READY TO TREAT?

LIFE AS A PRIVATE in the U.S. Army

Keeping FEMALE OFFICERS in the U.S. Air Force

ALZHEIMER’S DRUGS: A future challenge
Russia uses social media to exert influence all over the world, but the Kremlin’s propaganda campaign is particularly focused on its neighbors in eastern Europe. Senior behavioral scientist Todd Helmus outlined several ideas to counter this threat in testimony before the Senate Select Committee on Intelligence in August 2018.

MORE AT www.rand.org/t/CT496

The Global Order Will Outlast U.S. Leadership

Even if the U.S. bails on the international order, it’s likely that Europe, China, Japan, and the rest of the developed world will maintain existing multilateral structures and build new ones. The order will survive but may become less liberal, less democratic, and perhaps less peaceful, writes Ambassador James Dobbins.

MORE AT www.rand.org/b180823

Understanding Russian Propaganda in Eastern Europe

Mosul

As the battle to liberate Mosul from ISIS ended last summer, researchers Shelly Culbertson and Linda Robinson published a report that helped shape international efforts to stabilize the city. Nine months later, they videotaped their visit to Mosul to check on its progress firsthand and learn more about several key challenges.

MORE AT www.rand.org/v180822
Committed to Care
Researcher Jodi Liu on single-payer health care and the possible future challenges of Alzheimer’s care

Veteran Health Care
Are private-sector providers ready to meet the health care needs of veterans?

Research Briefly
Create your own hospital rankings and more

Commentary
The U.S. Air Force is working harder to retain female officers

Infographic
Is the health care system ready for an Alzheimer’s therapy?

Private Life
An inside look at expectations and experiences in the Army’s junior ranks

Giving
RAND’s new head of development on philanthropy as relationship

atRANDom
Hitting a high note on America’s Got Talent

Jodi Liu is an associate policy researcher at RAND whose work aims to improve health and health care. She recently led an assessment of a single-payer health care proposal in New York State. She also has modeled the supply-and-demand challenges that would arise if a treatment for Alzheimer’s became available.
Research Briefly

Create Your Own Hospital Ratings

Those hospital report cards you might have seen in magazines or on consumer websites all share one major flaw: They’re made for an “average” patient. And you won’t find many of those walking around a real-world hospital.

A new tool on the RAND website allows users to create their own hospital report cards, based on the measures that matter most to them, not on some average statistic. It’s there to prove a point.

With so much data available on the internet, and so many ways to slice it, there’s no reason to keep rating hospitals just on the average needs of an average patient. Instead, people should be able to go onto a ratings website, fill in what’s important to them, and pull up their own customized hospital report, researchers argued in a recent article in the New England Journal of Medicine. They built the online tool as a demo.

Users enter their zip code to see a list of nearby hospitals, with star ratings based on 2016 data from the Centers for Medicare & Medicaid Services. They can then weight that data to better reflect their own health needs.

A pregnant woman, for example, might put more weight on safety, effectiveness, and timeliness, and less on readmission rates. A patient going in for routine knee surgery might be more concerned about the overall patient experience, and less about hospital mortality rates. Neither would look anything like that average patient of other hospital rating systems.

The researchers built the tool to illustrate what’s possible, not to compete with Consumer Reports, U.S. News & World Report, and other purveyors of hospital ratings. It’s a proof of concept, meant to show that patients should expect more than one-size-fits-all hospital ratings. Funding for this venture was provided by gifts from RAND supporters and income from operations.

“If the intent of hospital quality ratings is to inform patient choice,” said Mark Friedberg, a senior physician scientist at RAND who led the project, “why not ask patients for their input?”

MORE AT www.rand.org/t/TL258
Is Obesity Contagious?

Health researchers have long noticed that obesity tends to cluster in some communities. That raises an interesting possibility: Could obesity be contagious?

Attempts to answer that, though, have run into a chicken-or-the-egg problem. Was it something about those communities that was making people obese? Or did obese people just choose to live in those communities?

Researchers found a way to solve that problem in a recent study. They looked at more than 1,500 Army families, assigned—without a say in the matter—to 38 different bases around the country. Some went to places like El Paso County, Colo., with a very low obesity rate. Others went to places like Vernon County, La., where the obesity rate approaches 40 percent.

