Interagency Institute for Federal Health Care Executives

THE RECORD

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Fall 2010

From the Director...

The 118th Interagency Institute has recently concluded and I am pleased to report that it was very successful. Most of the sessions were informative and challenging. We confronted many current issues - from prospects for peace in the Middle East, terrorism and its ghastly consequences, the unstable political situations associated with shaky coalition governments, economic crises brought about by massive public deficits, wars and private sector greed, the application of ever-expanding new technologies, and the health, social and economic consequences of aging populations. Our faculty did not provide us with clear-cut solutions to these and the many other problems we face in 2010 and for the foreseeable future. They did, as I had requested them to do, make us think about how these issues impact on our roles as federal health care executives and citizens in this increasingly globalized world.

Janet and I were very impressed with the work and high quality of the small groups throughout the 118th Institute. We are sure that alumni/ae will read the reports included in this newsletter with great interest. Many of you may even find these discussions of the issues and recommendations for dealing with them of immediate value in your current or future roles!

I also want to express our sincere appreciation to CDR Cathy Slaunwhite and her colleagues at the Embassy of Canada for allowing us, once again, to hold our 'Lessons From Other Countries' session in their beautiful embassy. We are especially grateful to our Canadian friends for hosting the luncheon and refreshments for our participants.

Again, it was a special privilege to have Surgeons General VADM Adam Robinson, Lt Gen Bruce Green and Commodore Hans Jung, all Institute alumni, participate in the Surgeons General panel, along with BG Richard Thomas, MC, USA, and Mr. Paul Hutter, Chief of Staff, VHA. It may not always be possible for Commodore Jung to travel from Canada to join us, but he is most welcome as a member of the faculty. This panel is one of the highlights of the program and provides a great opportunity for our participants to interact with the senior leadership of the federal health systems. It is complemented by the special opportunities provided for similar interaction with the leadership of the Public Health Service and other representatives of the Veterans Health Administration.

Another special acknowledgement and thank you is due to the Hon P. T. Henry and Delta Dental of California for their generous support of the Institute Dinner for participants and alumni/ae. We were very fortunate to have Mr. George Wunderlich, Executive Director of the National Museum of Civil War Medicine, as our guest speaker. George gave a stimulating, informative and relevant address and a summary of his remarks is included in this newsletter. It was also a great pleasure to have LTG Eric Schoomaker, the Army Surgeon General, and his wife Audrey, present. Janet and I appreciated LTG Schoomaker's kind comments very much indeed.

With best wishes.

Richard F. Southby, Ph.D., F.F.P.H., F.C.H.S.E.
Director

Two International participants attended the 118th Institute (see photo on next page). Other participants included 16 U.S. Air Force, 15 U.S. Army and 12 U.S. Navy officers; 6 VHA personnel; 5 USPHS officers; and one physician from the Bureau of Prisons.

Letter from the FHCEIAA President, 30 September 2010

Dear Colleagues,

Congratulations to the graduates of the 118th Institute! I was so gratified to meet many of you during the cocktail hour and dinner and then to be able to speak for a couple of moments about the Alumni Association and our goal of promoting and fostering joint federal healthcare collaboration and education. The evening was so special since we had LTG Schoomaker (Army TSG) and his wife with us as well as Mr. George Wunderlick, our guest speaker, who provided us with wonderful insights and anecdotal information about the health care lessons from the Civil War. And of course, Drs. Janet and Richard Southby were our usual wonderful hosts. On behalf of our fellow Alumni members, I welcome those of you who have chosen to become members of the Federal Health Care Executives Interagency Institute Alumni Association (FHCEIAA) and I encourage you to become active in FHCEIAA activities.

The FHCEIAA Annual Business Meeting will be held on 2 November, 2010 (0645 – 0745), at the Hyatt Regency Downtown (Curtis B Room) in Phoenix, Arizona at this year's AMSUS meeting. Our guest speaker is MG David Rubenstein, the commander of AMEDD Center and School at Fort Sam Houston, Texas. All FHCEIAA graduates are invited and encouraged to attend the annual business meeting. The agenda includes the announcement of the annual FHCEIAA Distinguished Service Award winner.

The alumni association provides wonderful benefits in addition to great networking opportunities mentioned. We receive the "Record" from each IAI course which provides feedback and information from the most recent IAI course to include key speaker info and workgroup updates. Additionally, the Alumni Association annually awards a $1000 scholarship to the son/ daughter or dependent grandchild of an alumnus. Applications can be found at our website, www.fhceiaa.com. This website also offers you an opportunity to stay in touch with alumni and so if you have any updates on assignments, successes etc., please forward to president@fhceiaa.com or rah4bucs@comcast.net. Your board is always in search of opportunities for improvement of your alumni association so please do NOT hesitate to share those recommendations at the email addresses above. Please continue to keep our deployed service members and civilians in your daily thoughts and prayers.

