DEFENSE HEALTH BOARD
OPEN MEETING MINUTES

November 29, 2023
8111 Gatehouse Rd, Falls Church, Virginia 22042

1. **Attendees – Appendix One**

2. **November 29, 2023 – Opening Remarks**

- CAPT Clausen welcomed the Defense Health Board (DHB) Members, Distinguished Visitors (DVs), and public attendees to the meeting and called the meeting to order.
- Dr. Guice welcomed the Members and discussed the meeting agenda.
- The Members and DVs introduced themselves.
- CAPT Clausen provided administrative remarks.

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

Dr. Browne presented the decision brief for the *Eliminating Racial and Ethnic Health Disparities in the Military Health System (MHS)* report. After the September 2023 DHB Meeting and report deliberation, the DHB sent this report back to the Health Systems Subcommittee (SC) for rework. Please see read-ahead slide deck (**Appendix 3**) for more information. Dr. Browne reviewed report findings recommendations. The Members approved the language to the findings and recommendations, with edits (**Attachment 1)**. Discussion points of note:

- Finding and Recommendations 1:
  - The members discussed beneficiaries' ability to self-report and edit their racial and ethnic (R&E) data in the Defense Enrollment Eligibility Reporting System (DEERS). They also discussed the proposed changes to DEERS R&E categories and the technical feasibility of making these changes, including interoperability with other data systems and managing records with the previous categories.
  - A member asked whether the recommendation to collect R&E data via TRICARE enrollment forms was adequately supported by chapter content. Dr. Guice suggested adding content to Chapter 2 to support recommendation language.
  - Dr. Cordts and Dr. Browne discussed the current visibility of R&E data in MHS GENESIS and the need to establish a single authoritative data source to facilitate data harmonization.
- Finding and Recommendations 2: The member discussed importance of a standalone Recommendation 2D and the proposal to combine it with Recommendation 2A. The members discussed the importance of Recommendation 2E and if it is necessary since the MHS is already doing this work. The members voted to approve Recommendations 2A, B, C, and E with minor amendments. RADM (Ret.) Chinn opposed to including Recommendation 2E.
- Finding and Recommendations 3

- Dr. Browne discussed the urgency of Recommendation 3A's language pertaining to maternal health disparities. Dr. Cordts and Ms. Hart discussed ongoing efforts to remedy these disparities. Dr. Cordts stated the effectiveness of these interventions is not yet known. Ms. Hart stated small sample sizes extend the time horizon for measuring the effectiveness of treatment interventions. The members discussed possible causes for these disparities and how to best convey the urgency of remedying them through recommendation language. Dr. Maybank suggested adding language related to "reevaluating and accelerating current efforts."
- Dr. Barfield commented on maternal death disparities. Dr. Armstrong and Dr. Guice discussed the need for a framework to assess interventions effects.

- Finding and Recommendation 6
  - Dr. Browne discussed language changes in Finding 6 pertaining to Social Determinants of Health (SDOH). CAPT Clausen asked whether estimates quoted in Finding 6 refer to the US alone. Mr. Schaettle clarified the figures are from the Department of Health and Human Services and so refer to the US population.
  - Dr. Parkinson and Dr. Cordts discussed the applicability of DoD's Total Force Fitness paradigm to SDOH concerns.
- Finding and Recommendation 8: The members discussed how the effectiveness of health equity training might be measured.
- Finding and Recommendations 9
  - Regarding Recommendation 9A, which addresses diversity, RADM (Ret.) Chinn stated the Services are only concerned with warfighting. Dr. Guice suggested directing the recommendation to DoD rather than to the Services.
  - Dr. Browne suggested combining Recommendations 9D and E (now 9C and D). Dr. Maybank suggested removing the reference to "provider-patient racial concordance" because, in the revised context, it could be interpreted as promoting racial segregation in medicine. Several members echoed this concern.
  - The members voted to approve Recommendation 9D (new 9C) with language added to address retention. Dr. Armstrong and RADM (Ret.) Chinn opposed.
  - The members and DVs discussed implementation and ethical concerns related to voicing support for patients choosing medical providers based on race. The members, DVs, and SC discussed the tension between non-discrimination and cultural competency concerns. Dr. Maybank suggested language referring to providers who "culturally meet patient needs." The members voted to approve Recommendation 9F with the revised language.
- Finding and Recommendations 10: Dr. Armstrong stated the DHB's recommendations should not "assign" tasks to the Assistant Secretary of Defense for Health Affairs but could recommend topics for their review. The members and DVs discussed whether quarterly (rather than annual) reviews are necessary or overly burdensome.

4. Tasker Introduction: Prolonged Field/In-Theater Care

Dr. Armstrong presented a new tasking on better integrating military-civilian partnerships to improve prolonged field/in-theatre care. He discussed the future of warfare and the challenges likely to accompany prolonged field and in-theater care in a near-peer global conflict. He summarized the SC's activities and reviewed their emerging findings. Dr.

Armstrong proposed to the DHB deliberating an interim report at the March 2024 meeting with a final report in June or September 2024. He highlighted the urgency of recommendations to the Department from the interim report. Please see attached slides (**Appendix 4**) for more information. Discussion points of note:

- The Members discussed how coalition Force capabilities will be accounted for in this report. The interim report would focus on US medical capabilities and gaps and coalition Force capabilities will be in the Final report. Dr. Luby suggested reaching out the William Beaumont Army Medical Center to learn from medical emergency simulations.
- The Members and DVs discussed factors that contribute to the urgency of this tasking:
  - News media reports detail emerging global "hotspots" and potential conflicts;
  - A shift in focus from a small number of casualties to large scale combat;
  - Fighting in a more distributed fashion and embracing more austere environments, such that supply lines may be cut off and those on the front lines will need to decide which injured SMs to save and how to stabilize for longer periods of time without support.
- The Members and DVs discussed casualty estimates for future conflicts and how there may not be a "rotation of Forces," where SMs would stay in theater until the conflict ends. This implied that injured SMs will have to rehab in place. A member noted caring for an injured person for several days is very different than caring for an injured person for several hours.
- A member asked about the use of wearable technologies and how it might be included in this report. Dr. Armstrong stated this would likely be addressed in the final report but that the SC has investigated this already.
- BG Andrus stated readiness and healthcare are components of the same mission. He stated his concern that the military is not adequately stressing this point to younger leaders. He proposed providing more in-patient training to primary physicians in anticipation of moving them to forward environments. He offered to meet with the Trauma and Injury SC to discuss some details from Dr. Armstrong's slides.

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

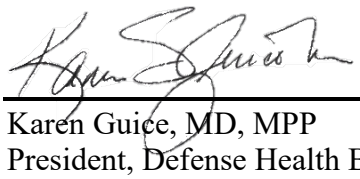
Dr. Bishop updated the DHB on the Public Health SC's Health Communications report. She discussed emerging report findings and areas for further investigation. Please see attached slides (**Appendix 5**) for more information.

6. Closing Remarks

CAPT Clausen and Dr. Guice thanked everyone for their attendance. CAPT Clausen adjourned the meeting.

