

Department of Defense
Military Family Readiness Council Meeting Minutes
Teleconference
April 29, 2020
10 a.m.-12 p.m.

Meeting Attendees:

Office of the Secretary of Defense:

Mr. William G. Bushman, Chairman, Performing the Duties of the Deputy Under Secretary of Defense for Personnel and Readiness (P&R)

Ms. Carolyn Stevens, Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy (MC&FP), Director, Office of Military Family Readiness Policy (OMFRP) and Office of Special Needs (OSN)

Army:

LTG Jason T. Evans, Army Headquarters, Deputy Chief of Staff, G-9

Ms. Jill Waters, Spouse of Regular U.S. Army Member

Marine Corps:

SMMC Troy E. Black, Sergeant Major of the Marine Corps

Ms. Marie C. Balocki, United States Marine Corps (USMC) Headquarters, Director, Marine and Family Programs

Ms. Heather Zane, Spouse of USMC Reserve Member

Navy:

MCPON Russell L. Smith, Master Chief Petty Officer of the Navy

Ms. Evelyn Honea, Spouse of Regular U.S. Navy Member

Air Force:

Mr. H. L. Larry, Director of Air Force Services

Mrs. Jill La Fave, Spouse of U.S. Air Force Reserve Member

Air National Guard:

Maj. Gen. Dawne Deskins, Director, J-1, National Guard Bureau

Military Family Organizations:

Ms. Shannon Razsadin, Military Family Advisory Network

CMSgt (Ret) Ericka Kelly, Reserve Officers Association

Ms. Patty Barron, Association of the United States Army

Advisors:

Ms. Julie Blanks, Executive Director, Office of the Under Secretary of Defense for P&R

Mr. Marcus Beaugard, Director, Defense State Liaison Office

Ms. Kimberly Joiner, Deputy Assistant Secretary of Defense for MC&FP

Ms. Rebecca Lombardi, Associate Director, Office of Special Needs, Exceptional Family Member Program (EFMP)
Mr. Joe Ludovici, Principal Director, MC&FP
Ms. Kristen C. McManus, Program Analyst, Morale, Welfare, Recreation, and Resale Policy, MC&FP
Ms. Beth Riffle, Director, Military Community Outreach, MC&FP
CAPT Ed Simmer, MD, Tricare, Defense Health Agency (DHA)

Speakers:

Ms. Karen Dalheim, Senior Attorney, Department of Defense Office of General Counsel, Standards of Conduct Office
LTG Ronald J. Place, Director, DHA

DoD Military Family Readiness Council Designated Federal Officer:

Mr. William Story, Designated Federal Officer (DFO)
Mr. Bill Hampton, Alternate DFO

DoD Military Family Readiness Council Support Staff:

Mr. Frank Emery, Travel and Logistics, OMFRP, MC&FP
Ms. Melody McDonald, Human Resource Liaison and Logistics, OMFRP, MC&FP

Public Submissions: 19

- Bereavement (1)
- Department of Defense Issuance Request (1)
- Early Identification and Intervention for Eating Disorders (2)
- Exceptional Family Member Program (2)
- Federal Register Announcement by the Health Defense Board (1)
- Local Schools and Special Education Services (6)
- Medical (5)
- Military Family Readiness Council Schedule (1)

Proceedings of the Meeting:

On Wednesday, April 29, 2020, the DoD Military Family Readiness Council (MFRC) held its first meeting of fiscal year (FY) 2020 via teleconference.

The purpose of this meeting was to discuss one of the Council's FY 2020 focus areas: Changes in Dependent Health Care Systems and Implications for Military Family Readiness.

A full transcript of the meeting and attendance of members and advisors present is available.

Call to Order

The MFRC Designated Federal Officer, Mr. William Story, welcomed Council members, advisors, and public guests. He initiated roll call, reviewed the agenda, and explained that the session includes the annual ethics briefing for the Council members and a presentation on one focus area. Mr. Story explained how to contact the Council.

Mr. Story introduced the Council Chair, Mr. William G. Bushman, the alternate chairman in Mr. Matthew P. Donovan's absence. Mr. Bushman welcomed everyone to the meeting. He noted that presentations during this meeting would include how family care is linked to combat readiness for military personnel. The work of this Council is of strategic importance to national defense. As military families adjust to the new COVID-19 environment, the Department of Defense (DoD) workforce continues to adapt and modify support methods.

