The 121st Interagency Institute was held during a period of serious discussions about a number of major policy issues, including the potential rejection of the Patient Protection and Affordable Care Act by the Supreme Court, proposals for restructuring the organization of defense health care at the highest levels, the challenges confronting the Gulf States, the volatility of the financial markets and the global economic situation, and the rapidly increasing rate of technological developments and their application throughout the world. As has been typical for some time now, all of these topics, and more, were part of the Institute program. It is also the case, that there are no clear cut answers to these persistent and challenging topics but the opportunity was provided to hear wide ranging views on trends and possible policy and programmatic responses.

I hope that the participants gained a better understanding as a result of their attendance at the Institute that there are many forces which are often viewed as being outside the health system’s area of concern that actually do impact on our practices in significant and far reaching ways. Even if it was uncomfortable! I also trust that there was the realization that the “interagency imperative” is real and there is much that we can learn from each other by crossing the organizational and professional boundaries. Teamwork, collaboration and understanding that someone outside our normal sphere of activities, even from another country, may be able to offer us insights and suggestions for alternative policies and programs are all hallmarks of the Institute experience.

In addition, we are in another election year and, when all the speculation and punditry is over, November may bring us into a quite different political environment. We exclude ourselves from acknowledging and discussing these global issues at our peril. As senior federal health care executives, our participants and alumni must be willing to understand, debate and develop strategic solutions to these and the many other challenges which come crashing in on our agendas. When dealt with, or ignored, they may slip away but often come back again in slightly different forms at some time in the future. I believe that the significance of this ‘revolving door’ scenario is validated as one looks back at the topics and viewpoints covered in the Interagency Institutes for the past quarter century and more.

Perhaps, by the time of the 122nd Institute later this year there will be a little more clarity, but there will probably be some new topics which are not even on the horizon at this time.

I want to take this opportunity to thank LtGen Bruce Green, USAF, MC, who will be retiring as Surgeon General of the Air Force later this summer. General Green has been a long time friend and supporter of the Interagency Institute, from being a participant and Institute graduate to a consistent and active member of many Surgeons General Panels. Janet and I appreciate his friendship and support and wish him well in his future endeavors.

I also express appreciation to MG David Rubenstein, MS, USA, Chief, Medical Service Corps, as he retires from active duty. A graduate of the Institute, he recently has chaired our Training and Education Committee. His distinguished army career has included being the first MS officer to serve as Deputy Surgeon General. We have enjoyed General Rubenstein’s friendship and support for many years and wish him all the best for the future.

Best wishes to all our alumi/ae, faculty members and friends of the Institute.

Richard F. Southby, Ph.D., F.F.P.H., F.C.H.S.M.
Director
Letter from the FHCEIAA President

Dear Colleagues,

Congratulations to the graduates of the 121st Interagency Institute (IAI)! It was a great opportunity to meet many students, alumni and friends. We are so appreciative of Delta Dental of California’s continued support for this wonderful evening. On behalf of our Alumni Association, I welcome those who have become members of the Federal Health Care Institute Alumni Association (FHCEIAA) and I encourage you to become active in FHCEIAA activities. I had yet another opportunity to share with the students, the benefits of joining the FHCEIAA in terms of networking and meeting our goals of promoting and fostering joint federal health care collaboration and education. Dr. Ronald Glasser, author of *Broken Bodies, Shattered Minds: A Medical Odyssey from Vietnam to Afghanistan*, joined us as our guest speaker. He shared insights and observations about continued changes in health care delivery, especially in the military health care system. He is the . He met many of the participants and autographed many books after dinner.

The FHCEIAA Board of Directors recently met at AMSUS Headquarters in Bethesda MD. We reviewed the bylaws and discussed a number of issues to include the benefits of being a member of the alumni association. In addition to the networking benefits, we receive *The Record* following each IAI course which provides feedback and information from the recent course to include key speaker information and workgroup updates. We continue to update our FHCEIAA website, [www.fhceiaa.org](http://www.fhceiaa.org), with current information and accessibility to our membership roster. Please visit the site and let me know if you have recommendations for future upgrades. This website offers an opportunity to connect with alumni and if you have updates on assignments, address changes, successes, etc. Don’t hesitate to send this information to president@fhceiaa.org or rah4bucs@comcast.net.

Finally, I remind all members of the $1,000 scholarship opportunity for Alumni dependants. Frankly, we do not receive many applicants for this scholarship opportunity so I ask you to share this information with your alumni friends. The Alumni association annually awards a $1,000 scholarship to the son/daughter or dependent grandchild of an alumnus. More information can be found at our website. Applications are due 1 July 2012, so please plan ahead. Send applications to COL(R) Roy A. Harris, 9865 Diversified Ln, Ellicott City MD 21042.

