



**DEFENSE HEALTH BOARD
MEETING
JUNE 14-15, 2011**
Army National Guard Readiness Center
DSC Room
1100 South George Mason Drive
Arlington, Virginia 22204

June 14, 2011—Administrative Session

- 1. **ATTENDEES - ATTACHMENT ONE**
- 2. **NEW BUSINESS**
 - a. **Administrative Session**

Discussion:

During the administrative session, Defense Health Board (DHB) members submitted their votes for the DHB Co-Vice Presidents by anonymous ballot. Ms. Camille Gaviola was introduced as the Deputy Director of the Board, and Dr. Jenkins was announced as the new Chair of the Trauma and Injury Subcommittee. In addition, dates and locations were noted for upcoming DHB meetings: August 8-9, 2011 at Joint Base Lewis-McChord, Washington, and November 14-15, 2011 in the National Capital Region. Following, Ms. Marianne Coates, Senior Communications Advisor to the DHB provided a briefing on media relations and Dr. George Anderson provided an overview of the Association of Military Surgeons of the United States, the society of the federal health agencies.

Action/POC: None.

- b. **Opening and Administrative Remarks**

Discussion:

Dr. Nancy Dickey, DHB President, welcomed Board members and public attendees. Mr. Allen Middleton, Principal Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy called the meeting to order as the DHB Designated Federal Officer.

Following a moment of silence to honor Service members, Board members and meeting attendees introduced themselves. Ms. Christine Bader, DHB Director, introduced Ms. Camille Gaviola, DHB Deputy Director, and provided several administrative remarks.

Action/POC: None.

c. VOTE: Psychotropic Medication and Complementary and Alternative Medicine Interim Report

Discussion:

Dr. Charles Fogelman, Psychological Health External Advisory Subcommittee Chair, reviewed the question to the Board pertaining to psychotropic medication and complementary and alternative medicine (CAM), subcommittee membership, and the approach used by the subcommittee to address this issue. Dr. Fogelman explained that the Board initially established two work groups, the Psychotropic Medication Work Group and the CAM Work Group, and charged them with refining the scope of the request and drafting the report with proposed recommendations. However, this charge was absorbed by the Psychological Health External Advisory Subcommittee, after the majority of the CAM and Psychotropic Medication Work Groups' membership appointments had expired. Since November 2010, the members held four meetings. The draft interim report has been divided into five sections, each of which includes findings and preliminary recommendations: Prevalence of Psychological Health Conditions, Prevalence of Psychotropic Prescription Drug Use, Complementary and Alternative Medicine, Clinical Practice Guidelines, and Training.

Dr. Michael Parkinson, former Chair of the Psychotropic Medication and CAM Work Groups, reviewed findings pertaining to prevalent psychological health conditions and discussed three primary data sources from which the subcommittee obtained its information. He requested that the members provide any comprehensive data not addressed in the report. Discussion ensued regarding potential military subpopulations that might have been overlooked; the distinction between sleep and rest; and, treatment adherence issues. Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs, recommended that the group review reservist and National Guard patient data from the Department of Veterans Affairs (VA), as many seek care for mental health issues at VA facilities upon returning from deployment.

Dr. Parkinson reviewed the remaining findings and recommendations. Dr. Woodson noted that many changes have been implemented during Operations IRAQI FREEDOM (OIF) and ENDURING FREEDOM (OEF), including pre-deployment mental health screening, in order to prevent issues from manifesting down-range. He inquired whether the members considered the application of civilian standards to be appropriate for the deploying Service member population. Dr. Parkinson indicated that the subcommittee discussed this issue, specifically, the need for an operational equivalent to cognitive therapy. He commended the work of the DHB Tactical Combat Casualty Care (TCCC) Work Group for its development of TCCC treatment protocols and guidelines for the battlefield. Dr. Dickey added that TCCC has had a tremendous impact and should be mimicked in other applicable areas; Dr. Fogelman agreed, stating that a psychological health analog to TCCC should be established.

After reviewing the findings and preliminary recommendations pertaining to CAM, Dr. Parkinson requested that Dr. Kurt Kroenke, Psychological Health External Advisory Subcommittee member, comment on issues representing the interface between CAM and psychological health. Dr. Kroenke noted that current evidence-based treatments for

psychological disorders include antidepressants and psychotherapies such as cognitive behavioral therapy. The existing evidence base supporting the effectiveness of certain CAM modalities (such as herbal treatments and mindfulness-based interventions) is modest and less evidence exists regarding their effectiveness for treating post-traumatic stress disorder (PTSD).

