



**DEFENSE HEALTH BOARD
MEETING
AUGUST 8-9, 2011
Hotel Murano
Venice Ballroom 3-4
1320 Broadway
Tacoma, Washington 98402**

August 8, 2011

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

Discussion:

During the administrative session, Ms. Marianne Coates, Senior Communications Advisor to the Defense Health Board (DHB), provided a briefing on media relations and indicated which media representatives were expected to attend the following open session. DHB members then held a vote regarding the dates and locations for the forthcoming 2012 DHB meetings. The confirmed dates are listed below:

- February 21-22, 2012: San Antonio, Texas
- June 25-26, 2012: National Capital Region (NCR)
- August 21-22, 2012: Chicago, Illinois
- November 27-28, 2012: NCR

DHB members reviewed current Board taskings and deliberated how those on hold, due to pending subcommittee member reappointments, should be addressed. Board members were requested to share their areas of interest and expertise for addressing outstanding taskings. COL Wayne Hachey reviewed additional information regarding the status of the reappointments and the changes to the DHB Bylaws, which include subcommittee realignment. Gen (Ret) Richard Myers requested additional information regarding the reappointment procedures in a written document.

Action/POC: Draft document regarding the status of reappointment procedures/DHB staff.

b. Opening and Administrative Remarks

Discussion:

Dr. Nancy Dickey, DHB President, welcomed Board members and public attendees. Mr. Allen Middleton, 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, Dr. Dickey introduced Gen (Ret) Myers and Dr. Richard Carmona as the first and second DHB Co Vice-Presidents, respectively. Following introductions of all Board members and attendees, Ms. Christine Bader, DHB Director, provided administrative remarks.

Action/POC: None.

c. Welcoming Remarks from MG Philip Volpe, Commanding General, Western Regional Medical Command (WRMC), and Senior Market Executive for TRICARE Puget Sound

Discussion:

MG Philip Volpe, Commanding General, WRMC, welcomed meeting attendees to the Pacific Northwest region and provided an overview of WRMC and the unique aspects of military medicine. WRMC functions in a close partnership with TRICARE West, as well as local hospitals and medical centers in the Puget Sound area. He highlighted the recent change to the mission statement to include a patient-centered approach to health care and decision making in order to provide an integrated team approach to well-being. MG Volpe discussed the strategic charter and road map, which featured self-assessment measures to help determine the quality with which resources are being used to meet end goals. An example of the self-assessment measure includes the semi-annual mission brief, which is provided quarterly to all commanders and includes metrics addressing quality of care, implementation of initiatives, and budget execution in an effort to correlate business planning, resources, and performance.

Following, MG Volpe provided an overview of WRMC, comparing it to the Northern and Southern Medical Command Regions. While WRMC is geographically larger, these three regions each have approximately equivalent numbers of TRICARE enrollees. WRMC's service area recently expanded from four to 16 states, which has created challenges in maintaining similar growth in its resources. MG Volpe then described the hospitals and facilities within WRMC and highlighted the close working relationships between the different medical centers as well as Department of Veterans Affairs (VA) clinical support. MG Volpe indicated that some of the facilities within the WRMC are located in underserved areas with limited ability to recruit additional providers. Another challenge is the shift from inpatient to outpatient care with subsequently decreased bed occupancy rates coupled with an increased patient population which has a direct impact on medical treatment centers physical plans and composition of medical staff.

MG Volpe discussed key initiatives and stressed efforts to provide improved care and education on several issues including: pain management, mild traumatic brain injury (TBI), readiness and soldier services, comprehensive behavioral health, partnerships and collaborative efforts and patient centered medical home. He indicated that the area of pain management has received particular focus due to the difficulties of addressing it in an operational setting. Efforts are underway to introduce alternative modalities such as acupuncture, biofeedback, yoga, and meditation to reduce overreliance on pain management. MG Volpe highlighted the National Intrepid Center of Excellence as a model TBI treatment center, and suggested that the development of a similar TBI center at Madigan would be beneficial. Readiness and soldier services work to ensure Service members are fit to perform their duties and are resilient to both physical and mental illness. The WRMC staff continues to partner and collaborate with the VA and other medical facilities throughout the Puget Sound area in order to provide integrated services.

MG Volpe noted several challenges faced by the Western Region and goals to increase efficiency and better serve all Service members. These plans include the transition to a web-based personal health record; shift in focus to prevention, wellness, and health; reduction in inpatient bed space and staff; availability of virtual behavioral telehealth; and, the development of a standardized unified medical command.

