DEFENSE HEALTH BOARD
OPEN MEETING MINUTES

June 28, 2023
8111 Gatehouse Road, Rooms 345-346
Falls Church, VA 22042
and
Virtual via Zoom

1. **Attendees – Appendix One**

2. **Opening Remarks/Introductions**

- CAPT Gorman welcomed all attendees, introduced himself, and called meeting to order.
- Dr. Guice, DHB President, welcomed attendees to the meeting, introduced herself, summarized the events of the previous Board meeting, and provided an overview of the meeting schedule and briefings.
- Dr. Guice announced CAPT Gorman's retirement.
- Dr. Guice asked for a moment of silence to honor the men and women who serve in the United States military.
- The Members and Distinguished Visitors introduced themselves.

3. **Administrative Remarks**

- CAPT Gorman reviewed the rules, report deliberation process, and logistics for the meeting.
- CAPT Gorman thanked the MicroHealth and BookZurman contract support staff for their work in putting this meeting together and all attendees for their participation.

4. **Written Statements to the Defense Health Board**

Dr. Guice reviewed the two written statements to the DHB. Ms. Elaine Saejung and Ms. Heather Gardner, spouses of the 909th Air Refueling Squadron members stationed in Japan, wrote about their personal experiences about challenges of overseas beneficiaries' access to mental health (MH) care. Both statements relate to the Beneficiary Mental Health Care Access (BMHA) report. The Neurological/Behavioral Health (NBH) Subcommittee (SC) received the statements prior to the meeting. Dr. Guice stated Dr. Valadka will provide how the Subcommittee responded to these statements during his BMHA presentation.

5. **Beneficiary Mental Health Care Access (Attachment One)**

Dr. Valadka, Chair of the NBH SC, discussed recent BMHA report updates addressing feedback from DHB members, distinguished visitors, and overseas military families. Dr. Valadka stated that the report acknowledges and references other recent government and non-government reports addressing MH. He stated that the report does not prioritize recommendations in terms of importance but presents them in line with chapter content. He further stated the report now addresses limitations in Chapter 9, adds discussion of MH smartphone applications ("apps") in Chapter 7, and addresses concerns received from overseas military families. Discussion points of note:

- Dr. Guice asked to reword Recommendation 1e. Dr. Lazarus provided rewording. Dr. Schorr discussed MH triaging procedures with Dr. Lazarus. Dr. Malanoski stated LTG Crosland would like the initial patient interface in MH visits to be digital and noted Recommendation 1e supports this goal. Dr. Guice and Dr. Parkinson discussed the impact of provider supply challenges on virtual visits. Mr. Mounts expressed support for licensure portability and stated that DHA's effort are complementary and will enable Air Force targeted care efforts. Dr. Landreaux stated that the Defense Health Agency (DHA) is working on this issue.
- Dr. Guice questioned the single point of contact as called for in Recommendation 3d. Dr. Schorr stated the intent is to simplify the regulatory environment for providers. Dr. Guice clarified providers contact Managed Care Support Contractors (MCSCs) rather than TRICARE, per se. HON Clegg Dodd asked whether a single point of contact is necessary to the goals of Recommendation 3d. CAPT Gorman read public comments in support of Recommendation 3d. The members agreed to the revised language proposed by Dr. Lazarus.
- Dr. Parkinson stated that it is the DHA's responsibility to ensure quality and questioned whether Recommendation 4 outsources this responsibility. Dr. Guice stated that the SC received conflicting accounts on MH access in the purchased care network. The members discussed the merits of the term "secret shopper" in this context as well as the optimal frequency of quality review audits. Dr. Berwick and Dr. Malanoski discussed the impact of potential changes under the TRICARE T5 contract on this issue. The members agreed to revised language.
- RADM (Ret.) Chinn asked for clarification on the responsibilities of MCSCs, as discussed in Finding 5. Dr. Schorr discussed DHA's limited leverage over purchased care network in comparison to the direct care network. Dr. Valadka stated that it is unclear how DHA can meaningfully enforce adherence to access to care standards in the purchased care network. Dr. Guice stated that DHA's leverage is generally stated in the TRICARE MCS contract.
- Dr. Guice asked if Recommendation 6 falls within the DHA's authorities. Dr. Alleyne, Dr. Armstrong, and Dr. Valadka discussed terminology. Dr. Armstrong, RDML Via, Dr. Malanoski, and Dr. Guice discussed the recommendation's feasibility. The members agreed to keep the finding and to return to the recommendation language.
- Dr. Guice stated the Integrated Referral Management and Appointment Center is a relatively new tool and that Recommendation 8b represents a major undertaking. Dr. Parkinson and Dr. Browne agreed. RDML Via and Dr. Guice discussed appointment scheduling in the context of obstetrics patients. The members agreed to recommendation edits.
- RDML Via discussed suicide prevention outside the context of clinical care and encouraged broad recommendation language. Dr. Lazarus expressed concerns that Finding 9 is inadequately supported by the text. Dr. Schorr discussed where the report addresses suicide. Ms. Weathers, an advocate for patients and providers, spoke to the need to improve relationships between MCSCs and providers. Dr. Alleyne asked if language could be inserted pertaining to alternative evidence-based therapies. Dr. Valadka stated that alternate therapies are addressed in Chapter 8. The members agreed to minor edits to Recommendation 9c.