The next FHCEIAA Annual Business Meeting will be held on **Tuesday, 13 November 2012**, at the 118th Annual Meeting of the Association of Military Surgeons of the United States (AMSUS) in Phoenix AZ. Exact details are yet to be arranged but it will include a breakfast from 0630 to 0730. Our board is always in search of opportunities for improvement for YOUR alumni association so please do NOT hesitate to share those recommendations at the email addresses above.

I trust all of you will take some time to be with family and friends during the summer months.

Carpe Diem!

Roy A. Harris, RN, PhD
COL, USA, Ret
President, Federal Health Care Executives Institute Alumni Association
Every war has its own signature wounds and the effort of the military to successfully deal with those injuries eventually work their way into civilian medicine to become a universal standard of care. Good ideas, better understandings of disease and injury, more effective procedures and treatments have a power all their own whether on the battlefield or in a large urban emergency room or intensive care unit.

In Vietnam you were shot and in Iraq and Afghanistan you are blown up and that makes a big difference when the object is to save lives. The penetrating chest and abdomen wounds of 1965 to 1975 necessitated the development of arterial and venous graphs, better and more effective antibiotics and the use of whole blood to replace the plasma developed during World War II. Getting blown up demanded better prosthetic devices and a better understanding of the brain, how it functions and the whole issue of traumatic brain injuries and the relationship between concussive brain injuries and Post Traumatic Stress Disorder. And now with over 400,000 of those 2.4 million soldiers and marines with multiple deployments to Iraq and Afghanistan and another 300,000 with or expected to develop the symptoms of PTSD while still on active duty or after discharge from the military, the physicians within the DOD as well as the VA are leading the way to both a better understanding of brain injuries as well as the best treatments along with new understandings of the best preventive measures.

As a physician in private practice working at a large children’s hospital, I can assure you that civilian neurologists and neurosurgeons are already employing the understanding developed within the military to better diagnosis, treat and prevent traumatic brain injuries in our patients.

It is now clear from research done at Landsthul Medical Center in Germany that the usual imaging techniques to detect traumatic brain injuries are not adequate to detect the brain pathology that result from blast injuries. The need to use the newest tensor MRIs to discover the damage to brain fibers unseen by convention imaging has been adopted by civilian hospitals in their evaluation of possible head injuries by young athletes playing football, ice hockey and soccer.

Studies funded by the Pentagon and the VA to better understand the connections between concussive injuries and the development of PTSD has lead General Peter Chiarelli to propose that the definition of Post Traumatic Stress Disorder be changed to simply Post Traumatic Stress to better define a disorder that is not a disorder of the mind, but rather the result of damage to the brain.

What is clear from the military studies is that both combat soldiers exposed to the blasts from explosive devices as well as athletes suffering blows to the head are at risk of developing significant psychiatric issues and that if such injuries continue to the currently incurable neurological disease called Chronic Traumatic Encephalopathy. It is hoped from both the increasing military and the new found civilian interest in CTE that both treatments as well as preventive measures will follow these new understandings of how shaking the brain can lead to such clearly unexpected and catastrophic outcomes.

Editorial submitted by Ronald J. Glasser, M.D., author of the acclaimed "365 days" about the Vietnam War and "Broken Bodies Shattered Minds" recently nominated by the American Library Association as the outstanding non-fiction book of 2011. Dr. Glasser was the guest speaker for the Participants’ and Alumni Dinner, 121st Institute.

A Bakers Dozen of “Must Reads” recommended at the 121st Institute:

- A Lesson Before Dying, Gaines
- Influencer: The Power to Change, Patterson, et al.
- Managing at the Speed of Change, Conner
- Nudge, Improving Decision About Health, Wealth, & Happiness, Thaler & Sunstein
- Our Iceberg is Melting, Kotter
- Outliers, The Story of Success, Gladwell
- Predictably Irrational, The Hidden Forces That Shape Our Decisions, Ariely
- Primal Leadership, Goleman, et al.
- The Black Swan The Impact of the Highly Improbable, Taleb
- The Innovator's Prescription, A Disruptive Solution for Health Care, Christensen, et al.
- The Price of Civilization, Sachs
- Thinking, Fast and Slow, Kahneman
- Today Matters, Maxwell
Group I Project Report: Which is the Most Significant of the “Seven Revolutions”?

Group members: CAPT Iris Boehnke, USN; LTC Jorge Carrillo, USA; LTC Chinneth Iluminada, USA; Col James Clapsaddle, USAF; CDR Peter Colella, USN; Col Scott Corcoran, USAF; CAPT Robert DeMartino, USPHS; Ms Nancy Donovan, DVA; Dr Michael Ebert, DVA; CAPT Kurt Henry, USN; Col Angela Montellano, USAF; Col Catherine Nelson, USAF; COL Peter Nilsen, USA; and Col Danielle Savard, Canadian Forces.

