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From the Director…

I am pleased to report that the recent Institute, the 132nd, was most successful. The participants were very involved and their questions and comments were major factors in making this professional development program enjoyable and educational for all involved.

There is no doubt that we are currently experiencing very challenging and troubling times, both domestically and globally. Many of these issues were core topics addressed by our faculty throughout the two weeks. These included the presentations on the 2018 Global Health Care Outlook, the multiple pressures on federal health services and the many, and varied, 'hot spots' of conflict around the world. Whether we like it or not we cannot escape the fact that, while we may not able to influence many of these challenges directly, they do impact us in so many ways. At the very least, as health care leaders, we need to be aware of their existence.

Once again, I was very favorably impressed by the commitment and zeal demonstrated by the participants in the way they approached the small group exercises. The class presentations and the published reports in this newsletter are of a very high standard and I am sure that our alumni/ae and others will be very interested to read them.

Our 'Lessons from Other Countries' session was held at the Embassy of the Federal Republic of Germany. I am most grateful to COL Kai Schlolaut, COL Weber, LTC Hans Perko, and SGM Schulz for organizing and coordinating this interesting and positive experience. Also, thank you to Mr. Boris Ruge, Deputy Chief of Mission, for his kind welcome and informative remarks.

I am pleased to announce an important 'first' for the Interagency Institute in that we had our very own "Artist and Cartoonist in Residence" as a participant in the 132nd Institute. LCol Andrew Currie, one of our Canadian participants, captured a number of the major points from the faculty presentations and transformed them in to a series of excellent cartoons. I am delighted to include his artwork in this newsletter for all to enjoy.

We were most fortunate to be able to hold the 132nd Institute at the DoubleTree by Hilton in Bethesda, MD. In addition to very good meeting facilities, it was especially helpful for most of the participants to stay in the hotel where continuing discussions and collaborations could occur outside of the formal sessions.

With best wishes,

Richard F. Southby, Ph.D. (Med), F.F.P.H.

Letter from the President, FHCEIAA

Congratulations to the alumni of the 132nd Interagency Institute and welcome to the Federal Health Care Executives Institute Alumni Association (FHCEIAA)! We are thrilled to have you have join our team and ranks. A special thanks to Delta Dental of California, Health Net Federal Services, LLC, Express Scripts, Inc., and Spectrum Healthcare Resources for their generous support of our Institute dinner on 12 April 2018 at the Army Navy Club. Unfortunately, I was unable to attend due to being TDY, but understand it was a truly exceptional dinner, venue and gathering. I am pleased that our alumni association treasurer, CAPT (ret) Gayle Dolecek, spoke on behalf of the organization and encouraged your membership and participation.

Spring is in the air! Along with a change of seasons comes an infusion of new Institute alumni and I am confident that the incredible resourcefulness and continued resilience of this amazing group of leaders will advance the needle of excellence in federal healthcare. The Defense Health Agency assuming responsibility for the administration of MTF budgets, health care management, military construction, and other central functions beginning 1 Oct 2018 is another change that will occur just following the fall Institute and many of you will be involved with this monumental transition.

FHCEIAA has a social media presence on Facebook! Please check out the site and stay tuned for updates. We highly encourage you to use this tool to post your own updates, maintain connections, collaborate and respond. You can connect by name search or use the link: https://www.facebook.com/Federal-Healthcare-Interagency-Institute-1805076689707896/

Please consider becoming a member of the FHCEIAA if you have not already done so. Membership ensures the maintenance of essential connectivity and collaborative wisdom to maximize our resourcefulness and effectiveness. Additional noteworthy opportunities for members include continuing to receive Institute newsletters, notice of alumni activities and meetings, eligibility to apply for FHCEIAA scholarships, opportunities to make a difference and much more.

FHCEIAA Scholarship: The agreement is to commit $3K annually to scholarships. In the past, they have ranged from $1K to 1.5K. The scholarships are awarded to children and grandchildren of members. The scholarships are intended for children continuing to college after high school. Members are eligible to apply and tentatively the committee recommended $2K could be set aside for those. Details are available at http://www.fhceiaa.org. If you have any questions, kindly contact our treasurer, CAPT (ret) Gayle Dolecek, at gjdolecek@verizon.net.

Each year, at the Annual Meeting, the association presents a Distinguished Service Award to acknowledge a senior federal health care leader who has been supportive of the Institute and its objectives. The award includes a $500 honorarium. Last year, the award was presented to VADM Raquel Bono, MC, USN.

This year, the FHECIAA Annual Meeting will be a breakfast event on November 29, 2018, during the AMSUS Annual Continuing Education Meeting at National Harbor MD, November 26 - 30. More details will be provided in the fall newsletter.

