

Thursday 15 February 2024
Breakout Sessions 8am – 9am
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DHN Continental and DHN Central Director Panel Discussion

- *Maj Gen Thomas Harrell, Director, Defense Health Network (DHN) Central*
- *Maj Gen Jeannine Ryder, Commander, Air Force Medical Agency (AFMED Agency) and Chief, Air Force Nurse Corps*
- *RDML Tracy Farrill, Principal Deputy, Assistant Director Health Care Administration, USPHS*

Why Change What DHA is Doing: DHA Advancement reinforces both the DHA Strategic Plan and the focus on Ready Reliable Care as a High Reliability Organization. Using lessons learned from the initial DHA Market model, DHA is streamlining processes and aligning similar functions to strengthen their system so that it improves the work environment for their employees and enhances the patient care the MTFs provide to those we are privileged to serve.

The DHA Market model is solid, but there are gaps that DHA is fixing by simplifying and improving on the model. Aligning every MTF to a flag officer / general officer (FO / GO) led Defense Health Network (DHN) eliminates stand-alone MTFs, supports every MTF with FO / GO level authority/decision-making, and strengthens relationships with military partners.

Communication lines from the markets to DHA HQ are confusing, and communication from

What You Should Expect: DHA Advancement is a deliberate, fundamental shift in how DHA manages health care delivery, combat support, and enterprise support. DHA Advancement includes three phases starting the summer of 2023 and ending with DHA HQ at full operational capability (FOC). Phase 1 focuses on defining the Defense Health Network (DHN) and Defense Health Support Activity (DHSA) functions and staffing; Phase 2 aligns MTFs to one of the nine DHNs and establishes DHSAs that provide support to DHNs in geographically designated areas; and Phase 3 is DHA HQ alignment.

Defense Health Network (DHN). DHA is moving from twenty (20) Markets to nine (9) flag officer / general officer (FO / GO) led Defense Health Networks (DHN), aligning every MTF, including current standalone MTFs, to a DHN. This advancement capitalizes on FO / GO authorities, leadership, and decision-making, enhancing the expertise and abilities of DHA members across the organization, simplifying relationships, and improving internal communication. DHN directors will be dual-hatted, exercising authorities delegated to them from the DHA director and authorities inherent in their MILDEP leadership roles. This is not a component model, the DHA director is delegating authorities to the DHN Directors, not to the military services. DHN initial operating capability (IOC) is scheduled for October 1, 2023.

Defense Health Support Activity (DHSA). The current intent is to stand up four (4) Defense Health Support Activities (DHSAs) at the DHA HQ. The DHSAs are DHA HQ elements that report to the J3/5/7, they are not an additional organizational level between the DHA HQ and DHN directors. The DHSAs are comprised of functional experts that will action issues at DHA HQ, as appropriate, for the DHN directors, and will provide communication and coordination activities between DHA HQ and the DHN. DHSA IOC is scheduled for October 1, 2023.

Modernization the Army Health System to support LSCO

- *COL James Jones, Director, Medical Capability Development Integration Directorate (MED CDID)*

Evacuation and en route care are key capabilities required for managing casualties across the continuum of care. Evacuating the large number of expected casualties across the depth and breadth of the battlefield during LSCO will challenge current evacuation assets, and as the battlefield becomes more distributed, portions of the battlefield could become inaccessible for long periods of time, thereby delaying evacuation. The Joint Services require a synchronized and responsive medical evacuation (MEDEVAC) system (ground, sea, and air) that is capable of rapidly clearing the battlefield of casualties, providing en route care that ensures the highest possible survivability rates, and effectively unencumbering maneuver elements to enable freedom of maneuver.

The future MEDEVAC capability must not only employ ambulance assets with greater mobility, speed, modularity, and en route care capabilities, it should also integrate autonomous systems into capability sets and employ autonomous and semi-autonomous capabilities leveraging artificial intelligence and systems. Robotic and autonomous systems (RAS), artificial intelligence (AI), machine learning (ML), and semi-autonomous medical treatment and evacuation capabilities will facilitate and assist in the optimization of clearing the battlefield of casualties, maximizing return to duty rates, and overcoming contested logistics throughout the future operational environment. To ensure the highest possible survivability rates and unencumber maneuver elements to enable freedom of movement, future MEDEVAC platforms must provide en route care capabilities and operate throughout the continuum of care, starting at the POI. RAS within the MEDEVAC system is intended to augment the assigned medical provider to deliver care, monitor, and provide treatment decision support. Medical RAS can be a significant force multiplier, decreasing the cognitive and physical workload of the provider and increasing the number and treatment level of patients.

