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Qualifying Military Health Care Officers as “Joint”

Weighing the Pros and Cons

Sheila Nataraj Kirby, Harry J. Thie

Prepared for the Office of the Secretary of Defense

Approved for public release; distribution unlimited



Center for Military Health Policy Research

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Preface

Over the past few years, there has been increasing recognition that the Military Health System (MHS) has to transform itself and the way it does business. This is driven by the rapid escalation in health care costs, a changing environment with a growing emphasis on performance management, the unprecedented challenges facing the U.S. military at home and abroad that require new roles and responsibilities, and the need to transform the medical force so that future medical support is fully aligned with joint concepts. For example, the 2006 MHS Quadrennial Defense Review (QDR) Roadmap for Technical Transformation highlighted the importance of preparing health care leaders to succeed in joint, performance-based environments.

However, U.S. Department of Defense (DoD) policy precludes the inclusion of professional specialty positions that require medical, dental, veterinary, medical service, nursing, biomedical science, chaplain, and judge advocate officers on the Joint Duty Assignment List (JDAL), the traditional way of providing experience to joint qualified officers. Recent evidence suggests that some health care officers are indeed serving in billets that need and provide joint duty experience for which these officers should receive credit.

As part of a larger project, RAND was asked to examine the ways in which leaders in the medical field are prepared and supported in the civilian and military sectors, to determine the competencies necessary to be a leader in the current joint environment, and to recommend ways to enhance performance-based training and lifelong learning for medical personnel and leaders. As part of that task, RAND was asked

to examine the need for and feasibility of qualifying health care officers as “joint” officers. The study team used data from the 2005 Joint Officer Management (JOM) Census survey to compare the experiences of and work being performed by 400 health care officers to those of 6,000 officers serving in billets on the JDAL, recognized by law as exemplifying jointness. While this was a small, purposively selected sample of health care billets, it suggests that some proportion of health care officers are indeed working on joint matters. Other data on all health care authorizations also suggests that a sizable proportion of billets are external to the services, though these data do not show the extent to which officers in these billets are performing “joint” work. Under the new JOM system, officers in these billets may be eligible to apply for joint duty credit. The study found substantial barriers to providing health care officers with traditional joint professional military education (JPME). This monograph documents the results of these analyses and should be of interest to personnel and military planners involved in medical leadership development.

This research was sponsored by the MHS Office of Transformation. The study was conducted jointly by RAND Health’s Center for Military Health Policy Research and the Forces and Resources Policy Center of the RAND National Defense Research Institute (NDRI). NDRI is a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, the Unified Combatant Commands, the Department of the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community. The principal investigators are Sheila Nataraj Kirby and Harry J. Thie. Comments are welcome and may be sent to Harry_Thie@rand.org or Sheila_Kirby@rand.org.

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Summary

The unprecedented challenges facing the U.S. military at home and abroad have highlighted the need for officers to be educated and trained in joint matters¹ so that they are prepared to take on the new roles and responsibilities that the current environment demands. In his 2005 *Vision for Joint Officer Development*, Chairman of the Joint Chiefs of Staff (CJCS) Peter Pace emphasized the need for *all* colonels and Navy captains to be educated and experienced in joint matters (U.S. Joint Chiefs of Staff, 2005). There is increasing recognition that the roles that the Military Health System (MHS) is being asked to play—especially with respect to national emergencies (such as pandemic influenza) and reconstruction operations—require working strategically with other nations, other militaries, and other agencies. The 2006 Quadrennial Defense Review (QDR) highlighted the importance of preparing health care leaders to succeed in joint, performance-based

¹ DoDI 1300.19 (2007) defines *joint matters* as follows:

Matters related to the achievement of unified action by multiple military forces in operations conducted across domains such as land, sea, or air, in space, or in the information environment, including matters relating to national military strategy; strategic planning and contingency planning; command and control of operations under unified command; national security planning with other departments and agencies of the United States; and combined operations with military forces of allied nations. In the context of joint matters, the term “multiple military forces” refers to forces that involve participants from the armed forces and one or more of the following: other departments and agencies of the United States; the military forces or agencies of other countries; non-governmental persons or entities. (para. E2.16)

environments. Joint is inclusive of multiservice, interagency, intergovernmental, and multinational environments.

As part of a larger project examining the way in which leaders in the medical field are prepared and supported in the civilian and military sectors, the RAND National Defense Research Institute (NDRI) was asked to assess the need for and feasibility of qualifying health care officers as “joint” officers. This monograph documents the results of that analysis.

Exclusion of Professional Specialties from Joint Officer Development

Until recently, the way to develop joint officers has been to provide officers with the opportunity to attend schools offering joint professional military education (JPME) and to serve for specified periods in specific billets that provide them with joint duty experience. These billets constitute the Joint Duty Assignment List (JDAL). The new U.S. Department of Defense (DoD) policy on joint officer management (JOM) published in October 2007 (DoDI 1300.19, 2007) acknowledges that joint duty experience may be gained in non-JDAL billets and that the level of joint experience attained by an officer is a function of the currency, frequency, and intensity of experience rather than an arbitrary length of time in a billet. Thus, the new system recognizes different levels of qualification and awards differentially weighted points for education, training, and experience. The common requirement is that the appropriate level of JPME must be completed in order to achieve joint qualification.

However, both the traditional and current DoD policies (DoDI 1300.20, 1996; DoDI 1300.19, 2007) preclude positions requiring officers in the professional specialties from being on the JDAL. These include medical officer, dental officer, veterinary officer, medical service officer, nursing, biomedical science officer, chaplain, and judge advocate positions. In addition, professional officers and those in the technical and scientific specialties are provided waivers on a case-by-case basis

from the requirement that all officers being considered for promotion to general or flag officer have served in joint duty assignments (JDAs).

The reasons for the traditional exclusion of professional specialty billets from the JDAL are not clearly laid out in the original legislation that formalized the policies and procedures for JOM (Pub. L. 99-433, Goldwater-Nichols Act of 1986) or subsequent reauthorizations. The most likely explanation was the need to keep the JDAL to a manageable size. Other likely reasons include (1) the perception that health care officers are not likely to be as involved with “joint matters” or formulation of joint policy or doctrine as line officers and (2) recognition of the high opportunity costs of sending clinicians to JPME or to a JDA for lengthy periods of time.

New Evidence on Types of Billets Staffed by Health Care Officers

New evidence from the 2005 JOM Census survey conducted for the Office of the Secretary of Defense (OSD) as well as data on where some health care officers are serving suggest that some of these officers are indeed serving in billets that need and provide joint duty experience and for which they should receive credit. The 2005 survey encompassed JDAL billets, billets in organizations external to the military services with some billets on the JDAL, and internal service billets nominated by the services as being “potentially joint.” Among the 21,000 respondents were about 400 health care officers. Table S.1 compares the characteristics of the JDAL billets with those staffed by health care officers. Although billets in which health care officers are serving do not rise to the level of jointness of JDAL billets in all cases, they do appear to rank high on several metrics of jointness, particularly with respect to the kinds of joint experiences they provide, the kinds of tasks being performed, and the usefulness of joint education and experience for the billet.

Defining a Potential JDAL for Health Care Officers

We also examined all health care officer authorizations to screen for existing billets that were in external organizations and thus could be potential JDAL billets. About 270 billets are predominantly in OSD, the Joint Staff, the combatant commands, NATO, the Defense Logistics Agency, and the Defense Threat Reduction Agency. The distribution of these billets across the services was 33 percent Air Force, 44 percent Army, and 23 percent Navy. A wider screen to identify potential positions—including internal service billets—that routinely require interactions with other service, interagency, or international communities resulted in 840 positions: 45 percent Air Force, 38 percent Army, and 17 percent Navy billets. Overall, these billets constitute 3.2 percent of all Air Force, 3.4 percent of all Army, and 1.4 percent of all Navy health care officer authorizations.

Table S.1
Comparing JDAL Billets and Billets Staffed by Health Care Officers on Typical Metrics of Jointness, 2005 JOM Census Survey

Selected Characteristics	Respondents (%)	
	JDAL Billets (N = 6,131)	Billets Staffed by Health Care Officers (N = 397)
Billet involves serving full-time with members of another military department	91.5	73.3
Billet focuses primarily on strategic or operational matters	97.2	91.4
Billet supervised by non-own-service supervisors	77.9	64.2
Billet involves performing one or more “highly joint” tasks: Providing strategic direction and integration Developing/assessing joint policies Developing/assessing joint doctrine Fostering multinational, interagency, or regional relations	78.2	57.2
Billet provides significant experience with multiservice matters	83.0	82.4

Table S.1—Continued

Selected Characteristics	Median	
	JDAL Billets (N = 6,131)	Billets Staffed by Health Care Officers (N = 397)
Billet provides significant experience with interagency matters	72.6	67.0
Billet provides significant experience with multinational matters	63.0	46.4
Billet provides significant experience in two or more of these areas	77.0	70.3
Prior joint education required/desired for successful performance in billet ^a	91.8	76.8
Prior joint experience required/desired for successful performance in billet	88.9	80.5
Number of non-own-service organizations with whom officer interacts frequently (monthly or more)	6	3
Types of non-own-service personnel with whom officer interacts frequently (monthly or more)	5	4

^a A large percentage reported that they had no experience with JPME II and as such did not offer an opinion. The percentage shown is of those who responded to the question—38 percent of health care officers and 69 percent of officers in JDAL billets.

There is minimal cost to adding existing external positions to the JDAL. If the 270 billets that were identified by the narrow screen were added to the JDAL and if officers served the required three-year tours, approximately 90 officers each year would receive credit for qualifying joint experience. If the 840 positions identified by the wider screen either were added to the JDAL or served as the basis for the alternative joint experience qualification, then about 280 per year could potentially qualify.

However, given the size of the overall population, this represents less than 1 percent of officers in both cases, which is far short of the CJCS vision for joint qualification. Moreover, the majority of those who would qualify would be medical service corps officers, given the

preponderance of those positions in the two sets of positions we identified as potentially joint. If joint qualifications became a requirement for promotion to flag officer rank (currently waived), the services would need to be very selective in selecting officers for joint assignments, focusing on those who were in a leadership track.

Barriers to Extending Joint Duty Requirements to Health Care Officers

If joint experience is a potential roadblock to gaining full joint qualification, JPME is even more so. Becoming fully joint qualified requires both experience and education. There are very few seats assigned to health care officers at JPME II schools. In addition, there are large opportunity costs in assigning additional health care officers, particularly highly trained clinicians, either to a resident JPME school for a sustained period of time or to work on joint matters for two to three years.

There are other costs to be considered as well. Maintaining clinical skills requires continuing and extended practice. JDAs are, by definition, not clinical; thus, sending away clinicians for long periods of time, either for JDAs or for resident JPME, may have significant adverse impacts on their proficiency levels. There are two possible ways to mitigate these costs. The first is to consider the shorter Joint Forces Staff College (JFSC) course, which is 10 weeks in length, rather than a full year. The second is to provide opportunities for clinicians to practice in nearby military treatment facilities. This is similar to what individuals in staff jobs do to maintain their clinical proficiency. However, this would work only for some clinical specialties. In addition, most professional specialties set mandatory continuing education requirements that are needed for licensure renewal. These requirements need to be added on top of the service and joint education and training requirements.

Recommendations

We recommend a blended approach to JOM for health care officers: Use processes similar to those used for line officers to give credit for experience and develop separate processes for joint education. This would require the following:

- *Validating joint experience for health care officers through the standard JDA (S-JDA) formal process or through individual certification as allowed in the current DoD and CJCS instructions (DoDI 1300.19, 2007; CJCSI 1330.05, 2008):* It is obvious from the numbers of health care positions that are potentially joint and from the experiences of health care officers serving in operational venues that a not-insignificant number of health care officers are getting qualifying joint experience. There are few costs from implementing this recommendation. The impact of this recommendation would be to allow joint experience qualification based on existing positions and not to expand positions providing such qualification.
- *Developing a system of joint education and training that fits the requirements of and is targeted to the medical professions, either as permanent policy or as a step toward full JPME II requirements:* While some health care officers do attend JPME II, there are so few seats available to them that the vast majority of health care officers will not have the opportunity. Moreover, there are significant costs to expanding the formal JPME II opportunity for one year for such officers. The medical community should validate shorter-term training and education opportunities or consider blended learning courses to ensure that such officers receive sufficient joint training and education.

Acknowledgments

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Abbreviations

AJPME	advanced joint professional military education
CJCS	Chairman of the Joint Chiefs of Staff
CJCSI	Chairman of the Joint Chiefs of Staff Instruction
COCOM	combatant command
DMRTI	Defense Medical Readiness Training Institute
DoD	U.S. Department of Defense
DoDI	U.S. Department of Defense Instruction
EIPT	Executive Integrated Process Team
FORMIS	Forces Management Information System
FOSC	Flag Officer Steering Committee
GNA	Goldwater-Nichols Act of 1986
JDA	joint duty assignment
JDAL	Joint Duty Assignment List
JFSC	Joint Forces Staff College
JOM	joint officer management
JPME	joint professional military education

JQO	joint qualified officer
JSO	joint specialty officer
JTF	joint task force
MHS	Military Health Service
NWC	National War College
OSD	Office of the Secretary of Defense
QDR	Quadrennial Defense Review
S-JDA	standard joint duty assignment
SSTRO	security, stability, transition, and reconstruction operations
USJFCOM	U.S. Joint Forces Command

Introduction

The mission of the Military Health System (MHS), as defined in its Strategic Plan, is “[t]o enhance the Department of Defense and our Nation’s security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care” (Military Health System, 2007, p. 7). The full range of operations includes not only the more traditional military operations but also expanded U.S. Department of Defense (DoD) roles in security, stability, transition, and reconstruction operations (SSTRO); homeland defense; and the provision of a range of military support to civil authorities. Over the past few years, there has been increasing recognition that the MHS has to transform itself and the way it does business. This is driven by the rapid escalation in the costs of health care, a changing environment with an increased emphasis on performance management, the unprecedented challenges facing the U.S. military at home and abroad that require new roles and responsibilities, and the need to transform the medical force so that future medical support is fully aligned with joint force concepts. For example, the 2006 Quadrennial Defense Review (QDR), and, more specifically, the MHS Roadmap for Medical Transformation (2006), highlighted the importance of preparing health care leaders to succeed in joint, performance-based environments (DoD, 2006a).

