DEFENSE HEALTH BOARD
MEETING MINUTES
NOVEMBER 1-2, 2010
KEY BRIDGE MARRIOTT
14th Floor
1401 Lee Highway
Arlington, Virginia 22209

November 1, 2010

1. ATTENDEES - ATTACHMENT ONE

2. NEW BUSINESS – OPEN SESSION

a. Opening Remarks and Introductions

Discussion:

Dr. Gregory Poland, Defense Health Board (DHB) Co-Vice President, welcomed meeting attendees. Ms. Christine Bader called the meeting to order as the DHB Designated Federal Officer (DFO), after which she conveyed the regrets of Mr. Allen Middleton, Acting Principal Deputy Assistant Secretary, for being unable to attend the meeting. Following, DHB Members, invited guests, and public attendees introduced themselves.

Action/POC: None.

b. Vote: Proposed Revisions to Fluid Resuscitation in Tactical Evacuation Care

Discussion:

CAPT Jeffrey W. Timby, Medical Corps, US Navy Surgeon, II Marine Expeditionary Force (Forward), provided an overview of the proposed revisions to the current Tactical Combat Casualty Care (TCCC) Fluid Resuscitation Guidelines, for which deliberation and voting had been postponed since the August 18, 2010 DHB meeting.

CAPT Timby reviewed the history of the Guidelines, including the Special Operations Biomedical Research and Development project that customizes guidelines for the battlefield. CAPT Timby gave an overview of pre-hospital fluid resuscitation research, noting that the aggressive treatment approach, previously recommended by the TCCC Guidelines, is not ideal. CAPT Timby stated that though infusion of a crystalloid solution is acceptable in the civilian emergency transport setting, it is not appropriate for use on the battlefield due to longer patient transport times. CAPT Timby reviewed the 1996 TCCC Guidelines, which suggest delaying intravenous (IV) fluid resuscitation as well as other forms of fluid resuscitation. A limited amount of Hespan (under 1500 cc) was permitted for casualties in shock from hemorrhage but had been subsequently stabilized.

CAPT Timby noted that during the January 2010 Fluid Resuscitation Conference sponsored by the U.S. Army Institute for Surgical Research (USAISR) and the Joint Medical Research and Materiel Command (MRMC), it was reaffirmed that the administration of fluids is not necessary for patients not undergoing shock. Hextend was recommended due to its weaker coagulative properties in comparison to Hespan. These changes were adopted by the Committee on Tactical Combat Casualty Care (CoTCCC), published in the Revised 5th edition of the Prehospital Trauma Life Support (PHTLS) Manual, and have been widely used in the U.S. military. CAPT Timby also explained several current TCCC Guidelines, including processes for shock assessment, taking pulse, fluid administration, and resuscitation, as well as treatment alterations for casualties with a traumatic brain injury (TBI).

CAPT Timby outlined the following four issues reflected in the current TCCC Guidelines: (1) the use of blood pressure measurements is not indicated, even where these may be available during Tactical Evacuation Care (TACEVAC); (2) current theater trauma practice is not reflected in transfusions consisting of packed red blood cells (pRBCs) and thawed plasma in a 1:1 ratio; (3) even when plasma and pRBCs are available, Guidelines call for Hextend to be used initially; and (4) there is a need for a recommendation regarding fluid resuscitation in the instance of a TBI and altered mental status.

CAPT Timby then reviewed the changes proposed by the Trauma and Injury Subcommittee, which include: (1) recommending fluid resuscitation until palpable radial pulse is detected, in the field and during evacuation if the casualty has an altered mental status due to suspected TBI (the previous recommendation did not address altered mental status); (2) adding a recommendation to maintain a target systolic blood pressure (BP) of 80-90 mmHg if blood pressure monitoring is available during evacuation (previous recommendation did not address BP monitoring); (3) adding separate recommendations if blood products are available (for example, plasma, pRBCs, or fresh whole blood); (4) replacing the limitation of the volume of Hextend that should be administered to a patient in shock with a recommendation to continue resuscitation with Hextend until the target BP is reached.

CAPT Timby noted that these changes were approved unanimously by the DHB Committee on Tactical Combat Casualty Care (CoTCCC) and the Trauma and Injury Subcommittee on August 3, 2010. After proposing these changes to the DHB for deliberation, CAPT Timby received questions and comments from DHB members. Dr. Frank Butler, Chair of the CoTCCC, clarified the use of fresh whole blood is proposed only for use in the field or an emergency medical situation in the absence of adequate medical staff or supplies. Dr. Parkinson suggested that an ethically-sound randomized controlled trial (RCT) for trauma surgery in the field would provide more clarity and could replace the currently available C-level evidence (case studies).

