THE RECORD

Interagency Institute for Federal Health Care Executives

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From the Director…

Over the years that I have been directing the Interagency Institutes we have celebrated a number of special highlights, two brothers attending the same Institute, a father and then, some years later, his son, and now we have had a former participant attend for a second time! Ms. Helen Pearlman, Associate Director, Patient Care Services, at the Minneapolis VAMC, was a participant in the 130th Institute having previously attended as a Navy Nurse Corps officer. It was a great pleasure to welcome Helen once again to the program and, most importantly, she assured me that the content has changed!

As happens in all organizations, the character of groups vary for all kinds of reasons, and the Interagency Institute is no exception. Sometimes it takes a few days to 'break the ice' regarding questions and discussions. The participants in the 130th Institute, however, wasted no time in jumping in with lots of good questions and comments. This is exactly what we hope will happen. It gives significant added value to the participants and faculty in terms of greater learning from each other and assists in the development of long-term professional relationships.

For many years the energetic inputs into the Small Group Activities by the participants, their presentations to the entire class on the final day and then the publication of their papers in 'The Record' has been a special component of the Institute program. The papers you will read in this newsletter continue to reflect the high standards of intellectual activity and professionalism. The five topic areas illustrate major areas of concern for us as a nation and also globally.

The Institute and Alumni Dinner was held for the first time, as a result of the gracious sponsorship of the Hon P. T. Henry, at the Army Navy Country Club. It was a most enjoyable evening and we were honored to have LTG Gary Cheek, Director of the Army Staff, as our guest speaker. We introduced the idea of having 'Alumni/ae Table Hosts' and this was so successful we will continue it in the future.

Our 'Lessons From Other Countries' program was once again held at the Embassy of Canada, and we sincerely thank Cdr Ian Torrie, Defence Health Attaché, and his staff for their strong support and gracious hospitality. Brig Gen Colin MacKay, Surgeon General, Canadian Defence Forces, flew from Ottawa especially for this day and we were honored and delighted by his presence. It is with some sadness, however, that I report that Brig Gen MacKay and Cdr Torrie will be retiring this summer. We thank both these outstanding officers for their commitment to, and support of, the Interagency Institutes over the years. I am very proud of the fact that both are distinguished graduates of the Institute. The next Surgeon General will be Col Andrew Downes, also an Institute graduate. We congratulate Andrew and look forward to his participation in future Institutes.

I conclude my remarks with sincere thanks to President Richard Thomas, Dean Arthur Kellerman, and COL (Ret) Robert Thompson, and many staff members at the Uniformed Services University of the Health Sciences for their excellent support of our program and for making us feel so welcome as members of the university community.

With best wishes,

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

Helen Pearlman and Richard Southby

Letter from the President, FHCEIAA

Congratulations to the alumni of the 130th Interagency Institute and welcome to the Federal Health Care Executives Interagency Alumni Association! It was truly an honor to meet the current participants in the Institute at the Participants and Alumni Dinner on 26 Apr 2017 at the Army Navy Country Club, Arlington, VA. It is a tremendous privilege and we are thrilled that you have joined our team and ranks. There, we had the pleasure of receiving some insightful remarks from our guest speaker, LTG Gary H. Cheek, USA, Director of the Army Staff, regarding, "Current and Evolving Challenges Confronting the Military." I would also like to extend a heartfelt thank you to the generous sponsors of the dinner, education program and transportation to Delta Dental of California and Spectrum Healthcare Resources.

Spring is in the air! Along with a change of seasons, we have a new administration and continue to navigate through challenges of a potential government shutdown, NDAA 2017 MHS provisions and more. I am confident that the incredible resourcefulness and continued resilience of this amazing group of leaders in federal healthcare will transcend any real or perceived obstacles we face.

We have launched FHCEIAA onto Facebook and now have a social media presence! Please check out the site and stay tuned for changes. You are highly encouraged to post updates, maintain connections, collaborate and respond. You can search for the site by name or more comprehensively our Facebook page link is:
https://www.facebook.com/Federal-Healthcare-Interagency-Institute-1805076689707896/

I highly encourage each of you to become members of the FHCEIAA, if you have not already. This official pledge ensures the maintenance of essential connectivity and collaborative wisdom to maximize our resourcefulness and effectiveness. An additional noteworthy contribution is the FHCEIAA scholarship providing an opportunity to make a difference and much more. If you have questions or would like to inquire, please contact CAPT (Ret) Gayle Dolecek at gjdolecek@verizon.net.

Administratively I would ask you to add CAPT (Ret) Gayle Dolecek's e-mail address (gjdolecek@verizon.net) to your e-mail contacts so that timely FHCEIAA correspondence will not end up in your spam folder. Thank you kindly in advance.

As always, we look to tap into the energy and enthusiasm of our highly respected alumni as well as welcoming new graduates as ideas evolve on how to advance the association. I will continue to make myself readily available and am eager to serve as a responsive resource. I continue to be truly honored and humbled to be serving as your president this year. I look forward to continuing to achieving extraordinary accomplishments together!

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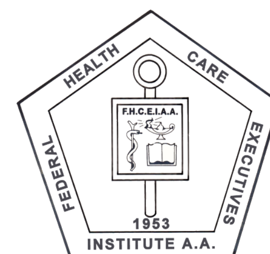
LTG Gary H. Cheek, USA, Director of the Army Staff, was the guest speaker at the Interagency Institute Participants and Alumni Dinner held at the Army Navy Country Club, Arlington, VA, on April 26, 2017.

Visit the FHCEIAA website: http://www.fhceiaa.org/



Group I Report: How America Lost Faith in Expertise: And Why That's a Giant Problem

Reference: Nichols, T. How America lost faith in expertise: And why that's a giant problem. Foreign Affairs, March/ April 2017, 96 (2), 60-73.