The researchers found that family members stationed in counties with higher obesity rates did indeed have higher odds of being overweight or obese themselves. Not only that, but the odds increased the longer they stayed in those counties.

In fact, for every percentage point increase in a county’s obesity rate, the soldiers and their spouses had 5 percent greater odds of obesity. Their children were 4 percent more likely to be overweight or obese. The researchers used standard definitions for both terms: A body mass index of 25 or more was overweight for an adult; 30 or more was obese.

The researchers did not find anything in the physical environment of those more-obese counties that could explain the higher rates. Instead, they identified a menu of programs and interventions that had worked in other communities and had scientific evidence to prove it. Those ranged from hot-spot policing and Neighborhood Watch to youth mentoring and vocational education. But an effective suite of strategies will need something extra: strong community support, at all levels.

The researchers made just one recommendation, for the Walton Family Foundation and anyone else interested in taking on crime and violence: Form a local coalition or steering committee that can mobilize the community itself for the long, hard work of change. Their report provides a starting point, an assessment of the problem and some proven ideas for how to improve life in the home of the blues.

For a Better Delta

The Mississippi Delta was the birthplace of the blues. Today, it is one of the poorest regions in America, plagued with low-performing schools, struggling government, and a homicide rate that rivals that of St. Louis or Baltimore.

The nonprofit Walton Family Foundation asked RAND to study how it could help reduce crime and violence in the Delta. Researchers interviewed dozens of community residents, government leaders, and social service providers, as well as outside philanthropic organizations with experience working in criminal justice, to map out what change might look like.

The Delta straddles southeastern Arkansas and northwestern Mississippi, a few hundred miles upriver from the actual Mississippi River delta. It’s a region rich in culture and history, but desperately poor by most other measures. Residents there described fractured communities, with few opportunities for young people, little support for families, and a widespread belief that government and law enforcement had simply failed.

The researchers did not try to come up with a silver-bullet solution. Instead, they identified a menu of programs and interventions that had worked in other communities and had scientific evidence to prove it. Those ranged from hot-spot policing and Neighborhood Watch to youth mentoring and vocational education. But an effective suite of strategies will need something extra: strong community support, at all levels.

The researchers made just one recommendation, for the Walton Family Foundation and anyone else interested in taking on crime and violence: Form a local coalition or steering committee that can mobilize the community itself for the long, hard work of change. Their report provides a starting point, an assessment of the problem and some proven ideas for how to improve life in the home of the blues.
The Q & A

What made you decide to focus on health policy?
Before I went to the Pardee RAND Graduate School, I had trained as an engineer, worked as a scientist, and studied public health. But my work has always focused on health. I think the common thread is trying to improve health and health care for different groups, as well as a focus on doing rigorous research and using data to solve problems related to health.

What do you see as the biggest challenge facing American health care?
That’s a hard question because there are so many challenges. A lot of my work has focused on health care costs, and rising health care costs will continue to be a problem. I think another big concern over time will be long-term care costs and making sure that people can get the care they need.

That leads into your recent Alzheimer’s study. What did you find?
There’s no cure for Alzheimer’s today, but there are many therapies in development and some optimism that we might someday be able to delay or halt the disease’s progression. Our project was really trying to think ahead: When a therapy is available, will the health care system be ready to deliver it? We looked at supply and demand, because most therapies in development target early stages of the disease, which implies a large patient population. We found there would be an urgent need for more specialists to screen and diagnose patients as a first step to identifying who would benefit from the therapy. We’d also need better screening tests. It’s really a call to action, demonstrating that this is a potential problem. We need to start thinking about what policies and planning are needed.

You’ve gotten some additional funding to continue this work. What are you working on now?
We’re doing the same kind of infrastructure analysis for other countries. We’re looking at some European countries and Canada. All of the countries have an aging population, and they could face similar infrastructure challenges in delivering a therapy like this.

Let’s talk about single-payer health plans. What did you find in your study of the New York proposal?
So, the New York Health Act would provide all state residents with comprehensive health care coverage. People would pay for the plan through taxes instead of premiums and out-of-pocket payments. This kind of analysis requires a lot of different assumptions, and there are many different factors that people disagree about. But we estimated that total health care spending in the state could potentially be about the same or slightly lower over time. The state would need to raise $139 billion in new tax revenue, but those tax payments would replace people’s premiums and the majority of their out-of-pocket payments. This is spending that’s already occurring, but the plan would shift the types of payments people make.