CAPT Timby then addressed the questions that were raised during the October 21, 2010 CoTCCC teleconference. In response to Dr. Poland's request, CAPT Timby reviewed the CoTCCC membership and its decision-making processes, as well as reviewed the conclusions from the January 2010 State of the Art of Fluid Resuscitation Conference. He noted that the report which came out of this conference was scheduled to be published in the March 2011 edition of the *Journal of Trauma*. CAPT Timby also provided additional insight on the process

following the creation of new Guidelines, stating that all Services are committed to immediate implementation.

Discussion ensued regarding the use of Hextend and indicators of shock in theater. CAPT Timby stated that Hextend has not been found to produce either negative effects or to improve resuscitation efforts. He explained that Hextend has a logistical benefit due to its relatively small volume, which makes it easier for combat medics to carry. Specifically, CAPT Timby noted that the hypertonic (saline dextran) solution has not been approved by the Food and Drug Administration (FDA), making Hextend the "next logical choice". Hespan is not recommended during cardiopulmonary bypass procedures due to increased risk of coagulative abnormalities and bleeding.

With regard to assessing shock in the field, CAPT Timby explained that combat medics do not carry an electronic BP monitor in their backpacks; those surveyed indicated that they would not want to carry an electronic BP monitor. CAPT Timby noted that the combination of radial pulse character and mental status assessment has been found to most accurately predict whether an intervention would be beneficial, though the addition of the Glasgow Coma Scale and radial pulse assessments would have the greatest level of reliability.

Dr. Frank Lewis, Executive Director of the American Board of Surgery and an invited subject matter expert (SME), offered detailed comments and concerns regarding the use of Hextend. Dr. Lewis expressed concern regarding the lack of discussion regarding the molecular weight of the fluids, and the mixed data available regarding whether colloids or crystalloids would be preferable. Additionally, he urged the Board to critically review the available evidence, as the studies cited were not randomized. Dr. Lewis indicated that, considering the molecular weight and pressure, Hextend is equally as effective as a saline and albumin combination, though it would be 24 times greater in cost. Dr. Lewis also highlighted the extreme difficulty in assessing shock, especially in a combat setting, which he suggested the Board consider when reviewing the Guidelines. Dr. Lewis stated that measuring radial pulse is the most accurate method to assess for shock in the absence of a blood pressure cuff; however, there is also a highly accurate battery-powered "travel size" cuff, which he suggested be used during evacuation. Dr. Lewis summarized his point of view that the use of Hextend is unwarranted; although unharmful, Hextend is expensive and is as equally effective as saline.

Dr. Shamoo noted that combat-setting research protocols are lacking, and added that such studies would strengthen the evidence base. Additionally, Dr. Howard Champion, Trauma and Injury Subcommittee and CoTCCC member, expressed concern that hypertonic dextran (HSD) is not FDA approved, despite its global widespread use. CAPT Timby added that US casualties who have been evacuated to NATO partner territories have received HSD. Dr. Lednar stated that the DHB could strongly recommend FDA approval of HSD. Dr. Donald Jenkins, Trauma and Injury Subcommittee and CoTCCC member, stated that the evidence requested by Dr. Shamoo already exists, and highlighted a study undergoing review for publication regarding the use of Hextend in theater. He has also found that soldiers are not willing to carry a BP monitor or saline into the field as they are too heavy.

Board members passed the proposed revisions to the TCCC Guidelines by unanimous vote with no abstentions.

Action/POC: Finalize draft recommendation memorandum regarding fluid resuscitation in TCCC Guidelines/ DHB Staff.

c. Information Brief: National Intrepid Center of Excellence

Discussion:

Dr. James Kelly, Director of the National Intrepid Center of Excellence (NICoE), provided an update on the development and opening of the Center in Bethesda, Maryland. Funded mostly from philanthropic contributions to the Intrepid Fallen Heroes Fund (IFHF), the NICoE was dedicated on June 24, 2010, received its first patients in October 2010, and would accept the third cohort of patients within the next few days. Dr. Kelly reviewed NICoE's significant milestones as well as its vision and mission: "to be a leader in advancing world-class psychological health and traumatic brain injury treatment, research and education." Dr. Kelly provided an overview of the staffing plan and current personnel as well as a profile of prospective patients. At full operating capacity, NICoE would have 111 personnel, of which 38 would work in clinical operations. NICoE would serve patients on an outpatient basis only, and would offer individualized, comprehensive, treatment programs for up to 20 patients and families at any given time. An interdisciplinary team of specialists and other medical and psychological health professionals would determine who would be accepted for treatment at the Center. This team would also be responsible for creating the treatment plan, which encompasses a patient and family-centered holistic clinical care model.

