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THE OBJECTIVE MEDICAL GROUP NEXT GEN:

OUTDATED OR AN OVERHAUL?

by

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Biography

Lt Col Wade Adair was commissioned in the US Air Force in 1998 as a Medical Service Corps officer after graduating from the US Air Force Academy with a Bachelor's Degree in Management. He is a board-certified healthcare executive and possesses a Master's Degree in Healthcare Administration from the Medical University of South Carolina. He began his career as a Medical Logistics intern at the 88th Medical Group at Wright-Patterson AFB, OH. He served as a flight commander in Medical Logistics at the 437th Medical Group at Charleston AFB, SC, and in Business Operations and Beneficiary Support at the 314th Medical Group at Little Rock AFB, AR. Following flight command, he completed a Resource Management fellowship and served on the major command staff in the HQ Air Education and Training Command Surgeon's Resource Management Branch. From there, he was the Chief, of Business Operations followed by the wing Director of Staff for the 59th Medical Wing at Lackland AFB, TX. Next he took command of the 52d Medical Support Squadron at Spangdahlem AFB, GE, where he also served as the deputy group commander. After his command tour, he completed an assignment on the HQ Air Force staff for the Air Force Surgeon General in the Air Force Medical Service Comptroller's office as the Chief of the Financial Management Division. Lt Col Wade Adair is currently a student assigned to the Air War College, Air University, Maxwell AFB, AL.

Abstract

This paper presents a call to change to reduce unnecessary leadership overhead in small Air Force Medical Service (AFMS) Medical Treatment Facilities (MTFs). AFMS MTFs can be more efficient and effective especially by reducing overhead. This is not a call to change based on a crisis, ground breaking game changing innovation, or zero day type vulnerability in medicine. This is a call to modernize the Objective Medical Group (OMG) structure. Organizational inefficiency with our current MTF leadership structure must be modernized and streamlined. An extensive review of the OMG history and leadership structures in the VA, Army, Navy, and large civilian healthcare networks was conducted to evaluate peer and best-in-industry practices. Similar to the AF, the Army, Navy, and VA has experienced little change at the organizational structure level. This paper also evaluates whether the limited changed is for sound leadership and management reasons or is simply from lack of organizational effort.

While there were a few new trends noted from the review, the current AFMS MDG dual-professional leadership structure with group commanders, functional leaders, and squadron commanders remains relevant and optimized through the ages and ready for the future. There is no model in the civilian sector currently that would warrant significant changes to the current AFMS structure. Under the proposed OMG Next Gen construct, this paper proposes downsizing 5 MDGs below 150 total manpower authorizations to O-6-commanded medical squadrons as pilot units for one year. If successful, the remaining 9 MDGs below 200 authorizations plus the initial 5 MDGs should be programmed in the POM at the next available POM onramp. From the expansive review, a few more proposals to streamline MDGs at the leadership level are suggested including a recommendation to create a Patient Experience Officer Education with

Industry slot for the next year. An overhaul is not warranted nor indicated. This OMG Next Gen structure has the AFMS ready for the foreseeable future.

"It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medication somehow think that we can afford to pay for doctors, hospitals, medication and a government bureaucracy to administer it."[1] – Thomas Sowell

Introduction

Since 1993 the Air Force Medical Service's (AFMS) Military Treatment Facility (MTF) core organizational structure at the medical group (MDG) and medical squadron level has remained largely unchanged.[2] For the purpose of this paper and its audience, MTF and MDG are interchangeable. All MDGs are MTFs, but not all MTFs are MDGs because they can be smaller than a group. In 1993, the Chief of Staff of the Air Force (CSAF) directed the AF Surgeon General to reorganize into medical groups and medical squadrons to match and align with the US AF's new Objective Wing model.[3] Prior to this reorganization, MTFs were structured in a functional manner similar to a civilian hospital except with a medical group commander added to operate in the Chief Executive Officer role with G-series orders for command responsibilities. Medical squadron commanders and group superintendents did not exist.[4] The functional leadership structure was also outlined and prescribed by the civilian healthcare organization that provided accreditation of hospitals and ambulatory care for the entire Military Health System and the civilian sector.[5] This prescribed organization included positions on the MTF's executive staff to provide oversight of key healthcare processes and functions, and also the services lines and personnel in clinical and administrative departments.