Carpe Diem!

Roy A. Harris RN, PhD
COL, USA, Ret
President, Federal Health Care Executives Institute Alumni Association

Left to right: LTC Shaun Fletcher, RAAMC; Dr Richard Southby, Director; Col Richard Pucci, Canadian Forces; and Dr Janet Southby, Assoc Director

Health Care Lessons for Today from the American Civil War

The American Civil War saw more fatalities than any other war in our nation's history. In an era when germs were still unknown and antiseptic surgery did not exist, what hope could there be for the tens of thousands of wounded that made their way back to the field hospitals during and after battle? The hope came in the form of new organizational and logistical practices that transformed the old regimental medical practice into an efficient, modern system of care.

The battle of Antietam would prove to be the watershed that brought about this vital innovation. Major Jonathan Letterman was the medical director of the Army of the Potomac in the fall of 1862 and faced the bloodiest single day in our nation's history. The battle of Antietam occurred on September 17th and resulted in over 23,000 casualties. Despite the daunting task of dealing with the aftermath of battle, Letterman stayed focused on his lifesaving mission as a medical director and began a complete reorganization of the medical department of his army.

Between October 4 and 28 of that year Letterman succeeded in giving his command its first truly unified medical system. He brought logistics, command and control, transportation, evacuation and record keeping into alignment. His plan allowed for care from very near the point of injury through echelons of ever increasing care farther from the field. He brought the ambulances under medical control and continued the ambulance training program started by his predecessor, Major Charles Tripler. He clarified job descriptions to include medical record keeping at the field hospital level and organized triage done by specifically selected officers. He even redefined the surgical team to include only those who were most qualified. No part of the department was left untouched from pre-battle logistics to post-battle communications. The result was dramatic. The battlefields of Fredericksburg, Chancellorsville and Gettysburg would prove the value of his system. In 1864 Congress passed the Letterman Plan into law.

This one man saved countless lives through organizational and managerial genius. His orders of October 1864 reflect many of the same best practices still in use to this day. His story is both uplifting and cautionary. After the war much of his plan was lost due to reductions in manpower and staff as the Army was reduced to more of a peacetime force. The failure to study his plans resulted in undue suffering and loss of life when the nation entered the Spanish American War.

Letterman still holds the honored title of "father of battlefield medicine" and was recently honored with a bronze plaque on the medical dormitories at the Bagram Air Force Hospital. Hopefully, his memory will serve to inspire others to remember the past for the sake of a better future.

George C. Wunderlich
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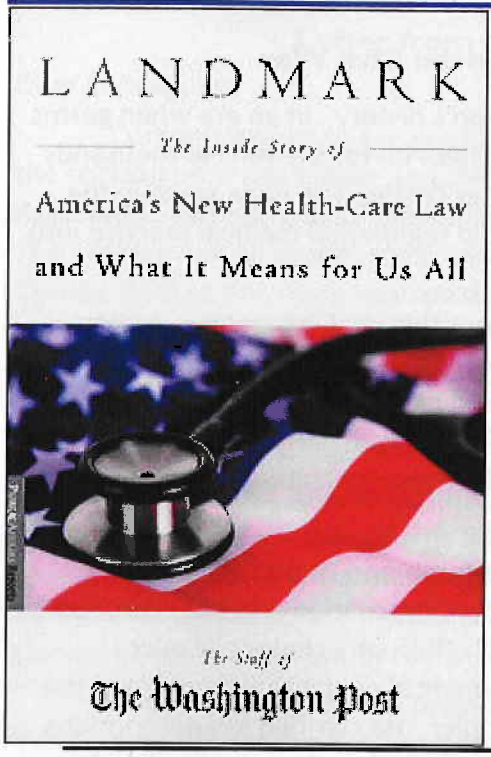
NATIONAL MUSEUM OF CIVIL WAR MEDICINE
Divided by Conflict, United by Compassion

"When the past no longer illuminates the future, the spirit walks in darkness." Alexis de Tocqueville



After a year-long political war, President Obama and the Democratic leaders of Congress achieved in March 2010 a victory that has eluded lawmakers for many years: an overhaul of America's health care system. Despite the incessant and often rancorous debate that preceded the bill's passage, most Americans still don't understand what is in the final legislative package or what reform will—or won't—mean for them.

