DEFENSE HEALTH BOARD MEETING
APRIL 23, 2018
9:00 AM – 5:00 PM EDT
Defense Health Agency
8111 Gatehouse Dr., Room 345
Falls Church, VA 22042

1. ATTENDEES – ATTACHMENT ONE

2. OPEN SESSION

a. Administrative & Opening Remarks

Dr. Nancy Dickey opened the meeting and welcomed the attendees. CAPT Juliann Althoff called the meeting to order as the Defense Health Board (DHB) Designated Federal Officer (DFO). Following a moment of silence to honor Service members, meeting attendees introduced themselves.

b. Trauma and Injury Subcommittee Update: Low-Volume High-Risk Surgical Procedures Tasking

Dr. Donald Jenkins, Board member and Chair of the Trauma and Injury (T&I) Subcommittee, opened the meeting by introducing the subcommittee members and then presenting the low-volume high-risk surgical procedures tasking assigned by Mr. Tom McCaffery, the Acting Assistant Secretary of Defense (ASD) for Health Affairs (HA) on March 28, 2018.

Research presented in the 2015 U.S. News and World Report suggest that patient outcomes are poorer when complex, high-risk procedures are performed by surgeons and/or at hospitals that rarely perform such surgeries. For patient safety, it is important for the Military Health System (MHS) to understand whether there are increased risks associated with low-volume surgery, evaluate the contribution of high-risk surgical procedures to medical readiness, and to develop policies and methods to prevent and mitigate such risks. In the civilian sector, three hospitals have pledged to maintain minimum standards for surgeons and hospital volume for ten surgeries considered to be of high-risk.

Dr. Jenkins noted that the subcommittee has already begun discussing this tasking, which will include reviews of current procedures and policies of both MHS as well as civilian and Veteran Affairs (VA) hospitals, in addition to reviews of the medical readiness of surgeons. Over the next six months, recommendations related to direct care in Military Treatment Facilities (MTF) will be developed. The subcommittee will provide a progress update at the August Board meeting and plan to brief out their report to the Board in October. In the following six months, an additional effort will focus on the MHS Purchased Care system (TRICARE) and will evaluate the potential for the MHS to sign onto the "surgical volume pledge." Dr. Jenkins noted that this tasker offers an opportunity for the MHS to lead the American healthcare system in this topic.

c. Considerations for Addressing Low-Volume Complex Surgical Procedures within the MHS

The discussion revolving around low-volume high-risk surgical procedures continued with Dr. Paul Cordts, Deputy Assistant Director (DAD), Strategy, Plans, and Functional Integration, of the, Defense Health Agency (DHA), presenting an overview of the MHS and the "surgical volume pledge."

Dr. Cordts noted that the MHS is a large integrated healthcare system, responsible for the healthcare for over 9.4 M beneficiaries in both deployed settings as well as on the home front. It is a provider as well as a purchaser of care. The DoD informs the civilian sector, most recently on wartime best practices, and must also look for opportunities to be informed by the best practices in the civilian sector.

The "surgical volume pledge" was jointly developed by Dartmouth-Hitchcock Medical Center, Johns Hopkins Medicine, and University of Michigan Hospital system. It represents the agreement that within their academic medical systems, they will direct surgical care for certain low-volume high-risk procedures to facilities which meet and maintain volume thresholds for ten surgeries considered to be of high-risk, which include bariatric staple surgery, esophagus cancer, lung cancer, pancreas resection, rectum cancer, carotid artery stenting, complex abdominal aortic aneurysm repair, mitral valve repair, hip replacement, and knee replacement. However, it was noted the pledge does not address rural or low-volume facilities outside of their academic medical systems. While the intent of this pledge is to improve patient outcomes, there may be unintended impact on limiting access and possible health disparities that may arise, especially in the MHS, and this must be studied. Dr. Cordts summarized research articles that supported different sides of this debate.

