UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

CORE BOARD MEETING

Fairfax, Virginia

Thursday, November 12, 2009

ANDERSON COURT REPORTING

706 Duke Street, Suite 100

Alexandria, VA 22314

Phone (703) 519-7180 Fax (703) 519-7190

PARTICIPANTS:

WARNER ANDERSON

PETER G. BLAIN

LIEUTENANT COLONEL CHRISTOPHER COKE

COMMANDER EDMOND FEEKS

CHARLES J. FOGELMAN

CAPTAIN MARTHA GIRZ

COLONEL WAYNE HACHEY

LYNN LAWRY

WAYNE LEDNAR

ANNE MOESSNER

GREGORY A. POLAND

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P R O C E E D I N G S

(9:08 a.m.)

DR. LEDNAR: Okay, if everyone please would take your seats. Good morning, everyone. This is the opening of the meeting of the Defense Health Board, the Core Board meeting. I would like to extend our appreciation to all the Core Board members, guests, and briefers who have joined us today for this meeting.

I want to extend a special welcome to new board members and any new Subcommittee members and Task Force leaders that are here with us. We have a very ambitious agenda in the next day and a half. But what we would like to do is to officially open the meeting and ask Colonel Christine Bader who is our alternate Designated Federal Official for this board activity if she would please open the meeting. Colonel Bader?

Col BADER: Thank you, Dr. Lednar. As the alternate Designated Federal Officer for the Defense Health Board, a federal advisory committee, and a continuing independent scientific

advisory body to the Secretary of Defense via the Assistant Secretary of Defense for Health Affairs and the Surgeon General of the military departments, I hereby call this meeting of the Defense Health Board to order.

DR. LEDNAR: Thank you, Colonel Bader. In keeping with the tradition of the board, we'd like everyone please to stand for a moment of silence. Let's remember to honor those that we are privileged to come and serve. This particular past week has been a very difficult one with the killings at Ft. Hood and the impacts on their family members, fellow soldiers, the community around them, and the entire military community worldwide. So let's please keep all of them in our thoughts and prayers.

(Moment of silence)

DR. LEDNAR: Thank you. Please be seated. We'd like to first start by doing introductions.

So we'd ask, starting with the board, and then we will go throughout the room, if you

would please identify your name, your affiliation of where your day job is, and for those who have responsibilities with the Defense Health Board, perhaps as a Subcommittee member, Task Force leader, if they would identify and share that information as well.

So, can we begin with Major Fea?

MAJ FEA: Good morning. I'm Major Mike Fea. I work over at the Joint Staff. My boss is the Joint Staff Surgeon Rear Admiral David Smith.

CDR SLAUNWHITE: Hello. I'm Commander Cathy Slaunwhite. I'm a Canadian Forces Medical Officer in a liaison role at the Embassy in Washington, D.C.

CAPT NAITO: Captain Neal Naito, Director of Clinical Care and Public Health for Navy Medicine here in Washington, D.C.

DR. BLAIN: Professor Peter Blain. I'm a Professor of Environmental Medicine at Newcastle University in the UK and a physician there, but I'm here as a Chairman on the Advisory Group on Military Medicine for our Ministry of Defense.

DR. LEDNAR: Dr. Blain, thank you for joining us.

CDR FEEKS: We'll be hearing from Professor Blain later this morning and we'll hear more about him, too, but I just want to say, it's a great honor to have you here, sir. Thank you for coming.

CAPT COWAN: Group Captain Alan Cowan. I'm the former British Liaison Officer to the U.S. Department of Defense and the Department of Veterans Affairs.

DR. BENETATO: Good morning. I'm Bonnie Benetato, the Acting Director of the War-Related Illness and Injury Study Center in Washington, D.C., for the Department of Veterans Affairs, and I'm the liaison member to the board.

MS. CARROLL: Bonnie Carroll, the Director of the Tragedy Assistance Program for Survivors and the Co-Chair of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces.

DR. BUTLER: Morning. Frank Butler,

Chairman of the Committee on Tactical Combat Casualty Care, and this morning sitting in for Dr. John Holcomb, the Chairman of the Trauma and Injury Subcommittee.

DR. FOGELMAN: I'm Charlie Fogelman. I'm Chair of the Psychological Health Subcommittee and I am an independent clinician and consultant.

DR. WALKER: David Walker, Pathologist, University of Texas Medical Branch at Galveston, member of the Core Board and Infectious Disease Subcommittee.

DR. PARISI: I'm Joseph Parisi, Professor of Pathology at Mayo Clinic in Rochester, Minnesota. I'm a member of the Core Board and Chair of the Subcommittee on Pathology.

DR. SILVA: Joe Silva, Professor of Internal Medicine and Infectious Diseases, Dean Emeritus, University of California School of Medicine at Davis, and I'm a Core Board member and a member of the Infectious Diseases Subcommittee.

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

Core Board and of the BRAC Subcommittee.

DR. MASON: I'm Tom Mason, Professor of Environmental and Occupational Health, College of Public Health, University of South Florida, Tampa, member of the Core Board and also a member of the Subcommittee on Occupational and Environmental Health and Medical Surveillance.

DR. LUEPKER: Yes, and I'm Russell Luepker, and I'm a Professor of Epidemiology and Medicine at University of Minnesota. I'm a member of the Core Board and of the Health Care Delivery Advisory Board.

DR. CLEMENTS: John Clements. I'm the Chair of Microbiology and Immunology at Tulane University School of Medicine in New Orleans, also the Director of the Tulane Center for Infectious Diseases and I'm on the Infectious Diseases Subcommittee.

CDR FEEKS: Commander Ed Feeks, Executive Secretary of the Defense Health Board.

DR. LEDNAR: Wayne Lednar, one of the two Vice Presidents of the Defense Health Board

and Global Chief Medical Officer for the DuPont Company.

DR. POLAND: I'm Greg Poland, Professor of Medicine and Infectious Diseases at the Mayo Clinic in Rochester, Minnesota, VP of the Board, and Chair of the Infectious Diseases Control Subcommittee.

Col BADER: Good morning. Christine Bader. I am a Senior Advisor to the Assistant Secretary of Defense for Health Affairs, and I'm your alternate Designated Federal Officer for today's meeting.

Rev CERTAIN: I'm Robert Certain. I'm an Episcopal Church clergyman in Atlanta, retired Air Force chaplain, former combat aviator Vietnam, former POW, and served on the Core Board, the Subcommittee on Medical Ethics, psychological health, and the Task Force on Suicide Prevention.

DR. HALPERIN: Bill Halperin. I chair the Department of Preventive Medicine at the New Jersey Medical School and the Department of Quantitative Methods, Epidemiology by Statistics,

at the School of Public Health. I am Chair of the Subcommittee on Military Occupational and Environmental Health and Medical Surveillance and a member of the Core Board. And I'm retired from the Centers for Disease Control.

DR. KAPLAN: Good morning. I'm Ed Kaplan, Professor of Pediatrics at the University of Minnesota Medical School in Minneapolis. I'm a Core Board member and a member of the Infectious Disease Subcommittee.

DR. OXMAN: Good morning. I'm Mike Oxman. I'm a Professor of Medicine and Pathology at the University of California in San Diego and a member of the Infectious Diseases and Pathology Subcommittees.

DR. PARKINSON: Good morning. I'm Mike Parkinson. I'm the Past President of the American College of Preventive Medicine. I currently work with health care, employer, and other organizations to improve prevention and productivity. I'm a member of the Core Board and also the Health Care Delivery Subcommittee.

DR. SHAMOO: I'm Adil Shamoo, Professor and former Chair University of Maryland, School of Medicine, and a member of the Core Board and the Chairman of the Medical Ethics Subcommittee.

MS. MOESSNER: Good morning. Anne Moessner. I'm a TBI Clinical Specialist for the Mayo Clinic. I also do TBI research and currently the Chair of the TBI Family Caregiver Panel.

RADM KAHN: Good morning. Ali Kahn, Assistant Surgeon General, U.S. Public Health Service, and CDC liaison to the board.

COL MOTT: Morning. Colonel Bob Mott. I'm a Preventive Medicine Staff Officer from the Army Surgeon General. I'm the Army liaison.

COL KRUKAR: Good morning. I'm Colonel Michael Krukar, the Director of the Military Vaccine Agency.

COL HACHEY: Wayne Hachey, Director of Preventive Medicine, OSD Health Affairs, Force Health Protection and Readiness.

CDR SCHWARTZ: Commander Erica Schwartz. I'm the Preventive Medicine Liaison for

the Coast Guard.

Lt Col GOULD: Lieutenant Colonel Philip Gould. I'm the Preventive Medicine alternate for the Defense Health Board from the Air Force.

CDR SPRINGS: Good morning. Julia Springs, the Preventive Medicine Officer for Health Services Headquarters, Marine Corps.

DR. COHOON: Barbara Cohoon. I work for the National Military Family Association. I handle health care for them, and I'm also a member of the TBI Family Caregiver Panel.

DR. ERDTMANN: Good morning. My name is Rick Erdtmann. I'm a staff member at the Institute of Medicine, direct the Board on the Select Population Health at the Institute of Medicine.

MR. RABOLD: Ridge Rabold, Office of the Director, Armed Forces Institute of Pathology.

LT DANIELSON: I'm Lieutenant Roxanne Landismann. I'm a Resident in Preventive Medicine at the Uniform Services University.

MS. WARD: I'm Claudine Ward. I'm also

a resident at Uniformed Services University.

COL MACEDONIA: I'm Colonel Chris Macedonia. I work in the Office of the Chairman of the Joint Chiefs of Staff and I'm a Special Assistant to the Chairman for Warriors and Families.

MAJ JOSEPH: Tath Joseph, Joint Staff, Health Service Support Division.

CAPT LEE: Captain Roger Lee, Environmental Health, works on the Joint Staff Health Service Support Division.

MR. PERRY: Michael Perry, Director of Operations for the American Registry of Pathology.

Col McPHERSON: Colonel Joanne McPherson. I'm the new Executive Secretary for the DoD Task Force on the Prevention of Suicide.

LtCol COKE: Good morning. Lieutenant Colonel Chris Coke from the Joint Staff Operations.

MS. JARRETT: Lisa Jarrett. I'm the contractor for the Defense Health Board.

MS. CAIN: Christina Cain, DHB support

staff.

MS. JOVANOVIC: Olivera Jovanovic, DHB support staff.

MS. KLEVENOW: Jen Klevenow, DHB support staff.

MS. GRAHAM: Elizabeth Graham, DHB support staff.

DR. LEDNAR: And on the telephone, can we please identify ourselves?

DR. MILLER: I'm Mark Miller, Director of Research at the Fogherty International Center at the NIH, and on the Infectious Disease Subcommittee.

MS. COATES: Marianne Coates. I'm a contracted consultant to the Defense Health Board for communications and public relations.

DR. LEDNAR: Thanks to everyone in the room for introducing yourself. Can I ask, is there anyone on the telephone? Okay. We'll just try to remind ourselves that we may have one or two Core Board members who join us on the telephone. And if that's the case, we'll just

have to be sure that we use the microphones so they can hear. Did someone join us on the telephone?

Okay. With that, I would ask Commander Feeks, he has some administrative remarks before we begin our first briefing. Commander Feeks?

CDR FEEKS: This is Commander Feeks. Thanks, Dr. Lednar. Good morning everyone, welcome, thank you for being here.

I want to thank the Hyatt Fair Lakes Hotel for helping with the arrangements for this meeting. I want to thank all the speakers who have worked hard to prepare briefings for us. I want to thank my staff, Jen Klevenow, Lisa Jarrett, Elizabeth Graham, Olivera Jovanovic, Christina Cain and Jean Ward, back at the home office, for arranging this meeting of the Defense Health Board.

If you have not already done so, please be sure to sign one of the rosters at the table outside the room whether it be if you're an official attendee or a member of the public. The

law requires us to keep a record of who attends our meetings.

For those of you who are not seated at this table, there are handouts provided on the table at the far end of the room. Restrooms are located down the hall and to the left. If you need fax, telephone, copier, or messaging service, please see a member of my support staff, in particular Jen Klevenow or Lisa Jarrett.

This open session is being transcribed -- actually, it's being recorded and if you look over your shoulder, Christine Allen is sitting at the table with the technicians. You'll notice that she's not typing, she's recording. Someone's going to type this later. So, each time you speak, please say your name because the person who does the typing will not recognize your voice at that time. Also, if you find that your name is easily misspelled, I suggest that you write it down on a piece of paper and give it to Christine at some point during the meeting so that we'd be sure to spell your name correctly in the

transcript.

Refreshments will be available for both morning and afternoon sessions. We'll have a catered working lunch here for our Board members, ex officio members, service liaisons, support staff, speakers, and distinguished guests. For others looking for lunch options, the hotel restaurant is open for lunch. There is also a Whole Foods located around the corner in the East Market Shopping Center that has some dining-in options. Also in East Market are a Starbucks, a Pei Wei Asian Diner, and in the shops at Fair Lakes, there are additional options including Logan's, Blue Iguana, McDonald's, Pizza Hut, Taco Bell, and Joe's Crab Shack. There are many other dining options all within a few miles radius. If you need further information, please see a staff member of mine or talk to someone at the hotel front desk.

Okay. The group dinner tonight is scheduled for 6:00 p.m. at Sakura Japanese Steak and Seafood House. Sakura is located about a mile

from the hotel and shuttle service is being provided by the hotel. The shuttle will leave from the hotel at 6:00 p.m. with a second run likely to accommodate our group's size.

Return shuttle service to the hotel will also be provided. However, if you have not already RSVPed for this dinner, please see Jen Klevenow so that we have a good head count.

For those who need to take the Metro after this meeting, the hotel operates a complementary shuttle to the Vienna Metro Station every 30 minutes. Please see the shuttle schedule at the registration desk or visit the hotel front desk.

Finally, the next meeting of the core of the Defense Health Board will be at a date that has not been named and at a location that has not been decided at this point, but we will put that information out as soon as it's available.

DR. POLAND: Just be there.

CDR FEEKS: Right. You all come. Okay. All right. And at that meeting we

anticipate receiving updates from Subcommittees as well as information briefings, draft recommendations for vote, and so on.

This concludes my remarks. Dr. Lednar?

DR. LEDNAR: Thank you, Commander Feeks. We'll move to our first briefing.

And since a mission of the board is to serve the men and women who defend our country, our first speaker this morning is Lieutenant Colonel -- Promotable -- Chris Coke of the Joint Staff. He's assistant division chief from EUCOM of the Joint Staff Operations Directorate. The division is responsible for monitoring and coordinating of all Joint Staff actions for operational activities within NATO Headquarters in the U.S.-European Command. He is also a Marine Corps helicopter pilot. Among his many awards are the Bronze Star, Meritorious Service Medal, Ear Medal with the Third Strike Award, Navy and Marine Commendation Medal, and two Navy and Marine Corps Achievement Medals.

Lieutenant Colonel Coke has also been

selected for promotion to colonel. That cannot come fast enough and we look forward to congratulating him when that happens, hopefully in the near future.

Lieutenant Colonel Coke will provide us with an overview of U.S. military operations worldwide and highlight one of the health issues of priority to the Department, that "keep up the line commanders at night." His presentation slides may be found under tab 1 of your meeting book. Lieutenant Colonel Coke?

LtCol COKE: Thank you and good morning. It's always a pleasure to be among you all. This is the third time and equally as so to be out of the Pentagon, out of the basement where there's actually more oxygen and light, so all good.

I'm honored and pleased to be joined by Colonel Macedonia, who was previously introduced to cover specific medical issues that have emerged. But what I'd like to talk to you about is similar to what we've talked about previously, but with a little bit more focus on engagements and concerns as well as operations that we're

facing.

As somewhat fortuitous to Commander Feeks' comments, to one of the questions or concerns was really we are in a transition period and we feel this across the board. If you look, and not to provide a history lesson, but at every juncture of administrations, there's been a transition period, some rather dramatic, perhaps not so much, but we have an awful lot on our plate, as you all well know. And those things that we had no control over -- you know, economics, emergent Russia, China -- we'll talk about those things; and then perhaps those things that we do have control about that we're trying to effect change to: Those operations in the Middle East, one could say medical issues and health care and things like that. So, all makes for a very busy timeframe for all of us to include those in uniform and those within the building.

Our vital national interests still remain the same and that is to secure our homeland and those Americans from a catastrophic attack.

So, when we look at this and then we look at, though just as important, but other interests such as assuring access to strategic resources, you know, oil and water and such for our folks, flourishing in national global economics, trade -- and this kind of ties into the last bullet -- global influence and leadership, but access to the commons, the ability to be able to trade fairly across the world and of access to all those resources on a fair share basis across the international community.

And then, of course, you know, being able to manage our military in such a manner that allows us to keep the edge. So, this is where our focus is.

You'll notice that one could argue Iraq and Afghanistan interweaves throughout all of those, depending on where you sit, so -- and that obviously leads into the debate that we're having and we'll talk about that in a little bit. But, unarguably, I don't think, is certainly the implications of a Israeli-Iranian engagement or

further deterioration of North Korea and the Korean peninsula or other type activities that would gain our attention very quickly and present a hit on us in the sense that we would be very heavily engaged.

Again the environment that we're sitting is still -- it's unique in the sense that there are emerging spheres or domains that haven't been traditional domains. I bring up cyberspace and space. We're seeing more issues and actually have stood up a Cyberspace Command, a 4-star general under a Strategic Command, to address these issues. But then we still do have our typical issues around the world, certainly much centered around the Middle East, Southern Asia, Africa, where we see much of the instability, perhaps, from ungoverned or less-than-governed spaces. And then, of course, other issues which we'll talk more specifically to such as natural disasters. So, this is what is keeping us busy.

Where our priorities rest. Of course, and like I alluded to, we are in a transition

period, but without reading through this specific slide, we are trying to integrate and understand better how we integrate soft and hard power; hard power being military, soft being economic, political, information or other venues. And how do we do that across the interagency, and how we do that across the international community aligning them with everybody's priorities because they are different. So, as we move from the Presidential level to the Chairman's level, obviously, you know, our national interests, our vital national interest in the Middle East, you know, emerges as the number one concern right now and to this board and to the end of obviously the health of the force, just not in its ability to be able to fight today's wars, but also what's going to happen in 2020. And then lastly is to balance this risk. There's only so much resources that we have and to be able to balance it across the spectrum of the globe and the areas that we need to focus on.

We'll start by kind of going around the

world. NORTHCOM, basically here at home, remains number one, homeland defense. Defend, provide the defense borders both north and south, and obviously from the oceans. Disaster response, ability to be able to respond to Katrina-type events -- earthquakes and forest fires and things like that -- and then to be able to deal with other type activity. Still a lot of counterdrug activity coming up through Mexico.

And to just segue a little bit into Mexico, because Mexico is part of Northern Command, the things that we've seen with Caldera and the reemphasis on counter-narcotic activity within Mexico as well as the success that we've seen in Southern America has actually, kind of, you know, squeezing of the balloon where we've seen, you know, increased activity within Mexico, within the borders. So, trying to curtail that. At the same time, we have a lot of weapons that are shipping south, so leads to a very busy border.

(Interruption)

LtCol COKE: As we look at SOUTHCOM, I talked about the counter-narcotic and counterdrug activity that's been going on. We've seen a fair amount of success in such countries as Colombia, and working with those governments, specifically those militaries, on how to train and how to conduct counter-narcotic activity. Somewhat different from counterinsurgency activity that we'll talk about in a little bit.

Other areas of concern in SOUTHCOM, Guantanamo Bay. Consensus is we will not get to our deadline that we had made back in January as far as fully closing that facility. It continues to remain in the front of our senior leader's attention.

The other sort of unknown, but really, the theater security engagement that we're having in South America has proved to be very successful when we look at such things as the U.S. Comfort sailing recently as last spring and looking at what it was able to do in preventative medicine such as in Haiti and other South American

countries. A lot of success there. Again, not so much -- certainly providing a service to people, but also training the trainers and providing the leadership and the expertise so that you're building capacity within these individual countries.

Europe, still growing much active in the global picture, probably the most important aspect is NATO and really corralling the efforts with ISAF and all things Afghanistan, providing the senior leadership. The important thing that NATO is also involved in Kosovo continues, they're also involved in what we call two standard NATO maritime groups of ships that provide counter-piracy operations -- and we'll talk specifically about piracy in a little bit -- off the -- Amman and the coast of Somalia as well as being present within the Mediterranean.

Also, other elements, we have a NATO response force which is ready to basically provide reaction to any kind of Article V, protect the alliance requirements, and that's a NATO-wide

group. And then, of course, Baltic Air Police and over flight within the Baltics as an enduring mission.

Other European issues, we continue to look at Israel and quite a bit of news recently with Abbas not stepping up for another term and how do we bring the West Bank and Gaza together between Fatah and Hamas and bring them to the table opposite Israel? Several efforts to that extent. We've had the Security Cooperation Mission there, which has taken West Bank and Palestinians through the help of Jordan and to train those and basically providing their own security for and within the West Bank. Small U.S. Contingent basically there to facilitate. Small success in pockets, is trying to expand that, that's the challenge.

And then a lot on missile defense as we go into this new architecture as far as missile defense, just not in Europe, but also around Japan and Korea; and how do we go forward with the decision to change course in what we were going to

have under the previous administration and working with those countries, Poland and Czechoslovakia specifically.

Central Command, really three emphasis. And we'll talk specifically about Iraq and Afghanistan here in a minute, but also piracy and counter-piracy continue to have several international groups. You have Operation Atlanta, which is the operators -- it is the EU that provides 11, 12 ships from across the EU for counter-piracy operations. You still have Task Force 151, which is a cooperation among several nations for counter-piracy operations. And then you have SNGMs, the NATO groups that we've talked about, along with a lot of bilateral relationships and unilateral such as the Chinese and Iran, for that matter, as well.

Pacific Command, again everybody tends towards Korea and Kim Jong-Il, and last summer it was whether he was alive or dead, and now what are their intentions to return back to the Six Part Talks, to look at avenues that we can decrease our

presence. We still maintain 25,000 people thereabouts in South Korea, still part of the armistice, so -- and then to that end, similar to Iran, counter- proliferation. Still have, although not as newsworthy, interdiction operations taking place around the Sea of Japan and Korean shores.

Tied into PACOM also is India, so when we look at the relationship between India and Pakistan, reflect back on Mumbai and how we're posturing ourselves in the event of hostilities breaking out, trying to work with those two governments and particularly those two militaries; to understand that for Pakistan, the threat really isn't India, it's more Pakistan Taliban; for India to understand that the threat is broader than just its neighbors. So, trying to work with those governments to look at things more holistic, perhaps more comprehensively.

Some success in different pockets, particularly in the Philippines, as we continue to work with them on counterterrorism activity and

their own, as history has shown, emergence of different insurgence type activities.

AFRICOM, my newest COCOM a little over a year ago. Again, a couple of focuses. Trans Sahara still quite a bit of illicit activity that used to be part of the old GWOT terrorism, now kind of refocused on being a breeding ground, per se, of insurgent activity and illicit material. It ties into the old 150 operations within the Red Sea and moving what was basically being produced in Northern Africa over into the Arabian Gulf.

Still have a fairly strong standing there in Djibouti as far as the Horn of Africa in providing a response force, and then looking at theater security engagement and partnership within the various governments in Africa. The uniqueness of this is looking at it from more a comprehensive approach, certainly billeted under the combatant commander, second in charge, breaks out where you have a military type and then you have an ambassadorial level type, you know, looking at other things than just military.

And then globally, obviously economics still. We're still on the recovery there. H1N1. And then as we talk to the lines that divide the various COCOMs in geography really are fading and thus our work on the Joint Staff in OSD has increased. We're working at seam issues, so when we deal with terrorism or al Qaeda or groups as such.

And then how do we source, and we'll talk a little bit about this, but basically balancing all these with the right forces at the right place at the right time.

Afghanistan. Really, there's two things that press us and that is security and governance. And as we look at the great debate that's taking place on the resourcing of Afghanistan and how we bring to bear what it is we think to -- on this issue, we agree pretty much and principally across the globe that the strategy and the focus from General McChrystal's assessment, and what we've pretty much known is on the people, it's a population-centric, where we might say, the center

of gravity needs to be focus.

This isn't new. We've had 3 Block War or counterinsurgency type operations all the way back in history. But what it entails is the ability -- and I'll use an example within the Helmand Province -- to be able to provide election support and to be able to provide the security so people can actually elect a government. At the same time or around -- you know, on the different block, be able to actually engage the enemy with kinetic activity. And then to hold that ground, to allow the population to be -- get out from being under the scrutiny and under the control and to allow that governance to develop.

And then lastly to teach, and to be a part of building that capacity within their own security, within the other elements of government. So, obviously, this is just not a military solution. This is a broad brush, a broad, comprehensive approach, and that pretty much forms the basis of the strategy.

Now, how we resource that is obviously

the great debate that's going on today. You all may have heard in the news today that Ambassador Eikenberry has come out against increasing any troop levels. So that will go into the mix of the discussion. But I think the point is, is that when we look at Karzai and we look at the government, that we have to have an honest and a real partner there in order to make this thing work. The military is posed to do that, is posted to do that based on my next slide, which is Iran, that we have a responsible withdrawal -- I'm sorry, Iraq -- a responsible draw down from Iraq in order to provide those resources to Afghanistan. Specifically are the resources that deal with enabling: the logistics, the ability to be able to feed and care and provide support to the personnel that are providing the actual security and doing these operations. And again, this is just not military; it's international military and it's all forms of government.

It's probably good to just reflect and to reemphasize that this is an international

effort. When you look at, by population, in those contributing countries, it is rather stark in the sense that we have 53 countries participating and 24 of those countries have sustained killed in action. And of those, strangely enough, Estonia has .05 of a percent, 6 people to their population, so they rank number 2. And then everybody else kind of comes down, but we're number six. So, when you look at population and what various countries are giving, I mean, we're obviously in the top 10, but we're not the first.

Iraq. Again, being able to hold the success and allow the success to continue with those enforcing and assisting the Iraqis themselves tied to what we call a responsible withdrawal to the point -- or exit, to about 50,000 next August, by the end of next August. We're seeing more and more of this where the Iraqis are actually taking responsibility for their own security to the point that we're able to, once we get past the elections here in the next couple of months, start sizably withdrawing

those regiments.