Dr. Woodson remarked that greater efforts should be expended to mentor civilian care providers who treat Service members with mental health issues. Dr. Higginbotham commented that as a medical educator, she felt a significant effort should be made to educate medical students about military medical health issues.

Dr. Parkinson reiterated that the TCCC model would be an optimal approach to develop psychological health training initiatives, particularly in regard to professional competencies, due to the continuous review and rapid implementation of best practices based on findings and observations. He inquired about available mobile devices that could be used in theater. Dr. Joseph Silva commented that information regarding whether providers were being given the necessary tools to reduce stress and other mental health problems would be beneficial for inclusion in the report.

Dr. Dennis O’Leary stated that within the second recommendation of the Training section, the word “assessed” should be inserted in the first sentence in order to read: “Professional competencies must be consistently assessed, maintained and updated to reflect best evidence, and continued professional supervision should be available.”

Dr. Carmona commented that if the recommendations were to be implemented, efforts to change the military culture would be critical to encourage acceptance and reduce stigma associated with psychological health issues and care-seeking. Dr. Dickey agreed, indicating the subcommittee should consider addressing this issue in the future.

Dr. Anderson motioned that the Board hold a vote to approve the interim report to include the suggestions regarding training programs for the line command and chaplains, as well as their implications. Dr. O’Leary seconded Dr. Anderson’s motion. Gen (Ret) Myers agreed with Dr. Anderson, adding that non-substantive edits should be included in the report following the meeting, and substantive edits should be discussed during the meeting. He noted that the Board should approve the report if no further content-based edits were identified.

Discussion ensued regarding the text of the second finding under the Prevalence of Psychological Health Conditions section. Rev Certain suggested that the finding be rewritten as: “Despite these exposures, the majority of military members and their families do not appear to have experienced immediate adverse psychological effects requiring medical and mental health care.” GEN (Ret) Franks indicated that the report should note that the issues discussed within the report may manifest differently within Reserve components. Dr. Dickey responded that the subcommittee could note within the Way Ahead section that differences may exist between National Guard members, reservists, and Active Duty members, as well as add Dr. Carmona’s concern about stigmatization issues. She noted that the report should ensure the suggestions within that section are not exhaustive, as new issues could arise. With these noted amendments, the Board unanimously approved the interim report, with no abstention.

Action/POC:

1. Prepare interim report including approved amendments for signature/DHB staff.
2. Conduct data search regarding mental health care services provided to reservists and National Guard members at VA facilities/Psychological Health External Advisory Subcommittee.

d. VOTE: Tactical Evacuation Care Guidelines

Discussion:

Dr. Frank Butler, Chair of the TCCC Work Group, provided a decision brief regarding tactical evacuation (TACEVAC) care guidelines. He introduced COL Virgil (Tom) Deal, U.S. Special Operation Command Surgeon, noting his strong support of the two issues which Dr. Butler is presenting to the Board. He also noted that Dr. Anthony Pusateri, a prominent researcher on hemostatic agents, was present among the public attendees.

Dr. Butler explained the differences among TACEVAC terminology, including medical evacuation (MEDEVAC) and casualty evacuation (CASEVAC), noting that TACEVAC includes MEDEVAC (platform marked with a Red Cross without armor or weaponry) and CASEVAC (armed and armored platform not dedicated solely to casualty evacuation).

Dr. Butler then described three different in-theater evacuation platforms: Army “DustOff”, which employs a HH-60 helicopter and an Emergency Medical Technician-Basic (EMT-B) flight medic; the Air Force “Pedro”, which includes a HH-60 helicopter and two paramedics; and, the United Kingdom (UK) Medical Evacuation Response Team (MERT), which utilizes a CH-47 and includes an emergency medicine or critical care physician, two EMT-Paramedics (EMT-P) and a critical care nurse. MERT providers are trained in advanced skills; therefore, this platform is used routinely for the most critical casualties. It offers many unique capabilities, such as enabling the establishment of advanced airways and insertion of chest tube. In addition, the MERT platform is equipped with plasma, packed red blood cells (PRBCs), ketamine, and tranexamic acid (TXA).

Dr. Butler described two casualty cases recently discussed during the weekly Joint Theater Trauma System (JTTS) teleconference in order to highlight differences in care and patient outcomes across the platforms. Dr. Butler noted that the Army Surgeon General’s Task Force on Dismounted Complex Blast Injury (DCBI) has brought the issue of current TACEVAC capability to the forefront. LTC Robert Mabry, who recently deployed as Medical Director for Enroute Critical Care Nurses (ECCN) in Afghanistan, has also spoken and written extensively on the urgency of this issue.