In *Landmark*, reporters and editors from the national staff of the *Washington Post* provide a comprehensible summary of the legislation the president will sign into law, and examine the impacts it will have on Americans in various categories, on health care providers and insurers, and on the health care system as a whole. The legislation is described as "evolutionary, not revolutionary" in that it does not change the basic system of private or employer based health insurance nor does it set limits on insurance premiums or reimbursement rates. However, the law will move Americans much closer to the goal of universal health care coverage which is the centerpiece of the legislation. The behind-the-scenes narrative includes how the legislation came together and the political obstacles, events, negotiations, and compromises that helped determine its shape.

One group of participants received the following exercise: **Based on your reading of the book assigned for this Institute, "Landmark", your own knowledge, and presentations at the Institute, outline your assessment of the 'Patient Protection and Affordable Care Act' signed into law on March 23, 2010 by President Obama. What do you consider are the legislations' major strengths and weaknesses? If the Democrats lose control of the House in the November elections, and maybe the Senate, as well what areas of the legislation are most vulnerable to change?** Their assessment follows:

STRENGTHS

This law will result in 95% of all American citizens and legal residents having health insurance within six years, reducing the number of uninsured from 54 million to 22 million. This will be accomplished through two primary mechanisms, Medicaid and Health Insurance Exchanges.

- Medicaid will be available to qualified beneficiaries under the age of 65 whose income is less than 133% of the federal poverty line.
- Health insurance exchanges will be available to those whose income is above the Federal poverty line who cannot obtain insurance from their employer or those who are self employed. Exchanges will be available to small businesses with less than 100 employees, as well. Exchange plans must have 4 tiers of coverage options, plus a catastrophic option available to those less than 30 years of age, and will be administered by the States.
- Other provisions in the law allow children to remain on their parents' policy until age 26, prohibit lifetime limits, cancellation of coverage and exclusions for pre-existing conditions.

In addition to coverage for more Americans, the law also provides for expanded benefits to include certain preventive health services and immunizations, mental health and substance abuse treatment services as part of the "essential health services". prescription drugs through Medicare Part D, eliminating the "doughnut hole", and a national long term insurance system that will pay for care that is currently provided by family and friends. On the other hand, this legislation aligns with the Hyde Amendment, which severely limits coverage of abortion.

While the law does not create a national, single payor insurance program, there will be greater Federal

involvement administratively and financially. It creates a Federal Coordinated Health Care office to coordinate the care of the poorest and sickest on Medicare and Medicaid and provides greater Federal funding for Medicaid and income adjusted subsidies for those using the Exchanges. There also will be new Federal funding for research.

Other benefits anticipated from the legislation include overall long term increased savings and better care. Decreased hospital admissions will be achieved through use of community health clinics with fewer hospital and emergency room visits.

WEAKNESSES

While most of the weaknesses are based on projections of the law as it is written, the true weaknesses will not be known until the regulations and policies from the Federal and State agencies have been written and implemented. The major weaknesses are cost and regulations, each of which has the potential of creating a large impact on the implementation of this law and the American people.

The first weakness has received the most attention, which is the cost to the American public. This expansive law will present the American public a very expensive bill if the revenues are not generated as projected to provide coverage of the expenditures. That debt will be passed on to our children and grandchildren in the form of an increased national debt. There are three areas that have the potential of falling short of generating capital for this legislation: taxes, increased rates and penalties. The projected cost will be $938 billion over the next ten years while the projection of generated revenue will be $1 trillion over the same time period. These projections are based on estimates over that same time period where the variables in taxes, rates and penalties will remain constant. History has provided examples where there are too many variables in our political, economic and social system to reasonably believe that these projections will be valid when the regulations that will implement the law have not been written.

The second weakness is the law's complex regulations that go hand-in-hand with cost and which will have a large impact on the implementation of this law. Each agency at the Federal and State level will have to review, interpret and write the regulations that govern their area of this law. These regulations must be nested both vertically, horizontally and at all levels to provide the rules that the people must follow in order to implement this law. As one speaker pointed out this may take over a decade to work out the details in the regulations between these government agencies. If the regulations are not written in a clear and concise manner across the government at the start of the execution phase then the projected revenue gains might not be realized, thereby increasing the cost of this law.

VULNERABILITIES

Many details of the law do not go into effect until 2014. Critical elements such as what defines "essential services" and how regulators will calculate insurer's medical loss ratio require clarification and have been left to the agencies to delineate. These provisions are the most vulnerable to manipulation for the purposes of accomplishing a political agenda. Inadequate funding of the IRS could also sabotage its ability to enforce and collect penalties and calculate subsidies.