- Dr. Guice and RDML Via discussed changing Recommendation 10a-c to refer to "DoD and Services." Dr. Jacobs stated that the phrase "socially connected" evokes social climbing. Dr. Valadka and Dr. Schorr discussed terminology. Dr. Guice suggested leaving the language as written except for the addition of "and the Services" to Recommendations 10a-12c. The members agreed to these edits.
- Regarding Recommendation 11, RDML Via suggested that MH stigma is, in part, generational. Dr. Guice discussed a finding from Blue Star Families that 21% of military families would avoid MH care for their children out of concern for their (potential) future careers in the military.
- On Recommendation 12, Dr. Parkinson spoke to family resilience and screening for anxiety. Dr. Valadka stated that screening concerns may be addressed in the DHB's Mental Health Accessions Report. Dr. Guice said Dr. Parkinson's comment seems apropos to Recommendation 13.
- Recommendation 13:
    - Dr. Guice suggested adding the word "encourage" or "mandate" to Recommendation 13a. CAPT Gorman cautioned against the word "mandate." Dr. Lazarus stated the SC relied on Dr. Upender's expertise for this recommendation. Dr. Parkinson recommended adding the word "require." The DHB members further discussed and subsequently, agreed to wording change of "ensure training of" for Recommendation 13a.
    - RDML Schobitz suggested adding the phrase "evidence-based treatment options" to Recommendation 13b. The members agreed.
    - MG Appenzeller spoke about training for non-commissioned officers and Officers on sleep hygiene. Dr. Valadka stated that context for Recommendation 13c is in the text of the report. Dr. Guice suggested changing "DoD" to "DHA." RDML Schobitz spoke about medical schools and the Services. Dr. Guice suggested to add "the Services" to recommendation language. Dr. Browne asked if sleep training was specifically for Cognitive Behavioral Therapy for Insomnia. Dr. Zebrowski suggested changing Recommendation 13c to "for sleep disorders" to be more specific. The members agreed to the recommended changes.
- Dr. Parkinson discussed Finding and Recommendation 14. Dr. Guice suggested adding "should eliminate TH barriers within their authority" to Recommendation 14b. MG Appenzeller suggested adding the phrase "should advocate for" to Recommendation 14c and 14d. Dr. Guice and Dr. Parkinson discussed prioritizing virtual MH appointments.
- Regarding Finding and Recommendation 15, Dr. Browne commented on the issue of security and clearance. Dr. Parkinson called for greater clarification on these issues. Dr. Lazarus stated that the assessment of risks can include security. Dr. Luby discussed DoD policy restrictions. Dr. Alleyne asked to include discussion of alternative therapeutics, such as animal assisted therapies or culturally appropriate therapies.
    - Dr. Lazarus suggested adding the phrase "and other therapies" to Recommendation 15b
    - Gen (Ret.) Chilton suggested removing the second bullet on Recommendation 15b. Dr. Bishop asked if the DHB wants to give examples in the recommendation. Dr. Armstrong stated his concern that Finding and Recommendation 15 could distract from other findings and recommendations of the report. He suggested combining Recommendations 15a-c and asking DoD to

clarify conditions for research support of and participation in emerging mental health therapies and novel therapeutics. RDML Via stated he understands Dr. Armstrong's concerns and suggested adding "understanding operational and individual risks and opportunities." Dr. Lazarus stated the language for 15b and 15c could be added to the body of the report rather than as recommendations.

