THE RECORD

Interagency Institute for Federal Health Leaders

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From the Director…

I am very pleased to report that the ***141st Interagency Institute for Federal Health Leaders*** was held successfully at the Milken Institute School of Public Health at The George Washington University from September 18-29, 2023.

Dean Lynn Goldman, Dean of the School of Public Health, gave a warm welcome to the participants on the opening day of the course. I am most grateful to Dean Goldman for allowing the Institute to be held in the school's first-class facility, the best location in the many years I have served as Director. Sincere thanks are due to the numerous School staff who made sure that everything functioned smoothly throughout the course.

I have continued the strong emphasis on strategic leadership as I believe this is very appropriate for the participants, many of whom will be moving on to more senior leadership positions in their agencies in the future. I appreciate all of the federal and civilian speakers for their commitment and participation.

One new faculty member was Dr. Margie Warrell, a psychologist by background with diverse international experience in business, coaching and psychology who inspires braver action in an increasingly cautious world. Margie's recent book, 'Stop Playing Safe', was selected as the book for the 141st Institute. You will see that one of the Small Groups was focused on this book.

All five Small Groups worked very hard throughout the course and produced excellent reports which are included in this newsletter. I am sure you will enjoy reading these reports.

Our 'Lessons From Other Countries' day was once again held at the Embassy of Canada. Commander Iain Beck, who had only recently arrived in Washington, made sure that everything went very smoothly throughout the day. Major General Marc Bildoeau, Surgeon General, Canadian Armed Forces, again made a special trip from Ottawa. I am most grateful to him, all the speakers and panel members, and the Embassy staff for their outstanding support of the Interagency Institutes.

I have commented on a number of occasions in *The Record* that we are living in turbulent times, domestically and globally. All of these factors impinge on Federal health services, directly or indirectly, and are addressed to varying degrees in the course. As I write this piece the conflict in the Middle East and numerous natural disasters throughout the world are dominating the headlines. It is necessary, but difficult, to remain optimistic that better times will return.

Sincerely,

Richard F. Southby, PhD (Med), FFPHM, FRSPH, FCHSM, FCLM (Hon)

Funding for the Institute from the Defense Health Agency (DHA) and the Uniformed Services University with continuing education credits awarded through the DHA J-7 CEPO is gratefully acknowledged.

Letter from the President, FHCEIAA

Dear FHCEIAA members,

I really love this time of the year. Temperatures are finally starting to cool off and the holiday seasons are almost here! My favorite part of the season is spending more time with my beautiful wife, awesome son, friends and family and reflecting back on all of the people and events that have played a significant and positive role in our lives. I truly have so much to be thankful for and feel so blessed.

That's why I would like to take this opportunity to give a heartfelt thank you to our entire FHCEIAA team, Dr. Richard Southby, Dr. Janet Southby; CAPT (Ret) Aaron Middlekauff, Dr. Kathryn Sapnas, Col Jim Kile, Mr. Joe Salvatore, and all of our FHCEIAA members.

Also, I again thank CAPT (Ret) Gayle Dolecek for his 35-plus years of steadfast dedication and leadership to our Association. Gayle, thank you! We miss you and wish you Godspeed!

There has been so much change this past year, but one thing has remained constant, the strength and resiliency of our members. We are so extremely proud of you and thank you for your professionalism, dedication and support to the entire federal health care system.

Congratulations to the alumni of the 141st Interagency Institute and welcome to the Federal Health Care Executives Institute Alumni Association! We are thrilled you have joined us.

I invite all to join us for the FHCEIAA Annual Business Meeting which will be held in conjunction with the AMSUS meeting,12-15 February 2024 at the Gaylord Hotel, National Harbor, Maryland. Our alumni association meeting will take place on Tuesday,13 Feb 2024, from 4:00 - 5:30 PM at the Gaylord. Refreshments will be provided for attendees and you do not need to be a registered AMSUS attendee to attend the business meeting.

Registration will be posted when it becomes available. The AMSUS Annual Meeting Website is: https://www.amsus.org/events/annual-meeting-2/

I encourage you to save our FHCEIAA website. This site provides valuable information and facilitates critical connections. You can locate us by name search or through our direct link: https://www.fhceiaa.org/

Please consider becoming a member of the FHCEIAA if you have not already done so. This commitment assures the maintenance of essential connectivity and collaborative wisdom to maximize our resourcefulness and effectiveness. Additional noteworthy opportunities for members include receiving the newsletter, access for dependent children or grandchildren to apply for one of two $1,500 FHCEIAA scholarships, and the availability for members to apply for a $2,000 professional development scholarship.