When surgery is necessary, two important questions are who will do the procedure and where will it be performed. It is important to acknowledge that every member–to include the surgeon, residents, interns, anesthesiologists, surgical nurses, circulating nurses, medicals, surgical technicians, and other personnel–are all critical to quality and patient safety. The capabilities of the facilities where these procedures are being conducted are also critical to outcomes and must be considered. Dr. Cordts emphasized four policy considerations for the Board to consider: 1) quality of care and patient safety looking at volume and outcomes, 2) policies that support development and maintenance of skills and teams, 3) facility infrastructure (look to the VA structure), and 4) improving transparency to maintain and enhance the trust of its patients.

d. Clinical Readiness Program: Combat Casualty Care KSAs Briefing

Acknowledging that the development and maintenance of surgical skills and surgical teams within the MHS are vital to the low-volume high-risk surgical discussion, Dr. Dickey introduced

CAPT Eric Elster, Professor and Chairman, Department of Surgery, Uniformed Services University (USU) and Walter Reed National Military Medical Center (WRNMMC). CAPT Elster provided an overview of the work being done with combat casualty care knowledge, skills, and abilities (KSAs) within the clinical readiness program at USU. The problem is perishable skills–the current approach to specialty skills training in the MHS is fragmented and not sufficient to maintain critical wartime combat casualty care skill sets, this KSA approach provides a core metric to focus the Direct Care System on readiness, not just of the surgeon but the entire system.

The four-tiered approach to clinical skills is currently piloted at six sites across the National Capital Region (NCR). The focus of this effort includes joint essential KSAs which define the knowledge base, skills, and abilities needed for the provider and to develop means of assessing both cognitive and procedural tasks.

CAPT Elster reviewed the Clinical Readiness Lifecycle and the process of how KSA scores are developed. The goal is to maximize the readiness of the MHS while enduring challenges that include deployment tempo, staffing, and coding. Mapping KSAs to peacetime workload yields a readiness indicator for each clinician, MTF, and market. All necessary metrics have been defined and all dashboards are developed. During the six site visits across the NCR, providers have offered very positive feedback.

e. Panel Discussion

Board members and attendees complemented CAPT Elster on the development and practice of the KSA methodology in the clinical readiness program and asked for a timeline regarding the KSA development cycle and any plans to implement throughout the MHS. When discussing the execution of KSAs, an attendee mentioned the National Surgical Quality Improvement Program (NSQIP) and its role in the clinical readiness program. NSQIP is a validated, risk-adjusted, outcomes-based nation-wide program to measure the quality of surgical care that provides participating hospitals with data to make informed decisions about improving quality of care. These quality metrics were noted to be critical, and all MTFs performing surgeries in the MHS participate in this program. Also discussed were the cost of KSAs, training requirements for application, and how to continue with the intent of Congress and the recommendations of the National Defense Authorization Act (NDAA) 2017.

Other dialogue included best practices for training, such as simulation environments, virtual reality, animal testing, and cadaverous operations. Some procedures are more realistically trained within live tissue models while waiting for the maturity of simulation technology. It was acknowledged that virtual reality will certainly become more prominent in the future. It is important to note that these programs are meant to teach how to operate, and not how to perform operations. There was discussion on the role of simulations, especially when considering small,

isolated DoD installations. If providers are not going to have the volume, simulation could allow Services to maintain competencies. The question of emotional IQ was raised, and it was noted that the importance is the dynamic of the entire surgical team. Low-volume is not just a military issue, but one that also impacts rural communities across the U.S.

Attendees provided several recommendations for the Board to consider to include: examining the potential partnership for MTFs with universities and/or the VA, using a hybrid model to fill MTFs with patients who need total care, best practices for developing a transparency policy without overwhelming patients, looking at the Joint Program Committee-1, Medical Simulation and Information Sciences (JPC1/MSIS), and evaluating policies and scenarios for how military team members can be utilized in a university program to practice under another credential provider.

f. Stop the Bleed Campaign

Dr. Jenkins was joined by Dr. Lenworth Jacobs, a member of the Board and the T&I Subcommittee, in introducing the Stop the Bleed Campaign, which was first launched in October 2015 by the White House. Stop the Bleed is a national awareness campaign and a call to action intended to encourage bystanders to become trained, skilled, and prepared to help in a bleeding emergency before professional help arrives. Attendees were then given the opportunity to participate in the hands-on training, demonstrating knowledge and practice of preventing a victim from bleeding out.

