Lieutenant General Ronald J. Place
Director, Defense Health Agency

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DWG: We're honored to have today as our guest Lieutenant General Ronald Place who is the Director of the Defense Health Agency. Sir, thank you very much for joining us.

We have one hour. We're on the record. There will be a transcript made of this which should be up on our web site tomorrow or at the latest the following day. But those of you who are on the call obviously have the advantage of getting the information fresh and being able to be among the first to file on it.

General Place, your agency just celebrated it's 7th anniversary, I understand. So it's a relatively new defense agency. I wonder how it's going and what kind of a role is DHA playing in the tackling of the pandemic's impact on the U.S. military.

Lt. Gen. Place: You're right, we are one of if not the youngest agencies in the Department of Defense, and in terms of tackling pandemic or how we're handling those challenges, it really gets back to the core mission of the Defense Health Agency which is to become an integrated system of readiness and health with the idea that the DHA then does that through a complex matrix of priorities and people supporting the National Defense Strategy.

In terms of COVID, our responsibility is to then balance the delivery of healthcare along with the readiness of the force.

If you look at the Secretary of Defense's priorities, it's to protect our people, protect our ability to do our missions and support the whole of government effort. In order to do that we have to support the medical readiness of the force. That means they're ready to do their mission wherever they are, but it also means ensure the readiness of the medical force. Individually and collectively are we prepared to do the medical tasks that the department asks us to do either in support of COVID, whole of nation effort, or operational missions around the world. What that really means then is delivering healthcare at our hospitals,

clinics, medical centers, et cetera, nearly 700 of them across the world and in collaboration with the TriCare Health Plan, optimize medical surveillance and research to identify health threats, infectious disease threats among them, and then develop proposals or clinical practice guidelines or whatever is necessary to make that happen.

Then the scope of is where it becomes interesting. 9.6 million beneficiaries in the Military Health System. Of those, 1.3 million are active duty service members, and 1.6 million of those are active duty family members. That means understanding at the individual level, taking care of individual people or assuring the readiness of individual service members but collectively having a scale and scope that supports all 2.9 million of the active duty and active duty family members, and an entire beneficiary population of 9.6 million.

That's the way we have to do it.

Now the readiness part of it, that medical readiness force part of it that I described therefore means in our hospitals, in our medical centers, in our clinics, we see those as sustainment platforms or operational platforms, and inside of those facilities, that's where our newest members of our team obtain their critical skills and competencies and our existing staff sustains the currency and competency of their medical specialties so that again, they're individually and collectively prepared to do their healthcare mission.

I hope that answered your question.

DWG: That's a good overview. But how has COVID, presumably COVID has changed the way you have to work, perhaps rather dramatically. Can you talk about that?

Lt. Gen. Place: Yes and no. In some cases we're using technology to do things -- tele-health as an example, or tele-work is another example for administrative staff -- to do disaggregated efforts to still get the mission set done. That said, healthcare is often a high touch competency and sometimes it's not even the physical exam part, which is a requirement for much of what we do, speaking as a physician, speaking as a general surgeon, but some of what we do is high touch because of the empathy, because of the compassion required, that as human beings requiring human interaction. Some of that interaction

comes in the form of physical touch. So we're balancing the safety of our staff and the outcomes that we're hoping to achieve, great outcomes for every single person for every single clinical condition, balancing safety and outcomes with what's required both individually and collectively in this sort of high touch requirement. So we are looking at every single factor. What can be cone using technology. How can we keep our clinical staff safe, our administrative staff safe, et cetera, but then do everything that we can to optimize the clinical outcome.

DWG: I'm going to turn now to the questions of the other journalists on the line, but while I do that, can I just sneak in one more because I think people are going to want this, if you have it. Do you have the latest figures on the number of people in your responsibility who have contracted COVID and how many have died?

Lt. Gen. Place: Within the DoD we do keep numbers of that and we report them out through the OSD Public Affairs on a weekly basis. The most current information I've seen is maybe a day or so old, but the total number of DoD cases is just a little bit more than 55,000. The total number of DoD deaths is 79. That includes one active duty; that includes seven Reserve or National Guard -- so a total of eight uniformed service members. Then when you count in dependents, retirees and retiree family members, that's an additional 71. So a grand total of 79 DoD case fatalities.

DWG: Thank you very much.

Travis Tritten of Bloomberg Government. Are you on the line and do you have a question?

DWG: I'm here, but I don't have a question at the moment. Thank you.

DWG: Great. Barbara Starr of CNN. Do you happen to be on the line and do you have a question?

Meghann Myers of the Military Times? Meghann, do you have a question?

DWG: I have a question not specifically about the members of the Joint Staff ho have tested positive for COVID but about the therapeutics that COVID patients using military healthcare might have access to if they are in that situation.