Action/POC: None.

d. Commander's Overview of Madigan Army Medical Center

Discussion:

COL Dallas W. Homas, Commander, Madigan Army Medical Center and Director of Health Services, Joint Base Lewis-McChord (JBLM), reviewed the Center's mission and strategic objectives to provide world-class military medicine, as well as compassionate and innovative health care for Warriors and their families. He provided background information regarding the Madigan Healthcare System, including the size of the military treatment facility (MTF) and satellite facilities, inpatient capacity, active community engagement connector programs, patient demographics, as well as staff and personnel composition.

COL Homas discussed the Madigan tradition of excellence and provided information regarding the unique services available, such as robotic laparoscopic procedures and interdisciplinary pain management services, as well as the noteworthy programs that originated at Madigan like TeamSTEPPS® and the mobile obstetric emergency simulator. Similarly, he shared medical education opportunities and highlighted the impressive 94 percent first-time Board Examination pass rate for interns. The Andersen Simulation Center was re-accredited as the highest level Education Center, Level 1, by the American College of Surgeons in 2008. It is the only Department of Defense (DoD) simulation center to receive this level of accreditation.

COL Homas reviewed Madigan Medical Center's key initiatives, including soldier-centered medical homes, the Health and Resiliency Promotion Program, behavioral health, and interdisciplinary pain management. The soldier-centered medical home will provide on-site

primary care, physical therapy, and behavioral health to allow wounded Service members to receive care and reduce the amount of time traveling to MTFs. Interdisciplinary pain management is a key initiative that focuses on assessing treatment modalities by monitoring functional status, quality of life, depression, anxiety, and opioid use. COL Homas noted that some of the challenges associated with these initiatives include facility availability, space optimization, and the efficient provision of appropriate levels of care for soldiers.

Action/POC: None.

e. VOTE: Proposed Updates to the Tactical Combat Casualty Care (TCCC) Guidelines

Discussion:

Dr. Donald Jenkins, Chair of the Trauma and Injury Subcommittee, with the assistance of MSG Harold Montgomery, Special Forces Medic, U.S. Army 75th Ranger Regiment, provided a decision briefing pertaining to three proposed updates to the TCCC guidelines. Dr. Jenkins noted that study data indicate the majority of potentially survivable combat fatalities in Iraq and Afghanistan are due to hemorrhage. Further, many of those injuries are due to exsanguination from wounds that are noncompressible or non-tourniquetable due to their location on the body. Dr. Jenkins stated that recent injury patterns include junctional hemorrhage associated with the high incidence of dismounted complex blast injuries. This represents a significant gap in battlefield care as these injuries are rarely able to be mitigated by a standard tourniquet. Furthermore, Combat Gauze™ is the only TCCC-endorsed tool for treating non-compressible hemorrhage and is not able to stop all significant hemorrhages. Dr. Jenkins explained that the TCCC Work Group, via the Trauma and Injury Subcommittee, proposed the following solutions to address this current TCCC gap, during its meeting held the prior week:

1. Mechanical pressure devices to control hemorrhage (such as the Combat Ready Clamp™ (CRoC™)).
2. Use of an antifibrinolytic, tranexamic acid (TXA), to reduce bleeding by preventing activation of anti-clotting factor.

At Dr. Jenkins' request, MSG Montgomery provided background information about the proposed solution for junctional hemorrhage using the Combat Ready Clamp™. MSG Montgomery explained that the U.S. Army Medical Research and Materiel Command posted a Request for Information for ideas that could potentially stop bleeding at compressible sites where regular tourniquets could not be applied; the only Food and Drug Administration (FDA)-approved device that was provided in response was the CRoC™. The device is approved for inguinal and pelvic application. Abdominal and axillary application points are currently being studied. There are no outcomes data following use of this device; reportedly, it has been used on a local national casualty in theater and currently fielded by three U.S. Special Operations Forces units and Memorial Hermann Hospital's Life Flight in Houston, Texas. MSG Montgomery noted that the CRoC™ is ideal for medics as it is lightweight and easily broken down to fit into a medic's aid bag. He noted that in a test on perfused cadavers, the

CRoC™ was effective in stopping all flow with pressure applied to the external iliac artery, and was easy to apply and tighten. Potential issues include stabilization during transport and the potential impact on a preexisting pelvic fracture. MSG Montgomery indicated that no alternatives exist to meet this critical need, and that the CRoC™ is the only FDA-approved device for this purpose. He then reviewed the text of the proposed change to the TCCC guidelines, noting that it was worded specifically to allow for similar devices that may be developed in the future.

