussion of the task force's report. Costs and  
12 fees are not really within the board's sphere of  
13 decision making and I would ask that we not focus  
14 on these but, rather, spending our time on  
15 discussion of the substantive issues before us.  
16 Similarly, issues outside of the task force's  
17 charge would be less relevant or fruitful in our  
18 discussion this morning. Finally, while those in  
19 attendance as I mentioned earlier are welcomed and  
20 encouraged to listen, this first discussion is  
21 between the task force and the Defense Health  
22 Board, and later is there is time and if you have

1 registered, we will provide time for the public to  
2 make statements.

3 So if I can, I will move to Rear Admiral  
4 Smith who is here representing General Corley, and  
5 then Gail Wilensky for their opening remarks.

6 RADM SMITH: Good morning, Dr. Poland,  
7 Defense Health Board, Dr. Cassells, Ms. Embrey,  
8 task force members, and guests, welcome. And on  
9 behalf of the task force, thank you for the  
10 opportunity to appear before you this morning to  
11 share Task Force on the Future of Military Health  
12 Care's final report, findings and recommendations.

13 General Corley, our co-chair, sends his  
14 regrets. He could not be here this morning, and I  
15 think it is telling of senior flag officer and  
16 general officer schedules that even a four star  
17 cannot control his schedule because he sincerely  
18 wanted to be here but has to be overseas at this  
19 time. So Dr. Wilensky will carry on without him.

20 Earlier this year in our interim report  
21 the task force provided you preliminary findings  
22 and recommendations relative to DOD health care

1 costs in general, and recommendations concerning  
2 cost sharing in the pharmacy program in  
3 particular. Those preliminary findings and  
4 recommendations have been further developed and  
5 supplemented in the final report. Congress asked  
6 the task force to address a broader array of  
7 elements in its final report such as the DOD  
8 wellness initiatives, disease management programs,  
9 the ability to account for true and accurate costs  
10 of health care in the military health system, the  
11 adequacy of military health care procurement  
12 systems, as well as an assessment of the  
13 government cost-sharing structure required to  
14 provide military health benefits over the  
15 long-term.

16 Earlier in our term as Dr. Poland  
17 pointed out, we adopted a set of guiding  
18 principles presented in our interim report that  
19 have remained the same and helped us frame our  
20 final assessments and recommendations. With those  
21 in mind, we have sought to preserve the best  
22 aspects of the current system, which has many, and

1 to identify ways to further enhance delivery of  
2 acceptable quality health care for the long-term.  
3 With that short introduction, I will now turn over  
4 the presentation and the discussion to our  
5 co-chair, Dr. Gail Wilensky, for her remarks.

6 DR. WILENSKY: Thank you very much  
7 Admiral Smith. As he indicated and as I have had  
8 email correspondence with General Corely, he very  
9 much wishes he could be here today but has been a  
10 very active member of the task force.

11 It has been just about exactly a year  
12 that the task force has been meeting to assess and  
13 make recommendations for sustaining military  
14 health care services for members of the armed  
15 forces, retirees, and their families. The work  
16 that we have been engaged in has been a very large  
17 task indeed. The 14 members of the task force and  
18 our executive director and very able staff have  
19 worked very hard to make this actually come to  
20 fruition within the course of 12 months. We have  
21 during the last 12 months convened some 15 public  
22 meetings in order to gather information. We have

1 visited areas in different parts of the country to  
2 try to better inform ourselves. Several of us had  
3 the opportunity to travel to Qatar, Iraq, and  
4 Germany, to better understand some of the  
5 forwarding- operating base health care delivery  
6 operations and morale issues that our servicemen  
7 and -- women are facing.

8           We would like people to understand that  
9 in trying to look at these very complicated issues  
10 that Congress asked us to address, we did it  
11 within the context of the U.S. health care system  
12 since it is impossible to assess what is going on  
13 in any other way. The task force is independent.  
14 All of us came on to this activity agreeing that  
15 we would have not preconceived outcomes or  
16 opinions or recommendations, but would let  
17 ourselves be guided by what we heard and the facts  
18 as we know them, and that is what we have done.  
19 As has been indicated, this is a final piece in  
20 what has been a deliberative, open, and  
21 transparent process and it is important that it is  
22 regarded in that way.

1           In looking at the issues that we have  
2       been asked to address with regard to the future of  
3       military health care, we understand that health  
4       care in the military is increasing just as it is  
5       increasing everywhere else in the United States.  
6       It is a problem that has been an issue for this  
7       country. In making sure that we get both the best  
8       value and find ways to moderate spending on health  
9       care has been an issue for all of health care as  
10      well as the Department of Defense. We also note  
11      that the Tricare premiums and cost-sharing  
12      provisions have been level, that is flat in actual  
13      dollar terms, for nearly a decade and that has  
14      been contributing to some of the issues that we  
15      have been facing.

16           As Dr. Poland indicated and as we very  
17      much believe, that looking at the role of the  
18      military and the role of military health care  
19      places it in a unique position. The deployments  
20      and duties of people who are part of the military  
21      is different from that which most of the rest of  
22      us face in this country. Military health care has

1       been an important part of the compensation and  
2       benefits system. In trying to go forward as you  
3       heard again, we set out some guiding principles  
4       that we felt were important to articulate at the  
5       beginning at our first formal document, our  
6       interim. That is that the Department of Defense  
7       must maintain a health care system that meets  
8       military readiness, appropriately sized and  
9       resourced; able to withstand and support the long  
10      war on terror as well as the support of  
11      conventional war; and that equally it is important  
12      that quality, accessible, cost-effective health  
13      care is available and provided for the long-term.  
14      We have recognized and we have said it in our  
15      interim report and say it again multiple times as  
16      we go forward that it is important that we have a  
17      generous health care benefit in recognition of the  
18      importance service that our members, retirees, and  
19      their families have provided.

20                    But we also recognize that it is  
21      important for the American taxpayers to be  
22      comfortable that there is some balance in terms of

1 quality and efficiency, fiscal responsibility, and  
2 affordable cost. What we have attempted to do  
3 over the course of these last 12 months is to  
4 bring some balance.

5 We believe that many of the  
6 recommendations if implemented will affect how  
7 health care is provided through the military  
8 health care system and that it is important that  
9 the recommendations that we are making to the  
10 extent that they involve changes in cost will not  
11 affect active- duty personnel or their families  
12 for health care and we thought this was an  
13 important principle that we should maintain.

14 I am going to describe the major  
15 recommendations that we have come to agreement on  
16 as a task force. The action items will be  
17 something that we can discuss in greater detail as  
18 we come to complete deliberation for this report.  
19 But the recommendations themselves have been  
20 discussed sufficiently that we feel comfortable  
21 saying this is where the task force now is and  
22 reflects the best belief of this group as ways to

1 go forward.

2           In our final report we will indicate  
3 those activities that can be accomplished  
4 administratively by the Department of Defense, and  
5 those relatively few items that will require  
6 congressional action. As a member of the  
7 Dole-Shalala Commission, I have learned two  
8 important strategies over the course of this year.  
9 The first is to try to limit the number of  
10 recommendations that we are making. We are making  
11 12, and actually in many ways 10 with the last two  
12 of a somewhat different level of order. And also  
13 to indicate those areas that can be accomplished  
14 administratively, therefore we can try to pressure  
15 the Department of Defense to go do what it is able  
16 to do now without waiting for congressional action  
17 but highlight those things which will require  
18 congressional action and try to have that occur in  
19 as expeditious manner as is possible.

20           The recommendations are the following.  
21 The first and in many ways the most overarching  
22 recommendation is to develop a strategy for

1 integrating direct and purchased care. That is,  
2 the department needs to have a more deliberate  
3 planning and management strategy that integrates  
4 the direct health care system with the purchased  
5 health care system and to promote the integration  
6 at the level where health care is being provided.  
7 We understand the need for having flexibility and  
8 the desire for optimizing the delivery of health  
9 care to all DOD beneficiaries and we think that it  
10 will be very difficult to have this function well  
11 without better integration at the local level  
12 where care is actually provided than occurs in the  
13 current environment.

14 Our second recommendation is that there  
15 be a better collaboration with other payers on  
16 best practices. Specifically, we think there  
17 should be an advisory group to enhance military  
18 health care collaboration with the private sector  
19 and other federal agencies in order to share,  
20 adopt, and promote best practices. There are some  
21 areas where the Department of Defense and the  
22 Veterans Administration already represent best

1 practices, but there are other areas where there  
2 is much to be learned from best practices that go  
3 on in the private sector and we think more needs  
4 to be done here.

5           The third is that there should be an  
6 audit of financial controls. DOD should request  
7 this audit to determine the adequacy of the  
8 processes by which the military ensures that only  
9 those who are eligible for health benefit coverage  
10 receive such coverage and that there is compliance  
11 with law and policy regarding Tricare as a  
12 secondary payer and that it be done in a uniform  
13 way. While we do not have explicit indication  
14 that there is a problem, we are that when such  
15 audits have been done elsewhere in the private  
16 sector they have usually indicated a possibility  
17 for improved processes and we think that is likely  
18 to be the case in the military and will only know  
19 that when such audit occurs.

20           The fourth recommendation is that there  
21 should be wellness and prevention guidelines  
22 implemented. That is, the department should

1 follow the national wellness and prevention  
2 guidelines and promote the appropriate use of  
3 resources through standardized case management and  
4 disease management programs. It is not that these  
5 do not occur in any way, they do not occur in a  
6 sufficiently uniform way across all of the health  
7 care delivery sites.

8           The fifth is that there should be  
9 priority given to acquisition at the Tricare  
10 management activity. DOD needs to restructure the  
11 Tricare management activity in order to place  
12 greater emphasis on its role in acquisition.

13           The sixth recommendation has to do with  
14 implementing best practices in procurement.  
15 Because the Department of Defense is such a large  
16 procurer of health care services, it is important  
17 that ways be found to aggressively assess and  
18 incorporate the best practices that go on in both  
19 the public and private sectors with respect to  
20 health care purchasing.

21           The seventh recommendation has to do  
22 with existing contracts. We are recommending that

1 the department reassess requirements for purchase  
2 care contracts to determine whether more effective  
3 strategies can be implemented to obtain those  
4 services and capabilities.

5 The eighth recommendation is to improve  
6 medical readiness of the Reserve component. We  
7 believe it is important that the department  
8 improve the medical readiness for the Reserve  
9 component recognizing that its readiness is a  
10 critical aspect of overall total force readiness  
11 and that it is not operating in that way during  
12 the current environment.

13 The ninth recommendation is that there  
14 should be a change in the incentives in the  
15 pharmacy benefit. Congress and DOD need to revise  
16 the pharmacy tier and co-pay structures based on  
17 what is known about clinical and cost-effective  
18 standards in order to promote greater incentives  
19 to use preferred medication and more cost-  
20 effective points of service.

21 The tenth recommendation has to do with  
22 revising enrollment fees and deductibles for

1       retirees. It is a multiple-part recommendation.  
2       We believe that the department should propose and  
3       Congress should accept phased-in changes in  
4       enrollment fees and deductibles for retirees under  
5       the age of 65 that would restore cost- sharing  
6       relationship put in place when Tricare was  
7       created. We believe that most of these fees and  
8       deductibles should be tiered so that they are  
9       higher for those receiving higher retirement pay.  
10      The task force also recommends changes in other  
11      features such as co-payments and a catastrophic  
12      cap which should be phased in over a period of  
13      years and which should be reassessed in a periodic  
14      manner.

15                   In addition, we believe that the  
16      department should propose and Congress should  
17      accept a modest enrollment fee for Tricare for  
18      Life beneficiaries. This is not being proposed in  
19      order to reduce the department's cost but, rather  
20      to foster personal accountability and consistent  
21      with the task force's philosophy that military  
22      retiree health care should be very generous but

1 not free. It is also a change even though there  
2 is a very modest enrollment fee that should be  
3 phased in over a number of years. The task force  
4 believes in addition that DOD should propose and  
5 that Congress should accept automatic annual  
6 indexing of enrollment fees that maintain the  
7 cost-sharing relationship put in place when  
8 Tricare was created to account for future  
9 increases in per capita military medical records.  
10 Unless there is an automatic indexing put in  
11 place, the cost shares restored at any one point  
12 in time in terms of retiree cost sharing will not  
13 be maintained. Other elements of cost sharing  
14 such as deductibles and co-payments should not be  
15 indexed annually, but they should be reassessed at  
16 least every 5 years.

17 The eleventh recommendation is that  
18 pilot programs be considered and studied that  
19 would aim at having a better coordination between  
20 Tricare and private insurance coverage. The  
21 department should commission a study and then  
22 consider pilot programs aimed at better

1 coordinating insurance practices among those  
2 retirees who are eligible for private health care  
3 insurance as well as for Tricare.

4 Finally, as the twelfth recommendation,  
5 we believe that metrics need to be developed so  
6 that the success of the military health care  
7 system's transformation can be assessed  
8 appropriately. That is, as these changes are  
9 being implemented, the department should develop  
10 metrics so that the success of any of the planned  
11 transformations of the command-and-control  
12 structure of the military health care system which  
13 is now in process of occurring will be able to be  
14 considered along with its costs and benefits.

15 In summary, what we are suggesting is a  
16 focus on strategy integration, preserving what we  
17 regard as the best aspects of the current system,  
18 creating efficiencies by streamlining operations,  
19 improving effectiveness and the accessibility of  
20 quality care, borrowing where appropriate the best  
21 practices from both the public and private  
22 sectors, and changing in ways that will not

1       diminish the trust of beneficiaries or lower the  
2       current high quality of health care services  
3       provided military personnel, family members,  
4       retirees, and their families. We believe it is  
5       urgent that the department and the Congress act  
6       now. Given the current and likely future military  
7       commitments, there needs to be a sense of urgency  
8       in resolving the persistent problems that the  
9       department has been facing and is likely to face  
10      in terms of new challenges. Thank you.

11                 DR. POLAND: Thank you very much, Dr.  
12      Wilensky. I would also like to give an  
13      opportunity for members of the task force to make  
14      any comments that they would like to make or any  
15      additions.

16                 DR. WILENSKY: I would like to indicate  
17      though the enormous amount of work that the task  
18      force has provided in coming to the  
19      recommendations and in writing up the various  
20      chapters. This has very much been a collective  
21      effort and it would have been impossible to  
22      produce a document such as you have seen in draft

1 form without the very hard work of the task force  
2 members in addition to the very able staff  
3 supporting them.

4 DR. POLAND: Yes, ma'am?

5 MG ADAMS: Actually I was going to say  
6 almost the same thing that Dr. Wilensky said.  
7 This task force really did our homework. We did  
8 not take anything at face value. If there was  
9 information to be gathered on a topic, we  
10 aggressively went after it. There was much debate  
11 among the group, but I am proud to say there was  
12 total consensus. Everyone's voice was heard and  
13 these recommendations reflect our collective  
14 support of the recommendations. So it did not  
15 come easy, but I think what we put forth is very  
16 worthwhile and will stand the test of time, and I  
17 want to thank the assistant secretary for the  
18 opportunity to work with this group. I cannot think of  
19 a better group of professionals who could have  
20 come forth with this type of report, so thank you.

21 DR. POLAND: Other comments from members  
22 of the task force? We will open it up to the

1 board. I will maybe give my own opinion first. I  
2 always have a morbid of being on an airplane  
3 without enough work to do and you have prevented  
4 that fear from becoming reality. So I really did  
5 have time to in-depth look at it several times.

6 I am going to keep this report because I  
7 think it is a model of how reports should be  
8 written. What I mean by that to reiterate again,  
9 I very much like and appreciate that it started  
10 with a set of guiding principles and as best I can  
11 tell, every recommendation fits under the rubric  
12 of those guiding principles. Even more  
13 importantly, in a task as complex as this, I  
14 appreciate that there was not a simplistic view of  
15 let's do these five things and it fixes the  
16 system. Indeed, what I saw, and I would almost  
17 like to add a subheading to the title of your  
18 report, is a roadmap for transformation, and to me  
19 that is what this actually provides. It provides  
20 12, sounds like a twelve-step problem, but 12  
21 steps by which to begin the process of this  
22 journey of further improving the health care

1 system.

2 I also want to say my personal opinion  
3 is that military health care is one of the crown  
4 jewels of DOD and I would not like to have  
5 somebody think that this is a task force or a  
6 recommendation designed to fix a failing system.  
7 I do not believe that to be the case. I have been  
8 the beneficiary of military health care. I have  
9 seen it as president of this board and as a member  
10 of the predecessor board, the AFEB. Members of  
11 this board have been for example to the Center for  
12 the Intrepid. It is a state-of- the-art facility  
13 that is the envy of the world. What is at issue  
14 here I believe is how to take this crown jewel and  
15 keep it in a way that is fiscally feasible to  
16 continue into the future. In a way, maybe to put  
17 another word on it, this is sort of a sleeping  
18 beauty and it just needs that roadmap to reach the  
19 next level of evolution. So again I commend you  
20 very much on a superb report, very well thought  
21 out. I often approach reports much like reviewing  
22 a grant where my job as a reviewer is to fine the

1 hole. I did not find holes. Every recommendation  
2 I saw was data driven. The data was transparent.  
3 It is available to anybody that would want to have  
4 it. So bravo and congratulations for just a  
5 superb report.

6 Let me now open it to other members of  
7 the board to ask questions or to make comments  
8 that you may have. Mike?

9 DR. PARKINSON: Thanks, Greg, and thank  
10 you, Dr. Wilensky for the overview of the report  
11 and for all the hard work. I agree with Dr.  
12 Poland's comments.

13 As a veteran of the DOD and working on a  
14 not exactly similar project for the last 2 years  
15 of my military career called the MHS Optimization  
16 Plan which was designed in many ways to deal with  
17 the staffing issues and the financing issues  
18 related to Tricare, I know how difficult this is.  
19 I really hope that the integrated 12  
20 recommendations can make an impact in the  
21 department as well as on the Hill.

22 I have some comments that I am going to

1 make in really no particular order and if you deem  
2 so to respond or react to them, that is fine, but  
3 they are really meant to be constructive in the  
4 sense of reading through the report much as Dr.  
5 Poland did with a fine-tooth comb.

6 Full disclosure, I spent 6 years as a  
7 medical director in a consumer-driven startup plan  
8 that was subsequently acquired by the nation's  
9 largest health insurer so I come at this a little  
10 bit from just having left the inside of a big  
11 industry, if you will, and some of the  
12 perspectives might be very personal at this point,  
13 but they are personal. And also with kind of a  
14 long commitment to prevention and behavior change  
15 which also is kind of the core sine qua non and if  
16 the country is going to get ahead of this it has  
17 to do that. So it is really those two recent  
18 experiences that I do that.

19 As Dr. Poland mentioned, DOD in certain  
20 areas of medicine and health care has been the  
21 unparalleled leader in infectious disease, trauma  
22 care. Certainly these are the areas that are the

1 foundation of the EPE Board and now the  
2 reenergized Defense Health Board. But in other  
3 areas where DOD could exert tremendous market  
4 power and also clinical innovation and business  
5 innovation, for a variety of well-understood  
6 reasons we have not done it. I would hope that  
7 one of the tones of the report is that DOD commit  
8 to being a cutting-edge innovator. Given that  
9 there are political challenges with benefit  
10 structure, there is no reason that we should not  
11 be as innovative in the way we deliver peacetime  
12 health care or the way we buy peacetime health  
13 care as we are in the way we do trauma care or the  
14 way we do preventive medicine. So we have a  
15 benchmark, and as Greg noted we have those, and  
16 part of what I see us doing not so much in this  
17 report, but we should surpass best practices with  
18 a very innovative prototyping R&D type of entity  
19 just as we would do for new weapons systems to  
20 demonstrate to the country that DOD can lead as  
21 well as just catch up to whatever the big Fortune  
22 500 companies are doing with large health plans.

1       So it is a sense of tone that we should commit to  
2       leading perhaps the nation.

3                 Daniel Fox who is in at Milbank and came  
4       down and saw our effort in 1998 and 2000 said this  
5       is important. The military should lead just as  
6       they led in such major areas as racism and  
7       discrimination under Eisenhower. If we have a  
8       country that is amok and a medical industrial  
9       complex that will spend all the GDP, maybe DOD can  
10      offer something there as well. It is in the  
11      report, but the way it is articulated might be a  
12      little more proactive and positive. Just a  
13      thought.

14                The V.A. is an example, and I am not  
15      going to make any comments about the Unified  
16      Medical Command except to say somewhere in here  
17      there is a best practice and I sometimes opine out  
18      loud. If the progress that the V.A. Has made in  
19      relatively dramatic fashion around certain quality  
20      and standardization across facilities all over the  
21      country, a rhetorical question, could they have  
22      done that without Ken being the strong head of the

1 V.A. that he was and a structural line of sight  
2 that went from him to the visns (?). We will  
3 leave that aside, but in an organization that  
4 knows command and control, who knows it better  
5 than DOD, and I would urge us around this table to  
6 go with all the political considerations aside,  
7 what is the best practice to get efficiency so  
8 that cost goes down faster in DOD than it goes up  
9 anywhere in our U.S. health care system? It  
10 should. We are blessed with people who come with  
11 better risk factors, they are healthy enough to be  
12 in the military, 10, 20, 40, 60 years downstream  
13 we should benefit from that if you will health  
14 capital that we bring in in the way we make them a  
15 fit and healthy fighting force.

16 David Walker I saw met with your  
17 committee which is great. David is on a campaign  
18 as you know as the Comptroller General of the  
19 United States going around and essentially saying  
20 from a unique platform because he is a relatively  
21 free voice which I should we all listen to, is  
22 that unless we do three things, it does not matter

1        what system you are in and you are not going to  
2        cap costs and hurt the economy any more than it  
3        has with health care, and that is true of DOD's  
4        overall budget. In DOD we see the tail of health  
5        care wagging the dog of DOD rather than vice versa  
6        in a way, and that is just the same that every  
7        corporate employer has seen.

8                    Those three things are align incentives  
9        at all levels. So if the individual does the  
10       right thing, they should be rewarded for it  
11       meaning lower health care costs not higher health  
12       care costs, more incentives, premium  
13       differentials, whatever that might be, all of  
14       which are being pushed and experimented with in  
15       the private sector, as you know, Dr. Wilensky.  
16       And the tone of their report had in little bit in  
17       there about incentives, about smoking cessation,  
18       and we don't really cover that, but there is  
19       dramatic work being done in the private sector.  
20       You do not need to go into it in the report if you  
21       do have a best practices panel that says no, many  
22       employers have dramatic differentials in smoking

1 and in weight and in things like that you see, and  
2 there is some allusion to those in couple of  
3 places but it might be stronger around incentives.

4           Number two as David Walker says is  
5 foster transparency. That is not co-pays, it's  
6 not deductibles, it's the full cost of the  
7 services. You do mention in that in your  
8 recommendations. We want transparency to the  
9 beneficiary not to the doctor or the MTF, but they  
10 need to see it as well because they don't have a  
11 clue how much a drug costs either I can tell you.  
12 But everybody needs to see the full price of the  
13 drug, not the co-tiered payment, that's a  
14 structure, but even if I pay \$10, you should know  
15 that the drug itself is \$180 or whatever the  
16 number is. So an emphasis on transparency which I  
17 liked in there, but there might be an exclamation  
18 point around it because it drives dramatic changes  
19 in personal behavior when people see the full cost  
20 of a doctor's visit.

21           Then finally, the notion of  
22 accountability. So incentives, transparency, and

1       accountability. They are in your report, but I  
2       would just hope that as we go forward in this  
3       effort that we pull those front and center because  
4       those are the reorganization of magnetic fields  
5       that drive behavior change throughout the whole  
6       system.

7                       Specific areas for comment, and I'll  
8       just throw these out to get our discussion going.  
9       I have spent a lot of time with Fortune 50,  
10      Fortune 100, Fortune 1,000 employees over the last  
11      6 years and I will tell you that they are not  
12      aware and frankly they may not care that Tricare  
13      was ever intended as a second payer. They are in  
14      business to survive globally and if you find  
15      employees who have a \$460 family benefit versus  
16      whatever, it is good economic sense for the  
17      company to promote that, and they do. From a  
18      public good as a citizen, is that bad? If I'm  
19      giving a \$187 billion tax exemption to employers  
20      and we can debate whether or not we should do away  
21      with that and go to an individually purchased  
22      which is on the platforms of the presidential

1 campaigns, but I am not sure what to do with that  
2 because good employers are saying why in the world  
3 would they be on mine if they already are entitled  
4 after 20-plus years in the military to a  
5 reasonable benefit that is just as good, and as a  
6 matter fact, we don't even pay them to move that  
7 way? You know, Dr. Wilensky, many people are  
8 saying I'll pay you to take somebody off of our  
9 coverage. I am glad you raised that issue, but I  
10 will tell you after doing this for 6 years there  
11 is no awareness among employers that it was ever  
12 intended as a second payer, nor I think among the  
13 beneficiaries who are now military retirees who  
14 understand that. It's just if it's a better deal,  
15 why not? So I am think I'm glad you raised that.  
16 I do think some specific language around  
17 consumer-driven account-based plans would be nice.  
18 It doesn't have to be in here.

19 You can underwrite these models even  
20 with the Tricare benefit, and the rapid  
21 prototyping of a Tricare choice or Tricare  
22 consumer model might be something to look at very

1 quickly and roll out and determine how that might  
2 fit because even though there's relatively little  
3 out of pocket now, particularly if you raise  
4 co-pays and deductibles, you could put enough  
5 bucket of money together to initially fund a  
6 health reimbursement arrangement or health savings  
7 account and go forward such that people have the  
8 right behavior and they monetize the benefit.

9           Even Medicaid is doing that for Medicaid  
10 disabled now, giving the voucher equivalent of  
11 purchasing power to Medicaid rather than the usual  
12 co-pay models.

13           So, just something to think about. I  
14 know it's in your import to have best practices,  
15 but it might emphasized because McKinsey will be  
16 releasing their second report shortly, looking at  
17 the experience of consumer-driven plans. They  
18 mitigate healthcare costs faster and, if done with  
19 incentives, with higher satisfaction than  
20 traditional PPOs or HMOs.

21           One of the questions I had at the end of  
22 reading the report is would a DoD beneficiary be

1 able to take advantage, under this scenario, of  
2 emerging low-cost, high- value innovations in the  
3 provider sector? Can I walk in to Wal-Mart, if I  
4 so choose, and get one of the 400 drugs for \$4 if  
5 I'm a DoD beneficiary? Isn't that a good deal?  
6 Okay?

7 Can I walk into a MinuteClinic and, for  
8 60 different services at \$40, pay out of my pocket  
9 as an alternative to whatever I might get under  
10 one of the big three mega-contracts?

11 So we might want to think because the  
12 provider sector is rapidly fleeing some of the  
13 practices of traditional managed care contracts.  
14 So, 2000 retail clinics staffed by physician  
15 assistance and nurse practitioners who, by the  
16 way, we started in DoD, are growing all over the  
17 country, flat fee, totally transparent, \$40.  
18 Those are the types of innovations that I would  
19 ask, going forward, do we allow those types of  
20 things in our contracts?

21 Just again, positive questions:  
22 Reimbursable e- visits; if I want to pay my doctor

1       \$25 over the internet as opposed to waiting to see  
2       him through a Tricare support center, can I do  
3       that? You've got that in your best practices  
4       panel. They can talk about that.

5                Incentives with teeth; as I mentioned  
6       before, financial incentives right back into the  
7       accounts, premium differentials up-front,  
8       additional rewards for care engagement and  
9       completion. You've mentioned some of those  
10      things, but they're very impactful. I notice that  
11      Congress wants to hear a lot about incentives.

12              And, then, you say it in here very  
13      nicely, but I would just put an exclamation point.  
14      In 2007 or 2010, our big mega national contracts,  
15      which are farther away from transparency, farther  
16      away from direct interaction of the consumer with  
17      a doctor and the consumer with a facility, is that  
18      the direction that is going to create a highly  
19      efficient that roots out inefficiencies and the  
20      consumer, the beneficiary, benefits? If we can  
21      find those low- hanging fruit, it may not be  
22      possible to do it through mega regional contracts,

1 and you've raised that nicely in the questions  
2 through some of the things you've talked about,  
3 looking at the best business practices.

4 So, a long-winded way of saying, yeah,  
5 there are some things there that I would have  
6 liked to see personally a little bit more based on  
7 our experience in dealing with a lot of employers,  
8 but you hit the mark. It's just yea, verily, you  
9 know, exclamation point under the recommendations  
10 you did make.

