DEFENSE HEALTH BOARD MEETING
AUGUST 6, 2019
Defense Health Headquarters
Pavilion Salons B and C
7700 Arlington Boulevard
Falls Church, VA 22042

1. ATTENDEES – ATTACHMENT ONE

2. OPEN SESSION

a. Administrative, Opening Remarks, & General Comments

Gen (Ret.) Richard Myers opened the meeting and welcomed the attendees. CAPT Gregory Gorman called the meeting to order as the Defense Health Board (DHB) Designated Federal Officer. Following a moment of silence to honor Service members, meeting attendees introduced themselves.

Of note, Dr. Jeremy Lazarus assumed responsibilities as the DHB President during this meeting. In addition, the Board recognized the support of RADM Colin Chinn, Joint Staff Surgeon, upon his upcoming retirement, and CAPT Martin Ruth, United Kingdom (U.K.) Liaison to the DHB, upon his end of tour.

b. Decision Brief: Healthy Military Family Systems: Examining Child Abuse and Neglect Review

Dr. Lazarus, DHB Member and Child Abuse and Neglect (CAN) Work Group Chair, briefed this report to the Board for deliberation. The report addressed the policies and practices in place to prevent, detect, assess, and treat abusive behavior and the resulting injuries that occur in military families. Dr. Lazarus shared the story of Talia Williams, a five-year old who was beaten to death by her father, a Soldier stationed at Schofield Barracks, Hawaii, in 2005. Although Congress enacted Talia's Law in 2016 to improve reporting requirements related to CAN, gaps in Department of Defense (DoD) processes remain. Dr. Lazarus also discussed the phenomenon of "gaze aversion," or the tendency to avoid painful or unpleasant issues, topics or situations, and its relationship to CAN. The Board and members of the public discussed the following themes that emerged from the report:

- A public health approach: Discussion included the use of screening and predictive analytics to proactively address CAN, with members cautioning against interventions that increase stigma. Members also noted the merits of the universal CAN public-health approach. Dr. Lazarus provided examples of best practices, such as the DoD's New Parent Support Program and Kaiser Permanente of Northern California's systems-based violence prevention model. Data suggests that various types of violence tend to overlap. Members remarked that this co-occurrence of violent behaviors is particularly relevant in the military, a profession-of-arms where the use of force may be required in the context of mission execution.
- The Military Health System's (MHS) role in addressing CAN in DoD: Members remarked about the need to sustain existing CAN expertise, which includes five child abuse pediatricians (CAPs) and the Armed Forces Center for Child Protection, where two of the five CAPs work. Members noted the importance of these resources for the entire enterprise, both CONUS and OCONUS. Members acknowledged the limited number of CAPs in both

the DoD and civilian sector and the need to review barriers to entry to this specialty. Members also discussed the need for medical personnel on the incident determination committee, a multi-disciplinary team that determines CAN incident disposition within the military.

- Coordination within DoD and between DoD and civilian partners: Service family advocacy program (FAP) structure and MHS coordination differ; this includes varying FAP provider access to the electronic health record (EHR). In addition, there are DoD challenges related to formal civilian agreements (e.g., MOUs) due to the lack of child protective services reciprocal reporting requirements. The DoD is working with the Department of Health and Human Services to improve information-sharing; however, CAN regulatory requirements are largely a state responsibility. More federal authority would maximize effectiveness.
- Surveillance and outcome metrics: DoD CAN rates appear to be lower than civilian rates but the statistics may not provide an accurate picture; the scope of the problem is difficult to ascertain in both populations. Determining true CAN rates in the DoD may be complicated in part by stigma and differences in the populations served by FAP and the MHS. The Millennium Cohort, a longitudinal, large-scale military study, provides an opportunity to evaluate CAN-related outcomes and factors such as adverse childhood experiences.
- Military-unique factors: Female Soldiers are at greater risk of engaging in child maltreatment in the six months prior to deployment, while male Soldiers are at greater risk post-deployment. Further studies related to demographics, including gender and single parent status, may provide insight. Families of junior enlisted Service members are at highest risk for CAN. Stressors such as frequent moves and spousal unemployment may be contributing factors. Addressing CAN among military families stationed OCONUS is complicated by several factors, including varied definitions of what constitutes child maltreatment and resources for addressing CAN across host nations. Members noted the likely benefits of requiring new DoD health care providers to receive military family life orientation, with an overview of unique stressors and beneficiary implications.