Mr. Bushman acknowledged the new Council members. Mr. Bushman welcomed the Deputy Assistant Secretary of Defense for Military Community and Family Policy (MC&FP), Ms. Kimberly Joiner, formerly of the Office of the Secretary of Defense (OSD) for Public Affairs. He also welcomed Mr. Joe Ludovici, who joined as Principal Director of MC&FP in November.

Mr. Bushman introduced the meeting speakers, Ms. Karen Dalheim, DoD Senior Attorney, who presented the annual ethics update; and LTG Ronald J. Place, Director of the Defense Health Agency (DHA), who briefed the military health system transformation.

Administrative Items

Mr. Story acknowledged the DoD MFRC membership departures. Mr. Story explained that the MFRC is an independent committee that provides independent advice to the Secretary of Defense. All MFRC documents are available for review on the Military OneSource MFRC webpage. Mr. Story performed a roll-call of the Members and established that quorum was present. This MFRC meeting was not a town hall meeting. The public was allowed and invited to listen, but not participate. The public may make submissions to the MFRC mailbox at any time.

Mr. Story reviewed the written public submissions. The Members had no comments. Mr. Story turned the meeting over to Ms. Dalheim.

Ethics for Advisory Council Members

Ms. Dalheim provided the annual ethics briefing to the MFRC members. Ms. Dalheim placed particular emphasis on potential conflicts of interest. She explained that her role is to protect members and the DoD. The MFRC members are designated by their federal position or chosen based on their expertise with military family matters. Ms. Dalheim advised new members and reminded current members to keep their MFRC roles and their private lives separate. Council work and recommendations should not affect personal financial interests. Any

nonpublic information at a meeting that may benefit an outside organization cannot leave the meeting.

Ms. Dalheim referred to the MFRC Charter. Members provide independent assessments for the DoD and advice in the form of recommendations for the Secretary of Defense and Congress. Members act as consultants, and those members who are not regular government employees (RGEs) serve as special government employees (SGEs) for no more than 130 days in a 365-day period.

Be mindful of appearance concerns. While not criminal in nature, making affiliated recommendations outside of the committee appears as if a member used his or her authority to help outside organizations.

Members may mention committee membership in a publicly accessible biography if members include other background information. Membership status cannot be used to advance personal careers.

Members cannot speak on behalf of the committee if asked by an outside entity (even Congress). Members may state personal opinions by directly saying “this is my personal opinion,” but members are not to speak officially as a consultant on behalf of the DoD. Members should report all inquiries to Mr. Story and he will work with the DoD Public Affairs Office for an official response.

This is a political election year, so when members engage in work on behalf of the committee, they should not work on political partisan campaign items.

Mr. Story will send the new members an Advisory Committee Member Guidance Booklet, complete with contact information. If members have questions, please call Mr. Story, or Ms. Dalheim on her direct line: 703-571-9446.

Focus Area Presentation: Changes in Dependent Health Care Systems and Implications for Military Family Readiness

The Transformation of the Military Health System: Readiness, Reform, and the Priorities of the Defense Health Agency

LTG Place spoke to the Council members about the transformation of the Military Health System (MHS). Multigenerational families are the lifeblood of recruitment, and military families hold military health accountable. From that perspective, LTG Place reviewed the DHA mission points:

- The DHA Pledge to Families: Family medical care begins the day a person pledges to serve our Country; consequently, the DHA pledges to keep military personnel and their families well.
- Health Readiness: The DHA has a planning effort in place to determine needs, such as personnel, equipment, and technology training. Health care includes region-specific

health risk mitigation. The DHA assists in illness response, stabilization, and humanitarian aid.