- Dr. Browne inquired about clinical trials referenced in Recommendation 16. Dr. Valadka suggested removing Finding and Recommendation 16 since its content is now covered in Recommendation 15. Dr. Parkinson noted the National Institutes of Health are conducting trials like those discussed in Recommendation 16.
- CAPT Gorman asked Ms. Weathers for a summary of her recommendations in the chat (Appendix Two). Ms. Weathers thanked the DHB for their work. She stated that beneficiaries experience points of failure in the care pipeline. She further described points of frustration and the need to include military spouses as providers. Ms. Weathers stated TRICARE limits the availability of alternative treatments by refusing to cover them. She stated primary care managers need additional training on drafting referrals to avoid claim denials and that DoD must hold MCSCs to their contracts.
- Dr. Guice led a final discussion of report findings and recommendations with appeals for motions, seconds to amend each, and subsequent votes after all amendments were considered. Attachment One includes the edits to the final Findings and Recommendations language. Changes highlighted in yellow were made prior to this deliberation with Subcommittee input and changes in red were made with the DHB members during deliberation discussion:
  - Recommendation 1e: "continue to work" and "relevant mental and behavioral health."
  - Recommendation 3:
    - 3c. Remove "and address where possible" add "and work with MCSCs to address the issue" at end.
    - 3d. Replace "create a single point of contact" with "ensure a simplified mechanism."
  - Finding 4: Remove last sentence.
  - Recommendation 4: add "independent" before "3rd party" and insert "secret shopper" after "conduct."
  - Recommendation 6: Change to "The DHA should encourage MCSCs to develop academic and community partnerships to increase the MH workforce."
  - Recommendation 8b: Change maintain to "ensure" and add "is available for patient and MTF use" at end.
  - Finding 9: Add "DoD MH and suicide prevention" to beginning.
  - Recommendation 9c: Change to "Pilot studies and other evidence-based research should include quality and outcome measurements."
  - Recommendation 10: Add "and the Services" after "The DoD" for 10a-10c.
  - Recommendation 11: Add "and the Services" after "The DoD" for 11a-11c.
  - Recommendation 12: Add "and the Services" after "The DoD" for 12a-12c.
  - Recommendation 13:
    - 13a: Replace "encourage" with "ensure training of," remove "to prioritize training" and "treatment."

        - 13b: Replace "Cognitive Behavioral Therapy for Insomnia (CBT-I) is" with "evidence-based treatment options for sleep disorders is."
        - 13c. Replace DoD with "DHA and the Services."
    - Recommendation 14:
        - 14b. Replace "address" with "eliminate" and add ", within its authority," after "TH barriers."
        - 14c. Replace "continue to" with "advocate for."
        - 14d. Replace "ensure" with "advocate for."
        - 14e. Continue to and through.
    - Finding 15: On the second bullet, add a comma after "processes" and change end of sentence to "and DoD policy restrictions."
    - Recommendation 15: Remove 15b and c. Change to only one recommendation: "The DoD should clarify conditions for research support of and participation in emerging MH therapies and novel therapeutics."
    - Finding and Recommendation 16: Delete.
- The Board voted to approve the report's findings and recommendations as amended. Dr. Valadka thanked the DHB members and staff for their efforts. Dr. Guice thanked Dr. Valadka for his leadership.

6. Eliminating Racial and Ethnic Health Disparities

Dr. Michael-Anne Browne briefed on the DHB's report "Eliminating Racial and Ethnic Health Disparities" (REHD). Discussion points of note:

- Dr. Lazarus asked how dental outcomes became part of the recommendations. Dr. Browne stated the finding came from a Health System (HS) SC site visit in San Diego where they found that dental health impacts readiness. She said they suspect that racial and ethnic disparities in dental healthcare are related to socioeconomic factors.
- Dr. Lazarus asked about use of the term "disparities" in some recommendations and "equity" in others. Dr. Browne stated the REHD report's first focus is on describing the state of REHDs within the Military Health System (MHS). She stated that some studies show no REHDs but there does not appear to be a systematic effort in the MHS to mitigate them.
- Dr. Lazarus then asked if the SC thought about including an equity lens in other reports. Dr. Browne stated public health communication would need to consider culturally appropriate messaging.
- Dr. Medows differentiated health equity from health equality or equal access. She noted that Service members (SMs) experience inequalities before enlisting and that understanding this social context is critical. She stated that doing so requires diligence and operational knowledge. Dr. Medows noted this task differs from Diversity, Equity and Inclusion (DEI) and that clear definitions for DEI and health equity are needed in the report. Dr. Alleyne agreed to providing clear, concise definitions for equity, disparity, and DEI, and to include context. Dr. Browne stated the definitions section of the report will be revisited.
- Dr. Alleyne would like to make sure the report includes Hispanic Service Institutions along with Historically Black Colleges and Universities. He stated the Satcher Health