Introduction: SEVEN REVOLUTIONS is a project at the Center for Strategic and International Studies (CSIS) to identify and analyze the key policy challenges that policymakers, business figures, and other leaders will face in the out years and to promote strategic thinking on the long-term trends that too few leaders take the time to consider. CSIS has tracked the “revolutions” identified in Figure 1 since 2006 and predicts that each will profoundly shape the world by 2025.

Group I selected Governance as the most significant of the Seven Revolutions. A drought in the Sudan in 2011 killed thousands, displaced hundreds of thousands, and put an estimated 17 million people at risk of starvation. In 2006, England suffered one of its most severe droughts in a century. People were not allowed to wash their cars. Fruit was pricier. Lawns died.

There are innumerous differences between the Sudan and England, but the most important one—the one that determined whether people lived or died—is governance. The quality of each nation’s governance determined their ability to plan, organize, and respond to the threat of drought.

What is Governance and why is it important? When a person or group exercises authority and control, they are governing. A governing body can be large and international like the United Nations or a multinational corporation or they can be as common as a country or as small as a neighborhood association.

Governance sounds esoteric and dull, but it is unique in that it is the only revolution that has the ability to fully leverage the opportunities and benefits presented by other revolutions (like technology or resource stewardship), while also preventing or mitigating threats posed by other technologies (like the population explosion or conflict).

Governance’s relation to the other revolutions: The following summary cannot address governance’s impact on all the trends, so examples of how governance can impact three, current, real-world revolutions that pose threats to peace, wealth, and the health of nations will be presented.

1. Economic Integration Revolution (Globalization)

The Opportunity and the Threat: Globalization is the increasing interconnectivity of the world’s people, cultures, and economic activities. We cannot stop globalization, but we can guide and govern it. Nations are now so fiscally interconnected that Italy’s failure to pay off its international debts, for instance, could denigrate the health retirement account or stock holdings of a retired farmer in Iowa. Italy’s government has poorly managed its wealth to the point to where it owes more money to creditors than the nation can produce in a year. If Italy fails to pay off its 2012 debt, the entire European Union’s (EU) economy may be damaged. Since the EU is the U.S.’s second largest trading partner (behind China), any financial problems the EU suffers will undoubtedly impact the U.S.

Governance’s Opportunity or Mitigation: Two revolutionary governance organizations could save Italy; the International Monetary Fund (IMF) and the European Union (EU). Both are Non-Governmental Organizations (NGOs). Numerous countries belong to them, trust in them, and contribute funds to invest in the financial stability of its member nations. They will help Italy restructure its debt and government, likely lend them the funds to survive, and could prevent its collapse. Such NGOs did not exist 60 years ago; they have arisen only in the last half century, but they are growing in number and power. NGOs like these revolutionize how resources are managed among nations and in doing so, they may benefit the Iowa farmer’s retirement and billions of other people worldwide.
2. Population Revolution

The Threat: To limit rapid population growth, China’s leaders enacted a One-Child Policy in 1979 with painful and unintended consequences. There are now 114 men to 100 women (normal populations have 104:100), fewer children to care for elderly parents, and Chinese men seek foreign wives who, in the minds of Chinese, dilute ancient bloodlines by infusing other bloodlines and cultures. Even more threatening in the minds of some Chinese is that men are marrying women of the neighboring “Stan” regions who are predominantly Muslim and may introduce religion and potential rebellion into an officially atheistic China. In short, the one-child policy threatens Chinese healthcare, culture, and national security.

Governance’s Opportunity/Mitigation: This example demonstrates the impact and unintended consequences of poor governance. China is famous for grand governance schemes impacting millions of its citizens. For instance, China is currently planning the creation of a yet-unnamed megacity projected to be 1.5 times the size of Massachusetts and will hold 42 million people (New York: 8 million). China’s communist government is unique in the sheer power of its governance to manipulate the impact of populations. Time will tell whether or not such heavy-handed governance is beneficial.

Population revolutions do not impact China alone; for instance, the increase in life spans and growing number of elderly impacts almost every nation. The USA will see its 65-year-old and older population increase from 12% of the population in 2010 to 25% by 2030. This is problematic since elders consume four times the care as others, pay far fewer taxes to support their benefit, and there are enough physicians trained to provide gerontology care. Governance will impact how well the U.S. mitigates this looming threat through benefit restructuring and increasing/changing medical school curricula to meet this potential crisis.

3. Conflict Revolution

The Threat: War and genocide in the 20th century killed an estimated 160 million people. The mere threat of war motivates nations to amass militaries which consume from 2% to 10% of their national budgets. The CIA reports that in 2009, the world spent an estimated $1.3T on militaries, nearly $800B was spent by the U.S. alone. Preparing for—and engaging in conflict—diverts funds that could be used for health care and conserving life rather than its destruction. War and the threat of war is the largest single threat to health on the planet.