11 So, thank you for the opportunity to  
12 comment.

13 DR. POLAND: Thank you, Mike. Other  
14 comments from Board members? Wayne?

15 DR. LEDNAR: Wayne Lednar. I'd like to  
16 add to Dr. Poland and Dr. Parkinson, my  
17 appreciation for the real Herculean task the  
18 taskforce took on, and I really like the crispness  
19 of the recommendations and how they fall together.

20 I guess a couple of just impressions  
21 that I would share: I like the fact that this is  
22 data-supported. Decisions really need to be made

1 in a fact-based way.

2 I like the fact that it's  
3 mission-focused. Much of healthcare is, in fact,  
4 focused on healthcare and not the real question of  
5 why do we provide it. So the mission focus for  
6 DoD is a very critical area that I think you've  
7 brought attention to, and I wish more of our  
8 colleagues in the healthcare business would attend  
9 to that as you have.

10 We shouldn't forget, as Dr. Poland  
11 mentioned, this is an activity which is global in  
12 presence. It's not just domestically placed; it's  
13 global. In effect, what we want to do is build on  
14 the long tradition of success of military  
15 healthcare and make it even better for the future.

16 When I think back of some of the  
17 evidence of some of that success, the DoD has been  
18 a leader in clinical diagnostics and therapeutics,  
19 techniques that have been adopted by the private  
20 sector because of the response to the need,  
21 particularly on the battlefield.

22 I think about providing support for good

1 care management, the electronification of medical  
2 records, the challenge of trying to coordinate  
3 care from the battlefield and the theater of  
4 operations back to the tertiary care medical  
5 centers, whether they're in Europe or back in the  
6 U.S., a very complex set of moving parts, and I  
7 think we want to build from that success in the  
8 future.

9 SO, a couple of ideas: One is to really  
10 promote and encourage innovation with  
11 accountability, not just new ideas but  
12 accountability, and accountability in a way that  
13 ties the parts together. You mentioned sourcing,  
14 and logistics is a very important area of  
15 activity.

16 I think that there are some activities  
17 in the private sector, perhaps in government,  
18 around sourcing which is not only looking at the  
19 individual contract and contractor and their  
20 performance but rather how do the parts fit  
21 together, in fact, to sign up the entire supply  
22 chain for a common goal with revenues at risk for

1 the performance of the chain, not just their  
2 individual part. This will get parts talking to  
3 each other and making decisions that rationalize  
4 for the good of DoD rather than the individual  
5 contracting company.

6           When we think about metrics, clearly  
7 important to know, keep the focus on priorities to  
8 make sure progress is being made, but I would  
9 encourage that we need more than just metrics on  
10 transactional care process. We need more metrics  
11 on outcomes. Is it really helping patients? Does  
12 it make a difference, and especially does it make  
13 an impact on mission? Not just healthcare, health  
14 outcomes, does it make an impact for line  
15 commanders and to make that link very explicit and  
16 to really show that?

17           Then the last thought I'd offer is a  
18 solution that has the goal of sustainability.  
19 Clearly, we want a system that continues, that can  
20 get the mission accomplished, can meet the future  
21 needs regardless of what they are. We have an  
22 aging healthcare task, a healthcare set of

1 providers. We have an aging set of capital  
2 facilities. We have needs for bringing in new  
3 technology. How do we develop a system that  
4 doesn't just patch it for the ability to continue  
5 today but really to thrive as we go into the  
6 future?

7 So, thank you from the Board's point of  
8 view for your hard work and for these  
9 recommendations and the chance to comment.

10 DR. POLAND: Thanks, Dr. Lednar. Mike  
11 mentioned his area of expertise in this area. I  
12 should also say Dr. Lednar has been a critical  
13 mover in first Kodak's and now DuPont's,  
14 healthcare delivery transformation too.

15 Other comments? Dr. Silva?

16 DR. SILVA: I want to also add my  
17 congratulations to your committee. It took on a  
18 lot of tough issues which obviously the civilian  
19 community is also dealing with, and there are a  
20 lot of different formulations that are corrected.

21 I wonder, was there any thinking within  
22 your committee, how to sequence these changes in?

1       Are there some components that are so  
2       interconnected that they should be pieced out into  
3       a stage one versus stage two or can all these be  
4       implemented at variable speeds?

5                     Thank you.

6                     DR. POLAND: Let me now, before taking  
7       further comments, allow Dr. Wilensky or other  
8       members of the Board. I'm sure this will have  
9       stimulated some thoughts or comments that you may  
10      want to make.

11                    DR. WILENSKY: Let me respond to a  
12      couple of the issues. These are very good,  
13      thoughtful points that people have raised and  
14      reflect the fact that you have read our drafts and  
15      given them a lot of thought, and I appreciate  
16      that.

17                    One of the areas that we have struggled  
18      the hardest with is the notion of coordination  
19      with private plans for retirees who are still  
20      working. The Congress has made it illegal for  
21      employers, as I understand it, to actually pay to  
22      push people out of their healthcare plans, but we

1 recognized that there are two issues that are  
2 still important to be dealt with. The first is  
3 making sure for people who actually carry both  
4 Tricare and private insurance, that Tricare does  
5 function as the second payor. We think there is  
6 some reason to believe that does not happen all  
7 the time and that we need to make sure it does  
8 happen.

9           There's a comparable issue for employed  
10 individuals after the age of 65 where their  
11 employer- sponsored insurance is first payor and  
12 Medicare is second. In this case, Medicare is  
13 also a first payor to Tricare. But to make sure  
14 that Tricare, when they're in the face of held  
15 existing insurance, is really the second payor and  
16 that there are a number of strategies that can be  
17 done to make sure that the system is functioning  
18 as the Congress intended and as all of us think it  
19 should.

20           The more complicated issue, which we've  
21 raised -- I think we've raised it more than we've  
22 resolved it -- which is why the recommendation was

1 to study, assess and consider doing pilots, is  
2 recognition that there are issues of both benefits  
3 and economics on the one hand for individuals to  
4 consider. We were as worried about the downside  
5 of not having a good integrated plan for  
6 individuals and believe that having one  
7 coordinated plan, whichever that is, Tricare or  
8 the private plan, is superior for many times for  
9 most people to using two plans.

10 And so, what we are suggesting in our  
11 recommendation to assess and do pilots is whether  
12 there may be ways to focus on a single plan but of  
13 a plan of the choosing of the individuals and to  
14 structure in a way that all parties feel they are  
15 better off. Not easy to do, but that was the  
16 thinking that underlay the recommendation number  
17 11 that I mentioned during my presentation.

18 We very much agree with the notion of  
19 being an innovator in wellness and in aligning  
20 incentives and try to reward the kind of behavior  
21 that we think is appropriate and try to indicate  
22 the importance of wellness and prevention for DoD

1 to carry on its mission readiness functions as  
2 well as providing best healthcare, and so, we'll  
3 have to see as to how to best frame it.

4 The notion, I was attracted to the  
5 comment you made that we all recognize the  
6 innovations in trauma care and surgery that occur  
7 during wartime and maybe having that as a model in  
8 our minds for the role that the Department of  
9 Defense for military healthcare can have in terms  
10 of prevention and wellness are to be taken with  
11 that same drive. I'm not sure that we quite  
12 thought about it that way. I thought that was a  
13 very interesting way to look at it.

14 The challenge will be something that  
15 we'll think about over the course of the next week  
16 or 10 days about the sequencing of activities.  
17 Some of them fit together more obviously than  
18 others. In changing either some of the benefits  
19 or the payments, our interest is in doing so in  
20 what we think is a fair and predictable way. So  
21 we have a lot of emphasis on phasing in. Our  
22 phase-in is presumed to be, for the most part, a

1 four-year phase-in and to have periodic  
2 reassessments for those things that don't lend  
3 themselves to annual indexing so that, on a  
4 regular basis, you look to see where you are.  
5 Those, I think, are one set of activities.

6 But with regard to the contracting and  
7 the assessment of changes in the unified command  
8 and particularly the need with regard to better  
9 integration between the purchased care and the  
10 direct delivery of care. Those are as soon as at  
11 all possible to get started on, but the realities  
12 will depend somewhat on the contracting cycles  
13 that are beyond the control, basically, of  
14 probably anybody in this room, even Dr. Cassells,  
15 because they're in motion already in terms of what  
16 the contracting schedules are.

17 But we had, as our first recommendation,  
18 a better integration between the purchased care  
19 and the direct delivery care, not because no one  
20 has thought of this before -- we're aware that  
21 this type of recommendation has been made to the  
22 Department -- but that it is so integral to

1 everything else that comes after, that it is  
2 impossible to really have an alignment of  
3 incentives at any stage including the interesting  
4 one of putting revenues at risk for the  
5 performance of the chain.

6 None of this can occur without having a  
7 better integration between purchased care and  
8 delivery care, and everything that spins off of  
9 that, all of the procurement, all of the  
10 contracting, all of that is contingent on this  
11 notion of what it is you're trying to produce at  
12 the end of the day and all of the pieces that  
13 move. So, thinking about what has to go together  
14 and what not is something we'll have to ask people  
15 on the taskforce, particularly those who are more  
16 involved in that portion to give us more thought.  
17 That is not something I personally have thought  
18 about.

19 Are there comments from any of the other  
20 taskforce members, specifically about the issues  
21 that have been raised thus far? Dr. Roudebush?

22 LTG ROUDEBUSH: I thought Dr. Parkinson

1 provided some very thoughtful points for  
2 consideration, and I think many of those were  
3 raised during the deliberations relative to  
4 various aspects that we addressed.

5           Something I would offer for your  
6 consideration as you discussed alignment of  
7 incentives, and command and control is an  
8 opportunity to drive efficiency. Those are  
9 certainly things that we considered. I think  
10 efficiency, in and of itself, is obviously an  
11 important aspect of what we considered and  
12 continue to consider.

13           But, quite honestly, effectiveness is a  
14 significant and perhaps more important driver in  
15 much of what we do. If you look at what our  
16 military medical system is asked to do in terms of  
17 providing a healthy, fit force that's protected  
18 and prepared to go forward and do what we ask our  
19 military to do in virtually any situation around  
20 the globe, that's one aspect. Providing medical  
21 personnel that are prepared, trained and able to,  
22 one, do all that's necessary to produce that

1 healthy, fit force and then support them wherever  
2 they find themselves, take care of them and bring  
3 them home safely should something adverse occur is  
4 an aspect of what we do.

5           Providing the healthcare to our  
6 beneficiaries, which, one, provides that healthy,  
7 fit force and, two, provides those trained,  
8 current and competent and capable medics to go  
9 forward, all of these activities with the  
10 incentive being that healthy, fit force, that  
11 prepared medic, that operationally-effective  
12 military, those incentives are not necessarily  
13 always efficient. So much of what we considered,  
14 we considered on the basis of cost- effective.  
15 Managing each resource so that the best benefit  
16 was derived in the most responsible and  
17 cost-effective way is one of those guiding  
18 elements that helped us in our deliberations.

19           So, as we align incentives, the  
20 incentive of that operationally-effective force,  
21 well supported medically at home and deployed, is  
22 not always efficient, and a coalesced command and

1 control does not necessarily drive that kind of  
2 effectiveness, particularly as we look at  
3 doctrinally-effective forces: Airspace and  
4 cyberspace, (off mike) at sea, subsurface.

5           There were aspects of that that we did  
6 deliberate on, and I think our considerations  
7 drove the report to reflect those considerations,  
8 but I think your suggestions relative to  
9 opportunities to, in fact, engender efficiency  
10 wherever and whenever we can is an important  
11 aspect. I think that, as Dr. Wilensky pointed  
12 out, really drove the consideration of a strategy  
13 that appropriately integrates both the direct care  
14 system and the contracted or the private care  
15 system, so that we manage those both to best  
16 effect, to mutual benefit and to best cost and,  
17 most importantly, to best outcome. Whether it's a  
18 healthy, fit force, whether it's a healthy family  
19 member, whatever that best outcome should be, I  
20 think, really drove us in our deliberations and  
21 allowed the construct of the recommendations as we  
22 provided those.

1                   So I think your observations certainly  
2 reflect the importance of doing that, and I  
3 thought your issues and ideas relative to  
4 innovation were also telling and I think should  
5 inform the execution and the further deliberations  
6 of this report as it's crafted and as it's  
7 delivered. So I truly appreciate that. Thank  
8 you.

9                   DR. POLAND: Dr. Luepker?

10                  DR. LUEPKER: Yes, Russell Luepker.  
11 Your last point, Dr. Wilensky, talks about metrics  
12 and measurement. I guess I'd like to hear a  
13 little more. In this very complex system and a  
14 multilevel set of recommendations, how would you  
15 know you've succeeded here?

16                  DR. WILENSKY: That is an excellent  
17 question. We were at least clever enough to  
18 recognize if we didn't put a directive of setting  
19 up metrics so you can assess where you go to in  
20 addition to where you've been from, you'll never  
21 be able to answer the question of have you  
22 succeeded.

1           Well, our concern about metrics was very  
2 much focused both at the first recommendation and  
3 with the last recommendation but frankly is true  
4 all the way through. That is, as I've indicated,  
5 we are not the first group to reflect that the  
6 incentives driving the direct care system and the  
7 purchased care do not always seem to be aligned.  
8 Within each, they may be aligned more or less all  
9 right. But in terms of being able to produce the  
10 desired outcome at the local level that makes the  
11 most sense, given the complex missions which is  
12 the medical readiness plus delivery of healthcare  
13 per se to the people using the system, how do you  
14 try to set up an alignment of incentives that has  
15 the best outcomes for the costs that you are  
16 incurring?

17           What that requires is deciding what  
18 defines success. As General Roudebush indicated,  
19 it is more a focus on the outcome, the health  
20 outcome and the readiness outcome, and not on the  
21 inputs specifically that are used. So we  
22 recognize that the difficulty of saying this is

1       what you're trying to do and this is how you  
2       numerically define that and then try to measure  
3       how well you've achieved it or not achieved it.

4               It was also in reflection to a recently  
5       released GAO report that had to do with command  
6       and control and going to the issues of unified  
7       medical control. We recognized that when we  
8       started this taskforce, this had been an issue  
9       under considerable debate and discussion in the  
10      Department for the preceding year or two or maybe  
11      decade or two at some levels and that some initial  
12      levels of decision-making -- yes, forever.

13              Some initial decisions had been made as  
14      to how to proceed going forward, but there had  
15      been noted in the GAO report that it wasn't clear,  
16      if it occurred, what metrics had been used by the  
17      Department in terms of assessing the costs and  
18      benefits of the various options under  
19      consideration, yet alone the actual choice that  
20      was ultimately arrived at. And so, what we were  
21      indicating is, given that a process is unfolding  
22      now, it is important to establish the metrics of

1        what will define success and then assess how this  
2        strategy looks in comparison to those metrics and  
3        to the extent that there are other measures of  
4        success that could be considered when different  
5        strategies or choices are made going forward, that  
6        that's clearly defined.

7                    So it is trying to be as clear as we can  
8        throughout the report that our concern is a focus  
9        on clinical outcomes, on meeting the readiness  
10       mission first and foremost which makes all of this  
11       more complicated to what is already a complicated  
12       issue of how do you know when you've had good  
13       quality, cost-effective healthcare being provided.  
14       As all of you know, this is not a slam-dunk issue.  
15       In the private sector that doesn't have to worry  
16       about medical readiness, it becomes much more  
17       important.

18                    Complicated, when you do, but not making  
19        the metrics clear and measuring as best you can  
20        doesn't resolve anything. We just need to  
21        acknowledge the complexity of the combined  
22        mission.

1           RADM SMITH: And just to further pile on  
2 to that, part of the intent of the first one is  
3 that there's been a fair amount of concentration  
4 on unit cost but because of the lack of a common  
5 accounting system, because we segregate the  
6 purchased care from the direct care system, it's  
7 difficult to get the whole cost associated and  
8 whether or not, as has been shown in other  
9 systems, if you spend too much time on the unit  
10 cost, you may not actually be reducing the overall  
11 whole cost and also may not be helping ultimate  
12 outcomes which is clearly our highest priority.

13           DR. WILENSKY: This was in the  
14 discussion, some of the discussions we had on  
15 pharmacy benefit, for example. Trying to look at  
16 this point, that it is important in general when  
17 we're looking at military healthcare, as in  
18 healthcare all over, to remember that even if you  
19 minimize unit cost, however defined, the cost of  
20 producing good, healthy outcomes may not be  
21 minimized and that it may require not minimizing  
22 unit cost but allowing enough flexibility with an

1 alignment of incentives and reward structure so  
2 that overall healthcare is provided in the way  
3 that makes the most sense.

4 In some instances, that will be  
5 different configurations between purchased and  
6 direct delivery care and, in some instances, may  
7 be to allow for a different view of the use of  
8 pharmacy care versus the rest of healthcare and to  
9 remember the focus is on the healthcare outcome.  
10 It's easy to focus on what you can most easily  
11 measure which are the unit costs of care, but that  
12 misses the point of what we're trying to do.

13 DR. POLAND: Dr. Walker had a comment,  
14 and then we'll have a response and then maybe take  
15 a break and come back to the conversation. Go  
16 ahead.

17 DR. WALKER: I'm another David Walker.  
18 I'd like to address recommendation number eight  
19 which I think you did excellent an excellent job  
20 of explaining the difficulty and the importance of  
21 this problem. Maybe it's my lack of insight, but  
22 I don't see the solution. I see the

1 recommendation to do it, but how will it come  
2 about?

3 The recommendation is the Department of  
4 Defense should provide medical readiness for the  
5 Reserve component which seems to me the most  
6 detached and difficult group to maintain their  
7 health, recognizing that its readiness is a  
8 critical aspect of the overall task for the force  
9 readiness.

10 MG SMITH: I'll take a stab at that.  
11 The genesis behind is that more than 50 percent of  
12 the medical assets for readiness and for delivery  
13 of medical services around the world is in the  
14 Reserve components. If you don't have those  
15 people coming to the colors and going forth, we  
16 cannot have a future military healthcare system  
17 when you've got an asset that's over 50 percent.

18 Recognizing that, we're saying to DoD,  
19 you have to ensure that an asset will be in place  
20 as we go to the future, and that asset is not  
21 always a reach out and touch with an order in 24  
22 hours. That asset has to come from the employer,

1 has to come from the families and come from  
2 America all over.

3           So what we're saying is what are the  
4 inhibitors, whether it be access or the inhibitors  
5 for these people coming to the colors. We have  
6 found the data at mobilization sites that dental  
7 readiness is the number one deterrent for a person  
8 being mobilized, and you have other medical  
9 things. Well, we don't control the daily lives of  
10 the civilians because of their civilian status.

11           And so we're saying, what can we do to  
12 help increase the awareness of a Reservist that  
13 they need to be medically fit? What are the  
14 processes and procedures that we can employ and  
15 help them with? So that if their unit is called,  
16 they can come, get through the mobilization site,  
17 and we can send those units forward as necessary  
18 to do what we have to do for the medical  
19 readiness.

20           And so, we've recognized that, saying  
21 that there are some things that we're seeing that  
22 need to be emphasized and implemented. We talk

1 about it. I haven't seen it. We talk about more  
2 of the individual understanding that when they  
3 sign up for the Reserve components, they're also  
4 signing up to say: I want to be medically fit and  
5 I'm going to be medically fit and I'm going to do  
6 what is necessary through lifestyle, through  
7 physical fitness, through eating, diet and various  
8 things. So that when our unit is called, I'm  
9 going to go forth.

10 So this is what I think we're really  
11 addressing is that we can't have an asset for  
12 America, but we can't access that asset or then  
13 when we access it, it's not there because they're  
14 not medically fit. This is I think what we're  
15 trying to drive in recommendation eight and the  
16 awareness of this asset.

17 DR. WILENSKY: There's also a  
18 recognition that there have been a number of  
19 changes with regard to the Reserve in the last few  
20 years, and so we think it's important to assess  
21 whether or not some of the changes that occurred  
22 with regard to the Tricare Reserve Select Program

1 have the kind of impact that was hoped for or  
2 presumed when they were being implemented. It's  
3 something that we think needs to occur but will  
4 require a two or three-year period before the  
5 effects of having this change occur.

6           It is a very big issue. As you've just  
7 heard from General Smith, most of our focus has  
8 been on education, trying to make clear the  
9 personal responsibility and accountability of  
10 medical readiness by the Reservists. Whether or  
11 not this is being appropriately engaged in, in  
12 terms basically as a condition of participation,  
13 both in terms of the individual and the  
14 leadership, is important to be able to achieve  
15 this sense of medical readiness and assessing  
16 whether what has been done both in terms of  
17 medical and dental has improved what existed prior  
18 to that or not and, if not, what else might be  
19 considered.

20           DR. POLAND: I think there was another  
21 comment.

22           GEN MYERS: Let me just make one

1 comment, Dr. Wilensky and Bob.

2 I think the context for this is a  
3 Reserve component that's used a lot differently  
4 today than when it was conceived, and so this  
5 medical readiness issue is a huge -- a huge issue.  
6 As Gail said, this Tricare Reserve Select is an  
7 attempt, another attempt to try to fix the medical  
8 readiness in the Reserve components.

9 Whether or not it's going to succeed or  
10 not, we don't know, and that's why our  
11 recommendation reads as it does. Somebody ought  
12 to assess that because there's no question that  
13 the Reserve component medical readiness has lagged  
14 that of the Active component and, given the way  
15 the fundamental shift in the way we use the  
16 Reserve component today, that needs to change.

17 We're hoping the changes have already  
18 taken place, but we've increased emphasis here,  
19 and we recommend that the Department monitor that  
20 to see if it's having the effect, the intended  
21 effect that Congress wanted when they implemented  
22 Tricare Reserve Select.

1 DR. POLAND: Ms. Embry?

2 MS. EMBRY: I'm responsible for medical  
3 readiness in the Department. About four years ago  
4 we instituted a metric to evaluate individual  
5 medical readiness in the services, and it's a  
6 metric that every individual is measured in their  
7 units by their commanders for their medical  
8 readiness. Reserve components are among those  
9 that are being tracked.

10 We use those metrics to push  
11 accountability and responsibility in the Reserve  
12 components, and we implemented a rather aggressive  
13 Reserve component health program to institute  
14 annual reviews of health and to accomplish the  
15 important immunizations, physical assessments,  
16 mental health assessments and so forth as required  
17 to achieve and monitor readiness in the Reserve  
18 components.

19 The catch is that it is the Reserve  
20 components that pay for that, not the Defense  
21 health program, as is appropriate. And so, I  
22 think the issue is, for the Reserve components,

1       there is not enough money.  If they actually paid  
2       everything they needed to pay for that, they would  
3       have little left to pay for the training and  
4       readiness of the force to perform the mission.  So  
5       it's a fiscal issue.

6                    But I do think the Department is doing a  
7       considerable amount to address the issue of  
8       Reserve component readiness.  It's a matter of  
9       fiscal priority.

10                   DR. POLAND:  Okay, I think we'll take a  
11       brief break here and reconvene about 10 to.

12                    Again, if there are members of the  
13       public or audience that would like to make  
14       comments, if you would register at the desk, I  
15       think we should have time in the hour following  
16       our reconvening here to entertain those questions.  
17       Thank you.

18                    (Recess)

19                    DR. POLAND:  Thank you, everybody.  
20       We'll reconvene here and continue our discussion  
21       of the Task Force on the Future of Military Health  
22       Care Report.  From the Board members, any

1 additional questions or comments; Doctor Oxman?

2 DR. OXMAN: First of all, I'd like to  
3 thank the Task Force for a fantastic job. As  
4 somebody who's relatively the ignorant in the  
5 area, I found the reading compelling and the  
6 organization fantastic.

7 I wanted to ask if you could expand a  
8 little bit upon the -- your thoughts about taking  
9 advantage of the enormous buying power of the DOD  
10 to minimize -- maximize the quality and minimize  
11 the cost, particularly in the area of pharmacy  
12 benefits?

13 MG KELLEY: Well, let me just take a  
14 stab at that to start off with. And we did talk  
15 quite a bit about maximizing the benefits in terms  
16 of the ability and using volume for discounts.  
17 Most of the people that we discussed that with  
18 felt that -- because we talked about it in terms  
19 of combining with the VA for even a bigger  
20 possibility of a volume, and because of the size  
21 of both the VA and the DOD programs, the feeling  
22 was that there would be very little marginal gain,

1 because you've already taken the volume discounts  
2 and there's not that much. And so there is some  
3 pieces of that, and currently the federal pricing,  
4 where we get the volume discounts, is only  
5 available in the MTF's and also in the mail order  
6 pharmacy, and so none of the retail pharmacies  
7 provide that. So it's much more expensive to use  
8 the retail pharmacy.

9 We certainly don't want to take that  
10 ability to use the retail pharmacy away, but we  
11 want to incentivize the use where we get the  
12 volume discounts.

13 DR. OXMAN: Thank you.

14 MG ADAMS: Another aspect of that that  
15 we talked long about, and without getting into  
16 specifics, was that we're aware that there are  
17 other practices available in the commercial side  
18 of it, where you better manage the pharmacy  
19 benefit in terms of the therapeutics of the health  
20 care that you're providing.

21 And looking at some of those unique  
22 arrangements, where you're able to prescribe the

1 drugs, take into effect the clinical efficacy, as  
2 well as the cost. And the Department does some of  
3 that, but we do it at such a high level that we  
4 have not really penetrated the market like we  
5 could if we were taking advantage of some of those  
6 commercial practices. So I think it was not only  
7 the buying power, but also then in terms of what  
8 type of new practices based upon the new  
9 therapeutics that we're taking advantage of.

10 DR. WILENSKY: This was one of those  
11 issues where lowest unit cost may not give you  
12 either best outcome or lowest cost for the  
13 treatment of care provided, and it was important  
14 to look at that, as Nancy was just indicating, as  
15 to whether or not there were best practices that  
16 either weren't being or could only be adopted with  
17 difficulty.

18 But we also have felt that the  
19 incentives in place didn't reflect the actual cost  
20 differences, and part of the changes that need to  
21 go forward is to incent and reward those who make  
22 use of the lowest cost therapeutics available to

1       them in the lowest cost setting. And so part of  
2       what our recommendations will do is to try not to  
3       prevent people from going wherever, but to incent  
4       and reward those who make use of the lower cost  
5       potentials available.

6                   DR. PARKINSON: There are a couple of  
7       questions. I was trying to intuit reading through  
8       your introduction the level of analysis that  
9       you've done, which is obviously exhausted. But a  
10      couple of basic questions. Were you able to parse  
11      out for the appropriate comparison population  
12      whether or not the DOD, particularly our purchase  
13      care benefit, is accelerating equal to, greater  
14      than, or less than a civilian health care benefit  
15      as purchased by a fortune 1000 company, I mean is  
16      that possible even to do? So the rate of  
17      acceleration that we see and the numbers that  
18      Doctor Poland cited, is that greater than, equal  
19      to, or less than what we've seen over the seven  
20      year period of time for the civilian sector,  
21      because that says something I think about how we  
22      purchase, maybe, okay.

1           The second question is, in terms of the  
2 three major buckets that we look at, pharmacy,  
3 out-patient services, and perhaps surgery/advanced  
4 imagining, which is right now the focus of most of  
5 the traditional managed care industry, is looking  
6 at the dramatic growth in out-patient surgeries,  
7 dramatic growth in advanced scanning, MRI, CT,  
8 things like that; do we have any sense in the  
9 reports that we get back through the managed care  
10 contracts that we're monitoring at least the major  
11 building blocks of what makes up trends?

12           So the first is, our trend versus  
13 civilian, and second is components, pharmacy,  
14 out-patient services/advanced diagnostics, or  
15 scans.

16           RADM MATECZUN: I'll try to answer both  
17 of those, Doctor Parkinson, and some of the  
18 dialogue that we had. Try to take a look at the  
19 cost and the increase in cost. We did -- were  
20 able to parse out part of the root causes of that  
21 increase over that time span. Number one cause is  
22 increased benefit, so that Congress has added

1 benefit over time that has added significant cost  
2 to that structure, including the Tricare Reserve  
3 Select program as an example that we were talking  
4 about, so that's number one.

5           Number two is that as the benefit has  
6 not changed in terms of the price structure that's  
7 out there, and as people have left the insurance  
8 plans that they are in, that has driven an  
9 increased population into the benefit population,  
10 or at least the population that is actually using  
11 the benefit.

12           That seems to have leveled off. But  
13 those are the two causes, root causes of the  
14 increase in cost. Therefore, over that period of  
15 time, with those two things happening, very hard  
16 to compare with a civilian population where the  
17 benefit hasn't changed in their plan and try to  
18 come to any kind of conclusion.