Dr. David Hovda inquired about the placement of the device above the inguinal ligament and whether it would be able to compress the external iliac artery. Dr. Jenkins responded that its placement would allow compressing both the external iliac and the femoral artery to a certain extent.

Confirming there were no further questions, Dr. Dickey asked whether there was a motion to approve the recommendation. Dr. Richard Carmona moved to pass the recommendation and Dr. Hovda seconded. The proposed recommendation was unanimously passed.

Dr. Dickey indicated that the subcommittee should update the Board when data on the use of this device becomes available. Dr. Jenkins indicated that data would soon be available on the use of CRoC™ by Life Flight in Houston, Texas. Dr. Michael Parkinson asked whether there had been any devices developed that were modeled similarly to the anti-shock trousers, which use air and balloon pressure. Dr. Jenkins responded that there were several alternatives to the CRoC™, some of which utilized that technology; however, these devices were not determined to be feasible for battlefield use.

Dr. Jenkins then provided a briefing on the use of TXA. He reviewed data from the Clinical Randomization of an Antifibrinolytic in Significant Hemorrhage (CRASH-2) and the Military Application of Tranexamic Acid in Emergency Resuscitative Surgery (MATTERS) studies, both of which were briefed to the DHB on June 14, 2011, by Dr. Frank Butler. The CRASH-2 study was a large prospective randomized controlled trial assessing TXA use for trauma patients. The results of the study indicated that TXA reduced mortality in the study population. Dr. Jenkins noted that following a review of this data, the work group concluded that the results were not substantial enough to change the TCCC Guidelines. Since then, the Cochrane Review concluded that TXA should be added to normal management of hemorrhaging trauma patients worldwide, and the MATTERS study provided evidence that TXA successfully reduced mortality in trauma patients in theater. Following the release of this new data, Dr. Jenkins indicated that the TCCC Work Group recommended TXA be added to the TCCC Guidelines, and the Trauma and Injury Subcommittee approved forwarding this proposed recommendation to the Board for consideration. He stated that the work group and the subcommittee concluded that TXA is the only drug to have a demonstrated benefit in treating significant trauma induced hemorrhage, that it must be administered within three hours of injury, though earlier is preferable, and that the overall safety profile of TXA is reassuring.

Dr. Jenkins stated that the recommendation of the Trauma and Injury Subcommittee would be to add text to the Tactical Field Care and Tactical Evacuation Care portions of the TCCC Guidelines directing care providers to administer TXA to casualties who have an anticipated

need for significant blood transfusion. Dr. Joseph Silva inquired about temperature storage constraints of TXA and how this might be handled in the field, to which Dr. Jenkins responded that many medications carried by medics had similar temperature storage ranges and the medics were trained to deal with these issues. Dr. Carmona inquired whether there were any known effects with concomitant blunt head trauma or TBI. Dr. Jenkins said that it was hoped that TXA would improve outcomes for this population, but that it was unknown at this time. He added that it was one of the few tools that could be carried in a medic's aid bag, which may improve outcomes. Dr. Dennis O'Leary motioned to pass the recommendation and Dr. Carmona seconded the motion. The members unanimously approved the recommendation.

Dr. Jenkins then presented a final proposed change to the TCCC Guidelines pertaining to resuscitation. Dr. Jenkins explained that the current Tactical Field Care Guidelines note that cardiopulmonary resuscitation (CPR) is futile in that setting; however, evidence from the Armed Forces Medical Examiners Office suggests that some combat fatalities have tension pneumothoracies. Therefore, the work group and subcommittee recommended that the Tactical Field Care Guidelines be updated to indicate that bilateral needle decompression should be performed on pulseless casualties with evidence of thoracic or blast injury prior to discontinuation of care to ensure that the casualty does not have tension pneumothorax. The work group and subcommittee also proposed a recommendation to change the Tactical Evacuation Care Guidelines to reflect this guidance, with the addition that CPR may be performed during this phase of care if the casualty does not have obviously fatal wounds and would be arriving at a medical treatment facility with surgical capability within a short period of time. Dr. Dickey inquired whether it was possible to leave the needle in place in order to review fatality data to determine whether needle decompression was attempted and was successful; Dr. Jenkins replied that it is the standard practice; however, sometimes the needle becomes dislodged. He also noted that the TCCC Casualty Card allows this data to be recorded and captured in the Joint Theater Trauma Registry. Dr. Carmona moved to accept the recommendation and Reverend Robert Certain seconded the motion. The members accepted the proposed recommendations by unanimous vote.