Would ordinary residents pay more or less under the plan?
The bill specifies two new taxes that would scale with income,
If an Alzheimer’s therapy becomes available, will the health care system be ready to deliver it?

but it doesn’t say what the rates would be. So we estimated a few different tax schedules. We found that the majority of households could pay less, but the highest-income households would be paying much more. That has really important implications, because people could change their investment decisions or even move out of state to avoid those taxes. If even a small fraction of the wealthiest people move, that really changes the funding picture.

This issue of single-payer health care has gotten a lot of coverage recently. What’s missing from the public discussion?

People have a very strong reaction when you talk about single payer, often an emotional reaction, on both sides. I think it’s important to understand that this is a financing issue at its core. Part of the challenge is understanding how the current financing system distributes health care costs, and then deciding what you think about changing to a single-payer system that redistributes the costs differently. It’s important that a place like RAND is doing this kind of work, to look at the issue in its entirety and not just show one side, to help both sides have a real discussion about the pros and cons. One of the news stories about our study that I really liked said RAND was giving fuel to both sides, because there are always trade-offs to consider with this kind of far-reaching policy change.
Women are underrepresented among the Air Force’s senior leadership, which could be robbing the service of the potential to improve innovation, agility, and performance.

Air Force Chief of Staff Gen. David Goldfein has recognized the value of diversity, stating that “recruiting and retaining diverse airmen cultivates innovation. Like different aircraft and missions make up one Air Tasking Order, different people make the best teams when integrated purposefully together.” The Air Force has worked to address diversity in the service through a series of diversity and inclusion initiatives, and it continues to work to improve demographic representation within its ranks, including the representation of women.

One factor contributing to this underrepresentation is that women tend to leave the active-duty Air Force at higher rates than men. RAND undertook research to better understand the factors that female Air Force officers consider when deciding whether to remain in the active-duty Air Force. The project team conducted focus groups with female officers in mid-2016 from multiple installations.

In the Air Force, female officers currently make up 21.1 percent of officers in pay grades 0–1 (second lieutenant) through 0–5 (lieutenant colonel), but only 13.9 percent of officers at the 0–6 level, and only 7.5 percent of officers at brigadier general (0–7) or higher. In addition to promotion-related differences, research finds that persistent differences in retention are important drivers of the differences in career progression for men and women in the Air Force and military services more broadly.

Most Air Force officer occupations require a four-year active-duty service commitment. Pilots make a 10-year active-duty service commitment, and both combat system officers and air battle managers make a six-year commitment. As expected, officers in aeronautically rated occupations have higher cumulative continuation rates in general because they tend to have a longer initial service commitment. However, female officers tend to have lower overall continuation rates than male officers in both aeronautically rated and nonrated occupations.

For example, the majority of male nonrated officers (55 percent) are retained through 10 years, while the cumulative continuation rate for female nonrated officers at that point is only 48 percent.
37 percent. The gender differences among rated officers are even larger than among nonrated officers. Through 13 years (at which point initial service commitments would have been complete), 63 percent of male rated officers remain, on average, compared with 39 percent of female rated officers. Thus, understanding the reasons for these differences in retention rates is important for improving overall female representation within the Air Force, including among senior leaders.

In our study, the female Air Force officer focus groups discussed children or the desire to have a family as major factors influencing decisions to remain in or leave the service, noting the difficulty of frequent moves, deployments, and demanding work schedules. Most groups also discussed issues with child care facilities on military installations, difficulty in timing pregnancies to fit within rigid career time lines, and difficulties in finding accommodations for pumping breast milk following maternity leave. (Nearly half the groups discussed issues related to breastfeeding.)

Female officers said a new maternity leave policy that extends leave to up to 12 weeks is a step in the right direction. Still, some participants expressed concern that taking longer maternity leave could negatively impact their careers. In addition to this change in maternity leave policy, some female officers raised the issue of extending paternity leave and adoption leave, saying such a change could reduce the stigma associated with only female officers taking maternity leave.

