DEFENSE HEALTH BOARD
OPEN SESSION
MEETING MINUTES

August 10, 2022
Captain James A. Lovell Federal Health Care Center
Building 4, Bourke Hall
North Chicago, IL

1. **Attendees – Appendix One**

2. **August 10, 2022 – Opening Remarks/Introductions**

- CAPT Gorman welcomed attendees, introduced himself, and called the Open Session meeting to order. He noted that this is the first in-person meeting in more than two years and thanked CAPT McKenzie and the Lovell Federal Health Care Center (LFHCC) team for hosting.
- Dr. Karen Guice, Defense Health Board (DHB) President, welcomed attendees, and provided an overview of the meeting schedule.
- Dr. Guice asked for a moment of silence to honor the men and women who serve in the United States military. Members introduced themselves. CAPT Gorman recognized the distinguished guests attending the meeting.

3. **Administrative Remarks**

- CAPT Gorman reviewed the rules and logistics for the meeting. He thanked the LFHCC command staff for all their support in preparing for the meeting.
- CAPT Gorman commended the MicroHealth and BookZurman contract support staff for their work in putting this meeting together and thanked all attendees for their participation.

4. **Lovell Federal Health Center Overview**

Dr. Robert Buckley and CAPT Chad McKenzie presented a history of LFHCC and an overview of the different facilities and services provided. Discussion points of note:

- Dr. Alleyne asked how they determine standardization since there are two systems providing services at LFHCC, Veterans Affairs (VA) and DoD, and if the standardization is operational or clinical. Dr. Buckley replied that the hospital and hospital system have their own needs and approaches and each specialty has their own standards; however, the Joint Command supervises the system and each system learns from the other. For example, the VHA has adopted the DHA's tooth marking protocol as a best practice.
- Dr. Valadka asked for more details on staffing for Mental Health (MH) services at LFHCC. CAPT McKenzie responded that the community partners work well with LFHCC providers. The common goal is to get Service members healthy and to begin out-processing if necessary. The clinical psychologists play a big part as do the behavioral health (BH) technicians. The BH technicians are usually an enlisted rank of E3-E4, which are a peer group to recruits. CAPT McKenzie noted that since the BH technicians are integrated into the team, they are able to triage the situation before an

individual has the opportunity to see a clinical psychologist. This better prepares individuals for the clinical psychologist and better helps recruits.

- Dr. Armstrong asked how the Cook County Trauma partnership is managed and what metrics and training are used. CAPT McKenzie replied that Knowledge, Skills, and Abilities (KSA) are tracked by the number and complexity of cases. There is a memorandum of understanding, managed by Navy Medical, between LFHCC and Cook County. CAPT McKenzie reported that Cook County loves the arrangement, as they welcome the staff at all levels and actively engage in the training. Dr. Armstrong asked about Navy surgical teams' training. CAPT McKenzie replied that they provide a ready surgical team.
- Dr. Jacobs commented on the state of trauma surgical readiness. He noted that in recent years the preference for minimally invasive surgeries have been on the rise, which may negatively affect capabilities of military trauma surgeons. He suggested embedding surgical teams in battlefield-like environments is critical to surgical readiness.
- Dr. Browne asked about the success rate of recruits who enter Navy basic military training. CAPT McKenzie stated he will find out the wash rate.
    - LTG Place added an example of the challenges Marine recruits face at Parris Island. If Marine recruits can stay in the care of the Military Health System (MHS), they are twice as likely to complete basic military training.
    - Brig Gen Harrell concurred with this statement for the Air Force (AF). Joint Base San Antonio uses the consortium between Air Force and Army to keep the recruit pipeline going—quarantining onsite during COVID like LFHCC. LTG Place mentioned other coordination, like Army and Marine Corps in many places.
    - Dr. Buckley mentioned that historically railroads and airfields made Chicago a great place to have a training center. He noted there needs to be reasonable integration of electronic health records for multi-Service/civilian care provisions.
- Gen (Ret.) Chilton asked about the advantages and disadvantages of the TRICARE system. Dr. Buckley replied that various factors push patients away from military treatment facilities (MTFs). While the MHS tries to keep all services available to families, it is not always possible; there are ebbs and flows in the ability to care for TRICARE beneficiaries. For example, child/adolescent psychiatry was moved out of the MTFs to prioritize meeting needs of ADSMs. CAPT McKenzie noted that from a user perspective, using TRICARE in Chicago has been the same as everywhere else and seamless for his family to enroll. He also noted young female veterans having children can get care at the LFHCC.