Dr. Butler commented that access to the MERT platform is contingent on the continued presence of the UK in the Afghanistan Theater of Operations. Therefore, the Trauma and Injury Subcommittee proposes that the DHB recommend that DoD develop an advanced TACEVAC capability.

Dr. Butler then reviewed the specific elements of the proposed recommendation to include the platform/capabilities; provider skill level and oversight; response time; standardization; documentation procedures; and, quality assurance.

Dr. Carmona noted that historically, physicians sent into the field sometimes caused more damage than medics because they were not trained or experienced in tactical medicine. He added that continuous review of new data and modifications to the guidelines would be necessary, especially since there is currently no strong evidence regarding MERT. Dr. Butler explained that a recent study of the impact of critical care flight paramedics (CCFP) for TACEVAC by LTC Mabry demonstrated a significantly lower mortality rate for those treated by CCFPs when compared to traditional EMT-B trained medics.

In response to Dr. Dickey's inquiry about improvements in TCCC data collection analysis, Dr. Butler asked LTC Russ Kotwal to comment. LTC Kotwal indicated that prehospital data collected since 2001 demonstrated that no preventable fatalities occurred during this time within Ranger units, based on the care provided on the battlefield. All Rangers received TCCC training. LTC Kotwal noted that small unit leadership could be responsible for this success.

Dr. Woodson stated that he had discussed increasing the skill level of TACEVAC care providers with the Service Surgeons General, and emphasized his support. He recommended that the use of specific evacuation platforms should not be required, as certain situations may call for immediate casualty extraction and rapid delivery to definitive care, whereas others may allow for adequate care to be received during flight. Dr. Woodson added that he felt that the Black Hawk might be best suited for TACEVAC in most situations due to its agility. He agreed that better medical control is critical; however, there may not be enough physicians to deploy on every TACEVAC mission. Lastly, Dr. Woodson noted the importance of improving data collection processes. Dr. Butler indicated that MERT has deployed primarily from Bastion Royal Air Force Base in Helmand Province, Afghanistan, where the Marines have recently experienced elevated levels of DCBI from IED blasts; however, this platform might not be needed in other areas with fewer critical care trauma patients.

Dr. Jay Johannigman commented that determining whether the intervention or the skill abilities of the provider were responsible for differences in mortality, as well as time limits between injury and intervention, would be essential to defining optimal platforms and response times.

Board members held a vote for each of the 12 proposed recommendations. Dr. Carmona made a motion for the Board to approve the first recommendation regarding the development of an Advanced TACEVAC Care Capability, which was seconded by Gen (Ret) Myers, and passed unanimously by the Board with no abstention.

Discussion ensued regarding the second recommendation pertaining to the optimization of TACEVAC response times. Dr. Butler noted that a patient should be evacuated as quickly as possible. Dr. Dickey reminded the members that a quicker response time may mean having to use a less advanced platform with fewer capabilities, which may not always be optimal. The recommendation was passed with an amendment to read: "optimize response times in mission

planning.” Dr. Anderson made a motion for the Board to pass the amended recommendation, which was seconded by GEN (Ret) Franks, and passed unanimously with no abstention.

Dr. Carmona made a motion for the Board to pass the third recommendation regarding hostile fire evacuation planning, which was seconded by Dr. O’Leary, and passed unanimously with no abstention.

A discussion followed regarding the wording of the fourth recommendation. Board members and liaisons expressed concern about staffing challenges and the optimal TACEVAC provider skill levels. Board members conferred over the wording of the remaining recommendations. Dr. Dickey stated that the recommendation memorandum would indicate that the recommendations pertaining to TACEVAC were goals that the Services should strive for, with the understanding that they could not realistically be implemented immediately. Gen (Ret) Myers made a motion for the Board to adopt the remaining recommendations, and Dr. Carmona seconded this motion. The Board passed the remaining recommendations unanimously, with no abstention.

Action/POC: Develop recommendation memorandum, incorporating amendment into recommendation text/ DHB staff.

e. VOTE: Freeze-Dried Plasma Use In Theater

Discussion:

Dr. Butler provided a decision brief regarding the usage of freeze-dried plasma (FDP) in theater. He discussed potential causes of coagulopathy on the battlefield, noting that data suggest coagulopathy worsens outcomes among casualties with TBI or uncontrollable hemorrhage. Dr. Butler stated that based on lessons learned in OEF and OIF, the civilian sector now uses a higher ratio of plasma to red blood cells in casualties requiring massive transfusions. He noted that, despite updated guidelines, large volume crystalloids are still being used for resuscitation. Maj Julio Lairet, of the U.S. Army Institute of Surgical Research, also found (in preliminary results) that 87 percent of the casualties arriving to combat hospitals had received large volume crystalloids.