Now what's keeping us up at night? Very much, if you were here last -- or when I gave this very much same thing, we sort of have near term and long term. In strategic balance, in the near term, is more aligned to being able to provide those resources for right now, to be able to provide those resources in Afghanistan, to arrest the continued success of the Taliban and al Qaeda; at the same time, be able to withdraw from Iraq. We can't do both at the levels that certainly Iraq has been and certainly we need to go in Afghanistan.

Pakistan and India -- let me back step one thing. We understand that success in Afghanistan is interlinkedly tied to success in Pakistan. So those two -- and how we deal with that, now throwing in India, is front and center on our minds.

Talked about the Middle East, you know. And it's just not the potential of red lines being crossed either on Iran or Israel principally, as

far as whether they start shooting at each other, but also countering such things -- or interdicting arms shipments, particularly when we look at arms shipments to Hamas and Hezbollah and potentially Syria.

And then the threat to homeland defense as previously depicted on the slides was these ungoverned spaces and less than governed spaces. Somalia being an example where illicit material and people are allowed to breed and continue to fight.

Talk about North Korea and then talked about the links that exist between, you know, several groups, whether it be piracy, whether it be al Qaeda, whether it be Taliban, but sort of the link of the bad brotherhood.

And then in the long term is strategic balance as far as how we balance across the forces to be able to provide what it is we need in 2020, where we're going to be in 2020. Who is going to emerge as potential threats and are we going to have the right resources? Are we going to have

the right people trained with the right strategies and the right doctrine to be able to deal with these emerging threats much, much further beyond than what we're facing today, understanding that we're kind of in a time period of diminishing resources?

We talked about the cyber and ungoverned spaces. Where we're going to go in the Middle East, particularly with Iran and Israel, this is a long term, but you have some very short-term implications. You know, there's a lot of strategies that still are being developed and get tested. A good example would be Georgia last year where we sort of have to reflect on what is our strategy with Russia? Is Russia really an emergent threat? Or is it an emerging partner within the global community? And how do we, you know, foster and assist in the latter? Understanding that they just whacked their neighbor pretty good, perhaps provoked, perhaps not. And then obviously we're all affected by the global crisis.

The last slide, just want to talk about the commanders a little bit. And when I'm talking about commanders, talking about the combatant commanders and how things have changed. Everything happens faster and really one could look at the media and the way information flows. It really is a 24/7 world, and that's a very different paradigm and environment to be in. I mean, it's been emerging, we've known this for a while, but we're really almost here. We will not act specifically within a COCOM and be tied to a geographic region. We understand that the seams between the COCOMs, the combatant commanders, are really eroding, particularly when you look at some of the domains such as cyber. So, the COCOMs have to work with each other and thus we have to work with the secretary and with the chairmen and the various staffs, that it's no longer go it alone, just as much as our country no longer has a go it alone policy. It's an international effort. We within the military understand this intrinsically.

And the point, too, is as much as we

need to be able to react to those threats, it is -- the prevention is becoming more and more to the forefront. The ability to build capacity within individual countries is really more of the mission than simply being ready, being in barracks ready to go when the conventional call cries.

And then, just to bring it to closure, the idea that -- and I've said this several times -- that the COCOMs are part of an interagency and a global partnership, that it's just not a military solution. And that goes back to the slide that, you know, as we look at foreign policy and bringing to bear all the tools of government and all the tools we have on these various issues around the world, it's just not the U.S. military. It's part of a growing international community and interagency within our government.

With that, I'm going to turn it over to Colonel Macedonia to talk specifically about medical issues. And I'll stand by afterwards to address any operational or way ahead questions you all may have.

Thank you.

COL MACEDONIA: Is it possible to use this mic over here instead of standing up? Yeah, I saw these people over here craning their neck to see the briefer and I hate standing at the podium, so I'd rather look people in the eye as I'm giving the briefing.

I'm Chris Macedonia. I'm the Chairman's Special Assistant for Warriors and Families. And so this isn't exactly health briefing. In fact, when the chairman handed me the job he says, Chris, I need you to stop thinking like a doctor. Okay? Stop thinking like a doctor. Think about families, think about the more global issues of health of the force, and don't think just about disease. So I do want to clear that up.

We've already covered this, but I just want to say that the second strategic mission statement out of the Chairman actually has even been updated since that time, it's health of the force. So the second thing that -- I don't want to say keeps him up at night because everybody

calls Admiral Mullen "Midnight Mike," and there's a reason for that: Because he's the hardest working man in the building, I have to say, and so I don't know when he sleeps, actually.

Chairman Mullen, if he said, if there was only one message to send to the Defense Health Board about his priorities it would be that we have to change the culture. And it's not just within the health fields, it's change the culture primarily in the building. We need to catch up with the culture change that has happened at the 05 Level and below, the people that have been fighting the various wars on this plant, the people have deployed over and over and over again, they have all -- their culture has already changed. And that culture change involves not thinking about people as widgets, as replaceable parts. Sort of, you know, when I came into the military, all we thought about was fill the gap, all we thought about was fighting the Russians, and at that time a person was far less important than the M1 or whatever weapons system they

occupied.

We now have a military where that's completely inverted on its head and vehicles are expendable. In fact, if anybody saw the report this morning on CNN talking about the new versions of the MRAPs, the vehicles are deliberately designed to fly apart when they get hit by an IED except for the crew compartment, so that the crew is the last thing to be hurt. The engine can fly away, the tires can fly off. We have to change the culture and the way we think about our individual people who wear the uniform, and their families and stop the -- you know, for instance, if I want a new solider into my unit, I still fill out, guess what? A personnel requisition, just like I'm ordering a part. We have to change the culture. And if we're going to improve the health of the force, we have to have the rest of the force, and that means the 06 and above, and the rest of the bureaucracy in D.C. to start thinking about people as people and not as replacement parts.

The second objective is -- his second priority is develop objective measures of what we're doing. How are our programs working? I'm sure this group has been briefed on a million different programs: how to reduce suicide, how to help TBI, how to make people's teeth whiter, I mean, just everything. But the fact of the matter is, is that we need to have good objective measures on what we're doing because we're spending lots of Treasury money on things and we need to make sure that every penny goes to improving the health of the force. And if it's not improving the health of the force, we need to call it what it is, kill the program, and fund something else, but that means developing objective measures to do that.

The next one, realign the organization and funding of DCoE and subordinate centers. Now, this seems rather tactical, you know, it's a center. It's one piece of a very large organization called Department of Defense. But remember, the Defense Centers of Excellence is the

Congressionally designated bellybutton for all things related to the invisible wounds of war, which really ties up our system.

So we've got to get this thing right.

And the very fact that the DCoE still doesn't have a manning document, still doesn't have a TDA, you cannot put it on a wiring diagram within the Department of Defense. And I know this because I sat down at TMA a month ago while we actually tried to find where DCoE existed on the wiring diagram at Department of Defense and we failed to find where the connectors reached. So, we need to align it under some organization.

I think we're making great strides in certain areas. So, for instance, the Chairman took the TBI issue head on, sent two teams into theater: Grey Team 1 and Grey Team 2. And, in fact, the reason that Admiral Smith isn't here at the Defense Health Board is the fact that he is briefing the final phase of instituting a revolution in the way we do TBI care in theater.

I already talked about establishing a

TDA. And then develop resiliency and rehabilitation programs focused on operational health using evidence-based traditional, as well as complementary and alternative medicine approaches. And, you know, I do want to say that the chairman wants us to look at all options. And again, you can have evidence-based, complementary and alternative medicine integrated, but we're hearing that every time we go out to installations, every time we go out amongst the troops where it's here in CONUS or overseas, people are asking about, you know, new methods, new therapies, and we need to be open-minded about that.

The fourth one, establish a uniformed -- and that means the Vice Chairman, the Joint Chiefs along with the Vice Chiefs, basically reestablish the DMOC. So, there is this organization. For those of you that don't know, there's an organization created called the Miser. And I would just implore people to go into Google or open up a dictionary and look up the word "miser,"

and it says it all. Okay? Whoever was the genius that came up with the word "miser" to describe how we allocate our Defense Health line dollars, you know, they may have been a very smart person, but they're pretty stupid if you actually look the definition of "miser" up. And by all means, if you have a BlackBerry and you want to look that definition up now, you can go ahead and do it.

So what the Chairman would like is that members of the military, who are the constituency that actually receives military health care, have some say in the way health care dollars are allocated within the Department of Defense. So that's a priority of the Chairman.

Joint electronic medical record used all the way from theater of operations through the MHS and into Veterans Affairs. And actually we need to change that slide because it also needs to say, "and for life into the civilian health care system." In other words, whatever happens to Joe on the battlefield needs to be visible all the way to people when that person ends up being in Blue

Cross/Blue Shield after they separate from the service. And, you know, obviously we have to get it right in-theater first and we don't even have that one solved. If you're getting care in a Role 1 facility or half of our Role 2 facilities in Afghanistan, you're still getting your health care done on paper. And even if it's done electronically, ironically, we're still losing that stuff, too. And I know this because I just came out of Afghanistan three weeks ago and we're still seeing it. And I can tell you, as few as two days ago, one of the people in my office who's a severely wounded soldier, had almost his entire medical records related to his prosthetics lost by Walter Reed. So we've got to get this right, guys, okay? Do I have a little passion in my voice when I talked about my soldier having his records lost? I'm not happy about that. As a physician who is in the Walter Reed and Bethesda health care system and takes care of patients, it bothers me tremendously we still lose records.

Improve mental health services for

service members and dependents. You know, I think given the events of last week, I don't need to hammer this too, too hard. I think, hopefully, everybody here gets it. We've got to reduce the stigma of receiving care for services related to post traumatic stress. We've made great strides. You know, the change in question 21 was huge, but we have to do more and this is a complex problem. It's not as easy as saying, hey, there's no stigma. You can't do that. Again, that's part of the culture change, but we have to open up some ability for people to be able to talk in the open and get help.

We need to improve access to residential and mental behavioral health care for our dependents. It's a huge problem because remember, this war doesn't just take a drain on the combat wounded, it takes a huge drain on families. And really, we have certain gaps and one is in our dependent health care, particularly on the residential mental health side.

DR. FOGELMAN: Excuse me, what does

"residential" mean?

COL MACEDONIA: So, for instance, somebody receiving -- a for instance is if you have a 14-year-old child and they have a drug and alcohol problem related to --

DR. FOGELMAN: You mean in-patient?

COL MACEDONIA: That's correct. But, you know, there are facilities that are kind of stand alone facilities outside of hospitals, residential facilities.

Standardize the DoD and VA crisis prevention and suicide hotline. And I'm not going to get in the detail of that because there is so much whirling and swirling around that one, but I will tell you that that is an ongoing discussion.

And then DoD and VA aggressively account for, assess, and support homeless veterans. I might add, we just need to account for all the veterans, everybody who's filled out a DD-214 is no longer in the service, but the homeless, obviously, are a target for the Chairman. He and I flew up to Holyoke and actually visited a group

that was doing tremendous work for homeless veterans and we need to promulgate more programs like that dealing with the homeless. And there is a growing problem with female homeless veterans and they represent kind of a different population than the traditional homeless. That population, they tend to be single parents and they tend to bring their children to the homeless shelter. It's very different than the Vietnam generation homeless. And then we estimate about 12,000 of those in the system right now.

And then develop mechanisms where service -- Wounded Warrior programs can closely work with nongovernmental organizations in order to support validated requirements. This is basically, we need to have means by which people in uniform and people from the charitable organizations, the VSOs and others, can work hand-in-glove in helping wounded veterans.

And then establish a DoD family programs standards for service programs which leverage the best practices from each service. In part, we do

this every week in what we call the Warrior Roundtable where right now it's confined to the Wounded Warrior programs, but we want to expand this across all programs. And there are others, I realize, but the Chairman's committed to that, so is Deborah Mullen, Mrs. Mullen.

Develop programs that focus on the ability and retention of quality Service members. So, you know, we have a disability system right now, and the key word there is "disability." And what we want to focus in on is abilities, okay, and not disabilities. We want programs that maximize the potential of that individual in society, whether it's in the society of the military or the civilian society as a whole. So, for instance, allowing disabled members of the military to remain on active duty, but somehow receive their benefits. And we are in discussion with VA on this one.

Allow service members to grow beyond end-strength to accommodate for recovery of wounded, ill, and injured. This is really -- this

is not just a problem for being retained on active duty. This is also a problem for deploy ability, particularly for the Army, because the Army basically says if you've got somebody who is injured in any way, in order for you to requisition a new person, that person has to be out of your unit, which means they have to go to the WTU, which means the WTU gets flooded with lots of people who are in the business of getting their disability evaluation done in order for units to deploy. If those units were allowed to go above strength, encode that person as being in the middle of a board process, and that not count against that unit, then the units could retain those people and the person wouldn't have to leave their military family. That paratrooper wouldn't have to leave the paratroop unit to go to the WTU. They would be able to -- okay, so it has all sorts of second and third order effects.

Allow wounded, ill, and injured to accrue leave while hospitalized, on con-leave, or vocational rehabilitation. I think that's pretty

simple.

And then that home adaptation business has to do with the fact that we have a whole generation of people now who get care in one regional center that has expertise, say, in TBI, and then perhaps has to go for long-term therapy for their orthopedic injury. And the problem is that there are variations in the cost to the individual, and we want to eliminate that so that it's neutral to the individual.

And then obviously, we want to complete actions already underway, so DES reform, caregiver compensation, equalizing that out, and abolishing concurrent receipt for military retirees.

So, anyway, that was a quick once-over of the world of sort of where the Chairman's mind is at. It's not totally limited to that.

Let me just finish up by saying that it's all about changing the culture, about thinking about people as people and not as widgets, not as numbers, but faces. You know, I think if you look at the events of Ft. Hood and

the way that was handled, in the President's address he talked about each person as a person and what they did and what they lived for. That's a very, very different President and it's a very, very different way of thinking about our individuals than in previous generations. And it has to do with the fact that what you saw in the previous presentation, which is the complexity of global threats, means we have to have individuals in uniform who never before had to do the complex kinds of tasks that any military has asked of them: running very complex weapons systems, having to learn multiple languages, all these other things, very small force carrying on very, very big missions. And because of that, we have to think about our people differently.

So that's all I have subject to your questions.

DR. LEDNAR: Thank you, Colonel Macedonia and Lieutenant Colonel Coke. I think what we've heard now in the last 45 minutes is the array of threats and military activities that are

going on around the world. What Colonel Macedonia shared with us is how a non-health care provider thinks about the importance of health to the force, to the families, and to the mission. And that isn't always necessarily how we doctors and nurses and other health care people think. And I think it's very helpful to get that insight and it really is clear that Admiral Mullen is engaged. He's there for us. And if we can be understanding his agenda as he sees it and being responsive, you can't get a better advocate of the Chairman of the Joint Chiefs.

With that, we have time for a few questions for Colonel Macedonia or Lieutenant Colonel Coke. Any questions from the board?

DR. WALKER: Yes, Walker. Under the Developing Resiliency in Rehabilitation, you talked about evidence-based tradition, you talked of complementary and alternatives. Is that also evidence-based?

COL MACEDONIA: Yes, I think everything needs to have evidence, you know. And along those

lines, there's going to be a conference at the Uniformed Services University, I think the 6th to the 9th, and it was convened at the behest of the Chairman to include speakers to come and actually present any type of evidence they have for complementary and alternative medicine. But it's much more. The conference itself is on what's called total fitness, so it includes programs on physical fitness, mental, spiritual fitness, comprehensive soldier fitness. So General Cornum will be briefing at that and the people from the complementary and alternative medicine world will actually present some of their information. But any type of broadly spoken program that we use out with the force, people need to show evidence that it works. Otherwise, we could be foisting things on people that actually makes them worse.

DR. LEDNAR: Dr. Oxman?

DR. OXMAN: Mike Oxman for Dr. Macedonia. When you said that the records, the data on your colleague's limb was lost, was that paper data or was it electronic data?

COL MACEDONIA: It was both. And, in fact, it wasn't -- it was an eye and palate prosthesis, so you know, we have to consider that. I mean, there are -- if you look at the HL7 standards, there are standards for compiling information about, you know, all sorts of things, not just text data. And the reason -- I don't know the reason behind the loss. I happen to know that he's having to undergo a repeat CT scan to rebuild and refashion the models under which his prosthetics were formed.

DR. LEDNAR: Dr. Mason?

DR. MASON: Tom Mason. Question for each of you. If we look at the Post-Deployment Health Assessment and we admit candidly that it doesn't capture the information that we need, and as a ready Reserve officer who gets the officer, and look at Post-Deployment Health Reassessment, having soldiers go back to soldiers, I really appreciate hearing from you guys as to where the devil are we and how are we going to get to where we need to be?

LtCol COKE: As a victim of being reassessed, I can speak to -- at least from the Marine standpoint, it kind of made you wonder where, you know, where we were going with this and certainly, you know, where was the focus as far as where the concern was, I guess, but, you know, that's more from an individual standpoint.

I can't really speak to the broader standpoint.

COL MACEDONIA: That's an excellent question. And not to beat up on the Post-Deployment Health Assessment and Post-Deployment Reassessment, for what it was set up to do it's a pretty good instrument. But remember what it was. And I had this discussion with Dr. Casscells just before he left over an article that Dr. Hoge was about to publish.

The Post-Deployment Health Assessment was a stopgap measure. It was never intended to be used in 2009, eight years into a conflict. It was a stopgap for the fact that we didn't have accurate medical records in-theater so the

conclusion was, well, at least when they come back, we can take a decent assessment when they roll back in. Then they studied the accuracy of the data that people gave when they first came back in and, like me, who wanted to go back home, we were like, no, no, no, I didn't see dead bodies. I didn't shoot people. I didn't -- you know, because you know what, I want to get back to my family. I know the answers -- I know if I hit those, they're going to want me to see somebody, so I'm going to lie.

Okay. So they said, well, it turns out that people are a little bit more honest in their answers if you hit them up four to six months later. So they came up with this Post-Deployment Health Reassessment, okay? The fact of the matter is, what are we trying to fix? We're trying to fix accurate medical records. And if we did it accurately in-theater, we wouldn't need Post-Deployment Health Assessment/Reassessment. We would have it in their medical record to begin with. So let's fix the problem in-theater. Let's

give the requisite bandwidth, let's get the electronic medical record on the ground, usable by the providers and the medics, the corpsmen, the people that have to enter data, and let's do it right.

Look, they use Blue Force Tracker in the Humvees and MRAPs have this sophisticated computer where they tap in, you know, where they engage the enemy and this and that. We've got planes flying around unpiloted with full motion video eating up all sorts of bandwidth and we give this little tiny sliver of bandwidth to what? Our most important asset which is our people. Let's fix this problem.

DR. MASON: Would it be helpful for this board to go on record as being supportive of what you've just suggested?

COL MACEDONIA: Oh, absolutely. I'd shine your shoes, you know, whatever. If you need your driveway shoveled --

DR. MASON: Thank you, Colonel. My shoes are shined. Don't ask my students because

it's rare for me to be in closed-toed shoes because in Florida, I can wear sandals. But the issue is a very simple one: Is there something that we can do?

COL MACEDONIA: Absolutely.

DR. MASON: Because this facilitates so much of what we talk about, whether it's the Subcommittee that I proudly serve on with Dr. Halperin or whatever. If we don't have a clue over an expanded period of time as to the experiences of our workforces -- of our forces, our fighting forces and the support forces, we're doomed to failure from the standpoint of making informed evidence-based decisions.

COL MACEDONIA: You know, amen to that. Let's look at the TBI and PTSD issue, and this is in part one of the conundrums. When you assess people at Post-Deployment Health Assessment and Reassessment, they may be eight months out from the inciting events or injuries or whatever and our ability as people to recall, whether it's being blown up with TBI or whether or not we fell

off our bike, you know, on Old Georgetown Road, or whatever. I fell off the left side of my bike or the right. You know, I mean, it's not just in war that collecting data 8, 10 months after the fact is kind of counter to good medical practice. We were doing it because we felt that we didn't have the sophisticated electronic records system in-theater. Let's solve the sophisticated electronic record problem. Keep the PDHA and PDHRA as the stopgap, but let's not get so wrapped around polishing Post-Deployment Health Assessment and Reassessment to the point where we forget what it was stood up for originally, which was just as a stopgap.

DR. LEDNAR: I'm going to have to bring this session to a close. I'd like to just share, however, with Colonel Macedonia, because I believe it was on our third slide about what the chairman's priorities are for the health of the force, you're talking about bringing to conclusion important initiatives which have been started. And I'll call that, you know, executing to the

objective. You also mentioned the importance of an electronic medical record and the flow through the entire chain. More than 10 years ago, this Board recommended to the Department of Defense exactly that issue be addressed. Ten years ago, and it hasn't happened yet. So there's opportunities to execute and I think it's fair to say that the Board is supportive of your desire, your interest, and the need. And we can talk offline structurally about how we can put something together in writing that we can share back with DoD. But thanks.

(Recess)

DR. LEDNAR: Can we take our seats, please?

Okay, I'd like to call us back to order. We are a little bit behind, but I think it's important that we spend the time that we should in the discussion.

The next topic deals with international military health issues. And Commander Bill Hughes is here with us, and he's going to introduce this

topic and our speaker for the next briefs.

Commander Hughes? Thank you.

CDR HUGHES: I'm from a similar school to Colonel Macedonia on this regard, too.

You know, when I was at the Naval War College a couple of years ago, there was a favorite line that a number of the professors liked to put up there and it was about slides. And there was a Russian naval officer who came over after the fall of the Soviet Union. And when he was asked by a public affairs officer who would have won a war between the Soviet Union, and the United States, and NATO, and he said, well, while you were making your slides we'd be killing you.

I have four slides but they're not going to be broadcast for you because I want to give you a history of what led to the development of the International Health Division and what our initiatives are that we're doing now in health affairs.

Two years ago, the International Health portion of the Civil Military Medicine Division,

was established with contract support and one Navy 05. Shortly thereafter, Dr. Casscells, the Assistant Secretary for Health Affairs, called up Dr. Anderson. Dr. Butch Anderson is a -- I should say is -- yeah, once you are Special Forces, always are Special Forces. Kind of like once a Marine, always a Marine. He just recently retired as a Special Forces physician combat-wounded veteran. And he had taken his job with the Indian Health Service out in his home state of New Mexico. He's a Health and Human Services Officer. And he was called by Dr. Casscells and asked to come in and start the International Health Division, which had been going just a bit but inside Civil Military Medicine. He thought about it, I guess, for a little bit. Well, he's with us now. He's not with us today; he's out in New Mexico on emergency leave. But Dr. Anderson got this going.

What led to International Health being developed? Now, back in the 60s, there was a Dr. Robert Wolinsky, an Army battalion surgeon. He

wrote about the results of Medical Civil Affairs Programs (MEDCAPs). Largely, a lot of money thrown in to doing these MEDCAPs. They were unplanned. They made a lot of patient contacts. Nothing about measures of effectiveness. It was strictly about the outcomes that we had.

But over time, we've seen other things develop that led us up to this point, too. The National Security Strategy of the United States has made it clear that one of the major strategies for the United States will be to secure global public health. We have the Laws of Armed Conflict in the Geneva Convention. We will -- if we are currently occupying a country, we will have to oversee the health care for the people. Not just military personnel, mind you. The Geneva Convention makes it clear that we have to provide health care for all as long as we are in occupying power, which clearly we are. As long as we argued about it, it's clear what we are and have been in Iraq.

But also in 2005, DoD came out with the

Joint Operation Concept that said Stability Ops would be on par with major combat operations. Around that time, Homeland Defense was also made a joint operating capability. Those joint operating capabilities are part of the JopC family. The JopC family says this is a problem and here's a solution that you will look at 8 to 20 years down the line. That was in November of 2005. Four years ago. So it's developing quite clearly.

Also came out back then was the Department of Defense Directive 3000.05, which at that time was called Military Health Support to Stability Security Transition and Reconstruction Operations. Now, it developed primarily out of two and a half years of our experience in Afghanistan and in Iraq. It was nation building. Listening to NPR on my way in this morning as they were talking to the former head of the International Crisis Group (ICG). And when she was in Iraq, she was talking about nation building. Still talking about it. Not a very popular subject with our DoD senior leadership.

And it wasn't.

But the directive came out this month four years ago, and it reflected quite a bit what direction we took as a government. Now, this is Bill Hughes' opinion on this. You don't have to say you agree with it or not because I really don't care; it's my opinion. And that is that it reflected the unilateral approach that the United States was taking in its foreign policy. It was very heavy handed. It said that not only would stability operations be comparable to major combat operations, but it also said DoD will be prepared to provide for its medical personnel and stability operations, these nation building concepts, if the rest of the government wasn't willing or able to do it. Wasn't willing to do it. Now, it seems to me that was somewhat a reflection of our leadership. Looking across the Potomac and saying unwilling, incapable, unable.

Well, over time that has changed. It's really reflecting what it is we had to do. Just as our stability operations have changed, this

notion of stability operations has changed and it has really influenced our other federal partners in this. Now, recently when I was giving a lecture to the Joint Medical Planners Course at Bethesda, I asked the Army, Navy, and Air Force personnel -- I didn't expect the two Canadian personnel to know this -- had you ever heard of Department of Defense Instruction 3000.05? Not one of them raised their hand. But you can sure bet that our interagency partners heard about it back then. It scared the daylights out of them. They thought here comes DoD to militarize diplomacy and development.

Well, that Department of Defense directive changed a little bit. It is now a Department of Defense instruction. The Department of Defense instruction 3000.05 clearly shows the direction we are trying to take with stability operations. No longer is it Military Health Support to Security Transition and Reconstruction Operations. It's flat out Stability Operations. And it makes it clear that what we are going to do

as a Department of Defense, is we are going to have our military portion of our whole government approach and all the elements of power, which we heard Lieutenant Colonel Coke talk about -- diplomacy, informational, military and economic -- to be used together to change and shape an environment. And changing that shape and environment isn't just pre- conflict or post-conflict, but it can also include humanitarian assistance and disaster response. They are now part of Stability Operations.