Lt. Gen. Place: We have clinical practice guidelines and within those clinical practice guidelines we have therapies that either FDA has given general licenses to or we have use under emergency use authorizations. The most common of those involve the use of steroids. Dexamethasone is a good example of it. COVID convalescent plasma, so the blook plasma of those who have recovered from a prior COVID infection. And Remdesivir. Those are all the ones that we have in are armamentarium that are again either licensed or under emergency use authorization for use within our facilities.

We also have the capacity for any agent that any organization has that has been made available to the FDA under investigational new drug protocols or INDs. We just have to make a request to the maker or the maker can make gifts to us or suggestions to us to use those, but it would have to be done under specific investigational new drug protocol.

Does that answer your question?

DWG: Yes it does. Thank you.

DWG: Courtney Kube of NBC. Are you on and do you have a question?

DWG: I'm on, but my question's been answered. Thank you. Thank you for doing this.

DWG: Scott Maucione of Federal News.

DWG: Hi, General. Thank you so much for doing this.

I wanted to ask a question that I think is probably on a lot of people's minds, [inaudible] the leaders of the military services wrote in some concerns about transitioning military treatment facilities to the Defense Health Agency. I'm curious what you've done with that and how you've taken those concerns into account and how DoD and DHA will be moving forward, especially considering that there's been probably a good bit of pushback on this.

Lt. Gen. Place: The Secretary of Defense and Deputy Secretary of Defense take all concerns about every issue seriously. In regards to COVID back in March the Deputy Secretary put a halt to

several things such as elective surgical procedures, elective dental procedures, elective other invasive procedures in order to protect our staff, preserve personal protective equipment and potentially use some of our staff in other missions across the United States.

At the same time the Deputy Secretary put a pause on all transition activities associated with exactly what you're talking about. Section 702, 703, et cetera, of the 2017 National Defense Authorization Act.

But in those regards there was a requirement for my organization to come back with recommendations on what things should be considered to start again in the transition or transformation process. We've done that. At the same time, leaders within the military departments brought forth some additional concerns that they believe that the leaders of the Department of Defense should take into consideration and should inform what a future state should look like.

That process of gathering that information, both from the military departments as well as outcomes or measurement data about what effect COVID has had on each of the military departments and medical treatment facilities that they currently manage, what effect that's had within the Defense Health Agency, What effect that's had within the research and development portfolio within the Defense Health Appropriation, et cetera, and then bring all that information back to the Deputy Secretary of Defense and the Secretary of Defense to help determine a way forward as we move past, at some point, the requirements that we have in support of COVID-19 and then get back on whatever the next stage of transformation looks like.

So I don't think that any of this is bad. I think this is good. There are so many people invested in making sure that a future state of the Military Health System is the absolute best that it can be, fully in support of best clinical outcomes for America's sons and daughters -- both those serving today and their families as well as those who are retired.

I hope that addressed your question.

DWG: Yes, I was wondering if you could go through a couple of the recommendations that you're considering. I know you talked about the data, but are there any specific recommendations that

you can explain to us?

Lt. Gen. Place: Some of it is how decision-making is made. Where is it appropriate for decision-making to be made centrally for an enterprise decision, and where is it appropriate for decisions to be made at an installation level, for example. There are advantages of both, both from a standardization which is good because then everybody knows what the message is; but yet if an infection disease -- this particular case, or even casualties which may be a different case -- affect individual installations differently, how much authority left and right of that normal standardization should an installation leader have?

Those are the things that we're trying to work through. Those are the factors that have come up within this COVID-19 that the department didn't have a complete plan rolled out on.

So before we get ahead of ourselves making our decisions that in the long run may not be good, that's the type of information that the department is examining and trying to make decisions on the way forward.

DWG: Kimberly Underwood of Signal Magazine, are you on and do you have a question?

DWG: Thanks so much. Thanks, General, for your time today.

I want to talk to you about healthcare information technology. I know you all have success kind of under your belt with the record-breaking, bomb-breaking [inaudible] completed in June with the PEO Defense Healthcare Management System accelerated migration project that moved [inaudible] of secondary healthcare data. You know, it's AWS, it's 20 vendors. I don't know if you want to comment on that project specifically, but could you also talk about kind of the plan for the next year or two of where you all are going with information technology to improve healthcare. Thank you.

Lt. Gen. Place: The large umbrella is within the overall mandate of the Defense Health Agency and that's standardization where standardization is useful to drive improvements in our outcomes. Those outcomes may be clinical outcomes, they may be administrative outcomes or some combination thereof, but standardization where standardization is appropriate. And in so doing, we've chosen tools. One of them as you've already

described, the health information technology tools that are in support of that standardization process. The largest part of that tools the MHS Genesis Program. I'm not going to get into the particular companies that we're buying our commercial off the shelf equipment from, but the program is an electronic health record as a platform to lead to improvements in that standardization.

