



**DEFENSE HEALTH BOARD
MEETING
MARCH 7-8, 2011**
Hilton Washington Dulles Hotel
Belmont Room
13869 Park Center Road
Herndon, Virginia 20171

March 7, 2011—Administrative Session: Former Board Members

- 1. ATTENDEES - ATTACHMENT ONE**
- 2. NEW BUSINESS**
 - a. Opening Remarks and Introductions**

Discussion:

Dr. Wayne Lednar, former Defense Health Board (DHB) Co-Vice President, presided over the meeting. After welcoming attendees, he thanked them for their contributions while serving as Board members.

Action/POC: None.

- b. Lessons Learned and Way Ahead**

Discussion:

Attendees discussed issues pertaining to DHB history and evolution; internal and external communications, to include Department of Defense (DoD) leadership; board member and president appointment processes; and, approaches to improve the visibility, utility, and efficiency of the DHB. Attendees recommended that the board develop a formal transition plan for future changes in membership and leadership in order to maintain institutional memory and its ability to pursue ongoing activities.

Based on their collective experience and perspective, the former board members developed a list of guiding principles to aid the new board members as they assume their roles and responsibilities. In addition to highlighting key characteristics of the DHB, these principles are intended to represent issues and approaches that would assist the members to optimally represent the DHB to the DoD. The guiding principles address the following: the scope of the DHB charge and its functional areas; internal and external communications; board membership composition; establishment of valuable partnerships; processes and approaches to identify and address potential issues; development and implementation of performance measures to assess the

board's effectiveness and utility; and, procedures for reviewing and accepting DoD requests. Attendees indicated that the board would welcome additional guiding principles from the DoD regarding how the DHB may more effectively serve its needs.

Discussion ensued regarding how the DHB could best represent its value to the DoD. Attendees considered possible performance measures that would indicate DHB's effectiveness and efficiency; these measures would also help identify any gaps within the board's operational processes and the membership's areas of subject matter expertise.

Action/POC: Provide draft document including guiding principles and lessons learned to attendees for review and approval for distribution/DHB staff.

c. Final Thoughts

Discussion:

Dr. Lednar and Dr. Gregory Poland, former DHB Co-Vice President, thanked the former board members for their dedicated efforts during the past four years. They emphasized the importance of developing a strong working relationship with the new board members and in providing guidance to the board during its current membership transition.

Action/POC: None.



DEFENSE HEALTH BOARD
MEETING MINUTES
MARCH 7-8, 2011
Hilton Washington Dulles Hotel
Belmont Room
13869 Park Center Road
Herndon, Virginia 20171

March 7, 2011

- 2. ATTENDEES - ATTACHMENT ONE**
- 2. NEW BUSINESS – ADMINISTRATIVE SESSION**
 - a. Opening Remarks and Introductions**

Discussion:

Dr. Nancy Dickey, Defense Health Board (DHB) member, presided over the meeting. Following Dr. Dickey's welcoming remarks, Mr. Allen Middleton, Principal Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy, and DHB Designated Federal Officer, called the meeting to order.

Following a moment of silence to honor Service members, Ms. Christine Bader, DHB Director, introduced COL Wayne Hachey, DHB Executive Secretary, and provided several administrative remarks, after which DHB members introduced themselves.

Action/POC: None.

- b. Defense Health Board Background**

Discussion:

Ms. Bader provided a brief overview of the DHB, including its establishment in 2006 following the realignment of three preceding entities (the Armed Forces Epidemiological Board (AFEB), the Armed Forces Institute of Pathology, and the Board of Directors for Amputee Patient Care Program) under delegated authority of the Assistant Secretary of Defense for Health Affairs (ASD(HA)). She then highlighted several notable accomplishments of the Board, and described its current structure as well as the process by which the Board issues recommendations to the Department. Ms. Bader stated that although the subcommittees primarily review evidence-based literature and conduct in-depth examinations of issues, the DHB Board members deliberate these topics in open session and vote on recommendations proposed by the subcommittees. Ms. Bader indicated that in addition to its members, who are appointed by the Secretary of Defense, the

Board includes both Federal and Service Liaisons. The Board is currently composed of 17 members, though the DHB Charter allows a maximum of 21 members. Ms. Bader noted that questions to the DHB are presented to the DHB president, who subsequently determines whether the Board will accept a request and if so, which subcommittee will address the question. She concluded her presentation by reiterating the DHB mission statement, to: “provide independent authoritative advice to maximize the health, safety and effectiveness of the United States Armed Forces.”

Action/POC: None.

c. Travel/Citi® Card Briefing

Discussion:

COL Hachey provided an overview regarding travel, which encompassed the Defense Travel System (DTS), including travel authorizations and reimbursement vouchers, the FedTravel Web site and hotel room blocks. Prior to a Board meeting, Ms. Jean Ward, DHB Staff Assistant, will contact each member to arrange their travel in DTS.

COL Hachey noted that the DoD-issued Citi® Cards that are required to be used for all airline, rental car, and hotel reservations, may additionally be used for expenses associated with authorized travel. These additional authorized charges are the responsibility of the cardholder to settle unless they designate that the additional amount should be added to their government credit card allotment. He then described the U.S. General Services Administration (GSA) per diem allowance rates, noting that they vary by location, and represent the maximum government reimbursable amounts, regardless of actual expenses incurred.