Female officers also indicated that frequent moves and deployments were challenging for their civilian spouses. They noted that civilian male spouses often faced a lack of support from Air Force spouse groups and programs. For couples in which both spouses are in the military, separation due to incompatible assignments and back-to-back deployments were described as difficult to endure.

More than half of the groups raised the issue of inflexible career paths as a reason for female Air Force officers to leave the service. The groups described the Air Force career pyramid as a rigid path that allows for very little deviation and few alternatives. They perceived this strict career path to often be incompatible with family and personal lives.

When asked about the importance of leadership on their retention decisions, they discussed the difference that a supportive leader can have compared with a toxic one on job satisfaction, motivation, and desire to remain. Most groups also discussed the importance of having female role models in senior leadership positions, noting they rarely see female leaders who are married with children.

When asked how, if at all, gender composition across career fields influenced retention decisions, female officers had mixed responses. Many in male-dominated career fields reported often facing sexism and the existence of an “old boys’ network.” Some also associated male-dominated career fields with experiences of sexual harassment and assault. A few also cited cases in which either they or people they knew had left specifically because of a sexual assault.

Over half of the groups mentioned other retention factors including a number of Air Force benefits that were important in deciding to remain in the service, like health care, education, and retirement benefits.

By drawing upon and integrating this focus group feedback, the RAND team was able to offer specific recommendations to promote female representation among officers. These recommendations fell into three broad categories of action: dissemination of additional information or education, enhancements to existing programs or policies, and broader structural changes to the personnel system.

The combination of senior leader involvement, internal focus, and analytically based recommendations has enabled progress within the Air Force. The service recently modified or established policies designed to address some of the retention issues noted above.

The updated maternity leave policy extends maternity leave and defers fitness tests and deployments for one year after the birth of a child. The Career Intermission Program allows for inactivation and transfer to the Individual Ready Reserve with partial pay for up to three years before returning to active duty.

New service initiatives include working to avoid involuntary assignments that separate dual-military couples and working to provide new parents in the Air Force with additional support and guidance by pairing them with other airmen who have been able to balance work and family.

Continued pursuit of these and related initiatives, such as expanded subsidized child care, increased maternity leave, and designated nursing facilities, should allow the Air Force to take better advantage of the many benefits of a more diverse workforce. ♦
Jordanna Mallach came home from Afghanistan with a rasping cough that she could not explain. She called it her Army asthma. She had chalked it up to the strain of the deployment when it first started, when she would wake up gasping for breath as if something was squeezing the air from her lungs. But it didn’t end with the deployment. Her civilian doctors were just as puzzled and powerless as she was. “They just didn’t know what questions to ask,” she says now.

Her experience underscores what RAND researchers found when they surveyed hundreds of private-sector health care providers. Most lacked the specialized knowledge and training to treat veterans like Mallach. Few even asked their patients whether they had ever served in the military.

That raises a fundamental question as the U.S. Department of Veterans Affairs shifts billions of dollars for veteran care to outside providers: Are those providers even ready?
Access is an issue, but so is quality

Mallach faced a problem familiar to many veterans when she came home from her 2010 deployment with the Army National Guard struggling to catch her breath. Nearly one-third of all U.S. veterans live 40 miles or more from the nearest VA medical center; in her case, living in rural upstate New York, it was more like 100. When her breathing problems got bad, she opted for the nearest urgent care clinic instead.

In recent years, the VA has tried to make it easier for veterans like her to get health care from private-sector providers closer to home. It plans to spend more than $14 billion on such outside care in the coming year alone. “We are committed to moving care into the community where it makes sense for the veteran,” then-Secretary of Veterans Affairs David Shulkin promised last year.

Yet nobody had taken a close look at whether those outside providers were fully prepared to treat veterans, a small but medically complex population with higher rates of post-traumatic stress, toxic exposures, cancer, and diabetes. With more veterans preferring to seek care in the community, the nonprofit New York State Health Foundation decided that question needed some answers. It brought in RAND to investigate.

Researchers surveyed more than 700 private health care providers across the state, from New York City to the small farming towns of western New York. They were
Fewer than half screened their patients for conditions common among veterans, like sleep problems or suicide risk.

Most were unfamiliar with deployment-related health stressors (63 percent), unprepared to address the unique health needs of women veterans (78 percent), and unsure how to refer a patient to the VA (73 percent). Fewer than one in five even asked their patients if they had ever served.