Dr. Butler discussed mortality risks associated with coagulopathy, including the association between large volume crystalloid use and increased mortality and worsened coagulopathy with traumatic brain injury (TBI). In addition, he noted the logistical benefits of Hextend[®] due to its lighter weight (although not used to treat coagulopathy); and the lack of data establishing the relative benefit of Lactated Ringer’s solution over Hextend[®] in improving survival. He also noted that liquid plasma has been established as the standard of care for treating coagulopathy and has been found to increase survival as part of the damage control resuscitation protocol.

Dr. Butler highlighted comments from some of the proponents of prehospital plasma administration, to include the Mayo Clinic in Rochester, Minnesota, and Memorial Hermann Hospital in Houston, Texas. He noted that dried plasma would be a viable alternative to liquid plasma, which is not an option on the battlefield. However, dried plasma is currently not approved by the Food and Drug Administration (FDA). Dr. Butler reviewed the types of dried

plasma being used by the French, British and German militaries and the differences between each, adding that a similar version is currently undergoing clinical trial in the U.S. FDA approval would not be likely until 2015 or later.

Dr. Butler then reviewed the proposed recommendation regarding a need for expedited studies and data collection on currently-used FDP. The subcommittee also recommended the Department support the development of an FDP product that would be submitted for FDA approval in order to expedite its use in theater. Dr. Johannigman stated that in order to facilitate FDA approval, a strong risk must be demonstrated with crystalloid use in fluid resuscitation. Following, members discussed the existing evidence base for the use of plasma and other products in fluid resuscitation.

Dr. Anthony Pusateri, U.S. Army Medical Research and Materiel Command (MRMC), stated that a program announcement had recently closed for a study to be conducted at MRMC regarding the development of a dried plasma product.

Dr. Bullock inquired about the use of recombinant factor VIIa, to which Dr. Butler responded that it has not been approved by the FDA, could not be refrigerated, and cost \$7,000 per use. Historically, the FDA does not grant approval for products to be used specifically for combat trauma; therefore, the use of any drugs or medical devices on the battlefield would be “off-label.”

Dr. Carmona motioned that the Board hold a vote to approve the proposed recommendations; Dr. O’Leary seconded this motion. The Board approved the proposed recommendations unanimously with no abstention.

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

f. Information Brief: Potential Change to the Tactical Combat Casualty Care Guidelines: Tranexamic Acid

Discussion:

Dr. Butler presented a brief regarding the in-theater application of tranexamic acid (TXA), and reviewed published studies supporting TXA use, including the Clinical Randomization of an Antifibrinolytic in Significant Hemorrhage (CRASH) and CRASH-2 studies. Whereas the CRASH study was a large, randomized controlled trial, the CRASH-2 study was a randomized, double-blinded, placebo-controlled trial that analyzed a subgroup of the CRASH study population. The results suggest an association between TXA use and a significant reduction in mortality.

Dr. Butler provided an overview of the Military Application of Tranexamic Acid in Traumatic Resuscitative Surgery (MATTERS) study, which examined the impact of TXA on mortality rates among patients evaluated via MERT. Patients who received TXA had a lower mortality rate

than those who did not. Dr. Butler stated that this issue would potentially be presented to the Board for a vote at the next DHB meeting.

Action/POC: Further discuss data pertaining to this issue for potential suggested recommendation to Board/CoTCCC Work Group and Trauma and Injury Subcommittee.

g. Information Brief: United Service Organizations

Discussion:

Mr. Sloan Gibson, President, United Service Organizations (USO), provided an overview of the USO, including its mission and objectives. He indicated that the USO assists Wounded Warriors in their recovery by establishing partnerships to ensure that health care services reflect best practices; initiating new programs for Wounded Warriors; and, increasing awareness of issues faced by both Wounded Warriors and their families.

Mr. Gibson highlighted various USO programs, stating that the USO has recently launched a new initiative to increase career opportunities for Wounded Warriors preparing for reintegration. In addition, the USO would be breaking ground on June 27, 2011 for two new sites, at the Walter Reed National Military Medical Center (WRNMMC) and the Fort Belvoir Community Hospital (FBCH), which will be designed to facilitate the healing process and meet the non-medical needs of Wounded Warriors and their families. Mr. Gibson noted that centers for reintegration and family visitation centers are critical, particularly since the average length of hospital stay for amputees is approximately 18 months.