Sincerely,

Aaron

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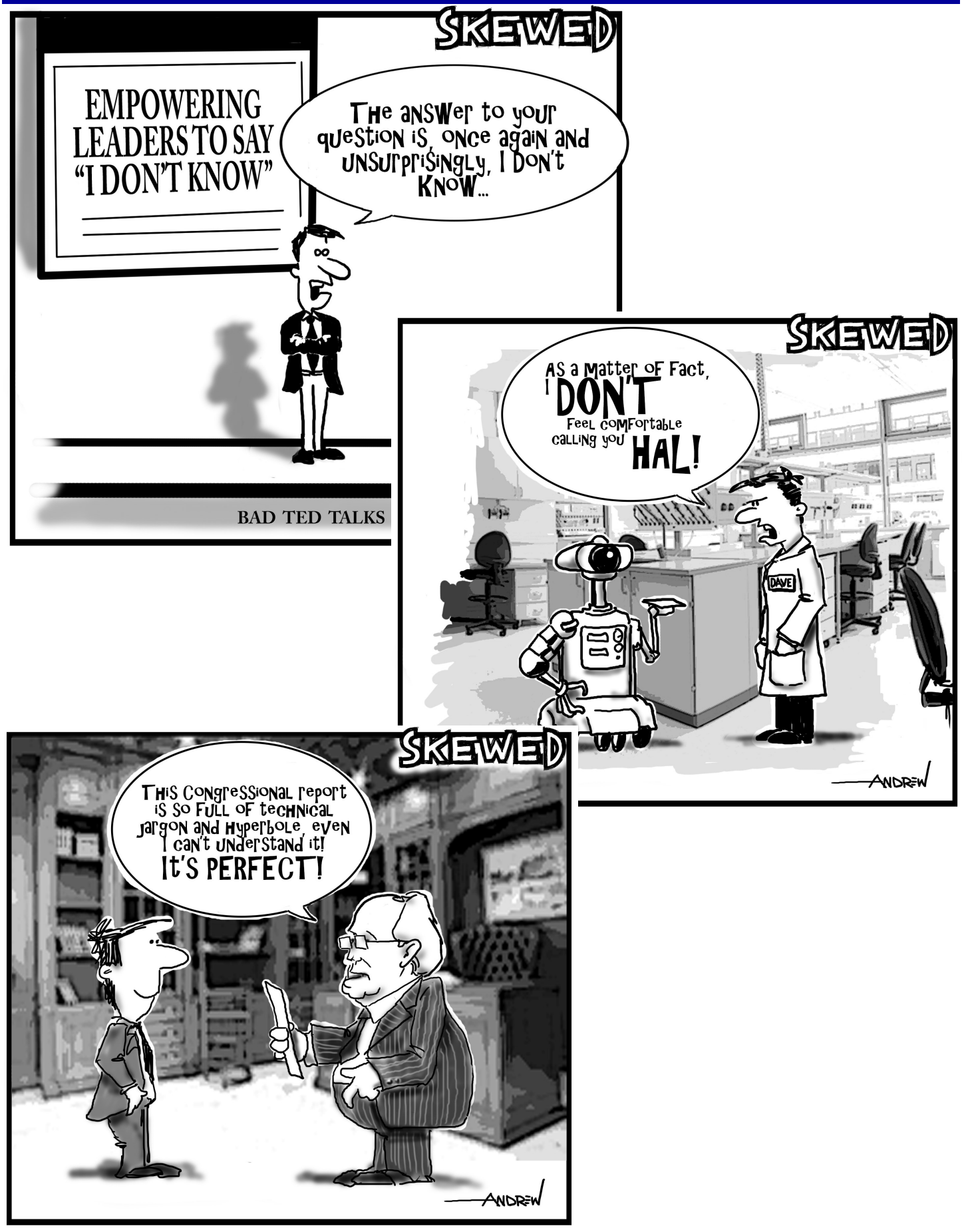
SKEWED
EMPOWERING LEADERS TO SAY "I DON'T KNOW"
THE ANSWER TO YOUR QUESTION IS, ONCE AGAIN AND UNSURPRISINGLY, I DON'T KNOW...
BAD TED TALKS
SKEWED
AS A MATTER OF FACT, I DON'T FEEL COMFORTABLE CALLING YOU HAL!
DAVE
ANDREW
SKEWED
THIS CONGRESSIONAL REPORT IS SO FULL OF TECHNICAL JARGON AND HYPERBOLE, EVEN I CAN'T UNDERSTAND IT! IT'S PERFECT!
ANDREW

Deloitte's *2018 Global Health Care Outlook - The Evolution of Smart Health Care*, was selected as the group reference for this Institute. A copy was provided to each participant.

The report offers insight on global health care sector issues in 2018 including strategically moving from volume to value; responding to health policy and complex regulations; investing in exponential technologies to reduce costs, increase access, and improve care; engaging with consumers and improving the patient experience; and shaping the workforce of the future.

A small working group of participants was asked to review the scope and focus of the report's recommendations for policy and the health care system for our society, to provide lessons that could be learned for the federal health services represented in the interagency institute, to outline three top priorities for the senior leadership in all five agencies, and to address what steps need to be taken within the next six months.

Group I Members: CAPT John Aragon, USN; CDR Daniel Clark, USN; COL Lozay Foots , USA; Col Markus Gmehlin, USAF; Col Scott Hartwich, USAF, Col Jim Kile, RCMS; Col Mary Stewart, USAF; CDR Sarah Unthank, USPHS; Mrs. Michelle Willoughby-Brooker; VHA; and COL Alisa Wilma, USA.

Introduction: When the group compared the Deloitte publication content against the Military Health System (MHS) Quadruple Aim of Cost Containment, Quality of Care, Access to Care, and Readiness and the Canadian Forces Health Services HERO aims of Healthy Population, Enhanced Patient Experience, Resource Stewardship, and Operational Readiness, readiness ranked last, suggesting that the global health care issues had less to say about military readiness than the healthcare industry at large (see figure 1). The group took a reverse approach and brainstormed challenges relevant to the members' respective services and considered Deloitte data to determine priorities for a MHS commander to ensure the benefit AND maintain readiness.

