THE RECORD

Interagency Institute for Federal Health Leaders

Volume 25, Issue 1

Spring 2022

From the Director…

The ***138th Interagency Institute for Federal Health Leaders*** was held from April 18-29, 2022, at the Bush School of Government and Public Service, Texas A&M University, in Washington, DC.

Once again we had a very full schedule of presentations from our distinguished faculty and I was also pleased with the active participation from the participants.

I was hoping that we would continue progressing to something like the pre-pandemic 'normal'. The world, however, lurched into yet another crisis, the Russian invasion of Ukraine, with all the disastrous consequences in terms of human casualties, destruction of homes and buildings and severe disruptions to world trade. Regrettably, it does not seem to be likely that this terrible situation will improve in the near future.

I was invited to coordinate a Leadership Workshop for the 2022 USPHS Scientific & Training Symposium, organized by the PHS Commissioned Officers Association, in Phoenix, Arizona. The panel included Dr. Josef Reum, Dr. Boris Lushniak, Dr. David Goldman and Lt Gen (Ret) Jay Silveria. In addition, I was invited to speak at the formal 'Anchor and Caduceus Dinner' and decided to address the topic, *The Interagency Imperative,* one of the most important themes of our Institutes. The following are some of the principles I emphasize in planning each offering of the Institute and I hope they will be of interest to you as graduates of the IAIFHL.

First, as the participants are selected by the Army, Navy, Air Force, Public Health Service and the Veterans Administration on the assumption that these individuals have the potential for promotion to the highest levels of leadership within their agencies, they need to be challenged in various ways. It is important to think outside their 'silos', to be visionary and understand that there are usually no 'cookbook' solutions to the challenges confronting the five agencies. Second, the participants will have the opportunity to learn from the experiences of other federal health agencies through their active participation in the Institute course. In other words, accept and exploit the concept of the 'Interagency Imperative'. Third, and very importantly, they must be aware of trends, challenges and opportunities by understanding, or at least be aware of, what is happening outside the health field, nationally and globally. In a direct or indirect way, these topics will impact their agencies. Fourth, the overriding theme of the Interagency Institute is **leadership.** There is no one 'best' leadership theory so it is essential that participants hear a variety of perspectives on leadership. They must be able to assess the positives and negatives of the numerous theories and utilize them in responding to the challenges and situations they find themselves in as leaders.

I wish you all a pleasant summer and thank you very much for your continuing support of the Interagency Institute.

Sincerely,

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

OUTLINING A STRATEGY TO MAINTAIN ESSENTIAL PUBLIC HEALTH PROGRAMS IN A POST-COVID-19 ERA

Small Group Assignment: In light of a national post-COVID-19 strategy released by the White House and a roadmap for living with COVID-19 assembled by a team of public health experts, create a plan that identifies some of the best lessons learned as well as which public programs that need to stay in place to best serve the public health needs of the country.

Group Members: CAPT Virginia Blackman, USN; CAPT Kristi Erickson, USN; Col Dale Harrell, USAF; Mr. Derrick Jaastad, VHA; Col Mark Levin, USAF; COL Jennifer Stowe, USA; CDR Alexander Varga, USPHS.

Introduction: In response to the COVID-19 pandemic, Congress authorized significant discretionary spending that enabled many Americans to receive aid and healthcare in ways that were not previously imaginable. As the pandemic recedes from center stage, and in all likelihood becomes endemic, significant pressures exist to decrease or eliminate pandemic-related funding. Given the realities of current fiscal pressures, the following analysis highlights lessons learned and presents strategic policy and investment recommendations to best sustain the health of our nation.

Communication: A coordinated communication campaign, one with consistent and simple messaging, is imperative to a successful federal government response to this pandemic and pandemics or other public health crises of the future. This would include personalized messaging among predefined, vulnerable populations in order to inform the public about all facets of the pandemic and subsequent response measures. This communication plan should be adaptable, and once formed, should be used on all media platforms. A special emphasis on social media should occur in an attempt to drown out the deluge of misinformation that was witnessed by the COVID-19 pandemic. Communication will be key to maintain and fund the programs that are recommended in any plan going forward.

Research: The path forward for future pandemics will require maintaining a steady stream of research funding to detect, prevent, protect, and treat future pandemics. Funding must be authorized by Congress and States to prepare for future pandemics as well as advance health security and preparedness for future pandemics. Our path forward relies on maintaining and continuously enhancing the numerous research strategies for private sector and government collaborations. Research must continue in areas of zoonotic diseases, disease detection, vaccines, therapeutics, and the impact of COVID-19 on health, the economy and our health care system.