Group Members: CDR Troy Brooks, USN; CDR Raul Carrillo, USN; Col Carol Copeland, USAF; LTC Cheryl Creamer, USA; Col Alfred Flowers, USAF; CDR Richard Gilliard, Jr, USN; CDR Josefine Haynes-Battle, USPHS; Dr. Mark Hynum, VHA; LTC Gwynne Kinley-Way, USA; Col Christine Kress, USAF; and COL Richard Malish, USA.

Introduction: Tom Nichols is Professor of National Security Affairs at the U.S. Naval War College. In 2017, he published the book: The Death of Expertise: The Campaign Against Established Knowledge and Why It Matters. Our group addressed the referenced essay adapted from the book. Mr. Nichols relates that "Americans have reached a point where ignorance —at least regarding what is generally considered established knowledge in public policy—is seen as an actual virtue." In addition, the knowledge of experts is not valued. This results in public opinion based on "feelings, emotions, and whatever stray information they may have picked up here or there along the way." This has profound implications for continued effectiveness in our representative government.

Major Points Made by the Author

Americans have come to disregard expert opinions. The author describes how segments of American society pronounce themselves as self-professed know-it-alls, with little actual subject knowledge, earned via a "Google-fueled, Wikipedia-based" curriculum. Deference to an expert is often only done in times of crisis.

For example, only one in six Americans could locate Ukraine on a map, but when queried, favored military intervention in a scenario for which they had little or no knowledge. In a 2015 survey, a significant number of Americans interviewed supported the bombing of Agrabah, a fictional country in an animated Disney movie.

The author finds this trend disconcerting, as he fears it may lead to a society in which experts and leaders cease to attempt to inform "an ignorant electorate." As a result, major political decisions that are politically influenced would cease to be rationally based.

The healthcare field has not been spared from effects of the uninformed American consumer. The anti-vaccine campaign is an example of this complicated problem. Eight percent of parents in a highly-educated Northern California county recently elected to refrain from immunizing their children against infectious disease. Their decisions were based on misinformation that challenged established medical science.

Identified Strengths and Weaknesses

The author identifies and expounds upon the need for societal "experts," as well as a better-informed public, however, the discussion is primarily supported by anecdotal rather than actual data. He encourages "experts" to be intellectually honest, to practice humility and integrity, and to avoid blunders and conceit while "identifying errors and correcting them, which ultimately drives intellectual progress." He notes that "Laypeople," on the other hand, "must educate themselves about the difference between errors and incompetence, corruption, or outright fraud." How society is to embark on this transformation is unclear.

Can Other Approaches Be Recommended?

Implications for the Delivery of Healthcare: Patients today are media savvy and often receive healthcare information from sound bites and from social media. Healthcare providers must become knowledgeable in healthcare media outlets and special attention should be made to counter any media misinformation posted on the sites.

Health care delivery requires special skills in communication. Empathy is an important antecedent to establish patient trust. The health professional must develop communication skills to be effective in a culture where "expertise" is not valued as in past generations. Medical information must be conveyed in simple, basic language and made personal to the patient.

Regarding healthcare, the group also offers the following suggestions:

Building Trust. Showing genuine compassion and interest in the patient enhances trust between the healthcare team and the consumer. Cultural sensitivity is an important factor in establishing this relationship.

A Multidisciplinary Approach. Similar recommendations from several "experts" may be more readily accepted when each team member has the opportunity to emphasize individual patient education. When the consumer elects to obtain secondary and tertiary opinions, have the humility to accept and facilitate their request.

Acknowledge Differences. There are occasions when the caregiver and the patient will disagree. Healthcare experts are servants of a democratic society and government. Share your expertise of value and science-driven healthcare with the understanding that your advice will not always be taken.

If you're wrong, own up to what you didn't do right. That's how you learn and earn respect.

Own Your Mistakes. When there is a failure, true experts own their mistakes and practice transparency. Experts openly show the steps being taken to correct errors.

Utilize Consensus Statements. Consensus statements and Evidence-Based Guidelines may be more easily accepted by the patient and more difficult to dismiss. They can also address misinformation in the public domain.

Conclusion:

Tom Nichols discussed our societal culture in which expertise is no longer blindly valued. Today, Americans often base opinions on limited information and personal emotion. This creates challenges for our representative democracy and unique challenges for the delivery of healthcare. The author supports a paradigm change in which there is a well-informed citizen population who value expert opinion. When both the patient and the healthcare provider accept individual responsibility, trust and mutual respect develop, which are essential for the effective delivery of healthcare. This is the foundation of our democracy and republican government.

Note: Reference for quotations: Nichols, T. How America lost faith in expertise: And why that's a giant problem. Foreign Affairs, March/April 2017, 96 (2), 60-73.

The 130th Interagency Institute was hosted by the Embassy of Canada for one day's sessions on May 4, 2017. Speakers included Canadian, German, United Kingdom and United States representatives from the diplomatic, military or congressional sectors, This photo was taken from the roof top of the Embassy.

Group II Report: How To Hunt a Lone Wolf

Reference: Byman, D. How to hunt a lone wolf: Countering terrorists who act on their own. Foreign Affairs, March/April 2017, 96 (2), 96-105.

Group Members: Col Michelle Aaron, USAF; CDR Maria Barefield, USN; Col Christine Berberick, USAF; Col Marc Bilodeau, RCMS; Col John Brooks, USAF; COL Jamie Burk, USA; Dr. Joseph Duran, VHA; CDR Gregory Freitag, USN; COL Jay Greenwood, USA, and CAPT Cynthia Gunderson, USPHS.

Introduction: Our review seeks to clarify the national security threat identified as the "lone wolf" terrorist, examine some of the arguments and recommendations provided by the author to deter such attacks, and propose unconsidered elements to mitigate the rising tactic in the terrorism play book.