After Board deliberation, the Findings and Recommendations, including the agreed upon changes, were approved by vote. Once finalized, this report will be routed to the Assistant Secretary of Defense for Health Affairs (ASD(HA)) for consideration, coordination, and Department response.

c. Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Processes

CAPT Gorman, DHB Executive Director, provided an overview of a new DHB tasking: On July 29, 2019, the Board was tasked to provide recommendations to the DoD in order to improve mental health accession measures/processes. The Neurological/Behavioral Health Subcommittee will be leading this one-year review. CAPT Gorman noted that a significant number of individuals are separated from service in the first 180 days after accession due to pre-existing disqualifying conditions which are either not disclosed or not detected through current screening practices. In addition, there are several readiness challenges associated with mental health diagnoses: Service members with any mental health diagnosis during the six-month period of initial eligibility were 77% less likely to deploy or complete 48 months of service. Members discussed the rising rate of suicide in the military, which surpassed the civilian rate in 2008 and is now a 71% higher than the civilian population. Members also discussed potential suicide

prevention strategies (e.g., the utilization of adverse childhood experiences information and predictive analytics), as well as parity between physical and mental accessions standards.

d. Low-Volume High-Risk Surgical Procedures: Surgical Volume and Its Relationship to Patient Safety and Quality of Care Report

Dr. Paul Cordts, Acting Deputy Assistant Director, Medical Affairs, Defense Health Agency (DHA), provided an update regarding the Board's recommendations from the two Low-Volume High-Risk Surgical Procedures reports (November 2018 and May 2019). The ten recommendations from the first report have been tasked to the appropriate personnel. The DHA is exploring increased partnerships between military medical treatment facilities (MTFs) and civilian medical centers, as well as with the Department of Veterans Affairs (VA). The DoD and VA plan on establishing an interagency surgery office. Dr. Cordts also noted an opportunity for the DoD to partner with rural surgeons to improve surgical quality and safety in remote areas. Dr. Cordts discussed the application of the National Surgical Quality Improvement Program (NSQIP) and other registries, such as the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) and the Trauma Quality Improvement Program (TQIP), to enterprise wide surgical performance improvement. Dr. Cordts presented NSQIP data indicating that most MTFs perform equivalent to the 800 civilian hospitals in the database. He emphasized that it is important to understand the processes of both high-performing and low-performing MTFs. Other discussion items included: the standardization and transparency of quality measures (e.g., through Hospital Compare and the Leapfrog Group); potential adoption of a facility infrastructure policy, similar to the Veterans Health Administration's (VHA) directive; expansion of the KSA initiative; the need to capture clinical guidelines (and subsequent adherence) in MHS GENESIS; and continuing analysis of the volume-outcomes relationship at the MTF level.

e. Active Duty Women's Health Care Services

Dr. Catherine Zebrowski, DHB Executive Secretary/Clinical Consultant, provided an overview of a new DHB tasking: On July 29, 2019, the Board was tasked to provide recommendations to the DoD to identify health care needs, improve accessibility and quality of health services, and optimize individual medical readiness for Active Duty (AD) women. The Health Care Delivery Subcommittee will be leading this one-year review. Women comprise 16.6% of the AD force and in recent conflicts held approximately 10% of all deployed positions. More than 25% of the total cadet and midshipmen seats at Military Service Academies are women. Despite the increasing presence of women in the military, health disparities between AD men and women and gaps in health care for female Service members have emerged. Identified issues among military women include musculoskeletal injuries, reproductive hazards, and field care for gynecological health, as well as gaps in contraception availability and mental health. There are several disparate DoD efforts focused on women's health. However, a more integrated, Enterprise approach may help improve military readiness of AD women.