As part of a larger project, the RAND National Defense Research Institute (NDRI) was asked to examine the way in which leaders in the medical field are prepared and supported in the civilian and military sectors, determine the competencies necessary to be a leader in the cur-

rent joint environment, and recommend ways to enhance performance-based training and lifelong learning for medical personnel and leaders. The objective of the research was to understand how best to develop military health care officers to perform successfully in both joint and service-specific environments. This monograph presents the findings of that study, addressing the following:

- what it means to be a joint qualified officer (JQO)
- the policies governing joint officer management
- the exclusion of professional specialties from gaining such joint duty experience and the rationale for such exclusions
- whether some health care officers are serving in billets that provide them with a joint experience
- the need for and feasibility of qualifying health care officers as “joint” officers prior to their selection as general or flag officers.

Rationale for the Study

The Goldwater Nichols Act of 1986 (GNA) (Pub. L. 99-433) forged a cultural revolution by improving the way in which DoD prepares for and executes its mission; it is the driving force behind today’s joint officer management (JOM). The act was a landmark document that changed the way in which officers are educated, trained, and given experience in joint operations. The importance of joint experience and education is underscored by the fact that prior joint duty experience and education are, with some exceptions, prerequisites for promotion to general or flag officer ranks.

Until recently, the way to develop joint officers has been to provide them with the opportunity to attend schools offering joint professional military education (JPME) and serve in billets that provide joint duty experience. These billets form the Joint Duty Assignment List (JDAL), which typically includes 100 percent of billets in certain organizations, such as the Joint Staff or the Office of Secretary of Defense (OSD); 50 percent of billets in other external organizations; and, by law, no positions in an officer’s own military department. The assump-

tion underlying the JDAL—until recently—was that these non-JDAL billets did not provide a joint duty experience.¹

Traditional DoD policy (DoDI 1300.20, 1996) also precluded positions requiring officers in the professional specialties (medical officers, dental officers, veterinary officers, medical service officers, nurses, biomedical science officers, chaplains, and judge advocates) from being on the JDAL. In addition, professional, technical, and scientific officers were provided waivers on a case-by-case basis from the requirement that all officers being considered for promotion to general or flag officer have served on joint duty assignments (JDAs). These exclusions and waivers were reiterated in the new DoD policy on joint officer management published in fall 2007 (DoDI 1300.19, 2007; see also CJCSI 1330.05, 2008).

Reasons for Exclusion of Professional Specialties from the JDAL

The reasons for the traditional exclusion of professional specialty billets from the JDAL are not clearly outlined in the original legislation (GNA and subsequent reauthorizations) that formalized the policies and procedures for JOM in various DoD directives and instructions. The most likely explanation, as we show here, is the need to keep the JDAL to a manageable size.

A review of original material from the legislative and executive branches found no direct reference to the reason for the exclusion. However, one can surmise that the exclusion emerged from an internal DoD study that examined implementation issues associated with GNA (Office of the Assistant Secretary of Defense, 1990, pp. 35–37). The law set no requirements for the total size of the JDAL, leaving DoD with the dilemma of developing a list that met all the considerations of the law in addition to the requirements of the services. The list that evolved was the result of a number of considerations:

The list had to be large enough to allow the greatest opportunity for officers to qualify under the O-7 rule but small enough to be

¹ A small number of positions, called *critical positions*, were deemed to require an officer with prior joint experience, but the JDAL is essentially a list of positions that provide joint experience.

supported by JPME, the JSO [joint specialty officer] and JSO nominee requirements, and an equitable distribution of quality officers within competing priorities and demands. (Office of the Assistant Secretary of Defense, 1990, p. 36)

In March 1987, the Joint Chiefs of Staff recommended that the JDAL contain no more than 9,000 positions—a compromise between the 3,000–4,000 on the operationally focused list and the much larger 16,000-billet list, the result of the final JDA definition that was expanded to include both operational and support positions. The broad definition allowed for a larger JDAL than a more restrictive definition would have produced and recognized that there were many officers performing duties that met the definition of *joint matters*.

To constrain the overall size of the list, only O-4 and above positions were included. The list was further constrained by limiting the defense agencies and other selected activities to only about 50 percent of their field-grade positions. The initial list included no more than 8,000 positions.

The medical and other professional specialties appear to be ideal candidates for exclusion to keep the JDAL small in that any of their requirements in the GNA could be waived. The GNA did have two provisions that could have affected the medical specialties: attendance at a capstone course for new general and flag officers and a JDA as a prerequisite for promotion to general or flag officer grade. The Secretary of Defense was allowed to waive both requirements for "a medical officer, dental officer, veterinary officer, medical service officer, nurse, biomedical science officer," or chaplain, in the case of the first requirement, and chaplain or judge advocate, in the case of the second (Pub. L. 99-433). These requirements and waiver authority emerged from the House version of the GNA, and the Senate agreed to them in conference. The respective and preliminary reports and legislative initiatives that led to the GNA are almost completely silent on the medical specialties with respect to joint matters. The one exception is the reported widespread shortcomings in medical readiness in U.S. European Command following the Beirut bombing in 1983 (Zimble Report, DoD, 1984). The Assistant Secretary of Defense rec-

ommended that a command surgeon position be established at U.S. European Command to oversee subordinate medical units in Europe. A command surgeon was not appointed until late in 1985. “One reason was that the service medical corps have strongly and actively opposed having a joint authority placed over them” (U.S. House of Representatives, 1986, p. 11). For practical purposes in 1986, another reason not to directly include the medical professions on the JDAL was that there were so few of those positions.

Other likely reasons for excluding professional officers from joint duty requirements include (1) the need for and importance of maintaining clinical skills, which would preclude such officers from spending a substantial portion of time attending JPME schools, and the perceived substantial opportunity costs of sending a clinician to JPME in residence or on a joint assignment, and (2) the perception that health care officers are not likely to be as involved with “joint matters,” or the formulation of joint policy or doctrine, as line officers.

Need to Revisit the Issue

Some recent developments suggest the need to revisit this issue. First, in his 2005 *Vision for Joint Officer Development*, Peter Pace, Chairman of the Joint Chiefs of Staff (CJCS), emphasized the need “to produce the largest body of joint officers suitable for joint command and staff responsibilities” and for “*all* [emphasis added] colonels and [Navy] captains to be *skilled joint warfighters*, who are *strategically minded, critical thinkers*” (U.S. Joint Chiefs of Staff, 2005, p. 3). According to DoD’s *Strategic Plan for Joint Officer Management and Joint Professional Military Education*, “The term ‘warfighter’ is not limited to officers serving in the combat arms. It also applies to those who are skilled in the ‘capabilities specific to joint operations’ whether in the conduct of war or operations other than war” (DoD, 2006b, p. 11, fn. 24).

This vision applies to all officers, regardless of whether they are in the professional specialties. There is increasing recognition that the roles that the MHS is being asked to play—especially with respect to national emergencies (such as pandemic influenza) and SSTRO—require working strategically with other nations, other militaries, and

other agencies, and, thus, health care officers need to be trained in joint matters.

Attaining the rank of colonel and captain will signify that an officer fundamentally thinks in a joint context at the operational and strategic levels of war and thereby possesses an unprecedented ability to integrate capabilities across the depth and width of the joint force. (U.S. Joint Chiefs of Staff, 2005, p. 3)

Second, the old paradigm failed to recognize or give credit for what an officer did on the job or the intensity of that experience. It placed importance on the organizational location of the billet and the grade. However, as we discuss in Chapter Three, a series of reports and analyses has provided evidence to the contrary, showing that some positions on the JDAL failed to provide joint duty experience while some internal service billets that were by law excluded from the JDAL did. This led to a new JOM joint qualification system, which was implemented in 2007. New evidence from the JOM Census survey conducted in 2005, as well as data on where some health care officers are serving, suggest that some of these officers are indeed serving in billets that need and provide joint duty experience for which they should receive credit.

Organization of This Monograph

Chapter Two provides an overview of the military competencies required to be a successful leader in today's environment and the *CJCS Vision Joint Officer Development* (U.S. Joint Chiefs of Staff, 2005), which encompasses *all* officers. Chapter Three provides a brief introduction to the GNA and then describes the new joint officer management and qualification system that went into effect in October 2007. Chapter Four provides evidence from the 2005 JOM Census survey on the experiences and opinions of health care officers serving in joint or potentially joint billets. A number of complex questions arise when considering either requiring or opening up JDAs for health care officers. These questions are discussed in Chapter Five. Chapter Six offers

conclusions and recommendations. The appendix provides supporting material for Chapter Four.

Developing Military Leaders

One of the primary goals of the management system is to produce qualified senior leaders who can function in both joint and service-specific environments and who possess the necessary competencies determined to be important for successful leadership. At the outset, we should note that we use the term *leader* to identify those individuals who are likely to be in command or executive positions in the organizations. However, as noted next, leadership knowledge and skills—traditionally defined as the knowledge and ability to set goals for the organization, adopt strategies to achieve those goals, and motivate and inspire subordinates to be committed to the organization and to help achieve its objectives—make up only one of several competencies that military services seek in their leaders.

Military Leader Competencies

Robbert (2005) reviewed the competencies that the military services seek in their leaders and suggested a useful categorization encompassing four dimensions of competencies:

- *domain knowledge*: deep knowledge of and extensive experience with the functional area
- *management skills*: sophisticated ways of choosing among alternatives and ensuring effective implementation of the chosen path, ensuring that resources are available, and establishing feedback loops to determine whether the organization is on track

- *leadership skills*: ability to envision appropriate goals for the organization, make decisions to enable the organization to move toward those goals, and motivate followers to help the organization realize those goals
- *enterprise perspective*: understanding of how the leader’s role relates to the overall objectives of the larger organization and the context in which the larger organization operates (Robberts, 2005, pp. 257–259).

This fourth area of competency—an enterprise perspective—is increasingly seen as important for military leaders as military operations become more “joint” and integrated (interservice, interagency, intergovernmental, and multinational). The *Capstone Concept for Joint Operations*, version 2.0 (DoD, 2005), which describes how the military will operate in the future as a joint force and provides a format for leader development, states that joint force leaders should be “knowledgeable, empowered, innovative, and decisive leaders, capable of leading the networked joint force to success in fluid and perhaps chaotic operating environments, with more comprehensive knowledge of inter-agency and foreign cultures and capabilities” (p. 24).

Vision for Joint Officer Development

The *CJCS Vision for Joint Officer Development* (U.S. Joint Chiefs of Staff, 2005), DoD’s *Strategic Plan for Joint Officer Management and Joint Professional Military Education* (DoD, 2006b), DoD’s *Joint Qualification System Implementation Plan* (DoD, 2007a), the National Defense Authorization Act for Fiscal Year 2007 (Pub. L. 109-364), and CJCS Instruction (CJCSI) 1330.05 (2008) consolidate current laws, policies, and guidance regarding military officer professional development in a joint context. The *CJCS Vision* outlined a framework for JOM that sets forth new goals and approaches in joint officer development and directs that “joint training and education will be recast as a component of lifelong learning and integrated across the Total Force”

(U.S. Joint Chiefs of Staff, 2005, p. 3).¹ The *CJCS Vision* developed a learning continuum that develops the professional military officer with the skills, competencies, and experiences of a joint leader. The continuum is based on four interdependent pillars:

- joint individual training
- self-development
- JPME
- joint experience.

Joint individual training, defined as “imparting of specific joint skills to individuals,” is offered through multiple avenues: service-specific training venues, institutional training modules, or distance learning (U.S. Joint Chiefs of Staff, 2005, p. 5). It ensures that joint concepts are introduced early in an officer’s career.

The *self-development* pillar “recognizes that empowering individuals with responsibility to actively participate in growth is a necessary and positive step” (U.S. Joint Chiefs of Staff, 2005, p. 6). It enables officers to be self-directed and self-motivated as a means of preparing themselves for future assignments and greater responsibilities.

JPME is the cornerstone of joint leader development and consists of two phases. Phase I (JPME I) is normally accomplished prior to promotion to lieutenant colonel or commander, and phase II (JPME II) is normally accomplished prior to becoming a colonel or captain. Professional military education, including JPME I, can be attained through attendance at institutions or via nonresident delivery modes (i.e., distance learning, correspondence courses, or satellite classes).

Joint experience is the application of the three preceding pillars while serving in a position that is classified as joint billet.

Joint experience is a key learning opportunity, as it is where the other aspects of the [joint officer development] approach move from the conceptual to the actual. The intellectual understanding of war that is gained through operational experience rounds

¹ The total force encompasses all active-duty and reserve component personnel, including National Guard members.

out the continuum of joint learning. The joint experience pillar implicitly recognizes that the successful application of what individuals learn via [joint individual training], JPME, and self-development is essential.

Joint Warfighting is not an academic pursuit; its competencies must be demonstrated by practice. Simply put, *joint experience accrues where jointness is applied*. (U.S. Joint Chiefs of Staff, 2005, p. 6; emphasis in original)

Each pillar helps an officer grow as a military leader and attain a joint focus early in his or her career path. Each service now measures leader development against this model and is revising its communities’ career paths and educational curricula to correlate with its dictums (U.S. Joint Chiefs of Staff, 2005, pp. 4–7).

However, as mentioned earlier, the opportunities for health care officers to qualify as joint officers are limited for two reasons. First, current DoD policy precludes positions requiring officers in the professional specialties from being on the JDAL, though individual officers may apply for joint duty credit under the new JOM system (described in the next chapter). Second, the number of seats assigned to health care officers at schools offering JPME is small.

The next chapter describes the current JOM system.

Joint Officer Management

Joint Officer Management: 1986–2007

The GNA, passed in 1986, was a landmark document that changed the way in which officers are managed, and it provided specific goals that must be met.¹ The GNA has driven changes in the way that officers are educated, trained, and experienced in joint operations, and successes have been achieved. The intent of the JOM provisions was to enhance the quality, stability, and experience of officers in joint assignments, which, in turn, would improve the performance and effectiveness of joint operations.

The GNA established and directs numerous policies for the management of joint officers. The statutory requirements are contained in U.S. Code, Title 10, Chapter 38, Joint Officer Management. In particular, the act established the qualifications for JSOs—officers who are trained specifically in joint matters—in terms of experience and education.

