DEFENSE HEALTH BOARD MEETING
AUGUST 9, 2016

The St. Anthony Hotel, San Antonio
Peraux Room
300 East Travis Street
San Antonio, TX, 78205

1. ATTENDEES – ATTACHMENT ONE

2. OPEN SESSION

a. Administrative & Opening Remarks

Dr. Nancy Dickey opened the meeting and welcomed the attendees. Ms. Christine Bader called the meeting to order as the Defense Health Board (DHB) Designated Federal Officer. Following a moment of silence to honor Service members, Dr. Dickey introduced a new Board member, Dr. Tadataka Yamada. She then announced the pending departures of the DHB Executive Director, Ms. Bader, and the DHB Executive Secretary, Col Douglas Rouse, and thanked them for their outstanding support to the DHB. Dr. Dickey welcomed CAPT Juliann Althoff, the new Executive Secretary, and recognized CAPT Stephen Bree, the British Liaison Officer for Deployment Health, who will be returning to the United Kingdom. Meeting attendees then introduced themselves.

b. Military Health System Population Health Portal

Col David Carnahan, Chief of the Enterprise Intelligence Branch in the Defense Health Agency's Health Information Technology Directorate's Information Delivery Division, presented an overview of the Enterprise Intelligence Branch, followed by a summary and demonstration of the Military Health System Population Health Portal (MHSPHP). The Enterprise Intelligence Branch consists of a data science lab, an analytics workbench, and an information portal. The Branch uses data to create meaningful and insightful information by developing measures, performing analytics, creating visualizations, conducting training, developing registries, and implementing an alert system. The goal is to translate everything through the Quadruple Aim and achieve MHS strategic goals. Col Carnahan is attempting to align and integrate the MHSPHP with MHS GENESIS, as it will soon be an additional data source which MHSPHP utilizes.

Data have demonstrated that the MHSPHP can improve patient care, as evidenced by its use at Wilford Hall Ambulatory Surgical Center and other military treatment facilities (MTFs). Col Carnahan highlighted that the MHSPHP can consolidate and analyze a large volume of data from different sources, which can be used, for example, to examine compliance with vaccination rates; report on the prevalence of high-risk conditions; identify populations with similar Adjusted Clinical Groups; and study a population's Resource Utilization Band and Illness Burden Index. It can also be used to examine care coordination and the cost and impact of poor care

coordination. Although it can be difficult to integrate data from a large number of sources, the MHSPHP is flexible and responsive and quickly generates information that allows clinicians to succeed.

The group discussed the Health Care Delivery Pediatric Clinical Preventive Services tasking, questioning whether pediatric beneficiaries are not being immunized or whether data are not being adequately captured. Col Carnahan described that each data source has limitations that make it difficult to fully capture care that is being provided. The group also discussed what population the MHSPHP monitors, with Col Carnahan emphasizing it captures data for TRICARE Prime and Plus beneficiaries, or approximately 3.5 million people. Finally, members and guests deliberated how this wealth of information could be used for research efforts, noting that there may be quality of data issues as the tool relies on provider-coded data.

c. 59th Medical Wing: Mission and Initiatives

Maj Gen Bart Iddins, Commander of the 59th Medical Wing (MDW), described the strategic agenda of the 59th MDW, based on the Golden Circle model that emphasizes the "why," "what," and "how" of an organization. The "why" for the MHS is to provide care for active duty Service members and beneficiaries; however, health care costs in the MHS are unsustainable, and the MHS is not excelling at access to care, quality, and patient safety as evidenced by the *Military Health System Review: Final Report to the Secretary of Defense*.

The 59th MDW's "what" includes: patient safety, high reliability organization, continuous process improvement, quality improvement, patient-centered care, access to care, education and training, combat readiness, innovation, and enhanced effectiveness and efficiency. Maj Gen Iddins described tenets of high reliability organizations; highlighted aspects of the 59th MDW's readiness mission, identifying it as the largest medical mobility commitment in the Air Force; discussed its prolific education, training, and research programs; and described the limitations of the organizational structure of the San Antonio Military Health System. Specifically, he discussed how, although San Antonio is an enhanced Multi-Service Market, the system is not fully integrated and relies on a lot of inter-Service collaboration.