Lastly, COL Hachey recommended that members refer to the FedTravel Website, www.fedtravel.com, as a resource to identify DoD-contracted carriers and rental car agencies prior to booking any travel. Lastly, COL Hachey provided necessary contact information for DHB staff.

Following COL Hachey’s presentation, Dr. Dickey and Ms. Bader facilitated a brief discussion regarding issues briefed thus far. Ms. Bader noted that the DHB usually meets on a quarterly basis; the June 2010 meeting was held in the National Capital region, in conjunction with the annual meeting of the Combatant Command (COCOM) Surgeons, to allow the COCOM surgeons to attend the DHB meeting. She stated that the DHB is usually briefed at this time on the Chairman of the Joint Chiefs of Staff annual biological threat list. Following discussion, Ms. Bader stated that she will contact Major General Douglas J. Robb, Joint Staff Surgeon and Chief Medical Adviser to the Chairman of the Joint Chiefs of Staff to obtain the dates of this annual meeting, in order to coordinate the DHB meeting to occur in conjunction with the COCOM surgeons meeting again.

Dr. Dickey recommended that moving forward, subcommittee meetings, when possible, be held in conjunction with Board meetings, to increase Board Members’ ability to attend subcommittee meetings, and that the Board should make a concerted effort to have Board members serve on

subcommittees. Discussion ensued regarding past site visits including the Naval Air Station in Key West, Florida, the U.S. Military Academy at West Point, New York, and the Center for the Intrepid in San Antonio, Texas, as well as suggestions for future visits, such as the new facility at the U.S. Army Institute for Surgical Research (USAISR) in San Antonio, Texas.

Action/POC:

1. Discuss coordinating the next DHB meeting to occur in conjunction with the June 2011 Combatant Command Surgeons meeting with Maj Gen Robb/Ms. Bader.
2. Recommend, when possible, that subcommittee meetings be scheduled in coordination with DHB meetings/Ms. Bader.

d. Appointment Affidavits/Federal Advisory Committee Act Briefing

Discussion:

Mr. Frank Wilson, Director, Administration and Program Support, Washington Headquarters Services, and DoD Federal Advisory Committee Act (FACA) Management Officer, administered the oath of office to all incoming Board members. Ms. Joecille Morris and Ms. Marilyn Howard of the TRICARE Management Activity (TMA) Human Resources Office, collected appointment affidavits from the newly sworn-in Board members.

Mr. Wilson then provided an overview of the appointment process as well as FACA rules and regulations, and how they apply to the DHB. He distributed a memorandum, "DoD Federal Advisory Committee Management Program-Duties and Responsibilities," dated July 27, 2010. Mr. Wilson noted that the Committee Management Secretariat (CMS) conducts a FACA Training Course, and that additional information regarding the course is available on the General Services Administration (GSA) website, <http://www.gsa.gov/portal/content/101147>.

Mr. Wilson reviewed governing principles of advisory committees and their respective subcommittees. The following statutes and regulatory guidelines govern Federal Advisory Committees: Federal Records Act of 1950, as amended (44 U.S.C. Chapters 21, 29-33); Freedom of Information Act of 1966 (5 USC § 552), as amended; FACA of 1972, as amended (5 U.S.C. Appendix); and Executive Order No. 12674, "Principles of Ethical Conduct for Government Officers and Employees," April 12, 1989, as amended. A Federal advisory committee's records are maintained online at GSA's FACA database, located on the Federal Interagency Databases Online (FIDO) network, at the following Web site: <http://fido.gov/facadatabase/>.

Action/POC: None.

e. Ethics Briefing

Discussion:

Ms. Laurie Rafferty, Office of General Counsel, TMA, discussed ethical guidelines applicable to Board members, including potential conflicts of interest, and issues regarding the confidential financial disclosure form (Form OGE-450). Ms. Rafferty concluded her presentation by

requesting that members fill out their financial disclosure forms and encouraged members to review the ethical guidelines provided in the fact sheet.

Action/POC: None.

f. Working Lunch

Discussion:

During the working lunch, outgoing Board members were presented with plaques in recognition of their outstanding service to the DHB.

Action/POC: None.

g. Media Relations Briefing

Discussion:

Ms. Marianne Coates, Senior Communications Advisor to the DHB, and Creative Computing Solutions, Inc. contractor, provided a brief pertaining to Board communication with the media. Ms. Coates noted that she has previously served as the Director of Communications to the ASD(HA), and served as a civilian in military medicine for 41 years. She stated that though many members might have experience communicating with the media, she would welcome and encourage members to utilize her expertise. Ms. Coates provided examples of how the Board has worked with the media in the past, and how members effectively communicated with the media. Lastly, she indicated that the DHB President is the only member who should communicate with the media on behalf of the Board.

Action/POC: None.

h. Remarks from DHB Past Co-Vice Presidents

Discussion:

Following introductions by both outgoing and new Board members, Dr. Dickey introduced the former Co-Vice Presidents of the DHB, Dr. Gregory Poland and Dr. Wayne Lednar, who provided remarks to the new Board Members. Dr. Poland commented on the Board's legacy and value to the DoD and Service members. Dr. Lednar conveyed his honor to have served the Board and Service members, and discussed several lessons learned by the outgoing members.