g. Continuing Education for DoD Health Professionals

Mr. Gerald Creech, Chief of Business Operations for DHA Education and Training (E&T) J-7, provided an update on the Board's recommendations made in the 2015 Report on Continuing Education for Department of Defense Health Professionals. Overall, J-7 concurs with the recommendations within the report and the Department's response to the report is currently being reviewed by Mr. McCaffery.

Mr. Creech briefed that the Continuing Education Program Office has been launched on a small scale and has initiated several successful Joint Accreditation initiatives. A one-year study was conducted in response to the report which determined a central office was necessary and should be mandated. It was noted that E&T currently does not have the authority to centralize as much of the training and responsibilities remain with the Services. He remarked that this program office is worthy of expansion, and issues like staffing and contract constraints must be addressed. Legislation will be needed to get the funding for the manpower and systems.

Ideas were given for alternative approaches to handle challenges, such as expanding the use of Joint Knowledge Online (JKO) for more types of educational opportunities. JKO currently

provides continuous, career-long development for joint knowledge and joint readiness for individuals, staff, Combatant Commands, Combat Support Agencies, and the Services. The main concern from the Service perspective on going Joint is loss of control over the allocation of funds which could result in failure to meet their Service specific training requirements. There was discussion and concurrence on centralizing provider privileging in a similar manner, although this was noted to be outside the scope of this briefing.

h. DoD Medical Ethics Center at the USU

COL Frederick Lough, Chief, Department of Surgery, WRNMMC and Deputy Chair of the USU and WRNMMC Department of Surgery, provided an update on the Board's recommendations made in the 2015 report Ethical Guidelines and Practices for US Military Medical Professionals.

Since the report, the DOD Medical Ethics Center (DMEC) was created along with a steering committee to lead this effort. The briefing began by introducing DMEC's mission objectives; 1) establish, implement, and maintain the DoD Medical Ethics Program (DoDMEP) Office, which will serve as the national and international lead in military medical ethics, 2) participate in development of policy, guidance, and oversight for matters related to medical ethics within the MHS, 3) develop a plan for MHS training, 4) develop and maintain a DoD health care ethics portal that will centralize resources for health care ethics information with the capability of receiving inquiries and requests for consultation, and contain links to relevant policies, guidance, and laws, information about sources of education and training, and to 5) maintain a contact list of designated subject matter experts in health care ethics to provide consultative services and develop procedures to support an auxiliary consultation capacity for health care professionals.

This program will capture societal and media perceptions of military medical practice, varying influences on ethical thoughts/practices dependent on age, culture, economic background, and religious beliefs of providers, both military and civilian, advances in medical technology, determining the roles of patient providers in decision making, potential conflicts between autonomy and beneficence, ethical practices in deployed environment, appropriate parameters of patient and healthcare workers conduct, confidentiality and disclosure of personal health information, and military mission/chain of command influence and potential conflict of interest. DMEC will need funding for implementation, hire personnel, and to identify and meet potential customers within the MHS. An Initial Operation Capability (IOC) is anticipated by fall 2018.

Board members congratulated COL Lough on the development of this program and were excited to hear about these significant and positive developments.

i. DoD Family Advocacy Program Overview

Mr. Bill Huleatt, LCSW, Office of Military Family Readiness Policy, Office of the Deputy Assistant Secretary of Defense (OSD) for Military Community and Family Policy (MC&FP), provided an overview of the Family Advocacy Program (FAP). FAP is congressionally mandated, serves as the policy proponent for, and a key element of, the DoD's Coordinated Community Response system to prevent and respond to reports of child abuse/neglect and domestic abuse in military families. FAP is located at every installation with command sponsored families, within and outside the continental United States. FAP support, clinical, and case management services are provided to individuals who are eligible for care in MTFs. FAP is focused on prevention, rehabilitation, and family well-being, with over 900 licensed clinicians who provide case management and treatment.