In all, the researchers estimated that just 2 percent met every standard to ensure timely, high-quality care for veterans.

Knowing what to look for

“There’s this belief sometimes that the private sector has all the solutions and that by providing veterans with more choice and greater access to community-based providers, somehow their needs will be met,” said Terri Tanielian, a senior behavioral scientist at RAND who led the study and has focused for more than a decade on how to improve veteran care. But, she added, “You can’t make a diagnosis if you don’t ask the questions.”

Mallach’s doctors were asking the questions, but they missed the clue. They knew she had just come home from Afghanistan; they thought she might have developed a blood clot in her lungs during the long flight home. It was a pulmonologist at the VA who took one look at her file and asked, “Were you near the burn pit on your base?”

The burn pit. She had jogged past the noxious tower of burned plastic and smoldering garbage almost every day during her morning laps around the base. Service members exposed to burn pits on overseas bases have sometimes complained of asthma-like symptoms and other breathing problems. The VA doctor gave Mallach a steroid inhaler. She was breathing freely within a few days.

“The civilian doctors were trying to treat something they just didn’t know about,” Mallach says now. “They were running a whole series of tests based on me having a blood clot. I just don’t think they had the awareness. None of the civilian doctors recognized it for what it was.”

What we’ve learned from New York State

RAND’s study looked only at New York providers. But there’s no reason to think its conclusions would be much different in other states. New York has the fifth-largest population of veterans in the country, so if anything, its providers might be more familiar with veteran health needs than providers elsewhere.

The VA has some leverage to make improvements. It could require more training and testing on veteran care before it signs any community care contract with a private-sector provider, researchers wrote. It also could better monitor the providers it works with, to make sure they meet the same standards it sets for itself. The state, too, could drive home the importance of veteran care by adding questions about screening and treating veterans to its licensing exam.

It will take “significant efforts” to better prepare private-sector providers to deliver high-quality, culturally competent care to veterans, RAND’s study concluded.

“The military goes to war, but I don’t feel like we’ve gone to war as a country, where everyone feels like we all need to serve in some capacity,” said Derek Coy, a former Marine who served in Iraq and is now the veterans’ health officer for the New York State Health Foundation. “I think more people would get on board if we put it out there like that. They’d see serving veterans as serving their country, as a form of service, which benefits everyone.”

Previous RAND research has shown that around half of all New York veterans would choose to get care from community providers if they could. That adds up to potentially hundreds of thousands of patients in need of high-quality, specialized care, in one state alone.

Jordanna Mallach is one of them. She still sees her pulmonologist at the VA twice a year, just for checkups; but she stays closer to home for most other health needs. When a dump truck slammed into the back of her car a few years ago, her community doctors and therapists had all the training they needed to get her back on her feet.

Ready or Not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans is available for free download at www.rand.org/t/RR2298.
As the number of criteria for readiness increases, the percentage of ready providers plummets.

- **92%** Accepting new patients
- **59%** Prepared to treat conditions common among veterans | Accepting new patients
- **42%** Uses clinical practice guidelines | Prepared to treat conditions common among veterans | Accepting new patients
- **25%** Screens for conditions common among veterans | Uses clinical practice guidelines | Prepared to treat conditions common among veterans | Accepting new patients
- **17%** Accommodates patients with disabilities | Screens for conditions common among veterans | Uses clinical practice guidelines | Prepared to treat conditions common among veterans | Accepting new patients
- **5%** Familiar with military culture | Accommodates patients with disabilities | Screens for conditions common among veterans | Uses clinical practice guidelines | Prepared to treat conditions common among veterans | Accepting new patients
- **2%** Screens patients for military/veteran affiliation | Familiar with military culture | Accommodates patients with disabilities | Screens for conditions common among veterans | Uses clinical practice guidelines | Prepared to treat conditions common among veterans | Accepting new patients
Private Life

Soldiers Telling It Like It Is

By Doug Irving, Staff Writer

Tens of thousands of young men and women serve in the junior ranks of the U.S. Army. Their stories almost never get told. History records the names of generals, not of the privates filling out supply forms, cleaning out trucks, or huffing through another training exercise.