Vaccination/Vaccine Development: The COVID-19 pandemic meant that a vaccine needed to be rapidly and safety developed, produced, and distributed because vaccines are the most effective defense against COVID-19. For future pandemics, a comprehensive plan should be created that streamlines and authorizes the U.S. Food and Drug Administration (FDA) to rapidly approve a vaccine. Incorporated in this plan should include the lessons learned developing the COVID-19 vaccine. Additionally, the U.S. Department of Health and Human Services (HHS) should develop a strategy to monitor future authorized vaccines for the efficacy and durability against current and future variants and make recommendations to optimize protection. To increase American manufacturing capacity to reliably produce and distribute vaccines to fight the next pandemic, funding to enhance public-private partnerships should be prioritized. Coupled with vaccine development is the need for a regular updating of a vaccination outreach and education strategy to combat misinformation and disinformation.

Testing: The availability of home test kits, either through retailers or free of charge, through government sources such as USPS, has simultaneously streamlined and complicated our ability to understand how COVID-19 is moving through our nation. As we have progressed through COVID-19 and home testing, the periodic reporting has introduced a degree of random variation into the epidemiological data and confounded our analysis. As a result of inconsistent test reporting, the healthcare delivery system at large

cannot surge to address the needed capacity in both beds and staffing creating a perpetual reactive or responsive state of delivery instead of a proactive or anticipatory delivery system. A national testing system that enables both at-home testing and provider testing infrastructure to have tests captured, curated, and reported without undue delay or administrative burden will provide a much greater understanding of the disease evolution, penetration, and inform our delivery system of pending demand. Reporting discipline, or the consistent reporting of standard data elements from states on a regular cadence through the early pandemic would provide epidemiologists with a well-established backdrop. With consistent reporting, epidemiologists could direct contact tracing, implement isolation protocols, and begin to understand the R-0 or transmissibility of the virus. Further, the emphasis on testing without a systematic plan for facilitating test result reporting may inadvertently create additional public health risks by undermining the system of reportable illnesses.

Global Outreach: As COVID-19 has demonstrated we cannot address this pandemic and future pandemics / threats in isolation, it must be a global effort. To this end, the above programs addressing communication, research, vaccine development, vaccination and testing must be supported by developed nations through-out the world. Financial buy-in is needed from around the world and approaches need to be multifaceted and funded by developed nations. The goal is for the world not to be caught behind the curve when the next biological threat develops and quickly limit the spread and hopefully prevent another pandemic. The World Health Organization and other Non-Governmental Organizations have vaccine programs that can be expanded on. With the importance of consistent messaging, the U.S. should place high emphasis on global outreach. Education on masking to prevent or diminish viral spread and vaccines efficacy in the more remote and highly populated regions of the world should be a clear and high priority. Evolving science will guide our approach which our leaders need to be able to effectively and efficiently turn into policy and programs to prevent fewer deaths.

Medical Infrastructure: The COVID-19 pandemic highlighted the fragile nature of the American health care system. Resources, money, providers, and facilities are not equally distributed around our nation and we rob Peter to pay Paul, especially with providers. Our supply chain felt extreme amounts of strain to supply the needed PPE, ventilators, and other consumables. Plans must be refined and reviewed to incorporate the lessons we learned from standing up facilities and sending the USPHS and military to different localities so that next time we can do better. Our manpower shortage was highlighted and the education systems for health professionals and paraprofessionals is an area where additions need to be made. Data collection also is a component of the health infrastructure that needs to be considered. The data from hospitals, community testing, at home testing, impacts of illness, vaccination rates, and many other data sets need to be safely collected and processed for communication, research and global outreach.

This report has highlighted a few of the lessons learned and policy areas that should be addressed to ensure the health of our population during future epidemics.

Potential Pitfalls for Dealing with Pandemics	Stockpiling – medications, personal protection equipment
	Data – collection, reporting, processing, sharing, discipline
	Medical Infrastructure – manning, geographic inequity, financial inequity
	Funding – federal and state having and allocating money, flexibility of spending, distribution of funds
	Relevancy – todays plan will not work in tomorrow's reality (key for testing, therapeutics, communication)
	Sustainability – out of sight, out of mind
	Risk Balance – need clear articulation of risks and priorities in risk allocation and acceptance

