



THE RECORD

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From the Director...

I am very pleased to report that, in spite of all the pandemic and fiscal disruptions over the past two years, we were able to hold a one-week virtual Institute in May and a 'normal' two-week Institute in October 2021.

The 137th Institute was the result of a very successful collaboration in funding and implementation among the Defense Health Agency, the Uniformed Services University of the Health Sciences and the Washington-based Bush School of Government and Public Service, Texas A&M University. I am most grateful to LTG Ronald Place and Brig Gen Anita Fligge, DHA; Mr. Bob Thompson, Chief of Staff, and Mr. Walt Tining, Vice President for Finance and Administration, USUHS; and Lt Gen Jay Silveria, Executive Director, the Bush School, for making this most recent Institute possible.

The Institute was held in the new facilities of the Bush School in downtown DC, very close to the White House. In addition to a very pleasant environment, another significant advantage was that we did not have to deal with all the security challenges associated with the Naval Support Activity at Bethesda in getting non-DoD persons access to the campus.

I am hoping that this collaborative model will be our 'new normal' for the Interagency Institute for some time to come. Close working relationships with Texas A&M should prove to be mutually beneficial to all the partners in the future.

There is no question that we are living in extremely turbulent times that show no signs of abating any time soon. While it may be attractive to try to ignore these pressures and challenges as federal health professionals we do so at our peril. Senior health leaders in both the public and private sectors need to be aware of national and global forces that influence health and health care and lead proactively to ensure delivery of the highest quality of health care to all beneficiaries.

These disrupters mean that we must constantly adapt what and how we teach the participants in the Interagency Institutes. We would be negligent in our responsibilities if we do not do this. I hope that our participants will recognize the importance of understanding these ever increasing challenges from within and without the world of health care and be prepared to adapt and develop new leadership capabilities. It will not be easy but it is vital.

Sincerely,

Richard F. Southby, Ph.D. (Med), F.F.P.H.M., F.R.S.P.H., F.C.L.M. (Hon)



TEXAS A&M UNIVERSITY
The Bush School
of Government & Public Service



MISINFORMATION AND DISINFORMATION OF THE COVID-19 VACCINE

Small Group Assignment:

- What are the examples of misinformation/disinformation of the COVID-19 vaccines?
- How is the misinformation/disinformation of the COVID-19 vaccines being distributed?
- What organizations are involved in the spreading of misinformation/disinformation?
- Develop a strategy to counter the misinformation/disinformation of the COVID-19 vaccine to include a time frame for implementation and potential funding.

Group Members: Col Michelle Aastrom, USAF; LTC Antione Barnett, USA; Col Peggy Dickson, USAF; Dr. Kim S. McDonald, VHA; COL Scottie Roofe, USA; CDR Heather Shibley, USN; Dr. Colleen Walsh-Irwin, VHA

Introduction

Misinformation and disinformation about the COVID-19 vaccines are proving to be major barriers to reaching the goal of getting the majority of the U.S. population vaccinated. Misinformation is the false or inaccurate claims shared largely unwittingly and without intention to deceive. Disinformation is the deliberate engineered and disseminated false information with malicious intent which often serves personal, political, or economic agendas. The development of a strategy is needed to counter the problems of misinformation and disinformation of the COVID-19 vaccine. Our strategy includes examples of misinformation and disinformation, identifies by whom and how the information is being distributed and explains the timeline and funding required to counter the problem.

Examples of misinformation/disinformation of the COVID-19 vaccines

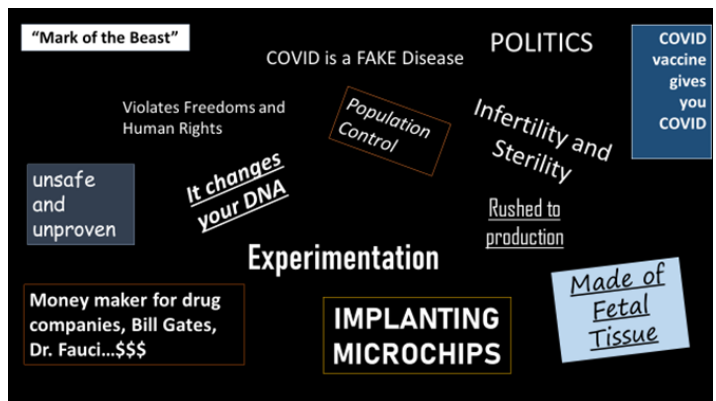
There are four types of false information concerning the COVID-19 vaccines:

- 1) Mischaracterization of the disease or protective measures that are needed,
- 2) false treatments or medical interventions,
- 3) scapegoating of groups of people, and
- 4) conspiracy theories—often about the existence or origin of the pathogen.