Discussion:

Understanding "Lone Wolf" Attackers

"Lone wolf" attacks pose a vexing challenge for national security policy makers and it postulates they should be identified and countered. These attacks are not a new problem. Over the last couple of years, such attacks have increased in number and have become an emerging terrorist threat. Despite the low numbers of casualties, these attacks are nothing more than acts to produce terror and have a powerful psychological impact on society.
In his article, Byman highlighted that "lone wolf" attacks are hard to predict or prevent. He identified why some individuals with no terrorist affiliations engaged in such attacks and provided reasons why they are not fully understood or evident. Unlike the criminal mass-murderer seeking notoriety, "lone wolf" attackers are solitary agents driving a tactical operation and its impact on the body politic. In many instances, these assailants have closer ties to radical groups and are not independent actors. However, the government's difficulty with stopping and keeping "lone wolf" attacks from occurring is these attackers have little, if any, prior communication, associations or affiliations with known terrorist groups.

Byman asks us to consider if "lone wolf" attacks have become the "new normal"? He proposes the rise of social media has put the "process on steroids". Ostensibly, "lone-wolf" attackers were not fanatics to radical ideas; but rather, individuals who were searching for meaning in their lives and who found it by committing violence in the name of a movement.

Byman's Proposal

To combat "lone wolf" attacks, Byman carefully considered how government policies of community outreach, counter-actions against extremist ideology, and isolation of the radical elements can lead to successful early identification and prevention of "lone wolf" attacks. Byman examined four major points: 1) work to keep lone wolves isolated; 2) build strong relationships between Muslim communities and law enforcement agencies; 3) direct security services to monitor and infiltrate jihadist social media accounts and encourage private companies to shut them down; and 4) try to discredit the ideology embraced by lone wolves.

A Better Way

We believe that some of Byman's arguments oversimplify the scope of the problem. Byman's essay would have been more effective if he approached it from an overall policy perspective and then listed strategies that would achieve this policy. Byman's focus, while quasi-preventive, is more reactive. Our position is that more overt effort, taken earlier, would have more lasting results. There are a few key elements that are essential in increasing individual and community resilience as a policy response to the lone wolf terrorism phenomenon.

Conclusion:

First, instead of solely targeting the Muslim communities for building relationships with the police and trying to isolate the individuals who are presenting behavior at risk, any intervention should support a stronger all-culture (not only Muslim) intra-community (between members) effort. An increased feeling of belonging potentially reduces the incidence of lone wolf incidents by fighting societal isolation. Community support could take the form of peer support in schools, neighborhood surveillance programs, or more formal communities like churches, mosques or other religious or social clubs or affiliations and would have to be respectful of individual community identities.
Furthermore, education is a key component to better inform these communities about the risks of isolation as

contributory to lone wolf incidents. Education holds the promise of teaching community members how to recognize other behaviors that may be indicators of radicalization and when to reach out to police. Additionally, increasing community employment within the ranks of police, fire and other first responders has the triple impact of adding insider knowledge of communities to governments, providing informal educators within the community, and making non-community government representatives more readily accepted in the community. [1]

The second element strengthening the response to lone wolves relates to educating key players of traditional media. We believe the press bears a responsibility to not over-sensationalize lone wolf incidents or other mass-shooting events in order to reduce the incidence of copycats or the imitation phenomenon described by Byman. While there may be limited effect of such intervention due to media's desire to maintain the freedom of press, appealing to the media's social responsibility and code of ethics may be a way to encourage responsible reporting in support of national security. Specific recommendations include minimizing the use of the perpetrator's name and images, as well as responsible reporting both qualitatively and quantitatively of the incidents by the media.[2] Finally, the media should be reminded about their role in providing the full picture of a specific incident in relation to the overall terrorism issue.[3]

Therefore, by providing and targeting early education and awareness efforts coupled with increased community employment within key facets of government and media outreach will provide a longer, more holistic and enduring cure to the scourge of lone wolves!

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[1] National Security Critical Issue Task Force – Report Lone Wolf Terrorism, June 2015
http://georgetownsecuritystudiesreview.org/wp-content/uploads/2015/08/NCITF-Final-Paper.pdf
[2] Mother Jones: How the Media Inspires Mass Shooters, Mark Follman, Oct 2015
http://www.motherjones.com/politics/2015/10/media-inspires-mass-shooters-copycats
[3] Dr Frederic Lemieux, Georgetown University, Interagency Institute for Federal Health Care Executives, 3 May 2017.

Photo on left: Group Captain Martin Ruth, RAF, British Healthcare Liaison Officer, DHHQ; Colonel Hans-Ulrich Holtherm, Director Training/Education, Bundeswehr Medical Service Academy, Munich; and Cdr Ian Torrie, RCMS, Defence Health Attaché, Embassy of Canada and DHA Canadian Liaison Officer. The "Lessons From Other Countries" session addressed the military and civilian health systems in the United Kingdom, Germany, Canada and Australia at the Embassy of Canada on May 4, 2017.

Photo on right: Brig-Gen Colin MacKay, Surgeon General Canadian Forces; Maj Gen Dorothy Hogg, USAF, Deputy Surgeon General and Chief Nurse, USAF; RADM Terry Moulton, MSC, USN, Deputy Surgeon General, USN; and BG Ronald Place, MC, USA, Assistant Surgeon General for Force Projection, USA, addressed military health care.

Group III Report: Make America Dignified Again

Reference: Brooks, A.C. The dignity deficit: Reclaiming Americans' sense of purpose. Foreign Affairs, March/April 2017, 96 (2), 106-117.

Group Members: LTC Francisco Dominicci, USA; Col Kelly Dorenkott, USAF; COL Tara Hall, USA; CDR Brian Hatch, USN; CDR Daniel Meyerhuber, USN; Dr. Alfred Ozanian, VHA; CDR Johvin Perry, USN; Dr. Ruth-Ann Phelps, VHA; Col Iris Reedom, USAF, and CAPT Esan Simon, USPHS.

