DEFENSE HEALTH BOARD MEETING
August 11-12, 2014

Defense Health Headquarters
7700 Arlington Blvd.
Falls Church, VA 22042

1. ATTENDEES – ATTACHMENT ONE

2. NEW BUSINESS

August 11, 2014—Administrative Session

Dr. Nancy Dickey welcomed Defense Health Board (DHB) members and subcommittee members to the meeting. Ms. Christine Bader also welcomed the group, discussed a new tasking to the DHB on automated neuropsychological assessment metrics, and highlighted the recent proposed relocation of the Defense Suicide Prevention Office. Ms. Marianne Coates provided a brief media update to the members, describing several recent events covered by the media including the recent transport of Ebola patients back to the United States (U.S.) and the contaminated drinking water at Camp Lejeune, NC. Ms. Bader briefly summarized the work of the Independent Review Panel on Military Medical Construction Standards and reminded members to report any conflicts of interest they may have related to subject matter in the meeting.

Action/POC: None.

August 11, 2014--Open Session

a. Administrative & Opening Remarks

Dr. Dickey opened the meeting and welcomed the attendees. Ms. Bader called the meeting to order as the DHB Alternate Designated Federal Officer. Following a moment of silence to honor Service members, meeting attendees introduced themselves, including those members present via telephone.

Action/POC: None.

b. Pain Management Task Force: Downrange Pain Control – What has Changed?

COL Chester Buckenmaier provided a briefing on the Defense and Veterans Center for Integrative Pain Management. He described the history of pain management throughout military medical history from the time of the Civil War, highlighting the changes over the course of the last 13 years of conflict. He described the chronic pain cycle, which when poorly managed adversely impacts a patient in their everyday functions, as well as overlapping issues of traumatic brain injury and post-traumatic stress disorder. He also discussed the use of alternative medicine including acupuncture, stating the importance of multidisciplinary teams and pain

management in medical education. COL Buckenmaier highlighted the work of the Pain Management Task Force, recommending the DHB read their final report issued in 2010. The Defense and Veterans Pain Rating Scale was also described as a useful tool to evaluate pain.

The members discussed future research in pain management including the identification and use of biomarkers to identify those individuals in need of specialized pain management. COL Buckenmaier noted the importance of pain management as a part of preventive care, providing the example of diabetics who lose feeling in their feet and are therefore at risk for unintentional foot injuries. Members also described the warrior ethos of viewing pain as weakness to work through, citing the need to overcome such beliefs. Members and guests also discussed the reliance on opioids for pain management and the need for alternative medications such as ketamine.

Action/POC: None.

c. Challenging the Dogma for the Resuscitation of Traumatic Hemorrhagic Shock

Dr. Phillip Spinella thanked the members for inviting him to speak, highlighting the role of Dr. Donald Jenkins as one of his mentors. He described the percentage of deaths caused by hemorrhage during the recent conflicts and highlighted the work of the Trauma Hemostasis and Oxygenation Research Network (THOR) in this area, noting the span of the network from the battlefield to research, with a variety of international partners. He explained both the dogma of transfusion medicine and those attributes of the dogma that need to be reconsidered in light of recent research. Dr. Spinella highlighted the movement in the 1960-1970s to separate whole blood into individual blood products to address particular needs, noting that this practice of product specific therapy can pose a problem in those individuals who need multiple blood products due to high volume blood losses.

Dr. Spinella cited a 2009 paper from *the Journal of Trauma,* which documented that per unit, component therapy used three times the volume of anticoagulant and additives with reconstituted whole blood as compared to whole blood. Dr. Spinella also cited a 2009 paper from *the Journal of Trauma Injury, Infection, and Critical Care* that showed significantly higher survival rates in those patients with combat related traumatic injuries that received fresh whole blood, as compared to combination therapy. This increase in survival was replicated in several additional studies in both 2011 and 2013. Dr. Spinella described that the use of whole blood is not emphasized or routinely taught to medics. However, the Committee on Tactical Combat Casualty Care recommends the use of whole blood in their guidelines over individual components. He also noted that the Royal Caribbean Cruise Lines maintains the use of emergency whole blood, as ships are often 24 hours from any port. In regard to red blood cell storage, he cited a study showing lower survival in trauma patients transfused old (>= 28 days) compared to fresh (<28 days) red blood cells. In addition, he indicated opposition to a new plan to consider using red blood cells out to 56 days due to decreased efficacy and safety, stating usage should not be permitted past 42 days, and less than 28 days would be optimal.