19           The second piece on the components of  
20 the contract, I guess in short I would say, no,  
21 there is no structured way of looking at that. In  
22 fact, that is why we recommended that the

1 Department should have a strategy, to take a look  
2 at the components in the purchase care sector,  
3 what's going on. I mean there is a cost, we know  
4 what the cost is for each of those. But are we  
5 able to compare that cost and the effectiveness  
6 and efficiency with the cost and the direct care  
7 system? No, we are not.

8 DR. LOCKEY: Just briefly to the first  
9 part of your question, we looked at a number of  
10 indices in connection with our studies, and the  
11 rates of growth and things like the defense, the  
12 Military Expenditure Panel Survey, the Kaiser  
13 Foundation data, are similar especially since 2000  
14 than we're seeing in Tricare, they're not  
15 identical, but they're in the same mix especially  
16 since 2000, so I think that goes to the first part  
17 of your question.

18 DR. PARKINSON: Doctor Lockey, a  
19 question.

20 MR. LUEPKER: I found this is an  
21 incredible work product, and I really enjoyed  
22 reading it. One of the questions I had was

1       regarding Chapter 11, and that chapter dealt with  
2       the mix of military and civilian personnel, and  
3       the Task Force was addressed -- was charged to  
4       address this appropriate mixture of military and  
5       civilian personnel to meet future readiness and  
6       high quality health care service requirements.  
7       And the problem is well outlined. The problem was  
8       that there's always been a -- retain the high  
9       quality personnel, that's been a chronic problem  
10      for the Armed Forces, and then this conversion of  
11      military to civilian health care professionals has  
12      created I guess some problems.

13                 But in the conclusions, the issue really  
14      was not addressed. It seemed like pending  
15      legislative initiatives acted as an impediment in  
16      order for the Task Force to address these issues.  
17      And it wasn't clear to me why that was the case.  
18      I mean it's a very innovative report overall, but  
19      in this particular area, there really are no  
20      solutions offered.

21                 MG ADAMS: I think the reason why we  
22      ended up with that conclusion was that

1 historically, the services have approached the  
2 military/civilian mix differently. But in recent  
3 times, within the last three to five years, all  
4 three of the military departments were directed to  
5 convert more military positions to civilian  
6 positions.

7           And following the direction of Congress,  
8 all three military departments significantly  
9 increased the number of civilians working in  
10 military medicine. However, recently, within the  
11 last year to 18 months, the Congress realized that  
12 there were problems that were inherent to  
13 converting more military to civilian; most  
14 importantly, you decrease the rotation base, and  
15 therefore, you influence quality of life for those  
16 dedicated men and women who are serving in a  
17 hostile environment, so they gave the departments  
18 permission then to slow down the conversion. So  
19 that's -- we're kind of left in the middle flux,  
20 where we saw the ramp up with the civilians, but  
21 we realize we're not sure how steep that ramp  
22 needs to be.

1           We've got a holding action right now, so  
2 I think we need also to let the department sort it  
3 out in terms of what is going to be the proper mix  
4 for the services for the way ahead, taking into  
5 account the deployment needs, as well as the  
6 recruiting retention implications when you  
7 civilianize more of your rotation basis, which is  
8 what we have in terms of the civilian places that  
9 are back in the United States.

10           DR. WILENSKY: This was one of the areas  
11 where I hope we were clear, that it's complicated,  
12 we think it needs to be assessed, both in terms of  
13 understanding where we are now and particularly  
14 the appropriate strategies that are available for  
15 the future, and that we just -- we're not able to  
16 take the time that it requires in order to be able  
17 to provide good strategies and alternatives going  
18 forward. So there are a lot of ramifications with  
19 regard to future work force needs in terms, not  
20 just of the civilian military, but the whole  
21 reserve, active duty, particularly as it relates  
22 to the medical component that ought to be

1 considered as we go forward, but we really weren't  
2 able to do it. So unlike other areas where we  
3 thought we understood the issue sufficiently well,  
4 that we could make recommendations for a change,  
5 this is -- more needs to be done.

6 LTG ROUDEBUSH: If I might add just one  
7 additional perspective to that. I think the Task  
8 Force made a wise decision in not being  
9 prescriptive, because the appropriate balance of  
10 military and civilian members within the MHS is  
11 something that begins at a very high level in  
12 terms of -- and missions, a national strategy that  
13 translates into a national military strategy, and  
14 all the forces that are required in order to  
15 support and execute that strategy, and that's an  
16 evolutionary process.

17 There is no one prescriptive mix that  
18 allows you to fight today's fight and fight  
19 tomorrow's, as well. So I think the  
20 recommendations that we made support the ongoing  
21 process within the department that will, in fact,  
22 drive the appropriate balance and mix to give us

1 the kind of forced structure, both military and  
2 civilian, that allows us to meet the mission and  
3 deliver the benefit, as well. So I think it  
4 almost goes a bit beyond the purview of this Task  
5 Force. Although it's clearly within the purview  
6 to support and facilitate and help inform that  
7 process as it goes forward, with the over arching  
8 strategy to appropriately integrate the direct  
9 care system and the private sector or contracted  
10 care to achieve the best outcome for all the  
11 sectors.

12 So I think it is, as Doctor Wilensky  
13 points out, a very complex, but it's a very  
14 dynamic and evolutionary process, as well, that  
15 does not foster a prescriptive or one time  
16 solution.

17 DR. LOCKEY: Just one follow-up comment.

18 DR. PARKINSON: Go ahead and follow up  
19 and then --

20 DR. LOCKEY: Does that also apply to the  
21 statement about recruiting and retaining high  
22 qualified health professionals that's been a

1 chronic problem for the military? Is this  
2 something the Task Force was not really asked to  
3 address?

4           RADM MATECZUN: I'd like to address it a  
5 little bit with you right now. The work force and  
6 how we get the work force, the necks of the work  
7 force are critical questions for us. I think that  
8 you heard, we have about 133,000 people working  
9 within the military health system. That doesn't  
10 include those people that are out there working  
11 within the purchase care sector. That's within  
12 the direct care system. So it's a very big  
13 system, and we have a need for high quality  
14 personnel to be able to stay within that work  
15 force.

16           We have not done as well in recruiting  
17 in the services over the last few years, and, for  
18 instance, our scholarship programs for physicians.  
19 This is a problem kind of across the services, and  
20 the Department needs help, it needs help from  
21 people like yourselves as you go back to your  
22 institutions.



1 Recruiting and retention has been difficult over  
2 the last few years.

3 DR. WILENSKY: But again, these are --  
4 we recognize these are major issues for the  
5 Department, they are very big issues, and I think  
6 somewhere specifically we indicate that we think  
7 this ought to be the subject of a separate task  
8 force, because there are so many issues that go to  
9 recruitment and retention, the mix of civilian and  
10 military, the mix of active duty and reservists,  
11 and how you try to project where you want to be in  
12 the future, that was beyond what we thought we  
13 could give any justice to, and therefore, other  
14 than laying out what we have recognized as the  
15 problem, didn't feel it was appropriate to go  
16 forward. But it was not because we don't think  
17 it's serious, it's really the opposite, we think  
18 it's such a big issue that we didn't want to make  
19 recommendations that didn't begin to do justice to  
20 this issue, so we hope it will be taken with the  
21 seriousness going forward that it deserves.

22 DR. PARKINSON: Let me just point out

1 before I get to you, Kevin, that Doctor, for the  
2 record, that Doctor Dan Blazer has joined us.  
3 Dan, we went around and introduced ourselves. Do  
4 you want to just briefly tell your affiliation?

5 DR. BLAZER: Dan Blazer,  
6 psychiatrist/epidemiologist, Duke University, I've  
7 been on this Board for a while.

8 DR. PARKINSON: Okay; Kevin.

9 DR. MCNEILL: Thank you. As a former  
10 practitioner in the military health care system  
11 and now a retiree and beneficiary, I'd like to  
12 thank the committee for this excellent report and  
13 all of the hard work that went into it. And I  
14 mentioned this as -- aside to a couple of members,  
15 but I would really like to commend particularly  
16 the idea of a better coordination between Tricare  
17 and private health insurers. This would be  
18 extremely beneficial for retirees such as myself  
19 who live in undeserved areas, there's no military  
20 installation anywhere around, and there is  
21 basically no provider network. And the idea of  
22 being able to access either/or, even if it meant

1 additional, you know, financial contributions by  
2 me, I would consider that a wonderful improvement  
3 to the current system, because even though the  
4 benefits are there, gaining access is very  
5 difficult, so I commend that idea, and I think  
6 it's certainly a mix for the duration.

7 DR. PARKINSON: Doctor Parisi.

8 DR. PARISI: I'd like to echo everyone's  
9 congratulations on this very excellent and  
10 complete report. I'm impressed with the care and  
11 the thought that has been given to many of the  
12 issues.

13 One comment is that the report is great  
14 at identifying the problems, but my reality part  
15 of me asks is, implementation possible or  
16 practical. And I'm sure the committee wants to  
17 deliberate about maybe legislative activities that  
18 are -- legislative actions that would be necessary  
19 to allow the implementation of some of these  
20 recommendations, and I just would ask for some of  
21 your comments about that.

22 DR. WILENSKY: The good news is that

1 relatively few of the recommendations require  
2 statutory change, and I regard that at least as  
3 the good news. We will be very clear when we  
4 issue our final report in terms of the 12  
5 recommendations with the action items as to what  
6 we believe can be done administratively and what  
7 requires new statutory authority. Most of it is  
8 able to be done administratively. That doesn't  
9 make it easy, it just makes it easier than needing  
10 actions by Congress before you can proceed.

11           Probably the more difficult issue is  
12 that while we tried to be as specific as we could  
13 in the action items underneath each recommendation  
14 to give guidance as to where or what would be  
15 required in order to achieve the outcome we're  
16 recommending. They almost by necessity always  
17 stay, if not at 30,000 feet, will probably never  
18 get much under about 12,000 feet, except for some  
19 of the financial changes that we discuss more  
20 explicitly.

21           And therefore, it will require follow-on  
22 activity to be embraced by the Department, to pull

1 together individuals appropriate and concerned to  
2 try to make these changes happen.

3           It doesn't happen that often with task  
4 forces, but it can happen. Again, my experience  
5 on the Dole Shalala Commission earlier in the year  
6 has resulted in what are enormously gratifying  
7 efforts by the Department to try to embrace along  
8 with the VA those areas that can be done  
9 administratively. So there is clear indication  
10 that the Department can take these areas that are  
11 identified and begin to implement them in a very  
12 quick order if it is agreed that they are  
13 important and the kind of interest to do so.

14           So we will make very clear, at least  
15 according to the guidance we have, there's always  
16 some dispute that goes on as to whose general  
17 counsel opines as to exactly who has what  
18 authority, but we think probably we will be  
19 relatively safe in designating those areas, which  
20 probably need legislative change as opposed to the  
21 others. But I will tell you, most of what we are  
22 recommending, as best we can tell, can be done by

1 the Department directly.

2 DR. PARKINSON: Doctor Shamoo.

3 DR. SHAMOO: Thank you. The military  
4 has been at the forefront of issues of equities  
5 once they make up their mind. And I think part of  
6 my question was asked the last time we were  
7 together. There's two types of equity, equity in  
8 terms of type of health care services we render,  
9 especially behavioral versus other medical ailment  
10 issues, and equity, currently it's superb, it's at  
11 the peak, and that is equity to, regardless of the  
12 service rank, we provide the same health care  
13 services. The two part question is, should we  
14 have some kind of safeguard, because no one can  
15 predict that societal ills don't creep into the  
16 system of some inequity, and at the same time, to  
17 ensure the equity of the type of health care  
18 services we render.

19 DR. WILENSKY: I don't dispute what  
20 sounds like an admiral goal. I'm not sure  
21 specifically what, other than following metrics  
22 that focus on outcome, that recognize that what it

1 takes to produce good health may differ in terms  
2 of the health care, how it's provided, and when  
3 and where it's provided.

4 That's basically a presumption of  
5 medical readiness, that you take individuals as  
6 they come in, and achieve a medical readiness so  
7 that they can be deployed as the military sees  
8 appropriate.

9 And it is -- it functions more on the  
10 desired outcome rather than on the specific inputs  
11 that might be required in order to get there. So  
12 I mean it strikes me in general, that is the  
13 function that the military, particular with regard  
14 to its active duty, provides.

15 It's a little hard to have quite that  
16 same specific focus in terms of retiree care,  
17 which you can provide our benefits to individuals  
18 after they leave active duty military, but other  
19 than putting in safeguards that contractors do  
20 what they say they will do, and using metrics to  
21 make sure that when you think you've changed the  
22 system in a way to improve it, that you monitor

1 the outcomes and not just the input changes. So  
2 if you have something else specifically in mind --

3 DR. PARKINSON: General Kelley and then  
4 General Adams.

5 MG KELLEY: Doctor Shamoo, I think that  
6 we did consider this, and as we talked about  
7 discussing adjusting co-pays, enrollment fees and  
8 that, we talked about the tiering process, so that  
9 those individuals who have retired at lower rank  
10 or with lower retirement pay would pay less than  
11 other individuals.

12 And so specifically to address your  
13 concern about those at economic disadvantage, a  
14 disincentive to using the system, we adapted the  
15 recommendations to have a tiering process to make  
16 it easier for them to use the system.

17 DR. PARKINSON: General Adams, did you  
18 want to --

19 DR. SHAMOO: May I comment on that? I  
20 appreciate your answers, but inequity -- the  
21 current inequity crept in from our society, and  
22 that is between behavioral coverage versus

1 non-behavioral coverage. It's in everywhere in  
2 this society, and was not by design, and everybody  
3 measures out. So contrary to the existing  
4 practices, mental health coverage is one-tenth of  
5 what ought to be in all health insurance, whether  
6 it's -- everywhere, so I am not -- that the  
7 outcomes alone will take care of it, any segment  
8 of our society.

9 DR. WILENSKY: Well, actually, it's rare  
10 that people look at outcomes. They mostly --  
11 because they're harder and there's more dispute  
12 about measurement. Normally what they do is,  
13 focus, if at all, on the amount or the cost of the  
14 inputs, and not on the outputs.

15 With regard to the issues relating to  
16 mental health, that has clearly become a much more  
17 prominent an issue because of the interest and  
18 focus on PTSD and also traumatic brain injury. We  
19 do not deal specifically with that issue in terms  
20 of the overall strategy of the report. Again,  
21 there are a number of other task forces that were  
22 specifically focused to that issue. So I mean I

1 think those are better places to look to.

2 DR. PARKINSON: Ms. Embrey.

3 MS. EMBREY: Being the designated  
4 federal official and not being a member of the  
5 Board, I did not have an opportunity to review the  
6 draft. But I do want to -- based on the  
7 conversation, I would appreciate it if you could  
8 elaborate more specifically on what you mean by  
9 improving integration between direct and purchase  
10 care system. Is this the management of both in  
11 the delivery of care, is it system integration, is  
12 it provider focused, is it -- I don't understand  
13 what integration means.

14 RADM MATECZUN: Ellen, I think that's  
15 why we said what the Department needs is a  
16 strategy for taking a look at the integration. If  
17 the Department defines the outcomes that are  
18 desires, all of those things you mentioned, any of  
19 those things you mentioned, then you can align the  
20 two systems to achieve the outcome and work across  
21 them to make sure that you haven't disincentivized  
22 or given the wrong incentives.

1           If you're not able to do that, if you  
2       don't know, if you don't have a strategy for the  
3       outcomes you'd like to achieve, then you're going  
4       to achieve the outcomes that you get. So I think  
5       that, in part, it was, yeah, the Department needs  
6       to take a look at that and say, what are the  
7       outcomes that we desire.

8           MS. EMBREY: So the message is then that  
9       we have two systems of care that are not focused  
10      on the same goals, and we need to figure out what  
11      that is?

12          RADM MATECZUN: They may or may not be,  
13      but there's no strategy that says that they are.

14          DR. WILENSKY: There was also an intent  
15      to recognize the need to make sure there's an  
16      alignment of incentives at the place where care is  
17      actually delivered, which is at the local level.  
18      There may be higher level views of how the  
19      integrated -- the purchase care and the direct  
20      care align themselves in general, but that doesn't  
21      provide the incentive or flexibility to have the  
22      best outcomes occur at the place where care is

1 actually divided, which becomes particularly  
2 complicated in areas like our own because of the  
3 National Capital region has not only multiple  
4 providers between the direct and the purchased,  
5 but multiple services active in each.

6           So it is not clear it is happening at  
7 the local level, even when there is just one  
8 installation, and it is particularly complicated  
9 in the region of the country where there are  
10 multiple installations. We visited San Antonio.  
11 That was an obvious one. The National Capital  
12 region is an obvious one.

13           But there are others as well. And  
14 that's all in addition to making sure that there  
15 is a well articulated strategy at the top about  
16 what you're trying to do with these two.

17           But even if that occurs, and we think  
18 that more needs to be done to articulate that  
19 strategy, that doesn't necessarily mean at the  
20 local level, where the care is being provided,  
21 there's enough flexibility with the right  
22 incentives so that the movement back and forth

1       between purchased care and direct care can occur  
2       in the most effective way.

3                   It's not that there isn't any  
4       flexibility. Our sense in interviewing and  
5       listening to what people told us is it was very  
6       hard and cumbersome to happen, and that was true  
7       both from the direct care's point of view and from  
8       the contractor's point of view. Thank you.

9                   LTG ROUDEBUSH: And it also underpins  
10       the requirement for an accounting system that  
11       allows you to properly characterize the cost of  
12       delivering that particular type of episode of care  
13       so that you can look at best outcome and best  
14       cost. And the outcome is certainly a favorable  
15       health outcome, but it's also a favorable  
16       operational outcome so that you can begin to  
17       strategize and put that kind of capability in  
18       place and leverage each system, which has  
19       strengths, in order to get to the best integrated,  
20       not coalesced, but best integrated system overall.

21                   DR. WALKER: That does raise a question,  
22       and, you, of course, being currently serving, we

1 have a joint budgeting process, but we don't have  
2 an integrated cost accounting system. Each  
3 service has their way of doing that. So from a  
4 practical standpoint, is the Committee or is the  
5 Task Force recommending that we centralize the  
6 cost accounting system for this purpose?

7 RADM MATECZUM: Standardization I think  
8 is, how do you cross those systems. Once again,  
9 this is part of the Department's strategy. If the  
10 Department doesn't do that, it can never arrive at  
11 costs that can be accountable.

12 DR. WALKER: Well, as you know, each  
13 service has to live within the accounting system  
14 of that service in order to get its budgets and  
15 manage its people and, you know, operate. And so  
16 if we had a separate health accounting system that  
17 would divorce you from your service accounting  
18 systems.

19 So the challenge is difficult. I would  
20 like your views.

21 LTG ROUDEBUSH: I don't think it  
22 necessarily separates us from our services'

1 accounting system. I think the standardization  
2 across the systems because the health accounting  
3 system is something that is a bit set aside from  
4 much of what the services do. But in terms of how  
5 we're able to compare the military systems, one  
6 with another and with the private sector, until we  
7 have those standardized methods of characterizing  
8 those costs and inputs, we have a very difficult  
9 time saying this is the best cost for the best  
10 outcome.

11 So I think, as Admiral Madison, points  
12 out, it's not so much centralization as it is  
13 standardization and getting to a common accounting  
14 methodology that allows us to make that  
15 comparison.

16 DR. WALKER: It was one of the issues  
17 perhaps not emphasized enough in response to the  
18 earlier question of how does the Department of  
19 Defense compare relative to the civilian sector.

20 Yeah, it would be very difficult to make  
21 that comparison because there have been rather  
22 extensive changes in the benefits during this

1 decade, and that makes it hard to compare.

2 But even if that hadn't happened, the  
3 problems with the accounting system would make it  
4 extremely difficult to be able to make that  
5 assessment within and across the Department of  
6 Defense.

7 DR. LUEPKER: Dr. Walker?

8 DR. WALKER: Thank you.

9 DR. LUEPKER: Yeah, Russell Luepker.  
10 I'd like to go back to Dr. Shamoo's question. We  
11 heard a report a few minutes ago from the mental  
12 health task force. And they suggested that  
13 everything wasn't just fine for either active  
14 personnel, reserve personnel, and or their  
15 families.

16 When you said, well, that's a different  
17 committee, and it's true, their recommendations  
18 were structural ones about how to better integrate  
19 the system and deliver services, and it worries me  
20 a bit to hear you not talk much about how this  
21 comes together.

22 If we continue to treat behavioral and

1       mental health problems as separate and out there,  
2       they will continue to be problems.  And I  
3       personally see the overlap with what you're doing  
4       a hundred percent.  It's part of health services,  
5       but it's particularly unique in that it's not  
6       doing well.

7                   MS. EMBREY:  In my other job, I serve as  
8       the line of action lead for the Department of  
9       Defense on the Department's response to the Mental  
10      Health Task Force recommendations and many other  
11      recommendations relating to the subject of how the  
12      Department is organized to address traumatic brain  
13      injury and mental health and PTSD, and, as we've  
14      re-characterized it, psychological health, which  
15      sort of embodies not only the medical, but the  
16      pre-clinical and non-medical services that support  
17      psychological health.  We've made a series of  
18      accepted all nine -- well, 94 of 95  
19      recommendations coming out of the Mental Health  
20      Task Force, and we are actively engaged in  
21      implementing many of those as we speak.

22                   So they'll become a component of our

1 health system, but frankly, some of the new  
2 aspects of those programs were not under  
3 consideration by this task force, particularly  
4 those on the early intervention and prevention  
5 programs and the building of resilience in our  
6 service members and their families to address  
7 stressful situations, such as a war or financial  
8 difficulty or whatever.

9           So I do think that the Department is  
10 addressing this issue and expanding capacity, both  
11 in personnel and systems.

12           We will be implementing an electronic  
13 mental health record as part of our overall health  
14 system record, so it will be accessible to primary  
15 care providers. We are embedding mental health  
16 professionals in our primary care settings, and  
17 we're embedding them in our war fighting units;  
18 and we are engaging in significant amount of  
19 training and outreach to individuals about what it  
20 is to have psychological health and how to  
21 maintain that health in the same way that we  
22 adjusted for physical health and fitness.

1           So the impact that we'll have is we will  
2     have an infrastructure to address in the mental  
3     health realm anyway, and we also have similar  
4     initiatives going on in TBI, but I didn't talk  
5     about that.

6           So I think whatever the future of the  
7     military health system is going to be, it's going  
8     to be part of that infrastructure, and these new  
9     programs will have to be addressed as part of  
10    that.

11          So I don't think it will be an equity  
12    issue because this is focused on the total force,  
13    not only the service members, but their families.

14          DR. WALKER: It was also -- I served as  
15    the liaison between this four-year task force and  
16    the Dole- Shalala Presidential Commission that ran  
17    from March to the end of July. PTSD and TDI, its  
18    impact in active duty military and in the veterans  
19    population and the crossover in between and how to  
20    try to have that be better effect and more  
21    effective as a health care service was one of the  
22    six subcommittees of that presidential commission.

1 We were also aware that there was a task force  
2 specifically focused on mental health issues.

3 Our value added was not to be in those  
4 areas given the work that was done, but to attempt  
5 to look at what was a very large set of issues  
6 that we were asked to look at in terms of the  
7 congressional language. Now I don't think it's in  
8 any way a sense that more effective care and  
9 integration of mental health with the rest of  
10 health care is a question in our minds. But if  
11 we're going to try to focus on the 10 or 12 most  
12 important changes going forward, knowing the work  
13 that's been done during the course of the year, it  
14 wasn't clear what else we would say on that issue,  
15 particularly because our expertise was really  
16 designed to try to respond to the issues that were  
17 in our charge, and it is I think a very unusual  
18 mix of private sector, public sector non-  
19 military, and military across the service group  
20 that we have put together, but not particularly,  
21 starting with myself, expert in terms of mental  
22 health per se.

1           COL GIBSON: Just as a reminder to the  
2 Board, we have established a Behavioral Health  
3 External Advisory Subcommittee for the Department,  
4 as we all as a TBI, Traumatic Brain Injury  
5 subcommittee, so you will be hearing more about  
6 this and you folks will be part of that  
7 Department's solution to these problems.

8           DR. BLAZER: Just as a member of the  
9 Mental Health Task Force, just to make a couple of  
10 statements. I think we on the Task Force were  
11 very pleased with the initial response of the DoD  
12 to the recommendations that we've made. We also  
13 are very pleased with the response of Congress in  
14 fusing new monies.

15           There are concerns. This is not a small  
16 hill to climb that we'll climb this year. This is  
17 a long mountain that's going to take quite a while  
18 for us to traverse, and so the issues of sustained  
19 funding and sustained emphasis I think is going to  
20 be important.

21           I don't think now is the time to  
22 evaluate the DoD's response to the Mental Health

1 Task Force. I think it's going to take probably  
2 three to five years to see how things go.

3 But we do have a steep hill to climb on  
4 this, and I just feel like that we need to  
5 recognize that and keep that emphasis for a while.  
6 This is not a one-time thing.

7 DR. POLAND: Yes. Other comments?

8 RADM MATECZUM: In terms of the question  
9 of addressing parity separate from mental health  
10 and the benefits that are contained within the  
11 current structure, I was trying to think of an  
12 example of any time that a coverage has been  
13 reduced, and I couldn't think of any.

14 So the parity may change in proportion,  
15 but there -- the Congress has never reduced a  
16 benefit once it started, once it's in place.

17 DR. POLAND: Roudebush, did you have a  
18 comment?

19 LTG ROUDEBUSH: Actually, my comment was  
20 a question, and I would direct it back if I would  
21 be interested in your thoughts.

22 Do you see anything in this report that

1 would preclude the Department and the military  
2 health care system from being responsive to the  
3 inputs of this task force and others, which, you  
4 know, we anticipate will inform both deliberations  
5 and actions in the days, weeks, months, and years  
6 ahead?

7 So are you seeing something that takes  
8 you in a rather different direction from the work  
9 that the task force has provided?

10 DR. LUEPKER: No, I don't. I was  
11 looking for some reassurance that this was being  
12 integrated. Ms. Embrey provided that, and I'm  
13 comforted by the way this is going forward.

14 It again is a unique area that has more  
15 difficulties than some of the other health-related  
16 areas, and but needs to be integrated desperately.

17 DR. POLAND: Okay. Dr. Halperin, maybe  
18 one other comment and then if there are any  
19 comments from the public or audience, we'll take  
20 those.

21 DR. HALPERIN: Halperin, from the Board.  
22 It is very gratifying to hear the prominence of

1 wellness and prevention in the major focus of the  
2 report.

3           There has -- and also the idea of  
4 creating metrics, and it's also good to know about  
5 the implementation of the electronic medical  
6 record within the military.

7           But many of these things as far as are  
8 there going to mandated offers; are there going to  
9 be mandated benefits? Are people participating  
10 in? What's the rate of participation compared to  
11 other medical systems -- really does hover around  
12 the issue of data. And the source of the data is  
13 the electronic medical record.

14           So I'm wondering whether someone might  
15 want to comment about the issue of the focus on  
16 electronic medical records within the various pay  
17 orders, if you will, and various systems that are  
18 -- that are part of this -- these recommendations?

19           DR. WALKER: We did spend some time with  
20 -- in discussions with people from DoD about their  
21 progress in terms of the development of the system  
22 within DoD and across DoD and VA in terms of where

1       they were in being able to integrate information  
2       which is at the moment primarily outside of the  
3       hospital rather than inside in the ancillary care,  
4       but movement ahead in terms of the development of  
5       in- patient record with plans for how that will  
6       integrate with the VA system.

7                 One of the issues we did not  
8       specifically address, but since you've mentioned  
9       it, I will at least raise, is that there may well  
10      be for some time in the future difficulties in  
11      integrating purchased care and direct care so long  
12      as much of the outside purchased care is not using  
13      electronic medical records, and that is probably  
14      an issue too big for DoD per se to resolve,  
15      although hopefully other pressures and interests  
16      in trying to get electronic medical records and  
17      interoperability, and the private sector will help  
18      resolve that issue.

19                So we did -- this was not a specific  
20      focus, but we did get briefed on where the  
21      Department is and how it's progressing and, again,  
22      in the Dole-Shalala, we spent more time looking at

1       how each VA and DoD are moving forward. One of  
2       the concerns we had is as much as we want to have  
3       it pushed faster, it has taken so long to get it  
4       going as well as it is now. There's a lot of  
5       reluctance to change its course because it will  
6       ultimately delay the process even longer, so we're  
7       mindful of that.