Introduction: In the article, Arthur Brooks highlighted the anger that exists within large sectors of white rural America through the "alienation and disaffection of less educated white voters in rural and exurban areas" and proposed that this partly explains the surprise victory of President Trump. This phenomenon started with President Johnson and his War on Poverty as his administration truly believed providing welfare was necessary, but had the unintended consequence of robbing recipients of a sense of worthiness. The author proposed that we must understand how the nation has deprived generations of Americans of their sense of dignity in order to start the process of healing America, and offers a variety of solutions. However, as we have learned at the Interagency Institute of Federal Healthcare Executives, such problems require complex remedies.

Discussion: To understand the voting preference of less educated, white voters who chose President Trump, the authors make two fundamental assertions. First, that these voters are at or below the poverty level, and that this socio-economic condition and government support influenced their sense of dignity. This resulting siege on dignity contributed to a sense of being undervalued and ignored by politicians. Second, that government approaches to creating jobs and incentivizing work did not improve poverty levels after decades of trying and trillions of dollars spent. Though the authors effectively provided data for their supposition that poverty levels have not changed and that this group of people may feel disenfranchised, they failed to provide evidence that a sense of dignity is the underlying motivation to work, or for that matter, was a primary influence in voting preference. The authors failed to provide a sociological context for the election, which could provide a broader understanding of the influences that President Trump's policy positions and approaches to immigration, health care, and tax reform may have had on voting preference. It remains unclear to what degree, if any, American nationalism, citizen preferences for social and economic isolationism, or underlying racism influenced the voting preferences of this group of Americans.

The recommendations and opportunities for resolution discussed in the article focused mainly on policy creation that is radically pro-work. The recent transition of power to a Republican majority, creates an environment where there is potential for both welfare and immigration reform. In particular, a potential target is reducing federal disability insurance, which has had a 40% increase since 2005, with the end goal of decreasing the overall jobless rate and bringing individuals back into the work force.

Second, tax reform has major support from the White House and various Republican party members. The hope is that reducing the corporate tax rate will attract foreign business owners to consider building infrastructure for increased production inside the U.S. Other options include government subsidies of minimum wage (in order to encourage businesses to hire the unemployed) as well as expanding the earned income tax credit for low-income individuals. All of these strategies show a commitment to developing human capital in the blue-collar worker.

Conclusion: The appeal to historical American principles such as hard work, education, the value of the family, etc. can engender cultural harmony, increase family integrity, and decrease isolation to promote social cohesion. Sharing cultural and moral norms could be the beginning of closing the cultural divide between high and low income earners. For example, women with a high school education have a 50% rate of children born out of wedlock, versus 10% for women with a college degree. Children born out of wedlock are more likely to have mental health problems and are less likely to work later in life. While the belligerent overtones in national discourse have recently marginalized segments of the population, sharing what brings success and happiness to both the unemployed and underemployed will provide a more inclusive message.

French economist Frédéric Bastiat once commented, "Government is the great fiction, through which everybody endeavors to live at the expense of everybody else." So it is with liberals preaching wealth redistribution such as

President Lyndon B. Johnson's famed "War of Poverty" as well as with the conservatives proclaiming wealth creation by stimulating economic growth (e.g. "Make America Great Again (MAGA)"). Neither extreme has ever proven effective at bringing parity in dignity between the haves and have nots. In fact, British social epidemiologist, Richard Wilkinson, known for his work, "Spirit Level: Why More Equal Societies Almost Always Do Better", argues with compelling United Nations and World Bank data that equality over wealth within a given society bodes the better outcome for all. Perhaps the dignity deficit isn't as much about dollars as it is about all members of a given society feeling they bring value to the equation in the form of morality, self-sufficiency, respect, and autonomy.

The author attempted to venture into something along those lines that merits a more open dialogue in America, however due to political correctness it would prove difficult to openly explore this in our overly sensitized country where demagoguery is in and God is out. The mention of a simple policy litmus test that ensures that the traditional family remains the basic building block of society rather than weakening the integrity of that unit by things such as erecting barriers to religious expression or rewarding idleness was the author's subtle attempt to suggest that perhaps our society needs to stop calling good evil and evil as good (see Isaiah 5:20-24). In addition to what the author mentioned, there are other potential strategies to improve the sense of dignity among those receiving government assistance.

Establishing policies that reduce disparities in healthcare by reducing cost and improving access; encouraging a patient-centered approach to care, to include end of life care; and regaining public trust in America's ability to provide the highest quality of Veteran care are all essential to improving dignity amongst our most disenfranchised citizens. Winston Churchill's polarizing quote, "The inherent vice of capitalism is the unequal sharing of blessing. The inherent blessing of socialism is the equal sharing of misery," suggests that narrowing the disparity in dignity will be found somewhere in the middle of capitalism and socialism.

"The Dignity Deficit:
Reclaiming American's Sense of Purpose"

Arthur C. Brooks

~ Class Polling ~

- Get Your Phones Out
- Text "**brianhatch731**" to **22333** (carrier rates apply)

Responses to five polling questions will all be numerical

The group polled the class seeking the first 25 numerical responses to five questions using their cell phones to respond.

Left to right in the photo:
First Lieutenant Anna-Carina Endres;
Dr. Richard Southby, Director, Interagency Institute;
Col Dr. Hans-Ulrich Holtherm, MSc, Director Training/Education, Bundeswehr Medical Service Academy, Munich, Germany;
Colonel Kai Schlolaut, German Healthcare Liaison Officer, DHA.

Photo taken at the Embassy of Canada, Washington, DC, May 4, 2017.

Group IV Report: Writing Under the Influence

Reference: Kleiman, Mark A.R. High stakes: The future of U. S. drug policy. Foreign Affairs, March/April 2017, 96 (2), 130-139.

Group Members: Col Edward LaGrou, USAF; LTC(P) Christopher Lindner, USA; CDR Nam Ly, USN; LTC Jeffrey Neigh, USA; Ms. Helen Pearlman, VHA; CDR Anton Petrich, USN; Col Jerry Rumbach, USAF; Dr. Kathryn Sapnas, VHA; Col Thomas Stamp, USAF; and CDR John Volk, USN.

