

1 I, Andrew E. Carmichael, swear under penalty of perjury under the laws of the United
2 States to the following:

3 1. I am a Senior Trial Counsel at the United States Department of Justice and counsel
4 of record for Defendants in this action. I submit this declaration in support of Defendants'
5 Motion to Stay Discovery Pending Disposition of Mandamus Petitions.

6 2. Plaintiffs in this action have served and the Department of Defense ("DoD") has
7 responded to 86 Requests for Production and 25 Interrogatories.

8 3. Plaintiff-Intervenor Washington in this action has served and DoD has responded
9 to 21 Requests for Production and 18 Interrogatories.

10 4. In the related cases *Doe v. Esper*, No. 1:17-cv-1597 (D.D.C.), *Stone v. Trump*,
11 No. 1:17-cv-2459 (D. Md.), and *Stockman v. Esper*, No. 5:17-cv-1799 (C.D. Cal.), Plaintiffs and
12 Plaintiff-Intervenor California have served and the Department of Defense has responded to 129
13 Requests for Production and 49 Interrogatories.

14 5. Due to the parties' Cross-Use Agreement, *see, e.g.*, Dkt. 183, except for
15 information specific to individual Plaintiffs, discovery provided in one set of Plaintiffs in the four
16 related cases has been provided to all Plaintiffs and Plaintiff-Intervenors.

17 6. On September 8, 2020, I asked the Department of Justice, Civil Division, E-
18 discovery contractors to provide a summary of the document discovery produced to date in this
19 litigation. I was informed that to date, Defendants have provided 112 document productions
20 (including 13 *in camera* productions) amounting to 99,592 documents, totaling 612,160
21 pages. When excluding slip sheets to mark where a document was withheld for privilege, I was
22 informed that Defendants have produced 61,018 documents totaling 413,041 pages to Plaintiffs
23 and Plaintiff-Intervenor Washington to date in this litigation.

24 7. On September 10, 2020, I asked the Department of Justice, Civil Division, E-
25 discovery contractors to provide a summary of the documents produced to Plaintiffs and Plaintiff-
26 Intervenor Washington between the time period of December 13, 2017 and February 22, 2018. I
27 was informed that the number of documents produced to Plaintiffs and Plaintiff-Intervenor
28 Washington where meta-data from the document indicates the last modified date for the file or

1 sent date for an email was between December 13, 2017 and February 22, 2018 is 14,233, totaling
2 79,226 pages.

3 8. Attached to this declaration as Exhibit A is a true and correct copy of DoD’s Third
4 Supplemental Response to Plaintiffs’ Interrogatories 16, 17, and 18 served on Plaintiffs and
5 Plaintiff-Intervenor State of Washington on March 23, 2020 in response to the Court’s Order of
6 March 5, 2020. Dkt. 458.

7 8. Attached to this declaration as Exhibit B is a true and correct copy of DoD’s Third
8 Supplemental Response to Plaintiff-Intervenor State of Washington’s Interrogatories served on
9 Plaintiffs and Plaintiff-Intervenor State of Washington on June 3, 2020 in response to the Court’s
10 Order of April 20, 2020. Dkt. 486.

11 9. Attached to this declaration as Exhibit C is a true and correct copy of the
12 declaration of Lernes J. Hebert, Deputy Assistant Secretary of Defense for Military Personnel
13 Policy, with exhibits, filed in *Doe v. Esper*, 1:20-cv-10530 (D. Mass.). This declaration was
14 previously filed on the docket in this action without exhibits. *See* Dkt. 542-5.

15 Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true
16 and correct.

17 EXECUTED this 10th day of September, 2020.

19 */s/ Andrew E. Carmichael*
20 ANDREW E. CARMICHAEL
21 Senior Trial Counsel
22 United States Department of Justice
23 Civil Division, Federal Programs Branch
24 1100 L Street, N.W.
25 Washington, DC 20530
26 Telephone: (202) 514-3346
27 Email: andrew.e.carmichael@usdoj.gov

28 *Counsel for Defendants*

EXHIBIT A

FILED UNDER SEAL

EXHIBIT B

FILED UNDER SEAL

EXHIBIT C

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
BOSTON DIVISION**

LT JANE DOE,

Plaintiff,

v.

MARK T. ESPER, *et al.*,

Defendants.

CIVIL ACTION NO. 1:20-cv-10530-FDS

DECLARATION OF LERNES J. HEBERT

I, Lernes J. Hebert, do hereby declare as follows:

1. I am currently the Deputy Assistant Secretary of Defense for Military Personnel Policy, in the Office of the Under Secretary of Defense for Personnel and Readiness. I have held this position in either an acting or appointed capacity since January 2017. As the Deputy Assistant Secretary, I am responsible for overseeing the full spectrum of human resource policies, including accessions, compensation, development, separations, and recognition programs for over two million active duty, Guard, and Reserve military personnel serving in the Department of Defense (“DoD” or “the Department”). I am also directly responsible for policies to sustain the all-volunteer force.

2. Between September 2012 and January 2017, I served as Principal Director, Military Personnel Policy in the Office of the Under Secretary of Defense for Personnel and Readiness and have served in Military Personnel Policy since August 2003. During that time, I have led the Department through a number of major personnel initiatives and policy changes

including initiatives to restructure career longevity provisions, joint officer management, and general and flag officer management.

3. Prior to my retirement from the United States Air Force in the rank of Colonel after 24 years of active service, I served at every level of the field of personnel management to include key assignments in the Office of the Secretary of Defense, the Air Staff, at the Air Force Personnel Center, and with Air Combat Command. I hold a Master of Science degree in National Security Strategy from the National War College, a Masters of Arts degree in Management and Computer Resource Management from Webster University, and a Bachelor of Science degree in Management from the University of Louisiana.

4. In the exercise of my official duties, I have been made aware of the above-captioned lawsuit, as well as four additional suits by transgender individuals pending in other jurisdictions. I submit this declaration in support of Defendants' Consolidated Opposition to Plaintiff's Motion for a Preliminary Injunction and Motion to Dismiss Plaintiff's Complaint, or, in the Alternative, Motion for Summary Judgment. The statements made herein are based on my personal knowledge and information available to me in the course of my official duties.

Secretary Carter Initiates a Policy Review

5. On July 28, 2015, then-Secretary of Defense Ashton Carter issued a memorandum to the Secretaries of the Military Departments announcing that effective July 13, 2015, the authority to approve any involuntary separation or denial of reenlistment based on gender identity was elevated and required the personal approval of the Under Secretary of Defense for Personnel and Readiness. This memorandum also created the Transgender Service Review Working Group ("TSRWG"), which was chartered to formulate policy options for DoD regarding the military service of transgender service members and provide the Secretary with

recommendations within 180 days. The memorandum specifically directed the TSRWG to presume that transgender persons can serve openly without adverse impact to military effectiveness and readiness, unless objective, practical impediments are identified.

6. Shortly after Secretary Carter made this announcement, the Office of the Secretary of Defense (“OSD”) was contacted by the Joint Chiefs of Staff who asked for a briefing on the forthcoming policy review. Some of the Service Chiefs expressed concern that the review may not be objective and that the presumption appeared to mandate a pre-determined outcome. A similar concern was expressed to DoD in a letter from the then-Chairman of the House Committee on Armed Services.

Formation of the TSRWG

7. The TSRWG was chaired by then-Acting Under Secretary of Defense for Personnel and Readiness Brad Carson and was composed of senior civilians and military personnel representing the Services’ personnel offices, the Surgeons General from the Services and Joint Staff, representatives from the U.S. Coast Guard, as well as senior OSD staff from Personnel and Readiness, Health Affairs, Legislative Affairs, Public Affairs, and the Office of the General Counsel. At the time, I served as the Principal Director for Military Personnel Policy. Mr. Anthony Kurta, who at the time was serving as the Deputy Assistant Secretary of Defense for Military Personnel Policy, and I were key representatives of the Office of the Under Secretary of Defense for Personnel and Readiness at TSRWG meetings. I personally attended and participated in 11 of the 13 TSRWG bi-weekly meetings held between August 15, 2015 and January 19, 2016. I also participated in a debrief of the results of the TSRWG’s various lines of effort and products that was given to Mr. Carson on February 17, 2016.

8. At the beginning of the TSRWG process, there was some degree of disparity in the level of familiarity and expertise among working group members regarding transgender issues, including the medical needs of transgender service members. Portions of some of the earliest meetings were devoted to getting all TSRWG members to a base level of understanding. For example, some TSRWG members initially did not fully appreciate that gender dysphoria is a separate behavioral health condition affecting only a portion of transgender individuals. As we learned, the Fifth edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (“DSM-5”) states that individuals with gender dysphoria are a subset of transgender individuals who experience “significant distress or problems functioning” as a result of an incongruence between their expressed gender and/or secondary sex characteristics.

Challenges Faced by the TSRWG

9. In my experience, it was unusual that a medical condition, such as gender dysphoria, should carry with it a presumption of fitness for military service, as directed by Secretary Carter, and particularly unusual for a mental or behavioral health condition in the DSM-5 to carry such a presumption. I am unaware of any other medical condition or any other mental or behavioral health condition where such a presumption of fitness for military service is applied. Indeed, as outlined in Department of Defense Instruction 6130.03, many mental and behavioral health conditions in the DSM-5 are presumptively disqualifying when applying the medical standards for appointment, enlistment, or induction into the military.

10. The TSRWG attempted to come to grips with several other thorny issues, some of which are addressed in the TSRWG’s written “Report Out,” which was briefed to Mr. Carson on February 17, 2016. A copy of the Report Out is attached as Exhibit A. For example, one

challenge was a lack of information regarding the efficacy of transition treatment to relieve the “significant distress” associated with gender dysphoria. The TSRWG was presented with the results of several studies suggesting that individuals diagnosed with gender dysphoria have higher than normal associated rates of depression and suicide, as well as medical research that indicated important short-term medical and psychiatric benefits from gender reassignment treatment in some individuals. But, there was limited data on the rates of improvement or the continued level of improvement during transition or post-transition. This made crafting a policy that would account for a stability period after which a transitioning service member would again be worldwide deployable or a transitioned applicant for military service would be able to complete basic training extremely challenging. This challenge was exacerbated by the fact that a number of studies and experts in the field of transgender care often seemed to blur the lines between scientific research and advocacy. In fact, some of the advocacy groups that the TSRWG consulted consistently advocated for no stability period beyond the standard recovery periods associated with surgical procedures. Those groups opined that any post-transition distress was purely due to the social stigma and not due to gender dysphoria which they claim transition entirely resolved. Yet, the TSRWG could not identify any empirical data which supported these theories.

11. In a related matter, a senior military member of the TSRWG who represented the Office of the Surgeon General for one of the Services complained about an apparent outsized role that advocacy groups had in shaping the TSRWG’s medical analysis and recommended that the TSRWG also hear from a medical professional, Dr. Paul R. McHugh, who was known to have differing views. While the TSRWG did invite a distinguished plastic surgeon and distinguished endocrinologist to speak on transgender care in the civilian community, the

working group never heard from Dr. McHugh or any doctor who had treated gender dysphoria (or its comorbidities) from a psychiatric or psychological perspective.

RAND Study and Report

12. To assist the TSRWG, DoD also contracted the services of the RAND National Defense Research Institute. RAND was to complete its study and provide its recommendations within the 180-day window Secretary Carter had allotted to the TSRWG to complete its review. The RAND study encountered some challenges similar to those faced by the TSRWG because of gaps in reliable data. Indeed, in its final report, RAND included a discrete section of “limitations and caveats” in which it recommended caution in interpreting its study results because of “the lack of rigorous epidemiological studies of the size or health care needs of either the U.S. transgender population or the transgender population serving in the military” and “no definitive data” on these populations.

13. In the course of assisting the TSRWG, RAND researchers gave several presentations to DoD in which these and additional challenges were highlighted. For example, in one presentation given in January 2016, attached as Exhibit B, RAND specifically noted that “[u]ncertainty remains regarding the long term efficacy of G[ender] R[eassignment] T[reatment], though existing data suggests potentially important short term medical and psychiatric benefits[.]” In that same presentation, RAND opined on the impact to unit cohesion and noted that there was “[n]o direct evidence, applicable surveys, or systematic information to determine attitudes on transgender individuals among military members[.]” Although RAND further stated that “evidence from previous integration efforts (*e.g.*, gays, lesbians, and women) indicates that such integration had minimal impact on unit cohesion and readiness,” both the TSRWG and the later Panel of Experts found that such prior examples of integration had little

applicability to the unique concerns at issue in its review of military service by individuals diagnosed with gender dysphoria because those integration efforts did not involve potential lost deployment time due to a medical condition.

14. Other assumptions made by RAND to support some of their conclusions, subsequently turned out to be simply wrong. For example, in February 2016, RAND again briefed members of the TSRWG. That presentation is attached as Exhibit C. In that presentation, RAND estimated the maximum total non-deployable days for certain medical treatments for gender dysphoria. Although RAND identified cross-sex hormone treatments as the largest percentage of treatments, and noted that deployment limitations may apply based on such treatments, it accounted for zero non-deployability days based on “pending accommodations[.]” In its final report, RAND explained that it based its estimate of zero non-deployability days for cross-sex hormone treatments on an assumption that DoD would either depart from Endocrine Clinical Practice Guidelines for the Treatment of Gender-Dysphoric / Gender-Incongruent Persons or deploy independent medical personnel to supervise hormone treatments administered to individuals diagnosed with gender dysphoria in a deployed environment. Ultimately, however, as the Panel of Experts discovered during its subsequent policy review, several of the Military Services and at least one Combatant Command¹ (*i.e.*, MOD 13 to USCENTCOM Individual Protection and Individual/Unit Deployment Policy) determined that administering hormone treatments in a forward deployed environment or declining to apply established medical guidelines, were not feasible accommodations.

¹ A Combatant Command is a military command which has broad, continuing missions. *See* 10 U.S.C. § 161. These commands are established to provide effective command and control of U.S. military forces, regardless of branch of service, in peace and war. They are organized either on a geographical basis or on a functional basis. U.S. Central Command is the geographical command responsible for responding to crises, deterring and defeating threats, and increasing regional stability throughout the Middle East.

15. In addition, subsequent data showed that RAND underestimated the utilization rates of medical treatment for gender dysphoria. Specifically, RAND estimated that the open service directive would result in approximately 140 active duty service members initiating transition-related hormone treatment. However, the data provided to the Panel of Experts, based on actual treatment records of military service members, shows that the rate of hormone-related transition care was approximately five times higher than RAND's estimate.

Input from Military Medical Professionals

16. Early in the process, the TSRWG was presented with the results of recently completed work on gender dysphoria from DoD's Accessions Medical Standards Working Group ("AMSWG"). The AMSWG is a standing committee established under the direction of the DoD Medical and Personnel Executive Steering Committee ("MEDPERS"). (Since January 2017, I have served as the MEDPERS co-chair.) The AMSWG is composed of medical and personnel subject-matter experts from across the Department, the Military Services, and the U.S. Coast Guard and meets regularly to review military accession standards involving over 30 bodily systems and medical focus areas, carefully considering evidence-based clinical information, peer-reviewed scientific studies, scientific expert consensus, and the performance of existing military medical accession standards in light of empirical data on attrition, deployment readiness, waivers, and disability rates. The TSRWG was presented with the AMSWG's recommendations to update the Department of Defense medical standards for accessions into the military—DoD Instruction 6130.03—in light of updates to DSM-5.

17. As reflected in the minutes of their April 2015 meetings, attached as Exhibit D, the AMSWG recommended that a current diagnosis or history of gender dysphoria be disqualifying for accession unless: (1) the applicant was stable without psychotropic medications or mental health treatment for 36 months; (2) outpatient mental healthcare for the

resolution of gender dysphoria was not required for greater than 24 cumulative months. (If therapy is more supportive in nature, *e.g.*, through the transition process, the same provision would not apply); and (3) the applicant did not require inpatient mental health treatment in hospital or residential facility.

Input from the Military Services and Decision

18. As part of the TSRWG process, input was sought from personnel experts from the Military Services on a new accessions standard for transgender individuals and individuals diagnosed with gender dysphoria. The positions of the Military Services were collected and assembled into a matrix which was presented to Mr. Carson in February 2016. The matrix is attached as Exhibit E. As reflected in the matrix, there were several disagreements between the Military Services regarding accessions standards, including whether DoD should require potential service members' biological sex to correspond with their gender identity, the length of any period of stability required before an individual could access into the military, and whether or not service members should be allowed to transition within their first term of service. The Army and Marine Corps recommended a more conservative approach, similar to the policy that was recommended by the Panel of Experts to Secretary Mattis in 2018. The Navy and the Air Force recommended a policy that would allow for service in one's preferred gender, with the Navy recommending a stability period prior to accession in the military of 12 months and the Air Force recommending a 24-month stability period.

19. Although not captured in this particular matrix, some of the Service Surgeons General advocated for a stability period between 24 and 36 months, after which waiver would be permitted, to more closely align with the comorbidities of gender dysphoria—*anxiety disorder and major depressive disorder.*

20. Ultimately, then-Secretary Carter adopted the views favoring service consistent with one's gender identity and set the stability period for accessions at 18 months, as announced on June 30, 2016, as DTM 16-005, Military Service of Transgender Service Members. Secretary Carter also directed that these accessions standards be reviewed within two years and be maintained or changed consistent with applicable medical standards and clinical practice guidelines in order to ensure military readiness and promote effectiveness in recruiting and retention.

The New Administration

21. Following the start of the Trump Administration, some of the Services sought to have then-Secretary Mattis reconsider the Carter policy, based in part on recent challenges encountered while implementing the 2016 policy. Further, the Service Surgeons General formally recommended extending the 18-month Carter policy accessions stability period to at least 24 months, noting that "currently accepted clinical practice guidelines and our experience in DoD demonstrate that successful gender transition is a protracted process, often requiring several years to reach clinical stability." This memorandum is attached as Exhibit F.

22. In response to these concerns, on May 8, 2017, then-Deputy Secretary of Defense Robert Work directed the Military Services to assess the Department's readiness to begin accessing transgender applicants into military service on July 1, 2017, as directed under the Carter policy. Each of the Service Secretaries formally responded to the Deputy Secretary, and each one of them recommended a delay of the Carter accessions policy. The Services' responses are attached as Exhibit G. The Army requested "a delay in implementing the draft accessions policy until July 1, 2019, to allow for a meaningful analysis and determination regarding the impact of transgender accessions on the Army's readiness," noting that "some

transgender Soldiers experience extensive medical non-deployability both before and after transition[.]” The Air Force recommended a 12- to 36-month delay of the Carter accessions policy, noting that “information received from Combatant Commands (CCMDs) raises significant concerns about the potential availability, readiness, and deployability of potential transgender accessions that warrants more study.” The Navy stated that it was ready to access new accessions but was willing to support the delay requested by the other Services. And, the Marine Corps requested a 24-month delay of the Carter accessions policy.

23. On June 30, 2017, before the Carter accessions standards were set to take effect, Secretary Mattis approved the Services’ recommendation to delay the implementation of those standards for an additional six months to evaluate more carefully their impact on military readiness and lethality. Secretary Mattis also established a study group that included the representatives of the Service Secretaries and senior military officers, many with combat experience, to conduct this six-month review.

24. On August 25, 2017, while this review was ongoing, the President sent the Secretaries of Defense and Homeland Security a memorandum expressing his concern that the Carter policy “failed to identify a sufficient basis” for changing longstanding policy and that “further study is needed to ensure that continued implementation of last year’s policy change would not have ... negative effects.” The President then directed DoD and the Department of Homeland Security (“DHS”) to reinstate the preexisting policy concerning accession of transgender individuals “until such time as a sufficient basis exists upon which to conclude that terminating that policy” would not “hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources.” The President’s Memorandum also made clear, however,

that DoD and DHS could notify him “at any time, in writing, that a change to this policy is warranted.”

Creation of Panel of Experts

25. On September 14, 2017, then-Secretary Mattis created a Panel of Experts (“the Panel”) comprised of senior uniformed and civilian Defense Department and U.S. Coast Guard leaders and directed them to consider the issue of military service by transgender individuals and individuals with gender dysphoria and develop policy proposals based on data, as well as their professional military judgment, that would enhance the readiness, lethality, and effectiveness of the military. The Panel consisted of senior military and civilian leaders who had the statutory responsibility to organize, train, and equip military forces and who, based on their positions and experience, were uniquely qualified to evaluate the impact of policy changes on the combat effectiveness and lethality of the force. The Panel’s task was to “conduct an independent multidisciplinary review and study of relevant data and information pertaining to transgender Service members.” The Panel was supported by three working groups, which were assigned areas of focus and expertise. Secretary Mattis also directed the Panel to provide its best military advice based on increasing the lethality and readiness of the armed forces, without regard to any external factors.

Work of the Panel of Experts

26. The Panel met 13 times over a span of 90 days. I attended and participated in all of the Panel’s meetings. In the first Panel meeting on October 13, 2017, Mr. Kurta, who was then performing the duties of the Under Secretary of Defense for Personnel and Readiness, chaired the Panel and gave an overview of Secretary Mattis’s direction. Mr. Kurta advised the Panel that because the President’s memorandum made clear that at any time the Department

could advise the President that a change in policy was warranted, the Panel was free to consider a full range of policy options. The Panel members agreed that this was the correct interpretation of the President's Memorandum and Secretary Mattis's direction to the Panel. Additionally, the members of the Panel agreed that their recommendations should be free of political considerations.

27. To fulfill its mandate, the Panel addressed three primary questions:

- Should the Department of Defense access transgender individuals?
- Should the Department allow transgender individuals to transition gender while serving, and if so, what treatment should be authorized?
- How should the Department address transgender individuals who are currently serving?

28. In order to provide evidence-based recommendations regarding these questions, the Panel met with and received input from transgender Service members, commanders of transgender Service members, military medical professionals, and civilian medical professionals with experience in the care and treatment of individuals with gender dysphoria. The Panel also reviewed information and analyses about gender dysphoria, the treatment of gender dysphoria, and the effects of currently serving individuals with gender dysphoria on military effectiveness, unit cohesion, and resources. The Panel's analysis was also informed by the Department's own data and experience obtained since the Carter policy took effect, *e.g.*, Health Data on Active Duty Service Members with Gender Dysphoria, December 13, 2017. This data was not available to RAND or the TSRWG in 2016.

29. Unlike the TSRWG, the Panel was not required to apply a presumption that transgender persons, including transgender individuals diagnosed with gender dysphoria, were

generally qualified for military service; the Panel made no assumptions but instead attempted to apply the relevant standards applicable to every service member to determine the extent to which transgender persons, including transgender individuals diagnosed with gender dysphoria, are qualified for military duty. Further, while the RAND report analyzed the factors of military readiness, deployability, unit cohesion, and cost on a force-wide or macro level, the Panel also looked at impacts at the unit or micro level, including the impact that high numbers of non-deployable military personnel place on families whose service members deploy more often to backfill or compensate for non-deployable persons.

30. After extensive review and deliberation, which included evidence in support of and against the Panel's recommendations, the Panel concluded that there are substantial risks associated with allowing the accession and retention of individuals with a history or diagnosis of gender dysphoria and who require, or have already undertaken, a course of treatment to change their gender. Furthermore, the Panel found that exempting such persons from well-established mental health, physical health, and sex-based standards, which apply to all service members, including transgender service members without gender dysphoria, could undermine readiness, disrupt unit cohesion, and impose an unreasonable burden on the military that is not conducive to military effectiveness and lethality. The Panel did recommend, however, that individuals who relied on the Carter policy be allowed to continue serving in their preferred gender.

Adoption of Panel Recommendations

31. Once the Panel finalized its recommendations, the then-Under Secretary of Defense, Robert Wilkie, Mr. Kurta, and I presented those recommendations to the Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs of Staff and then to Secretary

Mattis. Secretary Mattis made his decision to accept the recommendations of the Panel and directed a formal report to be created. That report, titled Department of Defense Report and Recommendations on Military Service by Transgender Persons, was created under the authority of Under Secretary of Defense for Personnel and Readiness and submitted to then-Secretary Mattis, who in turn submitted it to the President, along with a three-page cover memo on February 22, 2018. On March 23, 2018, the President accepted then-Secretary Mattis's recommendation and withdrew his August 25, 2017 Memorandum.

Conclusion

32. Having participated in both the review by the TSRWG convened by then-Secretary Carter and the Panel of Experts convened by former Secretary Mattis, it is my view that the work of both groups reflected thoughtful, considered processes that incorporated the experience and expertise of dedicated military and civilian officials to address difficult, complex, and controversial issues. In my opinion, the most substantial factors that account for the different outcomes in these reviews are: (1) the general presumption of fitness for military service that was applied by the TSRWG but not the Panel of Experts; (2) additional knowledge DoD and the Military Services gained from their experience under the Carter policy; (3) the additional data available to the Panel of Experts to review regarding impacts under the Carter policy; (4) the fact that the Panel of Experts' review included more analysis of unit-level implications than during the TSRWG review; and (5) that Secretary Mattis was less willing than Secretary Carter to assume risk in the absence of clear data regarding impacts on military readiness and deployability.

Pursuant to 28 U.S.C. § 1746(2), I declare under the penalty of perjury that the foregoing is true and correct.

Executed on this 18th day of May 2020, in Arlington, Virginia.



Lernes J. Hebert
Deputy Assistant Secretary of Defense for Military
Personnel Policy
Office of the Under Secretary of Defense for Personnel
and Readiness

EXHIBIT A TO HEBERT DECLARATION

TRANSGENDER SERVICE REVIEW WORK GROUP REPORT OUT

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Introduction

The Transgender Service Review Work Group (TSRWG) was specifically chartered by the Secretary of Defense via Memorandum for Secretaries of the Military Departments, dated July 28, 2015:

Effective as of July 13, 2015, no Service member shall be involuntarily separated or denied reenlistment or continuation of active or reserve service on the basis of their gender identity, without the personal approval of the Under Secretary of Defense for Personnel and Readiness. This approval authority may not be further delegated.

The Under Secretary of Defense for Personnel and Readiness chaired a working group composed of senior representatives from each of the Military Departments, Joint Staff, and relevant components from the Office of the Secretary of Defense to formulate policy options for the DoD regarding the military service of transgender Service members. The working group started with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective, practical impediments are identified, and shall present its recommendations to me within 180 days. Pending the issuance of DoD-wide policy following the submission of the working group's report, any interim guidance issued by the Military Departments will be coordinated with, and subject to the prior personal approval of, the Under Secretary of Defense for Personnel and Readiness. If questions relating to the service of transgender members arise, the Military Departments should address them to the Under Secretary of Defense for Personnel and Readiness.

Overview

In order to fulfill the Secretary's direction, to comprehensively analyze the policy and readiness issues associated with open service by transgender persons, and to ensure we took advantage of the lessons learned from a very successful policy review construct, we reviewed the work from the DADT Repeal Implementation Team (RIT). That review informed the make-up of the TSRWG and much of the review agenda. Additionally, we reviewed the March 2014 Report of the Transgender Military Service Commission, a nonpartisan national commission – co-chaired by former U.S. Surgeon General Elders - comprised of medical and psychological experts, to consider whether Pentagon policies that exclude transgender service members are based on medically sound reasons. SPARTA (Service Members, Partners, Allies for Respect and Tolerance for All), an advocacy group of current and former Service members, published "Transgender Military Service: A guide to Implementation" that we found particularly useful.

Work Group Composition

The work group was composed of Senior Executives, General/Flag Officers, and subject matter experts representing the following offices: Service/National Guard Bureau (NGB) Manpower and Reserve Affairs Secretaries; Joint Staff, Service and NGB Personnel Chiefs; Joint Staff and Service Surgeons General, and the Chairman's Senior Enlisted Advisor. Representatives from the Coast Guard and the US Public Health Service also participated. Additionally, OSD staff (Personnel and Readiness, Health Affairs, Legislative Affairs, Public Affairs, and Office of the General Counsel) subject matter experts were present to inform the group's deliberations.

The first TSRWG meeting was held on August 19, 2015, with 12 subsequent meetings conducted through February 2016. The meeting agendas, which can be found at TAB A, allowed the work group to educate itself and discuss the issues required to form sound policy recommendations.