8                     But it will be harder to get direct care  
9       or "downtown care." However, you want to  
10      categorize it, fully integrated, if they're not on  
11      the same information systems or at least  
12      interoperable information systems.

13                    DR. POLAND: We didn't have anybody sign  
14      up, but are there any audience questions or  
15      comments?

16                    BG FOX: Dr. Poland, I'm a subcommittee  
17      member and therefore did not have the opportunity  
18      to read this very detailed report, and I will do  
19      so in subsequent time following this.

20                    I would offer the same applause that  
21      everyone has in appreciation for the level of work  
22      and intensity that went into this and the

1 recommendations, and the thoughtful health board  
2 members who have articulated points back and  
3 forth. I would like to come back and illustrate  
4 perhaps a little bit that General Roudebush, if I  
5 might, sir, your comment about effectiveness,  
6 because it's in the understanding of effectiveness  
7 of the MSH and what is its purpose that I think we  
8 should perhaps put some exclamation points to the  
9 unparalleled and Herculean efforts that have been  
10 accomplished by the MSH given its primary mission  
11 for effectiveness to support a military at war and  
12 the defense of the nation. It is a fact that the  
13 disease and nonbattle injury rate is the lowest it  
14 has ever been in the history of conflict. It is  
15 also a fact that the battlefield life- saving  
16 capability of our military health system is the  
17 best it has ever been in history of conflict. It  
18 is also a fact that the military health system  
19 that exists today deployed multidisciplinary  
20 doctors, nurses, and medics to that battle space  
21 and have accomplished that mission in an echelon  
22 health care system that is unparalleled by

1 anything that human history has seen to date.

2 At the same time that the MHS system has  
3 maintained to my knowledge every hospital passing  
4 JACO standards, every hospital integrating in  
5 doctors and nurses who are from the civilian  
6 sector into a military infrastructure and health  
7 care system and yet providing quality. So while  
8 this panel has rightfully pointed out perhaps a  
9 roadmap as you suggest, Dr. Poland, for future  
10 reviews and critical reviews of efficiencies, I  
11 hope one does not lose the perspective that  
12 effectiveness of that system to deploy doctors and  
13 nurses and medical staff to not only deal with the  
14 complexities of the military environment  
15 themselves but be able to deliver the kind of  
16 quality of care that they have heretofore  
17 delivered to our soldiers, sailors, airmen and  
18 Marines in combat should not be lost. Tomorrow's  
19 battlefields will not be the same battlefields of  
20 today and we are compelled like all military  
21 infrastructure is compelled to look at the future,  
22 and the system has to be creative and allow that

1 future to be reviewed and assessed so that we can  
2 deploy the right kinds of medical teams to deal  
3 with the very flexible and agile battlefields of  
4 tomorrow and the very flexible and agile and  
5 growing capabilities are combat forces have to  
6 deliver combat power in austere places around the  
7 globe simultaneously.

8           That infrastructure has to exist and in  
9 that is effectiveness. It may not be the most  
10 efficient cost- effective system from the  
11 perspective of a civilian health care model which  
12 looks at maximum efficiency for the dollar. So I  
13 only offer that opinion and comment as one who has  
14 been a member of that distinguished system and  
15 very proud of it and one who has been equally  
16 blessed to be a member of a subcommittee who is  
17 very focused on taking care of soldiers, sailors,  
18 airmen, and Marines who have been wounded in  
19 combat. Thank you.

20           DR. WILENSKY: I hope, Dr. Fox, as you  
21 have a chance to read the report you will see we  
22 went to great pains to try to make exactly that

1 point, that when you look at what is provided by  
2 DOD in terms of military health care, you have to  
3 be very careful not to judge it by a real cost  
4 efficiency point of view because of the complex  
5 mission that it has in terms of being able both  
6 for the present and in the future to respond to  
7 the needs of the military present and retired. So  
8 hopefully when you see it you will say, yes, you  
9 made that point. If we didn't, we will all feel a  
10 little chagrin.

11 DR. POLAND: Let me say thank you for  
12 that comment too. It is why I consider it to be  
13 one of the crown jewels of DOD. Seeing no other  
14 respondents or comments, we are going to end the  
15 morning session of the Defense Health Board. I  
16 again want to thank Dr. Wilensky and the other  
17 members of the task force for your hard work and  
18 for coming to address the draft findings. The  
19 process from this point is prior to the board's  
20 next meeting, the task force will be  
21 disestablished but we will take the comments that  
22 we receive today, try to synthesize those into a

1 cover letter that will accompany the task force's  
2 final report.

3 I would also like as we close here to  
4 offer the task force committee members a token of  
5 appreciation and remembrance of your service on  
6 the task force with the Defense Health Board coin.  
7 I will give one of those to each of you as a thank  
8 you for the hard work that you have done.

9 One other thing before we close here is  
10 the CME form has gotten lost in somebody's stack  
11 of papers, and so we do need to find that. Lisa  
12 can take that. Colonel Gibson, do you want to  
13 make any other comments with regard to lunch?

14 COL GIBSON: The board subcommittee  
15 members and task force members will have a working  
16 administrative lunch in the break room and the  
17 liaison officers and other invited guests are  
18 welcome. We will reconvene at the appointed time.

19 DR. POLAND: Very good. 1:30.

20 COL GIBSON: 1:30. That's all I have.

21 (Whereupon, a luncheon recess was  
22 taken.)

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

2                   COL GIBSON: I was remiss at the end of  
3 the last session to not formally thank Colonel  
4 Christine Bader and her staff detailed to that  
5 Task Force on the Future of Military Health. They  
6 put in a tremendous amount of hours and that task  
7 force would not have been able to complete that  
8 project without them. So for the record, the  
9 Board and I thank them very much for their work.

10                  DR. POLAND: Our first speaker for this  
11 open session is Mr. Bill Carr, Deputy Under  
12 Secretary. He oversees recruiting, retention,  
13 compensation and related resource management for  
14 the 1.4 million active-duty military members of  
15 the U.S. armed services. Mr. Carr will update the  
16 board and discuss the disability evaluation system  
17 reengineering plan. As the members of the Board  
18 will recall, Mr. Carr briefed us at our last  
19 meeting. Since that time, a Board subcommittee  
20 has met with Secretary Cassells and Mr. Carr to  
21 discuss a number of matters related to how the DOD  
22 and VA are addressing the concerns outlined by the

1 Board's Independent Review Group and Mental Health  
2 Task Force as well as the Dole-Shalala Commission.  
3 Progress has been made in a number of areas, and  
4 Mr. Carr is here to update us. His slides I  
5 believe are in tab 3. Mr. Carr?

6 MR. CARR: I am Bill Carr. I am the  
7 Deputy Under Secretary for Military Personnel  
8 Policy. For this first slide, I will not be on  
9 this long. It simply says that in the course of  
10 looking at improvements to the Disability --  
11 System, that there was no shortage of advice from  
12 the various panels and commissions that assembled.  
13 There was enormous overlap in terms of the  
14 recommendations' commonality in terms of the  
15 recommendations that came from those commissions  
16 and the system that we have come up, and you be  
17 the judge and I would be delighted to take your  
18 comments, is one that the services seem pretty  
19 satisfied with that will make the system quicker,  
20 although quicker as was pointed out to us by the  
21 Army Surgeon General yesterday, is not necessarily  
22 anyone's objective because the Army more so than

1 the other services is interested in saving the  
2 career, rehabilitation, and I will report my own  
3 appraisal that the Marine Corps and the Air Force  
4 on the other hand if the career is not going to  
5 work out or rehabilitation is going to be  
6 protracted and the member is willing to separate  
7 than they normally would separate, so there is a  
8 little bit of difference among the services and  
9 the way they would approach.

10 But having said that, we set out to and  
11 we have apparently achieved in a small scale the  
12 capacity to proceed more quickly than has been the  
13 case in the past and also far more simply. This  
14 simply shows that there were a lot of things that  
15 informed us, and I've got only one slide and that  
16 is this slide.

17 If you look at the top, the essential  
18 changes are the ones shown with the Xes. I will  
19 describe the flow as it used to exist typically  
20 for someone with a broken leg at Fort Bragg, North  
21 Carolina. They would go to the emergency room  
22 with the broken leg. If it was a severely

1       compromised knee then the emergency room and their  
2       physician may refer them down the hall to the  
3       Medical Evaluation Board because it appeared their  
4       career was in trouble. At the Medical Evaluation  
5       Board they would develop the facts about that  
6       injury, they would ask the commander for his  
7       appraisal of the sergeant's capacity to do his  
8       job, and they would also query about whether or  
9       not the injury was incurred in the line of duty,  
10      all of which bears on the government's treatment  
11      and cognizance over that particular injury.

12                 They would then package that information  
13      together if it appeared that the member was going  
14      to be probably unfit, meaning they wouldn't meet  
15      retention medical standards that are laid out in  
16      detail in various policies. In this case, if the  
17      flexion in the knee were severely compromised,  
18      they probably would not meet retention medical  
19      standards. So Fort Bragg, Womack, would pack up  
20      the packet from Womack Hospital and sent it to the  
21      Army Physical Evaluation Board. There an informal  
22      board would be conducted. Let's look at the

1 papers. I see the knee. I know what the  
2 retention medical standards are and I know the  
3 person's capacity to do their job. From that I  
4 will render a decision about fit or unfit and then  
5 I will afford a rating. There is of course a  
6 Disability Manual. Proponency rests with the VA,  
7 but it is used by VA and DOD. It says, for  
8 example, if the flexion in the knee is less than X  
9 degrees, then you have a severely compromised knee  
10 and the disability is 30 percent. So the Physical  
11 Evaluation Board looks at it and says 30 percent  
12 and you are unfit, and because it was 30 percent I  
13 am medically retired. Had it been 20 or 10, I  
14 would have been given a severance payment instead  
15 of a retirement and separated from the service.

16 That is the process. So I leave DOD.  
17 But then I start all over again after that line  
18 that says separation and I walk across the street  
19 to VA, and this is the case today at Fort Bragg,  
20 and I submit a claim for the injuries that I have.  
21 It is not only knee. I will talk about my sleep  
22 apnea and my hypertension. The VA will then

1       conduct another physical exam. After they have  
2       done that, the VA will conduct another rating  
3       using the same manual. When that is all done,  
4       then VA would award a claim, and that is going to  
5       take 6 months minimum.

6                 In the case of an injury of this  
7       compromised knee at Fort Bragg, I have been  
8       treated at Fort Bragg. They have determined I am  
9       in trouble. They have sent it to the Physical  
10      Evaluation Board who has the authority to decide I  
11      am unfit and to award a rating. They did that. I  
12      went to VA and the whole process repeated itself.

13                What we have done for the National  
14      Capital Region, and we started on November 26th,  
15      and when we think it is working okay, that may be  
16      January, February, or March, whenever we are  
17      satisfied that the bugs are worked out, and it  
18      appears to be working pretty well so far, then we  
19      will begin to gradually extrapolate it worldwide.  
20      The way it will work is that we will eliminate DOD  
21      doing the rating because that will be done by VA  
22      in a means I will describe in just a minute, and I

1       won't have to submit a VA claim after leaving  
2       active duty. I will have already done that while  
3       I'm on active duty and VA then would give me the  
4       rating. Let me explain how that works, and now I  
5       am working from the picture on the bottom.

6                   I have had the injury and I have gone to  
7       the physician and the physician said that I'm in a  
8       bad way. I have then gone to the Physical  
9       Evaluation Board and they have looked at it and  
10      said you are probably not going to meet retention  
11      medical standards. Here is where the change  
12      starts. I will fill out a VA form listing all of  
13      my maladies and it will go to a VA certified  
14      physician who will conduct the physical exam using  
15      templates that the VA has long designed saying if  
16      it's hypertension, gather this evidence, if it's a  
17      bad elbow, gather that evidence. When all of that  
18      is completed by the VA certified physician, in the  
19      case of D.C. probably at the VA Hospital, although  
20      it may be the physician going over to Walter Reed  
21      to do it, those are logistical matters that do not  
22      matter, I have been to the Medical Evaluation

1 Board at Walter Reed, they have decided I am  
2 headed for trouble and they've sent me to get a  
3 physical exam. I now have that physical exam at  
4 the Medical Evaluation Board and I send it to the  
5 Army Physical Evaluation Board. Just as in the  
6 past, that board makes a decision as to whether or  
7 not I'm fit or unfit. Here is another change. If  
8 the decision is that I'm not fit, then it's sent  
9 to VA to do the rating and DOD will accept their  
10 rating unquestioned. Sometimes that leads to the  
11 question, I always heard that the VA rates a lot  
12 higher, and the answer is, not really. We found  
13 in a sample of 12 what one of the commissions  
14 found in a sample of 33,000 and just by sheer luck  
15 they were identical, and that was that there was  
16 an 8-point difference when looking at the same  
17 condition. So if DOD and VA look at the same knee  
18 or elbow or what have you, they will come up  
19 somewhat different, VA a little bit to the high  
20 side. Fine. Who knows what's right? Who knows  
21 whether it was a 30 or a 20 or a 40 or a 50? So  
22 we will simply accept VA's and we will action it

1 under law on DOD's side of the fence. Remember,  
2 DOD's side of the fence addressing only unfit  
3 conditions and so in this case if I had  
4 hypertension and a bad knee, it is the bad knee  
5 that prevents your continued service, not the  
6 hypertension, probably. That is treatable on oral  
7 meds and so forth and so it is certainly not a  
8 reason to be separated.

9 So I would leave for my bad knee 30  
10 percent disability medically retired, and then I  
11 would walk across the street to VA. Remember,  
12 they did the physical exam or at least it was done  
13 to their standards, they did the rating, and they  
14 already have me in their system. So when I walk  
15 across the street, within weeks, I'll say a month,  
16 the VA says less than a month, but sure faster  
17 than 5 months, then my VA payments will commence.  
18 So I have done fewer pushups in the system in  
19 terms of getting a physical exam and filling out  
20 documents and experiencing ratings and it is fully  
21 actionable, and it was a lot simpler for me.

22 That takes us through that turquoise

1 area and we are now over in the purple area. I  
2 went through this new experiment in D.C. I had a  
3 bad knee because of a motorcycle accident, it  
4 could have been something from the theater as  
5 well, but I will work on a Beltway motorcycle  
6 accident that compromised the knee, and I have  
7 been determined medically unfit. I have been  
8 rated by the VA at 30 percent. I have been  
9 informed now in a communication from the  
10 department that it is 30 percent disability and  
11 that I am unfit. I may quarrel with either of  
12 those facts. I might say I'm fit, in which case  
13 DOD takes care of that. Only the military  
14 services decide on fitness for the military.  
15 Clearly those are not problems of VA and couldn't  
16 be. But if it comes to the rating and I say you  
17 rated me at 30 and I believe it to be 50 because  
18 of my familiarity or someone has showed me the  
19 rating manual and I think it's 50, then VA will  
20 give one rebuttal opportunity, and it's a powerful  
21 one. While still on active duty you will, just as  
22 if it would have happened if it had occurred after

1     you were separated and you had a quarrel with VA,  
2     if I am on active duty and I have a quarrel with  
3     the rating, then there is a disability review  
4     officer from the VA. They are high-paid talent, a  
5     sharp group, they are very good at settling things  
6     authoritatively and usually are successful in  
7     remaining within the rules and so forth and good  
8     government. But in any event, that official will  
9     talk to me and that will decide whether or not the  
10    rating is 30 or 40. If that official looked at it  
11    and said I have looked at it, it's 40, DOD will  
12    take that and run with it. Fine. Forty. Then  
13    the person is retired at 40 percent disability.

14                 So the system is simple. But let's take  
15    one other complication and say I got through all  
16    of that. I am now 40 percent retired, but I said  
17    50 and I just don't think I really got justice.  
18    Then I would continue after I separate to go  
19    through VA appellate processes, appeals courts and  
20    so forth, and if one of those decided it was 50,  
21    then the case comes back to the secretary of the  
22    military department in what is frankly a fairly

1 straightforward administrative process called the  
2 Board for Correction of Military Records and I say  
3 here's the deal, here's my packet, there's my  
4 file. I got 30, then I got 40, I thought it  
5 should be 50, and look here, an appeals court  
6 agrees with me that it should be 50. The Board  
7 for Correction of Military Records says 50 it is,  
8 fixes your record, and it's done.

9 So we have got this from just about any  
10 angle in a straightforward, who's responsible,  
11 who's going to say yes or no, I want to talk to an  
12 empowered individual, kind of context. So that's  
13 what we have delivered for the National Capital  
14 Region and we'll be looking at whether or not we  
15 could proliferate it.

16 DR. POLAND: Bill, before you leave that  
17 point, is there a double-jeopardy process within  
18 that? Might that board say it's 20?

19 MR. CARR: As a technical matter, yes,  
20 they could do that. As a practical matter, it  
21 virtually never happens. And that is not my lane.  
22 That is a commentary, but that's the way I would

1 appraise it for you.

2 DR. MILLER: Two questions. First of  
3 all, does that delay the separation point?

4 MR. CARR: No. It accelerates it.

5 DR. MILLER: The separation is  
6 accelerated? It looks like your diagram, the old  
7 way puts separation early in the process rating  
8 and now it is later.

9 MR. CARR: Do you know what I didn't say  
10 that I wish I had said? The separation point is  
11 about the same. The time to the end of that arrow  
12 which involves both system times is cut about in  
13 half, but the separation point is about the same  
14 because most of the period that was invested prior  
15 to your separation was invested in diagnosis and  
16 treatment. The administrative part rarely is the  
17 long pole in the extent except to the extent that  
18 the member would like to protract it and sometimes  
19 they do, and that's okay if that's what satisfy  
20 them that they received due process, they ask to  
21 hold off while they consult with an attorney, then  
22 that's okay too. So I would say the separation, I

1 have no reason to believe it would be anything  
2 other than identical, but the total system time  
3 would be cut in half.

4 DR. MILLER: The other question, I hope  
5 I am not answering something you already said when  
6 I was out of the room answering a page, and that  
7 is has anyone looked at 70 people with the same  
8 injury in the VA and looked at the range of their  
9 ratings?

10 MR. CARR: They did. What I was told, I  
11 asked that question of Tom Pamperin, the Deputy  
12 Director of Compensation and Pension Services for  
13 the VA, and they do that as a matter of routine.  
14 There are something like 58 boards around the  
15 nation. So they evaluated them and there were a  
16 couple of outliers and I can't quantify it. He  
17 qualified it as saying I was amazed at how closely  
18 they overlaid. Again that is really a question of  
19 the VA and I am parroting what a knowledgeable VA  
20 colleague shared with me, but their assertion was  
21 that if you went across New Mexico, Arizona,  
22 Phoenix, and those various rating panels that VA

1 was very consistent with a few oddballs.

2 DR. MILLER: I must say I would like to  
3 see that data before betting the ranch.

4 MR. CARR: That is fair enough. That  
5 one will come probably from the VA, but I can  
6 gather that from Pamperin and pass that over to  
7 the board. That's perfectly legitimate.

8 CPT JOHNSTON: The VA's rating system,  
9 is it compartmentalized between the various  
10 conditions that a patient has?

11 MR. CARR: Let me see if I've got this.  
12 Let's say for example I have an orthopedic problem  
13 and a cardiovascular problem. It would go to one  
14 physician. He may employ specialty consults and  
15 so forth. But it all ends up in a package  
16 describing templates I talked about that would  
17 describe the cardiovascular and the orthopedic.  
18 And when they went to VA for a rating, it would  
19 just be a single rating panel comparing the  
20 medical conclusion which asks for certain  
21 empirical facts against a book as an  
22 administrative determination.

1           If there were medical question, then it  
2 would go back to a physician, but for the most  
3 part these templates force the physician to  
4 respond in ways that allow an administrator to  
5 cross and walk to the cookbook.

6           RADM SMITH: But there is a percentage  
7 given for each separate diagnosis, if that's your  
8 question, if they're compensable.

9           CPT JOHNSON: Yes, that was it. If  
10 you're looking at rating it is that's being used  
11 to discharge the person or separate the person,  
12 are you only taking into account the bits of it  
13 that are applied to the discharging condition?

14          RADM SMITH: That's correct. It is only  
15 the unfitting condition applies on the DOD side.

16          MR. CARR: Let's take for example there  
17 was a 30 percent orthopedic and a 20 percent  
18 cardiovascular. We know that the template cause  
19 the facts to compare to the cookbook and I decided  
20 30 and 20. Then what that means in terms of  
21 rating is I am 30 percent which subtracted from  
22 100 is 70, plus 70 times 20 percent, round up,

1 that's the way it's mathematically accomplished.

2 DR. POLAND: Dr. Halperin?

3 DR. HALPERIN: I am never quite sure I  
4 get this, so let me use this as an example. I  
5 think you know what I'm going to ask you. I have  
6 been in for 20 years and I have this horrendous  
7 accident or injury and I'm 50 percent disabled. I  
8 get 50 percent times 20 years times 2-1/2 per  
9 year, so I get 25 percent of my regular pay. If  
10 I've been in for 2 years and I'm 50 percent  
11 disabled, I get 50 percent times 2 years times  
12 2-1/2 percent, so I get 2-1/2 percent of my  
13 regular pay for being permanently disabled for the  
14 rest of my life?

15 MR. CARR: Yes. One of the provisions  
16 we have proposed to the Hill is there be a minimum  
17 attached to that, but, yes, that is correct.

18 DR. HALPERIN: The clearance of the  
19 impediments is really very good, but in many ways  
20 it's a short-term alleviation of the pain of going  
21 through the system. The long-term pain is I'm 50  
22 percent disabled, I'm 20 years old and I'm getting

1 2-1/2 percent.

2 MR. CARR: You are correct. For DOD  
3 that is the answer. But remember then I would go  
4 to VA and I would say to VA I am 70 percent  
5 because VA looked at this other stuff like cardio  
6 and VA says if you're 70 percent then you receive  
7 so many hundreds of dollars per month and that in  
8 the case of a retirement is additive.

9 DR. HALPERIN: If you don't mind if I  
10 follow-up on this a little bit, it is a very  
11 complex system and as a semi outsider it's -- but  
12 I thought if you were disabled, what the VA did  
13 was give you that amount of money tax free.

14 MR. CARR: They do.

15 DR. HALPERIN: They do?

16 MR. CARR: They do. That monthly  
17 stipend I was talking about, if I were let's say  
18 50 percent disabled, it's going to be something  
19 like, and this figure isn't going to rock you, but  
20 it's going to be about \$500 a month tax free.

21 DR. HALPERIN: Tax free. So a 50  
22 percent disabled person when you combine the DOD

1 pension and the VA pension would be getting about  
2 \$500 a month?

3 MR. CARR: I would have to do the math.  
4 It would be more. \$500 is the VA part, but added  
5 to that would be whatever pension I was drawing  
6 from DOD for my disability retirement.

7 DR. HALPERIN: Which could be 2-1/2  
8 percent.

9 MR. CARR: Right.

10 DR. HALPERIN: So it could be let's say  
11 \$550 a month for somebody who is 50 percent  
12 disabled?

13 MR. CARR: Yes.

14 DR. HALPERIN: I think that for us to  
15 fully understand this system, whenever I hear this  
16 and go through the math I kind of don't really  
17 believe that I'm really understanding it.

18 MR. CARR: For disability, we say 50  
19 percent and it can be tempting to say that means  
20 I'm half capable. I wish I could think of a good  
21 example of a 50 percent. It may be I think  
22 hysterectomy was roughly that. The VA if you look

1 at the bases for ratings, hemorrhoids, so there  
2 are some things that are less sympathetic in terms  
3 of capacity to earn a living. I am not talking  
4 about quality of life. That's a whole different  
5 ballgame. But with regard to capacity to earn a  
6 living, we could say 50 percent, but it doesn't  
7 mean half capable of earning. It can mean of  
8 course that your quality of life for hysterectomy,  
9 for example, would be affected, but when we say 50  
10 percent, please don't jump as I did years ago to  
11 the notion that it means you're half capable. The  
12 person could be considerably less sympathetic.

13 DR. POLAND: Maybe Bill what you were  
14 going to say is it might be nice for the board to  
15 see a couple of logical scenarios in order to  
16 appreciate how it really works.

17 DR. HALPERIN: Yes. I would appreciate  
18 it. Good idea.

19 DR. POLAND: It is hard for the board to  
20 understand. Dr. Shamoo, and then Dr. Leupker.

21 DR. SHAMOO: This is not a good analogy,  
22 so this is backwards from heaven forbid in a car

1 accident, the younger you are the more money you  
2 get, the older you are thinking gainful number of  
3 years is smaller. So if you are 70 years old and  
4 have a car accident the average lifespan is 77, so  
5 they pay you only for 7 years, whether it's 50  
6 percent or 20 percent, so it's backwards from  
7 liability.

8 MR. CARR: It is. There are actually  
9 words for this stuff.

10 DR. SHAMOO: Yes, I understand.

11 MR. CARR: I can't remember, but the  
12 lifetime earning part is short and the other one  
13 is something like -- but you're right, this is not  
14 the tort future earnings.

15 DR. SHAMOO: I understand. I  
16 understand. So a young man who volunteered to  
17 serve his country and he is truly 50 percent  
18 disabled, he will get less money than a 60 year  
19 old or a 66, my age who volunteered to serve his  
20 country, and we got hurt the same way, that poor  
21 young man will get way less than I would?

22 MR. CARR: It could be.

1 DR. SHAMOO: I have a second question.

2 MR. CARR: And we will cover that in the  
3 examples so that you can be the judge of that.

4 DR. SHAMOO: The separation point you  
5 have delineated here, do they get paid at the  
6 point of separation, and what do they get paid at  
7 the point of separation and what do they get paid  
8 after the disability has been determined? Could  
9 you tell me that? At the point of separation do  
10 they get money, a check?

11 MR. CARR: In the case that you are less  
12 than 30 percent disabled, remember, I said if you  
13 are 10 or 20 you get a severance pay lump sum,  
14 that is one answer, something like \$20,000. If on  
15 the other hand you're retired, then you don't get  
16 that lump sum, you begin an annuity stream.

17 DR. SHAMOO: At the point of separation?

18 MR. CARR: At the point of separation.

19 DR. SHAMOO: What do they get after they  
20 are declared disabled 50 percent after all the  
21 process after the separation? Do they get  
22 additional disability payments?

1           MR. CARR: Before they separate they  
2 will be categorized. So let's stipulate 50  
3 percent at the point of separation. Then in that  
4 case they would not receive a lump sum, they would  
5 begin an annuity stream. Then they would walk  
6 across to VA and they would begin an additional  
7 annuity stream.

8           DR. SHAMOO: After the disability has  
9 been determined?

10          MR. CARR: After.

11          DR. SHAMOO: After.

12          MR. CARR: Because the disability is the  
13 predicate for all of it.

14          DR. SHAMOO: Sure.

15          MR. CARR: In our example where we  
16 talked about a percent person who is separated,  
17 presumably we are talking about somebody medically  
18 separated.

19          DR. SHAMOO: But is there a way between  
20 the point of separation to the point of  
21 determination of disability that they get paid  
22 something as if they are disabled in order to

1       compensate for their loss of gainful employment  
2       and other things?

3               MR. CARR: I love the question, and that  
4       is going to come up at 3 o'clock. We've got a  
5       meeting with Secretary England and the Senior  
6       Oversight Council and one of the slides raises  
7       that point which we have raised from our office  
8       for a while, and that is the following. If you  
9       were to ask RAND or someone does the disability  
10      system work, then they will answer it by saying  
11      let's look at life stream earnings, and the answer  
12      is, yes, it works out. The disabled work fewer  
13      hours, but, yes, it works out. But they said  
14      lifetime earnings. It is absolutely indisputable  
15      that in the months immediately following  
16      separation you're in a whole because you will have  
17      moved from \$50,000 a year to \$500 a month while  
18      you're looking for a job.

19              DR. SHAMOO: That's right.

20              MR. CARR: At issue is is that  
21      satisfactory to the government or should it be  
22      satisfactory to the government. VA might not in

1 an appropriation context welcome that question,  
2 but it is one DOD asks out of interest and so  
3 forth, and I'm sure VA asks it of itself too. We  
4 unambiguously take somebody at \$50,000 or \$40,000  
5 and they move to \$400 a week until they find a  
6 job. Granted, we don't want in the case of a  
7 relatively moderate condition --

8 DR. SHAMOO: No, I understand that.

9 MR. CARR: But it sure is the case that  
10 you've got to come back from Germany, reintegrated  
11 yourself in some community, go look for a job. So  
12 in any event, that is coming up at 3 o'clock  
13 today. I can't answer the question, but I share  
14 precisely the point and the concern that you  
15 expressed.