Introduction: The first thing to note when digesting the referenced article is the author's affiliations. His ties to the Washington State Liquor and Cannabis Board may introduce some bias. Indeed, Mr. Kleiman struggles to keep his positions veiled. The article opens with the scope of the current U. S. "substance use disorder" problem. In his description of the public health impacts of drug use, Mr. Kleiman asserts making drugs illegal creates illicit markets and leads to violence due to enforcement efforts. Mr. Kleiman downplays the impact of cannabis use on society while emphasizing the dangers of opioid addiction. The remainder of the article focuses on comparing policy options between cannabis and opioids, with no mention of the raging methamphetamine problem.

Discussion: After providing some background on legal and illegal drug markets, Mr. Kleiman addresses cannabis. After 43 states have voted to legalize the use of medical or recreational marijuana, his stance is the nationwide prohibition policy on marijuana cannot be undone. The state laws conflict with federal law which makes for a precarious situation. The federal government does not have the manpower to enforce a ban on cannabis without the aid of state law enforcement agencies. Mr. Kleiman offers that federal policy is needed to address the current trend of state marijuana legalization. He presents cogent and relevant options related to current alcohol and tobacco policy. Per Mr. Kleiman, low taxes and industrious marketing have created more heavy alcohol users with significant long-term health issues. He proposes that a cannabis policy similar to the deplorable alcohol policy would result in more extensive daily use, driven by the for-profit cannabis industry.

Alternatively, Mr. Kleiman favors a marijuana policy which emulates that of tobacco, granting the federal government more control. He posits taxation would increase prices, making it more expensive for users to become heavy daily users and thus curb addiction. While these recommendations are realistic, Mr. Kleiman makes the assertion that more regulation will lead to reduced addiction and lower overall use. While price may be one factor in controlling demand, he offers no evidence that addiction or escalation to more dangerous drugs would be reduced. Also, there is likely a price point in which users will start to seek black market alternatives, circumventing the regulatory oversight of the federal government.

Mr. Kleiman fails to address two major issues with the legalization of marijuana. First, he does not discuss the second and third order effects of marijuana use on the health of our citizens outside of addiction. Second, he does not mention how marijuana use should be regulated from a public safety perspective, such as working or driving under the influence of cannabis.

In addition to Mr. Kleiman's marijuana regulation proposal, the federal government would need specific regulations requiring states to address addiction, negative health effects and public safety issues. Evidence-based support of medical effects of smoking marijuana need to be incorporated into policies. Furthermore, effective policy would regulate potency and marketing to consumers, which would likely lead to fewer cases of addiction. Finally, marijuana should be tightly regulated, if it is to be advertised at all. In line with the pharmaceutical model, any advertising would include risks, benefits, side effects and possible black box warnings.

In the latter half of the article, Mr. Kleiman turns his attention to opioid drugs and U. S. policy. His position is policy inaction in the face of the current opioid epidemic would have higher costs than that of inaction on cannabis. He opines some blame for the opioid epidemic lies with the trend of assessing pain as the fifth vital sign and the subsequent manipulation of the medical system by drug-seeking patients. Mr. Kleiman also links opioid abuse to heroin addiction.

Mr. Kleiman opens his final push for policy change with a great deal of promise, but his arguments ultimately disappoint. To his credit, Mr. Kleiman identifies problems with the treatment of pain disorders, the influence of pharmaceutical companies on the treatment of pain and the importance of widespread use of naloxone to treat overdoses. He also identifies the underlying dynamics of addiction and the ongoing problems of addicted patients. In a high point of the article, he thoughtfully discusses the impact of possible changes to the Affordable Care Act on drug treatment. Unfortunately, Mr. Kleiman discounts the value of Prescription Drug Monitoring Programs, doesn't address non-pharmacological ways to treat abuse, and makes no mention of the stigma of drug dependence hampering treatment. After recognizing the scope of the opioid imports into the U. S., he concludes better pain treatment solutions are needed. As a parting shot, he predicts "Ultimately, the opioid epidemic, like all epidemics, will burn itself out." Such a terse conclusion leaves the reader wanting much more relating to the Trump administration's approach to a long-standing and vexing public health issue.

Conclusion: In addition to the policy proposals made by Mr. Kleiman, any policy on opioid use should include provisions which balance an appropriate mix of education, prevention, enforcement, and treatment. The strong political polarization surrounding U.S. drug policy has created an emotionally volatile situation, while an evidence-based drug policy would better serve the American people. Finally, the lobbying power of the pharmaceutical industry has had a significant impact on drug policy and should be curtailed or neutralized in future policy decisions.

Although Mr. Kleiman's article hit a number of salient points on current U. S. drug policy, his opinions would have been much more effective had he provided more depth on future drug policy options and written from a more neutral position.

Additional references:

Drug Policy Alliance (2016). Making Drug Policy More Evidence-based: The Role of Scientists and Other Scholars. http://www.drugpolicy.org/blog/making-drug-policy-more-evidence-based-role-scientists-and-other-scholars, April 29, 2017.

National Governors Association (NGA) (2014). Reducing Prescription Drug Abuse: Lessons Learned from an NGA Policy Academy. https://www.nga.org/files/live/sites/NGA/files/pdf/2014/1402ReducingPrescriptionDrugAbuse-Paper.pdf, April30, 2017.

Rand Corporation (n.d.). Assessing U.S. Drug Problems and Policy: A Synthesis of the Evidence to Date. http://www.rand.org/pubs/research_briefs/RB9110/index1.html, April 27, 2017.

White House (2015). Commission on Narcotic Drugs Endorses Alternatives to Incarceration for Substance Use Disorders. https://obamawhitehouse.archives.gov/blog/2015/03/26/commission-narcotic-drugs-endorses-alternatives-incarceration-substance-use-disorder, April 27, 2017.