Outside Participants

To educate work group membership on the unique aspects of transgender military service, personnel from outside DoD headquarters were invited to participate or contribute as invited. Outside personnel included a currently serving transgender Service member, medical and behavioral health experts, and LGBT policy advocacy groups. Additionally, the work group contracted with RAND to provide specified research and support.

With limited experience in treating transgender patients resident in DoD medicine, the work group sought out experienced and recognized medical experts in the field and invited several to brief the work group in person. Dr. [REDACTED]

Dr. [REDACTED]

[REDACTED]. Finally, the Group consulted with the World Professional Association for Transgender Health (WPATH). Finally, behavioral health specialists (names and credentials here) were consulted. More information about these medical professionals can be found at TAB E.

LGBT policy groups were consulted and several addressed the work group as a whole, or individuals and Service leadership separately. These groups were helpful in educating the work group on the unique attributes of transgender service in the military, social and medical issues related to transgender military service, and policy provisions that need to be addressed to facilitate the open service by transgender Service members, from their point of view. Among the groups represented were: SPARTA; The Palm Center; Human Rights Campaign (HRC); and the National Center for Transgender Equality (NCTE). Further information can be found at TAB E.

Allied Partner Experience

Several U.S. allies have previously revised their military policies to allow open service by transgender personnel. We specifically exploited the policy experience gained by Canada, Australia, and the United Kingdom. OSD staff, the Services, the LGBT advocacy groups and RAND each consulted with our allies to discern their lessons learned with respect to accession medical standards, how to accommodate in-service gender transition, berthing/uniform/grooming standards, and readiness effects. In particular, we found two Australian publications very useful (“Understanding Transitioning Gender in the Workplace, by the Australian Department of Defence, and the “Air Force Diversity Handbook: Transitioning Gender in Air Force, by the Australian Air Force).

Research by RAND suggests the following best practices and lessons learned from the Allied Partner Experience.¹

Best Practices:

- Leadership support important to executing policy change
- Integrate into current diversity and harassment training for the total force
- All-inclusive military environment that embraces broad-based diversity can support integration of openly serving transgender personnel
- Subject matter experts/gender advisers should be made available to commanders integrating transgender personnel
- Presenting a “business case” for diversity and emphasizing the advantages of an inclusive military, including better retention and recruiting, can help reduce resistance to policy change

Lessons Learned:

- While limited, there were reports of bullying and harassment of transgender personnel who made their gender transition public
- Problems caused by the lack of explicit, clearly written policy (e.g., medical care, berthing, facilities)
- Issue of awards/medals issued prior to gender transition (i.e., re-issuing in post-transition name)

Collaboration

A DoD collaboration web-site (Max.Gov) was established to share resource documents used to promote dialogue at TSRWG meetings and collaborate on TSRWG work. This website was restricted to SES/GO/FO TSRWG members (Service and Joint Staff 1s, M&RAs, and Surgeons General) and special advisors within OSD (Office of General Counsel, Legislative Affairs, Health Affairs, Military Personnel Policy, Public Affairs, and Senior Enlisted Advisors). Transgender Service Review Work Group documents (available at TAB A) include: Timeline with Milestones, Matrix for Policy Considerations, Activity Outline, and Agendas.

¹ From yet to be released RAND research for the TSRWG.

Workgroup Agenda

Informed by the DADT RIT work, the TSRWG developed five (5) distinct lines of effort (LOE).

- 1) Medical Readiness and Healthcare related issues
- 2) Personnel Policy (Accessions/Retention/In-Service Transition)
- 3) Force Training Material Development
- 4) Strategic Communications
- 5) Administrative Actions

Background

Sex refers to the designation of a person at birth as either "male" or "female" based on their anatomy (e.g. reproductive organs) and/or their biology (e.g. hormones). Gender refers to the traditional or stereotypical roles, behaviors, activities and attributes that a given society consider appropriate for men and women.

The word “transgender” – or trans – is an umbrella term for people whose gender identity is different from the sex assigned at birth. The transgender community is incredibly diverse. Some transgender people identify as male or female, and some identify as genderqueer, nonbinary, agender, gender fluid, or somewhere else on or outside of the spectrum of what we understand gender to be. Some take hormones and have surgery as part of gender transition, and some don’t. Some choose to openly identify as transgender, while others simply identify as men or women.

Discerning the population of transgender Service members is difficult as DoD does not survey our members to identify as transgender individuals nor do we have any existing mechanism to identify personnel as transgender Service members. Therefore, we must rely on general demographic estimates. However, there are reasons to believe that rates may be higher in military populations than the general population. A recently published article in the *New England Journal of Medicine* estimates there are 12,800 actively serving uniformed personnel.² Data from the 2008 National Transgender Discrimination Survey³ (NTDS), estimated that “approximately 700,000 adults in the US are transgender”⁴ and “more than 134,000 transgender individuals in the US are veterans or have retired from the Guard or Reserve service.”⁵

Some who identify as transgender individuals may have a medical diagnosis of gender dysphoria (GD), a medical condition previously classified by the American Psychiatric Association as Gender Identity Disorder (GID). For a person to be diagnosed with

² Aaron Belkin, “Caring for Our Transgendered Troops – The Negligible Cost of Transition-Related Care,” *The New England Journal of Medicine* 373 (September 17, 2015): 1089-1092

³ Published jointly by the National Center for Transgender Equality and the National Gay and Lesbian Task Force

⁴ Gary J. Gates and Jody L. Herman, “Transgender Military Serving in the United States,” *The Williams Institute, UCLA School of Law* (May 2014): 1-5.

⁵ *Ibid.*

gender dysphoria, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. As of October 2015, 113 Service members (Active and Reserve) were diagnosed with gender dysphoria.

Gender dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender.

It is important to note that:

- Not all individuals experience distress as a result of their gender incongruence
- The source of distress may, instead, be situational (*i.e.*, due to unavailability of physical interventions such as hormones or surgery)

When it comes to access to care, many of the treatment options for gender dysphoria include counseling, cross-sex hormones, gender reassignment surgery, and social and legal transition to the desired gender, depending upon an individual patients' needs and desires. To get insurance coverage for medical treatment, however, individuals need a diagnosis.

Medical Readiness and Healthcare Related Issues

Under this line of effort, the work group considered three (3) questions:

Is the military healthcare system capable of providing all necessary medical services to transgender Service members?

Are there any restrictions on which medical procedures will be provided transgender Service members (e.g. sex reassignment surgery, mastectomy, facial feminization surgery)?

What medical readiness rates can we expect from transgender Service members?

To the first question, the Military Health System has all necessary authorities and tools to provide any and all necessary medical services to ALL Service members, and does so. Care provided in military medical treatment facilities (MTFs) is subject to very few legal limitations; DoD has broad discretion to shape the scope of services based on medical, policy, and readiness considerations. This includes treatment of gender dysphoria.

Care for active duty members outside of military facilities is handled under the Supplemental Health Care Program (SHCP), under which DoD has some discretion to pay for medically necessary and appropriate treatment for gender dysphoria.

- By statute, SHCP coverage rules generally follow TRICARE rules (i.e., rules applicable to dependents and retirees), but are “subject to such exceptions as the Secretary of Defense considers necessary.”⁶ This exception authority is reflected in DoD regulations which allow the Director of the Defense Health Agency to waive limitations that generally apply to TRICARE.⁷ Thus, while TRICARE rules are very restrictive in relation to gender dysphoria treatment, these restrictions may be waived for SHCP.
- While there is some discretion in relation to the treatment of gender dysphoria, it is not unlimited. By statute, the Supplemental Health Care Program may not pay for “elective private treatment.”⁸ Evaluating the scope of that exclusion in the context of the spectrum of care potentially available for treatment of gender dysphoria requires further analysis in conjunction with medical specialists.

Care for the Select Reserve members is provided under the TRICARE Reserve Select (TRS) program, which is subject to the TRICARE statutory limitations on treatment of gender dysphoria. Service members covered under TRS will need to have their private insurance cover any treatments related to gender dysphoria.

There are some medical issues associated with the open service of transgender persons, which could affect their medical readiness and deployability. As the work group discussed these issues, we concluded that existing policy and procedures exist to address each issue. For example:

- High rates of depression and suicide. Several studies suggest that those diagnosed with gender dysphoria have higher than normal associated rates of depression and suicide. While some have opined that these higher rates are partly due to social stigma and lack of access to medical care and are improving, DoD has existing medical capability to evaluate an individual and determine if their medical condition is compatible with either entry into, or retention in, the Armed Forces.
- Hormone Therapy. Treatment for gender dysphoria often includes hormone therapy, which may last a lifetime. In some cases, taking hormones may lead to a period where the patient is non-deployable. Additionally, supply, availability, and adequate supervision of taking these hormones would have to be available in all deployed environments to facilitate the world-wide deployment availability

⁶ 10 USC 1074(c)(2)(A): “Subject to such exceptions as the Secretary of Defense considers necessary, coverage for medical care for members of the uniformed services . . . shall be comparable to coverage for medical care and standards for timely access to such care under the managed care option of the TRICARE program known as TRICARE Prime.”

⁷ 32 C.F.R. 199.16(f): “Waiver authority. With the exception of statutory requirements, any restrictions or limitations pursuant to the general rule in paragraph (c) of this section, and special rules and procedures in paragraph (d) of this section, may be waived by the Director, [Defense Health Agency], at the request of an authorized official of the uniformed service concerned, based on a determination that such waiver is necessary to assure adequate availability of health care services to active duty members.”

⁸ 10 U.S.C. 1074(a)(1): “Funds appropriated to a military department, . . . may be used to provide medical and dental care to persons entitled to such care by law or regulations, including the provision of such care (other than elective private treatment) in private facilities for members of the uniformed services.”

required of our Service members. The work group concluded that DoD has the existing capability to evaluate whether an individual on hormone therapy should be accessed into military service, be retained in the Armed Forces, and provide for the availability and supervision of hormone treatment in a deployed environment.

- Sex Reassignment Surgery. Generally, MTFs do not currently have the expertise to provide sex reassignment surgery. As noted previously, DoD has the necessary tools to outsource this surgery to the civilian community if and when necessary. Should it become necessary in the future, DoD could develop some capability to perform these procedures inside a limited number of MTFs. As with all medically necessary surgical procedures, varying convalescence periods are associated with sex reassignment surgery. The work group concluded that DoD has existing procedures to determine if medically necessary procedures are compatible with continued service or a patient need be referred to the Disability Evaluation System or separated administratively.

Medical Treatment Plans

Once a Service member is diagnosed with gender dysphoria, a medical treatment plan must be developed by the military medical provider and the Service member. This treatment plan should include any medically necessary treatment, such as behavioral health counseling, cross-sex hormone therapy, and surgical procedures. As with all medical treatment, the military medical provider has broad discretion to determine what is medically necessary and the time element associated with that necessity. Not unique to medical treatment plans for transgender Service members, each plan must be evaluated by the Service in the context of deployability and readiness standards.

Personnel Policy (Accessions/Retention/In-Service Transition)

Facilitating open military service by transgender persons presents several personnel policy issues. While these issues are broad in nature, three general categories of policy issues encompass many of the personnel policy issues.

Accessions Standards and Process

Accessions into the Armed Forces are governed by DoDI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services. The DoDI sets common physical standards for the appointment, enlistment, or induction of Service personnel and applies to the Military Services, the U.S. Coast Guard, the Reserve Components (to include the Army and Air National Guards) and the United States Merchant Marine Academy. Common physical standards ensure that individuals under consideration are:

- Free of contagious diseases that probably will endanger the health of other personnel.
- Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
- Medically capable of satisfactorily completing required training.
- Medically adaptable to the military environment without the necessity of geographical area limitations.
- Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

Approximately every four years, all medical accession standards are reviewed by the Department and this periodic review began in 2015, independent of the TSRWG. The work group took advantage of this work as the Accession Medical Standards Work Group (AMSWG) gathered experts from across the Services and DoD to examine all medical conditions addressed in the DoDI for updating. The work of the AMSWG included a review of the existing standard associated with the outdated term Gender Identify Disorder. Even absent the establishment of the TSRWG, the DoDI required updating to address the change from Gender Identity Disorder to Gender Dysphoria. The work of the AMSWG on gender dysphoria was presented to the work group.

The Chief Medical Officer (CMO) at each of the 64 Military Entrance Processing Stations (MEPS) is responsible for evaluating each applicant against the established medical standards contained in the DoDI. A detailed flow chart of the process is at TAB B. The CMO may determine that:

- the applicant meets the standards and clear him/her for further processing,
- the medical record is incomplete or not determinative and request further information from the applicant or refer the applicant out for further medical consultation (with a civilian provider or with Service medical authorities)
- the applicant does not meet the standard but may be within normal waiver limits; disqualify the applicant and work with the applicant's recruiter to seek a waiver from the Service Medical Waiver Authority
- the applicant does not meet standards; disqualify the applicant and terminate processing.

A comprehensive medical standard to address transgender applicants must encompass standards on gender dysphoria, gender transition, surgery, and clearly define who is qualified for accession without a waiver from their Service medical waiver authority.

Gender Dysphoria

As previously noted, a diagnosis of Gender Dysphoria indicates clinically significant distress or impairment in social, occupational, or other important areas of functioning,

lasting at least six months. The CMO must determine if the current extent of dysphoria is compatible with accession. Some existing diagnoses of gender dysphoria are resident to ensure ongoing access to medical care and may not indicate current, significant distress or impairment.

Gender Transition

The term “gender transition” is the subject of much debate. The Human Rights Campaign defines gender transition as:

“The process by which some people strive to more closely align their internal knowledge of gender with its outward appearance. Some people socially transition, whereby they might begin dressing, using names and pronouns and/or be socially recognized as another gender. Others undergo physical transitions in which they modify their bodies through medical interventions.”

There are no current standards in the DoDI relating to gender transition. While there is consensus that gender transition should be complete prior to accession into the military, there is no consensus on the definition of “complete” due to the unique nature of every individual’s gender transition. For example, some individuals and their medical providers may consider a gender transition complete after behavioral health counseling and dressing in their desired gender. Others may undergo cross-sex hormone therapy and be considered complete once their body has undergone the desired changes (generally about 18 months from the start of taking hormones). Some undergo only “top surgery” (mastectomy or breast implants) and others undergo both top and “bottom surgery” (genital reconstruction) before their transition is considered complete. A single medical definition to describe a completed gender transition does not exist; hence, the standard to be incorporated into the accessions DoDI will largely be a policy determination.

Cross-Sex Hormone Therapy

A common element of treatment for gender dysphoria includes cross-sex hormone therapy. Cases recently in the public realm of currently serving transgender Service members have focused on the availability of both hormones and adequate medical oversight of their use while deployed in some environments. The accessions DoDI, as currently written, contains no criteria to assess the suitability for accession for anyone undergoing cross-sex hormone therapy.

[Per WPATH Standard of Care – hormonal therapy will typically have a maximum effect within 24 to 72 months. Per WPATH - “The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender-nonconforming population include:

Feminizing Hormones	Masculinizing Hormones
Venous thromboembolic disease	Polycythemia
Gallstones	Weight gain
Elevated liver enzymes	Acne
Weight gain	Androgenic alopecia (balding)
Hypertriglyceridemia	Sleep apnea

Surgery

Current Policy: History of major abnormalities or defects of the genitalia such as including but not limited to change of sex; current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias, is disqualifying. Gender dysphoria is not specifically discussed, nor is gender transition. Any breast or abdominal surgery within the past 6 months, and any surgical procedure to the genitalia, is disqualifying and requires a waiver. The Chief Medical Officer (CMO) at each MEPS determines if an applicant meets the DoDI accession criteria. If not, the applicant's recruiter may seek a waiver through their Service Medical Waiver Authority.

Retention

DoD sets broad policy with respect to the ability of the Military Services to separate (and by extension, retain) enlisted members in DoDI 1332.14, and officers in DoDI 1332.30. Within those broad policy guidelines, the Service Secretaries are directed to "develop and maintain Service policies, standards, and procedures in accordance with this instruction" (enlisted) or "prescribe regulations consistent with the policy and procedures established in this instruction" (officers).

To permanently implement the transgender service policy released by the Secretary of Defense in July 2015, OSD will update the DoDIs referenced above and direct the Services to publish regulations or policy to ensure no Service members are involuntarily separated or denied reenlistment or continuation on active or reserve service on the basis of their gender identity. Such guidance would not restrict Service Secretary authority to retain or separate individuals based on world-wide deployability, medical readiness, or other currently established criteria.

In-Service Gender Transition

An essential policy element of open service by transgender Service members is creating a common, DoD-wide construct by which Service members can transition gender while serving, and for the formal, administrative recognition of a change in gender through the Defense Enrollment Eligibility Reporting System (DEERS).

DoD formally recognizes a Service member's gender in DEERS. That gender is currently established by birth certificate, U.S. passport, or U.S. passport card. From gender, a Military Service holds a Service member accountable to meet the corresponding uniform standards, grooming standards, Physical Readiness Test (PRT) standards, body composition standards (BCA), and Military Personnel Drug Abuse Testing Program (MPDATP) standards (DoDI 1010.16). Additionally, each Military Service generally directs berthing, bathroom and shower use according to the recognized gender.

Gender transition can encompass both social transition (commonly referred to as "Real Life Experience") and legal transition.

Social transition/real life experience, in the military context, will generally encompass dressing in the new gender, cross-sex hormone therapy (which will change external appearance) and, at some point, being held to the uniform, grooming, PRT, BCA, and MPDATP standards of the new gender, as well as using the new gender berthing, bathroom and shower facilities. Due to the unique requirements of military service, most transgender Service members will likely start their social transition during off duty hours. At some point, in consultation with their commander and medical provider, the Service member will live in their desired gender while on duty. Ideally, the change in standards and the use of facilities will occur simultaneously. Top and/or bottom surgery may or may not be part of a social transition.

Legal transition refers to changing personal identification documents to match the new, or desired, gender. For civilian documentation, this is done via a new or amended birth certificate (state dependent), U.S. passport, Social Security card, or court order. For military documentation, legal transition encompasses changing the gender marker in DEERS and, subsequently, the Armed Forces of the United States Geneva Conventions Identification Card.

Gender Transition Plans

Providing a common, DoD-wide construct by which Service members can transition gender while serving will help transgender Service members, commanders, and the force in general. As noted previously, this process will be guided by a Gender Transition Plan.

The Gender Transition Plan is an outline of milestones for a Service member to transition from their birth or currently recognized gender to their desired gender. Each plan will be as unique as needed to account for the needs of the individual, medical treatment necessities, and the unit's operational requirements.

Elements of a Gender Transition Plan should include milestones for:

- All elements included in the Medical Treatment Plan
- Social transition/real life experience off duty

- Uniform standards
- Grooming standards
- PRT standards
- BCA standards
- MPDATP procedures
- Change in use of berthing, shower, and bathroom facilities
- Surgical procedures determined not medically necessary

The gender transition plan must be a collaborative effort between the individual Service member, military medical provider, and the individual's Commander. The Commander must agree to and facilitate the date(s) after which the individual will be held to the uniform, grooming, PRT, BCA, and MDPATP standards of the target gender. Ideally, the change in standards will all occur simultaneously. However, Service Secretaries currently have the authority to grant individual accommodations to standards as they deem appropriate. It must be noted, however, that not every Gender Transition Plan may be compatible with the Service's needs or deployability requirements. While the Commander and the individual's Service cannot disapprove a Gender Transition Plan, they can determine it does not meet the unit's operational needs. In such a case, the Commander and the Service have many options. Based on Service requirements, they can propose alternate dates/milestones in the Gender Transition Plan, move the individual (permanently or TDY) to a unit where the dates do not conflict with operational needs, encourage the Service member to enroll in the Career Intermission Program (CIP), or separate the Service member administratively for the good of the Service.

To provide uniformity amongst Service Gender Transition Plan procedures, OSD P&R will publish DoD-wide guidance on the composition and procedures for establishing Gender Transition Plans.

Change in DEERS Gender Marker

The last step, generally, in a military gender transition is the formal change of the gender marker in DEERS. Ideally, the change in the DEERS gender marker will occur simultaneously with the change in standards and use of the facilities, but it need not be thus.

This step may be distinct from changing state-issued documents that identify gender, such as birth certificates⁹ and drivers' licenses, or other federal documents such as the Social Security card. Requirements for amending or re-issuing birth certificates vary greatly among the States¹⁰. Some states require full sex re-assignment surgery, others

⁹ Three states will not allow gender to be changed on birth certificates: Idaho, Ohio and Tennessee. The remaining states, and DC, will issue either a new birth certificate or an amended one reflecting a change in gender.

¹⁰ In the states permitting issuance of new or amended birth certificates, 25 explicitly require the individual undergo sex reassignment surgery before legally changing genders. In 11 states, persons may change their gender marker with proof of hormone therapy or other "contemporary treatment options." All states allowing amendment or reissuance of birth certificates require some form of medical evidence (e.g., physician's affidavit, medical report / examination) to effectuate the change.

require little more than certification from an attending physician attesting that gender transition is in progress. Due to this wide variance, and because a Service member is limited to the requirements of the State of his or her birth to receive a changed birth certificate, DoD will accept multiple documents as sufficient to change the gender marker in DEERS. Qualifying documents are:

- State issued birth certificate
- U.S. Passport (two¹¹ or ten¹² year)
- Valid court order

If a Service member presents one of these documents, and a letter of approval from their Commander, the local Service personnel support activity will change the gender marker in the Military Personnel Data System, which results in a change to the gender marker in DEERS. The Service member may also be issued a new Armed Forces of the United States Geneva Conventions Identification Card (CAC), as necessary. Of note, CAC cards do not indicate gender of the holder.

¹¹ If a physician certifies that your transition is in process, you are eligible for a limited validity two-year passport.

¹² If a physician certifies that your transition is complete, you are eligible for a full validity ten-year passport.

TAB A (Work Group Documents)

Policy Outline

Overview/Background

The Secretary of Defense has charged the Acting Under Secretary of Defense for Personnel and Readiness (USD(P&R)) with chairing a work group composed of senior representatives from each of the Military Departments, Joint Staff, and relevant components from the Office of the Secretary of Defense to formulate policy options for the DoD regarding the military service of transgender Service members

Directed Mission and Purpose

The working group will start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective, practical impediments are identified. The work group shall present its recommendations to the Secretary of Defense by January 28, 2016.

Desired End State:

A Service-coordinated implementation plan (with timeline) for accession, open service, and retention of transgender (TG) service members.

Interim guidance:

- **Separations:** No service member shall be involuntarily separated or denied reenlistment or continuation of active or reserve service on the basis of their gender identity without the personal approval of the USD(P&R).
- **Accessions:** Current military accession policy standards remain in effect during the review until such time additional guidance is released. TG/Gender Dysphoric (GD) individuals may take initial entrance testing requirements during this period.

Participants (additional subject matter experts as required):

GFO/SES-level representatives from:

- Military Department M&RAs
- Services (1s and Surgeons General) & National Guard Bureau
- Joint Staff (J1 and Surgeon)
- Office of the General Counsel
- OUSD(P&R)
 - Military Personnel Policy (Accessions Policy & Officer & Enlisted Personnel Management)
 - Health Affairs
- Legislative Affairs
- Public Affairs

Lines of Effort:

- **Medical Readiness and Health Care (Lead: HA)**
 - Types of care
 - Diagnosis
 - Disclosure/Health Insurance Portability & Accountability Act (HIPAA)

- TRICARE and Gender Dysphoria (GD) treatment
- Treatment commencement/outline/guidance
- Prior gender reassignment surgery disqualifying for retention or accession
- Medical records guidance
- Medical/physical evaluation board trigger events
- Limited duty & non-deployable periods due to treatment
- Deployment guidance during treatment period
- Military Treatment Facility (MTF) treatment capabilities
- Accession Medical Standards Working Group (AMSWG)
- Costs incurred (facilities, training, treatment)

- **Policy (Lead: MPP)**
 - Recruiting guidance
 - Accession standards
 - Potential retention disqualifiers
 - Prior discharged guidance/reaccessions
 - Active to Reserve Component transition
 - Separation characterization/coding
 - Leave policy
 - Changing gender (legal/medical/social)
 - Personnel Information Technology systems (DEERS, etc.)
 - Uniform wear standards
 - Housing/facilities guidance
 - Military technicians
 - Physical fitness standards
 - Urinalysis
 - Separation characterization and coding
 - Career Intermission Pilot Program
 - Allied forces experience and policy
 - Annual evaluations (periods of non-rated time)
 - Physical fitness standards
 - Civilian sector experience
 - Security clearance
 - Waiver policy
 - Costs incurred (facilities, training, treatment uniform allowance)

- **Development of Force Training Materials (Lead: Readiness)**
 - Commander's toolkit
 - Service member education on transgenderism
 - Policy implementation training guidance
 - Leadership best practices
 - Non-discrimination/Military Equal Employment Opportunity (MEO) policy & complaint process
 - Reinforcement of DoD policy treating all with dignity and respect
 - Definitions

- Clinical terminology
 - Gender identity
 - Transgender
 - Transition (social and medical)
 - Transition point
 - Target gender
 - Affirmed gender
 - Costs incurred (facilities, training)
- **Strategic Communications Plan (Service members, Families, Congressional Engagement, Advocacy Organizations, Media; Lead: PA)**
 - Reinforce existing policies with regard to dignity and respect
 - Develop overarching communication strategy
 - Standards of Conduct
 - Command Climate
 - Retaliation
 - Veterans & Military Service Organizations
 - Centralized information web-site (Frequently Asked Questions, etc.)
 - Costs incurred (facilities, training, treatment)
- **Administrative Actions (Lead: MPP)**
 - Review all DoD, Joint Staff, and Service directives
 - Administrative and medical checklists
 - Non-discrimination/Military Equal Opportunity (MEO) policy & complaint process
 - Boards for Corrections of Military Records guidance
 - Capture lessons learned
 - Implementation plan
 - Transition templates
- **Impacts for other federal agencies (VA, DHS/USCG, PHS, NOAA)**

Matrix with Policy Considerations

	Policy Area	Focus Area	Stakeholders
1	Medical Readiness & Health Care Lead: HA	<ul style="list-style-type: none"> • Types of care • Diagnosis • Disclosure / Health Insurance Portability & Accountability Act (HIPAA) • TRICARE and Gender Dysphoria (GD) treatment • Treatment commencement / outline / guidance • Prior gender reassignment surgery disqualifying for retention or accession • Medical records guidance • Medical / physical evaluation board trigger events • Limited duty & non-deployable periods due to treatment • Deployment guidance during / after treatment period • Military Treatment Facility (MTF) capabilities • Accession Medical Standards Working Group (AMSWG) • Costs incurred (facilities, training, treatment) 	<ul style="list-style-type: none"> • Service Members • Medical Clinicians and Administrators • TRICARE
2	a. Policy (Accessions/Retention) Lead: MPP	<ul style="list-style-type: none"> • Recruiting guidance • Accession standards • Potential retention disqualifiers • Prior discharged guidance / reaccessions • Active to Reserve Component transition • Separation characterization / coding • Waiver policy • Costs incurred (facilities, training, treatment) 	<ul style="list-style-type: none"> • Service Members • Recruiters • Public Affairs • Legislative Affairs • Family Members • Members of Congress • Advocacy Groups

Policy Area	Focus Area	Stakeholders
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2	<p>b. Policy (Personnel)</p> <p>Lead: MPP</p>	<ul style="list-style-type: none"> • Leave policy • Changing gender (legal / medical / social) • Personnel Information Technology systems (DEERS, etc...) • Uniform / grooming standards • Housing / facilities guidance • Military technicians • Physical fitness standards • Urinalysis • Separation characterization and coding • Career Intermission Pilot Program • Allied forces experience and policy • Annual evaluations (periods of non-rated time) • Physical fitness standards • Civilian sector experience • Security clearance • Costs incurred (facilities, training, uniform allowance) 	<ul style="list-style-type: none"> • Service Members • Retention professionals • Public Affairs • Legislative Affairs • Family Members • Members of Congress • Advocacy Groups • Inspector General
3	<p>Development of Force Training Materials</p> <p>Lead: Readiness</p>	<ul style="list-style-type: none"> • Commander's toolkit <ul style="list-style-type: none"> • Service member education on transgenderism • Policy implementation training guidance • Leadership best practices • Definitions <ul style="list-style-type: none"> • Clinical terminology • Gender identity • Transgender • Transition (social and medical) • Transition point • Target gender/affirmed gender • Costs incurred (facilities, training) 	<ul style="list-style-type: none"> • Service Members • Public Affairs • Legislative Affairs • Family Members • Members of Congress • Advocacy Groups • Inspector General