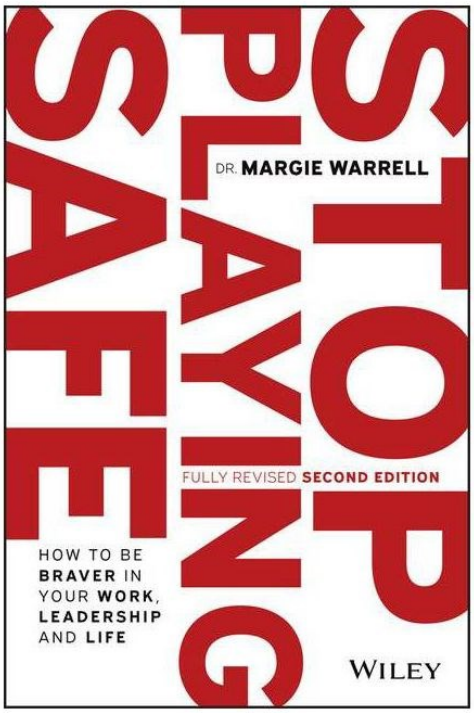
As always, we look to tap into the energy and enthusiasm of our highly respected alumni for fresh ideas on how to advance our organization. If you are interested in serving as a board member, kindly send an email to me at johnmammano7@gmail.com or to CAPT Aaron Middlekauff at amiddlekauff@yahoo.com.

It is an honor and I am humbled to serve as your president. Enjoy the upcoming fall and winter seasons with your friends and family and as always please stay safe; we need you!

God bless, be well, and wishing you all the best!

Colonel (Ret) John "Mambo" Mammano, USAF
DBA, MSHSA, CFAAMA, CPHIMS
President, FHCEIAA

STOP PLAYING SAFE



Group Assignment: From your knowledge and experience, after reading "Stop Playing Safe" by Margie Warrell, respond to the following:

- In what ways can you foster a 'culture of courage' that emboldens more courageous leadership for those emerging through the leadership ranks?
- What lays at stake if there is a deficit of such leadership?
- Where do you see the need for more courageous leadership?
- Where might failure to take short-term risk create longer term vulnerability in your agency?
- How can you be more courageous in your role to mitigate against this vulnerability?

Group Members: CAPT(s) Javier Agraz, MC, USN; Ms. Jessica Blue-Howells, VHA; Col Felicia Burks, USAF, MSC; CAPT(s) Prasad Diwadkar, MSC, USN; Mr. Josh Geiger, VHA; COL Danielle Holt, MC, USA; Ms. Sara Huntsman, DHA; Col Angela Lacek, USAF, NC.

Group Response: Thought leaders like Maya Angelou argue that intellect is not as important to inspiring people as much as emotional connection may be. As healthcare executives we are in the culture of leading, nurturing and connecting with people, ultimately inspiring courageous leadership. To inspire courageous leadership, we must create an environment of trust and safety for the patient and the staff. According to Dr. Warrell, this psychological safety is paramount to accomplish ultimate greatness and taking the limits off (Warrell, 2021). Moving towards this environment, healthcare leaders must understand that trust is critical and courageous leadership is no longer an option.

How do we normalize a culture of courage that leads to better quality decisions and outcomes from both a medical readiness and healthcare delivery perspective? Healthcare leaders are at a pivotal inflection point where voice must be amplified on true concerns of health care by placing their patients first. We must strive towards a just culture to cultivate a climate of courageous leadership through incorporating concepts such as a High Reliability framework for a medically ready force and ready medical force.

A lack of courageous leadership results in a loss of focus on long-term strategic goals which addresses adaptive problems in favor of tackling short-term technical solutions. Lacking courage may lead to indecision creating a void of deliberate action to solve existing problems. Costs span multiple domains which may impact organizational viability leading to poor health outcomes, loss of personnel, and even threaten capability. The failure to challenge assumptions may lead to loss of customer base to network care. The reliance on out-of-network care is more costly and offers poorer quality health outcomes in comparison to the military, veterans health systems, and public health services (Trivedi, Matula, Miake-Lye, 2011). This continued dependance can perpetuate a perception of an inefficient federal healthcare system. Ultimately, failure to align priorities between direct care and network care drives misalignment with patient and organizational goals. Secondary effects results in a disconnect between the clinical and readiness missions which leads to burnout and additional negative effects.

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To impact vulnerabilities of the status quo, courageous leadership is needed. This is necessary in multiple areas to bridge gaps between the Defense Health Agency (DHA) and non-medical Service leadership. There needs to be a deliberate approach to deconflict messaging between the non-medical Service leadership and the MHS. There is a "say-do" gap between what is said and what is being implemented that leads to continued confusion.

Service parochialisms are often in conflict with the bigger picture effectively hindering the operational mission. Courageous leadership is necessary to create effective solutions for strategic organizational leaders.