Photo on the left, left to right: CDR Josefine Haynes-Battle, USPHS; Dean Boris Lushniak, School of Public Health, University of Maryland; CAPT Esan Simon, USPHS; and CAPT Cynthia Gunderson, SPHS.

Photo on the right, left to right: CDR Brian Hatch, MSC, USN; CDR Maria Barefield, MSC, USN; VADM Raquel Bono, MC, USN; Director, Defense Health Agency; CDR Raul Carrillo, NC, USN; and CDR Gregory Freitag, MC. USN.

Group V Report: An Internet Whole and Free

Reference: Raustiala, K. An internet whole and free: Why Washington was right to give up control. Foreign Affairs, March/April 2017, 96 (2), 140-147.

Group Members: CAPT Judy Dye, USN; Col Craig Lambert, USAF; CAPT Chad Roe, USN; CDR John Sisson, USN; Ms. Traci Solt, MSN, VHA; Ms. Sherri Stephan, VHA; LTC/P Kelley Tomsett, USA; Col Jay Vietas, USAF; and Col Tambra Yates, USAF.

Introduction: Dr. Raustiala 's essay initially posed the question, "Who should control the internet and what influence would they have?" Secondly, the author followed up with a brief historical perspective of the internet's evolution, coupled with domain nomenclature and maintenance, which rests with the Internet Corporation for Assigned Names and Numbers (ICANN).

Major points made by the author:

In the 1960s, the Internet was originally launched as a project of the U.S. Defense Department's Advanced Research Projects Agency (ARPANET). During the 1980s, access to the ARPANET expanded with the aid of U.S. taxpayer funded grants via the National Science Foundation.

During this time, the International Telecommunication Union (ITU), a United Nations (UN) agency, believed the Internet was a natural part of their portfolio. The ITU contended, the Internet should have a global governing authority, not a sole country, to enable equalization of world powers and authorities. The Clinton administration postured the idea that control by a multilateral body such as ITU would increase vulnerability, oversight, and censorship by governments who did not strongly support freedom of expression.

The internet had no real status authority, as it evolved in the 1990s. The Clinton administration's idea of wanting the internet to be controlled by the private sector was strongly opposed by China, Iran, and Russia. These leaders favored the authority to be placed with large economic powers for shared governance. A subsequent call for proposals resulted with ICANN based out of Los Angeles, California operating under a Commerce Department issued contract. The primary function of ICANN was coordination of the unique identifiers (used worldwide) that users could type into computer browsers to access different internet sites.

Over the years, ICANN became more autonomous, where eventually the U.S. Government's role became primarily symbolic. In October 2016, the Obama administration answered the notion of internet control with the decision to let the ICANN contract expire which in essence, released internet naming convention from U.S. control. The response to the newly autonomous ICANN was met with a broad spectrum of incredulity.

Strengths and weaknesses in the essay:

A strength of the essay is the author's historical description of the internet and the purpose for which ICANN was instituted. This background provided a framework to include the evolution of control and the ongoing political implications surrounding ICANN. Despite the strength and importance of the historical background, the title is somewhat misleading. Over the years, there has been much debate over what control the internet would look like. The author leverages this by providing a strong hook of intrigue with the title and introduction.

Unfortunately, the article fails to present a balanced approach or in-depth discussion as to how ICANN governs the internet. Where it lacks control is over the digital domain and the assurance of internet freedom in the future. For example, the author states, "ICANN's convoluted approach is probably the worst form of Internet governance - except for all others". However, his argument for support of ICANN is limited to the statement, "the Internet has thrived since ICANN's creation". The author's approach appears to be politically slanted and is devoid of any discussion of possible alternatives. While a summation of the author's true position of valuing US influence over the internet is apparent, it lacks exploration of a true analysis of internet control. Something that seems warranted but, is conspicuously absent is discussion of what is being given up with the lack of direct U.S. control of ICANN.

Recommendations:

The recommendations championed by Dr. Raustiala are sound within the context they present. The proposition of devolving power to a diverse group with shared basic values has the potential to maintain some semblance of control thru shared efforts which may enhance prospective U.S. interests. By leveraging an inimitable assembly of experts with decades of experience, the World Wide Web (WWW) will remain capable and in somewhat predictable hands for generations to come.

Opportunities

The current name, WWW, infers a culture that is global inclusiveness embracing humanistic diversity symbolizing the world we live in. This presents an opportunity to bring together a myriad of cultures and political divisions for the greater good.

Sound judgment dictates an accepted naming convention that remains unchanged for the sake of continuity. These naming conventions have been established, accepted, and are widely known.

Challenges

There will continue to be critics who ask if President Obama was within his purview to relinquish U.S. control without being granted explicit authority to do so by Congress. The art of mitigating the fear of censorship with a transparent decision making process is in the best interest of all. Despite the population that continue to question Presidential authority, this group has come to a unified decision that relinquishing ICANN was in the best interest of the global economy.

Approaches

The recommendations, as the group sees it, are three-fold: first, foster global agreements; second, de-politicize process to encourage collaboration across cultures; and third, maintain public accessibility through a WWW which represents the world community.

To determine the spectrum of nomenclature control, few alternatives have been explored in earnest. The overall decision by the U.S. to relinquish control of WWW naming conventions exhibited good faith and directly supported global acceptance and goodwill. The consensus of this review is that there were no immediate negative impacts resulting from the decision, but it remains to be seen if this will continue to hold true in the future.

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Janet and I want to thank the alumni of the 130th Interagency Institute for their gracious expression of appreciation at the closing session. Col Al Flowers, MSC, USAF, addressed his impressions of the two-week experience. Ms. Traci Stolt, VHA, presented a very kind and almost overwhelming thank you on behalf of the group. Again, we thank you and repeat our gratitude for your positive attitude and ready participation throughout the two weeks.
Sincerely, Richard

Rethinking The United States' Military Health System

Arthur Kellermann, Rethinking The United States' Military Health System, *Health Affairs* Blog, April 27, 2017, http://healthaffairs.org/blog/2017/04/27/rethinking-the-united-states-military-health-system/
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During Operations Enduring Freedom and Iraqi Freedom (2001 – 2014), the United States' military health system completely transformed its approach to casualty care, achieving the highest rate of survival from battlefield wounds in the history of warfare. It is one of the most remarkable accomplishments in the history of US medicine.