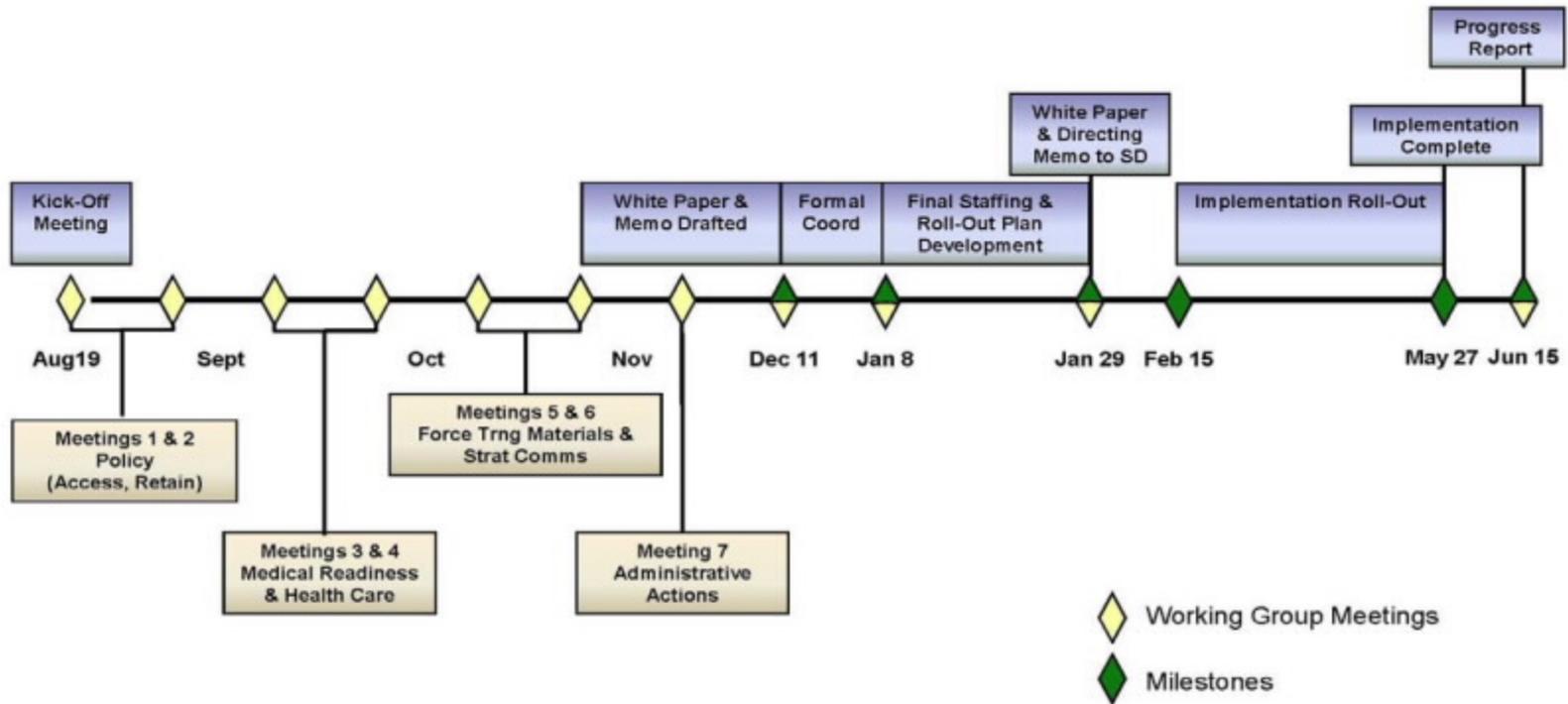
Policy Area	Focus Area	Stakeholders
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<p>4 Strategic Communications</p> <p><u>Lead:</u> PA</p>	<ul style="list-style-type: none"> • Reinforce existing policies with regard to dignity and respect • Develop overarching communication strategy • Standards of Conduct • Command Climate • Retaliation • Veterans and Military Service Organizations • Centralized information web-site (Frequently Asked Questions, etc.) • Costs incurred (facilities, training, treatment) 	<ul style="list-style-type: none"> • Veterans Service Organizations (VSOs) • Public Affairs • Legislative Affairs • Family Members • Service Members • Members of Congress • Advocacy Groups • Inspector General • Military Criminal Investigation Organizations (MCIOs) • Media
<p>5 Administrative Actions</p> <p><u>Lead:</u> MPP</p>	<ul style="list-style-type: none"> • Review all DoD, Joint Staff, and Service directives • Administrative and medical checklists • Non-discrimination/Military Equal Opportunity (MEO) policy & complaint process • Boards for Corrections of Military Records guidance • Capture lessons learned • Implementation plan • Transition templates 	<ul style="list-style-type: none"> • Public Affairs • Legislative Affairs • Service Members • Inspector General • Chaplain

Timeline with Milestones



Transgender Service Review Work Group (TSRWG) Timeline with Milestones



Agendas

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: 19 August 2015

Time: 1600-1700

Room: 3D1063

Overview:

The inaugural meeting for the Transgender Service Review Working Group (TSRWG) will set the stage for important work that will be done over the next six months. A baseline understanding of common terms of reference from the medical community will be a critical part of today's discussion. Further, an overview of recently completed work by the Accession Medical Standards Working Group (AMSWG) will be covered to assist the group in understanding recommended changes.

Subject	Speaker	Duration
Working Group Introduction	Mr. Carson (Acting USD P&R)	1600-1620
ROE and Administrative	Mr. Kurta (MPP)	1620-1630
Medical Introduction	Dr. Guice (HA)	1630-1640
Medical Accessions	Ms. Miller (MPP/AP)	1640-1700
Next Meeting Overview	Mr. Kurta (MPP)	1700

Next Meeting and Homework:

The next TSRWG meeting will be announced shortly. In the meantime, please visit the group's Max.Gov web-site for read ahead materials, meeting minutes, reference materials, and future agendas.

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: September 3, 2015

Time: 1300 – 1430

Room: 3D1063

Overview:

To start this meeting and to introduce some topics we will confront on a more personal level, we will spend about 30 minutes listening to currently-serving uniformed transgender member(s). The intent is to baseline some of our understanding of any unique issues encountered by some of our serving personnel. Additionally, we will continue the accession medical standards discussion that was initiated at the inaugural meeting. The “Accession Medical Standards” document has been posted on the Max.Gov collaboration web-site and we will have time for the Services, briefly, to present their position. For new business, we’ll ask for Services’ input on training; while there may be advantages to DoD creating a centralized training product (for example, a “Transgender 101”), Services may prefer to create and deploy training on an individual basis. Lastly, from our legal brethren, we will introduce our first take on proposed documentation that DoD would accept in order to change the gender marker in DEERS.

Subject	Speaker	Duration
Guest Speaker	[REDACTED]	1300-1330
Accession Medical Standards	Ms. Miller (MPP/AP)	1330-1415
Training Standards	Mr. Kurta	1415-1425
Gender Marker Change Documentation	Mr. Kurta/Mr. Gruber	1425-1430

Meeting Homework/Deliverables:

- (1) Review “Accession Medical Standards” document posted on the Max.Gov web-site prior to meeting; be prepared to discuss and present Service position during the meeting.
- (2) Consider whether DoD should have a centralized training product/policy or if by consensus Services should develop their own.

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: September 16, 2015

Time: 1500-1630

Room: 3D1063

Overview:

To start this meeting we will continue the gender marker change discussion using the document provided at the last meeting. We will also discuss transgender training materials and potential tools that could be used. To initiate the discussion, we will look at documents created by our allied partners.

Subject	Speaker	Duration
Gender Marker Change Documentation	Mr. Kurta/Mr. Gruber	1500-1600
Training Material Discussion	Mr. Kurta	1600-1630

Meeting Homework/Deliverables:

- (1) Review Gender Marker Change Documentation.
- (2) Review Australian Air Force Diversity Handbook: Transitioning Gender in Air Force
- (3) Review Australian Department of Defense Handbook: Understanding Transitioning in the Workplace

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: October 1, 2015

Time: 1230-1400

Room: 3D1063

Overview:

This meeting will focus on the medical aspects of transgender personnel. We are honored to have two guest speakers who bring a wealth of information to the table. Dr.

Dr. [REDACTED]

Subject	Speaker	Duration
Guest Speaker Introductions	Dr. Karen Guice	1230-1235
Transgender Medical Perspectives	Drs. [REDACTED]	1235-1345
Revised Accession Medical Standards and Gender Marker Change Review	Secretary Carson	1345-1400

Meeting Homework/Deliverables:

- (1) Read background information on today's guest speakers: Dr. [REDACTED] and Dr. [REDACTED].
- (2) Review proposed Accession Medical Standards and Gender Marker Change documents.

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: October 14, 2015

Time: 1300-1430

Room: 3D1063

Overview:

This meeting will further focus on 'Transgender 101' issues with experts from two groups that have been championing transgender efforts. The first group, Service Members, Partners, Allies for Respect and Tolerance for All (SPARTA), is a group of LGBT people who currently serve or have served in the military and our families as well as veteran and uniformed allies. SPARTA is a membership organization, built by, for and with members from all parts of the LGBT military community.

The second group, The Palm Center, is an independent research institute committed to sponsoring state-of-the-art scholarship to enhance the quality of public dialogue about critical and controversial public policy issues. Their research on sexual minorities in the military has been published in leading social scientific journals. The Palm Center seeks to be a resource for university-affiliated as well as independent scholars, students, journalists, opinion leaders, and members of the public.

Subject	Speaker	Duration
Guest Speaker Introductions	Mr. Tony Kurta	1300-1305
Q&A Session	SPARTA & Palm Center	1305-1430

Meeting Homework/Deliverables:

(1) Visit the websites for the two groups: <http://www.palmcenter.org/> and <http://www.spartapride.org/>. Also, please note the documents from the two groups that are posted at MAX.Gov.

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: November 2, 2015

Time: 1500-1630

Room: 3D1063

Overview:

As we move into our sixth Transgender Service Review Working Group meeting, we will conduct an in-progress review. Feedback from a meeting with the Secretary of Defense on October 16, 2015, will be provided. Decisions, products, timeline and gender marker change will also be discussed.

Subject	Speaker	Duration
Secretary of Defense Meeting Feedback	Hon. Brad Carson	1500-1515
Decisions/Products/Timeline	Mr. Tony Kurta	1515-1545
Gender Marker Change	Mr. Tony Kurta	1545-1630

Meeting Homework/Deliverables:

- (1) Review baseline documents that were discussed at the August 19, 2015, kick-off meeting.
- (2) Designate Service representative who will serve as a writer on work group deliverables.

Save the following dates for upcoming meetings: Wednesday, November 18, 2015 (1:30 p.m. – 3:00 p.m.) and Tuesday, November 24, 2015 (1:30 p.m. – 3:00 p.m.).

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: November 18, 2015

Time: 1530-1700

Room: 3D1063

Overview:

The accession processing flow chart and the current thinking of the Service medical reps related to an accession standard will be discussed. Also, as noted in a separate e-mail to Service leads, Services should come prepared to discuss any issues with the draft Gender Transition construct. Service alternatives, if any, may be presented.

Subject	Speaker	Duration
Accession Flow Discussion/ Accession Standards	Ms Miller, Dr. Guice	1530-1630
Transition in Service DoD Gender Transition	Mr Kurta & Service Reps	1630-1700

Meeting Homework/Deliverables:

(1) Each Service Representative should review the revised DoD Gender Transition graphic and accompanying language and be prepared to present concerns and recommended changes. The following document is located at MAX.Gov to support this activity: DoD Gender Transition slide and draft handbook language.

(2) Review accession course of action and be prepared to discuss, noting Service concerns and recommended changes. The following documents are located at MAX.Gov to support this activity: Accession Flow Diagram and the 'Unless' accession criteria.

Save the following dates for upcoming meetings: Tuesday, November 24, 2015 (2:45 p.m. – 4:15 p.m.), Tuesday, December 1, 2015 (1:30 p.m. – 3:00 p.m.).

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: November 24, 2015

Time: 1445-1615

Room: 3D1063

Overview:

The last two meetings have focused exclusively on In Service DoD Gender Transition and Medical Accession Standards. At this meeting Service positions for both topics should be presented using the baseline documents provided at earlier meetings (and posted at Max.Gov) as a reference.

Subject	Speaker	Duration
Overview of Federal, State, and Local Anti-Discrimination Protections for Transgender Persons	Mr. Hershel Eisenberger	1445-1505
Medical Accession Standards Service Positions	Services	1505-1540
In Service DoD Gender Transition Service Positions	Services	1540-1615

Meeting Homework/Deliverables:

(1) Review Medical Accession Standards courses of action that were discussed at November 18 meeting. If a different or modified course of action is proposed, write it up and be prepared to present it to the larger group.

(2) Review the "In Service" DoD Gender Transition slide. If a different or modified plan is proposed, write it up and be prepared to present it to the larger group.

Save the date for next meeting: Tuesday, December 1, 2015 (1:30-3:00 p.m.), Room 3D1063.

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: December 8, 2015

Time: 1000-1130

Room: 3D1063

Overview:

Based on the November 24th meeting, revised courses of action (COAs) that capture Service inputs will be briefly reviewed. The four COAs for consideration are: COA1 (with Dept. of Army, Dept. of Navy, and USCG alternates); COA2 (OSD 1), no change; COA3 (OSD 2), no change; and COA 4 (Air Force). Current standards are also listed for comparison. Next, a modified In Service Transition (based on Service inputs) will be reviewed. Finally, the way ahead over the next 60 days will be reviewed.

Subject	Speaker	Duration
Revised Medical Accession Standards Review	Mr. Kurta	1000-1015
In Service DoD Gender Transition Review	Mr. Kurta	1015-1115
The Next 60 Days	Sec. Carson, Mr. Kurta	1115-1130

Meeting Homework/Deliverables:

(1) Review Consolidated COA slide for Medical Accession Standards.

(2) Review the "In Service" DoD Gender Transition slides. This slide is a modified version that includes Service inputs.

Save the date for next meeting:

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: December 15, 2015

Time: 1500-1630

Room: 3D1063

Overview:

Based on the way ahead presented at the December 8 meeting, today's focus will be on medical care related issues.

Subjects

- a. Medical and Behavioral Health Treatment Plans
- b. TRICARE Restrictions for Certain Types of Care
- c. How to Manage Reserve Component
- d. How and When Care Should be Delivered
- e. Information Privacy Concerns (if any)
- f. Interaction Between Line and Medical Regarding Timing of Medical Treatment
- g. Current Provision of Care for Active Duty
- h. WPATH Training for MEPS Chief Medical Officers

Facilitator

Dr. Guice

Meeting Homework/Deliverables:

1. Your designated representative attended a December 11, 2015 (2:30-4:30 p.m.), medical sub-group meeting; ensure you are tied-in with the discussion that occurred.

Save the date for next meeting:

January 5, 2016 (1400-1530); January 12, 2016 (1400-1530); January 19, 2016 (1400-1530); January 26, 2016 (1400-1530)

TRANSGENDER SERVICE REVIEW WORKING GROUP AGENDA

Date: January 5, 2016

Time: 1400-1530

Room: 3D1063

Overview:

Based on the way ahead presented at the December 8 meeting, today's focus will continue with medical care-related issues, training, and retention/re-enlistment.

Outstanding Medical Issues Dr. Guice 1400-1445

- a. Training and education for providers;
- b. IDES for non-voluntary separation;
- c. Reserve and Coast Guard issues;
- d. Counseling for family members of TG individual;
- e. "Medical necessity" at MTF;
- f. Dependent care at MTF; and
- g. Other issues

Training Mr. Tony Kurta 1445-1510

- a. Training timeline (120 days)?
- b. Review of Service training plans by OSD
- c. Implementation timeline, completion of Service direction/instructions/guidance

Retention/Re-enlistment Mr. Tony Kurta 1510-1530

- a. Retention/Re-enlistment guidance from OSD (prohibit denying retention or re-enlistment to any Service member solely based on them being a TG Service member).
- b. Service Re-entry by anyone previously discharged due to TG status
- c. DD 214 modifications

Meeting Homework/Deliverables:

1. Your designated representative attended a January 4, 2016 (4:00-5:00 p.m.), medical sub-group meeting; ensure you are tied-in with the discussion that occurred.

Save the date for next meeting:

January 12, 2016 (1400-1530); January 19, 2016 (1400-1530)

TRANSGENDER SERVICE REVIEW WORK GROUP AGENDA

Date: January 12, 2016

Time: 1400-1530

Room: 3D1063

Overview:

The focus for this meeting will be medical issues and a discussion of the issues that warrant policy guidance (COAs).

Outstanding Medical Issues Dr. Guice 1400-1445

- a. Training and education for providers;
- b. IDES for non-voluntary separation;
- c. Reserve and Coast Guard issues;
- d. Counseling for family members of TG individual;
- e. "Medical necessity" at MTF;
- f. Dependent care at MTF; and
- g. Other issues

Courses of Action Mr. Kurta 1445-1530

Meeting Homework/Deliverables:

1. Your designated representative attended a January 11, 2016 (4:00-5:00 p.m.), medical sub-group meeting; ensure you are tied-in with the discussion that occurred.

Save the date for next meeting:

January 19, 2016 (1400-1530); January 26, 2016 (1500-1630)

TRANSGENDER SERVICE REVIEW WORK GROUP AGENDA

Date: January 19, 2016

Time: 1400-1530

Room: 3D1063

Overview:

The focus for this meeting will be to discuss Service inputs to the “Book of COAs” presented at the January 12, 2016, meeting.

Homework/Deliverables:

1) Table drops will not be provided. Please navigate to the MAX.Gov web-site to post your Service inputs to the “Book of COAs” and download/print documents. You can navigate to the site by using this link: <https://community.max.gov/x/EQBtOw>.

2) Upload Instructions. Once you have navigated to MAX.Gov using the previously mentioned link, upload your documents by selecting "add attachments" from the 'Documents' section. Please label the file with your Service name (e.g., Army_Book of COAs_15 JAN.docx). Files not utilizing the templates may be uploaded here as well. If you need assistance, please e-mail [REDACTED].

Save the date for next meeting:

January 26, 2016 (1500-1630)

TRANSGENDER SERVICE REVIEW WORK GROUP AGENDA

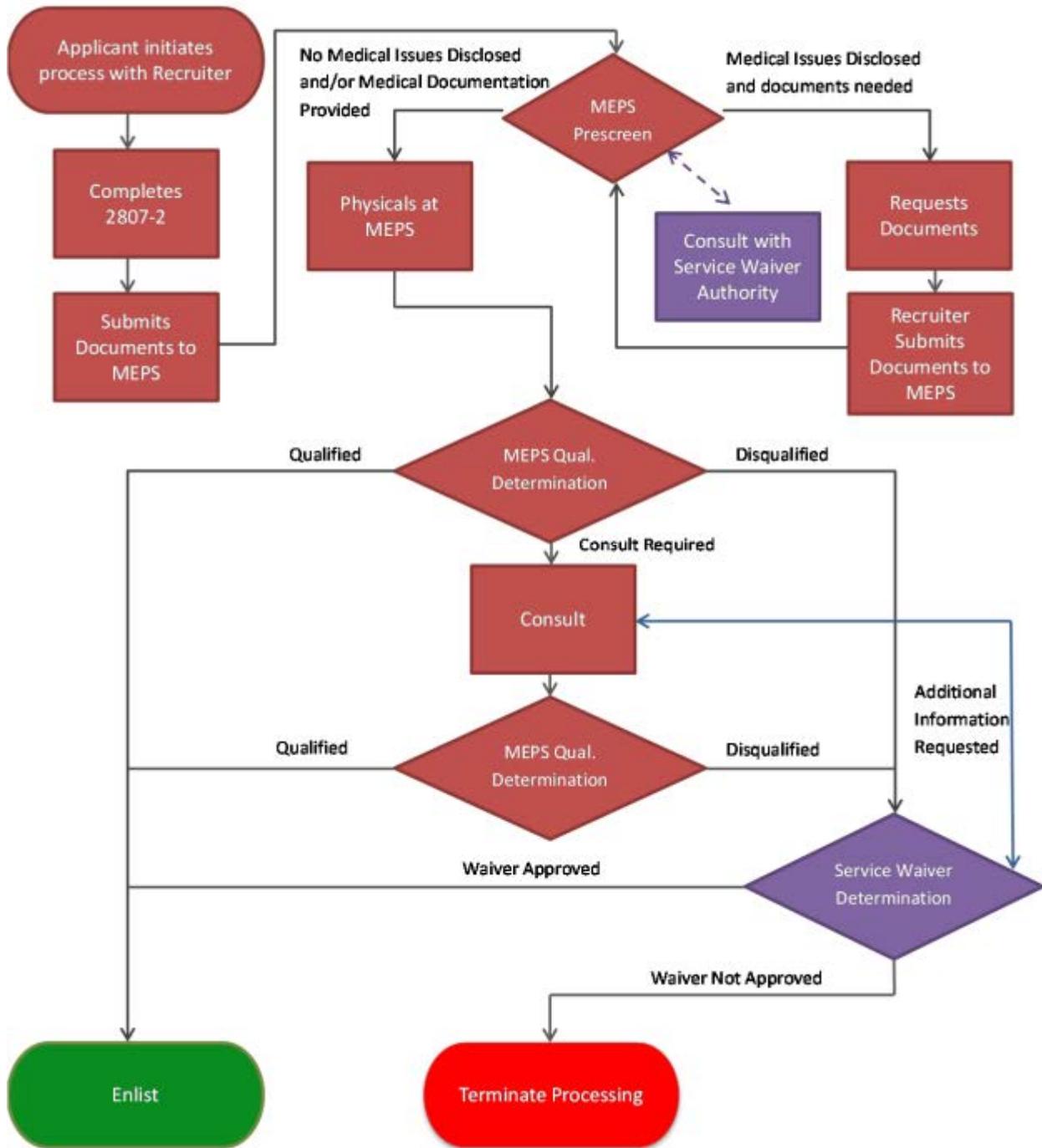
Date: TBD
Time: TBD
Room: 3D1063

Overview:

This wrap-up meeting will address lingering issues and close with a brief by RAND covering their research: Allied Experience, Medical, and Readiness.

Applicant Medical Processing

Enlisted Applicant Medical Processing



TAB B (RAND Report)

**TAB C (Handbook: Understanding Gender Transition in the
Department of Defense)**

TAB D (Service-Specific Inputs)

Major Decision Points

The main areas with potential policy and readiness implications discussed within the TSRWG deliberations were: Medical Accession Standards, In-Service Gender Transition, and Force Training Requirements.

1. Medical Accession Standards

Background: Accessions into the Armed Forces are governed by DoDI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services. The DoDI sets common physical standards for the appointment, enlistment, or induction of Service personnel and applies to the Military Services, the U.S. Coast Guard (CG), the Reserve Components (to include the Army and Air National Guard) and the United States Merchant Marine Academy. Common physical standards ensure that individuals under consideration are:

- Free of contagious diseases that probably will endanger the health of other personnel.
- Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
- Medically capable of satisfactorily completing required training.
- Medically adaptable to the military environment without the necessity of geographical area limitations.
- Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

Current Policy: History of major abnormalities or defects of the genitalia such as including but not limited to change of sex; current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias, is disqualifying. Gender dysphoria is not specifically discussed, nor is gender transition. Any breast or abdominal surgery within the past 6 months, and any surgical procedure to the genitalia, is disqualifying and requires a waiver. The Chief Medical Officer (CMO) at each MEPS determines if an applicant meets the DoDI accession criteria. If not, the applicant's recruiter may seek a waiver through their Service Medical Waiver Authority.

A comprehensive medical standard to address transgender applicants must encompass standards on gender dysphoria, gender transition, surgery, and clearly define who is qualified for accession without a waiver from their Service medical waiver authority.

Work Group Discussion: Service positions are depicted in below graphic.

-----INSERT FINAL SERVICE-SPECIFIC INPUT MATRIX-----

2. In-Service Gender Transition

Background: An essential policy element of open service by transgender Service members is directing a common, DoD-wide construct (via DoDI) by which Service members can transition gender while serving, and for the formal, administrative recognition of a gender marker change in the Defense Enrollment Eligibility Reporting System (DEERS), through a Gender Transition Plan.

DoD formally recognizes a Service member's gender in DEERS. That gender is currently established at the time of accession based on presentation of a birth certificate, U.S. passport, or U.S. passport card or other state federal identification means. Based upon sex or gender at accession, a Military Service holds a Service member accountable to meet the corresponding uniform standards, grooming standards, Physical Readiness Test (PRT) standards, body composition standards (BCA), and Military Personnel Drug Abuse Testing Program (MPDATP) standards (DoDI 1010.16). Additionally, each Military Service generally directs berthing, bathroom and shower use according to the recognized gender.

A comprehensive policy on Gender Transition must address:

- What does a Gender Transition plan include?
- Who approves/disapproves the plan?
- When do new target gender standards apply to the Service member?
- What are the requirements to change the DEERS gender marker?
-

Current Policy: There is no current policy allowing a Service member to change their gender while serving, nor for DoD to formally recognize a change in a Service member's gender.

Work Group Discussion: Service positions are depicted in below graphic.

-----INSERT FINAL SERVICE-SPECIFIC INPUT GRAPHICS-----

3. Force Training/Implementation Period

Open service by transgender Service members will depend upon strong leadership, a clear message, and proactive education. It is necessary to equip commanders in the field with the education and training tools to educate the force on what is expected of them. A handbook that is being created for commanders, transgender Service members, and all Service members establishes common themes meant to assist open service by transgender Service members:

Leadership. The clear message from the Working Group's assessment is "leadership matters most." Leaders at all levels of the chain of command set the example for members in the unit and must be fully committed to DoD policy to sustain unit effectiveness, readiness, and cohesion.

Professionalism. Leaders must emphasize Service members' fundamental professional obligations and the oath to support and defend the Constitution that is at the core of their military service. In the profession of arms, adherence to military policy and standards of conduct is essential to unit effectiveness, readiness, and cohesion.

Respect. Unit strength depends on the strength of each member. We achieve that strength by treating each member with respect.

Work Group Discussion: That the handbook (TAB C), "Understanding Gender Transition in the Department of Defense," developed by DoD in collaboration with the Services, be used as a primary training document. Services are directed to train their personnel on all new aspects of policy associated with the open service by Transgender Service members, change all Service directives, instructions and policy to align with new transgender service policy, and submit all new or changed policies for prior approval by the Under Secretary of Defense for Personnel.

4. Amending Service Documents

DD 214s

Approximately 18 months ago, OSD OGC began working with the Service boards for correction of military records on requests from transgender veterans to amend their first name on their DD-214 - the form does not list a person's gender. The boards collectively agreed to provide relief to petitioners who allege they suffered an injustice from having their former first name on their DD-214, as this effectively requires them to reveal their transgender status when using the form. The petitioner must provide some justification for their claim - this can be a narrative describing their situation - as well as a court ordered name change.

All of the Service boards support the language below; it would be part of a larger page on amending or correcting DD-214s.

"The Board will consider applications for name changes to the DD214 to correct an error or remove an injustice. The applicant must provide justification demonstrating that they were a victim of an error (i.e., genuine error) or that having their former name on their DD-214 causes an injustice (e.g., due to a divorce or their transgender status). A signed and authenticated court order providing proof the applicant's name was legally changed should accompany the application. As with all applications to the Board, each application for a name change will be considered on its own merits."

Work Group Discussion: Current policy presented by OSD OGC is currently being used to modify DD 214s. Services support continuing this approach.