16 DR. POLAND: I am going to ask Colonel  
17 Gibson to comment. Then Russ, did you have your  
18 hand up? And then Mike and Mark.

19 COL GIBSON: Just a quick question for  
20 clarification. This goes to concurrent receipt.  
21 What you are talking about here is a person who is  
22 let's say 22 years in service eligible to retire,

1 is medically retired. From what I am hearing from  
2 you, and I know that this is issue of combat, that  
3 person would get an annuity from the department  
4 and an annuity from --

5 MR. CARR: I was jumping to the Senate  
6 mark-up of the defense authorization. You are  
7 quite right. When the Senate passed concurrent  
8 receipt which means simply if you are getting  
9 money from the VA and you are getting money from  
10 DOD, keep them both because before that provision  
11 was enacted you could keep either, and you would  
12 always pick the VA amount because it was tax free.  
13 But if the MDAA proceeds as expected, then what  
14 are called Chapter 61 retirees, that means  
15 disability retirees, could benefit, would benefit,  
16 from concurrent receipt. So I answered it in that  
17 context.

18 COL GIBSON: That individual, if I  
19 understand the legislation and granted it is still  
20 in mark-ups at this point, correct?

21 MR. CARR: It's not in mark-ups. It has  
22 passed. The conference bill has been produced.

1 It's going back to both chambers. The likelihood  
2 of the Congress passing it approaches 100 percent.  
3 The promise of the president signing it I don't  
4 know, not for that reason, but for other reasons.

5 COL GIBSON: This does not have an  
6 impact on an individual who retires, goes to the  
7 VA, is found to be 40 percent disabled. That  
8 person in the way I read it is not eligible for  
9 concurrent receipt.

10 MR. CARR: That person is not a part of  
11 my presentation. They are not disability  
12 retirees.

13 COL GIBSON: And this would take away  
14 the issue of just strictly for combat medically  
15 retired, this would open it up for all folks who  
16 are DOD medically retired?

17 MR. CARR: I think we got too many  
18 questions collinear. With regard to a retiree,  
19 that's a longevity transaction, not disability,  
20 not medical. Granted, a retiree for longevity  
21 might pursue a claim with VA and they are welcome  
22 to. That's a separate matter which we could talk

1 about, but I'm not talking about it in this  
2 context. Then the second part of the question?

3 COL GIBSON: The question was that the  
4 legislation before made concurrent receipt  
5 possible for combat veterans, people who were  
6 disabled due to combat or training for combat.  
7 Will this new legislation open that up for  
8 noncombat medical disability?

9 MR. CARR: That I'm going to have to get  
10 back with you on. I frankly can't remember that  
11 aspect.

12 COL GIBSON: Thank you.

13 MR. CARR: Thank you.

14 DR. POLAND: Dr. Leupker?

15 DR. LEUPKER: When you were here a few  
16 months ago one of the questions that was raised  
17 was duration that it was taking to do this. It  
18 looks like it's been simplified, and I realize you  
19 are in pilot testing, but do you have any estimate  
20 what kind of dwell time you're likely to have if  
21 this all works as planned?

22 MR. CARR: There is an answer to that

1 and I will get back with you. What we had  
2 stipulated for the pilot is a threshold for each  
3 event. VA has 30 days to do this, and then for  
4 those metrics would then have a data plan proving  
5 it. That is knowable, answerable, and I will pass  
6 that back to the committee. It's going to be  
7 something on the order of 4 or 5 months, something  
8 like that. Most of that is spent again in medical  
9 procedures and so forth, not in administrative  
10 procedure.

11 DR. POLAND: Mike?

12 SPEAKER: I think Colonel Gibson  
13 approached this, but let me clarify it for myself  
14 a little bit. Is there a different between  
15 somebody whose knee injury occurred in combat  
16 versus somebody whose knee injury occurred when  
17 they were on leave and on their motorcycle?

18 MR. CARR: In terms of the military  
19 disability system, no.

20 SPEAKER: Thank you.

21 MR. CARR: There is I will comment for  
22 traumatic injuries, loss of a limb, loss of

1 vision, loss of hearing, for traumatic injuries  
2 there is a special lump-sum payment. That aside,  
3 the treatment is identical.

4 DR. BLAZER: And that has nothing to do  
5 with combat?

6 MR. CARR: You are right, that does not  
7 have anything to do with combat. Let me clarify  
8 that. The traumatic, if I lost a leg whether it  
9 be in a motorcycle accident or an IED, then I  
10 would receive that amount which brings me back to  
11 the first point, the simple answer is, no, there  
12 is not a difference.

13 DR. POLAND: I think it was Dr. Miller,  
14 Dr. Lednar, and there was one other. Then we  
15 will need to wrap up here to move on to the next  
16 one.

17 DR. MILLER: Is there any  
18 differentiation between this system and  
19 mental-health disorders, or are mental- health  
20 disorders also incorporated into this?

21 MR. CARR: It's incorporated in this.

22 DR. MILLER: Posttraumatic stress

1 disorders and others?

2 MR. CARR: The administrative handling  
3 of it becomes you are faced with when will PTSD be  
4 comfortably diagnosable. So what VA does is for a  
5 claim of PTSD knowing that it's going to take some  
6 time to answer that question, they start it at 50  
7 percent. So if I were to present with PTSD and it  
8 appeared reasonably that that could be medically  
9 possible, then VA will immediately start payments  
10 at 50 percent. I might subsequently be rated at  
11 30 or 70, but they will start immediately at 50  
12 because that is an ambiguous area, so they will  
13 give substantial benefit of the doubt to the  
14 affected veteran.

15 DR. MILLER: How about for a naturally  
16 occurring disease like multiple sclerosis, for  
17 example? How is that compensated for?

18 MR. CARR: If one were found unfit for a  
19 congenital disease, it falls under the same  
20 rating. There is a different rule for how long  
21 you have in service, frankly. So if I were with  
22 more than 8 years of service, then it would be as

1 if I just acquired it or any other injury that  
2 rated at 40 percent. If however I had fewer than  
3 8 years of service the MDAA seeks to make it 6  
4 months, then it would be until it does change if I  
5 had less than 8 years, then it is preexisting and  
6 it's not compensable. So again at the 8 year  
7 point, but that 8 year point is about the slide to  
8 the left to 6 months. So it's a practical matter.  
9 If it's when it's discovered then it would be as  
10 compensable as a broken knee.

11 DR. POLAND: Dr. Lednar and then Mike.

12 DR. LEDNAR: Would it be fair to say  
13 that a goal of this process change is to speed up  
14 the cycle time from beginning to decision?

15 MR. CARR: It is to speed it up, but  
16 it's to make it transparent and friendly just  
17 about as equal imperatives.

18 DR. LEDNAR: So simpler and more  
19 customer friendly?

20 MR. CARR: Simpler, friendlier, faster,  
21 all in about equal quantity.

22 DR. LEDNAR: Part of the reason I'm

1 asking is if there are steps that you can take out  
2 of the current system if the pilot works, should  
3 the board have confidence that someone else in the  
4 department is not going to try to cash those  
5 savings, shrink the staff, and end up basically in  
6 the same position we started with?

7 MR. CARR: There is never a guarantee  
8 except that we would say it is something for 10  
9 years, 12 years, the public conscience is going to  
10 be wounded on this one as is defense's for a good  
11 10 to 20 years. So could those savings be pulled  
12 off to a tank? I don't think so because first the  
13 administrative costs are not very great. The  
14 medical costs simply stay in medical. So I don't  
15 see how you can dent things very much as a  
16 programmatic possibility.

17 DR. LEDNAR: The clarity of the goal of  
18 the change and keeping that right up front?

19 MR. CARR: Yes, sir, you are right. It  
20 is not a money saver.

21 DR. LEDNAR: So the solution is judged  
22 against that.

1                   MR. CARR: Yes. In fact, a lot of times  
2                   that's a wrap that comes out in the media, let's  
3                   see if we can do personality disorders instead of  
4                   PTSD, a whole new area. We can go there if you  
5                   have a lot of time. But the notion being that we  
6                   are going to try and save some money, there is no  
7                   incentive like that. It doesn't exist. I have  
8                   never heard of it, never felt it, never sensed it.  
9                   Ask those in uniform if you're -- look, please  
10                  don't give them this diagnosis, we want to get  
11                  them out on the cheap, I have never met any  
12                  physician military or civilian that can tell me  
13                  any of that stuff exists in Earth. I don't know.  
14                  If it does, say it. But I don't sense it does.  
15                  So I don't think it is about saving money, never  
16                  was, never is.

17                         It is about faithful execution of what  
18                         can be a government rule that looks cheap to us.  
19                         So we might say for example I've looked at the  
20                         cookbook and it says you lose your leg, you're 10  
21                         percent. It doesn't say that. But that's a fair  
22                         hit because that's a systematic government

1 behavior. But to say that we would try to  
2 diagnose this way which by the way requires a  
3 psychiatrist or a Ph.D. or a psychologist and that  
4 they are in collusion with us to save a few bucks,  
5 it just can't happen.

6 DR. POLAND: Dr. Parkinson?

7 DR. PARKINSON: I recently reread Kafka.  
8 I just got to shake my head. We have been  
9 knocking at this for 46 minutes. People don't  
10 know how this works.

11 MR. CARR: Pardon me?

12 DR. PARKINSON: People don't know how  
13 this works. Have we missed the mark?

14 MR. CARR: I don't think so.

15 DR. PARKINSON: Let me just say this.  
16 The average American does not know the distinction  
17 between DOD and VA.

18 MR. CARR: Right.

19 DR. PARKINSON: They don't understand  
20 any of this. In any company in America, you get  
21 hurt on the job, off the job, there is some  
22 process to determine disability and to pay you

1 promptly or recourse to do it.

2 MR. CARR: Right.

3 DR. PARKINSON: That's what they know.

4 MR. CARR: Right.

5 DR. PARKINSON: Way upstream of this,  
6 and I just don't remember in the multiple reports  
7 we've seen, in the legislative agenda of DOD and  
8 VA is there a bill or something in place that  
9 would eliminate three-quarters of that slide?

10 MR. CARR: Yes. The president has  
11 proposed the Dole-Shalala Bill.

12 DR. PARKINSON: Where is that bill and  
13 what do we need?

14 MR. CARR: In the hands of the Congress.  
15 It wasn't adopted.

16 DR. PARKINSON: I appreciate you going  
17 to one slide, but there's another whole set of  
18 slides on the other side which is the VA system  
19 when they go into the DVA, that little box down  
20 there that says oops, hop to the next slide which  
21 is the DVA claims going over there now. You know,  
22 so I'd have hoped that because we're feeling

1       uncomfortable with the lingo that to the average  
2       citizen and the person of the military and their  
3       dependents, it's still (off mike).

4               MR. CARR: Right.

5               DR. PARKINSON: And so if we can maybe,  
6       Mr. Chairman, if we can have an update perhaps,  
7       Roger, on this status of legislation to take out  
8       the things that -- you're a good job, you have to  
9       execute the statute --

10              MR. CARR: Um-hmm.

11              DR. PARKINSON: -- but the statute needs  
12       to be changed so that as soon as I know that I'm  
13       disabled, I can no longer serve in the Air Force,  
14       wham. I can either have one or two things: If  
15       the law is going to continue to say, you're belong  
16       30 percent and you get a single check, great; or,  
17       if I'm above 30 percent, even if that's true, then  
18       you get a check from sustenance for the rest of  
19       your life.

20              MR. CARR: Right.

21              DR. PARKINSON: (off mike) pride, which  
22       is not to understand the grid, it's to change the

1 grid.

2 MR. CARR: Good. There is -- my answer  
3 is not complicated. You're right, the President  
4 proposed what Dole and Shalala suggested. What  
5 they suggested is simply this: DoD decides if  
6 you're unfit; and if you are, you immediately  
7 leave with an annuity. And VA hikes up the  
8 benefits. I can talk about how. That's what the  
9 President proposed.

10 By the time he proposed it, by the time  
11 Dole/Shalala finished their work, the House and  
12 the Senate had their ideas, and they chose not to  
13 go there, and I think there was some partisan  
14 considerations in there -- my opinion just as a  
15 taxpayer, not a public official. And so the  
16 Congress stayed with really the current framework,  
17 and they embellished a little bit and talked about  
18 workload management, but it didn't change the  
19 fundamentals, and the President's would have.

20 So if what were the legislation,  
21 Dole/Shalala, read the President's things,  
22 whitehouse.gov. It's very straightforward, and

1       it's very clear, it's no mystery. And the  
2       Congress chose not to do that. While anybody in  
3       the administration agrees with you, that is not  
4       what the Congress did.

5                 DR. POLAND: Roger -- Colonel Gibson,  
6       you wanted to ask a couple of questions?

7                 COL GIBSON: Yes, just a couple of  
8       technical questions. Where are the -- for this  
9       pilot, where are the VA physicals being done, at  
10      VA or in DoD facilities?

11                MR. CARR: I've got to ask Dr. Cassells  
12      or one of the health affairs colleagues. Karen,  
13      do you know?

14                LTC FAVRET: All that --

15                COL GIBSON: Use the mike.

16                MR. CARR: It varies. It's going to be  
17      by VA protocols, but HA, that's their line and  
18      they're still working that out, Health Care.

19                LTC FAVRET: But we decided for the --  
20      because you needed a VA certified provider to  
21      actually do these exams, the only ones in the area  
22      that we have right now are at the VA Medical

1 Center. So anybody who is capable of being  
2 transported -- I mean, we're not taking inpatient  
3 folks and bringing them down to the VA Medical  
4 Center, but they are able to schedule the exams at  
5 multiple providers in one day.

6 So we think it may shorten it because we  
7 have access to these certified examiners. At  
8 least here this may be false, but we at least get  
9 an idea that we can use the VA exam, and it is  
10 more equitable. That, to me, if you're going to  
11 take away something, each member will have an  
12 equitable exam. What we saw was different ones,  
13 and so the VA has the worksheets. The VA is going  
14 to do these at the Medical Center. They're going  
15 to do review of medical records for people who  
16 cannot be transported and give them their rating.

17 MR. CARR: Goods. And as Karen would  
18 say, well, that's the case for D.C., when we go to  
19 another little site, it's a whole new ball game,  
20 might be done at DoDMTF.

21 LTC FAVRET: We have --

22 MR. CARR: But for DoD for D.C. that's

1 the answer.

2 COL GIBSON: Very quick follow-on  
3 question. MEBs are making narrative sums up to  
4 make their decision on fit or not fit. Is that  
5 information being forwarded to VA, and is it part  
6 of their decision process?

7 MR. CARR: No.

8 LTC FAVRET: What is being boarded to  
9 the VA is the -- is a referral, which is pretty  
10 consistent with the normal narrative summary that  
11 most docs write.

12 Once the referral goes with all the  
13 conditions that the doc thinks, and a basic  
14 medical history and the complete medical record,  
15 the VA will have a copy of the complete medical  
16 record. Every member will get a general medical  
17 exam, and then whatever the claim conditions are,  
18 it's specified in --

19 MR. CARR: : Let's be clear about one  
20 term.

21 LTC FAVRET: And that --

22 MR. CARR: You used the term "narrative

1 summary." It has a distinct meaning.

2 LTC FAVRET: Right.

3 COL GIBSON: Purposely.

4 MR. CARR: It is that which happens at  
5 the end of the MEB.

6 LTC FAVRET: Right.

7 MR. CARR: Now, we don't know what  
8 should be in that summary until the physical,  
9 therefore your question is, does the "nar sum" go  
10 to the VA doctor? It cannot, because it has to be  
11 written after that.

12 LTC FAVRET: Right. So there's a  
13 terminology that we did site about initial Navy  
14 term of "nar sum" will be called a referral across  
15 the Services, and the narrative summary which will  
16 be the final evaluation of all the records, they  
17 may agree with the VA, they may not, but here's  
18 the provider, referring provider, to the MEB who  
19 will write the narrative summary.

20 COL GIBSON: I asked that narrative sum  
21 purposely, and thank you very much for the answer.

22 DR. POLAND: Okay, I'm going to end.

1 We're about a half hour over, but I think it  
2 reflects the importance of the issue.

3 Thanks again, Mr. Carr, you're very  
4 patient with our questions. The Board, obviously,  
5 remains very interested in how DoD and the VA are  
6 working to make the disability system more in line  
7 with the needs of our service member. Please  
8 engage with us in any area where you think we can  
9 help, and I'd also say that we'll plan on inviting  
10 you for yet another update at our April meeting,  
11 particularly to see if we can look at some of the  
12 scenarios of the legislative issues and any  
13 results of the pilot that might be available by  
14 then. So thank you very much.

15 Okay, the next part of our meeting will  
16 be on the Psychological Health External Advisory  
17 Committee Report. Our speaker will be Lt. Colonel  
18 James -- is it Favret? Favret. He will brief us  
19 on their information. You can look under tab 4  
20 for his information.

21 LTC FAVRET: Thank you and good  
22 afternoon. I would also, should like to just give

1 a -- rather than go through slide by slide -- to  
2 give a synopsis, if that would be preferable,  
3 given the time?

4 DR. POLAND: That's fine.

5 LTC FAVRET: Okay, very good. Just is  
6 102 -- this is an informational briefing. I've  
7 been working on the Red Cell, which is a team of  
8 folks put together to work Live Action 2, which is  
9 working traumatic brain injury and PGSD, which we  
10 extended out to the broader psychological health.  
11 And this briefing was just to inform you of two  
12 conferences that were held in the fall on some  
13 topics, specific topics that are recommended by  
14 the DoD Mental Health Task Force.

15 One was on women's psychological health  
16 needs and there was a recommendation from Task  
17 Force to do certain things with regard to  
18 addressing women's psychological health needs in  
19 DoD and VA. And the other was a recommendation  
20 from the Task Force that we look across DoD at  
21 imbedding psychological providers into operational  
22 units as a way to make our services more

1 accessible and to decrease stigma.

2           So real quickly, you can look at your  
3 slides. The COFT reports are included in your  
4 information. Both these conferences are brought  
5 together, subject matter experts, essentially with  
6 the women's psychological health issues. The  
7 thrust of the recommendations were that the DoD  
8 and the VA try to discern where are women's  
9 psychological health needs different than men?  
10 And, specifically, with combat trauma, with sexual  
11 assault trauma, with treatment, with surveillance,  
12 do we need to consider -- we do need to consider  
13 and look at how do we best serve women and where  
14 their needs and issues and concerns are different  
15 from men, and is there a better way to do it?

16           When we develop things such as the  
17 battle mind program that the Army put together to  
18 foster resilience in soldiers, are we including  
19 women in those scenarios to try to address their  
20 issues and needs?

21           There was also a portion of that  
22 conference that dealt with two issues where the

1 preponderance of victims are women, and that is  
2 domestic violence and sexual assault. A few years  
3 ago you may be aware that DoD offered restricted  
4 reporting to victims of sexual assault as a means  
5 to enable them to seek treatment and care without  
6 having to trigger an investigation. So further  
7 assessment and evaluation of how we're dealing  
8 with restrictive reporting, and how effective is  
9 it getting folks into treatment and care sooner,  
10 and having more victims get the help that they  
11 need?

12           The other area that I mentioned, it was  
13 a separate conference at looking at imbedding  
14 mental health providers into line units. And,  
15 essentially, what they found is that each of the  
16 Services have -- are doing this to a limited  
17 extent, and it seems to be effective. But each  
18 Service is different in how they're configured and  
19 how they deploy, so what the Conference tried to  
20 do is look at sort of the commonalities and the  
21 needs of, you know, how does it make sense to try  
22 to imbed mental health providers? How does it

1       make it work for commanders and for troops and so  
2       forth? And again, I would refer you to the  
3       conference report for specific recommendations and  
4       highlights from those conferences.

5                   And I will entertain any questions that  
6       you have. Sorry so brief, but I do want to try to  
7       get you heading back to getting on time, if  
8       possible.

9                   DR. POLAND: Questions or comments from  
10       the Board?

11                   DR. BLAZER: Dr. Blazer. Just one  
12       comment. If you do rev up the imbedding of  
13       individuals into combat forces, it seems to me  
14       that that's something that would lend itself very  
15       well to documenting what the effectiveness of that  
16       is. I just would hope that an effectiveness  
17       evaluation mode is put into that.

18                   LTC FAVRET: Yes, sir, thank you.

19                   COL GIBSON: This is Colonel Gibson. I  
20       would add again, we do -- we have stood up to  
21       subcommittees that are going to be working very  
22       closely with the Center of Excellence on doing

1 exactly the types of recommendations that Dr.  
2 Blazer has mentioned. We also have two members of  
3 that subcommittee sitting right beside me here, so  
4 --

5 LTC FAVRET: Thank you.

6 COL GIBSON: -- that's basically what I  
7 add at this time.

8 LTC FAVRET: Yeah, there's a strong push  
9 in the Mental Health Task Force recommendations  
10 for using evidence-based treatment, and I think  
11 with the Center of Excellence is going to help us  
12 so each Service isn't just going out doing  
13 whatever they think is going to work that,  
14 especially when it comes to assessment and  
15 treatment for psychological needs, we use things  
16 based on good research evidence.

17 DR. POLAND: Very good. Thank you very  
18 much.

19 LTC FAVRET: Thank you very much.

20 DR. POLAND: Just to let everybody know  
21 that I've approved the establishment of the Board  
22 Psychological Health External Advisory Committee,

1 and I understand from Colonel Gibson that  
2 candidates to serve on the subcommittee have been  
3 identified, and they'll be forwarded for  
4 nomination in the next few weeks.

5 Okay, our next speakers are Ms. Kathy  
6 Helmick and Ms. Hollman. They'll present  
7 information on the new subcommittee traumatic  
8 brain injury family caregivers panel, and  
9 information on their presentation is under tab 5.

10 MS. HELMICK: Thank you. Good afternoon  
11 to the Board. I wanted to give you a quick brief  
12 on a new initiative called the Traumatic Brain  
13 Injury Family Caregiver Panel. The creation of  
14 the TBI Family Caregiver Panel came about in  
15 December 2006 when Congress addressed the needs of  
16 current former armed service members and their  
17 families. They passed the National Defense  
18 Authorization Act which was an unfunded mandate  
19 given to MRMC up at Fort Detrick, and therefore  
20 given to the Defense and Veterans Brain Injury  
21 Center, DVBIC, whom I represent today.

22 This mandate was given to us in April

1 2007. Of note is that this congressional mandate  
2 originally went to uses and was transferred over  
3 due to DVBIC's expertise in the spring of 2007.  
4 The funding for this project came through in  
5 September 2007, and staff was hired to begin the  
6 project.

7           What does the law really say? It's an  
8 establishment of a 15-minute member panel, and  
9 this panel should develop a coordinated, uniform,  
10 consistent training curricula to be used in  
11 training family members in the provision of care  
12 and assistance of members and former members of  
13 the Armed Forces with traumatic brain injury. So  
14 this was Congress' response to allow family  
15 members to get clear criteria and guidance to help  
16 support them as patients go through the recovery  
17 trajectory.

18           The law stipulates that these 15  
19 panelist members should come from certain  
20 categories, and some of these have listed below  
21 medical professionals that specialize in traumatic  
22 brain injury as well as combat PBI, including

1 psychologists with expertise in the mental health  
2 arena. Family caregivers and representatives of  
3 family caregivers or Family Caregivers  
4 Associations, DoD and DVA, health and medical  
5 personnel with expertise, as well as experts in  
6 training criteria -- training curriculum.  
7 Finally, family members of members of the Armed  
8 Forces.

9           The panel members are appointed after  
10 receiving the DoD and White House approval.  
11 Certain tasks of this panel group are to review  
12 the literature and evidence for curricula content.  
13 They'll develop consistent curricula for TBI  
14 caregiver education and recommend dissemination  
15 modalities throughout the DoD and VA. So,  
16 basically, this panel will assemble, give guidance  
17 for development of curricula, and also give  
18 guidance in terms of how this curricula can be  
19 disseminated to get to the stakeholders, which are  
20 families and patients.

21           The panel selection. How this came  
22 about was that panel nominees which we forwarded

1 to you all were selected via the following  
2 methods. We have established the DVBIC network  
3 within the TBI field. DVBIC has been around for  
4 15 years and we have a long established  
5 collaboration with many federal and civilian  
6 agencies.

7 The panelists were also selected based  
8 on the guidelines that I just outlined in the law,  
9 at least those five sectors that were represented,  
10 as well as geographical representation. We  
11 prepared the slate of panel nominees that included  
12 ex officio members, expert consultants and  
13 contingency members. The nominee slate was  
14 forwarded for review on 26 October, and currently  
15 the nomination package is at Health Affairs' front  
16 office for SIC.

17 There are two scheduled panelist  
18 meetings that are planned. The first one's coming  
19 right up within a month 9-10-January, 2008, in  
20 Silver Spring. This will be the coordinated  
21 meeting to get the work started as well as to  
22 discuss the curricula contents.

1           The second meeting is anticipated during  
2 your board meeting in April out at Washington  
3 state, and that meeting is slated to present to  
4 you at that time the pilot curricula. So about  
5 four months to get this curricula planned and be  
6 ready to be disseminated.

7           DVBIC's role at this project is to  
8 provide programmatic and logistical support to  
9 ensure that the development of the criteria is  
10 along with congressional language as well as the  
11 content validity and accuracy, and then a very  
12 important implementation phase so we get the  
13 product out there. Part of the implementation  
14 will be evaluation of the curricula and to see  
15 what needs to be tweaked, to see what needs to be  
16 added so that it compliments the caregiver  
17 experience after traumatic brain injury.

18           The education, the ongoing effort of  
19 this family education panel and further education  
20 directives will be through the DoD Center of  
21 Excellence for Psychological Health and Traumatic  
22 Brain Injury.

1           Currently, activity as we're gearing up  
2           to the panel meeting in about four weeks, work is  
3           being done to identify health education writers  
4           and editors as well as research organizations that  
5           specialize in qualitative focus-group type  
6           research, family care organizations with curricula  
7           experience. And we are in the throes of the  
8           logistical work that it takes to assemble folks  
9           from around the country to get together and begin  
10          their group work.

11           The benefits of a consistent curricula  
12          is exactly that: It provides consistent constant  
13          message. The curricula also gives tools for  
14          coping and gaining acceptance and assistance as  
15          well as giving hope on navigating life  
16          posttraumatic brain injury. The curriculum will  
17          be informative and accurate, provide  
18          self-management skills, be user friendly and  
19          culturally appropriate.

20                    Questions?

21                    DR. POLAND: Colonel Gibson?

22                    COL GIBSON: I have a few comments to

1 add to this that will help clarify for the board  
2 members what does this have to do with us.

3 If you look carefully at the slide of  
4 the members that Congress said had to be on this  
5 panel, there are nonfederal folks on there. That,  
6 by definition, makes it a federal advisory  
7 committee. We went, after discussing this with  
8 Dr. Poland, we went to the DoD lawyers and said,  
9 Can we make this a subcommittee of the Defense  
10 Health Board as a panel?

11 After due deliberation, the lawyers came  
12 back and said, yes, we can, similar to what we did  
13 with mental health and the past, present, and  
14 future military health care, and the IRG. This is  
15 a subcommittee of the Defense Health Board as soon  
16 as Dr. Poland says it can be. DoD says and wants  
17 it to be. It's up to Dr. Poland as the president  
18 of the Board to say, Yes, that's okay.

19 What we have done is through DVBIC come  
20 up with the nominees, the candidates for  
21 nomination. Dr. Cassells is the only one who can  
22 nominate, formally nominate to the Secretary of

1 Defense those panel members where that package is  
2 forwarded to him for his signature, and we are  
3 hoping desperately to have everything signed out  
4 and these members appointed for this January  
5 meeting so they can go to work.

6 Final piece to this is once this panel  
7 delivers that set of recommendations, and,  
8 hopefully, that'll be in April, we will then turn  
9 over the oversight of that execution, including  
10 pilot tests, et cetera, to the TBI External  
11 Advisory Committee for long-term follow up.

12 As you all know, there's no such thing  
13 as a final curricula. They are iterative  
14 products, and it's going to have to have care and  
15 feeding for a long, long time.

16 DR. POLAND: Thank you, Roger, for that  
17 introduction and, obviously, I've agreed to the  
18 creation of it. But awful, I think, important for  
19 the Board and others to understand that  
20 increasingly we'll be doing business this way,  
21 given the breadth and the depth to which each of  
22 these panels and subcommittees will have to go,

1 and we'll begin to function more as the Defense  
2 Science Board, for example, functions in a very  
3 similar way.