Governance’s Opportunity/Mitigation: The opportunity to prevent war. When countries are mutually dependent upon each other for wealth they rarely attack each other. Thomas Friedman described this as the Golden Arches Theory or Democratic Peace Theory; he posits that no two nations with a McDonalds have ever gone to war with each other. His point is that nations mutually reliant for trade and who boast strong democracies are much more likely to resolve conflict with words, not weapons. This is a relatively new development, as previously nations sought to expand their wealth by conquering other nations. Now, the process of globalization poses economic prosperity as more readily achievable by international and cooperative governance rather than war. For the record, Russia attacked Georgia in 2008 and NATO bombed Serbia in 1995. All parties had at least one McDonalds, proving the exception to the Golden Arches theory, however, the idea that economically intertwined nations are more likely to avoid conflict remains valid.

Governance and Health Care. It is not difficult to see how the three scenarios can tie into healthcare: Economic problems dry up healthcare funding, population explosions dilute health care resources, war kills. Good macro-governance can mitigate these problems, but good governance is also critical at the micro-level - managing development of the Electronic Health Record, legislating healthcare reform, exploiting technology to assist underserved locations, etc.

Unfortunately, good and effective governance is a rare commodity; witness the deadlock of the our own U.S. Congress in 2011/2012 and its failure to address the energy, employment, financial, and health care crises before it. Our own government’s failure serves as testimony that progress is possible only with good governance; nothing is achievable without it. End
**Group II Project Report: Medical Home**

**Group Members:** Col Scott Calder, USAF; CAPT Debra Crowell, USN; Col Leslie Dixon, USAF; CDR Karen Dorse, USPHS; Mr. Shane Elliott, DVA; Col Alden Hilton, USAF; CAPT David Jones, USN; Col Allen Kidd, USAF; Ms Rachel Mitchell, DVA; LTC Michelle Munroe, USA; LTC Ricardo Nannini, USA; CDR Shay Razmi, USN; and LTC Luis Rivero, USA.

**How is the medical home concept being applied in federal health care?**

All three military services, as well as the Veterans’ Health Administration (VHA) are actively implementing and/or utilizing the Patient-Centered Medical Home (PCMH) concept. The intent is to improve patient health and health outcomes with a secondary goal to slow the increases in healthcare costs. Similar efforts are evidenced by Geisinger, Kaiser, Bon Secour and many other groups who often provide health insurance in addition to medical care. The concept is being implemented along the guidelines set by the National Committee for Quality Assurance (NCQA), driven by higher command emphasis on outcome metrics, such as Healthcare Effectiveness Data and Information Set (HEDIS) and patient satisfaction, and propelled by advances in information technology and management.

Results so far have been promising, with increased Primary Care Manager (PCM) continuity, increased HEDIS metrics and patient satisfaction. Implementation has had its challenges as across the board there are difficulties in hiring adequate support staff to support the number of providers in the medical homes. There is intense competition for personnel among all healthcare organizations. Supporting space requirements (number of exam rooms per provider) in the smaller Medical Treatment Facilities (MTFs) is also challenging.

The Army has been implementing PCMH for several years with the recommended enrollment of 1250 enrollees per Full-Time Equivalent (FTE) provider. The PCMH team is multidisciplinary, with providers (physician and mid-level PAs and NPs), RNs, LPNs, and medical clerks in a ratio of 3 support staff per provider. Clinical pharmacy (75 more Clinical Pharmacists required for a staffing level of 8500 enrollees per FTE Pharmacist) and embedded behavioral health providers are envisioned. The MTFs have been implementing the concept independently with three variations: the “traditional” PCMH operated by the Army Medical Command, the Soldier-centered medical home (run by the unit-assigned operational medicine providers), and the community-based PCMH that is located off-post and closer to the community it supports.

The Navy’s version, the Medical Home Port (MHP) has been implemented world-wide. The typical MHP enrolls 1250 beneficiaries per FTE provider. Teams consist of 4 or 5 providers supported by 2 RNs, 2 LPNs and 1-3 clerks. Case managers, clinical pharmacists, and embedded behavioral health support (1 provider per 7500 enrollees) are envisioned. There are pilot programs to implement a Marine-centered Medical Home for care of active duty Marines in addition to establishing a Fleet Forces-Centered Medical Home concept.

The Air Force implemented PCMH worldwide in CY11 at the direction of the AF/SG, Lt Gen Green. It assigns 1250 enrollees per provider with each team consisting of two providers and 5 support staff. The Air Force team adds a Health Care Integrator (HCI), carried over from an earlier health care delivery model, whose role is to conduct development and maintenance of sound health care practices through the use of disease management, case management, utilization management, evidence-based practice and population-based health care. The Air Force has considered integrating a medical administrative technician to the team as well. The PCMH concept in the Air Force strictly limits cross-booking, which enhances patient/provider continuity.