ACTION/POC:

1. Develop recommendation report for CRoC™ addition to the TCCC Guidelines/DHB staff.
2. Develop recommendation report for the addition of tranexamic acid to the TCCC Guidelines/DHB staff.
3. Develop recommendation report for the revision to the TCCC Guidelines pertaining to traumatic cardiac arrest in tactical field care/DHB staff.

f. Vote: Psychotropic Medication and Complementary and Alternative Medicine (CAM) Use Draft Report

Discussion:

Dr. Michael Parkinson, Former Chair, CAM Work Group, and Dr. Silva, Former Chair, Psychotropic Medication Work Group, discussed the question to the Board regarding psychotropic medication and CAM, subcommittee membership, and the changes made to the report based on direction received during the previous Board meeting. Dr. Parkinson shared findings from two recent studies that supported the proposed recommendations.

Dr. Parkinson reviewed the proposed recommendations and data used to inform the report, information which the Board received during the presentation of the interim report at the June 2011 Board meeting. He highlighted DoD's valuable efforts to address issues as a result of the unprecedented duration and nature of the current war. Dr. Parkinson presented the revised psychotropic medication findings and recommendations, particularly those related to diagnostic coding and embedded electronic medical record decision support tools, the risks and benefits of polypharmacy, tracking prescription drug data, and monitoring off-label use. Dr. Parkinson also addressed CAM issues to include: healthy lifestyles and alternative modalities, such as acupuncture and mindfulness, as the cornerstones of coping skills; military relevant coping skills, psychological first aid, and self- and "buddy-care" training. He recommended using TCCC as a model for rapid cycle testing to determine the effectiveness and utility of interventions. Dr. Parkinson discussed the trend of increased use of psychotropics over the past three years, but emphasized that this is likely similar to the increase seen in the civilian population.

After reviewing the findings and proposed psychotropic medication and CAM recommendations, the text of the second finding under the Prevalence of Psychological Health Condition section was discussed. Dr. Dickey suggested that the finding be rewritten as: "despite these exposures, the majority of military members and their families do not appear to have experienced excessive or disproportionate adverse psychological effects leading them to seek out medical and/or mental health care." Dr. Parkinson and Dr. Silva agreed; however, Dr. O'Leary inquired whether this could be supported through data. Dr. Parkinson clarified that "the majority of" implies that while there is not a consistent number, most individuals who have deployed and returned are not seeking immediate mental health care or showing signs that they are disabled. He elaborated that it would be difficult to provide a rate of disability due to the DoD-wide difficulties in obtaining a consistent denominator and numerator, particularly prior to 2008. With those nuances in mind, Rev Certain motioned that the Board vote to approve the final report with this amendment included. Dr. Eve Higginbotham seconded Rev Certain's motion.

Following, Dr. O'Leary stated that within the second recommendation of the Training section, the phrase "initially assessed and periodically reassessed" should be inserted in the first sentence, to read: "professional competencies must be initially assessed, periodically reassessed, consistently maintained, and updated to reflect best evidence, and continued professional supervision should be available." Dr. George Anderson moved to approve the final report with these two noted amendments. Rev Certain seconded Dr. Anderson's motion. With these noted amendments, the Board unanimously approved the final report.

Action/POC: Prepare final report including approved amendments for signature/DHB staff.

g. Vote: Automated Neuropsychological Assessment Metrics (ANAM) Question

Discussion:

Dr. Kurt Kroenke, Psychological Health External Advisory Subcommittee representative, reviewed the question to the Board pertaining to the ANAM and Neurocognitive Assessment Tools (NCATs), subcommittee membership, and the approach used by the subcommittee to address the issue. Dr. Kroenke explained that the Board initially suspended its examination of this issue due to the expiration of the TBI External Advisory Subcommittee member appointments. Following the March 7-8, 2011 DHB meeting, the Assistant Secretary of Defense (Health Affairs) renewed the charge to the Board and the task was assumed by the Psychological Health External Advisory Subcommittee.