7. Certification of Minutes

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



2/21/2024

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.	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
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.	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	Research 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			
Brig Gen	John	Andrus	Joint Staff Surgeon, The Joint Staff, Office of the Chairman of the Joint Chiefs of Staff
Maj Gen (Ret.)	Sharon	Bannister	Executive Healthcare Consultant, rockITdata; CEO, Sharon R. Bannister & Associates, LLC.
RADM (Ret.)	Wanda	Barfield	Director, Division of Reproductive Health, Centers for Disease Control and Prevention; DHB Health Care Delivery Subcommittee member
Dr.	Georges	Benjamin	Executive Director, American Public Health Association, DHB Public Health Subcommittee Member

Ms.	Kimberly	Bogart	Student, Doctor of Nursing Practice,
CDR	Shamika	Brooks	Chief Program Management Officer for PHS Engagement; Executive Assistant to the Deputy Surgeon General; Program Manager, OSG Chartered Advisory Committees
Dr.	Steve	Cersovsky	Deputy Director, Defense Health Agency (DHA) Public Health
Dr.	David	Classen	Infectious Disease Physician, University of Utah School of Medicine; DHB Health Systems Subcommittee Member
BG	Thad	Collard	Deputy Commanding General of Operations, Office of the Surgeon General, US Army Medical Command
Dr. (SES)	Paul	Cordts	Deputy Assistant Director, Medical Affairs, DHA
COL	Sandrine	Duron	French Health Liaison Officer
Dr.	Marion	Ehrich	Professor, Department of Biomedical Sciences and Pathobiology, Virginia-Maryland College of Veterinary Medicine; DHB Public Health Subcommittee Member
Ms.	Theresa	Hart	Senior Nurse Consultant; Women Health and Special Medical Programs; Integrated Clinical Operations and Policy Support, Clinical Support Division, Medical Affairs, DHA
Ms.	Miranda	Janvrin Le	Research Associate, Henry Jackson Foundation
Mr.	Timothy	Jones	Senior Associate Director, Federal Relations, The Joint Commission
Ms.	Patricia	Kime	VA and Military Health Care Reporter, Military Times
Ms.	Jessica	Korona	Research Associate, Henry Jackson Foundation
LCDR	Harun	Lucas	Deputy Chief of Staff, Medical Affairs, DHA
Ms.	Diana	Luan	Deputy Program Manager, Military Health System Research Program
Ms.	Catherine	Madsen	Program Manager, Henry Jackson Foundation, Center for Health Services Research, Uniformed Services University for the Health Sciences
Dr.	Catherine	McCann	President, Ellipses, LLC; DHB Health Systems Subcommittee Members
BG	Anthony	McQueen	Deputy Surgeon General, Office of the Surgeon General, US Army Medical Command
Ms.	Ellen	Milhiser	Editor, Synopsis
RADM	Pamela	Miller	Medical Officer, US Marine Corps
Dr. (SES)	Richard	Mooney	Acting Deputy Assistant Secretary of Defense, Health Services Policy and Oversight
Ms. (SES)	Sieleen	Mullen	Principal Deputy Assistant Secretary of Defense for Health Affairs
Lt Col	Syrah	Nicaisse	Medical Management Director, Wright-Patterson AFB
Ms.	Sabeeha	Quereshi	Special Assistant to the Assistant Secretary of Defense for Health Affairs, Office of the Secretary of Defense
Mr.	Michael	Rainone	Senior Consultant, TransformCare, Inc.
CAPT	Misty	Scheel	DHA Liaison Office, Bureau of Medicine and Surgery, US Navy
Dr.	Jayakanth	Srinivasan	Chief Engineer, VA Health Innovation and Central Office, the MITRE Corporation; DHB Health Systems Subcommittee Member
Lt Col	Michelle	Woodies\	Chief, Pain Management, DHA

APPENDIX TWO: MEETING CHAT

07:55:39 From Brigid McCaw to Everyone:
I agree with Dr. Brown. A key value of the Board is the opportunity to hear the diverse perspectives and consider how to incorporate or address those in the final report.
09:46:16 From Aletha Maybank to Everyone:
Add language "or latest version"; but the SPD 15 number may change.
11:33:58 From Wanda D. Barfield to Everyone:
https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm
11:35:15 From Aletha Maybank to Everyone:
You may want to definitely chime in on this one Barfield when it opens up to the audience
11:35:27 From Aletha Maybank to Everyone:
*Dr Barfiled
11:41:29 From Wanda D. Barfield to Everyone:
Pregnancy-related deaths vary by race/ethnicity. Black women experience higher risks for pregnancy-related deaths due to cardiovascular conditions, white women due to mental health conditions, Asian women due to hemorrhage.
11:51:22 From Aletha Maybank to Everyone:
"Prioritize maternal and infant health by reevaluating and strengthening current efforts and adopting known best systems and practices in the..."
11:55:32 From Wanda D. Barfield to Everyone:
https://www.cdc.gov/reproductivehealth/maternal-mortality/preventing-pregnancy-related-deaths/state-strategies.html
12:10:49 From Wanda D. Barfield to Everyone:
With respect to maternal mortality there are resources in the state-strategies document (above) that provides a framework for the nation. Maternal health, even for active duty military and dependent spouses still may operate in the context of the communities they live in (social determinants). DHA may have unique opportunities to provide risk-appropriate care in terms of transportation and triage of high-risk pregnant and postpartum women that may be different than civilian sectors. CDC has worked with military leaders to help develop DoD-specific maternal mortality review committees which provide recommendations for prevention and intervention (e.g. Perinatal Quality Collaboratives and AIM bundles)
12:12:32 From Aletha Maybank to Everyone:
Dr. Barfield thank you for being here today (and your leadership overall!). And sorry you were not able to get to speak the above comment that you just placed in the chat. It will certainly be shared.
12:13:01 From Brigid McCaw to Everyone:
I agree with Dr. Maybank.
12:18:58 From Wanda D. Barfield to Everyone:
In the focus to reduce pregnancy related deaths, it is important to note that more than half occur 1 week to within the first year after delivery. So addressing quality improvement in peripartum period is insufficient. The DHA has a unique opportunity to improve care in the later postpartum period by for example, monitoring post-partum blood pressure and

cardiovascular status, conducting mental health screening and treatment, and ensuring follow-up. Currently, 40 states in the US will be providing post-partum coverage up to 1 year after delivery.

12:42:38 From Rhonda Medows to Everyone:
The DOD should use the category "multiracial" for person identifying as more than one race, instead of "other".

13:31:18 From Brigid McCaw to Everyone:
I strongly agree with the inclusion of the yellow highlighted sentence to recommendation 6A.

13:49:14 From Aletha Maybank to Everyone:
Offer training on impact of SDOH and how to identify HRSN and appropriately document those needs in the medical record

13:49:54 From Brigid McCaw to Everyone:
An option Offer trainings….." how to appropriately document and address SDOH/HRSN"

13:55:46 From Wanda D. Barfield to Everyone:
Military units are communities that can also help and support families and identify resouces (e.g. WIC)

13:56:37 From Aletha Maybank to Everyone:
Agree

13:56:47 From Aletha Maybank to Everyone:
With Dr Lazarus

14:04:57 From Wanda D. Barfield to Everyone:
Exceptional Family Member Program

14:11:25 From Aletha Maybank to Everyone:
https://www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf

14:47:00 From Rhonda Medows to Everyone:
Regarding Recommendation #1: Please add to the meeting minutes and the discussion portion of this report my concerns that (a) attributing poor health outcomes suffered by multiracial people to all their multiple racial groups will negate and obscure health disparities impacting this group. and (b) not offering people the option to self report as "multiracial" may result in more people from this growing demographic choosing to decline stating their race(s).

