DEFENSE HEALTH BOARD
OPEN MEETING MINUTES

September 11, 2023
River's Edge Community Center
850 Sterling Cook Street (Bldg. 256)
Portsmouth, Virginia 23708

1. **Attendees – Appendix One**

2. **September 11, 2023 – Open Session Opening Remarks**

- CAPT Clausen welcomed the Defense Health Board (DHB) members, distinguished guests, and members of the public to the meeting.
- Dr. Guice welcomed the members, introduced CAPT Clausen, discussed the meeting agenda, and acknowledged the national observance of the anniversary of the September 11, 2001, terrorist attacks.
- The members and distinguished guests introduced themselves.

3. **Decision Brief: Eliminating Racial and Ethnic Health Disparities in the Military Health System**

- Dr. Browne briefed on Eliminating Racial and Ethnic Health Disparities in the Military Health System (MHS). Please see read-ahead slide deck (Appendix 3) for more information. Discussion points of note:
  - Dr. Maybank commended the Health Systems (HS) Subcommittee (SC) for its work. She stated the report's social determinants of health section (SDoH) appears to conflate social needs and social determinants.
  - Dr. Parkinson commended the HS SC on describing the challenges associated with collecting race and ethnicity data and the flow of these data between DoD and MHS data systems.
  - Dr. Jacobs noted the importance of artificial intelligence (AI) to the tasking.
  - RADM (Ret.) Chinn asked if the report includes any Defense Health Agency (DHA)-specific findings.
  - Dr. Alleyne raised concerns related to implementing recommendations.
  - Dr. Maybank stated the report could do a better job explaining why MHS racial and ethnic disparities matter and should more explicitly state that race is a social construct.
  - Dr. Browne stated references to Diversity Equity and Inclusion (DEI) programs were omitted to insulate the report from politics. Dr. Maybank and Dr. Alleyne discussed how the report's findings and recommendations intersect with DEI.
- Dr. Browne reviewed report recommendations. Edits to the language are in Attachment 1. Discussion points of note:
  - Finding and Recommendation 1:
    - A distinguished visitor (DV) asked about Service members (SMs) accessing their own race or ethnicity data. Dr. Browne stated the HS SC has asked this question to the Defense Enrollment Eligibility Reporting System (DEERS) and is awaiting

their response. LTG Crosland asked how DEERS race and ethnicity data are updated. Dr. Guice stated these issues should be clarified by DoD policy.
    - HON Clegg suggested changing the phrase "conform to" in Recommendation 1A.
    - Dr. Guice discussed challenges associated with DEERS collecting race and ethnicity data, and asked whether DEERS is prevented by law, regulation or policy from collecting such data from non-DoD employed civilians, such as SM beneficiaries. Dr. Zebrowski stated the Office of General Counsel has informed her there are no legal or regulatory barriers to collecting these data.
    - Dr. Browne stated DEERS does not let users directly access the system to change their race. Dr. Medows stated private-sector systems record race and ethnicity data in a similar fashion to DEERS. Dr. Browne stated the HS SC is asking the DHB to recommend requiring DEERS to collect and record dependent race and ethnicity data.
    - Dr. Medows stated patients need to be educated as to why they are being asked these questions and added that the only acceptable method of racial and ethnic identification is self-identification.
    - Col Cantilina, DHA Chief Health Informatics Officer stated MHS GENESIS does collect race and ethnicity data independent of DEERS, although there is also a field that shows the DEERS collected race and ethnicity data as well. He stated that SMs need to visit a DoD Real-time Automated Personnel Identification System center to change DEERS data. Dr. Medows asked if original race and ethnicity data collected is always self-reported. Col Cantilina stated MHS GENESIS requires self-entry of these data except in trauma or other emergent situations where the patient cannot provide this information, or it would be impractical to do so. He stated, in such cases, these data are subsequently updated during routine care visits. He stated race and ethnicity questions are not repeated when identification cards are updated and that patients cannot self-update GENESIS data.
    - Dr. Browne stated she does not yet know whether TRICARE race and ethnicity data is separate from DEERS.
    - Dr. Browne asked whether the DHB should assign these recommendations to the Defense Manpower Data Center or to specific offices. She suggested language changes to Recommendation 1A. The members accepted the language change.
    - The members discussed Recommendations 1C and 1D and agreed to revisit them later.
    - COL Catalina stated clear DHB guidance would help MHS GENESIS to better classify race and ethnicity data.
    - Dr. Guice stated Recommendation 1E, which calls for replacing DEERS, is not supported by evidence in the report. Dr. Browne stated the HS SC heard from many sources that DEERS is outdated.
    - Dr. Maybank stated other aspects of individuals' identities must be recorded alongside race and ethnicity, such as gender identity.
- After spending time deliberating Finding and Recommendation 1, Dr. Guice asked the DHB members if they thought this report was ready for a vote today or if it should be sent back to the Subcommittee for further work. The Members agreed to send the report back to the Subcommittee for rework but to continue the discussion of the rest

of the Findings and Recommendations and provide the Subcommittee with the Members recommendations and concerns.

- Finding and Recommendation 2:
  - Dr. Lein stated race and ethnicity data should be standardized to enable comparisons of like data between data sources. Dr. Browne stated while "apples-to-apples" comparison with external data is desirable, the MHS also needs the ability to measure racial and ethnic health disparities within the MHS.
  - Dr. Browne discussed the role of race in some medical calculators, including blood pressure control and kidney function.
  - Dr. Medows discussed the merits of recording race and ethnicity data to measure disparities. Dr. Maybank stated explicit standards for reporting race and ethnicity are needed. Dr. Parkinson noted that DoD does not have a dedicated office or system to track disparities.
  - Dr. Armstrong asked about site-to-site variation in treatment outcomes. Dr. Browne stated the HS SC saw evidence of substantial site-to-site variation.
  - LTG Crosland asked if language could be adjusted to target disparities that disproportionately impact minority racial groups. Dr. Browne stated that without better data such disparities are unknown.
  - Dr. Armstrong suggested language changes to Recommendation 2D. RADM (Ret.) Chinn suggested adding the phrase "reduce unwarranted variation."
  - Dr. Maybank stated medical care is only a small part of health and the focus should be on decreasing disparities in SDoH. Dr. Medows stated disparities should be studied more rigorously.
  - MG Place suggested the report state the MHS, like civilian systems, is at risk for disparities due to SDoH.
  - Dr. Maybank stated the report's narrative is as important as its findings.
  - Dr. Browne stated patients' lived experiences factored into report findings. Dr. Kaplan stated health outcomes are complex and affected by multiple causes including SDoH and clinical care.
  - Dr. Maybank stated the concept of race was created to marginalize groups and that the report must address racism.
- Finding and Recommendation 3:
  - Dr. Guice stated the DHB needs to act on the information it has rather than wait for better data.
  - RDML Case stated the recommendation should emphasize pediatric disparities. Dr. Berwick suggested emphasizing asthma in Recommendation 3B.
  - Dr. Browne stated purchased care network disparities are of concern to the MHS and that the disparities noted in the report speak to both purchased and direct care.
  - Dr. Cordts stated MHS racial and ethnic c-section disparities are lower than those found in civilian medicine. Dr. Browne stated rates of post-partum hemorrhage show no racial or ethnic disparities in the MHS.
  - Dr. Guice and Dr. Cordts discussed statistical significance in the context of racial and ethnic health disparities. Dr. Alleyne referenced an article discussing maternal health outcome disparities. He stated statistical significance may obscure negative health outcomes.
  - Dr. Browne recommend adding race and ethnicity data to readiness reports.

- Dr. Berwick suggested adding "disparities in these areas, among others" as well as a specific reference to pediatric asthma.

- Finding and Recommendation 4:
  - Dr. Guice asked why the recommendations do not reflect the report's narrative regarding the business side of the MHS.
  - The members discussed potential concerns with AI and the need for a central clearing house for AI information. Dr. Alleyne stated the Coalition for Health AI.org has done some work on these issues.
  - Dr. Lazarus stated he sees this set of recommendations as standing alone.
  - Dr. Maybank and Dr. Alleyne raised concerns that Recommendation 4B's reference to "race-agnostic" algorithms could be misinterpreted. Dr. Browne stated oversight is warranted in cases where AI algorithms treat people differently based on their race or ethnicity.
  - Dr. Berwick asked whether guidelines from sources external to the MHS would be reviewed in the report's AI section. Dr. Browne stated it would.
  - Dr. Jacobs discussed concerns with AI algorithm inputs.
- CAPT (Ret.) Gorman suggested the DHB keep recommendation language general and focus on encouraging DoD to develop solutions to problems identified by the DHB. He noted many existing health outcome measures cannot be stratified by race and ethnicity. He encouraged the members to adopt President Reagan's policy of "trust but verify" to ensure report recommendations are implemented. He stated that although there might be a DoD policy, this does not mean the policy is followed in practice.
- Finding and Recommendation 5: Dr. Guice suggested adding National Institutes of Health (NIH) language "appropriate to the scientific question being studied."
- Finding and Recommendation 6:
  - Dr. Bishop offered language changes to Recommendation 6A related to screening tools.
  - Dr. Alleyne stated the Department of Health and Human Services is working on SDoH. Dr. Maybank suggested adding the phrase "health-related social needs" to the SDOH recommendations.
  - Dr. Armstrong suggested adding "TRICARE region" into Recommendations 6A and 6B.
  - Dr. Guice suggested replacing "promote resources" with "refer patients to" in Recommendation 6D.
- Finding and Recommendation 7: The members discussed language pertaining to SDoH.
- Finding and Recommendation 8: Dr. Maybank asked whether appropriate evaluation of "health equity" training exists.
- Finding and Recommendation 9: MG Place asked for clarification of language referring to the Reserve Officers' Training Corps. Dr. Guice stated the apparent intent is to expand medical career opportunities for members of underrepresented racial minority groups.
- Finding and Recommendation 10:
  - The members, MG Place, and LTG Crosland discussed the implications of focusing on health disparities over health outcomes.

- Dr. Berwick asked why the HS SC gave the report a three-year timeline for response from the DoD. Dr. Lazarus stated that the DHB does not usually include a request for an update in its recommendations. Dr. Guice clarified the DHB can request update briefings from the DoD. Dr. Browne stated the SC would like to emphasize the importance of the DHB receiving an update on the implementation of its recommendations.

4. Defense Health Agency – Moving from Transition to Execution

LTG Crosland briefed on Defense Health Agency – Moving from Transition to Execution. She focused on the execution of the mission to provide oversight of the health care system. She explained the agency delivers health care for about 9.6 million beneficiaries, explaining only 3 million beneficiaries are active duty Service members and their families, while the rest are retirees and families. Please see read-ahead slide deck (Appendix 4) for more information. Discussion points of note:

- Dr. Bishop asked if MHS Genesis and the Veterans Affairs (VA) Electronic Health Record are interoperable. LTG Crosland stated they are not. She noted other healthcare systems are working on this challenge and that technology may enable greater data sharing across platforms in the future.
- Dr. Alleyne and Dr. Berwick asked about ways for DHA to improve access and outcomes.
- RADM (Ret.) Chinn described his first-hand challenges transitioning from MHS care to VA care. LTG Crosland stated the DHA is working on these issues, and that DHA needs to improve primary and behavioral health care, specifically.
- Dr. Jacobs asked how the war in Ukraine impacts DHA modernization. LTG Crosland stated finding the balance between capabilities and modernization is important.
- Dr. Parkinson asked how DHA can medicalize the non-medical aspects of SDoH, noting the importance of sleep to Total Force Fitness. LTG Crosland stated there is a need to reimagine care delivery to address non-medicinal care. She stated that virtual care also represents a fundamental change in care delivery.

5. Defense Health Agency Tidewater Market Overview

RDML Case briefed on the Defense Health Agency Tidewater Market. He provided some history and context of Naval Medical Center Portsmouth (NMCP) to the DHB members. Please see read-ahead slide deck (Appendix 5) for more information. Discussion points of note:

- RADM (ret.) Chinn asked about NMCP's recent designation as a Level II trauma center and how that came to be. RDML Case noted that there is a civilian Level I trauma center nearby and there has been resistance in obtaining another similar designation so close geographically. However, since NMCP already had many of the resources but the trauma surgeons were going over to the Level I center for "free work", it was imperative to evaluate and obtain recognition from the American College of Surgeons as a trauma center.
- Dr. Alleyne discussed civilian partnerships and asked about potential growth opportunities. RDML Case stated that making efficient use of space is most important.

He stated civilian partnerships are important, citing partnerships with Virginia Commonwealth University in the Tidewater area and East Carolina University for Camp Lejeune, but that using Tidewater facilities fully is most important.

- Dr. Parkinson asked what can be done to provide more services to retiree patients. RDML Case stated the care Tidewater delivers is tremendous, but that accessing care is difficult. He stated he has focused on boosting enrollment numbers by "capturing" TRICARE Plus patients.