4           So any comments or questions about this?  
5 I'll just make one, and I think you answered it  
6 when you talked about DVBIC. And it harkens back  
7 to Dr. Blazer's question of valuation of the  
8 effectiveness in this case of the curricula. And  
9 I think I heard you say that they'll actually be  
10 responsible for that aspect of it, and it will  
11 occur.

12           MS. HELMICK: That's correct, and that  
13 will occur of the focus groups using qualitative  
14 research techniques to evaluate the curricula and  
15 make recommendations for edits.

16           DR. POLAND: Dr. Lednar?

17           DR. CLEMENTS: I guess a question I have  
18 about the curricula and its goals, if the goal of  
19 the curricula is to convey information that helps  
20 caregivers of service member and the PBI  
21 understand, that sort of sounds like an  
22 informational goal.

1           If the goal of the curricula is to help  
2           the PBI service member and their family, it feels  
3           like there would be different activities involved.  
4           Well, there's a tool kit to know that you need  
5           this, that, and some other resource. If you live  
6           in a remote area, you have no transportation, and,  
7           by the way. your family cash flow is \$35 per week,  
8           how is this going to help?

9           So I guess when it comes to evaluating  
10          the curricula, it seems very important to say what  
11          is the goal and evaluate to that. But I hope that  
12          in the end this will be something that brings a  
13          level of understanding, perhaps in a separate  
14          pilot, to caregivers, and I mean health care  
15          providers to community members, others around not  
16          just the family who lives with this every day and  
17          probably has quite a large and deep understanding  
18          of what it means PBI.

19          MS. HELMICK: I think it's important to  
20          note that the stakeholders are all over the  
21          country, so we do have to remember our guard  
22          reserve, everybody that are in rural- type areas,

1 underserved areas, and connect them via this  
2 curricula, be looking at the clinical services  
3 needed to facilitate recovery as well as those  
4 supportive services, the nontangible clinical  
5 services that look at supporting family, community  
6 resources, vet centers, those other types of  
7 things that can help with caregiver fatigue and  
8 compassion fatigue as well.

9           So making sure that we understand all  
10 the stakeholders in this endeavor is going to be  
11 extremely important.

12           DR. CLEMENTS: Just a short follow-up  
13 question, and then there would be some other  
14 evaluation, see if the care for the TBI patient  
15 and caregivers is, you know, are utilizing these  
16 various resources and this is being helpful.

17           MS. HELMICK: Yes. The evaluation piece  
18 can be twofold: one is to ensure that is there a  
19 difference in the care, the type of outcomes that  
20 we have from severe and penetrating TBI patients  
21 now in 2007 prior to any type of home curricula.  
22 So you can compare it that way and as well as to

1 make sure that it's effective for the care -- for  
2 the family members.

3 DR. POLAND: Wayne, I think, too, at  
4 least the first part of your question will  
5 actually be under the purview of the TBI External  
6 Advisory Committee and not so much this one.

7 Other comments? Dr. Parkinson?

8 DR. PARKINSON: Yeah, it -- first, I  
9 think it's a great effort, obviously. What  
10 concerns me a little bit, and I hope just in terms  
11 of our advisory capacity here, that the term TBI,  
12 as we know from a clinical, pathological,  
13 definitional challenge, there's a spectrum in  
14 there and that, as you go forward, clearly people  
15 who represent certain types of flavors of TBI  
16 versus other might need different type of  
17 services. So knowing which type of support to  
18 provide in one instance versus another is going to  
19 be important, and that'll, you know, spread it out  
20 with enough granularity that you're able to do  
21 that. And I'm sure you will.

22 My second thing gets really to Wayne. I

1 mean, as a veteran of building and funding many  
2 curriculum development in the federal government,  
3 as you know, it's rife to go nowhere fast unless  
4 you very clearly articulate it -- and it was great  
5 the way you said it -- is that what's the skill  
6 set I want out of the other end of this thing, and  
7 how do I initiate those skills, and how do I  
8 sustain those skills?

9           And what we're learning about behavior  
10 change, because this is really about initiation  
11 and sustaining new and fatiguing behaviors on the  
12 family caregiver, is you need support. You need  
13 coaches, you need peers, you need virtual, you  
14 need electronics, so I would urge the group to  
15 look very early on if not it defines the  
16 objective, the creation of meaningful peer-to-peer  
17 support so that you use it in advance of going  
18 back to wherever you people live with their loved  
19 one, so that you already have it in place: You  
20 know the people, you know how to log onto the web,  
21 you know community chat rooms, you know expert  
22 counsel.

1           I mean, it's all available. There are  
2 private sector vendors who are building these out  
3 today in such areas as prevention and wellness,  
4 disease management, stress, and look right now at  
5 what is best to be practices in the civilian  
6 sector similar to our first panel who talked about  
7 we're not doing enough in the civilian sector  
8 about creating communities of support because  
9 whatever you learn in the curriculum will not be  
10 sustained unless you build in that community  
11 support, and kind of said it, but I just wanted to  
12 put an exclamation point behind it, because that's  
13 going to be very important, and at least some of  
14 us will be looking for that coming forward when we  
15 meet in April. I think it will be important.

16           MS. HELMICK: Thank you.

17           DR. POLAND: Okay, thank you very much.  
18 We're going to take a 15- minute break, and we'll  
19 reconvene at 3 o'clock. Just so you have an  
20 accurate agenda here, we'll talk about emergency  
21 blood transfusions, and then Colonel Hachey will  
22 talk about pandemic influenza. So we're going to

1 take the last part of tomorrow and move it to the  
2 last part of today.

3 (Recess)

4 DR. POLAND: We're running about 20, 25  
5 minutes behind, so I want to keep us moving.

6 Our next speaker is our own Dr. David  
7 Walker from the Department of Pathology,  
8 University of Texas, Medical Branch, Galveston.  
9 Dr. Walker is the Chair of the Board's  
10 subcommittee addressing the question regarding  
11 emergency blood transfusions in the combat  
12 environment. And Dr. Walker will lead discussions  
13 on the subcommittee's findings and  
14 recommendations. His slides are under tab 6.

15 David.

16 SPEAKER: Hold on just a second. Turn  
17 on his mike.

18 DR. WALKER: So one of the questions  
19 besides the use of whole blood was the impact of  
20 this practice on the policies now for HIV testing.  
21 And so the 5FOE of combat operations have resulted  
22 in instances of blood collection under emergency

1 protocol and transfusion without complete  
2 FDA-approved testing. That is, the aligning up  
3 donors taking the blood and using it without being  
4 able to test them for HIV, HCV, and hepatitis B.

5           And so we were asked to review the  
6 issues associated with the collection and  
7 transfusion of the blood products under emergency  
8 conditions in a combat environment and to provide  
9 comments and recommendations regarding optimal  
10 strategies to minimize risks to the recipients.

11           So most of the transfusions that are  
12 given in Iraq and Afghanistan and theater come  
13 through a single blood trans-shipment center, and  
14 the center is the control point providing the  
15 blood and blood products in the area of  
16 responsibility, and they really have a pretty good  
17 coverage of being able to get the blood there  
18 twice a week of over 1,000 units. And it only  
19 meets their routine needs, but there have been --  
20 I'm going to give you some more information about  
21 the number of times that they were given the  
22 transfusions. There's more up-to-date data.

1           But under the emergency conditions, they  
2           are sometimes being given with HIV test, this  
3           rapid test, but it's not FDA-approved for blood  
4           donation. And some donors are prescreened, that  
5           is to say the blood samples of their blood is sent  
6           to the United States for testing before blood  
7           products are given, so the serum can tell them  
8           whether they've got hepatitis C or HIV in some  
9           instances but not most of the time.

10           So this is a picture of the order of  
11           magnitude. This is a number of whole bloods, that  
12           is blood collected fresh and transfused there in  
13           Iraq and Afghanistan. And you can see that it  
14           ramped up and peaked in 2006, although this year  
15           isn't over, and this year it could well go above  
16           last year.

17           And this is the number of patients, so  
18           what we're talking about, usually here is the  
19           setting of massive transfusion, which is defined  
20           as ten or more units over a period of 24 hours.  
21           And so you've got a lot of blood going into a few  
22           hundred patients. So when service members come in

1       because the public law and the Department of  
2       Defense requirement, they really -- they have  
3       their blood drawn, their serum drawn, and there  
4       was no testing required but most of them really  
5       are tested for HIV. And the sample is collected  
6       within any year of deployment by regulation. So  
7       they're routinely tested, and I think that's about  
8       Ira Howar recommendations every two years, but not  
9       -- routinely tested for HIV, but not tested for  
10      hepatitis C.

11                 They are screened for hepatitis B virus,  
12      immune status, and immunized when they come in, so  
13      hepatitis B really should not be a problem.

14                 So there are two scenarios where  
15      emergency whole blood transfusions occur. One of  
16      the mass casualty events where local blood and  
17      blood products supply is exhausted and the state  
18      of the art that most people practice is that if  
19      you've got a massive transfusion need, you use  
20      (off mike) red blood cells, fresh frozen plasma,  
21      and that's the ones in which the factored are  
22      still at high enough level that they're not below

1 the level that you need for coagulation. And you  
2 would like to also give platelets, but getting  
3 platelets is a problem in the field because of the  
4 distance of transport and from the time it's  
5 collected.

6 So the other setting -- so that one, you  
7 know, you can imagine there's not much you can do  
8 about that. There's no blood, and so you have to  
9 draw it and use it or the patient dies.

10 The others are situations of mass severe  
11 trauma in which people are getting large number of  
12 transfusions, and the surgeon believes kind of  
13 almost on a mystical basis that fresh whole blood  
14 is better, that the patients are going to do  
15 better. And there's really not strong evidence to  
16 support that this enhances survival.

17 So the dilemma is that the Department of  
18 Defense has got to provide a safe blood supply,  
19 and there are going to be situations in which  
20 safe, absolutely safe is not attainable, and so  
21 while we can reduce the risks and that's our  
22 charge, we may never be able to get to completely

1 safe.

2           And we've got to provide the best care  
3 to the soldiers for this often incredibly severe  
4 trauma. And, historically, the military and  
5 wartime has given ups opportunities to learn new  
6 things about how to take care of wounds and to  
7 make things that actually translates into civilian  
8 -- better care of civilians as well.

9           A problem that we wrestle with, and I  
10 don't have the knowledge to deal with this --  
11 hopefully, as a group we can come up with the  
12 right answers -- is that it's hard to collect data  
13 under the situation in which you're doing  
14 something in an emergency setting, all you can as  
15 fast as you can, and trying to keep up. And, of  
16 course, that would be the way progress would  
17 really be made would be scientifically to have  
18 the data and be able to analyze it. And we  
19 believe that we really ought to have valid  
20 evidence of benefit before subjecting patients to  
21 untested blood products risks.

22           So there are our tentative

1 recommendations, and they're certainly open to  
2 discussion and change, strengthening or  
3 modification. We recommend that we should limit  
4 emergency blood transfusion protocols, instances  
5 such as mass casualty events where the available  
6 FDA-licensed blood and blood products are  
7 exhausted.

8           And we also recommend that predeployment  
9 hepatitis C virus testing should be done to reduce  
10 the risk of blood transfusion-related infections,  
11 so the persons will know whether their hepatitis C  
12 virus infected or not and pose a risk if they  
13 donate the blood. And this will reduce hepatitis  
14 C risk in emergency transfusion cases, but we have  
15 to think a about the further implications of this  
16 and that it can actually cause the loss of some  
17 soldiers who may not have been in the Service long  
18 enough to where they can be, actually, dismissed  
19 from the Service because they've only between in  
20 six months or less. And this is found to exist.  
21 And there are other second and third order  
22 implications which those of you who understand and

1 know these can bring them up, and we can discuss  
2 as we consider the recommendation of this  
3 hepatitis C virus testing.

4 We also recommend that we review the  
5 current area of responsibility there in Iraq and  
6 Afghanistan of the blood supply logistic system.  
7 We believe that a more agile system is required  
8 that's able to meet mass casualty event needs.  
9 And we have stated that we wish to further  
10 investigate establishing blood collection and  
11 processing capability forward in the theater.

12 As a person who practices medicine in a  
13 resource-limited location, limited by state amount  
14 of funding, we have to decide what we're going to  
15 do and not do all the time. And although it's  
16 going to cost \$10 million to set up a blood  
17 processing center, I was quite willing to (off  
18 mike) we can't do it. But luckily, we had some  
19 people there who understand what we're really  
20 doing is giving advice to the Department of  
21 Defense, and I think that's probably not the best  
22 advice. Thankfully, John Clements pointed that

1 out to us in a teleconference, and we may want to  
2 further strengthen that recommendation.

3 We also should review the current HIV  
4 interval and predeployment testing policy. The  
5 AFED had recommended every two years based on the  
6 assumption that there would be rare use of a  
7 walking blood bank; but that assumption is really  
8 not valid now, and so we need to consider what to  
9 do. And I would recommend predeployment testing  
10 of all of the blood, testing of all these soldiers  
11 yearly.

12 We also recommend that we repeat the  
13 Department of Defense hepatitis C virus sero  
14 incidence study. This is a study that shows not  
15 only that there is a low prevalence of infection  
16 with hepatitis C virus in the military but the  
17 incidence, that is, the number of new cases that  
18 occur over each one-year period is very low. And,  
19 but it's been a while since that was performed,  
20 and -- I think it was 2001, so it's been about six  
21 years, seven years -- and so we recommend that  
22 that be repeated to find out exactly what's the

1 situation now.

2 We also believe that the Department of  
3 Defense should partner with industry to develop  
4 new FDA-licensed rapid testing. It's a lot of  
5 money put into research. This is something that  
6 we should really try to push to see that it  
7 happens. HIV rapid test with acceptable  
8 sensitivity and specificity exists for FDA -- for  
9 testing patients for diagnosis, but not approved  
10 for blood collection. So there is one that might  
11 be evaluated.

12 And then the development of rapid  
13 hepatitis C, hepatitis B testing is needed. And I  
14 think this is something that's going to really  
15 turn out to be needed, for example, in a domestic  
16 mass casualty event where you don't have time to  
17 collect a lot of blood, send it off, get it tested  
18 and 24/48 hours later get the answers back as to  
19 whether the blood is safe or not.

20 We also recommend that that  
21 comprehensive look-back program so that those  
22 patients who have received transfusions that turn

1 out after the blood is sent to -- the donor sero  
2 is sent to the United States and it's found to be  
3 infected to find out what happens to the  
4 recipient. Did they become infected or not?

5 So just to reiterate that we believe  
6 that the use of untested fresh whole blood and  
7 blood products outside the established human  
8 subjects protected trauma protocol should be  
9 discontinued. It would be good if this novel  
10 trauma treatment approach could be evaluated under  
11 human subjects approved protocol even in a combat  
12 environment and perhaps a joint theater trauma  
13 team could lead the effort to improve data  
14 collection and evidence for these methods,  
15 particularly relating to the use of fresh whole  
16 blood and platelets.

17 So that's the end of our tentative  
18 presentation. We've got a draft of  
19 recommendations, but they're stated pretty clearly  
20 here, and I think we'll take your advice before we  
21 come back to you with a final --

22 DR. POLAND: Thank you, David, that was

1 a very nice look at this issue. Dr. Shamoo, you  
2 had question, and then Dr. Parkinson.

3 DR. SHAMOO: I don't have a question, I  
4 have a clarification, David. When blood is  
5 exhausted, we inherently said it's okay, the blood  
6 supply is exhausted. But the recommendation is we  
7 have to abandon it completely, which I think is  
8 inconsistent with the consensus we reached, that  
9 is, you're right when the blood is exhausted -- I  
10 mean not exhausted, is available. However what we  
11 commended which was a little different, and that  
12 is we suggest that even when the blood supply is  
13 exhausted that they do these, if possible, if  
14 humanly possible, under an approved protocol, so  
15 we could collect the data, see if there is  
16 evidence.

17 So I think that this is slightly  
18 different than the way the slide shows, that's  
19 all.

20 DR. WALKER: You're right. I agree.

21 DR. POLAND: Dr. Parkinson?

22 DR. PARKINSON: Thank you, David. It

1 would help me clarify in my mind of -- and again  
2 not being in the theater and not being a surgeon,  
3 and those are both variables -- other physicians,  
4 because ultimately the surgeon is there and  
5 responsible -- of the 5,000 instances that we're  
6 roughly aware of, do we have even a qualitative  
7 estimate of what proportion fits into what I would  
8 define as three buckets. In other words, are we  
9 answering the right question?

10 The first is, what proportion of the  
11 5,000 was due to the fact that it was a true  
12 shortage of blood products, to Dr. Shamoo's first  
13 point?

14 The second proportion is, what  
15 proportion of the 5,000 was due to the logistical  
16 administrative challenges? Even if I had the  
17 products, is there a value seen in the rapidity  
18 with which you can administer that vice whole  
19 blood. So, a) I don't have it at all; b) I've got  
20 the components or whatever the things I'd like to  
21 do, you know, so that's another instance that I  
22 could essentially see of the 5,000.

1                   And the third is kind of the surgeon  
2           sense of when I just have a gut feeling that whole  
3           blood's going to be better. So if we could parse  
4           those three out, then I think we can get into  
5           whether it's the randomized controlled trial of  
6           whole blood right on the spot versus everything  
7           else, which is the third category versus the  
8           second, which is just -- it's just kind of clunky  
9           to having to do the components, and I've got  
10          somebody with multiple trauma, you know, multiple  
11          limb injuries where it's just not there.

12                   So is there any, in your analysis as you  
13          looked at this, was there any way to break out  
14          those 5,000 instances into some typology like  
15          that?

16                   DR. WALKER: There was a lot of them  
17          given in Baghdad. A lot of these transfusions  
18          were given in Baghdad, and so that doesn't mean  
19          for sure that they have run out of blood, but it's  
20          much less likely that they would have run out of  
21          blood than when it was done in a more remote  
22          location.

1                   So I think a good proportion of these  
2                   are the surgeon's belief that the blood is better.

3                   DR. PARKINSON:  And if I can follow-up  
4                   on that, have we got any opportunity to get -- and  
5                   this almost sounds like an oxymoron -- a focus  
6                   group of surgeons together to discuss this issue  
7                   in gathering data, which is somewhat qualitative  
8                   but, in other words, say why do we feel this way,  
9                   guys?  I mean -- or gals or whatever.  I don't  
10                  know.

11                  SPEAKER:  We did that.

12                  DR. WALKER:  I got my E.R. director and  
13                  sat him down and talked to him about it, and he  
14                  had heard these presentations by these people, and  
15                  he was not convinced.  And he's one of those real  
16                  cut-and-slash guys.  I mean I think he could have  
17                  gone either way.  but he was -- he did not believe  
18                  that the data supported -- it was just  
19                  hand-waving.

20                  What were your other questions?  You  
21                  were asking --

22                  COL GIBSON:  The focus group exists, a

1 joint theater trauma team. They're the ones  
2 who've been advocates for this approach. They  
3 have, taking their data which is spotty, as you  
4 could full attest, you know, try to do this in a  
5 combat environment, and, as Dr. Walker says,  
6 they've presented it in various forum. And they  
7 -- the trauma surgeon community is not yet  
8 convinced that this is the right way to do.

9 We're not saying, as you know, that  
10 combat casualties has led to major paradigm shifts  
11 in trauma care across the United States,  
12 historically, for years and years and years. What  
13 I'm saying, this isn't, you know, the right way to  
14 go; it's just that there's not enough evidence  
15 yet, and we need to collect the data correctly so  
16 they can validate it.

17 DR. POLAND: Dr. Oxman?

18 DR. OXMAN: Two questions. First of  
19 all, if you had predeployment data, are we  
20 convinced that it would be available when in a  
21 urgent situation volunteers were asked to give  
22 blood? In other words, would it be available,

1 would the data be available, reliably in the field  
2 if we knew somebody was HCV-positive before they  
3 were deployed?

4 COL GIBSON: I was the one who was  
5 supposed to talk about third -- second and third  
6 order of facts of these data collections. That's  
7 part of it.

8 If we do this very close to deployment,  
9 given the sensitivity specificity of the available  
10 tests and all the other information, it's very  
11 likely that we're going to be calling people back  
12 that are already in Iraq to find out -- to get  
13 them retested to find out what their test results  
14 were because there's still some question on those  
15 data, on the -- with respect to that test.

16 We have to have a system in place to  
17 notify that individual of his status so that he  
18 doesn't come forward to donate. We have to have  
19 some sort of logistics system to make that data  
20 available in theater in case they do come forward.

21 We have to consider the second order of  
22 facts of what happens according to the study that

1 we did on sero incidents and prevalence of HCV in  
2 the military community back in 2001. And, Bob,  
3 correct me if I'm wrong, if something like 80  
4 percent of those folks who are positive are over  
5 30 years of age, you've got a cohort issue here to  
6 deal with that would impact the reserve community  
7 in greater -- to a greater extent than the typical  
8 active-duty community. What does that do to their  
9 military retention? I'm not sure, but it's very  
10 -- it's possible that they may not be able to  
11 remain on reserve status with an HCV- positive  
12 test. I'm not sure.

13 Certainly, the young airmen -- or,  
14 excuse me -- young soldier who's in that EPTS  
15 window, who is identified as HCV-positive is  
16 disqualified for military service.

17 SPEAKER: He is.

18 DR. OXMAN: The other half of that, if  
19 it were decided to do it, the DoD already has  
20 superb, rapid turnaround PCR, which is the, you  
21 know, done right is more sensitive than the  
22 serologic tests for HCV, and certainly at least as

1 sensitive for done right for HIV. And that could  
2 be utilized routinely predeployment.

3 SPEAKER: Right.

4 COL McRAE: This is Colonel McRae,  
5 Internal Medicine consultant of the Army. Just to  
6 complete the thought about the study that was  
7 published in 2001, actually it was based on data  
8 on service members who were on active duty or in  
9 the Reserves in 1997. And that data suggested  
10 that of the cases 85 percent would actually be age  
11 35 and older, and that's what led to the policy,  
12 DoD's policy not to do forthright screening but to  
13 offer screening to service members age 35 and  
14 older who were separating from the Service.

15 Just thinking about the implications, if  
16 those prevalences hold true today, it would -- and  
17 again you sense the age group skews a little bit  
18 older in the Reserve components, it would have a  
19 little bit more impact on the Reserves. But we  
20 were thinking you're talking age 35 and older,  
21 those are your senior NCOs and officers that would  
22 be predominantly affected, 85 percent of them.

1                   Now, whether that's true 10 years later  
2           I don't know, but I don't have any reason to think  
3           it would be that much different, but who knows? I  
4           mean, the study does need to be repeated.

5                   But thinking through the implications of  
6           this screening, it's interesting because I think  
7           this would be the only screening program that we  
8           would do if we were to do it. That would actually  
9           not be done to protect the individual but his  
10          potential implications to transmit it, and so  
11          there's some personal implications to the, you  
12          know, what do we do with that soldier? You would  
13          need a workup.

14                   Right now, hepatitis C positivity, per  
15          se, is not -- it does not preclude you from  
16          staying on active duty, and we don't screen  
17          soldiers for hepatitis C upon accession. It's not  
18          an accession requirement. So one would think that  
19          one might, you know, think about starting a  
20          program of HCV screening that would mimic or  
21          parallel the HIV program. That would make -- that  
22          would have some appeal to that since we've trod

1 the ground. But again, I think that the  
2 philosophy would be a little but different than  
3 the HIV program in the sense that it's done to  
4 protect the individual as much as it is to  
5 protect those who might come in contact with it.

6 COL GARDNER: A couple of questions. Is  
7 there any policy that, when urgent transfusion is  
8 done in the field that the blood is retro- --  
9 samples retrospectively saved, or not ret -- saved  
10 for subsequent testing, and what have we found of  
11 that?

12 DR. WALKER: Yeah, the blood is -- the  
13 blood is sent back to the United States and  
14 tested.

15 COL GARDNER: And have they found --

16 DR. WALKER: They have found that they  
17 transfused HIV-positive blood on at least one  
18 occasion, and hepatitis C-infected blood on about  
19 six occasions. It doesn't have to be only  
20 transfusion, I mean it is actually transmissions.

21 COL GARDNER: If that were done rapidly  
22 -- if that were done rapidly, it seems to me you

1       could treat almost the HIV like a needle stick or  
2       hepatitis B with immunoglobulin.  There's some  
3       things you would do acutely, therapeutically, for  
4       a recipient of blood that received either of  
5       those, so I think that -- that should become a  
6       policy part of the protocol that a rapidly -- a  
7       rapid assessment be done on all the blood that is  
8       given in the field.

9               I can't imagine, it seems to me we have  
10       to be sure, as sure as we can, that this blood is  
11       free of HIV, hep B, and hep C.  And so it seems to  
12       me a policy needs to be established.  I would hope  
13       that everybody who goes to the field would be  
14       willing to volunteer to be a donor under certain  
15       circumstances.  And that, if they're going to be  
16       on the volunteer list, they would get a -- they  
17       would get their blood tested before they were  
18       allowed to actually transfuse acutely.  That might  
19       be a way out, but I think that's the only policy I  
20       can look at that would really stand up under the  
21       glare of scrutiny.

22               COL GIBSON:  Let me add to that.  If all

1 of them are volunteers, then you've effectively  
2 put in a policy for HCV and HIV testing. We  
3 looked at one of the concepts of this whole thing  
4 was, can you establish a cohort, a smaller cohort  
5 of volunteers? The problem is small units,  
6 geographically separated, moving around, when you  
7 need it -- they may not need in location where  
8 you can use them.

9 SPEAKER: It's not so --

10 COL GARDNER: I thought maybe you could  
11 clarify for me, Roger, I thought you said that if  
12 an accession for someone to have the hep C  
13 positive in the first few months, they were not  
14 allowed to join the Service. But didn't I hear  
15 over here that -- I thought I heard something  
16 different over here.

17 COL GIBSON: But we do not test for  
18 hepatitis C or hepatitis in general as part of  
19 entrance into the military; however, if an  
20 individual has hepatitis within the six months of  
21 active duty, then that individual has to be -- it  
22 is conceived that he had hepatitis before -- it

1       existed prior to service, and then he's  
2       disqualified from serving.

3                The rub comes in, the Catch 22 comes in  
4       in the fact that we do blood collection. A lot of  
5       our blood is collected that we use in various  
6       locations at our basic training centers. They're  
7       encouraged to donate blood. They get about, oh,  
8       what, two or three hours off of downtime. They  
9       get cookies and orange juice, so they go over and  
10      they donate, and then they find out that they're  
11      hepatitis C positive, and --

12               COL GARDNER: You're screwed.

13               COL GIBSON: -- you know, two weeks  
14      later they're out of the military.

15               COL GARDNER: But they don't get the  
16      choice with HIV, right?

17               DR. McNEILL: No, that's right.

18               COL GIBSON: I'm sorry, say again?

19               COL GARDNER: For HIV it happens  
20      automatically.

21               COL GIBSON: HIV is a disqualifying --

22               COL GARDNER: And for hep B, I thought.

1 It's a --

2 COL GIBSON: Hepatitis B is not a  
3 disqualifying factor. We deal --

4 COL GARDNER: Even if --

5 COL GIBSON: -- screening and immunized  
6 for hepatitis B at training centers.

7 COL GARDNER: What if someone is  
8 actually antigen, E-antigen positive for hepatitis  
9 E?

10 DR. OXMAN: It would be H-bag positive.  
11 H-bag. Hepatitis B antigen- positive.

12 COL GARDNER: Yeah.

13 COL GIBSON: So if he's hepatitis B  
14 antigen-positive, I believe -- I'd have to  
15 doublecheck -- but I believe that he's then  
16 disqualified for Service.

17 COL GARDNER: No, I don't think so.

18 COL GIBSON: So what we're testing for,  
19 though, is antibodies. We don't test for antigen.  
20 And we immunize based on antibodies.

21 SPEAKER: Surface antibodies.

22 COL GIBSON: Surface antibodies.

1                   DR. POLAND: Screening not for infection  
2 but for the presence of immunity to know whether  
3 to give vaccine.

4                   Okay, Dr. Clements, and then there's  
5 some others after that.

6                   DR. CLEMENTS: Dr. Clements. So we're  
7 really dealing with kind of multiple issues here,  
8 and you've got the blood supply that comes in  
9 twice a week from Qatar, that's safe. That's  
10 fully screened. That goes into the level 3 trauma  
11 units. It goes into Baghdad, it goes into Balad.  
12 You got the level 2 trauma units, the level 2  
13 units out, and your battalion aid stations, they  
14 don't have -- they have some blood on hand that's  
15 been screened, but in a mass casualty they're  
16 going to go through that very, very quickly. And  
17 then, so they may have to turn around and start  
18 bleeding the troops in order to get that.