In the VHA System, the concept is known as Patient Aligned Care Team (PACT). The ultimate goal is to transform primary care throughout the system in order to provide a coordinated approach to delivering healthcare that is centered around, and customized for, each Veteran. Each PACT consists of the physician, the RN care manager, an LPN and clerical support. This unit is referred to as a “teamlet” and it coordinates the Veteran’s care through multiple avenues including telephone, secure messaging, telemedicine, group visits, community connections and the capacity for same day face-to-face visits. Staff and resources have been allocated to ensure there is a ratio of 3 support staff to 1 physician. Daily clinic practice has been redesigned to use staff efficiently and to improve access to care for the Veteran. Other support services are added to augment the teamlet, including social work, pharmacy, mental health, and dietitians as required. The VHA has also created an office to focus efforts on implementation and expansion to specialty services.
throughout all medical centers and clinics. The next step in PACT development is to integrate Health Promotion/Disease Prevention, Mental Health, Geriatrics, Women’s Health and other Specialty Care Services within Primary Care.

What are the differences in the application of this concept in the public and private sectors?

For purposes of this discussion, we have defined the public sector as the federal healthcare system, and the private sector as the civilian healthcare system. The private sector has certain advantages in implementing PCMH. They can be more agile in having staff adopt PCMH, can often more easily remove a staff member who is not willing or able to adopt the PCMH model, and often have more stability of staff and patients, thus allowing continuity between the patients and their providers and between the support staff and providers. In the military sector, service members and families and active duty or married to active duty medical care providers move frequently and/or are deployed disrupting continuity between the PCMH team and patients as well as within the PCMH team.

Since the military is not a for-profit healthcare delivery organization, it does have some benefits in implementing and applying PCMH to primary care health delivery. An obvious advantage is the ability to hire a potentially large number of employees nationwide at once, thus hiring the resources required to make PCMH work. This is presented as an advantage although the hiring mechanism is slow and cumbersome and is often perceived as a major impediment to hiring. The government can also leverage data gathered on the beneficiaries, such as HEDIS, in order to support PCMH efforts. Another downside is that many systems the government relies on, especially tri-service ones such as AHLTA (Armed Forces Health Longitudinal Technology Application), are not flexible and adaptable enough to be changed quickly to enhance PCMH support, while smaller civilian medical groups can make quicker changes to an Electronic Health Record (EHR), Epic for example, in order to support PCMH efforts. Evidence of this is how Bon Secours was able to develop a referral tracking system more quickly in Epic, while the Military Health System (MHS) has not been able to come up with a single solution for all three armed services because it is much more difficult and costly to make changes to a larger organization.

Where does this concept differ from earlier models of coordinated community based health care?

In military and civilian sectors alike, implementing PCMH is a culture change for both staff and patients. PCMH attempts to address issues that currently plague the U.S. healthcare system - high cost, poor quality, poor coordination and accessibility. Before the PCMH concept, most medical systems provided episodic health care based on productivity, while patients were used to seeking health care only when they had a problem. PCMH looks to change that, creating coordinated acute, chronic and preventive care that works together seamlessly for the patient and in the end should produce a healthier population with reduced hospitalizations and fewer visits to the emergency room and acute care clinics.

No other model of community-based healthcare has taken strong roots in the military. In the 1990’s, there were efforts toward more coordinated community based health care, and in the late 90’s, PCM-by-Name received support from the TRICARE Management Activity (TMA) and the VA Health Affairs, however, it did not receive much emphasis in many facilities. The Air Force previously adopted the concept of Primary Care Optimization (PCO). The PCO enrolled 1500 patients per provider, with a staff of one RN, two LPNs, and 0.5 administrative staff support per provider. PCO was not as successful as desired due to poor resourcing, unrealistic timelines, and metrics that drove behavior rather than outcomes. One major problem of the PCO was liberal cross-booking, which significantly affected continuity of care. The model also lacked provider freedom to manage empanelled patients, a significant positive feature of the PCMH. Efforts ceased and the country became focused in war efforts following the events of 9/11, and it was not until 2006-2008 that PCMH efforts were begun in MTFs.

References:
Group III Project Report: Affordable Care Act

**Group Members:** Ms. Deesha Brown, DVA; CAPT Lynn Downs, USN; CAPT Tim Howell, USN; Ms Nhi Nguyen, DVA; Col David O’Brien, USAF; CDR Kyle Petersen, USN; Col Phil Preen, USAF; Col Marina Ray, USAF; CDR Paul Reed, USPHS; COL Judy Robinson, USA; Col Rebecca Seese, USAF; COL P.K. Underwood, USA; and CDR Donna Williams, USN.

The Patient Protection and Affordable Care Act (ACA) seeks to modify US health insurance programs with the goals of increasing access, containing cost and improving patient health outcomes. This new legislation provides many strengths and challenges for US healthcare stakeholders. This paper will examine ACA strengths and challenges on various population segments and healthcare organizations.

