



**DEFENSE HEALTH BOARD
MEETING
FEBRUARY 21-22, 2012
Marriott Rivercenter
Salon C-D
101 Bowie Street
San Antonio, Texas 78205**

February 21, 2012

- 1. ATTENDEES - ATTACHMENT ONE**
- 2. NEW BUSINESS**
 - a. Administrative Session**

Ms. Christine Bader, Defense Health Board (DHB) Director, welcomed attendees. Members then introduced themselves.

Discussion ensued regarding the Dover Port Mortuary (DPM) Independent Review Subcommittee report findings and proposed recommendations. DPM staffing and training issues were discussed. Dr. Jacquelyn Taylor stated that the DPM is understaffed for large-scale events. Although it might not be feasible to augment staffing, particularly during peacetime, efforts should be expended to ensure embalmers are well-trained.

GEN (Ret) John Abizaid discussed the proposed command and oversight structure figure, providing an overview of the various organizations that support the Air Force Mortuary Affairs Operations (AFMAO) mission. He stated that the various activities of these organizations and lack of appropriate coordination among them contributed to difficulties within the DPM regarding the handoff of remains. Issues pertaining to the U.S. Army's role as Executive Agent for Department of Defense (DoD) Mortuary Affairs, chain of command, authority, the Central Joint Mortuary Affairs Board (CJMAB) and oversight were discussed.

GEN Abizaid stated that the subcommittee strongly recommends that the AFMAO command structure be strengthened and that the CJMAB be granted increased oversight and authority. He noted this would speed up policy development and implementation, particularly important during wartime. The subcommittee also recommends that a Department of Veterans Affairs (VA) representative be included among the CJMAB membership. GEN Abizaid also indicated that the subcommittee felt an outside Board of Visitors should be established with subject matter experts to provide regular reviews and necessary guidance. He noted that the subcommittee was specifically precluded from looking at disciplinary matters involved in particular incidents that happened at AFMAO.

Gen (Ret) Richard Myers suggested that the term “Board of Advisors” would be preferable than “Board of Visitors” as the latter is often limited to academia. In addition, he recommended that an alternative to DoD Inspector General (IG) oversight be identified, noting that it might not be the appropriate body to conduct that function. Gen Myers suggested the subcommittee consider a military Service or the Joint Services IG to conduct this regular review, as DoD IG might not be as responsive to Services leadership as required. GEN Abizaid stated that the subcommittee particularly sought a DoD coordinated effort to provide oversight for this system, at least annually to ensure seams are properly addressed, and that the different organizations are coordinating appropriately.

Ms. Marianne Coates commented briefly on public affairs issues. Although the DPM issues have received considerable media interest, the media have not responded to the publications of the Federal Register or media advisory and PR Newswire notices regarding the DHB meeting. She did not directly contact media to inform them of the DHB meeting. Ms. Coates anticipated that questions will arise following the release of the subcommittee report. Both the report and presentation slides will be posted to the DHB Web site. She concluded by requesting that members refer media inquiries to her and to contact her with any questions.

Dr. Nancy Dickey, DHB President, thanked the subcommittee for its work. She also noted that Dr. John Baldwin took the oath of office that morning and welcomed him as a new member of the Board prior to adjourning the administrative session.

b. Opening and Administrative Remarks

Dr. Dickey welcomed Board members and public attendees. Mr. Allen Middleton called the meeting to order as the DHB Designated Federal Officer. Following a moment of silence to honor Service members, Board members introduced themselves and Ms. Bader provided administrative remarks.

c. Decision Brief: Dover Port Mortuary Independent Review Subcommittee

GEN Abizaid provided an overview of the subcommittee’s charge and requested that the members introduce themselves. He then reviewed the subcommittee’s Terms of Reference, emphasizing that it was not requested to review disciplinary actions. The subcommittee’s methodology and guiding principles were discussed, explaining that the subcommittee’s objective was to ensure that Fallen Heroes are treated with dignity, honor and respect and in a manner that is transparent and compassionate for the families concerned. He indicated the importance of restoring confidence in troops and families.