While the federal health system overall (Military Health System, Defense Health Agency, Public Health Services, and Veterans Affairs) is moving more towards a focus on experience and scholarly data, which helps coordinate an evidence-based approach to align strategies, the continued misalignment leads to multiple risks. A short-term risk with this misalignment of service missions creates blind spots that cause disconnect between federal health organizations. Reciprocal effects of the short-term risk impact both medical and non-medical leaders' ability to achieve trust and build sustainable competency of the organization (Warrell, pg. 53). Long-term risks which create long-term vulnerabilities are associated with the overall issues aligning mission requirements for accomplishing a medically ready force and a ready medical force. Ultimately this leads to a dilemma between mission priorities. When these two are in conflict it perpetuates a scenario of inaction due to the lack of clarity. Though an uncomfortable conversation to be had as a medical leader it is an important one (Warrell, pg. 69).

This unsettled environment of mission focus directly impacts how and what a non-medical Service leader may respond. Therefore, it requires operational leaders to push where there is a struggle to accomplish upthe-chain awareness to strategic leaders. It is important to communicate this information, while having the courage to ask bigger questions while bringing solutions. Proper communication and a preparedness to engage in the challenge to deconflict priorities mitigates against vulnerabilities that the disconnect can create. The ability to translate a concise message down the line to staff creates an environment of psychological safety and innovation which leads to inspiring staff to engage in the mission.

It is the responsibility of leaders to continually reframe the circumstance and disrupt the status quo while providing the ability to meet the wider mission. Dr. Warrell suggests that focusing your attention from the many to the singular leads to accomplishing what you can do. We must embrace vulnerabilities and understand them. The operational leaders must become the strategic leader at their current level to curate a natural environment that embraces growth and connection. In short, be courageous.

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FHCEIAA Annual Business Meeting

Tuesday, February 13, 2024, 4:00 - 5:30 PM, Gaylord Hotel, National Harbor MD

Refreshments will be provided. You do not need to be a registered AMSUS attendee to attend the business meeting.

Registration will be posted when it becomes available. The AMSUS Annual Meeting Website is: https://www.amsus.org/events/annual-meeting-2/

OBESITY IN THE U.S. MILITARY POPULATION: CHALLENGES, CURRENT RESPONSE, AND THE WAY FORWARD

Small Group Assignment: For many years the military services have been responding to the challenges of overweight and obesity in potential recruits. Your task is to review the policies and programs implemented by the Army, Marine Corps, Navy, and Air Force, evaluate their effectiveness and propose new solutions to these problems which are detrimental to maintaining a fit fighting force.

Group Members: LTC (P) Chuck Bane, VC, USA; CAPT Ian Fowler, MC, USN; CAPT Aaron Frank, MSC, USN; Col Benjamin Hughes, DC, USAF; Col Ryan Mihata, MC, USAF; Col Rick Palmer, MSC, USAF; COL Mark Plooster, MS, USA; COL Prentice Price, AN, USA; CAPT Calvin Suffridge, DC, USN.

Background: 40% of adults and 18% of children in the U.S. are obese resulting in estimated medical costs of $147-$210 billion per year with numerous negative effects on physical and mental health and social well-being (Police & Ruppert, 2022). Evidence indicates that the military faces similar obesity problems amongst service members, negatively affecting health, readiness, recruitment, and retention with annual costs over $1 billion (Police & Ruppert, 2022). Only 23% of Americans ages 17-24 are eligible for military service with obesity being the largest ineligibility reason (American Security Project, 2022). The impact is detrimental; the Army, Navy, and Air Force are expected to miss their recruiting goals by 15,000, 10,000, and 3,000 recruits, respectively, for 2023 (Miller & Frazier, 2023).

Factors contributing to obesity in the military include stressors of military life, accessibility to high-calorie foods, and decreased physical activity due to sedentary job duties (Police & Ruppert, 2022). The COVID-19 pandemic further exacerbated these factors with additional psychological stressors resulting in the consumption of less healthy foods (Miller & Frazier, 2023). As the military becomes more reflective of a diverse society, other considerations may need attention. Evidence demonstrates increased obesity in socioeconomic, racial, ethnic, and gender disparities in the Latino, African American, and female populations (Barroso, 2019).

Responses by Service and Their Effectiveness:

Army

In 2020, the Army launched its Holistic Health and Fitness (H2F) program to improve the health and wellness of Soldiers and optimize individual performance while preventing injury and illness. This revision of Army Physical Readiness Training took a comprehensive look at health moving beyond mere physical fitness to total health. The H2F approach has five pillars: Mental Readiness, Physical Readiness, Spiritual Readiness, Nutritional Readiness and Sleep Readiness. The program links physical readiness and performance to the key areas of nutrition, necessity of solid eight hours of sleep, as well as the mental and spiritual health of the Soldier. The Army embedded athletic trainers and strength coaches at the brigade level and updated fitness facilities and equipment. These improvements are evidenced in the CrossFit and performance-focused gyms visible across Army installations. Perhaps most importantly, the Army has educated leaders on comprehensive fitness and codified a curriculum in professional military education courses.