WHOLE WORLD VACCINATION STRATEGY

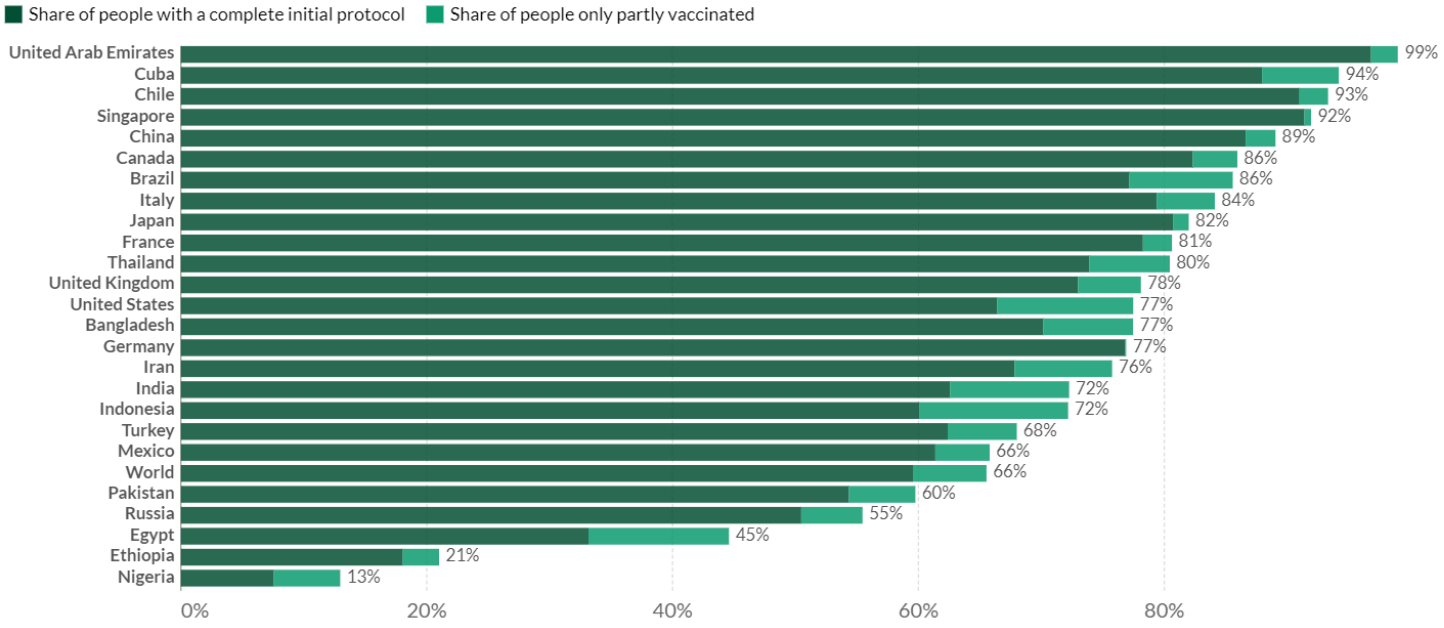
Small Group Assignment: Outline the major elements of a global program designed to bring the current pandemic under control by vaccinating as many people as possible.

Group Members: CDR Jonathan Levenson, USN; COL Andrea Maya, USAF; COL Brian G. Min, USAF; COL Brianna Perata, USA; CAPT Donna Poulin, USN; LTC Dennison Segui, USA; COL Betty A. Venth, USAF; Jonathan Zivony, VHA.

Introduction: The COVID-19 global pandemic has challenged the world population since March 2020. With over 6.2 million deaths from the COVID-19 virus, it is essential that vaccine manufacturing, distribution, and administration be completed as soon as possible as the COVID-19 virus has demonstrated its ability to morph into other variants.

Facts: Over 6.2 million deaths have occurred.[1] As of 17 April 2022, there are 7.9 billion people in the world. Currently, 65% of the world population has received at least one dose of a COVID-19 vaccine. However, only 21% of people in Africa have received at least one dose thus 79% remains at risk.[2] The challenge has morphed from production to logistical challenges of distribution and administration of the vaccine. it is projected that over 20 billion COVID-19 vaccine doses will be produced in 2022. If so, there will be sufficient doses to vaccinate the World Health Organization's goal of 70% of the world population.[3]

Share of People Vaccinated Against COVID-19, May 12, 2022



Source: https://ourworldindata.org/covid-vaccinations

Challenges: Knowledge of the COVID-19 virus and the vaccine must reach the most rural areas in countries where there are gender biases and classes of citizens with different levels of privilege. A consistent account of the threat and the availability and benefits of the vaccine needs to be presented. Logistically, the preferred method of distribution is to the governments of countries around the world with the anticipation they will utilize governmental and non-governmental agencies for local distribution and administration of the COVID-19 vaccine to the population. Public affairs agencies in every country must provide factual information to the population and emphasize the need to be vaccinated in an effort to protect the global population.