Ironically, the same health care system that worked miracles "down range" in Iraq and Afghanistan faces mounting criticism at home. How can this be? In part, it is because the military health system has two distinctive missions: support combat and humanitarian assistance missions overseas and provide comprehensive health services to millions of service members, their families, and military retirees at home.

The core mission of the military health system is unique. Unlike the Department of Veterans Affairs (VA) and large, private health care systems, the military health system must be ready to deploy thousands of health care providers to the other side of the world at a moment's notice and fly critically wounded warfighters home within one to three days of injury. Since the founding of our Republic, military medicine has supported our armed forces whenever and wherever they go in harm's way.

The other mission of the military health system is to deliver health care at home through a network of military hospitals and clinics, supplemented by health care purchased from thousands of private doctors and other providers. This second mission reinforces the first: Service members stay healthy, and when deployed, they can be confident that their families will be looked after. Military health care providers between deployments maintain their clinical skills by treating service members and millions of beneficiaries. Military hospitals provide valuable platforms for teaching the next generation of uniformed health care professionals and standby capacity for combat casualties.

THE CURRENT CHALLENGE

Some critics allege that the military health system's stateside mission costs too much, delivers care of uneven quality, and doesn't attract enough complex cases to keep provider skills sharp between deployments. They want the Department of Defense to close most of its remaining facilities, outsource the care to the private sector, and position more military providers in civilian hospitals. Before these ideas receive serious thought, it is worth examining the assumptions on which they are based:

Costs

According to the Congressional Budget Office (CBO), the Department of Defense spends $52 billion, about 10 percent of its budget, to provide a variety of services to 9.4 million beneficiaries. This total includes costs not counted by civilian health systems, such as $1 billion annually for military health research and billions more for "TRICARE for Life," a first-dollar, wraparound plan Congress mandated to supplement the Medicare coverage of military retirees. In fact, yearly spending varies by $2 billion or more due to fluctuations in military construction. To put this in context, in 2016 Kaiser Permanente collected $64.6 billion to care for its 11.3 million members. The Department of Defense's FY2017 budget for military health is $48.8 billion to care for its 9.4 million beneficiaries.

Growth in health care spending is not limited to the military. Civilian health spending has outpaced our nation's economy as far back as 1950. Between 1999 and 2009 alone, health spending grew so fast, it wiped out the income gains of average US families. Military health spending grew too, but recently it has increased at a far slower pace than civilian health spending. According to the Centers for Medicare and Medicaid Services (CMS), between 2009 and 2015, civilian health spending increased 32.6 percent. During the same timeframe, military health spending grew 13.9 percent. A recent analysis produced by the CBO attributes most military health spending growth since 2000 to congressionally mandated expansion of TRICARE benefits, including the establishment of TRICARE for Life, an insurance option that eliminates most out-of-pocket costs faced by Medicare-eligible military retirees and their families.

US health care is not only costly; it is inefficient. The National Academy of Medicine estimates that our nation wastes $750 billion per year on "unnecessary or inefficient services, excessive administrative costs, high prices, healthcare fraud and missed opportunities for prevention." In 2015, aggregate health care spending approached $3.2 trillion dollars. Only 1.5 percent is devoted to military health. Given these facts, it is hard to see how outsourcing more care will save money.

Quality

Critics assert that the military health system does not perform enough complex surgical procedures in peacetime to maintain provider skills. The volume-quality relationship is strong, but it is not absolute. High-quality training and strict adherence to procedures—an approach first championed by military aviation—can largely compensate for smaller case volumes. In 2014, the military health system compared its performance to three of our nation's top health care systems—Geisinger, Intermountain Healthcare, and Kaiser Permanente—and found that it did better in some areas, worse in others, and generally as well overall.

A recent American College of Surgeons assessment of surgical outcomes, based on national data, identified several military health system hospitals as top performers. Another study found that the military health system does not have the racial disparities in care commonly seen in civilian hospitals. A recently published analysis of more than 10,000 military health system beneficiaries with carotid artery stenosis (a condition that can lead to stroke) found that patients treated by military doctors got fewer procedures but had better outcomes than beneficiaries treated by private, fee-for-service doctors.

Productivity

Is the military health system less productive? That depends on how productivity is defined. Because most civilian hospitals rely on fee-for-service billing, their staffs have a strong incentive to see lots of patients and order large numbers of tests and treatments. This translates into the appearance of productivity as measured by "relative value units" (RVUs)—the most commonly used metric of clinical workload. There are two problems with this approach, however. First, RVUs measure the volume of care, not its value. It doesn't even matter if a procedure helped the patient; it only matters that it was done. Second, RVUs undervalue primary care and overvalue procedures performed by specialty providers. As a result, keeping patients healthy looks less "productive" than filling hospital beds and performing lots of complex procedures.

Consider the previously-mentioned study of military health system beneficiaries with carotid artery stenosis. Although military doctors performed fewer expensive procedures and the patients they treated were less likely to die or have a stroke than those treated by fee-for-service doctors, judicious management looks less "productive" since it generates fewer RVUs.

The purpose of the military health system is to protect the health of the force, not to generate RVUs. In 1866, Dr. Jonathan Letterman, the "father of battlefield medicine," wrote: "A corps of medical officers was not established solely for the purpose of attending the wounded and sick. The leading idea is to strengthen the hands of the Commanding General by keeping his army in the most vigorous health, thus rendering it, in the highest degree, efficient for enduring fatigue and privation, and for fighting." In light of this responsibility, using RVUs to assess the clinical productivity of the military health system makes as much sense judging the effectiveness of a combat unit by counting the number of bullets it shoots.