6. Tasker Update: Effective Public Health Communications Strategies with Department of Defense Personnel

Dr. Bishop briefed on Effective Public Health Communications Strategies with Department of Defense Personnel. Please see read-ahead slide deck (Appendix 6) for more information. Discussion points of note:

- Dr. Lazarus asked whether the report would consider other "hot button" health issues including reproductive rights and transgender care, and whether the Public Health (PH) SC would reach out to Dr. Anthony Fauci, Dr. Francis Collins, and Dr. Cliff Lane of the NIH. Dr. Bishop stated Dr. Fauci was not available to brief the SC. Dr. Zebrowski stated DHB Staff are planning to speak to Dr. Lane. Dr. Bishop stated that the PH SC has not considered the other noted "hot button" issues.
- Dr. Jacobs noted the importance of cyber disinformation. Dr. Zebrowski stated AI is on the PH SC's research agenda.
- Dr. Parkinson described his own research on government, academia, and the press. He noted that each have "perverse incentives" to stir up issues for attention, votes, or money. Dr. Parkinson stated the PH SC needs to understand how institutional incentives intersect with misinformation. He stated trust is earned rather than assumed and that the PH SC should determine where and when DoD is widely trusted. He suggested that, while DoD should rarely be involved in generating new data, there are DoD-specific studies the PH SC could review.
- Dr. McCaw offered to share an article discussing a NIH program called "advancing health communications." She stated this report may have a larger footprint than expected, given that the NIH program was shut down. Dr. Bishop stated the PH SC has reviewed a RAND report on vaccine compliance. She encouraged the members to share any relevant materials they have with the Public Health PH SC.
- Dr. Lein noted several post-COVID-19 health disasters, including the Red Hill Water Contamination Crisis and radon leaks at Marine Corps Air Ground Combat Center Twentynine Palms. He asked whether the report would address burn pits and the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act. Dr. Bishop stated these topics are not currently on the PH SC's agenda but that they would consider them.
- Dr. Browne commended the PH SC for meeting with Dr. Jay Bhattacharya. She stated one of the major challenges science faces is how to address feedback from good people with good intentions who see the same information and come to different conclusions. She noted that the same challenges exist in addressing gender-affirming care in children. She stated that resolving this challenge is key to maintaining public trust in science. She further noted the importance of engaging with people who reside in disadvantaged

communities. Dr. Lazarus agreed with Dr. Browne and asked how health messages can be crafted for MHS providers. Dr. Bishop stated the American Medical Association (AMA) has articles addressing this question.

- MG Place stated it is unclear how SMs access health information, noting that they are unlikely to consult the AMA. He noted there are likely to be conflicts between different trusted messengers and resolving conflicts, in such cases, is a challenge. MG Place suggested the PH SC consult health risk communicators rather than public affairs officers. Dr. Zebrowski asked MG Place to recommend health risk communicators the DHB could speak to. MG Place agreed to provide contacts to the PH SC. He stated, during the COVID-19 Pandemic and Red Hill Water Contamination Crisis, health risk communicators exercised discipline by waiting for adequate information before issuing guidance and subsequently, pursued consensus with senior commanders. He stated a small percent of commanders disagreed with the consensus view but that his units were able to rapidly get to 95% vaccination, for example.
- Dr. Alleyne stated community vulnerabilities impact force readiness. He noted that during the COVID-19 pandemic, he dealt with multiple avoidable outbreaks. He stated that, to his surprise, health professionals sometimes refused to support or even actively resisted health communications efforts. Dr. Armstrong stated DoD needs to lay the architecture for health communications prior to emergency events. He noted two-way communication with the public reinforces trust.
- RADM (Ret.) Chinn suggested consulting command ombudsmen and military spouse networks. He stated there are multiple audiences for DoD health communications to address. He noted changes to TRICARE benefits frustrate beneficiaries and may erode trust.
- Maj Gen Bartrum stated that his unit had communications and PH teams. He suggested the PH SC speak to the Department of Health and Human Services Assistant Secretary for Preparedness and Response for information on coordinating health messages. He stated PH doesn't work at speed of relevance. Gen (Ret.) Chilton suggested reviewing prior research on vaccine mandates; however, he noted that the information environment during those periods may not be comparable. Dr. Bishop stated the PH SC has discussed this issue.

7. Topic Brief: Prolonged Casualty Care

CAPT Drew briefed on Prolonged Casualty Care. Please see read-ahead slide deck (Appendix 7) for more information. Discussion points of note:

- RADM (Ret.) Chinn noted potential challenges, including the DoD's inability to dominate the global commons during a near-peer conflict and the resulting disappearance of the "golden hour" for trauma care. He stated the volume of patients during such a conflict would be "astronomical" and would quickly overwhelm DoD medical capacities.
- Dr. Alleyne asked what resources are needed to achieve and maintain readiness for prolonged casualty care. CAPT Deaton stated the ICU nurse skill set is a good proxy for readiness.
- Dr. Jacobs expressed concern regarding training over the next 2-10 years. CAPT Drew noted the problem of the "Walker Dip," a drop in trauma care experience among military

medical personnel during peacetime. He stated that bringing line officers into agreement with the needed prolonged casualty care skills is key and that DoD would need to be involved at a high level.

- MG Place stated the military is going to be widely dispersed on the battlefield at a time when concentrated medical resources are needed. He stated junior SMs need to understand what they can do with what they have at their disposal. CAPT Drew stated there is a need to better describe how triage works, and that the challenge will increasingly be "who can I save with what I have?" CAPT Deaton stated the American people do not understand the scale of the casualties the nation faces in a large-scale conflict. He stated that the DoD need the DHB's help bringing this topic to the public's attention. Dr. Lein added that the DHB can help the MHS leverage national societies such as the American College of Surgeons to support development of senior-level strategies to confront this challenge.
- CAPT Drew stated the military relies on civilian partnerships for training. Dr. Jacobs discussed bed shortages during COVID-19 and the need to look at strategies used during WWI and WWII when civilian hospital systems were overloaded by casualties. Dr. Lazarus stated that many people are in denial about the scale of the challenge the DoD faces.
- CAPT Drew stated his unit updated their tourniquets policy based on the Ukraine conflict. He stated there is no civilian licensure equivalent for the skills possessed by a Corpsman and that licensure is a component of retention, insofar as it adds value to military service.
- Dr. Guice asked who and how many civilian partners does DoD need, and where it needs them. CAPT Drew stated he would get back to Dr. Guice on this question.
- Dr. Lazarus asked if CAPT Drew has consulted with the Federation of State Medical Boards. CAPT Drew stated he has not.
- Dr. Guice stated certain providers may want to limit the role military medics might play in civilian medicine. She suggested that, in a national emergency, this barrier might be overcome.
- COL Gurney referenced "The Blue Book: Military-Civilian Partnerships for Trauma Training, Sustainment, and Readiness" which focuses on the "trauma team." She stated the military's biggest need is experience with saving lives.

8. Introduction to Navy Afloat Medical Capability

CAPT Sauter briefed on Introduction to Navy Afloat Medical Capability. Please see read-ahead slide deck (Appendix 8) for more information. Discussion points of note:

- CAPT Deaton described the Marine Corps Valkyrie program, which was created to introduce blood transfusions to general corpsmen.
- Dr. Jacobs asked about sick SMs utilizing bedspace in open air conditions. CAPT Sauter stated the beds in question are not monitored because this ship, a USS San Antonio class vessel, is not a hospital ship. RDML Case stated use of these beds for medical purposes come at the cost of combat capabilities.
- CAPT Sauter explained that "Authorized Medical Allowance List" (AMAL) refers to the list of a ship's necessary and authorized allowances of equipment and consumable supplies.

9. Closing Remarks

CAPT Clausen and Dr. Guice thanked everyone for their attendance and noted the next DHB meeting is scheduled for November 29, 2023. CAPT Clausen adjourned the meeting.

10. Certification of Minutes

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

10/16/2023

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.	K. Aletha	Maybank	Chief Health Equity Officer and Group Vice President, American Medical Association
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	Shawn	Clausen	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	Management Analyst, MicroHealth LLC
Mr.	Tanner	Dean	Management Analyst (Office Support), BookZurman, Inc.
Mr.	Rubens	Lacerda	Management Analyst (Meeting Support), BookZurman, Inc.
Dr.	Keila	Miles	Associate Research 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			
Ms.	Alison	Barninger	Executive Assistant to Assistant Director, Healthcare Administration (HCA), Defense Health Agency (DHA)
Maj Gen	John	Bartrum	Mobilization Assistant to the Surgeon General of the Air Force and Space Force
Dr.	Krystyna	Bienia	Clinical Psychologist and Senior Policy Analyst, DHA

CDR	Erin	Blevins	Pediatric Hematologist/Oncologist and Healthcare Disparities and Equity Working Group, Naval Medical Center San Diego
CDR	Shamika	Brooks	Chief Program Management Officer for PHS Engagement; Executive Assistant to the Deputy Surgeon General; Program Manager, OSG Chartered Advisory Committees
CAPT (Ret.)	Frank	Butler	Former Chairman of the Committee on TCCC
Dr.	David	Bychkov	Research Consultant, UC Institute for Predication Technology
Col	Thomas	Cantilina	Chief Health Informatics Officer / Deputy EHR Functional Champion, DHA
RDML	Matthew	Case	Director, Tidewater Market, DHA
Dr.	David	Classen	Infectious Disease Physician, University of Utah School of Medicine; Chief Medical Information Officer, Pascal Metrics
Dr.	Cheryl	Conner	Section Chief of Hospital Medicine, Jesse Brown VA Medical Center
Dr. (SES)	Paul	Cordts	Deputy Assistant Director, Medical Affairs, DHA
LTG	Telita	Crosland	Director, DHA
CAPT	Travis	Deaton	Division Surgeon, 1st Marine Division
Dr.	Susanna	Didrickson	Nurse Consultant, Women's Health Clinical Management Team, Directorate of Medical Affairs; Office of Clinical Support, Assistant Director HCA, DHA
COL	Sandrine	Duron	Canadian Forces Health Services Attaché
Dr.	Marion	Ehrich	Professor, Dept of Biomedical Sciences and Pathobiology, Virginia-Maryland College of Veterinary Medicine
Ms.	Annita	Ferencz	Synopsis
Dr.	Sandra	Gharabaghli	Nursing Consultant, Office of Clinical Quality; Quality Management Department; Naval Medical Center San Diego (NMCSD)
CAPT (Ret.)	Gorman	Gregory	Former Executive Director, DHB
Dr.	Odette	Harris	Associate Professor of Neurosurgery & Director of Brain Injury, Stanford University School of Medicine
Ms.	Theresa	Hart	Senior Nurse Consultant; Women Health and Special Medical Programs; Integrated Clinical Operations and Policy Support, Clinical Support Division, Medical Affairs, DHA
RADM	Denise	Hinton	Deputy Surgeon General, Department of Health and Human Services
Ms.	Eileen	Huck	Senior Deputy Director, Government Relations, National Military Families Association
Mr.	Tim	Jones	Senior Associate Director, Federal Relations, The Joint Commission
Dr.	Robert	Kaplan	Senior Fellow and Professor Emeritus, Harvard Business School
Col	Nathan	Kellett	Commander/Military Treatment Facility Director, 633rd Medical Group, Joint Base Langely-Eustis
LTC	Erin	Keyser	Program Director, Gynecologic Surgery & Obstetrics, Chair, Physical Health & Wellness WorkGroup, Brooke Army Medical Center; Associate Professor, USUHS
Ms.	Patricia	Kime	VA and Military Health Care Reporter, Military.com
Dr.	Tracey	Koehlmoos	Professor & Director, Center for Health Services Research, USUHS
Dr. (SES)	Brian	Lien	Assistant Director, Healthcare Administration, DHA
Mr.	Brian	Lounsbury	President and Chief Executive Officer, December Group, LLC
Dr.	Catherine	McCann	President, Ellipses, LLC
MG	Place	Michael	Chief of Staff, Office of the Surgeon General, US Army Medical Command

Ms.	Ellen	Milhiser	Editor, Synopsis
MSG (ret.)	Harold	Montgomery	Joint Program Manager Tactical Combat Casualty Care - Vice Chair CoTCCC
CAPT (Ret.)	Mollie	Mullen	Advisor for Clinical Quality, Directorate for Surgical Services NMCSD
HON	Seileen	Mullen	Principal Deputy Assistant Secretary of Defense for Health Affairs
Col	Robert	Paz	Deputy Director, Tidewater Market, DHA
Maj	Kathleen	Pombier	Chief, Women's Health Clinical Management Team, Clinical Support Division, Medical Affairs, DHA
Ms.	Brittany	Powers	Media Relations Specialist, DHA
Dr.	Anju	Ranjit	Maternal Fetal Medicine Fellow and Clinical instructor, University of California San Francisco
LTC	DeMarcio	Reed	MEDDAC Commander
LCDR	Stacey	Schmiedecke	Chief Medical Informatics Officer, NMCSD; Acting Chief Health Informatics Officer, San Diego Market; Assistant Professor, USUHS
CAPT	Joel	Schofer	Deputy Commander, Navy Medicine Readiness and Training Command Portsmouth; Deputy Director, Naval Medical Center Portsmouth
Dr.	Jayakanth	Srinivasan	Chief Engineer, VA Health Innovation and Central Office, the MITRE Corporation
Ms.	Kimberly	Taylor	Women’s Health Clinical Management Team, Clinical Support Division, Medical Affairs, Assistant Director HCA, DHA
Ms.	Amanda	Vicinanzo	Media Relations Specialist, DHA
Ms.	Alison	Welski	Public Affairs Officer, DLA Troop Support
Ms.	Noelle	Wiehe	Office of Strategic Communications, DHA
MCPO	Justin	Wilson	Senior Enlisted Advisor, Joint Trauma System

APPENDIX TWO: MEETING CHAT

09:43:02 From Dr. Jayakanth (JK) Srinivasan to Everyone:

Part of the emphasis on DHA in the report is a recognition that DHA has responsibility for the direct care system

10:09:02 From Thomas Cantilina to Everyone:

The Race/Ethnicity captured in MHS GENESIS while fed to from/DEERS is an independent data set from the Race/Ethincity captured by RAPIDS centers. Race/Ethnicity is not captured or changeable on milconnect

10:11:04 From Dr. Catherine Zebrowski - DHB Staff to Everyone:

Thank you Col Cantilina

10:12:01 From Thomas Cantilina to Everyone:

DEERS does not overwrite MHS GENESIS

10:26:20 From Alizondo, Maria Caban to Everyone:

I agree.