Mr. Gibson stated that the USO is following a new approach to support families of Wounded Warriors that includes conferences targeted specifically for family members and caregivers; a partnership with the National Military Families Association; and, a collaboration with TriWest Healthcare Alliance for the implementation of mental health and wellness initiatives. Dr. Dickey suggested that the Board coordinate with the USO to visit one of its centers at a future Board meeting.

Action/POC: Coordinate to visit a USO facility at future DHB site visit meeting/DHB staff.

h. Information Brief: Joint Task Force National Capital Region Medical-Integration of Services

Discussion:

VADM John Mateczun, Commander, Joint Task Force National Capital Region Medical (JTF CapMed), thanked the USO for its persistence and dedication in supporting the Armed Forces. Following, he provided an update on the progress toward achieving world-class DoD healthcare capabilities in the National Capital Region (NCR). He noted that he expected this to be the last update to the DHB prior to the completion of construction and outfitting, which is currently scheduled for transition by September 15, 2011.

VADM Mateczun reviewed the path that the NCR medical facilities have taken since November, 2005, when Base Realignment and Closure (BRAC) initially directed the transition of Walter Reed Army Medical Center (WRAMC) to WRNMMC in Bethesda, Maryland, and FBCH at Fort Belvoir, Virginia. In addition to updates provided at the November 2010 DHB meeting, VADM Mateczun noted that the funding for the Comprehensive Master Plan (CMP) was approved with the President's 2012 budget. This funding will allow the project to be completed and meet the "world class" definition developed by the DHB and codified into law in 2009.

VADM Mateczun showed pictures and construction timelines for both WRNMMC and FBCH, and noted that the 1.81 million square feet of construction to be undertaken in Bethesda was currently 84 percent complete, while the 1.52 million square feet of construction to be completed at Fort Belvoir was already 93 percent complete. The majority of equipment has already been installed, as well.

VADM Mateczun indicated that WRNMMC will have the following new capabilities: Vision Center of Excellence, National Intrepid Center of Excellence, Level I Trauma Care, Consolidated Cancer Center, and a Joint Pathology Center. Of note, the Consolidated Cancer Center, which will include all cancer centers currently at WRAMC, will be the first comprehensive cancer center within DoD. It will involve a partnership with the National Cancer Institute, located across the street from the new facility. The outpatient building at WRNMMC will be the largest outpatient building in a military health center, achieving Leadership in Energy and Environmental Design (LEED) Gold status along with the inpatient facility. He noted that DoD had only been targeting silver LEED certification status. Both of these buildings are complete, though outfitting of equipment is ongoing. Construction and outfitting is in progress for the administrative, fitness and parking complexes, support facilities, Warrior Transition and Lodging Complex, as well as parking and gate renovations.

VADM Mateczun stated that FBCH would also have a wide range of new capabilities including many specialty centers and single patient rooms, and has already integrated smart suite technology into the rooms. Construction is complete in all outpatient clinics at FBCH and outfitting with equipment is approximately two-thirds complete. Construction and equipment outfitting is scheduled to be completed at FBCH in the inpatient building and Warrior Transition and Lodging Center by early August, 2011.

VADM Mateczun reiterated that transition was currently on schedule for completion of BRAC by September 15, 2011, in accordance with the requirements of Sec. 2714, National Defense Authorization Act for Fiscal Year 2010. He further stated that a higher priority is that casualty care not be interrupted, which could potentially affect the completion date (but was not expected to). After BRAC is complete, VADM Mateczun noted that the CMP projects would begin in Fiscal Year 2012, with a completion target of 2018. In addition, he provided an update to the Board regarding the NICOE and the JPC. NICOE reached its full clinical case load in February 2011, while JPC became operational and began its clinical mission on April 1, 2011. VADM Mateczun also stated that the new and improved hospital centers will consolidate to improve sharing of medical imaging, and enhance stability and availability of electronic medical systems.

Dr. Dennis O’Leary, Dr. David Hovda, and GEN (Ret) Franks praised VADM Mateczun and noted that they were impressed with all that had been achieved.