Action/POC: None.

i. Subcommittee Briefs: The Way Forward

Health Care Delivery Subcommittee

Discussion:

Dr. Lednar provided an overview of the Health Care Delivery Subcommittee, noting that the Scientific Advisory Board for Pathology and Laboratory Services and the Panel for the Care of Individuals with Amputation and Functional Limb Loss were realigned under the subcommittee due to the Secretary of Defense's Efficiencies Initiative. The subcommittee is charged with addressing operational programs, policy development and research needs in areas related to health care delivery for DoD beneficiaries. With the realignment, the subcommittee would be responsible for undertaking the charges of the two other subcommittees as well, which includes addressing the latest developments to provide recommendations regarding amputee and functional limb loss patient care and treatment within the DoD, examining issues pertaining to operational programs and policies concerning the delivery of pathology and laboratory services to DoD beneficiaries. Though the subcommittee has not met since 2009, it has issued recommendations, including Preliminary Findings Pertaining to the Establishment of the DoD/Department of Veterans Affairs Centers of Excellence and the Review of the Joint Pathology Center (JPC) Work Group Concept of Operations for the Establishment of the JPC. Dr. Lednar indicated that the subcommittee currently has six issues under review, including topics pertaining to the quality and efficiency of care delivery within the MHS.

Action/POC: None.

Psychological Health External Advisory Subcommittee**Discussion:**

Dr. Charles Fogelman, Psychological Health External Advisory Subcommittee Chair, stated that the subcommittee was formed in 2008, and has since held 20 meetings, of which 11 were in-person and nine were via teleconference. He noted that the TBI External Advisory Subcommittee was recently realigned under the Psychological Health External Advisory Subcommittee due to the Secretary of Defense's Efficiencies Initiative. Dr. Fogelman explained that the subcommittee was charged with addressing issues pertaining to prevention, recognition, clinical management, and treatment of psychological and mental health issues among military Service members. An additional charge of the subcommittee is to provide external scientific advice to the Defense Centers of Excellence for Psychological Health and TBI (DCoE); however, despite that the subcommittee has offered assistance, DCoE has not yet formed a relationship with the subcommittee. Dr. Fogelman noted that there are several active issues before the subcommittee, to include a review and comment on psychotropic medication prescription practices and use, as well as complementary and alternative medicine use in the DoD, a review of the Post-Deployment Health Assessment and Post-Deployment Health Reassessment screening tools' ability to address psychological health and TBI issues in the Services, and a review of the Automated Neurocognitive Assessment Matrices testing tool. Following, he reviewed past recommendation topics and recent activities of the subcommittee.

Action/POC: None.

Infectious Disease Control Subcommittee

National Capital Region Base Realignment and Closure Advisory Panel

Discussion:

Dr. Kenneth Kizer, former Chair of the National Capital Region Base Realignment and Closure (NCR BRAC) Advisory Panel, noted that the panel was convened in August 2008 to advise the DoD in establishing a joint Armed Services integrated healthcare delivery system within the NCR. In addition, the panel served as a blue ribbon advisory committee established under the National Defense Authorization Act (NDAA) for Fiscal Year 2009 to review the design and construction of the Fort Belvoir Community Hospital (FBCH) and Walter Reed National Military Medical Center (WRNMMC), and determine whether they were meeting “world-class” medical facility standards. Dr. Kizer remarked that this Congressionally-mandated NCR BRAC Health Systems Advisory Subcommittee, which he chaired, met several times prior to submitting its report in May 2009, and presenting it to the DoD in July 2009. He indicated that several subject matter experts augmented the subcommittee membership, including health care facility architects. Dr. Kizer and Dr. Dennis O’Leary, Board and subcommittee member, developed a definition of “world-class medical facility”, and used this definition to base the report’s findings and recommendations. He noted that this report, *“Achieving World Class: An Independent Review of the Design Plans for the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital,”* indicated that neither WRNMMC nor FBCH were found to achieve the standards of a “world-class” medical facility. The report also included multiple recommendations for improving the architectural design and proposed governance plan for WRNMMC.

Dr. Kizer stated that the subcommittee’s definition of “world-class medical facility” was codified into law, with the signing of the NDAA for Fiscal Year 2010 (P.L. 111-84, § 2714), which also stipulated that the DoD develop a master plan. The subcommittee has not reviewed this plan, which was drafted by the Joint Task Force National Capital Region Medical, since the appointments of its members and of the NCR BRAC Advisory Panel expired in 2009. A brief discussion ensued, during which current and former DHB members commended Dr. Kizer for the subcommittee’s important achievements.

Action/POC: None.

Medical Ethics Subcommittee

Discussion:

Dr. Adil Shamoo, former Medical Ethics Subcommittee Chair, provided an overview of the history of the subcommittee. He noted that the Subcommittee held two meetings and is currently awaiting member reappointments. The Medical Ethics Subcommittee is charged with addressing issues pertaining to moral values as they apply to medicine and their practical application in clinical settings, and reviewing the latest developments in medical ethics as they pertain to the DoD. Dr. Shamoo discussed the subcommittee’s activities regarding a request pertaining to the dual loyalties held by military medical professionals, in helping assure successful military mission readiness and completion, while adhering to the ethical and practice standards of the

medical profession. Dr. Shamoo stated that the Subcommittee would receive additional briefings, including one from a line officer, prior to drafting a memorandum with proposed recommendations.