14:59:14 From Aletha Maybank to Everyone:
Agree with dr meadows

15:09:40 From Wanda D. Barfield to Everyone:
Military health providers need promotion opportunities and loan forgiveness/deferral opportunities.

15:11:40 From Aletha Maybank - to Everyone:
That is not that hard to find though

15:16:26 From Brigid McCaw to Everyone:
I agree with Dr. Bishop and Parkinson's comments about inclusion of the word 'retention'

15:29:08 From Brigid McCaw to Everyone:

I agree this recommendation as a directive is problematic. Offering ‘concordance’ by race/ethnicity, gender, age has potential unanticipated outcomes, that haven’t been fully considered.

15:44:41 From Wanda D. Barfield to Everyone:
Are you referring to Joint Commission Health Equity Standards?

15:48:58 From DHB Staff to Everyone:
Dr. Barfield, it is the reference, the Joint Commission complimentary publication, R3 Report - Requirement, Rationale, Reference; issue 36, June 20, 2022

16:53:28 From Brig Gen John Andrus to Everyone:
This is Brig Gen Andrus, Joint Staff Surgeon. I am now dialed in and could add my comments after the next briefing if that is ok.

16:53:59 From DHB Staff to Everyone:
Thank you, Brig Gen Andrus. You can also type them here.

16:58:02 From Brig Gen John Andrus to Everyone:
Thanks for the great presentation. A couple of thoughts for the report. Too many still talk of "readiness" and "healthcare delivery" as if they are two separate and distinct topics. While they are funded differently which tends to drive the distinction they are both elements of one system - the Military Health System that must prepare military forces to operate, assure medics can support and deliver healthcare to beneficiaries. Perhaps some thoughts on how to more effectively bring our mindset to a point where we see one system in the report it might help.

16:59:00 From Brig Gen John Andrus to Everyone:
Also, perhaps a comment on the importance to increasing inpatient training and practice opportunities for primary care physicians and providers to prepare them to manage patients that will need to be held would be helpful.

16:59:41 From Brig Gen John Andrus to Everyone:
Lastly, your slide on Roles of care is not consistent with joint doctrine. There is no Role 5 described in JP 4-02. I am happy to meet with you to help clarify if you desire.

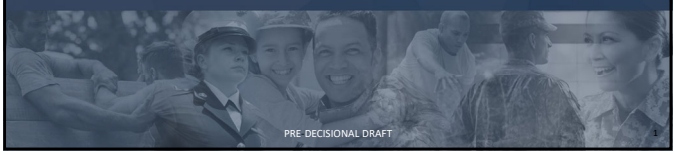
16:59:47 From Brig Gen John Andrus to Everyone:
That's all. Thanks.

Appendix 3

PRE DECISIONAL DRAFT

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

Michael Anne Browne, MD
Chair, Health Systems Subcommittee
November 29, 2023



PRE DECISIONAL DRAFT

Overview

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

PRE DECISIONAL DRAFT

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

PRE DECISIONAL DRAFT

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).**

PRE DECISIONAL DRAFT

Tasking: Background

- 24% of Active Duty personnel self-identify as a racial minority
- 16% of Active Duty personnel self-identify with Hispanic ethnicity
- Physical and mental health inequities exist in the MHS despite its universal health care benefit

PRE DECISIONAL DRAFT

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.

PRE DECISIONAL DRAFT

Summary of Activities to Date (1/4)

Meeting Date	Discussion Top cs
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

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PRE DECISIONAL DRAFT

Summary of Activities to Date (2/4)

Meeting Date	Discussion Top cs
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

PRE-DECISIONAL DRAFT 8

PRE DECISIONAL DRAFT

Summary of Activities to Date (3/4)

Meeting Date	Discussion Top cs
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

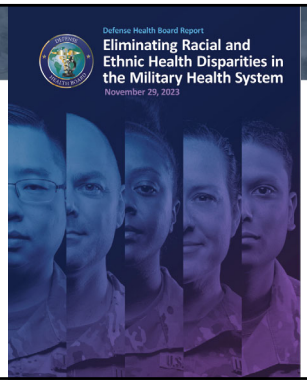
PRE-DECISIONAL DRAFT 9

PRE DECISIONAL DRAFT

Summary of Activities to Date (4/4)

Meeting Date	Discussion Top cs
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
September 11, 2023: DHB Meeting	Report Deliberation
October 2, 2023: HS Meeting	DHB Feedback Discussion
October 13, 2023: HS Meeting	Findings and Recommendations; Full Report Discussion
October 27, 2023: HS Meeting	Findings and Recommendations; Full Report Discussion
September – October 2023	Teleconferences with: • DHA Chief Information Officer/DHA Chief Health Informatics Officer • Defense Manpower Data Center • DHB members

PRE-DECISIONAL DRAFT 10



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PRE DECISIONAL DRAFT

Report Overview and Updated Sections

- Review of MHS health disparities literature
- **DoD and MHS race and ethnicity data***
- Prioritization of interventions to address inequities
- Data use and misuse, including Artificial Intelligence
- Social Determinants of Health **and Health-Related Social Needs***
- Training and workforce initiatives to reduce inequities
- Leadership accountability and proposal for sustainable progress

***New or updated content from September 11, 2023, deliberation**

PRE-DECISIONAL DRAFT 12

PRE DECISIONAL DRAFT

MHS Health Disparities Literature Review

- Review included 60 published articles or DHA information briefs
- Literature suggests some racial and ethnic health care disparities are more narrow or less apparent in the MHS compared to other U.S. health systems
- Statistically significant disparities in maternal health outcomes by race are evident – and warrant immediate attention and action
- Race and ethnicity data for beneficiaries are often missing or incorrect
- Many MHS disparities studies are one-time data pulls conducted by individuals with little institutional support
- Physical and mental health inequities exist in the MHS despite its universal health care benefit

PRE DECISIONAL DRAFT

Race and Ethnicity Data in the DoD

- DoD includes innumerable data systems and databases for managing demographic and health-related data
- 1997 Office of Management and Budget Statistical Policy Directive No. 15 (OMB SPD 15): Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity
- Currently DEERS and some data sets used for disparities research contain categories that do not follow guidance set by OMB SPD 15
- Service members may self-report and correct their race and ethnicity through their Service personnel office, but not directly in DEERS
- Dependent beneficiaries may not self-report their race and ethnicity through either the Service personnel office or directly in DEERS. These dependents may be able to inquire and request corrections to their race and ethnicity in MHS GENESIS by working with Military Treatment Facility personnel, but they cannot self-view or self-correct their data
- This leads to large numbers of "unknown" entries for race among dependent beneficiaries

PRE DECISIONAL DRAFT

Service Member, Dependent, and Retiree Race and Ethnicity Data

- Service members self-identify race and ethnicity upon accession into the Armed Forces
- The Military Services provide these data to Defense Manpower Data Center (DMDC)
- DMDC incorporates these data into the Defense Enrollment Eligibility Reporting System (DEERS) which transmits these data to other systems, including the Military Health System (MHS)
- DD Form 1966: Allows for more than one race to be selected

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	

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

- DD Form 1172-2: Application for ID Card/DEERS Enrollment (for dependents) **does not** have fields for race or ethnicity