Dr. Kelly explained that small working groups (SWGs) including expert panels have provided recommendations regarding NICoE's clinical evaluation processes, while the Clinical Operations Integration team is now determining clinical practice guidelines/standard operating procedures (SOPs), as well as personnel, equipment, and follow-up requirements. Dr. Kelly reiterated that NICoE staff are currently developing the program and are receptive to new ideas and suggestions. Staff had been seeking feedback from patients and their family members in order to modify referral forms. In addition to being a clinical facility, NICoE seeks to be a collaborative research center for military health studies. Dr. Kelly discussed several challenges that NICoE has encountered, including limitations regarding the research universities with which it is permitted to collaborate. NICoE would like to offer Continuing Medical Education (CME) and Continuing Education Units (CEUs) and fellowships and would try to collaborate with Defense Centers of Excellence (DCoE), leverage telehealth and telemedicine systems, and create other strategic partnerships such as with the Center for Deployment Psychologists. Discussion ensued regarding the process for identifying patients, defining family involvement in care, research projects and budget planning, and the frequency of visits.

Action/POC: None.

d. Information Brief: Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces Update

Discussion:

MG Philip Volpe, Co-Chair of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, provided an update on its recent activities. MG Volpe reviewed the order to establish the Task Force and the final report, which was submitted to the Secretary of Defense on August 24, 2010. MG Volpe stated that the final report contains 76 recommendations and 13 "foundational recommendations". He noted that the Task Force had received many requests for briefings since the report was released, and emphasized the Task Force's commitment to continue briefings even though it has disbanded. Since the release of the report, press conferences and briefings have been conducted with the Secretary of Defense, Deputy Secretary of Veterans Affairs, and Admiral Mike Mullen, Chairman of the Joint Chiefs of Staff (CJCS). MG Volpe stated that ADM Mullen is committed to taking immediate action. He also noted that a Suicide Policy Division may be developed within the office of the Under Secretary of Defense for Personnel and Readiness.

MG Volpe also stated that the Task Force would draft a report explaining their clinical and operational methodology, which other DHB Subcommittees and Work Groups could reference for similar initiatives. MG Volpe explained that military suicide prevention activities are divided between the Services, with no one solely responsible for addressing suicide across the Services. He suggested that this is a preventable leadership issue that junior leaders could be instrumental in changing. MG Volpe expects that the report would lead to the development of an implementation plan for DoD. The Secretary of Defense would submit a report with a response to Congress on 24 November 2010, after which the DoD would be required to develop and provide an implementation plan within 90 days.

Action/POC: None.

e. Information Brief: Department of Defense Response to Evidence-Based Metrics Recommendations

Dr. Michael Dinneen was unable to attend the meeting due to travel difficulties resulting from Hurricane Tomas.

f. Information Brief: Military Occupational/Environmental Health and Medical Surveillance Subcommittee Update

Discussion:

Dr. William Halperin, Military Occupational/Environmental Health and Medical Surveillance Subcommittee Chair, provided an update on the status of the Subcommittee's three current activities, which include: (1) the reviews of the Deployment Health Research Center (DHRC) in San Diego, California, Deployment Health Clinical Center in Bethesda, Maryland, and Armed Forces Health Surveillance Center in Silver Spring, Maryland; (2) questions posed by the Office of the Inspector General (OIG) regarding the Qarmat Ali Water Treatment Plant in Iraq; and (3) the request for reviews of the "DoD Report on a Theater Air Monitor Plan" and the AFHSC's

"Epidemiological Studies of Health Outcomes among troops Deployed to Burn Pit Sites" from the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

Dr. Halperin explained that the site visits and reviews of the DHRC were completed on 11-12 May 2010. The DHB memorandum, "Review of the Department of Defense Center for Deployment Health Research Center", was finalized on 18 August 2010, with the Subcommittee's recommendations presented and approved by the DHB on 18-19 August 2010. Recommendations were approved by the ASD(HA) and assigned to the Deputy Assistant Secretary of Defense (DASD) for Force Health Protection and Readiness to review and develop a plan for action. Dr. Halperin and DHB support staff would conduct site visits to review the Deployment Health Clinical Center and the Armed Forces Health Surveillance Center, and would report its findings to the Subcommittee in early 2011.

Dr. Halperin stated that on 25 June 2010, the OIG requested input and comments on questions posed by the Inspector General regarding the Qarmat Ali water treatment plant in Iraq. The Subcommittee provided a response on 16 September 2010.