Dr. Kroenke presented background information relevant to the findings and proposed recommendations. He highlighted data regarding the prevalence of TBI throughout both the Services and civilian population and discussed the risks of concussion with early return to duty. Over the past decade, mild TBI has been the source of the majority of cases, while moderate and severe cases have remained steady or in slight decline. Dr. Kroenke also provided a history of the implementation and use of ANAM as a mandatory pre-deployment NCAT and a post-injury assessment for return to duty guidance.

Dr. Kroenke reviewed ANAM findings and proposed recommendations. Recommendations stated that ANAM should not be used as a diagnostic tool or universal post-deployment measure, but instead as a selective and targeted post-injury instrument. Due to the substantial amount of ANAM normative data for military populations, it should continue to be used in its current format as the brief NCAT measure, until evidence suggests that another tool would provide a significant advantage. The proposed recommendations were approved unanimously with one amendment, indicating that NCATs should be continually studied and updated.

Dr. Kroenke addressed questions regarding the findings and recommendations. Dr. Anderson inquired whether it would be beneficial to complete a baseline ANAM on all military members, given the mild TBI incidence within the military population. Dr. Kroenke agreed that a military-wide population baseline ANAM test is a valuable current endeavor; however, he cautioned against implementing a population-wide mandate for such screening. Dr. Anderson responded that TBI is a growing civilian concern, particularly for high school and college athletes and that NCATs are being used by school systems and colleges as a pre-participation baseline measure. He stated that the normative data being collected by DoD may be extremely valuable for the nation. Dr. Kroenke agreed but expressed reluctance in including that information in the report.

Dr. Hovda commended the report and recommended that the subcommittee include a distinction between assessing individuals upon their return from theater, and assessing individuals in theater to guide return-to-duty decision-making. He also highlighted the duration of mild TBI issues and the value of distinguishing between acute and chronic brain injury. Dr. Ross Bullock agreed,

and stated that the report is fairly conservative. He suggested that the report include a recommendation related to the need for continued monitoring and additional research related to ANAM validity and reliability. Dr. Hovda moved to approve the report with this amendment included as Recommendation 10. Dr. Jenkins seconded Dr. Hovda's motion. With this amendment, the Board unanimously approved the final report.

Action/POC: Prepare final report including approved amendment for signature/DHB staff.

h. Information Brief: Military Infectious Diseases Research Program (MIDRP)

Discussion:

COL Julia Lynch, Director, MIDRP, provided an overview of MIDRP's current projects and discussed problems and challenges in delivering force health protection products for infectious disease. MIDRP strives to conduct focused research and product development that leads to improved protection and treatment for Service members and their families globally. These force health protection missions are limited to naturally-occurring infectious diseases.

COL Lynch discussed the impact of infectious disease on military operations and highlighted the complexity of infectious disease global distribution due to the dynamic nature of pathogens. In order to prevent decreased combat effectiveness and medical costs, a consensus threat list is developed by an expert panel of infectious disease representatives from all Services through an information-based iterative process. The infectious disease threat list was validated in 2010, and decision support software provided insight into the strength of the consensus. The top three pathogens on the list, malaria, dengue, and diarrheal bacterial pathogens, received 100 percent consensus.

COL Lynch described the top three pathogens, explaining their global footprint and the areas in which DoD personnel might come in contact with them. Although malarial attack rates are decreasing, DoD personnel remain extremely vulnerable. COL Lynch highlighted significant compliance issues for personal protective measures and chemoprophylaxis. MIDRP continues to develop new anti-malarial prophylactic drugs to protect Service members; however, the development of a malaria vaccine remains a great challenge. Dengue is the second most important pathogen, and is the most prevalent vector-borne viral disease globally. There is currently no FDA-approved vaccine and prevention is entirely based on personal protective measures. COL Lynch reviewed the history of dengue and the increasing distribution due to the improvement in air travel and shipping capabilities. COL Lynch noted that diarrheal bacteria can be significantly detrimental to combat effectiveness and performance.