Figure 1. Quadruple Aims

Military Health System

Canadian Forces Health Services Group

Cognizant of the quadruple aims and the challenges highlighted by Deloitte, three major domains were identified where federal agencies should concentrate action to optimize health care: **Aggressive Policy Review, Leverage Technology, and Community Readiness**. Specific actions were identified that could be initiated within a six-month period at the CEO level.

Aggressive Policy Review: According to Appendix 3 of the Military Health System Review there are "39 separate quality of care policies." Commanders must identify and review institutional and local constraints, redundant instructions, and conflicting policies. Clarification is necessary in order to optimize expectations. Commanders must aggressively review whether limitations are requirements. Often times "we can't" is self-imposed. . . an assumption based on a poor interpretations of higher level instruction/regulation.

The credentialing and privileging process needs to become universal and seamless across the services. At any time, DoD should know how many privileged and credentialed providers are in the inventory and capable to move between MTFs and services. Variance between services and facilities that guide practitioners through the process should be eliminated with greater standardization. Delays in practice and frustrations due to the credentialing process can be minimized. With the increased movement of providers practicing in joint platforms, it makes no sense not to have a centralized, universal credentialing and privileging process.

A review of the purchase process is necessary to determine most effective procedures to ensure innovation while maintaining resource stewardship in relation to purchase, maintenance, updates, transfer, etc. Some purchasing control should be returned to the end users (MTF commanders, OICs, Squadron commanders). The system of checks, balances, and standardization, while sound for large scale adoption, is cumbersome and a hindrance to innovation. If end users can purchase, use, and evaluate equipment in their respective areas, the DoD can get real time feedback on the best products to research and purchase on a large scale.

Leverage Technologies: The Deloitte report and others highlight the fact that technology is fundamentally changing the way healthcare is delivered. For the MHS to be at the cutting edge of medical technology, change in military acquisition is required.

The Defense Health Agency should be in the position to expeditiously evaluate emerging technologies for implementation on the battlefield and at home. Within six months, a shared service "innovations group" of Health Information Technology (HIT) should convene to review emerging technologies and ensure appropriate evaluations in representative operational care environments with appropriate research design/analytics support – such as the Defense Innovations Board (Defense.gov, 2018) or the Navy's Digital Vanguard - to identify the best technologies for implementation.

Focus on technologies that improve care (i.e. "advanced" vital signs, population screening tools, wearable technology), enable moving care away from the MTF, and are tolerant of mission variance (such as web-based technologies) is key, as is appreciation of economies of scale. Diagnostic and monitoring capabilities by health care providers from afar may enable deployed members to remain in the battle space longer. In isolated locations like small ships or amphibious settings manned by medics or Independent Duty Corpsmen will make clinical decisions, treat, and measure outcomes employing technologies like 3D printing, companion diagnostics and biosensors.

Equipment standardization is critical to leveraging technology across the Federal Health Services. For clinically acceptable, cost-effective and timely medical procurements to occur, the Federal Acquisition Regulation must be reviewed in regards to relief from the Trade Agreements Act. Both hamper timely procurement and standardization compared to commercial health system peers. The Trade Agreements Act limits purchases to US-made or designated country end products. Developing a process to leverage buying power and cost savings across the Federal Health Services is necessary so that the DoD and VHA could procure standardized equipment and supplies as a single system. A well-staffed, responsive contracting entity within DHA that serves all DoD MTF requirements versus the current fragmented Service-specific system is highly recommended.

Community Readiness: Address "total worker health" through family and war fighter readiness and occupational and environmental health. Family readiness ensures that family health needs are met during deployed and non-deployment periods and encourages opportunities for families to communicate and bond as a unit and establish relationships with others. Occupational and environmental health at family and community levels addresses acute and chronic health issues affecting quality of family life and workforce contribution. This approach decreases stressors and increases the well-being of the community, family and individuals.

Publish community scoreboards that track community health: Average BMI, Top 20 diagnoses, Top 20 pharmaceuticals, Diagnostic spikes. Leverage social media for families and training platforms for AD to highlight communal diseases and prevention campaigns (i.e. an increase in Hand/Foot/Mouth, influenza, GI illness). Fast track access to over-the-counter medications for self-management and treatment. Leverage telehealth to encourages patients to manage their health. Employ self-care education programs and implement web-based platforms for routine screenings at home. Apply "minute clinic" concepts – use protocols that enable corpsmen and medics to provide a level of value-based service such as screenings, medication renewals, data entry.

Providers are expected or will be to use analytics to address the challenge of measuring outcomes in non-traditional settings. Further, effective analytics will guide demand management with predictive capability for telehealth volume, what social media campaigns are needed and what skill sets are needed. An effective analysis of population healthcare may determine that could be more effective- where and how to provide more care, more complex care, across a wider geography, etc.

The Deloitte report highlights domains with far reaching implications in the healthcare industry. While the industry as a whole must grapple with issues that will shape future technology, patient experiences, and the means of healthcare delivery, the military must be agile enough to adopt and adapt these concepts at all levels of healthcare across the services and in support of world-wide deployment and military readiness. Just like the industry at large, the federal health services must rethink how it delivers healthcare. The domains listed in this report, policy reviews, technology optimization, and community readiness, may serve as a framework for leaders to innovate healthcare delivery to their service members, families, and veterans. ■

THE OPIOID CRISIS: IDENTIFYING ROOT CAUSES AND DETERMINING POTENTIAL SOLUTIONS

Small Group Assignment: There is no question that the United States is in the midst of an 'Opioid Crisis' which is having deleterious effects on the health of large numbers of people and families. There are also major consequences for society in terms of increased demands for health care, as well as disruptions to employment and productivity, along with soaring health and social expenditures.