Examples of mischaracterization of the vaccine include the vaccine can cause infertility/sterility, is made of fetal tissue, causes testicular swelling, and affects the menstrual cycle. Other misinformation concerning the COVID-19 vaccine involves the vaccine being unsafe and unproven, and the vaccine is a way for drug companies to make money. False and ineffective treatments have included an unapproved chloroquine phosphate treatment, Ivermectin for the prevention or treatment of COVID-19 in humans, inhaling bleach or disinfectants, gargling salt water, and exposure to sunlight and cold weather. Scapegoating of the vaccines include statements that “people who have received the vaccine can still get COVID” and “the COVID-19 is a hoax.” Just as discouraging is conspiracy theories making allegations that the COVID-19 vaccine changes the DNA of humans, will give you COVID, and is a way to control the population.

Distribution of misinformation/disinformation of the COVID vaccines

The misinformation and disinformation of the COVID vaccines are distributed through multiple means. The most common involves the use of social media platforms such as, but not limited, to Facebook, Twitter, Instagram, and Tiktok. Other misinformation and disinformation distribution outlets consist of talk radio,





news outlets, the internet, and media sensationalism. None of which are held accountable to be credible or fact based. Equally vocal on the topic are celebrities, politicians, churches, employees, and peers. Lastly, intelligence has shown that state actors such as Russia, China, and Iran are performing anti-science aggression by weaponizing health communication such as anti-vaccine sentiments.

Strategy to counter the misinformation/disinformation of the COVID-19 vaccine

The misinformation and disinformation of the COVID-19 vaccine should be elevated from a public health risk to national security risk being that false health-related information is occurring during a national health emergency. Therefore, disinformation must be combatted at the source by acknowledging this threat to the U.S., educating the public on adversaries' negative influence, and most importantly developing an interagency Task Force to effectively target and dismantle all efforts of the opposition. The National Security Council should be responsible for developing and overseeing the U.S. strategy for preventing and responding to the management of health-related misinformation and disinformation for the public health emergency of COVID-19. The National Security Council should involve collaborative efforts from the departments of Health and Human Services, Defense, Homeland Security, the State Department, and the intelligence community to develop a comprehensive communication strategy.

The strategy would involve four pillars:

- 1) Intervene against false and damaging content as well as the sources propagating it,
- 2) promote and ensure the abundant presence and dissemination of factual information,
- 3) increase the public's resilience to the misinformation and disinformation, and
- 4) coordination of a national strategy that includes input from social and news media, government, national security officials, constitutional scholars, public health officials, scientists, and the public.

The strategy must also involve holding social media outlets accountable during this implementation process. This can be achieved through the establishment of a commission made up of social media operators, mitigation strategies, and interventions against disinformation or misinformation content that would involve issues of public health. This strategy would seek funding through multiple sources to include the America's Rescue Plan, the CARES Act, Corona Response and Consolidated Appropriate Act, and application for FEMA grants. The overall counter-strategy should occur within 3-6 months to create an immediate impact on the targeted audience to achieve herd immunity at 80% of the U.S. population.

Summary

The spread of misinformation and disinformation through various means can affect COVID-19 vaccine confidence. Most information and disinformation that has circulated about COVID-19 vaccines has focused on vaccine development, safety, effectiveness, and denialism. This misleading information is creating a national emergency with public health. As an immediate counter-measure, a national strategy has to be promptly implemented to combat the threats from all fronts. The strategy would involve collective planning to include stakeholders from social media, news media, government, national security officials, constitutional scholars, public health officials, scientists, and the public. This strategy is crucial to achieving the U.S. national goal of herd immunity.

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DESIGNING A GLOBAL COVID-19 VACCINE STRATEGY

Small Group Assignment: Outline the major elements of a global program designed to bring the current pandemic under control by vaccinating as many people as possible.

Group Members: Ms. Ann E. Doran, VHA; Col Christopher Estridge, USAF; LTC Christopher Everett, USA; Col Maureen Farrell, USAF; CAPT Tracy Isaac, USN; LTC(P) Jeffery Limjuco, USA; CDR David Rasmussen, USN; Col Bill Rideout, CAF

Introduction: Since the COVID-19 pandemic began in March 2020, the world has experienced significant health, economic, and societal changes. In 18 months, five million people worldwide perished and countless were negatively impacted. While the advent of effective vaccines provides hope for a path out of the pandemic, significant work remains to minimize further negative effects of this global health challenge. This discussion will focus on the role of vaccines considering the broad areas of economics, politics and logistics.

Economics. Gavi, the Vaccine Alliance, is a public-private partnership focused on improving vaccine access for lower-income countries. While currently focused on COVID-19, the strategy should support flexible and scalable vaccine development in different parts of the world and multi-year funding to facilitate efficient financial planning and minimize fiscal timeline waste. As Dr. Hotez stated in *Preventing the Next Pandemic*, “the anti-vaccine movement...represents our latest threat to global health security,” funding must also be made available for significant education campaigns to combat the anti-science movement. Funding a proactive, science-based information campaign is as important as funding the actual manufacturing and distribution of the vaccine itself.