Joint Duty Assignments, Joint Duty Assignment List, and Joint Duty Credit

A JDA is “[a]n assignment to a designated position in a multi-Service or multi-national command or activity that is involved in the integrated employment *or support* of the land, sea, and air forces of at least two of the three Military Departments” (DoDI 1300.20, 1996,

¹ This section relies heavily on research presented in Harrell et al. (1996) and Thie et al. (2005).

para. E2.1.7). The duties of an officer in a qualifying JDA involve producing or promulgating national military strategy, joint doctrine, joint policy, strategic plans, or contingency plans or commanding and controlling operations under a combatant command (COCOM). Assignments to an officer's own military department or assignment for joint education or training do not qualify and are not covered by this definition. Successful completion of a JDA is a criterion for designation as a JSO.

The JDAL is a consolidated roll that contains all the billets² that are approved JDAs for which joint credit can be applied. Billets are added to and deleted from the JDAL, and there is a validation process to review positions nominated for addition. A joint duty validation board, composed of representatives of OSD, the Joint Staff, and the military departments, considers the joint content of nominated billets. A billet is evaluated and voted on according to its merit for inclusion or exclusion from the JDAL by the validation board.

Joint duty credit is the joint credit granted for the completion of an assignment (or accumulation of sufficient time in assignments) to a JDA that meets all statutory requirements (CJCSI 1331.01C, 2005). The 1996 National Defense Authorization Act (Pub. L. 104-106) authorized that credit for a full JDA or credit countable for determining cumulative service would be awarded to officers serving qualifying temporary joint task force (JTF) assignments.

Joint Professional Military Education

Professional military education enhances an officer's knowledge of military science and the art of war, and there is a continuum of education that officers receive throughout their careers. JPME focuses specifically on joint matters. JPME instruction that qualifies an officer as a JSO or JSO nominee is performed both at the military service colleges (resident and nonresident) and at National Defense University.

JPME I is incorporated into the curricula of the military service colleges at both the intermediate level (O-4) and the senior level (O-5

² In the past, only 50 percent of the positions in defense agencies could qualify as JDAs, while 100 percent of the positions in other joint organizations were on the JDAL. These limits no longer exist.

and O-6). The Joint Forces Staff College (JFSC) provides JPME II³ to both intermediate- and senior-level students. Intermediate-level colleges teach joint operations from the standpoint of service forces in a joint force supported by service component commands. Senior-level service colleges address theater- and national-level strategies and processes. Curricula focus on how unified combatant commanders, the Joint Staff, and DoD use the instruments of national power to develop and carry out the National Military Strategy (CJCSI 1800.01C, 2005). The Joint and Combined Warfighting School at the JFSC (for JPME II credit) provides instruction in joint operations from the perspective of the CJCS, unified combatant commanders, and JTF commanders. The course develops joint attitudes and perspectives and exposes officers to other service cultures while maintaining a concentration on Joint Staff operations. National War College (NWC) and Industrial College of the Armed Forces (ICAF) courses of instruction provide full JPME credit for graduates.

To meet the educational prerequisites to become a JSO or JSO nominee, officers must, at a minimum, complete one of the following:

- JPME I at (an accredited) service intermediate- or senior-level college.⁴
- JPME II at NWC, ICAF, JFSC, or the Joint and Combined Warfighting School.

In 2007, senior-level service programs became eligible for future JPME II accreditation through the Process for Accreditation of Joint Education. These include the U.S. Army War College, the U.S. Navy College of Naval Warfare, the U.S. Marine Corps War College, and the U.S. Air Force Air War College.

³ The duration of the JPME II course of instruction at JFSC was reduced from 12 weeks to 10 weeks, which allows for an additional session to be held each year. Liaison with JFSC officials indicates that four sessions are now held (beginning in FY 2005), with a maximum capacity of 255 students per session.

⁴ Officers (other than those with a critical occupational specialty) must attend JPME II prior to completing their joint assignment to qualify as a JSO. Attendance at JPME II prior to completing JPME I requires a waiver from the CJCS.

Promotion to O-7

Under Title IV of the GNA (Pub. L. 99-433), an officer cannot be promoted to O-7 unless he or she has served in a JDA. However, this requirement can be waived

- when necessary for the good of the service
- in the case of an officer whose proposed selection for promotion is based primarily on scientific and technical qualifications for which joint requirements do not exist
- in the case of a medical officer, dental officer, veterinary officer, medical service officer, biomedical science officer, chaplain, or judge advocate.

Title IV also requires that all officers appointed to O-7 receive joint education under the capstone course after their appointments. Again, this requirement could be waived for those whose immediately previous assignment was a JDA or for the good of the service, as well as for officers selected for professional, scientific, and technical qualifications.

The New Joint Officer Management and Qualification System: 2007–Present

Over the two decades following the passage of the GNA, several shortcomings of JOM were noted. One of the major shortcomings of the system centered on the lack of recognition of service in JTF headquarters or service component commands and service units assigned to JTF. Focusing on the administrative process of "credit" rather than actual joint experience appeared misdirected, but it was a reflection of the system that was in place until 2007, which did not always adequately acknowledge the validity of joint experience gained with a JTF. This was recently recognized in the strategic plan for JOM and JPME put forward by DoD in 2006:

Joint Task Forces (JTFs) now define the way we array our armed forces for both war and operations other than war. The effective-

ness of joint operations is no longer simply the integration and/or interoperability of two or more military services; it requires the synergistic employment of forces from multiple services, agencies, and nations. Non-governmental agencies and commercial enterprises must now be routinely combined with these traditional military forces and the interagency component to achieve national objectives. (DoD, 2006b, p. 3)

It also explained the need for a new JOM:

Human resource management systems within the Services have evolved from a one-size-fits-all approach for assignments, education and training, to more flexible systems, responsive to the needs of the organization as well as the needs of the individual. It is time for the joint officer management system to adapt as well. This begins with recognizing that joint experience can be gained in a myriad of locations and organizational constructs. Another consideration is [that] the level, or amount, of joint experience attained by an officer is a function of its currency, frequency, and intensity rather than an arbitrary period of time in a billet. Now is the time to transition from a system where the Joint Specialty Officer (JSO) designation is the only recognized level of joint capability to one that offers various levels of qualification based on joint experience. (DoD, 2006b, pp. 15–16)

This led to the development of an implementation plan for the proposed JOM joint qualification system in March 2007 (DoD, 2007a) and, most recently, to the publication of DoD Instruction (DoDI) 1300.19 on October 31, 2007, establishing the new policy for JOM.

This plan describes a four-level JQS that provides a path for attaining joint qualification through either a traditional joint duty assignment or by accumulating an equivalent level of joint experience, education, and training over the course of a career. The common requirement is that the appropriate level of JPME must be completed in order to achieve joint qualification.

The methodology used to account for this joint experience, education, and training is a points system. This points system provides

an inherent advantage over the traditional time-based system in that it creates an opportunity to account for the intensity of each joint activity. This plan leverages this unique characteristic by giving added value to joint combat and non-combat contingencies. The points system also allows the level of involvement of the individual to be weighted. Individuals who lead or plan joint exercises are given an increased number of points over participants. The fidelity afforded by this methodology vastly enhances the value of the JQS to the Department. (DoD, 2007a, p. 1)

The remainder of this chapter references DoDI 1300.19 (2007), revised as of August 2008. In May, CJCSI 1330.05 (2008) established the detailed regulations and procedures for implementing DoD’s new JOM program.

Broadening the Definition of Joint Matters

The GNA had defined *joint matters*, iterated in Title 10 of the U.S. Code, as

matters relating to the integrated employment of land, sea, and air forces, including matters relating to national military strategy; strategic planning and contingency planning; and command and control of combat operations under unified command. (10 U.S.C. 668)

In December 1986, the Secretary of Defense expanded the definition to include *support* of land, sea, and air forces, joint doctrine and joint policy (Office of the Under Secretary of Defense for Personnel and Readiness, 1994).

As the JOM joint qualification system implementation plan (DoD, 2007a) points out, the reality of how the U.S. military operates in the 21st century makes it prudent to expand that definition: “Jointness” has migrated to organizations such as the JTFs, joint operations include both military missions (such as Operation Desert Shield/Desert Storm, Operation Enduring Freedom, and Operation Iraqi Freedom) and domestic operations (such as JTF Katrina and the ongoing border patrol missions), and U.S. forces regularly train and conduct opera-

tions with interagency, international, and nongovernmental partners. The John Warner National Defense Authorization Act for Fiscal Year 2007 (Pub. L. 109-364) enabled DoD to recognize a range of joint experiences. As a result, DoDI 1300.19 (2007) defines *joint matters* as follows:

Matters related to the achievement of unified action by multiple military forces in operations conducted across domains such as land, sea, or air, in space, or in the information environment, including matters relating to national military strategy; strategic planning and contingency planning; command and control of operations under unified command; national security planning with other departments and agencies of the United States; and combined operations with military forces of allied nations. In the context of joint matters, the term “multiple military forces” refers to forces that involve participants from the armed forces and one or more of the following: other departments and agencies of the United States; the military forces or agencies of other countries; non-governmental persons or entities. (para. E2.16)

The Joint Duty Assignment List and Joint Qualified Officers

Under DoDI 1300.19 (as in the earlier legislation), a list of standard JDA (S-JDA) positions is to be published, and some positions are to be identified as critical S-JDAs. Specifically, DoD policy is as follows:

4.3. To identify positions that provide officers significant experience in joint matters, as defined by section 668 of Reference (j), as joint duty assignments (JDAs).

4.4. To publish a joint duty assignment list (JDAL) of standard joint duty assignment (S-JDA) positions, and of those positions, identify positions that require the incumbent to be previously trained, educated, and experienced in joint matters (or at a minimum the position would be greatly enhanced by such an incumbent), as critical S-JDAs in accordance with statute.

4.5. That assignments in an officer’s own Military Department may provide an opportunity to gain joint experience; however,

Service positions/billets will not be designated as S-JDAs or added to the JDAL.

4.6. To assign officers to S-JDAs for a length of time that provides stability to the joint organization. [Active component] and full-time [reserve component] general and flag officers . . . shall be assigned to S-JDAs for not less than 2 years; all others shall be assigned for not less than 3 years. *S-JDA tour length requirements for RC officers who serve less than full-time shall be a cumulative total of 4 years for [general and flag officers] and a cumulative total of 6 years for all others.*

4.7. To designate as JQOs sufficient numbers of quality officers who have completed Joint Professional Military Education (JPME) Phase II (or in the case of RC officers, Advanced Joint Professional Military Education (AJPME) and a full S-JDA or who have met such additional criteria as prescribed by the Secretary of Defense in Enclosure 3 of this issuance.

4.8. That only officers in the grade of O-4 or above may be designated as a JQO. (DoDI 1300.19, 2007)

The following position categories qualify for the JDAL:

E4.7.1. OSD Positions. The incumbents of these positions are responsible for developing and promulgating policies in support of national security objectives.

E4.7.2. Joint Staff Positions. The incumbents of these positions are responsible for matters relating to national military strategy, joint doctrine or policy, strategic planning, and contingency planning.

E4.7.3. Combatant Command Headquarters Positions. The incumbents of these positions are involved in matters relating to national military strategy, joint doctrine or policy, strategic planning, contingency planning, and command and control of combat operations under a Combatant Command.

E4.7.4. Defense Agency Headquarters Positions. The incumbents of these positions are involved in developing and promulgating joint policy, strategic plans, and contingency plans relating to national military strategy.

E4.7.5. Organizational Positions (other than those in the OSD, the Joint Staff, Combatant Command HQs Positions, or Defense Agencies HQs Positions). The incumbents of these positions are involved with matters related to the achievement of unified action by multiple military forces in operations conducted across domains such as land, sea, air, space, or in the information environment; where the preponderance of the incumbent's duties directly deal with producing or promulgating national military strategy, joint doctrine, joint policy, strategic plans or contingency plans, commanding and controlling operations under unified command, or national security planning with other departments and agencies of the United States. (DoDI 1300.19, 2007)

Positions requiring officers in the professional specialties are still excluded from the JDAL.

Joint Experience

The DoDI continues to maintain that the majority of the force will continue to complete a traditional S-JDA to earn full or cumulative joint credit. But some proportion of officers will be able to earn joint qualifications from an accumulation of joint experiences over their careers. The explanation for the change to a points system is described in greater detail in the JOM joint qualification system implementation plan:

This system will enable officers to be recognized, through a points system, for their joint experiences in a systematic, progressive manner. Under the JQS, joint experiences will accrue points toward four successive levels of joint qualifications and provide the joint commander (e.g., COCOM commander) a greater degree of fidelity in assessing the capabilities of each officer. This will tremendously improve the ability of the Department to ensure the appropriate mix of joint-experienced officers in each organization. (DoD, 2007a, p. 4)

As Enclosure 6 of DoDI 1300.19 (2007) points out, joint experience may be gained in the performance of duties that involve both aspects of the definition of *joint matters*: with whom the duty is performed and what it entails.

E6.1.1.1. The “who” includes: multiple military forces which refers to forces that involve participants from the armed forces and one or more of the following: other departments and agencies of the United States, the military forces or agencies of other countries, and non-governmental persons or entities.

E6.1.1.2. The “what” includes: operations conducted across domains such as land, sea, or air, in space, or in the information environment, including matters relating to national military strategy; strategic planning and contingency planning; command and control of operations under unified command; national security planning with other departments and agencies of the United States; and combined operations with military forces of allied nations.

E6.1.2. Officers may gain joint experience while serving in positions internal to their Service; however, these Service positions will not be placed on the JDAL. The Chairman of the Joint Chiefs of Staff shall establish a method of assessing joint experience gained from “in-Service” positions. (DoDI 1300.19, 2007)

Different Levels of Joint Qualification

The FY 2007 National Defense Authorization Act (Pub. L. 109-364, §516) directed the Secretary of Defense to “establish different levels of joint qualification, as well as the criteria for qualification at each level.” While, as noted previously, an S-JDA is still the primary means of achieving joint experience and joint duty credit, the new policy establishes a multilevel system that gives credit for joint experiences, regardless of where they accrue. DoDI 1300.19 (2007) establishes four different, progressive levels of joint qualification: levels I, II, III (joint qualified officer), and IV.

Table 3.1 shows the various qualification levels and the criteria for each. Joint qualification points are based on a formula that accounts

for the type, intensity and environment, and duration and frequency of the joint experience. The formula also takes into account education in joint matters. Table 3.2 shows the point-accrual formula.