A sense of social responsibility and personal obligation to possess health insurance, especially on the part of our young, healthy individuals, is needed to implement this reform. If they choose to pay or ignore the fines, the risk pool will be unbalanced, leaving older, high risk groups with higher health care premiums.

Although the overall number of uninsured will be reduced, states with larger ineligible immigrant populations and high risk populations may bear larger cost burdens than other regions. The expansion of Medicare in these states could further increase the deficit, forcing future taxpayers to foot the bill for a new entitlements program. (Continued on page 12)

Walter Reed National Military Medical Center at Bethesda

Background: The 2005 Defense Base Realignment and Closure (BRAC) Commission mandated that in September 2011 Walter Reed Army Medical Center (WRAMC) would be closed and all health care services integrated at the current location of National Naval Medical Center (NNMC) in Bethesda, which will be become the Walter Reed National Military Medical Center (WRNMMC) in Bethesda. It will be a state-of-the-art medical center with 345 inpatient beds, larger operating rooms, and a new outpatient building. Additionally, a new 120 bed hospital (3 times larger than the current) is being built at Fort Belvoir. The cost for these two facilities is $940M.

Group members: LtCol Jeffery Alder, CAPT Christine Benally, Mr Duane Flemming, COL Lori Fritz, COL Theresa Gonzales, CAPT Daizo Kobayashi, Col Rose Layman, Col Rob Marks, LTC Hugh Mclean, Col Keith Morita, CAPT John O'Boyle, CAPT Nita Sood, Mr Steven Taaffe, CAPT Patricia Tordik

Discussion: Several areas were analyzed to determine the success of this monumental project: Command and Control (C2), patient access and satisfaction, the costs of providing care to eligible beneficiaries, and retention and professional development of health care personnel.

There are many C2 opportunities in the combined WRNMMC. The new organizational structure with increased number of directorates will improve communication within each directorate by making the span of control more effective and efficient. Working in a joint environment will bring together a diversified team of professionals, which will promote knowledge sharing to develop better leaders. The Department of Defense has an opportunity to develop best practices such as standardized privileging. Control efficiencies will also be gained through the collocation of personnel and assets located in one area, WRNMMC.

Some of the challenges in the C2 areas are associated with the high visibility of this project; failure is not an option. This consolidation is viewed as setting the necessary conditions by some as setting the conditions for the beginning of a Joint Medical Command. It will be particularly difficult to not only merge, but also preserve service cultures. Due to the different service involvement, developing an equitable process for rotating key leadership positions will be very important. With more personnel the wide span of control is difficult to manage and achieve goals. Joint processes and regulations must be developed, written, and agreed upon. The need service specific personnel support for active duty support will remain. Another challenge will be merging two budgetary systems into one and migrating to a new Civilian Personnel System. Completion of the joint manning document has proven to be very time intensive and will not be completed at time of transition.

There are many opportunities in the area of patient access and satisfaction such as greatly improved access in the southern part of the Washington, DC area due to increasing the hospital size and the number of specialists at Fort Belvoir. With WRAMC closing, providers and patients do not have to travel between WRAMC and NNMC, Bethesda. With providers travelling less it saves up to an hour of provider time each day and should lead to increased access. This consolidation of healthcare also means that there is improved coordination of patient care, reduced duplication, collocation of specialists, consolidation of resources, and collaborative research. Patients will be satisfied that there is a Metro stop on Wisconsin which is right next to NNMC. Another satisfier is that Fort Belvoir is a brand new state of the art facility, which will certainly mean a better first impression. Merging the two large medical centers will also pave the way to standardization of Warrior Care.

Patient satisfaction and access challenges with the WRAMC/NMMC merger will cause some patient enrollment sites to change and patients may feel displaced. In the absence of a good strategic communication plan, maintaining patients in the direct care system during the transition may prove difficult. Some of the tangible challenges are parking and traffic difficulties. These will both be worse before they get better during

initial construction. Another challenge will be to build partnerships with neighbors and address community issues. This is achievable through consultation with local and state planning agencies and public meetings. Lastly, displacement of patients and staff will continue as construction at WRNMMC persists through 2018.

Some real opportunities in the area of costs of providing care to eligible beneficiaries can be realized. First, there are an anticipated decreased purchase care costs due to increased direct care access: WRNMMC and the Fort Belvoir Community Hospital. Along those same lines gains in economies of scale will be seen by decreasing redundant services. Along with a state of Art building (2.4 M sq feet of new construction) one should see decreased maintenance cost, decreased security costs (only securing one campus), and increased patient safety. Energy savings will be seen at Fort Belvoir due to being green. Lastly, the Pharmacy Home Delivery can be aggressively marketed to lower costs and decrease WRNMMC traffic.