Strategy: Considerations for the production, packaging, freighting, refrigeration, and appropriate reception and handling of the COVID-19 vaccine are paramount. The U.S. and partners have the capacity to strengthen supply chains globally by using public-private partnerships. This has been evident with the expansion of government and civilian corporations united efforts Global logistics companies and multilateral architecture such as the COVID-19 Vaccines Global Access (COVAX) Facility allow for mass distribution. Expenditures for the vaccines to underprivileged countries should be sponsored by more fortunate and financially stable economies. When receiving the vaccine, it is imperative that governments engage and integrate local, grassroots actors to navigate the cultural and religious aspects of their unique populations. Through these avenues, people should 'buy-in' to the need and trust the government's desire to vaccinate everyone.

Timeline: Considering 20 billion doses will be created by the end of 2022, governments need to requisition manufacturers via the COVAX Facility. This facility is a global risk-sharing mechanism for pooled procurement and equitable distribution of COVID-19 vaccines.

Strategic Communication Plan: Communication plans should shape and promote a strategic narrative to persuade and gain the trust and support of the African people. The aim being to educate leaders and the people. America must involve its allies and partners to shape messaging that is considerate of cultural and political sensitivities and offers unique perspectives, experiences, and insights. Various interagency allies and partners must distribute this unified messaging. It should be through a visible and credible proactive media campaign to educate, enlighten, and promote the vaccination efforts. The narrative will require clear definitions, consistent messaging, and repetition that support the World Health Organization's goal of 70%. This communication effort should entail processes to counter arguments and responds to the anticipated negative responses. Ultimately, a public chronicle that communicates action taken and successes achieved and marketed by all countries involved should gain backing.

Partnerships: The world nations must apply a collaborative strategy to disease management equivocally focused at equitable access to COVID-19 vaccines. COVAX is a strategic initiative with direction being led by "the GAVI Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations, and the World Health Organization, alongside key delivery partner UNICEF."[4] In the Americas, the Pan American Health Organization Revolving Fund is the recognized procurement agent for COVAX. In recognition to ignite access to tests, treatments, and the vaccine, COVAX is co-leading the Access to COVID-19 Tools. Prioritizing populations like those at most risk and health care workers can and will mitigate the public health and economic impact of this pandemic.

Summary: The consequences of not achieving high vaccination coverage worldwide could eventually prove severe as the emergence of new variants may further threaten the world's efforts to mitigate disease outcomes. In many underdeveloped countries, COVID does not rise to the priority level as a serious threat on par with other health problems that are using scarce health care resources. A focused strategy of improving vaccination efforts on areas of high-risk populations using local catalysts who can communicate and navigate the infrastructure may prove to be the most demonstrable way to maximize success. Effective coordination and partnerships of community networks, government agencies, and private sector enterprises will likely continue to be the most impactful way to improve vaccination efforts and slow new and emerging variants of the virus in a highly interconnected world.

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[1] Website: www.worldometeres.info/coronavirus/

[2] Website: www.ourworldindata.org/covid-vaccinations

[3] Website: https://catalyst.phrma.org

WHAT PEOPLE AROUND THE WORLD LIKE - AND DISLIKE - ABOUT AMERICAN SOCIETY AND POLITICS

Assignment: Pew Research Center Study: Why does it matter and what should we do about it?
Citation: Pew Research Center, Nov, 2021. "What People Around the World Like – And Dislike – About American Society and Politics"

Group Members: CDR Denise Boggs-Wilkerson, USN; LTC Patti Glen, USA; Ms. Marcia Insley, VHA; Col John Modra, USAF; CDR Elizabeth Skorey, USN; Dr. Anne Utech, VHA; Col Jay Veeder

Background: In February of 2021, the Pew Research Center surveyed citizens of 17 countries with advanced economies to gather perceptions of various societal aspects of the United States. Most countries, including the U.S., perceived the U.S. Healthcare system as one of the worst. Also, the U.S. was perceived as having an average standard of living compared with other developed nations surveyed. Opinions about U.S. technological advancements, entertainment, and military were generally identified as best or above average and opinions about U.S. Universities were mixed. This report will focus on the significance of the perception of the United States' Healthcare System, the implications, and what response (if any) the United States should take to the criticism.

Review: Considering when the interviews were conducted is extremely important as recent political, financial and social events may have influenced survey responses. In the months preceding the survey, the world witnessed the United States' first modern day insurrection with images of the recent Capitol attack consuming the international news cycle; U.S. political leaders voiced controversial opinions on COVID masking requirements, lockdowns, and social distancing; and the U.S. was reeling from civil unrest and widespread criticism of the overall state of civil rights following the murder of George Floyd.