Table 3.1
Joint Qualification Matrix

Level	Criteria
I	<ul style="list-style-type: none"> a. Awarded upon joint certification of pre-commissioning and basic officer course completion. <ul style="list-style-type: none"> — These courses provide learning objectives dealing with “Joint Introduction and Awareness.” b. Junior Officers are focused on Service competencies. c. Qualification points begin to accrue following commissioning via opportune joint experiences, joint training, joint exercises, and other education.
II	<ul style="list-style-type: none"> a. Awarded upon completion of JPME Phase I and accrual of 18 points and certification by the Chairman of the Joint Chiefs of Staff. b. A minimum of 12 points must come from “Joint Experience.” c. Discretionary points may be derived from joint experience, joint training, joint exercises, and other education. <p>NOTE: Officers who have Full Joint Tour Credit and have completed JPME Phase I are automatically designated as Level II.</p>
III	<ul style="list-style-type: none"> a. Awarded upon completion of JPME Phase II or AJPME ([reserve component] officers) and accrual of a minimum of 36 total points (based on Level II point requirements, normally 18 more points since Level II) or Full Joint Duty Credit, and certification by the Secretary of Defense or his designee. b. Recency requirement: a minimum of 12 points must come from “Joint Experience” since Level II designation. c. Discretionary points may be derived from joint training, joint exercises, and other education. d. Formal designation: Joint Qualified Officer (JQO). e. Effective 1 Oct 2008, JQO [status] required for appointment as an O-7 ([active component] Only).
IV G/FO Only	<ul style="list-style-type: none"> a. Awarded upon completion of CAPSTONE ([active component] only) and accrual of 24 joint experience points or full joint G/FO credit from an assignment in a [general or flag officer] joint billet in OSD/[Joint Staff]/COCOM HQs/JTF HQs/Defense Agency HQs, hold designation as a JQO, and certification by the Secretary of Defense or his designee. b. Officers must be a [general or flag officer] (for pay purposes) for at least one day while filling the [general or flag officer] S-JDA or during the period for which joint experience points are earned.

SOURCE: DoDI 1300.19 (2007, Table E3.T1).

Table 3.2
Point Accrual Formula

Component	Formula
Joint qualification level	Joint education + experience points + discretionary points
Joint experience points	Duration (months) × intensity factor ^a
Discretionary points ^b	Education + training + exercise
Education or training	degree or certification related to "joint matters" ^c
Exercise points	Role ^d

SOURCE: DoDI 1300.19 (2007, Table E3.T2 and para. E3.4.1.2–E3.4.2).

^a Duration: one month = 30.4 days. Intensity: combat = multiplier of 3; noncombat = multiplier of 2; steady-state employment = multiplier of 1. DoDI 1300.19 states, "The combat intensity factor will be correlated to the receipt of [Hostile Fire/Imminent Danger] pay." It lists as examples of the noncombat intensity factor "JTF Katrina, tsunami relief, and drug interdiction operations" and states, "The Chairman of the Joint Chiefs of Staff shall identify and certify which events/operations will qualify in this category." Finally, steady-state employment "includes any staff assignment in OSD, the Joint Staff, COCOM headquarters, Defense Agency headquarters, DoD Field Activities, or Military Department elements of U.S. Government Agencies outside the Department of Defense. This may also include joint experiences gained while assigned to a Service position, excluding those qualifying experiences in combat."

^b "'Discretionary' points may be earned from joint training, joint exercises, and other education that contribute to an officer's expertise in joint matters. Non-JPME education shall be included as a source of 'discretionary' points as a future implementation action only after appropriate and viable criteria for assessing joint content and value are defined."

^c Points for a degree or certification related to joint matters are listed as "to be determined."

^d Participant = 1 point; key participant or planner = 2 points; leader = 3 points.

According to DoDI 1300.19 (2007), to be a JQO, an officer must complete both JPME I and JPME II. Other programs, as approved by the Chair of the Joint Chiefs of Staff, may satisfy the JPME I requirement. However, an officer must complete JPME II at an approved school or college and will not be credited with JPME II until he or she has completed JPME I. Reserve component officers may complete AJPME in lieu of JPME II.

Promotion to General or Flag Officer

As in the original legislation, the new system maintains the requirement of a full tour of duty in a JDA for promotion to the grade of O-7, as well as the waivers for scientific and professional specialties:

The Secretary of Defense may waive the JDA requirement, the JQO requirement, or both on a case-by-case basis for the following reasons:

E11.3.1. Good of the Service. When this waiver is granted, the first duty assignment as a G/FO must be to an S-JDA.

E11.3.2. Scientific and Technical. This waiver may be requested for an officer whose selection is based primarily on scientific and/or technical qualifications for which S-JDA positions do not exist. . . . [O]fficers receiving scientific and technical waivers must have served continuously in the specialized field or serve in an S-JDA before reassignment to any other general/flag officer non-scientific/non-technical position. . . .

E11.3.3. Professional. For an officer whose military occupational specialty is medical officer, dental officer, veterinary officer, medical service officer, nurse, biomedical science officer, chaplain, or Judge Advocate General officer. (DoDI 1300.19, 2007)

Attendance at a capstone course (a course at National Defense University “designed to prepare O-7s to work in the joint environment”) is required within approximately two years of the selection’s confirmation by the Senate, “unless such attendance is waived” (DoDI 1300.19, 2007). The instruction lists the following reasons that a waiver might be granted:

E11.6.1. If the officer’s assignment immediately before selection to the grade O-7 was an S-JDA and the officer is thoroughly familiar with joint matters.

E11.6.2. When necessary for the good of the Service concerned.

E11.6.3. In the case of an officer whose selection for promotion is based on scientific and technical qualifications for which JDA positions do not exist.

E11.6.4. In the case of a medical officer, dental officer, veterinary officer, medical service officer, nurse, biomedical science officer, chaplain, or Judge Advocate General officer. (DoDI 1300.19, 2007)

Thus, the new JOM policy still excludes health care officers from joint duty credit requirements. The points system established by the new JOM policy should allow individual health care officers to request joint duty credit for serving in billets that provide them with joint duty experience, provided that this is validated by the board.⁵ However, to be fully joint qualified, an officer will still be required to attend JPME II. This is likely to be a large barrier, given the small number of seats set aside for health care officers and the opportunity costs of attending such a long program.

The next chapter presents data on experiences and the opinions of a sample of health care officers who participated in the 2005 JOM Census survey.

⁵ The most recent board validated 77 percent of officer applications for joint experience credit. The review panel relied heavily on the definition of *joint matters* presented in DoDI 1300.19 (2007) to determine whether the experience was joint.

Health Care Officers Serving in Joint or Potentially Joint Billets: Findings from the 2005 JOM Census Survey

The purpose of this chapter is to compare the experiences and work performed by the officers in health care billets to those of officers serving in JDAL billets, which are recognized in law as exemplifying “jointness,” using data from from the Web-based 2005 JOM Census survey. The survey was conducted under the guidance of the Office of the Under Secretary of Defense for Personnel and Readiness and analyzed by RAND. The data should help shed light on the issue of whether health care officers should be excluded from receiving joint duty credit, as is currently the case, regardless of the characteristics of the billets in which they are serving.

Background on the 2005 JOM Survey

The purpose of the 2005 JOM Census was to survey billets that required or were likely either to require prior joint experience or to provide officers with joint experience.¹ All billets on the JDAL were included automatically. Services and external organizations with some billets on the JDAL were asked to identify: (1) billets in which a prerequisite joint education and experience tour might better qualify an officer to perform the mission requirements of the position and (2) billets that provide officers with significant experience in joint matters (for example, billets that provide multinational, multiservice, or interagency experi-

¹ For a more detailed description of the survey and overall findings, see Kirby et al. (2006).

ence) and thus could be deemed similar to JDAs. Each service used its own criteria for nominating billets.

The 30,043 billets that were surveyed included 8,475 JDAL billets (out of 9,700 billets in 2004), 6,384 billets in external organizations, and 15,184 service-nominated billets.²

Overall, of the 30,043 unique billets that were identified, RAND received a total of 21,214 responses—a response rate of 71 percent. About 71–72 percent of JDAL and non-JDAL external organization billets responded. Of the services, the Navy had the highest response rate (90 percent) and the Marine Corps the lowest (44 percent). The Army and Air Force had response rates of 65 and 68 percent, respectively. The response rates varied considerably across billet organizations.

About 81 percent of the respondents were billet incumbents, 6 percent were supervisors of the billet, and another 13 percent were proxy respondents assigned to complete the survey.

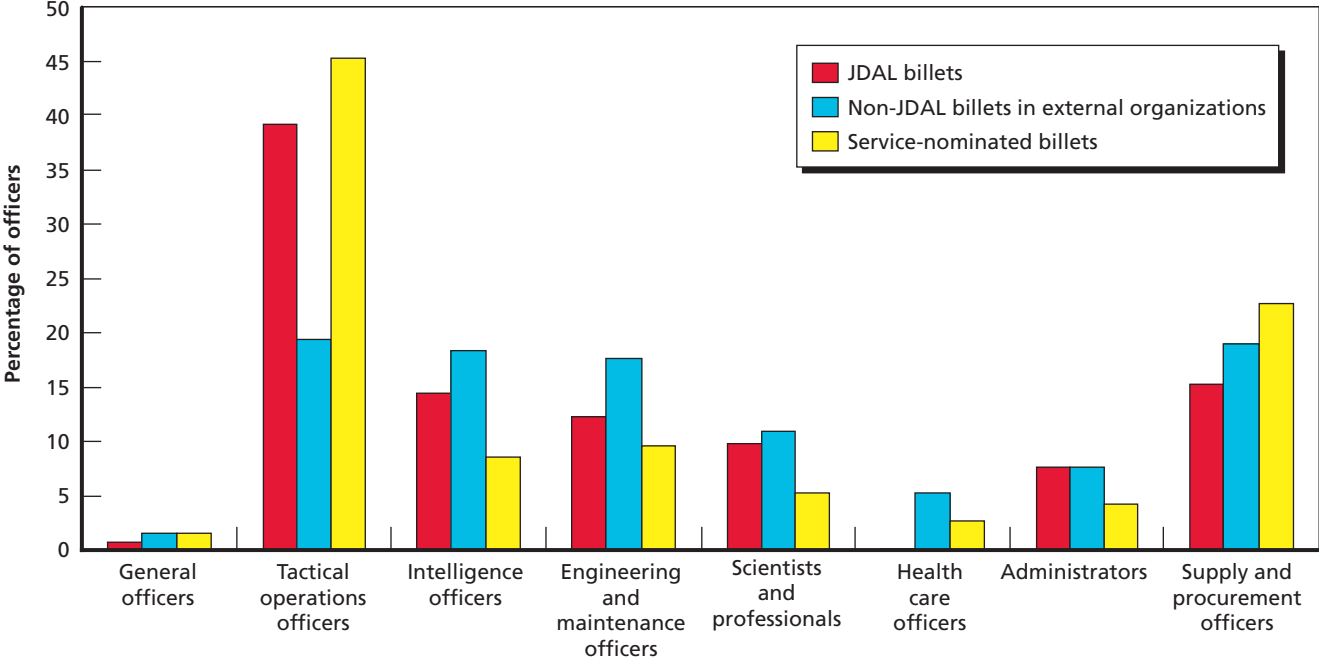
Occupational Distribution of Respondents

Billet incumbents were asked to identify their one-digit DoD occupational code. Close to 38 percent of incumbents were working in jobs classified as part of tactical operations. About 20 percent were supply and procurement officers, 12 percent were intelligence officers, and another 12 percent were engineering or maintenance officers. About 10 percent identified themselves as scientists and professionals, while 6 percent served as administrators. About 1.3 percent were general officers, and about 2 percent (N = 397) identified themselves as health care officers.

Figure 4.1 shows the distribution of officers by occupation for the three billet categories. Much higher proportions of officers assigned

² Although the intention had been to survey all billets that met these criteria—in other words, conduct a census of actual and potential JDA billets—the survey actually encompassed a subset of billets because of an outdated sampling frame, so some organizations were inadvertently excluded. We were unable to correct for nonresponse bias, so it should be noted that the survey findings are representative only of the survey respondents, not the entire population of joint or potentially joint billets.

Figure 4.1
Distribution of Officers by Occupation and JDAL Billet Status



RAND MG775-4.1

to JDAL or service-nominated billets were tactical operations officers, compared with those in non-JDAL billets in external organizations. More engineering/maintenance and intelligence officers served in these latter positions. As the figure shows, most health care officers were in non-JDAL positions.

Thus, among the 21,000 respondents, 397 officers identified themselves as health care officers. Of these, eight were serving in JDAL billets, 165 were in non-JDAL external organization billets, and 224 were in service-nominated billets. Among the remaining 20,817 billets, close to 30 percent (N = 6,131 billets) were JDAL billets. We used data on these two sets of billets (billets filled by self-identified health care officers and JDAL billets staffed by non-health care officers) to examine how the former sets of billets compared with JDAL billets in terms of work, experiences, and requirements for joint education and prior experience. For the remainder of this monograph, for ease of exposition, we refer to the latter set of billets as “JDAL billets,” without the additional qualifier “filled by non-health care officers.”

Descriptive Profile of JDAL Billets and Billets Staffed by Health Care Officers

We first present some descriptive data on the two sets of billets and the officers serving in these billets to set the context for the later analysis that examines how these billets rank on some typical metrics of jointness.

Table 4.1 shows that JDAL billets were overwhelmingly coded for grades O-4 through O-6. In contrast, billets filled by health care officers were coded for both lower and higher grades. For example, about 17 percent of billets filled by health care officers were O-3 billets, compared to none of the JDAL billets; another 6 percent were coded at the general officer level, compared to about 0.2 percent of the JDAL billets. The table also shows the major billet organization to which these

Table 4.1
Distribution of Billets by Billet Pay Grade, Major Billet Organization, and Billet Category

Billet Characteristic	% of total	
	JDAL Billets	Billets Staffed by Health Care Officers
Billet pay grade		
O-3	0.1	16.9
O-4	42.5	22.4
O-5	40.7	36.5
O-6	16.5	17.4
O-7–O-9	0.2	6.0
Unknown	0.0	0.8
Major billet organization		
Army	0.0	13.9
Navy	0.0	2.3
Air Force	0.0	40.3
Marine Corps	0.0	0.0
Joint Staff	11.0	2.5
OSD	3.3	4.3
U.S. Central Command JTF	0.0	0.0
International organizations	12.8	0.0
Combat support agencies	3.6	8.6
Other non-OSD defense agencies	3.6	1.3
OSD defense agencies	0.2	10.8
Educational agencies	2.1	0.8
Geographic commands	45.6	10.1
Force provider	5.3	1.5
Functional commands	12.8	3.8
Total billets	6,131	397

billets were assigned.³ The largest percentage of JDAL billets were assigned to the geographic commands (46 percent); another 11–13 percent were assigned to the Joint Staff, international organizations, and functional commands. The largest share of the billets in which health care officers were serving were in the Air Force (40 percent). The Army, Combat Support Agencies, and the geographic commands account for between 10–14 percent each.