Dr. Spinella also discussed the use of Group O blood, highlighting the historic use of Group O whole blood and the countries which currently use low-titer or conditional Group O. He also highlighted the use of filters to leukoreduce whole blood. Dr. Norman McSwain recalled advantages of using whole blood in the past, but noted resistance among some medical professionals to the use of whole blood today. Dr. Spinella added that another benefit of fresh whole blood is that it improves endothelial function. COL Buckenmaier noted that while in Afghanistan, the British forces had a thromboelastography (TEG) machine to measure efficiency of blood coagulation and asked if there were efforts to include the machine in U.S. military medical facilities in the deployed setting. Dr. Spinella stated there are efforts to include the use of a TEG machine, but it often depends on the medical staff in the field at that time. COL Buckenmaier added that the machine often helped to guide clinical decisions.

Action/POC: None.

d. Saving Lives on the Battlefield (Part II)

COL Samuel Sauer provided a briefing on the recent report *Saving Lives on the Battlefield (Part II)*, a 2014 update to the 2013 report. He highlighted the high survival rate of individuals wounded in theater. He reviewed the outcomes of the report, highlighting the lack of attendance at Tactical Combat Casualty Care (TCCC) courses, the intermittent use of ketamine in theater, and the inconsistent inclusion and non-standard contents of pill packs in individual first aid kits. COL Sauer reviewed key causal factors and friction points responsible for such failings. He described the importance of data and metrics, noting that point of injury data was not well captured until 2013. In terms of prehospital and trauma expertise, many providers were not well trained in the TCCC guidelines and prehospital care. Regarding TCCC guidelines, he noted that operational medical leaders have to justify ordering them as opposed to having the latest versions pushed to them, due to the guidelines not being operationalized by doctrine as authorizations and requirements. Lt Gen Douglas Robb indicated he would look into the issue of distributing TCCC guidelines.

COL Sauer described the difficulty of maintaining skills when health care providers are considered "school trained." Time is therefore spent on the additional requirements of Soldiers and not those of health care providers. He emphasized the leadership of battlefield care must be established at the Senior Line level, in order to maintain lessons learned. Lt Gen Robb questioned if similar issues were found in the Navy and Air Force. COL Sauer stated that similar issues were seen and provided examples, including the use of tourniquets. Captain Stephen Bree asked if a common training gateway was required for medics. COL Sauer stated that it was not, and noted despite consolidated medical training locations, there were not consolidated training programs.

Dr. David Smith stated there is a Department of Defense (DoD) Instruction in development that will put medical training requirements and guidelines into the infrastructure, as much of it evolved over the course of war. DoD is also figuring out the governance aspect of the issue, noting episodic changes to the TCCC guidelines make updating relevant policy difficult. Dr. Smith reminded the group that while TCCC was endorsed by all of the Surgeons General and the

Office of the Assistant Secretary of Defense for Health Affairs, this spot audit conducted for the *Saving Lives on the Battlefield (Part II)* report showed that implementation was still an issue. Regarding the issue of penetrance of TCCC training, Lt Gen Robb noted they have an education director within the Defense Health Agency (DHA) with oversight for accession and maintenance training, and he believes the DHA can help facilitate improvement in this area. However, the responsibility ultimately lies with the Services. The group also discussed the Advanced Trauma Life Support pilot program in San Antonio, entitled ATLS-Operational Emphasis, which is intended to fill the gap between traditional and operational care and is supported by the American College of Surgeons.