Ms. Mary "Tib" Campise, LCSW, Senior Program Analyst, OSD FAP, discussed DoD FAP initiatives and programs, such as evidenced-based programs, coordinated community response to child abuse and neglect, domestic abuse integrated project team, and the defense state liaison child welfare initiative. The competency, training, and certification requirements for clinicians, victim advocates, and primary prevention educators/outreach were also discussed, which all have Service specific requirements.

There was a discussion about current mechanisms in place for tracking families as they relocate. There are many programs that support families during relocation such as family support centers, relocation assistance, deployment support, and non-medical counseling are available on Military OneSource, a DoD program that provides resources and support to active-duty, National Guard and Reserve Service members, and their families at any time around the world at no cost. FAP can track the uniformed member. Protocols are in place before the member is permitted to relocate, which includes reporting to FAP, if necessary. Current events, such as the opioid crisis and the #MeToo movement, were suggested for further investigation as it is relevant to child abuse/neglect and domestic abuse/violence.

3. NEXT MEETING

The next DHB meeting is tentatively scheduled for August 26–27, 2018 with the location to be determined.

4. CERTIFICATION OF MINUTES

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

Nancy W. Dickey MD

June 29, 2018

Nancy W. Dickey, MD — Date
President, Defense Health Board

DEFENSE HEALTH BOARD MEETING
APRIL 23, 2018
9:00 AM – 5:00 PM EDT
Defense Health Agency
8111 Gatehouse Dr., Room 345
Falls Church, VA 22042

ATTACHMENT ONE: MEETING ATTENDEES

BOARD MEMBERS			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
Dr.	Craig	Blakely	Professor and Dean, School of Public Health and Information Sciences, University of Louisville
Dr.	Nancy	Dickey	*DHB President* Professor, Department of Family and Community Medicine, Texas A&M University
Dr.	John	Groopman	Edyth H. Schoenrich Professor of Preventive Medicine, Department of Environmental Health and Engineering, Johns Hopkins Bloomberg School of Public Health; Associate Director for Population Sciences, Sidney Kimmel Comprehensive Cancer Center, Johns Hopkins School of Medicine
Dr.	Eve	Higginbotham	Vice Dean, Inclusion and Diversity; Senior Fellow, Leonard Davis Institute of Health Economics; Professor of Ophthalmology, Scheie Eye Institute, Perelman School of Medicine
Dr.	Lenworth	Jacobs	Chief Academic Officer and Vice President of Academic Affairs, Hartford Hospital
Dr.	H. Clifford	Lane	Director, Division of Clinical Research, National Institute of Allergy and Infectious Disease, National Institutes of Health
Dr.	Jeremy	Lazarus	Clinical Professor of Psychiatry, University of Colorado Denver School of Medicine
Dr.	Vivian	Lee	Former Senior Vice President, University Health Sciences; Former CEO, University of Utah Health Care; Dean, School of Medicine, University of Utah
RADM (Ret.)	Kathleen	Martin	Chief Executive Officer, Vinson Hall Retirement Community - Vinson Hall LLC; Executive Director, Navy Marine Coast Guard Residence Foundation
Gen (Ret.)	Richard	Myers	*DHB First Vice President* President, Kansas State University/RMyers & Associates LLC
DEFENSE HEALTH BOARD SUPPORT DIVISION			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
CAPT	Juliann	Althoff	DHB Executive Director/Designated Federal Officer (DFO)
Mr.	Brian	Acker	DHB Program Manager, Knowesis Inc.
Ms.	Christina	Bacon	DHB Management Analyst, Knowesis Inc.
Ms.	Alexandra	Andrada	DHB Research Science Analyst, Knowesis Inc.
Ms.	Shandila	Collins	DHB Management Analyst, Karna LLC
Ms.	Camille	Gaviola	DHB Deputy Director/Alternate DFO
Ms.	Amanda	Grifka	DHB Research Science Analyst, Knowesis Inc.
DEFENSE HEALTH AGENCY SUPPORT			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
Ms.	Michelle	Holt	Analyst, Deloitte
Mr.	Sol	Kim	Analyst, Deloitte
Ms.	Jordan	Lillie	Analyst, Deloitte