Table 4.2 shows the organizations in which these 397 health care officers were serving. Of the eight JDAL billets filled by health care officers, three were at National Defense University, two at U.S. Southern Command, one at OSD, one at U.S. Northern Command, and one in the DoD Inspector General's office.

About 40 percent of officers serving in JDAL billets were tactical officers; another 12–14 percent were intelligence and engineering and maintenance officers. Scientists and professionals accounted for about 10 percent of those serving in JDAL billets, and about 8 percent were supply and procurement officers.

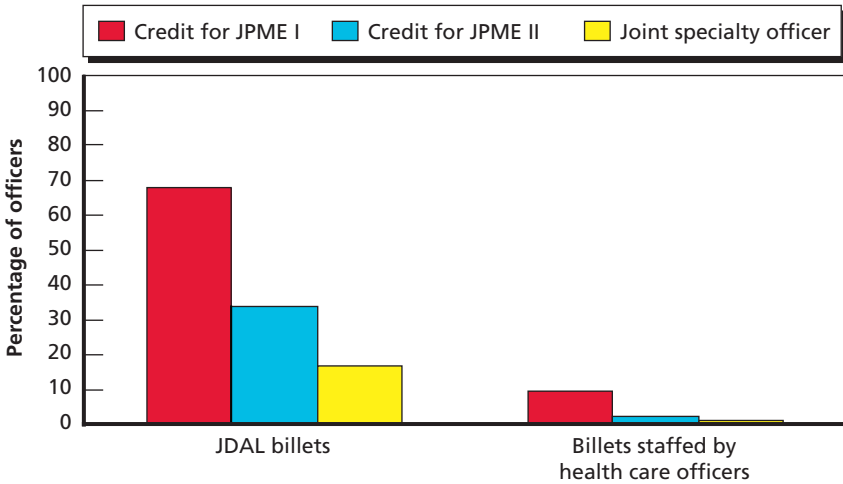
When we examine the education and prior joint experience of officers serving in these billets, we see marked differences between officers serving in JDAL billets and health care officers (see Figure 4.2), which is not surprising, given the exclusions and exemptions in the law about health care officers requiring joint professional education and serving in JDAs. For example, while 68 percent of those in JDAL billets reported receiving credit for JPME I, less than 10 percent of the health care officers did so. About a third of the former had received credit for JPME II, compared with 2 percent (N = 7) of health care

³ The geographic commands include U.S. Central Command, U.S. European Command, U.S. Northern Command, U.S. Pacific Command, U.S. Southern Command, and U.S. Special Operations Command; the international organizations include the Inter-American Defense Board and NATO; the functional commands include U.S. Strategic Command and U.S. Transportation Command; the force provider is U.S. Joint Forces Command (USJFCOM); and the combat support agencies include the Defense Contract Management Agency, Defense Information Systems Agency, Defense Intelligence Agency, Defense Logistics Agency, and the Defense Threat Reduction Agency. See Kirby et al. (2006) for a complete crosswalk between individual billet organizations and the major billet organization category.

Table 4.2
Location of Billets in Which Health Care Officers Were Serving

Billet Organization	Number
Army	55
Navy	9
Air Force	160
Joint Staff	10
OSD	17
DoD Inspector General	6
U.S. Central Command	5
U.S. European Command	6
U.S. Northern Command	8
U.S. Southern Command	5
U.S. Pacific Command	7
U.S. Joint Forces Command	6
U.S. Strategic Command	2
U.S. Transportation Command	13
U.S. Special Operations Command	9
National Defense University	3
TRICARE Management Activity	35
Defense Threat Reduction Agency	3
National Security Agency	3
Defense Contract Management Agency	1
Defense Intelligence Agency	15
Joint Requirements Office, Chemical, Biological, Radiological, Nuclear	2
Defense Logistics Agency	15
Pentagon Force Protection Agency	2
Total billets	397

Figure 4.2
Percentage of Officers Receiving Credit for JPME I, JPME II, and JSO Status, by Billet Category



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officers. Only two health care officers (less than 1 percent) reported being JSOs, compared with 16 percent of those assigned to JDAL billets. This is not surprising, given that achieving JSO status required both joint education and service in JDAL positions.

More than 90 percent of officers serving in JDAL billets were serving full time with members of another military department, and about 11 percent were serving in a billet assigned to another military department. Among health care officers, 73 percent reported serving full time with members of another military department, and 7 percent were serving in a billet assigned to another military department. About 15 percent of officers serving in JDAL billets were serving full time with armed forces of another nation or with an international military or treaty organization, and about half of these positions were billets in a foreign military or international organization. Among health care officers, about 4 percent served with foreign or international organizations, and only three (less than 1 percent) were actually assigned to a foreign or international organization.

Typical Metrics of Jointness

Earlier analyses done by RAND defined some typical metrics of jointness, including billet characteristics and tasks performed; frequent interactions with different organizations and personnel; types of education, training, knowledge required, desired, or considered important for carrying out the assignment; and types of joint experience afforded by the billet (e.g., multiservice, multinational, interagency). We now analyze how JDAL billets and those in which health care officers were serving ranked on these typical metrics of jointness.

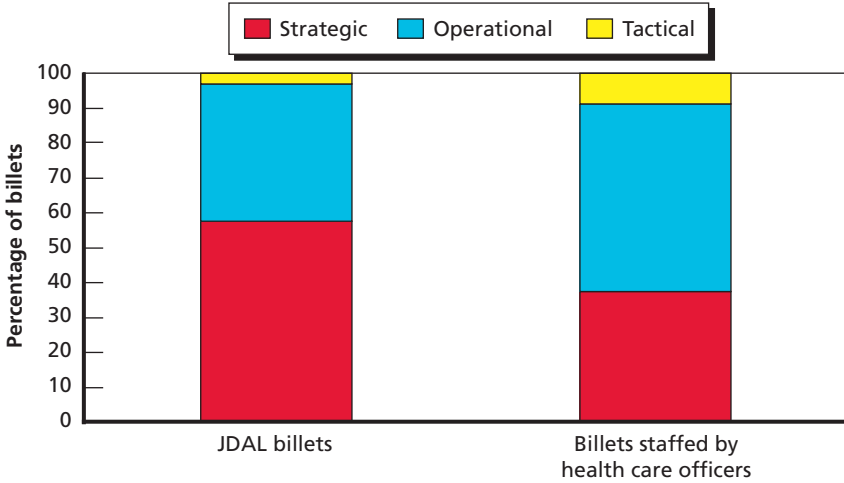
Categorization of Jobs, Supervision of Billets, and Joint Tasks Performed

Figure 4.3 shows the percentages of billets in each category that were described as primarily strategic, operational, or tactical. Close to 60 percent of JDAL billets were described as primarily strategic, compared with less than 40 percent of billets staffed by health care officers. The remaining JDAL billets were described as primarily operational, with less than 3 percent being described as dealing primarily with tactical matters. Billets staffed by health care officers appear to be more similar to JDAL billets in terms of being largely strategic and operational. In contrast, our earlier work (Kirby et al., 2006) showed that less than one-quarter of service-nominated billets were described as strategic and about 27 percent were described as dealing primarily with tactical matters.

Figure 4.4 speaks to the question of supervision of billets by non-own-service personnel, including civilians. Close to 80 percent of JDAL billets were supervised by non-own-service supervisors (including civilians), as are 64 percent of billets staffed by health care officers. This is considerably higher than the 20 percent of all non-JDAL service-nominated billets that were supervised by non-own-service supervisors (Kirby et al., 2006).

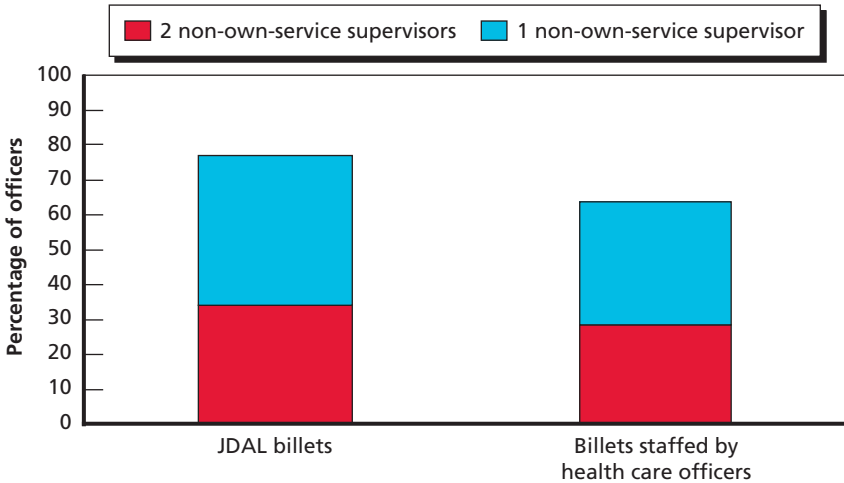
Officers were also asked about the different joint or potentially joint tasks they performed during a typical workweek. There is little difference in the median number of tasks performed ($N = 5$) during

Figure 4.3
Categorization of Billets by Primary Focus of Job, by Billet Category



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Figure 4.4
Percentage of Billets Supervised by One or More Non-Own-Service Supervisors, by Billet Category

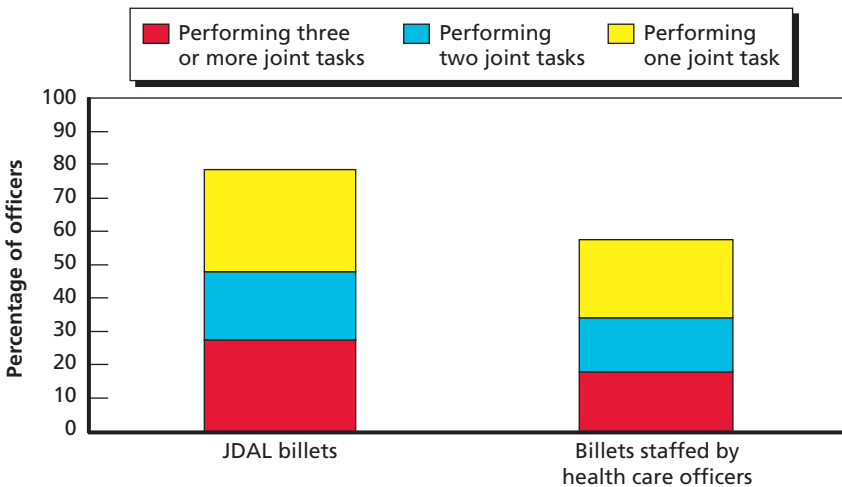


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a typical workweek by officers in the two billet categories. Some tasks, however, are arguably more “joint” than others. In earlier work, we identified four “highly joint” tasks: providing strategic direction and integration; developing or assessing joint policies; developing or assessing joint doctrine; and fostering multinational, interagency, or regional relations. Overall, we find that close to 80 percent of officers assigned to JDAL billets reported performing one or more of these highly joint tasks during a typical workweek; this was true of 57 percent of health care officers (see Figure 4.5).

It is also interesting to examine how many officers in each billet category perform the specific tasks and the importance of the task to the billet. Table 4.3 reports the percentages of officers in the two billet categories who reported performing each of these four highly joint tasks. The table also shows the percentage of officers (among those performing the task) who ranked the task as being of “primary importance” or “vitaly important” to their job. Close to 60 percent of officers

Figure 4.5
Percentage of Officers Performing One or More “Highly Joint” Tasks, by Billet Category



in JDAL billets reported providing strategic direction and integration, and between 30 and 40 percent reported developing or assessing joint policies and doctrine and fostering complex relations among agencies, regions, or nations. A substantial percentage of health care officers (almost half) also reported providing strategic direction and integration, and close to 30 percent reported being involved with developing or assessing joint policies. Smaller percentages (17–22 percent) reported developing or assessing joint doctrine or being involved with interagency or multinational relations. However, among those officers who reported doing a given task, between 40 and 76 percent rated the task as of primary or vital importance to their job.

Table 4.3
Percentage of Officers Performing Selected “Highly Joint” Tasks and Reporting That the Task Is of Primary or Vital Importance to Their Job, by Billet Category

Task	% of Total	
	JDAL Billets	Billets Staffed by Health Care Officers
Provide strategic direction and integration	59.0	47.4
Develop/assess joint policies	37.5	28.2
Develop/assess joint doctrine	32.8	21.7
Foster multinational, interagency, or regional relations	31.6	17.4
Of Those Performing a Given Task	% Reporting That the Task Is of Primary or Vital Importance to Their Job	
Provide strategic direction and integration	76.3	75.3
Develop/assess joint policies	47.6	56.9
Develop/assess joint doctrine	39.3	47.0
Foster multinational, interagency, or regional relations	66.3	44.8

Interactions with Organizations and Personnel

Officers were asked about interactions with different organizations and types of personnel and the frequency of those interactions. If we examine the median number of non-own-service organizations with which officers reported interacting monthly or more frequently, we find a substantial difference between JDAL billets and those staffed by health care officers. JDAL billets typically required frequent interactions with six organizations, other than their own service, compared with only three for the latter set of billets. The middle 50 percent of officers in JDAL billets reported that they frequently interacted with between two and 11 organizations, compared with one to seven for health care officers.