Where does that leave us as a Military Health System? We now have what's developing and will be ready for signature soon, I hope, is a draft instruction, 6000.AA, Military Health Support to Stability Operations.

There are some key components to it, and some of them have been quite difficult for us. One is what will be the standard of care? How will you provide care in an environment, whether it's hostile; whether it's for humanitarian mission; whether it's a planned or unplanned

humanitarian mission; how are we going to fund these things? You know, Department of Defense Instruction 3000.05 said that it will be funded. I have yet to see it. That it will be part of the planning programming budget and execution process. I still have not seen that. Where is this money going to come from? We have strict rules about what it is the Defense Health Program's money can be used for.

But we already have rules in place on what money can be used for for humanitarian operations, humanitarian civic assistance programs. The only difference between those two is one is unplanned; the other is planned. Disaster response, homeland defense issues. We have rules in place for money. There is money available, but it is going to entail a change. It's part of the paradox of military success. When the bullets stop flying, commanders have gone out with a robust surgical capability in the field. Well, when you have these highly trained medical professionals sitting around, not

necessarily doing -- seeing just patience. I shouldn't say that they have nothing to do.

But as they see their workload decrease in these environments, what do we do with them? We send them out on these MEDCAPs. We send them out on these other missions -- these humanitarian assistance missions. Well, is it going to be any different if we're not planning for them than what it was for Dr. Wilensky in his view of how we approached medical civil affairs in Vietnam. If we are not planning for these things, we are not training, staffing, and equipping our personnel to do this. How much of what we have seen for our military since 1985 -- how much actual time has been spent in major combat operations?

I can certainly think of a lot of times through there where our Military Health System has been called upon for disaster response, humanitarian assistance. Not just because it's a good photo op. I mean, we saw tsunami relief efforts really making a difference in terms of what the indigenous population thought about the

American people and the American government after tsunami relief. Well, how did we sustain that? How do we sustain that effort? How have we gone out to make those continuing -- those little bites.

Those are some of the things that have helped shape the International Health Division and brought us here today.

DR. LEDNAR: Commander Hughes, the Board will certainly follow with interest as the Department of Defense evolves in its approach to medical stabilization operations. I propose we move to the brief on Afghanistan as a way to inform us that what has been our experience over the last nine years, and obviously will be helpful to the Board, and I think relevant to the thoughts of the Department.

CDR HUGHES: That's great. You just beat me to the punch. Thank you. That was actually my next --

I'd like to introduce to you, Dr. Lynn Lawry. Dr. Lawry is a member of our staff in the

International Health Division. She has significant experience in the NGO community. She can tell you a little about herself. She is a certified internal medicine physician. She has a number of teaching positions, including Harvard, Uniformed Services University of Health Sciences, but significant experience out in the field. And she's going to talk to you about what DoD is doing, how we have put our division into action overseas in Afghanistan as an example.

DR. LAWRY: Thanks, Bill. So my way of doing this is to give you sort of a historical approach. I think it's always good to go back so many years later. To go back and look at the history. Because a lot of the history changes with media, and I think it's important to make sure that we understand.

So this is all of the visas that I've ever gotten from Taliban Daison. So you've got Taliban visas, Northern Alliance visas, interim government visas, and finally, the newest one. My entire passport has the history of Afghanistan in

it.

So let's start with Afghanistan 2000 to 2001. I was there. I was working for Physicians for Human Rights, and I was doing research on women's health and human rights issues. Usually alone. And I want to be able to present to you some of these studies only because I think the contextual nuances are important.

So let's go back to the history. At the time -- and this is 2000 -- there had been 20 years of armed conflict and human rights violations. What is sort of forgotten is that during the Soviet occupation, a million Afghans were killed. A million. That's a huge portion of their population. And what is also forgotten is at the time it was the largest refugee caseload with 1.4 million refugees in Iran and 1.2 million in Pakistan, primarily in the Peshawar area. Seventy-five percent of these refugees were women and children. And during this time, after the evacuation of the Russians, there was Mujahedin groups that were fighting violent struggles, and

this is when the Taliban came about.

This is a picture of the refugee camps in Peshawar. Sort of typical housing. So, Afghanistan during the Taliban years. The Taliban came to be with that sort of vacuum in power. They were -- the term Taliban actually means student of Muslim religious studies. And the Taliban at that time -- and I think this is an important point -- were not generally Afghan. They were foreigners. They were Saudis, Chechens, Wahban groups from other countries. Although they were poorly educated Pashtun youth, they weren't necessarily Afghan Pashtun youth. They were primarily Pakistan Pashtun youth. And one of the reasons that it was so common to have so many young boys in these madrasas or these religious schools was this was a place where you could get three meals a day, a place to sleep. And so many Afghan families turned their boys over to these groups to be able to get them "educated", not quite understanding that the education was memorization and not really school education.

At the time, the Taliban were led by Mullah Omar. And in 2000, they controlled 95 percent of the country; only 5 percent of the country was Northern Alliance. And their real claim was to restore peace through Islamic law, imposing Taliban interpretation of Sri Allah. And institutionalizing women's rights so that there were absolutely none. Not one.

Women in Afghanistan before this and during -- at the time of the Taliban, women could only leave home when escorted by a male relative. This was problematic for widows who may not have a son who was old enough or did not have a family member that could come and escort them, meaning they couldn't get to health care. They were limited to seeing male physicians. It's really not well known, but women in Afghanistan will see a male physician. They will be examined by a male physician if it's an emergency. If it's not an emergency, then they prefer to go to women, not unlike what we have in the U.S. where 75 percent of my practice were females because they just

prefer to go to females.

They were not allowed to attend school, other than religious schools up to the age of eight. Another unknown fact is that actually during the Taliban years it was the highest number of girls in school up to that point because what they had done was create underground schools, many of the NGOs. And so you had the highest number of girls in school during Taliban years.

Prior to that, 70 percent of the teachers were women, 50 percent of the civil servants were women, and 40 percent of the physicians were women. Civil society ran with a huge number of women involved.

In 2000, I was asked to do a population-based health and human rights survey. We needed a survey that was written in English and translated to Dari. It had to be easy to administer. There had to be some safety measures built in. And I'll go back to that.

We translated it and back translated it three times with Dari speakers. And then we had

all kinds of other things that we needed to do. One, because I couldn't be caught with data sheets or data on my computer, and so we had to be able to satellite -- get the data out. And so we needed to enter data while we were in the field.

The safety measures that we undertook were coded words and phrases. Basically what we did was if we wanted to know about Taliban's edicts against women, we would use a two letter in Dari -- two letter acronym and then that meant that the data collectors knew. Instead of saying the financial situation, which is what it looked like, they would say Taliban's edicts against women.

We had data collectors. And here's a picture of my data collectors, both under burqa and out. I think this is a wonderful picture. And I had eight medical students who helped to do this survey. We had letters of safety. How did I do this? I went to Taliban leaders. I usually picked Afghan Taliban leaders because they were not particularly wedded to the Taliban movement.

They were there because they could be fed and clothed and they could support their families. I also knew that they were illiterate, so I would pass them the survey written in Dari. And by Afghan culture, they will not tell you that they can't read. They'll pass it back to you because they don't want to lose face, particularly in front of a Western woman. And so I was able to get letters of safety by asking them to review the survey.

We had unidentifiable data sheets. We buried questions about human rights issues, primarily because that gave us a chance to figure out what households we were in. These were randomized, you know, knock on the door surveys. And we didn't want to be in a Taliban leader's house and start asking about Taliban's issues. And this gave the data collectors a way out.

We used informed consent. It was a randomized survey. We looked at places in both Taliban-controlled areas and non-Taliban controlled areas. I believe the papers are in

your folder. If you'll notice, they're under my previous name and not my name currently. But one of the interesting things about that publication was at the time it was too dangerous to publish exactly where we were. So we only said Taliban-controlled and non-Taliban-controlled. It was actually Feyzabad, which was Northern Alliance-controlled, and Jalalabad that we did these surveys.

So let me just sort of go through the data. I'm not going to go completely into the data. But we asked about equal education for women, equal work, health services, and freedom of movement. And of course, women thought that this was important for them. But if you look, men also thought that it was important. This is not what we were hearing in the media. We heard that Afghans don't want human rights. And again, remembering that the foreign fighters of Taliban were outsiders, this was not the case for Afghan men and women.

When we looked at freedom of expression,

participation in government, protection of rights and freedom of dress code, you see sort of varying about 45 percent supported. What's interesting about this is we did the same survey in Iraq and the data is completely different. Only 20 percent of men and women supported these same rights, whereas the Afghans actually had some more support. And we're seeing that. We see that there's a ministry of women's affairs. There are women in government; there are women that run for office. We don't see that in Iraq. So, clearly, Afghanistan did have sort of a sense of rights for women.

When we asked about food, shelter, clothing, emergency relief, demining, of course, everybody thought that was really important. And at the time where basic needs were quite not there, it was extremely important for them.

Again, we looked at community development, infrastructure, and peace. All men and women thought that it was important that women participate in all of these. The only one that

they weren't so -- they wanted -- they thought that these were all important for them but they weren't so sure that women should be participating in all of this. A lot of this at the time may have been because of the safety issues that women had to deal with then.

When we looked at community development compared to basic needs and human rights, human rights, again, we're not seeing huge, you know, 20 percent numbers. We're seeing above 50 percent of men and women that supported human rights. And we didn't just ask about human rights. We asked directly about each type of human rights, understanding that all human rights violations have a health consequence. And that was how we got at these.

We did the first mental health study among Afghan women. This was done in Feyzabad and in the Pakistan refugee camps, as well as Jalalabad. This was before CDC did their study in the mid-2000s. And what you see is huge rates of major depression, suicidal ideation, and somewhat

rates of suicide attempts, particularly bad among Taliban areas, but also bad in the Pakistan refugee camps where it was actually quite -- depending on the camp that you were in, it could be quite conservative. And it was as though you were living in a Taliban area.

So our summary at the time was that Afghan women and men believe community development included basic human rights and individual freedoms; that anything restricting these rights was not consistent with opinions and attitudes; and health practitioners should involve the community in promoting health and well-being.

So let's move to October 2001. I'm skipping a whole lot of trips, but I was actually there with my daughter in August of 2001, just before 9/11. We then had a planned study that was going to go on, and it became apparent that working for a human rights organization that we needed to have somebody on the ground. So I went back in late September, early October. And then made my way into Afghanistan by the Farhar Passing

which was from Tajikistan forward. And that could take another entire story of how that happened.

I did this at night. I ended up in Afghanistan, I believe, on October 30, 2001. This was before the civil affairs teams made it over. I met them in the Northern Alliance leaders' hut

at the time. And these are pictures of some of the IDPs that had occurred in this area. This was the Kunduz-Faizabad area. These were the Uzbek tribe of women, and then you see a picture of me with the tribal leaders talking about their needs and laying the groundwork for the next study.

In 2002, we needed to do a maternal mortality study. But using it more as an index of the status of women's rights, as opposed to looking at how bad maternal mortality was. We knew it was bad, but we really needed a rapid and accurate estimate of maternal mortality. And at the time, because of the Congressional funding directives, we needed data. And we wanted to do this quickly, so we chose one province. Why did we pick Herat? Herat was one of four provinces

that has a maternal hospital, and so it would be interesting to see what the maternal mortality rate is in this one province, given the fact that there is a hospital that can address these needs.

We also wanted to look at women's human rights, and we wanted to assess maternal health services in the region. And again, we wanted to use this data to present with the Minister of Public Health to a Congressional Panel when they were talking about emergency funding and making sure that there was a line for women's health in that. Otherwise, if it gets mixed up into health it doesn't necessarily go to women's issues.

We interviewed women 15 to 49. We interviewed more than 5,000 households, 7 of 13 districts. It was random sampling. At that time, 73 percent of the population was represented by this study. And again, Herat is primarily rural, like most of the provinces in Iraq. And then only 25 percent was urban.

So what did we find? Mean age of our respondents were 31, 88 percent were married, 10

percent were widowed. On average, they had been there 17 years, so certainly we could get a good idea of stability and we didn't have migration in and out.

The mean years of formal education for these women was .35 years of formal education. This actually went against many of the nonrandomized studies where the mean age of -- or the mean number of years of education was 12 years. Those were the highly educated and elite Afghan women. This is the sort of generalized Afghan woman. And 84 percent ranked food, shelter, and clean water as their primary problems at the time.

We used something called the indirect sisterhood method. What we found was that 92 percent of the deaths were in the rural areas, despite the fact that there's a functioning maternal hospital in Herat that is pretty well funded. And the rate that we got was 593 per 100,000 live births. Again, if you put this in context in the U.S., it's 8 per 100,000. And in

the developed world, it's 8 to 12 per 100,000. So we're talking about a huge discrepancy.

Now, if you go back to the number that's now quoted for Afghanistan, which is 1,600 per 100,000, or a woman dying every 30 minutes, again, this number is not actually correct. If you use the CDC data that Linda Bartlett had, including the Wahkim Pass, which is that narrow part that goes into the Himalayas, it's actually about 3,500 per 100,000. But she was not allowed to present that data.

We looked at marriage, family, reproductive health characteristics. And why do I tell you this? I think this is sort of grounding. It gives you an idea of what the health issues are. The mean age of marriage was 15, but again, the range was 5 to 39. Five being that in Afghan culture, you can be promised to a male in another family. It doesn't mean that you go to that family at that age, although some will do it if the bride price is high enough. But in general, they wait until they're all of the great age of 11

before they send them, which means that they're sexually active at 11. They have much higher risk of having a child young. Their pelvises are small. The most common cause of maternal mortality in Afghanistan is actually hemorrhage because of obstruction, which is that sort of back-end of or the outside the curve reasons that maternal mortality occurs.

The desired age they stated was 18. Again, the range was 5 to 30. Eighty-five percent said they wanted to marry at the time of marriage, but 20 percent also reported feeling pressured.

When you looked at the number of children or the age that they really wanted to start having children, it was 19. When you looked at the number of children that they wanted, it was six. It was actually about eight children was what we found as the number of children in this sample. But again, the difference between six and eight probably means that despite the fact that they can't get birth control, they do have some control over timing and spacing using other

methods. And so when they said that 88 percent of them reported timing and spacing was decided equally between husband and wife, I think they were actually accurate. They were able to somehow do that despite the fact that they didn't have birth control.

One of the other things that we heard was that women could not get to health care because they needed permission. The other part of that is, well, if you needed permission, did you get permission? And that was the question that we asked. And less than one percent were ever refused. So it's traditional to ask the male in the family whether they can go, but it doesn't necessarily mean that they won't be able to go.

And, of course, in any study you end up with data that is the data that you never thought would make a difference, but this was the data that made a difference. In this province, we looked at how many of these people -- how many of these women had actually delivered with a trained birth attendant. It turned out that only one

percent had delivered with a trained -- actually 99 percent delivered with either an untrained traditional birth attendant or alone in an area where there is a maternal hospital. And so when we used -- presented this data at the Congressional meeting, we sort of said, well, if you've got women who have not had education for six years, to get them to the level of being midwives, we're talking a 10, 15 year balance of trying to get trained health care providers. We have to do something immediately given the number of deaths. Traditional birth attendants, although there's no good data to support this -- although later there was data that was better -- then USAID needs to start thinking about supporting interim programs for training traditional birth attendants in concert with training women to become the providers, OB-GYNs, or midwives. We were able to get some money for that.

We looked at attitudes and beliefs about marriage, family. A woman should have the right to freely choose a husband. Ninety percent agreed

with that, although that is not the case in Afghanistan. They can say no, but generally they don't have that right to say no. A woman should have the same right as her husband to decide number and spacing. And if you look down, the one that is a little more disturbing is a husband has the right to beat his wife if she disobeys him. Forty-four percent of men and women thought that was the case. So domestic violence and gender-based violence rates are high in Afghanistan.

So the key recommendations -- and I think this is actually interesting -- and when I found this slide, to go back and look at what our key recommendations were in 2002. And frankly, they're not any different than they were then. Although some of this has moved -- and I'll talk a little bit about that -- the recommendations still stand.

So let's move to 2005. In 2005, Afghanistan was much more open. Again, we could travel. I have a penchant for eating at roadside

cafes. Most people wouldn't do that but I do. So we were there looking at something called the Afghanistan Talking Health Book, and I have brought that for any of you who would like to take a look at this. This was a health education module for women, primarily. And we were testing it for health and human services to see if it was a valuable way to get health education out to women in very austere areas.

Here you see a picture of an Afghan woman. Using these -- again, these are all my pictures. One of the good things about being a female is that you can get pictures of unburqaed women, and so I have a lot of pictures of beautiful women's faces in Afghanistan.

The problem with this book was there was a ceiling effect on knowledge. The assumption at the time by HHS was that there was no health education. Remember, I told you civil society was running, despite the fact that there were numerous wars, numerous issues. Civil society still ran. There was a huge cadre of community health workers

who were doing health education. So when they went in and talked about hand washing and then looked at it after the book, of course, 98 percent already knew about hand washing. So getting another two percent to understand hand washing was not a big thing.

It was developed by HHS by Afghan-Americans. Again, this was problematic. Many of these were Afghan- Americans who were in their twenties who had never been to Afghanistan; had never been on the ground; who were actually part of, you know, the elitist society. And therefore, understanding what a tribal or village Afghan woman needed was problematic.

The translations were poor. We had it both in Pashtun and both in Dari. The problem was whoever recorded the Dari translation did this in a mixed Herati translation and an east translation. So when they went to put the talking -- the stick on the word, the word would come out in Herati and they didn't understand what it was because the language in Jalalabad was very

different -- or the dialect was different.

There was no coordination with the Ministry of Health. The Ministry of Health was not contacted; was not told; was only informed when it was happening. And so that was problematic. Also, Leap Frog made 80,000 of these without doing testing, and they're currently sitting in a warehouse in Afghanistan. Their batteries are probably corroding. And also, they used batteries in these that are AAAs, which you cannot find in the market. The only thing you can find is AAs. So a sustainable way of using these would be impossible until now.

Afghans like the idea, but they preferred to have it actually administered with a community health worker. Again, this is cultural Afghanistan. They like the community health workers. They trust them, and trust in Afghanistan is a huge part of the society. So if the community health worker came and worked with them on the book, it was better for them. And what we found, in the paper -- you have the paper

-- is that the children actually like this as well. And so you had an up-level of teaching to the parents through the children.

So in August of 2009, this year, we went back. I went to meet with the Afghan Surgeon General to talk to him about the Afghan National Army and the Afghan National Police. These are the two different health care systems. If you don't know this already, Afghanistan actually has three health care systems -- has the civilian, the Afghan Army, and the Afghan National Police. This is problematic. If you can't support one, how can you support three? And there's varying amounts of equity among those three.

What we were there for at the time was to discuss the issue of doing a traumatic brain injury study among the military police. This was based on a study that our division did in Liberia, which found that of the third of the ex-combatants in Liberia, many of them had TBI much higher than what we had suspected. And that if this is one of the things that our military is

doing with their military, than we need to pay attention to this given that DoD is the expert in TBI.

They gave us the typical Afghan huge spread for lunch, and these are all of the CSTCA staff that were there, as well as the Afghans. Now, the CSTCA Surgeon is the surgeon for the -- and Bill, you'll have to help me with the combined --

CDR HUGHES: Security and Training Command.

DR. LAWRY: Security and Training Command for Afghanistan. So this is the CSTCA surgeon and this is actually the surgeon general of the police in Afghanistan.

So let me move to DoD health efforts, because that's my cue to tell you what you actually wanted to hear. So what is DoD to do? Or what can it do? It's based on authorizations, and it's based on legalities. Our role is mil to mil. And I say "our" as a contractor because I work within DoD. I can't speak for DoD, but I say

"our" because I'm part of this.

Within the military to military things that they're doing -- and this is not completely inclusive -- again, I didn't -- I'm not going to talk to you about the care for troops. That's obvious. What I want to talk to you about is the more international issues and how the reconstruction of the Afghan health system.

There is a military medical school that has been started by CSTCA. It's actually quite remarkable. There are 27 female military members in that military medical school. It is somewhat patterned after the Uniformed Services University, but it is remarkable that there is a military medical school, as well as the Kabul Medical School and about 10 others in the region. A lot of what the military does is train the trainers in emergency care, professionalism, first responder. There's some work to improve the ANA and the ANP hospitals and clinic. Again, there's a lot of discussion about whether there should be one system for both ANA and ANP, but politically, it's

just not going to happen. And for us to think that it will takes us down a path we don't want to go.

Now, when you're looking at civilian health care -- the way the military can do civilian health care -- so to add to the effort in Afghanistan is quite minimal. One of the reasons is because there are so few authorizations. There are three types of funding. One is the overseas humanitarian disaster and civics assistance money; the civics assistance money; and then CERP funds, which are the, you know, caseloads of dollars that the commanders carry around to do projects like that without having to go through a whole paperwork trail.

OHDACA funding is about 58 to 85 million plus, but it covers all COCOMS, so it can't all be used in Afghanistan. It requires that you put in a proposal to do it. It doesn't require any type of monitoring and evaluation, and it does not require any type of coordination with the host nation whatsoever, although it would be better if

it were.

The HCA funds can only be used for projects that involve the training of military health personnel. Sometimes you can find a secondary benefit to it, but again, it's primarily set for training military health professionals. And so this is where you get the MEDCAPs and the DENCAPs and all of these types of projects.

The CERP funds are more common in conflict. They kind of dry up in an extended reconstruction or development phase. It's usually based on the commander's intent, and it may not be coordinated with the COCOM Surgeons or any of the surgeons for that matter. And so they are a bit more difficult.

We were able to look at the OHDACA database, which was from 2000 to 2007. And we have a study that is coming out in the disaster medicine and public health preparedness which talks about how the OHDACA funds were used in that period.

Afghanistan was second to Iraq for

projects. The primary projects were school construction and refurbishment; health and water infrastructure, meaning they went in and refurbished clinics. It didn't necessarily mean they paid providers, because they couldn't with those funds. Disaster response infrastructure and disaster response training projects. Only 15 percent of the projects in OHDACA were actually health infrastructure. The largest percentage were actually school. The problem was -- and if you want to look at education as a means for health -- again, education is the primary indicator of health -- then it counts as a public health project. However, if you only build a school, you don't do the curriculum, and you don't pay the teachers, it's not helpful. And if you build it a block from the one that the NGOs built, it's problematic, as well.

So going back to more DoD health efforts, let me just tell you what our division has done primarily for Afghanistan. Our role is to respond to the needs of the COCOM Surgeon. We

recently were able to help CSTCA in the procurement of medicine and medical supplies in Afghanistan. Not from the usual ways of doing it, but on the market there is a procedure for doing that. It is somewhat difficult, but we were able to help a bit with that.

We also assess, research, and evaluate topics relative to health stability. One of the things that we're looking at doing is the TBI study of the ANSF. We also did an evaluation of the overall interagency health coordination in Afghanistan. And I know that you got a presentation from Dr. Peterson, who said that the Ministry of Health is great. Let me just nuance that a bit. It is great. If you look at the strategic documents that the Ministry of Health in Afghanistan has created, there are 11. If you look at the number of strategic documents that Iraq has for the Ministry of Health, it's zero. So we're talking about quite a difference in the ability and capacity of the Ministry of Health.

The Ministry of Health also has control

over its funds, whereas, most of the ministries in Afghanistan do not. And the Ministry of Health coordinates all NGO activities. So if an NGO wants to go in and do a project, they have to coordinate with the Ministry of Health. This is unheard of in most of the places that I've worked in.

We've also discussed the need for a health attaché. Again, we've got multiple interagency groups in Afghanistan. We've gotten a lot of resistance from some of our interagency partners, but we're still steadfast on the need for a "health attaché," someone that would be able to sort of walk the lines within the interagency to be able to say what DoD can and cannot do, what they're doing, what the PRTs are doing, and what the Minister of Health recommends in his newest strategic document.

We serve as a resource for the Ministry of Public Health. We have a great relationship with him. We sit with him one on one. I was invited in August to sit with him for an hour and

20 minutes of his time. That's kind of unheard of in most of these places that I've been, but I was able to get a lot of helpful information of his needs and his worries at the time.

We serve as a liaison for civil military issues. Again, I think Dr. Peterson said that NGOs don't want the military near them. I don't think that's nuanced enough. That's not necessarily the case. Although NGOs will publicly say that, behind the scenes they are doing many things with the military, particularly the PRTs. So they will do it, but it has to be with confined rules and lines in the same to make sure that NGO security is complete and stays the same. Remember, NGOs rely on their local perception of not neutrality, but impartiality, to be able to be safe.

And we have just recently finished the Guide to Nongovernmental Organizations for the Military. This is a 400-page book that will be online, BlackBerry downloadable. It has a lot of helpful hints for the military about how to work

with NGOs and work within the strategic documents of the military so that there's an understanding that, yes, you use this term but the NGOs use this term. And if you want to really be effective, you need to use their term because the interagency doesn't understand your term.

So some of the things that you may not have seen about Afghanistan, everybody things it's, you know, completely shut down. I will tell you that my view from 2000 to 2009 is hugely drastic. And there's huge changes. This is a wedding hall in Afghanistan, and this is one of about 20 on a stretch of road. It looks like Las Vegas. And who knew that lights actually came in pastel colors? But one of the reasons the power grid I have a feeling can't keep up is because of this. The number of lights are just unbelievable.

You can't see this very well. Anyway, this is a picture of an Afghan wedding. One of the good things about being a contractor is you can have a little bit of leeway in where you go and what you do. And so I was able to go to some

of these weddings at night. And what you do see is you see women now in short sleeve and sleeveless outfits. This -- I didn't come to say that I went native in this outfit; I actually came because the most common question is what did you wear when you were in Afghanistan. And this is what I wore.

When I went to the tailor in Afghanistan that I used previously, there were no longer any of the salwar kameez; they were all sleeveless for the summer. And so things have really changed.

And on the street, I passed groups of five and six women without -- or girls -- with makeup on, western dress, no burqa, just a head scarf. So it really has changed.

There are now more than 35 restaurants and bars. There are two shopping malls in Afghanistan. You can buy Christian Dior in Kabul. That to me is just unheard of. And I actually pulled this from the Safi Airway book that they had in the back of the seat. And for those of you who want to see very interesting pictures, it's in

there.