GEN Abizaid then explained a figure depicting the proposed command and oversight structure. He discussed the Department of the Army’s role as Executive Agent and issues pertaining to chain of command, authority and oversight. Findings and proposed recommendations pertaining to command were discussed. GEN (Ret) Frederick Franks discussed concerns regarding oversight issues.

Dr. Eve Higgenbotham referenced proposed recommendation number five, stating that although she believes operational oversight is important, quality of performance should be maximized. She recommended that the Board of Advisors develop a dashboard or metrics by which quality and effectiveness can be assessed objectively, particularly due to the complexity of the AFMAO organization. GEN Abizaid stated that although the subcommittee did not recommend specific metrics, it would agree that performance metrics should be developed, should the Secretary of Defense decide to establish the Board of Advisors. He noted that with the subcommittee's approval, that suggestion will be included in the report.

VADM John Mateczun suggested that the Uniform Code of Military Justice (UCMJ) authority issue be clarified in the report, since it is assumed that the commander may be able to exercise UCMJ authority to assigned personnel. GEN Abizaid agreed, indicating the final report will include this statement.

Dr. Donald Jenkins underlined the importance of the Feedback to the Field efforts, stating that the Committee on Tactical Combat Casualty Care (CoTCCC) receives quarterly updates regarding its work and recognizes the great value of feedback provided to field operators in real time. He recommended that the subcommittee report highlight this initiative as one that should be preserved and retained. GEN Abizaid agreed, stating that a Feedback to the Field report should be included in the report appendix.

Dr. John Gandy indicated that in regard to the proposed recommendation number five, he is concerned that the commanders and command authority would not report to their respective chain of command but rather to the Board of Advisors with expertise in mortuary affairs. GEN Abizaid stated it would be important to report through the appropriate chain of command in addition to undergoing oversight by an independent, professional body.

Dr. Bruce Parks then provided an overview of the Armed Forces Medical Examiner System (AFMES), including its mission focus and realignment issues. He described the procedure for the processing of remains, as well as chain of custody, stating that remains received are frequently fragmented portions. Concerns regarding visibility and personnel morale were outlined.

Dr. Victor Snyder discussed issues pertaining to statutory authority for AFMAO and AFMES, as well as the process for the disposition of remains belonging to those other than Fallen Heroes. Dr. Parks then described the current and final layout of the DPM facility, AFMAO and AFMES ownership, chain of custody for remains, and the software system used to track specimens and ensure all documents are received prior to their release to AFMAO. He discussed the subcommittee's findings regarding the AFMES exposure control plan as well as the notification and communication processes to inform staff of contagious and potentially contagious remains. Dr. Snyder indicated the subcommittee was impressed with the AFMES facility; however, it might be overwhelmed should a surge occur. AFMES's command isolation had presented challenges in planning for extraordinary events. Dr. Parks then reviewed findings and proposed recommendations pertaining to training, certification and accreditation of personnel and the facility. He indicated that current staffing appeared to be adequate.

Dr. Snyder discussed issues pertaining to the identification of fragmented remains and the notification of family members regarding subsequently identified remains. He also commented on the significant volume of fragmented remains received by AFMES for identification, due to the widespread use of improvised explosive devices. The subcommittee found no reason to recommend changes to the AFMES practice of not testing portions of remains weighing less than 500 grams.

Dr. Ross Bullock commented that during the early years of Operation IRAQI FREEDOM, research conducted by the academic sector was confronted with challenges associated with distinguishing mechanism of injury. Researchers were unable to access AFMES autopsy data. Dr. Bullock inquired whether policy changes might be implemented that would allow this access. GEN Abizaid conveyed his impression that a feedback mechanism to the broader medical community exists; however, he would have to inquire whether AFMES reports are available and would provide a response during the following meeting break. Dr. Dickey stated that the report should recommend that a clarified process be established that academic entities who wish to partner with AFMES could follow.