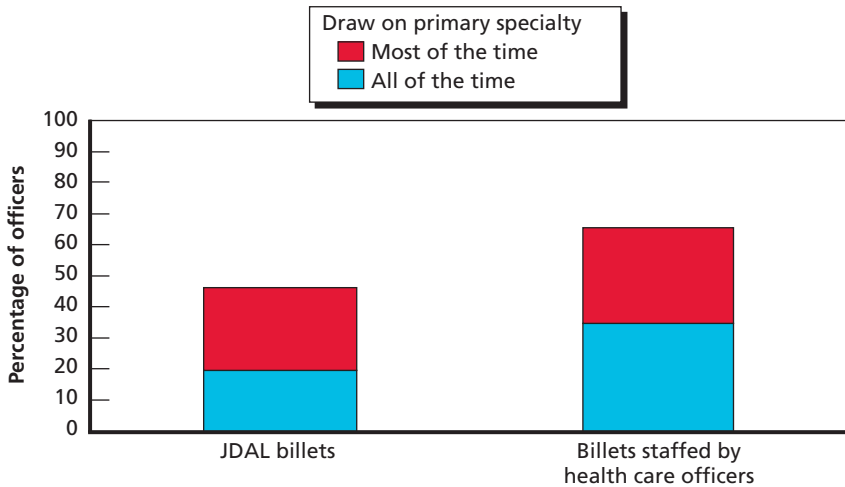
Interestingly, there is not much difference in the variety of personnel with whom the two types of officers interacted on a frequent basis (monthly or more). Officers serving in JDAL billets appeared to interact frequently with five different types of personnel, compared with four for health care officers.

Importance of Specialty, Expertise, Service Competency, Education, and Experience

Respondents were asked a series of questions about what was needed to carry out their respective assignment's responsibilities successfully. Figure 4.6 shows the percentage of officers reporting that they drew on their primary specialty most or all of the time. Health care officers tended to rely on their primary specialty to a much larger degree than officers in JDAL billets. For example, 65 percent of health care officers reported relying on their primary specialty most or all of the time, compared with 47 percent of those in JDAL billets.

Officers were also asked to rank the skill, education, expertise, and experiences that were most important to them in successfully carrying out their billet duties. Figure 4.7 shows these responses. Across both groups, functional expertise in nonacquisition matters was rated most important (29 percent of officers serving in JDAL billets and 34 percent of health care officers), followed by service core competencies (20–21 percent). A higher percentage of JDAL officers ranked prior

Figure 4.6
Percentage of Officers Reporting That They Drew on Their Primary Specialty Most or All of the Time in Carrying Out Assignment, by Billet Category

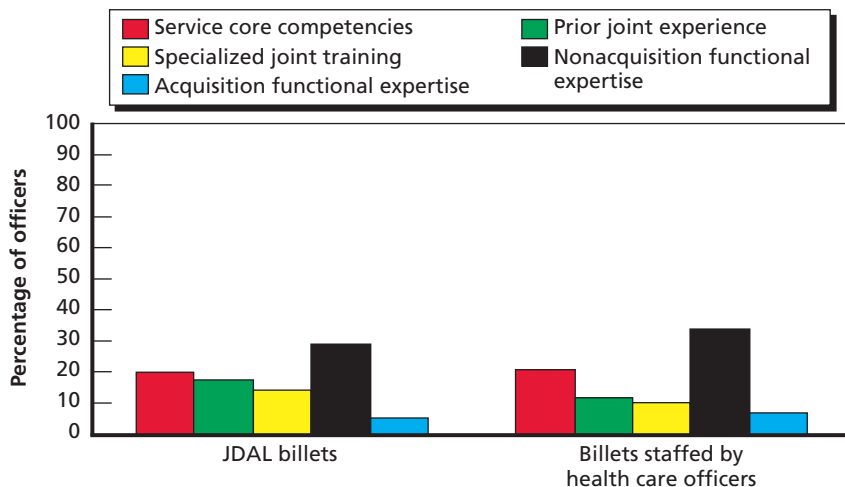


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joint experience and specialized joint training as key to success compared with health care officers (32 percent versus 23 percent).

If jobs require specialized service expertise, they are not likely to be as “joint” as the law intends them to be. An indicator of this is the opinion of those serving in the billet regarding the substitutability of civilians and officers from another service in that billet. Figure 4.8 examines the responses of officers to questions regarding the ability of civilians and officers from another service to carry out the assignment effectively. Almost one-third of officers in JDAL billets and one-quarter of health care officers agreed or strongly agreed that civilians could carry out their duties just as effectively as they could. Between half and two-thirds of officers in these billets reported that officers from another service could do so. This agrees with what we discussed earlier: Service core competencies were not as important as functional expertise or joint training and experience in carrying out billet duties.

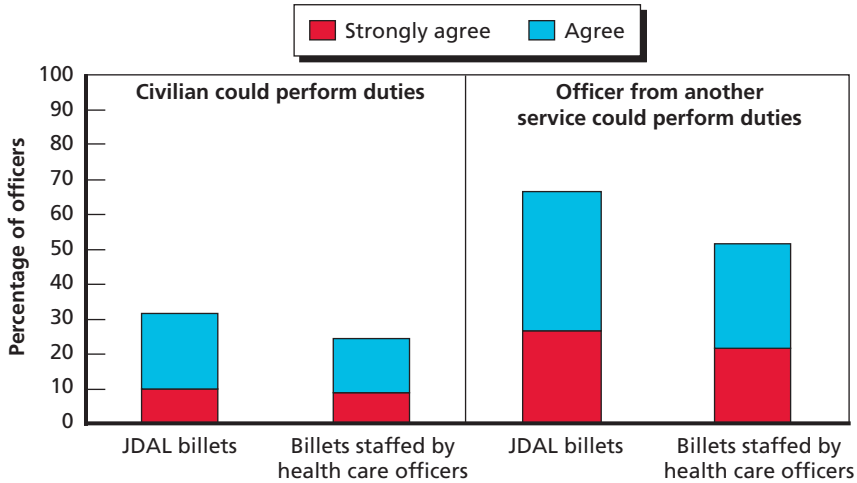
Figure 4.7
Percentage of Officers Ranking Service Competencies, Joint Experience, and Functional Expertise as “Most Important” in Carrying Out Assignment, by Billet Category



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Figures 4.9 through 4.10 examine officers’ responses with respect to the desirability of prior joint education or experience for the billet. Because greater emphasis is given to the professional education and knowledge of health care officers, their opportunities to attend JPME I and JPME II are fairly limited. As a result, close to 60 percent of health care officers (compared with 15 percent of officers serving in JDAL billets) reported that they had no experience with JPME I and, as such, did not want to offer an opinion as to whether JPME I was needed to perform billet duties successfully. The percentages of those who reported that they did not have any experience with JPME II and did not offer an opinion were understandably higher (72 percent of health care officers and 31 percent of officers in JDAL billets). The data reported in the figures and discussed here exclude the “no experience/no opinion” responses.

Figure 4.8
Percentage of Officers Agreeing or Strongly Agreeing That Civilians or Officers from Another Service Could Carry Out Assignment Effectively, by Billet Category

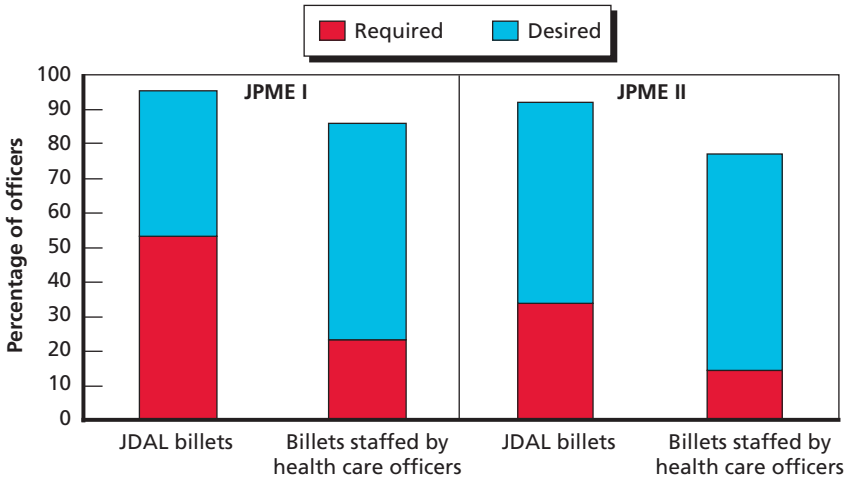


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Almost all officers in JDAL billets (95 percent) reported that JPME I was at least *desired* for successful billet performance, and about 45 percent reported that JPME I was required (see Figure 4.9). Health care officers were less likely to believe that JPME I was required (23 percent), but more than 60 percent reported that JPME I was desirable for successful performance. More than 90 percent of officers in JDAL billets and over three-quarters of health care officers believed that JPME II was either required or desired for successful performance in the billet.

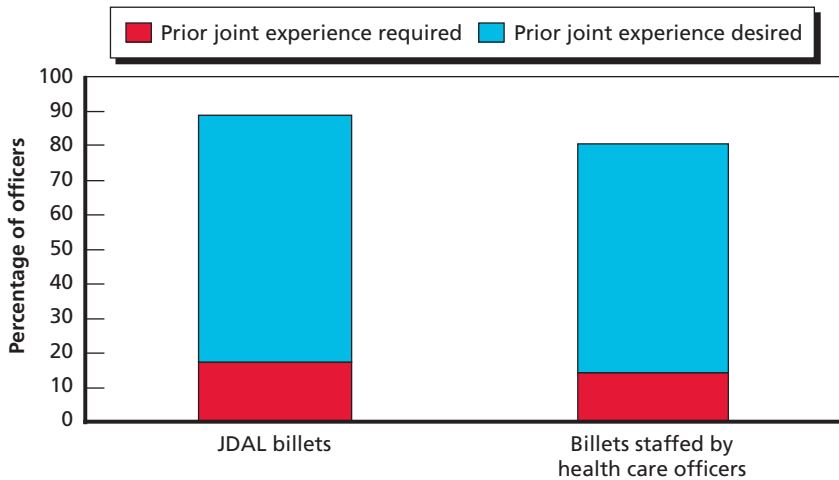
Close to 90 percent of officers in JDAL billets and 80 percent of health care officers reported that prior joint experience was required or desired for the billet (see Figure 4.10).

Figure 4.9
Percentage of Officers Reporting That JPME I and JPME II Were Required or Desired for the Billet, by Billet Category



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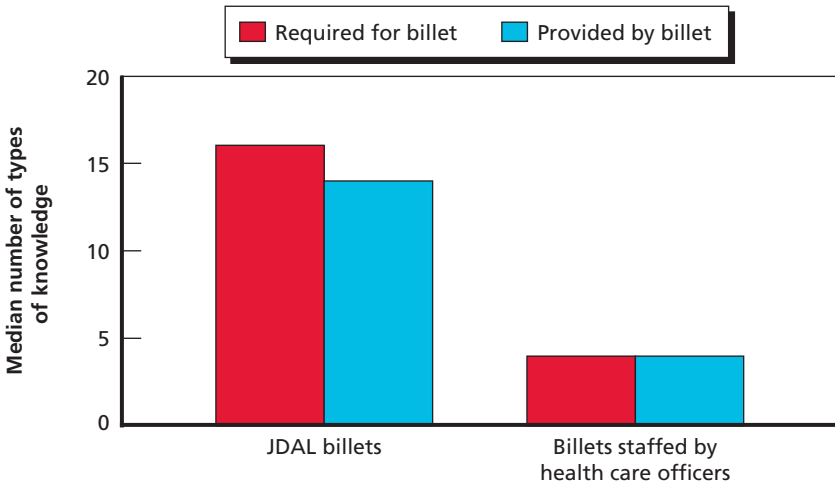
Figure 4.10
Percentage of Officers Reporting That Prior Joint Experience Was Required or Desired for the Billet, by Billet Category



RAND MG775-4.10

In addition to these questions, officers were presented with a list of several different categories of knowledge (drawn largely from the JPME curriculum) and asked to rate these in terms of whether the specific knowledge was required for the billet and whether proficiency in such matters was gained by serving in the billet. Figure 4.11 shows the median number of different knowledge types that were required and provided by the billet. There are substantial differences in the responses: Officers in JDAL billets reported that their billets required about 16 types of knowledge, on average, compared with four types reported by health care officers. While officers serving in JDAL billets believed that they required a much broader set of knowledge to perform the job successfully (for example, knowledge of national military capabilities, national military strategy and process, theater strategy and campaigning, and geo-strategic context, among other broad categories), health care officers reported needing specific kinds of knowledge. In particular, knowledge of medical or health care, manpower or personnel, and

Figure 4.11
Median Number of Types of Knowledge Required and Provided by the Billet, by Billet Category



scientific matters were more frequently mentioned by health care officers than by their counterparts serving in JDAL billets.

Types of Experience Provided by the Billet

Until 2007, the criteria for becoming a JSO include completion of JPME II and serving in a JDAL billet. It is important to identify billets that provide joint experience to see whether these would qualify officers serving in them to get joint duty credit.

An important finding from the survey is that the ability to get a variety of joint experience is not limited to JDAL billets. This is amply demonstrated by Figures 4.12 through 4.14, which present officers' responses about whether the billets in which they were serving provided them with multiservice, multinational, and interagency experience. For example, 40–42 percent of officers in both types of billets “strongly agreed” that the billet provided them with multiservice experience.