f. Mental Health Accession Overview

CAPT Mike Colston, Director for Mental Health Programs, Office of the ASD(HA), discussed mental health and the accessions process, specifically within the context of the rising military

suicide rate. In the early 2000s, the military suicide was equivalent to that in the civilian sector; the rate is now 71% higher than the civilian population. The increasing suicide rate is perplexing given the application of focused military resources, such as embedded behavioral health units, to fighting it. For example, the U.S. Marine Corps has four mental health care systems: MTF-based; unit-based (Operational Stress Control and Readiness Program (OSCAR)); community-based counseling; and installation-based. It was noted that suicide prevention, in the context of a public health approach, is unsatisfactory compared to other public health concerns, such as opioid abuse. CAPT Colston provided potential models and policy changes to support a way ahead, including but not limited to interventions at the VA and by the Israeli Defense Forces (IDF), and a review of the length of the probationary period. First, CAPT Colston noted that the VA's approach to suicide is patient-focused and is well resourced. Second, CAPT Colston summarized a study of an IDF means-restriction initiative, which found that removing weapons from first-term enlistees during evenings and weekends resulted in lower suicide rates. Other international practices, such as those in the U.K. and Canada, were discussed, although caution was expressed regarding any direct comparison between the U.S. Armed forces and any foreign military. Third, CAPT Colston referenced the Army Mental Health Task Force's recommendation to increase recruits' probationary period. CAPT Coston remarked that this recommendation warrants further analysis. Members also discussed recruit challenges and the relationship of demographics to accession, including potential overrepresentation from areas experiencing economic and social stress.

g. Improving Defense Health Program Medical Research Processes Report

Dr. Lazarus noted that the Board received a written statement in advance of this meeting related to the DHB's 2017 report, *Improving Defense Health Program Medical Research,* from Ms. Jane Pellegrino and Ms. Beatrice Nichols, both military medical librarians urging that medical libraries be included in the infrastructure of DHP Medical Research. These comments were provided to the Board in advance of the meeting and were made available to the attendees. Dr. Sean Biggerstaff, Deputy Director for the Research & Development (R&D) Directorate (J-9), DHA, then provided an update to the Board's recommendations from the 2017 report.

Dr. Biggerstaff's overview of the major MHS and DHA changes since the report included the DHA's assumption of authority, direction, and control of MTFs and the establishment of a new R&D organization. He explained the various sources of funding for medical research, including Service-level funding primarily for the Army and Navy, as well as J-9 funding.

Dr. Biggerstaff provided the concurrence status and progress for each of the Board's 25 recommendations—DHA concurred with 13 recommendations, partially concurred with 8 recommendations, and did not concur with 4 recommendations. One recommendation has been completed. It was noted that many of the non-concur and partially concur recommendations do not fall under the authority of the DHA and thus cannot be enforced, specifically the recommendations that address Service responsibilities, including personnel matters, which are addressed in *U.S. Code Title 10*. For example, career progression was highlighted as an important Board recommendation, although the DHA is limited in its ability to execute due to the allocation of responsibilities in *U.S. Code Title 10*. Members noted that a focus on expanding research career paths within the DoD still requires attention. Dr. Biggerstaff also discussed the implications of recent legislation and explained the Department's decision not to use National

Institutes of Health's RePORTER. Members discussed the importance of supporting medical research at MTFs and at Research, Development, Test, and Evaluation (RDT&E) facilities. A recently established governance body is evaluating a regional market model for medical research, such as one already established in San Antonio. It was noted that a technology transfer (T2) office was recently established and the T2 DHA Procedural Instruction was issued in June 2019 to support these research efforts.

h. Deployment Pulmonary Health Report

Dr. Kelley Brix, Director, Interagency Research Coordination, R&D Directorate (J-9), DHA, and Dr. Ralph Loren Erickson, Chief Consultant, Post Deployment Health, Patient Care Services, VHA, provided an update to the Board's recommendations from the 2015 report, *Deployment Pulmonary Health*.