Dr. Jacquelyn Taylor presented the AFMAO Work Group findings and proposed recommendations. The DPM and DoD Mortuary Affairs have undergone significant changes within the last decade, and the findings and proposed recommendations focus primarily on personnel. She also stated that all training should be measured against established benchmarks.

Mr. Caleb Cage presented the findings and proposed recommendations pertaining to alternatives for retirement at sea for the disposition of cremated identified portions of remains elected not to be received by the Person Authorized to Direct Disposition. He described additional options that are available per discussions with the VA.

Dr. Taylor discussed two additional events that raised concerns and received public attention. She reviewed the issue regarding the use of the DPM crematory for a Service member who was cremated in a container and not the casket selected by the family. Dr. Taylor noted that this incident underscored the lack of standards and policies concerning the proper use of the crematory at DPM. The subcommittee is recommending that DPM not conduct full body cremations. Dr. Taylor also discussed the issue pertaining to the shipment of fetal remains from Landstuhl, Germany and stated that the subcommittee confirmed to the best of its ability that proper containers are currently being used.

Dr. Jenkins inquired whether civilian accreditation or training standards exist for AFMAO personnel, Service liaisons, case managers, and casualty assistance officers. If so, recommendations numbered 13 and 14 should be clarified to include these standards. Dr. Taylor provided examples of available training, but noted that the intent was to use broad language in these recommendations to allow standards to be explored. Dr. Jenkins commented that if left too broad for interpretation, intended standards might not be met. He noted that adequate resourcing cannot be provided to meet standards if requirements are not established. Dr. Dennis O'Leary distinguished the terms "accreditation" and "certification", noting that the former refers to organizations while the latter refers to individuals. He emphasized that competency assessment should be the critical issue.

Dr. Dickey thanked the subcommittee for its presentation. She indicated that written comments were not received prior to the meeting, then provided the opportunity for members of the public to address the Board and pose questions to the subcommittee.

COL Katherine Richardson, British DHB Service Liaison Officer, mentioned the “500-gram rule” and inquired whether families are asked whether they wish to be contacted should subsequent portions be found. Dr. Taylor confirmed that is the current practice.

GEN Abizaid reiterated the importance of understanding the systematic failures that contributed to the issues that arose at DPM: the lack of issuing policy expeditiously and lack of proper oversight and command. He noted that these problems could be resolved. GEN Abizaid emphasized importance of establishing a technical board of advisors, since it would allow for transparency, the expeditious exchange of information, and would enable improvements. Topics not addressed in the subcommittee’s presentation may be found in the report. GEN Abizaid stated that the subcommittee stands by its conclusions and recommendations, noting that the verbiage suggested by the Board will be incorporated in the final report. He then thanked the subcommittee and DHB staff for their efforts.

Dr. Dickey thanked the subcommittee for its work and suggested the Board vote on the 20 proposed recommendations, although the report itself would be revised slightly. The recommendations were presented verbatim on the briefing slides. Dr. Anderson made a motion for the Board to accept the subcommittee report and approve the proposed recommendations. Dr. Baldwin seconded this motion. Dr. Dickey inquired whether any recommendations should be removed from the report. No such suggestions were offered. The Board approved all recommendations by unanimous vote; GEN Franks abstained from voting as having participated on the subcommittee and development of the report.

Action/POC: Finalize the subcommittee report/DPM Independent Review Subcommittee.

d. Working Lunch: Administrative Session

COL Mary Garr, Chief Operating Officer, San Antonio Military Health System (SAMHS), provided an overview of the SAMHS. The history of SAMHS was discussed, with an emphasis on the years preceding the 2005 Base Realignment and Closure (BRAC) law. Its implementation resulted in opportunities for collaboration between two large military medical facilities: Brooke Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC). Objectives of this partnership, as well as the SAMHS mission, vision, assets, and components were discussed.