The OMG was the newly-minted moniker given to the AFMS' effort to match the Objective Wing. The OMG was implemented AFMS wide at every MTF no matter the size and scope of the facility.[6] The organizational changes were implemented to project and present

forces while aligning with the AF readiness mission and requirements. By way of context, these changes were as a result of lessons learned from the Gulf War in the early 1990s with regard to pre-deployment posture of Airmen and structure of expeditionary medical units in theater during the war.[7]

Under the OMG, squadron commanders and senior enlisted positions like group superintendents were added to each MDG. In smaller MTFs, functional leaders became dual-hatted as squadron commanders. In larger MTFs, these positions remained separate in order to ensure healthcare accreditation compliance and the dual-professional nature of command and medicine was adequately led and executed. Once this dual-profession leadership structure was implemented it has remained intact over the last 24 years. There have been iterative changes since 1993 where a few squadrons merged with others. Some small medical groups have become medical squadrons and Limited Scope MTFs, but those changes have been few. Some of these mergers and reductions have also been undone since then for various reasons like mission changes or higher headquarters direction. In the last two decades, the AFMS has additionally downsized many MTFs converting hospitals into clinics and large hospitals into smaller hospitals to adjust to industry trends and lack of workload.

This paper outlines the history of the OMG and proposes changes to the group and squadron leadership model the AFMS must undertake to align MDG size with a more reasonable leadership scope expectation. The AFMS is simply not optimized with the number and size of squadrons and groups based on their patient population. There are too many squadrons and groups, and there is a more efficient way to deliver the same level of medical readiness capability and medical and dental care without unnecessary overhead. The positions gained can be reinvested in clinical areas, used for other leadership positions to grow mid-level leaders in

the resulting larger squadrons generated by this new model, or added to the AFMS POM manpower pool for other higher priority AF/SG requirements. These changes must be pilot tested on a small scale first then programmed for all identified MTFs after successful testing.

Thesis

The AFMS has undergone MTF level reorganization efforts since its inception. Most of these reorganizations however, have been focused on the flights or product lines within the MDGs based on a new manpower model, downsizing in MTF services due to innovation in the way healthcare is delivered (i.e., industry advances resulting in shorter stays in the hospital or shifts to same day/outpatient surgery), or downsizing due to lack of workload or decreases in patient enrollment to the MTF. Very few reorganizations have occurred at the leadership level in MDGs or medical squadrons. Not since the implementation of the OMG has there been any significant effort to evaluate and change the integrated medical dual-professional and squadron and group command structure. While continuity and stability are successful organizational attributes, the scope and size of medical squadrons have changed over the years to reflect changes in mission or the other aforementioned reasons.

The scope, breadth, and depth of the MDGs has evolved over the years to industry, beneficiary enrollment, and patient demand changes yet the command structure of MDGs and their corresponding medical squadrons has largely remain unchanged. The span of control of MDG commanders and medical squadron commanders across each installation is inconsistent and varies wildly because of this from group to group. Is the dual-professional model with commanders and medical functional leaders still valid? Is this the best structure for commanders to manage and lead Airmen today and into the future? Is the wide variance in size and scope of the medical squadron and MDG cohort still the best way for the AFMS to perform its readiness

mission and deliver peacetime healthcare to DoD beneficiaries? This paper outlines support for the first two questions and suggests change for the last. Implementing change in smaller MTFs will also integrate and align with recent Congressional changes as part of the National Defense and Authorization Act (NDAA) of 2017.[8]

OMG Background

Since inception, AF MTFs have been organized in two basic structures: the current structure called the OMG and the structure prior to its implementation in 1993 more in line with civilian hospitals.[9] Similarly, the AFMS has a unique role of being a dual-profession similar to that of the Judge Advocate General along with the added command structure. This dual-professional role exists as being in both the profession of arms and the profession of healthcare. In some ways they are congruent and parallel and in others there are differences. Healthcare functional leadership is separate and different from the squadron and group command role. The AF contingency readiness mission is unique and not a function in existence in civilian healthcare or any other civilian entity. This unique difference of providing medical readiness (deployable casualty care and home-station disaster response capability) to the installation's Airmen at home and down-range creates additional overhead requirements for the MDG leadership structure as compared to a civilian hospital. Not just the command structure, but all of the necessary administrative personnel to ensure Airmen are trained and medically ready to deploy comes with an added unnegotiable cost. At the top, the command leadership structure is imperative to any military organization and equally important for an AF MTF to stay aligned with the core AF organizational construct and overall AF mission.

Prior to 1993, the previous MTF organizational model closely resembled a civilian hospital.[10] The leadership structure and functional areas within the MTF were organized almost

identical to civilian hospitals. Product lines in a civilian hospital mapped to the department names in AF hospitals. Departments were named the same as if they were a civilian hospital. The senior leadership team in the MDG, referred to as the Executive Staff (MDG/CC, Administrator (SGA), Chief Nurse (SGN), Chief of the Medical Staff (SGH), and Chief of Dental Services (SGD)), had the same position titles as a civilian hospital. The only difference being the MDG/CC was called a CEO or President in a civilian hospital. There would be modifications later to the Executive Staff, but this was the core leadership team at every AF MTF. MDG Superintendents were added as part of the OMG implementation and a Senior Biomedical Sciences Corps (SGB) functional was also added during this period.[11]