But those privates keep the Army running, and so their stories matter, especially as the Army looks to the future after 17 years of war. RAND researchers traveled to bases around the country and interviewed dozens of privates to find out who they are, why they joined, what they think about the Army, and how they see their futures.

The results provide a unique glimpse—for officers, Pentagon planners, and the outside world in general—at what it really means to serve in the junior ranks of the U.S. Army.
Army specialists, like this mechanic with the 346th Military Police Company (Combat Support), were included in RAND’s survey if they had recently been promoted from private.
Honor in the everyday

“This is not a set of experiences that you hear about all the time,” said Rebecca Zimmerman, a policy researcher at RAND who has spent two years deployed with the military in Afghanistan as a civilian analyst. She coauthored the new report, Life as a Private.

“I dislike the fact that in society today we over-value our veterans,” she added. “Not every soldier is a hero. But there is this honor in the everyday tasks of what the enlisted force does to keep the military moving, to keep it grounded and motivated and ready to do the incredible things that it might have to do. There is this dignity and honor in the enlisted profession that is hard to understand as an outsider.”

The researchers interviewed 81 first-term soldiers. Most were between 19 and 21 years old; 11 were women; and many had never lived away from home before. They could not speak for the Army as a whole, or even for their own units or specialties. What they could provide, with their identities protected, was their own unfettered take on life in the ranks.

They had joined for adventure, benefits, and a sense of duty, in that order. Nearly two-thirds said a family member influenced their decision to join—a mother or father, an uncle who had fought in Vietnam, a two-year-old son. Most saw the Army as their best chance to make a decent living, but a few had left jobs and taken pay cuts to join. They wanted to get out in the field, go on missions, jump out of airplanes—anything but sit around and shuffle papers.

The reality? Sometimes, they were sitting around and shuffling papers. Those in support roles, especially, like mechanics and supply clerks, complained of endless bureaucracy and forms to fill out. Medics and infantry soldiers, meanwhile, grumbled about excessive downtime and busy work that didn’t seem to have anything to do with their jobs—what one soldier described as “sweeping wet grass.”

“A few said they were frustrated at the lack of deployments. On the other hand, one soldier somehow thought the whole experience “was going to be more laid back, honestly.”

“[The recruiters] show you this awesome video with Bradleys shooting stuff and motorcycles and all this cool stuff and we don’t actually do any of that stuff.”

—ARMOR SOLDIER

Many missed family and friends back home. Some missed the personal time and independence they had before the Army. The work could be physically demanding, and a few of the soldiers were nursing injuries. But they liked the camaraderie with their fellow soldiers; most said that was the best part of life in their unit. They considered their leaders their most important source of support. One applauded the “really good” food. A solid majority said they felt financially secure, no small finding given that most had little or no college education or work experience. Almost all said they still thought the Army was their best option, and more than half said they planned to reenlist.

“I think you need to know what this generation is,” Army Secretary Mark Esper told the Army Times for a story about the RAND findings. “What motivates, what drives them to serve.”

That’s important for a few reasons. For one thing, the life of an Army private is one that very few Americans

“So many forms and paperwork and stuff that we have to learn. It’s a lot different from what they told me. It’s actually hard. It’s a lot of work.”

—SUPPLY SOLDIER

“Hell yeah... The more and more I stay in this job, the more and more I feel like I was built for this, I can do this. I mean, it’s just a state of mind, you have to have the right mind-set.”

—ARTILLERY SOLDIER
know. By some estimates, only around 7 percent of the population has ever served in any branch of the military. A 2015 poll of young adults underscored that divide: 60 percent supported sending ground troops to fight the Islamic State; but when asked if they would go, 85 percent said either probably not or definitely not.

“My platoon, my section—we pick these guys up, even though you may be having a bad day. We’re going to take care of you, we’re going to get this done.”

—SOLDIER

The RAND report also could help the Army strengthen its recruiting efforts, especially as it shifts from a constant war footing and spends more time in garrison. The Army could highlight family ties and the bonds among soldiers, the researchers wrote—but should avoid setting unrealistic expectations. Potential recruits could use the report to get a better sense of what they’re signing up for. Officers could use it to make sure the experience is all that it can be—maybe with a little less sweeping of wet grass.