Leadership Institute developed the "gold standard" for tracking population data but that other tools and technologies need to be leveraged and added to the report. Dr. Medows stated the examples from other institutions will be helpful to illustrate best practices. Dr. Browne stated there needs to be a set of experts to advise the military treatment facilities (MTFs).

- Dr. Alleyne stated that the REHD report should clarify how to operationalize measurements, how to integrate recommendations, and how to measure implementation and results. Dr. Medows added that priorities and performance measures should be included as well.
- Dr. Browne stated that she has not seen REHD data pertaining to trauma but that she has seen surgical data that did not show evidence of disparities (e.g., appendicitis). She stated disparities are more likely in cancer and maternity care. Dr. Medows added disparities are evident in pain management. Dr. Jacobs discussed penetrating wounds disparities in civilian health care and asked if such disparities are present in the MHS. Dr. Browne said these disparities are not evident in the MHS and added the need for systematic reporting.
- Dr. Parkinson asked about racial and ethnic classification and whether self-designation represents the "gold standard." Dr. Browne discussed the Office of Management and Budget's (OMB) Statistical Policy Directive 15 from the 1990s. The OMB contains two ethnicities, and five race options and allows a person to check any box. She then discussed the operation of the Defense Enrollment Eligibility Reporting System (DEERS), which has different categories, including "other" and "unknown." Dr. Browne noted that the unknown category complicates efforts to track patients. CAPT Gorman described a case where a patient checked several race boxes on paper at accessions but appeared with only one marked in DEERS. Dr. Medows described how the "multiracial" category may obscure disparities. She added that some SMs do not check any of the provided boxes because they believe that there are no good choices for them. Dr. Alleyne stated that changing how race and ethnicity is recorded will make replication from previous datasets difficult.

7. Health Communications

Mr. Richard Breen, Director of Strategic Communications for MHS/DHA, and Mr. Derik Crotts, Communications Strategists for MHS/DHA, briefed on "The War on COVID: Pandemic Communications in a Government Setting." Mr. Breen and Mr. Crotts described the DHA's efforts to manage health communication challenges during the COVID-19 pandemic, including targeting advertising and strategic discussions with unit leaders. They described the "Six Ps" of pandemic communication in a government setting: plan, practice, promulgate, products, pace, and pray. Discussion points of note:

- Dr. Bishop asked for a copy of their office's "after action" report and asked whether they had considered the issue of vaccine hesitancy. Mr. Breen stated that they have not looked at this issue but that they can investigate it and brief the DHB later. Mr. Crotts stated that vaccine hesitancy and anti-vaccination sentiment existed prior to COVID but that the speed at which incorrect information disseminated increased vaccine hesitancy during the COVID-19 pandemic.