Because the delivery of healthcare to an individual patient; the actual exam, surgery, or inpatient stay is similar between military and civilian healthcare it was only logical to be structured similarly. Additionally, the only accrediting healthcare agency at that time inspected both civilian and military facilities. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), now just The Joint Commission (TJC), provided a very prescriptive inspection and standards for MTFs to uphold.[12] Within the standards of TJC, they prescribed the functions of the clinical, business, and administrative departments of the hospital, and the titles of the positions and committees providing oversight and management to these functions.[13] As this was the Military Health System (MHS) wide inspecting body for MTFs, it was only natural for MTFs to follow the guidance from the JCAHO. As the JCAHO rebranded and evolved to TJC, they evolved to an outcomes based inspection system similar to the AF writ large moving from the old standards based Unit Compliance Inspection to the new AF Inspection System. Even though TJC changed its inspection approach, they did not change the composition and

names of its leadership structure for healthcare facilities. The healthcare functional leadership structure and naming convention has remained unchanged from the early days.

The Objective Wing provided change to the AF at each installation. The Objective Wing was implemented beginning in 1991 as directed by CSAF Gen McPeak.[14] Gen McPeak's Objective Wing added Groups for operations, maintenance, and support to simplify the chain of command, provide direct lines of authority on installations, and decentralize leadership from staff agencies to wings.[15] Gen McPeak also directed the AFMS to evaluate this concept and in 1994 the AFMS implemented the OMG after a yearlong pilot study at five MTFs.[16] The OMG left the medical functional positions intact and added squadron commanders. In smaller squadrons, these positions were dual-hatted where the Medical Operations Squadron Commander would also be the SGN and the Medical Support Squadron Commander would also be the SGA. In larger MTFs, these positions became separate authorizations. The OMG also changed departments into flights and elevated leadership roles for enlisted within squadrons and groups. The role of squadron and group Superintendents were added. Newly-created flights now reported to the squadron commanders and the functional representatives like the SGH became advisors only but retained medical oversight and responsibility for the compliance of their specific medical and business related functions.

Other changes in the OMG have occurred since 1994, but these changes have largely happened for Force Development purposes. For a time, Group Command positions were designated by Corps to ensure each Corps had enough senior leaders to ensure competitiveness for General Officer positions. Additionally, for the non-Department of Personnel Management Act (DOPMA) Corps which are not constrained for the number of O-6 positions in the AFMS, there has typically been a higher number of O-6 squadron command positions under the OMG.[17]

Lastly, other OMG related changes involved either merging very small squadrons or later splitting the same squadrons to add squadron commander positions for other Corps.

Current Environment and Congressional Pressure

Healthcare costs continue to rise across the US at a pace higher than inflation and higher than other industries. Healthcare in the MHS in some ways is a microcosm of healthcare nationally. Even though the MHS is government funded and managed healthcare, cost growth is still a significant factor. MTFs refer a large portion of military beneficiary care to networks outside military installations. The MHS is not only a large healthcare system providing care to over 9.4M beneficiaries, it is also a large consumer of healthcare.[18] Cost of MTF healthcare and network healthcare exert immense pressure on the DoD budget. The MHS budget for the Army, Navy, and Air Force healthcare tops $50B annually.[19] In fact, the MHS healthcare budget is ten percent of the overall DoD budget compared to the nuclear weapons and personnel budget is under five percent.[20]

There is significant Congressional pressure on healthcare reform to cut cost nationally. Congress has exerted its power of the purse to cut funding for Medicare and Medicaid nationally in addition to sponsoring pilot studies for efforts exhibiting merit for cost reduction on these entitlement programs. Congress also continuously exerts pressure on the MHS to cut cost. Rightfully so. As healthcare costs increase, the MHS budget eats into the remaining DoD budget taking vital military equipment, personnel, and modernization funding. Congress and DoD leaders understand the risk and threat an unrestrained MHS budget is to new weapon systems, modernization, and end strength growth. Numerous attempts at cost control have been made in annual National Defense Authorization Acts (NDAA) to reorganize military healthcare systems

by reducing the Services headquarters overhead, mandating a collocated and joint headquarters, cutting administrative contracts, and mandating cuts to specific programs. These cuts have all been able to bend the cost curve of the MHS budget, but so far not enough to substantially impact cost growth and ultimately not to satisfy Congress.

The 2017 NDAA levied significant change on the MHS and each individual Services structure and organization of their headquarters.[21] Additionally, it also changed the responsibility of MTF policy and oversight. The Services are now no longer solely responsible for the execution of MTF healthcare. Congress mandated the Defense Health Agency was now responsible for setting policy for each of the Services and provided oversight of MTFs operations. DHA replaced each of the Services HQ Surgeons General (SG) in this role. This role reversal now made the Services' SGs advisors to their Service Chiefs while maintaining the same role in Readiness of their medical personnel. DHA would be responsible for the MTF healthcare and compliance, but the SGs would remain responsible for organizing, training, and equipping. The effort focused on standardization of healthcare across the Services and reduction of overhead.