Action/POC: None.

f. Decision Brief: Combat Trauma Lessons Learned from Military Operations of 2001-2013

Dr. Jenkins provided an overview of the Trauma and Injury (T&I) Subcommittee roster and described the work done by the Subcommittee, including their meetings. He reviewed the lessons and subsequent recommendations within the draft report. Dr. Jenkins noted that the video game titles referenced in Recommendation 6.6 should be identified as copyrighted titles and requested the DHB staff do so.

Dr. Eve Higginbotham stated that it was an excellent report but questioned the extent to which the report addresses rehabilitation and community integration. Dr. Jenkins responded that at this time there is little ability to follow a trauma patient beyond their rehabilitation and as such that aspect of care was omitted. He added that he appreciated the recommendation and would add it to the report. The group discussed the training undertaken by military medical providers, including the importance of training together and in teams with which they will deploy, noting that the United Kingdom employs such a system and would be a good model to follow. Dr. Dickey questioned the inclusion of global positioning system information in recommendation 3.2. Dr. Jenkins responded that the recommendation highlights such information should be used only as the mission allows. The group also discussed the recommendation that the Joint Trauma System (JTS) be designated a Center of Excellence responsible for standards of care, and that the JTS should move to the DHA. GEN (Ret) Frederick Franks questioned such a move, noting he was hesitant to put a staff agency in charge of a command function. Lt Gen Robb responded the DHA is defined as a combat support agency. The group noted the issues pointed out by COL Sauer in his earlier presentation, highlighting the difficulty of coordinating trauma support within the Services. Dr. Anderson questioned the endorsement of the *United States Military Joint Trauma System Assessment*, asking if the DHB wanted to approve the entirety of an outside report in recommendation 5.1. Dr. Dickey agreed and suggested the Subcommittee revise the recommendation to specify the aspects of the *United States Military Joint Trauma System Assessment* that the Subcommittee endorses, as similar recommendations are likely addressed in the Subcommittee's report.

Dr. Dickey cited the significant discussion of the report and requested the Subcommittee revisit the report to address points raised by the members. She asked the Subcommittee to brief the report again at the upcoming November DHB meeting for final approval noting the members would not vote on the recommendations during the current meeting. The members requested the following specific revisions.

- Recommendation 2.1-Change "Defense Health Agency" to "a senior level organization such as the Defense Health Agency."
- Recommendation 2.3- Change "fully current" to "fully competent" and "practice standards" to "professional and practice standards."
- Recommendation 3.1-Clarify the inclusion and use of telecommunications.
- Recommendation 4.1 A-Add "to the degree possible beyond rehabilitation to community integration."
- Recommendation 4.1 E- Include affirmation of best practices.
- Recommendation 5.1-Edit to clarify the specific recommendations being endorsed from the *United States Military Joint Trauma System Assessment*.
- Recommendation 5.2-Include ways to enhance the execution of best practices.
- Recommendation 6.1-Enable oversight, as currently done by the U.S. Army Institute of Surgical Research and potentially by DHA.
- Recommendation 6.1 E- Clarify what is meant by "command."
- Recommendation 6.2- Include the importance of team focused training.
- Recommendation 6.3- Potentially include a curriculum for U.S. military medical personnel before deployment.
- Recommendation 6.5- Ensure that TCCC Guidelines are codified as a living document, with periodic updates.
- Recommendation 6.6- Clarify the recommended training courses.

Dr. Jenkins recommended that the members review the report again as the Subcommittee would appreciate any additional input. Dr. Dickey agreed, suggesting guests and visitors do the same.

Action/POC:

1. Add copyright symbols in Recommendation 6.6/DHB staff.
2. Revise the Combat Trauma Lessons Learned from Military Operations of 2001-2013 report based on DHB member discussed/T&I Subcommittee.
3. Provide an updated decision brief at the November DHB meeting/T&I Subcommittee.

g. Decision Brief: Deployment Pulmonary Health

The Board discussed the report at length, focusing on the findings and recommendations. Members and guests discussed deployment pulmonary health screening and diagnosis, surveillance, registries, research, and prevention. Various DoD and non-DoD stakeholders attended and several commented on the implications of the report, including the U.S. Army Public Health Command, the Defense Health Agency, the US Navy Bureau of Medicine and Surgery, and the Sergeant Sullivan Center. With additional considerations suggested by

members, the report will be reviewed again and finalized at the November 2014 meeting. Dr. H. Clifford Lane thanked the Public Health Subcommittee and the DHB staff for their work and presented the findings and recommendations.