Action/POC: None.

i. Information Brief: Implementation of Recommendations from the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces

Discussion:

Mr. Leonard Litton, Operations Research Analyst for the Director of Operational Readiness and Safety, Office of the Secretary of Defense, provided a progress update regarding DoD’s implementation of the recommendations provided by the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces, released in August 2010. Mr. Litton noted that the Secretary of Defense was required by the National Defense Authorization Act of 2009 to submit the final report to Congress within 90 days of receiving the report from the Task Force, as well as to develop an implementation plan for submission to Congress within 90 days. Mr. Litton noted that because the report was extremely comprehensive, and included 49 findings, 13 foundational recommendations, and 76 targeted recommendations, it required a comprehensive review. For this reason, DoD developed a charter to regulate the response process and provided an initial response to Congress in March 2011. DoD plans to finalize its implementation plan by September 30, 2011, and execute an ongoing governance process in October 2011. A Suicide Prevention Working Group was developed consisting of a core group that meets weekly and matrixed groups that meet monthly.

In the first phase of the review process, the Working Group reviewed all 13 of the foundational recommendations and determined that DoD was already taking action on three of the recommendations, and decided to accept the remaining 10 for action. Mr. Litton indicated that the Working Group had met multiple times, and the General Officer Steering Committee had met six times. During this time, 39 of 76 targeted recommendations had been reviewed. Mr. Litton noted that consensus was emerging on which governance entity would be responsible for overseeing the implementation process, strategic communication, data collection and standardization, and a comprehensive training strategy. In response to an inquiry from Rev Certain, Mr. Litton noted that the recommendations in the Task Force report were similar to those in reports from the Army and the RAND Institute.

Action/POC: Provide updates to the DHB periodically regarding the final plan and implementation of the plan/ Office of the Secretary of Defense.

j. Information Brief: DoD Response to Evidence-Based Metrics

Discussion:

Dr. Michael Dinneen, Director, Office of Strategy Management for Military Health System (MHS), provided an overview of the MHS Strategic Imperatives Scorecard. He explained that MHS adapted its “Quadruple Aim” initiative from Donald Berwick’s concept of the “triple aim.”

The “Quadruple Aim” mission includes: readiness, experience of care, population health, and per capita cost. Within the Strategic Imperatives Scorecard, each portion of the Quadruple Aim has strategic imperatives (target improvement areas), and specific performance measures for each imperative. Dr. Dinneen provided Board members with the most recently updated scorecard. He explained the status of each of the performance measures and future targets. Dr. Dinneen also noted that the Information Management/Information Technology portfolio is currently being realigned with the strategic initiatives. He stated that his presentation would focus specifically on Quadruple Aim population health issues.

Dr. Dinneen shared that one strategic imperative within the population health arm of the “Quadruple Aim” is to engage patients in healthy behaviors. The Clinical Proponent Steering Committee, chaired by Dr. Warren Lockette, Deputy Assistant Secretary of Defense for Clinical and Program Policy, sponsors this imperative.

Per Dr. Dickey’s request, Dr. Dinneen reviewed the performance measures for overweight/obesity, and showed the Board members the Scorecard for that issue. Board members made many suggestions for improving the Scorecard, specifically pertaining to these measures.

Dr. Dinneen then shared a socioecological model that DoD may use to guide the development of population health outcome measures, and to develop a comprehensive measure of the burden of disease within DoD. The diagram, which he provided to the Board members in hardcopy, illustrated the relationship between determinants of and factors affecting health, to include: individual risk factors, intermediate outcomes, states of health, and quality of life. Dr. Carmona suggested the inclusion of epigenetics within the determinants section of the model. In response to an inquiry from Dr. Higginbotham, Dr. Dinneen stated that improving the readiness and well-being of the Service members and their families is a goal of Dr. Clifford Stanley, Under Secretary of Defense for Personnel and Readiness.

Action/POC: None.

k. Administrative/Closing Remarks

Discussion:

Dr. Dickey thanked the members and public attendees for their participation. Ms. Bader provided administrative remarks regarding activities for the evening, and reminded the attendees that the Board would be meeting in closed session the following day. The meeting was then adjourned.

Action/POC: None.



**DEFENSE HEALTH BOARD
MEETING**

JUNE 14-15, 2011

Army National Guard Readiness Center

DSC Room

1100 South George Mason Drive

Arlington, Virginia 22204

June 15, 2011—Closed Session

1. ATTENDEES - ATTACHMENT ONE

2. NEW BUSINESS

a. Opening/Administrative Remarks

Discussion:

Mr. Allen Middleton, Deputy Assistant Secretary of Defense (DASD) for Health Budgets and Financial Policy, called the meeting to order as the Defense Health Board (DHB) Designated Federal Official.