There are 10 hotels, compared to the one that I stayed in during Taliban years and during the wars. Several of them are 4-star. I ate at them. I could hardly believe the food that was coming over. It was no longer greasy goat and rice; it was real food.

And when I traveled through Europe, I used to call -- every picture I had of Europe they had Euro-cranes and it was the ever present Euro-crane. Now in every photo that I have in Kabul is the ever present Afg-crane. Why? Because rebuilding is happening. There are mansions. The entire valley in the Kabul area is lit up. There are mansions that have been built. The terminal is full of Afghan-Americans and Afghan-Europeans that are bringing their family back to visit and then leaving. It's no longer filled with U.N. Officials and NGOs. It is a completely different place than it was.

And there is now an international and a domestic terminal. The airport that I knew in

2000 was one you didn't fly into; you flew into a dirt road somewhere on a U.N. Flight, if you could. Generally, you went over Smuggler's Pass or you hired a taxi in Jalalabad and drove to wherever you needed to be. But the left picture -- and this is not one that I took -- is what the airport looked like. This is what the airport looks like now, and this is actually a picture from 2004. It only shows one airline. There are about six airlines now that fly in and out of Kabul. One of them actually flies from Europe straight because they've been able to secure the European and American security measures that allow direct flights now.

This is pictures of -- if you look in the book, this is the picture of the mall. It looks like any mall. And any of you who have been in a mall anywhere in the U.S., it looks exactly the same. And then the number of hotels.

Ten years ago I would have laughed if you told me I'd be buying Lego in the Kabul airport duty-free, and I really would have. This

is unimaginable to me. Considering the places that I generally go to, there has been no change in Darfur; there's been no change in the Congo; there's been no change in many of the places that I've been. In Afghanistan, there are huge changes.

And although I'm telling you about Kabul, you have to understand that Afghanistan is not one place. It's -- as may provinces as there are, that's the many Afghanistans. The tribal cultures will still exist no matter what. It's the cities that you have to look for the marker of economic improvement and security. The rural areas will always stay the same, and you will always see these different tribes. And this is actually the Timoni tribe in Afghanistan. A very small tribe that I actually ran across and who are quite different from many of the others.

And that's it.

DR. LEDNAR: Dr. Lawry, thank you for sharing your experience and all the changes that have occurred in Afghanistan.

We have time for one or two questions for Dr. Lawry, if there are any.

SPEAKER: One question I would ask for Dr. Lawry, are your learnings from over the years in Afghanistan being communicated to the Uniformed Civil Affairs Units that might deploy into these areas, especially the rural and tribal areas?

DR. LAWRY: Yes, actually --

DR. LEDNAR: Do they go in well-informed?

DR. LAWRY: We actually -- we do a lot of teaching and talking. Our International Health Division does a lot of teaching and talking with the Civil Affairs Units. And so we do present the information that we have and they've seen a lot of this.

Actually, something that I didn't say was that in Herat -- I needed some help in Herat at the time that I was doing the maternal mortality study, and I worked closely with one of the Civil Affairs teams there, as well.

DR. LEDNAR: Other questions for Dr.

Lawry? Dr. Silva.

DR. SILVA: Thank you for your report. You've been very courageous to go into some of these areas, particularly in the early years.

I'm interested, the Russians were there for over 10 years. Are there any residuals of their culture, language, or anything of that sort that stuck? Because we're not going to be there a long time, and I wonder how much stuff will stick besides Legos and shopping malls. So, anyhow, sociologic question.

DR. LAWRY: Yeah, there's more Pakistani culture because of the 20, 30 years that a huge portion of the population lived in Pakistan, so a lot of the food has changed. One of the things that I didn't talk about was that, you know, within a few years the rice fields were up. There were no longer sheep because of the drought, but they were bringing in Pakistani bulls and livestock. So some of that has changed.

As for Russian, absolutely not. There is one exception, and that's within the drug areas

where they no longer use the term "warlord"; they use the term "mafia." And I think that refers to -- from all of my communications, it refers to not the government of Russia, but the mafia of Russia that are heavily embedded in the drug trade.

DR. LEDNAR: Dr. Lawry, thank you very much for spending this time with us and for this presentation. Thank you.

Okay. I'd like to move to our final speaker of the morning. We on the Defense Health Board have a real opportunity today in some shared learning. And Group Captain Alan Cowan, who is a regular member with us as a liaison officer, has, in fact, arranged for us to learn about a sister organization that does work similar to ours, but for the U.K. military. So I would ask Group Captain Cowan if he would please introduce Professor Blain.

CAPT COWAN: This is on? I'm delighted to introduce Professor Peter Blain.

Peter is a consultant physician in Acute Emergency Medicine Directorate of the Newcastle

Hospital's NHS Foundation Trust and a consultant in emergency response medicine of the United Kingdom Health Protection Agency. He's a Professor of Environmental and Occupational Medicine, and a Director of the Medical Technology Research Center, a joint facility of the U.K. Health Protection Agency and Newcastle University.

Professor Blain has extensive experience in the health effects of industrial chemicals -- industrial environmental chemicals -- with a specific interest in clinical neurotoxicology. He leads chemical, biological, radiation, and nuclear research in the United Kingdom Health Protection Agency where he provides (inaudible) advice to the U.K. government, and also serves as a medical toxicologist at a number of U.K. government advisory committees, both in the Department of Health and the Ministry of Defense.

He also chairs the Advisory Group on Military Medicine, a non-departmental public body providing specialist advice to the U.K. Ministry of Defense. The Advisory Group on Military

Medicine performs a similar function in the United Kingdom to that of the U.S. Defense Board. And it was with that connection in mind that I proposed to my Surgeon General last December that we should offer to highlight the role of this advisory group and provide you, the members of the Defense Health Board, with an overview of its function.

I'm delighted, therefore, that Peter is able to join us today. And I'm most grateful to Dr. Lednar, your Co-Vice President, for agreeing to his attendance in this presentation.

So, as I stand between you and lunch, without further ado, I give you Professor Peter Blain.

DR. BLAIN: Thank you, Alan. And good morning, everyone. Thank you very much for inviting me here.

Just following Alan's introduction, as someone did say to me that a wife should give the introduction because you get a far better, accurate character reference than you get there. It was my wife that said that.

I'm sorry I brought British weather with me, but I've been here two weeks and I know the sun does shine in Washington, and I'm sure it will again.

I'm very pleased to present to you some of the information and the background to the Advisory Group on Merchant Medicine. Our Surgeon General is very keen that we explore how we might benefit from working together on areas of mutual interest. And I hope as I go through this that some of these might arise and we can explore some of them later on if there's time before lunch.

As Alan said, I'm a Director of the Medical Toxicology Centre. Because of all the other things I do, it's often commented I'm a visiting professor rather than the actual professor. But we'll leave that.

Do I press the arrows?

SPEAKER: Yes.

DR. BLAIN: Excellent. Now, the AGOMM, which is the acronym, the Military Medicine Committee, was actually set up a year ago. And

previous to that it was known as the Advisory Group on Medical Countermeasures, which had been in place since the late '90s. What happened there was, as I'm sure you'll remember, there was some issues over the anthrax vaccine policy. And the U.K. politicians thought that one way of putting this issue to one side, particularly as the Gulf War -- the Gulf had flared up again and we were deploying, was to give it the question as to what should be the policy on anthrax vaccine to a group of academics, in the hope that it would be kicked into long grass and nothing really would come out that would cause political problems.

Unfortunate for them, the group which I chaired, very quickly recognized that among a (inaudible) policy was really the only way forward in order to maintain protection of the service unit. We couldn't just have some people or some people not protected. That was not politically what was expected, but it did at least show that we were independent and that we actually gave objective advice on issues. It's still an issue

as to whether that policy for vaccinations should be mandatory, and we're still running a voluntary program, but we're trying very carefully and very hard to persuade people that the uptick should be as near 100 percent as possible. We can come back to such issues later.

However, last year our current Surgeon General, Lou Lillywhite -- Lieutenant General Lou Lillywhite -- recognized that there were other pressures going on which needed advice and needed a group of independent experts to provide advice to the Secretary of State, in particular for Defense. Some of those issues were the operational need. There was a broader need than just on medical countermeasures. The development of new medical interventions and the advice on the use and the risks associated with some of the new technologies. And also within the U.K. military there were capability gaps in certain medical areas. I think it's a problem in lots of countries' military as to what spread they've got and what resources they've got in their military

specialties.

So in light of that, General Lillywhite proposed that we converted the Advisory Group of Medical Countermeasures to the Advisory Group on Military Medicine.

Now, the reason I'm here, as I said earlier, is, hopefully, we can identify, as I go through what we do and what we've been recently doing, similar areas of interest and work. And we can develop a scope, if indeed a scope comes through, for interaction between the two bodies, sharing views on relevant issues. We may eventually look towards joint working groups for common, mutual problems common to both military.

We could exchange (inaudible) documentation obviously with the usual caveats and the usual considerations. And perhaps more importantly, just simply maintaining awareness of each other's work and looking for how we can support each other.

Now, Dr. Lednar provided me with this list of topics that he felt would be useful to

discuss for the Defense Health Board to discuss with me. I'm going to run through them one by one. I won't read them all on that list because each title will come up as I go through them.

The first one is the charter or purpose of AGOMM. It's constituted as a non-departmental public body. That's a classification in the U.K. that means it's not part of a government department; it's independent, although it's supported by a government department in the sense of the Secretariat and the organizational side of it is provided by that department.

There are some restrictions on who is appointed. And because of the changes to the requirements for governance and probity and public life, the posts have to be advertised and people short-listed, interviewed, and the like. There's a little bit of a difficulty when you're dealing with something military or other areas that are classified in that for our -- the Advisory Group -- because we deal with issues that are of a sensitive nature frequently, then the membership

of that body is classified and not released to the public.

So you have this paradox that you apply for a post on a committee and then no one ever knows or should know whether or not you got it. But that's just to protect the individuals. The Chairman, I have to say, is not protected and we have certain ministers standing up in Parliament naming the Chairman for which I'm eternally grateful to the Minister for that.

Our function is to provide independent expert advice to the Secretary of State for Defense. And we work through the Surgeon General's Department, as well, on specific areas that come to light for Surgeon General. We can be tasked, obviously, by the Secretary of State. I'll come to that shortly.

We're also increasingly being used to provide expert advice for urgent operational needs. Now, that can be something quite administrative, like moving the expiree date of combo-pens and approving that on the evidence base

that this will not be a health issue. It can be quite significant matters, such as the use of various haemostatics or the issues of blood-borne viruses for which there is a major problem and needs a quick response. For that we tend to put together a small group of relevant experts and the Chairman's action can transfer that conclusion of that group into the Surgeon General Department's advice.

The thing for the bottom there was one of the previous Surgeon Generals when I asked early on what exactly -- this was for the Medical Countermeasures Group -- what exactly was my role. And he, being a RAF or an Air Force chap, said I was Top Cover, which made me feel rather grand. You know, I was important. That was in the spit-fires, as it were. But then I realized that Top Cover is the first thing that goes down when you go and attack on a squadron. So I think I knew what he was saying.

The second topic was what skills and expertise do we have. Now, I've listed them all

there. We have acute medicine. We have anesthetics. Medicine's approval and licensing. That's because so often now, as opposed to not so long ago, we do try to use approved licensed medicines. There is still off-licensed use of medicines, and for that we have one of our little groups which will approve individual patient prescription or other ways that we can use a drug off-license. Ciprofloxacin, for example, is not licensed for use for treatment of anthrax, but obviously, we are using that as one of our countermeasures. So we have on the committee the Chairman of our Medicine Licensing Committee in the UK.

We also have a lawyer and a human rights expert that gives us advice on ethics and law. And he was very useful when we were discussing the anthrax vaccine policy as to what was permissible within law in terms of a mandatory policy and what was not, and what the ethics around that are. So he can be quite a busy chap, that one.

We have a clinic of pharmacologists,

clinic of toxicology, and medical microbiology. We also have an expert in vaccinology, specifically one of the people in the Health Protection Agency whose role there is on vaccine development.

Clinical infectious diseases, occupational medicine, radiation medicine, and psychiatry -- an increasing problem. And I think you already referred in your own work to the psychological aftermath and issues associated with combat. And finally, the bottom, we're just retreating a trauma surgeon onto the new committee.

How the committee is structured. There's a Chairman and a Deputy. The Secretary's Committee, as I alluded earlier, is part of Surgeon General's compliment. And that's the Staff Officer I for MBC and Medical Intelligence. The staff officers rotate, and obviously, this is part of their -- a small part of their very big workload. But we get well served, I have to say, by the Military Secretaries.

The Executive Officer is the Surgeon General, himself and then we have the members. And we also have attendance by officials -- both military officials, the Defense Civil Service officials, and also we invite health civil servants. So we have on the membership the Director of Emergency Preparedness and Response for our Department of Health. And this helps to -- well, first of all, make the awareness of each other's -- the two departments' activities better. You won't be surprised, I suppose, to realize that often the Department of Health didn't know much about what was going on in MOD, in the Ministry of Defense, and vice versa. And so often they have common issues, certainly around the medical field. So we have on the committee the Director from the Department of Health.

We have the main committee, and then the structure allows us to have Subcommittees and workgroups and Task Force and the like. Two of the Subcommittees that are almost standing Subcommittees is the one on Special Medicine

Countermeasures and the one on the Medical Implications of Less Lethal Technologies. The one on Special Medical Countermeasures, it covers the use of perhaps novel medical countermeasures or the nonconventional use of medical countermeasures for Special Ops and special operational needs. And that one is quite a challenging committee at times because we're working in areas where we're looking for a solution and then we're looking to overcome the hurdles to that solution in as best way as we can.

The medical implications of less lethal technologies. This was set up originally because of the medical issues around the use of the baton rounds in Northern Ireland. And as part of the Patton Report that led to the peace process within that was an obligation to develop safer -- if you can have that -- less lethal technologies for civil disturbance control. So the committee looks at the developing technologies and provides an objective medical assessment, which goes to the Secretary of State of Defense, as well as the

Northern Ireland office and the home office in the UK. It's perhaps a recognition of its objectivity is that both Amnesty International and the Ministry of Defense and the home office are satisfied with its output in the sense it would not view it as being parties on what appeared as being totally objective.

More recently we've been dealing with tasers, the electronic stun gun, and the medical implications of the use of those in dealing with individuals causing problems. And we also have worked on human incapacitants and looking at the threats posed to our armed forces, as well as our civil forces from the use of incapacitants, such as were used at the Moscow Theater siege.

We have short-term working groups -- one on vaccination policy, which I've mentioned. These are just examples: Blood-borne viruses, the haemostatics, I've mentioned. Because of the problems with amputees, a blast injury, and the other trauma received by our troops in Afghanistan, in particular, we're looking more and

more at rehabilitation and recovery from the effects of trauma. And we've recently started to explore working with the Armed Forces Institute for Regenerative Medicine, which is obviously a U.S.-based grouping. And that we hope will help us with even simple things, like development of an adequate stump for a prosthetic in the amputee. It's a difficult problem and it's become a very significant problem for us.

On the bottom there is a new development. It's the Pfizer (inaudible) hyoscine patch, which replaces the previous prophylactic treatment for nerve agent exposure. And this is a patch that the drugs are released at a set rate through the skin, into the skin, and absorbed. And this, we've been looking at the science about the kinetics and making some comments on its efficacy as a replacement.

How do we connect into the U.K. military? As I said earlier, the committee is based in the Defense Medical Services, which is the Surgeon General's department. And we're

networked through the military by our secretary, our staff office, to whatever part of the military units are relevant.

All of the members on the committee, the independent members, have a security clearance. The basic one is to say security and there are some who sit on the Subcommittee -- the relevant Subcommittees who have clearance to direct (inaudible) and DV clearance, which I think is comparable to the U.S. situation. We all have national ranks, which, first of all, made us feel very -- well, for one thing, they made us feel slightly humble that we were given ranks, but they also made us feel quite puffed up a bit. Until I asked someone why are we given national ranks? Oh, it's just so we know where to sit you in the plane or in the convoy or which cabin to give you on the ship. It's just so we know where to put you; it's nothing more than that. And I think I brought us down to earth. It was just to know where we sat; it wasn't anything else.

Regular interaction has been the uniform

civil leadership, the example being the other Services' Surgeon Generals. Well, we only have one Surgeon General in the UK. We do have Director General of the Medical Services in the three Services. So, we relate to Surgeon General, but the Directors obviously can relate to us through the Surgeon General's department. And we do have direct dealings with each of the services.

We make visits to military establishments. We no longer have military hospitals in the UK. They've all been devolved into the National Health Service. So you have, for example, in the Royal College of Defense Medicine in Birmingham, you have uniformed doctors, nurses, and other health care staff working in a National Health Service hospital, while there is a dedicated military ward, but the consultants and nurses also work with civil patients. There's a lot of discussion as to whether this has been a good idea or not. I don't think I'll explore that here, but it certainly is the situation we are now in.

We visit other military establishments, though. We visit Institute of Naval Medicine, the Center for Aviation Medicine, and we also, until fairly recently, we were able to attend exercises. Because of the operational stretch and also the economics, the funding side of things, exercises have been reduced quite markedly. I was going to put a picture up to show that I actually got sand on boots and things, but one of my children made the comment that it made me look -- I was in uniform in Amman -- it made me look like somebody called Gunner Sudgeon. It was a comedy character in one of the British comedy shows, so I decided I wouldn't do that in case any of you have seen it.

We also attend research reviews from military research establishments. And in particular, the Defense, Science, and Technology Laboratories, DSTL, which is (inaudible) and many of you have known about that as CBDE or CBD. It changes its name, but essentially it's the (inaudible). In particular, they have a research program in CBRN, although they are expanding the

areas that they research, including battle trauma and various other areas, as well. And we attend as independent assessors. It's also very useful for keeping us up to speed on the research activities within MOD.

And finally, we get regular operational updates, as much as you've heard this morning. We also get threat briefings, intelligence briefings, on new agents, on conventional agents. I was giving a talk last week to the G8 on the clinical requirements for responding to mass casualties of a chemical attack. And I put up a new book that's come out called "State Secrets" by a former Russian scientist working on their chemical weapons program. And within it, it has for the first time the structure of some nonconventional agents -- the first time in public that they've been put out. And when I put it up, one of the colleagues from -- I forget which agency -- pointed out that that book was actually now classified. And I said, well, you can buy it on Amazon. Yes, but once you've bought it, it's

classified.

So, enjoy yourselves if you're going to get it. How does AGOMM receive requests for assistance from the U.K. Ministry? Well, first of all, we are directly tasked by the Secretary of State, and that's where the anthrax vaccination policy came from. That's where a lot of the major requests come from.

The Surgeon General's departmental staff and also other military staff -- procurement and various other departments -- can request assistance from us to review and give an opinion. Other specific departments, such as the CBRN policy and also the Chief Scientists at the Ministry of Defense, can request some work of us. And the Director General of Science and Technology can ask us to review research or to recommend research requirements in order to meet the particular objectives.

As I said earlier, the individual service can request advice and request us to participate in work with them. And we do get

frequently, as I said earlier, requests from Operational Command for quick response and advice. And that has been getting more frequent recently.

This is the other way around. As an independent advisory body, can we suggest areas to cut, particularly if we have issues of concern? And we do do that. The way we manage it is so that there is some control on this, is that the agent is approved by the Chairman. It's put forward, obviously, by the Surgeon General's department, but it's approved by the Chairman who can amend it as he sees fit. Members raise areas of concern through the Chairman, and they will then be discussed with the Surgeon General, in particular, about including them in the agenda.

Sometimes there are other issues -- other context about a problem that we may not be aware of. And that is the safeguard to prevent us creating problems or to prevent us from raising things at the wrong time.

The opinion -- the output that we have is taken by the Surgeon General to the rest of

MOD. And we always ask for feedback on our opinion, on our work, to make sure that we actually -- well, we're actually being useful, for one thing, and that also to make sure that our recommendations -- if we feel strongly that they are significant -- they are taken forward. They are actually recognized and taken forward. That we do have an impact on the military requirements.

We produce an annual report of the Secretary of State. This can be quite comprehensive. It can include all the work we've done and examples of, well, conclude all our output, essentially, although we are advised to do one page only for the Secretary of State because that's as much as he can read. So we do a list of the most important things on the first page in the hope that he'll at least get to the bottom of that.

Other defense advisory groups that we have -- and this is three here as examples -- we have Surgeon General's Research Strategy Group, and that is largely made up of military personnel,

who are identified -- medical military personnel, who are identifying areas of concern, and the group develops the research strategy to address them. That may feed down to us for advice as whether this is the best way forward or for us to actually review the research, the output from that particular project.

We also have the Defense Scientific Advisory Council, which a wee while ago I was on. This is primarily tasked with dealing with the hardware of military science. That is to say the electronics, the weapons platforms. That end of science. It does still have a human factors role, as well, primarily because the human factors of the use of the weapon or how the human fits into the weapon system, which we heard about earlier from one of the earlier speakers.

The important thing about not only its role there, but the other important thing is it has a register of security cleared subject matter experts. So, we have a register of people in particular areas of expertise. And we can call

upon them throughout the MoD, throughout the Ministry of Defense, and also sometimes across the government departments, if we need something done quickly and we need to have experts brought together. They're security cleared.

I don't know -- well, I do know what it's like in the States because I've been security cleared in the states, and it takes a little while to get through that process. Whereas, here we can simply have them together by the end of the week if we need to move fairly quickly with advice. We also have an independent Ethics Board, which looks at the research ethics, in particular. There are also other aspects, and that's across the whole of MoD.

Now, I was suggested that since it's bad weather I finished with a funny cartoon. This is just showing that risk isn't always what you think it is.

Anyway, thank you very much, ladies and gentlemen.

(Applause)

DR. LEDNAR: First, Professor Blain, thank you very, very much from all of us on the Board. I was reflecting back on some of the thoughts I was building and sending through Group Captain Cowan. You were very patient with my long list of requests. Thank you for going through so much of that. I think for those of us on the Board, I hope you see many similarities, and also some new ideas, potentially.

Why don't we spend a few minutes and open it up for questions for Professor Blain. Any questions?

Dr. Shamoo, did you get some ideas on the importance of ethics?

DR. SHAMOO: Yeah, we should have an independent Ethics Board for DHB.

DR. LEDNAR: Dr. Parisi?

DR. PARISI: Thank you very much. That was very interesting. I noticed, though, there was a conspicuous absence of histopathology and post-mortem medicine.

DR. BLAIN: Say it again?

DR. PARISI: There's an absence -- a conspicuous absence of post-mortem medicine and histopathology. Are those also included in your -- or maybe there's a different organization.

DR. BLAIN: It is. There are other directly military committees which deal with those areas. We haven't, as yet, had an independent -- need for independent expertise. That's why it's not on that list.

I personally think we will get there, we will have one, because I think we need -- at times when we're interpreting results of either research or we're looking at straightforward histopathology data, we need someone who knows what they're talking about. And I think you're right. I think it is a capability gap that you've identified.

DR. LEDNAR: Dr. Mason?

DR. MASON: Tom Mason from the University of South Florida.

As an epidemiologist and an anthropologist by marriage, I'm very interested in why our disciplines aren't specifically mentioned.

And apropos the discussions we had earlier today, this interface and this intersection -- because, unfortunately, in too many organizations -- and it's not just the military, and it's not just we, in academic medicine -- there are too bloody many silos and very little cross fertilization.

DR. BLAIN: I'm happy to agree with you. I mentioned that the DSAC, the Defense Scientific Advisory Council, had human factors as part of its skill, its portfolio. And on there it does have epidemiology and it does have -- the person is not an anthropologist -- a sociologist. And there is a psychosociologist person. Now, they may not be in the right place anymore because when I left the Defense Scientific Advisory Council, the medical emphasis moved across with me, as it were, to the now -- the Group of Military Medicine.

We do have a need -- and I'll give you an example of where we have a need -- when we were doing some work with the Less Lethal Technologies Group on crowd control, there were some very interesting things that came out of the impact of

firing baton rounds on crowds. Such things like the fact that some smoke appears is a very good deterrent and makes a crowd disperse. You don't have to fire anything, but the smoke -- the new baton rounds were much more efficient that you didn't get smoke. And that was, you know, a negative. But we wanted to know also about how you control crowds from the point of view of the psychology of the crowd. Because you shouldn't really be firing at people. You should be able to passively control them, if you see what I mean.

And we drew upon expertise actually at DSTL, the Defense Science Technology Laboratories, that there are papers for us on issues around crowd control and what you might do to in order to disperse crowds and what technologies you could use that would be less -- even less lethal than what we had been considering.

But, again, the Military Medicine Committee has only been going for a year in that sense, and we are building up our expertise. We do have access, if we want, to epidemiologists and

the like from that register. And we have used them. When we've looked at issues around vaccination uptake rates, we've looked at the reporting of adverse effects with the vaccine around Gulf War illness, basically. We have drawn in epidemiologists to advise us on that. But as a substantive member, we're not, again, like the histopathology, we are not other yet.

DR. LEDNAR: Dr. Luepker, Dr. Shamoo, and then Dr. Halperin. Dr. Luepker.

DR. LUEPKER: Yes, Russell Luepker. Thank you for the presentation.

It sounds like you have quite a broad charge and I'm curious about one practical aspect after listening to all the positions you hold. How much time is actually spent -- how often do you meet as a group?

DR. BLAIN: Yeah, we meet at least three times a year, sometimes more, the main committee. Outside -- and that's for a day. Outside of that, there's a lot of work that goes on by mail, by consultation. And we would draw in the small

groups that I referred to for very specific issues to be addressed.

We probably will start to meet more frequently because the workload is increasing. Once we've moved from being just focused on medical countermeasures itself into the broader charge, we're going to have to meet more often. Either that or we're going to have to spin off more Subcommittees that are focused on a particular area. And it may be that we have to have, for instance, have a Combat Battle Injury Committee itself. Because I think there are some topics that require more energy on them.

I'm also aware at meetings that when we may be discussing something that I'm particularly keen on and, therefore, we're spending a bit more time on it, the other members who are -- it's not in their area, they switch off. And I don't -- I want them all to be participating. So, it's a balance.