To address the recruiting crisis, the Army created the Future Soldier Preparatory Course (FSPC) to help recruits meet academic and fitness eligibility requirements. The course leverages the H2F concepts at FSPC locations, Ft Jackson SC or Ft Moore GA, where recruits have 90 days to meet prescribed academic and fitness goals. Those who graduate FSPC then go on to Basic Combat Training. At the one-year anniversary of the program in August 2023, both tracks boasted a 95% graduation rate with students on the fitness track losing an average of 1.7% of body fat per week. While early results are encouraging, the long-term effectiveness of H2F and the FSPC remains to be seen. (continued on the next page)

Navy and Marine Corps

The Navy launched a pilot program, The Future Sailor Preparatory Course, in April 2023 targeting those shy of meeting the body composition requirements. They report to Great Lakes IL to participate in the three-week pilot for training to get them into shape before transitioning into boot camp. Recruits are assessed at the end to determine if they meet the goal of 26% body fat for men and 36% for women. Those who do not pass initially can try again within 90 days. In addition to exercise, the program teaches nutrition and good health practices, including sleep. Under the program, modeled after the Army FSPC, the Navy does not have to lower its fitness standards; more time is spent helping potential recruits meet requirements.

The Ship Shape (SS) and Semper Fit programs are the official weight management programs for the Navy and Marine Corps, respectively. Both offer training on nutrition, physical activity, mindset, and nutrition. The Navy's Fitness Enhancement Program (FEP) is a mandatory program that focuses on goals like SS for Sailors who fail the physical readiness test. One study demonstrates that SS and FEP result in 71% and 78% success rates with much better participation rates in SS (Wisbach, 2018).

Air Force

Like the other services, the Air Force introduced its way to better prepare interested recruits and made some accommodation to widen its available pool of eligible recruits. The Delayed Entry Program App, available via Apple and Google Play, has a 14-week training plan aimed at improving the overall fitness (strength/cardio training and nutrition) for potential recruits. In addition, recognizing limitations in the current pool of candidates, the Air Force adjusted the calculation of body composition in accordance with DoDI 1308.03 to accommodate larger waistlines. This initiative, though it received some unfavorable headlines, was a shrewd means to open the door to otherwise ineligible recruits with the goal of having them eligible for service by passing physical fitness requirements during basic training.

SOLUTIONS

Potential solutions should be approached from a societal perspective as well as specific requirements related to the military services. From a societal perspective, the U.S. Department of Health and Human Services recommends at least 60 minutes of moderate to vigorous activity a day; multiple sources recommend this as a minimum starting point (Cheney & Xenakis, 2018). Further, increasing physical activity and decreasing social media and screen time combined with the use of personal electronic devices that aim to improve physical fitness and mobilization could prove useful from a population health perspective. Attention to schools including healthy food programs, nutrition education and physical activity could greatly improve societal obesity rates.

Military service specific solutions should consider expanding programs similar to the Army's Future Soldier Preparatory Course and basing physical fitness and weight standards on the specific military specialty/job for which the recruit is being brought into the military rather than using "one size fits all" requirements. For example, a Marine infantry member and a Space Force satellite operator clearly have different requirements from a physical capability standpoint.

CONCLUSION

Obesity impacting military recruiting efforts is not new. Various means to improve prospective recruits' ability to qualify physically have been introduced; however, these efforts will likely not be enough. Improving the numbers of physically eligible recruits will require a coordinated whole of government approach to combat child and adolescent obesity addressing nutritional and physical fitness norms in all communities. Simply increasing the number of available physically qualified recruits does not guarantee an increase in recruiting. Among other things, it will require recruiters to increase their presence to act as role models for potential candidates from earlier ages which is beyond the scope of this analysis.

(References are cited on page 8)

SUICIDE - A MAJOR MENTAL HEALTH CONCERN

Group Members: CDR Brooke Basford, USN, NC; CAPT Wade Brockway, CAF, MC; COL Sarah Eccleston, USA, AN; CDR Amanda Fix, USN, DC; Col Nathan Kellett, USAF, MSC; COL Albert Kincaid, USA, MS; Col Anthony Mitchell, USAF, MC; Mr. Matt Rogers, VHA; CDR Jeff Showalter, USPHS .

Introduction: Suicide remains a pressing national health crisis affecting both military and civilian sectors. This report aims to describe past federal initiatives, assess their effectiveness, and propose strategies to enhance overall well-being.

Despite the multitude of initiatives, the Center for Disease Control reports suicide deaths increased by 2.6% from 2021 to 2022.[1] Additionally, suicides are ranked as leading cause of death in the United States, accounting for over 48,000 deaths in 2021.[1] Alarmingly, the suicide rate for veterans ages 8-34 is three times higher than non-veterans.[2] This issue cannot be attributed to a single cause; reduction of suicide requires a comprehensive understanding of the contributing factors and a multi-faceted strategy for prevention and intervention.