Before exploring implications of this survey and any response the U.S. might take, it is also important to consider the possible underlying assumptions and perceptions of those surveyed. Respondents were asked whether the U.S. healthcare system is the best, above average, below average, or the worst compared to other developed nations. Interviewees may not have differentiated between U.S. healthcare, the U.S. healthcare system, the health of the U.S. population and their perception may be limited or skewed. Many gain their knowledge of U.S. healthcare from social media or various news outlets. These sources often offer anecdotes, perceptions and attitudes as opposed to actual experience with the system. Most countries surveyed were more homogenous and smaller in population and geographical distribution. Comparing the U.S. healthcare system to their own would not be an equitable comparison. Additionally, there is no context provided regarding whether respondents view the U.S. healthcare system as better, worse or the same as their own.

While U.S. healthcare is one of the most advanced in the world with respect to technologies, pharmaceutical research, and innovative therapies, Pew's findings suggest there are critical issues that require attention. Access to this world-class healthcare is limited to certain socioeconomic subsets of the population. The term "healthcare system" implies that healthcare is organized, integrated, coordinated, and standardized; by this definition, the U.S. does not have a singular healthcare system. The Peterson-KFF Health System Tracker Dashboard (www.healthsystemtracker.org/dashboard/) compares healthcare accessibility, interventions, and outcomes between advanced countries; in some of these areas the U.S. is rated lowest, including maternal mortality rate, percent of the population covered by health insurance, and life expectancy.

In a 2020 article, "Global Health is National Security" (www.justsecurity.org/72623/global-health-is-national-security), Dr. Joia Mukherjee wrote "The COVID-19 pandemic has demonstrated that the national security

of the U.S. depends on the country reckoning with its outdated health-care architecture. The pervasive damage to the global system of commerce, profit and labor wrought by the coronavirus has proven that we are, indeed, an interdependent world. The U.S. stands out as exceptionally ill-prepared for this threat. For too long, many have believed that outsized military might would guarantee U.S. national security. But, COVID-19 demonstrates that national security – the security of everyday men, women, and children, of small business, of schools, of the food supply, of livelihoods – relies on health. And health in the U.S. is inextricably linked to the health of everyone around the world."

Conclusion: Given the link between national security and health, Department of Defense, U.S. Public Health Service and Department of Veterans Affairs leaders must take a multi-faceted approach to the perceptions highlighted in the Pew survey:

1. Partner with Pew Research Center or another survey provider to gather further insight into negative healthcare perceptions. Questions about quality of care, patient experience, access to care, cost of care, prevention and outcomes could bring areas of improvement into focus.
2. Promote and harness innovation from non-traditional partners through transparency. Educate leaders, patients, and industry on healthcare system challenges to shed light on perceptions, change perspective and seek innovative solutions.
3. Publish and promote Department of Defense, Public Health Service and Veterans Health Affairs best practices. Focus on patient wellness and look for opportunities to expand programs to non-federal populations.
4. Advocate for continued focus on social determinants of health including access to healthy foods, improved community layouts, affordable housing, and availability of healthcare services and expanded preventative services across the United States.

While the perceptions of the U.S. healthcare system both domestically and abroad are affected by context and assumptions of the Pew survey, the result remains that these perceptions highlight real opportunities for examination and improvement. The healthcare challenges faced by federal and private health care providers are multi-faceted and will require ongoing energy, investment, and innovation. Gaining ongoing detailed feedback from patients and stakeholders regarding their perceptions of healthcare will be essential.

Faculty
138th Interagency
Institute, April 2022

Left:
MGen J.D. Marc Bilodeau, CD, MD, Canadian Armed Forces Surgeon General

Right:
Boris D. Lushniak, MD, MPH, Professor and Dean, School of Public Health, University of Maryland

THE MILITARY HEALTH SYSTEM (MHS)

Small Group Assignment: Review the current structures and operation of the MHS, identify the major successes and failures of the system, and develop the elements of a strategic plan to ensure high quality, comprehensive, coordinated care for active duty personnel, retirees and their families.

Group Members: CAPT Robert, Anderson, USN; Col Jennifer Bein, USAF;
CDR Debra Buckland-Coffey, USN; LTC Christopher Stucky, USA; CDR Ian Sutherland, USN;
COL Mike Szczepanski, USA; Col Marilyn Thomas, USAF.