Awards/Medals/Efficiency Report Documentation

Current Policy: Name changes are not made to documentation when Service members change their name due to marriage or divorce. No written guidance exists with respect to name changes specifically due to a change in gender

5. Release From Service Commitment

Work Group Discussion: Some Service members may decide they want to opt out of continued service if asked to serve alongside transgender personnel. There is no basis in policy allowing release from service commitments and voluntary discharge of Service members based on opposition to living or serving with transgender personnel. The U.S. military is an all-volunteer force, but once Service members join the Military Services, they are not guaranteed a certain legal or policy landscape for the duration of their commitment.¹³

6. Retention/Separation

Background: DoD sets broad policy with respect to the ability of the Military Services to separate (and by extension, retain) enlisted members in DoDI 1332.14, and officers in DoDI 1332.30. Within those broad policy guidelines, the Service Secretaries are directed to "develop and maintain Service policies, standards, and procedures in accordance with this instruction" (enlisted) or "prescribe regulations consistent with the policy and procedures established in this instruction" (officers).

Current Policy: No Service member shall be involuntarily separated or denied re-enlistment or continuation of active or reserve service on the basis of their gender identity, without the personal approval of the Under Secretary of Defense for Personnel and Readiness. This approval authority may not be further delegated. (SecDef memo dated 28 July 2015.)

¹³ Service members sign a DD Form 4/1 upon entry acknowledging that laws and regulations governing military personnel may change without notice.

7. Service Re-Entry

Work Group Discussion: Service members who have been previously separated for conditions related to gender identity be permitted to apply for reentry into the military, pursuant to the same criteria as others who seek reentry. The fact that their separation was related to gender identity related issue would not be considered as part of the Service member's application for re-accession. For example, a Service member separated for a gender identity-related issue, who received an honorable discharge, would be evaluated for re-accession under the same criteria that other Service members who had received honorable discharges would be. Further, consistent with the practice for other Service members who apply for re-accession, we recommend that the Service member who applies for re-accession after having been separated for a gender identity-related issue not be given any type of credit for the time out of service, subject to any actions a board for the correction of military records may, in its discretion, take.

8. Military Equal Opportunity (MEO)

Work Group Discussion: Consider transgender Service members be treated under the same general principles of military equal opportunity policy that apply to all Service members. Under the Military Equal Opportunity program, it is DoD policy to “[p]romote an environment free from personal, social, or institutional barriers that prevent Service members from rising to the highest level or responsibility possible. Service members shall be evaluated only on individual merit, fitness, and capability.”¹⁴ This policy goes hand-in-hand with Service-level policies and basic military values that call for treating every military member with dignity and respect.

When DADT was repealed in 2011, the Department did not include sexual orientation as part of the Military Equal Opportunity program. Instead, complaints were dealt with through the chain of command and the Inspector General system. The DOD Directive was signed by DSD Work June 8, 2015, to include sexual orientation as part of the MEO process.¹⁵ We recommend that gender identity be placed alongside race, color, religion, sex, national origin, and sexual orientation as a class eligible for various diversity programs, tracking initiatives, and complaint resolution processes under the Military Equal Opportunity Program. In a new environment in which transgender Service members can be open about their gender identity, we believe they will be accepted more readily if the military community understands that they are simply being permitted equal footing with everyone else.

Gender identity may not, in and of itself, be a factor in accession, promotion, or other personnel decision-making. Gay and lesbian Service members, like all Service members, would be evaluated only on individual merit, fitness, and capability. Likewise,

¹⁴ Department of Defense, DoDD 1350.2, *Department of Defense Military Equal Opportunity (MEO) Program*, August 18, 1995, 2–3; Department of Defense, DoDD 1020.2, *Diversity Management and Equal Opportunity (EO) in the Department of Defense*, February 5, 2009, 4.

¹⁵ At this time, we can refer service members to the DoD Directive 1020.02e once it is published. They may also reference the current version of DoDD 1350.2 for background on the existing MEO Program. It is important for those reviewing DoDD 1350.2 to note that it is under conversion into a DoD instruction.

the Department of Defense should make clear that harassment or abuse based on gender identity is unacceptable and that all Service members are to treat one another with dignity and respect regardless of gender identity.

Additional Considerations

1. Standards of Conduct

Work Group Discussion: Military standards of conduct—as reflected in the Uniform Code for Military Justice, Service regulations and policies, and unwritten Service customs and traditions—already prohibit fraternization and unprofessional relationships. They also address various forms of harassment and unprofessional behavior, prescribe appropriate dress and appearance, and provide guidelines on public displays of affection. It is not necessary to establish an extensive set of new or revised standards of conduct with regard to open service by transgender personnel. Concerns for standards can be adequately addressed through training and education about how already existing standards of conduct continue to apply to *all* Service members, regardless of gender identity. Services agreed to review their current standards to ensure that they are gender neutral and that they provide adequate guidance to the extent each Service considers appropriate on unprofessional relationships, harassment, public displays of affection, and dress and appearance

2. Privacy and Cohabitation

Work Group Discussion: The creation of a third and possibly fourth category of bathroom facilities and living quarters, whether at bases or forward deployed areas, would be a logistical nightmare, expensive, and impossible to administer. At the same time, commanders would retain the authority they currently have to alter berthing or billeting assignments or accommodate privacy concerns on an individualized, case-by-case basis, in the interests of morale, good order and discipline, and consistent with performance of mission.¹⁶ It should also be recognized that commanders already have the tools—from counseling, to non-judicial punishment, to UCMJ prosecution—to deal with misbehavior in either living quarters or showers, whether the person who engages in the misconduct is transgender or not.

3. Moral, Religious, and Freedom of Expression Concerns

There is always a concern that Service members may raise religious and moral objections to transgender personnel or to serving alongside someone who is transgender. Some may feel that open service by transgender personnel might limit their individual freedom of expression and free exercise of religion, or require them to change their personal beliefs regarding the morality of changing gender. These views cannot be downplayed or dismissed. Special attention should also be given to address the concerns of our community of 3,000 military chaplains. A large number of military

¹⁶ Each Service has directives on command authority, for example: Department of the Air Force, AFI 51-604, *Assumption of Command*, April 4, 2006; Department of the Army, AR 600-20, *Army Command Policy*, April 27, 2010.

chaplains (and their followers), as with homosexuality, may view transgender personnel as sinners and an abomination, and that they are required by God to condemn it as such.

Work Group Discussion: Within the chaplain community, the solution to this issue can be found in the existing guidance developed by and for our chaplains, which should be reiterated as part of any education and training concerning repeal. Those regulations strike an appropriate balance between protecting a chaplain's First Amendment freedoms and a chaplain's duty to care for all. Existing regulations state that chaplains "will not be required to perform a religious role...in worship services, command ceremonies, or other events, if doing so would be in variance with the tenets or practices of their faith."¹⁷ At the same time, regulations state that "Chaplains care for all Service members, including those who claim no religious faith, facilitate the religious requirements of personnel of all faiths, provide faith-specific ministries, and advise the command."¹⁸

4. Surveys

Work Group Discussion: Options were discussed for follow-on surveys. It was suggested that current survey tools, such as the Status of Forces survey, DMDC Quick Compass Survey, or a JAMRS Data Collection Vehicle (e.g., Current Events Tracker, Influencer Poll, Military Ad Tracking Sponsor Market), be used. Additionally, the Services could choose to do their own surveys to assess any number of items related to open service by transgender personnel.

¹⁷ Department of the Army, AR 165-1, *Army Chaplain Corps Activities*, December 3, 2009, 12.

¹⁸ Department of the Navy, SECNAVINST 1730.7D, *Religious Ministry within the Department of the Navy*, August 8, 2008, 5.

TAB E (Outside Consultants)

Dr. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Dr. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Human Rights Campaign (HRC)

www.hrc.org

As the largest civil rights organization working to achieve equality for lesbian, gay, bisexual and transgender Americans, the Human Rights Campaign represents a force of more than 1.5 million members and supporters nationwide — all committed to making HRC's vision a reality.

HRC envisions a world where lesbian, gay, bisexual and transgender people are embraced as full members of society at home, at work and in every community.

The Human Rights Campaign Fund was founded by Steve Endean in 1980 as one of the first gay and lesbian political action committee in the United States. The Fund's mission was to provide financial support on behalf of the gay and lesbian community to political candidates who supported gay civil rights legislation. Vic Basile served as the Fund's first executive director.

The Fund quickly rose to prominence – after its first election cycle in 1982, the Fund was the 17th largest independent political action committee in the United States.

In 1995, under Executive Director Elizabeth Birch, the organization dropped “Fund” from its name and expanded its reach far beyond political lobbying work. Programs such as the Workplace Project and the Family Project became part of the newly created educational arm, the Human Rights Campaign Foundation. All of HRC's research, communications, marketing and public relations functions were greatly expanded. It was a key transformation that paved the way for the powerful organization that it is today.

National Center for Transgender Equality (NCTE)

<http://www.transequality.org/>

About Us. The National Center for Transgender Equality is the nation's leading social justice advocacy organization winning life-saving change for transgender people. NCTE was founded in 2003 by transgender activists who recognized the urgent need for policy change to advance transgender equality. With a committed board of directors, a volunteer staff of one, and donated office space, we set out to accomplish what no one had yet done: provide a powerful transgender advocacy presence in Washington, D.C. Today, NCTE has grown to a staff of ten and works at the local, state, and federal level to change laws, policies and society.

Mission. The National Center for Transgender Equality is a national social justice organization devoted to ending discrimination and violence against transgender people through education and advocacy on national issues of importance to transgender people. By empowering transgender people and our allies to educate and influence

policymakers and others, NCTE facilitates a strong and clear voice for transgender equality in our nation's capital and around the country.

Projects

Racial and Economic Justice Initiative (REJI). NCTE's Racial and Economic Justice Initiative ensures the perspectives and priorities of transgender people of color, and those who live in urban and rural poverty, are part of the national policy and advocacy agenda. This includes federal policy, local and state advocacy, and collaborating with other racial, social, economic and criminal justice movements and initiatives. Currently, the Initiative's work includes reforming detention conditions for transgender people in correctional facilities and in immigration detention.

Trans Legal Services Network (TLSN). NCTE helps ensure every transgender person can navigate the complicated name and gender change process and confidently address other legal issues they may face. NCTE created the Trans Legal Services Network to increase support for organizations across the country who are serving or aiming to serve the legal needs of our communities. Comprised of over 50 organizations, the Network shares advice, provides technical support and legal resources to support their work and expand their services.

PALM Center

www.palmcenter.org

The Palm Center is an independent research institute committed to sponsoring state-of-the-art scholarship to enhance the quality of public dialogue about critical and controversial public policy issues. Our research on sexual minorities in the military has been published in leading social scientific journals. The Palm Center seeks to be a resource for university-affiliated as well as independent scholars, students, journalists, opinion leaders, and members of the public.

SPARTA (Service Members, Partners, Allies for Respect and Tolerance for All)

<http://sparta.nationbuilder.com/>

Who we are:

SPART*A is a group of LGBT people who currently serve or have served in the military and our families as well as veteran and uniformed allies. We are a membership organization, built by, for and with members from all parts of the LGBT military community.

Mission:

SPART*A's mission is to advocate for and support our actively serving LGBT military members and veterans, and their families, while working to ensure the military provides

equal opportunity for all service members regardless of race, national origin, religion, sex, sexual orientation and gender identity.

We are committed to:
Professional Development and Networking
Direct Peer Support
Policy Advocacy
Legal Referrals

SPART*A Values:

SPART*A is a nonpartisan, inclusive, member-based organization that is committed to providing support and ensuring equal opportunities, benefits, and rights for all LGBT servicemembers and veterans and their families.

This is an LGBT organization that is committed to full equality and will work with allied groups and organizations to ensure justice for all LGBT service members, LGBT veterans and their families.

All SPART*A members are committed to educating key stakeholders and the public about issues that impact LGBT servicemembers, veterans and their families in order to continue accomplishing our mission of strengthening the culture of inclusion and diversity within the United States military.

World Professional Association for Transgender Health (WPATH)

www.wpath.org

The World Professional Association for Transgender Health (WPATH), formerly known as the (Harry Benjamin International Gender Dysphoria Association (HBI/GDA), is a 501(c)(3) non-profit, interdisciplinary professional and educational organization devoted to transgender health. Our professional, supporting, and student members engage in clinical and academic research to develop evidence-based medicine and strive to promote a high quality of care for transsexual, transgender, and gender-nonconforming individuals internationally. We are funded primarily through the support of our membership, and through donations and grants sponsored by non-commercial sources.

Mission to promote evidence based care, education, research, advocacy, public policy, and respect in transgender health.

Vision to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transgender, transsexual, and gender-variant people in all cultural settings.

Goals and Tasks

As an international interdisciplinary, professional organization, the World Professional Association for Transgender Health (WPATH) will work to further the understanding and treatment of gender identity disorders by professionals in medicine, psychology, law, social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech and voice therapy, and other related fields.

WPATH provides opportunities for professionals from various sub-specialties to communicate with each other in the context of research and treatment of gender identity disorder including sponsoring biennial scientific symposia.

WPATH publishes the Standards of Care and Ethical Guidelines, which articulate a professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders, and help professionals understand the parameters within which they may offer assistance to those with these conditions.

EXHIBIT B TO HEBERT DECLARATION



NATIONAL DEFENSE RESEARCH INSTITUTE

A photograph of a large group of military personnel in blue camouflage uniforms marching in formation on a tarmac. The personnel are seen from behind, moving away from the camera. The background shows a large aircraft and a clear sky.

Transgender Military Personnel Policy

Healthcare and Readiness

Agnes Schaefer • Charles Engel • Srikanth Kadiyala • Radha Iyengar
Jennifer Kavanaugh • Kayla Williams • Amii Kress

January 2016

Research Objectives

- Identify issues regarding the medical and health care needs of transgender service members, and the costs associated with extending healthcare coverage
- Assess the potential impacts on military readiness
- Review analogous experiences and lessons learned from U.S. allies and police/fire departments

Briefing outline

- Medical needs and healthcare costs
- Potential readiness implications
- Lessons learned from foreign militaries and police/fire departments
- Key takeaways

Key terms and concepts

- Gender Identity: one's inner sense of one's own gender (e.g., male, female, non-conforming)
- Transgender: umbrella term for individuals who have gender identity or expression that differs from their assigned sex at birth
- Gender Dysphoria: clinically significant discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth
- Transsexual: an outdated term, but still used to describe someone who desires to permanently transition from their gender at birth
- Sexual Orientation: one's sexual preference (e.g., gay, lesbian, bisexual, asexual)

Estimating number of currently serving transgender service members

We constructed a range of estimates

- Lower bound: based on general population estimates (LB = 0.3 %)
- Upper bound: based on non-representative sample survey of transgender individuals in the military (UB= 0.6%)
 - This is likely an overestimate, as the question asks if the respondent has ever been a member of the military—not if they are currently serving

	Total Force Size	Percent of Total Force	LB (0.3%)	UB (0.6%)
Active	1,350,079	56%	4,050	8,100
Selected Reserve	816,813	34%	2,450	4,901
IRR	250,000	10%	750	1,500
Total	2,416,892		7,251	14,501

Medical needs of individuals with Gender Dysphoria

Gender Dysphoria: A medical condition characterized by at least 6 months of clinically significant distress relating to significant identification with a gender different from gender at birth.

Individuals with Gender Dysphoria are at increased risk of depression, substance abuse, cardiovascular disease, physical violence, and HIV

There may be consequences to not providing necessary care (e.g., increased depression, anxiety, substance misuse, and suicidality)

Available data suggest the vast majority of individuals with Gender Dysphoria seek mental health care at some point

Transgender status alone is not a medical condition

Medical treatment for Gender Dysphoria

It is unknown what percentage of transgender individuals experience Gender Dysphoria

Consensus is emerging that some or all of the following care is medically necessary to treat Gender Dysphoria:

- Psychotherapy to affirm transgender identity and refer for medical treatment(s)
- Hormone therapy to minimize existing secondary sex characteristics and maximize desired feminization / masculinization
- Gender reassignment/confirmation surgery

Other treatments could be considered aesthetic or medically necessary

Approach for estimating transgender health care costs



Active component transgender health care utilization estimates

Using civilian health insurance data, our best estimate on individual annual claimants

~50 military personnel

Upper bound estimate: our best estimate on individual annual claimants

~100 military personnel

Accounts for the possibility that transgender prevalence in the military is twice as high as in the general population

Veterans' data, which already has population characteristics similar to military population, implies

~ 90 new individuals diagnosed with gender identify disorder each year

Potential active component transgender medical treatments

Using NTDS data, best estimates of annual surgeries and hormone therapy

~185 treatments

Using NTDS data, upper-bound estimates of annual surgeries and hormone therapy

~370 treatments

	Assumptions Regarding Prevalence	Annual Major Surgeries	Annual Hormone Treatments
Active Component Estimates	0.3%	90	95
Active Component Estimates	0.6%	180	190

Active component transgender health care cost estimates

Based on combined private health insurance estimates, we estimate that active component health care costs are expected to rise from

.038% to .054%

Based on combined private health insurance estimates, we estimate additional annual health care costs to be approximately

\$2.4 M to \$3.4 M

Sensitivity Analysis 1: If male/female effects are different and male/female active component population distribution is taken into account, estimates range from

\$2.8 M to \$4 M

Sensitivity Analysis 2: If transgender prevalence in the military is twice that of the civilian population, estimates range from

\$5.6 M to \$8 M

Other cost considerations

Private health plan experience does not show evidence that adding a transgender benefit attracts more transgender individuals and thus dramatically increases health care costs

What are the health care costs in the reserve component populations that are covered by the military health system?

What are the treatments that should be covered in the health care benefit and the implications of coverage for utilization and costs?

What costs are associated with extending benefits to beneficiaries?

Briefing outline

- Medical needs and healthcare costs
- Potential readiness implications
- Lessons learned from foreign militaries and police/fire departments
- Key takeaways

Estimating impacts on deployment over the lifecycle

Our approach to estimating deployment impacts

1



2

Use lifecycle estimates to look at number of individuals likely to seek treatments over a 20 year military career (compared to annual rates used in costing)

Usage may not occur in a single year (i.e. not all transgender members may initiate hormone therapy in a given year)

Number of transgender individuals seeking treatment: lifecycle estimates

Population	LB (0.3% rate for transgender in military, transgender only for medical treatments)	UB (0.6% rate for transgender in military, all transgender, gender non-conforming, and cross-dressers for medical treatments)	Foreign Military (Australia usage rate suggests 0.009% applied to total force estimate)	California Health Insurance (Civilian usage rate 0.0044% applied to total force estimate)
Total Transgender	7,250	14,500		
Total Transgender who will transition	3,065	6,100		
Total Medical Treatments	2,500	4,500	193	106
Major Surgery	600	1,200	N/A	N/A

Estimates from non-representative survey are large compared to other evidence but still small compared to total size of the force (<0.2%)

Impact on deployment: medical treatment delays (lifecycle estimates)

	Recovery Time	Treatment and Recovery Time	# of Personnel Over Total Lifecycle (LB - UB)
Male-to-Female	Hormone Only	Long-term, 90-day doctor visit for a year then regular lab work	2,000-4,000
	Breast Augmentation	1 week no work, 4- 6 weeks restricted physical	550-1,100
	Facial Surgeries	2 weeks no work, up to 4 months restricted physical	440-880
	Genital Surgeries (Orchiectomy, Vaginoplasty)	4-6 weeks no work, 8+ weeks restricted physical	600-1,300
Female-to-Male	Hormone Only	Long-term, 90-day doctor visit for a year then regular lab work	250-500
	Chest Surgery	1 week no work, 4- 6 weeks restricted physical	200-380
	Hysterectomy	2 weeks no work, 4-8 weeks restricted physical	90-180
	Genital Surgeries (Mediopasty, Phalloplasty)	2-4 weeks no work, 4-6 weeks restricted physical	9-30

Considerations for deployment

Medical needs may limit deployability in some circumstances (e.g., remote operating environments)

- Hormone treatment requires regular doctor visits (90 days for the first year, then lab tests every 6-12 months)
- Some hormone regimens require refrigeration
- Need to review policies and feasibility for some deployments

Reduced readiness and surgical care for an estimated upper bound of 5,000 individuals over their time in the military

- Need to assess timing and unit impacts of inability to deploy for these individuals
- May be particularly relevant for certain occupations and operational units
 - This may require guidance on when surgeries can be scheduled

Transgender status or gender dysphoria does not automatically make someone non-deployable

Evidence on unit cohesion

No direct evidence, applicable surveys, or systematic information to determine attitudes on transgender individuals among military members

- However, evidence from previous integration efforts (e.g., gays, lesbians, and women) indicates that such integration had minimal impact on unit cohesion and readiness

Limited evidence available:

- Foreign Militaries: no evidence of readiness impacts, some evidence of increased harassment
- U.S. Population: attitudes more negative to transgender than gays and lesbians
 - But attitudes improve with interactions with transgender individuals

Considerations for accessions and retention policies

Accessions

Revise language to match DSM-5 and review conditions related to:

- Mental Fitness: transgender status is not considered a mental disorder. Mental health screening should still be applied but language should match current disorders
- Physical Fitness: Language should clarify physical requirements (vice physical conditions) and clarify when target gender requirements will apply

Retention

Improve guidance and directives to clarify standards for review during and after transition:

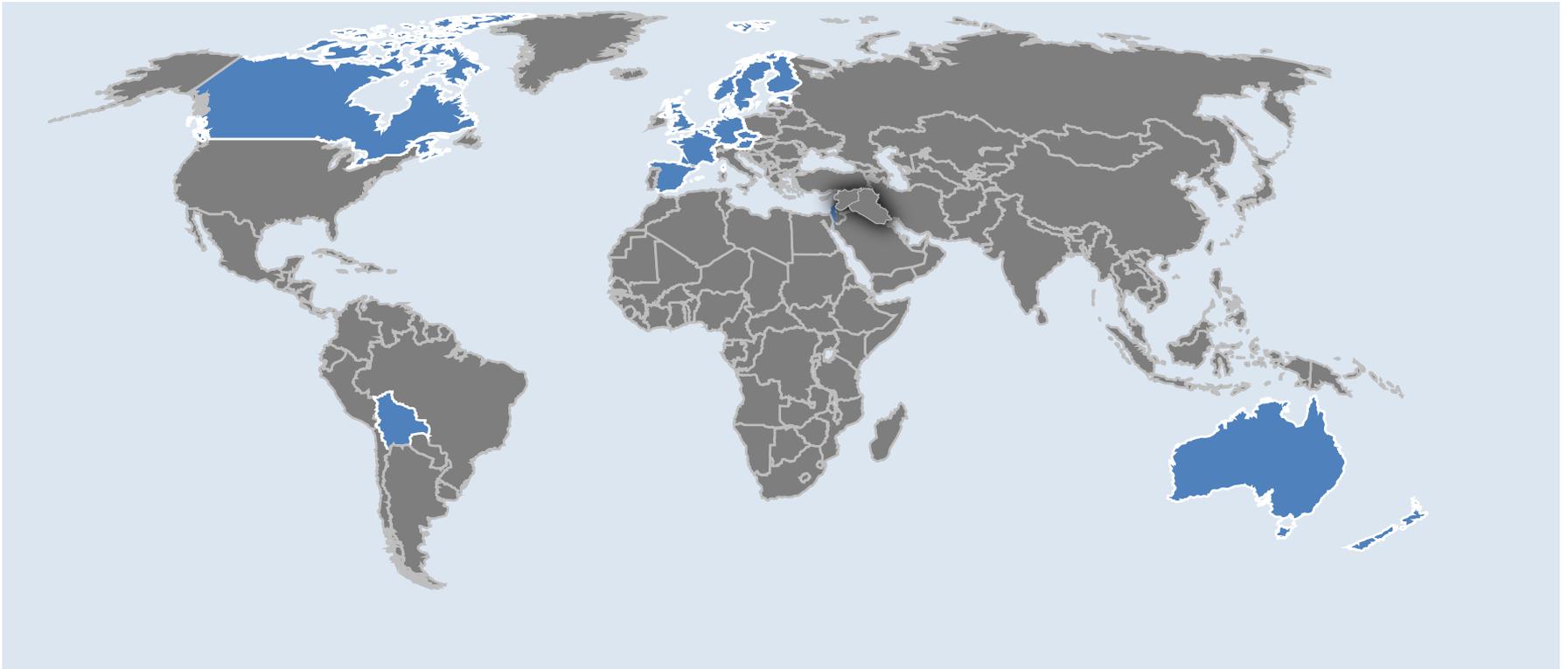
- Review for Separation: Language should be updated and should allow determinations of fitness to serve by medical evaluation board / physical evaluation board (MEB/PEB), in line with other conditions
- Physical Fitness: Standards for fitness may need to be adjusted during and after transition

Briefing outline

- Medical needs and healthcare costs
- Potential readiness implications
- Lessons learned from foreign militaries and police/fire departments
- Key takeaways

Approach and caveats

We began with a broad review of 18 countries that allow transgender personnel to serve openly in their militaries



We also examined the public literature on police/fire departments

Approach and caveats

We then narrowed our analysis to four specific countries, focusing on where most in-depth information was available



Per sponsor guidance, we relied on publicly available policies and research but did not conduct interviews

Foreign militaries have flexible policies

Health and readiness implications are addressed on a case-by-case basis; transgender individuals intending to or in the midst of transition are not automatically non-deployable

Policies regarding uniforms, facilities, name changes vary across foreign militaries

In Australia, Canada and UK, uniforms, restrooms, ID cards, and housing shift once individual begins living as target gender

In Israel, needs are typically accommodated but some limitations are in place, particularly in combat units

In all four countries, transgender personnel must meet physical standards of target gender once transition is complete

But foreign militaries have also faced challenges

Harassment and bullying have been a problem in all four countries

Ambiguities in policy documents have placed some transgender individuals in isolating situations (e.g. forced to use remote facilities or housing)

There are ongoing debates over policy (e.g., whether awards and medals should be transferred to the new name)

RAND



Findings from police and fire departments

There is no significant literature on the impact of transgender fire fighters or police officers on readiness or cohesion

There is some evidence that transgender police officers and fire fighters still face significant discrimination and harassment

There are no publicly available policies on how police and fire departments deal with physical standards for transgender personnel

None of the policies are clear on the logistics of transition-related absences

Briefing outline

- Medical needs and healthcare costs
- Potential readiness implications
- Lessons learned from foreign militaries and police/fire departments
- Key takeaways

Key takeaways

Estimates of currently serving transgender personnel range from 7,250 to 14,500

Additional healthcare costs are expected to range between \$2.4 million-\$8 million

Impacts on non-deployability are expected to be relatively small, but medical care may not be feasible for some deployments

Commanders will need clear guidance on how to implement new transition-related policies (e.g., uniforms, housing, restrooms, physical standards)

Overall, a change in policy is expected to be manageable



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Back-up Slides

Medical necessity of Gender Reassignment Treatment (GRT) for Gender Dysphoria

- Uncertainty remains regarding the long term efficacy of GRT, though existing data suggest potentially important short term medical and psychiatric benefits
- Determinations are increasingly toward the medical necessity of GRT:
 - Professional associations in support: American Medical Association, American Psychological Association, American Academy of Family Physicians, National Association of Social Workers, World Professional Association for Transgender Health, and American College of Obstetricians and Gynecologists
 - Centers for Medicare and Medicaid Services bans blanket Medicare exclusion of transition-related medical service reimbursement
 - Insurance carriers participating in the Federal Employees Health Benefits Program (mandated by Office of Personnel Management) reimburse for GRT
 - Blanket transgender coverage exclusions in health insurance are prohibited under non-discrimination laws in California, Colorado, Connecticut, Illinois, Massachusetts, Nevada, New York, Oregon, Vermont, and Washington, as well as Washington, DC

Lessons from foreign militaries

- No evidence of significant effect on readiness or operational effectiveness
 - Based on literature reviews that included summaries of interviews with commanders
 - Some commanders report in interviews that diversity improved readiness
- No evidence of significant effect on cohesion
 - Some reports of harassment or bullying, but no major impact on unit bonding or ability to work as a team

EXHIBIT C TO HEBERT DECLARATION



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A photograph of military personnel in blue camouflage uniforms marching in formation on a tarmac. The personnel are seen from behind, moving away from the camera. The background shows a large aircraft and other personnel in the distance.