“The Army inducts thousands of these young kids into the ranks,” said the report’s lead author, senior behavioral scientist Todd Helmus. “It’s really critical that the Army knows what the experiences of these young kids are.”

The researchers are now compiling six of the interviews into a book of oral histories. When it comes out early next year, it will provide one of the few accounts of the Army experience—the real Army experience—in the words of the privates who live it.
Early intervention is the key.

Because no drug has thus far been shown to reverse established Alzheimer’s dementia, halting progression in early stages of the disease is the most likely pathway for treatment. There is hope that one or more drug therapies, including infused drugs, may become available by 2020. At that point, a complex patient journey will start—sending those over the age of 55 on a four-part path, involving various specialists with multiple appointments at different facilities, to

1. **screen** for mild cognitive impairment (MCI).
2. **evaluate** for potential Alzheimer’s disease.
3. **test** for signs of brain pathology.
4. **treat** with intravenous (IV) infusion therapy.

Ideally, this process would happen as quickly as possible to prevent progression, but is the U.S. health care system ready? Projections based on a simulation model developed by RAND researchers suggest otherwise.

### Millions of patients would need to be seen.

Of the 88.4 million people 55 years and older who are eligible

- **70.7 MILLION** would get screened in a doctor’s office
  - Of the 14.9 million who screen positive for MCI
    - **7.5 MILLION** would see a dementia specialist for evaluation
    - **6.7 MILLION** would get amyloid biomarker testing
      - 3.0 MILLION might test positive for amyloid deposits and return to the specialist to learn about treatment
      - **2.4 MILLION** would receive treatment at infusion centers
        - 14 IV treatments in one year

RAND.ORG | NOVEMBER–DECEMBER 2018
Wait times might be extensive.

Patients could face more than a 14-month wait for their first appointment with a specialist. At the peak of demand, waits for amyloid testing could exceed 11 months.

By 2020, 33 million infusions might be needed. It could take more than a dozen years to clear the backlog of cases.

Delays in access to care could result in people getting sicker.

FAILURE TO INCREASE CAPACITY MEANS THAT AS MANY AS 2.1 million patients might develop Alzheimer’s dementia while waiting for evaluation and treatment between 2020 and 2040.

But with increased capacity, millions could be helped.

WITH ENOUGH CAPACITY FOR TESTING AND TREATMENT an additional 800,000 people would not develop Alzheimer’s dementia.

AND WITH ENOUGH CAPACITY FOR ALL ASPECTS OF CARE (DIAGNOSIS, TESTING, AND TREATMENT) an additional 2.1 million people might not develop Alzheimer’s dementia.

Action is needed to reduce capacity constraints.

Train more providers in dementia care and develop tools to make them more efficient.

Expand the range of diagnostic options.

Utilize all options for infusion therapy, including the home setting.

Ensure appropriate coverage of services and tests.

Brandon Baker remembers waiting at a college luncheon, nervous—terrified, really—to meet the man who had paid his way through school. That moment has always stuck with him: the gratitude he felt, the butterflies in his stomach, the awe of putting a face to philanthropy.
The experience gave him a keen appreciation for the human side of philanthropy—philanthropy as a relationship, not a transaction. It’s a lesson he brings to RAND as the new vice president of development.

“We get to provide an experience to our donors,” he said. “That’s what they’re supporting, the fact that they’re making a gift so they can feel an impact. We get to provide that impact to them, to society, to the world—but it really comes back to making sure they’re excited about it.”

Baker is 34 years old and estimates that he has personally raised more than $100 million over the course of his career as a fundraiser and strategist. He’s worked the phones for $250 gifts; at his last stop, at UCLA, he led a campaign to raise $250 million.

He grew up in small-town Alabama; his parents owned the local farm supply store. He earned a leadership scholarship to Martin Methodist College in Tennessee and thought he’d become a dentist. Then he met the donor who had paid for his scholarship.

“That one moment of getting to meet someone who selflessly gave so that someone like me could have that opportunity—that changed my life,” he said. “It really put me on a path where I wanted to make sure I was always providing opportunities for people to succeed. I tell donors that I am where I am today because of someone like them.”

He worked his way up from a fundraising internship at Columbia, to a front-line job at UCLA, to building up a West Coast office for Villanova University, and then back to UCLA as assistant dean of external affairs for the engineering school. He started at RAND in August.