COL Lynch discussed the solution set aimed to address these and other pathogens. The program invests heavily in vaccines and prevention therapies, diagnostics, and vector control products. She discussed the two primary funding streams as well as the corresponding research, development, testing, and engineering programs, which include rapid screening of blood for field transfusions, wound infection-related research, and respiratory disease. COL Lynch reviewed examples of current activities and FDA-approved, MIDRP-developed products. MIDRP work is unique from academia and industry research because it focuses on FDA approval for an adult

population; its research is embedded in military labs with uniformed researchers. COL Lynch discussed the challenges in funding and continuing research, including: changes in external partner dynamics making it increasingly difficult to develop force health protection products in the future; reduction in funding; and endangerment of the force health protection mission due to parallel and uncoordinated investments from the defense community.

COL Lynch then fielded questions. Dr. Jenkins inquired into the joint activity between MIDRP and the program office regarding nucleic acid testing for dengue virus. COL Lynch responded that MIDRP is actively working on dengue nucleic acid testing and would seek FDA approval. Additionally, she stated that work is in progress to develop low complexity tests to ensure blood supply safety, with a focus on screening for human immunodeficiency virus, as well as hepatitis B and C. Dr. Jenkins also highlighted the dramatic increase in mucor wound infection in theater over the last 120 days as an area for further study. COL Lynch agreed, and stated that there is an active concern regarding the increase of fungal infections in wounds, accompanied by a focus on drug development and wound infection management tools.

Dr. Carmona inquired whether MIDRP's legislative liaisons have received any information regarding how the Government-Owned, Contractor-Operated (GOCO) organizations would assist with research areas that drug companies are not addressing. He explained that in some instances, for example, if a patent runs out or there is not a projection for significant monetary gain, drug companies are moving away from research in areas that are still a great need for the nation. Dr. Carmona requested details regarding any collaboration with the Centers for Disease Control and Prevention (CDC) or the National Institutes of Health (NIH). COL Lynch agreed that the industry shift away from research in areas that are a national concern due to lack of monetary incentives has been problematic; however, MIDRP is not deeply engaged in the GOCO work. Additionally, she responded that, where appropriate, there is open discussion with the CDC and NIH.

Action/POC: None.

i. Information Brief: Department of Defense Institutional Review Boards

Discussion:

Ms. Caroline Miner, Program Manager, Research Regulatory Oversight Office for the Office of the Under Secretary of Defense for Personnel and Readiness, reviewed the history, scope, and oversight structure of the Human Research Protection Program (HRPP). HRPP is an integrated program in which all elements of an institution that supports or conducts research work together to protect the rights of human subjects. The Institutional Review Boards (IRB) are part of HRPP and are responsible for the review and regulation of research. Other elements of the DoD HRPP include quality improvement and assurance, policy development, education and training, as well as commitment to research integrity.

Ms. Miner reviewed the regulatory oversight structure and related initiatives. She stated that the regulatory compliancy oversight structure is "stove-piped" and communication between the Army, Navy, and Air Force systems is limited, which can complicate the research proposal

submission and review process. Collaborative research within DoD can be difficult and often results in multiple IRB reviews. HRPP recognizes these problems and is working to harmonize the review process by developing common templates, agreements, and training requirements, as well as a Service-wide network. An agreement between the Surgeons General and the Deputy Assistant Secretary of Defense (Force Health Protection and Readiness) has resulted in the development of a central IRB at the Uniformed Service University of the Health Sciences providing central administrative support, and a global headquarters oversight mechanism for the Infectious Disease Clinical Research Program. This agreement has been valuable in overcoming the stove-piped regulatory system. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) representative is chairing a work group to examine the feasibility of expanding this into the area of psychological health and TBI-related issues. Ms. Miner reviewed the benefits of Service-wide IRB harmonization, which includes ease in tracking studies, a streamlined review process, and a reduction in overall review time.

Following, Ms. Miner fielded questions. Dr. Higginbotham requested information regarding HRPP's integration with the VA system, given the electronic health record expansion. Ms. Miner stated that her office has experienced challenges to integrate with the VA. In response to an inquiry from CDR William Padgett, Ms. Miner clarified that current funding restricts the network to Defense Health Program sites; however, the HRPP is actively trying to expand to include other organizations. CDR Padgett recommended that the Board consider reviewing the role of DoD intramural and extramural research and the value of harmonizing research programs. Ms. Bader indicated that Dr. Jonathan Woodson, Assistant Secretary of Defense (Health Affairs) would need to request that the Board unilaterally review this issue for recommendation.