COL Garr described a graphic depicting the San Antonio Area Military Treatment Facilities (MTFs), which highlighted the increase in eligible beneficiaries and SAMHS MTF enrollment from Fiscal Year 2011 (FY11) to FY12. She outlined Wilford Hall Ambulatory Surgical Center (WHASC) services and staffing and compared two images of the WHMC facility in 2005 and the WHASC facility projected in 2015. COL Garr described the San Antonio Military Medical Center (SAMMC) and compared images of the current facility with that of BAMC in 2005.

Graduate Medical/Health Education were discussed. Programs offer a military-unique curriculum to ensure that graduates are ready to deploy. Education, training and research partnerships within the SAMHS were reviewed; these collaborations drive medical innovation and include the Battlefield Health and Trauma Research Institute, the Center for the Intrepid, academia, foundations, industry and other Federal agencies.

Following, COL Garr provided an overview of Critical Care Air Transport Teams (CCATT) and global intensive care unit-level care. The 59th Medical Wing (59 MDW), the primary CCATT unit, was discussed. It provides high-tech medical capabilities in combat environments. The 59 MDW is also deployed for training.

BAMC humanitarian assistance and deployment operations were reviewed. COL Garr outlined the SAMHS structure, governance, clinical and business operations within the SAMHS office, as well as near-term and long-term initiatives. The underlying objective of these efforts is to build and maintain relationships for future improvements in patient care. The achievement of this goal will require commitment from leadership including all levels of the SAMHS and Military Health System (MHS).

Maj Gen Byron Hepburn, 59 MDW Commander and Director, SAMHS, provided welcoming remarks to the Board. He provided an overview of the complexity of the health care system in San Antonio, Texas. Maj Gen Hepburn noted that medical recruiting, education and training are conducted at the U.S. Army Medical Department Center and School and described the Medical Education Training Center. He stated that the training and education provided examines history and lessons learned in order to envision future health care needs. He discussed the Center for the Intrepid, noting it is a world-class facility for the rehabilitation of Wounded Warriors; its primary focus is limb rehabilitation.

Maj Gen Hepburn concluded his presentation by stating that SAMMC supports all three military Services in producing enlisted medics, leaders, clinicians and administrators.

Dr. Dickey thanked Maj Gen Hepburn and COL Garr for their presentation. Dr. Robert Certain was then presented with a plaque in recognition by the Board for his service as a DHB member. Dr. Certain provided brief remarks and thanked the Board.

e. Information Brief: Joint Task Force National Capital Region Medical – Integrated Delivery System Update

VADM Mateczun, Commander, Joint Task Force National Capital Region (NCR) Medical (JTF CAPMED) provided an update regarding the BRAC integration of health services within the NCR. He discussed progress to date regarding the construction and relocation at Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH). VADM Mateczun emphasized that the “world class” standard is not an aspiration but a legal mandate.

JTF CapMed missions and BRAC changes were reviewed. BRAC hospital projects pertaining to patient reassignment and associated operational challenges for large hospital centers were

described, noting new approaches for medical emergency responses had to be devised. He indicated that Information Management/Information Technology developments play a large part in current efforts.

Challenges associated with the conglomeration of previously existing systems and adoption of legacy systems was reviewed. Current images of the WRNMMC and FBCH campuses were compared with those prior to construction; the capabilities of each facility were discussed. VADM Mateczun emphasized increasing efficiencies as one objective in efforts to integrate community hospital and medical systems. He reviewed lessons learned from BRAC-associated changes, compiled into the following six principle areas: Governance, Requirements, Communication, Resources, Plans and Culture.

The NCR Medical Integrated Delivery System was discussed. Consolidation of existing capabilities would result in operational effectiveness and efficiencies. VADM Mateczun outlined the NCR Medical Integrated Delivery System objectives, underlining their relation to the MHS Quadruple Aim. System standardization and establishment of common processes are required for integration.