How has this 'crisis' developed, what could have been done to prevent it from occurring and what needs to be done now to solve the resulting problems, keeping in mind there are many patients who genuinely need to have access to these drugs?

Group II Members: CDR Ron Citro, USN; Col John Cotton, USAF; Col Susan Davis, USAF: CAPT Eva Domotorffy, USN; LTC Elizabeth Duque, USA; LTC Tamara Funari, USA; Col Kara Gormont, USAF; CDR Kara King, USPHS; and Mr. Jeff Nechanicky, VHA.

Introduction: The opioid crisis is a true national emergency that has had significant impacts on the United States and demands significant action to alter the current course of events. It is estimated that over one hundred Americans die every day from opioid overdose. The following is an overview of its underlying causes, as well as what can be done to stem the still-rising tide of addiction.

The darker side of market capitalism forces and seemingly well-intentioned health care policy set the conditions for the epidemic. In 1995, the American Pain Society, sponsored by 28 pharmaceutical companies, recommended that pain be regarded as the "5th vital sign." Rather coincidentally, Purdue Pharma debuted OxyContin in 1996, with the following content in the packaging insert : Delayed absorption, as provided by OxyContin tablets, is believed to reduce the abuse liability of a drug. Combined with an aggressive marketing campaign (at one point comprising 70% of Purdue's ad budget), opioid prescriptions increased by 44 million over the next five years. Then in 2001, the Joint Commission started assessing medical facilities on patient satisfaction with pain treatment. OxyContin sales increased thirtyfold the next year. The Centers for Medicare and Medicaid Services initiated its Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey in 2006 and also included pain assessment questions. This increased focus on pain outcomes as measures of effectiveness created an economic force for physicians to prescribe more.

As America became flooded with prescription pain medication, the economic downturn started in 2007 and added fuel to the fire of addiction as thousands in post-industrial areas were left behind by globalization, unemployment, and financial straits. This was a serious blow to our nation's resilience. Many sought out opioids to treat their economic and – perhaps – existential distress.

By 2009, the medical community had begun to recognize the gravity of the situation. Under pressure, the Joint Commission removed the pain assessment requirement, and clinical practice guidelines and training began to be developed. As a result, opioid prescriptions decreased 10-15% by 2010. This was also the same year that OxyContin was formulated to prevent injection. Its increase in per-gram street price led to, by late 2010, a change in addiction patterns to the less expensive heroin, and eventually to fentanyl trafficked illicitly from Asia.

Reversal Points: The culpability of the pharmaceutical industry in this crisis cannot be overstated. Aggressive marketing practices, shaping APS and TJC recommendations, and lobbying Congress and the DEA to weaken enforcement rules of pharmaceutical distributor companies all contributed to the supply-side economics of the crisis. Had these companies' influence in the regulatory process been limited – or had it not gained favorable FDA labeling – the impetus for prescribing might have been less pronounced. However, the medical field is also to blame. Some physicians ran so-called "pill mills" that churned out opioid prescriptions to turn a profit. They were also late to create effective clinical practice guidelines and patient education materials, and slow to raise the red flag on the issue's magnitude and press for revisions to pain assessment measures tied to accreditation and patient experience. Had there been greater awareness of the issues and better prescribing surveillance, the crisis may have been identified much earlier or averted altogether.

Solutions: The opioid epidemic is truly a public health emergency. Combatting it and its effects will require further prevention, treatment, and oversight measures. While provider awareness, training, and some guidelines have already been implemented and TJC standards have changed, more needs to be done. It truly needs to be approached from a public health standpoint.

Primary prevention efforts should focus on controlling access to opiates and promoting resilience. A nationwide Prescription Drug Monitoring Program should be created to generate better data on prescribing practices. Greater emphasis must also be placed on judicious prescribing practices. The CDC should develop more comprehensive clinical practice guidelines (CPGs) for the management of the spectrum of pain (from assessment to screening for those at risk for abuse to the treatment of acute and chronic pain). The Joint Commission and CMS could revise their pain assessments to include how well healthcare organizations adhere to these CPGs and alternative/complementary medicine treatments for pain could be covered by insurance.
Secondary prevention should focus on the de-stigmatization of addiction and greater funding for substance abuse counseling and treatment, to include medicine-assisted treatment (MAT). Additional research is necessary into understanding addiction at its effects on the brain.

I, Surgeon General of the United States Public Health Service, VADM Jerome Adams, am emphasizing the importance of the overdose-reversing drug naloxone. For patients currently taking high doses of opioids as prescribed for pain, individuals misusing prescription opioids, individuals using illicit opioids such as heroin or fentanyl, health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose, ***knowing how to use naloxone and keeping it within reach can save a life.***

BE PREPARED. GET NALOXONE. SAVE A LIFE.

For tertiary prevention, naloxone should be deployed to more first responders to reduce overdose mortality, and clean needle exchange and safe injection site programs should be implemented to reduce the associated rises in HIV and Hepatitis B and C.

Some pharmaceutical companies have come under scrutiny for their role in the creation of this crisis and several lawsuits are pending, but the industry must be held more accountable. Congress should hold hearings to determine the extent to which they were responsible and use their findings to develop appropriate legislation for regulatory oversight. The administration should immediately fill the Office of National Drug Control Policy Director vacancy and garner all federal agency stakeholders to create a whole of government approach to the epidemic.