- Dr. Bishop asked about health messaging from unit commanders, specifically those operating outside the continental US. Mr. Breen stated MHS/DHA Strategic Communications provides specific metrics and guidance to Commands to assist leaders in communicating information to troops and beneficiaries. DHA knows that health information reaches unit commanders, but they can only track its dissemination on social media to gauge its reach and effectiveness. He noted the message should be repeated seven times to be considered "effective," but acknowledged messages may get truncated in the communication process.
- Dr. Bishop stated leaders should be brought into the health communications discussion prior to emergencies. She asked if DHA is planning for this. Mr. Breen stated that they, as a communications team, are included at some level with all operational exercises. Mr. Crotts stated that, early in the pandemic, LTG Place held town halls with worldwide commanders to have open and frank discussions about vaccine availability and communicate strategies. He stated those sessions were effective with high attendance and participation.
- Dr. Medows noted the discrepancy between COVID-19 and other pandemics (e.g., H1N1). She stated there was a delay and disconnect between the White House, the Centers for Disease Control and Prevention (CDC), and the Centers for Medicare and Medicaid Services that created a communications void. She noted the people who filled that communication information void used technology and created a "title wave of misinformation." She suggested the DoD can track and monitor social media to predict the next wave of misinformation's source... Mr. Breen responded the DoD is tracking and the DoD social media lead is a political appointee. Mr. Crotts stated the Services have social media teams as well.
- Dr. Lazarus asked if DHA has a way of assessing vaccine uptake outside of the military system and if they used other communications strategies. He also asked if there are other large systems that could serve as models. Mr. Breen stated that it is difficult to track vaccinations occurring outside of MTFs. He noted that DHA was able to track Active Duty SM vaccinations and briefed LTG Place on SM vaccination rates. Mr. Crotts added that outside vaccination data could be reported to the Department of Health and Human Services, but he was unsure of the current tracking efforts. In the future, an automated and integrated tool could be used to capture vaccine information.
- Dr. Lazarus asked who determines health communications messages and how they are disseminated. Mr. Crotts replied organizational leaders set the tone. Mr. Breen stated interagency communications and information sharing worked but that they have not assessed who was best able to disseminate their message.
- Dr. Bishop stated that Tennessee has a vaccine registry. Mr. Crotts confirmed every State has a vaccine registry, noting there are 68 locations, to include US Territories. He added the issue is how States are directed by their government to disseminate the information or in some cases not directed.
- Dr. Alleyne stated that Health Information Persuasion Explosion looks at why people embrace misinformation. He said that there is a vaccine information management field

guide. Dr. Alleyne said there is value in focusing on health literacy and to have military and civilians work collaboratively.

- HON Clegg Dodd stated part of the military's successful vaccine effort was the presence of a vaccine mandate for DoD personnel. She noted a mandate may not be available for the next pandemic. She said her organization found that many groups got the vaccine, including doctors (99%), healthcare aids (98%), and the broader community (~98%), but that nurses had low uptake (79%). She stated that, as companies researched this issue, they found the nurses' communications lines were feeding anti-vaccination information. She noted thousands of nurses left their jobs due to the vaccine mandate. She stated skilled nursing care companies spent a substantial sum of money to combat this messaging and that they eventually got nurses to 91% vaccination. HON Clegg Dodd encouraged additional research into the causes of communications and information dissemination breakdown.
- Dr. Parkinson emphasized the need to establish trusted community relationships, noting that it is leaders' job to make policy and experts' job to advise. He stressed leveraging existing community relationships towards this end.
- RADM (Ret.) Chinn asked how to deliver proper health information to line leadership, clinical staff, and beneficiaries when they are getting countering information from the White House and other authorities. Mr. Breen stated that leadership engagement and coordinating the responses across agencies can help to reduce cross-information and communication lags. Mr. Crotts emphasized the importance of consistency and the need to message on a variety of popular communications platforms.
- Dr. Armstrong stated that the COVID-19 vaccine should not have been an issue for SMs since they cannot avoid vaccines when joining the Services. However, he noted that SMs are not immune to social trends and the CDC guidance was far too complex. Dr. Armstrong suggested creating "vaccine ambassadors." Mr. Breen stated they had messaging that went into the closed-circuit television and a line leader's toolkit to communicate to the troops. Dr. Armstrong stated the COVID-19 vaccine was important for national security. He stated that entrance to the military is an opportunity for vaccine education. Dr. Parkinson agreed with the need for military health literacy.

8. Closing Remarks

CAPT Gorman and Dr. Guice thanked everyone for their attendance and noted the next DHB meeting is scheduled for September 11, 2023 at Portsmouth, VA. CAPT Gorman adjourned the meeting.