Some of that standardization means that while it's configurable, in other words what we buy from the vendor can be changed. It's not configurable locally. So that when you move from place to place as a provider, as you move from place to place as a patient, the system is still the same system which then drives similarity and understanding of the particular product.

Further, that standardization leads to a similar expectation of care for our patients as they go from place to place because everything is the same. At least the standardization in such things as our referral management modules, which means that when it comes to making an appointment as opposed to learning the system every place that you're assigned to, it's the same system and we make appointments the same way.

It also means as you transition from the Department of Defense to becoming a veteran, the same system and the same methodology would be used whether in a DoD facility or a Veterans Administration facility.

It has tools associated such as voice recognition technology that enables speed in the administrative aspect of the clinical care as opposed to the amount of time it either takes us to type or to write, and then if writing, the challenge that go with, at least from my handwriting as a physician, the recognition of what it is actually that we wrote.

And then the final part is, it supports both locally and nationally the interaction of Joint Health Information Exchanges which then means as we use our TriCare contract partners, that the information that we have out in the private sector care where we're using similar modalities or modalities or physicians offices or hospitals that also participate in this Joint Health Information Exchange, it makes it seamless for the information to travel back and forth about our patients so that no matter where our patients get care, the depth and breadth of the entirety of their medical problems can be viewed by each practitioner who's

participating in their care.

So ultimately, this health information technology is a tool that is in support of optimizing the clinical outcomes of our beneficiaries.

Does that address both your question and your comment?

DWG: Yes, sir. And just a follow-up question.

In using the [inaudible] are you looking at kind of more advanced tools to support analysis or data management or data use? Artificial intelligence, machine learning. Are you looking into any of those areas to support either improved care or research and development for care?

Lt. Gen. Place: Yes, ma'am. You're thinking exactly like the way we're thinking and that is how can we use, for example, natural language processing to do the same sort of data elements or data review to help us see things perhaps that we didn't see before. So not necessarily artificial intelligence, but national language processing to fit into those data analysis tools. That's one part of it.

The second part is, how can we use emerging technology, for example, in imaging, whether it be plain film imaging, regular x-rays, computed tomography, magnetic resonance imaging, ultrasound, et cetera, how can we use those AI protocols to do first pass reviews of those imaging studies to either put clues to the human being, the radiologist who's interpreting them, or in some cases even if they can demonstrate that they do better than humans, do we transition some of that reading over to the computer system so that we can improve the both speed and accuracy of the reading of those imaging systems.

So yes, that is the direction we're going and that's why we're going that direction. In some cases it may be cost effective. In some cases, and particularly early on it may become more costly. The whole driver, though, is improved outcomes.

DWG: Thank you so much.

Lt. Gen. Place: You're welcome.

DWG: Jeff Seldin of VOA, are you on the line and do you have a

question?

DWG: I am. Thank you very much for doing this, sir.

I was just wondering how has COVID impacted the Defense Health Agency's combat support role? Have you had to do different things because of COVID? And looking ahead, are you planning differently from what you've learned from COVID so far?

Lt. Gen. Place: The second part of the question is the question is the much easier one, and the answer to that is yes. We are consistently learning.

That said, my hope is that everyone believes that every element within the Department of Defense is a continuously learning organization. So whether it's COVID or it's support of combat operations or some other defense support to civil agencies or whatever element, a hurricane or an earthquake or whatever it is that we're a continuously learning organization. So from that perspective, yes.

Part of it also is, I'll give an example. We've developed a Clinical Practice Guideline for the care of persons infected with COVID-19. That could be anywhere from asymptomatic which is pretty easy to take care of, to mildly symptomatic to critically ill. And we constantly are evaluating both our own internal outcomes as well as the broad spectrum of what's being published in the literature, the medical literature, about care of COVID and we've updated I think five times so far our practice guideline which means that's how we expect the care inside of our facilities across the Military Health System. We're on the verge of publishing our sixth version of our Clinical Practice Guidelines to be able to drive those outcomes.

Now in terms of the combat support part of our organization, the answer to that is also yes. One of the elements of combat support is a crisis action team. So how do we fit into the Joint Staff? How do we fit into support of the COCOMs?

We've learned some things that were set up really well. I'm not going to get into details of those. But some things that were done really well and there are some other things that we don't think that we're organized as well as we could have. The information flow wasn't as fat as we'd like it to be. Or internally, the matrixing. So not the silo part of the

organization, the supervisor to the supervised, but the lateral communication networks that weren't as robust or solidified as we'd like them to be.

So all those things have happened in our recognition of COVID. We're pretty persistent about doing after-action reviews or ongoing lessons learned so that as we work through whether this pandemic or any other emerging requirement for the Department of Defense, we both learn from this but more importantly, we've relooked at our doctrine, our organization, the way we've trained, our materiel, our logistics, et cetera, to make sure that we're even more prepared for whatever the next emerging requirements ought to be.