As the 2017 NDAA landmark changes continue to be implemented, it remains to be seen if these efforts will produce the anticipated savings. Some questions remain unanswered. How large is too large for a joint health system to succeed and yet be nimble to respond to organizational requirements, patient needs, and industry trends? Can a joint headquarters of health system with over 419 facilities truly be effectively managed by one joint headquarters?[22] While a top down study of the DHA effectiveness should be conducted in the near future, the focus of this paper is at the production level. This paper assesses whether the current overhead in MTFs is adequate or requires adjustment.

Other Industry and Government Models

As previously mentioned, hospitals transitioned from an inpatient-centric model in the 1990s to a delivery model today maximizing same day surgery and outpatient care. As patient safety improved and outcomes improved, long inpatient stays for recovery were no longer practical, needed, or cost effective. This same industry trend occurred in the AFMS. A large amount of hospitals transitioned to smaller hospitals and clinics in the late 1990s and early 2000s. In some cases, the hospitals no longer needed to perform the care in an inpatient setting and in other cases more robust inpatient care was available in the TRICARE network. Throughout these delivery model changes to civilian and military healthcare, the leadership structure in military hospitals have remained the same. TJC is also no longer prescriptive of the positions in MTFs. They still prescribe specific governance functions and oversight responsibilities of those functions. With these industry transformations, should the leadership structure also modernize? Are there lessons learned or new models to be applied to the AFMS from civilian healthcare leadership?

I conducted interviews with AFMS personnel recently completing Education with Industry (EWI) assignments in leading civilian healthcare networks and a former senior executive in the VA healthcare system to determine if there are any applications to our present AFMS MTF dual-professional leadership model. To provide an adequate comparison first, the mission differences must be highlighted. Human resource and budgeting differences also dictate how organizations are structured. Budgeting differences are strong inputs into staff levels and amount of overhead in all organizations.

The obvious difference in military healthcare and civilian healthcare is the core mission difference of the readiness component. The readiness mission is the existential reason for military healthcare. The MHS exists not only to ensure its military personnel are medically ready for any contingencies and care for its combat wounded, but also to ensure its active duty medical personnel are clinically trained and proficient to provide care in a deployed environment anywhere on Earth. The deployed setting can range from point of injury on the battlefield, medical evacuation (MEDEVAC), forward surgical team, Aeromedical Evacuation at 30,000 feet, outpatient clinic, to a major theater hospital. All of these settings require military discipline, precision, and excellence to be successful. Commanders lead MTFs because of these unique and specialized differences. These are not functions that can be wholly contracted out or civilianized. Civilian directors of MTFs do not currently exist in the AFMS, but it is feasible for a civilian director to be added in the CEO type role. To do this though would then create a need to have stand-alone military deputy group commanders on G-series orders. Creating this setup would increase overhead, not reduce it. Additionally, with the predominance of staff in MTFs being active duty and the military focus on medical readiness, it follows that the head of the MTF should be an active duty commander. Functional leaders are still required for the core healthcare mission of MTFs in garrison and deployed. Conversely, in the VA and civilian healthcare organizations, there is no need for commanders.

Civilian healthcare organizations must be prepared for disasters in their community in and around their hospital, but this is an extension, albeit an irregular one, of their normal patient care mission. The major difference in the VA system is their workforce is civilianized in a civil service structure mixed in with contractors filling gaps for providers and support staff.[23] While there are retired military members working within the VA system, all are members of the civil

service with the exception of joint venture hospitals where care is integrated. DoD personnel do not have authority over VA personnel though in these facilities. Their leadership teams are also senior civilians. They are structured in departments and functional lines similar to military healthcare care and the civilian sector.

Similarly, the VA is funded through an annual Congressional appropriation like the military. Patient care is funded up front and each organization is not dependent on the amount of funds they bill and collect from workload. The emphasis then is on responsible, predictable budget execution and expense management against funding. Because of this reverse financial management and accounting construct, there is less internal pressure to control and reduce costs unless appropriated budgets are austere at the beginning of a fiscal year. Budget reductions and cost cutting measures still happen, but the same organizational profit/loss pressure is not present. Similarly, the VA and military are not at-will hiring organizations. As a result the same hiring practices, pay, and benefit structures are different. Staffing is usually the highest cost in an organization whether civilian or military and the most common area to reduce costs. In the military and the VA, reducing staffing during a fiscal year to cut costs is almost impossible. Reducing civilian personnel authorizations requires a future year planning effort to reduce programmed staffing.

Civilian healthcare organizations on the other hand are much more business motivated to maximize their revenue cycle. Accounts receivable and accounts payable matter much more. Scrutiny and competitive advantage on pricing for surgery and hospital charges are paramount. Personnel costs are much more scrutinized. Workload in high cost or low volume areas are important. Hospitals walk the fine line of balancing nurse staffing ratios with patient safety and state regulations. Ultimately, all of these constraints, revenue cycle/budget nuances, and staffing

factors produce scrutiny of overhead. Any non-revenue generating position in a civilian hospital has a much higher level of justification. Based on these constraints, a civilian hospital has less motivation to grow leadership positions on the organization's leadership team unless there is a return on investment or urgent and compelling need. As a result, there is a much higher threshold to grow the leadership structure.