Given the austerity of the environment, threat, operational tempo, unit dispersion, and expected casualty streams, medical units will be designed and equipped with the essential functions to deliver necessary treatment far forward, near, and at POI commensurate to the constraints of the environment. In a LSCO distributed operational environment, MEDEVAC of casualties may be delayed, resulting in medical personnel at echelon having to care for patients longer than accustomed to in previous conflicts since 2001. This will likely lead to medical sequelae not normally encountered in the current operating environment. New technologies and knowledge are needed to train medical personnel to provide this extended care.

On the front lines, medical personnel will require (1) capabilities that enhance the control of non-compressible hemorrhage and treat severe or penetrating Traumatic Brain Injury (TBI), (2) capabilities that predict and detect sepsis risk in injured Service Members, (3) capabilities that prevent/ treat wound infection, (4) AI to assist with life-saving techniques, and (5) new measures to repair skin and muscle tissue. Sensors and AI-enabled triage decision tools from POI through Role 3 (theater hospitalization) could assist leaders far forward, near, and at POI to manage and analyze large amounts of data and make rapid decisions regarding the effective use of evacuation assets.

Medical Care in Contested Distributed Maritime Operations

- *LCDR Scott Hughey, USUHS Bethesda & Department Chairman, Anesthesiology and Pain Medicine, Naval Hospital Okinawa, Okinawa, Japan*
- *LCDR Jacob Cole, Chief Medical Informatics Officer*
- *Kyle Checchi*
- *Joshua Kotler*

Contested and Distributed military operations (CDMOs) present a variety of challenges when delivering medical care. Doctrinal Role 1, Role 2, and Role 3 may be inadequate for future conflicts in these environments. The presentation will have a frank discussion of some of the specific issues of 1) Providing medical care in distributed maritime operations, 2) Challenges with doctrinal evacuation of casualties, 3) Concepts of expeditionary advanced base operations with prolonged combat casualty care, and 4) Cold-Chain Medical Logistics, Sterilization, and the Class VIII problem. Several “outside the box” and non-doctrinal solutions will be presented and offered for discussion.

Innovative Readiness Training Model for Active duty and Reservists

- *CAPT C. Kyle Gropp, PharmD, USPHS*
- *LCDR Erica Stoll, Medical Asset Support Team (MAST) Advanced Practice Provider (APP), USPHS*
- *Lt. Col. Rashida Fambro, Mental Health Clinical Pharmacist Practitioner*
- *CPT Miya Black*

This two-part session will discuss the Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law on 27 March 2020 provides both the authority and funding for establishment of the Reserve Commissioned Corps (RCC). Applicants meet the same appointment requirements as Regular Corps officers. The mission of the U.S. Public Health Service RCC is to provide trained, ready, and equipped public health professionals, capable of mobilizing and deploying to augment the active duty USPHS Commissioned Corps, under the authorities of the Secretary for Health in response to regional, national, and global public health emergencies. To accomplish this mission, RCC officers are required to complete an Annual Training (AT). Because the program is still in its expansion/growth stage, a mission essential training program is presently in development, but not yet implemented, executed, or assessed. The purpose of the training is to not only fulfill that AT requirement but build capacity to function in an Incident Command Structure, develop team cohesion, enhance critical thinking skills, prepare for deployments in austere environments, build resiliency, and ensure basic deployability readiness, that creates a model for more enhanced future training. This lecture will showcase the RCC, provide current force strength, speed of meeting basic readiness, lessons learned from RCC deployments, how the inaugural AT was developed, partnerships forged to better prepare Reservists for deployments and shape future trainings for the Commissioned Corps. In addition to AT, reservists attend monthly drills, Military Facility Annual Training (MFAT), Deployment Role Training, Innovative Readiness Trainings (IRT), and USPHS Emergency Response Training Psychomotor Experience with Emory University. To date, the RCC has 96 reservists with over 100 deployments and over 2300 deployment days supporting a wide range of missions and agencies including with the Administration for Strategic Preparedness and Response (ASPR), the Indian Health Service (IHS), Administration for Children and Families (ACF), the National Park Service (NPS), and the U.S. Coast Guard (USCG).

And continue with the Department of Defense (DOD) Innovative Readiness Training (IRT) is a military training opportunity that provides real-world training opportunities for service members and units to prepare them for wartime missions while addressing the needs of underserved American communities and its territories. Medical missions provide optometry, health exams, dental, and public health education to communities via no-cost healthcare. Service members receive practical, hands-on

training to hone mission-critical skills in an austere environment engaging in both real and simulated tasks in general clinical care and tactical combat care increasing warfighter medical readiness response. During the IRTs, junior officers and enlisted personnel gain leadership experience in a joint operational setting.