10:34:54 From Thomas Cantilina to Everyone:

First, if we establish an authoritative (acurate, i.e. the right ontology to describe reality) we can reconfigure the interfaces to support that approach

Second, the MIP is feed from MHS GENESIS so it can receive updates but we have to ensure we select the right data set to be used in down stream systems

10:53:11 From Bob Kaplan to Everyone:

The "progress" is reducing variation from site-to-site within the MHS, as well as improving the mean.

11:21:40 From Donald Berwick to Everyone:

I suggest adding “asthma” to the pediatric list.

11:31:07 From Donald Berwick to Everyone:

In 3.B, we should say, “…. in these areas among others….” The list is not complete.

11:55:22 From Alizondo, Maria Caban to Everyone:

Thank you Capt. Gorman.

11:56:21 From Alizondo, Maria Caban to Everyone:

Our experiences on site visits informed our discussions for this task - trust and verify for sure.

12:07:35 From Dr. Brigid McCaw - DHB Member to Everyone:

6A I don’t think text of report included term Health Related Social Needs but it should (Dr. Browne you mentioned this term in your presentation). There is increasing discussion and scrutiny about the usefulness/accuracy of screening tools for sensitive/stigmatized issues. I suggest modifying wording of recommendation to acknowledge this. Potential rewording of “These tools should be kept current through regular updates” to “The tools and screening practices/methodologies should be reviewed every 3 years to incorporate changes in SDOH screening.”

12:09:18 From Donald Berwick to Everyone:

I thoroughly endorse Dr. McCaw’s comment. We should make sure that the SDOH screening methods and tools used are both helpful and efficient…. And kept current. Otherwise, we could be adding to burden for primary care systems without benefit to patients.

12:10:52 From Donald Berwick to Everyone:

Regarding Recommendation 8, this is fertile ground for R&D within the military health system.

15:19:09 From Dr. Donald Berwick - DHB Member to Everyone:

The American Board of Internal Medicine Foundation has had a series of meetings and publications on trust. I believe they would be valuable for this project. Contact is ABIM President Dr. Rich Baron rbaron@abim.org

17:31:56 From DHB Staff to Everyone:

Minutes and slides will be posted online at health.mil/dhb

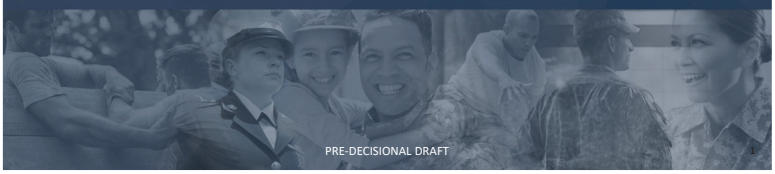
17:32:06 From DHB Staff to Everyone:

please email us with any follow up questions/comments at dha.dhb@health.mil

Appendix 3

Decision Brief: Eliminating Racial and Ethnic Health Disparities in the Military Health System

Michael-Anne Browne, MD
Chair, Health Systems Subcommittee
September 11, 2023



Overview

- Membership
- Tasking
- Summary of Activities to Date
- Report Overview
- Findings and Recommendations

Membership

CHAIR
Michael-Anne Browne, MD*

Maria Caban Alizondo, PhD, MA*

David Classen, MD

Robert Kaplan, PhD, MS

Catherine McCann, PhD, MS

Rhonda Medows, MD*

Jayakanth Srinivasan, PhD, MS

*Board Member

Tasking

On May 12, 2022, the Assistant Secretary of Defense for Health Affairs directed the Defense Health Board ("the Board") to **provide recommendations to address racial and ethnic health disparities within the Military Health System (MHS).**

Tasking: Background

- 24% of Active Duty personnel self-identify as a racial minority
- 16% of Active Duty personnel self-identify with Hispanic ethnicity
- Many MHS studies document disparate health outcomes across race and ethnicity over a range of conditions and age groups
- Physical and mental health inequities exist despite the MHS' universal health care benefit

Tasking: Objectives and Scope

- Review the existing literature on disparities in health outcomes of Active Duty Service members and other MHS beneficiaries by race and ethnicity. Compare those disparities to those experienced in other U.S. health care systems.
- Identify systemic barriers to eliminating racial and ethnic health outcome disparities within the MHS, considering policy, processes, staffing, and training.
- Provide recommendations to address health disparities by race and ethnicity within the MHS.

Summary of Activities to Date (1/4)

Meeting Date	Discussion Topics
Mar 30, 2022: DHB Meeting	Racial and Ethnic Health Disparities in the MHS
Jun 28, 2022: Subcommittee Kickoff Meeting	• Expansion on racial and ethnic health disparities in the MHS • Improving Health Equity via Recruiting, Retention and Education at Uniformed Services University of the Health Sciences
Jul 27, 2022: HS Meeting	• MHS Data Systems and Race/Ethnicity Data • Addressing Racial and Ethnic Health Disparities in the U.S.
Aug 10, 2022: DHB Meeting	• Update of report to DHB members • Veterans Health Administration efforts to promote health equity
Aug 24, 2022: HS Meeting	• Health outcome disparities in the MHS • Efforts to address health disparities at Naval Medical Center Portsmouth
Sep 28, 2022: HS Meeting	DoD Inspector General advisory on non-compliant race coding values in the MHS Data Repository
Oct 26, 2022: HS Meeting	• NPIC and NSQIP reporting on MHS race and ethnicity data • Racial and ethnic disparities in maternal health research and recommendations

Summary of Activities to Date (2/4)

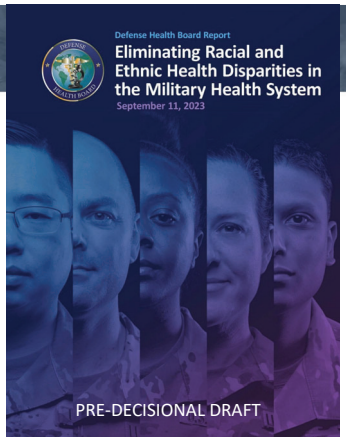
Meeting Date	Discussion Topics
Nov 30, 2022: DHB Meeting	• Report update to DHB members: Emerging themes • Data collection and availability issues
Dec 5, 2022: HS Meeting	Mental Health Disparities Research: • Psychiatric Conditions During Pregnancy and Postpartum • Minority Adolescent Mental Health Diagnosis Differences
Jan – Feb 2023: Informational Teleconferences	Cleveland Clinic; Institute for Healthcare Improvement; Rush University; Kaiser Permanente; Boston Medical Center; Providence
Jan 19, 2023: HS Meeting	• Mayo Clinic Health Equity Initiatives • Potential Recommendations
Feb 16, 2023: HS Meeting	• Overview of informational teleconferences • Report Development: Outline and Recommendations
Mar 2, 2023: Visit to Naval Medical Center San Diego	NMCSD initiatives to identify and address racial and ethnic health outcome disparities
Mar 16, 2023: HS Meeting	Report Development: Outline, Recommendations, and Background

Summary of Activities to Date (3/4)

Meeting Date	Discussion Topics
March 22, 2023: DHB Meeting	Report update to DHB members: Emerging Findings and Recommendations
April 12, 2023: HS Meeting	Report Development: Findings and Recommendations
April 26, 2023: HS Meeting	Report Development: Findings and Recommendations
May 10, 2023: HS Meeting	Report Development: Recommendations & Social Determinants of Health
May 24, 2023: HS Meeting	Report Development: Recommendations & Data Use
May 26, 2023: Informational Teleconference	TCON with Dr. Terry Adirim, former Under Secretary of Defense (Health Affairs) to inform Leadership and Structure for Sustainability chapter
June 7, 2023: HS Meeting	Report Development: Recommendations & Leadership Chapter
June 28, 2023: DHB Meeting	Report update to DHB members: Emerging Findings and Recommendations
July 12, 2023: HS Meeting	DHA Medical Affairs briefing on efforts to integrate race and ethnicity data within MHS GENESIS and concerns related to accuracy of DEERS

Summary of Activities to Date (4/4)

Meeting Date	Discussion Topics
July 26, 2023: HS Meeting	Report Development: Findings and Recommendations
August 9, 2023: HS Meeting	Full Report Discussion
August 23, 2023: HS Meeting	Findings and Recommendations & Executive Summary Discussion



Definitions

- Ethnicity
- Genetic Ancestry
- Health Disparity
- Health Equity
- Race
- Social Determinants of Health
- Underrepresented in Medicine
- Underrepresented Population

Report Overview

- Review of MHS health disparities literature
- Problems with MHS race and ethnicity data
- High impact medical conditions for immediate action
- Data use and misuse
- Social Determinants of Health
- Training and workforce initiatives to promote better health outcomes
- Leadership accountability and proposal for sustainable progress

MHS Health Disparities Literature Review

- Review included 58 published articles or DHA information briefs
- Some studies observe more narrow or absence of racial and ethnic disparities in the MHS compared to other U.S. health systems
- MHS universal health coverage does not mean universal access to care
- Many MHS disparities studies are one-time data pulls conducted by individuals with little institutional support
- Statistically significant disparities in maternal health outcomes by race warrant immediate attention and action
- Race and ethnicity data for beneficiaries are often missing or incorrect

Federal Race and Ethnicity Data Standards – OMB SPD 15

- 1977: Office of Management and Budget (OMB) Statistical Policy Directive 15 (SPD 15) established federal standards for maintaining, collecting, and presenting data on race and ethnicity
- 1997: OMB SPD 15 updated following review by Interagency Committee for the Review of the Racial and Ethnic Standards:
  1. The "Asian or Pacific Islander" category will be separated into two categories – "Asian" and "Native Hawaiian or Other Pacific Islander,"
  2. The term "Hispanic" will be changed to "Hispanic or Latino."
- Current Race Categories: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White
- Current Ethnicity Categories: "Hispanic or Latino" & "Not Hispanic or Latino"
- OMB SPD 15 states "self-identification is the preferred means of obtaining information about an individual's race and ethnicity," but this is not a requirement

Service Member and Retiree Race and Ethnicity Data

- Service members required to self-identify race and ethnicity upon accession into the Armed Forces
- DD Form 1966 - Allows for more than one race response
- Service personnel offices provide these data to Defense Manpower Data Center (DMDC)

DD Form 1966 "Record of Military Processing – Armed Forces of the United States"

7. A. ETHNICITY (X one)	7. B. RACE (Check all that apply)	
(1) HISPANIC OR LATINO	(1) AMERICAN INDIAN/ ALASKA NATIVE	(4) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
(2) NOT HISPANIC OR LATINO	(2) ASIAN	(5) WHITE
	(3) BLACK OR AFRICAN AMERICAN	

DEERS Race and Ethnicity Data

- DMDC operates the Defense Enrollment Eligibility Reporting System (DEERS), DoD's enrollment and eligibility system
- Race and ethnicity data are mostly available for Service members and retirees, but data imputation can lead to errors for dependents. The Health Systems Subcommittee learned:
  1. DEERS copies race and ethnicity of Sponsor to blank dependent records
  2. Real-Time Automated Personnel Identification System (RAPIDS) data entry personnel do not always confirm race and ethnicity of dependent at enrollment
- DD 1172-2: Application for ID Card/DEERS Enrollment does not have a field for race or ethnicity
- DEERS is the source of race and ethnicity data for many MHS databases

DEERS Race and Ethnicity Categories

- DMDC receives Service member race and ethnicity data from Service personnel offices
- Regroups "Asian" and "Native Hawaiian or Other Pacific Islander" into a single "Asian or Pacific Islander" category
- Currently does not comply with OMB SPD 15
- Plan to begin updating legacy records to display OMB SPD 15 compliant categories in December 2023