I hope I've addressed both of your questions.

DWG: Yes, thank you very much.

DWG: Ellen Millheiser, Synopsis?

DWG: Hello, sir. Thank you for taking these questions.

I was reading the Inspector General report last week about DHA and COVID and one of the things that struck me was the fact that a lot of MTFs were saying that they did not have adequate control of the personnel who remained in their buildings and who were deployed by their operational team or unit outside of the control of the DHA. How do you think DHA is going to be able to handle that with medical personnel assigned to an operational unit with a service, but DHA deploying teams where they need to be in MTFs

Lt. Gen. Place: We have to define what are the responsibilities and authorities of each part of the organization. The military departments are force providers. The Defense Health Agency manages MTFs and the TriCare suite of contracts.

DWG: What does MTF stand for?

Lt. Gen. Place: Sorry. Medical Treatment Facilities. So our hospitals, our clinics, our medical centers. We call them MTFs.

The military departments and the Secretary of Defense are -- so the military departments are the force providers. The Secretary of Defense with the work in the Joint Staff are the ones who authorize the ability for forces to be employed or deployed

somewhere. So in this particular case the ask came from wherever it came. It went through a process to make a decision, would it be beneficial for the department to support some mission. That decision was made yes. Part of that decision-making is what would be the impact locally.

Now I'll freely admit that when we take really well trained, highly qualified, passionate, hardworking staff out of any of our facilities, there will potentially be some negative effects in terms of how much work can be done. But while each of the instances that are in that DoD IG report imply that there was some sort of negative effect locally, the fact is there were no problems with access at any facility across the Department of Defense. There was no problem from an access perspective, getting access to either outpatient clinics or hospitals in the communities around our hospitals and clinics.

So while it did disrupt, certainly, the normal operations of each of our different facilities, in some form or fashion, either locally on the installation or using one of our TriCare partner facilities, every single person who needed care got care.

The challenge becomes how do you work through the details of every single person and every single case? And I won't pretend that that was perfect across the entirety of the Military Health System but it was really rare to find a case where it was a significant enough abnormality for us to really look at our process.

Did that answer your question?

DWG: I was just wondering if you think there's going to be any change in the future over who has control of the medical personnel in terms of making sure the MTFs are fully staffed at all times, and that the medical teams that are being deployed are --

Lt. Gen. Place: No, ma'am. I do not anticipate there being a change in that. The military departments will be the force providers. The responsibility of DHA will be to find a way to provide healthcare. Some of that will be in the MTFs and will continue to be in the MTFs -- the hospital or the clinic. And some of that will be using our network partners, the hospitals and clinics outside the installation. And my responsibility as the Director of the DHA is to ensure that we have processes in

place, whether it be staffing, augmentation, through contracts, through work with the military departments for the Reserves, or with our installation partners using the TriCare system to be able to provide healthcare.

So I do not anticipating that changing. Just who has the responsibility for what, and as I mentioned before, that matrixing what will be the challenges? So not necessarily will the department not move somebody, so the Army or the Navy or the Air Force won't move a uniformed person or move a uniformed team, but based on impact or input from the agency, they may choose it from a different location where the scope and challenge of continuing to provide healthcare using all those systems that I mentioned, might be easier to perform.

DWG: Thank you very much.=

DWG: Sean Naylor of Yahoo News. Are you on and do you have a question?

DWG: I am on. Yes.

General, have there been any outbreaks of COVID-19 in the military that you would say were either on the scale of or of the significance of the outbreak on the Theodore Roosevelt?

Lt. Gen. Place: In a unit there have been no outbreaks within a singular unit that has matched that for scale or complexity. There have certainly been outbreaks within units, whether those be units that are fully trained and in an ongoing readiness capacity ready to be deployed to whatever mission set around the world, and there have also been outbreaks within the training base at Basic Training or follow-on training. But nowhere near the scale, size or scope of what has already been reported from the Theodore Roosevelt.

DWG: Great. Thank you.

DWG: Paul Sinkman, US News?

DWG: Hi, General. Thanks very much for doing this.

I came in a couple of minutes late so I apologize if somebody's already asked this. I'd be interested to get your perspective on what you see from the COVID exposure from members of the Joint

Chiefs and the other senior officers who have had to quarantine. Did the system work the way that it should have? Was there a shortcoming? Are there new precautions that need to be put in place to prevent something like this from happening again?

Lt. Gen. Place: Without getting into some of the specifics about those very senior members of the Department of Defense, from the available data that I have, the senior most leaders of the department are following and have followed all of the protocols to keep themselves safe and their staff safe.

That said, one of the challenges of this particular virus and in fact many viruses is that you don't necessarily know that you're infected and you don't necessarily know that you have the capacity or capability of spreading that infection.