In 2023, Hoopa Valley, California (CA) was selected to be a site for this IRT. Hoopa Valley is in Northern CA on the Hoopa Valley Reservation and considered a vulnerable community. The Air National Guard, United States Air Force, United States Public Health Service (USPHS) Commission Corps, USPHS Ready Reserves, and local community partners served on this Hoopa Valley IRT from August 1-13, 2023. The team led, planned, and coordinated logistics, transportation, training, medical, and dental services for this mission.

Aiming for the Moon(shot): How VA is Making the Future of Cancer Care a Reality

- *Dr. Michael Kelly, Professor, Department of Medicine, Duke University Medical Center*
- *Dr. Kara N. Maxwell, Staff Physician, Corporal Michael J. Crescenz Veterans Association Medical Center*
- *Dr. Vida Cecilia Almario Passero, Staff Physician, Hematologist/Oncologist VA Pittsburgh Healthcare System*
- *Dr. Carolyn Menendez, Director, Clinical Cancer Genetics Program VA National Oncology Program Office Durham VA*

As VA brings about the goals of the Cancer Moonshot, we are working across disciplines to advance cancer treatment and execute cutting-edge research. In this session, you will learn how VA is committed to providing broad access to best-in-class cancer care across geographic barriers and advancing knowledge of molecular basis of cancer in Veterans to improve understanding of cancer etiology and effective precision treatment. Expansion of the Close to Me infusion service and implementation of the new Clinical Cancer Genetics Service are the latest examples of utilizing the VA National TeleOncology service to bring clinical expertise as close to Veterans as possible. Further, you'll learn about the pioneering research conducted by VA in mutational signatures of cancer and how it contributes to the broader medical community's understanding of cancer genetics, benefiting both Veterans and the general population. We will explore how this research can pave the way for more effective treatments and improved outcomes. Moreover, VA oncology leaders will provide insights into VA's unwavering commitment to maintaining the highest levels of safety and quality when delivering anti-cancer therapies outside of high-complexity VA medical centers. This session offers a perspective on VA's dedication to advancing cancer care and equitable access to groundbreaking research and safe treatment delivery, with the ultimate aim that tracks to the overarching goals of Cancer Moonshot: ending cancer deaths as we know them today.

The Bridge Builders: Reaching Back to Move Forward

- *CSM (Ret) Althea Green, PhD*
- *Mr. Mark Withers*
- *CSM (Ret) Ben Scott*
- *MCPO (Ret) Clinton Garrett Sr.*

Enlisted members have been involved in almost every facet of US military operations since its inception. Likewise, when George Washington's Continental Army formed the Army and Navy medical services in 1775, provisions were made to detail enlisted personnel to assist the medical officers. Over the years, as the services formed separate medical departments, the roles of the enlisted members

have changed, and today, they occupy a diverse range of military occupations in the direct care system as well as Warfighting units. Career senior enlisted members have been on the forefront of change throughout the history of the Military and the Military Health System (MHS). These are the people who have led and guided others through the various iterations of change, failures, and successes. This panel is comprised of individuals who served in senior leader roles within the Military Health System (MHS). They represent the three branches of the military that provide health service support to our Warfighters and Families at home and abroad - Army, Navy, Air Force. These leaders have served in various positions throughout their careers, successfully managed change, are now retired from the military, and have gone on to perform in a variety of new roles. The panel provides a unique perspective on leadership and offers insights into how to best connect people and ideas to achieve success. The panel's goal is to help current leaders learn from their experiences so they can lead effectively.

Breakout Sessions 9:15am – 10:15am

Clustering Cases Without Diagnoses: Knowledge Representation and Actionable Decision Support Using Medical Data Phenotyping

- *Dr. Thomas M. Wilkinson, Chief Medical Information Officer, US DHS*

This presentation will discuss how the DHS Office of Health Security is building an Integrated Phenotype Reference Model (IPRM) as a reference model for the patterns of medical knowledge surrounding individual patient care, especially in circumstances of high uncertainty. The IPRM can identify clusters of related cases and provide actionable decision support for providers without reliance upon any particular diagnoses or predetermined case definitions.

Public Health Implications of Climate Change: The Role of Youth, Mental Health, and Health Equity

- *CDR Jason Wilken, Career Epidemiology Field Officer, CDC*
- *LCDR Jonetta Johnson Mpofo, Analyst US HHS OASH OCCHE*
- *CAPT Sara Newman, Director, Office of Public Health, National Park Service*

This two-part presentation will include discussion of community initiatives that promote convening of funders and partners dedicated to local priorities can be leveraged to create and sustain resilience hubs. The Promise Zone Initiative, supported by the Department of Housing and Urban Development and the Department of Agriculture, may be particularly well suited to support resilience hubs by facilitating technical assistance, funding support, and convening of local, state, and federal resource partners.