Current vaccine manufacturing and logistics, relatively sophisticated and costly, are economic barriers for lower income countries. In today’s global village, an effective strategy will include the potential contributions of the public, private and global sectors. The WHO, World Bank and other global institutions are focused on financing and manufacturing COVID-19 vaccines with the goal of ensuring equitable access via two types of core funding mechanisms: Domestic revenue (generated via taxes) for developed countries and external funding for many low- and lower-middle income countries. Multilateral efforts include the Coalition for Epidemic Preparedness Innovations (CEPI), a global alliance founded by Norway, India, the Bill & Melinda Gates Foundation, the UK-based Wellcome Trust, and the World Economic Forum. In June 2020, the WHO, CEPI, and Gavi launched a global initiative, COVAX, a unique concept whereby richer countries subsidize COVID-19 vaccines for poorer nations with the goal to ensure global equitable access.

Politics. Medical-legal aspects, but more importantly, ethical perspectives need to be considered as nations consider how, and specifically who, administers the vaccine. This will be influenced by the sophistication required by each formulation. The ideal design would utilize a GLOBAL model for who can administer the vaccine and how to train for competency empowering local communities and building capacity. Promoting vaccine acceptance will require addressing geopolitics, vaccine nationalism, weaponized health communications, and political instability/identities.

Logistics. Given the complexity of supply chain activities, it is imperative to consider three major components: Cold chain storage systems (CCSS) allocation and the supporting power infrastructure; security for current and new supply chains; and decentralized manufacturing efforts to shorten the supply chain. National infrastructure capacity, specifically power grids, is seen as the primary impediment to CCSS and may require an expansion of country infrastructure, even if temporarily. In areas with viable supply chain routes, the integrity and safety needs to be ensured. Non-state actors and local militias have the potential to disrupt supply chain activities thereby interrupting global efforts to increase vaccination rates. To shorten supply chain activities, the establishment of decentralized manufacturing capabilities will be a key enabler.



Blue Marble. Dr. Hotez's "Blue Marble Health" concept presents an interesting launch point to examine other strategies that we tongue-in-cheek label as 'The Unpalatable Partner', the 'Coach Approach' and 'Target Rich Targeting.'

The Unpalatable Partner. Huge successes were realized with the partnership between the United States and the Soviet Union in the 1950's and 60's when they worked together to combat polio and smallpox. A similar partnership with China to establish vaccine diplomacy could result in an equally impressive victory over COVID-19. One country's race to become the leader in vaccine development, diagnostics, therapeutics, and innovation will be overshadowed by countries left behind. Global collaboration should be the goal with a unified effort by the world's most powerful countries.

Coach Approach. Economically and scientifically privileged countries have the ways and means to implement and deliver sophisticated healthcare with little regard to cost and logistical support. This represents a significant challenge when implementing similar strategies in less well-resourced areas. As with global efforts to eradicate polio, a lower-tech, less sophisticated vaccine could enable these areas. Sacrificing some effectiveness to gain efficacy may produce acceptable outcomes.

Target Rich Targeting. As an extension of the Blue Marble Health, what if a strategy focused on the high density, low resourced areas of the world at the expense of the rich and well resourced? Arguably, efforts to date have focused on low density countries such as Canada or resource rich countries such as the US and UK. These countries have other mechanisms at their disposal to withstand the illness onslaught without a vaccine through either their geographically dispersed nature or their relatively robust healthcare systems. Efforts at vaccination could then focus on countries with high density and weak social support infrastructure where mutation and propagation are likely to establish itself.

In summary, when developing a global vaccination strategy, the potential barriers must be considered for each region and to account for the political and economic climate at the time. A transparent strategy that incorporates vaccine diplomacy may address some obstacles. An effective transparent strategy against COVID-19 can be the driving force that reinforces the positive changes, regains public trust, and prepares society to address other public health challenges, current and future.

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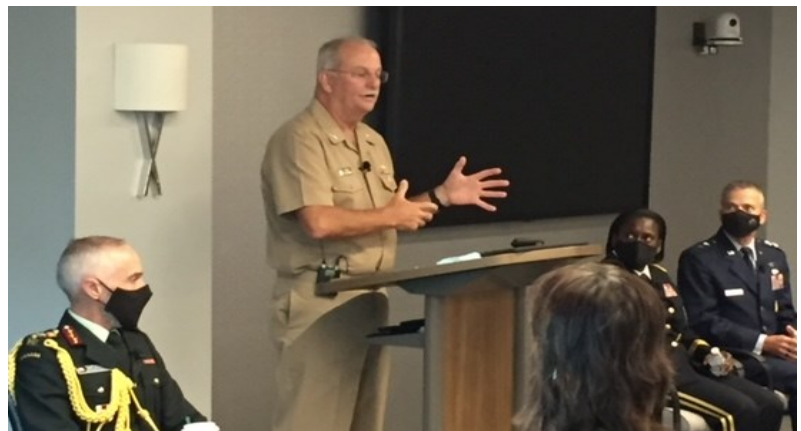
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Hoya Battalion Color Guard, Georgetown University, at the closing ceremony for the I37th Interagency Institute



L to R: MGen Bilodeau, CAF; RADM Gillingham, USN; MG Crosland, USA; Maj Gen DeGoes, USAF, speak at the I37th Interagency Institute



DEPARTMENT OF DEFENSE MEDICAL BILLETS

Assignment: The Department of Defense (DoD) has recently released a report indicating how it will make the proposed cuts in military medical billets.