DEERS Race and Ethnicity Categories
White
Asian or Pacific Islander
Black
American Indian or Alaskan Native
Other
Unknown

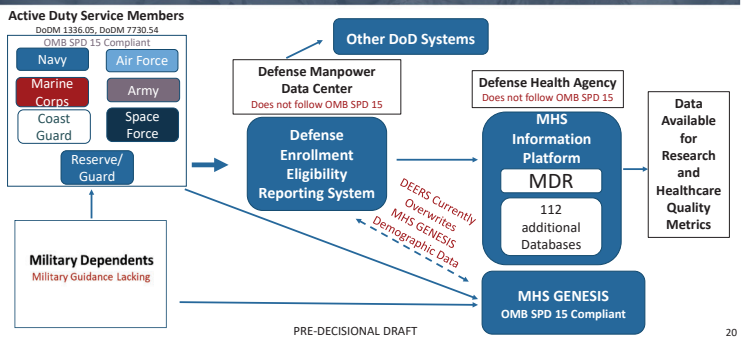
MHS Race and Ethnicity Data

- Military Health System Data Repository (MDR) – centralized data repository for MHS health care data including Direct Care and Purchased Care
- MDR race and ethnicity data dependent on DEERS data
- Most MHS disparities research based on MDR data
- Race categories not compliant with OMB SPD 15

From MDR Data Dictionary (September 2023)

Description
White
Asian or Pacific Islander
Black
American Indian or Alaskan Native
Other
Unknown

DoD Race and Ethnicity Data Flow



Race and Ethnicity Data Use and Misuse

- Studies show the inappropriate use of race in clinical decision algorithms and medical equipment design can lead to significant errors that contribute to disparate health outcomes
- Assumptions built into Artificial Intelligence can magnify health disparities
- Race and ethnicity data can be used appropriately to inform clinical decision-making for individuals, but must be placed in context

Social Determinants of Health

- MHS beneficiaries' life experiences affect their current health status
- Social Determinants of Health (SDOH) explain much of the variation, including by race and ethnicity
- SDOH data is essential to addressing beneficiary health
- Even with MHS universal health benefits, SDOH impact health across all domains among current Service members and beneficiaries

Training and Workforce

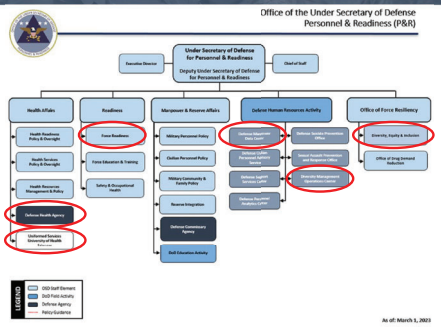
- Increased patient-provider racial and ethnic concordance according to patient preference enables a better patient care experience through improved communication, greater cultural competency or humility, and reduced implicit bias
- Health care patient-provider racial and ethnic concordance is not a panacea, and many factors impact outcomes
- It is important to expand the recruiting pipeline for pre-health careers and STEM among institutions whose students represent the ethnic, racial, and geographic diversity of the nation

References: (Shen, 2018; Takeshita, 2020; Saha, 2020)

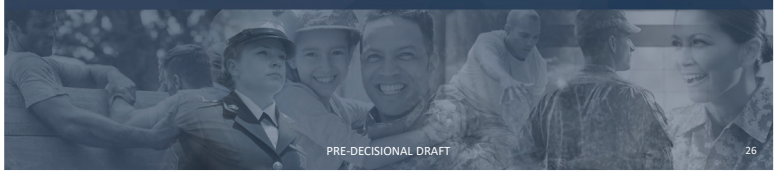
Leadership, Accountability, and Structure for Sustainable Progress

- Lack of a central authority and governance specific to racial and ethnic health disparities within DHA has led to uneven efforts to measure and reduce these disparities
- Best Practices suggest institutions should:
  - Designate accountable leaders and establish a reporting structure
  - Implement a framework for analysis of health equity within the organization
  - Proactively look for disparities through primary research and revisiting conclusions derived from standard statistical analyses
  - Engage with institution leadership, health care providers, patients, and community leaders to identify community needs and institutional capabilities
  - Establish goals at the organizational level to reduce disparities and measure progress in eliminating any disparities

Under Secretary of Defense for Personnel & Readiness



Findings and Recommendations



Finding 1

MHS data systems do not fully capture race and ethnicity data to fully describe the beneficiary population. Most MHS family member beneficiaries either have an incorrect or missing value for race and ethnicity in MHS data systems. Others have their race and ethnicity inferred from their active-duty Sponsor. The Defense Enrollment Eligibility Reporting System (DEERS), which serves as DoD's personnel, enrollment, and eligibility system, is the source of race and ethnicity data for the MHS GENESIS system. But Service members and beneficiaries are currently unable to view or edit race and ethnicity in their DEERS record. When a beneficiary or clinic staff attempts to update MHS GENESIS with more accurate race or ethnicity data, the fields are overwritten by DEERS at the next update. Studies using current MHS data, therefore, are often unable to determine whether disparities exist or do not exist.

As of January 1, 2023, the Joint Commission (JC) requires hospitals and other health care programs to collect race and ethnicity for all patients. The Office of Management and Budget (OMB) Statistical Policy Directive 15 (SPD 15) states that self-reported race and ethnicity data is the preferred method for collecting these data. The JC encourages organizations to use the five race and two ethnicity categories from OMB SPD 15, at a minimum. DEERS does not comply with the OMB reporting requirement because: (1) it combines the "Asian" and "Native Hawaiian or Pacific Islander" into a combined "Asian or Pacific Islander" category; (2) it includes a race category of "Other."

Recommendations 1A – 1C

Short-term Recommendations:

1.A. Conform to the JC requirement by collecting self-identified race and ethnicity data for all beneficiaries, not just active-duty Service members. Harmonize all race and ethnicity data between all administrative data sources, including MHS GENESIS.

1.B. Empower Service members and beneficiaries to view, self-identify, and correct their race and ethnicity data.

1.C. Conform with the OMB SPD 15 Federal Minimum Standards for Race and Ethnicity by:

- Separating the "Asian or Pacific Islander" category into the two OMB compliant categories "Asian" and "Native Hawaiian or other Pacific Islander."
- Replacing the "Other" category with "Multiracial" and eliminating the "Unknown" category.

Recommendations 1D – 1E

1.D. Require health facility staff to assist patients and help them update their data when they review their MHS GENESIS race and ethnicity data.

Long-term recommendation:

1.E. Replace DEERS with a modern personnel and beneficiary database that communicates with the medical system and allows for beneficiary self-service updates to demographic information.

Finding 2

Most of the literature on MHS health equity/disparities has been created by ad hoc, individual-initiated, one-time data analyses, or local Quality Improvement projects. These are neither cumulative nor systematic efforts. The MHS' and DHA's centralized outcomes tracking – internally and through external reporting in national registries – does not include racial and ethnic stratification or make such analyses easy to access.

The subcommittee observed high variation in outcomes across MHS sites including mental health, maternal health, and surgical outcomes. Such high variation may have a disproportionate impact on racial and ethnic minority groups, particularly those also experiencing adverse Social Determinants of Health. Without racial and ethnic stratification of patient outcomes, the subcommittee could not identify sites whose disparities were attributable to race and ethnicity. These data limitations prevented the subcommittee from making more targeted recommendations.

Recommendations 2A – 2C

2.A. Include racial and ethnic stratification of results in all patient care reporting (e.g., Joint Commission metrics, NCQA, HEDIS, registry reports, Patient-Reported Outcome Measures) as well as analysis of progress in reducing disparities.

2.B. Identify and designate a centralized group of epidemiologists, statisticians, and analysts such as the Armed Forces Health Surveillance Division, to perform analysis of potential racial and ethnic disparities. This group should stay abreast of findings in the civilian sector, and be a resource for other analysts and clinicians in the MHS who want to conduct their own assessments of racial and ethnic disparities.

2.C. Design initiatives and countermeasures to improve overall health outcomes by incorporating specific interventions (by race, ethnicity, region, Sponsor rank, or other factors) to reduce and eliminate known disparities and prevent future disparities when new treatments are introduced.

Recommendations 2D – 2E

2.D. Work with all national registries that the MHS participates in, such as NPIC and NSQIP, to allow MHS systemwide race and ethnicity reporting. This will help to inform actions to decrease the variation in outcomes between facilities throughout as well as overall disparities.

2.E. Standardize to best practice throughout the MHS to reduce variation and improve outcomes across the MHS.

Finding 3

When selecting clinical areas for improvement efforts, target areas with the largest potential impact for MHS beneficiaries.

Recommendations 3A-3B

3. A. Address maternal health urgently to adopt known best practices in the MHS systemwide to reduce the demonstrated racial disparities in maternal health outcomes in the MHS.

3. B. Prioritize clinical areas for improvement in disparities by those which have the greatest likely impact:

- Clinical conditions that affect a large population
- Clinical conditions that affect large number of actual or quality of life-years lost
- Clinical conditions that impact readiness of the force
- Clinical areas of known racial or ethnic disparity. Preliminary evidence suggests the existence of disparities by race and ethnicity in these areas:
  i. Cardiovascular (e.g., hypertension, heart disease, diabetes)
  ii. Obstetrics (e.g., maternal and infant health)
  iii. Pediatrics (e.g., vaccination, well-child visits, obesity)
  iv. Oncology (e.g., screening and outcomes)
  v. Mental Health (e.g., access and outcomes)

Finding 4

Race and ethnicity are relevant variables for some health conditions and should be carefully considered in the context of all variables affecting patients' health. Artificial Intelligence (AI) and Clinical Decision Support (CDS) tools have great potential to improve clinical treatments and health outcomes. However, biases in the underlying data stemming from study design, data collection and entry, algorithm choice, and dissemination of results can contribute to health disparities. Some medical risk calculators, decision-making tools, and equipment in use by MHS health care personnel introduce inappropriate or unjustified racial and ethnic bias.

Recommendations 4A – 4C

4.A. Create a centralized mechanism within the MHS to review data use, new protocols, and equipment to prevent inappropriate incorporation of race-based algorithms in MHS clinical practice. At a minimum, AI algorithms and CDS tools should include individual patient symptoms, family history, and genetic screening results.

4.B. Use this mechanism to review, replace, or eliminate existing race-biased tools, protocols, AI, Machine Learning algorithms, and equipment with the best-performing race-agnostic alternatives.

4.C. Develop, implement, and monitor clinical guidelines that include the outcome of AI and CDS tools, to be applied in the context of individual patients' symptoms, family history, and genetic screening results.

Finding 5

Most studies of MHS racial and ethnic health disparities omit other potential explanatory variables - such as socioeconomic status (approximated as rank in the MHS), geographic location (e.g., urban/rural), or primary language. Such variables may correlate with race and ethnicity and their omission limits the interpretation and response to research findings.

Recommendations 5A – 5B

5.A. Include socioeconomic status (or surrogates thereof), a measure of regional health services availability, and beneficiary's primary language in all DoD-conducted and DoD-funded research on disparities.

5.B. Include patients and participants from diverse populations in DoD-supported clinical trials and health research.

Finding 6

Evidence shows that up to 50% of variation in health outcomes is attributable to Social Determinants of Health (SDOH) factors. SDOH screenings are required and must be supported by other data to truly capture the lived experience of MHS beneficiaries who attempt to access and receive care, and manage their health.

Recommendations 6A – 6C

6.A. Institute SDOH screenings and documentation of SDOH indicators of MHS beneficiaries by integrating annual standardized SDOH screening tools and workflows in MHS GENESIS, particularly in adult primary care, pediatrics, and obstetrics. The MHS should use best practice standardized SDOH measurement tools and ensure that the collected SDOH data are embedded within MHS GENESIS. These tools should be kept current through regular updates. Recorded data must be accessible and reportable.

6.B. Use Patient-reported outcome metrics and patient-reported experience metrics, in addition to SDOH screenings, to better understand the experience of MHS beneficiaries as they navigate the MHS.

6.C. Offer trainings to clinicians on SDOH and appropriate documentation in the medical record. Incorporate this into health professional education.

Recommendations 6D – 6E

6.D. Proactively analyze results of SDOH screenings MHS-wide, throughout the Direct Care system, by Market, MTF, and TRICARE region, and then promote resources and interventions to address the needs of MHS beneficiaries.

6.E. Promote culturally appropriate health literacy initiatives designed for specific audiences at each location based on health outcomes data, community input, and best practice health messaging.

Finding 7

All virtual visits in the MHS revenue, registration, and scheduling system require entering the patient's preferred language, but in-person visits have no such requirement. Therefore, clinic staff spend time during the appointment attempting to connect to interpretation services or serving as interpreters themselves. Language barriers can contribute to adverse patient experience, a driver of variation in health outcomes.