Action/POC: None.

Trauma & Injury Subcommittee and Tactical Combat Casualty Care Work Group

Discussion:

Dr. Frank Butler, Chair of the Tactical Combat Casualty Care (TCCC) Work Group of the Trauma and Injury Subcommittee, provided an overview of the subcommittee's and work group's activities and accomplishments. Dr. Butler explained that TCCC addresses pre-hospital trauma care, highlighting differences between battlefield and in-hospital care, and offered examples of how TCCC training has evolved and improved over time. He also noted several challenges, including the lack of TCCC training for all deploying Service members. Though the TCCC Work Group has been aligned under the DHB since 2007, its history spans nearly ten years; previous funding was provided by the U.S. Special Operations Command at the Naval Operational Medicine Institute and USAISR.

Dr. Butler explained that he participates in a weekly teleconference with the Joint Theater Trauma Registry (JTTR), during which recent casualties are discussed in order to identify areas for training improvements. In addition, Dr. Butler noted that combat medical personnel, Service medical centers, as well as research and development experts provide the work group with valuable input during its meetings. The TCCC Work Group also reviews published pre-hospital trauma literature and JTTR casualty data. Dr. Butler stated that the work group periodically updates the TCCC curriculum, which is publicly accessible on the MHS website. He highlighted evidence-based literature demonstrating the effectiveness of TCCC. Dr. Butler indicated that TCCC training implementation requires significant improvement. Dr. Butler concluded by presenting an overview of several topics currently being addressed by the work group; he added that the Board has recently approved and issued the recommendations proposed by the subcommittee and work group pertaining to hypothermia and fluid resuscitation during tactical evacuation.

Action/POC: None.

j. Administrative/Closing Remarks

Discussion:

Dr. Dickey thanked all attendees for their participation, particularly the former board members for their service to the DHB, the DoD and Service members. Ms. Bader added administrative remarks regarding various activities planned for the evening and following day, after which Mr. Middleton adjourned the meeting.

Action/POC: None.



DEFENSE HEALTH BOARD (DHB)

MEETING MINUTES

MARCH 7-8, 2011

Hilton Washington Dulles Hotel

Belmont Room

13869 Park Center Road

Herndon, Virginia 20171

March 8, 2011

3. ATTENDEES - ATTACHMENT ONE

2. NEW BUSINESS – OPEN SESSION

a. Meeting Called to Order

Discussion:

Dr. Nancy Dickey, Defense Health Board (DHB) member, presided over the meeting. Mr. Allen Middleton, Principal Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy, and DHB Designated Federal Officer, called the meeting to order. Following a moment of silence to honor Service members, DHB members and meeting attendees introduced themselves.

ACTION/POC: None.

b. Opening Remarks

Discussion:

Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs (ASD(HA)), provided opening remarks to attendees. He highlighted his military experience, including his previous work with several board and subcommittee members, including COL Virgil Deal, Dr. John Holcomb, and Dr. Jay Johannigman. Dr. Woodson commented that the DHB plays an integral role in helping DoD achieve its Quadruple Aim, which addresses population health, per capita cost, experience of care, and readiness. He added that the DHB plays a critical role in instilling trust among Service members, since it encourages the pursuit of evidence-based practices in the military health system (MHS). Dr. Woodson concluded by conveying his enthusiasm to work with the DHB.

Action/POC: None.

c. Welcoming/Administrative Remarks

Discussion:

Ms. Bader, DHB Director, provided administrative remarks regarding the meeting schedule and lunch options for meeting attendees.

Action/POC: None.

d. VOTE: Tactical Combat Casualty Care Training for Deploying Personnel

Discussion:

Dr. John Holcomb, former Chair of the Trauma and Injury Subcommittee, presented his data collected from a recent trip to Landstuhl Regional Medical Center (LRMC), Germany, which indicated a significant increase in the rate of multiple amputations and genital injuries following combat related trauma in Afghanistan. Dr. Holcomb noted that these injuries have a significant negative impact on the emotional health of casualties, their families and providers. He stated that line leadership is already aware of this issue; it is presently being examined by a new rapid response task force, established by the Army Surgeon General.

Dr. Poland inquired whether operational changes in the war may justify the observed increase in amputation rates. Dr. Holcomb responded that although the DHB cannot address issues pertaining to tactics, techniques and procedures, line leadership is aware of associated dismounted injury patterns.

Major General Douglas J. Robb, Joint Staff Surgeon and Chief Medical Advisor to the Chairman of the Joint Chiefs of Staff, noted that he had recently returned from Afghanistan, where he observed that the frequency of combat-related injuries had not increased, although their severity had. He stated that the commanders and line chief leadership in Afghanistan were aware of this problem, and that several options are being examined to mitigate casualties from improvised explosive device (IED) blasts, including further use of dogs that are sent to inspect for IEDs ahead of troops, and the potential use of Kevlar[®] boxers, presently used by the British Armed Forces.

Dr. Woodson asked whether blood plasma was being considered for military aircraft use. Dr. Holcomb noted that it was being used at Memorial Hermann Hospital and across the U.S., as well as by the British Medical Emergency Response Teams (MERT) in Afghanistan. He added that the in-theater use of plasma could improve care. Maj Gen Robb stated that he recently helped ensure that critical care nurses would be a part of helicopter teams responsible for critical care transport, adding that the next issue that he would pursue would be the in-theater use of plasma. He also commented that the Army is currently pursuing improvements in medic training and resuscitation techniques, including the use of plasma.