Transgender Military Personnel Policy

Healthcare and Readiness

Agnes Schaefer • Charles Engel • Srikanth Kadiyala • Radha Iyengar
Jennifer Kavanaugh • Kayla Williams • Amii Kress

February 2016

Research Objectives

- Identify issues regarding the health care needs of transgender service members, and the costs associated with extending health care coverage
- Assess the potential impacts on military readiness
- Review analogous experiences and lessons learned from U.S. allies and police/fire departments

Briefing outline

- Health care needs and costs
- Potential readiness implications
- Lessons learned from foreign militaries and police/fire departments
- Key takeaways

Key terms and concepts

- Gender Identity: one's inner sense of one's own gender (e.g., male, female, nonconforming)
- Transgender: umbrella term for individuals who have gender identity or expression that differs from their assigned sex at birth
- Gender Dysphoria: clinically significant discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth
- Transsexual: an outdated term, but still used to describe someone who desires to permanently transition from their gender at birth
- Sexual Orientation: one's sexual preference (e.g., gay, lesbian, bisexual, asexual)

Medical needs of individuals with Gender Dysphoria

Gender Dysphoria: A medical condition characterized by at least 6 months of clinically significant distress relating to significant identification with a gender different from gender at birth.

Individuals with Gender Dysphoria are at increased risk of depression, substance abuse, cardiovascular disease, physical violence, and HIV

There may be consequences to not providing necessary care (e.g., increased depression, anxiety, substance misuse, and suicidality)

Available data suggest the vast majority of individuals with Gender Dysphoria seek mental health care at some point

Transgender status alone is not a medical condition

Medical treatment for Gender Dysphoria

It is unknown what percentage of transgender individuals experience Gender Dysphoria

Consensus is emerging that some or all of the following care is medically necessary to treat Gender Dysphoria:

- Psychotherapy to affirm transgender identity and refer for medical treatment(s)
- Hormone therapy to minimize existing secondary sex characteristics and maximize desired feminization / masculinization
- Gender reassignment/confirmation surgery

Not all individuals will prefer or need any or all of these options

Military Health System capacity and gender transition-related treatment

- Psychotherapy, Hormone Therapies, and Gender Transition-Related Surgery
 - Both psychotherapy and hormone therapies are available and regularly provided

- Reconstructive Surgery
 - A limited number of reconstructive breast, chest, or genital surgeries are performed on a limited basis for traumatic injury
 - The skills and competencies required to perform similar procedures on transgender patients are often overlapping

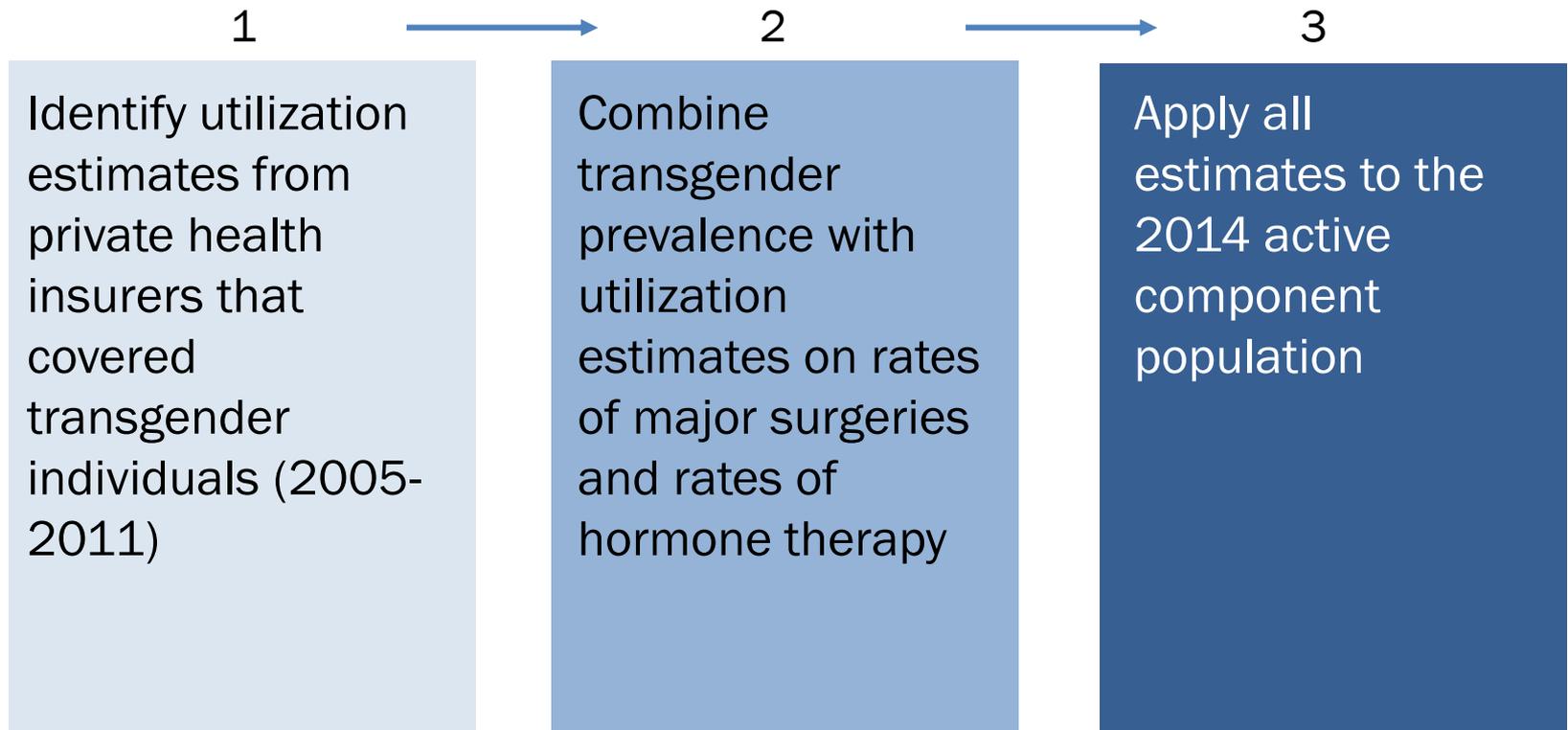
Estimating number of currently serving transgender service members

We constructed a range of estimates

- Lower-bound: based on general population estimates (LB = 0.3 %)
- Upper-bound: based on NTDS nonrepresentative sample survey of transgender individuals (UB= 0.6%)
 - This is likely an overestimate, as the question asks if the respondent has ever been a member of the military—not if they are currently serving

	Force Size	Percent of Total Force	Gender-Adjusted LB (0.3%)	Gender-Adjusted UB (0.6%)
Active – Male	1,125,581	52%	4,509	9,018
Active – Female	200,692	9%	398	796
Select Reserve – Male	682,233	32%	2,829	5,657
Select Reserve – Female	149,759	7%	250	500
Total	2,158,265	100%	7,986	15,971

Approach for estimating transgender health care costs



Active component transgender health care utilization estimates

Using civilian health insurance data, our lower-bound estimate on individual annual claimants

29 military personnel

Using civilian health insurance data, our upper-bound estimate on individual annual claimants

129 military personnel

Accounts for the possibility that transgender prevalence in the military is twice as high as in the general population

Veterans' data, which already has population characteristics similar to military population, implies

89 new individuals diagnosed with gender identity disorder* each year

Potential transgender medical treatments in Active Component

Combining information on transgender prevalence with NTDS data, lower-bound estimates of annual surgeries and hormone therapy

159 treatments

Similarly, our upper-bound estimates of annual surgeries and hormone therapy

382 treatments

	Assumptions Regarding Prevalence	Annual Major Surgeries	Annual Hormone Treatments
Active Component Estimates	0.3% (adjusted to male/female distribution)	92	99
Active Component Estimates	0.6% (adjusted to male/female distribution)	184	198

Estimated costs are a small fraction of military health care expenditures

Based on combined private health insurance estimates, we estimate that active component health care costs are expected to rise from

0.038% to 0.054%

Based on combined private health insurance estimates, we estimate additional annual health care costs to be approximately

\$2.4 M to \$3.4 M

Sensitivity Analysis 1: If male/female effects are different and male/female active component population distribution is taken into account, estimates range from

\$2.9 M to \$4.2 M

Sensitivity Analysis 2: If transgender prevalence in the military is twice that of the civilian population, estimates range from

\$5.8 M to \$8.4 M

FY2014 active component health care expenditures were \$6.27 billion and the FY2015 Unified Medical Program (UMP) budget was \$48.5 billion

Other related considerations

Private health plan experience does not show evidence that adding a transgender benefit attracts more transgender individuals and thus dramatically increases health care costs

- None of the private health insurance plans reported this phenomena happening and none of them adjusted their initial premium calculations by a substantial amount after implementing the benefit

Potential psychiatric comorbidity (depression, substance misuse, suicidality) may need to be handled on a case-by-case basis

Mental health services are an essential transition-related treatment

Briefing outline

- Health care needs and costs
- Potential readiness implications
- Lessons learned from foreign militaries and police/fire departments
- Key takeaways

Estimating impacts on deployment over the lifecycle

Our approach to estimating deployment impacts

1

Use lifecycle estimates to look at number of individuals likely to seek treatments over a 20 year military career



2

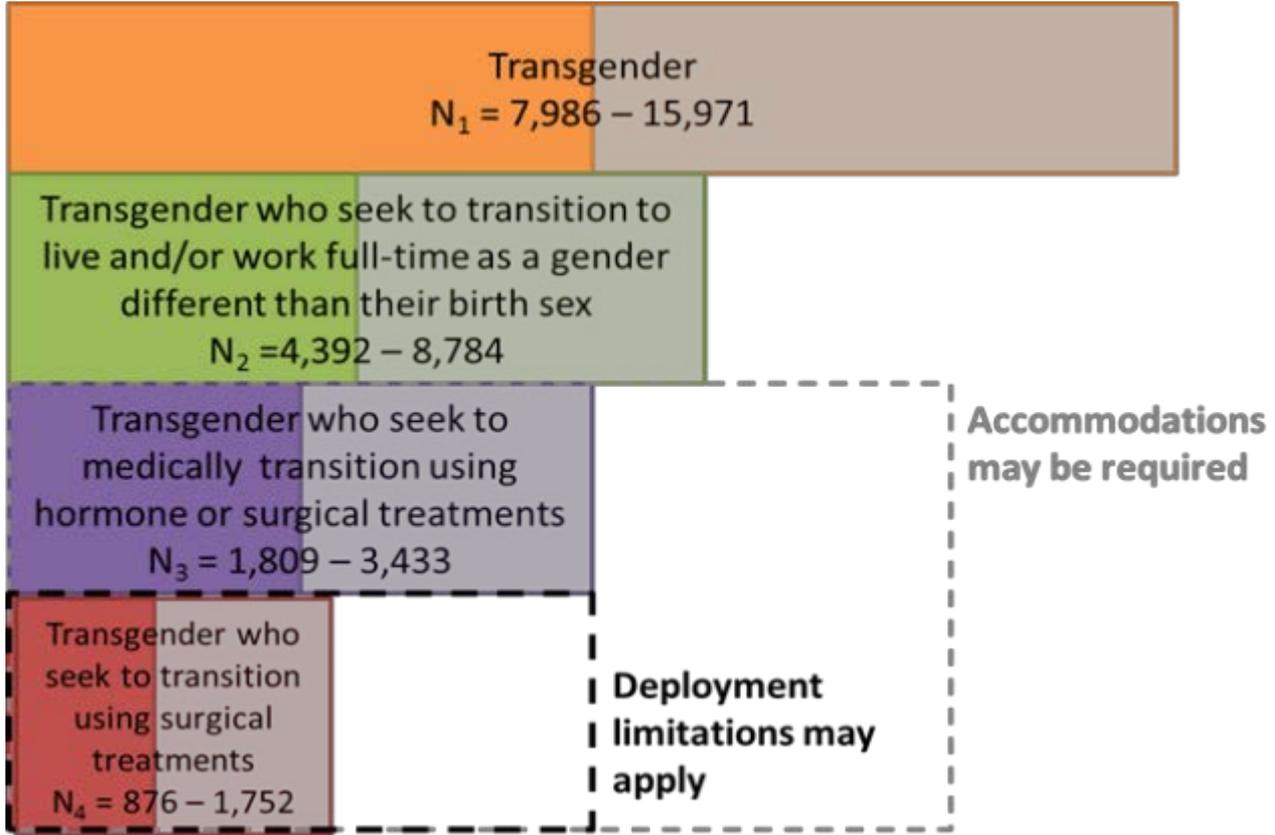
Usage may not occur in a single year (i.e. not all individuals may initiate hormone therapy in a given year)

Number of transgender individuals seeking treatment: lifecycle estimates

	LB (0.3% prevalence transgender, adjusted to male/female distribution)	UB (0.6% prevalence transgender, adjusted to male/female distribution)
Estimated Total Transgender	7,986	15,971
Estimated Total Transgender Who Will Transition	4,392	8,784
Estimate Total Medical Treatments	1,809	3,433
Estimated Major Surgery	876	1,752

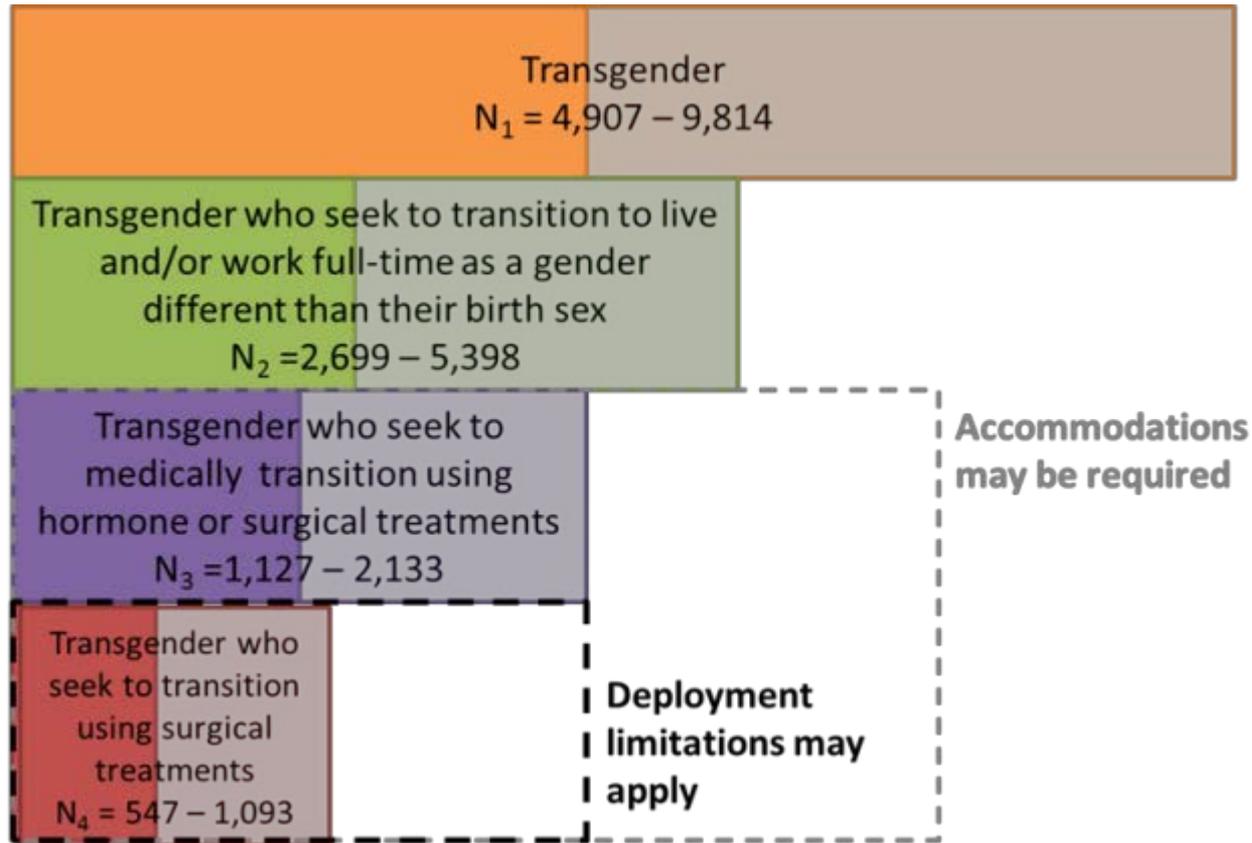
Foreign military and U.S. civilian utilization rates suggest that our upper-bound estimates may be 10 to 20 times larger relative to these actual utilization rates.

Only a fraction of transgender individuals will seek hormone therapy or surgery in Active and Select Reserve Components



NOTE: The darker shaded region represents estimates at the lower-bound and lighter color shaded region represents estimates at the upper-bound. This excludes the Individual and Inactive Ready Reserve members as comparable information on their demographics was not available for analysis.

Only a fraction of transgender individuals will seek hormone therapy or surgery in Active Component



NOTE: The darker shaded region represents estimates at the lower-bound and lighter color shaded region represents estimates at the upper-bound. This excludes the Individual and Inactive Ready Reserve members as comparable information on their demographics was not available for analysis.

Impact on deployment: medical treatment recovery times (lifecycle estimates)

	Recovery Time	Treatment and Recovery Time	# of Personnel Over Total Lifecycle –AC Only (LB – UB)
Male-to-Female	Hormone Only	Long-term, 90-day doctor visit for a year then regular lab work	519 – 1,038
	Breast Augmentation	1 week no work, 4- 6 weeks restricted physical	148-297
	Genital Surgeries (Orchiectomy, Vaginoplasty)	4-6 weeks no work, 8+ weeks restricted physical	339 - 678
Female-to-Male	Hormone Only	Long-term, 90-day doctor visit for a year then regular lab work	61 - 122
	Chest Surgery	1 week no work, 4- 6 weeks restricted physical	37 – 75
	Hysterectomy	2 weeks no work, 4-8 weeks restricted physical	18 – 36
	Genital Surgeries (Mediopasty, Phalloplasty)	2-4 weeks no work, 4-6 weeks restricted physical	5 – 10

Sources for recovery times: FDA; Vancouver Coastal Health, Transgender Support & Education

Society and Canadian Rainbow Health Coalition; The Philadelphia Center for Transgender Personnel Policy-19 February 2016
 Transgender Surgery; The Gender Centre (Australia).

Annual AC medical treatment – related readiness constraints

	Treatment	Treatment and Recovery Time	Leave and Deployment Implications	# of Treatments (AC Only)	Maximum Total Non-Deployable Days
Male-to-Female	Hormone Only	Long-term, No recovery required	None (pending accommodations)	519 – 1,038	0
	Breast Augmentation	1 week no work, 4- 6 weeks restricted physical activity	Up to 14 days medical leave, up to 60 days Medical Disability	148-297	3,600
	Genital Surgeries (Orchiectomy, Vaginoplasty)	4-6 weeks no work, 8+ weeks restricted physical activity	Up to 45 days medical leave, up to 90 days Medical Disability	339 - 678	14,850
Female-to-Male	Hormone Only	Long-term	None (pending accommodations)	61 - 122	0
	Chest Surgery	1 week no work, 4- 6 weeks restricted physical activity	Up to 14 days medical leave, up to 60 days Medical Disability	37 – 75	825
	Hysterectomy	2 weeks no work, 4-8 weeks restricted physical activity	Up to 21 days medical leave, up to 90 days Medical Disability	18 – 36	555
	Genital Surgeries (Metoidioplasty, Phalloplasty)	2-4 weeks no work, 4-6 weeks restricted physical activity	Up to 21 days medical leave, up to 60 days Medical Disability	5 – 10	162

Sources for recovery times: FDA; Vancouver Coastal Health, Transgender Support & Education Society and Canadian Rainbow Health Coalition; The Philadelphia Center for Transgender Surgery; The Gender Centre (Australia).

Estimated nondeployable days are a small fraction of available man-years

We estimate about 350 people per year will be nondeployable for some period of time with a total of about 36 deployable man-years lost annually

This represents 0.00021 percent of available deployable man-years at the upper-bound

The total available deployable man-years in the AC alone are about 17 million man-years for an AC of about 1.4 million service members

The Army alone currently has 50,000 nondeployable soldiers

Considerations for deployment

Medical needs may limit deployability in some circumstances (e.g., remote operating environments)

- Hormone treatment requires regular doctor visits (90 days for the first year, then lab tests every 6-12 months)
- Some hormone regimens require refrigeration
- Need to review policies and feasibility for some deployments

Reduced readiness and surgical care for an estimated upper-bound of 5,000 individuals over their time in the military

- Need to assess timing and unit impacts of inability to deploy for these individuals
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Transgender status or gender dysphoria does not automatically make someone nondeployable

Evidence on unit cohesion

No direct evidence, applicable surveys, or systematic information to determine attitudes on transgender individuals among military members

- However, evidence from previous integration efforts (e.g., gays, lesbians, and women) indicates that such integration had minimal impact on unit cohesion and readiness

Limited evidence available:

- Foreign Militaries: no evidence of readiness impacts, some evidence of increased harassment
- U.S. Population: attitudes more negative to transgender than gays and lesbians
 - But attitudes improve with interactions with transgender individuals

Considerations for accessions and retention policies

Accessions

Revise language to match DSM-5 and review conditions related to:

- Mental Fitness: transgender status is not considered a mental disorder. Mental health screening should still be applied but language should match current disorders
- Physical Fitness: Language should clarify physical requirements (vice physical conditions) and clarify when target gender requirements will apply

Retention

Improve guidance and directives to clarify standards for review during and after transition:

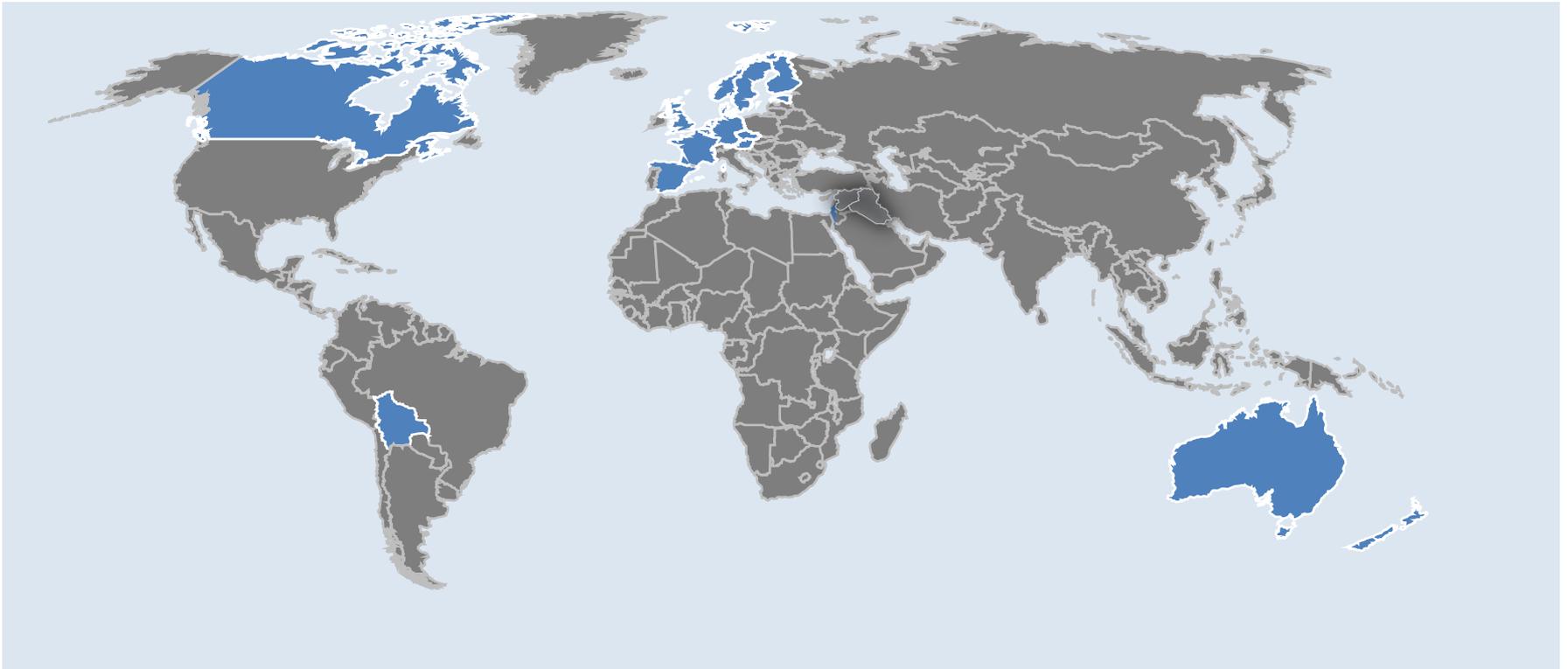
- Review for Separation: Language should be updated and should allow determinations of fitness to serve by medical evaluation board / physical evaluation board (MEB/PEB), in line with other conditions
- Physical Fitness: Standards for fitness may need to be adjusted during and after transition

Briefing outline

- Health care needs and costs
- Potential readiness implications
- Lessons learned from foreign militaries and police/fire departments
- Key takeaways

Approach and caveats

We began with a broad review of 18 countries that allow transgender personnel to serve openly in their militaries



We also examined the public literature on police/fire departments

Approach and caveats

We then narrowed our analysis to four specific countries, focusing on where most in-depth information was available



Per sponsor guidance, we relied on publicly available policies and research

Foreign militaries have flexible policies

Health and readiness implications are addressed on a case-by-case basis; transgender individuals intending to or in the midst of transition are not automatically nondeployable

Policies regarding uniforms, facilities, name changes vary across foreign militaries

In Australia, Canada and UK, uniforms, restrooms, ID cards, and housing shift once individual begins living as target gender

In Israel, needs are typically accommodated but some limitations to these accommodations, particularly in combat units

In all four countries, transgender personnel must meet physical standards of target gender once transition is complete

But foreign militaries have also faced challenges

Harassment and bullying have been a problem in all four countries

Ambiguities in policy documents have placed some transgender individuals in isolating situations (e.g. forced to use remote facilities or housing)

There are ongoing debates over policy (e.g., whether awards and medals should be transferred to the new name)



Findings from police and fire departments

There is no significant literature on the impact of transgender fire fighters or police officers on readiness or cohesion

There is some evidence that transgender police officers and fire fighters still face significant discrimination and harassment

There are no publicly available policies on how police and fire departments deal with physical standards for transgender personnel

None of the policies are clear on the logistics of transition-related absences

Briefing outline

- Health care needs and costs
- Potential readiness implications
- Lessons learned from foreign militaries and police/fire departments
- Key takeaways

Key takeaways

Estimates of currently serving transgender personnel in the total force range from 7,986 to 15,971

Additional healthcare costs are expected to range between \$2.4 million to \$8.4 million

Impacts on nondeployability are expected to be about 36 deployable man-years lost annually, representing 0.00021 percent of available deployable man-years

Commanders will need clear guidance on how to implement new transition-related policies (e.g., uniforms, housing, restrooms, physical standards)

Overall, a change in policy is expected to be manageable



NATIONAL DEFENSE RESEARCH INSTITUTE

Back-up Slides

Medical necessity of Gender Reassignment Treatment (GRT) for Gender Dysphoria

- Uncertainty remains regarding the long term efficacy of GRT, though existing data suggest potentially important short term medical and psychiatric benefits
- Determinations are increasingly toward the medical necessity of GRT:
 - Professional associations in support: American Medical Association, American Psychological Association, American Academy of Family Physicians, National Association of Social Workers, World Professional Association for Transgender Health, and American College of Obstetricians and Gynecologists
 - Centers for Medicare and Medicaid Services bans blanket Medicare exclusion of transition-related medical service reimbursement
 - Insurance carriers participating in the Federal Employees Health Benefits Program (mandated by Office of Personnel Management) reimburse for GRT
 - Blanket transgender coverage exclusions in health insurance are prohibited under non-discrimination laws in California, Colorado, Connecticut, Illinois, Massachusetts, Nevada, New York, Oregon, Vermont, and Washington, as well as Washington, DC