PRE DECISIONAL DRAFT

DEERS Data Feeds to MHS

- DEERS is one source of race and ethnicity data for the MHS
- DEERS sends data to many sources through different streams
- Data sent from DEERS to MHS GENESIS is in standard OMB SPD 15 categories, e.g., "Asian" and "Native Hawaiian or Other Pacific Islander"
- DEERS data feed to MHS GENESIS also includes "Other" race category
- Defense Manpower Data Center plans to update non-MHS GENESIS data feeds to display OMB SPD 15 categories beginning December 2023
- No current funding to correct legacy data

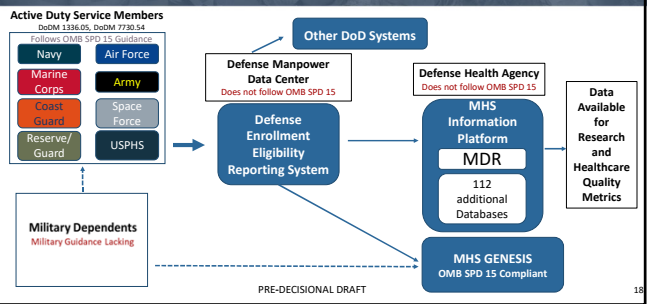
PRE DECISIONAL DRAFT

Opportunities for Improving Race and Ethnicity Data

- Non-retired Service members can currently update race and ethnicity through their personnel office, including an online portal
  - DEERS records contain a variety of information for Service members and instructions to view data such as Social Security Number, date of birth, sex, marital status, Personnel, Service records, Benefits, and contact information
  - DEERS website currently does not provide information about updating race and ethnicity with Service personnel office, as they currently do for name, gender, Social Security Number, or date of birth corrections
- There is no race and ethnicity field on the DEERS dependent enrollment form
- There is no current mechanism for dependent beneficiaries to view or update race and ethnicity in DEERS
- TRICARE does not collect race and ethnicity at enrollment, leading to unknown data for patients who access the "purchased care" network

PRE DECISIONAL DRAFT

DoD Race and Ethnicity Data Flow



PRE DECISIONAL DRAFT

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 (AI) 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
- The federal government and DoD have issued guidance for appropriate development and use of AI

PRE DECISIONAL DRAFT

Social Determinants of Health and Health Related Social Needs

- 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
- Health-Related Social Needs (HRSN) are related to, but distinct from SDOH and are "…specific adverse social conditions that are associated with poor health," such as housing instability, housing quality, food insecurity, employment, personal safety, and lack of transportation

PRE DECISIONAL DRAFT

Social Determinants of Health and Health Related Social Needs (cont.)

- Addressing HRSNs often falls outside areas of medical care
- Health systems can address HRSNs through:
  - Understanding which ones their patients face
  - Connecting patients to local community services
  - Partnering with community-based organizations
  - Developing their own interventions that would most benefit their unique patient populations
- Unlike disease screening tools, HRSN screening does not lead to an objective conclusion about a patient's social risks – "health care professionals must respect each patient's decision to seek, or not seek, assistance for social needs." (Garg, 2023)

PRE DECISIONAL DRAFT

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 pathways 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)

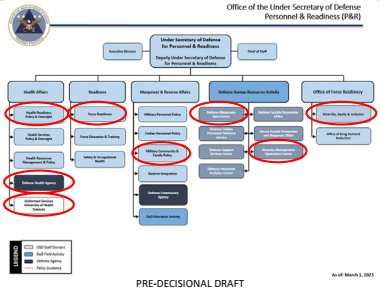
PRE DECISIONAL DRAFT

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
  - Devote resources necessary to accomplish the goals

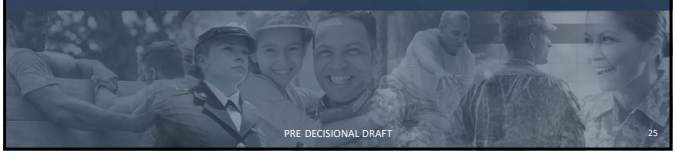
PRE DECISIONAL DRAFT

Under Secretary of Defense for Personnel & Readiness



PRE DECISIONAL DRAFT

Findings and Recommendations



PRE DECISIONAL DRAFT

Finding 1

Military Health System (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 in the Defense Enrollment Eligibility Reporting System (DEERS), which serves as DoD's personnel, enrollment, and eligibility system. DEERS data feeds into MHS GENESIS. Although active duty Service members may be able to correct their race and ethnicity through their Service personnel office, they and their civilian dependents are currently unable to view or edit race and ethnicity in their DEERS or MHS records. DoD does not transmit race and ethnicity data to TRICARE Purchased Care contractors, and TRICARE does not require its Purchased Care contractors to collect race and ethnicity from beneficiaries. Studies using current MHS data, therefore, are often unable to determine whether disparities exist or do not exist due to lack of self-reported data and lack of harmonization across information systems.

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."

PRE DECISIONAL DRAFT

Recommendations 1A – 1B

1.A. The DoD, through DEERS and MHS GENESIS, should comply with the OMB SPD 15 Standards for the Classification of Federal Data on Race and Ethnicity, and that best practice includes collecting self-reported race and ethnicity, for all beneficiaries. DEERS and MHS GENESIS should contain self-reported race and ethnicity for dependent civilians, not only active duty Service members. Establish mechanisms for non-Service member beneficiaries, such as civilian dependents and retirees, to conveniently view and correct their race and ethnicity as reported in DEERS. Establish mechanisms for all beneficiaries to conveniently view and correct their race and ethnicity in MHS GENESIS. Develop communication, training, and awareness of these mechanisms to view and self-correct race and ethnicity.

1.B. Comply with the OMB SPD 15 Standards for the Classification of Federal Data on Race and Ethnicity by separating the "Asian or Pacific Islander" category into the two categories "Asian" and "Native Hawaiian or other Pacific Islander."

PRE DECISIONAL DRAFT

Recommendations 1C – 1F

1.C. Replace the "Other" category with "Multiracial" when reporting a record that contains more than a single race.

1.D. Allow civilian dependent beneficiaries to "Decline to State" their race or ethnicity by creating a category for this variable in DEERS and MHS GENESIS.

~~1.E. Include race and ethnicity on TRICARE enrollment forms.~~ Replaced.

1.F. Ensure MTF patient check-in workflow requires confirmation of patients' current race and ethnicity categorization in MHS GENESIS and includes a mechanism for helping patients update their data when needed.

PRE DECISIONAL DRAFT

Recommendation 1G

1.G. Formally evaluate DEERS, DMDC data systems, MHS GENESIS, and other relevant DoD data systems to:

- Harmonize the communication of all identity and demographic data throughout the DoD
- Communicate identity and demographic data throughout the DoD using current national standardized nomenclature wherever possible
- Create a means of convenient beneficiary (including civilian dependent) self-service updating of demographic data

PRE DECISIONAL DRAFT

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 consistently 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.

PRE DECISIONAL DRAFT

Recommendations 2A – 2C

2.A. DHA should include racial and ethnic stratification of results in all internal and applicable external patient care reporting (e.g., Joint Commission metrics, National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS®), registry reports, Patient-Reported Outcome Measures) as well as analysis of progress in reducing identified disparities and comparisons of the MHS health disparity data with national benchmarks.

2.B. DHA should identify and designate a centralized group of epidemiologists, statisticians, and analysts (such as personnel in the Armed Forces Health Surveillance Division) to investigate potential racial and ethnic health disparities. This group should stay abreast of findings in the civilian sector and be a resource for other analysts and clinicians in the MHS. These investigations should be prioritized according to areas of greatest impact for the DoD and in areas of known 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.