**For uninsured, legal residents of the US:** There are 47 million (15% of the population) uninsured, legal residents in the United States. This population relies on the Emergency Department visits to obtain their healthcare, costing approximately $330 per visit. Only 23% of these visits are legitimate emergencies and cost five times more than a primary care visit. Also, the uninsured population typically cannot afford common lifestyle preventive measures. ACA addresses primary care and preventive medicine services, potentially offsetting disease treatment portions of skyrocketing healthcare costs. This increased focus on preventive health will ultimately reduce long term costs and improve quality of life for the uninsured.

The political challenge is convincing the remaining 85% of the population to fund this expensive proposal. Strong program implementation is critical, ensuring upfront funding for primary and preventive care to offset higher costs of emergency care. It would be beneficial for the US Surgeon General to field a non-partisan marketing campaign demonstrating benefits of primary care and prevention as less costly and ensuring a better quality of life. An oversight committee should report the results of health and financial ‘Return on Investment’ annually to the American public. Finally, ACA implementation needs to maintain preventive health incentives to reduce long-term healthcare costs.

**For retirees:** Early Retiree Reinsurance Program (ERRP). The $5 billion Early Retirement Reinsurance Program is a little-known provision of the last year’s health care reform law which encouraged companies to provide health care to early retirees, (people who retire in their 50s or early 60s before Medicare benefits kick in at age 65). The early retiree program stopped accepting applications in May after spending roughly half its funds in less than a year. Of additional interest, social security benefits continue to not count as income to determine Medicaid eligibility, another ACA advantage for retirees, both military and civilian. For military retirees, even with proposed increases in premiums for TRI-CARE for Life (TFL), it still appears to be the least costly alternative.

**For healthcare providers:** PCMs and rural general surgeons will get a 10% bonus from Medicare, however, this may be insufficient to move physicians into primary care or to rural populations. Additionally, a proposed raise in Medicaid fees to match Medicare fees might be undermined if Medicare reimbursement formulas are not reformed. There will be fewer obstacles to preventive medicine services, with no co pays for preventative care or procedures which will lower future disease burden and costs. Delivery of this benefit may be challenging since there is no provision to increase the number of gastroenterologists, radiologists or other specialists to meet the demand. ACA will require a transformation of preventive medicine delivery to meet increased demand and potentially limited funding, such a scenario could create a potential shortage of GI and radiology specialists.

Providers and hospitals will be highly encouraged to form Accountable Care Organizations (ACOs). New Center for Medicare and Medicaid Services (CMS) criteria will bring potential cost savings and quality awards if ACOs meet CMS criteria and financial penalties if goals are unmet. Pre-authorizations for pre-existing conditions will be eliminated, which might improve provider efficiency. Moreover, ACO requirements will likely bring an end to solo physician and small group practices. Finally, providers may receive some tort relief if a $50 million demonstration project for litigation alternatives is funded.

**For Hospitals:** Hospitals stand to gain financially as care for previously uninsured patients will now be reimbursed. Bundled payments to hospitals and providers will potentially provide leverage for larger hospital-based systems to control local markets. Additionally, evidence for the Massachusetts state healthcare reform suggests a reduction in total hospital stay days – however, readmission of patients will incur financial penalties and needs to be avoided. If the
Massachusetts experience is extrapolated, there is potential for increased patient volume as uninsured/underinsured obtain hospital care. This may create bed shortages in some markets, but not necessarily clear where new construction may be required due to questions regarding covered surgical benefits. Pilot studies today might help guide future hospital development. Teaching hospitals may potentially lose critical care cases due to reimbursement changes, thereby limiting medical education opportunities.

**For State governments:** There are numerous effects on states with ACA implementation; key elements include: 1) Medicaid coverage will significantly expand to include lower income individuals and families. 2) States will be required to establish state-level, public health insurance exchanges for the uninsured that are not eligible for Medicaid/Medicare. This may be accomplished through multi-state regional insurance exchange partnerships. 3) States should be able to achieve savings despite increased costs associated with newly eligible low-income adults due to increased federal funding and private insurance. States will likely encounter physician shortages as new insurance enrollees seek help. Timely provider access may also be hampered by lack of plans and infrastructure to accommodate millions of new patients.

**For the Federal Health Care System:** When examining how the Federal Health Care System (FHCS) is affected by the ACA, the following federal entities were considered: Veterans Health Administration (VHA), Military Health System (MHS), Indian Health Service (IHS) and Public Health Service (PHS). Two of the four entities are relatively unaffected by ACA and will be presented first. There is no change in VHA health care eligibility, covered benefits, co-payment or VHA healthcare operations. ACA does require the VHA to participate in the Interagency Working Group on Healthcare Quality, exempts VHA from a health insurers’ fee and provides free access to the National Practitioner Database. However, VHA could have a problem with decreased patient utilization since veterans could seek care in the community.