Conclusion: Annual opioid-related deaths have already exceeded those from falls, guns, or traffic accidents, and the average life-expectancy in the US has decreased for a second year in a row, which hasn't occurred since the 1960s. The economic burden is estimated to be at least $94 billion. The epidemic is affecting all segments of society and it has not showed signs of abating any time soon. We must act, and act decisively, now before it is too late. It is time to get to work. ■

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POLICY PAPER ON EMERGING OPPORTUNITIES, CHALLENGES, AND RISKS IN HEALTH DATA MANAGEMENT

Small Group Assignment: We are living in an era where data and rapidly changing technologies are transforming health care. What are the implications of this 'revolution' for patients, other members of society, health professionals, educators, health care leaders and politicians?

You are tasked with developing a policy paper with recommendations to ensure that the benefits of more and better data and more sophisticated technologies will be beneficial rather than detrimental to the US health care system.

GROUP III MEMBERS: Col Alan Chambers, LCol Andrew Currie, CAPT Raynese Fikes, Col Cherron Galluzzo, COL Claudia Henemyre, Dr. Kenneth Jones, Col Guy Majkowski, COL Nancy Parson, CDR Gwenivere Rose

INTRODUCTION: Between 2010 and 2020, the amount of internet-accessible data is estimated to increase 50-fold, with health data approaching yottabyte (1024 gigabyte) in volume.[1] This unprecedented growth includes health information, and the United States government (USG) is at a crossroads regarding the ideal strategy to leverage the potential benefits of rapidly growing medical data and supporting technologies, including mobile communication, health wearables, and artificial intelligence (AI). Although leading US firms have already announced plans to capitalize on this development to achieve cost savings, federal leadership is required to optimize the potential benefits to citizens while mitigating risks.[2]

Articulated goals, such as the National Academy of Science's vision for an integrated federal (DoD/VA) and civilian trauma system, depend on improved data collection and sharing capabilities between federal and private sectors.[3] NDAA 2017 supports the Core Quality Measures Collaborative (CQMC) and its aim to promote and standardize measures of alignment across public and private payers, increase electronic health record (EHR) data capability, and interoperability between registries.[4,5] However, better health data utilization faces several challenges and risks, requiring thoughtful design and implementation of a shared federal-private partnership strategy.

OPPORTUNITIES & ANTICIPATED BENEFITS: Leveraging data, AI, and wearable technology can improve the safety, effectiveness, and efficiency of healthcare by allowing real-time monitoring of patient data (e.g., glucose levels, arrhythmias and behavioral risks). This integrated health data will allow providers the ability to identify trends and markers of future disease, as well as diagnose and treat in a more predictive, preventive, participatory, and personalized fashion.[6]

These platforms can exploit new, diverse data to improve population health by guiding and supporting healthy lifestyle decisions. Effectively accessing and analyzing these data fuels drug discovery and makes research more efficient. Online diagnostic tools and genetic sequencing services hold the promise of better-informed and engaged patients.

CHALLENGES & RISK: In the midst of opportunity, the US faces a welter of challenges. Confidentiality and data security likely represent the most significant concerns for Americans and healthcare systems. Cyber attacks cost the U.S. $6.2B.7 annually with an average cost of $2.2M and 3,128 records compromised per incident.[8] These attacks are attributed to legacy systems networked to medical devices, weak or non-existent cybersecurity measures, severe shortages of cybersecurity trained personnel, and lack of financial resources.[7] Simultaneously, health information is currently siloed and compartmentalized, limiting the ability to appropriately share data—the lack of interoperability limits potential for clinical and research advances. Americans are also confronted by skyrocketing healthcare costs. Left unchecked, these costs could deny federal and private sectors the capital required to build an optimal system.

The availability of more data to both patients and providers raises ethical concerns as well. For example, if web-based information suggests intent for self-harm, who is obliged to intervene and how? Supporting technology may be disproportionately available to the affluent: what should government do to ensure equitable access and utilization to ensure a more, rather than less, just healthcare system? What about those who don't wish to participate? Could transparency encourage the young and healthy to opt out of insurance, making it harder for the less fortunate to be insured? Similarly, could knowledge of genetic risk impair insurance procurement?

RECOMMENDATIONS: In 2016, the US Congress convened the Healthcare Industry Cybersecurity Task Force to address these challenges. Four areas warrant particular attention to ensure that the benefits of more and better data and more sophisticated technologies will be beneficial rather than detrimental to the US healthcare ecosystem.

1. Security: The US Department of Health and Human Services declares "it is imperative that the privacy and security of electronic health information be ensured" and provides resources related to how the privacy rule can facilitate the electronic exchange of health information.[9] To protect confidentiality and data accuracy, leaders must institutionalize safeguards to protect high-fidelity data through redundant systems of storage and protection. Policies must protect against data theft and corruption. Poor security data practices must be punished. Adoption of the National Institute of Standards & Technology's Baldrige Cybersecurity Framework & Criteria should be considered as current best practice, but open architecture should accommodate future opportunities and needs.[10]

2. Accessibility and Responsiveness: Health Insurance Portability and Accountability Act policies and practices that focus on patient-centered accessibility should be updated to support a system that provides health data to authorized parties in a timely fashion. Patients should be able to select which individuals and organizations access their personal health information. Authorized users should be able to easily search information for a variety of purposes including clinical care and research.

3. Interoperabilty: The government should partner with industry to encourage the development of an integrated, interoperable health data system. Government leadership should consider modeling the European Union's efforts toward a single digital market, and be willing to modify such plans to match the resources, rights, and cultural expectations of American citizens.