The Challenges of Suicide Prevention: Various initiatives have aimed to prevent suicide in the public and private sectors by improving awareness, access to mental health services, and implementing crisis hotlines and peer support programs. Overall suicide rates, however, have not decreased. While policies aimed at addressing suicide may not have "failed," numerous initiatives have not been effective. For example, initiatives to reduce the stigma surrounding mental health and seeking help have made progress but have not eliminated the stigma that remains a persistent issue.. Many in the military and civilian sectors still hesitate to admit they need assistance due to concerns about impact on careers or social standing.

Efforts to improve access have had varying degrees of success. Increases in mental health providers and improved access protocols to services have not ameliorated appointment wait times and geographic disparities. Despite mandatory health screenings for early identification of at-risk individuals, follow-up services vital to ensure appropriate care remain elusive. Coupled with this is the risk of suicide in patients representing histories of dysfunctional family environments, substance abuse, and pre-existing mental health diagnoses (i.e. depression, anxiety, posttraumatic stress disorder (PTSD), bipolar disorder, and various other personality disorders).[2]

Finally, defining "acceptable" suicide rates is morally and systematically challenging due to the accuracy of data collection, quantitative/qualitative measures of effectiveness, and variances in suicides across populations, regions, and time periods. There are also notable ethical concerns in establishing a target for acceptable suicide rates.

Additional Strategies to Address Suicide Prevention: Adverse childhood events contribute to a high risk of suicide. To address early life factors, community intervention programs are crucial to fostering mental health awareness and suicide prevention. Mental health education, educator training, peer support, screening, and crisis response protocols may be tailored to specific community needs. A school-based early intervention program integrated into the overall community mental health support system will ensure continuity of care and support for students as they transition from school to adulthood. Thereby, communities build resilience, identify/mitigate early life factors, and promote mental health awareness which in turn may reduce suicides.

To reduce polarizing outcomes associated with previous initiatives, such as "zero tolerance" policies, there is need to address the ethics of suicide. The ability to combat suicide rates is subject to philosophical, ethical, and scientific debate. Respecting individual autonomy is a fundamental ethical principle in health-

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care and mental health services. The ability to make choices about one's life, including whether to seek help for mental health issues or thoughts of suicide must be considered. Free will is a complex and multifaceted variable. An essential aspect of human agency and autonomy, it plays a role in an individual's decision whether to seek help for mental health issues or suicidal thoughts. Therefore, suicide prevention requires a comprehensive approach that considers the influence of mental health conditions, external factors, and the limitations of free will. Effective suicide prevention efforts aim to create supportive environments that reduce barriers to seeking help, provide appropriate care to individuals in need, and recognize that mental health challenges can impact an individual's ability to exercise free will in a healthy and rational manner. While free will emphasizes individual agency, it is crucial to acknowledge that social and environmental factors also play a significant role in suicide risk. Socioeconomic disparities, access to mental health care, availability of support systems, and exposure to trauma are just a few examples of external influences that can impact an individual's choices and well-being.

The recommendations of the 2022 Suicide Prevention and Response Independent Review Committee (SPRIRC) should be adopted.[3] Advanced education and skill building across the career cycle of military personnel was recommended. While essential, it would be ideal if resiliency training could start even before one embarks upon a military career so that recruits would have developed a high level of resiliency prior to exposure to the stressors of military service. Evidence supports the effectiveness of resiliency programs. Pinto et al. (2022) published a systematic review and meta-analysis of resiliency programs for children and adolescents indicating effectiveness among adolescents' resilience and the follow-up analysis demonstrated continuation of results at the 6-month mark. Therefore, school-based resiliency programs would serve to improve the resiliency of adolescents resulting in military recruits joining with higher levels of resiliency than is presently the case. This comprehensive approach in conjunction with the implementation of the SPRIRC recommendations should lead to a reduction in the suicide rate within the U.S. military.

Conclusion: Combatting suicide requires a multifaceted approach that respects individual agency, addresses social factors, and fosters resilience. Shifting focus from rates to prevention, promoting mental health awareness, and early intervention can reduce suicide rates and improve mental well-being. Creating a society that supports mental health and offers equitable opportunities is essential. Leaders should prioritize strategies reducing suicide risk and focus on comprehensive prevention efforts addressing complex factors contributing to risk.

References

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[3] Preventing Suicide in the U.S. Military: Recommendations from the Suicide Prevention and Response Independent Review Committee, 2023.