Some of the challenges associated with the patient satisfaction and access are optimizing patient/staff flow management to improve transit time. Also, developing an optimization plan for the redistribution of patient care. To ensure the best health care possible, determining the correct staff mix at WRNMMC and Fort Belvoir is a large challenge. Although not a show stopper, there is a start up cost of $940M. One other challenge is that new beneficiaries and expanded clinical inventory may increase demand for services among beneficiaries and may attract a new cohort of users; built it and they will come.

Personnel are the most valuable resource any corporation has and investing in the retention and professional development of health care personnel is very important. An opportunity created by this merger is that force development and management provides the ability to train in a joint environment which has applicability during deployments. Personnel will want to work in a state of the art facility. If the team member works at WRNMMC there is a Metro stop at Medical Center on Wisconsin. Professionally, there is proximity to National Institute of Health, Uniformed Services University of the Health Sciences (USUHS), National Library of Medicine, and the National Intrepid Center of Excellence for traumatic brain injury (TBI) and psychological health. The collocation of specialists will provide greater continuity of care and an improved opportunity to develop more research and enrich academic achievement..

Some challenges with retention and professional development of health care personnel are developing equitable process for rotating key positions, which is very important for professional growth and perceived fairness. Along with key positions, standardizing position descriptions and scope of practice is critical to staff preservation. While efforts were made to give civilian staff members their location and assignment of choice; 100% satisfaction was not possible. Further efforts to retain these personnel will continue. Consolidation will stress GME and other training programs: volume, scheduling, etc. This may lead to reduction in positions and/or increased need to outsource experiences (Belvoir, Bragg, civilian/other). Defining commonalities for different promotion and award system requirements will present issues. Facilities for the Health Professional Education Programs will not be completed by the transition. They will be in swing space initially.

Conclusion: The enormity of the challenges that lie ahead must be met with equivalent resolve to successfully negotiate the way ahead in this federally mandated merger. We need to maximize best practices, develop joint policies, and standardize care across the health care continuum. Ultimately we must balance stewardship of tax payer dollars and optimize the care provided to our National treasure. Therefore, although goals, outcomes and measures have not been clearly defined, optimal healthcare, world class services and improved quality of care are the minimal expected benefits of this merger.

Group participants: LTC/P Telita Crosland, Col Richard Huot, Mr Shannon Novotny, Col William Pond, CAPT Michael Roncone, Col Steven Reese, Ms Betty Ruschmeier, CDR Debra Soyk, CAPT Bruce Stinnett, LTC Laura Trinkle, Col Janice Wallace, COL Justin Woodhouse, CDR Elizabeth Yuan, CAPT Julie Zappone.

This group responded to the following question: ***As a consequence of numerous trends over the past thirty years, an aging beneficiary population, ever increasing expectations, new health-care technologies, and strong competition for available resources (people, money and facilities), what do you think will be the implications for "TRICARE" in 2013? Outline your assessment of the likely changes to this program and the associated rationale.***

Although no one has a crystal ball, this represents our **best estimation** based to a large extent upon the lecturers and readings from the course, independent research and experience and the collaboration of group members.

The **framework** for analysis used the following questions:

What at the demographics and drivers?

What will most likely be the changes for TRICARE in 2013?

What changes will be in process by the year 2013?

What is the rationale for the changes as related to demographics, national and global economics and political realities?

TRICARE is a health care plan using military health care as the main delivery system. It is augmented by a civilian network of providers and facilities and serves our uniformed services, activated National Guard and Reserve, retired military, and their families worldwide. The TRICARE Mission is to enhance the Department of Defense and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care. The Vision and Expectations are for a world-class health care system that supports the military mission by fostering, protecting, sustaining, and restoring health.

Politics and societal expectations affect the implementation of TRICARE in 2010 and 2013. American soldiers, veterans and their families believe that they are entitled to medical care. This has been fostered for years by elected officials who reinforce the concept such as the statement by President Obama, "Whether you left the service in 2009 or 1949, we will fulfill our responsibility to deliver the benefits and care that you earned."

Factors that influence TRICARE policy are many and diverse: Eligibility with transitional assistance, expansion of benefits due to escalating expectations, coverage of dependents up to 26 years of age, saturated networks, pockets of high-density utilization, increased urgent and emergency care, aging providers, provider shortages, "Millenials'" age life style, continued increased healthcare costs, increased individual payments, telemedicine and information technology—so many significant considerations for the formulation of policy.