We also know that absent almost total isolation, there's not a great way for us to totally prevent spread. So these members, every time I've been around them, and I'll admit that hasn't been a lot of times, but I have spent time around members of the Joint Chiefs. They are very good about the modalities that we're talking about. Meaning physical distancing. We use the word social distancing. I don't like it. Physical distancing, and they're good at that. Wearing their face covering. They're very good at that. Not shaking hands and washing their hands. They're very good at that. They're very good at, if they themselves or anyone around them are exhibiting any signs of illness, of self-isolation, that sort of thing.

I think what this really shows is despite all of those best practices that we think that we know about how to try to contain this particular virus, it isn't 100 percent effective. Which then goes into the common sense about how do, when we travel, what's the value of restricting our movements or self-isolating?

If some member of our family is sick, why is that helpful for all of us to isolate ourselves until we can sort out are we really infected with COVID or is it some other sort of illness? That sort of thing.

So I think, at least my personal opinion, goodness has been done. Our senior leaders are following the rules and their role models for those rules and it's just reinforcing that we have to continue to stay vigilant at a time where complacency becomes an even greater risk factor across the world, really, but in

particular for us across America.

DWG: To just follow up on that, sir, if these senior officers know that they're role models, a good example of what they're supposed to, or as disciplined as you say they are, and I'm sure that that's true, and yet they still got infected and in at least one case still got sick, what do you say to those people who say, well I'm going to get sick anyway, and listen to what some might interpret to be the President's downplaying the need for some of these physical distancing rules and say I'm going to get sick anyway, I might as well live my life in a less restrictive way.

Lt. Gen. Place: I'm not going to comment on anything that any of the leaders said. I'm going to comment on what I think.

We don't have a system that will totally eliminate risk. So if some outside of the military want to accept increased risk by not doing some of these things that we know decrease risk, that's one of the things about being American. You can make those decisions yourself.

In some locations leaders have determined that additional factors must be followed. Those are the rules of the day.

Ultimately we know that nothing totally eliminates the risk other than complete and total isolation which is essentially impossible for most of us who don't live on self-sustaining pieces of land. So if that's the case, then what can we do within the requirements that we have to lower our risk? I think the factors that we're talking about are all about lowering risk, not eliminating risk, and then making conscious decisions about where we're willing to accept risk. That's really the essence of the discussion, at least in my opinion.

DWG: Thank you, sir.

Lt. Gen. Place: Dmitry Kirsanov of TASS.

DWG: I'm good, David, thanks. I don't have a question. Thank you for doing the call, General. We appreciate it

DWG: Jennifer Griffin of Fox? Are you on? Do you have a question?

If not, Jennifer [Vanitsa] of the Association of the U.S. Army,

are you on and do you have a question?

DWG: Yes, I do have one quick question.

Is there any discussion or guidance in place yet of how the vaccine will be administered to service members and their families in the future?

Lt. Gen. Place: This much I'll tell you. A significant amount of effort has been done by my organization, the Defense Health Agency, because we have the requirement for the immunization system for the Department of Defense, and we exercise that plan every single year with our Influenza Plan.

So we've utilized the year over year Influenza Plan as the skeleton, the backbone so to speak, for developing a COVID-19 vaccination, implementation plan.

There will likely be some differences. So for example, influenza is the same, the same thing no matter who the maker is, so that we can get it. In general influenza is a single injection.

Now when it comes to COVID there's lots of different companies. Operation Warp Speed is focusing largely on six potential manufacturers, but it's not just one. And some of those manufacturers have a requirement for, what looks at least to be a requirement for two injections; and at least one of those makers is looking at a single injection. So we have to be able to figure out not just how we transport, how we hold it, how we inject it, but how does it fit in the system with six different makers and if you get one, how do we make sure that the second dose that you get is from the same maker? That sort of thing.

Further, our requirements are put into the overall Operation Warp Speed requirement for the entirety of the United States. So when OWS, Operation Warp Speed, makes decisions about who gets the vaccination and when with the idea of course that first responders -- whether that be police departments, fire departments, healthcare workers in America, et cetera -- where does the department fit into that? And then when we have fit into that, then how do we make sure that we vaccinate all the people that we're responsible for?

So I tell you all those details to tell you that yes, we're involved in Operation Warp Speed. Yes, we're an integral part of

it. Yes, we have our own plan for how we'll be distributing vaccination throughout our system, both here in the United States and for forward deployed service members around the world.

DWG: Jen DiMascio of Aviation Week. Are you on and do you have a question?

Harrison Cramer, National Journal. The same for you. Are you on and do you have a question?

Sorry, I'm working from a list because of the nature of the call here so I don't know who's on and who's not.

Alex Ward of Vox. Are you on?

Paul Sonne of the Washington Post. Are you on and do you have a question?

DWG: I do have a question.