On July 19, 2010, the ASD(HA) sent a request to the Subcommittee to review current research protocol for burn sites in the Middle East, specifically the DoD report on a Theater Air Monitoring Plan and AFHSC's epidemiological studies. The Subcommittee held a teleconference on September 10, 2010 to establish a strategy for conducting the forthcoming reviews and identifying SMEs that could provide additional expertise regarding issues pertaining to health implications resulting from burn pit exposures. Experts in the fields of epidemiology, clinical occupational medicine, exposure assessment, chemistry/toxicology, and industrial hygiene were approached by Ms. Bader and most have accepted requests to assist the Subcommittee.

Action/ POC:

1. Finalize the recommendation memorandum regarding the DHB review of the Center for Deployment Health Research/DHB Staff.
2. Conduct remaining site visits/Dr. Halperin and DHB Staff.

g. Information Brief: Psychotropic Medication and Complementary and Alternative Medicine Use Work Groups Update

Discussion:

Dr. Michael Parkinson, Complementary and Alternative Medicine (CAM) Work Group Chair, and Dr. Joseph Silva, Psychotropic Medication Work Group Chair, updated the DHB on their Work Groups. Dr. Parkinson stated that the first organizational teleconference was held on October 21, 2010 and the first in-person meeting would be held on November 3, 2010. He also indicated that the final report, which would include recommendations to the Department, is due by March 31, 2011. Due to the short time frame, Dr. Parkinson would like the Subcommittee to define the scope and priority areas of the questions under examination (for example, limiting the context of prescription and use to in-theater, transition periods from theater, and post-deployment settings); develop a standard case definition of CAM; and identify the prevalence, availability

and use of psychotropic medication in theater. The group would use this information during the November 3, 2010 meeting to establish a way forward.

Dr. Silva stated that since there are over 80 psychotropic medications available, the Psychotropic Medication Work Group would need to identify those that are relevant and should be included for the current examination. Dr. Silva referenced a recent ProPublica report, *Dollars for Docs*, which outlines the high incidence of payments made to physicians by pharmaceutical companies for promoting certain drugs, suggesting that this could influence patient usage and should be considered in Work Group discussions. Additionally, Dr. Silva noted the following issues and considerations for the members' consideration: distinguishing necessary from unnecessary drugs; defining the specific modalities that would be classified under CAM (for example, probiotics, hypnosis, vitamins and supplements); and, the impact of usage on operational performance and military readiness (for example, drugs that are used to maintain vs. enhance functioning). Dr. Silva noted an apparent overlap in the missions of the Work Groups and of NICoE, and suggested that Dr. James Kelly, NICoE Director, should be invited to attend a meeting of the Work Groups in order to provide implementation advice.

Action/POC: Invite Dr. Kelly to attend a meeting of the Work Groups/Work Group Co-Chairs/DHB Staff.

h. Information Brief: Accomplishments and Critical Lessons Learned Regarding Department of Defense H1N1 Influenza Report

Discussion:

COL Wayne Hachey, Director of Preventive Medicine and Surveillance, Force Protection and Readiness Programs, Office of the Assistant Secretary of Defense for Health Affairs, provided an update on the 2009 novel influenza a/H1N1 and influenza surveillance and monitoring within the Armed Forces. COL Hachey presented an overview of the 2009-10 influenza season, noting that while the low number of deaths was typical, even one death was unacceptable. COL Hachey explained that DoD response plans were in place for a potential H1N1 outbreak; however the plans were based on an H5N1 pandemic threat. As a result, there was a predominance of oseltamivir in the DoD antiviral stockpiles. Despite a robust stockpile of oseltamivir, the Services generally elected not to use pandemic stockpiles stored at each military medical treatment facility (MTF), as nearly all antivirals prescribed were sourced from local seasonal stocks. COL Hachey highlighted several challenges in the implementation of the DoD influenza plan and policies, including the definition of essential staff, limited telework options due to the shortage of compatible laptops, and the lack of a unified DoD policy regarding employee absentee monitoring. This last challenge was in large part due to the Health Insurance Portability and Accountability Act (HIPAA) privacy policies.

COL Hachey then provided an overview of the DoD surveillance system, underlining its critical role in disease recognition and the resulting efforts concerning the H1N1 outbreak. The DoD identified the first four cases, raising awareness of the situation across the national public health community. COL Hachey described the difficulties posed by the shortage of laboratory assets and the confusion resulting from the establishment of different vaccine supply channels. He

stated that delivery of DoD operationally targeted vaccine, projected to be completed by late October – early November was not realized until December 25, 2009. COL Hachey noted that despite these challenges, the DoD distributed the vaccine to over 95 percent of Active Duty personnel.