TRICARE in 2013 will certainly include **items that are included in the 2010 Patient Protection and Affordable Care Act**, specifically:

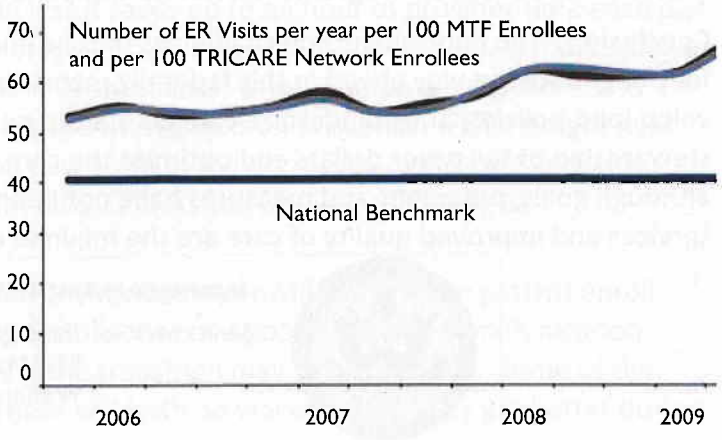
1) Coverage to age 26 for dependents
2)No exclusion for pre-existing conditions
3) No limit on life time benefits
4) No co-pay for preventative services
5)Increase in provider pay for Evaluation and Management (E & M) services.

TRICARE 2013 will have **pharmaceutical benefit management** with evidence-based formulary, higher co-pay for non-formulary medications, and cost incentives, such as requiring the patient to pay the differential between commercial pharmacy and mail order. This is imperative due to the spiraling medication costs. One estimate suggests that just federal pricing at retail pharmacies would save $400 million in FY10.

Emergency facility visits in 2013 will be managed by increased cost sharing for care outside the primary care provider, for example, a patient might be assessed:

1) $15.00 co-pay for care at an urgent care center, or
2) $30.00 co-pay for hospital emergency room, but have
3) Free access to phone nurse screener
4) --Waiver of co-pay if nurse screener refers to urgent/ emergency care center

All these items are designed to bring the utilization rate to the desired national benchmark of 40 visits/100 enrollees/year as shown in the graph below:



TRICARE 2013 will have **no funding for pregnancy termination services**. Political polarization has prevented funding by public programs in the past, and efforts to include such services in the 2010 were unsuccessful. Efforts to circumvent the provisions were also unsuccessful.

TRICARE Standard/Extra/ Prime fees will increase substantially. Political pressures have kept premiums unchanged, however, with other Americans paying increased taxes and premiums, political pressure will now force increase of TRICARE premiums which have not kept pace with inflation and which are well below market levels: e.g., TRICARE Prime premium family is $460.00/year and TRICARE Standard cap $1,000.00/year.

TRICARE for Life (TFL) will increase for the same reasons. According to the CBO, TFL pays "nearly all medical costs not covered by Medicare and requires few out-of-pocket fees." By limiting the amount of expenses covered by TRICARE for Life (such as not paying the first $525 of an enrollee's cost-sharing liabilities for calendar year 2011 and limiting coverage to 50 percent of the next $4,725 in Medicare cost sharing), the federal government could save roughly $14 billion and $40 billion through 2014 and 2019.

TRICARE 2013 will have substantial **Information Technology** changes:

1)Computerized medical record will be utilized by TRICARE providers

2) Personal electronic medical record will be encouraged in common language format

3) VA, military and TRICARE medical records will begin integration for a unified patient record

4) Health information will be provided to patients within 4 working days, electronic discharge summaries at time of discharge, and outpatient clinical summaries within 3 days

5) TRICARE users may to save their personal health data on their personal computer

6) Wellness, preventive reminders and patient specific education resources furnished to TRICARE users.

TRICARE 2013 will **have increased scrutiny for cost and quality**. Even when there is no appreciable difference in outcome or patient satisfaction, data indicate wide discrepancies in expenditure per member per month and rate of expenditure change.

Consequently, measures will be put in place to assure quality and cost effectiveness,

1) Referrals will be reviewed for appropriateness,

2) Tests and procedures will be done using evidence based medicine,

3)Consequently, measures will be put in place to assure quality and cost effectiveness,