What is the scope of these reductions? How will the DoD become more efficient?

Make a list of the work that the Military Health System (MHS) can eliminate with minimal impact on the mission and describe why.

Which service will be affected most?

What will be the impact on access to care for all beneficiary groups?

What are the anticipated cost/savings associated with these reductions?

What will be the impacts on recruitment and retention of military health professionals and for overall recruitment to the military services?

Group Members: Mr. Mark Stevenson, DHA; CAPT Edward Owens, USN; COL Mark Ochoa, USA; Col Dolphis Hall, USAF; CDR Jared Geller, USN; CAPT Kelley Fox, USN; Col Courtney Finkbeiner, USAF

Introduction: Three National Defense Authorization Acts (NDAA) called on DoD to optimize the military medical end strength to meet operational requirements. The Military Departments (MILDEPs) reviewed and analyzed the requirement to shape the force to meet National Security Strategy (NSS), National Defense Strategy (NDS), and Defense Planning Guidance (DPG) to cut over 12,000 billets from the Army, Navy, and Air Force. This analysis addresses specific impacts of these reductions to both the DoD and MHS in light of challenges from the COVID-19 pandemic and an ever increasing urgency to address near-peer threats to national security.

Service	Absorb	Hire	Network	Replace	Reshape	Student	Grand Total
Army	1,016	1,248	--	--	684	--	2,948
Navy	1,043	3,250	97	375	--	404	5,169
Air Force	1,207	2,616	66	--	--	795	4,684
Grand Total	3,266	7,114	163	375	684	1,199	12,801

Service Impacts & Scope: A total of 12,801 proposed billet reductions will affect all services by strategies to include absorption, new hiring of civilians and contractors, engagement of the private network, replacement or repurposing of billets, force reshaping mechanisms, and reduction of student billets. Enlisted medical billets are proposed to be reduced at a rate of roughly 2.5x the rate of officer medical billets. Proportionally, the Navy and Air Force stand to be affected equally while the Army will be affected to a much lesser degree. Billet reductions will affect 220 Military Medical Treatment Facilities (MTFs), research activities and educational activities, with the National Capital Region (NCR) seeing the largest portion of reductions as it is deemed to have the greatest capacity to hire from the private sector. Of note, Behavioral Health (BH) and Graduate Medical Education (GME) activities are outside of the scope of the billet reductions.

Cost/Savings: The anticipated cost/savings confers risks and benefits. A reduced military medical force raises concerns about the DoD's ability to respond to the next pandemic, threats from adversaries, disasters requiring mass casualty response, etc. There are potential risks in shifting medical staff from military to civilian. For example, there may be challenges in hiring medical staff in specific health markets, offering commiserate salaries in competitive markets, and increased costs in the hiring process. Additionally, shifting patients from



MTFs to the civilian market may drive up private sector healthcare costs. Savings associated with the proposed cuts would be found in less need for military personnel requiring permanent change of station and eliminating or reducing specific medical specialties associated with bonuses. Last, DoD will benefit from cost savings by having fewer personnel in terms of military retirements, healthcare, and absorbed billets.

Efficiencies: The proposed cuts create efficiencies of scale across the DoD. Cost savings can be reinvested into ready and lethal joint force capabilities and support of the NDS such as long-range fires, mobile air, and missile defenses, cyber technology, electronic warfare capabilities, holistic health and fitness programs. The MHS can streamline medical staffing models that best support the mission requirements set forth by the Unified Combatant Commanders (COCOM) to focus on a medically ready force and a ready medical force. By using the military medical reserve, establishing Memorandums of Agreement (MOA) and Understanding (MOU) with the Veteran Health Administration (VHA), and shifting beneficiary and retired population to the TRICARE civilian networks, the services can mitigate the impact on the highest priority across the spectrum of operational medical care.