Action/POC: None.

j. Panel Discussion: Line Commanders

Discussion:

JBLM line commanders joined the Board for a panel discussion. Participants included CPT Adam Stover, HHC 864th Engineer Battalion; CPT Clint Nold, FSC 864th Engineer Battalion; CPT Rex Broadrick, 565th Engineering Company; CPT David Korman, 617th Engineer Company; and CPT Tristan Manning, HHC Madigan Health Care System. The line commanders shared their deployment history and discussed issues related to the following topics:

- Processes to prevent the deployment of Service members who are not medically fit.
- Processes to prevent Service members from misrepresenting behavioral health problems in order to return from deployment early.
- Quality and availability of behavioral health specialty treatment in theater.
- Willingness of line commanders and subordinates to contact a mental health professional to express concern regarding another Service member down range.
- Difficulty of discussing behavioral health problems of other Service members with providers stateside due to rules and regulations regarding anonymity.

- Level of effort and attention that line commanders place on monitoring mental health as a part of readiness.
- Competencies that would be valuable for Service members in addressing combat-related stress.
- Stigma related to behavioral health problems and seeking help, as well as the changes over time in the perception of Service members who require assistance.
- The existence and prevention of substance abuse in theater.

Board members expressed their gratitude to the line commanders for their willingness to engage in an open discussion regarding their experience in theater. Dr. Dickey provided the panel discussion participants with a DHB coin to show the Board's support and appreciation.

Action/POC: None.

k. Panel Discussion: Physicians

Discussion:

Madigan Healthcare System physicians joined the Board for a panel discussion. Participants included COL David Vetter, internist; MAJ David Harper, pediatric specialist; COL Tommy Brown, general surgeon; and CPT John Alvitre, physician assistant. The physicians shared their deployment history and discussed issues related to the following topics:

- Competing priorities for deployment readiness, including identifying Service members with medical issues, while also completing the unit mission.
- Role and benefit of an integrated provider for each unit, particularly as they relate to behavioral health issues, stigma, and continuity of care.
- Deployment schedule for surgeons and the resulting challenges regarding training students and maintaining clinical services at JBLM with multiple surgeons deployed.
- Reduction in stigma related to behavioral health, particularly due to the Re-Engineering Systems of Primary Care Treatment in the Military program, as well as the increased access to care.
- Implications of the duration of the conflict, particularly related to retention and recruitment of surgeons who have difficulty remaining academically competitive during deployment.
- Post-deployment retraining opportunities for physicians to reintegrate into their specialty field.

Board members expressed their gratitude to the line commanders for their willingness to engage in an open discussion regarding their experience. Dr. Dickey provided the panel discussion participants with a DHB coin to show the Board's support and appreciation.

Action/POC: None.

I. 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 conducting site visits at JBLM the following day in an administrative session. The meeting was then adjourned.

Action/POC: None.

August 9, 2011—Administrative Session

1. ATTENDEES - ATTACHMENT ONE

2. NEW BUSINESS

a. Joint Base Lewis McChord (JBLM) Site Visits

Discussion:

Defense Health Board (DHB) members received a tour of JBLM in an administrative session. Site visits included the Soldier Readiness Center/Program, the Madigan Healthcare System, the newly-opened Warrior Transition Battalion Barracks, the Medical Simulation Training Center, the Anderson Simulation Center, and the National Center for Telehealth and Technology. Board members expressed their gratitude to the soldiers at JBLM during a lunch with Wounded Warriors and their family members.

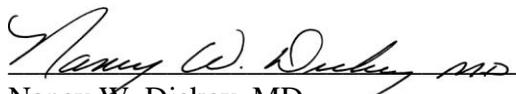
Action/POC: None.

3. NEXT MEETING

The next DHB meeting will be held on November 14, 2011 in Arlington, Virginia.