In 2016, a question on wheezing was added to the Post-Deployment Health Assessment (PDHA), the Post-Deployment Health Reassessment (PDHRA), and the Periodic Health Assessment (PHA). In addition, the DoD and VA established referral centers for specialized care for post-deployment pulmonary symptoms and are working to coordinate the development of an improved, consistent approach to evaluation of symptoms. The DoD is also evaluating potential use of spirometry for pre-deployment screening and conducting feasibility study assessments of pre-deployment spirometry in selected groups. The DoD is developing the first-ever Individual Longitudinal Exposure Record (ILER) where unclassified data can be shared with outside investigators. Additionally, the Defense Manpower Data Center (DMDC) is developing processes to declassify individual deployment location data with the current focus on data from 2002-2017 in the Southwest Asia theater of operations. The briefers noted that the DoD has made several efforts to improve International Classification of Diseases (IDC)-10 coding accuracy, as well. The DoD also has funded research projects related to pulmonary health, including at National Jewish Health in Denver, CO and Walter Reed National Military Medical Center, and held DoD/VA Airborne Hazards Symposia/Burn Pit meetings. It was noted that the DoD has funded two Joint Pathology Center studies to evaluate lung tissue and developed a facemask prototype. The DoD established the Addictive Substances Misuse Advisory Committee (ASMAC) Tobacco Subcommittee in response to the Board's recommendation to provide evidence-based tobacco cessation programs. Dr. Brix also explained efforts underway to continue to better characterize and minimize harmful environmental and occupational exposures, including enforcement of existing regulations on the operation of open burn puts and efforts to improve overall waste management. Further, the briefers discussed the VA Airborne Hazards and Open Burn Put Registry, which began in June 2015 as a Congressional mandate.

3. NEXT MEETING

The next DHB meeting is scheduled for November 4, 2019 at Joint Base Lewis-McChord, Tacoma, Washington.

4. CERTIFICATION OF MINUTES

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

September 13, 2019

Jeremy Lazarus, MD — Date
President, Defense Health Board

September 13, 2019

General (Ret.) Richard Myers — Date
First Vice President, Defense Health Board

ATTACHMENT ONE: ATTENDEES

BOARD MEMBERS			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
Dr.	John	Armstrong	Associate Professor of Surgery, University of South Florida
Dr.	Craig	Blakely	Professor and Dean, School of Public Health and Information Sciences, University of Louisville
Dr.	Steven	Gordon*	Chair, Department of Infectious Diseases, Cleveland Clinic (Incoming Member)
Dr.	John	Groopman	Edyth Schoenrich Professor of Preventive Medicine, Bloomberg School of Public Health, Johns Hopkins University
Dr.	Lenworth	Jacobs	*Chair, Trauma and Injury Subcommittee* Director, Trauma Institute, Hartford Hospital; Professor of Surgery, University of Connecticut
Dr.	H. Clifford	Lane	Director, Division of Clinical Research, National Institute of Allergy and Infectious Disease, National Institutes of Health
Dr.	Jeremy	Lazarus	*Defense Health Board (DHB) President* *Chair, Neurological & Behavioral Health Subcommittee* Clinical Professor of Psychiatry, University of Colorado Denver School of Medicine
Dr.	Vivian	Lee*	President, Health Platforms, Verily (formerly Google Life Sciences)
RADM (Ret.)	Kathleen	Martin	*DHB Second Vice President* Former Chief Executive Officer, Vinson Hall Retirement Community - Vinson Hall LLC; Former Executive Director, Navy Marine Coast Guard Residence Foundation
Gen (Ret.)	Richard	Myers	*DHB First Vice President* President, Kansas State University; RMyers & Associates LLC; 15th Chairman of the Joint Chiefs of Staff
Dr.	Michael	Parkinson	Senior Medical Director, Health and Productivity, UPMC Health Plan and WorkPartners; Principal, P3 Health, LLC (Prevention, Performance, Productivity) (Incoming Member)
DEFENSE HEALTH BOARD SUPPORT DIVISION			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
CAPT	Gregory	Gorman	DHB Executive Director/Designated Federal Officer (DFO)
Dr.	Catherine	Zebrowski	DHB Executive Secretary/Clinical Consultant/Alternate DFO
Ms.	Camille	Gaviola	DHB Deputy Director/Alternate DFO
Mr.	Brian	Acker	DHB Contract Program Manager, Knowesis, Inc.
Ms.	Alexandra	Andrada	DHB Research Science Analyst, Knowesis, Inc.
Ms.	Amanda	Grifka	DHB Research Science Analyst, Knowesis, Inc.
Ms.	Aileen	Mooney	DHB Research Science Analyst, Knowesis, Inc.
Dr.	Lauren	Zapf	DHB Task Lead/Analyst, Knowesis, Inc.
OTHER ATTENDEES			
TITLE	**FIRST NAME**	**LAST NAME**	**ORGANIZATION**
Dr.	Terry	Adirim	Deputy Assistant Secretary of Defense for Health Services Policy and Oversight
Ms.	Shannon	Best	Family Advocacy Program (FAP) Manager, U.S. Marine Corps
Dr.	Krystina	Bienia	Psychologist, Deputy Assistant Director, Medical Affairs (DAD-MA), DHA
Dr.	Sean	Biggerstaff	Deputy Director, Research & Development (R&D) Directorate, DHA
Ms.	Lauren	Bloch	Director, Faegre Baker Daniels Consulting
Dr.	Kelley	Brix	Director, Interagency Research Coordination, R&D Directorate, DHA