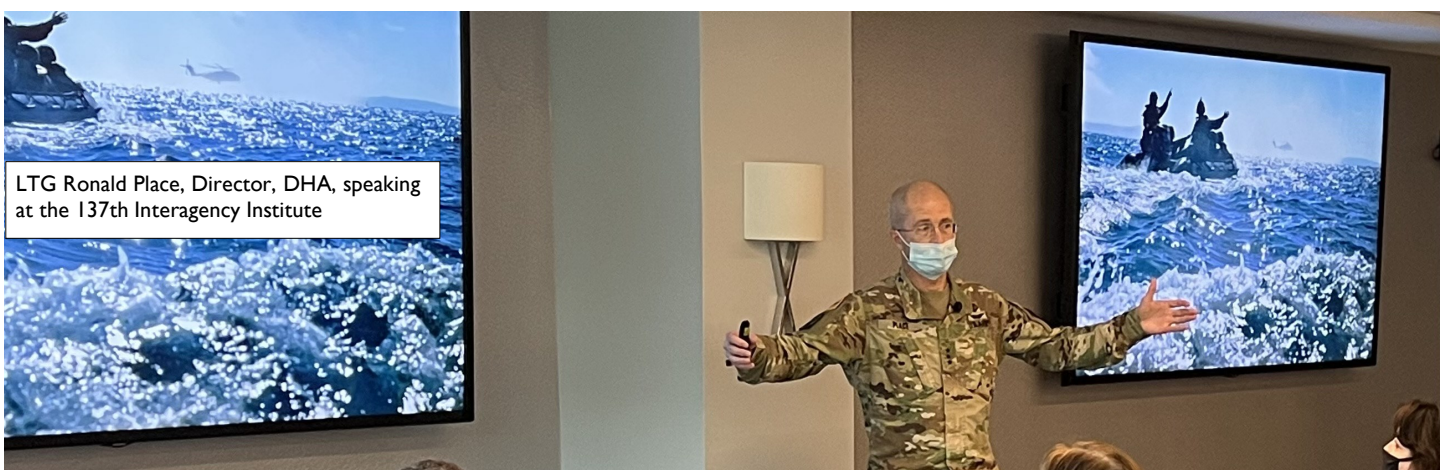
Access to Care: According to NDAA, Section 719, no eligible beneficiary will go without access to quality health care, which will continue to occur either in a MTF or through private sector care. For areas that have capacity/capability in the network (i.e. NCR), reductions will be prioritized within these areas. The “priority” will be the Active Duty Service Members (ADSM) to ensure that medical readiness is sustained/optimized.

Recruitment & Retention: Recruitment can benefit given the decreased “duty positions” that will be available. Challenges with recruitment will be the initial unreliable future and a decrease in opportunities for career broadening experiences/specialties in areas that will not have a “war fighter” focus or non-deployable billet. With respect to retention, a benefit is that the GME programs will be shielded from the reductions and focus on those specialties needed for deployment. A potential concern will be increased deployments, given a limited “pool” of available ADSMs to serve. Sustaining multiple deployments can lead to increased burnout.

Conclusion: As the response to COVID-19 continues to be defined, the DoD must ensure the scope of medical force cuts considers not only pandemic response capability, but also the true impacts of anticipated cost/savings associated with the reductions related to access to care for all beneficiaries in both the MTF and private sector and the overall impacts of military medical recruitment/retention. The ability of the DoD to modernize and increase efficiency to concur national security threats also includes the ability of the MHS to execute its operational mission in caring for the warfighter in large scale contingencies.

Billets to Eliminate with Minimal Impact on Mission (Non-deployable Duties)

- Non-clinical Administration
- Pediatrics
- Radiology
- Physical therapy
- Audiology
- Speech