The 59th MDW's "how" involves implementing innovative ideas, such as their method of organizational development known as the Gateway Performance System. Maj Gen Iddins noted other initiatives at the 59th MDW, including the Gateway Academy; utilizing process improvement methods to implement on-site referral booking; developing a rotation plan for medics to help them achieve civilian certifications; and developing a statement of financial value that compares product lines to one another. Finally, Maj Gen Iddins emphasized the importance of creating an enabling and collaborative culture and empowering Airmen to create truly patient-centered healthcare.

The group discussed the importance of maintaining readiness in the case of emerging infectious diseases and the ability of the 59th MDW to transport multiple infected patients back to the United States in a containment unit. Board members and guests then discussed factors that

would contribute to cultural change, such as unified policies, procedures, and processes; creating a more integrated system; preparing leaders to manage integrated enterprises; and decreasing how frequently Service members, specifically leadership, are rotated. Maj Gen Iddins described the 59th MDW's deliberate rotation process, noting that they have developed a 4NO rotation plan that allows Service members to become licensed vocational nurses at a civilian hospital. Finally, the group discussed that to enhance integration, variation should only exist where it is critical to accomplish the mission.

d. Review of 2014 Defense Health Board Report: Combat Trauma Lessons Learned from Military Operations of 2001-2013

Dr. Donald Jenkins, Trauma and Injury Subcommittee Chair, reviewed findings and recommendations from the DHB's March 2015 report, *Combat Trauma Lessons Learned from Military Operations of 2001-2013,* which focused on sustaining and expanding advancements that resulted in increased Service member survival rates in combat between 2001 and 2013. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) issued a response to the report in March 2016, which stated the report's recommendations align well with current and developing policies. Two developing policies referenced were a Joint Trauma System (JTS) Center of Excellence to establish and maintain global trauma care capability, as well as updated guidance for Military Readiness Training. Dr. Jenkins concluded by acknowledging the importance of the Board's report in light of the recent National Academies of Science, Engineering, and Medicine report, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury*.

The group discussed the importance of sustaining lessons learned from combat as a part of maintaining medical readiness, as well as the challenges associated with translating research into fielded products.

e. Joint Trauma System

CAPT Zsolt Stockinger, Director of the JTS, provided background on the JTS and updates on progress made since the publication of the *Combat Trauma Lessons Learned from Military Operations of 2001-2013* report. The JTS is a performance improvement organization without statutory, regulatory, or directive authority over trauma care, military treatment facilities, or the Services. Proposed language in the draft 2017 National Defense Authorization Act addresses many of the recommendations in the report, such as establishing a senior-level organization for the oversight of trauma care, establishing trauma-related health information technology capabilities, forming collaborative partnerships with civilian medical centers, and standardizing trauma care and training across the Services. However, CAPT Stockinger discussed that trauma experienced at civilian medical centers is not identical to the type of trauma experienced in combat. He also noted that, because there is little understanding about the differences between an electronic medical record and a registry, the Department of Defense Trauma Registry (DoDTR) is at risk while the role of the JTS continues to evolve. Specifically, electronic medical records consolidate manually entered data, while registries verify the accuracy of the

data being collected. Accordingly, CAPT Stockinger is an advocate of continuing to use of the DoDTR to measure and track trauma care.