9. Certification of Minutes

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

8/7/2023

Dr. Karen Guice, MD, MPP
President, Defense Health Board

Date

APPENDIX ONE: MEETING ATTENDEES

BOARD MEMBERS			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
Dr.	Karen	Guice	*DHB President* Executive Director and Chief Medical Officer, Ernst & Young, Government and Public Sector Advisory Services
Dr.	Lenworth	Jacobs	*DHB First Vice President* Director, Trauma Institute, Hartford Hospital
Dr.	Jeremy	Lazarus	*DHB Second Vice President* Clinical Professor of Psychiatry, University of Colorado, Denver
Dr.	E. Oscar	Alleyne	Managing Director, Public Health Division, MITRE Corporation
Dr.	John	Armstrong	Professor of Surgery, University of South Florida
Dr.	Donald	Berwick	President Emeritus and Senior Fellow, Institute for Healthcare Improvement
Dr.	Wilsie	Bishop	Vice Present of Health Affairs and Professor Emerita, East Tennessee State University
Dr.	Michael-Anne	Browne	Associate Chief Medical Officer, Stanford Children's Health
Dr.	Maria	Caban Alizondo	Director, Health Information Management Services, UCLA Health System
Gen (Ret.)	Kevin	Chilton	President, Chilton & Associates, LLC
RADM (Ret.)	Colin	Chinn	Chief Medical Officer, Peraton
HON	Jackie	Clegg Dodd	Founder and Managing Partner, Clegg International Consultants, LLC
Dr.	Christi	Luby	Independent Consultant and Researcher
Dr.	Brigid	McCaw	Senior Clinical Advisor, California Quality Improvement Learning Collaborative, University of California, San Francisco
Dr.	Rhonda	Medows	Chief Population Health Officer, Providence St. Joseph Health
Dr.	Michael	Parkinson	Principal, P3 Health, LLC
Dr.	Alex	Valadka	Professor and Director of Neurotrauma, University of Texas Southwestern Medical Center
DHB STAFF			
CAPT	Greg	Gorman	Executive Director/Designated Federal Officer (DFO)
Ms.	Camille	Gaviola	Deputy Director/Alternate DFO
Dr.	Catherine	Zebrowski	Executive Secretary/Clinical Consultant/Alternate DFO
Ms.	Angela	Bee	Research Analyst, MicroHealth, LLC
Mr.	Tanner	Dean	Management Analyst (Office Support), BookZurman, Inc.
Mr.	Rubens	Lacerda	Management Analyst (Meeting Support), BookZurman, Inc.
Ms.	Giovanni	Dingle	Management Analyst, MicroHealth, LLC
Mr.	Paul	Schaettle	Alternate Project Manager/Senior Analyst, MicroHealth, LLC
Dr.	Chris	Schorr	Research Analyst, MicroHealth, LLC
Dr.	Clarice	Waters	Project Manager/Senior Analyst, MicroHealth, LLC
PUBLIC ATTENDEES			
Mrs.	Darleen	Adkins	Health Readiness Coordinator, Army Reserve
Dr.	Sonia	Alemagno	Dean, College of Public Health, Kent State University
Ms.	Amy	Anda	Director and Health Practice Lead, Credence Management Solutions LLC
MG	George	Appenzeller	Deputy Surgeon General and Deputy Commanding General of Operations, USARMY
Dr.	Georges	Benjamin	Executive Director, American Public Health Association
Dr.	Kristi	Cabiao	US Air Force (USAF) Spouse, CEO Mission Alpha Advocacy

Mr.	Will	Culp	Associate Vice President, Business Development, Humana Military
Mr.	Shelton	Cumming	Health Readiness Coordinator
Dr.	Marion	Ehrich	Professor, Dept of Biomedical Sciences and Pathobiology, Virginia-Maryland College of Veterinary Medicine
Ms.	Stacey	Feig	Senior Team Lead, Psychological Health Program, US Army Reserves
Ms.	Elan	Green	Chief, Medical Benefits & Reimbursement Section, Health Plan Design Branch, TRICARE Health Plan
Mr.	Jeremy	Hilton	South Central Regional Liaison, Defense State Liaison Office, Office of the Deputy Assistant Secretary of Defense Military Community and Family Policy
Ms.	Monica	Hutcheson	Child and Family Behavioral Health Services, Brooke Army Medical Center
Ms.	Patricia	Kime	VA and Military Health Care Reporter, Military.com
Ms.	Evie	King	Board President, InDependent
Mr. (SES)	Darrell	Landreaux	Deputy Assistant Secretary of Defense for Health Resources Management and Policy, Office of the Assistant Secretary of Defense for Health Affairs
Ms.	Aileen	Legayada	Graduate Student Intern, The Joint Commission
Dr. (SES)	Michael	Malanoski	Deputy Director, DHA
Ms.	Ellen	Milhiser	Editor, Synopsis
Mr. (SES)	Stephen	Mounts	Associate Deputy Surgeon General, USAF
Ms.	Mollie	Mullen	Advisor for Clinical Quality, Directorate for Surgical Services, Navy Medical Center San Diego
Ms.	Kara	Oakley	Chair, TRICARE for Kids Coalition
Ms.	Sarah	Otto	Co-Founder and President
Mr.	Paul	Pirkle	Director, Military & Veteran Health Strategy, IQVIA Government Solutions
LTG (Ret.)	Douglas	Robb	Special Assistant to the President for Strategic Educational Projects, Uniformed Services University of the Health Sciences (USUHS)
Ms.	Elayne	Saejung	USAF Spouse
Mr.	Rasneek	Singh	Health Care Public Policy Intern, The Joint Commission
Ms.	Jennifer	Stankovic	Health System Specialist, DHA HCO
RDML	Richard	Schobitz	Director, Commissioned Corps Headquarters, U.S. Public Health Service,
RDML	Darin	Via	Interim Surgeon General, US Navy
Ms.	Amanda	Vicinanzo	Media Relations Specialist, DHA
Ms.	Corie	Weathers	Military Clinical Consultant
Ms.	Noelle	Wiehe	Media Relations Specialist, Serco, Inc.