Recommendation 7

7. Request and enter the patient's preferred language as a required field when making in-person appointments. Ensure appropriate interpretation services are available for all visits.

Finding 8

While data are limited on the direct impact of health equity training initiatives on health outcomes, some training methods appear to promote empathy and reduce bias which can improve health outcomes.

Recommendation 8

8. Carefully consider the qualities of any health equity training before implementing it and use vendors only with a proven record of delivering effective health equity training. Effectiveness should be measured by the training's impact on reducing racial and ethnic disparities in patient outcomes and experiences.

Finding 9

Increased clinician-patient racial and ethnicity concordance can lead to improved patient care experiences through better communication, greater cultural competency, and reduced inadvertent implicit bias. The U.S. Government has committed to expanding ROTC programs to more minority-serving institutions (MSI) with Science, Technology, Engineering, and Mathematics (STEM) programs as a pathway for careers in the Military Services for more underrepresented racial and ethnic minority groups.

Recommendations 9A – 9D

9.A. Ensure criteria for ROTC program expansion at MSIs such as Historically Black Colleges and Universities, Hispanic-serving institutions, and Tribal Colleges and Universities include nursing, pre-medical, and other pre-health career curricula.

9.B. Promote workforce diversity through recruitment activities with academic organizations focused on race and ethnicities underrepresented in medicine.

9.C. Collaborate with existing groups that are already promoting workforce racial and ethnic diversity in healthcare.

9.D. Assess the effectiveness of these efforts by documenting changes in the supply of underrepresented clinicians in medicine.

Recommendations 9E – 9F

9.E. Measure impact of interventions to increase clinician-patient race and ethnicity concordance by a range of stratifications including location and clinical service type.

9.F. Leverage Virtual Health to broaden the geographic range of options for patients to select health care providers of their racial and ethnic preference.

Finding 10

The Joint Commission (JC) requires the following actions to reduce health care disparities:

- Designate an individual to lead activities to reduce disparities for the organization's patients
- Assess patients' health-related social needs
- Stratify quality and safety data by sociodemographic characteristics
- Develop a written action plan to address disparities
- Inform leaders and staff about progress to reduce disparities at least annually

The DHB's review of best practices and the recommendation of the U.S. Centers for Medicare & Medicaid Services (CMS) to reduce health care disparities also stress leadership, and sustained commitment effort at all organizational levels.

Recommendations 10A – 10C

10.A. Commit to achieving the goal of eliminating any racial and ethnic health disparities among all MHS beneficiaries by:
- Measuring disparities
- Setting goals to reduce disparities by specific dates
- Allocating sufficient resources to eliminate disparities
- Regularly assessing progress

10.B. Ensure racial and ethnic stratification is included in all health care quality reporting, e.g., Joint Commission metrics, NCQA, HEDIS, registry reports, Patient-Reported Outcome Measures, and patient experience.

10.C. Add a racial and ethnic stratification to medical and dental readiness reports to monitor disparities in readiness. If disparities are found, hold leaders with command authority accountable to address and eliminate persistent racial and ethnic disparities in medical and dental readiness.

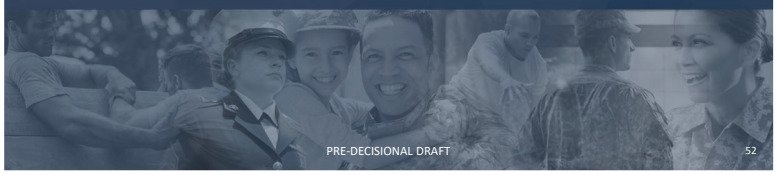
Recommendations 10D – 10F

10.D. Assign the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) as the accountable leader for health disparities. Establish a chartered Health Equity Committee by the end of Fiscal Year 2024 to support the USD(P&R), and to monitor and guide the implementation of the recommendations in this report by a targeted date. The Committee will:
- Report progress toward eliminating health disparities
- Include representative groups
- Report back to the Defense Health Board in three years

10.E. Assign the Assistant Secretary of Defense for Health Affairs (ASD(HA)) to report health outcomes, stratified by race and ethnicity, and report on ongoing initiatives to eliminate disparities, to the USD(P&R) no less than annually. The ASD(HA) should do this by submitting an annual health disparities report card to the Committee and USD(P&R). MHS should report Clinical Quality, Health Outcomes, and Patient-Reported Outcomes by race and ethnicity at least quarterly to the ASD(HA).

10.F. Incorporate Health Equity performance metrics and goals into quality and patient incentive programs for personnel providing care and managing military health services, such as those found in the Integrated Resourcing and Incentive System.

Questions



Findings and Recommendations

Finding 1: MHS data systems do not fully capture race and ethnicity data to fully describe the beneficiary population. Most MHS family member beneficiaries either have an incorrect or missing value for race and ethnicity in MHS data systems. Others have their race and ethnicity inferred from their active-duty Sponsor. The Defense Enrollment Eligibility Reporting System (DEERS), which serves as DoD's personnel, enrollment, and eligibility system, is the source of race and ethnicity data for the MHS GENESIS system. But Service members and beneficiaries are currently unable to view or edit race and ethnicity in their DEERS record. When a beneficiary or clinic staff attempts to update MHS GENESIS with more accurate race or ethnicity data, the fields are overwritten by DEERS at the next update. Studies using current MHS data, therefore, are often unable to determine whether disparities exist or do not exist.

As of January 1, 2023, the Joint Commission (JC) requires hospitals and other health care programs to collect race and ethnicity for all patients. The Office of Management and Budget (OMB) Statistical Policy Directive 15 (SPD 15) states that self-reported race and ethnicity data is the preferred method for collecting these data. The JC encourages organizations to use the five race and two ethnicity categories from OMB SPD 15, at a minimum. DEERS does not comply with the OMB reporting requirement because: (1) it combines the "Asian" and "Native Hawaiian or Pacific Islander" into a combined "Asian or Pacific Islander" category; (2) it includes a race category of "Other."

Short-term recommendations for DoD's personnel, enrollment, and eligibility system:

Recommendation 1. A: DMDC should ensure that Conform to the JC requirement by collecting self-identified race and ethnicity data for all beneficiaries, not just active-duty Service members. Harmonize all race and ethnicity data between all administrative data sources, including MHS GENESIS.

Recommendation 1. B: Empower Service members and beneficiaries to view, self-identify, and correct their race and ethnicity data.

Recommendation 1. C: Conform with the OMB SPD 15 Federal Minimum Standards for Race and Ethnicity by:

- Separating the "Asian or Pacific Islander" category into the two OMB compliant categories "Asian" and "Native Hawaiian or other Pacific Islander."
- Replacing the "Other" category with "Multiracial" and eliminating the "Unknown" category.

Recommendation 1. D: Require health facility staff to assist patients and help them update their data when they review their MHS GENESIS race and ethnicity data.

Long-term Recommendation for DoD's personnel, enrollment, and eligibility system:

Recommendation 1. E: Replace DEERS with a modern personnel and beneficiary database that communicates with the medical system and allows for beneficiary self-service updates to demographic information.

Finding 2: Most of the literature on MHS health equity/disparities has been created by ad hoc, individual-initiated, one-time data analyses, or local Quality Improvement projects. These are neither cumulative nor systematic efforts. The MHS' and DHA's centralized outcomes tracking – internally and through external reporting in national registries – does not include racial and ethnic stratification or make such analyses easy to access.

The subcommittee observed high variation in outcomes across MHS sites including mental health, maternal health, and surgical outcomes. Such high variation may have a disproportionate impact on racial and ethnic minority groups, particularly those also experiencing adverse Social Determinants of Health. Without racial and ethnic

stratification of patient outcomes, the subcommittee could not identify sites whose disparities were attributable to race and ethnicity. These data limitations prevented the subcommittee from making more targeted recommendations.

Recommendation 2. A: Include racial and ethnic stratification of results in all patient care reporting (e.g., Joint Commission metrics, NCQA, HEDIS, registry reports, Patient-Reported Outcome Measures). ~~as well as analysis of progress in reducing disparities.~~

Recommendation 2. B: Identify and designate a centralized group of epidemiologists, statisticians, and analysts such as the Armed Forces Health Surveillance Division, to perform analysis of potential racial and ethnic disparities. This group should stay abreast of findings in the civilian sector, and be a resource for other analysts and clinicians in the MHS who want to conduct their own assessments of racial and ethnic disparities.

Recommendation 2. C: Design initiatives and countermeasures to improve overall health outcomes by incorporating specific interventions (by race, ethnicity, region, Sponsor rank, or other factors) to reduce and eliminate known disparities and prevent future disparities when new treatments are introduced.

Recommendation 2. D: Work with all national registries that the MHS participates in, such as NPIC and NSQIP, to allow MHS systemwide race and ethnicity reporting. This will help to inform actions to ~~decrease the~~ reduce unwarranted variation in outcomes between facilities throughout as well as overall disparities.

Recommendation 2. E: Standardize to best practice throughout the MHS to reduce variation and improve outcomes across the MHS.

Finding 3: When selecting clinical areas for improvement efforts, target areas with the largest potential impact for MHS beneficiaries.

Recommendation 3. A: Address maternal health urgently to adopt known best practices in the MHS systemwide to reduce the demonstrated racial disparities in maternal health outcomes in the MHS.

Recommendation 3. B: Prioritize clinical areas for improvement in disparities by those which have the greatest likely impact:

- Clinical conditions that affect a large population
- Clinical conditions that affect large number of actual or quality of life-years lost
- Clinical conditions that impact readiness of the force
- Clinical areas of known racial or ethnic disparity. Preliminary evidence suggests the existence of disparities by race and ethnicity in these areas among others:
  i. Cardiovascular (e.g., hypertension, heart disease, diabetes)
  ii. Obstetrics (e.g., maternal and infant health)
  iii. Pediatrics (e.g., vaccination, well-child visits, obesity, asthma)
  iv. Oncology (e.g., screening and outcomes)
  v. Mental Health (e.g., access and outcomes)

Finding 4: Race and ethnicity are relevant variables for some health conditions and should be carefully considered in the context of all variables affecting patients' health. Artificial Intelligence (AI) and Clinical Decision Support (CDS) tools have great potential to improve clinical treatments and health outcomes. However, biases in the underlying data stemming from study design, data collection and entry, algorithm choice, and dissemination of results can contribute to health disparities. Some medical risk calculators, decision-making tools, and equipment in use by MHS health care personnel introduce inappropriate or unjustified racial and ethnic bias.

Recommendation 4. A: Create a centralized mechanism within the MHS to review data use, new protocols, and equipment to prevent inappropriate incorporation of race-based algorithms in MHS clinical practice. At a minimum, AI algorithms and CDS tools should include individual patient symptoms, family history, and genetic screening results.

Recommendation 4. B: Use this mechanism to review, replace, or eliminate existing race-biased tools, protocols, AI, Machine Learning algorithms, and equipment with the best-performing race-agnostic alternatives.

Recommendation 4. C: Develop, implement, and monitor clinical guidelines that include the outcome of AI and CDS tools, to be applied in the context of individual patients' symptoms, family history, and genetic screening results.

Finding 5: Most studies of MHS racial and ethnic health disparities omit other potential explanatory variables - such as socioeconomic status (approximated as rank in the MHS), geographic location (e.g., urban/rural), or primary language. Such variables may correlate with race and ethnicity and their omission limits the interpretation and response to research findings.

Recommendation 5. A: Include socioeconomic status (or surrogates thereof), a measure of regional health services availability, and beneficiary's primary language in all DoD-conducted and DoD-funded research on disparities.

Recommendation 5. B: Include patients and participants from diverse populations in DoD-supported clinical trials and health research appropriate to the scientific question being studied.

Finding 6: Evidence shows that up to 50% of variation in health outcomes is attributable to Social Determinants of Health (SDOH) factors. SDOH screenings are required and must be supported by other data to truly capture the lived experience of MHS beneficiaries who attempt to access and receive care, and manage their health.

Recommendation 6. A: Institute SDOH screenings and documentation of SDOH indicators of MHS beneficiaries by integrating annual standardized SDOH screening tools and workflows in MHS GENESIS, particularly in adult primary care, pediatrics, and obstetrics. The MHS should use best practice standardized SDOH measurement tools and ensure that the collected SDOH data are embedded within MHS GENESIS. These tools should be kept current through regular updates. Recorded data must be accessible and reportable.

Recommendation 6. B: Use Patient-reported outcome metrics and patient-reported experience metrics, in addition to SDOH screenings, to better understand the experience of MHS beneficiaries as they navigate the MHS.

Recommendation 6. C: Offer trainings to clinicians on SDOH and appropriate documentation in the medical record. Incorporate this into health professional education.

Recommendation 6. D: Proactively analyze results of SDOH screenings MHS-wide, throughout the Direct Care system, by Market, MTF, and TRICARE region, and then promote resources and interventions to address the needs of MHS beneficiaries.

Recommendation 6. E: Promote culturally appropriate health literacy initiatives designed for specific audiences at each location based on health outcomes data, community input, and best practice health messaging.