The group discussed the evolution of tactical combat casualty care recommendations, such as the use of tourniquets. They also discussed the importance of training providers to perform invasive procedures that are more frequently needed for combat trauma.

f. A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury

Dr. Donald Berwick, Chair of the Committee on Military Trauma Care's Learning Health System and its Translation to the Civilian Sector, described the findings and recommendations in the report, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury*. The Committee addressed its four charges by examining five case studies about common trauma-related injuries. Dr. Berwick then highlighted the importance of preventable deaths after injury, focused empiricism, and an expert trauma care workforce; defined the military and civilian burden due to potentially survivable injuries; and described the components of a continuously learning trauma care system. The Committee envisions a national trauma care system which unifies efforts and optimizes care to ensure continuous improvement of trauma care best practices in the military and civilian sectors. The Committee's findings and recommendations center around defining an aim of zero preventable deaths after injury and minimizing trauma-related disability; defining the role of national, military, and civilian sector leadership; and developing an integrated military-civilian framework for learning to advance trauma care, to include enhanced data collection and use, a collaborative research infrastructure, improved transparency and trauma care quality, and the development of an expert workforce. Dr. Berwick emphasized the importance of embracing pre-hospital care, such as care provided by emergency medical technicians, and allowing medical advances to come out of the field via real-time learning, as opposed to only coming out of clinical trials. He also highlighted the need to maintain trauma expertise in interwar years.

The group discussed whether pre-hospital training needs to be overhauled to included trauma care, noting that it would be challenging to standardize training as emergency medical services are local entities. They also discussed that many of the recommendations would also apply to other types of time critical care, such as myocardial infarctions, though the Committee was charged to focus solely on trauma care. The group also discussed Good Samaritan laws, which differ by state, but allow individuals to intervene and provide care in medical emergencies. Finally, the Board and guests discussed post-hospital care, which was not part of the Committee's charge, and value-based payment, which does not include care provided in the pre-hospital setting.

g. Public Health Subcommittee Update: Improving Defense Health Program Medical Research Processes

Dr. H. Clifford Lane, Public Health Subcommittee Chair, reviewed the Subcommittee's work on the tasking, Improving Defense Health Program Medical Research Processes. The Subcommittee's recent briefings have reinforced its preliminary observations, including: medical research is viewed as a secondary mission and accordingly has a lower priority for resources at MTFs; there are inadequate numbers of experienced research personnel to provide institutional knowledge and to help navigate research processes; the frequent rotation of personnel compromises the completion of research projects; and there are significant challenges associated with management of funds, although foundations provide a mechanism to more efficiently execute funding and contracting activities in support of research. Additionally, it is difficult to use grant funding to compensate for a shift in clinical obligations to contract staff to free up time of active duty personnel to conduct research. Further, there are challenges in recruiting and retaining Department of Defense investigators, such as slow hiring processes, less competitive salaries, and a lack of clearly defined career paths with promotion potential. Finally, there is limited enterprise-wide visibility on accomplishments of the clinical investigation programs. The group discussed the importance of knowledge translation to make sure Departmental research is available to those it would benefit.

h. Genitourinary Reconstruction Following Combat Trauma

LTC Steven Hudak, Staff Urologist at the San Antonio Military Medical Center and the San Antonio Uniformed Services Health Education Consortium, described the reconstruction and restoration of the genitourinary system after battlefield urotrauma. Despite limited published data, there has been growing interest and support for urotrauma care and research given the increasing frequency of injury, improved survivability of comorbid injuries, and enhanced recognition and acceptance of genitourinary trauma as an emerging problem. LTC Hudak then described the Trauma Outcomes and Urogenital Health Project, a longitudinal study of the long-term effects of genitourinary injury. Data indicated that the majority of Service members with genitourinary injuries were injured in the battlefield, were male, and were between 22 and 29 years of age. Additionally, many had comorbid injuries such as perineal, colorectal, or pelvic injuries; traumatic brain injury; or limb amputations. Consequences of severe genitourinary injury include urinary, sexual, psychological, and fertility complications. Although the severity of injuries has increased in recent conflicts, the mortality rate has decreased leading to a population of Service members learning to manage and survive with genitourinary trauma, such as partial penile amputation, severe burns and injury, or total phallic loss. The management of battlefield injuries includes initial, delayed, and long-term stages, all of which are critical to generating positive outcomes following injury.