Current Structures and Operation of the Military Health System: The MHS is a large and complex organization within the Department of Defense that interconnects health care delivery, medical education, public health, private sector partnerships, and medical research and development. The MHS exists to ensure (1) a medically ready force; (2) a ready medical force; and (3) a high-quality medical benefit for 9.6 million uniformed service members, military retirees, and family members (About the Military Health System, 2022).

There are five primary Department of Defense organizations involved in the governing of the MHS: Office of the Assistant Secretary of Defense for Health Affairs; Defense Health Agency (DHA); and the Medical Departments of the Army, Navy and Air Force.

The DHA is responsible for the administration and management of medical treatment facilities (MTFs) and as a combat support agency provides enterprise-level support to the combatant commands to meet the medical needs of the operating forces (Department of Defense, 2022).

Strengths and Opportunities within the Military Health System:

Multitasking. The MHS does an excellent job of multitasking as evidenced by the services delineated on health.mil: Providing excellent healthcare for both the active component and beneficiaries; medical education, including Graduate Medical Education (GME); medical research and development; and public health. While this flexibility is a strength, the inherent need to be all things to all people creates a risk for over-extension. This was noted in the DoD IG report on the MHS response to the COVID crisis, which noted burnout amongst MHS staff associated with the multi-pronged COVID response. In order to prevent members from feeling the strain of MHS mission, a review of requirements aimed at force optimization, most notably in the realm of administrative structure, training, and partnerships is recommended.

Administrative Structure. Ensuring that all staff are working to the top of their licensure is recognized in healthcare administration as a method to prevent burnout and improve resource utilization (Wright & Katz, 2018). A brief, unofficial staff survey confirmed this. A thorough review to identify and address the issues of staff utilization and appropriate clinical reduction for collateral duties is necessary to ensure that the MHS remains flexible without furthering a crisis of burnout within the front- line workers.

Training. The MHS provides initial clinical training for all health professions and military-specific training for medical personnel. For simplicity, only GME and operational team training is addresses. The MHS runs broad training activities. These rigorous programs have board pass rates consistently above 98%. Unfortunately, volume is lacking in some GME sites, earning citations from the ACGME. Despite citations, the ACGME in 2019 sent a letter to the MHS GME Manager highlighting the need for military GME programs, noting that there were insufficient civilian programs to absorb military trainees.

Partnerships: Military specific training for the role 2 and role 3 teams is predominantly accomplished through simulation and trauma training. Skills maintenance requires high acuity patient care performed as a

team. To continue rigorous training, a focus on partnerships with Veteran's Health Affairs (VHA) and civilian healthcare facilities is recommended. MHS faculty would augment current faculty, allowing for additional MHS trainees. Partner institutions would benefit from excellent faculty with military-specific instruction to military trainees, while MHS trainees benefit from learning in a high volume and acuity environment.

Command Structure: The MHS is excellent at crisis response (e.g. DSCA, NEO, HA/DR). While our crisis outcomes are outstanding, service coordination is weak, leading to tactical redundancies and capabilities gaps. We recommend creating a unified medical command that follows the structure of a combatant command. We are not the first to recommend this restructuring: the USAF SG initially vetoed this concept in 2006 due to inter-service differences. The proposal was revisited in 2016 by the Military Compensation and Retirement Modernization Commission but no formal action was taken. Most recently, the 2019 NDAA required a headquarters-level study of the Defense Health Command concept; the results of this study are pending. We recommend that DHA, along with the Military Medical Departments, complete an internal analysis and provide a framework for a unified C2 to the Assistant Secretary of Defense for Health Affairs. This action will ensure a structure that has been vetted with those who are intimately familiar with front-line medical capabilities rather than a structure dictated from outside of the medical services.

Conclusion: The MHS is a large and complex organization consisting of the DHA and the tri-service medical departments. It excels in flexibility and academic training, however, within each of these strengths is an inherent opportunity for improvement. Effective management of this large organization requires an overall re-evaluation of the mission requirements at the service levels and an ultimate re-organization of assets to ensure standardization for effective, efficient care of our military service members and beneficiaries.

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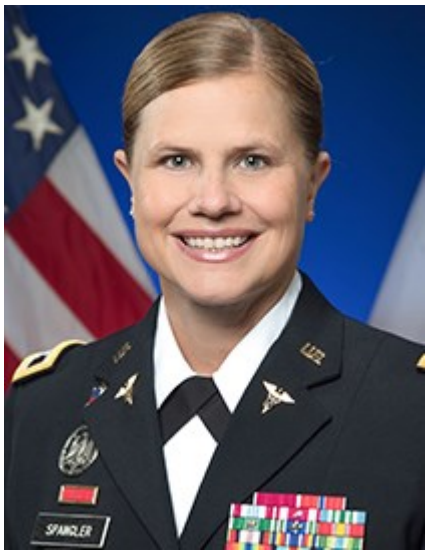
LEFT: CAPT Brian Lewis, MD, USPHS, conducting the USPHS Commissioned Corps Music Ensemble for the ensemble concert, 24 May 2022, at the 2022 USPHS Scientific and Training Symposium , Phoenix AZ.
Brian is an alumnus of the 134th Interagency Institute, Spring 2019.