VADM Mateczun reviewed the WRNMMC Comprehensive Master Plan Components and discussed how they would achieve mandates in the NCR. Issues pertaining to infrastructure and project funding were discussed. Although mandates pertaining to world-class care have been met, current capabilities could be expanded. Although all U.S. Americans with Disabilities Act of 1990 requirements have been met, not all Wounded Warrior needs have been addressed. Feedback provided by Wounded Warriors has driven changes (such as retrofitting bathtubs to make them wheelchair accessible). VADM Mateczun emphasized that unity of both command and effort are necessary for a successfully integrated health care delivery system; otherwise, components would operate independently and work to optimize themselves on an individual level.

VADM Mateczun thanked the DHB, in particular the members who served on the NCR BRAC Subcommittee. He noted that this presentation would be his final briefing to the Board, as he is retiring from the military on April 1, 2012. Members congratulated VADM Mateczun for his accomplishments, leadership and public service.

f. Information Brief: In-Theater Data Collection

Discussion:

COL Lorne Blackbourne, Commander, U.S. Army Institute for Surgical Research (USAISR) provided an overview of USAISR. Its mission, history, and organization were discussed. Burn, trauma and combat casualty care (CCC) are the primary research foci. He then introduced Col Jeff Bailey, recently appointed as Director of the Joint Theater Trauma System (JTTS), and Dr. Dave Baer, Director of Research at USAISR.

COL Blackbourne emphasized the importance of translational research and communication. Combat data from the Joint Theater Trauma Registry (JTTR) are translated to laboratory research. The uniqueness of the Battlefield Trauma and Research Institute was discussed.

Col Bailey then provided an overview of Joint Trauma System (JTS) located in San Antonio, Texas. Its history, mission, and goals were reviewed. Col Bailey emphasized the importance of current efforts, which are irrespective of region, conflict, or contingency, and underlined the concept of an enduring JTS. He noted that one of the most challenging goals to achieve is data capture from as far forward, and close to the point of injury as possible through the rehabilitation setting.

The relationship between the JTS and JTTR was discussed. Core functions and services were reviewed for each organization. Data are abstracted from patient medical records. Trained individuals review these records, extract information and include data in the JTTR. Medical Evacuation data are a critical component of the JTTR, representing about 60 percent of its information. About 10 percent of JTTR data undergoes quality assurance review. Approximately 20 percent of JTTR data is obtained from archived information collected from repositories.

Col Bailey reviewed various uses of JTTR data and provided examples. The information is applied for continuous concurrent performance improvement and development of evidence-based clinical practice guidelines. Col Bailey outlined examples of current performance improvement projects in theater.

Members posed questions about the quality of evidence used to develop clinical practice guidelines and whether it is distinguished in publications, issues regarding the Health Information Portability and Accountability Act and confidentiality, sources of JTTR data and the rate of prehospital data capture.

Dr. Baer provided an overview of CCC research at USAISR. He reviewed its mission, highlighting the focus on battlefield medical problems that result in data-driven questions, which influence laboratory and clinical research. Current examples of research projects were outlined. Dr. Baer recapitulated the data-driven nature of the projects undertaken to improve battlefield care. USAISR's interaction with the DHB, especially with the CoTCCC serves as a critical component in USAISR's efforts to enable the rapid fielding of innovations. Dr. Baer concluded his briefing by discussing forthcoming research areas of interest.

g. Decision Brief: Review of Department of Defense Centers for Deployment Health

Dr. Higgenbotham and Dr. George Anderson provided a brief regarding their findings and proposed recommendations following their site visits to the DoD Centers for Deployment Health. Dr. Anderson provided an overview of the presentation and history regarding the DHB review of this issue. Dr. Higgenbotham and Dr. Anderson conducted site visits to the Armed Forces Health Surveillance Center (AFHSC), Naval Health Research Center (NHRC), and the Deployment Health Clinical Center (DHCC). The Centers were reviewed according to a

modified version of the Performance Driver Model™. The drivers are: strategy, process, culture/people, and structure/programs.