Dr. Jenkins questioned if they considered inflammatory lung biomarkers. Dr. Lane indicated research is ongoing in this area, but no specific markers ready for clinical use have been identified.

Dr. Jenkins also noted that symptoms associated with pulmonary conditions such as asthma may worsen while in a deployed setting with specific exacerbating exposures, but may abate as the environmental stressors are no longer present. However, when deployed again, pulmonary symptoms may worsen. Dr. Dickey agreed, and noted a fair number of patients who have asthma have never been diagnosed or treated for asthma. Dr. Higginbotham, questioned the use of body mass index (BMI) in Recommendation 3.1, given that BMI is not very accurate, asking if the Subcommittee would consider waist circumference. Dr. Lane clarified the particular measurement was more related to establishing a baseline.

Dr. Lane highlighted that regarding surveillance, the Subcommittee found that the lack of individual exposure data made it difficult to determine associations between exposures, such as open burn pit emissions, and pulmonary disease. In addition, attempts to use deployed location as a surrogate of exposure were impeded by the classification of individual location data. He highlighted the importance of using registries, noting this would be important to evaluate the issue of deployment pulmonary health over time. It will also be important to ensure these registries provide a mechanism to continue follow-up of Service members after they retire or separate from the military. Dr. Lane added that Recommendation 6.2 contained a typo and should recommend a "prospective" study, not "prognostic" study. He also noted that Finding 7.3 was missing "difficulty," such that the finding should read "[P]atients and families have indicated difficulty navigating both the medical evaluation and treatment system (especially as a Reserve component member) and the disability evaluation process can be challenging."

Gen (Ret) Myers questioned if coordination with the Department of Veterans Affairs (VA) was considered in the recommendation regarding the range of resources available to patients and families. Dr. Lane acknowledged it was a good point that had not been addressed by the report. Dr. Higginbotham questioned whether the group considered Service members that came from heavily smoking areas of the country and the possible impact of such a factor on pulmonary health. Dr. Lane indicated this was not specifically addressed, but agreed that a focus on more aggressive smoking cessation was appropriate. Dr. Lane noted despite a lack of data to substantiate a potential association with a particular disease, it does not mean that a disease is not present. Dr. John Clements stated that burn pits and particulate matter from Operation IRAQI FREEDOM and Operation ENDURING FREEDOM receive a lot of attention. However, he noted the Subcommittee would be doing a disservice to focus solely on the Southwest Asia theater and attempted to not limit the report to that region. Dr. Dickey questioned if the literature has addressed those conditions that appear to be deployment-related in general. Dr. Lane asked Dr. Joseph Abraham to comment. Dr. Abraham stated this issue is being explored, but data are quite limited in terms of exposure and there are many changes that occur because of deployment,

though smoking is high on the list. Dr. Clements noted that stress is also a confounding factor, and other conditions might manifest as respiratory symptoms. GEN (Ret) Franks questioned if they looked at any pre-2001 data. Dr. Lane stated that they did. Gen (Ret) Franks noted that oil wells were set on fire in Operation DESERT STORM and that many Service members were exposed for days to the resulting smoke and fumes in the air. Dr. Clements noted that some reports show a lower rate of respiratory disease in individuals who deployed during that time but that the data are difficult to compare with newer deployment data.

Mr. Peter Sullivan provided public comment, thanking the Subcommittee for their work. He highlighted there are a number of other areas related to pulmonary health which should be studied, including comorbidities, disability data, and additional soil sampling. Mr. Sullivan also emphasized the importance of treating the whole person, despite a particular diagnosis, noting that some exposures may manifest as cancers. He stated it is important for Service members to establish why they are sick and how to prevent such conditions from occurring.