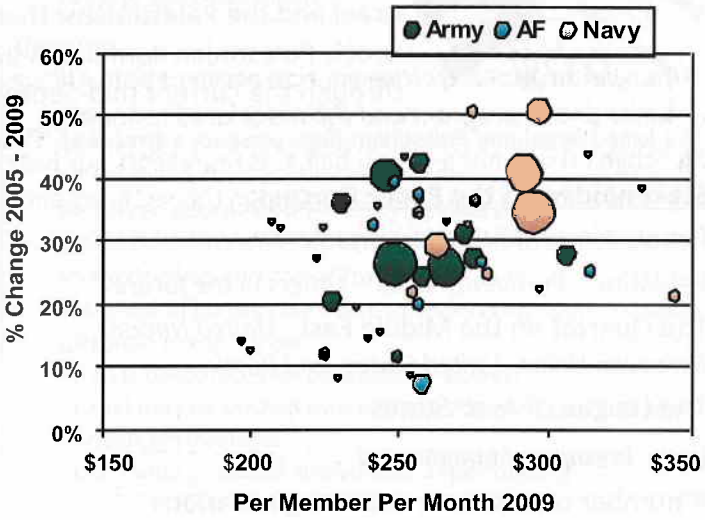
4) Outcomes-based reimbursements will become more prevalent,

5) High cost procedures will be referred to "Centers of Excellence" based upon both cost and quality,

6) Military medical treatment facilities will be to maximum extent possible, and

7) Patient satisfaction will be measured, tracked, trended and shared with TRICARE providers and payors.

Comparing MTF PMPM Costs



The Quadruple Aim of TRICARE in 2013 will be

* Patient-centered, compassionate care
* Cost-effective, evidence-based care
* Quality and safety foremost
* Readiness for our military members and our families—this will continue to be the primary focus and reason for TRICARE in the medical health care system in 2013.

Peace in the Middle East

Peace in the Middle East has been an extremely difficult and elusive goal for many years. This group was assigned to prepare a brief for the National Security Council, providing their assessment of the current situation and recommendations for the achievement of a 'durable peace' in this important region of the world.

Group Members: CAPT Brad Austin, Dr Bill Campbell, Col Kevin Glasz, Col Dorothy Hogg, COL Dallas Homas, COL George Hucal, COL Peggy Jones, CAPT Scott Jonson, CAPT Jason Maguire, CDR Joe Michael, CAPT Jeannie Proano, CDR Lou Ann Rector, Col Paul Skala, LtCol Pamela Smith.

Introduction: Although there are a number of Middle Eastern conflicts looming, discussion of "peace in the middle east" predominantly involves the conflict between Israel and the Palestinians; therefore, this presentation was limited in scope to the Israeli-Palestinian conflict. A detailed history and background of events from 1916 through the current mid-September state of affairs were presented to the audience.

The joined Israel and Palestinian flags serve as a symbol of "Peace in the Middle East".

Stakeholders in the Peace Process:

Israel: *Prime Minister Netanyahu*

Palestine: *President Abbas – Others in the future?*

The Quartet on the Middle East - *United Nations, European Union, United States, and Russia*

The League of Arab States

Iran: *President Ahmadinejad*

A number of other non-state organizations

Primary Negotiation Concerns:

Mutual Recognition: There are deep-seated distrust issues on both sides.

Borders: Proposals for a Palestinian State include the Gaza Strip, the West Bank, and East Jerusalem.

Control of Jerusalem: The Palestinians want to make East Jerusalem their capitol. Israel's Prime Minister has stated that "Jerusalem belongs to the Jewish people and will remain under Israeli sovereignty for eternity."

Israeli Settlements in Palestinian Territories: President Abbas insists on a freeze. Prime Minister Netanyahu has said he will not extend the freeze. The current freeze will expire on 26 September 2010.

Security: Both sides feel their security is threatened.

Water Rights: Water is scarce in and around Israel and the Palestinian Territories. With growing populations in the region, and limited access to water, competition for this precious resource is intense.

Palestinian Freedom of Movement: The Palestinian Authority is calling for Israel to remove the walls, fences, check-points, and roadblocks that limit their movement.

Israeli and Palestinian Refugees: Both sides claim they have over a million refugees that fled or were forced from their homes secondary to hostilities associated with the 1948 and 1967 wars. Both sides have similar versions of the Palestinian's "right of return" political assertion.

Prisoners: One Israeli is being held prisoner by the Palestinians, while 7,383 Palestinians are imprisoned by Israel.

Source: Addameer Prisoners' Support and Human Rights Association (as of November 2009) and Reuters.