And I think you're right. Sometimes we just have to accept that there's going to be a

bigger workload and look at ways of doing that, of meeting that without putting upon the experts. Because they've all got day jobs, as you all have. And more and more the day job is getting to be a bigger task on you as well. So it's quite a difficult problem at times.

DR. LEDNAR: Dr. Shamoo.

DR. SHAMOO: Yeah, Adil Shamoo. Since this whole process is to learn from each other, so since we have an issue really, the Defense Health Board is very hard and it's complicating our function. And that is the length of term of each of your Board members. And do they require an annual renewal?

DR. BLAIN: Now, what am I supposed to say here, Chairman? At the moment the way this works is that members are appointed for three years. They can be renewed for a third or three years, and then they have to be off the committee for one year before they can be considered to come back again. It's under what we call Nolan Guidelines. Nolan was the chap who was asked by

the government to look at governance and probity in public life and came out with these recommendations.

They are guidelines. You don't necessarily have to follow them because if, as there are in the UK, there may be one person who is our world expert on a particular topic. Ricin, for instance, we have one chap who really is our world expert. We're not going to say goodbye to him at the end of his sixth year just because it says in the guidelines that's what happens. So there are exceptions. If it's a very sparsely populated area of expertise, you can have exceptions.

DR. SHAMOO: So there is no requirement for annual renewal then?

DR. BLAIN: No.

DR. LEDNAR: Is somebody hearing this? Duly noted. Dr. Halperin?

DR. HALPERIN: If I understand, military hospitals are now part of the National Health Service.

DR. BLAIN: Yes. Yes.

DR. HALPERIN: There are no military hospitals?

DR. BLAIN: Hospitals still exist, but that's been taken into the local trust there. If you remember (inaudible).

DR. HALPERIN: Could you give some pros and cons? That's quite a different system than we have.

DR. BLAIN: Right. Personal opinion, yes? I think there is a need, personally, to have a military hospital. And I think that what's happening at the Royal College of Defense Medicine, which is in Birmingham, where initially there was a focus on a ward and that was given to the military. And they still remained separate. They are expanding out into treating civilian patients, and that broadens the experience and maintains skills. So, although I think there's a need to maintain the corporate identity of the military, which I think is very important. I mean, you have more experience and more knowledge

about it.

I also think that from the health care professional there's a need to maintain skill -- give the opportunity to maintain skills by breadth of experience. Because I think a lot of the younger doctors when I talked to them, they're concern in the past was that they be -- set themselves on a training program and then they get posted. And they'll be posted for however long and the training program would have moved on and they couldn't get fit back in. They'd have to start again. There were problems with training people up. But also, once they were trained up, maintaining the skills. Because if it was purely a military establishment, the range -- the case mix was limited.

So there are pros and cons. And I think the balance that's being attempted now at Birmingham, particularly when the Surgeon General's department is going to move from London up to close to Birmingham as part of a move, I think that is possibly going to achieve the best

of both worlds. You'll have a clear military establishment for medicine, but they'll also will be contributing to the civil health care provision. And some of the civil people, vice versa, so there will be an opportunity to maintain skills and develop skills, but also the case mix will be good.

So I think now it's taken how many years to get there?

CAPT COWAN: In '94, I began to be involved in this, and that's 15 years.

DR. BLAIN: So we move quickly, don't we? But I think the message is there. I don't think having six -- five or six military hospitals was sustainable at all, but I think the model of all being at Birmingham may well be the right one.

DR. LEDNAR: We'll have one final question by Dr. Mason.

DR. MASON: Tom Mason, University of South Florida. Follow-up on an earlier discussion this morning.

You're way ahead of us with regard to

"the seamless transition from military hospitals to VA hospitals to civilian hospitals." Where is the UK with regard to electronic medical records for all of your National Health Service?

DR. BLAIN: Um, yes, right. The government, as governments do, set up a contract with -- I won't say which company it was -- to do this. And the cost of this went up and up. I think it's something like 20 billion pounds at the moment, which is -- I don't know what the rate is at the moment, but it's probably about 35 or something million dollars -- billion. And they haven't produced anything.

They didn't listen to us physicians as to what we needed and started to produce things that are not right, not what we want. The same with the nurses on the ward. It wasn't what they wanted. It was what the computer nerd thought we wanted and things. And what's happening now is that some of the trust -- these are the hospitals -- I don't know if you're aware, but in the UK, although it's a National Health Service, hospitals

are semi-independent in the sense of they're responsible for their own budgets and what care they produce, the quality of care, and they're assessed and everything else.

Some of the trusts have now gone to alternative sources. And my own trust has an American -- somewhere north of here in Pennsylvania it comes from -- electronic record system, which went live -- although it's been trial, obviously, it went live a couple weeks back. And it seems to be working because I was saying last night to some people that I no longer have to write anything. It's all sort of, you know, keyboard stuff now. Even prescribing.

So it's not -- the NHS, it has not been done well by government basically, because they don't listen to the right -- my view. They don't listen to the right people when they're designing these things.

DR. LEDNAR: Professor Blain, thank you for sharing with us about the Advisory Group of Military Medicine. And I think we can explore

opportunities for continued sharing and experience.

And special thanks to Group Captain Cowan for having the foresight to see from his interactions with us as a liaison officer how we could learn from the Advisory Group on Military Medicine in the UK. So, thanks to both of you.

Professor Blain has agreed -- he's been very gracious to spend the rest of today and tomorrow with us. So he will be here if you have other questions that you'd like to ask him. I hope that you'll be able to join us this evening over dinner.

CAPT COWAN: Just a correction. Professor Blain has got an engagement tomorrow, so he's here all day today. So make the most if you need to with him today.

DR. LEDNAR: That's right. So make the most of today, everyone. And again, thank you.

Commander Feeks has just a word to say about lunch and when we will then reconvene for the afternoon sessions. Commander Feeks?

CDR FEEKS: Okay. This is Commander Feeks. We will break for lunch now. And as I said earlier, this is a catered working lunch for the Board members, ex officio members, service liaisons, support staff, distinguished guests, and speakers. However, we do have some work to do. We're going to use part of the lunch break for an administrative session. So what I would ask is that the members enjoy lunch, but return to this room at 12:45 so that we can take care of some administrative business.

Now, the liaisons are welcome to join us for that. Professor Blain, you're welcome to join for that. I'd ask that the public attendees allow us to do that work and to remain outside this room until we open the doors back up. At about 10 minutes past 1:00, we'll let everybody back in.

So, without further ado then, let's break for lunch.

DR. POLAND: Just one other thing. If we could have the Infectious Disease Control Subcommittee eat together to conduct a bit of

business.

(Whereupon, at 12:17 p.m., a luncheon recess was taken.)

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

(1:16 p.m.)

DR. POLAND: Okay, if everybody would take their seat. Wayne and I are sort of doing a tag team for the meeting and I'll try to shepherd along the afternoon session. We said we'd start at 1:15 and now that Mike's here, we'll do that. Just kidding you, Mike. We just kid the ones we love.

Okay, we've got Anne up there. We'll go ahead and get started on the Traumatic Brain Injury Family Caregiver curriculum. I assume that everybody on the Core Board had the opportunity to receive the curriculum.

Before we start, I just want to say -- and I warned Anne that I would embarrass her a little bit this way -- of all of the external products of the Board, this one, to me, stands head and shoulders above anything that we have done. Anne graciously said, well, you know, they had the resources to hire professional graphic art, et cetera, but they don't come up with the

content. This group came up with the content and I'm just immensely impressed.

So, Anne, the floor is yours.

MS. MOESSNER: Thank you. What a kind introduction. And so I've got about 45 minutes here. I'm actually hoping to get through the slide presentation, at least my part of the presentation, in about 20 minutes. We have a couple of family caregivers that are Panel members who are going to each speak for a couple of minutes as well about the process and the product, and just some words of wisdom from the voices of actual family caregivers, and then we'll certainly entertain questions at the conclusion. And certainly our hope in presenting this afternoon is that we can put the curriculum to the DHB for an approval vote today. So, that is the goal of our presentation.

Some specific objectives are listed, just a quick review for those of you who haven't heard us speak before. What was this Panel convened for, what have been the objectives? We

will spend a few minutes summarizing what was accomplished in our very last Panel meeting, which was a few weeks ago, also again requesting approval of the curriculum. We'll also try to summarize some Panel recommendations in terms of maintaining the curriculum and distribution, evaluation, so what happens to the curriculum after the content is approved. And also, I'll give you a brief update on where we are with content in terms of mild traumatic brain injury.

So, again, as a reminder, the National Defense Authorization Act of 2007 is the act that convened this particular Panel. And the goal was to have 15 individuals be identified as Panel members to develop coordinated, uniform, and consistent training curricula to be used in training family members who are caregivers of active Service duty -- active Service members and veterans that have sustained a severe traumatic brain injury.

The Panel members were appointed in March of 2008, reappointed in June of 2009, and

the appointments actually officially expire in June of 2010. There are -- just as a side note as we're discussing where things stand today, there are several Panel members who are very devoted to this project, and as we move forward into distribution and marketing phase of the curriculum, that have certainly spent a lot of time on the curriculum and are willing to stay involved as civilians, as subject matter experts, to continue to move forward with the project.

The tasks of the Panel are listed here: that it be an evidence-based product, that the curriculum is consistent, that it's accessible to family caregivers, and that the Panel go ahead and develop some recommendations for dissemination of the curriculum throughout the DoD and the VA.

DVBIC has been the agency of support and staffing for our Panel. And I'll pause for a moment and recognize them as really the perfect agency to work with us, with their subject matter experts and their previous experience with TBI education and dissemination.

So, the agenda for our final meeting was as follows: reviewing the curriculum; voting to approve it as a Panel; we had another presentation from CEMM, I'll talk more about that in just a minute; that we also as a Panel wanted to discuss dissemination, marketing, evaluation of the curriculum. And I know last time I presented to the DHB in August, that was on the minds of many individuals in this room, that it looks like it will be a good resource, but what's going to happen to it from here on out. So we spent quite a bit of time talking about all that and collating our thoughts, examining the mild TBI module, and then also considering responsible agencies for, again, policy, budgeting, programming, maintenance, and evaluation.

So, for each agenda item, we didn't spend too much time at our meeting going through the approval process because we had all spent so much time with the content and the curriculum, so there were some minor changes that were made. We had the writers and the graphic specialists in the

room with us at the meeting to make those last-minute changes. Those were incorporated within a couple of days and the curriculum went to printing so that it could get into your hands. I'm not sure when you received it, but, hopefully, within the past week to 10 days you were able to receive the curriculum and take a look at it.

We did go through -- when I presented in August, I shared with you a preliminary verbal report on the focus groups who had reviewed the curriculum, the end users. We were able to go through a very detailed written report at the meeting and there were no major findings that we hadn't already heard about through the verbal reports. So we did review that. And there was a unanimous vote to approve the curriculum by the panel. Our recommendation today then would be for the DHB to approve the curriculum.

The final title of the curriculum, by the way, which as you try to put together a title sometimes will end in a lively discussion and very detailed discussion, but the title that the group

ended up approving was, "Traumatic Brain Injury: A Guide for Caregivers of Service Members and Veterans." So that would be our first recommendation of today's presentation.

We also wanted to address -- when I presented in August, there were a few suggestions by individuals in the room and we wanted to get back to you to let you know that we did discuss those items and what decisions were made. I don't have time to go into great detail here, but just to let you know, we did talk about -- we had interviewed some family caregivers and inserted their quotes, vignettes, into the curriculum. And somebody had mentioned it might be nice to lend credence and sort of a sense of reality if there were pictures of the actual caregivers embedded in the curriculum. And that was approved by the Panel as something that we would definitely be interested in doing.

There was discussion about providing a certificate to family caregivers who have worked their way through this curriculum. Again, that

was a lengthy, detailed discussion with the idea that the implementation agency will need to work on that a little bit more. So there really was partial support that there be recognition, a letter of recognition, and perhaps a pin or something given to the family caregivers, but that it won't be an official certification of competence, per se, as a caregiver, but an acknowledgement that individuals got through the curriculum and we would like to acknowledge that in some way. So that, we did discuss in detail.

Someone mentioned social networking opportunities. We discussed that at length and there are some opportunities within CEMM and some of the other websites where the curriculum will be linked to. So that requires a little bit more discussion and study by the implementation agency. And then also the recommendation from the folks in this room was that there would be a very robust plan of communication marketing, and we certainly spent much time talking about that and completely concur.

CEMM, as you may remember, is the Center for Excellence and Medical Multimedia that's run out of the Air Force base in Colorado Springs by Lieutenant Colonel Randy Mauffray. He came to give us a final presentation. His website is really a thing of beauty, and he is poised and ready to upload the curriculum as soon as it is approved by the people that need to approve it.

He has a lot of features on his website. They actually are nearing the point of completing interviews with family caregivers. Those will be available. It's really -- and there's an interactive brain model on his website that people can really learn about the brain and the functions and the common difficulties and so on and so on.

He also has quite a bit of capacity on his website to help with the evaluation phase of this project whereby we can take feedback in through their website. There will be some steps involved with that, but at least the capacity is there. So we had a very nice presentation from Lieutenant Colonel Mauffray. Again, this is just

the face page of that website and you'll notice already on the bottom right-hand corner, the picture of the tree coincides with the cover of the curriculum that you received. And so the button is actually there, again, poised and ready, and then we'll load content onto there -- or Lieutenant Colonel Mauffray will when approval comes forth.

We spent a lot of time on this particular issue: communication, training, dissemination, and evaluation. I'll recognize Shannon Maxwell who's in the audience today, who will be speaking in a few minutes, and she is a family caregiver, but concurrently has a degree in marketing. And she and some other members from the Panel spent quite a bit of time putting together a fairly detailed marketing -- suggested marketing and rollout plan that includes many of these items: A market trend analysis, barriers to entering the market, channels of distribution, you know, market metrics.

The primary goals of that plan was to

get that legwork done, so, again, whatever agency will be assigned to move forward with the curriculum, again, this information has been thought about, pulled together, and that we really want the curriculum to be given out to family caregivers at appropriate intervals, in person whenever possible, so as not to overwhelm, but to educate in a supported, kind of regimented manner. And we also want to make sure the people who are handing out the curriculum or those on the provider end of the spectrum know about the curriculum and know about how to get it into the hands of the people that need it.

Some of the messages, the marketing messages, that we'd like to get out, or, again, the agency that will be taking this project forward to the audience of caregivers, the message will be that you really are a vital part of the recovery process. You're part of the healing process. You're not alone on this journey. So, again, the marketing plan would incorporate that type of message to the caregiver audience. To the

audience of high-level decision and policymakers, it would be that, again, the Panel feels this is a critical tool for caregivers, and that policies and funding are necessary for effective distribution and maintenance of the curriculum. To the advocates and the providers of care, that this exists, it's a comprehensive tool, help us get it into the hands of the folks that need it.

We spent some time -- this is just a very brief description. We actually have a lot more information about how this would be announced in a marketing communications sort of plan, certainly using electronic media. There are a multitude of existing websites that could link over to the curriculum at CEMM in an online manner, but even to announce the arrival of the curriculum. There was a lot of support for a mass, enormous marketing and communication plan to get the word out about this curriculum after approval is gained.

Certainly, there will be some, also, further efforts in terms of print media and

posters and flyers going out to announce it as well. And then there are existing conferences and meetings that providers and caregivers have that we would recommend be places to also share the information about the curriculum and its availability.

In terms of training, we do need to, of course, get information to the people who will be handing out the curriculum. So the various care coordinators, direct care staff, really need a little bit of training; not a lot, but we decided they needed some sort of a preparation to be able to hand this curriculum out to those who need it. So between webinars and, again, infusing staff into existing meetings and presentations, we thought we could develop a train the trainer type of approach. And the Panel felt strongly that not only getting to the people in those key positions now, but as things move forward, that these announcements and trainings would happen on an ongoing basis.

And we also have Panel members who are

scattered throughout the country who would be willing to continue to serve as proponents of the curriculum, but also as subject matter experts to help with rollout.

So, again, Panel members are very devoted to the project. So, we, as a Panel, really are supported of DVBIC continuing to do what they can now to prepare for rollout and DVBIC, as we've been in communication, would be willing to do that.

We actually put some pretty aggressive goals together in the marketing plan that right away, the minute approval is gained, we would like to get the curriculum into the hands of 80 percent of current caregivers or caregivers just entering -- just starting their journey, and that within six months or, you know, a reasonable amount of time, that we would actually up that to 90 percent of people. These are Service members and veterans with severe traumatic brain injury. They're in the system. They're fairly well known.

The mild traumatic brain injury group is

a different story, but for these individuals we thought very aggressive goals were reasonable because of the ease of which we can identify the Wounded Warriors. But also there was a lot of discussion about how do you go backwards to the people that have been injured in the years leading up to today? And so some fairly aggressive goals, but with more of a phase-in approach, were set for those groups of individuals as well.

The group thought about a 5,000 curriculum print run would be a place to start. Again, the agency that's designed to implement this project, you know, will have to figure out about housing, warehousing, distribution, those types of activities, but it seemed like that might be a reasonable number for a first print. And these were just some other goals of the Panel, that the curriculum, as you received it -- you know, it's quite large, and may look a little overwhelming. The focus groups told us they would rather have it all at once and not be given to them in a piecemeal manner. That was discussed

again at this Panel meeting and everybody in the room agreed that though it's large, you know, the expectation isn't the family member read the entire thing right away; that parts of it or more reference material, but that it really should be given out all at once and in person, absolutely, whenever possible.

In terms of evaluation, the Panel is recommending that evaluation of this project happen on a regular basis. So, within a year of implementation, that evaluation be conducted and that metrics be, you know, gained, data collected, that the evaluation of the curriculum is synchronized with the marketing plan goals, and that to accomplish this, you know, there would likely need to be funding for proper qualitative and quantitative feedback. But that would be something hard for DVBIC, let's say, to do without the proper funding and support to engage in such activities.

In terms of the mild TBI module, as I've presented to you all before, the Panel, although

not specifically charged with developing caregiver education for soldiers and veterans with mild TBI, we all know that this is the largest volume of injury. And the Panel is very devoted to also try to develop a companion piece explaining the nuances of mild TBI and the complexities with PTSD and other concurring conditions. Well, that is a more difficult topic to pull together in a succinct way and, you know, every week the information seems to be changing about mild traumatic brain injury and the findings and recommendations. So, the Panel remains interested. Specific members have offered to be ongoing content experts to work with the implementation agency on trying to pull together some curriculum, again, some means of putting together education for caregivers on this particular issue. But at this point in time, there is a rough draft that's finished and that's where it ended up due to time constraints.

So, moving on to policy and execution, again, this was the other topic that received a

considerable discussion at our meeting. And really -- and I got the sense when I was here last time as well that what we don't want to do is have this curriculum, which we hope is meaningful and accurate and really useful for caregivers, to sit and not be rolled out as quickly as possible and then not be maintained in a regimented way. But we decided this certainly will depend on the designation of an agency to publish policy for the curriculum, and then also for the execution of the policy and an implementation agency to be designated. And these were the thoughts of the Panel in terms of that the policy agency must cover the following elements: assignment of responsibilities, communication, training, dissemination, programming and budgeting, evaluation, and maintenance and updates.

So, the Panel set about establishing some criteria that they felt were important for this particular agency to have and that it be a policymaking body, that there be a DoD and VA collaborative track record, that this agency have

the capacity to influence chains of command, and that also they could influence across medical personnel, finance, other domains. And so the Panel's recommendation to the DHB is that the Office of the Under Secretary of Defense for Personnel and Readiness be the agency on record for policy and propensity.

In terms of the implementation agency, the Panel discussed the most reasonable agency for this act of the plan would be someone who's got experience with dissemination of materials, again, across the DoD and the VA, extensive knowledge of the curriculum, and a commitment to sustaining the curriculum. And our thought, after some discussion, was that DVBIC, or the Defense and Veteran's Brain Injury Center, who supported this project, would be a logical choice for an implementation agency.

So the summary of our recommendations today, again, I believe the item that would go particularly up for a vote would be approval of the curriculum itself. The other two items on

this particular side have to do with what I just mentioned, you know, that there be a policy agency and an implementation agency designated. And then these were the other recommendations: that DVBIC continue to do some preparation now so when approval is gained, they're poised and ready; and that funding will be needed for proper evaluation of the curriculum; and that also we would like to continue to work or serve, in a civilian capacity, serve as experts on the mild TBI content.

So, I'm going to move into -- Liza Biggers is here and she served as a Panel member from the beginning. She's going to talk just for a couple of minutes about her perspective, as will Shannon Maxwell. So they've each got three or four or five minutes of sharing to do with everyone. And then as a group, along with Meg Kotler, who is from DVBIC, and Dr. Barbara Cohoon, who also sits on the panel, we thought as a group of five of us that we would field your questions before we go to vote.

So, please, Liza?

MS. BIGGERS: Hi, my name is Liza Biggers. I was -- my brother Ethan Biggers was a Specialist in the Army and -- actually, I have two brothers, they're twins, they're both my younger brothers. I'm only two and a half years older than them, so they've been my best friends since they were born. They both served in the Army, both did tours of Iraq. And all of us share kind of a weird sense of humor. And I thought this picture was great showing Ethan, he's leaving out cookies and milk for his First Sergeant and CO for barracks inspections.

Ethan was shot in the head by a sniper on his second tour in Iraq on March 5, 2006. So, I would end up spending the next year taking care of him. I like to call it the VA Tour 2006 for the Biggers family. And from the beginning, my family and I were completely unfamiliar with this injury and we had no idea what to even expect or what was going on. Ethan was just bloated and huge and unconscious. And at that time it seemed -- it's really hard, you really want to help and

you want to do anything you can to help your loved one. And it's this defining point in his life where he's either going to live or die and it's so traumatic. And you'll take any information you can get as gospel, like, especially even from people whose cousin was in a car accident 10 years ago, you know, are telling you all kinds of stuff and you're just soaking it in.

So this is where this curriculum would be just outstanding to have. It would help the families, it would help the doctors and the nurses talking with families, describing this injury. It can also empower that caregiver to really feel like they can help instead of just standing around and staring at your loved one in the ICU for hours on end.

The other thing that was really important at the time, immediately, was finding other people that were going through this situation. So, anybody that you found, you just clung to because you wanted any kind of, you know -- just the fact that they knew what you were

going through was just the consolation you needed, just to hear from them.

So, once again, this curriculum gives that right away, that network of caregivers that have already been through this. They can read those quotes, they don't have to feel alone; it's not such a mystery of what's going to happen in the future.

So, at the beginning of Ethan's injury, it was my father and my stepmother and I that took care of Ethan. And then halfway through, my father was killed in a car accident, so my other brother Matt completed his service, came, and we took care of Ethan, and it was like starting all over again. So everything that my dad had been keeping track of paperwork-wise, now me and my brother had to do for Ethan. Once again, this curriculum would have been awesome to have then, even just to look up module IV, some of the stuff that we had no idea about.

At any point in this caregiver experience, I think this curriculum is completely

helpful.

One of the other things that I just wanted to bring up, I know there was a little bit of some critiques about the curriculum being written in a way that was almost too hopeful or unrealistic. And I would argue that you will get enough pessimism from doctors and nurses just doing their job, doing what they should be doing, so this was written in a way that should not be adversarial to any hope that the family members have. So, it should empower the caregivers to do the best job they can to help their loved one and not be adversarial to them in any way.

So, what I just really wanted to emphasize was the need for this. This was needed not yesterday, but like years ago. So I really, really would hate to see, after all this work -- it's been a year and a half that we were on this and I still feel like that's a year and a half too late, but I want to see this out to people now because it's just -- it would be so helpful to these people going through this particular hell.

They need any kind of helping hand they can get.

Thank you. Shannon Maxwell will be speaking next.

MS. MAXWELL: My name is Shannon Maxwell, and my husband, Tim Maxwell, Lieutenant Colonel, now retired, in the Marine Corps, was wounded October 7th of 2004, when a mortar landed outside his tent and he took shrapnel fragments to his brain.

When I joined the Panel, I joined it with a couple of different hats on: Not only just as a caregiver, but also as an advocate, not only for my husband and my family, but for the many families that we have attempted to work for over the past few years since my husband was wounded.

Tim has had a great recovery, really remarkable recovery, but there are certainly some challenges. There was a lot of information, even as highly educated individuals with master's degrees, that we could have used in his early phases and still could use. We have actually gone through two separate recoveries: the initial

recovery when Tim was wounded; and then about a year ago last summer, Tim had to go through another brain surgery to remove a piece of shrapnel from his brain that was leaching heavy metal toxins. That set about a course of extreme decline in his cognitive abilities, his motor functioning. And when the doctor removed that, again there was hope, again there was new information that we needed that we didn't have access to, new sequella that we were dealing with. So this curriculum, not only is it comprehensive in that it gives a family military -- Basic Military 101 when they don't know all the acronyms that are being thrown at them, it gives them basic definitions of what a TBI is and what the effects of that traumatic brain injury are. But it also has longevity in that it teaches the caregiver to be a caregiver, to remember to take care of them self. So many caregivers are very, very strong, and you have to be, but they will kill themselves giving everything they can to their Service member. And along with that, they're also taking

care of other family members: children, a sick husband, many of our families have exceptional family members along with the traumatic brain injury Service members. So, definitely longevity throughout recovery, which is, as you know, a traumatic brain injury is ongoing for a lifetime. The resources are extremely valuable.

But as Liza said, this curriculum needs to get into the hands of these caregivers now. It is relevant, it is pertinent, it is a lifeline for some of these families, not only for the caregiver to become educated themselves, but to educate the traumatic brain injury service member who's trying to understand why all these things are happening to them. It also has application in educating the children and why daddy is behaving this way, why can't he do the things he used to do, or our son trying to educate other family members, sisters, brothers.

I also see it have application in a greater forum as a severe or moderate traumatic brain injury patient moves through his or her

recovery and becomes a -- again, a contributing member of society. They start to adapt to a purposeful occupation, whether it's still in the military or in his civilian life. This curriculum has great capacity to educate the employer as well.

The Panel has really thought this out well. It is comprehensive. The application -- the partnership with CEMM to be able to get this application online so that everybody has access to it is incredible.