The group discussed salvaging sperm post-injury in Britain, which is currently not allowed in the United States, but could reduce complications related to fertility. They also discussed recent policy that allows Service members to freeze their sperm and eggs. Board members and guests also suggested that support groups for this population would be beneficial, noting that it is a very difficult subject for people to discuss publically.

i. Health Care Delivery Subcommittee Update: Pediatric Clinical Preventive Services

Dr. George Anderson, Health Care Delivery Subcommittee Chair, reviewed the Subcommittee's efforts on the Pediatric Clinical Preventive Services tasking and described the recent expansion of the tasking to include other aspects of pediatric health care services, including pediatric and specialty care, children with special medical or behavioral health needs, and behavioral health care. Dr. Anderson reviewed key areas of interest related to pediatric clinical preventive services, such as challenges monitoring pediatric preventive services due to multiple, non-interoperable data sources, challenges monitoring data in the purchased care component, and challenges tracking TRICARE Standard beneficiary care. Other areas of interest to the Subcommittee include tools used to monitor pediatric preventive services; the evolution of MHS quality improvement processes and governance; comparing TRICARE covered services to preventive services included in Medicaid's Early and Periodic Screening, Diagnostic, and Treatment program, the Affordable Care Act, and other national guidelines/recommendations for pediatric care; and the impact of vaccine exemptions and refusals. Board members and guests noted the breadth of the new tasking, suggesting that the Subcommittee will need to add a focus on the care of transgender family members now that the Department will provide care for transgender Service members.

j. Tasking Update: Deployment Health Centers Review

Dr. Eve Higginbotham, Deployment Health Centers (DHCs) Review Subset Lead, described the history of the DHCs Review tasking and reviewed the group's efforts to date. The Armed Forces Epidemiological Board (AFEB) was originally tasked in 2002 to serve as a public health advisory body and provide programmatic review of ongoing research and clinical efforts at the DHCs, which now include the Deployment Health Clinical Center (DHCC), the Armed Forces Health Surveillance Branch, and the Naval Health Research Center. The AFEB, and later the DHB, conducted several reviews with the last report submitted to the Department in 2012. The Board was then asked to do a subsequent review of the DHCC in 2013, completed in August 2013, followed by reviews of the three DHCs every three years for six years. The Subset is just beginning this review and will conduct site visits this fall.

3. NEXT MEETING

The next DHB meeting is scheduled for November 1-2, 2016, in Falls Church, Virginia.

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 10/5/2016

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

ATTACHMENT ONE: MEETING ATTENDEES

BOARD MEMBERS			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
Dr.	George	Anderson	*Defense Health Board (DHB) Second Vice President* Former Executive Director, The Society of the Federal Health Agencies
Dr.	Craig	Blakely	Professor and Dean, School of Public Health and Information Sciences, University of Louisville
Ms.	Bonnie	Carroll	National Director, Tragedy Assistance Program for Survivors, Inc.
Dr.	Nancy	Dickey	*DHB President* Professor, Department of Family and Community Medicine, Texas A&M University
GEN	Frederick	Franks*	Former Commanding General, U.S. Army Training and Doctrine Command
Dr.	Steven	Gordon*	Chairman, Department of Infectious Diseases, Cleveland Clinic Foundation
Dr.	John	Groopman	Anna M. Baetjer Professor of Environmental Health, Department of Environmental Health Sciences, Bloomberg School of Public Health, Johns Hopkins University
Dr.	Eve	Higginbotham*	Vice Dean, Perelman School of Medicine, University of Pennsylvania
Dr.	Lenworth	Jacobs	Chief Academic Officer and Vice President of Academic Affairs, Hartford Hospital
Dr.	Donald	Jenkins	Vice Chair for Quality, University of Texas Health Science Center at San Antonio, Department of Surgery – Trauma Division
RADM (Ret.)	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
RADM (Ret.)	Kathleen	Martin	Chief Executive Officer, Vinson Hall Corporation, LLC
Gen (Ret.)	Richard	Myers*	*DHB First Vice President* RMyers & Associates LLC/ Interim President, Kansas State University
Dr.	Gregory	Poland*	Director, Mayo Vaccine Research Group; Director for Strategy, Center for Innovation, Mayo Clinic and Foundation
Dr.	Tadataka	Yamada	Venture Partner, Frazier Healthcare Ventures; Adjunct Professor, Department of Internal Medicine, University of Michigan Medical School
DHB STAFF			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
CAPT	Juliann	Althoff	DHB Executive Secretary (incoming)
Ms.	Lisa	Austin	DHB Task Lead, Grant Thornton LLP
Ms.	Christine	Bader	DHB Executive Director/Designated Federal Officer (DFO)
Ms.	Camille	Gaviola*	DHB Deputy Director/Alternate DFO
Ms.	Reem	Ghoneim*	DHB Analyst, Grant Thornton LLP
Ms.	Sara	Higgins	DHB Analyst, Grant Thornton LLP
Col	Douglas	Rouse	DHB Executive Secretary (outgoing)/Alternate DFO