Finding 7: All virtual visits in the MHS revenue, registration, and scheduling system require entering the patient's preferred language, but in-person visits have no such requirement. Therefore, clinic staff spend time during the appointment attempting to connect to interpretation services or serving as interpreters themselves. Language barriers can contribute to adverse patient experience, a driver of variation in health outcomes.

Recommendation 7: Request and enter the patient's preferred language as a required field when making in-person appointments. Ensure appropriate interpretation services are available for all visits.

Finding 8: While data are limited on the direct impact of health equity training initiatives on health outcomes, some training methods appear to promote empathy and reduce bias which can improve health outcomes.

Recommendation 8: Carefully consider the qualities of any health equity training before implementing it and use vendors only with a proven record of delivering effective health equity training. Effectiveness should be measured by the training's impact on reducing racial and ethnic disparities in patient outcomes and experiences.

Finding 9: Increased clinician-patient racial and ethnicity concordance can lead to improved patient care experiences through better communication, greater cultural competency, and reduced inadvertent implicit bias. The U.S. Government has committed to expanding ROTC programs to more minority-serving institutions (MSI) with Science, Technology, Engineering, and Mathematics (STEM) programs as a pathway for careers in the Military Services for more underrepresented racial and ethnic minority groups.

Recommendation 9. A: Ensure criteria for ROTC program expansion at MSIs such as Historically Black Colleges and Universities, Hispanic-serving institutions, and Tribal Colleges and Universities include nursing, pre-medical, and other pre-health career curricula.

Recommendation 9. B: Promote workforce diversity through recruitment activities with academic organizations focused on race and ethnicities underrepresented in medicine.

Recommendation 9. C: Collaborate with existing groups that are already promoting workforce racial and ethnic diversity in healthcare.

Recommendation 9. D: Assess the effectiveness of these efforts by documenting changes in the supply of underrepresented clinicians in medicine.

Recommendation 9. E: Measure impact of interventions to increase clinician-patient race and ethnicity concordance by a range of stratifications including location and clinical service type.

Recommendation 9. F: Leverage Virtual Health to broaden the geographic range of options for patients to select health care providers of their racial and ethnic preference.

Finding 10: The Joint Commission (JC) requires the following actions to reduce health care disparities:

- Designate an individual to lead activities to reduce disparities for the organization's patients
- Assess patients' health-related social needs
- Stratify quality and safety data by sociodemographic characteristics
- Develop a written action plan to address disparities
- Inform leaders and staff about progress to reduce disparities at least annually

The DHB's review of best practices and the recommendation of the U.S. Centers for Medicare & Medicaid Services (CMS) to reduce health care disparities also stress leadership, and sustained commitment effort at all organizational levels.

Recommendation 10. A: Commit to achieving the goal of eliminating any racial and ethnic health disparities among all MHS beneficiaries by:

- Measuring disparities
- Setting goals to reduce disparities by specific dates
- Allocating sufficient resources to eliminate disparities
- Regularly assessing progress

Recommendation 10. B: Ensure racial and ethnic stratification is included in all health care quality reporting, e.g., Joint Commission metrics, NCQA, HEDIS, registry reports, Patient-Reported Outcome Measures, and patient experience.

Recommendation 10. C: Add a racial and ethnic stratification to medical and dental readiness reports to monitor disparities in readiness. If disparities are found, hold leaders with command authority accountable to address and eliminate persistent racial and ethnic disparities in medical and dental readiness.

Recommendation 10. D: Assign the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) as the accountable leader for health disparities. Establish a chartered Health Equity Committee by the end of Fiscal Year 2024 to support the USD(P&R), and to monitor and guide the implementation of the recommendations in this report by a targeted date. The Committee will:

- Report progress toward eliminating health disparities
- Include representative groups
- Report back to the Defense Health Board in three years

Recommendation 10. E: Assign the Assistant Secretary of Defense for Health Affairs (ASD(HA)) to report health outcomes, stratified by race and ethnicity, and report on ongoing initiatives to eliminate disparities, to the USD(P&R) no less than annually. The ASD(HA) should do this by submitting an annual health disparities report card to the Committee and USD(P&R). MHS should report Clinical Quality, Health Outcomes, and Patient-Reported Outcomes by race and ethnicity at least quarterly to the ASD(HA).

Recommendation 10. F: Incorporate Health Equity performance metrics and goals into quality and patient incentive programs for personnel providing care and managing military health services, such as those found in the Integrated Resourcing and Incentive System.

9/6/2023

Appendix 4

The Defense Health Agency: Moving from Transition to Execution

LTG Telita Crosland

September 11, 2023

DHA Mission, Vision & Priorities

MISSION:
The Defense Health Agency supports our Nation by improving health and building readiness – making extraordinary experiences ordinary and exceptional outcomes routine.

VISION:
Unrelenting pursuit of excellence as we care for our joint force and those that we are privileged to serve. Anytime, Anywhere–Always

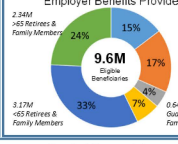
PRIORITIES:
- Enabling Combat Support to the Joint Force in Competition, Crisis, or Conflict
- Building a Modernized, Integrated, and Resilient Healthcare Delivery System
- Dedicated and Inspired Teams of Professionals Driving Military Health's Next Evolution

The Defense Health Agency: An Integrated Health System

Health Care Delivery System
"Medical Force Training Platform and Health Care Provider"

	FY22
Inpatient Hospitals & Medical Centers	45
Medical Clinics	525
Dental Clinics	138
Veterinary Clinics	250
Military Staff	71,865
Civilian Staff	57,106

Health Benefits Administrator
"Employer Benefits Provider"



TRICARE Suite
"Payer"

Civilian Network Care Contracts
- Two medical regions/contractors in US
  - Health Net (West) & Humana (East)
- One international medical benefits contractor
  - International SOS
- One pharmacy benefit contractor
  - Express Scripts
- One dental program contractor
  - United Concordia

TRICARE Benefit Plan Options
- TRICARE Prime
- TRICARE Select
- TRICARE for Life
- TRICARE Reserve Select
- TRICARE Retired Reserve
- US Family Health Plan
- TRICARE Young Adult
- Active Duty Dental
- TRICARE Dental
- FEDVIP

Combat Support Agency
"Partner"

Joint Medical Logistics	Research & Development	Global Public Health	Education & Training	Joint Trauma System
• Identify and deliver medical materiel solutions to meet operational requirements	• Provide novel medical tools, techniques, and clinical practice guidelines to modernize MHS capabilities for near-peer conflict	• Provide combatant commands with near real-time disease and bio-surveillance threat information	• Build and sustain a ready medical force through Medical Education & Training Campus and MTF platforms	• Maximize battlefield injury survival functional recovery rates

New Defense Health Network Structure

Director Defense Health Agency

Assistant Director Health Care Administration

DHA HQ Support and Coordination to Networks

- Dual-hatted Army FO/GO
- Dual-hatted Navy FO/GO
- Dual-hatted Air Force FO/GO
- Non dual-hatted FO/GO (JDAL)
- Reporting Relationship
- Support and Coordination

ADC of MTFs

Network 1	7 MTFs	Defense Health Support Activity Pacific
Network 2	9 MTFs	
Network 3	9 MTFs	Defense Health Support Activity West
Network 4	39 MTFs	
Network 5	13 MTFs	Defense Health Support Activity Central
Network 6	11 MTFs	
Network 7	7 MTFs	Defense Health Support Activity Atlantic-Europe
Network 8	10 MTFs	
Network 9	26 MTFs	

9/6/2023
9/6/2023

MTF Priority Efforts

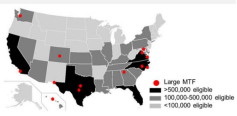
- **Quality & safety first,** the cornerstone and foundation of every MTF in the DHA
- **Align resources and manage behaviors** to generate the greatest impact on the mission while achieving business plans
- **Standardize processes** to reduce template variation and implement appointing processes that are person-centric, not system-centric
- **Optimize adoption of MHS GENESIS** and exploit agile, new capabilities in support of access, quality, and safety
- **Focus on people,** including hiring, onboarding, training & retention

DHA Core Values

Dependability	We are trustworthy, honest about our performance, and follow through on our commitments
Humility	We focus on listening, we are compassionate, and we take an active interest in understanding the needs and concerns of our teammates, partners, and patients
Agility	We adapt quickly and innovate effectively when presented with new opportunities and new challenges

Major Efforts to Advance Medical Readiness & Improve Healthcare Delivery in MTFs

Deliver More Complex Care in Large MTFs & Augment Primary Care Capacity at Smaller MTFs



Maximize Existing Hiring Authorities and Salary Caps & Reduce Time to Hire

Expand Partnerships with Dept. of Veterans Affairs (VA) and Civilian Partners

Locations with near-term opportunities for collaboration

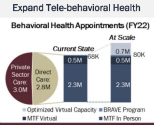
DHA MTF	VA VISN / Network
Joint Base Elmendorf-Richardson	20 / VA Alaska Healthcare
NMC Portsmouth	6 / VA Hampton Healthcare
Madigan AMC	20 / Seattle VAHCS
Eglin AFB & NH Jacksonville	16 / Gulf Coast Veterans HCS
MacDill AFB	8 / VA Tampa HCS
Evans ACH & USAF Academy	19 / VA Eastern CO HCS
Blanchfield ACH	9 / VA TN Valley HCS

Lead with Digital Health

Improve Pharmacy Tools & Processes

Expand Tele-behavioral Health

Behavioral Health Appointments (FY22)



Appendix 5

Tidewater Market Overview
11 September 2023

Improving Health and Building Readiness. Anytime, Anywhere Always

1

Tidewater's Past

1800 1825 1850 1875 1900 1925 1950 1975 2000 2015

1798 - The Hospital Fund
1830 - Birth of First Naval Hospital
1838 - Naval Burial Ground
1855 - Yellow Fever Epidemic
1861 - Civil War
1898 - Spanish-American War
1902 - Navy's First Corps School
1907 - Hospital Renovation
1908 - Navy Nurse Corps Established
1916 Langley Field Established
1917 – WWI
1918 – Ft. Eustis Established
1937-53 - WWII and Korea
1941 - Ft. Eustis opens first hospital
1960 - Tidewater's First Skyscraper
1964 – New hospital at Ft. Eustis (McDonald)
1999 - Charette Health Care Center
2005 - Navy Medicine East
2007 - McDonald downgrade to AHC
2007-16 - Warrior Transition Co. at McDonald
2010 - Joint Base Langley-Eustis (BRAC 2005)
2012 - Tidewater MSM
2014 - Tidewater eMSM

Improving Health and Building Readiness. Anytime, Anywhere Always

2

Tidewater's Present: Integrated Market Services

2015 2016 2017 2018 2019 2020 2021 2022 2023

2018-21 - Langley 633MDG becomes an Ambulatory Surgical Center
2018 - Langley/McDonald Integrated Surgical Services
2019 - CBMH Opened in Williamsburg
2022 - Certified as DHA Tidewater Market (TWM) Standardization, Integration, Optimization
2022 - USNH Guantanamo Bay and CAPT James A Lovell FHCC join TWM
2023 - NMCP designated by State of Virginia as a Level II trauma center
Fall 2023 - DHA Advancement; Network-5

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3

Tidewater's Present: Integrated Market Services

Navy (NMCP) Director:
CAPT Brian Feldman
Naval Medical Center Portsmouth
BHC, JEB Little Creek (Boone Clinic)
BHC, Dam Neck Annex
BHC, Norfolk Naval Station (Sewells Point)
BHC, Norfolk Naval Station (Sewells Point) Dental
BHC, Norfolk Naval Shipyard
BHC, Chesapeake (Northwest Annex)
BHC, Naval Air Station Oceana
BHC, Yorktown (Naval Weapons Station)
CBHC Virginia Beach-Portsmouth (former TPC)
CBHC Chesapeake-Portsmouth (former TPC)
CBHC Suffolk-Portsmouth (former TPC)

Army (MCAHC) Director:
LTC Demarcio Reed
McDonald Army Health Center, Fort Eustis
Troop Medical Clinic 1 (TMC1) – Skymaster Clinic
Troop Medical Clinic 2 (TMC2) – Resolute Clinic
Fort Story Army Health Clinic
Community-Based Medical Home (CBMH) Williamsburg
Tignor Dental Clinic, Fort Eustis

Air Force (633 MDG) Director:
Col Nathan Kellett
USAF Hospital Langley (633 MDG), Langley AFB
USAF 633rd Dental Squadron, Langley AFB

Federal (FHCC) Deputy Director:
CAPT Chad McKenzie
Captain James A. Lovell Federal Health Care Center

Naval Hospital Guantanamo Bay (NHGB) Director:
CAPT Rick Zeber
Naval Hospital Guantanamo Bay

MTFs/Beneficiaries within TMHS:
Air Force, Army, Navy

Eligible Beneficiaries:	**377,416**
Enrolled:	**227,484**
TWM (Tidewater Market) MTFs:	167,202
Tidewater Op Forces:	34,423
TWM MCSC (Managed Care Support Contractor)	25,859