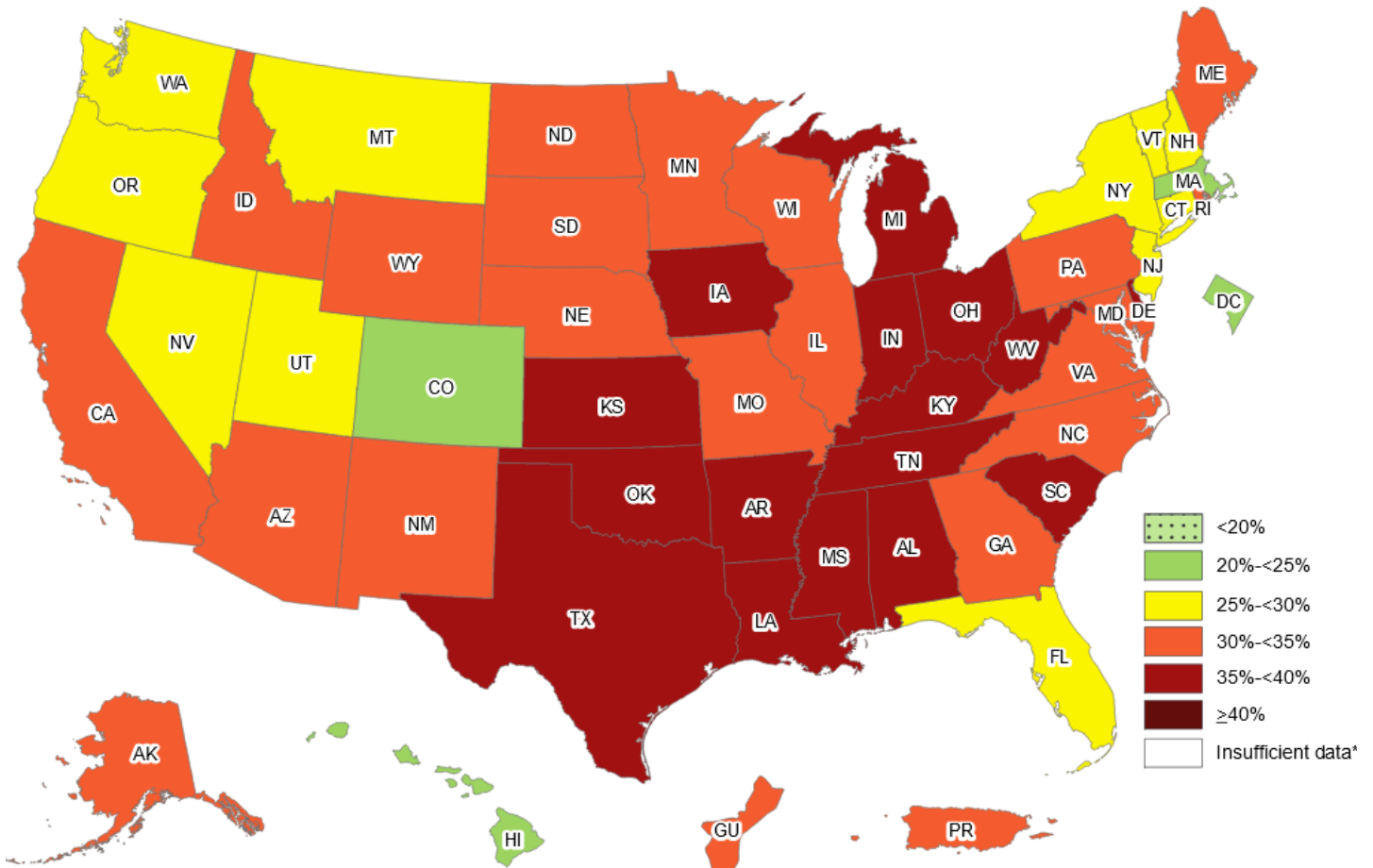


OVERWEIGHT AND OBESITY REMAIN A MAJOR PUBLIC HEALTH CONCERN

Small Group Assignment: Why does the U.S. have more obesity than other OECD countries? What are the causes? Why should health professionals be concerned? Outline approaches to deal with the issues and barriers to implementation.

Group Members: CDR Darla Deitrich, USN; COL Chris Flaugh, USA; Col Gwendolyn Foster, USAF; CDR Shari Gentry, USN; CAPT Mitchel Holiday, USPHS; Lt Col Joanna Jasminka, USAF, Ms. Nina Morris, VHA

Report: Within the US, obesity rates have increased from 30.5 - 42.4% in recent decades, with a 5% increase in those with severe obesity (See map below showing adult obesity in the US, 2020). Obesity rates among children and adolescents exceed 19% with rates likely to rise as younger school-aged children are experiencing the largest increases during the COVID pandemic.



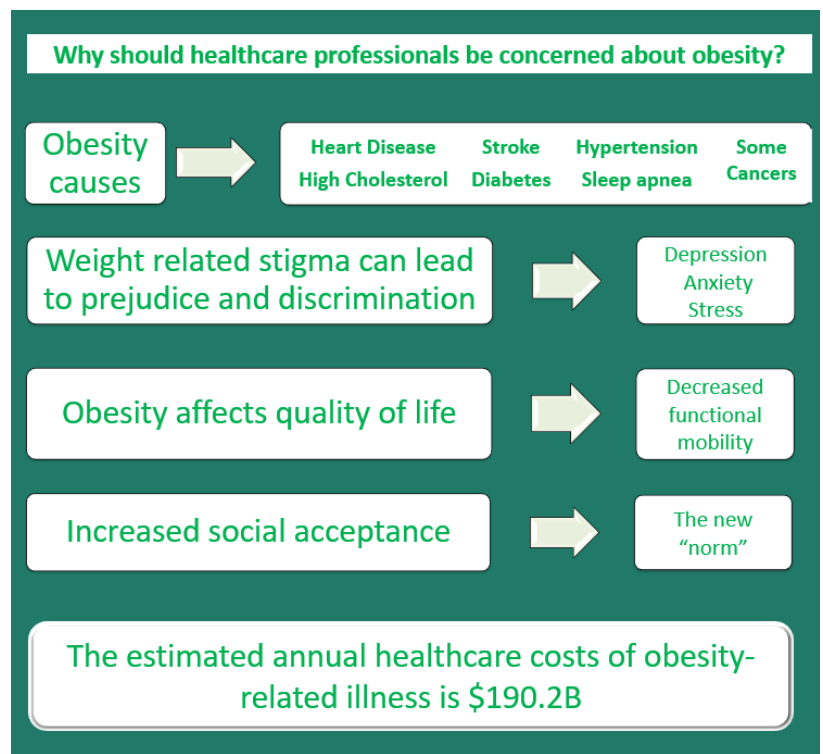
Non-Hispanic black adults had the highest prevalence of obesity (38.4%) overall, followed by Hispanic adults (32.6%) and non-Hispanic white adults (28.6%). Although the exact causes of these differences are not known, they likely in part reflect differences in social and economic advantage related to race or ethnicity. This aligns with the concept that health disparities are linked with social, economic, and/or environmental disadvantage based on racial or ethnic group. Underlying risks may include lower high school graduation rates, higher rates of unemployment, higher levels of food insecurity, greater access to poor quality foods, less access to convenient places for physical activity, targeted marketing of unhealthy foods, and poor access to health care or referrals to convenient community organizations that aid family-management or self-management resources.