SWOT Analysis: United States' Ability to Influence a "Durable Peace" in the Middle East

Strengths

- U.S. power, influence, and financial resources
- Issues between Israel and Palestine are well defined:
  - Israeli Settlements
  - Construction Expansion
  - Defining Borders
  - Mutual Recognition
  - Security
  - Control of Jerusalem
  - Refugee Relocation
  - Prisoners
  - Palestinian Freedom of Movement
- Regional stakeholders and EU have a vested interest in creating & maintaining peace

Weaknesses

- U.S. heavy dependence on Middle East oil, perceived as our primary agenda for involvement in Middle East issues
- Fundamental ideological differences exist between the Middle East and the West
- Non-state actors (Taliban, Al Qaeda, Hamas, Hezbollah, etc) don't want the West, specifically the U.S., involved in Middle East politics
- Israeli-Palestinian Nation State demographics are shifting in favor of the Palestinians

Opportunities

- Potential for improving perceptions of the U.S. with general population via Humanitarian Assistance efforts, civilian outreach opportunities, & partnerships with local governments to improve quality of life, leading to more regional stabilization
- Improvement of U.S. global image by taking a more balanced approach rather than perceived favor toward Israel
- U.S. led efforts to bring international businesses to the region which could provide improved economic stability

Threats

- U.S. public opinion lacks patience / public support for protracted actions / plans to bring about peace. Culturally, the Middle East measures time in decades / hundreds of years, while U.S. culture is more immediate
- Perceived decline of the U.S. as a global power
- World /U.S. economic situation translates to limited aid for strategic plans and commitments
- Maligned influences continue to seek recognition and destabilization in the region
  - Iran is desperate for recognition / power
  - Israel may be pushed into military action to protect own sovereign interests
  - U.S. military may be drawn into other regions

Recommendations:

U.S. promptly implement balanced approach with equal regard for Israeli and Palestinian interests

- *Must maintain freeze on Israeli settlement expansion*
- *Must withstand special interest pressure (pro-Israeli lobby)*
- *Emerging demographic shift to an Israeli minority in region (threatens democracy)*

U.S. facilitate a UN-led approach to achieve peace in the region

- *Must incorporate DIME-C (diplomatic, informational, military, economic, culture) instruments of power*
  - *Focus to be on soft power initiatives*
  - *Promote international private sector investments*
- *Must maintain long-term commitment to the region*
  - *Educational campaign for Americans to sustain public support*
  - *Infrastructure development throughout the region*

U.S. endorse a sovereign two-state solution

- *Equitable borders*
- *Contiguous Palestinian territories*
- *Renunciation of future territorial claims*
- *Palestinians granted limited "right of return"*
  - *Some will relocate to homeland*
  - *Some will return to West Bank*
  - *Remainder will be financially compensated in lieu of return*
- *Jerusalem boundaries must be fully defined*
  - *West Jerusalem – Israel; East Jerusalem – Palestine*
  - *International Holy Territory – Neutral zone for global worship*

(Continued from page 5)

A major area of controversy between the parties appears to be the issue of an individual mandate for health care coverage. State legal battles contesting the constitutionality of this portion of the law may delay or modify implementation of legislation designed to "bend the curve" of escalating health care costs.

Public and individual buy-in may be hampered due to toxic partisan politics and difficulties in interpreting and rationally implementing complexities of the law. The coverage or lack thereof by state insurance exchanges for abortion, for example, even with the requirement that no federal subsidy be used for abortion coverage, will remain a highly charged political lighting rod for the proponents and opponents to abortion rights.

Federal health officials will be left to decide whether to provide mental health and substance abuse coverage for existing Medicare recipients since this will be a service required under the law only for new Medicare enrollees.

GROUP PARTICIPANTS: Dr. Jeff Allen, COL Gino Auteri, Carol Bogedain, CAPT Jim Bradley, COL Steven Brewster, COL Traci Crawford, CAPT Brenda Davis, COL Paul Doan, COL Joycelyn Elaiho, LTC Shaun Fletcher, CAPT Anita Hickey, CAPT Jesse Lee, COL Richard Pucci, COL Steven Rumbaugh, COL Jeff Snyder.

ALUMNI NEWS

- CDR George Durgin, MFS, MS, USPHS, has departed his assignment as Assistant Secretary for Preparedness and Response. On June 7, 2010, he joined the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury in the Resilience and Prevention Directorate, 1335 East West Hwy, Silver Spring, MD 20901. George.Durgin@tma.osd.mil (301)295-8362.
- Mary Beth Skupien, PhD, former Deputy Director, Office of Public Health Support, Indian Health Service, has accepted a promotional transfer to the VA Central Office as the Rural Health Director for VHA, effective July 4, 2010. Her contact information is Marybeth.skupien@va.gov or (202) 461-7101.
- With regret, we acknowledge the death of life member Col(R) Nina K. Rhoton.

To receive the **newsletter, current membership and address** are necessary. Send changes to: CAPT(R) Gayle Dolecek, FHCEIAA Treasurer, 10280 Shaker Drive, Columbia MD 21046 or gdolecek@comcast.net.
Annual dues - $25, Lifetime membership - $75.

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