Discussion ensued about the lag between the start of the H1N1 outbreak and the administration of the H1N1 vaccine, the DoD antiviral portfolio, as well as the importance of including other biological threats and applying a broader context in the development of preparedness and response plans. COL Hachey indicated that a Tri-Service universal vaccine tracking system is being developed in order to improve tracking efforts that will include vaccine provided to dependent and retiree populations. He stated that a goal of the Office of the Assistant Secretary of Defense for Health Affairs is to establish sufficient vaccine stockpiles, targeting influenza strains with pandemic potential, in order to avoid potential delays in administration and the limitations associated with the control of vaccine allocation by other U.S. government agencies.

Action/POC: None.

i. Administrative/Closing Remarks

Discussion:

Ms. Bader offered several administrative remarks regarding various activities planned for the evening and following day, noting that the open session would adjourn earlier than scheduled due to modifications in the meeting agenda. Following, Ms. Bader adjourned the meeting.

Action/POC: None.

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1. ATTENDEES - ATTACHMENT ONE

2. NEW BUSINESS – OPEN SESSION

a. Opening Remarks and Introductions

Discussion:

Dr. Wayne Lednar, DHB Co-Vice President, welcomed meeting attendees and asked Major General Douglas J. Robb, Joint Staff Surgeon and Chief Medical Adviser to the Chairman of the Joint Chiefs of Staff, to provide remarks.

Maj Gen Robb discussed an article that appeared in the November 2, 2010 edition of the *Washington Post* titled: "The Well Armed Medic" by David Brown. He also announced that an HBO special called "War Torn" regarding issues pertaining to Post-Traumatic Stress Disorder (PTSD) would air on November 11, 2010.

Ms. Christine Bader called the meeting to order as the Designated Federal Officer (DFO), after which Dr. Lednar invited DHB Members, invited guests, and public attendees to introduce themselves.

Marianne Coates, DHB Senior Communications Advisor, added that the *Washington Post* article noted by Maj Gen Robb was part of a series that was well informed by DHB members, particularly by Dr. Frank Butler, Chairman of the Tactical Combat Casualty Care Work Group, who spoke with the author on numerous occasions.

Action/POC: None.

b. Information Brief: DoD Progress on enhancing World-Class Healthcare Capabilities in the National Capital Region

Discussion:

VADM John Mateczun, Commander, Joint Task Force National Capital Region Medical (JTF CapMed), provided an update on the progress toward achieving world-class DoD healthcare capabilities in the National Capital Region (NCR) at the Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) facilities. Since VADM Mateczun's previous update to the DHB at the March 2010 Board meeting, the Comprehensive Master Plan (CMP), informed by DHB recommendations, was submitted to Congress on April 23, 2010 to serve as a roadmap in achieving additional "world-class" attributes. The Supplement to the CMP (S-CMP) was approved by the DoD on August 31, 2010. VADM Mateczun reiterated the construction and renovations must be completed by September 15, 2011, per Federal Statute.

VADM Mateczun detailed recent design and construction efforts, and displayed several photographs of the facilities. The WRNMMC facility would require additional space, as 50 double-patient rooms would be converted to 100 single-patient rooms. It is estimated that this project would begin in Fiscal Year 2012 (FY12) and last until the end of the BRAC transition in the National Capital Region. He stated that a new environmental impact statement would be required before construction may begin, followed by refined cost estimates. VADM Mateczun reviewed infrastructure gaps that would require additional construction. He also reviewed details of the additions and improvements to the Bethesda Campus, including new administrative, gym and parking complexes; a zen garden and Warrior lodging complex with rooms that would be compliant with the Americans with Disabilities Act (ADA). VADM Mateczun showed a picture of the newly opened outpatient facility and discussed a study by the Washington Metropolitan Area Transit Authority (WMATA) which sought to identify the best strategy for transporting pedestrian traffic across the busy Wisconsin Avenue intersection to enter the facility.

VADM Mateczun detailed the design and construction progress at the FBCH facility, including presenting photographs of the layout of the facility's buildings, which will have two clinics, ample parking space, new ADA-compliant Warrior lodging, and an administrative facility; all buildings would be constructed using terracotta, which would be easy to replace in future renovations. VADM Mateczun stated that the FBCH facility is a leading example within the nation in evidence-based design.

VADM Mateczun concluded his presentation by reviewing NCR organizational and budgetary authorities and information management (IM)/information technology (IT), including Smart Suite technology, a Joint Medical Network, and Real Time Location System technology. He stated that as JTF CapMed Commander, he has operational control of WRAMC, National Naval Medical Center (NNMC), and DeWitt Army Community Hospital (DACH) to realign or authorize changes. VADM Mateczun also stated that JTF CapMed would maintain its authority over Joint Service hospitals (for example, WRNMMC and FBCH) after the BRAC transition, a strategy that would be aligned with DHB recommendations. VADM Mateczun noted that the DoD is committed to improving and enhancing world-class healthcare capabilities in the NCR and is thankful to the DHB for its support. Lastly, he noted that casualty care is a top priority to the JTF CapMed and complex trauma cases would continue to be a priority, due to the increased number of amputees returning from Iraq and Afghanistan.