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THE PERILS OF CLIMATE CHANGE

Group Assignment: The perils of climate change have been getting considerable attention worldwide since the 1960's but the trend lines towards catastrophic situations for our planet continue to move in the wrong direction. Experts are increasingly emphasizing that fundamental changes in our life styles, means of production and protection of our physical and social environments must be made now to avoid irreversible damage to our planet and our very existence. What are the major changes required, how can they be implemented, what are the obstacles and likelihood of success?

Group Members: Ms. Jill Albanese, VHA: CAPT Merideth Croft, NC, USN; COL Randy Dorsey MS, USA (DHA); COL Alisha Hutson, MS, USA; Col Kristen Nichols, USAF, DC; COL Rachelle Retoma, DC, USA; CAPT Rebecca Reyes, USPHS; Col James Weinstein, USAF.

Group Response: " Burning Down the House"

Rising global temperatures due to climate change affect agriculture, nutrition, food security, and a geographic change in the vectors contributing to disease spread. The World Health Organization estimates that between 2030 and 2050, climate change will cause nearly 250,000 additional deaths per year because of health conditions such as malnutrition, malaria, diarrhea, and heat stress. This essay will examine climate change through the economic, scientific, technological, and social lenses of ensuring continued access to high-quality, sustainable, accessible, and affordable healthcare for the people of this country. If we can leverage climate change as an opportunity to create and maintain new habitats that will allow us to not only survive but also thrive, we will produce survivors that are resilient and adaptable for generations to come.

To understand changes that need to be made and actions to be taken, we must first determine the detrimental challenges that climate change will create for our environment and the second and third-order effects that will have wide-ranging, detrimental environmental repercussions. As global warming progresses and temperatures climb, rising sea levels will cause flooding of coastal areas and salinization of freshwater supplies propelling large populations to move inland. The United Nations Human Rights Council estimated that approximately 25 million people were forcibly displaced each year from 2008-2016 due to climate-related events. Another estimate purports there will be 1.2 billion climate refugees by 2050. As temperatures rise and people are forced to move inland, heat stress injuries and deaths become a more significant concern. In 2021, 37% of warm season heat-related deaths were related to climate change.

Climate change-related environmental disasters include storms, ozone depletion, increased vector-borne diseases, and water contamination. Each may result in displacement of entire communities, damage to infrastructure, access to medical care issues, air quality impacts, increased disease burden, vector-borne diseases moving into new regions, and water-related illnesses. These may create additional challenges and emergencies. For example, listeria in a hospital's water supply led to new Joint Commission healthcare organization standards mandating increased line maintenance, testing, and flushing for monitoring and prevention of disease. The ensuing effects of environmental disasters will naturally lead to consequences from a social and safety perspective.

Climate change produces many social challenges inextricably linked to the impacts cited earlier. From a healthcare perspective, behavioral and physical healthcare needs will increase. Displacement due to migration creates "houselessness" undoubtedly expanding the demand for community-wide mental health care and social services. Sudden population migrations to areas that are not large urban centers will highlight insufficient infrastructure to handle the unexpectedly higher numbers of people. This will lead to food supply instability, food safety issues, nutritional concerns, and a food (continued on the next page)

distribution crisis. Sudden populations influxes bring safety and security issues for existing healthcare facilities, staff, and resources that may already be limited or in short supply. People, once healthy, may become less so, with the psychosocial and physical effects of being displaced especially in migrant encampments.

Another threat is pollution. Studies have linked pollution to antibiotic resistance and cancer. Individuals may also have increased susceptibility to cardio-respiratory and malnutrition-related illnesses. Sadly, the impacts will be the hardest on socially and economically vulnerable populations, those with pre-existing conditions, and people who are reliant on medical devices.

The disastrous effects of climate change need not be inevitable. The major solutions proposed fall under the broad categories of education, healthcare delivery infrastructure, and the physical environment of care. Some interventions can be started now, and others will need longer-term planning. Immediately, we can increase telemedicine to reduce onsite resources and increase overall access to care; test and/or modify the use of anesthetic equipment to decrease air pollution; incorporate environmentally friendly changes into current healthcare policies; reduce, reuse, and recycle whenever possible; retrofit older facilities with low-use equipment; build energy efficiency into facilities (e.g., LED light bulbs and low-water-use appliances); incorporate sustainable power systems to ensure uninterrupted medical care during critical situations; and improve the pipeline of healthcare workers for the future, to include training more instructors and utilizing creative methods for accessing training, the impact of which will decrease reliance on physical campuses.

In terms of long-range planning, we can develop environmentally friendly medical equipment (e.g., anesthetic gas alternatives), execute more relevant assessments of the environmental impact of healthcare systems, improve global collaboration, prepare a resilient infrastructure with consideration for geopolitics to meet local needs, reduce dependence on external resources, ensure that all new healthcare facility construction is Leadership in Energy and Environmental Design (LEED) certified, and create new healthcare policies that require the incorporation of environmental impact studies.