Clinically, obesity causes or is linked to numerous health conditions including heart disease, diabetes, high



blood pressure, asthma, infertility and as many as eleven types of cancer. The global economic impact of obesity has been estimated to be \$2.0 trillion or 2.8% of the GDP. In the US, overweight and obesity has shown to account for over \$480 billion in direct health care costs and an additional \$1.24 trillion in indirect costs in lost economic productivity.

In addition to health conditions associated with obesity, weight related stigma can lead to prejudice and discrimination increasing risk of depression, anxiety and stress. Obesity affects quality of life which, through a complex interaction of biopsychosocial and environmental factors, leads to decreased functional mobility. Obesity leads to lower work productivity and increased sick days (work absenteeism). Posing a challenge to a national security, 71% of young adults (age 17-24) do not meet military enlistment requirements with a leading cause being obesity. Force readiness is denigrated due current obesity rates (Navy 22%, Air Force 18.1%, Army 17.4%, Marines 8.3%).



With the priority for a ready fighting force, the Army is out front with the Holistic Health and Fitness (H2F) program, the Navy created SMART clinics, and the Air Force initiated athletics trainers in BMT and lifestyle management at different bases. The Veterans Health Administration is managing obesity and overweight in the primary care setting with an interdisciplinary approach. The Patient Centered Medical Home model was implemented in 2010 to make care more comprehensive and improve quality.

Combating obesity is going to take a whole nation approach addressing environment, healthcare systems and community design. For example, in our **Environment** advocate for increasing prices for unhealthy foods and improving access to healthy ones while designing communities that encourage walking and biking; having **Healthcare Systems** provide neighborhood access for vulnerable populations and shift payment towards value-based vs fee based; and in the **Community** advocate for children to be physically active, provide nutritious foods in schools, encourage interaction among community agencies, instead of working in silos, to help citizens manage their own health. Changes like this can have a significant impact. Over a 10-year period pre-COVID, there was an increase from 44% to 54% in physical activity and 26% fewer secondary schools across the nation sold less nutritious snacks or beverages. Yet, these efforts have been disjointed.

Conclusion: There is no national urgency to address overweight/obesity as a major public health issue although the health of the population is being negatively impacted and related health and economic concerns continue to get more evident. A holistic government approach to encourage interagency and private sector collaboration to consider the impact of the social determinants of health on the population with an emphasis on addressing obesity and overweight. The nation needs one message one voice the same way the US has attacked smoking. Until we have a sense of urgency with a targeted message, combating the obesity crisis will not be a priority.



ENHANCING INTERAGENCY COLLABORATION AND COOPERATION

Small Group Assignment:

- Design a strategy for greater interagency collaboration, cooperation and improving efficiency and effectiveness over the next decade
- Should there be more standardization within and across agencies or should local leaders be responsible for unique solutions to local challenges?
- What needs to be changed in our current environment?

Group Members: COL Lee Burnett, USA; CAPT Janet Cliatt, USPHS; CAPT Leslie Hair, USN; Col Larry Kroll, USAF; Col Sean O’Brien, USAF; Col Eric Sherman, USAF; CDR Brandon Limtiaco, USN; Dr. Miho Tanaka, VHA.

Introduction: Delivering care to 9.6 million beneficiaries, the Military Healthcare System (MHS) is one of the most diverse and complex healthcare organizations in the United States. The Veterans Health Administration (VHA) is the largest integrated health care system in the US, providing care to 9 million enrolled Veterans each year. Despite their closely aligned missions, there are multiple opportunities to improve collaboration and cooperation with a goal of delivering more efficient and effective healthcare. Our proposed strategy includes focus areas of information technology, equipment, credentialing, joint assignments, readiness training and human resources.

Information Technology. The MHS and VHA employ separate and independent electronic health records (EHRs). The MHS is in the process of transitioning from AHLTA to MHS Genesis (a Cerner product) with a goal to complete the transition by 2023. The VHA currently uses Vista and began transitioning to Cerner Millennium in 2021. Accelerating the transition in the VHA will allow for seamless transitions of care and information sharing between the MHS and the VHA. Other focus areas include the integration of smartphone technology for rapid check-in, shared workflows, and identifying processes and procedures for interagency telehealth delivery.