Dr. Kenneth Kizer commented that though he had not reviewed the CMP, he was glad to see that the committee responded to the DHB recommendations. Dr. Kizer noted that the majority of what is required to be considered "world-class" is unrelated to construction; rather, it is the "invisible infrastructure," such as office culture amongst medical staff members and operational processes. Attendees discussed traffic management on the Bethesda Campus, which is a concern for local residents. VADM Mateczun noted that strategies are under consideration to reduce traffic, including relocating pharmacy refill services off-campus. Dr. Kizer also suggested that the facilities should be designed to be adaptable to future needs that may arise from new conflicts or developments in warfare.

Action/POC: None.

c. Information Brief: Progress Report on Joint Pathology Center

Discussion:

COL Thomas Baker, Interim Director of the Joint Pathology Center (JPC), provided an update regarding the progress of the establishment of the JPC. COL Baker reviewed the "Five Pillars of the JPC": pathology consultation, tissue repository, pathology research, pathology education, and strategic partnerships. Four primary developments in the JPC plan occurred since the last brief in March 2010 to the Board: (1) the consultative, education, research, repository services would commence on April 1, 2011; (2) the Armed Forces Institute of Pathology (AFIP) would continue to be supported through the summer of 2011; (3) full operating capabilities would be achieved by September 2011; and (4) the mission would no longer be phased in over a period of time. The Office of the Director, led by COL Baker, was established on October 1, 2010 and 60 personnel were transferred to JPC from AFIP, of whom 45 were detailed back to AFIP until AFIP is dis-established in the summer of 2011. By October 1, 2011, 15 staff would be assigned to the Office of the Director.

COL Baker reviewed current projects undertaken in the Office of the Director relating to the establishment of the JPC, including overseeing the transfer of more than 500 pieces of equipment and the purchasing of new equipment; converting the AFIP laboratory information system; developing the JPC Web site and other information security measures; and, creating the budget for FY2012 and beyond. Ten AFIP pathologists have been transferred but would continue to operate with AFIP until the transfer to the JPC location is completed in April. COL Baker stated that many well qualified candidates were applying for positions with the JPC. The laboratory site had not been determined, and staff had been assessing the processes for mitigating risks that might arise from having one laboratory for two campuses (such as transport security risks). COL Baker stated that the benefits of having one centralized laboratory seem to outweigh the risks. Additionally, COL Baker noted, automation processes for histology stains are being assessed.

The education component of the JPC would focus on online education options, with CMEs being offered by the Uniformed Services University for Health Sciences (USUHS). The "Ask AFIP" education module would be incorporated into JPC online education offerings. COL Baker stated that acceptance of JPC residents and fellows on rotation would begin in July 2011. A

Memorandum of Understanding (MOU) with an oral pathology residency program is presently being developed for April 2011. In addition to education services, the JPC would focus on research, with 85 active protocols being transferred from AFIP. Pathology-driven research at the JPC would involve the development of a strong alliance with the Comprehensive Cancer Center initiative of the National Cancer Institute (NCI).

COL Baker explained that the Institute of Medicine (IOM) has been contracted to conduct a study and report back to the JPC with comprehensive recommendations for the operations of the DoD Tissue Repository. This two-part study would be completed in July 2012. The Repository contains 500,000 wet specimens and 18,000 frozen specimens, documents and images, as well as rare tumor and infectious disease tissue samples. The IOM study would recommend how these rare collections should be handled. COL Baker noted that active study protocols would be permitted to continue using the Repository, but new protocols would be considered on a case-by-case basis until the IOM study is complete. The veterinary pathology program is anticipated to assume function no later than June 1, 2011. In addition, the Forest Glen, Maryland location is currently being renovated. COL Baker stated that the veterinary residency program is the only one of its kind within the DoD.

COL Baker noted that Federal stakeholders such as the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), and the Department of Veterans Affairs (VA) were interested in the Repository. COL Baker stated that the JPC would assess stakeholder needs and build new partnerships. COL Baker added that JPC's top priority was to ensure the continuity of clinical services through the transition period.

Discussion ensued in which Dr. Joseph Parisi, Chair of the Scientific Advisory Board for Pathology and Laboratory Services, expressed concerns that the JPC was evolving into a hospital-centered pathology laboratory with an inadequate emphasis on research, which does not comply with the Federal mandate. Dr. Silva also questioned the recruitment processes, hiring requirements and quality assurance measures. Dr. Walker also inquired about the subspecialties of the pathologists. As a result, Dr. Silva and Dr. Shamoo requested that the DHB formulate an ad hoc committee to review the progress of the establishment of the JPC and provide recommendations to the Department. Dr. Parkinson expressed that the capabilities should be "cutting edge" if the facility is to be world-class, and suggested that COL Baker meet with Dr. Rick Erdtmann of the IOM and DHB Ex-Officio member for potential suggestions.