Col	Valerie	Castle	Service Liaison, U.S. Air Force
COL	Jean	Chester	Office of the Surgeon General (OTSG), U.S. Army
RADM	Colin	Chinn	Joint Staff Surgeon
COL	Eugene	Christen	Chief, Surgical Services Service Line, OTSG, U.S. Army
CAPT	Mike	Colston	Director for Mental Health Programs, Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA))
Dr.	Paul	Ciminera	Director, Accession Standards, OASD(HA)
Dr.	Paul	Cordts	Acting DAD-MA, DHA
CAPT	Meghan	Corso	Chief, Behavioral Health Clinical Operations, DHA
MG	Telita	Crosland	Commander, Regional Health Command-Atlantic
Dr.	Barbara	Craig	Director, Armed Forces Center for Child Protection
Mr.	Dominic	Curraco	Director, Federal Accounts, Allergan
Dr.	Bruce	Doll	Assistant Vice President for Technological Research and Innovation, Office of Research, Uniformed Services University (USU)
CAPT	Joel	Dulaigh	Chief of Staff, Office of the U.S. Surgeon General
LTC	Shoko	Edogawa	Service Liaison, Japan
Ms.	Denise	Edwards	Director, Government Affairs, National Children's Alliance
Dr.	Ralph Loren	Erickson	Chief Consultant, Post Deployment Health, Patient Care Services, Veterans Health Administration (VHA)
Ms.	Annita	Ferncz	Synopsis (Media)
Ms.	Ryland	Gaskins	Contractor, Force Health Protection (FHP), OASD(HA)
Mr.	Tom	Gray	Gray & Associates
Ms.	Crystal	Griffen	Deputy Director, Family Support Program, Navy Installation Command
Ms.	Ann	Holman	Director, Darnall Medical Library, Walter Reed National Military Medical Center (WRNMMC)
Mr.	Bill	Huleatt	Senior Analyst, OASD, Military Community and Family Policy (MC&FP)
Mr.	Steve	Jones	Director, FHP, OASD(HA)
Brig Gen	Mark	Koeniger	Commander, Air Force Medical Readiness Agency
MCPO	Anthony	Lark	Senior Enlisted Representative, DHA
BG	Paula	Lodi	Deputy Chief of Staff, OTSG, U.S. Army
Ms.	Johanna	Macgillivray	FAP Manager, U.S. Coast Guard
Ms.	Michele	Mason-Coles	Clinical Librarian, Darnall Medical Library, WRNMMC
Dr.	Patricia	Moseley	Senior Clinical Policy Analyst, DAD-MA, DHA
RADM	Terry	Moulton	Deputy Surgeon General, Navy Bureau of Medicine and Surgery
Mr.	Kenneth	Noyes	Associate Director, FAP; OASD(MC&FP)
Dr.	Christin	Ogle	Child Research Psychologist, Center for the Study of Traumatic Stress, USU
Dr.	Valija	Rose	Statistician, OASD(MC&FP)
CAPT	Martin	Ruth	Service Liaison, United Kingdom
Dr.	Jose	Sanchez	Deputy Chief, Armed Forces Health Surveillance Branch, DHA
Col	Kai	Schlolaut	Service Liaison, Germany
Ms.	Emily	Shohfi	Clinical Librarian, Darnall Medical Library, WRNMMC
Dr.	Twee	Sim	Senior Medical Adviser, DAD-MA, DHA
LTC	Michele	Soltis	Service Liaison, U.S. Army
CAPT	Shane	Steiner	Chief of Preventive Medicine, U.S. Coast Guard
Mr.	Gordon	Trowbridge	Strategic Communications, DHA
Lt Col	Sarah	Vick	Preventive Medicine Resident, U.S. Air Force
Dr.	Ronald	Whalen	Research Assistant Professor, USU
Ms.	Jessica	Zamiska	Managing Director, McAllister and Quinn

*Participated by phone