5. Health Systems Subcommittee Tasker Update: Eliminating Racial and Ethnic Health Disparities in the Military Health System

Dr. Michael-Anne Browne provided an update on the Health Systems Subcommittee tasker, Eliminating Racial and Ethnic Health Disparities in the Military Health System. She noted that individuals have been champions for research on disparities in certain health outcomes, but there is not a coordinated disparities research effort. She reported that race and ethnicity data for health outcomes is inconsistent. Discussion points of note:

- Dr. McCaw recommended inclusion of data on mental and behavioral health accession and outcomes.

- Dr. Alleyne noted that the Department of Health and Human Services (DHHS) has been implementing an Equity Action Plan and asked what the MHS is doing to better integrate and ensure synergistic approaches to racial equity. He cited the example of racial equity in post-partum outcomes. Dr. Browne responded that the Subcommittee will look at what has worked and will reach out to DHHS for lessons learned. Dr. Alleyne also initiated discussion on the following topics:
  - Regarding digital health literacy, everyone can log into a health system in the MHS, but there is still some disparity in digital health literacy. Dr. Browne replied the subcommittee is still in the initial discovery phase, but are mindful of the fact it is not just about the system but also about the people and their lived experience as they enter the system.
  - Regarding data integration and the ability to capture self-identified race/ethnicity, populations have changed how they self-identify. Dr. Alleyne asked if there is an opportunity to think about how to address informed bias, which may impact data collection methods and how people are entered into the system. Dr. Brown responded that there are holes in data due to unavailable categories, like biracial and multiracial.
- Dr. Maybank recommended looking at adverse childhood experiences (ACEs) in the context of pre-accession experiences. There is an opportunity to think about the framework of the report from the context of where disparate outcomes come from and what they lead to. Dr. Browne agreed ACEs are of great interest, as is resilience.
- LTG Place stated there is a balance in medicine between the effects of people's lived experiences and their genetic ancestry on health outcomes. He asked where genetic pre-disposition comes into racial and ethnic health disparities. Dr. Alizondo replied that racial categorization relates to an individual's identity but not necessarily genetic markers that affect pre-disposition to health outcomes. LTG Place added that there are security risks to genetic testing in the DoD.
- Dr. Browne stated that race is a social construct that can have powerful effects on health outcomes. Dr. Maybank stated there is evidence that supports outcomes based on self-identity. Dr. Browne agreed with Dr. Maybank and expanded, stating that health outcomes in the MHS are not determined only by care received but also by beneficiaries' lived experiences, self-perception, and the perception of others about them as patients. Dr. Alleyne added that Social Determinants of Health and life stressors, including racial and ethnic stress, could affect military readiness. Dr. Browne replied that the subcommittee expects to speak with Service members to learn more about their lived experiences.

6. DHB Report Update: Low Volume High Risk Surgical Procedures

Dr. Paul Cordts provided a Defense Health Agency update on the DHB Low-Volume High-Risk Surgical Procedures reports. Discussion points of note:

- Brig Gen Harrell discussed the AF's involvement in human capital distribution plan to maximize surgical practice. There is a readiness and comprehensive analysis group to evaluate smaller facilities in INDOPACOM. Dr. Cordts mentioned expanded civilian and VA partnerships (now just under 800) add value by increasing readiness.