I'm just wondering if you can expand upon and be a little bit more specific about the lessons learned that you guys feel like you have come across since the COVID pandemic started? And in particular the question of what DHA should be playing in the broader response to the pandemic outside the military that the Pentagon and National Guard have been [inaudible]?

Lt. Gen. Place: Some of the lessons learned are about a common operating picture. So in general, where we evaluate our system, we look at how ready are our deployable units or what's the available bed space inside of our hospitals, our medical centers, that sort of thing?

But as we talk through potentially massive deployments of service members, then what's the common operating picture of available staff? What's the common operating picture of available bed space and personnel? What's the common operating picture of medical logistics, not just for the deployable logistics, but medical logistics in support of every single clinic, hospital or medical center.

The services each look at it a little bit differently which then makes it an incomplete picture if you're looking at the entirety of the Military Health System. So that's' one of the lessons.

The following lesson to that is then how do you organize not just your operational medical logistics, but your medical logistics in support of all of your military Medical Treatment Facilities in addition if in support of a whole of government effort, how do you have a common operating picture that you know what you have that may be excess in your requirements over what period of time that then may be available to support a particular medical logistics requirement in a particular area of the United States, whether it be the early challenges that we saw in New York City or the Pacific Northwest or elsewhere.

And then if medical logistics, and by that I mean either durable medical equipment -- ventilators or IV pumps or whatever; or supplies -- medications, gauze, operating room disposable equipment, et cetera. Do you have a good picture on what you need and how much of a backlog you have, or a storage capacity you have of all that, and with reasonable projection, how much can you do without?

We found that we didn't have a very good predictive model. We have good casualty estimators but we didn't have a good infectious disease model for estimating where things are going to go.

We've since, all those things I mentioned, we've developed all those things. We now have an infectious disease modeling program that with reasonable injects can tell us what we think is going to be the requirement for outpatient care inpatient care and then the supplies to go with it. We have reasonably good models and systems that now see not just inside our own facilities but how much of that could be used from a logistics, durable medical equipment and disposable supplies, how much of that do we require for those particular disease [postulances] and what we might then be able to support to a whole of nation effort.

Those are the details of some of the lessons that we've learned and how we've solved those problems over the last six or seven months.

DWG: Tara Copp, are you on and do you have a question? McClatchy.

DWG: I am on. Thanks for doing this.

Do you have a role in providing guidance to the Joint Chiefs on

what sort of COVID precautions they should be following? It seems like earlier this year they were doing virtual VTC's with each other but somehow they all ended up in one room where now they're having to quarantine for different reasons. Then I have a follow-up.

Lt. Gen. Place: My organization has input into the Assistant Secretary of Defense for Health Affairs total input. I am specifically asked at times by the Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs about particular elements. Me personally, and my agency have significant input in multiple different ways on just about any sort of medical topic that you can think of, but specifically everything that has to do with COVID.

That said, some of what you're describing, I think the phrase that lots of us used in February or March of this year was in an abundance of caution. So we're doing lots of different things because we really didn't know. So almost everything administratively was done using tele-work early on.

But then as we were learning more and more about it we were actually learning that with some physical distancing, with some sort of face covering, with not shaking hands and being careful about what we touch and cleaning surfaces and washing our hands, we can really I'll say buy down that risk. All those things are what we're buying. We're buying down the risk of transmission between people. We're not eliminating it, but we're buying it down.

That said, again, not only are we human beings and there's a requirement for human contact, the fact of the matter is when people are together in rooms and the multiple conversations can still go on and you can hear them all, the efficacy of the communication is just way better.

Again, I think all of those senior leaders understand that there was some risk about being in the same room with each other or other people, but they evaluated the risk in such a way that it was worth the potential risk to make the mission of whatever was happening inside that meeting room or that collaboration room or whatever it was that they were together. So it's all about risk-making decisions. Senior leaders of the Department of Defense, that's what they do all day every day.

DWG: Do you suspect that as we go into the winter and there's still not a vaccine readily available that your agency might be making some stricter recommendations just to prevent spread?

Lt. Gen. Place: My organization will be making recommendations based on the data at hand. So if the data seems to indicate that moving to more physical distancing, less time together, more space away, if the data supports that then we will be making that recommendation. But I'm not going to speculate on what the data might be. But we will continue to make database recommendations. And again, if that's what the data shows, you bet, that's what we would say. Over.

DWG: Richard Sisk, Military.com. Are you on and do you have a question?

Patricia Kime, who I think is representing Kaiser Health News on this call.

DWG: Yes, I'm here. Thank you for taking my question.

DWG: Somebody is playing music.

Well, folks at DoD, can you do anything about getting rid of this music?

(Pause)

DWG: Patricia Kime.