The likelihood of these proposals being successful depends on overcoming multiple challenges. High initial costs and risks of investing in clean energy technologies and infrastructure may have little returns or guarantees. Rigorous staff training programs for proper operation and maintenance of clean energy systems and equipment must be created and implemented to ensure continued success. The most critical challenges are political roadblocks and obstacles to implementing policies, such as setting emissions standards and regulations that favor using clean energy via renewable energy options over fossil fuels. The power, influence, and financial clout of special interest groups and lobbyists that oppose the transition to a low-carbon economy will be felt as they fight to retain the economic benefits received with the present systems and processes in energy and manufacturing.

Legitimate concerns about the ultimate impact of implementing many of the proposed broad changes exist. For example, to support the production of electric cars, one must consider the environmental effects of the processes to create more batteries for such vehicles. More importantly, planning the addition of enough infrastructure to accomplish full implementation may reveal a range of deficiencies that may be extremely difficult and prohibitively costly to overcome. Lastly, no one truly knows if doing something other than maintaining the status quo will make things better or worse.

"You cannot use Cabernet grapes to make Rose."
~ Jill Albanese

TRANSFORMING UNITED STATES HEALTHCARE

Group Members: COL Gina Adam, MS, USA; Col Brad Brough, USAF, MC; LTC Maridelle Charit, MC, USA; CDR Kathryn Cheng, DC, USN; Dr. Christine Going, VHA; Ms. Neena Porter, DHA; CAPT(s) Shannan Rotruck, NC, USN; Col Nathan Schwamburger, USAF, DC.

Introduction. The United States (U.S.), the richest nation in the world, ranks 38th in life expectancy yet expends the highest cost for healthcare. This surprisingly negative statistic is because the U.S. healthcare system is structured as an entitlement and is challenged by its focus on treating sickness, lack of access to quality and timely care, and high cost. Re-envisioning medical care in the US requires viewing healthcare as a right for all, focused on preventive health, allowing access for all, at a sustainable cost.

> *"When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied."*
> *– Herophilus (325-255 BC).*

Whole Health & Nutrition. Unhealthy behaviors heavily contribute to the development of preventable chronic diseases like obesity, type 2 diabetes, heart disease, all of which predominate in the U.S. Treating these conditions is often more expensive and resource-intensive than preventing them through lifestyle changes. The connection between healthcare issues and social determinants of health (SDOH) is essential for a holistic understanding of one's overall health. Socioeconomic factors such as access to affordable food, physical environmental factors, including the lack of grocery store access, and clinical care factors, such as the high cost or lack of access to healthcare, all produce difficult tradeoffs and have effects on overall health. A paradigm shift from episodic "sick care" to whole health care is needed to address SDOH. A whole health approach is defined as physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities. Whole health also includes an interprofessional, team-based approach. Consider a simple change in how the healthcare team interacts with a patient; instead of asking "What is the matter with you?", the healthcare team asks, "What matters to you?"

Nutrition, physical exercise, and sleep are simple, yet key components of basic, good health. For example, there is significant research supporting an inverse relationship between the availability of appropriate nutrition and healthcare costs. The provision of health education, specifically on healthy eating, can impact the current relationship between chronic conditions (like diabetes and hypertension) and poor nutritional practices to the point of preventing many chronic diseases.

Access to Care. Article 25 of the United Nations Universal Declaration of Human Rights lists medical care as a basic human right. All advanced nations (and many non-industrialized) include healthcare as a right, except for the U.S. The U.S. sees healthcare through the lens of a "health insurance system" or as a consumer product. Healthcare viewed as a moral right leads to societal benefit, a public good like education or national defense. Data show all advanced nations have a higher life expectancy, better outcomes, and better access to primary care with overall lower cost than the U.S. Supporters of the U.S. system contend that healthcare as a right removes personal choice; however, there are ways to provide more efficient and effective healthcare while still allowing choice.

As the only advanced nation without universal healthcare, the U.S. can observe other nations' healthcare systems to find solutions for building a system focused on prevention, quality, and decreasing cost. For the past 50 years, Australia has successfully provided a universal healthcare benefit for its population. With the additional specialty and pharmacy coverage, Australia has ranked near the top in global health outcomes. Norway's centrally funded and locally executed healthcare system is ranked number one in administrative efficiency and number two for access and health outcomes compared to other high-

(Continued on next page)

income countries. The addition of private insurance also enables options to expand access. With the lowest ranking healthcare system among high-income nations, the U.S. would benefit from adopting elements of these countries' systems to improve outcomes while reducing cost.