PRE DECISIONAL DRAFT

Recommendations 2D – 2E

2.D~~. Work with all national registries that the MHS participates in, such as the National Perinatal Information Center, National Surgical Quality Improvement Program, and the American College of Surgeons National Cancer Database to allow MHS systemwide race and ethnicity reporting and analysis. This will help to inform actions to decrease the avoidable variation in outcomes between facilities throughout as well as overall disparities.~~ (combined with 2A)

2.E. To improve health equity, standardize to best practice throughout the MHS to reduce variation and improve outcomes across the MHS. BOARD APPROVED.

PRE DECISIONAL DRAFT

Finding 3

The DHB could find little evidence of systematic and sustained efforts to reduce racial and ethnic health disparities across the MHS.

PRE DECISIONAL DRAFT

Recommendations 3A-3B

3. A. While waiting for DHA disparities data to improve, the DHB recommends that DHA to address the documented disparities in maternal and infant health by adopting known best practices in the MHS systemwide to reduce the demonstrated racial disparities in these outcomes.

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

- 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)

PRE DECISIONAL DRAFT

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 poor study design, data collection and entry, algorithm choice, and dissemination of results can contribute to health disparities. This is also true for tools used in the calculation of health care costs. For example, one algorithm to predict a patient's medical needs used health care costs as a surrogate for degree of illness. But Black patients, having lower access to care, incurred lower health care costs than non-Black patients. The algorithm's use of health care costs as a surrogate for degree of illness disadvantaged Black patients as candidates for care intervention and, therefore, lowered their access to it (Obermeyer, 2019).

Some medical risk calculators, decision-making tools, and equipment in use by MHS health care personnel introduce inappropriate or unjustified racial and ethnic bias. The U.S. Government has outlined standards for the appropriate development and use of AI, including for health (Executive Order - October 30, 2023; Blueprint for an AI Bill of Rights, 2023).

PRE DECISIONAL DRAFT

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-biased algorithms in MHS clinical practice. At a minimum, AI algorithms and CDS tools should include individual patient symptoms, family history, and genetic screening results. Follow guidance from the federal government on appropriate development and use of AI. The DHB recommends that DHA participate in groups such as the Coalition for Health AI (CHAI™), which is developing guidelines and principles for the transparent, appropriate, and equitable use of AI in health care.

4.B. Use this centralized 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.

BOARD APPROVED 4A-4C

PRE DECISIONAL DRAFT

Finding 5 & Recommendation 5

Finding 5: Clinical trials are often conducted with homogeneous patient populations, leading to insufficient understanding of potential impacts of treatments on diverse populations. The DoD is a significant source of national funding for clinical trials and health research. BOARD APPROVED.

Recommendation 5: DoD should ensure that investigators include patients and participants from diverse and minority racial and ethnic populations in DoD-supported clinical trials and health research as appropriate to the scientific study under question.

BOARD APPROVED

PRE DECISIONAL DRAFT

Finding 6

Evidence shows that up to 50% of variation in health outcomes is attributable to Social Determinants of Health (SDOH) factors. The MHS, like civilian systems, is at risk of disparate outcomes due to SDOH. SDOH screenings are necessary 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. Addressing Health-Related Social Needs (HRSN) allows health systems to proactively reduce disparities due to SDOH. 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. The DoD has implemented Service-specific community and family support programs that address SDOH and HRSN. BOARD APPROVED.

PRE DECISIONAL DRAFT

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 that apply to the military population and ensure that the collected SDOH data are embedded within MHS GENESIS. These tools and emerging best practices should be kept current through regular updates on a 3-5 year cycle. 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 and access community resources. BOARD APPROVED

6.C. Offer trainings to clinicians on the impacts of SDOH and how to identify HRSN and appropriately document those needs in the medical record.

PRE DECISIONAL DRAFT

Recommendations 6D – 6E

6.D. Proactively analyze results of SDOH screenings MHS-wide, to assess needs and trends by both local and regional levels, and then connect patients to resources and interventions to address the specific needs of MHS beneficiaries. BOARD APPROVED

6.E. Include socioeconomic status (or surrogates thereof), a measure of regional health services availability, and beneficiary's primary language when analyzing health outcomes. BOARD APPROVED

PRE DECISIONAL DRAFT

Recommendations 6F – 6G

6.F. DoD should evaluate HRSN factors to identify and prioritize the most pressing needs of the beneficiary population and provide priority areas to address the factors that are contributing to racial and ethnic health disparities. Tailor military-wide programs, such as Total Force Fitness, Service-specific programs (such as Army Community Services, Marine Corps Community Services, Navy Fleet and Family Support, Airman and Family Readiness, and Coast Guard Work-Life Program), and community-based partnerships to best address these needs. BOARD APPROVED.

6.G. 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. BOARD APPROVED.

PRE DECISIONAL DRAFT

Finding 7 & Recommendation 7

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. BOARD APPROVED.

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.

BOARD APPROVED

PRE DECISIONAL DRAFT

Finding 8 & Recommendation 8

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. BOARD APPROVED.

Recommendation 8: Carefully consider the qualities of any health equity training before implementing it and leverage trainings that have demonstrated positive results in practice. Effectiveness should ultimately be measured by the training's impact on reducing racial and ethnic disparities in patient experiences and outcomes. BOARD APPROVED.

PRE DECISIONAL DRAFT

Finding 9

Increased clinician-patient racial and ethnic 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 Reserve Officers' Training Corps (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.

PRE DECISIONAL DRAFT

Recommendations 9A – 9C

9.A. DoD should expand the pathway for military careers as clinicians and allied health professionals for underrepresented in health and medicine racial and ethnic groups through ROTC, Health Professions Scholarship Program, and other recruitment activities at MSIs such as Historically Black Colleges and Universities, Hispanic-serving institutions, and Tribal Colleges and Universities, particularly those that have nursing, pre-medical, and other pre-health career curricula. Consider ways to expand these recruitment pathways to the community college, vocational, and high school levels. BOARD APPROVED.

9.B. Promote workforce diversity through recruitment activities and collaborations with academic organizations focused on racial and ethnic groups underrepresented in health and medicine and existing groups that are already promoting workforce racial and ethnic diversity in healthcare. BOARD APPROVED.

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

PRE DECISIONAL DRAFT

Recommendations 9D – 9F

9.D. (new 9C) Assess the effectiveness of ~~these~~ recruitment and retention efforts by documenting changes in the supply of underrepresented clinicians and allied health professionals.
BOARD APPROVED

~~9.E. Measure the impact of interventions to increase the health care workforce diversity by a range of stratifications including location and clinical service type.~~
BOARD VOTED TO STRIKE ORIGINAL 9E

9.F. Assess the feasibility of leveraging Virtual Health solutions to broaden the range of options for patients to select health care providers that culturally meet their needs.
BOARD APPROVED

PRE DECISIONAL DRAFT

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.