Figure 4.12
Percentage of Officers Agreeing or Strongly Agreeing That the Billet Provides Significant Multiservice Experience, by Billet Category

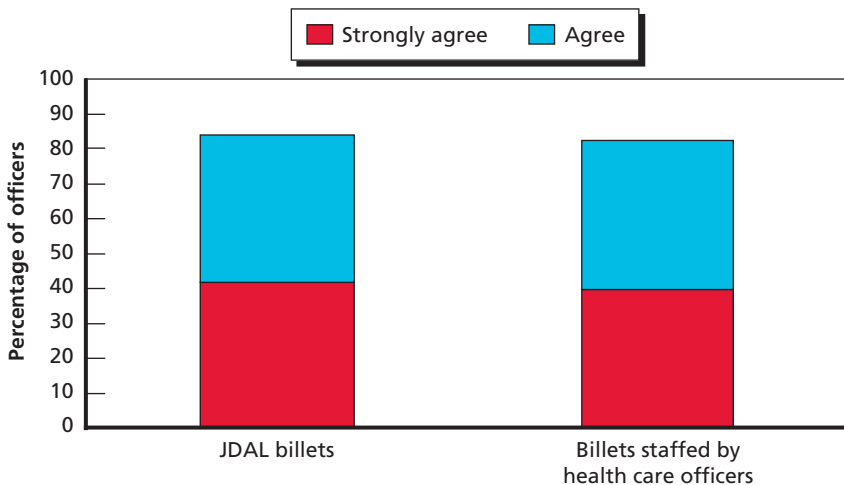
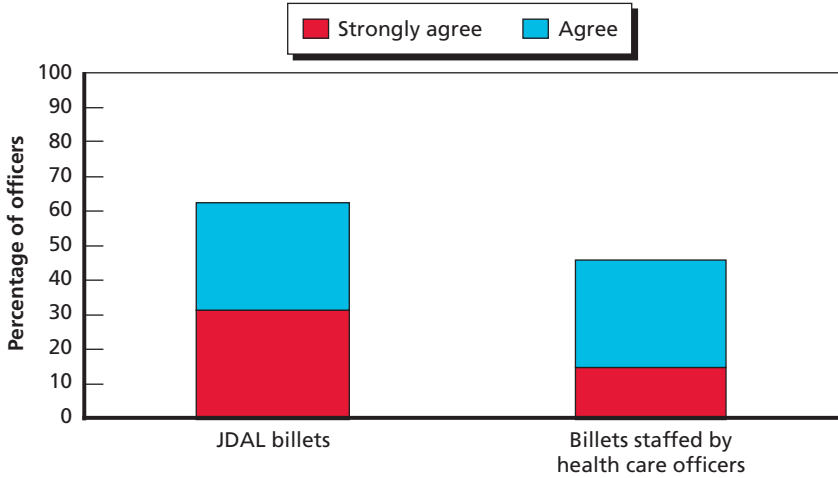
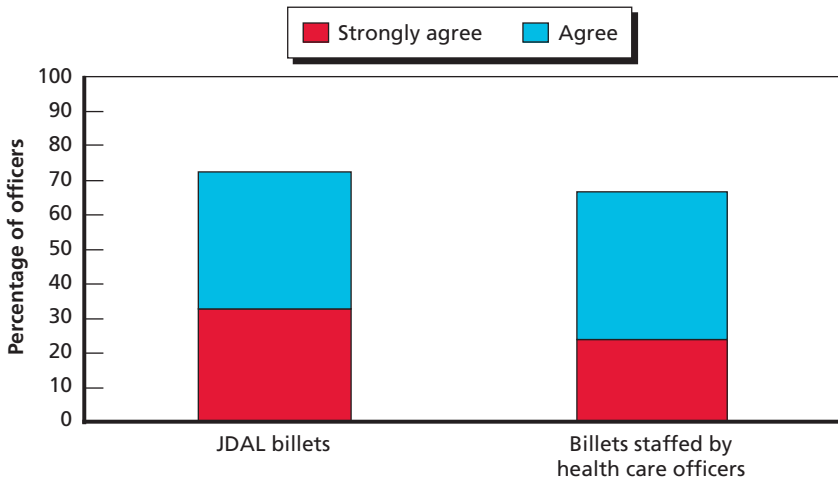


Figure 4.13
Percentage of Officers Agreeing or Strongly Agreeing That the Billet Provides Significant Multinational Experience, by Billet Category



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Figure 4.14
Percentage of Officers Agreeing or Strongly Agreeing That the Billet Provides Significant Interagency Experience, by Billet Category

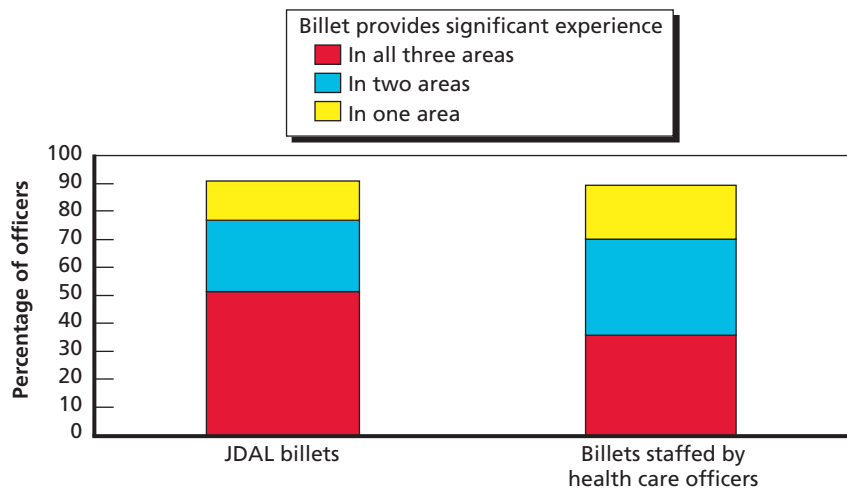


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If we include those who “agreed,” the percentage increases to 82–84 percent. The percentages of billets providing significant multinational experience were somewhat lower—63 percent of JDAL billets and 46 percent of billets staffed by health care officers. Between 67 and 73 percent of billets provided significant interagency experience. In contrast, our earlier work showed that only half of all service-nominated billets provided significant multiservice experience, and 40–44 percent provided significant experience in multinational and interagency matters (Kirby et al., 2006).

Figure 4.15 summarizes the types of significant experience provided by the two sets of billets. Ninety percent or more of both sets of billets provided significant experience in at least one key joint area. More than 70 percent of JDAL billets and billets staffed by health care officers provided significant experience in two or more key areas. The one major difference is that while more than half the JDAL billets provided significant experience in all three key areas, this is true of 36 percent of the billets staffed by health care officers. Thus, overall,

Figure 4.15
Percentage of Officers Agreeing or Strongly Agreeing That Their Billet Provides Significant Experience in One, Two, or Three Key Areas, by Billet Category



of the 397 billets staffed by health care officers, about 60 were characterized as providing significant joint experience in two or more areas. Of these 60 billets, 28 were internal Air Force billets, eight were assigned to the geographic commands, six were assigned to OSD agencies, and the others were distributed across the other major billet organizations.

Comments of Health Care Officers

Many officers provided additional comments at the end of the survey. The comments reinforce the findings presented in this chapter: Many health care officers are indeed working in joint environments that provide significant joint experiences and should be considered on a case-by-case basis for joint duty credit. Table A.1 in the appendix provides the complete set of verbatim responses.⁴ It also shows the billet pay grade and the type of billet in which the respondent was serving (JDAL billet, non-JDAL billet in an external organization, and service-nominated billet). A few typical, verbatim examples are provided here:

Joint Experience is essential for continued growth.

—O-5, in non-JDAL billet in external organization

Medical personnel serving in Joint Billets should be given the same opportunity and requirement as the rest of the services. Medical planners and operations personnel perform the same functions without the benefit of this training.

—O-5, in non-JDAL billet in external organization

Yes. As a medical staff officer in the Joint Environment, we should be able to become JPME trained and qualified as “Joint Qualified” officers. If medical isn’t the modal [sic] for joint then I don’t know what is. . . . It seems ridiculous that I have served over four years in the Joint environment (will have potentially over 7 years joint following this assignment) and I will not be “Joint Qualified” because Joint Qualification only applies to the

⁴ Some identifying details in the comments included here and in Table A.1 in the appendix have been blanked out to maintain the privacy of the respondents.

the [sic] line (DOPMA [Defense Officer Personnel Management Act]) officers.

—O-5, in non-JDAL billet in external organization

I think that this billet should be reclassified as a joint assignment because it is a unique situation where the three services work together to manage joint service programs and collaborate on joint [. . .] health issues that drive joint policies and doctrine.

—O-5, in internal service-nominated billet

A person serving in my billet interacts with all US military services, US embassy, host country armed forces, local host country civilian health care organizations and other host country governmental organizations.

—O-5, in internal service-nominated billet

Summary

While billets in which health care officers are serving do not reach the same level of “jointness” as the JDAL billets, they appear to rank high on several metrics of jointness, particularly with respect to the kinds of joint experiences they provide, the kinds of tasks being performed, and the usefulness of joint education and experience for the billet. The one major area of difference is the breadth of knowledge required to perform the duties of the billet successfully. Even then, it must be remembered that the analysis dealt largely in averages—individual billets may well require broader-based sets of knowledge that are not represented by the median. Thus, we recommend that billets be considered for inclusion on the JDAL on a case-by-case basis.

Qualifying Health Care Officers as Joint Officers: Implementation Issues

This chapter examines the feasibility of extending joint duty requirements and joint professional education to health care officers and the implementation issues that would arise in doing so. In particular, it addresses the following questions:

- What is the pool of likely positions that could provide joint experience to health care officers?
- How can health care officers gain joint professional education?
- What are the additional barriers to qualifying health care officers as joint?

Joint Experience: Defining a Potential JDAL for Medical Specialties

DoD policymakers stress that there are two components to a determination about joint qualification: “Whom” the officer interacts with and “what” he or she does (joint matters) during these interactions. We examined the billets in which health care officers are serving to identify a set of billets that potentially could fit the “who” part of the definition because they are non-own-service billets. Obviously, apart from the data on the limited set of billets included in the JOM Census survey and described in the previous chapter, we cannot address exactly whether billet incumbents are really involved with joint matters.

As mentioned earlier (and repeated here for convenience), DoDI 1300.19 (2007) currently excludes positions requiring officers in the

professional specialties (medical officers, dental officers, veterinary officers, medical service officers, nurses, biomedical science officers) from the JDAL. Thus, it is important to note that the billets we examine in this chapter already exist in organizations and have health care officers assigned to them. They are not new or additional billets. This section discusses including such billets on the JDAL, not creating additional positions.

We used data from the Defense Manpower Data Center (DMDC), its Forces Management Information System (FORMIS), and service manpower data files to explore the questions “who” and “what.”

We first examined all organizations that typically have billets on the JDAL and identified health care officer authorizations in those organizations. This screen identified about 270 billets: 33 percent Air Force, 23 percent Navy, and 44 percent Army billets. These positions are predominantly in OSD, the Joint Staff, the COCOMs, NATO, the Defense Logistics Agency, and the Defense Threat Reduction Agency. This provided a conservative lower bound for the number of positions that could potentially be placed on the JDAL to provide health care officers with joint duty experience and credit.¹

We then conducted a wider data-based screen of all organizations to identify potential positions—including internal service billets—that routinely require interactions with other services or interagency or international communities. This represents a larger pool of positions that could potentially provide joint experience.² This wider screen iden-

¹ Some positions are rotational (filled by different services on a sequential basis), and some are nominative (the incumbent is selected from service nominees). The position data are adjusted to reflect the service of the incumbent and change when a different service fills the position.

² We used data from the FORMIS system maintained by the Defense Manpower Data Center, which provides information about authorizations (specific billets or positions). Officers can also now apply for experience points while serving in worldwide JTFs that are heavily engaged in coalition, multiservice, or interagency operations, given that such service meets the test of joint matters. The numbers of such qualifying positions will vary over time based on military missions on behalf of U.S. security policy. Because of the increasing emphasis on SSTRO overseas and defense support to civil-authority operations in the United States, health care officers are more likely to gain experience in multinational, interagency, and intergovernmental matters.

tified about 840 positions: 45 percent Air Force, 17 percent Navy, and 38 percent Army billets. We suspect that many of the positions in this larger group may fail to pass the “what” part of the definition because the work required in the billet will likely not meet the definition of *joint matters*.

In the following sections, we show the positions identified in the wider screen, by service, compared with all authorizations for health care officers.

Air Force

In FY 2007, there were approximately 11,800 manpower authorizations for health care officers in Air Force units. Table 5.1 shows the distribution of these authorizations by grade and the five medical corps: Biomedical Sciences Corps, Dental Corps, Medical Corps, Medical Service Corps, and Nurse Corps.

The vast majority of these billets are in organizations internal to the Air Force. A total of 374 authorizations (3.2 percent of total Air Force health care billets) were in organizations external to the Air Force or in internal service billets with routine interactions with inter-agency or multinational organizations or with the other services. These

Table 5.1
Air Force Health Care Manpower Authorizations, by Corps and Rank, FY 2007

Corps	Lieutenant	Captain	Major	Lieutenant Colonel	Colonel	Total
Biomedical Sciences Corps	207	1,011	776	361	83	2,438
Dental Corps	—	369	260	211	179	1,019
Medical Corps	—	1,404	1,167	622	378	3,571
Medical Service Corps	48	351	288	256	74	1,017
Nurse Corps	794	1,761	853	297	78	3,783
Total	1,049	4,896	3,344	1,747	792	11,828

organizations spanned the spectrum from OSD to the Joint Staff to combatant commands to defense agencies. The distribution of these billets by rank and corps is shown in Table 5.2.

Thus, a small number of Air Force officers in medical specialties are serving in positions that could potentially be included on the JDAL or provide joint experience. Some of these positions are in organizations that might not be considered to be performing joint functions as specified in DoDI 1300.19 (2007), but many may well be.

As Table 5.3 shows, disproportionately more Medical Service Corps and Biomedical Sciences Corps officers are in potentially joint positions compared with officers in other specialties. For example, while Medical Service Corps officers comprise only 9 percent of all authorizations for health care officers, they occupy 24 percent of billets in external organizations. It is also clear that, relative to the size of the authorization base, there are limited opportunities to become a JQO. Medical specialties will have difficulty achieving the CJCS vision of full joint qualification at the rank of colonel.

Table 5.2
Air Force Health Care External Manpower Authorizations, by Corps and Rank, FY 2007

Corps	Lieutenant	Captain	Major	Lieutenant Colonel	Colonel	Total
Biomedical Sciences Corps	7	13	49	52	14	135
Dental Corps	—	—	1	2	4	7
Medical Corps	—	—	10	29	43	82
Medical Service Corps	—	10	23	50	7	90
Nurse Corps	—	12	20	22	6	60
Total	7	35	103	155	74	374

Table 5.3
Percentage Distribution of Air Force Total and External Health Care
Manpower Authorizations, by Corps, FY 2007

Corps	% of All Health Care Authorizations	% of External Health Care Authorizations
Biomedical Sciences Corps	20.6	36.1
Dental Corps	8.6	1.9
Medical Corps	30.2	21.9
Medical Service Corps	8.6	24.1
Nurse Corps	32.0	16.0

Army

In FY 2007, there were approximately 13,700 manpower authorizations for health care officers in Army units distributed by grade and the six corps: Medical Corps, Dental Corps, Veterinary Corps, Medical Specialist Corps, Nurse Corps, and Medical Service Corps. The distribution is shown in Table 5.4.