Considering this background information and constraints, there were some minor variations in the civilian healthcare organizations reviewed. One healthcare system's leadership positions were virtually the same positions in place from several decades ago. Individual facilities within this system had vice presidents with the same titles and functions as the system. Applying their model to the MHS would lead to no changes in the current construct. The other healthcare system had the same model with two key differences. They had additional positions at the system level and facility level focused more on information technology and financial management. This system was heavily invested in the implementation of their new information systems and the protection of healthcare information. Additionally because their 16 hospitals were scattered over two states, the system hired an economist to specialize in federal and state reimbursement policies, grants, patient demand dynamics, and emerging financial trends to ensure their hospitals and product lines were structured to maximize profit.[24] The concept of the Economist position presents an interesting opportunity and comparative analysis over and above the current budget staff in the MTFs and higher headquarters, but ultimately because the majority of MHS beneficiaries are covered beneficiaries and not paying customers there is not an overwhelming correlation. An economist or data analytics expert strictly focused on reimbursement could be useful in the short-term to ensure maximum billing from Third Party Collections, Medical Affirmative Claims, and intra governmental billing like the Coast Guard.

Currently these billing functions are managed by a mix of the MTF staff, higher headquarters staff, and centralized contractors. The distinction though is MTFs and the HAF do not analyze payer mix and ask MTFs to recapture patients based on their ability to pay or insurance statues. The primary MTF patient base is active duty, their families, and retirees. Asking an MTF to maximize pay patients first would distort priorities that is counter to the MHS mission.

Another emerging civilian healthcare trend in the last 3 years has been the Patient Experience Officer.[25] Neither of these systems had this position on staff, but other renowned health systems like the Cleveland Clinic has focused on patient satisfaction in the age of increased transparency and social media.[26] Organizations see this position as an enabler to maintaining a competitive advantage of their competitors and highly important to ensuring staff members are bought in to clinical excellence and customer service excellence. In this regard, patient satisfaction is a large enabler to profit margin in the civilian sector.

After reviewing the leadership models for the Army, Navy, VA, and civilian healthcare systems, there is limited correlation to the AFMS and our current MTF leadership structure. Based on the lack of discernable or beneficial extra positions in these organizations, I do not recommend modifying the MTF leadership structure to add or delete positions.

Why is Change Needed?

With the increasing complexity of healthcare, budget constraints, pace of change with information technology, the deployment of the MHS Genesis (the Tri-Service Electronic Medical Record), and the noble pursuit of a High-Reliability Organization called Trusted Care in the AFMS; the AFMS must be postured in the most efficient and effective manner for MTFs to innovate and succeed. Change is needed to remain cost effective and relevant in the world of

Congressional pressure for efficiency and cost reduction. Less bureaucratic leadership structures maximize organizational performance and decision-making. More bluntly, less bureaucracy drives less meetings and less decision making time which maximizes time spent in mission essential tasks. The dual-professional model where not dual-hatted by nature of having additional leadership positions translates to additional administrative burden on front-line clinical and administrative personnel. These changes are more than just adding white space back to calendars. Management layers must be removed where warranted. Any new MDG and medical squadron leadership model must pass the litmus test of meeting all of following requirements: improved mission performance, patient satisfaction, organizational nimbleness, AF Inspection System compliance, manpower savings, budget savings, less meetings, and less overhead.

Removing either the dual-professional leadership model or the OMG leadership structure would materially damage either the medical profession aspect or the readiness mission focus and AF wing alignment. Any changes must not impact readiness (Medically Ready Airmen in the Wing and Deployability of Medical Airmen) in any way. The dual-professional leadership model in MDGs then remains the best structure for success in this decade.

The dual-professional model still has inefficiencies that need to be changed. This is not change for change's sake. Simply, the AFMS has too many small MDGs with the same human resource overhead as larger MDGs. These small MDGs also have the same number of squadrons as larger MDGs when fewer squadrons would simplify span of control and reduce overhead in MDGs.

Current AF policy sets thresholds for groups. The AFMS is not completely in compliance with this guidance. AFI 38-101 requires groups to have at least 400 manpower authorizations (officers, enlisted, civilians, and thirty three percent of contractor manpower

equivalents) to earn a group and at least two squadrons. The AFMS has over 40 MDGs under 400 authorizations. The AFMS does however come close to following the threshold for earning a squadron. It is not completely clear as the contractor data is difficult to ascertain, but most come close without this additive. AFI 38-101 also states a medical unit must have at least 35 authorizations to earn a squadron.