Action/POC: None.

b. The Federal Government Approach to Infectious Disease Threats

Discussion:

Col George W. Christopher, Special Assistant for Biological Defense, Office for Countering Weapons of Mass Destruction, Office of the Secretary of Defense (OSD) (Policy), provided an UNCLASSIFIED briefing on the Federal government's approach to infectious disease threats. He discussed the dynamic strategic environment, including recent challenges and opportunities. Emerging infectious diseases, technological advancements that enable access to threat agents and materials, and terrorism were among the issues addressed. Col Christopher highlighted three themes: the synergistic relationship between public health and national security; integration of health issues and stakeholder involvement; and, biosurveillance.

Col Christopher provided an overview of the National Strategy for Countering Biological Threats, presented at the Biological Weapons Convention (BWC) Meeting of States Parties in December 2009. The strategy is aimed to improve global access to the life sciences in order to address infectious disease issues and counter threats, as well as to prevent the misuse of life sciences. There are seven objectives of this strategy: to promote global health security; reinforce norms of safe and responsible conduct; obtain timely and accurate insight on current and emerging threats; take reasonable steps to reduce the potential for exploitation; expand our

capability to prevent, attribute, and apprehend; communicate effectively with all stakeholders; and, transform the international dialogue on biological threats. Col Christopher provided examples of activities being undertaken to meet each objective. He concluded by stating that these efforts support a DoD goal to establish interagency and international partnerships that would address various issues pertaining to biosurveillance, nonproliferation of threat agents, capacity building, medical countermeasures, threat response and recovery, among others.

Action/POC: None.

c. Pandemic Influenza

Discussion:

Dr. Matthew Hepburn, Director of Medical Preparedness Policy, National Security Staff, The White House, provided an UNCLASSIFIED briefing regarding Federal initiatives to establish international collaborations for public health threat detection and response. Issues discussed included biosurveillance (with a focus on early detection, maintenance of situational awareness, information sharing and integration); workforce, clinical research program, and laboratory capacity-building, and public health infrastructure development. Challenges include leveraging DoD activities, to include clinical research programs, to facilitate host nation capacity building. Examples of successful engagements with host nations include the DoD overseas laboratories under the Global Emerging Infections Surveillance and Response Program.

The U.S. State Department has encouraged interagency educational training for U.S. Foreign Service health professionals. Challenges include developing a professional cadre with vast expertise and skill sets to lead global health surveillance and response programs, as well as identifying specific career tracks to address current needs.

Discussion ensued regarding current initiatives to coordinate U.S. government activities to enhance domestic public health capabilities and capacity. The current focus is to harmonize DoD program efforts, such as those of the Defense Threat Reduction Agency and the DoD Global Emerging Infections Surveillance and Response System. Dr. Warren Lockett, DASD for Clinical and Program Policy, suggested a “bottom up” approach wherein goals are established and approaches to achieve them are delineated. Metrics would be developed to evaluate the contributions of each initiative in achieving the stated goals. However, entities responsible for executing these activities should define how the goals would be addressed.

Action/POC: None.

d. Department of Homeland Security: Bioterrorism Risk Assessment

Discussion:

Dr. Andrew Page, Biological Threats Analyst, U.S. Department of Homeland Security, provided a briefing CLASSIFIED SECRET pertaining to Department of Homeland Security bioterrorism

risk assessment issues and the current biological threat landscape. The presentations were followed by discussions during which questions and comments were addressed.

Action/POC: None.

e. Chairman of the Joint Chiefs of Staff: Biowarfare and Infectious Disease Threats to DoD Personnel

Discussion:

Defense Intelligence Agency representatives Dr. Nicole Ark, Mr. Kevin Bartosek, and LCDR Glenn Dowling provided briefings CLASSIFIED SECRET pertaining to biowarfare and infectious disease threats to DoD personnel. The presentations were coordinated by the Joint Staff, J4/Health Service Support Division and preparedness, detection, and response issues were reviewed. The presentations were followed by discussions during which questions and comments were addressed.

Action/POC: None.

f. Joint Trauma Analysis and Prevention of Injury in Combat

Discussion:

Mr. David Wilson, Project Manager, Mounted Analysis Network, Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC), provided a CLASSIFIED SECRET overview of the JTAPIC program. Mr. Wilson described the regulatory and policy components that codify the implementation and mission of the JTAPIC program. The program was described as a partnership whose efforts are integrated by a partnership management office (PMO) that leverages existing expertise. The partnership provides a single access point for DoD customers to access integrated medical, operational, material, intelligence data and analysis products. The partnership mission is to improve the understanding of threat vulnerabilities and to enable the development of improved tactics, techniques, procedures, requirements, materiel solutions, models and policy in order to prevent and mitigate Warfighter's injuries. Efforts include weekly injury data feeds to partners and customers, responding to requests for information, providing subject matter expertise, and managing a variety of research efforts.