DWG: General Place, so there have been like 15,000 civilian employees who have contracted the COVID-19 Coronavirus and 83 have died. Can you tell me if -- these are DoD employees including contractors. Can you tell me how many health workers within DoD have contracted the virus and how many of the deaths may be health workers?

And then I do have a follow-up question.

Lt. Gen. Place: The exact number, ma'am, I don't have. From our registry I do know that if we look at a percentage of our beneficiary population that have been COVID positive, the employees, the healthcare employees are actually becoming positive at a lower rate than our non-healthcare workers. The exact number, though, I have not seen that number. That's not

the way that I track it. But if you're really interested in the specific question we'll get you that in a follow-up.

And no, I'm not tracking the specific numbers of healthcare worker deaths. I know it's not zero, but I'm not tracking that as a separate number compared to everybody else. But again, if you're interested in it, I'll do what I can to find you that number.

DWG: Thank you very much. And then one follow-up, obviously DoD has gotten involved through Operation Warp Speed with the AstraZeneca trials. Are you aware of any other talks with any of the other finalists who are in the phase three trials who might be partnering with DoD to do such tests, volunteer studies at MTFs.

DWG: Yes, ma'am. The first one that you're describing, the AstraZeneca test, as you're likely aware, that's on hold in the United States by the FDA. In other countries that hold has been lifted and AstraZeneca is continuing that phase three trial. And yes, the Department of Defense is a participant in another phase three trial. I think that's been publicly announced but I'm not going to mention who it is or what is because I don't know that it's been publicly announced. But if you're interested in it and I find out that it has been publicly announced we'll give you the name of the company and the additional locations within the Department of Defense that we're doing that phase three trial.

DWG: Thank you, sir.

DWG: Richard Sisk, Military.com.

DWG: Thanks, General, for doing this.

I wanted to ask because I couldn't quite hear earlier your response. On the transfer of the military hospitals to DHA, is that on hold now? And can you say how many have been transferred now and how many are you looking to do?

Lt. Gen. Place: Sure. It is still on hold and it's been on hold since the spring. All transition-related activities due to the attention that the Department of Defense has moved, and that attention meaning resources, to the COVID-19 fight, the total number of military Medical Treatment Facilities that have transitioned into the Defense Health Agency is 47 and that's out

of a total number of 451 military Medical Treatment Facilities around the world.

DWG: And can I also ask, sorry for maybe being dense about this, but your vaccine safety hubs, I believe that are four. Once the FDA does give approval to a vaccine for COVID, does DHA and your vaccinating hubs, do you also have to approve, decide upon its safety, effectiveness, beyond what the FDA Does? Or do you accept the FDA's findings?

Lt. Gen. Place: We accept the FAA's findings. We don't think of ourselves as better or smarter or more complete than the work that the FDA does when it comes to any vaccine. Whether it be COVID or any other.

Some of the challenges might be whether it's a fully licensed vaccine and just about every vaccine that all of us are aware of are fully licensed vaccines; versus a vaccine that's being delivered under an emergency use authorization, an EUA.

Fully licensed, the department may well consider it becoming a mandatory vaccine for service members, but it it's under an emergency use authorization, then how the department chooses to implement it may be a little bit different based upon the risks profile and the efficacy of the vaccine as presented by the vaccine maker to the FDA and then their evaluation of that safety and efficacy profile.

I hope that answers your question.

DWG: Okay, would it be complicated if the FDA, I believe there are six candidates they're looking at, if the FDA approves more than one.

Lt. Gen. Place: Complicated, sure. The reason it becomes complicated is we would have to then manage and track each of our beneficiaries through the different vaccine protocols associated with each of those manufacturers. And I'll remind you that the requirement for new vaccine phase three trials are typically a two-year follow-up period. So even those vaccines that may become available during an emergency use authorization, we would still have a requirement to remain in collaboration with that particular maker for up to two years after the utilization of the vaccine product.

DWG: Thank you.

DWG: Rachel Cohen of Air Force Magazine. Are you on and do you have a question?

DWG: I am on.

You have your COVID clearinghouse that you've been using for a little while now, and I'm curious if you're using that to help the military figure out how to approach the daily operations, the process of being near other people, as well as things like PT tests and other things that help impacts.

DWG: Yes, ma'am. That's a really great observation.

Part of what we're doing is figuring out when it comes to, whether it's infectious diseases or even other problems, musculoskeletal injuries from over-use or from non-use because we weren't doing PT for a while, for example, and then get back into it. What happened from that?

So all of those are being brought together into a central clearinghouse of information to make decisions on the way forward.

Towards the former part of your question when it comes it infectious diseases, the other thing we're working through is information technologies. What are the right apps? What are the right technological solutions not just for COVID, but for any potential emerging infectious disease, that we can have a system in place that does a lot of this evaluation both from a physical distancing, or from the ability that spreads aerosols or whatever they are, using technological solutions to supplement contact tracing requirements, for example, or how many people can be in a room based on the air flow of a particular room or aircraft or fighting vehicle, those sorts of things. That's all part of the discussion that the department is having internally as way of learning from this particular pandemic.