Dr. Craig Postlewaite thanked the Subcommittee for their efforts. He stated DoD had not found it to be common for those returning from deployment to have chronic pulmonary conditions, and mentioned it is important to recognize the existence of a certain baseline rate of these conditions in both the military and general population. Additionally, until a specific causative agent is identified, it will be difficult for DoD to provide targeted preventive information. He noted that a registry would be helpful to give an idea of how big the affected population is. However, he expressed concern about some of the recommendations; he felt some issues were not adequately addressed, and stated it would be helpful to have some indication of the priority of recommendations in the final version. Dr Abraham noted it would be helpful if the Subcommittee could be more specific in their recommendation for a prospective cohort study, clarifying what the appropriate cohort would be. Dr. Lane indicated he saw this as a task for the DoD, not the DHB. CAPT Robert Lipsitz noted that those who deploy have a pre-deployment health assessment, post-deployment health assessment, and post-deployment health re-assessment. Those individuals who are leaving the military might have a particular reason for answering a survey regarding their health differently, and individuals who do not deploy do not have these screenings.

Action/POC: Present the Deployment Pulmonary Health report at the November DHB meeting for final approval/Public Health Subcommittee.

h. Medical Ethics Subcommittee Update: Dual Loyalties of Medical Providers Tasking

Gen (Ret) Richard Myers, member of the Medical Ethics Subcommittee, provided an update on behalf of the Subcommittee on the issue of dual loyalties of medical providers. He highlighted the recent in-person meeting of the Subcommittee and areas of interest for the upcoming report. These areas include effective communication, leadership understanding, ethics training, and effective support mechanisms for providers.

Action/POC: None.

i. Health Care Delivery Subcommittee Update: Sustainment and Advancement of Amputee Care Tasking

Dr. Anderson, Chair of the Health Care Delivery Subcommittee, provided an update on the Subcommittee's tasking on the advancement and sustainment of amputee care. He highlighted the meetings held to date and areas of interest for the upcoming report. These areas include the current amputee care environment; collaborations; the use of technology; research, data and surveillance; and the future needs of amputees.

Action/POC: None.

August 12, 2014--Administrative Session

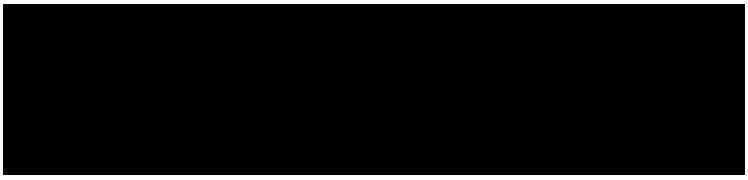
DHB members visited the National Institutes of Health (NIH), receiving a tour of the National Library of Medicine, NIH labs and inpatient facility. Members also received a briefing from Dr. Anthony Fauci on Ending the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome Pandemic and from Dr. Walter Koroshetz on Traumatic Brain Injury: DoD and NIH Collaborations.

3. NEXT MEETING

The next DHB meeting will be held on November 6-7, 2014.