PRE DECISIONAL DRAFT

Recommendations 10A – 10C

10.A. Commit to achieving the goal of eliminating any racial and ethnic health disparities among all MHS beneficiaries. The DHA should:
- Measure disparities
- Set goals to reduce disparities by specific dates
- Allocate sufficient dedicated staff at both centralized and local levels to eliminate disparities
- Assess progress regularly

BOARD APPROVED

~~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-Reported Experience Measures.~~
BOARD VOTED TO STRIKE 10B

~~10.C. Add a racial and ethnic stratification to medical and dental readiness reports to monitor disparities in readiness. If disparities are found, DoD should provide support to command teams to address and eliminate persistent racial and ethnic disparities in medical and dental readiness.~~
BOARD VOTED TO STRIKE 10c

PRE DECISIONAL DRAFT

Recommendation 10D

10.D. Given the breadth of activities and areas of responsibility that impact health and wellbeing, which include not only medical care but also SDOH and HRSNs, the DHB recommends that the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) be the accountable leader for eliminating 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

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PRE DECISIONAL DRAFT

Recommendations 10E-10F

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).

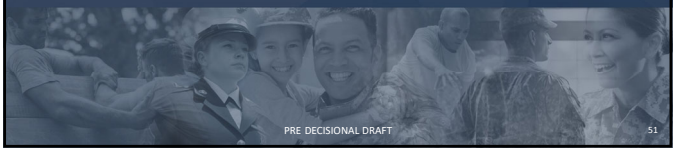
10.F. Incorporate Health Equity performance metrics and goals into quality and patient incentive programs for personnel providing care and managing military health services, such as those found in the Integrated Resourcing and Incentive System.

BOARD APPROVED

PRE-DECISIONAL DRAFT 50

PRE DECISIONAL DRAFT

Thank You



PRE DECISIONAL DRAFT 51

Findings and Recommendations

Finding 1: When Federal agencies collect data on race and ethnicity, they must comply with OMB's SPD minimum standards. Within the DoD, race and ethnicity data for Service members are captured in Service specific personnel systems and transferred to the DoD DEERS data system. DEERS provides data to other databases, including many in the MHS. While DEERS does contain OMB SPD 15 minimal standards, DEERS has been providing reformatted race and ethnicity data to the MHS that is not compliant with OMB SPD 15.

Furthermore, there is no requirement for DEERS to collect race and ethnicity data for civilian dependents. OMB SPD 15 states that self-report is the best method of collecting such data. Similarly, there is no requirement for DEERS to allow viewing, self-entry or self-correction of race and ethnicity within its data system, unlike Service personnel systems which do allow Service members to view and correct these data. The end result is insufficient validated data to ensure equity of care across the MHS for all beneficiaries.

Recommendation 1. A: The DoD should ensure that self-reported race and ethnicity data is collected and in compliance with the current OMB SPD 15 minimal Standards for the Classification of Federal Data on Race and Ethnicity across all DoD databases that contain, use or report health information. Furthermore, non-Service member beneficiaries, such as civilian dependents and retirees, should be able to conveniently input, view and self-correct their race and ethnicity information within DEERS, and all beneficiaries must be able to do so within MHS GENESIS. DoD must ensure that beneficiaries are provided with the relevant information and directions to do so.

Recommendation 1. B: DoD should modify the current OMB SPD 15 standards for the following circumstances:

- DEERS should use the term

~~**Finding 1**: Military Health System (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 in the Defense Enrollment Eligibility Reporting System (DEERS), which serves as DoD's personnel, enrollment, and eligibility system. DEERS data feeds into MHS GENESIS. Although active duty Service members may be able to correct their race and ethnicity through their Service personnel office, they and their civilian dependents are currently unable to view or edit race and ethnicity in their DEERS or MHS records. DoD does not transmit race and ethnicity data to TRICARE Purchased Care contractors, and TRICARE does not require its Purchased Care contractors to collect race and ethnicity from beneficiaries. Studies using current MHS data, therefore, are often unable to determine whether disparities exist or do not exist due to lack of self-reported data and lack of harmonization across information systems.~~

~~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."~~

~~**Recommendation 1. A**: The DoD, through DEERS and MHS GENESIS, should comply with the OMB SPD 15 Standards for the Classification of Federal Data on Race and Ethnicity, and that best practice includes collecting self-reported race and ethnicity,~~

~~for all beneficiaries. DEERS and MHS GENESIS should contain self-reported race and ethnicity for dependent civilians, not only active duty Service members. Establish mechanisms for non-Service member beneficiaries, such as civilian dependents and retirees, to conveniently view and correct their race and ethnicity as reported in DEERS. Establish mechanisms for all beneficiaries to conveniently view and correct their race and ethnicity in MHS GENESIS. Develop communication, training, and awareness of these mechanisms to view and self-correct race and ethnicity.~~

~~**Recommendation 1. B**: Comply with the OMB SPD 15 Standards for the Classification of Federal Data on Race and Ethnicity by separating the "Asian or Pacific Islander" category into the two categories "Asian" and "Native Hawaiian or other Pacific Islander."~~

~~**Recommendation 1. C**: Replace the "Other" category with~~ "Multiracial" and not the term "Other" when reporting collapsed race information for those who selected~~a record that contains~~ more than one~~a single~~ race.

- Civilian

~~**Recommendation 1. D**: Allow civilian dependent~~ beneficiaries should be provided a new category of "~~to "~~Decline to State" when selecting~~"~~ their race ~~or ethnicity by creating a category for this variable in DEERS~~ and ethnicity~~MHS GENESIS~~.

~~**Recommendation 1. E**: Include~~ **Recommendation 1. C**: DoD should ensure that TRICARE purchased care data can be collected and analyzed with a race and ethnicity stratification~~on TRICARE enrollment forms~~.

Recommendation 1. D: DoD should ensure

~~**Recommendation 1. F:** Ensure~~ MTF patient check-in workflow requires confirmation of patients' current race and ethnicity categorization in MHS GENESIS and includes a mechanism for helping patients update their data when needed not less than annually.

Recommendation 1. **E**: Ensure that~~**G**: Formally evaluate~~ DEERS, DMDC ~~data systems~~, and MHS GENESIS are harmonized with regard to~~:~~ ~~Harmonize the communication of all~~ identity and demographic data ~~throughout the DoD~~

- ~~Communicate identity and demographic data throughout the DoD using current national standardized nomenclature wherever possible~~
- ~~Create a means of convenient beneficiary (including civilian dependent) self-service updating of demographic data~~

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 consistently 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: DHA should include racial and ethnic stratification of results in all internal and applicable external patient care reporting (e.g., Joint Commission ~~metrics~~, National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS®), registry reports, Patient-Reported Outcome Measures). The DHA should ensure its contracts with external reporting entities include available racial and ethnic stratification and~~) as well as~~ analysis with benchmarking, at both the MTF and systemwide levels. The DHA should analyze its~~of~~ progress in reducing identified disparities ~~and comparisons of the MHS health disparity data with national benchmarks~~.

Recommendation 2. B: DHA should identify and designate a centralized group of epidemiologists, statisticians, and analysts (such as personnel in the Armed Forces Health Surveillance Division) to investigate potential racial and ethnic health disparities. This group should stay abreast of findings in the civilian sector and be a resource for other analysts and clinicians in the MHS. These investigations should be prioritized according to areas of greatest impact for the DoD and in areas of known 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: To improve health equity, standardize ~~D: Work with all national registries that the MHS participates in, such as the National Perinatal Information Center, National Surgical Quality Improvement Program, and the American College of Surgeons National Cancer Database to allow MHS systemwide race and ethnicity reporting and analysis. This will help to inform actions to~~

~~decrease the avoidable 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: The DHB could find little evidence of systematic and sustained interventions~~efforts~~ to reduce racial and ethnic health disparities across the MHS.