For organizational efficiency, mission effectiveness, and reduced overhead, there is no longer a justifiable reason for the large disparity in size (manpower authorizations). Figure 1 below shows the number of MDGs based on their size of total authorizations. Conversely, the 35 authorization for squadrons is too low, producing an overly-inefficient number of squadrons. Many AF units have flights larger than 35 personnel. While mission variations also create variations in difficulty, 35 personnel remains too low. The proposed new model will be outlined later, but threats to any changes must be addressed before detailing a new model.

Risks and Impacts

Currently there is no immediate impetus or external force driving the requirement to change the leadership structure within MTFs of any size. The office of AF/SG1/8 is currently conducting a review similar to this paper and the AF/SG1/8 (Brig Gen Burks) chartered a multi-functional and multi-AFSC working group tasked with reviewing the current model and proposing any changes. There was no direction to produce a manpower savings and no articulated savings quota to fund other corporate ideas or initiatives. The working group had a clean slate without constraints to design the optimal solution. The focus was completely on innovation. Specifically, Brig Gen Burks charged the working group to:

> "think boldly – in other words, not look for incremental changes around the margins of the current OMG/Flight Path, but instead assess the "art of the possible" relative to

> organizational and developmental constructs that support future operational/mission support requirements as well as care/benefit delivery requirements. This group must also consider leadership opportunities, professional growth, and developmental paths for the AFMS workforce across all seven (7) corps – five officer corps, enlisted corps, and civilian corps."[27]

With this guidance, the working group set out and conducted at least two on-site sessions and has provided status updates to the AF/SG. After attending the initial kickoff meeting, my involvement has been limited with the group and I am unaware of the final COAs identified. The focus of the working group was also heavily focused on force development and growth of senior leader positions. While the number of senior leader positions above MDG/CC at the FOA, MAJCOM, Joint, HAF, and DHA level are important, my analysis focused on purely analyzing the requirements of MDG and squadrons first without placing any external filters or bias. My aim was to review the secondary factors like impact on force development after completing the analysis to avoid force development being prioritized over mission requirements. The tantamount question is what is right for the tax payer, deployed military member, and the patient to ensure their healthcare is the best quality and the most cost effective.

Another important factor to be considered after the analysis is the POM process itself. Past manpower savings or manpower cut drills have historically been implemented with 100% of the cuts taken in the first year of the POM cycle. The AF and AFMS has done this many times only to regret the cut later due to mission changes, Congressional changes, or simply unintended consequences/POM broken glass from the cuts. Some historical examples include the President's Budget Decision 720 resulting in thousands of manpower losses across the AF, the repeated attempts to retire the A-10 and its maintenance personnel to fund the F-35 program, and

an overhaul of the Family Health Optimization Initiative which overlooked medical support personnel for primary care manager teams and cut medical records personnel at the same time. Once the manpower cuts have been implemented, it is almost impossible to get it back. For this reason, my proposed changes recommend a phasing approach over the POM cycle to allow for pilot testing and time to adjust from any unintended manpower cuts.

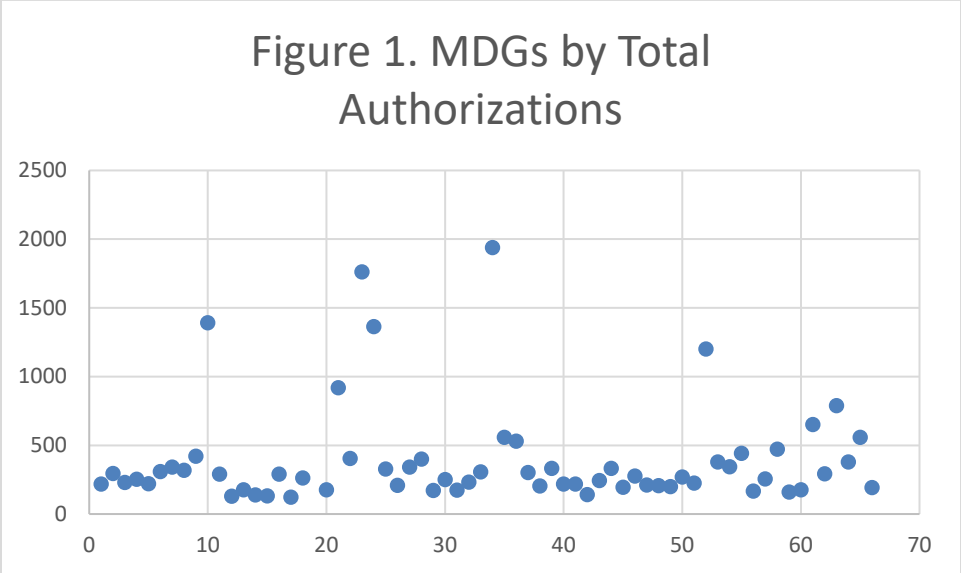
There are other strategic risks as well. With the military engaged in multiple wars across multiple theaters coupled with the budget uncertainty from Congress, other factors that must be balanced including the impact on readiness, AF end-strength growth, senior leadership positions, force development, and implementation of the recent 2017 NDAA. Specifically with the 2017 NDAA, the Services are realigning headquarters functions under the DHA. More than ever though, DHA needs senior leaders prepared to excel in the joint environment at DHA to move the MHS forward. It remains to be seen how the realignment will affect senior leader positions.