Dr. Luepker inquired whether the increase in amputation rates could be due to improvements in life-saving battlefield trauma care. Dr. Holcomb responded that this would be unlikely, as the rate of Service members killed in action had also risen.

Following Dr. Holcomb's presentation, Dr. Frank K. Butler, Chair of the TCCC Work Group, provided a decision brief regarding TCCC training. Dr. Butler stated that the TCCC Work Group, via the Trauma and Injury Subcommittee, would like the Board to emphasize the importance of TCCC training for combat leaders, medical department personnel, and all combatants.

Dr. Butler reviewed two recent scenarios wherein preventable fatalities occurred as a result of noncompliance with TCCC guidelines; the first fatality could have been prevented by earlier tourniquet application, and the second by the use of Combat Gauze™. Dr. Butler noted that the Board issued recommendations in 2009, "TCCC and Minimizing Preventable Fatalities in Combat." However, despite these recommendations and the subsequent memoranda issued by the Service Surgeons General directing Service members to follow these guidelines, evidence indicates they are not followed consistently. As an example, though the TCCC guidelines direct the use of Hextend® in fluid resuscitation, preliminary results from Maj Julio Lairet's pre-hospital interventions study provide evidence that medics are not following this guidance, as well as other TCCC guidance concerning hypothermia treatment. Additional preliminary findings suggest that pre-hospital care is being documented minimally. During the weekly Joint Trauma Theater System (JTTS) teleconferences, casualty case reviews have indicated that many TCCC Guidelines are not being followed, including the one for proper and timely tourniquet application. Medics who have returned from theater have indicated that physicians, other medical department personnel, and combat leaders provide medics with inconsistent directions. Dr. Butler commented that a study conducted by Dr. Russ Kotwal has been submitted for publication; this paper, "Eliminating Preventable Death on the Battlefield," documents a significantly lower incidence of preventable death among Army Rangers, who implemented TCCC guidelines previously for all Rangers and medical personnel, when compared to that of the overall U.S. military. Dr. Butler distributed the abstract of the forthcoming publication to the members for review.

Dr. Butler noted that only combat medics are receiving TCCC training, despite that the Board issued a recommendation to extend TCCC training to all deploying Service members in 2009. As a result, discrepancies have surfaced between pre-hospital and hospital care practices, as well as across military units.

Dr. Anderson made a motion to pass the proposed recommendations regarding TCCC training, which Dr. O'Leary seconded. The vote passed unanimously and without abstention.

Action/POC: Develop recommendation memorandum regarding TCCC training/Dr. Butler and DHB staff.

e. VOTE: Battlefield Trauma Care Research, Development, Testing and Evaluation Priorities

Discussion:

Dr. Butler presented a decision brief regarding a list of pre-hospital trauma research, development, testing and evaluation (RDT&E) priorities endorsed by the TCCC Work Group and the Trauma and Injury Subcommittee. Dr. Butler requested that the Board endorse these priorities in a recommendation memorandum addressed to the ASD(HA), which would also advise DoD to allocate combat casualty care research funding to these subjects. He indicated that the RDT&E topics were not prioritized in the document, which was provided to the members for review prior to the meeting.

Dr. Butler discussed background information related to these priority items, which were compiled by pre-hospital trauma care experts serving either on the TCCC Work Group or the Trauma and Injury Subcommittee. He stated that he would like the Defense Medical Material Program Office (DMMPO) to assist in assessing medical equipment performance. Dr. Butler also noted that the Great Britain's Medical Emergency Response Team (MERT) model has been extremely successful in preventing fatalities; the TCCC Work Group would be receiving a presentation from a MERT representative during its next meeting in order to determine whether any interventions implemented by MERTs should be added to the TCCC curriculum.

Dr. Anderson asked how the Board should assess the RDT&E priorities. Dr. Holcomb commented that TCCC research should receive more funding, due to particular relevance during wartime. Dr. Butler noted that medical research and development funding within the U.S. Special Operations Command (USSOCOM) is largely informed and influenced by line officers. Dr. Lednar requested that the subcommittee reorganize the list by rank order. It was then noted that the subcommittee had presented this list by rank order at the last DHB meeting and at that time the board requested that the list be represented to the board without prioritization via rank order. CAPT Chris Daniel, Deputy Commander at the U.S. Army Medical Research and Materiel Command (MRMC), indicated that MRMC would welcome the opportunity to focus its research on these items. He also stated that many of these issues were already being addressed to a certain extent, but prioritization would be helpful. Dr. Holcomb suggested that the DHB should ask Dr. Woodson to submit a memorandum to the Service Surgeons General in regard to the RDT&E priorities, and to allow the subcommittee to periodically provide updates to the Board regarding the progress achieved in addressing the priorities included in the list.

Dr. Jenkins motioned to approve the list of RDT&E priorities. Dr. Anderson seconded the motion, adding that an interim report should be included regarding the progress attained in addressing the RDT&E priorities; he suggested that the subcommittee confer with the Board on the Health of Select Populations at the Institute of Medicine regarding this list. The amended recommendations were approved unanimously by vote; there were no abstentions. Following, Dr. Fogelman, Chair of the Psychological Health External Advisory Subcommittee, offered his subcommittee's assistance in addressing any related psychological health topics.