4. CERTIFICATION OF MINUTES

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



10/1/2014

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

ATTACHMENT ONE: MEETING ATTENDEES
August 11-12, 2014

BOARD/SUBCOMMITTEE MEMBERS			
TITLE	**LAST NAME**	**FIRST NAME**	**ORGANIZATION**
Dr.	Alemagno	Sonia	Dean and Professor of Health Policy and Management, College of Public Health, Kent State University
Dr.	Anderson	George	*Defense Health Board (DHB) Second Vice President* Former Executive Director, The Society of the Federal Health Agencies
Dr.	Bennett	Brad	Tactical Medicine Consultant
Dr.	Bullock	M. Ross	Professor of Neurosurgery and Director of Neurotrauma Care, University of Miami
Dr.	Butler	Frank	Head, Prehospital Care Branch, Joint Trauma System
Dr.	Callaway	David	Director, The Operational Medicine Institute and Associate Professor of Emergency Medicine, Carolinas Medical Center
Ms.	Carroll	Bonnie	National Director, Tragedy Assistance Program for Survivors, Inc.
Dr.	Clements	John	Professor and Department Chair of Microbiology & Immunology; Director of the Tulane Center for Infectious Disease Research; Co-Director of the Louisiana Vaccine Center, Tulane University School of Medicine
Dr.	Dickey	Nancy	*DHB President* Professor, Department of Family and Community Medicine, Texas A&M University
GEN (Ret)	Franks	Frederick	Former Commanding General, U.S. Army Training and Doctrine Command
Dr.	Gordon	Steven	Chairman, Department of Infectious Diseases, Cleveland Clinic Foundation
Dr.	Higginbotham	Eve	Perelman School of Medicine, University of Pennsylvania
Dr.	Hovda	David	University of California, Los Angeles (UCLA) Neurosurgery, Departments of Surgery and of Molecular and Medical Pharmacology; Director, UCLA Brain Injury Research Center
Dr.	Jenkins	Donald	Senior Associate Consultant, Division of Trauma, Critical Care and General Surgery, Mayo Clinic; Associate Professor of Surgery, College of Medicine; Medical Director, Mayo Clinic Trauma Center
RADM	Lane	H. Clifford	Director, Division of Clinical Research, National Institute of Allergy and Infectious Disease (NIAID), National Institutes of Health (NIH)
Dr.	Lockey	James	Tenured Professor of Environmental Health, Professor, Department of Internal Medicine (Pulmonary Division); Professor, College of Allied Health Sciences, Department of Rehabilitation Sciences, University of Cincinnati College of Medicine
Dr.	McSwain	Norman	Professor of Surgery, Tulane University School of Medicine; Trauma Director, Spirit of Charity Trauma Center
Gen (Ret)	Myers	Richard	*DHB First Vice President* RMyers & Associates LLC
Dr.	O'Leary	Dennis	President Emeritus, The Joint Commission
Dr.	Otten	Edward	Professor of Emergency Medicine and Pediatrics Director, Division of Toxicology University of Cincinnati, College of Medicine

INVITED GUESTS & STAFF			
TITLE	**LAST NAME**	**FIRST NAME**	**ORGANIZATION**
Ms.	Bader	Christine	DHB Director/Alternate Designated Federal Officer (DFO)
Ms.	Badger	Katrina	DHB Task Lead, Grant Thornton, LLP
Brig Gen	Balserak	James	Assistant to the Director, Defense Health Agency (DHA)
CAPT	Bree	Stephen	*DHB British Liaison Officer* Surgeon Captain, (Deployment Health) United Kingdom Royal Navy
COL	Buckenmaier	Chester	Program Director, Defense and Veterans Center for Integrative Pain Management
Mrs.	Coates	Marianne	DHB Media Consultant/Creative Computing Solutions, Inc. (CCSi)
Col	De Jesus	Rafael	Deputy Joint Staff Surgeon
RADM	Doll	Bruce	DHA Research and Development
Dr.	Fauci	Anthony	Director, National Institute of Allergy and Infectious Diseases
Ms.	Gaviola	Camille	Deputy Director, DHB / Alternate DFO
Ms.	Higgins	Sara	DHB Analyst, Grant Thornton, LLP
CDR	Hollis	Trey	*DHB Service Liaison Officer* Director of Public Health & Preventive Medicine, Headquarters, U.S. Marine Corps
Dr.	Koroshetz	Walter	Deputy Director of the National Institute of Neurological Disorders and Stroke, National Institutes of Health
MG	Lein	Brian	Deputy Surgeon General/Deputy Commanding General (Operations)
CAPT	Lipsitz	Robert	*DHB Service Liaison Officer* U.S. Navy Bureau of Medicine and Surgery
Dr.	Lockette	Warren	Deputy Assistant Secretary of Defense for Health Services Policy and Oversight, Office of the Assistant Secretary of Defense (Health Affairs)
Mr.	Middleton	Allen	Deputy Director, DHA/DHB Designated Federal Officer
Brig Gen	Potter	Charles	Assistant Surgeon General, Health Care Operations and Chief of the Medical Service Corps, Office of the Surgeon General, U.S. Air Force
Ms.	Ribeiro	Elizabeth	DHB Analyst, CCSi
Lt Gen	Robb	Douglas	Director, DHA
Col	Rouse	Douglas	DHB Executive Secretary / Alternate DFO
COL	Sauer	Samuel	Dean, Graduate Medical Education; Program Director , United States Army School of Aviation Medicine Occupational Medicine Residency Program
CAPT	Schwartz	Erica	*DHB Service Liaison Officer* U.S. Coast Guard Preventive Medicine Officer
Dr.	Smith	David	Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, Office of the Assistant Secretary of Defense (Health Affairs)
Dr.	Spinella	Philip	Associate Professor, Pediatrics Division of Critical Care Medicine, St Louis Children's Hospital
COL	Stein	James	*DHB Service Liaison Officer* Preventive Medicine Staff Officer Office of The Surgeon General