Improving Health and Building Readiness. Anytime, Anywhere Always

4

Tidewater Market, Network 5, and the Future…

2023 2024 2025 2026 2027

Fall 2023 – DHA Advancement; Network 5
Gaining ADC of 8 additional facilities
Grow and Mature Network Office
Sustainment of integrated local Market
2023-27 – Grow Partnerships with VA
2024-27 - Primary Care Enrollment Recapture Increase Case-Mix and Complexity
2024 - Digital Door Front
2024 - Project Caladrius
2027 – Tidewater Market appropriately staffed and Trained to be a Battlefield Casualty Receiving Site

Improving Health and Building Readiness. Anytime, Anywhere Always

5

Questions

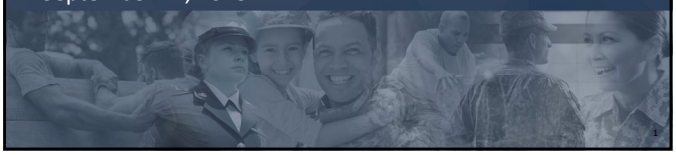
Improving Health and Building Readiness. Anytime, Anywhere Always

6

Appendix 6

Effective Public Health Communication Strategies with Department of Defense Personnel

Wilsie Bishop, DPA
Chair, Public Health Subcommittee
September 11, 2023



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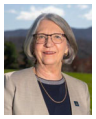
Overview / Agenda

- Membership
- Tasking
- Background
- Objectives and Scope
- Summary of Subcommittee Activities to Date
- Emerging Findings
- Areas of Interest
- Way Forward

2

Membership



CHAIR
Wilsie Bishop DPA, MPA*

Georges Benjamin, MD

John Clements, PHD

Marion Ehrich, PhD, MS

Ruth Etzel, MD, PHD

Christopher Johnson, PHD

*Board Member

3

Tasking

On May 12, 2023, the Assistant Secretary of Defense for Health Affairs directed the Defense Health Board (DHB) to **provide recommendations on how the DoD could better deliver health information within an environment of misinformation.**

4

Background

- Inaccurate information about health harms public health and undermines trust in public health professionals.
- Inaccuracies can be characterized as *misinformation* (good faith errors) and *disinformation* (intentional spread of falsehoods).
- The information landscape during the COVID-19 Pandemic was exceptionally complex and influenced by multiple factors.
- Tension between freedom of expression and protecting the public good permeates efforts to mitigate the impacts of mis- and disinformation.

5

Objectives and Scope

- Identify lessons learned about DoD's vulnerabilities and capabilities in disseminating health information during the COVID pandemic.
- Review DoD/DHA policies and processes used for health communications.
- Review academic, commercial, and government research on best practices for health communications.
- Provide recommendations for how the DoD could better deliver health information within an environment of misinformation and threats to credibility.

6

Summary of Activities to Date

Meeting Date	Discussion Topics
Jan 20, 2023: PH Meeting	Potential Health Communications tasking
Jun 14, 2023: PH Meeting	Health Communications report development overview
Jun 28, 2023: DHB Meeting	DHA Strategic Communications
Jul 24, 2023: PH Meeting	• Follow-up from DHA Strategic Communications • Public health response to COVID-19
Aug 25, 2023: PH Meeting	• Military culture • Misinformation and disinformation • A perspective on government censorship • Science of health communications • Informal military communications panel

7

Emerging Findings

- DoD health communications are military-specific but occur within a complex and influential civilian communication environment.
- Trust is essential to messaging uptake and to successful misinformation and disinformation mitigation efforts. Leadership and trusted messengers are essential components.
- Communicating the underpinnings of public health decisions (e.g., the role of uncertainty in the scientific process; how and why scientists and officials coalesce around certain positions) allows experts to partner with the public on public health decision making.

8

Emerging Findings

- Cultural perspectives, personal experiences, and beliefs may affect perceptions of the legitimacy of the scientific process and public trust. Bilateral communication and appropriate acknowledgement and treatment of minority scientific perspectives is vital even as consensus positions are actioned.
- Understanding variables that influence how communications are received, and working through non-official as well as official channels and mediums, are essential to making DOD communications the message of choice.

9

Areas of Interest

- Military spouse perspectives on health communications
- Health communications and the law
- Vaccine refusal
- Media information ecosystem and information flows
- Artificial intelligence technology
- Public understanding of scientific process and digital literacy
- Academic perspective on health communications
- Effectiveness of misinformation interventions (pre/debunking, fact checking etc.)

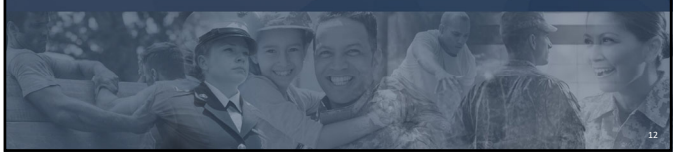
10

Way Ahead

- Subcommittee meetings with briefings from Subject Matter Experts every three weeks beginning September 19
- Regular report development updates to the Subcommittee Chair
- Quarterly updates to the Defense Health Board
- Anticipated Decision Brief June 4, 2024

11

Questions



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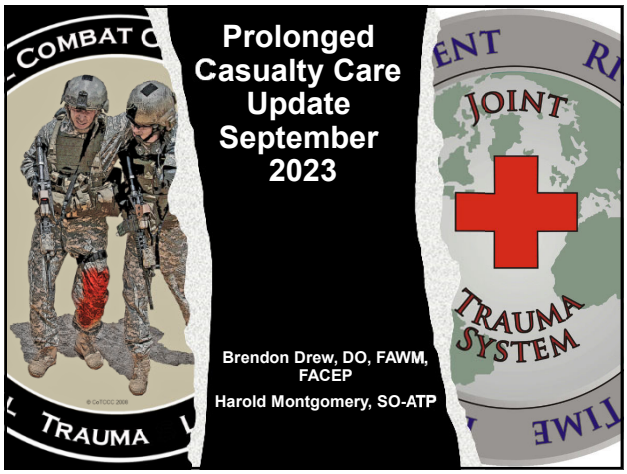

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Disclosures

- My views and opinions may not reflect those of the Defense Health Agency, the Joint Trauma System, the U.S. Navy, the U.S. Marine Corps or the Department of Defense
- My opinions may not reflect those of other medical directors
- No financial conflicts
- My friends and I share slides

2

Perspective

- An end-user of TCCC for 20 years
- My son is an end user
- Marine Expeditionary Force
  - Privileging Authority for 250+ providers
  - Medical director
  - No command authority

3

Nothing gets a pass because "That's the way we've always done it."

TCCC LEADERSHIP LESSON LEARNED NO. 1:
NOTHING GETS A PASS BECAUSE "THAT'S THE WAY WE'VE ALWAYS DONE IT"

Leadership lessons learned in Tactical Combat Casualty Care

Frank K. Butler, MD, FAAO, FUHM. *J Trauma Acute Care Surg Volume 82, Number 6, Supplement 1*

4

Focus

- Evidence
- Logistics
- Recommendations
- Guidelines (not protocols)

5

TCCC Employment

Medical Direction

Curriculum

Change Paper

Guidelines

Detail

6

PFC vs PCC

- Prolonged Field Care Continues
  - SOCOM effort
  - Broader focus
- Prolonged Casualty Care
  - Conventional Forces
  - Narrower focus
    - Continuation of TCCC
  - JTS Guidelines
  - JTET Curriculum

7

The “Capability Brief”

- Unreasonable logistical expectations of prehospital providers delivering care out of a backpack
- Unreasonable expectations placed on prehospital providers employing TCCC

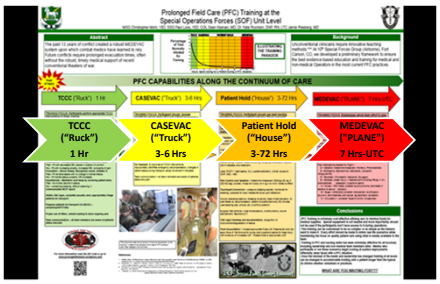
8

Prolonged Casualty Care

- The “impossible problem set”
- Not a capability
- Not a solution to the problem set
- What it is:
  - Logistical continuation of TCCC
  - Approach to the problem set
- Leverage the work of PFC experts for the conventional force

9

Prolonged Casualty Care



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PCC Consensus Statement

RECOMMENDATIONS

The Committee of TCCC and PCC-WG advocate for the following:

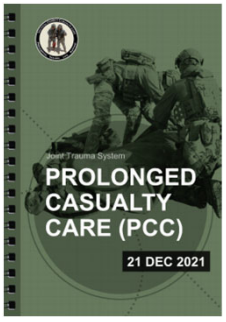
- As it pertains to trauma, there is no PCC without TCCC.
- PCC should never serve as the primary medical plan in support of a Commander’s casualty response system.
- Tourniquets, blood transfusion, airway, and ventilatory support are frequently required interventions for the seriously injured. Future PCC efforts should direct resources, technology, and training to field capabilities for sustained resuscitation, airway, and breathing support in the austere environment.[3] TCCC provides the foundation of skills upon which to build more advanced airway, ventilation, pain control, and resuscitation skills needed for complex trauma and disease non-battle injury patients.
- The recommendations within the PCC Guidelines should be incorporated into medical planning, pre-deployment training, service individual and collective training requirements, and combatant command theater entry requirements.
- PCC may require a triage methodology that shifts away from medically salvageable criteria to a continuous tactically or logistically salvageable paradigm.
- The PCC paradigm for subsequent Role 1 phases of care, based on time, sshould be incorporated into doctrinal and logistics planning criteria:

Role	Definition	Time Period
1a	Carried/Point of Need/Ruck	<1 Hour
1b	Mission-specific transportation platform/Truck	1-4 Hours
1c	Mission support site/House	>4 Hours
1d	Evacuation platform/Plane (as planned or available)	No Timeframe

11

Prolonged Casualty Care (PCC)

- **PCC Guidelines published Dec 2021**
- **PCC Curriculum Working Group developing learning objectives and curricula core requirements.**
- **PCC Working Group transitioning to standing subcommittee under CoTCCC.**



12

JOINT TRAUMA SYSTEM CLINICAL PRACTICE GUIDELINE (JTS CPG)

Prolonged Casualty Care Guidelines (CPG ID:91)

The Prolonged Casualty Care (PCC) guidelines are a consolidated list of casualty-centric knowledge, skills, and best practices intended to serve as the DoD baseline clinical practice guidance to guide casualty management over a prolonged amount of time in austere, remote, or expeditionary settings, and/or during long-distance movements.

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COL Cord Cunningham, MC, USA
COL Jennifer Gurney, MC, USA
Col Stacy A. Shackelford, USAF, MC
* Denotes a sub-working group chair

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Spectrum of Role I Care

DNBI:
Tropical Medicine
Mental Health
Ortho Injuries
Women's Health

30 min | 90 min | 70 hours +

Sick Call Screener
Prev Med Techs
Embedded Mental Health
EMT-Basic

TCCC
Valkyrie
Whole Blood

Prolonged Casualty Care

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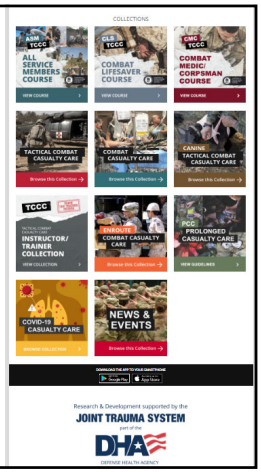
Deployed Medicine

www.deployedmedicine.com
"Deployed Medicine" mobile app on iOS or Android

- A Training, Education, Pre-Deployment and Down-Range Tool for individuals and organizations.
- All Course and Content can be downloaded to personal and gov EUD Smart Devices and Desktop
- Assessments are taken within Deployed Medicine and maintained in student record
- Now:
  - All TCCC Training & Reference
  - JTS Clinical Practice Guidelines
  - Canine Casualty Care
  - Prolonged Casualty Care
- Coming:
  - EWSC, ASSET+, KSA-related, Equipment Ref & Tng

Emerging:

Equipment Behavior Health SOF Medicine Global Health



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QUESTIONS/COMMENTS

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Partnerships

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Partnerships

- Barriers
  - Variation
    - Service product lines
    - Service medic/Corpsman training
    - Civilian certifications
    - Civilian institutions' motivation
  - Lack of standardization
- High acuity
  - Frequent tunnel vision

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Balanced Model

- Clarify focus
  - Individual training
  - Team training
- Institution
  - MTF
  - Local civilian
  - Remote civilian/military

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Institutional Characteristics

- University
- Research
- Commercial
- Site survey
  - GME
  - Supervision practices
  - Billing
  - Liability environment