Equipment. Equipment needs to be standardized across the MHS and VHA. For example, each of the services uses different ventilators resulting in a lack of interoperability. Investing in equipment that can be used in a variety of environments, including air and sea transport, would maximize efficiency and ensure that healthcare workers could easily transition between DoD and VA facilities.

Credentials. Although the Inter-Facility Credentials Transfer Brief (ICTB) allows MHS providers to work in VA facilities and VHA providers to work in DoD facilities, there are other opportunities to consolidate the credentialing process. The VHA uses VetPro (VHA’s mandatory credentialing software platform) to credential and privilege providers, while the MHS uses the Joint Centralized Credentialing Quality Assurance System (JCCQAS). These software platforms were developed 15 years apart and do not communicate with one another. Developing a consolidated credentialing platform would improve communication, costs and patient safety and facilitate sharing providers during a pandemic or unanticipated provider gaps.





Joint Assignments. Prioritizing assignments to meet individual service and agency requirements creates stovepipe leadership development, allowing the MHS, the US Public Health Service.

(PHS), and VHA to fall prey to ‘culture eats strategy.’ Creating Joint and cross-agency assignments will develop Joint experience, foster understanding, and build partnerships enhancing inter-agency collaboration. To reach full potential, the services and agencies should consider these as must-fill billets, staffed with high performing personnel from a variety of specialties and ranks, and emphasized as career enhancing assignments. If each service and agency commits to increasing Joint assignments and developing all personnel, the whole enterprise will reap rewards in future collaborative endeavors and policy creation.

Joint Training and Readiness. Future combat with a near-peer competitor will require joint all domain engagement. In a future Pacific theatre scenario, Marines and Army combat units may conduct island-hopping operations supported by Air Force and Navy assets while the VHA and civilian hospital systems may be required to provide Role 4 care. The military medical systems’ leadership has been understandably focused on the complex transition of medical care to the Defense Health Agency. As a result, the respective services’ medical commands have had little time to invest in defining Joint medical readiness for this future fight. Defining and mandating Joint medical tasks and establishing tri-service Joint medical readiness exercises would be a valuable first step in achieving effective Joint medical capabilities. Medical units should include Joint operational requirements as a component of their mission-essential tasks.

Training for medical professionals is highly variable under the current model. The ability to educate and train fully competent clinicians and technicians is difficult within the MHS due to various factors that limit the ability to achieve a standardized approach to developing a ready medical force. A significant barrier is the lack of standardized training opportunities to develop and sustain knowledge, skills, and abilities. Establishing mutual memorandum of understanding partnerships within the MHS, Veterans Administration, and civilian healthcare systems will provide training opportunities that will facilitate MHS’s commitment to excellence, service, and a community capable of providing high quality care in complex spectrum of environments.

Human Resources. Standardizing position descriptions and pay scales across the MHS and VHA will discourage unhealthy competition between the two healthcare systems. Benefits of increased human resource standardization includes easy transitions for employees, the encouragement of resource sharing within and between markets, improved retention, and increased efficiency. In addition, ensuring that all employees meet the same certification and licensing requirements improves the delivery of care in both healthcare systems.

Summary: Although the stand-up of the Defense Health Agency has created significant opportunities for standardization within the MHS, collaboration and cooperation with the VHA and MHS remains elusive. Focus areas over the next decade include information technology, equipment modernization, shared credentialing, Joint assignments, Joint training and readiness exercises and human resource consolidation. The official website of the MHS has a small section on DoD/VA collaboration that references a mutual VA/DoD Guidebook. It is no coincidence that the most recent guidebook was published in 2013 and the link is broken on the <https://www.health.mil> website. The Joint VHA-MHS Health Executive Committee may be one method of fostering improving collaboration and cooperation between the DoD, VA and PHS.

The expanded notes of the Group Assignment are included in the link:

<https://docs.google.com/document/d/1ZHBvjOiCnLzNfCkhcfl1sLxCb7lPmYU5/edit?usp=sharing&oid=118160337123444187618&rtpof=true&sd=true>

FEDERAL HEALTH CARE EXECUTIVES INSTITUTE ALUMNI ASSOCIATION (<https://www.fhceiaa.org>)

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Membership

To date, 62% of the 137th Interagency Institute alumni have completed applications to join. Welcome new members!

To date, **186 members' email addresses are not on file**. Your **personal** email address is needed to receive FHCEIAA notifications and your current USPS address is needed for the newsletter mailing list. Submit updates to gjdolecek@verizon.net.

Membership information is available at <https://www.fhceiaa.org/membership>.

Upcoming Resignation

Note that Gayle has announced his resignation as treasurer effective January 2023.

PLEASE inform Thad (thad.sharp@outlook.com) if you are interested in filling this critical position on the FHCEIAA board of directors.



INTERAGENCY INSTITUTE FOR FEDERAL HEALTH LEADERS

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ADDRESS SERVICE REQUESTED