4. Affordability: Future systems need to achieve greater efficiency and save money. The federal government will need to incentivize states, vendors, providers, and patients to participate, and help determine how to charge appropriately for virtual services rendered. Effective management and governance policy and controls are required to resist commercialization and potential monopolization by industry actors who could manipulate this emerging market. The role of government agencies such as the FDA in regulating health data technology, including mobile apps, needs to be defined in addition to broader concerns related to data storage and security.

SUMMARY: The global explosion of digital technology, internet, AI, EHR and big data, offers exponential advances in healthcare efficiencies and capabilities to address access to care, cost reduction, disease management, public health surveillance, and overall improvement of health through value-based innovation. However, this digital transformation of healthcare is not without threats, challenges, and tradeoffs that expose organizations and governments to increased risk and financial implications. Deliberate federal planning and action will be required to ensure a secure, accessible, responsive, interoperable, and affordable system which prioritizes the rights and needs of American patients. ■

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FEDERAL HEALTH SYSTEMS' CHALLENGES AND CRITICISM IN REGARDS TO ACCESS, QUALITY AND COST

Small Group Assignment: All five federal health systems represented at the Interagency Institute are facing serious challenges and criticism in regards to access, quality and cost of the health care services they are tasked with providing to enrolled beneficiaries. These challenges and criticisms are not new, but keep resurfacing with damaging consequences for leadership and health professional staff members.

What are the root causes of these problems and what policy and service delivery changes should be implemented to ensure better experiences for beneficiaries, staff and more effective and efficient use of resources?

Group IV Members: LTC Eric Danko, USA; COL Mike Franco, USA; Col MaryAnn Garbowski, USAF; CDR Thomas Hines, USN; CDR Kathy Kyser, USN; Col Paul Miller, USAF; Col Teresa Roberts, USAF; CDR Jennifer Smith, USN; Ms. Evelyn Sommers, VHA; COL Jason Wieman, USA; and CDR Jyl Woolfolk, USPHS.

Introduction: Costs, complexity, and the requirement to support global operations represent a unique challenge for the provision of federal healthcare. The Iron Triangle of Healthcare (Cost, Access, Quality) is a concept operating within the constraints of a non-profit system governed by a wartime mission, DoD regulations, and Congressional oversight rather than for-profit driven business practices.

Balancing the complexities of health services in terms of cost, access, and quality requires a departure from service-centric healthcare to the Defense Health Agency (DHA) and a comprehensive, interdependent, interoperable federated framework encompassing the Veterans Health Administration (VHA) as means to contain costs, while providing care quality and access. The DOD and VHA provide a wide spectrum of health services from medical preparation for deployment and dependent care, to treatment at the point of injury through rehabilitative services, and retiree care. The purpose of this abstract is to identify some potential root causes and formulate solutions to improve access and quality and decrease cost for the provision of health services.

	Quality	Cost	Access
Root Cause	Lack of Care Continuity Inconsistent Policies Variation in processes Workforce Development Financial Constraints Equipment Variation Mission Balance/Readiness	Entitlement Unfunded Mandates Infrastructure Optimization Late Appropriation Resource Management Organizational Specifics	Deployments Staff Turnover/Freezes Limited Specialization No Shows Wait Times inefficiency Rural Health Access Different populations Innovation/Technology Lack of IT Interoperability

Solutions: The central premise establishes a federal integrated system that is able to provide flexible, responsive, health services via a spectrum of health service operations involving health prevention to treatment at point of injury through rehabilitative services, and retiree services. After a cursory review of root causes, the following broad solutions emerge for consideration to affect change concerning the Iron Triangle variables. This is an initial proposal, not an exhaustive list, and worthy of deliberation to balance cost, quality, and access, while maintaining operational readiness.

1. Synchronize readiness operational requirements with the provision of health services.

- Link service medical capabilities directly to contingency requirements with an emphasis on essential medical and specialize medical capabilities required for operational readiness [MCRMC]. Temper the desire to build health services based on dependent care or specialized care.
- Provide for non-combat operational, subspecialty healthcare, and dependent care via purchased care or on a space available basis.

- Guide medical force development capabilities to support global force management requirements.
- Potential Impact: Reduce cost in terms of infrastructure, equipment, maintenance, etc., and wrap around medical services for specialty care. Potential to increase continuity, access and quality of care by connecting to the civilian medical community of interest.

2. Establish a standardized network for distributed health services planning and enhanced information sharing across the federal medical community.
    - Implement a medical common operating picture (e.g. functional EHR) with interoperable interfaces to the myriad of health IT systems required for the provision of health services.
    - Develop and implement robust virtual collaborative system to enable information sharing and coordination across federal internal and external networks and partners.
    - Increase the adoption of social networking to facilitate information and collaboration.
    - Sunset legacy IT systems to reduce the need for "work around" processes.
3. Identify, invest, and advance opportunities to incorporate technology into the provision of health services.
    - Fully optimize telemedicine type capabilities to improve patient interaction and compliance.
    - Incorporate AI decision support where appropriate to increase efficiencies (reduce FTEs, increase patient outcomes, or reduce overall health service costs).
    - Incentivize virtual encounters as an equivalent billing unit.
4. Policy Opportunities
    - Reduce unwarranted variation where appropriate and enhance patient safety and interoperability (equipment, workflow protocols etc.).
    - Provide relief from restrictive policies that don't allow for flexibility in purchasing (rewrite Federal Acquisition Regulation/Trade Act Agreement).
    - Look for flexibility of the commercial networks and to provide healthcare professionals a full range of options versus standardization as a positive to keep members in the Services versus financial rewards for standardization.
    - Create federal policies that mandate prevention and encourage new financial focus (i.e. reimbursement rates and insurance coverage).
    - Market a high reliability reputation and manage Congressional/political expectations (i.e. unexpected/ unanticipated/unfinanced operational requirements, resources (unfunded mandates).