Lessons from foreign militaries

- No evidence of significant effect on readiness or operational effectiveness
 - Based on literature reviews that included summaries of interviews with commanders
 - Some commanders report in interviews that diversity improved readiness
- No evidence of significant effect on cohesion
 - Some reports of harassment or bullying, but no major impact on unit bonding or ability to work as a team

EXHIBIT D TO HEBERT DECLARATION

MEETING MINUTES

ACCESSION MEDICAL STANDARDS WORKING GROUP
 APRIL 7-9, 2015, DEFENSE HEALTH HEADQUARTERS (DHHQ)
 7700 ARLINGTON BLVD, FALLS CHURCH, VA 22042
 DIAL-IN: 800-988-9474 ACCESS CODE: 1013632 HOST CODE: 68659

1. ATTENDEES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION	TELEPHONE	EMAIL
<input checked="" type="checkbox"/>	Dr.	Delaune	Jules	OASD(HA), C&PP	Office: 703-681-5155	jules.m.delaune.civ@mail.mil
<input checked="" type="checkbox"/>	LTC			OSD/MPP/AP		
<input checked="" type="checkbox"/>	Dr.			Army OTSG		
<input checked="" type="checkbox"/>	Mr.			USD		
<input checked="" type="checkbox"/>	CAPT			BUMED		
<input type="checkbox"/>	Col			Marines, Military Policy Branch		
<input checked="" type="checkbox"/>	CAPT			USN		
<input type="checkbox"/>	Lt Col			AF SG		
<input checked="" type="checkbox"/>	MAJ			AMSARA		
<input type="checkbox"/>	Mr.			HQMC		
<input type="checkbox"/>	COL			OSD Reserve Affairs		
<input type="checkbox"/>	COL			Dep NGB Surgeon		
<input checked="" type="checkbox"/>	COL			Army OTSG		
<input type="checkbox"/>	COL			Deputy Army OTSG		
<input type="checkbox"/>	Senior Chief			HQMC-MC Recruiting Command		
<input checked="" type="checkbox"/>	Mr.			Army G-1		
<input type="checkbox"/>	Lt Col			USMEPCOM		
<input checked="" type="checkbox"/>	LTC			USAREC		
<input checked="" type="checkbox"/>	COL			USMEPCOM		
<input type="checkbox"/>	Ms.			AFMSA/SG3P		
<input type="checkbox"/>	Lt Col			USAF AETC		
<input type="checkbox"/>	Mr.			HQMC		
<input checked="" type="checkbox"/>	Lt Col			AF SG		

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	TITLE	LAST NAME	FIRST NAME	ORGANIZATION	TELEPHONE	EMAIL
<input type="checkbox"/>	Ms.			Army G1		
<input checked="" type="checkbox"/>	Dr.			BUMED		
<input checked="" type="checkbox"/>	Mr.			DoDMERB, Deputy Director		
<input checked="" type="checkbox"/>	Col			DoDMERB Director		
<input type="checkbox"/>	COL			US Army Cadet Command		
<input checked="" type="checkbox"/>	COL			OSD Reserve Affairs		
<input checked="" type="checkbox"/>	COL			Army		
<input type="checkbox"/>	CDR			BUMED		
<input checked="" type="checkbox"/>	COL			USAREC		
<input type="checkbox"/>	CAPT			CNRC		
<input checked="" type="checkbox"/>	Ms.			C&PP/Creative Computing Solutions, Inc.		
<input type="checkbox"/>	Ms.			TRADOC		
<input checked="" type="checkbox"/>	CDR			USCG		
<input checked="" type="checkbox"/>	LTC			USA NGB		
<input type="checkbox"/>	CAPT			USCG		
<input type="checkbox"/>	CDR			USCG		
<input checked="" type="checkbox"/>	MAJ			USA, ARNG		
<input type="checkbox"/>	Ms.			NAVPER5		
<input checked="" type="checkbox"/>	Ms.			USMEPCOM		
<input type="checkbox"/>	Dr.			USAREC		

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SERVICE SUBJECT MATTER EXPERTS						
	TITLE	LAST NAME	FIRST NAME	ORGANIZATION	TELEPHONE	EMAIL
<input type="checkbox"/>				USA SG		
<input checked="" type="checkbox"/>	LTC			USA, Behavioral Health		
<input checked="" type="checkbox"/>	LTC			USA, Psych		
<input checked="" type="checkbox"/>	LTC			USN, Nephrology		
<input checked="" type="checkbox"/>	CAPT			BUMED, Specialty Leader Urology		
<input checked="" type="checkbox"/>	CAPT			OASD (HA)		
<input checked="" type="checkbox"/>	LtCol			USAF, Endocrinology		
<input checked="" type="checkbox"/>	COL			USA		
<input checked="" type="checkbox"/>	COL			USA, Chief of Urology, WRNMMC		
<input checked="" type="checkbox"/>	CAPT			USN, Naval Center for Combat & Operational Stress Control		
<input checked="" type="checkbox"/>	Dr.			OASD (HA)		
<input checked="" type="checkbox"/>	Dr.			USN		
<input checked="" type="checkbox"/>	Lt Col			AF, Neurology		
<input checked="" type="checkbox"/>	Lt Col			AFMOA, Psychiatry		
<input checked="" type="checkbox"/>	COL			USA		
<input checked="" type="checkbox"/>	COL			USA, CID		
<input checked="" type="checkbox"/>	CAPT			USN, Psychiatry Specialty Leader		
<input checked="" type="checkbox"/>				R2D		
<input checked="" type="checkbox"/>	LCDR			USN, Nephrology		
<input checked="" type="checkbox"/>				ASTHA		
<input checked="" type="checkbox"/>	Lt Col			959 th Medical Operation, Urology		
<input checked="" type="checkbox"/>	Ms.			USN		
<input checked="" type="checkbox"/>	CAPT			BUMED TBI SME/neurologist		
<input checked="" type="checkbox"/>	CAPT			USN, Neurosurgery Specialty Leader		

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2. ADMINISTRATIVE BUSINESS

a. Opening Remarks: Dr. Jules Delaune welcomed participants to the meeting, noting the meeting will be recorded; recordings will be made available to the group. High level minutes will also be generated. He cited the need to tighten up the DoD Instruction 6130.13(DoDI) itself in addition to its enclosure, however, evidence to support these changes will be essential. He also requested Service representatives provide him with specialty leaders who could be available for focused group meetings in advance of the Accession Medical Standards Working Group (AMSWG) meeting in June. Proposed standards should be evidence based and Service representatives should ensure that their comments represent the consensus of Service subject matter experts (SMEs). However, dissenting opinions are welcome.

Dr. Delaune reviewed the purpose of the DoDI, emphasizing that the group should focus on the first obligated period of service. MAJ ██████ noted this specific period is not written in the DoDI. Dr. Delaune also highlighted a graph of the detection of sound by hearing ability from a 1989 Price et al study which showed clear distinctions between the detection abilities of multiple hearing profiles, stating similarly explicit evidence should be used throughout the medical standards. Membership of the work group was reviewed.

COL ██████ noted the meeting is targeted to medical personnel and not policy personnel. Dr. Delaune agreed and explained that once these medical recommendations are made, the proposed standards will be forwarded to the Medical and Personnel Executive Steering Committee for further consideration.

3. DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS FIFTH EDITION AND MALE/FEMALE GENITALIA

Discussion: Dr. Delaune stated that the discussion of the fifth edition of the Diagnostic and Statistical Manual, (DSM5) should encompass more than just the issue of alcohol disorders and gender dysphoria. CAPT ██████ responded that such discussion would require a significant amount of time and an extensive review. Lt Col ██████ noted that DSM5 changes were made for a number of reasons ranging from formatting to political considerations and suggested a comparison matrix between the two most recent editions should not be attempted. COL ██████ added that there is also a lot of discrepancy in terms of naming but emphasized that the DSM5 is used for diagnosis. Dr. Delaune highlighted the related issue of waivers, stating the document is meant to set standards but these standards are often waived. CAPT ██████ agreed that this was an important conversation, but cited the current use of the DoDI as a screening exam, describing that the document would need to be much more detailed if it were to be used as an absolute standard. Mr. ██████ stated the DoDI authorizes individuals to access into the military via waivers if they are capable of performing the mission; this ability is what the group needs to review, clarifying when standards are evidenced based. Lt Col ██████ agreed, citing the complex and changing needs of the military. COL ██████ seconded, stating the Army prefers that the standard be stated as the minimum entrance

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criteria and waivers be given if necessary, emphasizing the importance of setting high standards. Mr. [REDACTED] cited the lengthy exercise of changing the standards, reiterating the need for timely flexibility in accessions as the needs of the Services change. CAPT [REDACTED] and COL [REDACTED] discussed that the Army and the Navy waiver similar amounts of accessions despite their difference in size, emphasizing that each Service uses the document slightly differently, according to their needs.

a. Alcohol Dependence/Abuse Definitions**Current Standard:**

s. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305.0), or other drug abuse (305.2 thru 305.9).

Recommended Standard:

s. Current or history of alcohol use disorder.

Rationale/Reference and Discussion: Dr. [REDACTED] described the 11 different elements used by the DSM5 to describe alcohol use disorders. Col [REDACTED] noted that the differences between the two most recent editions of the DSM were predominantly in nomenclature, not in diagnoses. COL [REDACTED] stated that the DSM elements were good because the real concern regarding alcohol use is a latent tendency that could manifest during training. LTC [REDACTED] Brown questioned the severity of alcohol use disorders described in the standard, explaining that a mild disorder would only require meeting 2-3 of the 11 parameters. Lt Col [REDACTED] asked if a history of alcohol use disorder would also be an issue, noting that an individual could have received treatment and no longer have a problem with alcohol. COL [REDACTED] stated that including a history would allow the Service to follow up with consultation to ensure that alcohol was no longer an issue. It was discussed that while some individuals may have had a onetime issue with alcohol, this may not translate to a diagnosis of an alcohol use disorder. Dr. [REDACTED] noted that alcohol is often associated with a number of other issues such as traffic accidents and sexual assaults. COL [REDACTED] stated that the U.S. Military Entrance Processing Command (MEPCOM) does not have any issue applying the current standard. Mr. [REDACTED] noted that the changes proposed by the group simply update the language in the standard to the DSM5 language. COL [REDACTED] cited the only criteria not included in the DSM5 language is the involvement with the law described in DSM4. CAPT [REDACTED] stated that legal consequences would be an issue for personnel and not medical standards. LTC [REDACTED] questioned the availability of data on alcohol related waivers. MAJ [REDACTED] explained that waivers would not necessarily link to alcohol use disorders and that the data currently gathered on waivers and attrition look at the first 6-12 months of service, as that is when the majority of immediate attrition takes place; alcohol related attrition may not take place until later, after leaving the strict training environment. Mr. [REDACTED] noted AMSWG could request that relevant data be collected regarding alcohol related attrition. Dr. [REDACTED] agreed he would pursue such data collection.

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b. Gender Dysphoria**Current Standard:**

r. Current or history of psychosexual conditions (302), including but not limited to transsexualism, exhibitionism, transvestitism, voyeurism, and other paraphilias.

Recommended Standard:

- r. Current or history of paraphilic disorder.
- s. Current or history of gender dysphoria (unless
 - (1) Stable without psychotropic medications or mental health treatment for 36 months.
 - (2) Outpatient mental healthcare for the resolution of gender dysphoria not required for greater than 24 cumulative months. If therapy is more supportive in nature (e.g. through the transition process) the same provision would not apply.
 - (3) Did not require inpatient mental health treatment in hospital or residential facility)

Rationale/Reference and Discussion: Dr. [REDACTED] described that gender dysphoria is a psychological condition resulting from gender identity questions; the questioning itself is not a diagnosis. COL [REDACTED] suggested that the language included in the standard should be updated to reflect DSM5 language. Dr. [REDACTED] clarified that this section of DSM5 was updated but also removed transsexualism and created a separate section on gender dysphoria. COL [REDACTED] added that the DSM5 makes the individual disorders more clear and includes concepts of risk, to get to the question of potential harm to oneself or others.

Dr. [REDACTED] described that DSM5 identifies the three terms of gender assignment, identity, and dysphoria. CAPT [REDACTED] questioned the need and support for holding gender dysphoria to a higher standard than other mental health conditions. CAPT [REDACTED] noted gender dysphoria is not a disorder in itself, but merely identifies those individuals who may present clinical distress over their gender identity. CAPT [REDACTED] suggested the condition should be disqualifying unless an individual met certain criteria such as being stable without mental health treatment for 24 months or no outpatient care for more than 36 months. These qualifiers would be consistent with depressive disorders. Dr. [REDACTED] questioned the possibility of disqualifying current or history of gender dysphoria, noting the possibility of someone who had a history of gender dysphoria but who had resolved their distress. COL [REDACTED] responded that at that point the individual would be evaluated by the waiver authority, to consider the needs and comfort level of the individual, and the Services can ultimately decide if the individual should be accessed. CAPT [REDACTED] noted that the position of the Navy Surgeon General is that the expertise to understand gender dysphoria and allow a more fair evaluation would only exist at the waiver level. Dr. [REDACTED] reminded the group that not all individuals go through gender reassignment surgery. CAPT [REDACTED] suggested adding statements to identify and allow those individuals who are stable and past gender dysphoria to qualify, suggesting that the SMEs identify characteristics of active vs. resolved issues. LTC [REDACTED] stated this was a logical step, though not evidence-based.

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COL [REDACTED] stated that while not a diagnosis, gender dysphoria still has huge implications on the social wellbeing of an individual, questioning the implications on being able to service. CAPT [REDACTED] highlighted that there is no normal pathway for transgendered individuals; some may experience dysphoria but never transition. CAPT [REDACTED] suggested that since there was no one path and no data to rely on then they should allow a case by case examination of these individuals in a waiver process. Lt Col [REDACTED] added that these individuals, if they began treatment around age 16, could still be in the process of transitioning and may require follow up for hormone treatment every two to three months. MAJ [REDACTED] noted the complexity of the issue, asking if chief medical officers (CMOs) would be able to make decisions regarding accessions and if a higher level review would allow for a clearer decision. Dr. [REDACTED] stated that as written the standard would still unequivocally disqualify these individuals. COL [REDACTED] summarized that there are significant comorbidities that go along with sexual reassignment surgeries. Lt Col [REDACTED] agreed, stating the issue overlapped with mental health, surgical concerns and endocrinology. She described that if a gender dysmorphic individual had to stop taking their hormone medication, there may be a mental health impact if the absence of hormones made them revert back. Lt Col [REDACTED] echoed this concern, citing that the Air Force medical system is not well equipped to take care of these individuals.

MAJ [REDACTED] cited that from the data side, without clinical coding, the Accession Medical Standards Analysis and Research Activity office (AMSARA) would not have any data regarding gender dysphoria and that without disqualifying and waiver information they will not be able to follow those individuals.

The group discussed hormone treatment, as it is typically standard to be diagnosed as dysphoric in order to receive hormone treatment. However, some individuals may take hormones without a proper diagnosis. Hormone therapy related to low testosterone and to thyroid conditions will also need to be considered in writing a standard. The group suggested addressing hormone therapy in the endocrine section of the standards. COL [REDACTED] noted that the real issue is the underlying condition and not the specific medication. It will also be important to specifically address the condition itself so that changes in medication do not affect the standard.

CAPT [REDACTED] stated that foreign literature has indicated that transitioned individuals have been stable. Dr. [REDACTED] suggested the group may need to revise the DoDI to clarify the use of the document as a screening tool. CAPT [REDACTED] cited that less than one percent of mental health waivers are successful. Ms. [REDACTED] suggested that it would be helpful if the DoDI had a glossary, as waiver is not currently defined in the document. This would allow additional clarification of the issue, as not everyone understands these nuances. CAPT [REDACTED] expressed his hope that the same standards and evaluating criteria are applied to other mental health conditions. Mr. [REDACTED] noted the SMEs would be able to inform the waiver authorities what they need to focus on.

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c. Male and Female Genitalia and other DSM5 Implications

Rationale/Reference and Discussion: Dr. [REDACTED] stated that the group will discuss the genitourinary and gynecology sections as they apply to transgender, non-dysphoric individuals. The standards themselves will be reviewed later on during the meeting.

Regarding the standard on primary amenorrhea, Col [REDACTED] posited that gender reassignment surgery would result in primary amenorrhea in a male to female transition, suggesting that the standard reference unexplained amenorrhea. COL [REDACTED] stated primary amenorrhea should not apply for male to female transitions and questioned how to apply these general standards in the view of transgendered individuals. Dr. [REDACTED] noted that the standard is ambiguous as it is currently stated. The group discussed that it was in the best interest of the individual to provide information regarding their physical status so that they can be provided appropriate care. Dr. [REDACTED] cited that several standards have limited use as stated and potentially could be interpreted as cover for not taking individuals who have undergone reassignment surgeries. CAPT [REDACTED] responded that the reference to transsexual individuals was removed and from a medical perspective transgendered individuals would be able to meet the current standards.

Dr. [REDACTED] stated that Health Affairs is taking a purely medical view of the issue, caveated by security and operational issues, that gender dysphoria needs to be rectified; if someone is actively transitioning in order to treat the dysphoria, the transition needs to be completed before the individual can deploy. If someone is undergoing a male to female transition, the argument would be that the individual could be medically managed, with a relatively short recovery period and a low chance of long term complications. Mr. [REDACTED] described the alternative perspective, that individuals should not be accessed in order to complete this transition. LTC [REDACTED] stated his concern regarding the ability to provide medical care, noting that individuals may be widely dispersed geographically. COL [REDACTED] noted that when requiring treatment in a remote area, the buddy of the individual will also be unable to be in the field, removing two individuals from the field. Col [REDACTED] explained there is a difference between accession and retention; accessing an individual with an existing issue is a "no go" while an individual that had already been accessed becomes a retention issue for a medical evaluation board. LTC [REDACTED] summarized that if an individual has a mental health disorder then they will not be accessed. If someone is actively transitioning, then the individual should be disqualified, to check if the individual is capable to meeting the mission of the Service.

COL [REDACTED] explained that the surgical implications of gender reassignment may have long lasting medical implications and suggested that these individuals should be examined more closely. While there might not be any issue with them physically, it would be important for the Service to be aware of their history. This would push the review process to a higher level, with additional documentation and potential medical consults. Dr. [REDACTED] responded that certain female to male surgeries are not complex and have been done through outpatient care. COL [REDACTED] then questioned if someone at a U.S. Military Entrance Processing station (MEPs) would be able to discern if someone would be fine or if additional review was necessary, citing

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that many conditions are disqualifying and the Services can ultimately decide to take the individuals regardless of the condition. COL [REDACTED] agreed that decisions regarding conditions impacting the ability to deploy and conduct the mission should be evaluated in a rational manner. Dr. [REDACTED] questioned the term “sex change,” asking if there was a more appropriate term to use. The group discussed that a change of sex would also entail hormonal changes. Dr. [REDACTED] and Lt Col [REDACTED] described studies of sexual reassignment surgeries, citing a 50 percent increase in mortality, a 19 fold increase in suicide and a 2.8 increase in psychiatric hospitalization, adding that 88 percent of those who receive hormone treatment proceed to reassignment surgery. Dr. [REDACTED] opined that this rate could change if the procedure were to be covered by insurance. COL [REDACTED] noted the wide range of potential impacts, suggesting that it may be appropriate to use the waiver process for this issue.

CAPT [REDACTED] suggested that the amputation of the penis remain a disqualifier as it could be amputated for other medical reasons. COL [REDACTED] proposed that the standards include mastectomies as well as facial reconstructive surgeries to appear more gender appropriate. COL [REDACTED] suggested any major surgery should be further examined. COL [REDACTED] noted that MEPCOM runs into breast augmentation and reductions and that the standard used by CMOs is that it has been more than six months since the surgery and an absence of any functional impairment. Dr. [REDACTED] noted the possibility of a prophylactic mastectomy. Dr. [REDACTED] responded that the issue of genetics will be addressed at a later point with the Office of General Counsel. Col [REDACTED] added that mastectomy is covered elsewhere under other topics. COL [REDACTED] stated he would argue that facial reconstructive surgery does not warrant inclusion because the reasons behind the surgery and the residual impact on military duty are what are important.

Action/POC:

1. Pursue AMSARA data collection regarding alcohol related attrition [REDACTED]
2. Add a hormone therapy section to the endocrine section/[REDACTED]
3. Update terminology regarding gender reassignment and “sex change”/[REDACTED]

4. GENITOURINARY SYSTEM REVIEW

Opening Discussion: COL [REDACTED] noted that the use of a “first contract period” sounds vague and suggested that the group specifically use the first eight years as a reference, citing the standard that if a condition arises during the first eight years of service, it is considered to have occurred while serving, even if the condition was known before entering. MAJ [REDACTED] stated he had the reference for that standard and would send it to the group. COL [REDACTED] questioned the average length of service, suggesting it was close to four years. Dr. [REDACTED] agreed to the eight year term, explaining that a lot of scholarships are for four years of schooling and five of obligated service. COL [REDACTED] stated that the Army looks to the ability for an individual to serve beyond the first term of service, asking the impact on a full 20 year career. Dr. [REDACTED] expressed his concern that the standards are being used differently by the different Services and his hope to make the document and its use more transparent. The group discussed the changing needs of the Services and the importance of not limiting the flexibility of the document.

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Mr. [REDACTED] asked the Service SMEs how far in advance they prepared for the meeting, emphasizing the importance of coming to the meeting prepared and with a perspective that has been vetted through their specialty consultants. SMEs had a range of responses, across the Services.

a. Urinary System

Current Standard:

16. a. Current or history of chronic/recurrent cystitis (595), interstitial cystitis, or painful bladder syndrome.

b. Current urethritis, or history of chronic or recurrent urethritis (597.80).

c. History or treatment of the following voiding symptoms within the previous 12 months:

(4) Urinary frequency or urgency more than every 2 hours on a daily basis.

(5) Nocturia more than two episodes during sleep period.

(6) Enuresis (788.30).

(7) Incontinence of urine, such as urge or stress.

(8) Urinary retention.

(9) Dysuria.

d. History of need for urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

e. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.

f. Current or history of abnormal urinary findings:

(1) Gross hematuria (599.7).

(2) Microscopic hematuria (3 or more red blood cells per high-powered field on 2 of 3 properly collected urinalyses).

(3) Pyuria (6 or more white blood cells per high-powered field in 2 or 3 properly collected urinalyses).

g. Current or recurrent urethral or ureteral stricture (598) or fistula (599.1) involving the urinary tract.

h. Conditions associated with the kidneys, including:

(1) Current absence of one kidney, congenital (753.0) or acquired (V45.73) (CPT 50220-50236).

(2) Asymmetry in size or function of kidneys.

(3) History of renal transplant.

(4) Current chronic or recurrent pyelonephritis (590.0) or any other unspecified infections of the kidney (590.9).

(5) Current or history of polycystic kidney (753.1).

(6) Current or history of horseshoe kidney (753.3).

(7) Current or history of hydronephrosis (591).

(8) Current or history of acute (580) nephritis or chronic (582) kidney disease of any type.

(9) History of acute kidney injury requiring dialysis.

(10) Current or history of proteinuria (791.0) with a protein-to-creatinine ratio greater

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than 0.2 in a random urine sample more than 48 hours after strenuous activity. Benign orthostatic proteinuria MEETS the standard.

(11) Current or history of symptomatic urolithiasis (592) within the preceding 12 months.

(12) History of stone(s) greater than 4mm in size, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.

(13) History of urolithiasis requiring surgical treatment or intervention requiring hospitalization.

Recommended Standard:

16. a. Current or history of interstitial cystitis, or painful bladder syndrome.

b. Lower urinary tract infection (cystitis)

For Males: Any cystitis unless it was related to an indwelling catheter during a hospitalization

For Females: Current cystitis or Recurrent cystitis of greater than two episodes per year, or requiring daily suppressive antibiotics, or non responsive to antibiotics for 10 days.

c. Current urethritis.

d. History or treatment of the following voiding symptoms within the previous 12 months:

(10) Urinary frequency or urgency more than every 2 hours on a daily basis.

(11) Nocturia more than two episodes during sleep period.

(12) Nocturnal Enuresis (788.30).

(13) Incontinence of urine, such as urge or stress.

(14) Urinary retention.

(15) Dysuria.

d. History of neurogenic bladder or other functional disorder of the bladder necessitating urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

e. Current or recurrent urethral or ureteral stricture (598) or fistula (599.1) involving the urinary tract.

f. Current or history of abnormal urinary findings in the absence of urinary tract infection:

(1) Gross hematuria (599.7).

(2) Persistent microscopic hematuria (3 or more red blood cells per high-powered field on 2 of 3 properly collected urinalyses).

(3) Pyuria (6 or more white blood cells per high-powered field in 2 or 3 properly collected urinalyses).

g. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.

h. Conditions associated with the kidneys, including:

(1) Current absence of one kidney, congenital (753.0) or acquired (V45.73) (CPT 50220-50236).

(2) Asymmetry in size or function of kidneys.

(3) History of renal transplant.

(4) Current chronic or recurrent pyelonephritis (590.0) or any other unspecified infections of the kidney (590.9).

(5) Current or history of polycystic kidney (753.1).

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(6) Current or history of horseshoe kidney (753.3).

(7) Current or history of hydronephrosis (591) on most recent imaging not related to pregnancy.

(8) Current or history of acute (580) nephritis or chronic (582) kidney disease of any type as evidenced by three month or more duration of any of the following: estimated GFR of less than 60cc per minute per 1.73 m2 BSA or abnormal renal imaging, casturia or abnormal renal biopsy.

(9) History of acute kidney injury requiring dialysis.

(10) Current or history of proteinuria (791.0) with a protein-to-creatinine ratio greater than 0.2 in a random urine sample more than 48 hours after strenuous activity, excluding benign orthostatic proteinuria.

(11) Current or multiple urolithiasis 3mm or greater

(12) History of symptomatic urolithiasis (592) within the preceding 12 months.

(13) History of nephrocalcinosis, bilateral renal calculi, or recurrent urolithiasis at any time.

(14) History of urolithiasis requiring a procedure.

Rationale/Reference and Discussion: COL ██████ stated that supplemental guidance will be necessary to define terms like current and chronic. Mr. ██████ questioned that level of specificity, suggesting that doctors be able to apply the standard as written. Typically urinary tract infections (UTIs) are treated episodically with antibiotics. LTC ██████ noted that it is important to capture those who get recurring pyelonephritis due to anatomic or other reasons and not those who may get UTIs which resolve with treatment. He added that chronic suppressive antibiotics would capture these recurring cases while anatomic conditions are addressed in other sections. COL ██████ noted that the standard on cystitis is currently working fine from his perspective. LTC ██████ requested the standards be specific on what is allowed and what is not. LTC ██████ noted that these issues may be more pronounced in female Service members as there is less field access to facilities. CAPT ██████ suggested that the cystitis standard specify interstitial cystitis in order to be gender neutral, noting that the condition in a male does warrant a review. She stated that the inclusion of antibiotics in the standard would indicate a chronic condition, adding that infections would only increase in the military environment. The group discussed the length of time necessary for a gonorrhea infection to resolve. Dr. ██████ stated he would take the issue of lower UTIs offline to discuss if a different categorization of UTIs was necessary. Mr. ██████ questioned the need to include additional guidance given the revised standard; COL ██████ responded that the standard was clear as written and no additional clarification was necessary.

COL ██████ noted that the supplemental guidance for urethritis was important, stating it will be important to make sure that the condition occurred in unique episodes, with clearing in between and that the supplemental guidance captures the time frame of the last 12 months. COL ██████ stated that urethritis is almost always secondary to another condition, typically a sexually transmitted infection (STI). Dr. ██████ noted that this is not the appropriate framework to address all STIs. CAPT ██████ suggested cutting the standard off at current

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urethritis, assuming that the condition only occurs with an STI. The Services concurred with this edit.