In his newly created position, Baker will lead philanthropic efforts and strategy at RAND and work with the Pardee RAND Graduate School. He sees it as a way to give back.

“I kind of felt proud that they called me,” he said. “I was their go-to in the moment, and I came through. Did it have an impact on their giving? It might have. But it was a way to show that we care about more than just their giving. We care about them as people.”

It’s that same lesson he learned as an awestruck college student: It’s all about the relationship. People give so that they can be a part of something—whether that means helping a researcher try to solve world problems, or just seeing a small-town kid from Alabama graduate from college.
Dr. Vivek H. Murthy, 19th Surgeon General of the United States, has been elected to the RAND Corporation Board of Trustees.

During Dr. Murthy’s term (December 2014—April 2017) as surgeon general, he published the first Surgeon General’s Report on Alcohol, Drugs, and Health, which placed drug and alcohol addiction alongside smoking, AIDS, and other public health crises of the past 50 years. It presented a vision for a comprehensive, effective, and humane public health approach to addressing addiction. As the Vice Admiral of the U.S. Public Health Service Commissioned Corps, Dr. Murthy also oversaw a uniformed service of 6,700 public health officers, serving the most vulnerable populations domestically and abroad.

Dr. Murthy has consistently emphasized the importance of prevention in addressing the nation’s most serious public health problems.

“I am pleased to welcome Dr. Murthy to the Board of Trustees, especially given our substantial and growing research portfolio on issues such as the opioid crisis and on social and economic policies,” said Michael D. Rich, RAND’s president and CEO. “His expertise communicating the implications and significance of research findings to the public will be of great benefit to RAND.”

Dr. Murthy’s commitment to medicine and health began early in life. The son of immigrants from India, he discovered the art of healing in his father’s medical clinic in Miami. A believer in the power of community, he and his sister cofounded VISIONS, a peer-to-peer HIV/AIDS education program in India, and Swasthya (“health and well-being” in Sanskrit), a community health partnership that trained women to defy the odds in their patriarchal villages and become health care providers and educators.

As a health care entrepreneur, Dr. Murthy cofounded TrialNetworks, a technology company that improves research collaboration in clinical trials around the world. He also cofounded Doctors for America, a nonprofit organization with more than 16,000 physician and medical student members from all 50 states dedicated to creating a high-quality, affordable health care system.

Dr. Murthy received his bachelor’s degree from Harvard and his M.D. and M.B.A. degrees from Yale. He completed his internal medicine residency at Brigham and Women’s Hospital in Boston and later joined Harvard Medical School as faculty in internal medicine. His research focused on vaccine development and later on the participation of women and minorities in clinical trials.
If you haven’t seen the Angel City Chorale, featuring two RAND singers, perform on America’s Got Talent, you should. Right now. We’ll wait. (It’s on YouTube.)

The 160-member choir made it to the show’s semifinals with an inventive and inspiring playlist, a message of diversity and inclusion, and some serious pipes. Judge Simon Cowell—Simon Cowell!—called it “probably one of the best choirs we’ve ever had on this show.”

RAND’s vice president for human resources, Allison Elder, performs with the choir as an alto. Jennifer Prim, an executive assistant in the Pardee RAND Graduate School, performs as a soprano and occasional soloist. A third RAND employee, adjunct mathematician Emmett Keeler, is also a choir regular but couldn’t make the show performances.

The choir, founded 25 years ago to showcase the talent and diversity of Los Angeles, made it onto the show with one of its signature songs: a cover of Toto’s “Africa,” with the singers snapping their fingers and patting their knees to mimic a rainstorm.

They earned a standing ovation and a “golden buzzer” from the judges for their rendition of a song in Swahili, “Baba Yetu.” They moved into the semifinals with the anthem, “This Is Me.” And then, on Sept. 11, they performed “The Rising,” by Bruce Springsteen, holding flashlights in the darkened auditorium.

That’s where the journey ended—but no regrets.

“It was just a really fun and joyful experience,” Elder said. “When we’re performing regularly, we’re not looking at (supermodel and show judge) Heidi Klum and Simon Cowell. We just felt such joy in creating something with all kinds of people coming together.”
The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.