Action/POC: Form ad hoc committee to review progress regarding the establishment of the JPC/DHB Co-Vice Presidents.

d. DHB Service Liaison Briefs, Introduction

Discussion:

Dr. Lednar noted that the Board was reinstating its tradition of receiving updates during its meetings from each Service regarding various health issues of concern. He stated that the DHB remains available to address any questions from the Services, and that all Services would have an

opportunity to brief the Board. Dr. Butler suggested that U.S. Special Operations Command (USSOCOM) be included among future Service Liaison updates.

Action/POC: Invite a USSOCOM representative to provide an update at a future DHB meeting/DHB Co-Vice Presidents, DHB Staff.

e. DHB Service Liaison Brief: Army

Discussion:

COL Robert Mott provided an update on recent Tuberculosis (TB) studies and developments. He acknowledged his sources for the presentation; LTC James Mancuso, MC, US Army and CAPT Gerald Mazurek, MD, of the CDC Division of Tuberculosis Elimination.

COL Mott shared the post-deployment screening procedures for TB. Following the release of new recommendations on June 25, 2010 regarding the use of Interferon Gamma Release Assays (IGRA) to identify TB, which were published in the CDC's Morbidity and Mortality Weekly Report (MMWR), related discussions were held during the Army Force Health Protection Conference in August 2010. In particular, the Army is considering discontinuing use of Tuberculin Skin Tests (TSTs) and adapting the more thorough, accurate and Mycobacterium TB, or MTB-specific IGRAs. COL Mott explained that there are four FDA-approved IGRAs; however, the assay is significantly more expensive at $86 per test, than the $18 TST test. IGRAs only require one patient visit, which is advantageous for Service members, in comparison to the TST, which requires a follow-up visit within a short time frame. COL Mott showed a graph illustrating an increase in the prevalence of TST reactions among Navy Service members, with a decrease in incidence of active TB in Navy and U.S. populations, which would suggest an increase in false positive test results. As such, the Army is considering whether more targeted testing should be conducted during pre-deployment health assessments, and whether TB screening questions should be removed from the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) and added to the annual Periodic Health Assessment (PHA). COL Mott noted that active TB case counts remain low across all Services. The CDC does not recommend targeted testing for low risk groups, including the U.S. military; however, the continued use of the TST could lead to months of unnecessary medication for soldiers receiving false positive test results. COL Mott concluded his presentation by stating that the Army would continue to analyze potential courses of action and may potentially request the DHB to examine this issue.

Dr. Poland inquired whether any of the reported cases were Multi-Drug Resistant (MDR) or Extremely Drug Resistant (XDR) TB, to which COL Mott responded that he was unaware of such cases being reported. Dr. Kaplan questioned differences in the prevalence and incidence rates of TB between the Services, noting that COL Mott reported only case counts. Dr. Parkinson commented that the rates have not changed in over 20 years. He also suggested that COL Mott conduct an analysis on the cost-effectiveness to account for both direct and indirect costs associated with the screening tests. Dr. Lednar commented that it would be useful to know how some of these tests function across the spectrum with MDR and XDR TB, pointing out that some soldiers are deployed on humanitarian missions to high risk areas. COL Mott responded

that the exposure rates in those areas are very low. Dr. Francis Ennis suggested that due to the higher specificity of the TST, secondary testing would only be useful in the instance of a positive TST result. COL Mott indicated that this approach has not been recommended by the CDC.

Action/POC:

1. Include detailed briefing regarding TB rates in the military on the agenda of the next Infectious Disease Control Subcommittee meeting/DHB Staff.
2. Report to Subcommittee regarding whether MDR or XDR were included among documented TB cases/COL Mott.

f. DHB Service Liaison Brief: Air Force

Discussion:

Lt Col Philip Gould provided a brief regarding the current status of obesity and its implications for the Air Force, the DoD and Military Health System. He noted that 39 states have reported that 40 percent of their youth are overweight or obese, while three states reported that over 50 percent of their youth fall into either of these categories. Lt Col Gould added that this situation presents a dilemma for military recruitment systems, since the Services have rejected 140,000 applicants between 1995 and 2008 who were overweight. Moreover, 1,200 first-term enlistees were discharged before reaching their term of duty for weight issues. Lt Col Gould reviewed the following Key Recommendations of the recent report from Mission: Readiness, "Too Fat to Fight": healthier food choices in schools; increasing funding for school lunch programs; and, supporting the development, testing and deployment of evidence-based public health interventions.