Action/POC: Develop recommendation memorandum/Dr. Butler and DHB staff.

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

Discussion:

Dr. Michael Parkinson and Dr. Joseph Silva, former Chairs of the Psychotropic Medication Use and Complementary Alternative Medicine (CAM) Work Groups, provided an overview of the groups' history as well as their recent activities. The work groups were charged with providing recommendations regarding CAM and psychotropic medication prescription practices and use within DoD, and to consider issues such as patient safety and operational challenges in their review. Dr. Silva noted that the request was presented to the DHB last fall, with a deadline of March 31, 2011.

Dr. Parkinson indicated that DoD had been extremely helpful in providing requested data, and noted that the work groups utilized the best resources, both within DoD and nation-wide. He remarked that the work groups met three times since November 2010; since the membership appointments have expired, the Psychological Health External Advisory Subcommittee has assumed this charge temporarily. Dr. Parkinson reviewed the topics discussed and presentations received during these meetings. He stated that a best practice model for combat stress should be developed and resemble the TCCC Guideline approach. Dr. Parkinson noted that a draft report was being developed, and that its findings and recommendations would be presented to the Board during the June 2011 meeting for deliberation and vote.

Action/POC: Prepare draft report for review/DHB Staff.

g. Information Brief: Medical Ethics Subcommittee Update**Discussion:**

Dr. Adil E. Shamoo, former Chair of the Medical Ethics Subcommittee, presented an update regarding its charge, membership and recent activities. He noted that the subcommittee membership reappointments have been pending since their last meeting, which was held on December 2, 2010. The subcommittee is charged with addressing issues pertaining to moral values as they apply to medicine and their practical application in clinical settings, and reviewing the latest developments in medical ethics as they pertain to DoD. Dr. Shamoo explained that during the December meeting, the subcommittee received several briefings related to their charge. Specific issues focused on the dual loyalties held by military medical professionals in helping assure successful military mission readiness and completion, while adhering to the ethical and practice standards of the medical profession. He stated that the subcommittee might address issues pertaining to ethics education for medical personnel within the MHS, as well as an ethics primer for Board members. Lastly, Dr. Shamoo suggested the new Board members be proactive in selecting timely and important medical issues for subcommittees to address.

Action/POC: None.

h. Information Brief: Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

Discussion:

CAPT Paul Hammer, Director, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), provided the Board with an overview of DCoE, including its history and recent activities. He acknowledged that the U.S. Government Accountability Office (GAO) released a report on February 28, 2011, "Management Weaknesses at Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Require Attention," which he and his leadership team would be addressing.

CAPT Hammer reviewed the events leading up to the establishment of DCoE by Congressional mandate via the National Defense Authorization Act for Fiscal Year 2008. He noted that DCoE was charged with addressing all aspects of psychological health and traumatic brain injury (TBI) for DoD. CAPT Hammer described DCoE's current mission and vision, as well as the executive steering committee and organizational structure. He then highlighted the responsibilities of DCoE's six component centers: Center for Deployment Psychology, Center for the Study of Traumatic Stress, Defense and Veterans Brain Injury Center (DVBIC), Deployment Health Clinical Center, National Center for Telehealth & Technology, and the National Intrepid Center of Excellence. CAPT Hammer concluded his presentation by reviewing DCoE's way forward in delivering quality products.

In response to Dr. Kaplan's inquiry regarding whether DCoE had collaborated with the Task Force on the Prevention of Suicide by Members of the Armed Forces, Col Joanne McPherson, Task Force Executive Secretary, indicated that although not represented on the task force, DCoE has recently collaborated with the Office of the Secretary of Defense in drafting a response to the Task Force report.

Dr. Parkinson inquired how a best practice could be defined, adding that certain areas such as TCCC have guidelines that have improved care significantly. CAPT Hammer highlighted a database project that he undertook in Afghanistan in 2005 to track mental health experiences of Service members, which was discontinued upon his departure, and stated that DCoE was collaborating with Maj Gen Robb regarding translational research. Maj Gen Robb added that an in-theater psychological health trauma system modeled after the JTTS was being developed. CAPT Hammer added that DVBIC personnel will be deploying to Afghanistan to further develop, improve and increase compliance among Service members with completing the Blast Event Concussion Incident Report, which will soon be used throughout DoD. Dr. Lednar suggested that DCoE present concurrent psychological and physical issues as co-morbidities, where appropriate, rather than considering these medical conditions separately during data analyses. CAPT Hammer stated that DCoE is already addressing this matter in its review.

In regard to Gen (Ret) Myers' inquiry, CAPT Hammer confirmed that DCoE has been working with the Massachusetts Institute of Technology (MIT) Collaborative Initiative's efforts to strengthen TBI/PTSD care and research within the MHS. Gen (Ret) Myers then asked CAPT Hammer how personnel turnover issues would be addressed, noting that many positions within DCoE's organization chart were designated for Active Duty Service members. CAPT Hammer explained that as DCoE reorganizes itself in accordance with the Secretary of Defense's efficiencies initiative, there would be more government civilian positions. Gen (Ret) Myers

requested that CAPT Hammer brief the DHB at a future board meeting regarding DCoE's progress concerning its reorganization and hiring efforts.