Dr. [REDACTED] questioned the age at which it is considered abnormal to have nocturnal enuresis. CAPT [REDACTED] responded the incidence is about 1 percent in 18 year olds; the stress of service might cause it to reoccur, though there is little data on that recurrence. COL [REDACTED] added that the incidence at 13 is less than 5 percent. Mr. [REDACTED] stated that enuresis cannot be included in one section with one standard and then in another with a different standard; any mentions of enuresis should be consistent. Dr. [REDACTED] responded that the group will need to review the psychological standards to ensure that they are consistent. CAPT [REDACTED] requested the standard specify if the enuresis was nocturnal or not, adding that the age and time limiting factors are also important. At age 15 it would warrant further evaluation but if someone were 20 and the condition had been resolved for 2 years, then that should be fine. Dr. [REDACTED] suggested using a 12 months as a time period, with the caveat that incontinence depends on the situation such as holding urine while in traffic. CAPT [REDACTED] agreed, noting that incontinence as a persistent daily occurrence is a different situation. The group agreed to qualify the standard by adding "nocturnal." COL [REDACTED] noted that the CMOs did not need any changes to this particular standard. Regarding the standard on urinary catheterization, CAPT [REDACTED] suggested specifying "history of neurogenic bladder or other functional disorder of the bladder necessitating urinary catheterization." The group agreed to this change.

Dr. [REDACTED] stated that she sees the standard on bladder augmentation as a frequent disqualifier and believes it is being applied appropriately. COL [REDACTED] stated that at this point, these individuals are being referred to urology for further examination and approval of a waiver based on current renal function. COL [REDACTED] noted that MEPs cannot perform these tests, pushing for a higher level of approval. The group agreed not to change the standard. Regarding the history of abnormal urinary findings, the group discussed that gross hematuria is often mentioned during a self-reported history. Mr. [REDACTED] stated that Department of Defense Medical Examination Review Board (DODMERB) has a dispensation from Health Affairs to not do screening for hematuria, promising to send the relevant literature support for that dispensation. LTC [REDACTED] stated that often, people with this diagnosis are not investigated, so that the diagnosis is used as a nonspecific catch-all. He recommended keeping the standard as is and added that with microscopic hematuria, there is no cut point where there is no risk. COL [REDACTED] questioned if microscopic hematuria was too broad. LTC [REDACTED] responded it was not too broad, but recommended adding the term persistent to the standard. Dr. [REDACTED] noted that they often see individuals with a history of hematuria with no further evaluation because it was deemed to be benign. LTC [REDACTED] explained that kidney disease has few symptoms, so that urine samples are examined to look for irregularities. MAJ [REDACTED] noted that a lot of the ICD9 codes are self-reported, not clinical diagnoses. Mr. [REDACTED] agreed, stating that the codes are used for data collection purposes. Col [REDACTED] questioned the need for urinalysis for these individuals, citing that they often end up having to track down the individuals for samples. COL [REDACTED] responded that the urinalysis tests were a low expense and not difficult to do and gives them the opportunity to work up any concerns further if applicants come in with no records or history. The group agreed to include "in the absence of UTI" in item F. The group also agreed to not

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change item G, with CAPT ██████ explaining that the more strictures are present, the worse the prognosis will be.

COL ██████ questioned the standard regarding the absence of a kidney, stating that if individuals have adequate function, they should be able to get a waiver. Dr. ██████ responded, asking if the condition would be made worse by military service. CAPT ██████ added that she was aware of a study that found 50 percent of patients that had congenital absence needed dialysis by age 30. It was noted that there is no good evidence based to quantify asymmetry. Regarding horseshoe kidney, Dr. ██████ noted that the condition can be associated with obstructions. COL ██████ added that it is important to clarify if the horseshoe is a fibrous bridge or not. CAPT ██████ stated that in her experience, hydronephrosis typically spontaneously resolves, suggesting that the standard specify a current condition on last imaging. It was added that hydronephrosis could be noted during a pregnancy as a result of increased screening.

LTC ██████ added a description to item 8 in order to include standard guidance to cover the spectrum of nephritis or chronic kidney disease, noting that the language had been in place since 2002. Mr. ██████ suggested revising the standard to specify what does not meet the standard. COL ██████ noted that proteinuria often results from an individual being dehydrated from trying to make weight standards. It was discussed that the screening is meant to look for kidney disease and that individuals with extra protein in their urine may still be able to serve, by qualifying with a consult or examining the medical history. Regarding urolithiasis, CAPT ██████ suggested clarifying a size parameter of 3mm or larger, as 3mm or smaller could be incidental discoveries. Larger stones would also not be passed and would require surgical intervention. It was noted that measuring stones was problematic and included margins of error. CAPT ██████ added that those who have stones and do not have surgical interventions for them can be at a higher risk, though the surgery itself does have an associated risk. It was also discussed that if someone had recently passed a stone, they may be metabolically at risk of additional stones. As such, the group agreed to add “recurrent urolithiasis” to item 12. The group discussed a history of urolithiasis, as some may not consider surgery as an intervention, agreeing to rephrase the standard to use the word procedure instead.

b. Female Genitalia**Current Standard:**

14. a. Current or history of abnormal menstruation unresponsive to medical management within the last 12 months, including but not limited to menorrhagia, metrorrhagia, or polymenorrhea.
 - b. Primary amenorrhea (626.0).
 - c. Current unexplained secondary amenorrhea (626.0).
 - d. Current dysmenorrhea (625.3) that is unresponsive to medical therapy and is incapacitating to a degree recurrently requiring absences of more than a few hours from routine activities.
 - e. Endometriosis (617) that is unresponsive to medical therapy.

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- f. History of major abnormalities or defects of the genitalia including but not limited to change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).
- g. Persistent or clinically significant ovarian cyst(s) (620.2).
- h. Polycystic ovarian syndrome (256.4) with metabolic complications.
- i. Pelvic inflammatory disease (614) within the preceding 30 days.
- j. Chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9).
- k. Pregnancy (V22), through 6 months after the completion of the pregnancy (
- l. Symptomatic uterine enlargement due to any cause (621.2).
- m. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.11) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. Herpes does not meet the standard if:
- (1) Current lesions are present.
 - (2) Chronic suppressive therapy is needed.
 - (3) There are three or more outbreaks per year.
 - (4) Any outbreak in the past 12 months interfered with normal function.
 - (5) Treatment included hospitalization or intravenous therapy.
- n. Abnormal gynecologic cytology within the preceding 2 years, including but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix (795.0), excluding atypical squamous cells of undetermined significance without human papillomavirus (079.4) and confirmed low-grade squamous intraepithelial lesion (622.9). For the purposes of this Instruction, confirmation is by colposcopy or repeat cytology.

Recommended Standard:

14. a. Unexplained abnormal uterine bleeding (period greater than 7 days, or more frequent than 21 days or greater than 35 days, or soaking more than one pad per hour for several hours) within the last 12 months.
- b. Primary amenorrhea (626.0).
- c. Current unexplained secondary amenorrhea (626.0).
- d. Dysmenorrhea (625.3) which is limiting to a degree resulting in recurrent absences or activity modification within the last 6 months.
- e. History of symptomatic endometriosis (617).
- f. History of major abnormalities or defects of the genitalia including but not limited to sex reassignment, genital reconstruction, or disorders of sexual development (to include hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis) (752.7).
- g. Current ovarian cyst(s) greater than 5 cm.
- h. Polycystic ovarian syndrome (256.4) with metabolic syndrome as specified NHLBI and AHA Guidelines.
- i. Pelvic inflammatory disease (614) within the preceding 6 months.
- j. History of chronic pelvic pain (6 months or longer) within the last 24 months.
- k. Pregnancy (V22), through 6 months after the completion of the pregnancy (

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l. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.11) or condyloma accuminatum (078.11), if sufficient severity to require frequent intervention or to interfere with normal function. Herpes does not meet the standard if:

- (1) Current lesions are present.
- (2) Use of chronic suppressive therapy is needed.
- (3) There are three or more outbreaks per year.
- (4) Any outbreak in the past 12 months interfered with normal function.
- (5) After the initial outbreak, treatment included hospitalization or intravenous

therapy.

m. History of abnormal cervical, vaginal, or vulvar cytology or pathology to include ASC-H, LSIL-H, HSIL, CIN 2 or 3, VAIN 2 or 3, VIN 2 or 3 without demonstrated resolution in accordance with ASCCP guidelines.

n. History of abnormal endometrial pathology to include simple or complex hyperplasia with or without atypia without demonstrated resolution in within the last 2 years.

Rationale/Reference and Discussion: Dr. ██████████ stated that item A was too focused on causes and suggested that the standard be revised to focus on the unevaluated etiology for abnormal bleeding with a more generic statement. COL ██████████ agreed, adding that unevaluated was a more appropriate term than abnormal. The group discussed the long term risk of abnormal menstruation, citing that it is often the method through which blood conditions appear. Dr. ██████████ also suggested using a time period of more frequent than 21 days, noting that this condition is often how polycystic ovary syndrome is diagnosed. The group discussed the term unexplained, noting that a specific diagnosis could be cited as the explanation. COL ██████████ noted that once it is explained, unless the condition falls out from other reason elsewhere in the standards then the individual should be fine. COL ██████████ questioned the time period of 21-35 days, asking if there was a greater risk associated with that specific time period. Dr. ██████████ clarified that some individuals may go without menstruation for a while and then have a large period, noting that is typically how polycystic ovary syndrome manifests. The phrase “soaking more than one pad per hour for several hours” was included to quantify volume, beyond simply spotting. ██████████ clarified that abnormal uterine bleeding an actual diagnosis.

COL ██████████ suggested removing the reference to hours in item D and suggested that the standard be clarified to include limiting requiring recurrent absences of activity modification. Lt Col ██████████ suggested a time period of 6 months. COL ██████████ recommended language specifying recurrent absences or activity modification in lieu of absences from routine activity. Regarding endometriosis, Dr. ██████████ suggested that any history of the condition should be disqualifying as the condition and accompanying chronic pain could return. ██████████ stated the individual needs to have been stable for at least two years. COL ██████████ recommended specifying the condition as symptomatic, as the condition may not be fully diagnosed.

Regarding major abnormalities or defects of the genitalia, Dr. ██████████ questioned female circumcision. Dr. ██████████ stated that depending on the level of injury, such individuals would likely have issues voiding urine and be prone to infections. The group noted any major abnormalities or reconstruction should be disqualifying, as an overarching rule. Regarding

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ovarian cysts, the group noted it is important to consider complexity and symptoms, as some cysts may resolve on their own. COL ██████ noted that an asymptomatic and persistent cyst would not pose a significant risk, though all current cysts should be evaluated. Polycystic ovarian syndrome was noted to have metabolic complications. Col ██████ stated that noting these complications would be helpful. COL ██████ however, highlighted that guidance regarding the syndrome could change. A reference to the guidance was added in the event that guidance is updated. Dr. ██████ also suggested adding six months to standard I, though it was noted the time period was arbitrary.

Dr. ██████ noted that individuals with chronic pelvic pain should be pain free for two years, describing that individuals would likely be intermittent. COL ██████ suggested removing the term “unspecified symptoms.” The group discussed the standard related to pregnancy, citing that a woman would not be able to deploy for 6 months and is eligible to move this time period up to 12 months if breastfeeding, promoting bonding with the child. Dr. ██████ noted this outcome was specific to a live birth and that individuals with other outcomes could receive waivers. The group discussed symptomatic uterine enlargement, noting that the any issues stemming from the condition would likely be caught by other standards. COL ██████ suggested the standard was redundant and the group agreed to remove the standard.

Dr. ██████ suggested adding a qualifier for item L to account for the herpes initial outbreak, as it may require more treatment than recurring infections. Col ██████ noted that additional hospitalizations would speak to the severity of the infection. Regarding abnormal gynecologic cytology, Dr. ██████ noted that the two year time period should be changed to three due to changes in the medical standards. The group discussed the specific types of abnormal cells, agreeing that these types should be listed in the standard. The guidelines associated with this condition were included in the vent that the guidelines are updated in the future. The group added a new standard to address those individuals whose conditions are resolved. Dr. ██████ questioned the need for a standard related to BRCA-1 genes. Dr. ██████ responded that that was viewed as an ethics issue and will not be included in the medical standards.

c. Male Genitalia**Current Standard:**

15. a. Absence of one or both testicles, congenital (752.89) or undescended (752.51).
- b. Current or history of epispadias (752.62).
- c. Current or history of surgery for proximal hypospadias (752.61).
- d. Distal (coronal) hypospadias without history of surgery DOES meet the standard.
- e. Distal (coronal) hypospadias treated with surgery when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction.
- f. Current enlargement or mass of testicle, epididymis (608.9), or spermatic cord.
- g. Current or history of recurrent orchitis or epididymitis (604.90).
- h. History of penis amputation (878.0) (CPT 54125, 54130-54135).
- i. Current penile curvature if associated with pain.

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j. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.13) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. Herpes does not meet the standard if:

- (1) Current lesions are present.
- (2) Use of chronic suppressive therapy is needed.
- (3) There are three or more outbreaks per year.
- (4) Any outbreak in the past 12 months interfered with normal function.
- (5) Treatment included hospitalization or intravenous therapy.

k. Current or history of urethral condyloma acuminatum.

l. Current acute prostatitis (601.0), chronic prostatitis (601.1), or chronic pelvic pain syndrome.

m. Current hydrocele (603) spermatocele associated with pain or which precludes a complete exam of the scrotal contents.

n. Left varicocele (456.4), if painful or symptomatic, or associated with testicular atrophy, or varicocele larger than the testis.

o. Left varicocele (456.4) that does not reduce or decompress completely when supine.

p. Bilateral or right varicocele (456.4).

q. Current or history of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs (608.9).

r. History of major abnormalities or defects of the genitalia such as change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).

Recommended Standard:

15. a. Absence of both testicles. Current undescended testicle or congenital absence of one testicle not verified by surgical exploration.

b. Current epispadias or hypospadias or history of corrected hypospadias or epispadias with any of the following:

- (1) 12 months s/p any surgical intervention.
- (2) Associated with history of incontinence.
- (3) With history of more than 2 surgical interventions.
- (4) Otherwise disqualifying conditions after most recent procedure based on 16A, C, E or 15F (UTI, urethral stricture, voiding dysfunction or symptomatic chordee).

(No strong evidence for time-complications can occur lifelong; to capture incontinent epispadias or DQ based on urinary sx's 16A, C, and E or DQ based on F below.)

c. Current enlargement or mass of testicle, epididymis (608.9), or spermatic cord.

d. Current or history of recurrent orchitis or epididymitis (604.90).

e. History of penis amputation (878.0) (CPT 54125, 54130-54135).

f. Current penile curvature if associated with pain.

g. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.13) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. Herpes does not meet the standard if:

- (5) Current lesions are present.
- (6) Use of chronic suppressive therapy is needed.

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- (7) There are three or more outbreaks per year.
- (8) Any outbreak in the past 12 months interfered with normal function.
- (9) Treatment included hospitalization or intravenous therapy.
- h. Current or history of urethral condyloma acuminatum.
- i. History of acute prostatitis within the last 24 months (601.0), history of chronic prostatitis (601.1), or history of chronic pelvic pain syndrome.
- j. Current hydrocele (603) or spermatacele associated with pain or which precludes a complete exam of the scrotal contents.
- k. Left varicocele (456.4), if painful or symptomatic, or associated with testicular atrophy, or varicocele larger than the testis.
- l. Left varicocele (456.4) that does not reduce or decompress completely when supine.
- m. Bilateral or right varicocele (456.4).
- n. Current or history of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs (608.9).
- o. History of major abnormalities or defects of the genitalia such as sex reassignment surgery or disorder of sexual development (to include but not limited to hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis).

Rationale/Reference and Discussion: CAPT [REDACTED] cited that missing one testicle should not be a disqualifier. COL [REDACTED] suggested that surgical exploration should be included to address any other concerns. CAPT [REDACTED] proposed revising the standards to address epispadias and hypospadias up front. Col [REDACTED] clarified that if corrected the condition should be allowed. Regarding genital infections, CAPT [REDACTED] suggested revising the standard to match that used in the female genitalia section. MAJ [REDACTED] noted that prostatitis should occur more in older men, than in the younger accessing population. CAPT [REDACTED] agreed stating that she would be concerned of a misdiagnosis. The group agreed to include a history of 24 months for the prostatitis. The language regarding change of sex was updated to current terminology.

Action/POC:

1. Send out reference for eight year timeline/[REDACTED]
2. Send out reference for hematuria screening dispensation/[REDACTED]

5. NEUROLOGIC STANDARDS REVIEW**a. Neurologic****Current Standard:**

- a. Current or history of cerebrovascular conditions, including but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation (437).

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b. History of congenital or acquired anomalies of the central nervous system (742) or meningocele (741.9).

c. Current or history of disorders of meninges, including but not limited to cysts (349.2). Asymptomatic incidental arachnoid cyst demonstrated to be stable by neurological imaging over a 6-month or greater time period DO meet the standard.

d. Current or history of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), peripheral nerves (337), or muscles (728).

e. History of headaches (784.0), including but not limited to migraines (346) and tension headaches (307.81) that:

(1) Are severe enough to disrupt normal activities (such as loss of time from school or work) more than twice per year in the past 2 years.

(2) Require prescription medications more than twice per year within the last 2 years.

f. Migraine (346) or migraine variant (346.2) associated with neurological deficits other than scotoma.

g. Cluster headaches (339.0).

h. History of head injury (854.0) if associated with:

(1) Post-traumatic seizure(s) occurring more than 30 minutes after injury.

(2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit.

(3) Persistent impairment of cognitive function.

(4) Persistent alteration of personality or behavior.

(5) Unconsciousness of 24 hours or more post-injury

(6) Amnesia or disorientation of person, place, or time of 7 days duration or longer post-injury.

(7) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging until resolved and 12 months has elapsed since injury.

(8) Associated abscess (326) or meningitis (958.8).

(9) Cerebrospinal fluid rhinorrhea (349.81) or otorrhea (388.61) persisting more than 7 days.

(10) Penetrating brain injury to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.

i. History of moderate head injury (854.03).

(1) Moderate head injuries are defined as:

(a) Unconsciousness of more than 30 minutes but less than 24 hours, or

(b) Amnesia, or disorientation of person, place, or time, alone or in combination, more than 24 hours but less than 7 days duration post-injury, or

(c) Linear skull fracture.

(2) After 12 months post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.

j. History of mild head injury (854.02).

(1) Mild head injury is defined as:

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(a) Unconsciousness of less than 30 minutes post-injury.

(b) Amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.

(2) After 1 month post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.

k. History of persistent post-concussive symptoms (310.2) that interfere with normal activities or have duration of more than 1 month. Such symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

l. Current or history of infectious processes of the central nervous system, including but not limited to meningitis (322), encephalitis (323), neurosyphilis (094), or brain abscess (324), if occurring within 1 year before examination, required surgical treatment, or if there are residual neurological defects.

m. Current or history of paralysis, weakness, lack of coordination, chronic pain (including but not limited to chronic regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes (344), including but not limited to Guillain-Barre Syndrome (357.0).

n. Any seizure occurring beyond the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.

o. Chronic nervous system disorders, including but not limited to myasthenia gravis (358.0), multiple sclerosis (340), tremor (333.1), and tic disorders (307.20) (e.g., Tourette's (307.23)).

p. Current or history of central nervous system shunts of all kinds (V45.2).

q. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope (780.2), including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.

Recommended Standard:

a. Current or history of cerebrovascular conditions, including but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation (437).

b. History of congenital or acquired anomalies of the central nervous system (742) or meningocele (741.9).

c. Current or history of disorders of meninges, including but not limited to cysts (349.2). Asymptomatic incidental arachnoid cyst demonstrated to be stable by neurological imaging over a 6-month or greater time period DO meet the standard.

d. Current or history of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), peripheral nerves (337), or muscles (728).

e. History of headaches (784.0), including but not limited to migraines (346) and tension headaches (307.81) that:

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- (1) Are severe enough to disrupt normal activities (such as loss of time from school or work) more than twice per year in the past 2 years.
- (2) Require prescription medications more than twice per year within the last 2 years.
- (3) Are associated with neurological deficient other than scotoma.
- f. Cluster headaches (339.0).
- g. History of severe or moderate brain injury (854.0) if associated with any of the following:
 - Severe injury defined as: 1. Unconsciousness of 24 hours or more post injury. 2. Amnesia or disorientation of person, place or time of 7 days duration or longer post-injury.
 - Moderate head injuries are defined as: 1. Unconsciousness of more than 30 minutes but less than 24 hours, or 2. Amnesia, or disorientation of person, place or time, along or in combination, more than 24 hours but less than 7 days duration post injury.
 - (1) Post-traumatic seizure(s) occurring more than 30 minutes after injury.
 - (2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit.
 - (3) Persistent impairment of cognitive function.
 - (4) Persistent alteration of personality or behavior.
 - (5) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging.
 - (6) Associated abscess (326) or meningitis (958.8).
 - (7) Cerebrospinal fluid rhinorrhea (349.81) or otorrhea (388.61) persisting more than 7 days.
 - (8) Penetrating brain injury to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.
 - (9) Any skull fracture.
- h. History of persistent post-concussive symptoms (310.2) that interfere with normal activities or have duration of more than 1 month. Such symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.
 - (1) Unconsciousness of 24 hours or more post-injury
 - (2) Amnesia or disorientation of person, place, or time of 7 days duration or longer post-injury.
- i. History of mild brain injury (854.03).
 - (1) Mild brain injury is defined as:
 - (a) Unconsciousness of less than 30 minutes post injury.
 - (b) Amnesia, or disorientation of person, place, or time, alone or in combination, of less than 24 hours post injury.
 - (2) After 1 month post-injury, applicants may be qualified if neurological evaluation shows no residual symptoms, dysfunction or activity limitations, complications or treatment.
 - (3) History of 3 or more episodes of mild brain injury.
 - (4) History of 2 or more with or without loss of consciousness within the last 12 months.

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j. Current or history of infectious processes of the central nervous system, including but not limited to encephalitis (323), neurosyphilis (094), or brain abscess (324).

k. History of meningitis within the last 12 months or with persistent neurologic defects.

l. History of persistent post-concussive symptoms (310.2) that interfere with normal activities or have duration of more than 1 month. Such symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

m. Current or history of paralysis, weakness, lack of coordination, chronic pain syndrome (including but not limited to complex regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes (344), including but not limited to Guillain-Barre Syndrome (357.0).

n. Any atraumatic seizure occurring beyond the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.

o. Chronic nervous system disorders, including but not limited to myasthenia gravis (358.0), multiple sclerosis (340), tremor (333.1), and tic disorders (307.20) (e.g., Tourette's (307.23)).

p. Current or history of central nervous system shunts of all kinds (V45.2) including endoscopic third ventriculocisternostomy.

q. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope (780.2), including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.

Rationale/Reference and Discussion: CAPT [REDACTED] suggested that any history of cerebrovascular conditions should require a waiver. The other SMEs agreed. Dr. [REDACTED] added that the military should be aware of these individuals for further examination before accession. Regarding item B, the SMEs agreed to current standard. CAPT [REDACTED] noted that referencing meningocele was vague, but noted that if there has not been a problem with the standard, then it might not need to be changed. COL [REDACTED] confirmed that the standard has not been a problem. Dr. [REDACTED] questioned if there was a size limit for arachnoid cysts. CAPT [REDACTED] stated size was not relevant and they would not operate unless the cyst was symptomatic or hemorrhaging. It was noted that some arachnoid cysts can become symptomatic and cause headaches. The group discussed the standard for migraines, noting it is a very common but manageable condition. COL [REDACTED] commented that despite being one of the most common reasons for missing work, these individuals should not be waived. Item E was rephrased to include migraines or migraine variants associated with neurological deficits other than scotoma.

Lt Col [REDACTED] noted that the current standards for head injury were accurate and current according to literature support. Dr. [REDACTED] questioned if individuals with a history of head injuries would have their condition worsened by military service, given the mounting evidence from the National Football League and the National Collegiate Athletic Association. Lt Col

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█████ responded that there is not enough data on these individuals to know if the condition would get worse, suggesting that in those situations when the condition does worsen; symptoms will be used to evaluate conditions such as headaches. CAPT █████ stated that severe brain injuries are an absolute contraindication for accessions and an individual who had had such an injury would require a very comprehensive neurological evaluation. Mr. █████ questioned if this was an absolute or if there was any give. CAPT █████ responded this was an absolute standard and suggested that these cases be clearly referred to as severe brain injuries in the standard.

In regards to mild brain injury, Col █████ noted that they often see two to five mild brain injuries in individuals. COL █████ stated that mild brain injuries are difficult to quantify, noting that CMOs often have to use personal judgement with these individuals. Dr. █████ suggested including a list for mild brain injuries as they had done with severe injuries. CAPT █████ noted that the symptoms of the two categories overlap somewhat but that a major difference was in the length of loss of consciousness. The group discussed the standard on the linear skull fracture. Dr. █████ stated that in his opinion, someone with a moderate head injury is at a higher risk of seizure later on. Dr. █████ suggested clarifying that it should be a brain injury associated with skull fracture. The group agreed to use the term brain injury over head injury in these standards as those are the terms used in the literature. As many of the symptoms associated with moderate and severe brain injuries are similar, the group agreed to include both injuries in one category, separating out mild brain injuries. COL █████ noted that they see a lot of mild head injuries and suggested clarifying a standard on multiple head injuries, since there is evidence that those individuals do have long term sequelae. CAPT █████ responded that in the field, guidelines state that those individuals with three episodes of mild brain injuries over the past year get a comprehensive evaluation by a neurologist. █████ suggested tightening this standard to a history of three mild brain injuries or two or more in the past year.

COL █████ questioned including absences from school or work or the inability to return to sports as a qualifier for post concussive symptoms, either in the standard or in supplemental guidance. Mr. █████ noted that schools often have a policy on returning to sports after a concussion, suggesting that the inability to play may not be related to residual effects of the concussion. The group agreed to keep the standard as is. CAPT █████ noted that primary encephalitis and meningitis would predispose an individual to continued neurologic conditions and could require limitations on deployment. CAPT █████ added that meningitis infections as an infant, with no subsequent issues could be ok. Dr. █████ suggested including a standard to limit disqualifying meningitis infections to those within the past year, adding that sequelae often show up quickly upon examination. Dr. █████ suggested clarifying that item M to be “complex regional pain syndrome” as that is the appropriate title for the syndrome.

Col █████ noted that it was important to specify seizures related to brain injury. CAPT █████ agreed, suggesting that they be specified as atraumatic seizures. Dr. █████ questioned the time period of five years post seizure. CAPT █████ clarified that there is a low risk of recurrence after that point. In terms of shunts, CAPT █████ noted that as written, the standard would miss those with a third ventriculocisternostomy, as it does not leave an actual

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device in place, suggesting that it be added to the standard. The group agreed to include a qualifier for a third ventriculocisternostomy.

Action/POC: None.

6. LEARNING/BEHAVIOR/PSYCHIATRIC STANDARDS REVIEW

a.. Learning/Behavior/Psychiatric

Current Standard:

a. Attention Deficit Hyperactivity Disorder (ADHD) (314) UNLESS the following criteria are met:

(1) The applicant has not required an Individualized Education Program or work accommodations since the age of 14.

(2) There is no history of comorbid mental disorders.

(3) The applicant has never taken more than a single daily dosage of medication or has not been prescribed medication for this condition for more than 24 cumulative months after the age of 14.

(4) During periods off of medication after the age of 14, the applicant has been able to maintain at least a 2.0 grade point average without accommodations.

(5) Documentation from the applicant's prescribing provider that continued medication is not required for acceptable occupational or work performance.

(6) Applicant is required to enter service and pass Service-specific training periods with no prescribed medication for ADHD.

b. History of learning disorders (315), including but not limited to dyslexia (315.02), UNLESS applicants demonstrated passing academic and employment performance without utilization of academic and or work accommodations at any time since age 14.

c. Pervasive developmental disorders (299 series) including Asperger Syndrome, autistic spectrum disorders, and pervasive developmental disorder-not otherwise specified (299.9).

d. Current or history of disorders with psychotic features such as schizophrenic disorders (295), delusional disorders (297), or other and unspecified psychoses (298).

e. History of bipolar disorders (296.4-7) and affective psychoses (296.8).

f. History of depressive disorders, including but not limited to major depression (296), dysthymic disorder (300.4), and cyclothymic disorder requiring outpatient care for longer than 12 months by a physician or other mental health professional (to include V65.40), or any inpatient treatment in a hospital or residential facility.

g. Depressive disorder not otherwise specified (311), or unspecified mood disorder (296.90), UNLESS:

(1) Outpatient care was not required for longer than 24 months (cumulative) by a physician or other mental health professional (to include V65.40).