APPENDIX TWO: Zoom Chat

09:24:45 From Donald Berwick:
Has there ever been a retrospective analysis of the most successful or impactful of our reports compared with those with less impact to glean lessons about factors for impact? Maybe a "Ten Reports" retrospective? For the purpose of learning.

10:08:30 From Ellen Milhiser:
What was the name of the next DHB Executive Director?

10:08:37 From Defense Health Board:
CAPT Shawn Clausen

10:08:50 From Ellen Milhiser:
Thank you!

10:37:00 From Corie Weathers:
Is the "purchased care network" the Tricare network or contracted entities like MOS?

11:06:42 From Elayne Saejung:
We are very happy that OCONUS and military spouse considerations were included - thank you for all of your work and effort.

11:06:46 From Amy Anda:
Credentialing and privileging also takes forever in the MTFs for anyone including military spouses and DHA often loses great people to other places because it takes forever so I think also mentioning in 1e supporting DHA's efforts and initiatives to streamline, centralize, and ultimately speed credentialing would be great

11:08:38 From Defense Health Board:
From Corie Weathers: YES! Many licensed spouses are trying to help and get credentialed as providers but are being blocked by Tricare contractors.

11:09:46 From Corie Weathers:
Have we included in the recommendations a way to survey provider experiences? Many MH providers are abandoning contracts (bigger problem than the shortage) due to a negative experience with Tricare Contractors.

11:11:55 From Corie Weathers:
Yes, to single point of contact and we also need a way to change demographic or practice information on our own/on the front end

11:13:16 From Corie Weathers:
Tricare contractors already provider regional managers as a POC

11:14:39 From Corie Weathers:

*provide a POC for credentialing.

11:16:09 From Kara Tollett Oakley:
Tricare for Kids coalition, which includes providers and beneficiaries, strongly supports this 3d recommendation and appreciates deeply the subcommittee's responsiveness to the barriers to access that we and many others I believe had shared. Breaking down barriers is such an important element for providers who are trying to serve Tricare beneficiaries well.

11:17:14 From Corie Weathers:
Yes to an investigation, please (as a military spouse provider myself that is collecting the issues from other providers)

11:20:59 From Darleen Adkins:
I would like 3d left in because of the experience in my role as Health Readiness Coordinator with soldiers and follow-on care. I have other details I can share here or in a follow up email.

11:21:29 From Corie Weathers:
Reacted to "I would like 3d left..." with a heart emoji

11:22:13 From Darleen Adkins:
The difficulty for us in not with DHA, it's after the hand off to managed care; i.e. TRICARE/HNFS/ and the providers.

11:23:05 From Darleen Adkins:
DHA-Great Lakes specifically handles our request for follow-on care and they do that well.

11:24:05 From Corie Weathers:
I agree- Darleen, as a provider, would you say the issue is in between? I see the Tricare managers blocking care.

11:27:15 From Corie Weathers:
Can providers have access to quality of care surveys of contractors (Humana/HelathNet).

11:29:18 From Darleen Adkins:
Reacted to "Can providers have a..." with a thumbs up emoji

11:30:00 From Darleen Adkins:
I'm not sure but that information might be helpful for their process to improve as well as managed care.