19                   But the troops that are back at level 3  
20 are the troops that give -- evacuated back to  
21 level 3 units, there's usually blood back there.  
22 And when there's not blood back there, then

1 sometimes they've actually set up their own little  
2 walking blood supply so they have volunteers. So  
3 in case of a mass casualty event, then they know  
4 who they can bleed, and they can process it.

5 The problem is that that blood is not  
6 screened for infectious diseases either. They  
7 take samples of that, and they send that back to  
8 CONVUS, and it may or may not be screened, or if  
9 it is, it's going to be screened after the fact,  
10 and that information may never catch up with the  
11 individual that got the transfusion.

12 So one of our recommendations was  
13 actually to establish a regular blood center in  
14 theater. You could put that in Balad, you could  
15 put that in Baghdad, and at least when you have a  
16 local blood supply, you'd have access to all of  
17 the FDA-approved processes and procedures that  
18 would ensure that.

19 And also, speaking as an old Marine  
20 supply officer, I'll tell you that the closer you  
21 are to the pointy end of the spear with your  
22 logistics, the better off you are, so that you

1       have a real possibility, then, because if you had  
2       pack cells and whole frozen, fresh material on  
3       hand in Balad or on hand in Baghdad, you're only  
4       30 minutes to 45 minutes away from a level 2  
5       station. So you can do something to effect that  
6       supply if those are a presence in theater.

7                 So one of our recommendations is to  
8       establish a blood center in theater, and that was  
9       the comment that David made earlier. My  
10       recommendation was, though, that we change the  
11       language, because the languages we have at right  
12       analysis further investigate establishing a blood  
13       collection and processing capability forward. I  
14       would take out the further investigate and must  
15       make the recommendation that we establish a center  
16       forward.

17                And the question came up, well, won't  
18       that cost \$10 million. and my response was, "I  
19       don't care."

20                DR. WALKER: I would agree with that.  
21       I'd like to point out one more reason why it's  
22       important. It's the platelets. It's the ability

1 to do platelet phoresis and process tests and have  
2 safe platelets.

3 I think the problem we have -- I can't  
4 imagine they have enough platelets there to do  
5 what they need to do now.

6 DR. POLAND: Dr. Oxman and then Dr.  
7 Shamoo.

8 DR. OXMAN: I think it's important in  
9 talking about a new principle that you would be  
10 screening for HCV to protect someone else. There  
11 has been rapid evolution in the treatment of HCV,  
12 and you have the same reasons for screening  
13 somebody for HCV as you do for HIV.

14 SPEAKER: Um-hmm.

15 DR. OXMAN: In other words, there are  
16 appropriate therapies that would improve survival,  
17 long-term survival of those individuals. So I  
18 don't think that's an issue.

19 DR. POLAND: Dr. Shamoo?

20 DR. SHAMOO: Just one more additional  
21 information. My understanding, David, of the data  
22 of what number of HIV and HCV they had was

1 haphazard. This is not the accurate numbers, one  
2 and six. This is -- some of them turn out to be  
3 one this way and six another way. So you don't  
4 have the data at true percentage, or the number of  
5 people with infection. Isn't that -- that was my  
6 understanding, Colonel Rogers.

7 COL GIBSON: The -- because we in some  
8 cases, is this blood has been given without  
9 identification of --

10 DR. SHAMOO: That's right.

11 COL GIBSON: So those numbers are  
12 incomplete.

13 DR. SHAMOO: That's correct.

14 COL GIBSON: Those are the ones we now  
15 about. Market -- or surprisingly, though, if you  
16 take the, particularly with HIV, you take the  
17 probability predictions based on what we know  
18 about HIV infections among, actually, deployed  
19 folks. It comes out to about the same number.

20 DR. SHAMOO: That's okay, yeah, but  
21 that's different. Wait, I have an additional  
22 comment, and that is trauma surgeons, not all of

1       them are unanimous. But the blood, whole blood,  
2       is the best approach. So there is even that kind  
3       of data we have to be aware of.

4                 DR. POLAND: Pierce, did you have a  
5       comment?

6                 COL GARDNER: I was just going to say we  
7       have to take into the possibility that the surgeon  
8       might be right and that -- and so the protocol  
9       should certainly involve a way to settle this  
10      issue as best we can. A lot of times surgeons  
11      have ideas that they don't subject to real  
12      science, but it turns out to be their hunch is  
13      better.

14                So we don't know. We don't know the  
15      answer, but this ought to allow us, if we organize  
16      it right, to settle it.

17                DR. POLAND: I realize the numbers are  
18      much different, but I wonder if either our  
19      Canadian or maybe -- did we lose our U.K. liaison?  
20      -- what their policies are.

21                CDR SLAVIN-WHITE: I'd have to check to  
22      be certain, but one, we don't have HIV testing or

1 HCV testing as a basic point. So for joining our  
2 military or on any basis in regular terms, we're  
3 not testing for HIV or HCV.

4 Now, in theater, we have worked with our  
5 Canadian blood service, and in Canada we don't  
6 have a military blood service, per se. It's all  
7 nation-led, and the problems of Quebec has its own  
8 blood service. And we have worked at establishing  
9 blood testing and blood collection in theater and  
10 I just -- I don't know all of those specifics, but  
11 we did work on having small pools, as you were  
12 mentioning, small pools of voluntary donors who  
13 would agree to testing before deployment, and then  
14 again the specifics of the testing in theater, I'd  
15 have to get back to you on.

16 But that was our approach, and just as a  
17 second aside, our trauma surgeons at a recent  
18 conference were speaking rather positively, but  
19 again anecdotally, on the fact that in several  
20 cases they thought that the fresh whole blood may  
21 have been lifesaving in one or two massively  
22 injured casualties. And they probably would not

1 want to be precluded from making a decision on use  
2 of whole blood even if it were not screened to  
3 regular Canadian standards, if they believed that  
4 it might be lifesaving.

5           And the presence -- very last point --  
6 the presence of HIV positivity in a serving member  
7 is not a reason for exclusion or loss of time in  
8 the military. You may serve, but, of course, we'd  
9 apply some restrictions and limitations. But we  
10 tend to look at some of these conditions as  
11 chronic conditions, and if a trained person can  
12 continue to serve for five years, eight years what  
13 have you, and still serve the country well, it  
14 would not be automatically disqualifying.

15           So there's some cultural and specific --

16           DR. POLAND: Let's -- we have a surgeon  
17 that is waiting to speak, so --

18           DR. WADE: My name's Dave Wade, and I am  
19 a surgeon, at least I used to be. And just I  
20 gathered from hearing the comments, it sounded  
21 like pathologists in preventive medicine  
22 specialists are sort of heavily represented in

1       this crowd, and I would echo what the commander  
2       just said, that when you talk to the surgical  
3       community. they're not necessarily 100 percent  
4       unanimous, but they're pretty warm on the fact  
5       that this whole blood transfusion has something to  
6       it.

7                   And so I would encourage you to try to,  
8       as party deliberations, to reach out. I know  
9       Roger and we are working on some things to try to  
10      get (off mike) subcommittee involved in that sort  
11      of activity. But there are folks that are  
12      involved in that. And when you read some of these  
13      papers in the surgical literature as to who's who  
14      of American surgery for trauma, that's the authors  
15      on these papers. So you need to take that a  
16      little bit, you know, in your calculus of how you  
17      make these decisions.

18                   DR. POLAND: And yet still, I mean  
19      caution. It is a fruitless endeavor to assign  
20      particularly good predictive powers to anybody.  
21      And just look at last week's JAMA, and counter to  
22      everybody's intuition antibacterials are not

1 helpful in acute sinusitis, for example.

2           So you really have to do these things  
3 until you know -- I don't have a problem with  
4 somebody exam- -- you know, trying different  
5 things and examining the data, but it has to be  
6 done to the extent possible under conditions that  
7 allow you to make a reasoned decision.

8           We've still got a lot of hands up. The  
9 two Mikes, and then back over to David.

10           DR. OXMAN: Just a point. If the risk  
11 in massive trauma in the field of acquiring HIV is  
12 one in a thousand, there are many other corners  
13 that are cut that are necessary for survival which  
14 greatly increase bacterial infections. And I  
15 think if you're really looking at this, you've got  
16 to look at the cost benefit analysis as a whole,  
17 and it may be that the corner- cutting on  
18 transfusions, if it's that low an incidence of  
19 infection, that may be very unimportant relative  
20 to many other necessary corner-cuts that reduce  
21 long-term survival.

22           So before making the big issue of that,

1 I think you really have to look at it in a broader  
2 perspective.

3 DR. PARKINSON: I want to come back to  
4 Bob Dufrates. Whenever I think I know something,  
5 I listen -- I really do listen to Colonel  
6 Dufrates, and he generally puts thing in a way  
7 that I think it would be a landmark mistake for us  
8 to concurrently institute anything related to HCV  
9 screening which has -- violates as best I could  
10 tell -- some of the core principles of screening  
11 in that there's little or no benefit of persons  
12 screened, and a theoretical benefit at best.

13 I mean, if the person is actively in a  
14 case of hepatitis is one thing. And then you  
15 treat them with globulins and other types of  
16 things, and even then the course is like, yeah.  
17 But to find the average is HCV positive at any age  
18 on the theoretical notion that at some time  
19 they'll be in theater, even in predeployment  
20 because that person might come up and be one in  
21 the 6,000 that comes up and we're not really quite  
22 sure whether or not it's better given, you know,

1 one-on-one case studies that people feel it's  
2 better, the energy to this Board should be devoted  
3 to getting the study done and helping -- wrapping  
4 our warm arms around the surgeons and saying, What  
5 would it take to get this study done?

6 The good news is that -- the bad  
7 news/good news is that the level of trauma that  
8 we've seen allows -- let's hope it doesn't occur  
9 at the rate it has, but if it does, we've got a  
10 rapid accumulation of cases, and if we could  
11 really apply ourselves as systematically to the  
12 issue of collecting the data and designing a good  
13 enough study, let's help them.

14 So that the more I think this through is  
15 concurrently instituting HCVD screening before  
16 we've absolutely put 95 percent of our efforts into  
17 doing the study in theater to randomize sites, to  
18 randomize cases, to go on with trauma scores and  
19 do it right, even to the point of putting in an  
20 infield blood bank for \$10 million, let's take  
21 whatever resources we have and (off mike) the  
22 Board to help to find the issue.

1                   This is the essence of where the  
2                   military excels in the unique environment. But  
3                   we've got to commit to that in a prioritized  
4                   fashion, not a concurrent fashion. And the ethics  
5                   of screening around this -- and again I don't want  
6                   to use the "epic" word lightly, but I got to dig  
7                   up my four principles of a good screening program  
8                   and I'm not sure this meets it, globally, even if  
9                   we say the military's a little different and  
10                  wartime is different, particularly when we could  
11                  devote our resources perhaps strategically to help  
12                  the real issue, is what you mentioned earlier,  
13                  Greg.

14                  DR. POLAND: David and then Mark.

15                  DR. WALKER: Yeah, I got three, three  
16                  points. One, Dr. Oxman, I think the government  
17                  defense has a policy of not using non-FDA-approved  
18                  products, and transfusion of blood that was not  
19                  properly tested would not be FDA-approved product.

20                  In emergency situation in which there  
21                  was no other blood available, of course, that  
22                  would be waived.

1                   And, Mike, I think that I agree with  
2                   you, and I point out that if we establish a blood  
3                   processing center point blank in theater, then you  
4                   don't need to do the HCV screening on everybody.  
5                   I mean, it's -- the idea of doing both of those is  
6                   unnecessary. If we decide to recommend and have  
7                   the ability to test the blood in theater, then we  
8                   won't need to screen for HCV.

9                   And I wanted to ask the question about  
10                  the screening of some donors for hepatitis C prior  
11                  to their NHIV prior to their being used as donors.  
12                  Is that blood sent back to the United States and  
13                  tested by an FDA-approved method, because I know  
14                  there have been rapid testing using some kits that  
15                  were bought from a European source that's not FDA-  
16                  approved for testing for hepatitis C virum and  
17                  hepatitis B virus, that were woefully insensitive.  
18                  I think the positive predictive value was about 20  
19                  percent.

20                  CDR SCHWARTZ: I will need to get back  
21                  to you on that to be certain, but I do know that  
22                  we developed our blood-testing in concert to meet

1 Canadian blood services standards. But I'll see  
2 if I can get that information before we close  
3 tomorrow. If not, I'll relay that back.

4 DR. POLAND: Neil?

5 MR. NATO: Yes, thanks. Neil Nato,  
6 Bureau of Medicine and Surgery. The issue is  
7 actually very, as we've all heard, very  
8 complicated. And so I've had a lot of -- actually  
9 the chip and pig (?) has had a lot of discussions  
10 with the Armed Forces blood program personnel.  
11 And so, you know, I think it would be good if we  
12 all talked with the subcommittee on this issue  
13 before these recommendations come out, because  
14 there are several issues.

15 In regards to -- I mean, from my  
16 perspective I think the HIV strategy right now is  
17 fine because our incidence is very low. And  
18 although it's not approved for screen of blood,  
19 the rapid HIV test is being used, and so that's at  
20 the point of transfusion for these whole blood  
21 transfusions, so that helps out a lot in that  
22 regards.

1                   And then also, I mean just the  
2                   population in the military is heavily screened  
3                   because, you know, we do screen for drugs and  
4                   other things, and people who misbehave who have  
5                   those risk factors are also administratively  
6                   separated from the military.

7                   So I would agree that the HIV testing  
8                   scheme is fine as it now, and then based on the  
9                   data, I think maybe one HIV blood-tainted unit may  
10                  be so. But I think the key thing is basically the  
11                  look-back program. I mean, I think it should be  
12                  treated as a like a meal stick.

13                  And, unfortunately, that's where things  
14                  break down, so if you're using this whole blood,  
15                  you know, you should screen it, and then you  
16                  should, you know, capture and send it back, and  
17                  you could -- although again it's not FDA-approved  
18                  test for this purpose but again the more quick is  
19                  very good, and you could test then, and get the  
20                  answer and then decide if you want to give HIV  
21                  prophylaxis. And then the other ones, the  
22                  incidence I think is low enough, based on a

1 current procedures that I wouldn't be for testing  
2 the HCD or H -- or hepatitis B before they go on  
3 deployment to SANCAL.

4 COL CLARK: Colonel Stan Clark, Army  
5 Surgeon General's Office. I just wanted to make a  
6 couple comments on reference to look-back. There  
7 has been an aggressive initiative to go back and  
8 identify and inform the individuals who may have  
9 received a non-FDA approved unit of blood which  
10 was collected in theater, and they've been very  
11 successful at finding those individuals. And then  
12 there is a set FDA protocol that testing at 036 12  
13 months out, various tests that may be transmitted  
14 through an infected unit, whatever that disease  
15 agent may be.

16 But also, I just wanted to point out,  
17 and I'm going to point out, probably, what's  
18 obvious, but I just want to remind people that you  
19 will never drive this risk to zero with  
20 predeployment testing. The only way to really  
21 drive it as close to zero as you can is to test  
22 the unit of blood with some sort of

1 highly-effective test at the moment you're drawing  
2 the blood from the donor.

3           You could -- you know, you could test me  
4 today. I could have risky behavior tonight, I  
5 could deploy tomorrow and donate a unit of blood,  
6 and someone else would get infected. And that  
7 certainly can apply where we're sending thousands  
8 of soldiers back and forth every year, every  
9 month, and that same sort of situation would  
10 apply. And, oh, by the way, they do go over  
11 there, and then they come back for R&R halfway  
12 through, and who knows what happens during their  
13 R&R period, their rest and recuperation when they  
14 come back to visit.

15           So, you know, without totally  
16 controlling what they do, it's going to be  
17 impossible to make this risk zero. And then you  
18 have to ask yourself, what level of risk are we  
19 willing to accept? With the HIV having -- a HIV  
20 test drawn or predeployment serum drawn one year  
21 before deployment or having an HIV test done every  
22 two years, we've sort of gotten that ingrained

1       into our procedures. But I would urge everybody  
2       to be very cautious we start a whole other program  
3       with another disease that we wanted to screen for,  
4       especially when there's some question as to, you  
5       know, validity and how well we can do the  
6       screening and how prevalent it is.

7                    To do the large screening program for  
8       disease that's low-prevalent in our population  
9       runs a lot of epidemiological situations that I  
10      don't need to get into with this group, obviously,  
11      because you know that.

12                   So just a word of caution we run down a  
13      road that we didn't realize we didn't want to go  
14      to Abilene, but we're going to be there.

15                   DR. POLAND: Okay. I think we'll move  
16      on. I think the consens- -- oh, Mark, did you  
17      have another comment?

18                   DR. MILLER: I just wanted to try to get  
19      a point of clarification about the military policy  
20      in general in terms of the distinction of  
21      hepatitis B carriers state, and which is hepatitis  
22      B is about two orders of magnitude more

1 transmissible than at least HIV. Why is there a  
2 distinction between HIV, hepatitis B carrier  
3 state, and hepatitis B? For historical purposes,  
4 is that still relevant?

5 COL GIBSON: The train of thought, if  
6 you will -- first of all, there's no vaccine for  
7 hepatitis -- or for HIV; there is one for  
8 hepatitis B, in fact, quite effective vaccine.  
9 The Department made a decision that a sessions  
10 would have -- would be either immunized for  
11 hepatitis B and/or tested. If they have  
12 antibodies to hepatitis B, it indicates that  
13 they're immune, therefore we would not give them  
14 vaccine.

15 So it was a cost-saving measure, but the  
16 whole issue was policy said we will immunize for  
17 hepatitis B, ensure immunity. That's why we went  
18 down this track. It goes to the possibility of a  
19 blood contamination during military service.

20 Your points are very well taken with  
21 respect to hep C versus hep B and with respect to  
22 transmission. We do have an effective vaccine.

1           The other things is we believe that  
2           because hepatitis B vaccine has been instituted in  
3           a pediatric setting in this country for some years  
4           now, the number of our population would soon reach  
5           a point where they're already immune, and we would  
6           not be able -- basically, we'd screen them and we  
7           wouldn't be immunizing very many at all.

8           We did some early work on that, and it  
9           looks like about 40 -- when we implemented the  
10          program in 2002, it was about 40 percent that were  
11          immune and we're a little higher than that now.  
12          So the issue was immunity to hepatitis B as part  
13          of a program.

14          DR. POLAND: Okay, it sounds like  
15          there's some controversy about the  
16          recommendations, and a recommendation made by one  
17          of the members that -- or, actually. Was it over  
18          here? -- that there's a working group that's  
19          looking at blood transfusions beyond our own? Is  
20          that right, or conversations that are occurring?

21          MR. NATO: The Armed Forces blood  
22          program?

1 DR. POLAND: Yes. Push the button.

2 MR. NATO: The Armed Forces blood  
3 program and then joint preventive medicine group  
4 had been discussing this back and forth a lot.

5 DR. POLAND: So I think I heard the  
6 recommendation that there be some -- perhaps it's  
7 a work group meeting or discussion with that group  
8 in order to further clarify your recommendations,  
9 and then we'll bring them back to the Board.

10 Okay, our final speaker for today is --  
11 where is he? -- there he is -- Dr. Wayne Hachey,  
12 who will update us on pandemic influenza  
13 preparations.

14 While he's going up there, some of you  
15 may have seen that there's concern that there  
16 might have been a human-to-human transmission of  
17 H5N1 in China, which would be of great concern,  
18 but who knows? It's hard to verify those things,  
19 and it's an ongoing investigation.

20 DR. HACHEY: I'd like to thank the Board  
21 for allowing me to provide another update on our  
22 pandemic influenza preparation endeavors. So the

1 agenda for this afternoon will be giving you an  
2 update of the current status of H5N1 to include an  
3 update on antivirals, particularly with  
4 resistance. The current draft of the national  
5 plan, the draft that DoD antiviral plan, some  
6 modeling efforts both in regards to vaccines and  
7 antivirals.

8 DR. POLAND: Dr. Hachey's slides are  
9 under tab 12.

10 DR. HACHEY: This is one of a number of  
11 slides that I have blatantly stolen from the CDC,  
12 and this just describes where H5N1 has been around  
13 with a global perspective. And all the little  
14 green dots represent where we've seen disease in  
15 birds and, more importantly, the purple dots are  
16 where we've seen disease in people this year. Of  
17 note there's a lot of purple in Indonesia and in  
18 Egypt, and we will be talking about those two  
19 countries in particular and why they're a bit  
20 different.

21 This is the hit list for this year.  
22 These are all the countries, numbering 25, that

1 have had confirmed H5N1 activity in poultry and  
2 wild birds for this year alone. And the majority  
3 of the activity has been in poultry, as we'll see.

4 This next slide, series 6, gives you a  
5 little glimpse of the year in birds for H5N1  
6 activity for 2007. So in January we saw a number  
7 of countries with disease primarily in poultry,  
8 and -- that's not supposed to happen, this may be  
9 a short slide. In February, we saw disease in the  
10 U.K. and Kuwait first reporting disease in  
11 poultry, previously reporting disease in wild  
12 birds. And then again a number of other countries  
13 with poultry outbreaks.

14 And the slide is not building the way it  
15 was sent, so to summarize the slide, lots of  
16 disease in poultry, now up to 60 countries all  
17 told, with a few cases of disease in wild birds.  
18 And one of the areas specifically with wild bird  
19 infections as opposed to poultry infections has  
20 been Germany where there's been three distinct H5  
21 strains identified. Two out of the three have  
22 been linked with wild bird migration from Russia.

1 But the overwhelming majority of the cases have  
2 been primarily in poultry populations.

3           Each one of these is supposed to  
4 disappear as the new one presented. Well, more  
5 importantly, where is the disease in people? And  
6 there are two hot spots remain Indonesia and  
7 Egypt, and, as you can see between the number of  
8 cases and deaths, you'd much rather be in Egypt  
9 with a drastically lower mortality rate. And this  
10 may be due to the Clade may be doing -- may have  
11 more to do with what those countries are doing as  
12 far as mitigation efforts.

13           So in Indonesia, Indonesia remains the  
14 hot spot with the highest number of new cases for  
15 2007, and it's essentially the sole source of  
16 cases of Clade 2.1 disease. The government of  
17 Indonesia continues to refuse to share samples  
18 with the rest of the world, although they've  
19 recently engaged in the Southeast Asia influenza  
20 clinical research network, which may facilitate  
21 some sharing.

22           Their mitigation measures also continue

1 to be hampered for a number of reasons, but one of  
2 the big reasons is their decentralized government  
3 and decentralized public health system.

4 In contrast, Egypt has the  
5 second-highest case rate. Instead of Clayd 2.1  
6 they are 2.2, and they have the lowest mortality  
7 rate of any of the regions. And, now, in contrast  
8 with Indonesia, they have a very effective control  
9 measures in place. They have impediment plan that  
10 really serves as a model for the area. They've  
11 begun to exercise their plan. They also have an  
12 extensive communications program that facilitates  
13 early recognition and treatment with subsequently  
14 improved survival.

15 They notice that most of their cases  
16 were kids, so what they did is they had their PR  
17 program geared towards parents saying, If your  
18 kids play with dead chickens, and they develop flu  
19 symptoms run, don't walk, to your nearest health  
20 care facility. And, in fact, referral patterns  
21 are being seen with referrals to medical treatment  
22 facilities well before 48 hours, in some cases

1 before 24 hours of the onset of symptoms.

2           They've also effectively addressed  
3 backyard poultry without changing cultural  
4 practices. If you take a look at the  
5 hieroglyphics in Egypt, you see backyard poultry,  
6 so this is something that's been going on for  
7 thousands and thousands of years and isn't going  
8 to change. So the way they've addressed it is  
9 they're vaccinating the chicks before they're sold  
10 into the backyard poultry market and have been  
11 somewhat effective as far as reducing the burden  
12 of disease in their poultry population.

13           So overall, in 2007 for human cases was  
14 not a bad year, particularly compared to 2006. We  
15 still have a substantial mortality rate. Today's  
16 total now for total number of cases is 337 with  
17 207 fatalities, and actually, it turns out that  
18 the suspected case of human teaming transmission  
19 in China did turn out to be a communal meal  
20 between father and son with some diseased chicken.  
21 But there's a new possible person-to- person  
22 transmission now in the Northwest Frontier

1 Province in Pakistan. So there's still hope for  
2 the virus.

3 Moving on to antiviral, and with  
4 antiviral what I'd like to do is talk to you a  
5 little bit about current resistance -- and again,  
6 this data was again blatantly stolen from the CDC  
7 -- but this slide depicts Adamantane resistance  
8 among the H5N1 viruses, and it differs between  
9 Clade and sub-Clade. So for Clade 1, and for that  
10 matter Clade 2.1, pretty much you have total  
11 resistance to the Adamantanes, whereas Clade 2.2  
12 and 2.3 resistance is minimal, at least at this  
13 time.

14 Moving to neuraminidase resistance using  
15 the Japanese data with seasonal flu represents  
16 about eight percent of the samples tested, and now  
17 there are two primary mutations responsible for  
18 neuraminidase resistance. The first, the H-274Y,  
19 confers almost complete resistance to oseltamivir.  
20 The good news is that you have decreased activity  
21 with that particular mutation. So it's really  
22 unpleasant if you are the individual with that,

1 but it's nice to be standing next to him.

2           On the other hand, a second mutation,  
3 the N295S seen primarily from samples out of Egypt  
4 is consistent with reduced susceptibility, so you  
5 can still get by with just increasing the  
6 oseltamivir dose. One problem with monitoring for  
7 neurominidase resistance, particularly in vitro,  
8 is that we're really uncertain of the clinical  
9 significance of in reaching resistance against  
10 neurominidases as via molecular markers are not  
11 all that well defined yet.

12           But we do know that there are  
13 differences in neurominidase inhibition  
14 susceptibility among H5 isolates. So, for  
15 example, Clade 1 is sixfold more sensitive to  
16 neurominidases than seasonal flu as far as an  
17 H1N1, which is three to fivefolds more sensitive  
18 than a number of the Clade 2 viruses. So we'll  
19 just have to wait and see what the particular  
20 susceptibility will be when the pandemic actually  
21 starts.

22           There are also two new novel mutations,

1       one identified in human samples and another in  
2       andean (?) samples. And the bad news about these  
3       is potential resistance depending on the sub-Clade  
4       to oseltamivirs and amavir and paramavir. But  
5       then we really want to know, though, is will  
6       oseltamivir work if your god- awful sick?

7                   And this one study I just published this  
8       month from Canada looked at hospitalized folks  
9       with laboratory-confirmed influenza. about 300  
10      adults, median age of 77, about half were male, 75  
11      percent had chronic underlying disease. Most,  
12      about 60 percent, presented to the E.R. within 48  
13      hours of symptoms, and they were reasonably ill.  
14      Sixteen percent ended up in the ICU, eight percent  
15      died. Just about everybody received antibacterial  
16      therapy, and 32 percent received oseltamivir. And  
17      the reassuring finding was the treatment with  
18      oseltamivir was associated with a significant  
19      reduction in mortality with an odds ratio of 0.21,  
20      which reassure in confidence intervals.

21                   Which leads us to the new draft national  
22      antiviral strategies, and the new strategy

1 proposes an increase in the national stockpile up  
2 to 200 million treatment courses. Now, currently,  
3 the target is 81 million, and against the 81  
4 million the national stockpile now holds 37  
5 million treatment courses. It also proposes  
6 outbreak prophylaxis for a certain high-risk  
7 health care settings and for first responders, and  
8 starts to initiate a strategy which includes  
9 household postexposure prophylaxis.

10 This is now in the public stakeholder  
11 engagement process, so it'll be a few months at  
12 least before we know whether this turn out to be  
13 the true national policy or not. Even if it is  
14 adopted, it's going to take a while. U.S.  
15 production capacity is about 80 million treatment  
16 courses a year, so, if adopted, it'll take a few  
17 years to meet this goal.

18 The draft DoD policy addendum for  
19 antivirals somewhat mimics the national policy.  
20 It increases the oseltamivir stockpile to --  
21 actually, it's a little closer to five million  
22 treatment courses. It establishes local

1 stockpiles to equal 30 percent of the population  
2 at risk for each geographic CoCOM. So that gives  
3 combatant commanders an off-the-shelf robust  
4 supply of antivirals for more immediate use while  
5 waiting for the strategic stockpile that DoD holds  
6 to get to their locales.

7           It also initiates a postexposure  
8 prophylaxis mitigation strategy while maintaining  
9 treatment and selected outbreak or operational  
10 prophylaxis strategies.