We did look through -- I don't know if you want me to get into this or not, when we were putting together the marketing and dissemination plan for this, the recommendations were to really again focus on the caregiver, the points of contact that we as a government, by the DoD or the VA, would have contact with the caregivers ongoing to get this curriculum in their hands. There were some consistent points of contact, both directly through the federal recovery coordinators, and the

RCCs. They're recovery coordinators that are on a

DoD level. They provide consistent contact with the families.

DVBIC also is a very, very strong proponent well thought of by caregivers in the community. It's when you look at that peer-to-peer contact between caregiver to caregiver, DVBIC is consistently an organization that is referred to. So having them continue to be involved in the dissemination of this curriculum and the maintaining of it, it's timeliness and relevance updates will be very crucial.

And I appreciate the fact that you all have considered this curriculum and that you're willing to vote on it today. I hope that you will vote on the curriculum in full. Every single module is important. Every single module will be important to give to the caregiver as a whole. The education-based thought of distributing this curriculum is very important because as a caregiver, when you're going through so much, some caregivers will take the time to read through, but

you also need a sounding board. You need somebody who can walk you through the curriculum, to give you a better understanding of what you're reading, to answer questions, and just to guide you through that process.

So, thank you very much.

MS. MOESSNER: Thank you. So, as a group, we're willing to entertain questions.

DR. POLAND: So, what I'd like to do is we'll have discussion, we'll have a vote, and then one other activity related to this topic. So, first, any questions or discussion?

DR. MASON: Tom Mason, University of South Florida, Tampa. Not only do I applaud what you've done, what I'm really interested in is the thought that you've given to maintaining currency. I mean, as it exists right now, it's a spectacular piece of work in my considered opinion, but, hopefully we will make progress.

MS. MOESSNER: Yes.

MR. MASON: And I would really appreciate your sharing with us, as you move

forward and as you find this is working really well, this really needs to be fine-tuned, which will come as no surprise to anyone. How do you propose using CEMM in a real world environment, in real time, to then keep and maintain the currency? Because, as you know, there's an awful lot of work, you know better than most, and a lot of that -- many of those reports and research findings will become available in the next months? So, what is your plan and proposal? And how do you see, basically, getting the materials out, but getting the feedback back in a timely manner and then acting on that feedback that you get?

MS. MOESSNER: Thank you. That was discussed at length, and basically, you know, everybody at the Panel meeting agrees that, again, what you don't want to do is put it out there and then not keep it current. There was risk in putting together a print product versus an electronic, that you could change at a moment's notice, but we had so much feedback from family caregivers that there had to be a print of

available, they need something they can take with them. And so the Panel's thoughts were that at least on an annual basis, the curriculum needs to be reviewed for accuracy and updates made. Again, we seem to, and all the discussions go back to, there has to be an agency designated to do that and support given to that agency to do that. There needs to be somebody and an agency identified to keep that up or otherwise, you're right, that will become an issue. So that would be one of our, you know, recommendations as a panel that this be part of the plan.

DR. MASON: If I might --

MS. MOESSNER: Please.

DR. MASON: -- just one additional thought. If perhaps you would use as a model the online resource that we use in disaster preparedness, lessons learned, information sharing, and have a hot button for hot topics, so that you can basically then share in real time. This is something that I've just seen, something that I've just learned.

On a regular basis, you're not going to go through everything, but something's going to happen, you can count on it. Something's going to happen a few months out that you really want to disseminate.

MS. MOESSNER: Yeah. Wonderful. Those are great ideas. Please.

MS. MAXWELL: One more point that I just wanted to add. When we were, as a Panel, talking about the dissemination and marketing and we looked at the agencies that could be involved, the education base, the direct contact with the families through, whether it's the FRCs or RCCs, they are going to be able to get that timely, direct feedback, and then feed that back to DVBIC. So that's one more avenue.

MS. MOESSNER: Yeah, as mentioned previously, the CEMM website, as this is uploaded, that there will be some real-time opportunity for feedback there. Also a lot of discussion about feedback cards going out with the curriculum. But, again, somebody being charged with keeping

track of the literature, the scientific findings that may impact the curriculum, that there needs to be folks designated to do that as well.

DR. POLAND: Could you identify yourself, please?

MS. CAMPBELL-KOTLER: Oh, I'm sorry, Meg Campbell-Kotler. I'm the manager of the Office of Education for DVBIC. And as the TBI operational component of the Defense Centers of Excellence, I think DVBIC is in a unique capacity to be sure that the curriculum remains current scientifically and medically. The component that perhaps will be more difficult is getting family feedback, getting user feedback, but certainly through the federal

recovery coordinators and through the recovery coordinators and around DVBIC, TBI care coordinators will have enough touchstones that we can pull that together.

I already had a chance to speak with the Federal Recovery Coordinators about this and they seem very receptive to even tracking to make sure that they keep track of who in their client base

has actually received the curriculum, so I think we'll have good cooperation.

DR. POLAND: Dr. Parkinson?

DR. PARKINSON: Yeah, Mike Parkinson. Congratulations again to everyone. I think, though, what I just want to put an exclamation point after again -- and I appreciate Anne going back. I probably was the most vocal person on what is almost an unfortunate term because it trivializes, I think, what it is. It's social networking, which is, I tell you, right now it is a huge, huge area of exploding discovery in the civilian health care sector, in behavior change, care engagement, cost mitigation, quality of life. It is huge and we're just beginning to learn how powerful it is.

Our family members, you both remarked, I just wanted to talk to somebody, I needed to talk to somebody, anybody, then, now. We have to accelerate the platforms for us to do this, I really believe that. I know the CEMM very well. I think it's a wonderful vehicle, but I would

listen to your own comments. At every stage of the healing process, from the first time you see your loved one in ICU to the 3:00 a.m. in the morning when you're all by yourself in Sedalia, Kansas, and there's nobody around, you need that person or that connection to do it, and you know it. And I just urge us as an organization to push that to, if not the head of the list, very high.

The second thing I would argue for us to do, and I didn't hear, but I hope it's there, I understand the desire to have all the materials for the caregiver in one place. But what we have to do, frankly, as the clinical side of the enterprise, is to break down those modules into the right process, marry them up to the clinical practice, put guidelines or standing orders in our neurological units, in our recovery units, in our ambulatory care centers, so that module 4 is a checklist item just the way we would do a medical safety issue as it relates to disposal of a sharp instrument or something.

So, embedding the modules into the

clinical practice guideline so the clinicians are expected to have that as part of their quality performance -- did the family have access to and understand module 4 -- at what 80 percent of the people will be in their clinical recuperation phase? So that's another area that we can do and that can all be automated into the EMR, AHLTA, for certain types. You can tie it into an ICD-9 code that tracks along with it. So, think about those things between DVBIC and the CEMM as you go forward.

MS. MOESSNER: Great. Excellent ideas as well.

MS. BIGGERS: I just have something quick to say on the social networking thing. I mean, that would be great, but you have to remember, too, severe TBIs are shipped everywhere, and your access to a computer is iffy. So, unfortunately, that's -- until that becomes more of a reliable, you know, accessibility, it's really hard. I was lucky to e-mail people if I could. So, I don't know, I have an iPhone now and

that helps. Back then it was, you know, the waiting room, waiting in line to use a tiny computer. So that's something that maybe should be looked at, too.

DR. POLAND: Any other questions or comments? Otherwise, we're going to ask for a show of hands to approve the curriculum, "Traumatic Brain Injury: A Guide for Caregivers of Service Members and Veterans." Can I have a show of hands for those that would like to approve the curriculum?

Anybody opposed? It's unanimous.

MS. MOESSNER: Thank you.

DR. POLAND: Before you leave, Anne, could I ask you to just stay there and ask the Exec Secs and my Co-VP to join me up at the podium?

There are occasional times in the universe when a problem becomes manifest, an individual becomes available, a group of people who bring passion, experience and content expertise, and wonderful things happen, and such

is one of those times in the universe.

I think, Anne, if anybody ever asks you how you served your country, you have an easy answer. Thank you so very much for the work that you and your panel have done.

MS. MOESSNER: My pleasure.

DR. POLAND: The plaque says, "With deepest appreciation for your outstanding contributions as Defense Health Board Subcommittee Chairman, Traumatic Brain Injury Family Caregiver Panel. Thank you for your selfless and dedicated support."

MS. MOESSNER: My pleasure. Thank you so much. And let me again advance the slides one more time here. Just so -- and you have this in your handout as well -- to the really devoted, diverse group of individuals that helped pull this project together. There were several appointed members, some ex officio members, some consultants both individuals who had survived traumatic brain injuries themselves, certain the family caregivers on the Panel were invaluable. We had contingency

members, and really in deep appreciation to the writers who spent, really, countless hours on the project. The Henry Jackson Foundation provided the graphic and packaging support. Colonel Mauffray at CEMM really has a wonderful website that I think will be extremely useful as we move into the future. A lot of the focus group participants and the families who provided their personal stories for the vignettes deserve thanks as well. Thank you to Commander Feeks, who supported the project as he attended all of our meetings and was very involved in phone calls and decisions along the way. And our deep appreciation for the DHB for your support of this project. Thank you.

DR. POLAND: Well, Anne, all of us are going to be found wanting after your presentation. Safe travels.

Ms. Maxwell, Ms. Biggers, thank you, too. Our next speaker is Captain Martha Girz. We have a 30-minute slot reserved for this. She serves as the J3 Assistant Chief of Clinical

Operations for the Joint Task Force National Capital Region Medical as well as being an Assistant Professor of Medicine at USSHS. She'll update the Board on the Department's progress regarding the establishment of the Joint Pathology Center, including the Department's response to this Board's recommendations, which we issued last year. Her slides are under tab 5.

CAPT GIRZ: Thank you, and good afternoon. I'm happy to update you where we are with the Joint Pathology Center, since I last updated you in March, based on your recommendations at that time.

Slide one, which is the status, you'll see that since March, the President has delegated the Joint Pathology Center establishment to the DoD. That occurred at the end of April. Within the Department of Defense, the military medical leaders all decided that the Joint Task Force would take on the leadership and would take on the Joint Pathology Center. However, that decision is still pending delegation from the Deputy Secretary

of Defense. That is currently in coordination and so we're waiting on that.

In the interim, the JTF CAPMED created a JPC implementation team because we know we needed to continue the process while we're waiting for the delegation. That team was chartered and set in July and had membership from across multiple agencies. As you can see, the AFIP was represented. We had the service pathology representatives, the consultants, or specialty leaders as you were for the services, the JTF CAPMED, obviously, the executive agent for AFIP, which is the Army, the VA; we have a rep from OSD HA, from TMA, and from USU.

The charter of the group was to plan, build, and execute, which is our methodology. So, in terms of plans, the current initial operating capability for the Joint Pathology Center is set for July of 2010 with the expectation we'll have full operating capability by the end of summer 2011.

The I Team is continuing to meet. We

are completing a gap analysis based on the Joint Pathology Center Health Affairs Working Group CONOPS, which was approved, which you all reviewed and gave recommendations to. We are currently developing a detailed operations plan, an implementation plan to include milestones is soon to follow and obviously all this is going to be in coordination with the AFIP's BRAC plan because we cannot work in a vacuum.

This slide goes over our Joint Pathology Center capabilities and, as I've already said, no later than summer of 2011 we will be at full

operating capability. And those are outlined there of what our full spectrum of pathology consultation service will be. I do want to point out that many of the things that you had recommended are in our review of the CONOPS, one of which is supporting the depleted uranium and embedded fragment analysis. So that analysis is underway and as well the support to AFME, the Armed Forces Medical Examiner System. We have plans to serve as the primary pathology reference

center for them as well.

You'll note that the first bullet, consultation, utilizing state of the art molecular testing, histopathology and histochemistry, are also there for full operating capabilities.

In terms of pathology education, you see that we plan to partner with USU to provide continuing medical education. Those will include VTC, online pathology courses, and virtual slide seminars, the content of which will be written by the staff of the Joint Pathology Center. USU will be our partner in supporting those CME activities for the administrative piece, but the content will be done by the members of the Joint Pathology Center.

In addition, in terms of education, the integral component of the Walter Reed National Military Medical Center and DoD pathology residency and fellowship programs, the Joint Pathology Center will be a participating institution in those, specifically derm pathology and the forensic fellowships, the DoD forensic

fellowships, as well as the Navy oral path residency. So the members of the Joint Pathology Center will be staff/faculty for those programs.

In terms of our clinical research, we obviously will be supporting military-relevant and military-critical research. The TBI Initiative is one that is currently underway, which we would plan to continue with the Joint Pathology Center. Also the Combat Wound Initiative, which you know is a Congressionally mandated initiative, the Joint Pathology Center will plan to continue that initiative. There are many U.S. Cancer Military Institute initiatives that we hope to look to partner with as part of the Joint Pathology Center.

Pathology research that is done through the Walter Reed National Military Medical Center and other military facilities will also be done in collaboration with the Joint Pathology Center where appropriate. Use of the repository for research is one of the areas that we need to do a lot more consideration of in determining how best

to use the tissue repository and that's certainly on our list of things to do.

Partnering with the U.S. Military Cancer Institute in ways that we've not done previously is one of the goals for the Joint Pathology Center as well. Utilizing cohort registries, of which there are many currently, and the ACTUR database for research is another area where we hope to utilize the Joint Pathology Center in conjunction with those resources.

The Tissue Bio Repository, by statute, we must maintain and modernize and that is one of the areas in which we need to do a lot more planning. And then we've already talked about use of the repository for research.

Also on this slide you'll see utilize strategic partnerships to leverage and enhance existing capabilities. This is one of the things that we think is very important that the Joint Pathology Center cannot function on its own in DoD, that there are many resources in DoD and the federal government that we need to partner and

collaborate with. And obviously USMCI, Uniform Services within the DoD, are two that we would plan to collaborate extensively with. And then other federal agencies, we haven't begun that list, but we know that there will be a long list of other federal agencies that we will need to collaborate with in terms of research, education, and clinical care.

In response to your recommendation that we reconsider where the placement of the Joint Pathology Center is within DoD and based on the CONOPS that we had originally presented, we did recommend that the JPC be a direct report to the JTF Headquarters, removing it from the Pathology Department of the Walter Reed National Military Medical Center up to the headquarters level. So that recommendation has been enacted.

In terms of resources, you also had recommended that we reconsider our staffing models, and we have done that through the gap analysis of the Implementation Team and you can see where our staffing currently stands. We've

added several areas of specialty that in the initial CONOPS were not thought to be needed, but on review of the gap analysis, we determined that we did need several of the specialties that were not initially thought, and those include cardiovascular, nephro, environmental, and I believe we added additional GU expertise to increase the number of board-certified pathologists from 23 to 29.

Additionally, we looked at our technical support and, based on your recommendations and, once again, the gap analysis, what the I Team is doing, we've increased the number of technical and administrative support as well.

In terms of the budget we are working closely with Health Affairs, TMA, to determine where the funding will come from. This will not be an earmarked organization and so looking at where the funding is going to come from DoD is going to be underway once we're further along in our operating plan and have our full staffing plan completed.

So, our way ahead is completing the gap analysis and our Operations Plan, the OPLAN. The I Team is continuing to deliberate on these things. Obviously we're working closely with AFIP so we can coordinate closely with their BRAC plan to ensure that there's no loss of continuity for patient care. And we're also working with all of the stakeholders to ensure that once our plans are in place that the services are programmed to those appropriate organizations.

And that is the end of my presentation. I'm happy to take questions.

DR. POLAND: Comments or questions. Joe?

DR. PARISI: Well, I have several comments.

DR. POLAND: Joe, introduce yourself.

DR. PARISI: Joe Parisi from Mayo Clinic. I have several questions regarding your presentation.

First of all, I guess I'm a little disappointed. I think we went through -- in

getting ready for this meeting we had asked -- actually asked you a series of very detailed questions and I see very little detail that you've provided here. So, I guess I'm a bit disappointed that we don't have the level of detail that we were expecting to receive today.

When someone talks about a reference center, I think the spirit of the law was that the President establish a reference center for the federal government, and so far I just see you providing service. Reference center, to most people, means that it's an academic center; it has very extensive research and educational activities embedded with the service. And what I see you emphasizing here is just the service part of it. And actually I see a conspicuous absence of other federal agencies being listed.

So, my question to you is, actually, was a survey of the other federal agencies done? What was the result of that? And can you comment on that?

CAPT GIRZ: Yes. That's not been done

yet, but is in the plan.

DR. PARISI: We talked about this more than a year ago.

CAPT GIRZ: Mr. Wardell, do you have any comments to answer?

DR. PARISI: What are you waiting for? We talked about a lot of these issues for over a year. And again, the level of detail -- the devil is in the details here -- is very lacking, I think.

CAPT GIRZ: One answer to your comment is that because the Joint Pathology Center has not officially been delegated to the Joint Task Force, we have been wading through the process of that to happen. The Joint Task Force is not in the business of getting out ahead of the process of being delegated.

However, knowing that this needs to happen, we've been moving along at a pace --

DR. PARISI: I'm hearing two different --

CAPT GIRZ: -- and that we don't get

beyond what has been delegated to us.

DR. PARISI: I'm hearing two different things. You're moving along in one direction, but you can't do the other things that seem to be very critical to establishing what the ultimate scope of this new JPC will be. So, I'm hearing two different things from you.

There's a lot of detail questions that I could ask that probably are not really appropriate for this forum, but I think, again, there's very little -- we're left with a lot of goals and things that sound perfect, pie in the sky stuff, but I don't see any real substantive points here directed.

You know, if someone came to me and said, Joe, design a federal reference center for pathology, I would go about it by, first of all, getting the smartest guys I knew, the academicians, the people that had vision, and getting together in a room for a day or a couple of days, and putting things out on the table. And you guys really have just -- at least what I see

here, you really just have designed a hospital-centric, anatomic pathology center that just is going to provide service and really very little else.

DR. POLAND: Let me make a suggestion. And I suspect without knowing, that there's more detail than what necessarily is in the slides. And I was just conferring with my colleagues here, and given Joe's point, I think an appropriate way to handle it would be to ask the Department for a detailed written response to the thoughtful questions that the Board raised last time rather than -- we've sort of forced you to artificially condense it into a handful of slides. And I think that would be an important document then for this Board to review and would allow you the opportunity to lay out in more detail what the timelines and what the responses to those questions would be. Is that fair?

CAPT GIRZ: Certainly.

DR. POLAND: Joe, is that helpful?

DR. PARISI: That would be very helpful.

You know, I think this is a golden opportunity that we're -- the Department of Defense is missing it. This is an international resource. If you look at the history of the AFIP, look at what it's done for medicine throughout the 150 years of its existence. And I understand there's issues and we need to move forward, but you have an incredible opportunity here. The government is asking you to make a reference center for the federal government that's going to be an international resource. And what we've got designed here --

CAPT GIRZ: I'd like to say it's for the federal government. There's nothing in the statute that says it's international.

DR. PARISI: Yeah, I know, but if it's for the federal government, by virtue of that, it's going to be an international resource.

DR. POLAND: Okay. I think then, in fairness, then what we'll do is we'll ask for a timely written response and we'll ask the Exec Secs to work with establishing that timeline, but a timely written response that would have the

level of detail that the questions envision behind them, and then ask the committee and Board to review it again.

Dr. Lednar also has a question.

DR. LEDNAR: The spirit of the Congress was to be sure that there was created a Center of Excellence for the -- I'll say the U.S. Federal Government, and you've identified a number of the pathology subspecialties that you see in the pathology staffing. The question I have is, as a reference center operating at the highest levels of pathology, how will you assure that not only is a physician credentialed and trained in an area of pathology subspecialty, but has the adequate experience and skill to be of a stature to be really a U.S. federal leader in their subspecialty?

Part of the concern I would have is in this time of transition, in this time of uncertainty, I would expect, without knowing, that you may be losing some current top talent. So you may be standing up the JPC as soon as next summer

in its earliest stages with sort of a diminishing pathology staff. So, I'm wondering how you're planning to address that, to recruit the caliber of talent that you need to really operate a Center of Excellence as the Congress expects?

CAPT GIRZ: Do you have a thought on that? I'm going to defer to Captain Larson, who is one of our pathologists who's been working on the Joint Pathology Center.

CAPT LARSON: I'm David Larson. I work at the National Naval Medical Center. I was the Navy consultant for pathology.

We appreciate that comment. It is something that we have concerns about, too, are we going to get the right talent? I think we are looking for a good number of folks from the Armed Forces Institute of Pathology currently to come over and I know that a good number of them have spoken with Colonel Baker about wanting to come over and join us at the Joint Pathology Center, so we're hopeful that we're able to.

We recognize that we need to move

quickly. I think we are undergoing a deliberative process to come up with the plan. You know, July is an aggressive timeline, but we want to do that in order to give them a goal and say this is when we're going to start up and that there is a job available for you as a part of this world-class federal resource.

DR. LEDNAR: If I can ask a follow-up question. If I remember, Colonel Baker was the Chair of the Department of Pathology in the Medical Center.

CAPT LARSON: He still is. He's the Chief of the Integrated Department. I am the Chair of the National Naval Medical Center because we still have two hospitals. So I'm the Lab Director, he is the Chairman of the Integrated Department.

DR. LEDNAR: The director of the JPC, when it stands up, would not be a second hat to the Department --

CAPT LARSON: No, no, and actually we have already undergone a process to select an

interim Director. That is pre-decisional because they are waiting for a delegation from DEPSECDEF to the JTF. Admiral Mateczun cannot name somebody to be the interim director of the JPC until he has official delegation of that. But they've already met -- I think there's a decision on who that's going to be, but it's pre- decisional and can't release that just yet.

But we're ready to go. I mean, as soon as they get it, we've got an interim director, we're developing the OPLAN, the Operations Plan, we're ready to go.

DR. POLAND: We've got a few more questions -- Dr. Walker, Dr. Silva, and then Dr. Oxman and, I'm sorry, I don't know your name.

DR. BARTON: Dr. Barton.

DR. POLAND: We'll get you fourth.

DR. WALKER: So, this is on our agenda here, is recommendations and progress updates, so clearly it's not a final -- it's not final. And in the recommendations, or what I read as recommendations under the JPC capabilities, are

three things related to tissue battle repository, the use of the battle repository material for research, maintain and modernize it -- modernizing it is certainly a good idea -- and use the material for clinical care and develop a process for utilization.

So, what's missing there is -- and it says here, implement the plan to modernize the tissue repository and to implement the plan to expand research and education. Those are things that I would really like to know what's planned and what resources are going to be put into them because --

DR. POLAND: And I think that's appropriate to ask and to receive in this more less-abbreviated format than what we're seeing today.

DR. WALKER: Right, but there's one detail here that I would like to just address and that 29 board-certified subspecialist pathologists sounds like a lot, and it certainly would be for any one hospital, but that's less than two per

subspecialty. And as the Chair of a department, I know that if I'm going to have a subspecialist, I've got to have at least two per subspecialty because somebody's going to be on vacation.

But the more practical thing is, the more realistic thing for the purpose of this, is that you have to have at least one of those in every subspecialty that is research- oriented to utilize the repository to create new knowledge, to push prognostics, theragnostics, and those things forward.

And so I would ask that that be thought through how that's going to be accomplished.

DR. SILVA: Yeah, I liked what Dave -- Silva -- I like what Dave suggested. I want to know how they're going to put them to work, also. While it looks heavy, it looks thin from many dimensions.

The other thing is, this thing has a lot of eddy currents to it. I barely understand all of them, and we keep seeing it and there's -- you know, there's not much movement. And if Joe

Parisi has questions that he's framed, maybe he wants to put them in writing and have them asked to the staff to see what they're going to do with it. Because it sounds like there are layers here that no one's going to be happy until we get answers, yea or nay.

Thank you.

DR. POLAND: Mike?

DR. OXMAN: This is the United States Center of Excellence, if you will, or that's the plan. The distinguished pathologists are in academic centers around the country, only a small fraction of whom are with the military. And I'm concerned, and I think the Subcommittee was concerned, about the ultimate oversight and decision-making process and that it be represented by a broad spectrum of the top pathologists in the country irrespective of their linkage to the Uniform Services Medical School or any other agency that's directly linked to the military.

The military needs help in this area if it's going to have an international reputation for

excellence.

DR. POLAND: There was a comment back there? Please come up and introduce yourself. And then one more and we'll move on.

DR. BARTON: I'm Dr. Joel Barton. I'm currently a member of the Gerontology Urinary Pathology Department at the AFIP. I think it's fair to say with the sparse nature of the presentation that we could spend hours in here trying to flesh out major, major gaps in the presentation. Hopefully, she will be able to provide those details to Dr. Parisi's questions and a number of others that we've had unanswered for months if not longer at the AFIP.

But two major things I'd like to bring up, you know, to reiterate what was said over here. There are 19 subspecialties of pathology listed in this presentation supposedly covered by 29 pathologists. If any of you have actually been at AFIP and seen the workload as it comes through various departments, that's less than two people per department. When someone's gone, when

someone's sick, there is no way you can keep up with the workload.

The other thing I did not see addressed here is a very, very crucial point, and that is where we're going to be located and what kind of space allocation there is per pathologist involved. What we have been told at this point is basically a large room, perhaps not even the size of this room, in which these "distinguished pathologists" that will be attracted to the JPC will be placed in cubicles in one room, probably along with their support staff, which is really very, very inadequate, and I would like that point addressed, please.

DR. POLAND: General Anderson. We'll let those be addressed in writing.

GEN ANDERSON: This is your relief coming. I'm George Anderson. I serve on the Defense Health Board Subcommittee on Healthcare Delivery. I'd like to make a statement and then ask a question that's really an opinion. The statement is that at least from my observation

point, having the Joint Pathology Center directly assigned to the Task Force during CAPMED is a nice thing given where we saw it originally.

Now, I do want to state, though, there is some ambiguity about the whole organization of the Joint Task Force. So what we would like you to continue to think about is the eventual home for this Center, which will be, you know, given the nature of the politics surrounding a task force that's still directly reporting to the Deputy Secretary of Defense, there's going to be an evolution there, too. So, when you go through your deliberations, when your OPLAN comes up, you know, we'll be watching that, too, from the Defense Health Board.

So, I just wanted to make that statement. You can't respond to that, so, there we go.