CDR	Torrie	Ian	*DHB Service Liaison Officer* Canadian Embassy
Ms.	Welsh	Margaret	*DHB Event Planner, Grant Thornton, LLP*
Lt Col	Witkop	Catherine	*DHB Service Liaison Officer* Air Force Medical Support Agency/SG3PM

MEDIA & PUBLIC ATTENDEES			
TITLE	**LAST NAME**	**FIRST NAME**	**ORGANIZATION**
Dr.	Abraham	Joseph	Epidemiologist U.S. Army Public Health Command (USAPHC)
Dr.	Brix	Kelley	Deputy Director, Defense Medical Research and Development Program, DHA
Mr.	Casterline	Dan	National Account Executive, Merck Vaccines
Dr.	Ciminera	Daniel	Director, Post 9/11 Era Environmental Health Program
Mr.	Clark	Leslie	Senior Managing Epidemiologist, Armed Forces Health Surveillance Center (AFHSC)
Dr.	Cordts	Paul	Clinical Support Division DHA
Ms.	Eilenfield	Barbara	Deputy Chief Innovation Officer
Dr.	Higgs	Elizabeth	Global Health Science Advisor, Division of Clinical Research, NIAID, NIH
Mr.	Hood-Cree	Robert	Master Capture Manager, Northrop Grumman
Dr.	Jackson	David	Science and Technology Director Director, Pulmonary Health Program US Army Center for Environmental Health
CDR	Kane	Michele	Executive Military Assistant, DHA
Mr.	Kelley	Kevin	Operational Medicine (OPMED), DHA
Ms.	Kime	Patricia	Senior Writer, Gannett Government Media/Military Times
Ms.	Therese	Lattimore	OPMED DHA
Ms.	Meehan	Virginia	Associate Director of Government Relations, Northwestern University
Dr.	Postlewaite	Craig	Director Force Readiness & Health Assurance, Defense Health Agency
Ms.	Rich	Arlene	Director Severna Park Health and Wellness Center Veterans and First Responders Project
Maj	Rohrbeck	Patricia	Assistant Director Division of Epidemiology & Analysis, AFHSC
LTC	Scherner	John	Program Director, NCC Pulmonary/Critical Care Medicine Fellowship, Walter Reed National Military Medical Center Staff Physician, Pulmonary/CCM, FBCH
Ms.	Shives	Kristin	Communications Lead, Force Health Protection and Readiness/DHA/Military Health System
Mr.	Sullivan	Peter	Co-Founder & Assistant Treasurer; Chair, Science and Policy Advisory Panel, The Thomas Joseph Sergeant Sullivan Center
Dr.	Teichman	Ronald	Occupational Medicine Physician, USAPHC

Mr.	Tritten	Travis	Capitol Hill reporter, Stars and Stripes
Mr.	Washington	Robert	Legislative Program Healthcare Advisor, Fleet Reserve Association
Mr.	Whitt	Ed	DHA Readiness