For the MHS, ACA does not significant challenges. TRICARE benefits, eligibility, covered benefits or copayments are unchanged. ACA provides a Medicare Part B enrollment window eligibility enabling certain individuals to gain TRICARE for Life coverage. It also potentially allows the MHS to expand coverage for Reserve and National Guard in remote areas at decreased cost via ACA exchange insurance rates rather than build TRICARE networks in low-density service areas. Additionally, active duty family members may opt out of TRICARE Prime and decide to purchase insurance through one of the state exchanges and seek care in the community. If a large number of family members opt out of TRICARE Prime, the Military Treatment Facility (MTF) utilization could be decreased and could affect the number of clinics in each Service.

IHS and PHS could be improved tremendously by the ACA. The major change for IHS is the permanent authorization of the Indian Health Care Improvement Act and authorizes multiple new programs within IHS. Furthermore, ACA will drive PHS to increase education and training opportunities in primary care and provides for loan repayment. However, the loan repayment feature has not been funded. Perhaps the most affected governmental agency is CMS which has the responsibility of ACA oversight and implementation.

References:
Health Capital Topics, Volume 4, Issue 5; Why do We Need ACOs?
Health Capital Topics, Volume 4, Issue 6; What are ACOs?
Fact Sheet-Health Reform for AIANs – Indian Health Service.
White House Fact Sheet: The Affordable Care Act: Supporting Innovation, Empowering States (February 28, 2011).
Group IV Project Report: "Broken Bodies Shattered Minds"

Group Members: COL Perry Chumley, USA; COL Lee Covington, USA; COL John Kent, USA; Col Kevin Murphy, USAF; Mr Sean Nelson, DVA; CAPT Angela Nimmo, USN; CAPT Corazon Rogers, USN; CDR Sophia Russell, USPHS; Col Lisa Schmidt, USAF; Dr Robert Smith, DVA; CAPT David Tarantino, USN; Col Richard Terry, USAF; and Col Chris Torres. USAF.

In the book, “Broken Bodies Shattered Minds”, Ronald J. Glasser, M.D., describes his personal trauma and difficulties serving as a physician during the Vietnam conflict. Using his experiences and those of men and women who have served in more recent conflicts, he builds a case that the VA and DoD have not acted quickly or effectively to address the problems attributable to current combat conditions such as repeated deployments or exposure to IED blasts.

While some of the perspectives offered in the book may be attributable to the author’s lack of knowledge of current VA and DOD efforts, that very deficit reflects the reality of the knowledge gaps of the general public and points to areas that should be addressed. These areas are divided into three broad “lessons learned.”

1. Integrated Surveillance Systems and Threat Responses

   The first lesson is that PTSD, TBI and complex blast injuries (polytrauma) were recognized early in the current conflicts but programs to address them were not adequately developed, implemented, or resourced. For instance, VA prevalence data demonstrated the increasing prevalence of new mental health diagnoses in successive cohorts of OEF/OIF veterans beginning in 2003 and continuing through the present (Seal et al. Am J Public Health. 2009; 99:1651–1658).

   While data on TBI are not as readily available, it is clear that blast injuries and their sequelae were recognized early in the conflict. Having said that, we caution that not all future problems are predictable and systems need to be developed that both recognize and treat current problems and are able to identify emerging problems rapidly. Therefore, proactive syndromic surveillance programs need to be incorporated into pre/post-deployment evaluations, while in theater, and longitudinally thereafter. These programs should support evaluation of TBI, PTSD screening, potential environmental exposures, and others; and must support rapid analyses of data and the utilization of the data to direct research and deployment of evidence-based therapeutics.

   In order to accomplish this, a systematic integration and analysis of current VA and DOD screening efforts is needed. These efforts (e.g. IED Surveillance Efforts in DOD; PDHA/PDHRA, OEF/OIF/OND Screening in VHA) must to be integrated into a single comprehensive system of records. This effort must include the development of common data definitions and storage systems for the range of syndromic surveillance data AND must include mechanisms to retrieve key information for clinical care, research, and other future uses both within and outside DOD or VA. In particular, there must be integration of key surveillance and screening data into the nascent development of an integrated VA/DOD EHR as well as into key personnel records. Key elements must also be shared with private sector care providers through incorporation into VLER development. It should be cautioned that any developing system must provide flexibility to allow inclusion of currently unforeseen elements (environmental exposures from fire pits; radiation exposure, etc.).

   Development of this element should be undertaken by OSD/Health Affairs with implementation potentially assigned to the Armed Forces Health Surveillance Center and with cooperation by VHA. Many of the elements to support this were felt to exist and could be funded from within the existing Agency budgets upon appropriate prioritization.