The different partners involved with the JTAPIC coordination process were listed as well as a number of JTAPIC accomplishments. These include advancements in personal protective equipment (PPE), confirmation of particular weapon use, provision of real time feedback to combat commanders and the provision of actionable information on vehicle protection upgrades. The presentation closed with a description of each JTAPIC product, customer, purpose and status.

Action/POC: None.

g. Office of the Armed Forces Medical Examiner System

Discussion:

Lt Col Laura Regan, Director of Operations, Armed Forces Medical Examiner System (AFMES), Office of the Armed Forces Medical Examiner, provided a CLASSIFIED SECRET overview of the AFMES. Lt Col Regan began with a description of the organizational structure of the AFMES and current capabilities. The composition of the forensic team that includes forensic pathologists, anthropologists and odontologists as well as experts in radiology and toxicology was described. AFMES is located at the Dover Air Force Base Port Mortuary which opened in November of 2003. This facility is being rebuilt to consolidate all DoD forensic activities on one campus. Even before the new construction, this was a world class facility.

The manner in which each casualty is processed was described to include initial screening for unexploded ordinance and radiographic analysis of the remains of each casualty. The importance and process used to determine a positive identification for each casualty was explained and includes fingerprint, dental and DNA identification techniques. For each casualty, the cause and manner of death is determined. The process includes a full autopsy and toxicological analysis. All casualties are received and processed at this facility in a dignified manner. AFMES also aggressively investigates deaths from natural causes supplemented by extensive use of consultants.

The Mortality Surveillance Division actively collects reports of all DoD active duty deaths in real time, investigates the initial reports and initiates subsequent responses if necessary. The Division collects medical cause and circumstances of deaths for all cases and maintains a database for surveillance, and research into specific types/causes of deaths and trending.

Beyond the autopsy, when possible, the analysis includes the evaluation of PPE, evaluation of shrapnel to rule out friendly fire and the application of medical devices. The strengths of this program include complete accountability of OIF deaths that includes scientifically validated identification, a full autopsy and full toxicology on every case. Data obtained regarding cause of death, PPE and medical devices are shared as a partner in the JTAPIC system to facilitate improvements to PPE and to ensure the mitigation of preventable deaths and complex injuries.

Action/POC: None.

h. Defense Medical Materiel Program Office

Discussion:

COL Colleen Shull, Chief of Staff, Defense Medical Materiel Program Office (DMMPO), OASD (Health Affairs)/Force Health Protection and Readiness, provided an UNCLASSIFIED briefing regarding medical equipment evaluation and surveillance. Classified material was discussed in response to questions from board members.

COL Shull began with illustrating where the DMMPO falls in the Health Affairs/TRICARE organizational chart and provided a chart depicting the internal DMMPO organization. DMMPO standardizes medical supplies and equipment to enable optimal Joint interoperability of medical capabilities. DMMPO has a number of key external relationships which include the AFMES, the DHB Tactical Combat Casualty Care Work Group (CoTCCC), the medical logistics community, the Army Institute for Surgical Research and others.

In consultation with AFMES, medical devices are evaluated, counterfeit items identified and feedback provided to the end users in the field. Examples of recent findings through this cooperative effort were discussed. One includes Bolin Chest Seals that had misaligned one-way valves. Following identification of the problem, the manufacturer modified the device. Another example provided was sternal insertion of tibial intraosseous needles due to inadequate product labeling. DMMPO notified the Food and Drug Administration and the manufacturer and the product now has better labeling ensuring that inappropriate application of this device due to incorrect identification will not take place. Samples of each of these products were provided to the board members for their inspection. The process in which tourniquets have been evaluated and fielded was explained as well as how their team identified that counterfeit tourniquets were fielded by some of our partners. How DMMPO, in collaboration with AFMES, provides feedback back to stakeholders was described as well as its relationship with the DHB CoTCCC.

DMMPO ensures medical materials are only procured through official supply channels and include only approved devices. Lessons learned include reports of equipment, material and device failures need to be consistently reported and Medical Material notices need to be communicated to all health care providers and not just limited to logisticians and commanders. DMMPO helps ensure that Service members are armed with the correct equipment to mitigate preventable deaths and injuries.

Action/POC: None.

3. NEXT MEETING

The next DHB meeting will be held on August 8-9, 2011 in Tacoma, Washington and Joint Base Lewis McChord, Washington.

4. CERTIFICATION OF MINUTES

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


Nancy W. Dickey, MD
President, Defense Health Board

August 26, 2011
Date