(2) The applicant has been stable without treatment for the past 36 continuous months.

(3) The applicant did not require any inpatient treatment in a hospital or residential facility.

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h. History of a single adjustment disorder (309) within the previous 3 months, or recurrent episodes of adjustment disorders.

i. Current or history of disturbance of conduct (312), impulse control (312.3), oppositional defiant (313.81), other behavior disorders (313), or personality disorder (301).

(1) History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Military Services.

(2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to military service.

j. Encopresis (307.7) after 13th birthday.

k. History of anorexia nervosa (307.1) or bulimia (307.51).

l. Other eating disorders (307.50; 52-54) including unspecified disorders of eating (307.59) occurring after the 13th birthday.

m. Any current receptive or expressive language disorder, including but not limited to any speech impediment or stammering and stuttering (307.0) of such a degree as to significantly interfere with production of speech or the ability to repeat commands.

n. History of suicidal behavior, including gesture(s) or attempt(s) (300.9) or history of self-mutilation or injury used as a way of dealing with life and emotions.

o. History of obsessive-compulsive disorder (300.3) or post-traumatic stress disorder (309.81).

p. History of anxiety disorders (300.01), anxiety disorder not otherwise specified (300.00), panic disorder (300.2), agoraphobia (300.21, 300.22), social phobia (300.23), simple phobias (300.29), other acute reactions to stress (308) UNLESS:

(1) The applicant did not require any treatment in an inpatient or residential facility.

(2) Outpatient care was not required for longer than 12 months (cumulative) by a physician or other mental health professional (to include V65.40).

(3) The applicant has not required treatment (including medication) for the past 24 continuous months.

(4) The applicant has been stable without loss of time from normal pursuits for repeated periods even if of brief duration; and without symptoms or behavior of a repeated nature that impaired social, school, or work efficiency for the past 24 continuous months.

q. Current or history of dissociative, conversion, or factitious disorders (300.1), depersonalization (300.6), hypochondriasis (300.7), somatoform disorders (300.8), or pain disorder related to psychological factors (307.80 and .89).

r. Current or history of psychosexual conditions (302), including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.

s. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305.0), or other drug abuse (305.2 thru 305.9).

t. Current or history of other mental disorders (all 290-319 not listed) that, in the opinion of the civilian or military medical examiner, shall interfere with or prevent satisfactory performance of military duty.

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- u. Prior psychiatric hospitalization for any cause.

Recommended Standard:

- a. Attention Deficit Hyperactivity Disorder (ADHD) (314).
 - (1) Recommended or prescribed an Individualized Education Program, 504 Plan, or work accommodations since the age of 14, or
 - (2) With a history of comorbid mental disorders, or
 - (3) Prescribed medication in the previous 24 months, or
 - (4) Documentation of adverse academic, occupational, or work performance.
- b. History of learning disorders (315) since the age of 14, including but not limited to dyslexia (315.02).
 - (1) Recommended or prescribed an Individualized Education Program, 504 Plan, or work accommodations since the age of 14, or
 - (2) With a history of comorbid mental disorders, or
 - (3) Documentation of adverse academic, occupational, or work performance.
- c. Autism spectrum disorders (299 series).
- d. Current or history of disorders with psychotic features such as schizophrenic disorders (295), delusional disorders (297), or other and unspecified psychoses (298) or mood disorders with psychotic features.
- e. History of bipolar and related disorders (296.4-7) (formerly identified as mood disorders NOS) to include but not limited to cyclothymic disorders and affective psychoses (296.8).
- f. Depressive disorder if
 - (1) Outpatient care including counselling required for longer than 12 months (cumulative), or
 - (2) Symptoms or treatment within the last 36 months, or
 - (3) The applicant required any inpatient treatment in a hospital or residential facility,or
 - (4) Any recurrence, or
 - (5) Any suicidality (IAW b)
- g. History of a single adjustment disorder (309) if treated or symptomatic within the previous 6 months, or any history of chronic (lasting longer than 6 months) or recurrent episodes of adjustment disorders.
- h. Current or history of disruptive, impulse control and conduct disorder to include but not limited to oppositional defiant (313.81) and other behavior disorders (313).
- i. Any personality disorder (301) including unspecified personality disorder //maladaptive personality traits demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency
 - (1) Repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Military Services.
 - (2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to

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military service.

(3) Any behavioral issues that have led to incarceration for any period.

j. Encopresis (307.7) after 13th birthday.

k. History of any feeding or eating disorder.

l. Any current communication disorder of such a degree as to significantly interfere with production of speech or the ability to repeat commands.

m. Suicidality to include suicidal ideation with a plan, suicidal gesture(s), or attempt(s) (300.9)

n. History of self-mutilation or injury used as a way of dealing with life and emotions.

o. History of obsessive-compulsive and related disorders (300.3).

p. History of post-traumatic stress disorder (309.81).

q. History of anxiety disorders (300.01) if:

(1) Outpatient care including counseling required for longer than 12 months. was not required for longer than 12 months (cumulative), or

(2) Symptomatic or treatment within the last 36 months, or

(3) The applicant required any inpatient treatment in a hospital or residential facility,

or,

(4) Any recurrence, or

(5) Any suicidality (IAW b).

r. Current or history of dissociative disorders.

s. Current or history of Somatic symptom and related disorders (300.8).

t. Current or history of paraphilic disorders.

u. Any history of substance-related and addictive disorders (with the exception of caffeine or tobacco use).

v. Any history of other mental disorders (all 290-319 not listed) that, in the opinion of the civilian or military medical examiner, shall interfere with or prevent satisfactory performance of military duty.

w. Prior psychiatric hospitalization for any cause.

Rationale/Reference and Discussion: The group agreed to rephrase standards to state disqualifying conditions. CAPT ██████ emphasized that the ADHD standards are meant to screen out individuals who would be so severely impacted that they would not be able to function in the operational environment without stimulant treatment. Individuals with minor conditions could be able to deploy and perform all duties without treatment and should be able to access. ██████ also expressed that a number of individuals might use educational programs and medication in order to get accommodations and not necessarily because of a true condition. LTC ██████ cited that many people used medications to help focus in graduate programs such as law school. The group discussed the use of a grade point average (GPAs), discussing that despite being an objective tool, there is no grade point average required to join the Services nor are GPAs equal across school districts. Mr. ██████ highlighted that the prescription of the educational program is more important than if the individual actually made use of the program. CAPT ██████ added that use of medication is not only widespread, but is also dependent on other, non-clinical issues, such as insurance and mood. The group discussed using similar language regarding educational programs for the standard related to dyslexia.

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Item C was updated to reflect the current language and classification used by the DSM5. CAPT ██████ suggested combining the existing standards related to disorders with psychotic features and mood disorders into one standard leaving bipolar disorders as its own standard. Lt Col ██████ noted that cyclothymic disorders should be moved to the standard on bipolar disorders, as the two are related. ██████ also noted that depression and anxiety are relatively common and treatable conditions. It was discussed that adjustment disorder can often be misdiagnosed depression and that major depression is notably different, requiring a different course of treatment. COL ██████ suggested identifying criteria for the depression standard in lieu of questioning a diagnosis of depression. Lt ██████ noted that an individual could receive treatment from a nurse practitioner, suggesting that the language for counselling be broad.

Col ██████ questioned the timeline of 3 months in the standard for adjustment disorders, asking if it should be a longer time period. COL ██████ noted the DSM5 uses a timeline of 6 months after the stressor ends. Col ██████ suggested using the DSM5 timeline. Six months is also the time period used to identify chronic adjustment disorders. Lt Col ██████ noted that the terminology related to disturbance of conduct should be updated to the current terminology as the disorders described have all come under disruptive impulse control and conduct disorders. COL ██████ cited that personality disorders should be included as a separate standard, as it is an important diagnosis. Dr. ██████ questioned if the standards could address borderline personality traits that may not be formally diagnosed. Lt Col ██████ suggested referencing maladaptive personality traits. The group included the existing qualifiers from the standard on disturbance of conduct to further elucidate the standard on personality traits. The group noted that a number of individuals fall through the crack without a specific diagnosis and that such individuals can be difficult to deal with.

The language regarding anorexia nervosa or bulimia was updated to current language of any feeding or eating disorder. Mr. ██████ noted that some people have suggested that subjectivity is an issue with item M. The standard was clarified by specifying “current communication disorder.” The group discussed suicidal behavior, with CAPT ██████ citing that ideation that comes to clinical attention confers a high risk. However, the interview process in which an individual is questioned on such thoughts is a contrived situation, where people are pressured to admit anything pertinent to the questions being asked. Even if someone gets waived, they will maintain a label regarding suicidality. The Navy representatives stated that they were not yet ready to agree to this standard. The group did agree to separate out self-mutilation or injury, specifically as it pertains to dealing with life or emotions, recognizing that it could be done during group events such as fraternity events or to prove machismo.

The standard related to obsessive-compulsive disorders was rephrased to reflect the current correct term of these disorders as obsessive-compulsive and related disorders. Post-traumatic stress disorder was separated out as its own standard. The language from the depressive disorder standard was used for the anxiety standard, as LTC ██████ noted that the two are related. COL ██████ cited that some phobias are relatively simple; LTC ██████ added that simple phobias are

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relatively easy to treat. Item Q was revised to reflect DSM5 terminology and separating out somatic symptom and related disorders. Items R and S are addressed in the DSM5 section of the minutes above. The standard on alcohol abuse was rephrased to clarify terminology as substance-related and addictive disorders. Exceptions were included for tobacco and caffeine. Mental disorders were changed to mental health disorders, as that is the current term used by the DSM5.

Action/POC: Review the standard on suicidal behavior and ideation/ 

12. NEXT MEETING

The next AMSWG meeting will be held 2-4 June 2015 at the DHHQ.

EXHIBIT E TO HEBERT DECLARATION

Medical Accession Standards – Transgender Service

	<u>ARMY</u>	<u>CSA/CMC</u>	<u>DON/NAVY</u>	<u>USAF</u>	<u>USCG</u>	<u>OSD #1</u>	<u>OSD #2</u>
<i>History of gender dysphoria, UNLESS:</i>	<ul style="list-style-type: none"> Stable w/o clinically significant distress or impairment in social, occupation, or other important areas of functioning for 24 months. 	<ul style="list-style-type: none"> Stable w/o clinically significant distress or impairment in social, occupation, or other important areas of functioning for 24 months. 	<ul style="list-style-type: none"> Stable w/o clinically significant distress or impairment in social, occupation, or other important areas of functioning for 12 months. 	<ul style="list-style-type: none"> Stable w/o clinically significant distress or impairment in social, occupation, or other important areas of functioning for 24 months. 	<ul style="list-style-type: none"> Stable w/o clinically significant distress or impairment in social, occupation, or other important areas of functioning for 24 months. 	<ul style="list-style-type: none"> Stable w/o clinically significant distress or impairment in social, occupation, or other important areas of functioning for 12 months. 	<ul style="list-style-type: none"> Stable w/o clinically significant distress or impairment in social, occupation, or other important areas of functioning for 6 months.
<i>History of gender transition treatment, UNLESS:</i>	<ul style="list-style-type: none"> Living in target gender for 24 months. If taking hormones, stable for 24 months. 	<ul style="list-style-type: none"> Living in target gender for 24 months. If taking hormones, stable for 24 months. 	<ul style="list-style-type: none"> Living in target gender for 12 months. If taking hormones, stable for 12 months. 	<ul style="list-style-type: none"> Living in target gender for 24 months. If taking hormones, stable for 24 months. Completed physician directed transition treatment plan. 	<ul style="list-style-type: none"> Living in target gender for 24 months. If taking hormones, stable for 24 months. 	<ul style="list-style-type: none"> Living in target gender for 12 months. If taking hormones, stable for 6 months. Completed physician directed transition treatment plan. 	<ul style="list-style-type: none"> Living in target gender for 6 months. If taking hormones, stable for 3 months.
<i>Surgery</i>	No changes to current standards.	No changes to current standards.	History of genital reassignment, UNLESS: <ul style="list-style-type: none"> 12 months have elapsed since any such surgery. No functional limitations or complications persist. 	No changes to current standards.	No changes to current standards.	No changes to current standards.	History of genital reassignment, UNLESS: <ul style="list-style-type: none"> 6 months have elapsed since any such surgery. No functional limitations or complications persist.
<i>Review Authority</i>	MEPS	MEPS	MEPS	Surgeon General	MEPS	MEPS	MEPS
<i>Misc.</i>		Genitalia = Gender.					

EXHIBIT F TO HEBERT DECLARATION



DEPARTMENT OF DEFENSE
SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

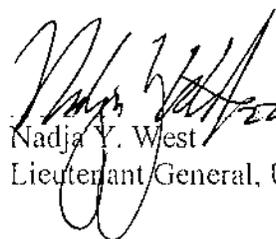
MEMORANDUM FOR THE UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND
READINESS

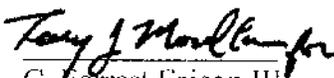
SUBJECT: Recommended Period of Medical Stability Prior to Accession of Transgender
Applicants into Military Service

Based on the available medical evidence and our Services' collective experience treating transgender members to date, we recommend the required period of medical stability for transgender military accessions be extended from 18 months to at least 24 months (ref: Directive-type Memorandum 16-005 for inclusion in DoD Instruction 6130.03).

There is a known and significant increase in the prevalence of operationally-relevant mental health conditions (e.g., major depression, anxiety, PTSD, and suicidality) in transgender individuals. Further, currently accepted clinical practice guidelines and our experience in DoD demonstrate that successful gender transition is a protracted process, often requiring several years to reach clinical stability. Taken together, these factors raise significant concerns about the health and readiness of transgender individuals with just 18 months of demonstrated stability prior to accession.

We recognize the medical evidence applicable to transgender individuals is still developing and the time needed for these individuals to reach clinical stability is imprecise. Due to the above factors, however, we believe extending the period of stability from 18 months to 24 months will better support the individual and the Department's mission.


Nadja Y. West
Lieutenant General, US Army


C. Forrest Faison III
Vice Admiral, US Navy

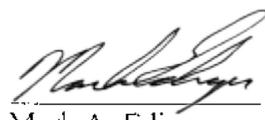

Mark A. Ediger
Lieutenant General, US Air Force

EXHIBIT G TO HEBERT DECLARATION



MAY 31 2017

FOR: DEPUTY SECRETARY OF DEFENSE

FROM: Heather Wilson

SUBJECT: Readiness of Military Departments to Implement Accession of Transgender Applicants into Military Service

- In response to your subject memorandum, dated 8 May 2017, we recommend a 12-36 month delay from the current 1 July 2017 accession policy implementation to allow for a period of further study to assess the readiness implications of transgender accessions. We reaffirm our commitment that currently serving transgender members be allowed to serve openly, freely, without discrimination and to ensure that all Airmen have the opportunity to focus on the mission and be successful. The Air Force is complying with OSD direction to educate our force through general Transgender Awareness Training, and anticipates completion by the OSD-directed target date of 1 July 2017.
- We believe that the combination of developing, but still immature, medical information and information received from Combatant Commands (CCMDs) raises significant concerns about the potential availability, readiness, and deployability of potential transgender accessions that warrants more study.
- It has been further noted that currently serving transgender members have had some significant readiness and deployment issues. Early medical evidence indicates that gender transition medical treatment may not be providing a lasting resolution to gender dysphoria and there is not sufficient data to draw conclusions on cited medical issues. This additional period would allow the opportunity to build upon a growing body of medical evidence on which to base a more informed decision on the readiness impacts of transgender applicant accessions.
- As a force provider, the Air Force takes these concerns seriously, particularly in light of understandable restrictions required by our warfighters. For example, US Central Command (USCENTCOM) MODIFICATION (MOD) 13, *Individual Protection and Individual Unit Deployment Policy*, provides that members with gender dysphoria, and those actively undergoing gender transition, are, due to complex medical and mental health needs, generally disqualified from deployment to the USCENTCOM Area of Responsibility until the process, including all necessary follow-up and stabilization, is completed without complication or persistent concerns (identified as stability). Additionally, other CCMDs have policies that limit deployment of any member, not solely transgender members, who have a condition with complex multi-specialty medical concerns without an approved waiver by the gaining CCMD, which is consistent with established Military Department and Service standards.

- Our point of contact is Martha P. Soper, SAF/MRR, (703) 693-9512 or via email at Martha.p.soper.civ@mail.mil

COORDINATION: None

Attachment:

DepSecDef Memo, 8 May 17

Prepared by: Martha P. Soper, SAF/MRR, (703) 693-9512



ACTION MEMO

05-25-17 A09:40 -OUT

FOR: DEPUTY SECRETARY OF DEFENSE

FROM: Robert M. Speer, Acting Secretary of the Army

Robert M. Speer, 5-25-17

SUBJECT: Readiness of Military Departments to Implement Accession of Transgender Applicants into Military Service

- This responds to your May 8, 2017 memorandum to assess the Army's readiness to begin accessing transgender applicants into the Army on July 1, 2017 (TAB A). The Army requests a delay in implementing the draft accessions policy until July 1, 2019, to allow for a meaningful analysis and determination regarding the impact of transgender accessions on the Army's readiness to meet the statutory requirement under 10 USC 3062, specifically the Army's obligation to be organized, trained, and equipped primarily for prompt and sustained combat operations.
- While the Army is on track to complete our transgender in service tiered training program by July 1, 2017, our assessment identified several impediments to starting accessions on July 1, 2017, potentially impacting our future ability to conduct "prompt and sustained" combat operations in furtherance of our statutory mission.
- Some transgender Soldiers experience extensive medical non-deployability both before and after transition. The Army reviewed the records of the 36 Soldiers with an approved gender marker change and found that seven (19%) were permanently non-deployable after their transition compared to 2% permanently non-deployable in the rest of the force. This rate is in addition to the 6 - 12 months medically non-deployable time (exclusive of time needed to recover from surgery) most transitioning Soldiers experience. Accessing additional individuals when the only empirical evidence collected suggests a 19% permanently non-deployable rate hurts the overall readiness of the force and reduces the ability of the Army to achieve our statutory mission of providing prompt and sustained combat operations. As we have just begun retaining transgender Soldiers, insufficient data exists to determine if more time would resolve the associated non-deployable conditions.
- Empirical evidence is not available to identify if the contemplated 18-month stability period is sufficient to support the overall readiness of the force. Many medical conditions require a waiting period to determine stability. The waiting periods are based primarily on published medical standards of care used to determine complete healing times or the point at which one reaches such a low risk of recurrence that the condition is considered medically resolved, for example, a 6-month stability period following refractive eye surgery. Gender dysphoria has a higher than average risk of being associated with mood and anxiety disorders and suicidal behaviors. Some of the waiting periods for disorders sometimes associated with gender dysphoria are greater than the contemplated 18-months of stability for gender dysphoria, for

SUBJECT: Readiness of Military Departments to Implement Accession of Transgender Applicants into Military Service

example depression (requiring a period of 36 months without treatment prior to accession), and anxiety (requiring a period of 24 months without treatment prior to accession). The minimum waiting period for transgender individuals should be that time necessary to resolve the dysphoria or any other attendant conditions.

- * Data to assess impact on readiness has only been available since October 2016. To address this insufficiency, the Army requests delaying implementation of an accessions policy for at least 24 months. The delay provides the necessary time to develop actual practical experience regarding the length and type of medical treatment needed to resolve periods of non-deployability and validate the presumption that transgender Soldiers will access in their preferred gender and experience no additional distress or dysphoria, requiring only routine behavioral health and endocrinological follow-up with minimum training disruption during service.

RECOMMENDATION: Approve the delay of implementation until July 1, 2019.

Approve _____ Disapprove _____ Other _____

COORDINATION: NONE

Attachment:
As stated

Prepared by: LTC Daniel McTigue, (703) 695-5666



May 31, 2017

MEMORANDUM FOR DEPUTY SECRETARY OF DEFENSE

SUBJECT: Readiness of Military Departments to Implement Accession of Transgender Applicants into Military Service

Pursuant to your memorandum of May 8, 2017, the Department of the Navy (DON) evaluated our readiness to begin accessing transgender applicants into military service on July 1, 2017. While both the Navy and Marine Corps are prepared to begin accessing applicants on July 1, 2017, as outlined in the attached Service assessments from the Director, Navy Staff and Commandant of the Marine Corps, I request consideration be given to extending the accession deadline by one year to July 1, 2018.

As directed, the Navy and Marine Corps developed Service-wide education and training plans to ready the force and ensure successful integration. Navy completed training as of April 30, 2017, and the Marine Corps will be complete by July 1, 2017. Additionally, DON published transgender policy in Secretary of the Navy Instruction 1000.11, *Service of Transgender Sailors and Marines*, on November 4, 2016.

A one-year delay will enable DON to assess the effectiveness of our policy to evaluate, treat, and integrate transgender Service Members within the existing population. This will allow us opportunity to apply the experience of our current efforts to identify any potential impacts of transgender service on readiness and deployability and to standardize and clarify DON procedures as required to preclude such impacts. During this period we will also assess the detailed policy impacts on individual Service Members and their ability to have full, uninhibited careers offering world-wide assignability. Additionally, we will work with the other Services, the Combatant Commanders, and the Office of the Secretary of Defense to promote consistency in implementation regarding deployed environment requirements, non-deployability periods, and the optimal stability period associated with the unique stressors of military life.

Those who join our all-volunteer force today do so with an expectation of being able to serve wherever the nation needs them. We owe them consistent and clear policies that maximize readiness while simultaneously ensuring individuals have the ability to contribute to the mission based solely on their abilities and qualifications.

Sean J. Stackley
Acting

Attachments:
As stated



DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

MAY - 8 2017

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHIEFS OF THE MILITARY SERVICES

SUBJECT: Readiness of Military Departments to Implement Accession of Transgender
Applicants into Military Service

In coordination with the Under Secretary of Defense for Personnel and Readiness, I direct you to assess the Department's readiness to begin accessing transgender applicants into military service on July 1, 2017.

The personnel policies of this Department are designed to enhance the warfighting readiness and lethality of the force that protects our country. We do not intend to reconsider prior decisions unless they cause readiness problems that could lessen our ability to fight, survive and win on the battlefield.

Current guidance prohibits the involuntary separation of otherwise qualified Service members solely because of gender identity and directs the Military Departments to prepare for the accession of transgender applicants into military service by July 1, 2017. That guidance also contained directions for each Department to conduct force-wide education and training to ready the force and ensure successful integration. Please report your assessment to me no later than May 31, 2017.

R. O. Dyer

cc:
Chairman of the Joint Chiefs of Staff
Under Secretary of Defense for Personnel and Readiness
General Counsel of the Department of Defense



OSD008501-17/ICMD007570-17



22 May 17

MEMORANDUM FOR SECRETARY OF THE NAVY

SUBJECT: Readiness of Military Departments to Implement Accession of Transgender Applicants into Military Service

Mr. Secretary, we are prepared to access transgender (TG) applicants into military Service on July 1, 2017. We conducted extensive policy reviews and training of the force, and established the required conditions for implementation of TG applicant accessions. The following criteria served as the basis for our assessment.

- Required revisions to Navy policy were outlined in NAVADMIN 248/16 and BUMEDNOTE 6000. Applicable Navy instructions were reviewed and any changes required are nearing completion and will be in effect by the planned date for TG accessions.
- All Navy policies and regulations are consistent with the standards of military readiness, effectiveness, unit cohesion, and recruiting and retention needs.
- As of April 30, 2017, the Navy completed TG policy training for both the active and reserve components.
- The Navy Service Central Coordination Cell continues to provide assistance and clarification to command triads and individual Sailors regarding personnel policies and gender transition, responding to over 460 inquiries since the July 5, 2016 standup.
- BUMED successfully stood up east and west coast transgender care teams, completed physician training and developed a multidisciplinary approach to care for transitioning Sailors.
- Navy Recruiting Command recruiters are prepared to accept TG applications.
- Navy accession sources at Naval Service Training Command and U.S. Naval Academy are ready to begin accessing TG recruits and officer candidates.
- Recruit Training Command (RTC) is on track to complete the minimum necessary modifications to ensure appropriate privacy for incoming TG personnel. No other facilities modifications are planned by Navy outside of RTC.

While Navy sees no impediments and assesses limited risk to start accessing TG applicants, I would not oppose a shift in the final implementation date if required by our sister Services. Navy agrees to the plan of 18 months stability requirement for Service entry of TG applicants, but awaits decision and release of DoD accession medical standards to review and update our policies and instructions accordingly. The accession of TG personnel is not expected to cause significant impacts to readiness, effectiveness, cohesion, recruiting and retention.


J. G. FOGGO



May 30, 2017

MEMORANDUM FOR DEPUTY SECRETARY OF DEFENSE
SECRETARY OF THE NAVY

SUBJECT: Readiness of the Military Departments to Implement Accession of Transgender Applicants into Military Service

The United States Marine Corps acknowledges the 30 June 2016 decision by the Secretary of Defense to begin accessing transgender applicants into the Marine Corps on 1 July 2017. The Marine Corps will comply with all Department of Defense (DoD) directives on this issue, but recommends extending the accession deadline to 1 July 2018. Since the implementation of the DoD transgender policy, we continue to learn from our transitioning in-service Marines who have bravely stepped forward. An additional year will give us the opportunity to continue to learn and to address ongoing concerns including:

- Since the implementation of the policy, we are beginning to better understand, via our in-service transitioning Marines, how transition impacts deployability and readiness. This information is important because the majority of Marines serve only a single term and we expect these Marines to be ready to train and deploy multiple times. With an additional year to implement transitioning/transgender accessions, we will be able to gain more insight from our experience with our in-service transitioning Marines and will be able to offer DOD a well-informed assessment on the impact on readiness.
- Facilities modifications are necessary at numerous training locations to respond to privacy concerns. These modifications have been impacted by the extended Continuing Resolution and, therefore, have not yet been completed. An additional year and a signed budget will allow us to complete these modifications.
- Notable inconsistencies exist between the clinical guidelines for transgender care and the DoD policy, specifically with respect to the requirement of real life experience (RLE). Defense Health Agency policy mandates DoD clinicians use guidelines requiring at least three months RLE prior to initiating hormone treatment. However, DoD policy which was developed with input from DoD medical experts does not permit RLE during duty hours and only allows partial RLE when Service members are off-duty. This incongruity reflects the lack of agreement within the medical and behavioral health communities and must be resolved to ensure appropriate care for our transitioning service members. By deliberately increasing this population before we have resolved the inconsistencies, we potentially expose newly accessed transitioning Marines to unacceptable health risks.
- Lastly, an extension would allow DOD and the Services to gain more certainty about DOD's interpretation of 10 U.S.C. §§6931, 9319, and 4319 which require the Services to provide sleeping and latrine areas separated by "male" and "female" at recruit training. The statutes

do not define the terms "male" or "female," but DOD General Counsel has suggested in a 5 July 2016 opinion that the terms will be interpreted to mean the member's gender marker as reflected in the Defense Enrollment Eligibility Reporting System (DEERS). The DOD General Counsel opinion indicates a belief that Congress will defer to DOD's interpretation of "male" and "female" because of the significant authority Congress has conferred on the Secretary of Defense and Service Secretaries concerning the administration of DOD and its personnel. DOD should take additional action prior to the accession of transgender applicants to ensure this view is consistent with congressional intent, in order to avoid potential risk of violation of these statutes.

In addition to these concerns, we continue to recommend the stability period for new accessions be established as 24 months, vice 18 months under the current policy. This 24-month stability requirement is consistent with other stability requirements within DOD's medical standards for accession in DODI 6130.03. Accession to military service is a significant and stressful event for all applicants; physical and mental stability are vital for success during recruit training or officer candidate school. A longer stabilization requirement would provide a better foundation for our transgender applicants and better position them to successfully complete rigorous initial training.

In summary, the Marine Corps will execute as required, but recommend the effective date for new accessions be delayed to 1 July 2018 so the Services can review and learn from current in-service transgender cases to better serve our transitioning/transgender members and to better understand the impacts of this new policy. We further recommend the stability period for new accessions be lengthened to 24 months.



Robert B. Neller