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Questions/Comments

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Appendix 8

DEFENSE HEALTH BOARD

INTRO TO NAVY AFLOAT MEDICAL CAPABILTY

CAPT Bettina M. Sauter, MC, USN
COMNAVSURFLANT
FORCE SURGEON
11 SEPT 2023

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Disclosures

- **The views and opinions may not reflect those of Navy Medicine, the U.S Navy, the U.S. Marine Corps or the Department of Defense**
- **No financial conflicts to report**
- **Inputs for this presentation were received from multiple sources and then interpreted and collated by me to result in the final slides.**

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Objective

- **Briefly discuss the Roles of Care in the operational setting**
- **Highlight the differences in medical capacity and capability**
- **Provide an overview of Navy Afloat Platforms Medical Capabilities**

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Roles of Care

- **Role 1 – Provides medical treatment, Initial trauma care, forward resuscitation (not surgical)**
- **Role 2 – Provides medical treatment, advanced trauma management, emergency surgery, and resuscitative care**
- **Role 3 – provides emergency and specialty surgery, intensive care, medical specialty care, and extended holding capacity and capability augmented by robust ancillary support**
- **Role 4 – Provides the full range of preventative, acute, restorative, curative, rehabilitative, and convalescent care found in the United States base hospitals and robust overseas facilities**

Source: DOD Instruction 6000.11 Patient Movement

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Capability vs Capacity

Capability
- This is what we can do now
  - Can increase with personnel
  - Can increase with equipment augments

Capacity
- Constrained mostly by the spaces on the ship
  - Augment personnel
    - Fleet Surgical Team (FST)
    - Casualty Receiving Treatment Ship M+1 (CRTS M+1)
    - Expeditionary Resuscitative Surgical System (ERSS)
    - En Route Care System (ERCS)
  - Beds to nurses
  - Blood supply, time to access (1.5 for first frozen unit / 45 min for first unit in WBB)
  - Time – may change depending on number/severity of casualties

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Afloat Platforms

SURFOR
Amphibious Force:
- **LHD**
- **LPD**
- **LSD**
- **ESB**

Surface Combatants:
- **CG**
- **DDG**
- **LCS**
- **FFG**

Command Ships:
- **LCC**

AIRFOR:
- **CVN**

Military Sealift Command (MSC)
- **T-AH**
- **EPF/EMS**

SUBFOR:
- **SUB TENDERs**
- **SSN/SSBN**

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USS WASP CLASS (LHD)

FACILITIES

Operating Rooms	4 (2 FOR LHA)
Medical Exam	4
Dental Operatories	4
Intensive Care Unit Beds	15
Ward Beds	38 (19 Top and 19 Bottom)
Quiet/Isolation Beds	6 (No negative pressure)
(*1 Room 2-bed, 1 Room 4-bed)	
Overflow Beds	275

(*Overflow consists of units commonly used for Marine berthing.)
WALKING BLOOD BANK DEPENDENT ON 10% sampling of Ship's company.

ANCILLARY SERVICES

Pharmacy	General Dentistry
Clinical Lab	Preventative Medicine
Bio-Medical Repair	Digital X-ray (Medical)
Blood Bank	Digital X-ray (Dental)
Aviation Examination	
Audiology Booth	
Intensive Care Unit (w/FST)	
General Surgery (w/FST)	
Psychiatry (w/FST)	

MANNING

Medical Corps	2
Dental Corps	1
Medical Service Corps	1
Independent Duty Corpsmen	2
Hospital Corpsmen	22

(*Includes 4 Corpsmen w/ Dental Tech NEC)

CASUALTY RECEIVING & TREATMENT SHIP CAPABLE
(18 PAX FST + 84 PAX AUGMENT = FULL CAPABILITY)

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USS SAN ANTONIO CLASS (LPD)

FACILITIES

Operating Rooms	1
Medical Exam	2
Dental Operatories	2
Intensive Care Unit Beds	6
Ward Beds	16 (8 Top and 8 Bottom)
Quiet/Isolation Beds	2 (No negative pressure)
(*1 Room 2-bed, 1 Room 4-bed)	
Overflow Beds	65

(*Overflow consists of units commonly used for Marine berthing.)
WALKING BLOOD BANK DEPENDENT ON 10% sampling of Ship's company

ANCILLARY SERVICES

Pharmacy	General Dentistry
Clinical Lab	Preventative Medicine
Bio-Medical Repair	Digital X-ray (Medical)
Blood Bank	Digital X-ray (Dental)
Intensive Care Unit (w/FST)	
General Surgery (w/FST)	
Psychiatry (w/FST)	

MANNING

Medical Corps	1
Dental Corps	1
Independent Duty Corpsmen	1
Hospital Corpsmen	11

(*Includes 2 Corpsmen w/ Dental Tech NEC)

CASUALTY RECEIVING & TREATMENT SHIP CAPABLE
(18 PAX FST AUGMENT REQUIRED)

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USS WHIDBEY ISLAND CLASS (LSD)

FACILITIES

Operating Rooms	0
Medical Exam	2
Dental Operatories	2
Intensive Care Unit Beds	0
Ward Beds	6 (3 Top and 3 Bottom)
Quiet/Isolation Beds	0
Overflow Beds	0

ANCILLARY SERVICES

Pharmacy	General Dentistry
Clinical Lab	Preventative Medicine
Digital X-ray (Medical)	

MANNING

Medical Corps	1
Dental Corps	1
Independent Duty Corpsmen	1
Hospital Corpsmen	9

(*Includes 2 Corpsmen w/ Dental Tech NEC)

NO
CASUALTY RECEIVING & TREATMENT SHIP CAPABILITY

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EXPEDITIONARY SEA BASE (ESB)

MANNING:

Independent Duty Corpsman	1
Preventative Med Tech	1

FACILITIES:
Main medical
2 beds

ANCILLARY SERVICES:
Pharmacy – limited to IDC formulary/AMAL
Labs – via POC testing

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USS TICONDEROGA CLASS (CG)

MANNING:

Independent Duty Corpsman	1
Hospital Corpsman	2

FACILITIES:
Main Medical treatment room
Ward with 2 bunk style racks
Battle Dressing station x 2

ANCILLARY SERVICES:
Pharmacy – limited to IDC formulary/AMAL
Labs – via POC testing

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USS ARLEIGH BURKE CLASS (DDG)

MANNING:

Independent Duty Corpsman	1

FACILITIES:
Main Medical treatement room
Ward with 2 bunk style racks
Battle Dressing station x 2

ANCILLARY SERVICES:
Pharmacy – limited to IDC formulary/AMAL
Labs – via POC testing

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LITTORAL COMBAT SHIP (LCS)

MANNING:
Independent Duty Corpsman 1

FACILITIES:
Main Medical treatment room
Ward with 2 bunk style racks
Battle Dressing station x 1

ANCILLARY SERVICES:
Pharmacy – limited to IDC formulary/AMAL
Labs – via POC testing

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COMMAND SHIPS (LCC)

USS MOUNT WHITNEY (LCC 20)

MANNING:

Independent Duty Corpsman	1
Hospital Corpsman	2
Medical Services Officer (CIVMAR)	1

FACILITIES:

Treatment rooms	2
Battle dressing stations	2*

ANCILLARY SERVICES:
Pharmacy – limited to IDC formulary/AMAL
Labs – via POC testing
Dental – exams only
Audiogram

USS BLUE RIDGE (LCC 19)

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USS NIMITZ/FORD CLASS (CVN)

FACILITIES:

NIMITZ CLASS:	
Operating Room	1
Intensive Care Unit Beds	3
Ward Beds	48
FORD CLASS:	
Operating Room	1
Intensive Care Unit Beds	3
Ward Beds	41

MANNING:

Medical Corps	3
Nurse Corps	2
Medical Service Corps	5
Dental Corps	3
Independent duty Corpsmen	2
Hospital Corpsman	42/47
With the Airwing:	
Flight Surgeon (MC)	2
Flight PA	1
Aviation Med Tech	5-6

ANCILLARY SERVICES:

Pharmacy	General Dentistry
Clinical Lab	OMFS
Bio-Medical Repair	Digital X-ray (Medical)
Blood Bank	Digital X-ray (Dental)
Aviation Examination	Radiation Health
Audiology Booth	General Surgery
Preventative Med	Optician
Mental Health	

NOT CONSIDERED A CASUALTY
RECEIVING & TREATMENT SHIP

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ROLE 2 Augments

FLEET SURGICAL TEAM:

- **18 Member Team (O=8/E=10)**
  - **OIC (physician), Medical Regulating Control Officer (MSC), Senior Enlisted HM,**
  - **General Surgeon, CRNA, Perioperative Nurse, Surgical Tech x 2, RT x 1**
  - **IM/FM Physician, Critical Care nurse, HM x 2**
  - **Lab tech x 2, Rad Tech**
  - **Psychiatrist, Behavioral Health Technician**
- **Embarks LHD for all ARG/MEU deployments**
- **9 Teams (5 SURFPAC/4 SURFLANT)**

CRTS M+1

- **84 member team**
  - **Augments the LHD to full Required Operational Capability (ROC) in Condition 1 and 2 operating environment, or as deemed necessary by the COCOM.**
  - **Adds additional surgical capability (orthopedics), nursing capacity, ancillary services**
  - **Manned by BSO-18/Navy Medicine personnel (from the MTF)**
- **7 Teams (4 NMFP/3 NMFL)**

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SUBMARINE TENDERS (AS Class)

FACILITIES:
Operating Rooms: 2 (in lay up)
Intensive Care Unit Beds: 0
Ward Beds: 12

ANCILLARY SERVICES:
Laboratory
X-ray
Pharmacy
Radiation Health
Undersea Medicine

MANNING:
Medical Corps 2
Dental Corps 1
Medical Service Corps 1
Independent Duty Corpsman 2
Hospital Corpsmen 10

Based in Guam:

- USS EMORY S. LAND (AS 39)
- USS Frank Cable (AS 40)

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SUBMARINES (SSN/SSGN/SSBN)

MANNING:
Independent Duty Corpsman 1

FACILITIES:
SSN – no dedicated medical space
SSBN/SSGN – single room medical space

ANCILLARY SERVICES:
Pharmacy – limited to IDC formulary
Basic labs – via POC testing

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HOSPITAL SHIPS (T-AH)
USNS COMFORT and MERCY

- USNS ship under COMSC (Military Sealift Command)
- COMMAND STRUCTURE
  - Hull maintained by CIVMAR crew
  - ADCON of MTF under COMSC
  - 95% of FOS MTF billets under BSO-18
- MISSION
  - Primary – Combat Support
  - Secondary- Theater Support Cooperation and HADR
- Additional info
  - ROLE III
  - Provides flexible, rapid response
  - 1000 bed – 500 actual
  - T/O:
    - 119 (Reduced Operating Status)
    - 1200 (+/-) (Full Operating Status)
    - Typical configuration to 250 bed ~750 AD

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Expeditionary Fast Transport (EPF) and Expeditionary Medical Ship (EMS)

EPF FLIGHT I

- Shallow draft, all aluminum, commercial-based catamaran providing high-speed intra-theater personnel and cargo lift capability.
  - Transports 600 ST of troops & cargo 1,200 NM at 35KTS
  - 20,000 SF cargo area
  - Berthing for 104 embarked personnel
  - Surge support for 312 passengers for 96 hrs
  - Up to H-60 capable flight deck
- EPF 13
  - Hybrid FLT I and FLT II
  - Built with various autonomous capability for concept testing, demonstration

EPF FLIGHT II

- Capable of conducting the same missions conducted by the EPF Flt I, but carries less cargo (331 ST vice 600 ST)
- Engineering and design improvements
- 11-meter RHIB for personnel transport
- CH-53 and MV-22 capable
- Berthing for 147 embarked personnel
- Capable of *embarking* an afloat Roll 2 Enhanced (R2E) medical capability (staffed by Expeditionary Medical Unit)
  - Provides en route medical care (up to 96 hours)
  - 1 operating room, 2 tables
  - 10 bed ICU
  - 23 bed medical ward
  - Patient / equipment elevator
  - Portable radiology equipment
  - Ancillary Services (Medical Laboratory, Pharmacy, Blood Bank)

EPF FLT III (EMS)

- *Dedicated* R2E medical platform.
  - Provides en route medical care (up to 96 hours)
  - 2 operating rooms, 2 operating tables
  - 20 bed ICU
  - 40 bed medical ward
  - 4 bed quiet room
  - O2 generation plant and fixed piping
  - Biomedical waste collection system
  - Ancillary Services (Medical Laboratory, Pharmacy, Blood Bank)
  - Fixed radiology
- 11-meter RHIB for personnel transport.
- CH-53 and MV-22 capable.
- Berthing for 180 embarked personnel.

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QUESTIONS?

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Tours for Tomorrow

- 0800 – 0830 DDG group 1 (Ship TBD)
- 0830 – 0900 DDG group 2 (Ship TBD)
- 0900 – 1000 LPD – USS FORT LAUDERDALE (LPD 28)
- 1000 – 1200 CVN – USS DWIGHT D. EISENHOWER (CVN 69)

Recommend arrival at the ECP of Pier 4 NLT 0745 to walk to the ship's berth

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