DWG: Thank you very much.

DWG: This is Travis at Bloomberg. I was hoping to be able to get my question in.

DWG: You may. Why don't you go now?

DWG: Great, thank you.

General, I wanted to loop back to you r comments about the transition or the restructuring of the healthcare system, and you said that David Norquist had put that on hold earlier this year and that you're in the process now of compiling information on how the system's been affected by COVID and that you're going to supply that to Secretary Esper and Norquist and they're going to do a review.

I'm just wondering if that review includes a plan to eliminate the 16,000 or so uniformed billets and also the plan to close clinics and move about 200,000 beneficiaries to off-base private care.

Lt. Gen. Place: Yes, sir. Every aspect of the transitions, and those are three big elements of it, the fourth of which is another thing I've already mentioned this afternoon and that's the rolling out of our new Electronic Health Record. Those are all part of the decision-making that the Secretary and Deputy Secretary are making.

That said, if I can take that descoping of certain numbers of our clinics and hospitals and the potentially affected 200,000, a little less than that, 190,000 beneficiaries. That in particular has my attention because my organization has ultimate responsibility for implementing that plan. And here's why there's additional challenges with that.

I think most of you are aware, but maybe you're not, some outpatient physicians offices have either downsized or closed themselves. Some hospitals across America have either downsized or closed. So some of the information that we were relying on to make recommendations to the department about where the capability may exist in the civilian community to effectively provide access to safe high quality care for some of these beneficiaries, that information may no longer be true.

So my organization just recently in fact, earlier this fall, started the process to revalidate every single bit of that information before I go back to the Assistant Secretary of Defense for Health Affairs to make recommendations on whether or not we should proceed in some of these areas or not.

DWG: Do you have a timeline for this? Of when you may finish your work and when the Secretary may make a final decision?

Lt. Gen. Place: Each of them are in different stages, so the potential downsizing of some of the uniformed medical staff, that's largely being led by the military departments themselves in collaboration with the Deputy Secretary and Secretary. So I don't know where that one is necessarily.

When it comes to the transition of the hospitals and clinics into the DHA, my part of that impact or information to the Deputy Secretary has happened. I know that he's still collecting other information from other locations. I expect that decision to be made in the really short term future, perhaps this month some time.

In term of the potential downsizing or descoping of facilities, that data gathering again, just restated here in the fall. I don't anticipate making any recommendations about a way forward whether it's the same or different any time before the first part of calendar year 2021.

DWG: Thank you very much.

DWG: Can I ask a follow-up This is Ellen Millheiser. Can I ask a follow-up to that last question?

DWG: Hello again.

DWG: Hi this is Ellen Millheiser. Can I ask a follow-up to that last question.

General Place are you still on?

Lt. Gen. Place: I am, sure.

DWG: I dropped out. I don't know whether I was the only one. For the second time just now. Call failure.

Yes, Ellen Millheiser, I recognize you. General I hope you don't mind if we run over just a couple of minutes here since we lost some time.

Lt. Gen. Place: That's okay.

DWG: -- on rescoping the MTFs going forward. Do you think you'll be taking into account what we've just seen happen where there might be plenty of capacity in a community and it can go away really quickly in the case of a pandemic. Do you think that that is going to change your decision-making on determining when capacity can be, not only exist,, but can be counted on?

Lt. Gen. Place: Your point is well taken. That will be a factor that we'll have inside our assessment. But that was a factor inside the other assessment.

Now how much extra capacity, that's really the question at hand. And how much extra should there be that the department relies on.

But that also goes to the way the department looks at itself. We have existing extra capacity inside our system such that we're flexible and agile enough to be able to support other missions around the world without negatively impacting our own requirements on our own installations. So some of that exists already.

The key decision-making to all of this and the information that we'll be providing to the leaders of the Department of Defense will be this is how much excess capacity we see, and they'll be making decisions about how much will be the requirement before we consider descoping any particular facility.

So the short answer to your question is yes. The harder question will be, but how much. If that makes sense.

DWG: Thank you very much.

DWG: Thank you. I just have one more person I'd like to recognize if he happens to be on the line still, and that's Billy Mitchell of [WebScoop]. Billy, are you on and do you have a question?

Hearing none, it just remains to thank you, General. This has been a very, very rich session in terms of data and we appreciate your time and your effort on this vey much.

Members, we have another event scheduled later in the month with the Assistant Secretary of State for Political/Military Affairs, Mr. Cooper on the 28th of the month. There's another session that may or may not come up in the next week or two. So keep an eye

on your emails for possible invitations.

With that, and in closing this session, again, thanking you, General Place.

Lt. Gen. Place: Truly my pleasure. Thank you.

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