The question is really more one of an opinion. And we looked at a rather aggressive schedule here from what you reported, where you have the AFIP BRAC generated timeline for action,

which has end dates in 2011 for sure. And you have your CONOPS moving to OPLAN now. And my question really is, are you seeing any roadblocks between those two different sets of directives as you move into the OPLAN? And then, you know, related directly to that was, how's the budget?

CAPT GIRZ: So, two questions --

GEN ANDERSON: You know, in the Department of Defense, what gets budgeted is what gets done, okay. So it's one question, but, you know, if you don't have the money to do it and are there roadblocks that you see coming?

CAPT GIRZ: Mr. Wardell, do you want to address the money piece?

DR. WARDELL: Yeah, I'm Mr. Scott Wardell, the Deputy Chief of Staff with the JTF CAPMED.

Great question, sir. Right now there are no roadblocks. TMA has been a -- TRICARE Management Activity, has been part of the deliberations and the formation of the OPLAN thus far. Really, quite frankly, what they're waiting

on is the exact figure of the number of personnel, you know, highlighting the fact, for instance, that driven by the original CONOPS, the JPC was an organization of 81 personnel. It has, through the gap analysis, grown to 104 people, primarily civilian personnel. Also the bed-down for instance, is going to drive some cost of initial outfitting and so on. All of those are in the existing baseline.

Now, the executive agent, being the Army and certainly TMA, have not expressed any concerns about it, at this point, an ability to meet that budget, nor carry that budget forward into the out years because, quite frankly, the baseline exists today. So, it will be a reprogramming of those existing resources into this to accommodate it.

Now, the Joint Task Force, as a standing element, is looking for the authorities necessary, as you know well, to become an allotment authority by FY '12.

(Recess)

DR. LEDNAR: I'm going to substitute for

the Chair of this afternoon's session to introduce our next speaker, Dr. Poland.

Dr. Poland, as everyone knows, is the Co-Vice President of the Defense Health Board and chair of the Infectious Disease Control Subcommittee, as well as its Vaccine Safety and Effectiveness Working Group and its Pandemic Influenza Preparedness Subpanel. Dr. Poland is a Professor of Medicine in Molecular Pharmacology, Experimental Therapeutics in Infectious Diseases, as well as Director of the Mayo Vaccine Research Group. And, I might add, a highly sought after speaker on national media to talk about topical interests in infectious disease.

He will present an update this afternoon regarding recent activities of the Pandemic Influenza Preparedness Subpanel, as well as Vaccine Safety and Effectiveness Working Group. Core Board members may find Dr. Poland's presentation slides under tab 6.

DR. POLAND: Who would have guessed, Wayne? I've always been told I had a face for

radio and a voice for print, so.

And as Chair of that Subpanel, let me just say that it's bothered me immensely to watch each of the speakers drink out of the same cup here.

So I'm going to do the two presentations back to back. I think I'll get us caught up here. I don't think I need as much time as was given to use here.

This is just a list of the Subpanel membership. All of these individuals have been very involved in the deliberations that we've had and the recommendations and products that we've delivered.

You'll recall that this Subcommittee was established in late 2005, basically to assist the Department in the issues that you see listed there.

Our recommendations were to be DoD-specific, focus on areas that were within DHB and DoD's sphere of influence. So, for example, we can't make vaccine. That's outside of our

sphere of influence. Focus on both immediate and try to look forward into the future recommendations and on what's feasible.

We have, over the few years we've been in existence, been, I think, fairly active. I'm pleased, and I think the Panel, when we last met and reviewed some of these, that there was very little of any of the recommendations we made that we felt needed to be changed or where facts had altered what we had tried to best simulate or model in terms of our recommendations.

Specific issues that we have dealt with and looked at include antiviral recommendations, vaccine recommendations, how decisions are being made, pandemic influenza research recommendations. You'll recall discussions we've had about convalescent sera recommendations, PPE, novel flu diagnostics, antimicrobial stockpiles, the use of pneumococcal vaccine, and clinical trial recommendations. So it's been rather a busy time and we've dealt with a lot of issues.

In September, we had a meeting with

representatives from Health Affairs, DHHS, and MILVAX, as well as our Subcommittee. We received at that meeting updates regarding DoD's preparedness and response.

And is Wayne here? Yes, Wayne is there. I want to just publicly thank Wayne for being very accessible, getting information to us very quickly. I know there are many times I've sent an e-mail at all sorts of times of the day, weekend, or night. And remarkably, often within minutes to no more than a few hours, Wayne has accommodated those requests. So, Wayne, thank you for facilitating our work.

And we specifically focused on H1N1 vaccine and pneumococcal vaccines, the stockpiles of equipment and antivirals, and what will be a bigger issue, which is the active and passive vaccine safety surveillance plans following H1N1 vaccine. And this has really become now a National Vaccine Safety and Assessment Working Group. MILVAX is there. As a representative of this committee, I also sit on that Board.

And we've had our first meeting now and have outlined I think I counted just under a dozen different databases and methods that will be appealed to in the civilian, on the CDC, and on the military side to examine the millions and millions of doses of vaccine that have been given, and trying to look at safety since that's a big issue in the public and in the recipient's minds.

Well, to get to some of these. As I mentioned, there are collaborative efforts in regards to vaccine safety. The plan is to share information in the effort to standardize and synchronize how information comes to that safety committee across the different databases. And the Vaccine Safety Datalink was used as a model for the DoD data structure approach and statistical techniques that were going to be used.

And, Mike, if I am misspeaking in any regard there, please speak up. Because it really is the first time that I've really sat on a federal working group like this and was truly impressed -- I think that even those words sort of

fail -- truly impressed at the interagency working at getting at these data and everybody agreeing on this is how we're going to analyze them, evaluate them, communicate them, et cetera.

We thought there would be potential significant challenges in the event that the pandemic worsened. There's no evidence for that. But trying to, again, look forward, primarily in regards to the availability of trained providers -- there's a limit on the number of people available -- a shortage of ICU nurses and supplies were it to get significantly worse, and budget issues.

So, you know, we're pointing those out. It's not, I don't think, necessary at this point that we come up with detailed plans because we've been through wave one, deep into wave two, and have seen no change in the virulence of the virus, mutations in the virus, et cetera.

Recent activities we heard about that have been undertaken by DoD include standardization of definitions, risk windows, what

ICD-9 codes were going to be looked at. They had submitted a three-phase surveillance study protocol for IRB approval, great attention being given to active surveillance looking for both any vaccine side effects and platforms, diagnostic platforms, for agent identification and confirmation. As you might imagine, and it's true for all of us on the civilian side, eventuating in CDC's recommendations, we actually test relatively few people, not everybody who would come with an influenza-like illness, or we would just spend all of our budgets and all of our time testing.

And finally, the pursuit of various communication approaches to inform everybody involved regarding H1N1 vaccine safety.

We recommended that careful attention be paid to diagnostic criteria and the role of an expert panel that would determine whether a specific case met a definition. I think this has been very well handled by this Vaccine Safety Working Group, and really is a response -- some of you may know the story behind trying to understand

Guillain-Barré as a side effect with the '76, '77 vaccine; a lot of messiness in that determination.

We reiterated our previous recommendation regarding maximizing essential resources and that they be available in the event of any sort of surge that would be necessary if things were to worsen or change.

And that was really it for that Subpanel's meeting. We felt that things were going well. We didn't have any specific or major directional changes or recommendations.

So comments or questions on that before we get into the next one?

And from any of the Panel members? Anything you want to add that I didn't emphasize or left out?

Mike, anything from your perspective?

DR. OXMAN: I think you did very well.

DR. POLAND: COL Krukar, anything you want to add?

COL KRUKAR: No, sir. I think we'll get a little bit more in-depth detail as to the

process when Wayne gives his presentation.

DR. POLAND: Okay. And just to give you one bottom line in terms of vaccine safety: Some 15 or 20 million doses have been given and, at least at this point, there has not been a single vaccine-associated serious adverse event attributed to the vaccine. May be early to tell some of that. There have been some febrile seizures. Some of you may have heard about a case of GBS.

If you're interested in this I would commend to you Steve Black's article that was published in The Lancet, a week or a week and a half ago, looking at the U.S. and some other developed countries, looking at background rates of things we might care about: GBS, optic neuritis, sudden death, spontaneous abortion, a few other things like that, and the number of cases that absent any sort of H1N1 program would occur in any given minute, hour, day, or week in relation to vaccine. And, you know, within 6 weeks, if you take 10 million women, 16,000 of

them, as I recall -- 10 million pregnant women, 16,000 of them will have a spontaneous abortion coincidentally within 6 weeks of getting H1N1 vaccine.

And this will be a really important part, not only of evaluating those data, but communicating to the vaccine recipients. Because the tendency among the public, and even among health care workers, is to assume that temporality is causality. And how many, many times we've learned the lesson that that is not correct. Makes for good hypothesis generation, but not a good way to prove a hypothesis.

Okay. I'll move on, then, to the other meeting that we had, which was the Vaccine Safety and Effectiveness Working Group. Again, the purpose of this, since I don't think we've briefed on this to the Core Board before, was to form a working group that had the objectives you see there: focus on FDA-approved vaccines; examine post-licensure vaccine safety, effectiveness, and surveillance studies in the context of DoD; review

the extant data available for vaccine safety and effectiveness for vaccines used in DoD; discuss future DoD vaccine safety, effectiveness, and surveillance studies; identify and highlight research priorities as well as gaps; and provide guidance regarding studies that could be done.

And here's where I want to compliment COL Krukar and Garman and MILVAX. Again, they were very, very open and transparent with us. We had an excellent meeting. Had people from around the U.S. throughout DoD who showed up and really gave a very detailed set of briefs in terms of what was happening.

As you can imagine from looking at those marching orders, it's an almost impossibly broad task. But we will now begin to chip away at those. This first meeting was meant to sort of get an overview of what's happening and what could be done.

I want to pause for just a moment here and plant the seed that a topic that could be considered for one of our "summer studies," either

at the level of the Board or perhaps at the level of our Subcommittee, would be to look at the issue of biodefense vaccine countermeasures. I believe it's the only thing mandated of the Board, is that we take the validated Chairman's Threat List and develop a memo that speaks to the countermeasures available. And the whole Board hears this. The whole Board has had some questions about the methodology; we won't go into that now. But, you know, we could ask the question, well, should other vaccines be used and others not used? What's the appropriate response? And that's something that would take, I think, focused briefs and consideration by the board. So I'll just plant that thought.

The membership of this particular Working Group is as you see there. We met in mid-September. And I'll just take you through the agenda topics. And I've listed the briefers, too, so you'll get a sense of the diversity of things that were going on. And this is sort of the tip of the iceberg of the things we were most

interested in. There's a whole lot of other things happening too, of course.

But we heard an update from Mike McNeil at CDC about the Vaccine Analytic Unit and the very close interactions between CDC and DoD in this regard.

Phil Pittman talked to us about a smallpox vaccine shedding study. As you know, a remarkable safety record with administering smallpox vaccine, particularly in the big surge in 2002. Nonetheless, there were a few episodes where shedding of the virus -- or I should say transmission of the virus to a non-intended recipient occurred. And Phil's been looking at that and methods such as topical iodine, for example, to decrease that shedding and the risk.

A number of briefs on smallpox vaccine safety projects. We were briefed through NHRC and MILVAX.

Seasonal influenza vaccine effectiveness, which was very interesting and in some cases quite controversial in terms of some of

the findings, which in turn will lead to refinements in new studies to try to understand is TIV or LAIV the best vaccine in a given subpopulation or in a given setting.

H1N1 Vaccine Safety Study in Pregnant Females. Again, more as a response to have the data to respond, rather than a known concern. But like many vaccines, they're Category C and not necessarily -- a large database doesn't exist. Manufacturers are reticent to study their vaccines in pregnant women, for example, because of liability issues.

I've already talked about the interactions between FDA, CBER, MILVAX, CDC, and other agencies in terms of H1N1 vaccine safety.

Some specific issues that we noted was we were very pleased with the enhanced interaction, coordination, and collaborative efforts that were being pursued not only within DoD, but from outside of DoD with other federal agencies. That is a topic that has come up many times across disciplines. And without trying to

overstate it, I think a model for how that could occur is what we've been seeing in regards to vaccine. Many questions regarding vaccines and the interagency interactions that were occurring. We were quite impressed.

NHRC is involved in a huge ACAM2000 post-licensure Phase IV study. I think it's 40,000 people that are being recruited from the military here.

COL KRUKAR: Twenty.

DR. POLAND: Pardon me?

COL KRUKAR: Twenty thousand.

DR. POLAND: Twenty thousand. Okay. So here's an example of an FDA mandate to a manufacturer of a vaccine that is primarily used within DoD. Wonderful interaction there. A myopericarditis and myocarditis registry that's been established and is ongoing in a number of AVA studies that are occurring.

We also heard about ongoing efforts to improve the quality and reliability of data capture, including a universal tracking system

that's under consideration to address differences across services. Right now, how they're captured, when they're captured, how they're sent and rolled up differ by Service, not too surprisingly. And what was pleasing was not only the recognition that that needed to be changed, but specifics about how that might happen.

Assessments that are being planned to evaluate DoD adverse event screening during this huge Phase IV study that's being done. Evaluating and looking in a metric driven way at the completeness and accuracy of the DMSS immunization database.

We also talked about, with MILVAX and MIDRP, what were priority research topics. And here the Working Group had been requested to comment and provide feedback on proposed studies of priority to DoD. We'll increasingly be dealing with some of those. Some of them included seasonal vaccine effectiveness, comparing LAIV and TIV because there are some controversies there, external validation of vaccine research

initiatives. I won't spend more time, but this was a large piece, for obvious temporal reasons, H1N1 vaccine safety.

And our findings were this. One was to develop and formalize closure mechanisms to facilitate -- and while we were dealing with specific issues around vaccines, it's a broader issue than just vaccines -- to facilitate DHB reviews and inform DHB in a timely manner regarding how the Department has pursued, what progress they've made, or decided not to pursue in regards to our recommendations. Availability of new data or research progress. Short of a briefing, we're not going to really know about a new research finding that might inform clinical policy, for example, absent hearing of those data. Many of those studies are only done within DoD, and if they're not published, we won't know about them until they're published. Of course, a very dynamic situation when you look, for example, at H1N1, and trying to keep abreast of shifts in DoD policies and priorities.

We thought there were continued ways in which we could improve communication between DHB and DoD, including increasingly, shall I say, inserting ourselves in discussions in the decision-making process and providing guidance for high-priority areas.

This is sort of along the lines of what I was mentioning as a possible summer study topic, and that is the process for evaluating whether a threat agent continues to pose a threat and what the best countermeasure or mitigation efforts might be in that regard.

Encouraging implementation of consistent risk analyses to inform decisions pertaining to vaccine administration. Remember that while sometimes they overlap quite a bit, in a number of areas the way vaccines are studied and licensed in the private sector/civilian setting can be different than the way they're going to be implemented in the DoD setting or the manner in which they're implemented. And so the risk analyses may well be different. The cost

effectiveness analyses, for example, and thresholds are different on the civilian side than the military side.

And, again, we commended the MILVAX initiative to unify research and funding priorities within DoD. They've worked very, very hard. It was grossly obvious in regards to the progress made in collaborations and endeavors to advance scientific understanding.

And the next steps that we plan on, just to let you know what our activities are, is at the next Biowarfare Countermeasures Workgroup meeting we'll be looking at smallpox and anthrax threat updates, determine whether any change should occur in regards to those recommendations. We didn't talk at our September meeting about adenovirus, but that's something that we'll endeavor to get back on our agenda and on the Board's agenda. I think it's time. It's been about a year or so, maybe a little longer, since we last heard the progress being made.

So there's an overview of what we have

done. We're not asking for a vote or making any recommendations at this point.

Questions? Adil?

DR. SHAMOO: My experience is even in clinical trials, so this is really word of caution. Because you said there are no serious adverse events even in 20 million vaccinated individuals.

DR. POLAND: Vaccine-related adverse effects.

DR. SHAMOO: Yes, I understand. But I'm saying in general, even in clinical trial, which is much better control than 20 million vaccinated individuals, there is a strong tendency in underreporting adverse events, and especially serious adverse events. That is by the patients --

DR. POLAND: Yeah --

DR. SHAMOO: -- by the hospital, by the doctor. They avoid it, et cetera, et cetera. And I have anecdotal, as well as published report. And for those of us who are very familiar with the

ethics and regulatory compliance of clinical trials, it's a big issue.

DR. POLAND: Yeah, absolutely.

DR. SHAMOO: So, I -- wait a minute. I would warn your committee to be really more vigilant. That when you hear none, does not mean there is none and they should go and look for it.

And second is, I tried to do the calculation, but I don't remember. Twenty million, you have normal death rates in about four weeks, you got to report a few deaths. So for them to claim there is not even one death among 20 million, that does not happen.

DR. POLAND: Well, again, let me be sure you understand what my words were. There is not yet known a single vaccine-related adverse event, serious adverse event. So there have been, for example, deaths. Those have been examined. One example I can think of is a, I can't remember the gender, but a person who had known cardiovascular disease, angina, congestive heart failure, diabetes, a litany of things, who, six weeks or

something after having vaccine, had a heart attack and died. Well, the judgment of the Committee was that that was not a vaccine-related adverse event.

The second thing is about 10,000 or so people have been studied in the context of a prospective clinical trial and no serious vaccine SAEs seen. And in the remaining, they are both prospective and retrospective examinations in, for example, the Vaccine Safety Datalink, where large managed care organizations actually prospectively track what's happening with people.

Your point is a fair one, is there can always be underreporting. So far the sense is because of the heightened public concern about this there have been a lot of VAERS reports, which is passive reporting, much more than what you would see for your typical seasonal vaccine. So I think they're doing the things they can do at this point.

DR. SHAMOO: All I'm saying is there should be vigilance. And I would strongly disagree with you because I know a few serious

adverse events from the vaccine that the hospitals do not want to report it that is serious adverse events. They say it has nothing to do with the vaccine. No one wants to take the responsibility. I'm not saying there are a lot of them, but I am cautioning the committee to be more vigilant and proactive in looking for serious adverse events.

DR. LEDNAR: Dr. Oxman.

DR. OXMAN: The other side of that coin, which I think affected the reputation of the 1976, '77 swine flu, was the fact that every adverse event in the general population is underreported. So that if you don't have a placebo group, and a particularly blinded, you know, a double-blind study in which you have a large placebo group which is well matched, it's very challenging to use background data as a metric for what would be an incidence that would not be affected by the vaccine because that's going to be underreported. Whereas if we follow Adil and look carefully at 20 million people who are vaccinated, there'll be less underreporting of Guillain-Barré or anything

else.

DR. POLAND: Right. And there are mechanisms to do that. There's a technique called rapid cycle analysis, for example, where you can repeatedly examine these data. And they are examined on a weekly basis and, by the way, posted to a public website. So, you know, nobody knows of another way to more closely look. I think that it will be fair to say this will be an unprecedented safety surveillance in regards to H1N1. And the limitations are the inherent limitations. If people are not going to report and we don't know about it, there's precious little we can do.

But what you can do is at a minimum, and even in a case like that, you can say are we seeing -- let's take sudden death -- are we seeing a sudden death incidence that crosses the known background rate of it?

DR. LEDNAR: Dr. Parkinson.

DR. PARKINSON: Yeah, Mike Parkinson. Greg, thank you. I'm not a member of the

Subcommittee, but I kind of date, time my awareness of DoD H1N1 when we were last at the Academy.

DR. POLAND: Yeah.

DR. PARKINSON: And they had just gone through an outbreak there. And there are at least three or four things that I think in my -- in the last period of time that I think are relevant. If you just want to comment on any of them vis-à-vis the Committee's work or anything we should be aware of.

One, of course, was what happened at the Academy got rapidly reproduced at a lot of colleges and universities in the subsequent months in pretty much the same pattern. If they could do the social isolation, it kind of petered out. My own community, Carnegie Mellon, Pittsburgh, you know, that type of thing, we saw that. So I didn't think there's much new there.

There seems to be a greater appreciation for the mortality of this, particularly in young children and the younger ages, much more so than

we saw that -- than we have -- I think for me, not being an immunologist or vaccinologist -- appreciated back in August.

The next thing is the medical-political fracas around what happened to the production supply and did we over promise before. That still is a festering boil that we have yet to see that play out. But I think it's going to be significant, just my political hunch from being in the middle of these things before.

And then the last issue is about the increasing public skepticism that we need to do this at all, which is --

DR. POLAND: Just say that again, Mike. Of whether to do it?

DR. PARKINSON: Increasing public skepticism that we need to do this vaccine program at all.

DR. POLAND: Oh, okay.

DR. PARKINSON: At this point. Either it came through my community; I didn't notice it.

So that's just a potpourri, and maybe

it's better for cocktail hour. But those are the four things that not being on the Committee that I see in the last four to six months that could all, each and of themselves be significant. Together, it could be really significant. Or maybe they're just petering out. I don't know. Any reaction --

DR. POLAND: I think you articulated them very well, Mike. And the sort of tagline I give it is the two extremes that we see are apathy and panic, and neither are appropriate. I think what is becoming clearer is more about the epidemiology. It is the younger people who are out of proportion infected and who get hospitalized. It is the older people that when and if they get infected and have risk factors, die out of proportion. So some differences compared to seasonal influenza. I think it is fair to say that for many people, once there's enough vaccine available, they'll sort of say, well, do I even need to get it?

It might be important to note that the Southern hemisphere has already made the decision

to have the A California 2009 H1N1 be the H1 component of their seasonal vaccine, which for them will be this summer. Almost certainly -- I'm not predicting it because who knows, but the decision will be made in February -- almost certainly we'll do that in the U.S., too.

DR. LEDNAR: Dr. Luepker?

DR. LUEPKER: Yes, Russell Luepker. I don't want to muddy the waters further, but just another --

DR. POLAND: Good, thank you. Are there other questions? I'm kidding you.

DR. LUEPKER: I'm vacillating between panic and apathy. You know, when the selected group of people that get this vaccine are going to be a healthier group. And comparing them to the usual level of cases may mislead you a bit.

DR. POLAND: Actually, just to correct, just the opposite. So, among the people who are getting the vaccine right now, they are, with the exception maybe of some of the healthcare workers and some of the younger children, they are people

who have risk factors and are most at risk.

DR. LUEPKER: You're right. You're right there. But the large numbers are in young kids.

DR. POLAND: Yeah, they're certainly in the younger kids. That's true.

DR. LUEPKER: I'm curious if we know, apropos of Mike's question or at least the illusion, so how many military personnel have been vaccinated, have there been issues, and what's the refusal rate?

DR. POLAND: I think, Wayne, might you get into that in your brief? We'll find out. On the civilian side, all I can tell you is the observation -- I can't quantitate it, Russ -- is that somewhere around the majority of health are workers are refusing the vaccine. By the way, about the same number as seem to be refusing seasonal vaccine, and you know how I feel about that.

DR. LUEPKER: That actually, we have some experience and it worries me. I mean, we

have wards full of bone marrow transplant --

DR. POLAND: I know.

DR. LUEPKER: -- and kidney and heart transplant people who --

DR. POLAND: Dr. O'Leary is not here right now. He just told me he sits on the National Patient Safety Foundation. And yesterday, I think it was, they endorsed a policy that the clinical standard of care should be mandatory vaccination of healthcare workers. And as you know, a number of states, IDSA, other professional associations, including the DoD, have also done that.

DR. LEDNAR: Dr. Oxman.

DR. OXMAN: And a number of institutions, despite having fairly strong union representation, have mandated it and required that those people who refuse wear masks at all times when they're involved in patient care or riding the elevators, which is the whole day. Very uncomfortable. And some of them have gone far enough as to have different colored identification

tags so that you know who should be wearing a mask. And we have a very strong union in San Diego, but I'm going to try to do that when I get back.

DR. POLAND: One approach --

SPEAKER: The mask.

DR. POLAND: One approach that I saw was that the physician ethicist who chairs or sits on the AMA's Biomedical Ethics Working Group feels that patients should have the right to know whether their health care worker refused vaccine and is unvaccinated because they represent a risk, a quantifiable risk to that patient. Interesting way of dealing with it.

DR. LEDNAR: Any other questions for Dr. Poland?

DR. POLAND: And we accomplished our goal in half the time.

DR. LEDNAR: If not, thank you, Greg, for this report.

As per the agenda, we're going to take a break. We're going to take a break early. And

we're going to take a break for 30 minutes. And by my watch, 10, 20 --

(Recess)

DR. POLAND: Okay, if folks will take their seats we will get going here.

We have next an update on influenza that is scheduled for about a half hour. It'll be given by Colonel Wayne Hachey. He serves as the Director as of Preventive Medicine and Surveillance in the Office of the Deputy ASD for Force Health Protection and Readiness. His primary responsibility is serving as a subject matter expert in pandemic and avian influenza. In the course of his duties, Colonel Hachey has developed, to a large extent, the Department's medical policies and guidance regarding avian and pandemic influenza. He speaks to a lot of groups about that.

He's also responsible -- though many in the Board just know him for pandemic influenza, he's also responsible for immunization policies which effect DoD, as well as force health

protection issues such as anti-malaria medications. I think many of you -- well, actually, just maybe people who were at the last meeting know that he's been promoted to Colonel, and the Board would like to extend its congratulations.

And I think Wayne's slides are under tab 7.

COL HACHEY: Well, thank you for allowing me to present to the Board. And as far as the promotion, it just proves that even a blind squirrel will find a nut on occasion.

But I was asked specifically to give the Board a briefing on the current status of H1N1, particularly on its impact on DoD, with one specific question, if it's impacted on the DoD mission. Then to discuss anti-viral acquisition processes, as well as where DoD is getting its vaccine and to describe the vaccine's safety program. So we'll be going through those in that order.

Just to start out with a timeline of

when this all started, back in December of 2008, there was, in fact, widespread influenza-like illnesses happening in Mexico. Unfortunately, that was unrecognized until April of 2009 with the identification of four cases of novel swine-origin influenza. This was identified because of the DoD influenza surveillance network. Those four cases, actually, were identified by three different components of our influenza network. So if it wasn't for DoD we may still be going, what is that?