- Standardization: LTG Place brings joint solutions to allies and partners for beneficiaries who use the MHS. He traveled on-site and noted that every military organization at every installation has an individual operating procedure. In many areas, staff and patients lacked a unified system. Procedures for how to handle appointment referrals, manage the data system, and contact pharmacies, for example, are different everywhere. Therefore, the DHA will work to standardize health care for those who serve.
- Military Readiness: World activity and globalization impacts the military health mission, directly and indirectly. The DHA is dedicated to ensuring that the United States remains a preeminent military force in the world. Resource investment on health care leads to military readiness. LTG Place presented two aspects of establishing readiness value:
 1. What can the DHA offer to combat forces as a medical enterprise? LTG Place, as DHA Director, has an obligation to both combat and operation sites through surgical and deployable medical teams. LTG Place coordinates with the Surgeon General on contract capabilities and combat response preparedness.
 2. How does illness affect missions? Disease and non-battle injuries cause the most deaths. The current pandemic demonstrates how disease affects readiness. Illness removes personnel from missions, slows the training of new recruits, grounds planes, and keeps ships at port. Good public health strategies, robust testing, research, preventive care, and elective surgical procedures help leaders formulate an enterprise view of the entire MHS.

LTG Place addressed two challenges the DHA will mitigate through reform:

- Challenge 1: A better-prepared medical force in the deployed environment. If there is a lack of Tricare operators, should the DHA open to civilian medical networks or send Tricare patients into the network?
- Challenge 2: A more responsive DHA that caters to the needs of DoD leaders/customers, such as combat commanders. What do leaders expect of the DHA during a mass mobilization or a mass casualty event? The DHA wants one unified response for building long-term strategic initiatives.

LTG Place presented four priorities to address the MHS health care challenges:

1. Great Outcomes: The DHA commits to optimizing the mission readiness of every Service member. Mission effectiveness depends on healthy Service members.
2. Ready Medical Force: The DHA commits to military treatment facilities (MTFs) that sustain team-based currency to enable a ready medical force. Prior to the pandemic, hospitals focused on efficiency. Now hospitals invest more in excess capacity to prepare

for the unexpected. Trauma and surgical centers now have more partnerships in the civilian sector. Most hospitals are low volume but are positioned in communities with large medical and civilian populations. Other MTFs lack nearby civilian hospitals. Others have civilian capability and capacity. The DHA is investigating better ways to deliver care for all MTF circumstances.

3. **Satisfied Patients:** Patients feel fortunate to have MHS care that helps them achieve their goals. Positive aspects of MHS care include ease of access to care, attentive and caring staff, high quality of care, good communication, and strong family support. The DHA offers the same quality of care in all services from in-person to virtual. The DHA has experienced explosive growth in its telehealth tools. Many patients find that virtual care is easier and safer under the current social distancing restrictions. The DHA monitors social media for good and bad feedback. Overall, people value the MHS.
4. **Fulfilled Staff:** People find MHS work rewarding and fulfilling professionally and personally. MHS employees connect the work they do to the people they support. All personnel embrace their medical deployment roles. The staff understands that their response to current events may shape military medicine.

In conclusion, LTG Place noted that environments of ambiguity affect health care and national security. A DHA transformation is underway to better support military and civilian leaders within the DoD. The size and organization of the military are critical. The DoD created the DHA to respond to the question: Does our system structure best support Military Service members?

Mr. Story thanked LTG Place for his presentation.

Q&A Session and Council Member Discussion:

Mr. Story presided over the question-and-answer session by roll call.

1. How does military leadership influence and prioritize civilian leadership for hospitals?

SMMC Troy E. Black shared that the Marine Corps has a unique structure in that it does not have its own primary health resources. The Marine Corps connects to community health through the Navy. The Navy makes health decisions based on its network of military versus civilian care. Sometimes there is competition for care.

LTG Place noted that the DHA solution may not be a Navy inpatient facility per se. The DHA can find other ways to keep a mission set contained to military personnel during essential Marine training. LTG Place will share ideas with SMMC Black to help health care facilities maintain basic military awareness.

2. What are the travel screening procedures for families accompanying a Service member overseas?

Ms. Carolyn S. Stevens asked for clarification regarding the administrative process for family travel within the military.

LTG Place reported that the DHA is working to standardize the MHS process for families moving to a Service location. Currently, individual Services have their own processes. A set of orders may send a Service member to health care provided by another Service. Travel screening procedures may not be readily apparent. Each Service does different screening for certain locations. The medical community is working to support family travel challenges. The family should receive the same quality of care inside and outside the Tricare network. Additionally, network evaluations need standardization between the Services personnel offices and the Service member families.