Recommendations

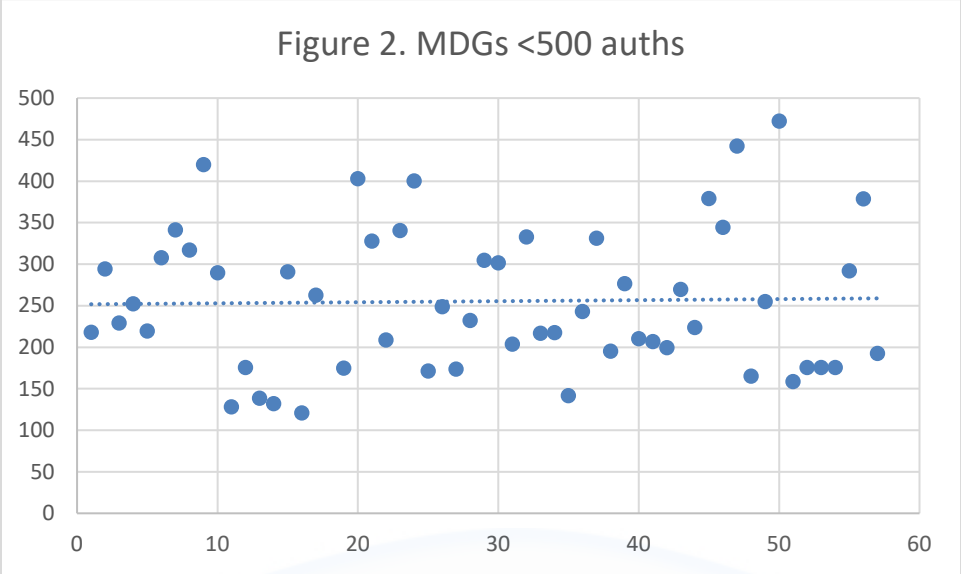
Through the stand-up of the OMG to present operations, the current dual-professional and command structure remains a proven and justifiable model. The leadership model should remain, however the size and number of squadrons requires analysis and evaluation. When beginning this journey of developing a new MTF leadership model for the AFMS, I expected a civilian healthcare structure with progressive advancements the AFMS could learn from and posture towards for future success. After reviewing the collective OMG history, other Services' models, models in the healthcare industry at large, and the current size of all MDGs and medical squadrons; several themes stand out. First, the current AFMS leadership structure of functional leadership with group and squadron commanders remains the best structure to lead the AFMS now and into the future given the current trends. Other than the commander and senior enlisted

positions, there is little variance between the civilian and military structure. Variance can be explained by the differences in financial management and budget execution of government-funded organizations. Civilian organizations are designed to maximize earnings and collections. Governmental organizations are designed to manage expenditures with somewhat predictable funding.

Secondly, while the structure is sound, some MDGs are not appropriately optimized in their leadership structure. Smaller MDGs have too few authorizations than necessary to be a group when a squadron would be more appropriate. Along these lines, smaller MDGs have too many small squadrons. Surprisingly, AF policy sends a mixed message. AFI 38-101 sets minimum authorization numbers for groups and squadrons. Groups must have a minimum of 400 authorizations (officers, enlisted, civilians, and 0.33 contractor FTEs).[28] Squadrons must have a minimum of 35 authorizations.[29] To a small extent, the AFMS is not compliant with this standard. I would argue 400 authorizations is too large for a group and 35 authorizations is too small for a squadron. The following scatter plot, Figure 1, illustrates the variance of MDG size.[30]



There is an obvious split where the bulk of MTFs are below 500 authorizations. Looking closer at the data, Figure 2 paints a more detailed picture.[31]



The median of the MTFs below 500 authorizations sits around 250 authorizations. There are 5 MDGs below 150 total authorizations and with rounding 14 MDGs below 200 authorizations. I chose 200 authorizations as the cutoff for medical authorizations due to data grouping and logical fit with squadron structure as well. Any number above 200 would have substantial impact on the AFMS and medical groups across the AF. The next logical grouping would have resulted in almost half of the MDGs downsizing to squadrons. The level of impact to stakeholders like the wing commanders, MAJCOM commanders, and senior AF leaders not to mention Congressmen, could make any further efforts untenable.