- RADM (Ret.) Chinn asked if there has been any progress on a DoD/VA partnership that would bring VA patients into MHS facilities to give DoD clinicians practice and VA patients' access to care. Dr. Cordts stated there has been progress in this program. Brig Gen Harrell mentioned there are several AF locations that take VA patients but this only happens in areas where there is a local arrangement. He would like to see a larger agreement for this type of program. LTG Place stated he supports a master agreement that expands upon local agreements for wider adoption of this arrangement. He added that the priority should bringing back patients already within the MHS beneficiary population, specifically 65+ year old patients, who do not require interagency coordination and the associated complexity.
- Dr. Guice asked for an explanation of Knowledge, Skills, and Abilities (KSA) breakdown on slide 22. Dr. Cordts explained that these data will inform the joint human capital plan comparing the workload contribution and KSA attainment by service area.
- Dr. Jacobs asked if there needs to be a military-ready standard for civilian hospitals so that military surgeons have more opportunities to train at civilian locations. He stated there is an opportunity to bring the resources of civilian health systems and the military together. Dr. Cordts stated there should be a standard and that this would be mutually beneficial. LTG Place added that recent National Defense Authorization Acts have included language requiring the DoD conduct pilot programs with civilian systems which moves toward the standard Dr. Jacobs described.
- Dr. Armstrong asked what can be done to change the narrative that surgeons are disaffected and leave the military before retirement due to opportunities for higher pay and better surgical case opportunities in the civilian sector. He added that military surgeons are exposed to civilian opportunities through valuable military-civilian partnerships. LTG Place answered that disaffection is not a universal experience for military surgeons. He noted that the new TRICARE contract proposals should include incentives for contractors to send cases that are high-generators of readiness to MTFs. He also explained that the new military retirement benefit is less of an incentive than it was in the past due to higher pay in the civilian sector and retirement benefits that accrue before 20 years of service.
- Brig Gen Harrell mentioned a pilot that improved KSAs through a system that auto-captures moon-lighting workload and training. Dr. Jacobs stated that this using database to track KSAs and number of cases would be very helpful in the civilian sector.
- Dr. Guice stated that if there is trouble recruiting now, it will probably get worse later, and if there is reliance on contract/civilian staff in MTFs when Service members deploy then it will be difficult to backfill those positions. She explained that DHA needs to look at future work force issues and how current issues compound them.
- Dr. Alizondo stated the military is reflective of what is happening in civilian care related to getting the right people in the right place to meet the needs of patients. Dr. Alizondo asked if there is an assumption that TRICARE patients will be able to get to the right facility for their care. LTG Place answered that TRICARE will pay for a beneficiary if they need to travel more than 100 miles or stay in a facility for a certain amount of time. This helps increase patients' ability to access the care they need if it is not local to them.
- LTG Place described a proposal that would improve critical care readiness by prioritizing training of other members of the care team including nurses and technicians. He

explained that they should use data to better prioritize training of all critical care team members.

- Dr. Armstrong asked how DHA could ensure that surgical team members receive standardized training nationwide. Dr. Cordts replied there needs to be a coordinated effort to standardize training.
- Brig Gen Harrell stated that in future conflicts, the U.S. is not likely to have air supremacy and emphasized that medical training should consider this new reality.

7. Towards Health Equity for Veterans

Dr. Ambareen Khan and Dr. Natasha Nichols, from the Jesse Brown VA Medical Center and Jesse Brown for Black Lives Clinical Committee, respectively, briefed their presentation entitled 'Towards Health Equity for Veterans.' Discussion points of note:

- Dr. Alleyne asked if the effort to eliminate the race coefficient in the estimated glomerular filtration rate (eGFR) is reproducible in other settings or clinical applications. Dr. Nichols answered that race is embedded in many medical algorithms for determining patient risk; if research shows race is not a relevant risk factor, it will take a national effort to revise the algorithms. Currently, there is not a coordinated effort to address all of the relevant calculations. Dr. Khan added that colleagues in the Pathology Department were key stakeholders in removing the race co-efficient for kidney disease risk as they were able to remove the option to select patient's race in the eGFR calculation. She also stated it is important for all members of the medical team to participate in groups that investigate these concerns. Dr. Parkinson added that an effort to compile and investigate race-based algorithms is a call to action for federal health systems and recommended a leadership summit to review and address race-based medical algorithms.
- Dr. Maybank expressed support and encouragement to Drs. Nichols and Khan and the Jesse Brown for Black Lives Clinical Committee. She cited the 2020 *New England Journal of Medicine* article "Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms" as a compilation of many race-based algorithms. She emphasized that collective change requires collaboration by people across all identities. Dr. Maybank referenced an American Medical Association initiative to investigate and address race-based algorithms.
- Dr. Browne stated the DHB has an opportunity to raise the issue of race-based algorithms and asked for recommendations on how to look for examples of race-based algorithms. Dr. Nichols answered that there are examples in many medical areas and recommended examining if clinical calculations or other practices lead to disparities and, if they do, determine the infrastructure needed to address them. Dr. Khan gave the example of two presumably "race-neutral" cost-savings policies (pre-filled insulin syringes, use of pill-cutters to avoid smaller tablets) found to be inadvertently causing disparate outcomes. She recommended examining policies to determine if they are causing harm inadvertently.