Recommendation 3. A: ~~While waiting for~~ DHA should prioritize ~~disparities data to improve, the DHB recommends that DHA start now to address the documented disparities in~~ maternal and infant health by reevaluating as well as accelerating current efforts to adopt~~adopting~~ known best practices in the MHS systemwide to eliminate~~reduce~~ the demonstrated racial disparities in these outcomes.

Recommendation 3. B: Prioritize additional 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 poor study design, data collection and entry, algorithm choice, and dissemination of results can contribute to health disparities. This is also true for some tools used in the calculation of health care costs. ~~For example, one algorithm to predict a patient's medical needs used health care costs as a surrogate for degree of illness. But Black patients, having lower access to care, incurred lower health care costs than non-Black patients. The algorithm's use of health care costs as a surrogate for degree of illness disadvantaged Black patients as candidates for care intervention and, therefore, lowered their access to it (Obermeyer, 2019).~~ [6]

Some medical risk calculators, decision-making tools, and equipment in use by MHS health care personnel introduce inappropriate or unjustified racial and ethnic bias. The U.S. Government has outlined standards for the appropriate development and use of AI, including for health (Executive Order - October 30, 2023; Blueprint for an AI Bill of Rights, 2022).

Recommendation 4. A: Create a centralized mechanism within the MHS to review data use, new protocols, and equipment to prevent inappropriate incorporation of race-biased algorithms in MHS clinical practice. At a minimum, AI algorithms and CDS tools should include individual patient symptoms, family history, and genetic screening results. Follow guidance from the federal government on appropriate development and use of AI. The DHB recommends that DHA participate in groups such as the Coalition for Health AI (CHAI™), which is developing guidelines and principles for the transparent, appropriate, and equitable use of AI in health care.

Recommendation 4. B: Use this centralized 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: Clinical trials are often conducted with homogeneous patient populations, leading to insufficient understanding of potential impacts of treatments on diverse populations. The DoD is a significant source of national funding for clinical trials and health research.

Recommendation 5: DoD should ensure that investigators include patients and participants from diverse and minority racial and ethnic populations in DoD-supported clinical trials and health research as appropriate to the scientific study under question.

Finding 6: Evidence shows that up to 50% of variation in health outcomes is attributable to Social Determinants of Health (SDOH) factors. The MHS, like civilian systems, is at risk of disparate outcomes due to SDOH. SDOH screenings are necessary 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. Addressing Health-Related Social Needs (HRSN) allows health systems to proactively reduce disparities due to SDOH. 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. The DoD has implemented Service-specific community and family support programs that address SDOH and HRSN.

Recommendation 6. A: DoD should institute annual, best practice standardized SDOH ~~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 and record results in MHS GENESIS. Data must be accessible and reportable~~. The MHS should use best practice standardized SDOH measurement tools that apply to the military population and ensure that the collected SDOH data are embedded within MHS GENESIS~~. These tools and emerging best practices should be kept current through regular updates on a 3-5 year cycle~~. 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 and access community resources.

Recommendation 6. C: Offer trainings to clinicians on the impacts of SDOH and how to identify HRSN and appropriately document those needs~~appropriate documentation~~ in the medical record. Incorporate these trainings~~this~~ into MHS health professional education.

Recommendation 6. D: Proactively analyze results of SDOH screenings MHS-wide, to assess needs and trends~~,~~ by both local~~Military Treatment Facility (MTF)~~ and regional levels~~by TRICARE region~~, and then connect patients to resources and interventions to address the specific needs of MHS beneficiaries.

Recommendation 6. E: Include socioeconomic status (or surrogates thereof), a measure of regional health services availability, and beneficiary's primary language when analyzing health outcomes.

Recommendation 6. F: DoD should evaluate~~Evaluate~~ HRSN factors to identify and prioritize the most pressing needs of the beneficiary population and provide priority areas to address the factors that are contributing to racial and ethnic health disparities. Tailor~~Examine~~ military-wide programs, such as Total Force Fitness, Service-specific programs (such as Army Community Services, Marine Corps Community Services, Navy Fleet and Family Support, Airman and Family Readiness, and Coast Guard Work-Life Program), and community-based partnerships to best address~~select those that best assist in addressing~~ these needs.

Recommendation 6. G: 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 leverage trainings that have demonstrated positive results in practice. Effectiveness should ultimately be measured by the training's impact on reducing racial and ethnic disparities in patient experiences and outcomes.

Finding 9: Increased clinician-patient racial and ethnic 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 Reserve Officers' Training Corps (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: DoD~~The Services~~ should expand the pathway for military careers as clinicians and allied health professionals for underrepresented in health and medicine racial and ethnic groups through ROTC, Health Professions Scholarship Program, and other recruitment activities at MSIs such as Historically Black Colleges and Universities, Hispanic-serving institutions, and Tribal Colleges and Universities, particularly those that have nursing, pre-medical, and other pre-health career curricula. Consider ways to expand these recruitment pathways to the community college, vocational, and high school levels.

Recommendation 9. B: Promote workforce diversity through recruitment activities and collaborations with academic organizations focused on racial and ethnic groups underrepresented in health and medicine and~~.~~

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

Recommendation 9. C~~D~~: Assess the effectiveness of these recruitment and retention efforts by documenting changes in the supply of underrepresented clinicians and allied health professionals.

Recommendation 9. D: Assess~~E: Measure~~ the feasibility~~impact~~ of leveraging~~interventions to increase the health care workforce and patient race and ethnicity concordance by a range of stratifications including location and clinical service type.~~

~~**Recommendation 9. F**: Leverage~~ Virtual Health solutions to broaden the ~~geographic~~ range of options for patients to select health care providers that culturally meet~~of~~ their needs~~racial and ethnic preference~~.

Finding 10: 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 stress leadership and sustained commitment effort at all organizational levels. We agree with the Joint Commission's (JC) summary of the actions required to reduce health care disparities as stated in the June 20, 2022 R3 Report:

~~**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. The DHA should:

- Measure disparities
- Set goals to reduce disparities by specific dates
- Allocate sufficient dedicated staff at both centralized and local levels to eliminate disparities
- Assess progress regularly

Recommendation 10. B: The~~**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-Reported Experience Measures.~~

~~**Recommendation 10. C**: Add a racial and ethnic stratification to medical and dental readiness reports to monitor disparities in readiness. If disparities are found, DoD should provide support to command teams to address and eliminate persistent racial and ethnic disparities in medical and dental readiness.~~

~~**Recommendation 10. D**: Given the breadth of activities and areas of responsibility that impact health and wellbeing, which include not only medical care but also SDOH~~

~~and HRSNs, the~~ DHB recommends that the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) be the accountable leader for ensuring that~~eliminating~~ health disparities are eliminated and that USD(P&R) charter a~~. 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~~

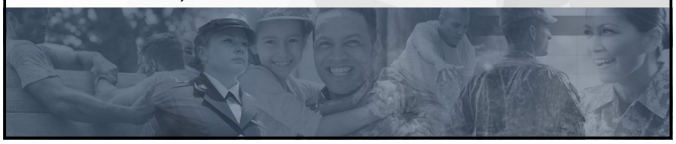
Recommendation 10. C: The~~E: Assign the~~ Assistant Secretary of Defense for Health Affairs (ASD(HA)) should~~to~~ report health outcomes, stratified by race and ethnicity, and report on ongoing initiatives to eliminate disparities, to the USD(P&R) no less than annually and quarterly when feasible~~. 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~~D: 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.