Of these 14 MDGs below 150 authorizations, the Bolling AFB MDG is already slated to reorganize under Andrews AFB MDG. The remaining 13 MDGs are structured with 2 squadrons per medical group (medical operations and medical support). Long-term, my recommendation is to convert all 14 MDGs below 200 authorizations to medical squadrons commanded by O-6 squadron commanders reporting to the wing commander similar to the

comptroller squadron that is part of wing staff. The squadrons would become flights. With senior Majors or junior Lt Cols. There are a large number of squadrons in the AF exceeding 200 authorizations and it is well within successful management and leadership models to downsize these groups into squadrons. The facilities are too small in breadth and depth to be organized as a group. The additional unnecessary overhead adds a level of inefficiency that can be avoided. The squadron command and civilian secretary authorizations at these locations can be returned to the AFMS corporate process for other POM priorities. As previously mentioned in the cautionary risk section, these changes should be phased in. As a result, my recommendation is to downsize the 5 MDGs below 150 authorizations in the first year as pilot units. At the end of the second year, if no unintended effects identified, then these changes along with the other 9 MDGs can be programmed. The new medical squadrons with O-6 commanders should be designated as corps neutral similar to all medical group commander positions to allow hiring authorities to select the best possible leader with the skills needed for that position at that time. Designating these former MDGs to a specific AFSC or medical corps provides a glass ceiling for leadership at that MTF and equally important restricts diversity in leadership and skills.

During the research of this paper, it became clear that further analysis should be conducted by either the HAF/SG or another AWC student in a few areas. There are disparities in size and rank of the squadrons that are commanded by O-5s and squadrons that are commanded by O-6s. All AFMS O-6 squadron command positions in existing MDGs should be reviewed and substantiated. This construct is unique to the AFMS as the line of the AF has zero squadrons commanded by O-6s. The AFMS is somewhat different due to the dual-professional nature of clinical positions like physicians, dentists, and nurses initial career focus is solely on developing functional competence and experience, not on leadership and management. This also leads to a

higher occurrence of senior ranks in MDGs that are not present in other line groups. In this case, it is logical to ensure a medical O-6 works for another medical O-6. Additionally, while evaluating the rank of the squadron command positions, a review of the number of squadrons in outpatient clinics in an MDG should also be evaluated. In clinic-sized MDGs once the MDG starts to grow past 200 authorizations, those MTFs have three or more squadrons. Any squadron under 50 authorizations should be merged with another one to maximize organization effectiveness. These new thresholds will also require AF/SG1/8 to submit a waiver to HQ AF/A1 or special addendum to AFI 38-101 to incorporate in new AF policy.

Lastly, the emerging trend of a Patient Experience Officer is one that has potential for considerable improvement in large MTFs. The MSC Developmental Team should evaluate the addition of a Patient Experience Officer Education with Industry slot in the next Health Professions Education Requirements Board with a follow-on assignment to a medical center reporting to the Administrator. MSCs have participated in educational residencies at Cleveland Clinic previously and their organization is the leader in this emerging role. This new concept and position is more than just a new way to improve customer service. This new leadership position has the potential to affect every process in an MTF that impacts patient satisfaction while producing meaningful and lasting improvements. From the literature, civilian networks are leveraging this position to integrate and standardize all inputs into patient satisfaction.[32] This position is not as tactical as a Group Practice Manager (GPM), but more inclusive of processes across the MDG like appointing (telephonic and TRICARE Online), patient electronic messaging, TRICARE enrollment, and referrals. This position is essentially a confluence of processes and customer service nodes currently belonging to the GPM, patient advocate, facility manager, clinic managers, TRICARE operations and patient administration flight, and the quality

manager. It places every patient contact point under the purview of one leader with the ability to act to improve customer/patient service. This new position should also be given the authority to direct changes in the MTF.

The AFMS strives to maximize readiness both in the Airmen it supports across the installation, downrange, and within its own MDG deployable Airmen. As each MTF performs this core mission, it must also be structured in a way leadership is streamlined and optimized for mission command and control. Unnecessary overhead adds inefficiency that is not ultimately helpful with providing superior healthcare to MHS beneficiaries in a cost effective manner to DoD and taxpayers. The current dual-professional MDG leadership model of a MDG commander, functional leaders, and medical squadron commanders is proven to succeed in today's dynamic environment. There is no better structure in the civilian sector. Most MDGs are optimized for success, but there is room for improvement. With minor reorganizations at smaller MDGs, this new model will reduce unnecessary overhead and free up some of the military bureaucracy. The OMG structure remains valid and ready for any future healthcare challenge. With minor tweaks to the MTF leadership model, AFMS MDGs will remain relevant and ready in the joint environment.

Notes

There are no sources in the current document.[1] Thomas Sowell, Thomas Sowell quote, 12 January 2018, https://www.brainyquote.com/quotes/thomas_sowell_393325.

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[27] Brig Gen James J. Burks, Director, Manpower, Personnel and Resources, Office of the Air Force Surgeon General, to Objective Medical Group Working Group, email, 17 August 2017.

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