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

09/23/11
Date

DEFENSE HEALTH BOARD MEETING

August 8-9, 2011

Attachment One: Meeting Attendees

BOARD MEMBERS			
TITLE	LAST NAME	FIRST NAME	ORGANIZATION
Maj Gen (Ret)	Anderson, M.D.	George	Association of Military Surgeons of the United States
Dr.	Bullock	M. Ross	University of Miami
VADM (Ret)	Carmona, M.D.	Richard	<i>DHB Vice President</i> University of Arizona
Rev	Certain	Robert	St. Peter & St. Paul Episcopal Church
RADM	Delany	Peter	Department of Health & Human Services
Dr.	Dickey	Nancy	<i>DHB President</i> Texas A&M University Health Science Center
Dr.	Higginbotham	Eve	Howard University
Dr.	Hovda	David	David Geffen School of Medicine at UCLA
Col (Ret)	Jenkins, M.D.	Donald	Mayo Clinic
Dr.	Johannigman	Jay	University of Cincinnati Medical Center Division of Trauma and Critical Care
Gen (Ret)	Myers	Richard	<i>DHB Vice President</i> RMyers & Associates LCC
Dr.	O'Leary	Dennis	The Joint Commission
Hon	West	Togo	TLI Leadership Group
INVITED GUESTS & STAFF			
TITLE	LAST NAME	FIRST NAME	ORGANIZATION
CPT	Alvitre	John	Madigan Army Medical Center
Ms.	Bader	Christine	<i>DHB Director</i>
CPT	Broadrick	Rex	565th Engineering Company
COL	Brown	Tommy	Madigan Army Medical Center
Ms.	Coates	Marianne	DHB Staff/Creative Computing Solutions, Inc. (CCSi)
Brig Gen	Ediger	Mark	Air Force Surgeon General Representative Air Force Medical Operations Agency
LTC	Garman	Patrick	<i>DHB Service Liaison Officer</i> Military Vaccine Agency
COL	Hachey	Wayne	<i>DHB Executive Secretary</i>
MAJ	Harper	David	Madigan Army Medical Center
COL	Homas	Dallas	Madigan Army Medical Center
Ms.	Jovanovic	Olivera	DHB Staff/CCSi
Ms.	Klevenow	Jen	DHB Staff/CCSi
CPT	Korman	David	617th Engineer Company
Dr.	Kroenke	Kurt	Regenstrief Institute, Inc.
MAJ	Lane	Jason	Madigan Army Medical Center
CAPT	Laraby	Patrick	<i>DHB Service Liaison Officer</i> Bureau of Medicine and Surgery
COL	Lynch	Julia	Military Infectious Disease Research Program
CPT	Manning	Tristan	HHC Madigan Health Care System
Mr.	Middleton	Allen	<i>DHB Designated Federal Officer</i> Health Budgets and Financial Policy
Ms.	Miner	Caroline	Research Regulatory Oversight for the Office of the Under Secretary of Defense (Personnel and Readiness) Force Health Protection and Readiness Programs
MSG	Montgomery	Harold R.	Headquarters, 75th Ranger Regiment
CPT	Nold	Clint	864th Engineer Battalion
CDR	Padgett	William	<i>DHB Service Liaison Officer</i> Environmental Strategic Health Care Group Department of Veterans Affairs
Dr.	Parkinson	Michael	American College of Preventive Medicine
Ms.	Peabody	Hillary	DHB Staff/Computer Technology Associates

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TITLE	LAST NAME	FIRST NAME	ORGANIZATION
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COL	Stanek	Scott	<i>DHB Service Liaison Officer</i> Office of the Secretary of Defense for Health Affairs, Force Health Protection and Readiness
CPT	Stover	Adam	HHC 864th Engineer Battalion
COL	Vetter	David	Madigan Army Medical Center
MG	Volpe, M.D.	Philip	Western Regional Medical Command Senior Market Executive for TRICARE Puget Sound
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CAPT (Ret.)	Becker	Richard	Western Washington with TriWest Healthcare Alliance
Mrs.	Bernard	Carrie	Madigan Media Relations Officer
Mr.	Brackett	Gary	Tacoma-Pierce County Chamber
Mr.	Bush	Davy	Military Vaccine Agency
COL	Coleman	Russell	U.S. Army Medical Material Development Activity Medical Research and Material Command
Mr.	Ebbeson	Jay	Madigan Strategic Communication
Mr.	English	David	
CAPT	Hammer	Paul	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injuries
Mr.	Hemstreet	Tyler	The Ranger/Airlifter
Dr.	Jacoby	Robert	
Mr.	Joaquin	Sapien	ProPublica
Dr.	Knauss	Larry	Madigan Army Medical Center
Mr.	Levin	Bob	Tacoma Community and Economic Development Department
Dr.	Ludwig	George	U.S. Army Medical Research and Material Command
Mr.	Menes	Joe	National Center for Telehealth and Technology
Ms.	Petrich	Marisa	Northwest Guardian Joint Base Lewis-McChord Public Affairs Office
MAJ	Sterling	Anne	Madigan Army Medical Center