11           Moving on to modeling efforts, we  
12 started modeling, asking the question, where  
13 should we be spending our excess money in the  
14 short term? We have funding for either antivirals  
15 vaccine or a combination of both, and the question  
16 is, where are we going to get that, essentially,  
17 the biggest bang for our buck, given the current  
18 state of science?

19           But first of all, just looking at  
20 NIH-sponsored modeling efforts, they indicate that  
21 being a household member containing in influenza  
22 cases the largest single risk factor for being

1 infected, which really shouldn't be an epiphany.  
2 But what was surprising is that antiviral  
3 postexposure prophylaxis of household of contacts  
4 may be effective in reducing attack rates by a  
5 third, and peak attack rates by 50 percent. But  
6 as we saw, it does require a rather robust supply.  
7 Unless treatment can be initiated by Day  
8 One, there's really little impact on community  
9 infection rates if use the treatment-only  
10 strategy. Added onto that, you can get some  
11 logistic effect on nonpharmacologic interventions.  
12 Alone may reduce the attack rate by half to a  
13 third. So if you start out at that baseline, then  
14 your antivirals have a much better chance of being  
15 effective, and you have a lot more antivirus to go  
16 around in adapting a postexposure prophylaxis  
17 strategy.

18 Which leads us to some of the DoD  
19 modeling efforts, and the first question we had  
20 is, well, just how cost-effective will vaccines  
21 be? And we had a detro-model sum for us, and what  
22 they did is they addressed the impact by their

1 zero percent rate of vaccination versus 100  
2 percent vaccination rate using a 30 percent attack  
3 rate in a vaccine with 30 percent effectiveness.  
4 And they found that if you happened to be in a  
5 rural installation, you get about 32 percent  
6 infected vaccinating no one, and 17 percent  
7 infected if you can vaccinate 100 percent.

8           Unfortunately, the reality is that it's  
9 unlikely we'll ever be able to vaccinate 100  
10 percent with the current prepandemic vaccine.

11           Shifting to an urban installation, 28  
12 percent were infected with antivaccine, and 15  
13 percent with 100 percent immunization. And this  
14 can actually lock the gates and keep everybody  
15 inside and not allow anybody from the community  
16 inside a no-term installation, which is probably  
17 not reality-based unless you're on a submarine or  
18 an island. Then you can lower those rates even  
19 further.

20           The one thing that was not terribly  
21 reassuring is that there's no herd immunity.  
22 Essentially, the folks who are vaccinated are the

1 folks who have the -- the only folks who have the  
2 potential of being protected.

3           We then took some of DTRA more simple  
4 formulas and applied that to some modeling on our  
5 own, and what -- we didn't set up zero 100 percent  
6 vaccination rates. We had variable vaccination  
7 rates with variable attack rates and variable  
8 vaccine effectiveness. So we used attack rates of  
9 30, 10, and 20 percent. Thirty percent, we felt,  
10 was a reasonable guesstimate of an unmitigated  
11 pandemic where no community mitigation efforts  
12 were implemented, 20 percent being consistent with  
13 effective but not wonderful results from your  
14 community mitigation measures, and then 10 percent  
15 more consistent with some of the projections with  
16 early implementation of those nonpharmacological  
17 measures.

18           Percent being a generous swag at an  
19 unmatched unadjuvanted vaccine, 50 it's  
20 essentially Christmas in July, our current  
21 unadjuvanted vaccine is a perfect match with the  
22 pandemic strain, and then 80 percent consistent

1 with some of the projections of what one might see  
2 with an adjuvanted vaccine.

3           So this gives you an idea of what the  
4 slope of the reduction in attack rate might look  
5 like. Just for illustrative purposes we used a  
6 population of 4 million, a 20 percent attack rate,  
7 and 50 percent vaccine effectiveness. You can see  
8 that the percent infected does go down but not  
9 really a terribly dramatic decrease. Whereas if  
10 we change that to a vaccine that has an 80 percent  
11 effectiveness, for example like the current  
12 adjuvanted vaccines are proposed to do, you can  
13 see that you get a much bigger bang for your buck,  
14 that the slope of that curve as far as the  
15 reduction and the percent infected is much more  
16 dramatic and really offers a much more viable for  
17 self-protection measure.

18           Overall, this one chart looks at the  
19 decrease in the percent infected for every 20  
20 percent vaccinated, and if attack rates decrease,  
21 so does the number of cases prevented with  
22 vaccine. So the worse the pandemic is, the bigger

1 bang you get for your buck with your vaccine.  
2 Then of course, as vaccine effectiveness  
3 increases, you get a greater reduction in the  
4 percent infected.

5 Looking at some of the slopes of  
6 proportion infected with increasing the percentage  
7 in those who are vaccinated with variable attack  
8 rates you can see here in green that if you drive  
9 the attack rate down to 10 percent with very  
10 effective nonpharmacologic measures but have a  
11 vaccine that is probably consistent with what we  
12 have right now that the slopes are pretty flat and  
13 especially at 10 percent. And even at 30 percent,  
14 it is not really a dramatic decrease as far as the  
15 proportion infected decreasing.

16 Bumping up to 50 percent with the higher  
17 attack rates you get a little better return from  
18 your investment. Still at a 10 percent attack  
19 rate if we're doing everything right, that slope  
20 is still kind of flat. Whereas if we have an  
21 effective vaccine, again a much more dramatic  
22 decrease as far as the projected yield you are

1 going to get from your vaccine even as you  
2 approach 100 percent.

3           Which leads us to antiviral modeling.  
4 From the vaccine modeling it looked like we might  
5 be better off waiting until there is a better  
6 vaccine available and then putting our resources  
7 toward vaccine procurement rather than continuing  
8 to purchase a vaccine with limited effectiveness.  
9 The question is then can we get a substantial  
10 response from our investment going antivirals. We  
11 did a couple of things. We did some very basic  
12 modeling using projected impacts on a variety of  
13 strategies on the DOD population. We then  
14 explored a number of existing models and then used  
15 one of those models, actually one developed for  
16 the Australian government, in plugging in some DOD  
17 data. The universal findings were treatment alone  
18 will not help the pandemic, and postexposure  
19 prophylaxis will probably blunt a pandemic and may  
20 actually stop it if you can combine that with  
21 effective nonpharmacologic measures.

22           This gives you an idea of what it will

1 cost in antivirals for the number of infected. We  
2 have treatment alone, nonpharmacologic  
3 interventions and treatment, postexposure  
4 prophylaxis, treatment without employing  
5 nonpharmacologic measures, and then clearly the  
6 best yield as far as reducing the number of  
7 infected would be combining nonpharmacologic  
8 interventions, treatment, and postexposure  
9 prophylaxis with just a modest increase in the  
10 amount of antivirals that would be required.  
11 Looking at exactly what those numbers would look  
12 like, these are estimates based on a presumed  
13 population of 4.7 million which is consistent with  
14 the number we have enrolled in Tricare Prime at  
15 the current time. You can see for a modest  
16 requirement that combined therapy gives you a  
17 substantial reduction in the number of infected  
18 while still having a number of antiviral courses  
19 available for outbreak prophylaxis.

20 This slide addresses some modeling we  
21 did again using the model developed for the  
22 Australian Department of Health. This defines the

1 population as either being susceptible, exposed,  
2 infectious, or removed, removed being either  
3 immune or dead. We then took out the Australian  
4 population demographics and stuck in ours, a  
5 population of 4.7 million. We examined variable  
6 infectivity with effective reproduction numbers of  
7 1.2 to 2.4. We also looked at the variables of  
8 30, 50, or 80 percent being provided postexposure  
9 prophylaxis. And then as a baseline, treated 80  
10 percent of those who were infected. With an  
11 unmitigated pandemic with an effective  
12 reproduction number of 1.2, the pandemic peaks at  
13 about 10 months and this curve represents the  
14 number of infected at any one point in time. At  
15 10 months you can expect about 50,000 people to be  
16 infected at that one point in time, so the total  
17 number is the area under the curve.

18           If you have a more severe pandemic, the  
19 curve is a little shaper, it peaks earlier, but it  
20 is peaking at about 80,000 cases. When we add  
21 postexposure prophylaxis, however, with again an  
22 effective reproduction number of 1.2, even with 30

1 percent of the contacts receiving postexposure  
2 prophylaxis, we can essentially stop the pandemic  
3 when combined with nonpharmacologic interventions.  
4 And instead of dealing with peak infection rates  
5 in the tens of thousands, here we are at about  
6 600. With a more severe pandemic with effective  
7 reproduction numbers at 2.4, treating 30 percent  
8 of the contacts with postexposure prophylaxis does  
9 not stop the pandemic, but with 50 and 80 percent  
10 of the contacts receiving postexposure  
11 prophylaxis, the pandemic again is stopped. Of  
12 note is the peak number of cases, again well below  
13 the 50- to 80,000, actually down just a little bit  
14 under 100. When we first saw the data we didn't  
15 believe it. We went back to make sure that we did  
16 not skip a decimal point somewhere. But after  
17 running it three or four times, we kept on getting  
18 the same results. If you look at the Australian  
19 data, they show the same kind of significant  
20 reduction in the total number of cases. Do the  
21 other models tell the same story? The other  
22 models do show that postexposure prophylaxis may

1 stop a pandemic, that postexposure prophylaxis  
2 will have a substantial reduction in the number of  
3 hospitalizations, and postexposure prophylaxis has  
4 the synergistic effect with other measures.

5 This slide here demonstrates the  
6 effective reproduction number achieved by using  
7 antivirals for treatment versus postexposure  
8 prophylaxis. This is the treatment curve, this is  
9 the postexposure prophylaxis curve, this axis is  
10 the effective reproduction number, and this axis  
11 is the percent of the population who either  
12 receive antivirals for treatment or antivirals for  
13 postexposure prophylaxis. The thing to note is  
14 that using treatment alone, this is the effective  
15 reproduction number at 1, so you are never far  
16 below 1 using treatment alone. Whereas using  
17 postexposure prophylaxis whether combined or not  
18 with treatment, here is an arnot (?) of 1, so you  
19 quickly fall below an effective reproduction  
20 number of 1 at least with this one model. Again,  
21 using postexposure prophylaxis as opposed to  
22 treatment, that theoretically a pandemic could be

1       stopped.

2                   The next issue is even with 50 percent  
3       compliance, can we significant reduce the number  
4       of hospitalizations using postexposure  
5       prophylaxis? The green curve and the blue curve  
6       represent no antivirals given versus treatment  
7       alone. This axis is the number of  
8       hospitalizations and this is time. You can see  
9       that the medical treatment facilities would easily  
10      be overwhelmed if we did not use antivirals or  
11      used a treatment alone strategy. Whereas this  
12      curve is what might expect as far as the number of  
13      hospitalizations if postexposure prophylaxis were  
14      used.

15                   The last slide demonstrates just the  
16      additive effect with a load approach that we have  
17      been proposing now for months. Daily incidence of  
18      infection over time, with no interventions the  
19      pandemic comes early and stays late and overwhelms  
20      your system. Whereas as you start adding  
21      quarantine, quarantine with isolation, quarantine  
22      with antivirals and so on, that curve gets lower

1 and lower as you go on.

2 In summary, our modeling show that  
3 unadjuvanted vaccines will have a modest impact on  
4 mitigation but really not a good investment at the  
5 current time. Whereas adjuvanted or more  
6 effective vaccines will have a substantial effect  
7 on pandemic mitigation, and when they are  
8 available it may be better to put DOD funds in  
9 that area as opposed to again continuing to buy  
10 ineffective or less-effective vaccines. Antiviral  
11 use limited to treatment alone will not result in  
12 substantial reductions in the overall impact on  
13 the DOD community, but adding an antiviral  
14 postexposure prophylaxis strategy combined with  
15 infection control and social distancing may  
16 actually halt a pandemic.

17 DR. POLAND: Very nice. Thank you,  
18 Wayne. Comments? Roger?

19 COL GIBSON: A couple quick questions  
20 around the modeling that you presented. What were  
21 the fatality rates in the model?

22 LTC HACHEY: Which model?

1 COL GIBSON: The first one. The first  
2 one is quite effective.

3 LTC HACHEY: As far as the fatality  
4 rates, we did not model for deaths, we modeled for  
5 the percent infected.

6 COL GIBSON: So that you didn't model  
7 for deaths. Obviously dead folks leave the  
8 cohort.

9 LTC HACHEY: In the fuel modeling,  
10 deaths are built into that and I believe that --  
11 the death rate varies whether you have an  
12 effective reproduction number of 1.2 versus 2.4.

13 COL GIBSON: That's the Australian  
14 model?

15 LTC HACHEY: Right.

16 COL GIBSON: Was there a coefficient for  
17 resistance that was included in those models?

18 LTC HACHEY: No. We did not model for  
19 antiviral resistance.

20 DR. POLAND: Mark?

21 DR. MILLER: I think first of all the  
22 general purpose of modeling is to highlight and

1 articulate a lot of the assumptions, many of the  
2 assumptions, and in the case of potential pandemic  
3 viruses and antiviral agents acting against it are  
4 really unknown so the best you can do is put in a  
5 range and then run a model and then try to  
6 highlight what are the most sensitive parameters  
7 and that helps to at least identify and focus  
8 areas or research and hopefully identify other  
9 policy-relevant issues.

10 I think the problem with a lot of the  
11 models is people take them too much to heart in  
12 terms of what they actually show as an outcome and  
13 really not use them for what they are really good  
14 for, to highlight those particular assumptions and  
15 help clarify any policies that are eventually  
16 going to be made.

17 There is a big problem specifically with  
18 antiviral modeling. The one that was originally  
19 done for Thailand I think tried to show when the  
20 MIDAS effort, this is the NIH effort, was tasked  
21 to look at a problem, if there was a point source  
22 of an outbreak somewhere in Asia could you rapidly

1       deploy antiviral agents and stop the pandemic from  
2       happening? There were about five independent  
3       variables each with their own probabilities that  
4       each would have to align up perfectly in order to  
5       effectively stop an outbreak. People took that  
6       paper to realize that actually it is possible, but  
7       when you multiply out the probabilities of each of  
8       those five independent variables, it is possible,  
9       but with a probability of extremely unlikely. Of  
10       course if you stop it one time as well, it is  
11       highly likely you are going to stop it the second  
12       time. So while I think models are useful, they  
13       are always wrong but some are helpful and this one  
14       in particular also is helpful to identify what are  
15       the issues.

16               I think part of the problem is that the  
17       transmission dynamics were not really looked at  
18       carefully with these particular models. I think  
19       you modeled 4.7 million people and I'm not exactly  
20       sure if that just represents the DOD beneficiaries  
21       or where you got that number from because part of  
22       a model is who is infecting who and if it is

1 related to DOD beneficiaries, they are scattered  
2 throughout the world so you cannot necessarily  
3 implement programs uniformly amongst those who you  
4 are trying to effectively model.

5 LTC HACHEY: The question to us as far  
6 as developing a model was how does this impact the  
7 DOD community. That is why we picked that 407  
8 because that is the DOD community. However, the  
9 modeling that DTRA did did take into account for  
10 the local community and that is why the  
11 differences between a rural and an urban  
12 installation were different as far as the overall  
13 attack rates because of interaction with the  
14 community. But the fuel that we did, we just took  
15 the DOD community as a point of reference.

16 DR. POLAND: Other comments?

17 DR. MILLER: Sorry, I forgot to make one  
18 more comment. I am not sure of your eventual  
19 outcome. It looks like your outcome was  
20 mitigation of influenza, but there is more to just  
21 influenza, it is also the secondary bacterial  
22 events. You did look at antivirals, but did you

1 also look at modeling other prophylactic measures  
2 for severe morbidity/mortality such as  
3 pneumococcal vaccines or antibiotic distributions?  
4 Those would all be part of a particular strategy  
5 for mitigating the impact of a pandemic.

6 LTC HACHEY: Our modeling was limited to  
7 two specific questions. One is the impact of  
8 vaccines, and the other one was the impact of  
9 antiviral strategies. We did not include the  
10 potential impact of different pathogens and biotic  
11 therapy. But given more time and more money --

12 DR. POLAND: Kevin?

13 DR. PARKINSON: Just one quick comment.  
14 I think that most of the strategies and modeling  
15 that I've seen and read, the prediction is the  
16 pandemic is going to spread so quickly, any  
17 effective application of postexposure prophylaxis  
18 is going to quickly break down because your new  
19 cases are going to far outstrip your public  
20 health, we are talking military or civilian here,  
21 capability to track these new cases and get to  
22 them within the I presume still 48 hour window

1 after onset of symptoms during which the  
2 antivirals are felt to be most effective. And  
3 then when you look at the modeling that was done  
4 at the rapidity of the spread of the 1918 pandemic  
5 throughout the United States in about a month or  
6 so and considering the limitations on movement of  
7 people, transportation and so forth, that  
8 prevailed during that early era in time, it's  
9 hardly likely that we are going to be able to  
10 control a pandemic once it strikes using  
11 antivirals or anything else. It's just going to  
12 have to burn itself out.

13 LTC HACHEY: Actually, our plan as far  
14 as the antiviral distribution, if someone comes in  
15 with symptoms, when they are treated and so are  
16 their family members, so hopefully as we target  
17 each individual case, then we are also targeting  
18 their families, or in the case of a barracks, if  
19 one person has the disease then his -- are also  
20 treated.

21 DR. PARKINSON: I should say that's not  
22 to imply that we should not do all of these things

1 and I am not suggesting that you are implying or  
2 anyone is implying realistically we are going to  
3 be able to stop a pandemic, that if anyone  
4 suggests that, I would question it strongly.

5 DR. POLAND: Dr. Lednar?

6 DR. LEDNAR: Part of the DOD pandemic  
7 preparedness is around the uniformed force and the  
8 civilian workforce that spends days on military  
9 installations. My question, Wayne, is how  
10 comfortable is DOD that their critical suppliers,  
11 the civilian companies who support DOD so that  
12 operations in DOD can continue, are prepared?

13 LTC HACHEY: Corporate America does seem  
14 to be bellying up to the bar, at least some of the  
15 larger corporations from what we are told are  
16 starting to stockpile antivirals and developing an  
17 pandemic flu plan of their own to protect their  
18 workforce. The federal government has identified  
19 specific key areas in the national infrastructure  
20 that have to be preserved, down to folks who  
21 deliver baby formula are clearly more important  
22 than folks who deliver bread because there are

1 more bread deliveries than baby formula  
2 deliveries. So certain key areas in industry have  
3 already been identified as being critical and  
4 deserving of extra protection. In the national  
5 plan, both antivirals and vaccines at least in the  
6 draft form are preallocated to preserve those  
7 critical elements of society which impact on DOD.

8 Our current plan as far as how we would  
9 use our antivirals does extend to our civilian  
10 workforce to include GS personnel and contractors  
11 now with our new buy of antiviral agents. So  
12 those folks who actually work for us are under our  
13 protective umbrella also.

14 DR. CLEMENTS: It may be worth a modest  
15 effort for a couple of selected key suppliers to  
16 DOD for some insightful DOD people to go out and  
17 actually verify just how prepared they are.

18 DR. POLAND: Maybe in some critical  
19 areas.

20 COL GARDNER: Every time we hear a broad  
21 presentation we hear about the new country that's  
22 immunizing its poultry and I believe you said

1 Egypt has now started to immunize its chickens.  
2 We know what the vaccine is and whether it  
3 actually works. If we really were facing a  
4 bird-related disease, we don't give much  
5 discussion to that approach in the United States.  
6 Is it a live or is a kill vaccine? What is the  
7 evidence that it works, and how do they make it?

8 LTC HACHEY: I don't know how they make  
9 it. Folks smarter than I do, however. I do know  
10 that there are a number of different vaccines  
11 depending on which country with variable  
12 effectiveness, but we do have some data. It  
13 appears that, for example, the vaccine that is  
14 used in Vietnam does appear to be effective as far  
15 as preventing disease. The problem is that they  
16 gave it to a lot of chickens which kept the  
17 disease from chickens, but they did not give it to  
18 the ducks and then ducks continued to carry the  
19 disease.

20 It is a big depend. It depends on the  
21 particular vaccine. There are a couple sub-clades  
22 that appear to be resistant to previous vaccines,

1       so it's somewhat of a crap shoot as far as which  
2       vaccine, which sub-clade and which manufacturer.

3               DR. POLAND:  If I can, I would like to  
4       ask Dr.  Bill Halperin to tell the board briefly  
5       about a potentially important paper that has been  
6       published and an idea that he and I have just  
7       briefly talked about.

8               DR. HALPERIN:  Some of you have probably  
9       seen a paper that was circulated by Peter Polisi  
10       from Mount Sinai who was addressing the question  
11       of why influenza propagated in the winter months.  
12       What he did, apparently the first part of it was  
13       to identify that he could tell from an animal  
14       model and he used guinea pigs.  The next was to  
15       take groups of guinea pigs and put them into  
16       environmental exposure chambers where he could  
17       modify temperature and humidity.  What he shows in  
18       the article is that the colder it is, the more  
19       propagation there is, and that is pretty clear.  
20       With humidity it is a little bit more of a complex  
21       relationship, but it looks like in the middle  
22       range there is lease transmission and when it is

1 very humid or very dry there is more transmission.  
2 And these are in ranges that are conceivably  
3 environmentally controlled in normal living  
4 situations through air conditioning, heating, and  
5 control of humidity.

6           What he concluded in the article and  
7 then probably has regretted is the question of  
8 whether this represents a potential  
9 nonpharmaceutical approach to control of influenza  
10 epidemics. I say conceivably regretted because  
11 the discussion has been to rush toward the idea of  
12 controlling epidemics this way and a lot of  
13 chatter about then why do we need vaccines, et  
14 cetera.

15           All that aside, the question is then if  
16 you are going to try to see whether control of  
17 environment actually worked in slowing the  
18 propagation of influenza, where and how could you  
19 test that hypothesis. This is what we were  
20 talking about comes out of the article. The issue  
21 is ethnically you would have to test this if you  
22 were going to do it in humans in a population that

1 would be highly immunized if there were a vaccine.  
2 If there were no vaccine, obviously they wouldn't  
3 be highly immunized. If they were highly  
4 immunized, you would look for truncation of  
5 propagation but that is after the effectiveness of  
6 the vaccine was in play. So if you assume that  
7 let's say vaccine is whatever, 60 to 70 percent  
8 effective, you would be looking for the truncation  
9 of the rest of the epidemic. So what population  
10 would be large enough that would be well enough  
11 controlled, that is, everybody would uniformly  
12 have immunization, where you would uniformly have  
13 data on propagation of influenza, and where there  
14 would not be a huge amount of mixing, that is, you  
15 would have cohorts of people that were highly  
16 immunized and in environments that were  
17 controllable, et cetera, and the only population I  
18 could think of like that would probably be the  
19 recruits in the services of the military with lots  
20 of training programs at various bases around the  
21 country where the folks are by and large cohorted,  
22 if there is a vaccine they are going to be

1 immunized uniformly.

2           There are several questions. One is  
3 what is the level of effectiveness of the vaccine  
4 because obviously if it's 100 percent effective  
5 then there is no more transmission to be  
6 controlled. The second is whether there is any  
7 capability of actually controlling temperature in  
8 the training barracks between let's say a range of  
9 80 and 60 degrees Fahrenheit and within ranges of  
10 humidity. It is an interesting article. It is  
11 the first I think article on this issue and  
12 obviously there is no confirmation from other  
13 laboratories, but that is the nature of the  
14 discussion, although very early, that we have had  
15 via email.

16           DR. POLAND: The interesting thing here  
17 would be, one, this potentially could be a  
18 suggested study reminiscent of those requested by  
19 the Influenza Commission back during World War II.  
20 Two, it may be something fairly inexpensive to do  
21 in the context of nonpharmacologic interventions.  
22 And three, there may be a unique population here

1 on which it can be done and for which the side  
2 effects or risks would be really essentially nil.  
3 Dr. Shamoo?

4 DR. SHAMOO: I think doing human subject  
5 experiments on large populations to test this  
6 hypothesis for a disease where I have heard right  
7 here presentations saying may never happen in 100  
8 years, you are going to have a hell of a time  
9 convincing the public that that is a necessary  
10 risk to take with any population. So I would  
11 caution really to even think of those kinds of  
12 experiments.

13 DR. POLAND: What do you mean risk?

14 DR. SHAMOO: The risk of having pandemic  
15 flu. You are doing it to prevent pandemic flu,  
16 but the risk of pandemic flu is so low.

17 DR. POLAND: We should maybe clarify  
18 that the value of a study like that would be of  
19 course during a pandemic, but also during seasonal  
20 epidemics where there may be a mismatch between  
21 the vaccine, for example, and that is circulating.  
22 So it would overlay both seasonal and pandemic

1 influenza. Bill?

2 DR. HALPERIN: Just to be perfectly  
3 clear, we are talking about perhaps changing the  
4 H-factor, humidity, air conditioning, et cetera,  
5 if there were evidence of influenza in the  
6 population. So there is absolutely no idea of  
7 introducing a virus into the population. It is an  
8 intervention.

9 DR. SHAMOO: That is much better.

10 DR. POLAND: I had trouble understanding  
11 what you meant by risk.

12 DR. HALPERIN: No, this is not  
13 experimental. This is more observational  
14 epidemiology, the intervention being the control  
15 of humidity and heat, if you will.

16 DR. POLAND: Mark and then Mike?

17 DR. MILLER: That study was interesting  
18 and it follows on actually a study by Ed Kilborn  
19 who had done a similar study in mice about 20 or  
20 30 years earlier. It does lend to some  
21 interesting issues, but it still doesn't explain a  
22 lot of the other issues, why flu circulates year

1 round in the tropics, and those are some of the  
2 more interesting points about influenza which we  
3 really do not know.

4 DR. POLAND: Mike?

5 DR. OXMAN: If this occurs in the  
6 setting of an epidemic, you would immediately  
7 screw up your experiment by using antiviral  
8 therapy as well. I wonder if the place where it  
9 might be even more easily done be on shipboard.  
10 When there is influenza on shipboard it's very  
11 impressive the spread on shipboard, and I would  
12 think if there is any place where you could  
13 control relative humidity it would on shipboard.

14 DR. SHAMOO: What is your control? One  
15 ship?

16 DR. POLAND: Let's not get into  
17 experimental details. This is just an idea. I am  
18 going to keep you engaged this late in the day,  
19 but --

20 COL GARDNER: When the meningococcal  
21 work was first being done suggesting that college  
22 freshmen were at increased risk, one of the

1 interesting risk factors that never really saw the  
2 light of day was not only were first- year  
3 students living in dormitories, it was dormitories  
4 that had radiator heat rather than other kinds of  
5 heat. So it's a little bit concordant with  
6 something happens to the mucosa I think presumably  
7 that may affect attachment or proliferation.

8 DR. POLAND: One other comment?

9 DR. HALPERIN: I would urge reading  
10 Polisi's article because what he argues is that  
11 the animals were put in the exposure chamber so  
12 quickly that they did not have time to dry out the  
13 mucosa. So his argument which I probably should  
14 have mentioned before is that it all has to do  
15 with how long the aerosol particles are suspended  
16 and that they last in the environment for  
17 different lengths of time if it's hot or cold or  
18 dry or wet, and it really has to do with the  
19 mechanics of transmission.

20 DR. POLAND: Thank you, Wayne, and I  
21 think we are finished and will adjourn for this  
22 event. A couple of things. I am glad Roger is

1 walking in. I cannot remember what the  
2 preparatory session is for tomorrow.

3 COL GIBSON: Actually what we have done  
4 is moved forward tomorrow so that we can get done  
5 so that you can get on your airplanes and fly home  
6 and get home on time. We are going to start with  
7 registration at 7:30 and actually start work at 8  
8 o'clock. That will give us time to move an  
9 administrative session to late afternoon, have our  
10 annual EPICS briefing, have lunch, and then head  
11 on out from there.

12 DR. POLAND: So we are not meeting at  
13 7:30?

14 COL GIBSON: This changed very recently.

15 DR. POLAND: Then we anticipate the  
16 formal part of the meeting ending about 11:00?

17 COL GIBSON: Yes, probably 11:00. It  
18 will be in that range.

19 DR. POLAND: Because we will move this  
20 up.

21 COL GIBSON: Colonel Hachey presented  
22 today which will give us more time and we will get

1 the EPICS briefing in there and have a short  
2 administrative session that will allow us to go  
3 over our organizational charts and a few other  
4 minor things.

5 DR. POLAND: We are dismissed.

6 (Whereupon, at 4:50 p.m. the  
7 PROCEEDINGS were adjourned.)

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