Appendix 4

Prolonged Field/In-Theater Care

John Armstrong, MD
Chair, Trauma & Injury Subcommittee
November 29, 2023



Overview

- Membership
- Tasking
- Objective and Scope
- Problem Statement
- Background
- Summary of Activities to Date
- Emerging Findings
- Way Ahead

Membership


CHAIR
John Armstrong, MD*


Julie Freischlag, MD


Odette Harris, MD, MPH


Lenworth Jacobs, Jr, MD, MPH*


Carla Pugh, MD, PHD


Gary Timmerman, MD

*Board Member

Tasking

On September 28, 2023, the Assistant Secretary of Defense for Health Affairs directed the Defense Health Board (DHB) to **recommend guidance on better integrating military-civilian training partnerships to improve prolonged field/in-theater care.**

Objectives and Scope

- ***Review the curriculum and experience*** of current military-civilian trauma training partnerships.
- ***Provide recommendations to best prepare DoD personnel*** at military-civilian trauma training partner sites for prolonged field care in near-peer conflicts. Comment on the curriculum, locations, frequency of training, occupational specialties of participating DoD personnel, and best use of selection and performance criteria outline in the Blue Book.
- Provide recommendations ***to better integrate military-civilian partnership*** with attention to Direct Care MTF staffing and Regional Medical Operations Centers.

Problem Statement: The Future of Warfare

- Peer/Near-Peer Conflict – Large-Scale Combat Operations
  - Multi-domain operations
  - High rate of casualties
  - Contested freedom of movement
    - Constrained medical logistics, including blood
  - Change in type of injuries seen
    - Disease non-battle injury
    - Chemical, biological, nuclear injury

Problem Statement: The Future of Warfare

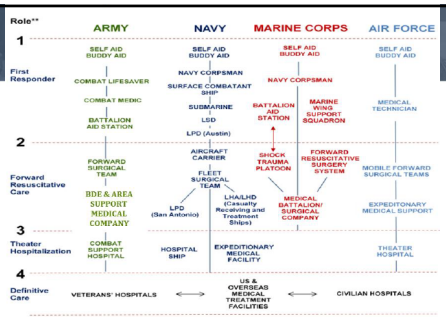
- Peer/Near-Peer Conflict (continued)
  - Changing face of the warfighter
  - Need for "reverse triage"
  - Delayed, complex, lengthy evacuations
  - Stress on continental US (CONUS) healthcare systems
    - Need for better integration of the military, Federal, and civilian healthcare systems

Background: Definitions

- Prolonged Field Care (PFC)
  - Evolved from observations by special operations Forces and Marine Corps medical personnel, and the need to provide care in resource limited, austere environments
- Prolonged Casualty Care (PCC)
  - Delivered by medics and corpsmen
  - Provision of Tactical Combat Casualty Care beyond the "Golden Hour"

Roles of Care

- Role 1: Immediate first aid delivered at the scene by combat lifesaver or combat medic
- Role 2: Increased medical capability with limited inpatient bedspace
  - Includes basic primary care
  - 100% mobile
- Role 3: Highest level of medical care in combat zone with bulk of inpatient beds
- Role 4: Medical and surgical care outside combat zone, but within the communication zone
  - Patients requiring more intensive rehabilitation or special care
  - Example: Landstuhl Regional Medical Center
- Role 5: Definitive care at hospitals in CONUS



+ Role 5

Summary of Activities to Date

Meeting Date	Discussion Topics
Oct 11, 2023: T&I Meeting	TOR Overview, Objectives, Guiding Principles, Report Timeline
Oct 25, 2023: T&I Meeting	Brief on Integrated CONUS Medical Operation Plan Report Development: Report Outline, Subject Matter Experts
Nov 1, 2023: T&I Meeting	Brief on Strategic Priorities in Peer/Near-Peer Conflict Report Development: Report Outline
Nov 8, 2023: T&I Meeting	Brief on PFC/PCC in the Joint Trauma System
Nov 15, 2023: T&I Meeting	Brief on Walking Blood Bank Report Development: Report Outline

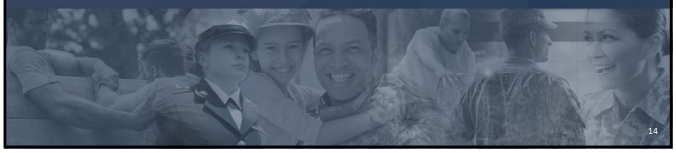
Emerging Findings

- Terminology is not standardized across the Services
- Training is not standardized across the Services
- Military-civilian partnerships (MCPs) are critical for trauma training and casualty care
- Critical shortages of blood are anticipated
- National resources may be stretched to meet ongoing U.S. healthcare and casualty care needs

Way Ahead: Anticipated Reports

- Interim Report: March 2024
  - Framework for in-theater care
  - Military-civilian education and training partnerships
  - Walking Blood Bank training
- Final Report: September 2024
  - Review of anticipated injuries
    - Joint Trauma System data
  - Further delineation of MCP requirements
  - Military/Federal/ civilian healthcare system integration and preparedness
    - Integrated CONUS Medical Operations Plan

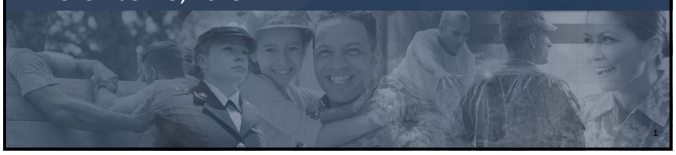
Questions



Appendix 5

Effective Public Health Communication Strategies with Department of Defense Personnel

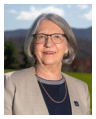
Wilsie Bishop, DPA
Chair, Public Health Subcommittee
November 29, 2023



Overview / Agenda

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

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

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.**

Background

- Inaccurate information about health harms public health and undermines trust in public health professionals.
- Inaccuracies can be characterized as *misinformation* (false or inaccurate fact claims) 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.

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.

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

Summary of Activities to Date

Meeting Date	Discussion Topics
Sep 19, 2023: PH Meeting	• DoD/DHA legal authorities • Chapter 1 discussion
Oct 10, 2023: PH Meeting	• Public health communication strategies • Civic Online Reasoning
Oct 31, 2023: PH Meeting	• Military spouses panel
Nov 21, 2023: PH Meeting	• Health risk communication • News and information environment

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 citizens on public health decision making.

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.

(Potential) Emerging Findings

- PH informs policy but does not dictate it. Elected leaders and individual citizens weight PH guidance alongside other values, interests, and concerns. Explaining and demonstrating this distinction to the public may help to ameliorate trust barriers and improve compliance.
- Trust and compliance may be impeded by audience perceptions that PH officials do not share their own values, beliefs, and experiences.
- DoD needs to provide *context* for its recommendations. For example, managing new viruses requires a cooperative effort to prevent transmission and sufficient vaccination to reach herd immunity.

Areas of Further Interest

- Impact of delayed communication during early phases of the pandemic
  - Implication for future pandemics and bio-incidents (natural, accidental, intentional)?
- Role of the clinician in health communications?
- Media information ecosystem and information flows
- Artificial intelligence technology
- Information Security
- Effectiveness of misinformation interventions (pre/debunking, fact checking etc.)

Way Ahead

- Subcommittee meetings with briefings from Subject Matter Experts
- Report development with the Chair and Subcommittee
- Quarterly updates to the Defense Health Board
- Anticipated Decision Brief June 4, 2024

Questions