DEFENSE HEALTH BOARD MEETING
APRIL 23, 2018
9:00 AM – 5:00 PM EDT
Defense Health Agency
8111 Gatehouse Dr., Room 345
Falls Church, VA 22042

OTHER ATTENDEES			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
Lt Col	Ruth	Brenner	Chief of Personalized Medicine, Air Force Medical Support Agency
CDR	Kimberly	Broom	Director of Public Health and Preventive Medicine, Headquarters Marine Corps, Health Services
Ms.	Mary	Campise	Senior Analyst, Office of the Deputy Assistant Secretary of Defense, Family Advocacy Program
RADM	Colin	Chinn	Joint Staff Surgeon, Joint Staff
Brig Gen	Sean	Collins	Assistant for Mobilization and Reserve Affairs, Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA))
Dr.	Paul	Cordts	Deputy Assistant Director, Strategy, Plans, and Functional Integration, J-5, Defense Health Agency (DHA)
Mr.	Gerald	Creech	Chief of Business Operations, Education and Training, J-7, DHA
Dr.	Bruce	Doll	Assistant Vice President, Uniformed Services University (USU)
CAPT	Christina	Dorr	Medical Director, Chief of Clinical Operations, North Tricare Regional Office, U.S. Navy Bureau of Medicine and Surgery (BUMED)
Lt Gen	Mark	Ediger	Surgeon General, United States Air Force
CAPT	Eric	Elster	Chair, Department of Surgery, USU and Walter Reed National Military Medical Center (WRNMMC)
Mr.	Steve	Flowers	Principal, Knowesis Inc.
Mr.	Joshua	Girton	Associate General Counsel, Assistant Professor, Medical Ethics, USU
Mr.	Steve	Hill	Senior Advisor, Directorate of Strategy, Planning and Functional Integration, J-5, Defense Health Agency
Mr.	William	Huleatt	Social Worker, Office of Military Family Readiness Policy, Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy, Family Advocacy Program
Mr.	Guy	Kiyokawa	Deputy Director, DHA
Dr.	Cara	Krulewitch	Director, Women's Health, Medical Ethics, Patient Advocacy, OASD(HA)
CDR	Alan	Lam	Deputy Associate Director, Emergency Preparedness and Response, BUMED
CAPT	Jaime	Lindly	Chief, Decision Support Division, DHA
COL	Frederick	Lough	Chief, Department of Surgery, WRNMMC and Deputy Chair, USU and WRNMMC Department of Surgery
COL	Myron	McDaniels	Director of Health Care Delivery, Office of The Surgeon General (OTSG), U.S. Army
Mr.	Bryce	Mendez	Defense Health Analyst, Congressional Research Service
Dr.	Patricia	Moseley	Military Child and Family Behavioral Health Senior Policy Analyst, Clinical Communities Support, Clinical Support Division, DHA
Dr.	Lolita	O'Donnell	Director, Continuing Education Program Office, Education and Training, J7, DHA

Mr.	Joseph	Procaccino	Legal Advisor, Defense Medical Ethics Program, USU
Dr.	Tulien	Sawal	Healthcare Fellow, McAllister and Quinn
RADM	Erica	Schwartz	Director of Health, Safety and Work-Life, U.S. Coast Guard (USCG)
LCDR	Alexandra	Singer	Clinical Investigator, DHA
LTC	Michele	Soltis	US Army Liaison, OTSG
Ms.	Laura	Stassi	Senior Writer, Health.mil, DHA
CDR	Shane	Steiner	Chief, Preventive Medicine, USCG
Mr.	Steve	Sternberg	Senior Writer, U.S. News and World Report
Mr.	Gordon	Trowbridge	DHA/HA Communications Representative
Dr.	Robert	Walker	Director, Health Strategy, OTSG
Dr.	Lauren	Zapf	Associate, Knowesis Inc.