The disease then spread, actually, in a matter of weeks, which in previous pandemics took a number of months, with the eventual declaration of a pandemic on 11 June by the WHO. Now like most blue-haired old ladies, the flu did go south for the winter, so we were very interested in what was happening in the Southern Hemisphere. And in the Southern Hemisphere we noted that H1N1 became the predominant virus.

If it wasn't there first it soon overtook the regular seasonal flu variants and

became the predominant strain. It then came back to Northern Hemisphere and, essentially, now all countries in the Northern Hemisphere with a temperate climate have widespread activity.

This next series of slides will just give you a visual depiction of what's happened across the country. And this starts out in August of 2009 and takes you through 31 October. And the thing to look for is the dark brown, which denotes widespread activity. So, as we go from week to week, there's just more and more brown. And here we are on October 17th and then the last one on October 31st. So, in the matter of just a few weeks, you can see where we went from either sporadic or local activity to widespread activity across the country.

Now, right now, 99 percent of the flu isolates are the 2009 H1N1. The proportion of deaths attributed to pneumonia and influenza are well above epidemic thresholds across the country. And outpatient influenza-like illness visits are also above the national baseline.

As far as hospitalizations in the U.S., now 17,838 laboratory confirmed hospitalizations, with 672 deaths, 85 of which are pediatric deaths. Over 70 percent of the people who are hospitalized do have an underlying medical condition, as well as about the same percentage of those who have died from H1N1 also have an underlying medical condition. About a quarter require intensive care, about a little over half --

Percent -- requiring mechanical ventilation. And one thing that makes this very different from seasonal flu is that 45 percent are under the age of 18. Seventy-five percent are treated with antivirals with, as expected, the earlier the treatment, the better it is as far as prognosis. Almost 80 percent received antibiotics and most of those are prior to admission. And 93 percent actually get discharged with an overall death rate of about 7 percent in hospitalized patients.

One thing that we worried about a lot when this first started was whether we'd be seeing

a lot of secondary bacterial pneumonias. If you crawl back to 1918, about half of the DoD deaths were due to secondary bacterial pneumonia and those were predominantly pneumococcal. Thus far bacterial co-infections have been in less than 30 percent of the cases. And now staph species are taking the lead over pneumococcal disease.

If you look at hospitalization's rates, again, very different from seasonal flu. Most of the folks that are being hospitalized are in the zero- to four-year age group. Almost, actually -- almost but twice that of any other age group. If you look at the DoD population -- that 18- to 49-year age -- then that represents relatively few hospitalizations compared to the other age groups.

As far as deaths, the story's a little different. The group that had the highest hospitalization rate -- the 0 to 4 -- actually has the lowest death rate, with the highest death rate occurring in the 50- to 64-year age group.

Well, as far as the impact on DoD, what we just saw as statistics generated by the Centers

for Disease Control that I blatantly stole. This is data from the Armed Forces Health Surveillance Center. And just looking at it over the last 10 weeks, you can see that influenza-like illness visits to our clinics has substantially increased, compared to prior seasons. So, for all the Military Health System, MTFs, it's up 60 percent, CONUS up 65 percent, in Europe, activity is rather robust at 123 percent. And, depending on which state, you can see that being in the Southwest, the activity seems to be a bit more robust.

This just looks at, again, graphically weekly ILI for all MTFs comparing 2008 in the blue versus 2009 in the red. And you can see that activity has clearly increased compared to last year. But bringing it down, not looking at a 10-week period, but just a recent 1-week interval -- for Week 41 of 2009 -- for all of the MTFs across the Military Health System, activity is up 33 percent, CONUS 36 percent, Europe has settled down a bit to 29 percent; and at this time, Pacifica region was still at -4, although activity

in that area now has picked up, particularly in Hawaii.

So, looking at a report from the Armed Forces Health Surveillance Center, as of 3 November, clinic visits for ILI are substantially increased across the board. Now, significant elevations, like we said, in Korea, Europe, and Hawaii, is that that lower ILI rate that they were able to enjoy earlier no longer is the case. And our sampling of 2009 H1N1, just like with the national sampling, that strain remains the predominant strain with 98 percent of the samples evaluated being novel H1N1.

Our death rate remains low. These deaths occurred fairly early in the process: two inactive duty members, two family members, and two retirees. And over the past few weeks that's not changed. And one of the active duty members, in fact, had some preexisting medical conditions, so the impact on DoD has not been significant as far as deaths are concerned.

Just during that week, activity by

services -- the Army, Camp Zama in Japan -- reported an increase of influenza-like illness, a cluster of cases at the Military Academy at West Point. And because of that, they got an early supply of vaccine. The Navy, some clusters aboard a large deck ship in San Diego and then a cluster among SEAL trainees; thinking back to a visit we had with the Defense Health Board with one of the SEAL training areas in Norfolk, I believe it was.

And then the Air Force, 41 percent of Air Force bases are reporting substantial increases in ILI. Despite that, this flu has not significantly impacted upon DoD's ability to do its job. So we're still able to continue our mission. There's been no significant degradation in our mission capabilities.

So, what are we doing about it? As far as mitigation measures, I'll be talking a bit about antivirals vaccine to include our vaccine safety monitoring and communication. So, first of all, antivirals. Oseltamivir represents the lion's share of our antivirals drug stockpile. We

have two stockpiles. You can consider one a tactical stockpile, the other is strategic.

The tactical stockpile represents about a million doses. And that is divided among all of the medical treatment facilities in CONUS. It also represents the stockpiles at medical treatment facilities and the EUCOM AOR. For the other combatant commands, they have a separate stockpile that's there for their use. But because many of them don't have fixed facilities, it's stockpiled at an area where they have ready access to antivirals.

In addition to that, we have a strategic stockpile that's divided into three depots: one about two hours north of here, another in the EUCOM AOR, and another in the Pacific. And that represents about 7 million doses of antivirals.

Because of the risk of Oseltamivir resistance, we also requested for supplemental funding to increase our Zanamivir stockpile. And since then, we've been able to add almost a half a million doses of Zanamivir to the stockpile and

we've received additional funding -- actually, we should have the cash in hand early next week to increase our antivirals stockpile so that at least 30 percent of the stockpile will be an antiviral drug other than Oseltamivir. And right now that would be Zanamivir, but if something else comes down the pike that's FDA approved, then we'd be adding that to our antivirals stockpile, as well.

The DoD policy for antiviral drugs mimics that at the CDC. It's recommended for treatment to our hospitalized with either confirmed, probable, or suspected disease. If you have suspected disease it also suggests treatment if you're at high-risk for complications. And to consider post-exposure prophylaxis, if you are in a household with an index case where you have individuals, again, at a high risk for complications. The last group includes those people where operational considerations may mandate antiviral prophylaxis. And that represents a very small group of folks.

We also stress that treatment is not

necessarily indicated if you have a healthy individual with mild disease. And then again, very limited outbreak prophylaxis. The people that we end up using outbreak prophylaxis on are the onesies and twosies that, if they go down, the whole mission fails; or folks like our Special Ops people where we would stick them on some kind of aircraft and drop them off in the middle of nowhere and then tell them, we'll see you in a couple of weeks. And if the area that we're dropping them off in has endemic disease in that particular locale, then giving them outbreak prophylaxis would be clearly an option.

Moving on to vaccines. As you all know, the choice was to go with an unadjuvanted vaccine and that's been approved by the FDA. And the approval was based on this being, essentially, just a strain change rather than a new vaccine. One dose requirement for those greater than or equal to 10. And the mantra that we have for the folks not on the ID Committee is that this is a safe vaccine. It's an effective vaccine. It's a

good match with the current strains that we're seeing today. The same manufacturing process, the same manufacturers. And what we've been telling folks publicly is that, if the virus had been just a little bit cooperative -- just a tiny bit -- and had shown up earlier, this would have likely just been part of the seasonal flu vaccine composition.

As far as where the United States is getting vaccine, CSL represents -- and this represents -- CSL is an Australian company. It represents just shy of 20 percent of the U.S. vaccine reply, Sanofi Pastuer, about a quarter. GSK, most of their vaccine, I believe, is going to the UK, so this represents a relatively small portion of the overall U.S. supply. Almost half is from Novartis and then MedImmune is about 6 percent. And I believe that's increased a bit to once their vaccine production was much higher than what they had anticipated. Their rate limiting step was the little applicator that squirts the vaccine up your nose. They had more vaccine than applicators. And then, both DoD and the U.S.

Government have purchased adjuvants, both from Novartis and from GSK, just in case we needed them.

So where does DoD fit in as far as that overall picture, as far as the national vaccine supply? Well, we actually get vaccine from three different programs, one source. The one source is HHS. But through those three different programs, we have vaccine that DoD purchased -- and we'll talk about each one of these in a minute -- and that's limited to operational use. There's the Federal Employee Allocation Program, and this targets civilian employees and also includes our OCONUS beneficiaries, once they're not included in the overall state allocation program. This cannot be used for active duty members.

The third program is the state allocation program. This targets health care workers, dependents, and retirees, and cannot be, again, used for active duty members, with rare exceptions based on medical risk. So, the example is, if we have a pregnant active duty member who

comes into a clinic and there's no operational vaccine, our policy is if you have any kind of vaccine, regardless of the source, that you protect that person.

So, starting out with the operational vaccine, DoD has purchased 2.7 million doses through HHS. As of 6 November, we've received 390,660 doses. We'll receive our total 2.7 million by Christmas. And the folks who are eligible to receive this vaccine are active duty, Reservists, National Guardsmen, and GS civilian employees. However, the priority to get the vaccine, who gets it first, are deployed and deploying, health care workers, our trainees -- to include basic trainees, but any of our large training venues -- and ships afloat.

After we covered those high risk groups as far as high risk for transmission, then the rest of DoD is immunized. It will be mandatory for all uniformed personnel. So that the question about vaccine refusal, that's not an option if you're in uniform. And if not medically

contraindicated, you get the vaccine. It's highly encouraged for all others and our DoD medical logistics systems moves this vaccine. So we get vaccine from HHS that goes to our depot and then our depot moves it out across whoever in DoD it's required.

The next one is the Federal Employee System. This is up to 1 million doses of vaccine. Thus far we've received a little over 25,000 doses. This is a program that's administered by the CDC and we're allotted vaccine as it becomes available through that system. This, too, the vaccine is supplied by CDC, but goes to our depot and then we distribute it as we deem fit. This can be used for any DoD civilian employee and it's also approved for use for our OCONUS dependents. So this is where our dependents who are overseas are getting their vaccine. This again cannot be used for active duty members.

The last system is the State Allocation Program. And all of these systems -- if you think this makes your head hurt, the folks who are

actually with boots on the ground implementing these programs, it's been an adventure, to say the least.

The State Allocation Program, this is for dependents and retirees who are in CONUS. Now, in this case, CONUS represents all of the states, to include Alaska and Hawaii, as well as our possessions and territories. But this is, again, a CDC-administered course. It comes, actually, with not only vaccine, but the ancillary supplies, so needles, syringes, sharps containers, alcohol wipes, gauze pads, band-aids, and everything you need. And the allocation is based on the state population. So, the way it works is that the hospital commander, or his designee, enrolls with the state as a immunization provider and puts in his request as far as the number of enrolled beneficiaries he has, not to include the active duty members. The state then sends that information to the CDC. The CDC compiles all of this and, as vaccine is available, then each state gets their share. The vaccine doesn't go to a

state distribution, but goes to a vaccine distributor -- in this case, McKesson -- who does a direct shipment to the MTF.

And the MTFs began receiving this vaccine in early October. And if you look at your own home newspapers, you know that vaccine is kind of trickling in. And that's what we're seeing in our DoD facilities, also.

Well, the question that we have is that everybody wants vaccine and everybody wants vaccine now. And the bottom line is that everybody will have access to vaccine. And, again, for uniformed personnel it's mandatory. So, shortly after the New Year, everybody in uniform should be protected. All others, our policy is that anybody who wants to get the vaccine, will get it, but you may have to wait your turn.

And the vaccine supply is expected to increase rapidly over the next few weeks and months. If you look at what we were receiving just a few weeks ago for our operational supply,

which gives you an idea of how much vaccine is coming into the system, we were getting sometimes well under 100,000 doses, sometimes 30,000, sometimes a couple hundred thousand. And with the ensuing weeks, we're looking at 300,000 to 500,000 each week. So it's clear that the supply is loosening up. And that, across the board, we should be receiving more vaccine, regardless of which program.

Moving on to vaccine surveillance or safety surveillance, and these slides I've, essentially, blatantly stolen from MILVAX. MILVAX, and specifically Colonel Krukar's group, is our tip of the spear as far as this program. So the Vaccine Safety Surveillance Program, what we did at Health Affairs is that we told MILVAX that you've got to do a program and it's got to be good. And they bellied up to the bar and this is what they've given us.

So, this will use the Defense Medical Surveillance System, or DMSS, and the military's electronic health record data. It's a project

that's a collaboration between MILVAX, the Armed Forces Health Surveillance Center, the FDA -- particularly CBER -- and the CDC Immunization Safety Office.

And the project includes three phases. The first phase is the pre-vaccination phase. And this phase, what the folks at MILVAX did is they looked at our -- with -- I should say, the people at MILVAX in conjunction with the Armed Forces Health Surveillance Center looked at a pre-specified potential adverse events.

What they did is, they looked at it so we can establish a true baseline. So, if we do see an increase in the number of cases of GBS, let's say, we'll know whether it's really, truly about the baseline or not. There's also a group of experts that established criteria for identifying the different adverse events, particularly like GBS, so that if it kind of looks like it, it doesn't get counted. It has to meet a fairly rigid definition. So this phase estimates the background rates that will be used for

comparisons in the later phases.

The next one is the Phase 2, and this is when vaccine is actually in the pipeline. So this represents advanced surveillance used to identify signals of, again, pre-specified adverse events among military vaccinees for up to 42 days post-vaccination. It also uses the rapid cycle analysis techniques that Dr. Poland had mentioned. And these were developed by the CDC Vaccine Data Link Network and this serves to solidify signals and compare findings with, again, pre-established background rates.

In addition to that, we also have weekly case control comparisons of confirmed adverse events. And when we do have a significant adverse event, they're all referred to the Vaccine Health Care Center's network within DoD. There's also some data mining used to identify unexpected adverse events that may be associated with this vaccine.

The third phase is, after this is all done -- I'm hoping this will end sooner or later,

but this is the post- N1H1 vaccination phase. It represents a retrospective cohort study that begins when a pre-specified number of vaccine doses have been administered. And this is designed to adequately assess the association between those pre-identified adverse events with the new H1N1 vaccine. And it compares incident rates up against those pre-specified events between H1N1 vaccine and the previous year's seasonal flu vaccine, as well as in an unvaccinated control group.

The last thing is just a little bit about communication. In the past, we briefed the Defense Health Board about the different products that we have to include webcasts, TV slots, printed materials. Probably the hallmark of what DoD's doing for communication is our DoD website.

We're surprised that is doesn't quite show up at this distance, but it essentially represents one-stop shopping for all things related to H1N1. So it includes any new policies that we have, any updates to pre-existing

policies. It has a separate screen for CDC flu updates. So this is one area where anyone who's interested in anything that even tangentially impacts DoD can go here and get the latest information.

It also includes information from, say, the Civilian Personnel Office. So if someone is wondering if they can forcibly send someone home or not. What's the status on granting leave if you have a sick family member? They can go again to this source to get the answer.

And thus far -- it just started in April, April through 21 October -- we've had a little over a million and a half hits to the Watch Board, so we know that at least someone is looking at this. The most active link is our Frequently Asked Questions page. We also have a Twitter site, and we have 425 participants there, as well as a number of Facebook fans.

So, you know, hopefully -- you know, the fact is that compared to pigs, we humans are unforgivingly slow to learn from pragmatic

experience. You know, hopefully, the lessons that learn with H1N1 will prepare us for the next pandemic -- particularly if it turns out to be more severe, as we are all worried that this one may evolve into.

Any questions?

DR. POLAND: Wayne, I'm not saying they're related, but 1-1/2 million hits and your mother has carpal tunnel syndrome, so --

A quick question for you. Just a week or two ago, FDA did let for emergency use authorization Permavir, and that's a little bit of a tricky thing, perhaps, within DoD. How, if needed, does it have to be a case-by-case, facility by facility application, or is there something done at Big DoD level?

COL HACHEY: Actually, the CDC holds all of the Permavir. And they have -- actually, on their website -- and we've taken information from their website and put it on the Watch Board for people to reference. And we've also sent out messages through the pharmacy community within DoD

of how to obtain the Permavir. So what it is, is -- it is a case by case. We had one fire drill where we thought we were going to need it for a case in Germany. So we've kind of gone through, at least, the process of how we would do that. And it looks like we could actually get it to some place like Germany within about 24 hours.

DR. POLAND: Okay. Joe, you had questions earlier, did we get them answered with this?

DR. PARISI: You've answered them, thank you.

DR. POLAND: Bill?

COL HACHEY: Oh, and by the way, actually it wasn't my mother. I taught my bird to just keep on --

DR. HALPERIN: Sorry. In DoD Phase 3 Vaccine Safety Surveillance, there's an unvaccinated control group. How does that work?

COL HACHEY: Actually, I'm going to turf that one to my colleagues at MILVAX. Actually, this question came up during the

Infectious Disease Subcommittee briefing on this. And, if I remember it, Colonel Garman did identify an unvaccinated group, but I do not recall exactly how they generated that.

COL KRUKAR: And sir, I'm going to have to claim a little bit of ignorance and have to get back to you on this.

DR. POLAND: I know that it being done on the civilian side. Is that part of it, or that was also planned on DoD side? And was that before vaccine -- I know they're looking back at a number of years to get background rates -- was it before vaccine was mandatory?

COL KRUKAR: Sir, I think what we want to be able to do is give the right answer and we want to do thorough search on it.

DR. POLAND: Yeah, okay.

COL HACHEY: Actually, influenza vaccine has been mandatory -- influenza vaccine was first developed by DoD back in, I believe, the late '30s.

DR. POLAND: Yeah.

COL HACHEY: And it was mandatory then and I believe it continued to be mandatory. And we can double-check on this, but if I remember right, what that unvaccinated group represents -- as far as the DoD population -- are those folks who were kind of last in line during the flu season. Comparing that interval with the folks who are immunized.

DR. POLAND: Okay, we'll move on. Our fifth speaker this afternoon is Dr. Charles Fogelman, who currently serves as Executive Coach and Principal Leadership, Development, and Management Consultant. He's also the Chair of the Psychological Health External Advisory Subcommittee and will provide a summary of the Subcommittee’s recent activities. We have 30 minutes scheduled for this. His slides are under tab 8 in your binder.

It's all yours, Charlie.

DR. FOGELMAN: I can't possibly begin. There's no hand sanitizer. What the heck, I don't care. Thereby illustrating both ends of Greg's

continuum about -- too late, I don't care anymore -- Greg's continuum about apathy and panic or being a good teaching example for rapid cycling bipolar disorder.

We have 30 minutes allotted, but I'm not going to -- I hope I'm not going to take anywhere near that. Most of these slides most of you have seen before. I thought about administering a test to see how many of you recognized the slides, but it's late in the afternoon and I won't do that.

Okay, so if I go that way. That's right. Hey. You have all these things on paper. You know who we are. One of the things that we did previously, after educating ourselves generally about what was going on, was to begin whining about not having any real new questions to answer. And one of the ways we solved that problem, you may recall from my previous presentations, was we sort of walked through our own creating a set of questions. And the one that seemed, in the end, the most sensible was about Guard and Reserve and the psychological health

issues that might be involved there. And we, you know, sent that question up the line and nobody said not to do it, but -- I'll finish that sentence in a moment.

We had a very interesting series of folks come talk to us when we met about 3 weeks ago. These are their names. The issues that came up for Guard and Reserve were -- there are just a few major ones. One was recognition. Please pay attention to the fact that there are large numbers of Guard and Reserve serving. And while they have some similar issues, they have a number of very different issues, including, for example, not having a job when they come back.

I know that's also true for veterans, but that's just illustrative of one of the kinds of points that was made to us.

And another was -- this won't be news -- accessibility and number of providers who know what they're doing. You know, there was money to have those things done. And finally, most of the folks who presented to us continued to talk -- or

talked in a continued way about stigma. Lots of public relations, lots of self-congratulation about how we're working on stigma. But the general sense of people who were working with Guard and Reserve was that that message wasn't getting to Guard and Reserve people, for whatever reason.

So, as I said, we made up this question for ourselves. And not too long after we made up that question, low and behold, two questions appeared from above. These questions were just posed to us just before our last meeting. You can see that they're essentially the evaluation questions about pre-clinical and clinical intervention programs. What do we have? How do we measure it? What's working and are we sure?

In order to deal with those two questions, which now move up to the top of our agenda, we had a telephone conference this past week. We divided ourselves up into two sub-groups -- actually, we divided ourselves into two sub-group leaders and I'm going to have to assign

people to the two different groups, who are going to do some background stuff between now and our next meeting, which is just three or four weeks away. And try to distribute materials to folks and if anybody has any idea about good material or useful individuals for us to use as briefings as part of that next meeting, I will be happy to take those suggestions from you, but not while I'm standing here because I promised to -- not only did I say I didn't have much to say, but I also promised the inestimable Vice Presidents that I would be very brief.

So we're going to start working hard on that in December. And one of the things we're going to do at our December meeting is to create targets and a timeline for ourselves for how we're going to proceed, and we're hoping to do it with some dispatch. I'm going to push to aim for June as a point of being able to present something here, assuming we have a meeting in June. But, roughly, that's my intent and folks in the Committee didn't seem to think that was a terrible

or unrealistic idea. Well, at least nobody said that to me.

I don't need to read them to you.

DR. POLAND: We get the point.

DR. FOGELMAN: And that is that. You have the background slides for this and all previous meetings and you know how to find me. And I know from the last time, you certainly know how to ask me questions. So, are there any?

DR. POLAND: Thank you, Charlie. Questions or comments?

DR. FOGELMAN: Cool. I'm out of here.

DR. POLAND: All right, thank you. We have one other item of business to attend to, then we'll adjourn the open meeting and go into closed administrative meeting for a few items. And that remaining item is a brief update. Dr. Kaplan, I think, is going to give on the Warren Repository. We have two and a half minutes scheduled for that.

DR. KAPLAN: No, that's too long. Just a brief update. On November 3rd, the Warren Sera were moved, thanks to this board. Next, please.

This is just a picture of the bill of lading. Next, please. The truck is -- I'm trying to prove to you that it has been moved after all these years.

An amazing group. Next, please. The two movers with the freezers in the truck.

SPEAKER: Which one is you, Ed? I can't see from here.

DR. KAPLAN: I'm standing behind him there. Next, please. Rick Erdtmann, who is here -- right back there -- going through the records. As you know, these have been transferred to the Institute of Medicine and a medical follow-up agency, looking at the computerized inventory. Next, please.

Looking at the data cards. And then just a couple of slides to show you some of the amazing data that's in these records for your historical interest. Next, please.

These are the original records from studies done 50 to 60 years ago. And those of you who know the field will know that this was a

classical paper. Next, please.

You can see the names -- forgive me, Dr. Shamoo for being unethical about this, but --

DR. SHAMOO: It's okay, Ed. No one can read them.

DR. POLAND: And it's not the first time, so --

DR. KAPLAN: Next, please. The records that were kept during this period of time are just amazing. Next, please. You can see that the detail that was there. And the last slide?

I am very grateful to this Board and to all who helped in any way. And, finally, after all of this long period of time in getting these moved. Thank you very much.

DR. POLAND: Thank you, Ed, for being the trusted guardian of those samples for, well, half a century.

DR. KAPLAN: Aw, come on.

DR. POLAND: You were five when you got them. Okay, I will turn it over to Commander Feeks and then our DFO to adjourn the meeting.

CDR FEEKS: This is Commander Feeks. First, I'm going to ask one of my staff to clarify something. My understanding is that this room is actually going to be used for something else this evening. If that is the case, that affects what we can leave here, which is probably nothing.

SPEAKER: Yes, you can leave it where it is.

CDR FEEKS: No? We can leave stuff? Okay, Beth says we can leave stuff.

SPEAKER: And our notebooks?

SPEAKER: Yep, (inaudible).

CDR FEEKS: All right, you can leave it where it is. Let's see.

SPEAKER: So what do they do in this room (inaudible)?

CDR FEEKS: You know, I'm just dying of curiosity myself. So, all right.

All right. For those of you departing today, we have provided a manila envelope in each of your binders, just to make it easy. You can remove the contents of your binder, put it in the

manila envelope, and, all of a sudden, it doesn't take up that space in your luggage. That is, if you don't wish to keep the binder yourself. You're welcome to take the binder if you want to.

Okay. Now Beth is trying to send me a signal here.

SPEAKER: (inaudible)

CDR FEEKS: Okay. So that the script is -- yes, yes, like me. All right.

SPEAKER: (inaudible)

CDR FEEKS: No you didn't, but you were thinking it. Okay. All right, where was I?

For Board members, ex-officio members, service liaisons, speakers, and invited guests, breakfast will be served prior to reconvening at 7:30 tomorrow morning in this ballroom to resume the public portion of the meeting.

For those of you joining us for the dinner tonight, please convene in the lobby by 6:00 p.m. The group dinner tonight, as I said this morning, is scheduled for 6:00 at Sakura Japanese Steak and Seafood House. Sakura's

located about a mile from the hotel in Fair Lakes Shopping Center. Shuttle service is being provided by the hotel. The shuttle will leave from the hotel at 6:00. A second run, likely, to accommodate the group size. Return shuttle service to the hotel will also be provided. If you have not RSVPed for the dinner, please see Jen Klevenow, who is occupied with a task from me right now, but she'll be back. If, likewise, you told her you were coming and you can't come, please let her know.

For those who need to take the Metro after this meeting, the hotel operates a complimentary shuttle to the Vienna Metro station every 30 minutes. Please see the shuttle schedule at the registration desk, or visit the hotel's front desk.

And that's all I have for now, Dr. Lednar.

Col BADER: I'd like to thank everybody for attending today, especially for the folks who gave such outstanding presentations. Thank you

all.

And at this time I would like to adjourn today's meeting of the Defense Health Board.

(Whereupon, at 4:28 p.m., the PROCEEDINGS were adjourned.)

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

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