RIGHT: COL Kathleen Spangler, AN, spoke at the 138th Institute dinner at the Army Navy Country Club, 20 April 2022.
Kathy is an alumna of the 127th Interagency Institute, Fall 2015.



UNIFORMED SERVICES – SEXUAL ASSAULT/HARASSMENT

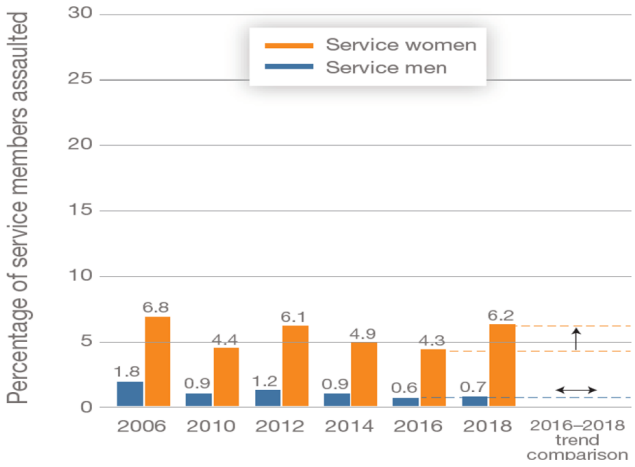
Assignment: The incidence of sexual assault has regrettably become a significant embarrassment in all the branches of the Uniformed Services. Identify the extent and scope of this matter, reviewing existing policies and protocols aimed at preventing this abusive behavior and punishing the perpetrators. Are there lessons to be learned from other nations? If so, which nations and what are the lessons?

Group Members: Col Marilynn Chenette, CAF; COL Randolph Harrison, VHA; Col Gilbert Harvey, ANG; CAPT Josephine Nguyen, USN; LTC Demarcio Reed, USA; CAPT Tami Rodriguez, USPHS; CDR Emily Sprague, USN; LTC Lauris Trimble, USA

Introduction: The Department of Defense (DoD) goal is a culture free of sexual assault, through prevention, education and training, response capability, victim support, reporting procedures, and appropriate accountability that enhances the safety and well-being of all persons. The rate of sexual assault in the military has garnered significant attention over the past decade from policymakers. There is some evidence that a majority of sexual offenses are not being reported as estimated prevalence of sexual assault from survey data consistently exceeds the reported number of incidents.

Uniformed Services Extent and Scope: The DoD has made significant efforts to address sexual assault and harassment in the U.S. military for the past ten years, however, both continue to be a persistent with negative consequences. One in 16 women and one in 143 men are estimated to experience sexual assault within DoD. At the service academies, one in six women and one in 29 men experience sexual assault. Estimates for sexual harassment are one in four women and one in 16 men. Deterrence alone is insufficient to prevent sexual assault and sexual harassment. In 2018, approximately 119,000 individuals reported experiencing sexual harassment and 6,053 reported sexual assaults with the estimated prevalence from surveys suggesting that over 20,000 service members were sexually assaulted. In 2019, the military services and the National Guard Bureau processed and investigated over 1,600 formal and informal complaints of sexual harassment.

Estimated Sexual Assault Prevalence Rates, 20016 - 2018



Source: Breslin et al., 2019.

Prevention Protocols and Policy: In 2021, RAND researchers found there were large gaps in prevention infrastructure elements. Annual sexual assault prevention and response training in the services does not employ best practices documented from the prevention literature. Their self-assessments of prevention efforts found that activities focused more on building awareness than skills, which is inconsistent with evidence-based prevention. Except for the Air Force, there are no personnel across DoD institutions or at the service academies whose sole job is implementing and evaluating sexual assault or sexual harassment prevention activities. Research suggests that the most important factor in predicting positive outcomes is the

opportunity for participants to interact and apply new skills and knowledge. As such, training to minimize lecture and maximize use of interaction to learn skills to prevent sexual harassment is critical.