3. How will the virtual health platform affect EFMP family member enrollment?

Ms. Stevens explained that family members rely on medical personnel for the EFMP enrollment process. There is concern that a virtual platform may decrease awareness or accessibility to EFMP enrollment.

LTG Place explained that the DHA will help with the EFMP process, but actual enrollment is a Service personnel issue and a collaborative event. Telemedicine and virtual health platforms aim to serve EFMP families.

4. How can the DHA work with civilian medical facilities to meet Guardsmen Tricare capacity needs?

Maj. Gen. Dawne Deskins has 37,336 Soldiers and Airmen in 54 states on 502 federally controlled orders in response to COVID-19. Guard members use civilian health care within communities. Orders give 31 days for access to Tricare, which will increase the population of people using Tricare, with new users. Maj. Gen. Deskins expects an increase in demand.

LTG Place offered that if the National Guard needs additional products delivered, he will relay needs to the DHA Team. Tricare volume management in areas of the country where Tricare numbers were initially low is a challenge. LTG Place welcomes strategies. The DHA has partnered with organizations to help. The DHA has waived Tricare fees in some instances. The DHA waived COVID-19 treatment and testing to help the beneficiary population.

Maj. Gen. Deskins will brief the Council at a future meeting.

5. Is the DHA tracking the technician numbers available for DoD military treatment center facilities?

Ms. Evelyn Honea expressed concern that there are enough surgeons but not enough technicians. She noted that her concern might be specific to her location in Hawaii. If doctors cannot perform surgeries due to a lack of technician support, the doctors lose the surgery exposure necessary to stay medically current.

LTG Place explained that support staff depends on the market within confined geographical areas. Honolulu is a market, for example. In some market regions, the ability to get support staff

(such as Government civilians or contract vehicles) is based on localized personnel shortages of specific medical specialties and training. LTG Place provided context. There are more than 100 different specialties within medicine for technicians. In general, it is not a contract vehicle problem, but a problem of specialty within a specific market. In some cases, contracts have changed, which affects personnel numbers.

6. Is the DHA noting a decrease or increase in MHS providers due to contract changes?

Ms. Honea noted that people have said they left a position because their contracts changed. She remains concerned about staffing number changes.

LTG Place reported that the MHS staff numbers remain stable. Numbers at a specific facility may appear problematically low, but there is no sustained trend. Currently there is no indication of a positive or negative trend.

7. Can the DHA encourage civilians to participate in Tricare through incentives?

Ms. Jill Waters expressed concern for health care options in a setting that is not an MTF. Ms. Waters is from Michigan and is part of a recruiting family. There is no military treatment nearby. Tricare offers her family remote reliance. Her family is not competing with civilians, but she has difficulty at times finding quality providers within network.

Of all the health plans that exist in America, Tricare is the most heavily regulated. LTG Place explained the context of two main challenges:

- The DHA must contract with a managed care support contractor, which adds an element between the MHS and health care providers.
- By law, there is a payment limit through Medicare rates. In general, participating hospitals, doctors, and pharmacies work by patriotism and not cash. Usually the MHS obtains high-quality providers through successful marketing. LTG Place will continue to negotiate with contractors and discuss with Congress.

8. How does the DHA care for military retirees?

Ms. Heather Zane is a military spouse. Her husband is in the Marine Corps Reserve serving the Detroit area. Tricare works well for her family. She appreciates the continuity of care. Ms. Zane stated that patient record digitization and patient access when on- and off-duty would be excellent features. Ms. Zane's husband reports to Quantico two weeks of the year to update digital health records. He is also a Marine for Life Representative and helps Marines find civilian employment opportunities. Military retirees depend on Tricare benefits and sometimes cannot find the health services they need. Health centers use benefits the United States Department of Veterans Affairs (VA) provides instead of Tricare from the MHS.

LTG Place replied that the DoD is five years into an eight-year process to fully digitize all medical records within a commercial health record system. The implementation phase lasts one and a half years. The DHA requires another three years of finalization so that practitioners anywhere in the world with Tricare can access the electronic health record system. The VA likewise chose the same system platform, and the digitization process will take several years.

The DHA is markedly increasing the tracking capability of medical care within the civilian community using a health information exchange platform. The platform launched ten days ago and includes 15 to 20 percent of doctor's offices, hospitals, and medical facilities across the country. The DHA recognizes that statutory limitations exist, which may affect how some health care systems respond to Tricare cases.