Ms.	Margaret	Welsh	DHB Management Analyst, Grant Thornton LLP
OTHER ATTENDEES			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
Dr.	Donald	Berwick*	President Emeritus and Senior Fellow, Institute for Healthcare Improvement
Surg Capt	Stephen	Bree	Surgeon Captain Royal Navy, British Liaison Officer (Deployment Health)
CDR	Kimberly	Broom	Director of Public Health, Headquarters Marine Corps, Health Services
LCDR	Mohneke	Broughton	Military Assistant (MA) to RADM McCormick-Boyle
MG	Joseph	Caravalho	Joint Staff Surgeon, Office of the Chairman of the Joint Chiefs of Staff
Col	David	Carnahan	Chief, Enterprise Intelligence Branch, Information Delivery Division, Health Information Technology Directorate, Defense Health Agency (DHA)
Lt Col (P)	Michael	Charlton	Defense Medical Readiness Training Institute
RADM	Colin	Chinn	Director, Research, Development, and Acquisition, DHA
Brig Gen	Sean	Collins	Assistant for Mobilization and Reserve Affairs, Office of the Assistant Secretary of Defense for Health Affairs
LTC	Duncan (Alex)	Gillies	Surety Medicine Officer/Public Health Directorate, Office of the Surgeon General
Maj Gen (Ret.)	Byron	Hepburn	Director, Military Health Institute, University of Texas Health Science Center at San Antonio
LTC	Steven	Hudak	Traumatic, Reconstructive, and Prosthetic Genitourinary Surgery, San Antonio Military Medical Center
Major Gen	Bart	Iddins	Commander, 59th Medical Wing, Joint Base San Antonio-Lackland
BG	Jeffrey	Johnson	Brooke Army Medical Center (BAMC) Commander
RADM	Rebecca	McCormick-Boyle	Representing the Navy Surgeon General; Commander, Navy Medicine Education and Training Command
Col	Patrick	Monahan	Chief, Population Health Operations, Air Force Medical Operations Agency
Capt	Christine	Mulshine	MA to Maj Gen Iddins
Col (Ret.)	Evan M.	Renz, MD	Former Commander, BAMC
Ms.	Dolores	Ross	Senior Operations Manager/Office of the Joint Medical Chair
Col	Kai	Schlolaut	German Health Foreign Liaison Officer to Health Affairs
Dr.	David	Smith	Deputy Assistant Secretary of Defense, Health Readiness Policy and Oversight
Col	Douglas	Soderdahl	Deputy Commander for Surgical Services, BAMC
CDR	Shane	Steiner	Chief of Preventive Medicine, U.S. Coast Guard
CAPT	Zsolt	Stockinger	Director, Joint Trauma System
CDR	Ian	Torrie	Health Services Attaché, Canadian Embassy
Lt Gen (Ret.)	Thomas	Travis	Senior Vice President, Uniformed Services University of the Health Sciences

*Participated via telephone.