FINDING A BETTER WAY

Rather than dismantle the military health system, policy makers should let it operate more efficiently. Among the options that follow are four opportunities created by provisions embedded in Section VII of the 2017 National Defense Authorization Act (NDAA):

1. Make greater use of enlisted providers—Overseas and aboard ships, the military health system relies on its corpsmen, medics, and med techs to deliver routine care under supervision, as well as save lives in combat. However, the moment these skilled providers come home, they are relegated to minor clinical or clerical tasks because no

comparable role exists in civilian health systems. If the military health system allowed them to function as "primary care technicians," it could expand access to care, reduce use of emergency departments and urgent care centers, and strengthen readiness for future deployments.

2. Consolidate treatment of complex cases—When a service member is wounded in combat, he or she is Medevac'd to the nearest combat support hospital, then flown by Critical Care Air Transport to a stateside military hospital. Two decades ago, the military health system used a similar approach inside the United States to concentrate complex care to its top medical centers. If it reinstituted the practice, patients and taxpayers would benefit. Studies show that Walter Reed's Murtha Cancer Center achieves better outcomes at lower cost than comparable civilian cancer centers.

3. Systematically improve practice—Many of the advances in trauma care in Iraq and Afghanistan came from the Joint Trauma System, which systematically analyzed casualty data to identify opportunities to improve. If the military health system employed a similar approach to assess delivery of high-risk care in stateside hospitals, it could ensure that beneficiaries get the right care at the right place for the right reason.

4. Standardize to optimize—The US armed forces have learned the value of training and fighting as a joint force. Military health care providers have learned the same lesson in combat zones but when they return home, they tend to revert to the old ways. Some variations in approach are inevitable, but the military health system should strive to standardize key workflows, equipment, and even the layout of its operating rooms and delivery suites. That way, when a military health system provider rotates to a new hospital, he or she can swiftly integrate into a new health care team.

5. Keep patients healthy—In war zones, protecting the health of the force is a top priority. Taking an equally diligent approach to population health at home could produce substantial benefits. Redoubling efforts to boost rates of vaccination, discourage smoking and use of smokeless tobacco, prevent injuries, and treat hypertension and obesity could generate huge downstream savings.

6. Treat selected civilians—In war zones, commanders have the latitude to treat ill and injured civilians if doing so will help win the support of the local population. Currently, most lack this authority in the United States. At present, only two military medical centers participate in their state's trauma system. If more were allowed to do so, their medical staffs would benefit from the extra caseload, and the civilians they treat would benefit from the world-class trauma, burn, and rehab care available at these medical centers. Any VA hospital with a waiting list should preferentially refer its patients to the closest military hospital. Section 717 of the NDAA should facilitate the needed changes in policy.

7. Ensure clinical proficiency—Military surgeons are already partnering with the American College of Surgeons to devise objective ways to assess surgeons' readiness to deploy. Recently, they devised a way to cross-walk Current Procedural Terminology codes used to track performance of surgical procedures to critical wartime surgical skills. Once this approach is refined, it will be extended to other wartime specialties such as emergency medicine, anesthesiology, and intensive care. This will help the military health system comply with Section 708 of the NDAA.

8. Measure what matters—To ensure military providers address the "quadruple aim"—readiness, better health, better care, and lower per capita costs—the military health system has adopted 30 "Partnership for Improvement" measures. Adopting a smaller, high-yield set of "vital signs" metrics devised by the National Academy of Medicine would allow military health system leaders to compare their system's overall performance to other large health systems and satisfy Section 730 of the NDAA.

9. Embrace Telehealth—In deployed settings, the military health system uses telehealth to support health care providers working in small forward operating bases and on ships at sea. Global teleconferencing allows trauma experts across 12 time zones to regularly meet, discuss complex cases, and identify opportunities to improve. Despite its success with telehealth overseas, the military health system was slow to adopt it at home due to stringent information security requirements and budgetary constraints. Section 718 of the NDAA directs the military health system to rapidly expand the use of telehealth in its clinical operations.

10. Centralize licensure and credentialing—Typically, military health care professionals change duty stations every two or three years. Federal law allows those licensed in one state to practice in others, but only on federal property.

If providers could reach outside their treatment facilities, the military health system could fully use telehealth and improve access to care. Provider credentialing is equally cumbersome. Although the military health system has a global reach, it still credentials most providers at the facility level. A system wide approach makes more sense.

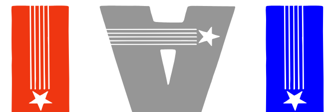
FACING THE FUTURE

In Iraq and Afghanistan, the military health system demonstrated a remarkable capacity to innovate when necessary to protect the health of US and coalition forces. Dr. Don Berwick, founder of the Institute for Healthcare Improvement, recently observed that “Military medicine put the learning health system framework into practice before the Institute of Medicine described it.” Today, US soldiers, sailors, airmen, and Marines know that if they are badly wounded in combat, the military health system offers their best chance of coming home alive and recovering. This confidence is a force multiplier on the battlefield.

Looking forward, we cannot assume that future conflicts will resemble the most recent ones. As US forces evolve to meet the threats posed by near-peer adversaries, the military health system must evolve, too. The best way it can maintain readiness to support combat operations and strengthen its capacity to innovate is to employ the same techniques, teamwork, and enterprising spirit that serve it so well “down range” to meet the health care needs of its beneficiaries in the United States.

Coaches often remind their teams that “You play the way you practice.” By “practicing” at home the way it “plays” overseas, the military health system can deliver better care at lower cost and strengthen its capacity to support and sustain our armed forces on any future battlefield.

Author’s Note: The author is dean of the School of Medicine at the Uniformed Services University (USU) of the Health Sciences, and as such he is an employee of the Department of Defense. His views are his own and do not necessarily reflect those of USU, the military health system, the Department of Defense, or the US government.



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