Lt Col Gould then described several graphs presenting overweight and obesity trends across the Military Services and the overall U.S. population. He noted that some graphs represented outpatient data, and were therefore likely to undercount significantly the prevalence of overweight and obesity in the military. Graphs depicting trends in military applicants demonstrated an increase in the proportion that have a BMI in the overweight or obese range. Self-reported data from the Behavioral Risk Factor Surveillance Survey (BRFSS) demonstrated significant increases in Body Mass Index (BMI) across the U.S., spreading in an epidemic manner.

Lt Col Gould concluded the brief by presenting, on behalf of the Deputy Surgeon General of the U.S. Air Force, the following two questions for the Board's consideration:

1. Given the trends in obesity in the U.S., how will the Defense Department's and Air Force's ability to recruit and retain active duty, guard and reserve military personnel be affected?

2. What is the optimal strategy that the Defense Department should adopt to address overweight and obesity in DoD dependents and retirees?

Dr. Parkinson regarded that the obesity issue is both a micro and macro problem, for which systemic factors should be considered. He questioned whether the military might need to ease health standards to maintain the number of Service members needed. Examining the graphs, Dr. Shamoo inquired why the Marine Corps had the lowest rates of overweight and obesity. Lt Col Gould indicated that the Marines' intensive physical exercise routine might offset their caloric intake. Dr. Dennis O'Leary noted that the obesity epidemic was a threat to both public health and national security, adding that the DHB would need to describe the broader impacts of obesity to fully address it. Dr. Poland noted that as this issue is multifaceted, the Board would need to determine the optimal mechanism through which it can be addressed. Dr. Lednar suggested that Lt Col Gould discuss with Ms. Bader how best to proceed with enabling the Board to address this topic.

Action/POC: Determine optimal mechanism through which the DHB might address obesity and overweight issues in the military/Ms. Bader and Lt Col Gould.

g. DHB Service Liaison Brief: Navy

Discussion:

CAPT Neal Naito introduced LCDR David Brett-Major, MC USN, Acting Special Consultant for HIV and Head of the Navy Central HIV Program (NCHP) at the Navy Marine Corps Public Health Center, who briefed the Board on behalf of CAPT Naito. LCDR Brett-Major provided an overview of the NCHP and discussed HIV prevalence in the U.S. Navy population. Following, he described the prevalence of HIV in the U.S., noting that the areas where prevalence and incidence rates are highest are also where populations are heavily concentrated; LCDR Brett-Major compared these rates with active Military Service areas where soldiers are recruited and trained. On a global scale, LCDR Brett-Major noted that areas with the greatest rates of transmission are also areas to which Navy and other Service members frequently deploy. LCDR Brett-Major reviewed the Navy's interest in HIV rates amongst Service members and its implications for the Navy. He stated that the incidence and prevalence rates are very low among both Navy and Marine Corps populations, with an approximate infection rate of one out of every 1,000 and one out of every 2,000 for Navy Service members and Marine Corpsmen, respectively. Those who are diagnosed are held, treated, and reassigned; however, they are not permitted to deploy outside the continental U.S. (OCONUS). LCDR Brett-Major explained that the current DoD policy is structured to reinforce privacy in order to reduce stigma. He noted, however, that potential exists for future change, particularly regarding personal behavior as the large majority of infections in the Navy are among men who have sexual contact with men. LCDR Brett-Major stated that insufficient evidence exists in order to determine whether a policy change would impact the HIV burden of the Armed Forces; therefore, appropriate surveillance and operational research activities would be required for such a decision. LCDR Brett-Major stated that there was a quality assurance and public health action project underway entitled RV314 that would result in a descriptive analysis of Sailors and Marines identified as HIV positive from 2005 onward. LCDR Brett-Major noted that sufficient funds were obtained for project initiation; however, additional funding for the molecular epidemiology aspect of the project, which is very costly, had not yet been obtained. LCDR Brett-Major concluded his presentation by adding that

RV314 had the potential to positively inform disease and program management coordination for HIV and other communicable diseases.

Action/POC: None.

f. Administrative/Closing Remarks

Discussion:

Dr. Lednar emphasized that issues pertaining to priority, timeliness, urgency, and relevance should be considered in determinations regarding how the DHB would select topics for examination. Ms. Bader indicated that she had no further administrative comments and subsequently adjourned the meeting.

Action/POC: None.

3. NEXT MEETING

The next meeting of the DHB would be held on March 7th and 8th, 2011 at the Hilton Washington Dulles Hotel, in Herndon, Virginia.