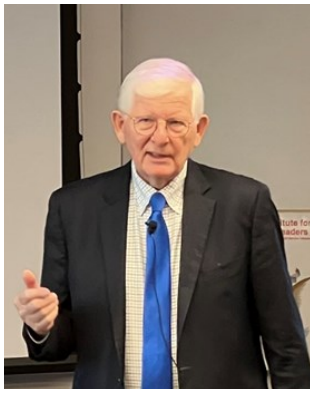
Cost & Policy. The reasons behind high healthcare costs in the U.S. include price opacity, the fee-for-service model, administrative inefficiencies, and a focus on treatment over prevention. Individuals often have no idea the cost of a medical procedure or service until they receive the bill. This price opacity makes it difficult for patients to make informed decisions and creates a market where prices can be artificially inflated. The fee-for-service payment model incentivizes healthcare providers to perform more procedures, which increases cost without necessarily improving outcomes. Inefficiencies and administrative overhead in the healthcare system also contribute to high costs due to complexity of billing and insurance program management. A healthcare system that predominantly focuses on treating diseases allocates a significant portion of resources to expensive medical procedures, medications, and hospital stays while allowing preventable diseases to flourish. This delays necessary care and increases reliance on emergency services and drives costlier procedures and hospital stays which all lead to a strain on healthcare resources.

A single-payer healthcare system with a private insurance option can produce several potential benefits in reducing the overall cost of U.S. healthcare. With a single-payer system, there is less complexity in billing and reimbursement, reducing administrative overhead for both healthcare providers and insurance companies. A single-payer system has bargaining power to negotiate lower prices for healthcare services and pharmaceuticals. Optional private insurance could be offered to allow individuals the choice to supplement their healthcare if they desire additional services or faster access, reducing strain on the public system. As the effectiveness of such a system would depend on the specific details of its design and implementation as well as the sociopolitical and legislative climate, the provision to allow for personal choice may help bridge the gap between the proposed and current healthcare system.

Conclusion. The U.S. finds itself in a paradoxical position, ranking 38th in life expectancy while spending exorbitantly on healthcare. This conundrum is rooted in a system that focuses on treating sickness rather than promoting health, resulting in a lack of access to timely and quality care, and soaring costs. To remedy this, a fundamental shift is imperative: viewing healthcare as a universal right, rather than a mere consumer product. Embracing a holistic approach to healthcare that addresses social determinants of health, emphasizing nutrition, exercise, and preventive measures, is essential. High costs are exacerbated by price opacity, the fee-for-service model, administrative inefficiencies, and the neglect of prevention. A price-transparent, single-payer system with optional private insurance holds promise in reducing costs, enhancing administrative efficiency, and ensuring access to care for all, while allowing individuals the choice to supplement their coverage. The path to a sustainable, more equitable U.S. healthcare system lies in recognizing healthcare as a moral right and embracing a comprehensive approach that prioritizes health and well-being for all citizens.

Current State	**Vision**
Healthcare = entitlement	Healthcare = right
Focus = treating sickness	Focus = health & prevention
Iron Triangle challenges (access, cost, quality)	Access for all
	Cost is sustainable

Candid photographs taken randomly during the 141st Interagency Institute for Federal Health Leaders



Left to right:

Dr. Lester Martinez-Lopez, ASDHA

Dr. Margie Warrell, Sr Partner, Korn Ferry

Dr. James Thurber, Emeritus Professor, American U.

LtCol James Vance, USMC Ret CEO, Vance Communications

GT ROTC Color Guard with Dr. Southby

Dean Boris Lushniak, SPH, UM

Mr. Thomas Kahn, JD Faculty, American U.

Dr. Paul Cordts Medical Affairs, DHA

MG David Rubenstein USA Ret Executive Consultant and Mentor (standing on chair to ask, "Do your people see what you see?")

PT Henry, Henry Consulting, moderating panel addressing private sector role in Federal Healthcare Services with Mr. Tom Jenkins, Express Scripts; Dr. Joyce Griffin, Health Net Federal Services; Mr. George Tracy, SPECTRUM Healthcare Resources; Ms. Julie Townsend, TRIWEST Healthcare Alliance

One of five participant small groups that lead class response and discussion at the end of the days' presentations

Left: Dr. Barry Wolcott, Associate Professor, USU

Below: Mr. Charles Kahn, III, President & CEO, Federation of American Hospitals

Left to right: Dr. Elizabeth Cobbs, Professor of Medicine, GW; Mr. Eric Peterson, Partner & Managing Director, Global Business Policy, A.T. Kearney, Inc.; Dr. Anthony Cordesman, Emeritus Chair in Strategy, CSIS; CAPT(N) Wade Brockway, Director of Mental Health, Canadian Armed Forces.
Below: Panel addressing the health professions: Col James Knowles, USAF, DC, Director, Air Force Dental Corps; COL Nicole Chevalier, VC, USA, Deputy Chief, VC; Dr. James Scott, Professor, Emergency Medicine, GW; and Dean Emeritus Patricia McMullen, School of Nursing, CUA. Dr. Tamara Ritsemsa, PA-C, was on Zoom.