8. Neurological/Behavioral Health Subcommittee Tasker Update: Beneficiary Mental Health Access

Dr. Alex Valadka provided an update on the Neurological/Behavioral Health Subcommittee Tasker Update: Beneficiary Mental Health Access. Discussion points of note:

- Dr. Parkinson stated the six pillars of lifestyle medicine are key to promoting mental health and recommended the DoD address these factors to alleviate the workload on clinical mental health practitioners in the MHS.
- Dr. Browne recommended looking at tele behavioral health to help connect beneficiaries with less severe mental health needs to services.
- Dr. Valadka stated the subcommittee has discussed more informal, community-level mental health resources such as leveraging the life experience of older community members as supports. Dr. Alleyne added that community health workers (CHW) could strengthen the network of support in addition to clinical providers. Dr. Maybank advised that public health programs should not rely on informal networks and that trained CHWs are important to community mental health efforts in instances when doctoral-level training is not required.
- Dr. Parkinson recommended reviewing research on neuroplasticity and the NEXT System, a non-clinical self-directed system for wellness that could scale to support less severe mental health needs in the MHS.
- Dr. McCaw stated that beneficiaries need to know they can get access to care.
- Dr. Browne recommended that the Health Care Delivery and Health Systems subcommittees share literature for their respective taskings.

9. Veterans Health Administration Telehealth Services

Dr. Darrin Worthington briefed the DHB on Veterans Health Administration (VHA) Telehealth Services. Discussion points of note:

- Dr. Jacobs asked if the VHA has thought about teaching standards for practitioners and the public on the use of VH technology so everybody can use the devices the same way. Dr. Worthington answered that the VHA uses the Blackboard platform for standardized visit experience. He added it is important to integrate telehealth training in practitioners' curricula.
- Dr. Alizondo asked if they have clinical outcomes for how patients are responding over time and if it correlates with inpatient admission or re-admission. Dr. Worthington answered they do not have specific data for every type of care, but for audiology there is a high correlation of satisfaction and better clinical results for those who use telehealth. Dr. Alizondo stated this matches with her organization's results and referenced her organization's work in Los Angeles using telehealth with unhoused populations as a tool for improving care.
- Dr. Alizondo asked how VHA provides information to patients about their health outcomes and feedback from their visits. Dr. Worthington replied that they are implementing a portal where providers enter an after-visit summary patients can view. This will allow better communications as patients may only remember 25% of the information from a visit correctly.
- Dr. Browne asked about the results of patient satisfaction surveys. Dr. Worthington replied that 27% of the patient population receives telehealth as some part of their care and that virtual mental health usage is quite high. He added they are looking at how to integrate telehealth services into specialty care modalities.

- Dr. Alleyne asked about their experience capturing best practices for patients with less digital literacy. Dr. Worthington explained the VHA loans digital devices for appointments, provides one-on-one assistance to do a practice appointment, and provides 24/7 support for the loaned device through the Connected Devices Program. He also explained that they work closely with the Office of Rural Health to identify areas of high need for telehealth.
- Dr. Parkinson applauded the four goals in the VHA Vision—all starting with accessibility. He asked how the VHA approaches using and implementing VH across different specialties. Dr. Worthington answered that expanding specialty care needs a clinical champion in each specialty and that it can be difficult to get provider buy-in from some specialty areas for VH.
- Dr. Armstrong asked about the quality assurance program, specifically clinical quality metrics and benchmarks relative to in-person visits. Dr. Worthington answered they do have a quarterly virtual care scorecard and a national telehealth quality team.
- RADM (Ret.) Chinn shared an anecdote about his very positive experience with VHA virtual health care tele-dermatology, including receiving direct provider feedback, next steps, and online test results.