9. How does the DHA plan to support behavioral health outside the continental United States (OCONUS)?

Ms. Shannon Razsadin noted that quality health care access for OCONUS families remains a challenge. Families are unable to access mental health services overseas.

LTG Place agreed that behavioral health OCONUS is a challenge. Behavioral health is culturally different in different countries, and there are different expectations. Information papers indicate differences. Tricare contractors overseas encounter limited numbers of facilities that practice American quality and standards of care. To deliver that, the DHA is working to train practitioners on the virtual health system. The challenge with virtual care is the state licensing laws that exist both in the state where the practitioner resides, as well as where the patient is. In general, licensing laws for U.S.-based people living overseas are difficult to obtain. Given that the pandemic qualified as a national emergency, states may be able waive restrictions to increase virtual health care capability. Not every state has waived restrictions. The DHA is still actively working on an OCONUS transition plan for the MHS. A February report to Congress described descopeing four dozen different MTFs across the world, per Section 703 of the FY2017 National Defense Authorization Act. As DHA director, LTG Place will evaluate 50 different areas to potentially descope but with access allowance for every beneficiary. Some areas may not transition due to COVID-19.

10. How does the DHA plan to realign EFMP in response to COVID-19, especially in terms of pediatric care?

Ms. Razsadin wanted to relay pediatric care options to the EFMP.

LTG Place noted that military families can schedule appointments at the next duty station through Tricare. DHA will standardize pediatric care access across the DoD.

11. How does the DHA respond to the stressors military air evacuation operators' experience?

CMSgt (Ret) Ericka Kelly was an Air Force ground medic who then transferred over to flying military air evacuations for 15 years. CMSgt (Ret) Kelly requested an update on the operational environment doctors, nurses, and technicians experience.

LTG Place thanked CMSgt (Ret) Kelly for her service. The DHA tracks the stressors of the 37,336 young men and women in the Army and National Guard in challenging situations. Several thousand Active Duty medical teammates are on ships or participate in urban augmentation teams from the Army. All have challenges. Military air evacuation operators respond to the significantly wounded and treat serious illnesses. The DHA continues to evaluate

air evacuation operators for physical health (on-site, post-deployment) and mental behavioral health. The DHA is launching behavioral health teams to verify how troops understand behavioral health needs. The DHA offers the same process to air evacuation crews.

12. How does the DHA compare military health services to civilian health services?

Ms. Patty Barron acknowledged that the DHA tracks efficiencies. Civilian health care should have the same quality as military health care.

LTG Place noted that health care comparisons depend on efficiency. The DHA works to provide the best military advice regarding resource provision challenges the American taxpayer navigates for good health care. If resources need reallocation, LTG Place makes a risk assessment of the health care delivery. Within that risk, LTG Place provides the best quality of care, including accessibility standards and outstanding cost effectiveness. The DHA offers equivalent or better than national standard health care. The DHA will partner with installations to ensure quality care off-installation.

13. How can the MFRC support DHA needs?

Mr. Bushman offered MFRC support if the DHA needs resources or encounters statutory restrictions or challenges.

In general, LTG Place has sufficient authority and resources. Military leaders fundamentally believe in their health care system within their own military branch. There is reluctance to transition to a standardized, overarching MHS. LTG Place understands and works to prove that the DHA will improve access and standardization across the MHS enterprise. Once Services experience DHA competency and value, the military will have a collective system. LTG Place asked that people believe in the DHA standardization process and trust the transition.

Closing Remarks:

Mr. Bushman closed by noting that the Council will continue to tackle these challenging issues, and appreciated the experts coming forward with their presentations.


The meeting adjourned at 11:48 a.m.

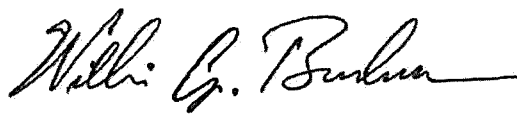
Next Meeting:

The Council will meet again virtually on Tuesday, June 9, 2020, from 1000-1200.

Submitted by

Certified by


William Story
Designated Federal Officer


William G. Bushman
Chairman
Performing the Duties of the Deputy Under
Secretary of Defense for Personnel and
Readiness