Dr. Anderson provided an overview of the missions, visions, structures and programs of the AFHSC, NHRC, and DHCC. Key findings within each driver were discussed for each Center. Key recommendations for the AFHSC included securing long-term funding within the POM; protecting Service Liaison positions from deployment, improving data collection processes in theater, and preserving the Global Emerging Infections Surveillance laboratory network.

Key recommendations proposed for the NHRC were to maintain its stability in any future Department of Navy Bureau of Medicine and Surgery reorganization, continue DoD funding for key longitudinal NHRC research projects, extend successful pilot projects that are not currently Tri-Service to all Services, and reassess the Millennium Cohort Family Study child enrollment process.

The following key recommendations were identified for the DHCC: a comprehensive strategic plan should be developed; Service Liaison positions should be broadened to include all military Services; standard evaluation/assessment processes should be developed; staff composition should be ensured to support strategic goals/mission; and cost-effectiveness of all research projects should be assessed.

Dr. Anderson reviewed applicable recommendations from the Government Accountability Office reports on the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (TBI) dated February 2011 and June 2011. He then presented overarching recommendations, advising that the DHB revisit NHRC and AFHSC in two years and revisit DHCC in one year.

Dr. Higgenbotham highlighted several points. The AFHSC and DoD Serum Repository are national treasures. On an ongoing basis, the DHB should help balance opportunities provided by modern technology with military needs. Current knowledge could be augmented significantly by learning about the disease states of aging Warriors over time. Additional funding is important to ensure current efforts are protected from volatile funding streams.

Discussion ensued regarding the findings and proposed recommendations. Dr. David Hovda proposed the recommendations be amended to include the word “value” and an external review process, noting that peer review is valued within academia. He suggested that funding be reviewed from a return on investment perspective to determine whether the Centers are being resourced and supported appropriately. Dr. Anderson agreed that systematic external review needs to be conducted and indicated those proposed amendments could be included in the recommendations.

Dr. Richard Carmona proposed the recommendations be further amended to indicate that the Centers should achieve economies of scale and efficiencies on a broad level, although recognizing there are sometimes Service-specific needs. Dr. Anderson indicated that the findings and proposed recommendations were intended to reflect their observations during the site visits rather than provide solutions.

Dr. Dickey solicited direction from the members regarding proposed actions for the way ahead. Dr. Hovda made a motion that the Board accepts the proposed recommendations with the amendments regarding external peer review and value. Dr. Baldwin seconded this motion. Dr. Carmona proposed that the Board consider the additional amendment to the recommendations pertaining to conducting a comprehensive analysis to identify opportunities to increase efficiencies and economies of scale and reduce redundancies while being sensitive to the needs of the Services. The Board accepted the amended recommendations by unanimous vote without abstention.

Action/POC: Incorporate approved amendments and finalize report/DHB staff.

h. Decision Brief: Addition of Ketamine to Tactical Combat Casualty Care Guidelines

Dr. Gandy emphasized the TCCC guidelines are intended for the pre-hospital phase of care, for combat medic use in the field at point of injury. Consequences of untreated pain and history of pain management were discussed. Morphine has been mainstay of pre-hospital pain control since the U.S. Civil War. Although considered the “Gold Standard”, many feel morphine is an outdated medicine.

Dr. Gandy discussed drawbacks for using morphine for pain management. It is most often delivered through the intramuscular route. He discussed results from surveys that queried experienced combat medics regarding their point of view on battlefield analgesia. Although it appeared they had less experience administering ketamine, combat medics rated ketamine as more effective than morphine or fentanyl in providing rapid pain relief for severe pain in the field setting. Dr. Gandy then reviewed the analgesics currently carried by combat medics.