10. Health Care Delivery Subcommittee Tasker Update: Optimizing Virtual Health in the Military Health System

Dr. Brigid McCaw provided an update on the Optimizing Virtual Health (VH) in the Military Health System tasking. Discussion points of note:

- LTG Place stated the MHS VH systems are similar to the VHA's but that the MHS does not have the same scale of VH visits as the VHA (11 million in VHA vs. 3 million in MHS). He added that it is challenging to measure the effect of VH on clinical outcomes compared to in-person visits.
- LTG Place stated there is a fundamental difference between VH care in a combat situation and domestically. He stated that VH in the MHS needs to promote readiness for clinicians on the battlefield and to consider the operational implications of VH.
- LTG Place explained that VH in the MHS has cyber security considerations that the VA does not need to take into account. He added that all members of the care team need to be well-versed in using VH technologies that comply with cyber security requirements so they are ready to use them in a combat situation. Gen (Ret.) Chilton asked about waivers in certain situations.
- Dr. Maybank stated the gap in accessibility for VH is for those who are in the margins and it is important to think about users' abilities and ability to access the technology. She also stated the MHS should be conscious of the implications of accessibility and security for immersive technologies.
- Dr. Alleyne asked about the current technical capabilities of VH. Dr. McCaw replied that the subcommittee is educating themselves on the specific capabilities of VH.

11. Due Outs

DHB Staff will:

- Follow up with CAPT McKenzie on the Navy Recruit Training Center wash-out rate

- Reach out to DHHS to learn about their Health Equity plan

12. Certification of Minutes

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

9/29/2022

Dr. 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.	E. Oscar	Alleyne	Managing Director, Public Health Division, MITRE Corporation
Dr.	John	Armstrong	Professor of Surgery, University of South Florida
Dr.	Michael-Anne	Browne	Associate Chief Medical Officer, Stanford Children's Health
Dr.	Maria	Caban Alizondo	Director, Health Information Management Services, UCLA Health System
Gen (Ret.)	Kevin	Chilton	President, Chilton & Associates, LLC
RADM (Ret.)	Colin	Chinn	Chief Medical Officer, Peraton
Dr.	Christi	Luby	Independent Consultant and Researcher
Dr.	K. Aletha	Maybank	Chief Health Equity Officer and Group Vice President, American Medical Association
Dr.	Brigid	McCaw	Senior Clinical Advisor, California Quality Improvement Learning Collaborative, University of California, San Francisco
Dr.	Michael	Parkinson	Principal, P3 Health, LLC
Dr.	Alex	Valadka	Professor and Director of Neurotrauma, University of Texas Southwestern Medical Center
DHB STAFF			
CAPT	Greg	Gorman	Executive Director/Designated Federal Officer (DFO)
Dr.	Catherine	Zebrowski	Executive Secretary/Clinical Consultant/Alternate DFO
Ms.	Angela	Bee	Research Analyst, MicroHealth, LLC
Mr.	Rubens	Lacerda	Management Analyst (Meeting Support), BookZurman, Inc.
Mr.	Paul	Schaettle	Alternate Project Manager/Senior Analyst, MicroHealth, LLC
Dr.	Clarice	Waters	Project Manager/Senior Analyst, MicroHealth, LLC
PUBLIC ATTENDEES			
MAJ	Michael	Brown	Aide-de-Camp to the Director, DHA
Mr.	Daniel	Casterline	Federal National Account Director – Vaccines, Merck & Co.
Dr.	Paul	Cordts	Deputy Assistant Director, Medical Affairs, DHA
Brig Gen	Thomas	Harrell	Commander, AF Medical Readiness Agency
COL	Mohamed	Nasri	German Health Foreign Medical Liaison
Brig Gen	Robert	Palmer	Senior Vice President, Government Relations, WPS Health Solutions; Mobilization Assistant to the Air Force Director of Public Affairs, AF Reserves
LTG	Ronald	Place	Director, DHA
LCol	Carlo	Rossi	Canadian Armed Forces Health Attaché, Office of the Assistant Secretary of Defense (Health Affairs)
Dr.	Darrin	Worthington	VISN 12 TeleHealth Program Coordinator/HSS, VA Great Lakes Health Care System