11:36:05 From Corie Weathers:
"DHA should investigate and audit barriers to care that exist for beneficiaries throughout the entire pipeline of mental health support."

11:39:10 From Corie Weathers:
Can the ID “secret shopper” be someone who is knowledgeable- a spouse beneficiary & provider

11:40:02 From Kristi Cabiao:
Agree with Corie, need to define the "secret shopper"

11:42:39 From Defense Health Board:
All - thank you for your comments. I have been sending them directly to CAPT Gorman, the Designated Federal Officer, live during this meeting. Due to time constraints, we may not have time to publicly acknowledge all your comments.

11:43:23 From Corie Weathers:
The answers you will get by only looking at patient satisfaction will only give you information we already have. We are missing the critical data behind the shortage of providers which is not the same as the shortage of providers on the civilian side. The real question is why they are leaving and how do we retain them. They are leaving due to COVID burnout, mistreatment and deficient oversight by Tricare Contractors, and red tape/blocking between the MTF and provider.

11:56:32 From Corie Weathers:
We can encourage more internship opportunities for military spouse providers. It helps with the military spouse employment issues as well as bringing in culturally competent providers. We are already piloting this in other departments. But there is a huge supply of military spouse providers.

11:58:56 From Corie Weathers:
Even if we open up LPC opportunities as well as internships that offer supervision and give preference to spouses, you will get a flood of more providers.

12:01:15 From Corie Weathers:
The DOD is already piloting it, please don’t delete it.

12:07:45 From Corie Weathers:
Recommendation- that contractors allow providers to update their own information, so it stays current

12:09:38 From Corie Weathers:
Even though we can update our demographics, it takes months if not years to simply change an address or detail about the practice.

12:27:19 From Paul Pirkle:
Would recommendation 9c be a continuation of an ongoing effort or something new? It is difficult to discern that given its overarching phrasing. Could these measurements, pilot studies, and research include aspects of artificial intelligence and natural language processing for

optimized informatics and analytics that would support predictive and preventive patient and HCP decisions?

13:20:54 From Defense Health Board:
Attendees, If you are signing in for the first time and were not present at this morning's session, CAPT Gorman has called an audible. We are continuing with the Report Deliberation discussion from this morning and will delay the next agenda items a bit.

13:57:56 From Corie Weathers:
The bigger issue is that Tricare (not the contractors) are directing beneficiaries to use Telemynd as a Telehealth provider, deflecting promised referrals from providers.

14:00:01 From Corie Weathers:
This then causes the providers to get frustrated and abandon contracts. Most providers (counseling) are providing Telehealth but are not getting visibility with Tricare pushing telemynd. It is great that we have this large provider as a solution, but not if those in contract are not getting the promised visibility + the broken directories. Again, healing this relationship must be primary.

14:01:35 From Corie Weathers:
Providers have told me that now that Tricare no longer covers sessions over 50 minutes, they cannot do EMDR. So, we can recommend new approaches, but if providers can't get paid to do them appropriately, they won't provide them.

14:03:07 From Corie Weathers:
"If you book sessions for Prolonged Exposure Therapy or EMDR that are more than 60-minutes, there appears to be no way to get reimbursed for anything beyond the 60-minutes at this time for any extended services. Which means that until this is settled (and perhaps a new code is designated), it's prudent to not schedule any clients longer than 60-minutes for mental health sessions (at least for TriCare and TriWest)"

14:33:36 From Defense Health Board Gatehouse:
Break until 2:45 PM (Eastern)

14:43:43 From Defense Health Board:
Attendees - we will be revising the agenda a bit. We will go to Dr. Browne's Tasker Update first before getting to Health Communications.

14:44:00 From Defense Health Board:
We expect to get to Health communications closer to 3:30

15:37:24 From Defense Health Board:
In case you missed that, Dr. Bishop will not present the tasker intro on Health Communications today; it is now Mr. Breen.

16:37:27 From Georges Benjamin:

Excellent point. Military is a ecosystem that can be leveraged for good communication

16:51:18 From Defense Health Board:
Thank you for joining meeting today - it is adjourned.

16:51:47 From Defense Health Board:
We will now be ending this zoom meeting. follow up comments/emails can be sent to: dha.ncr.dhb.mbx.defense-health-board@health.mil