And also, the U.S. Public Health Service Commissioned Corps officers in the Spring of 2023 held a joint event in a National Park with the Boys and Girls Club of Greater Washington. This event empowered kids with information about the impact of climate change on health, and promoted engaging with national parks as a mental health solution. Supported by HHS senior officials and the Office of the Surgeon General, youth engaged in facilitated discussions to consider the links between the impact of climate change on health and equity and promote parks as a health resource. Solutions to address the mental health effects of climate change on youth include building resilience and emotional intelligence, engagement in activities that support community wellbeing, and education about approaches to address the threats from climate change. Schools are important settings for many of these activities, as are existing youth outdoor programs and community resilience hubs. Federal agencies can help support states, localities, and families in developing and implementing these

mental health strategies and should focus on addressing the specific needs of the most vulnerable in a culturally appropriate manner.

Capturing Complex Medical Care enhances Medical Readiness at a Military Medical Center – Trauma, Comprehensive Cancer Care, and Transportation

- *CDR Timothy Donahue, Trauma Medical Director Naval Medical Center Portsmouth*
- *CDR Johathan L. Hallbach, Chair, Department of Surgery Tidewater, Attending Ped. Surgeon, Assoc. Prof. USU*
- *CAPT Timothy, Staff, Surgical Oncologist Naval Medical Center Portsmouth*
- *CAPT Joseph Kotora, Battlefield Medicine Subject Matter Expert, Military Expert Working Group, Office of the Undersecretary of Defense for Policy*

In this panel, we describe progressive achievement of our institution’s strategic initiative of capturing and retaining complex medical care with an overall aim of enhancing medical readiness. This was completed at a regional MTF through attainment of trauma center designation, establishment of a comprehensive cancer care center, and the creation of an air/ground medical evacuation system (“Project Caladrius”). The implementation of Level II trauma care at a military medical center is poised to yield countless readiness maximization opportunities across nearly all departments within the MTF. Our Cancer Coordination Center supports an emphasis on continuity of cancer care while safeguarding staff competency. The Caladrius program has already demonstrated an ability to recapture regional patients through coordinated transportation across multiple platforms. These strategic developments will result in a considerable rise in complex patient volume, consequently fostering the acquisition of knowledge, skills, and abilities (KSAs) among hospital staff. Additionally, the MTF is set to enhance the readiness of operational forces, further fortifying the Navy's capabilities in handling critical war time emergencies. These initiatives aim to attract and serve a broader patient base while enhancing hospital systems, staff training and expertise. We delve into the considerable challenges faced and the successful strategies employed to establish these vital services, highlighting the contributions of dedicated military physicians, nurses, and support staff who have been instrumental in driving this initiative forward. Join us to discover how this paradigm shift in care delivery has enhanced the hospital's mission and positively impacted patient outcomes while honoring the commitment to military personnel and their families.

Rethinking Suicide (TriWest)

- *Dr. Lori Highberger, TriWest’s Chief Medical Officer - Behavioral Health*
- *Dr. Craig Bryan*

Over the past two decades, the U.S. suicide rate has steadily increased despite expanded efforts to reverse this trend via expanded awareness campaigns, wide implementation of suicide prevention programs and initiatives, and increased mental health advocacy, and antistigma campaigns. To the befuddlement, confusion, and frustration of researchers, clinicians, family members, and many others, these efforts have not reversed the trend of rising suicides in the U.S. Why do suicide rates continue to rise despite our best efforts? Why aren’t we better at this? What are we doing wrong? This presentation seeks answers to these questions and proposes that our typical strategies for preventing suicide are inadequate.

Left Shift: The Strategic Imperative for Investing in Well-Being

- *LTC Stephanie Hightower, Director, Pulmonary Function Laboratory, WRNMMC*

About one in four Veterans lives with type 2 diabetes (T2D) — a rate nearly three times the general population, and about one quarter of pharmacy spend for Veterans is related to diabetes medications and supplies. The Veterans Health Administration partnered with Virta Health to provide ketogenic telehealth services for Veterans with T2D. Previously published outcomes show significant improvements in HbA1c, BMI, diabetes medications and cost, and outpatient visits in the first five-months, but long term durability of outcomes across the population and within subgroups is critical to positively impact diabetes care. This retrospective, real-world analysis assessed the effects of the ketogenic telehealth service on glycemia, diabetes medications, and body weight over two years in people with T2D who were prescribed an antihyperglycemic medication other than metformin, using medical record data and further explored effects according to self-reported race and ethnicity as well as geographical factors such as socioeconomic deprivation and rurality.