Pain management approaches were discussed. A multimodal method would reduce the side effect profile for any individual drug, since each would be administered with a decreased dosage. The uses for ketamine and its safety profile were reviewed. He emphasized that ketamine has been used on the battlefield for some time, just not by every combat medic. Dr. Gandy emphasized that no clinical overdose from ketamine has been reported. The Food and Drug Administration product safety insert for ketamine and the Clinical Practice Guidelines (CPGs) for Emergency Department Ketamine Dissociative Sedation: 2011 Update, including contraindications, were reviewed. Dr. Gandy stated that head trauma was removed as a contraindication. Prehospital doses of ketamine have been reported to be safe among possible TBI patients, a change in the historical perspective that ketamine should not be used in TBI patients. He noted that induction requires much higher doses than analgesia.

Contraindications were discussed. Inconclusive and conflicting evidence exists regarding increased intraocular pressure (IOP). The findings and conclusions of two studies were reviewed, which found no clinically meaningful association between ketamine and increased IOP. Dr. Gandy stated that although evidence is inconclusive, IOP should be included as a risk and should be addressed in CPGs. He reviewed side-effects, dosages and operational considerations.

Dr. Gandy then presented the proposed protocol, highlighting changes since the DHB was last briefed regarding this issue. Dr. Gandy highlighted that the range has been widened to account for differences in body weight, metabolism and gender.

Discussion ensued regarding the strength of the current evidence and findings indicating ketamine is safe, contraindications and the association with increased IOP. Dr. Ross Bullock and Dr. Higgenbotham expressed concern that the caveat regarding the association between ketamine and increased IOP was removed. Dr. Bullock indicated that the evidence to support its safety is weak. He noted that situations may arise wherein combat medics could be presented with casualties under coma and with mass lesions; ketamine should not be used in unconscious patients or those with large lesions at risk for herniation. Dr. Gandy replied that unconscious casualties would not receive pain medication in a field setting. He indicated he would not be opposed to including that comment in order to mitigate potential risks among some patients while helping others.

Discussion followed regarding whether the recommendations would be included in TCCC Guidelines or educational material. Concerns arose regarding the lack of experience of most combat medics with using ketamine; members deliberated whether the risk of increased intracranial pressure and a statement that ketamine should not be used in patients with suspected or obvious open globe injury should be included in the guidelines. Dr. Gandy stated that the protocol would be posted on a web site that might not be directly linked with educational material; TCCC Guideline amendments would be disseminated more rapidly than changes to educational material.

Dr. Dickey inquired whether the members wished to hold a vote to approve the protocols. Dr. O'Leary made a motion that the Board approve the protocols as they appear. Dr. Baldwin seconded the motion. The Board approved the protocols as presented by majority vote. Dr. Bullock, Dr. Higgenbotham, and Dr. Hovda opposed; there were no abstentions.

Dr. Anderson made a motion that the Board accept the stated contraindications and caveats to the proposed protocol pertaining to suspected increased intracranial pressure, presence of injuries that would cause increased intracranial pressure or potential open globe injuries. Dr. Hovda seconded this motion. The members approved the stated caveats be included in the protocol by unanimous vote with no abstention.

Action/POC: Include approved amendments and finalize report/DHB Staff.

i. Administrative/Closing Remarks

Ms. Bader provided administrative remarks regarding activities for the evening. Mr. Middleton then adjourned the meeting.

February 22, 2012—Administrative Session

1. ATTENDEES - ATTACHMENT ONE

2. NEW BUSINESS: SITE VISITS

The Defense Health Board (DHB) conducted a site visit to the San Antonio Military Medical Center in an administrative session. The members received a tour of the U.S. Army Institute for Surgical Research (USAISR), including the USAISR Burn Center and Battlefield Health and Trauma Research Institute, followed by a tour of the Naval Medical Research Unit – San Antonio, which included the Combat Casualty Care and Directed Energy Bioeffects Research Laboratory.

3. NEXT MEETING

The next DHB meeting will be held on June 25 – 26, 2012 in the NCR.

4. CERTIFICATION OF MINUTES

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



Nancy W. Dickey, MD
President, Defense Health Board

_____04/20/2012_____

Date