Conclusion: In summary, the US federal healthcare system is currently undergoing enormous change. This change cannot be sustained without leadership engagement and cultural adjustments. In this state of flux there is great opportunity to implement system-wide changes to enhance care which will stimulate decision-making that will lead to great access and quality while decreasing cost. ■

Sources:

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IMPORTANCE OF LEADERSHIP DEVELOPMENT IN THE AGE OF LEARNING

Small Group Assignment: New styles and approaches to leadership development have been recommended for health care in "The Age of Learning". Why has this become a necessary topic during the past two decades, what are the essential elements of these new styles and approaches to leadership and how should these be utilized within the five federal health agencies?

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Introduction: In health care facilities, activities in waiting rooms have drastically changed. Today, it is not uncommon to see 2-year-old children swiping iPads and teenagers texting friends who may be next to them. Peeking in the nursing areas may reveal staff connecting to patients via instant messaging or listening to patients demand service quicker than the local minute clinic. In the clinician spaces, one may see providers silently cursing at the latest electronic health record or smiling as they diagnose a dermatologic challenge in a deployed zone.

Stopping by Resource Management, the Comptroller may bark that the travel budget is experiencing more cuts and choices need to be made in targeted areas. The latest healthcare technology magazine may reveal new releases in everything from targeted gene therapy to 3D printing for drugs. Changes, occurring at a rapid pace, may leave one to wonder what style of leadership is needed to connect to this new generation of minds, interdependence, changing technology, and slimming budgets? From a leadership perspective, are leaders ready? This essay will explore the why, what, and how to develop leadership in the "Age of Learning" and showcase the new styles and approaches needed to deliver impactful healthcare in the next decade.

Why has this become a necessary topic during the past two decades? Strategic leaders must succeed in an environment marked by Volatility, Uncertainty, Complexity, Ambiguity and Disruption (VUCAD) (Department of Command, Leadership and Management, 2010). The current reorganization of the Military Health System resulting from the FY17 National Defense Authorization Act is a prime example of VUCAD, with demands for improved quality and access and budgetary constraints coupled with increasing costs, development of a seamless new electronic health record in addition to the implementation of the Veterans Choice Program. Stakeholders continuously question the cost of healthcare while leaders contend with ways to communicate and demonstrate cost versus value benefits. Simultaneously, information and medical technology continue to increase at exponential rates. These changes drastically impact the delivery of care, add personnel training requirements, and shorten the functional life of medical equipment.

Leaders must effectively align vision and strategy within the VUCAD environment. The structure, culture, personnel policies, and technology must be consistent with the vision to achieve and maintain competitive advantage (Korn Ferry, 2017). The workforce is very diverse by race, culture and age; therefore, understanding the methods and media required to effectively communicate, while tailoring messaging, is an essential leader skill not easily mastered. A commander inspired his unit quoting an African proverb, "If you want to go fast, go alone. If you want to go far, go together."

What are the essential elements of these new styles and approaches to leadership? Leadership development must change with the complex operating environments in which leaders now work. The days of the authoritarian leader with knowledge based solely on seniority are long gone. Rapid cycle change and adaptive problems will not allow leaders to solve problems and lead teams via framed solutions of the past. Given these challenges, leadership development must begin to focus on models that deliver significant growth opportunities, while simultaneously being adaptive to rapid cycle change.

One new model to tackle such challenges has been developed by Korn Ferry. The "Eight Imperatives of Impactful Leadership Development" describes a four-step development cycle, 1) Challenge, 2) Deliberation, 3) Adaptation and 4) Automation (Korn Ferry Institute, 2017). This cycle stretches the leader through a new challenge, forces deliberate reflection about the responses to the challenge, and explores and refines ways to handle or adapt to the problem. Finally, the new thinking becomes the new norm and automated in the leadership toolkit.

In response to the four-step development cycle, eight imperatives that make up the new model were constructed and lumped into three categories: (1) what we do, (2) who we are and (3) pause.

What we do : Embrace new experiences to spark learning and development.
Adopt deliberate practice and reflection to build skill and automate changes.
Learn from others, both in learning communities and when applying skills in the real world.

Who we are: Leaders foster a growth mindset; they must care, be curious, and open.
Leverage emotion to spark motivation and activate effort.
Optimize stress to move out of a comfort zone and into a learning zone.

Pause: Practice mindfulness to quiet ego and pause automaticity, creating space to choose a different approach.
Enact behavioral commitments to create sustained personal change.

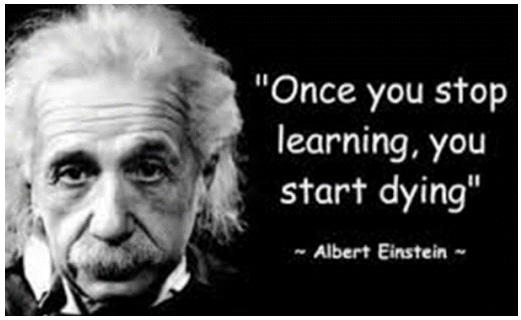
The new model is focused on creating new behaviors while leveraging periods of reflection to ensure that leaders do not revert into previous leadership patterns.