Dr. Hovda suggested that CAPT Hammer identify experts from other U.S. centers and academic institutions who have extensive knowledge in psychological health and TBI issues, in addition to the Massachusetts Institute of Technology. He recommended that Dr. Ross Bullock, President of the National Neurotrauma Society and DHB member, be requested to assist in these endeavors. Dr. Hovda emphasized the importance of data-driven research, noting that tracking concussion incidence has been a problem within the National Football League. Dr. Hovda indicated that DCoE should recognize that TBI and post-traumatic stress disorder (PTSD) are not mutually exclusive; accordingly, research regarding these topics should not be mutually exclusive as well. He encouraged DCoE to regard TBI as a disease process rather than an event followed by recovery.

Dr. Fogelman commented that the Psychological Health External Advisory Subcommittee has a responsibility, outlined in the DHB Bylaws, to offer advice and assistance to DCoE; however, DCoE has not taken sufficient advantage of this opportunity. Dr. Fogelman added that the subcommittee would be willing to assist DCoE with addressing the issues noted in the recent GAO report.

Dr. Jenkins inquired whether a "coalition best practice" could be developed regarding combat stress, noting that the Dutch armed forces do not deploy for periods greater than seven weeks at a time to minimize combat stress. CAPT Hammer stated that the DCoE Resilience and Prevention Directorate has studied the coalition forces, however, a specific best practice has not yet been identified.

Dr. Kizer asked CAPT Hammer to identify the most important actions that have been undertaken by DCoE to improve Wounded Warrior care. CAPT Hammer responded by stating that DCoE participated in key collaborations to revise the PTSD Clinical Practice Guidelines (CPGs) and develop the CPG for mild TBI, and has assisted in developing the directive-type memorandum from the Secretary of Defense regarding in-theater treatment of concussion and TBI.

Action/POC: Schedule brief from CAPT Hammer for upcoming DHB meeting/DHB staff.

i. Information Brief: Special Operation Command

Discussion:

COL Virgil Deal, US Special Operations Command (USSOCOM) Surgeon and member of the TCCC Work Group, provided an overview of USSOCOM and Special Operations Forces (SOF) Medical Operations. COL Deal reviewed USSOCOM's organizational role within DoD and its mission, "to provide fully capable SOF to defend the U.S. and its interests, and plan and synchronize operations against terrorist networks." He noted that the SOF team is made up of USSOCOM units within each of the Services and theater USSOCOM units world-wide.

COL Deal stated that in regard to medical planning, SOF must consider operational challenges associated with an “immature theater”, such as limited supplies and facilities. He noted that SOF medical support does not include combat hospitals, but that SOF combat medics are highly trained in trauma care. In addition to medics, SOF medical support includes small Special Operations Surgical Teams that include surgeons and other physician support; Special Operations Critical Care Evacuation Teams, consisting of an intensive care physician, intensive care nurse and a cardiopulmonary technician; Special Operations Resuscitative Teams, which include a variety of medical personnel equipped to resuscitate a wide range of critical and non-critical care patients; and veterinary support. COL Deal explained that USSOCOM operates a human performance program that ensures Service members are physically fit for duty prior to deployment, and provides rehabilitation services for those returning from deployment. He stated that USSOCOM has also been involved in emerging technology for damage control resuscitation because of the compromised environments in which SOF usually operates. Maj Gen Robb commented that the Joint Staff has been drafting the Joint requirement for tactical critical care transport, to include critical care nurses on aircraft during casualty transportation.

COL Deal stated that the SOCOM Care Coalition, which provides advocacy and oversight for initiatives that care for the convalescing sick and wounded, requires a rapid and fair adjudication of Wounded Warrior disabilities. He commented that in regard to Dr. Holcomb’s presentation, SOCOM has requested funding for sperm-banking and in-vitro fertilization for injured Service members, when needed. COL Deal indicated that a stronger evidence base is needed regarding TBI treatment and pain management approaches that do not impede performance. Dr. Parkinson remarked that operationally relevant data have been challenging to obtain during the Board’s examination of issues pertaining to the in-theater use of psychotropic medication. COL Deal agreed, indicating that he had also not reviewed operational data concerning this topic.

Action/POC: None.

j. Information Brief: Marine Corps Service Liaison

Discussion:

CDR William Padgett, DHB Marine Corps Service Liaison, provided a brief regarding TBI among Marine Corps Service members. CDR Padgett stated that the Marine Corps consists of 202,000 Marines, of which approximately 20,000 are currently in Afghanistan. Like SOF, CDR Padgett noted that Marines do not carry extensive supplies, and therefore Marine Expeditionary Units rely on Joint follow-on services for support, such as Navy Medicine, once ashore. There are 6,300 Navy Medicine support personnel that provide expeditionary medical care to the Marines.

CDR Padgett commented that General Amos, Marine Corps Commandant, identified the following four priorities: (1) continue to provide the best trained and equipped Marine units in Afghanistan; (2) re-examine the Marine Corps to ensure future mission-readiness; (3) improve education and training for Marines to succeed in complex environments; and (4) “keep the faith” among Marines, Soldiers and families.