   In order to make more effective use of the surveillance data, a “Health Threat Board” should be established and assigned the mission of assessing and rapidly evaluating emerging health threats or challenges. This entity would be charged with developing and prioritizing responses to these threats in a proactive fashion and with fast tracking screening, research, and therapeutic interventions. This effort is a joint VA/DOD responsibility that would require coordination between the Armed Forces Health Surveillance Center; Medical Research and Materiel Command; and the VA Office of Research and Development, Health Services R&D and Cooperative Studies programs. External entities including the Centers for Disease Control and the Institute of Medicine were felt to have essential contribution and could assist in the implementation of required interventions within the private sector where a significant portion of long term care needs will require care. This effort will likely require additional programmatic funding.

2. The need to inform the public of the ongoing mind and body issues with military returning from war

   The second lesson learned focused on the importance of keeping the public informed with respect to current combat
injuries. Service members returning from the war have complex physical and psychological injuries. While there has been a tremendous media focus on political and financial aspects of the war in Iraq and Afghanistan, it is not clear that the general public, policy makers, patients, families, or healthcare workers who care for the wounded have a clear understanding of the impact and toll the war takes on our returning military members. The author illustrates the need for continued understanding of the complexity and differences between military conflicts and related war injuries over the decades. Advances in initial treatment and management, and improved personal protective equipment have led to improved survival rates. However, these improvements have also resulted in an increased severity of injuries to body and mind among survivors.

Since October 2001, approximately 1.6 million U.S. troops have been deployed for OEF/OIF/OND in Afghanistan and Iraq. The rates of PTSD and TBI are rapidly increasing resulting in a continuing need to focus public attention on the long-term consequences of these injuries. Though numerous research projects are underway, there is limited evidence about the scope of the problem or the most effective treatment modalities.

The Wounded Warrior Project Mission statement epitomizes the overall goal for these returning service members by stating that their purpose is “to foster the most successful, well-adjusted generation of wounded service members in our nation’s history. Similarly, the Armed Forces Foundation believe that raising public awareness of the hardships our service members face is essential to our mission of "serving those who serve." To that end, they have begun a number of initiatives directed at raising awareness of PTSD and TBI since these are the signature injuries of the wars in Iraq and Afghanistan.

Current and future programs need to focus on campaigns to assure public awareness of the extent of war related injuries; early identification of signs and symptoms; education of available information and resources; and publicize success stories (advances in protective gear i.e. Body Armor, medical advances in the field i.e. fibrin bandages, prosthetics, and VAC therapy).

A focus on research and subsequent release of clinical results to the public are essential. One example of current research efforts include a project by RAND assessing the post-deployment health-related needs associated with post-traumatic stress disorder, major depression, and traumatic brain injury. They are examining the treatment capacity of the current health care system, and estimated the costs of providing quality health care to all military members who need it.

3. Coordinated Long-Term Follow-up and Treatment

The final lesson is that there is a need for coordinated services for medium and long-term follow-up related to injuries from the current conflicts. These include PTSD and TBI-related care, family and caregiver support, and long-term needs for warrior care.

Three distinct actions are felt necessary to provide optimal care for our Veterans and to provide support to those caring for our nation’s heroes. First, the DoD and VA must develop a policy and plan that will bridge the continuum of care between the DoD, VA and the private sector. The key initiatives supporting this are: a) Accelerating the creation/deployment of the Integrated Electronic Health Record; b) Enhancing the use of the US Armed Forces Health Surveillance Center; c) Leveraging Clinical Centers of Excellence; and d) Developing a role for the Patient Centered Medical Home. Secondly, the DoD and VA will need to develop training programs for current providers and future providers (e.g. GME, Nursing Education, etc.) to address issues of PTSD, TBI and complex blast injuries. Finally, public and private Family/Caregiver support systems require further development through family support efforts, awareness campaigns for existing services and identification and elimination of disjointed/duplicative services.

To address these issues, a joint DoD/VA integrated electronic healthcare record with capability for web-based sharing with the private sector is essential. The DoD and VA must enhance the consultative capabilities of the DoD and VA Centers of Excellence (COE) to improve the continuity of care and to support training of the entire healthcare team. Consultative support also extends to the Patient Centered Medical Home (PCMH). The COEs would utilize National Quality Foundation metrics to measure the effectiveness of these programs. Both of these initiatives should be led, coordinated and funded jointly by the DoD and VA. (Continued on page 12)
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The DoD and VA must continue working together to develop and enhance the VA Caregiver Support Program. An opportunity exists to leverage the COEs and lessons learned from the James Lovell Federal Health Care Center Home in Great Lakes, and to explore capabilities in the private sector to support and augment existing programs within the DoD and VA. Finally, coordinated marketing efforts are needed to advertise available resources and to create a support network for Veterans, families, caregivers and communities. Funding for these initiatives would come from the VA, while implementation is a joint effort by the DoD and the VA. **End**