How should these be utilized within the five federal health agencies? To transform leadership development in "The Age of Learning" through new styles and approaches, leaders need to embed these essential imperatives of leadership development in a constraint-free environment. This requires trust and a shared understanding by the senior leadership in the federal health agencies and a commitment to partner with each other and private institutions. By working together in a multi-sectoral environment and embracing new experiences in different healthcare institutions, we can expose future health care executives to the effective leadership styles of some of the best in the field. As an Executive Fellow in Healthcare Leadership at these institutions, he/she would be assigned a process-improvement project to improve business and/or clinical processes to test critical thinking skills, ability to influence others, and leverage innovative technology. These future leaders would be identified early in their careers and tested for potential and resiliency.

To help leaders succeed during rotational assignments, mentors are required to ensure a safe setting for candid feedback in order foster a growth mindset and exercise new behaviors to include mindfulness and self-reflection. Exposure to a fascinating and new environment promotes a level of emotional discomfort and stress that will make the mentee emotionally charged and motivated to succeed. To keep the developing leaders engaged and ensure transformation into an effective leader, a cadence of accountability is required to check the progress of both the mentors and the mentees. Ultimately, new styles and approaches to developing future leaders will require new experiences with strong mentorship programs in different health agencies with proven best practices. Rotational assignments are how we can develop healthcare leaders who are ready to lead.

How do we incorporate these into the five federal health agencies? The aforementioned changes require a paradigm shift in the process of leadership development within the five federal health agencies. To meet the demands of modern forces, deliberate efforts must be made to implement outcome based approaches and individualized, challenge-rich experiences. Organizations must break free of predefined agency specific rank/responsibility pipelines historically relied upon for leader development. Exposing junior leaders to joint agency career opportunities would serve to enrich leadership acumen by encountering a continuum of unfamiliar challenges while requiring the utilization of innovative and agile approaches to problem solving and mission accomplishment. Cross-pollination through shared leadership, clinical and project group roles would allow capitalization of these pivotal leadership experiences.

Conclusion: Generational and technological changes will continue to disrupt and impact organizations and business, challenging today's leaders. Future leaders require support to embrace a new vision of leadership, utilizing the principles of the Korn Ferry's Institute.



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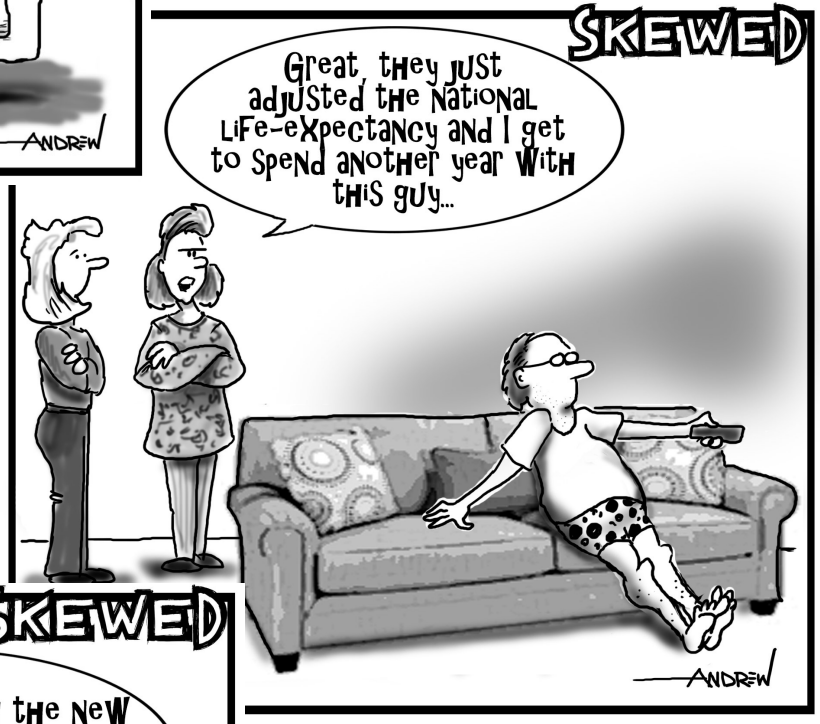
SKEWED
Let me start by saying that there ISN'T an app for that...
ANDREW


SKEWED
Great, they just adjusted the national life-expectancy and I get to spend another year with this guy...
ANDREW


SKEWED
This is Barry with the new tech for your office, and Greg who's gonna take it away 'cause it's obsolete.
ANDREW

Photo on left (left to right):
CDR Gwenivere Rose
CDR Jill Hammond
Dean Boris Lushniak
CDR Sarah Unthank
CDR Kara King
CDR Jyl Woolfolk

Five U.S. Public Health Service officers attended the 132nd IAI.

Dr. Boris Lushniak, RADM, USPHS, Ret., Dean, School of Public Health, University of Maryland, was one of the 45 presenters.

Photo above:
RADM Colin Chinn, USN, addressed role as Joint Staff Surgeon.

Photo on right:
President Richard Thomas, Uniformed Services University, spoke about opportunities offered at the university.

Photo on left:
Ambassador Edward Gnehn spoke about the Middle East.

Photo below:
Mr. Jonathan Davidson addressed the role of the Congressional staff.

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Annual dues - $25, Lifetime membership - $100

Save the date!

The FHCEIAA Annual Meeting and breakfast will be held Thursday, November 29, 2018, during the AMSUS Annual Continuing Education Meeting at National Harbor MD, November 26 - 30. More details will be provided in the fall newsletter.

Plan now to attend!