Upon initiation of carbohydrate restricted nutrition therapy such as a ketogenic diet, blood glucose rapidly declines, necessitating dose reductions and eliminations of drugs associated with hypoglycemia that are managed by licensed medical providers in anticipation of and in response to daily blood glucose and ketone concentrations. Deprescription of other medications can occur after lower blood glucose due to nutritional changes has been sustained.

Retention in this lifestyle therapy was high with 244 of 425 (57.4%) remaining under care after two years. Veterans under care for two years significantly improved HbA1c by $0.6 \pm 1.7\%$ from $8.1 \pm 1.5\%$ and the number of diabetes medications per patient reduced by 0.8 from 2.4, with the group requiring 43% fewer antihyperglycemic medications beyond metformin. In addition, patients sustained 7.5% weight loss from 241 pounds at time of enrollment in the clinic. Type 2 diabetes reversal within the group was evident in that the proportion of patients with $HbA1c \geq 9\%$ was reduced by over 40%, and despite starting on antihyperglycemic medication other than metformin, reversal to the point of drug-free T2D remission was observed in 7% of patients.

Subgroup analysis by race and ethnicity, area deprivation index as a marker of a geographical area's level of socioeconomic disadvantage, and urban versus rural and highly rural areas identified no significant differences between groups in the therapy's effect on HbA1c, medications, and weight loss.

Results from this real world analysis suggest that ketogenic telehealth services for T2D can effectively be utilized as an adjunct to care within the VA health system to improve blood glucose and body weight while reducing dependence on antihyperglycemic medication and provide Veterans an opportunity for T2D reversal and remission nationwide across races, ethnicities, and various levels of rurality and socioeconomic disadvantage.

Roads Less Traveled: Career Planning for Enlisted Members

- *Dr. Althea Green, Ph.D., CSM (Ret)*
- *HMCS Troy Brown, MCPO, Hospital Corpsman, US Navy*
- *Mr. Gustavo Ruiz, Program Administrative Specialist Recruitment and Outreach*

The military encourages enlisted members to take advantage of growth opportunities as these can be important elements in their personal and professional development. These types of opportunities can enhance technical education and skills, improve combat capability, and provide the service member with a competitive edge when being considered for promotion or assignment opportunities. This panel discusses some of the training and education programs – both inside the Department of Defense (DoD), as well as across the Federal Government enterprise – that are available to enlisted members. There are many resources and programs to help enlisted service members explore their options, develop skills, and find the best opportunities for their future. Leaders and other stakeholders should know about these types of opportunities to help their subordinates develop their skills,

knowledge, and potential, as well as improve their performance, retention, and satisfaction. Understanding the available training and education opportunities can also help leaders identify and nurture talent, foster a culture of learning and innovation, and enhance the readiness and effectiveness of their units and organizations.

Plenary Session
10:30pm – 12:30pm

Senior Leader Readiness Panel

Moderator

- *Dr. David Smith, Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight*

Panelists

- *LTG Telita Crosland, Director, DHA*
- *Brig Gen John R. Andrus, Joint Staff Surgeon*
- *MG Anthony (Tony) McQueen, Army Deputy Surgeon General*
- *RADM Darin K. Via, Navy Surgeon General*
- *Lt Gen Robert I. Miller, Air Force and Space Force Surgeon General*
- *Dr. Jonathan Woodson, President, USU*
- *MG Jill K. Faris, Director, Office of the Joint Surgeon General, National Guard Bureau*

Joint Q&A – Medical Readiness

The Military Health System (MHS) is one of America’s largest and most complex health care institutions, and the world’s preeminent military health care delivery operation. The central MHS mission is support of health readiness – the readiness of individual service members and the readiness of the medical team in support of the Combatant Commands and Military Departments. The Defense Health Agency (DHA), Office of the Joint Staff Surgeon (JSS), and Military Department medical organizations are responsible for ensuring the operation of an integrated system of readiness and health to improve and sustain operational medical force readiness.

Collaborative efforts across the MHS aim to optimize force health protection and medical readiness based on meticulous research, lessons learned, and best practices. These efforts enable medical providers in theater and in military hospitals and clinics to improve, protect, and sustain Servicemember health readiness and resilience.

The MHS plenary session includes a senior leader panel moderated by the Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight, Dr. David Smith, and featuring the Defense Health Agency (DHA) Director, the Uniformed Services University (USU) President, the Joint Staff Surgeon (JSS), and the service Surgeons General.