CDR Padgett highlighted a number of health challenges being addressed by the Marine Corps, stating that TBI is one of the highest priorities of the Commandant and throughout the Marine Corps, particularly since it poses a significant threat to combat effectiveness. Utilizing data from DVBIC, specifically TBI cases among both Active Duty and Reserve Marines in the MHS, CDR Padgett explained that although the frequency of severe and moderate TBI with penetrating injury has been stable or decreasing, mild TBI cases have been increasing. These trends have been correlated with the increasing violence within the present conflict, suggesting that current interventions have been successful in mitigating TBI severity. CDR Padgett stated that the Marine Corps has been successful in preventing many blast injuries through the use of tactical and strategic approaches; personal protective equipment, such as the Enhanced Combat Helmet; protective equipment such as the Mine Resistant Ambush Protected vehicle; and, IED detection mechanisms.

CDR Padgett highlighted mechanisms for determining blast exposure, including the use of the "50 meter radius rule", Military Acute Concussion Evaluation, TBI Directive-Type Memorandum, personal dosimetry, biomarkers, and neuroimaging. He stated that functional magnetic resonance imaging capabilities would soon be available in Afghanistan. CDR Padgett noted that efforts within the Marine Corps are focused on indentifying TBI treatments that have the strongest evidence base. He also stated that the usage of restoration centers and CAM practices, such as acupuncture, have demonstrated a positive impact on patient outcomes. CDR Padgett indicated that the Marine Corps is collecting data to determine long-term effects of TBI, as well as to identify areas for improvement (where follow-up would be needed).

CDR Padgett indicated that the Marine Corps would continue to work closely with DCoE and the Bureau of Medicine and Surgery, Department of the Navy, to emphasize the importance of TBI prevention through the use of IED detection mechanisms to avoid injury events; promotion of immediate TBI recognition and evidence-based care; research; and, the provision of comprehensive support for Service members throughout their treatment process.

In response to Dr. Lednar's inquiry, CDR Padgett confirmed that the Marines were receiving actionable, current information to inform expeditionary forces with regard to environmental hazards and infectious disease threats. Dr. Anderson inquired how data might be influenced by a previous medical history that includes potential TBI, such as for a Service member who might have incurred a concussion while playing high-school football, and asked how these types of injuries might influence in-theater blast injury outcomes. CDR Padgett agreed that baseline health and previous injury data would be critical in determining the long-term effects of TBI.

Action/POC: None.

k. Information Brief: Coast Guard Service Liaison

Discussion:

CDR Erica Schwartz, DHB Coast Guard Service Liaison, showed a brief video that provided an overview of the Coast Guard. She stated that the Coast Guard has 40,000 Active Duty members

and 8,000 Reservists. CDR Schwartz noted that although the Coast Guard is housed under the Department of Homeland Security, efforts are undertaken to align its policies with those of DoD.

CDR Schwartz reviewed the Coast Guard's response to the recent explosion at the Deepwater Horizon offshore oil drilling rig, which occurred on April 20, 2010 in the Gulf of Mexico and resulted in 11 mortalities. She stated that a massive Federal inter-agency response was launched and included over 48,000 personnel. On September 19, 2010, the oil leak halted, following the successful sealing of the well that had been leaking oil into the ocean. Nearly 7,500 Coast Guard personnel were involved with the cleanup effort, assuming command and control within hours of the event. Coast Guard personnel assisted with off-shore and on-shore operations, including: in-situ burns, beach cleanup, dispersant application, decontamination operations, as well as booming and skimming operations. CDR Schwartz noted that the National Institute for Occupational Safety and Health summarized potential hazards for the Deepwater Horizon response workers, adding that potential health effects are affected significantly by the workers' distance from the source. Potential hazards included cardiovascular disease, heat stress, and fatigue, as well as exposure to chemicals, particulate matter and odors.

CDR Schwartz explained that the National Institutes of Health (NIH) is conducting a prospective cohort study of potential short and long-term health effects associated with workers and volunteers involved with the cleanup efforts. The Coast Guard has partnered with the NIH to share its data for a sub-cohort study that includes baseline health data as well as health data recorded after the spill for Coast Guard personnel, as well as specific information concerning job duties and quantitative exposure measurements. CDR Schwartz commented that the Coast Guard was also considering utilizing the DoD Serum Repository to examine potential benzene exposure. She also noted that the Coast Guard hopes to collaborate with the Armed Forces Health Surveillance Center and the Uniformed Services University of the Health Sciences. CDR Schwartz stated that the Coast Guard would be interested in receiving the Board's feedback regarding how the data might be used to protect their Forces.

Action/POC: None.

1. Administrative/Closing Remarks

Discussion:

Noting that there were no comments or questions from DHB members or former members, Dr. Dickey thanked all attendees for their participation, after which Ms. Bader made brief administrative remarks and then adjourned the meeting.

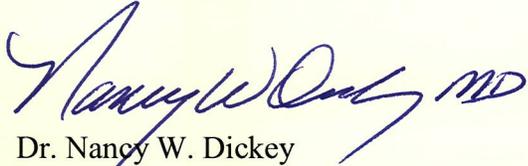
Action/POC: None.

3. NEXT MEETING

The next meeting of the DHB would be held June 14-15, 2011 in the National Capital Region.

4. CERTIFICATION OF MINUTES

I hereby certify that, to the best of my knowledge, the foregoing meeting records are accurate and complete.



Dr. Nancy W. Dickey
Presiding Member, Defense Health Board

5/4/11
Date