Other Nations Lessons Learned: In the **Canadian military,** sexual assaults will no longer be investigated or prosecuted under the National Defense Act and will instead be referred to civilian authorities. The **United Kingdom Ministry of Defense** followed suit and passed Armed Forces bill 2021 which moves serious sexual offenses away from the military justice system into the civilian system. The **Australian Defense Force Investigative Service** (ADFIS), a Defense investigative authority of investigators from all three services, conducts serious, sensitive and complex investigations involving Australian Defense Force members including reservists. ADFIS will sometimes investigate less serious matters but can also refer matters back to unit level to be resolved or to service police for investigation. The **Norwegian military and Israeli Defense Force** (IDF) have sexual assault policies that may allow more victims to report their sexual assaults. Both avoid using the chain of command as the primary reporting option. A third-party organization conducts the investigation once a complaint is received. In the Norwegian military, sexual victimization may be reported through the chain of command, the use of a whistleblower system, or an app to report anonymously. In the IDF the victim can make both civil and criminal complaints against the alleged perpetrator. This allows justice for the victim if an alleged perpetrator is found not guilty from a criminal standpoint but can still be held responsible for their actions through a civil lawsuit. The Norwegian military is different in this aspect because they do not have a military court system so cases related to military personnel are prosecuted before civilian courts.

In September 2021, U.S. Secretary of Defense Austin announced a roadmap featuring sweeping changes on how the military handles sexual assault and harassment complaints from service members. The changes will come via a four-tiered system with each tier dependent on the implementation of the previous. The priority recommendations under the first tier include removing the prosecution of sexual assaults and related crimes from the military chain of command and establishing the Offices of Special Victims Prosecutors to handle the cases. For sexual harassment cases, it calls for independent trained investigators and the mandatory discharge of those who engage in sexual harassment. A big change is taking the jobs of command-level sexual assault response coordinators — often collateral duties of officers with other full-time responsibilities — and making them permanent, specialized positions. Full implementation of the first tier must be completed by 2027 with implementation of the full slate must be accomplished by 2030.

Conclusion: Sexual assault and sexual harassment continue to be an underreported crime among the civilian and military populations. Our Australian, British, Canadian, Norwegian and Israeli military counterparts have taken steps to remove the prosecution of sexual assaults and related crimes from the military chain of command. Because 2021 GAO and RAND research that found large gaps in prevention infrastructure elements for sexual assault and harassment in the U.S. military, Secretary of Defense Austin announced that he would prioritize elimination of sexual assault and sexual harassment from the ranks. Consequently, the FY22 NDAA includes sexual harassment as a general punitive article under the Uniform Code of Military Justice. These reforms require independent investigations of complaints of sexual harassment with specified timelines. The bill further protects survivors by requiring the DoD to track allegations and prevent retaliation. It will take an enterprise effort to end the scourge of sexual assault which mandates strong leadership across the uniformed services.

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Department of Defense Instruction 6495.02 – Sexual Assault Prevention and Response Program Procedures, 10 Nov2021
Army Regulation 600-20 – Army Command Policy, 30 Jul 2020
Secretary of the Navy Instruction 1752.4C – Sexual Assault Prevention and Response Program Procedures, 10 Aug 2018
OPNAVINST 1752.1C – Navy Sexual Assault Prevention and Response (SAPR) Program, 13 Aug 2015

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

Officers

President, CAPT Thad Sharp, USN (thad.sharp@outlook.com)
1st Vice President, Col John Mammano, USAF
2nd Vice President, Dr. Kathryn Sapnas, VHA
Secretary, Col Jim Kile, Canadian Armed Forces
Treasurer, CAPT (Ret) Gayle Dolecek, USPHS (gjdolecek@verizon.net)

Activities

The leadership is seeking a good time, space and date for the ANNUAL MEETING during the 2023 AMSUS Annual Meeting, 13 – 16 February 2023.
Please let Thad or Gayle know if you are willing to serve on the 2023 Executive Committee.
Aaron Middlekauff will assume the reigns as Treasurer in 2023.
Funding transportation to the Participants and Alumni Dinner in April 2022 was greatly appreciated!

Membership

To date, 57% of the 138th Interagency Institute alumni have completed applications to join. Welcome!

Many email addresses are not on file. Your ***personal email address*** is needed to receive FHCEIAA notifications. Also, your current USPS address is needed for the newsletter mailing list. Submit updates to Aaron Middlekauff - amiddlekauff@yahoo.com - who is transitioning from Gayle to maintain the membership list and is updating the website.

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

INTERAGENCY INSTITUTE FOR FEDERAL HEALTH LEADERS
Dr. Richard F. Southby
Director
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Washington DC 20016

ADDRESS SERVICE REQUESTED