As with the Air Force, the vast majority of these billets were in organizations internal to the Army. Only 317 of the 13,725 manpower

Table 5.4
Army Health Care Manpower Authorizations, by Corps and Rank, FY 2007

Corps	Lieutenant	Captain	Major	Lieutenant Colonel	Colonel	Total
Dental Corps	—	200	275	291	288	1,054
Medical Corps	—	1,618	1,456	688	474	4,236
Medical Service Corps	643	1,228	947	643	220	3,681
Medical Specialist Corps	102	587	244	74	26	1,033
Nurse Corps	827	1,119	822	418	126	3,312
Veterinary Corps	—	112	148	105	44	409
Total	1,572	4,864	3,892	2,219	1,178	13,725

authorizations (2.3 percent) were in organizations external to the Army. The distribution by corps and rank is shown in Table 5.5.

As Table 5.6 shows, some corps are disproportionately represented among billets in external organizations. For example, the Veterinary Corps accounts for only 3 percent of all authorizations of health care officers but 17 percent of all authorizations in external organizations.

Table 5.5
Army Health Care External Manpower Authorizations, by Corps and Rank, FY 2007

Corps	Lieutenant	Captain	Major	Lieutenant Colonel	Colonel	Total
Dental Corps	—	—	—	5	—	5
Medical Corps	—	1	10	39	41	91
Medical Service Corps	1	16	50	60	16	143
Medical Specialist Corps	—	6	2	3	—	11
Nurse Corps	—	2	6	5	—	13
Veterinary Corps	—	6	24	15	9	54
Total	1	31	92	127	66	317

Table 5.6
Percentage Distribution of Army Health Care Manpower Authorizations, by Corps, FY 2007

Corps	% of All Health Care Authorizations	% of External Health Care Authorizations
Dental Corps	7.7	1.6
Medical Corps	30.9	28.7
Medical Service Corps	26.8	45.1
Medical Specialist Corps	7.5	3.5
Nurse Corps	24.1	4.1
Veterinary Corps	3.0	17.0

The same is true of the Medical Service Corps. On the other hand, the Nurse Corps has limited external positions relative to its size (4 percent of external authorizations compared with 24 percent of all health care officer authorizations).

Navy

In FY 2007, there were approximately 10,600 manpower authorizations for health care officers in Navy units (see Table 5.7) in four medical corps: Medical Corps, Dental Corps, Medical Service Corps, and Nurse Corps.

As with the Air Force and Army, the vast majority of these billets were in organizations internal to the Navy. Only 147 (1.4 percent) were in organizations external to the Navy (see Table 5.8).

The observations made for the other services are also true for the Navy. Disproportionately more Medical Service Corps officers were in potentially joint positions relative to the other specialties as shown in Table 5.9.

Developing Officers with Joint Experience

How officers are managed through these potentially qualifying billets affects the eventual number of officers with joint qualifications. A career management system that applies to tactical operations officers in the service-line communities and from which future leaders are

Table 5.7
Navy Health Care Manpower Authorizations, by Corps and Rank, FY 2007

Corps	Ensign/ Lieutenant, Jr. Grade	Lieutenant	Lieutenant Commander	Commander	Captain	Total
Dental Corps	—	446	309	208	238	1,201
Medical Corps	—	1,326	1,396	737	400	3,859
Medical Service Corps	328	1,168	551	317	137	2,501
Nurse Corps	844	1,089	649	350	111	3,043
Total	1,172	4,029	2,905	1,612	886	10,604

Table 5.8
Navy Health Care External Manpower Authorizations, by Corps and Rank, FY 2007

Corps	Ensign/ Lieutenant, Jr. Grade	Lieutenant	Lieutenant Commander	Commander	Captain	Total
Dental Corps	—	2	1	1	2	6
Medical Corps	—	2	1	18	24	45
Medical Service Corps	1	14	29	32	13	89
Nurse Corps	—	—	1	2	4	7
Total	1	18	32	53	43	147

Table 5.9
Percentage Distribution of Navy Health Care Manpower Authorizations, by Corps, FY 2007

Corps	% of All Health Care Authorizations	% of External Health Care Authorizations
Dental Corps	11.3	4.1
Medical Corps	36.4	30.6
Medical Service Corps	23.6	60.5
Nurse Corps	28.7	4.8

being developed features relatively shorter joint assignments to develop officers faster and higher promotion and retention rates for officers who have served in joint assignments. This ensures that officers with a higher likelihood of becoming general and flag officers have gained the relevant and required joint experience.

Another system appears appropriate to occupations that are already highly joint and would result in something like a joint cadre. The main feature of such a system is that officers who served in a joint assignment would be highly likely to serve repeatedly in joint assignments for longer periods of time. This joint experience would come at the cost of maintaining service expertise, depending on occupational

specialty. With this approach, fewer officers would attain joint qualification for the same number of qualifying billets.

Another system can distribute joint experience more widely through the officer corps and is particularly appropriate for services that emphasize equity or are reluctant to identify future leaders early. The system would give greater weight to maximizing the number of officers who have joint experience, not necessarily limiting the experience to the highest potential officers or to a cadre. Thus, this model sends more average officers to joint assignments and promotes and retains them at average rates.

Typically, the officer system focuses on filling vacant positions and does not systematically develop joint. It simply focuses on the question of who is available to assign when someone is needed.

A single system may not apply to all communities in all services. Depending on the goals of the system, one or more of these might be appropriate for the medical community, as discussed later.

Providing Joint Professional Military Education to Health Care Officers

If joint experience is a potential roadblock to gaining full joint qualification, JPME is even more so. Attaining full joint qualification requires both experience and education. There are limited opportunities for health care officers to get credit for a JPME II educational opportunity.

JPME is a body of objectives, outcomes, policies, procedures and standards supporting the educational requirements for JOM approved by the CJCS. It is a three-phase approach to professional development in joint matters consisting of JPME I, JPME II, and the capstone course. As mentioned earlier, JPME II credit is required to attain full joint qualification.

Currently, there are about 1,900 education seats that are authorized and certified for JPME II credit. These include seats at the NWC, ICAF, JFSC, and senior-level service programs, including the U.S.

Army War College, the U.S. Navy College of Naval Warfare, the U.S. Marine Corps War College, and the U.S. Air Force Air War College.

These seats are, for the most part, allocated to the military services and assigned, in turn, to the various communities. The health care professions have limited allocations. For example, the Air Force allocates about 15 seats each year at NWC, ICAF, and the Air War College to health care officers. The Army slated 10 health care officers to attend these senior service colleges in 2008. Opportunities to attain JPME II qualification are thus extremely limited—more so than the opportunity to gain joint experience. Only about 40 officers across the services would gain JPME II qualification annually.

We examined the biographies of 37 health care general and flag officers serving in general and flag officer billets³ to determine whether they had attended a JPME II–qualifying college. Among the 37 officers, 21 had attended a senior service school. Of course, it should be recognized that these officers received their training and education in the past, when joint education for health care officers was not widely considered. This may change in the future, especially since attendance at the senior service schools now qualifies for JPME II. However, the total availability of seats will remain a serious barrier.

Barriers to Extending Joint Duty and Education Requirements to Health Care Officers

Besides the limited opportunity to qualify selected officers in joint matters, there are other major barriers to extending or expanding JPME and JDA requirements to the medical field: the costs of medical training and the additional continuing education requirements that are mandatory for license re-registration in certain fields. We discuss each briefly in turn.

³ The billets were extracted from a database of general and flag officer positions maintained by OSD.

Cost of Medical Training and Use as Clinicians

One of the major issues that arises when considering adding JPME and JDAs to the professional careers of military health care officers is the large opportunity cost of sending highly trained clinicians to a resident JPME school for a sustained period of time or assigning them to work on joint matters for two to three years if they are not already doing so. A recent CNA Corporation report estimated the resources currently devoted to in-house training programs for physicians, dentists, and certified registered nurse anesthetists (Levy, Christensen, and Asamoah, 2006). Assuming an annual cost to DoD of about \$119,000 per student for graduate medical education programs and \$146,000 per student for graduate dental education programs, CNA derived an annual cost of \$320 million to train physicians at military treatment facilities in the 23 specialties in the study, \$57 million for the eight dental specialties, and \$21 million for certified registered nurse anesthetists. “Therefore, in total across these 32 officer specialties, the Services spend about \$387 million to train 3,168 medical officers” (Levy, Christensen, and Asamoah, 2006).

In addition, maintaining clinical skills requires continuing and extended practice. JDAs are, by definition, not clinical. Thus, the cost of sending away a different mix of health care officers (e.g., clinicians) for long periods of time, either for JDAs or for resident JPME, may have significant adverse impacts on their proficiency levels. There are two possible ways to mitigate these costs. The first is to consider the shorter JFSC course, which is 10 weeks in length, rather than a full year. One problem is that the number of seats for health care officers is quite limited. The second is to provide opportunities for clinicians to practice in nearby military treatment facilities. This is similar to what individuals in staff jobs do to maintain their clinical proficiency. However, this would work only for some clinical specialties. In any case, the impact on clinical proficiency needs to be carefully considered in any policy change designed to extend joint duty requirements to health care officers.

Need to Maintain Currency of Professional Qualifications

Most of the clinical specialties require continuing medical education for licensure renewal. For physicians and dentists, for example, the vast majority of state medical boards, along with those of the District of Columbia, Guam, Puerto Rico, and the Virgin Islands, require continuing medical education for licensure renewal (American Medical Association, 2008).⁴ Some states and territories require a certain percentage of the total credits to be either American Medical Association Physician's Recognition Award category 1 credits or equivalent American Osteopathic Association, American Academy of Family Practice, or American College of Obstetricians and Gynecologists credits. These medical boards require different numbers of continuing medical education credits, require that the credits be completed over different periods, and require different numbers of American Medical Association Physician's Recognition Award category 1 or equivalent credits. No state medical board requires more than an average of 50 credits to be completed in one year. Most state boards require credits to be completed over two or three years.

Thus, military health care officers have certain mandatory continuing education requirements that they need to meet to maintain good standing with the American Medical Association. These requirements need to be added to the service and joint education and training requirements that are outlined in the CJCS vision (U.S. Joint Chiefs of Staff, 2005).

Summary

There are significant opportunity costs to extending JPME II and JDA requirements more widely to officers in the medical field, and even marginal changes would need to be made carefully to minimize the costs in terms of both the system and the people.

⁴ Notable exceptions include Colorado, Hawaii (osteopathic doctors only), Indiana, Montana, New York, South Dakota, and Vermont, which do not require continuing medical education for licensure renewal.

There is minimal cost to adding existing external positions to the JDAL.⁵ If the 270 billets that were identified by the narrow screen were added to the JDAL and if officers served the required three-year tours, approximately 90 officers each year would receive credit for qualifying joint experience. If the 840 positions in the wider screen either were added to the JDAL or served as the basis for the alternative joint experience qualification, then about 280 per year could potentially qualify. However, given the size of the overall population, this represents less than 1 percent of officers in both cases, and that is far short of the CJCS vision for joint qualification.⁶ Moreover, the majority of those who would qualify would be Military Service Corps officers, given the preponderance of those positions. If joint qualifications became a requirement for promotion to flag officer rank (currently waived), the services would need to be very selective in choosing officers for joint assignments, focusing on those who were in a leadership track.

Overall, the current opportunities for health care officers to get credit for a JPME II are extremely limited. Attendance at a JPME II institution would largely govern the size of the pool of qualified officers for flag rank if full joint qualifications were a prerequisite.

⁵ If positions were added to the JDAL, officers serving in them would be subject to the promotion comparisons of the GNA. In essence, such officers would need to promote at a rate comparable to or better than a nonjoint peer group. Interviews with career managers indicated that this would not be a problem.

⁶ Over time, the level of joint experience accrues as officers retain and promote. Eventually, though, it will become level at a steady-state number that balances separations with newly experienced officers. Under the existing JDAL qualification process, this number is 50–70 percent (varies by service) for non–health care colonels and Navy captains, based on about 9,000 qualifying positions. See Thie et al. (2005) for a fuller discussion of this issue.

Qualifying Health Care Officers as Joint Officers: Alternatives and Recommendations for Implementation

The previous chapters discussed current practices for JOM for line officers, highlighted opinions of health care officers who have been in joint-related positions, presented data about potential JDAL positions and school seats, and addressed other barriers to JOM. The medical establishment, at this juncture, has choices to make with respect to implementing JOM practices.

Alternatives

There are different ways in which the joint officer system could be extended to include health care officers.

The first is to emulate the joint officer system in place for line officers. This change could be implemented by removing the prohibition on medical specialty positions on the JDAL, monitoring promotion data for those who have joint experience, and eliminating the waiver of being fully joint qualified for promotion to general or flag rank. This choice would need to use the S-JDA positions and, especially, the JPME II school seats judiciously to embrace the CJCS vision of qualifying significant numbers of officers by the grade of O-6 (colonel or Navy captain) as fully joint. Moreover, it would require an expansion of JPME II school seats for the medical communities or being highly selective in focusing them on future leaders in order for potential general and flag officers to gain the required joint education credential. This choice would impose costs on the system and people in it if a dif-

ferent mix of officers from the current mix were put in qualifying positions and billets.¹

A second alternative is to implement the Quadrennial Defense Review and *MHS Strategic Human Capital Plan* (DoD, 2006a, 2007b) recommendations by creating a JOM system that is unique to the health professions. This system could take advantage of already-existing positions that provide joint experience and the few available JPME II seats while recognizing additional joint training and education opportunities aimed at health professionals and courses available through Joint Knowledge Online.² In essence, this system would recognize the need to become more joint but would be implemented in such a way as to minimize the costs outlined in the previous chapter. This alternative could also be an intermediate step toward the first choice.

A third alternative is to continue the status quo. Although some officers are gaining joint experience either in JDAL-like billets or operationally, and a small number of officers are gaining JPME II education, most are not. While it appears that enough officers may be gaining the experience and education for a large enough pool of officers eligible for general or flag rank to be selective at promotion, requiring it would exclude officers who had not. Sufficient numbers of officers would be able to demonstrate the significant joint experience required by law for consideration for three-star (O-9) rank.

¹ Many JDAL positions require an officer but not one with a specific occupation. We did not consider expanding the use of health care officers in such positions.

² Joint Knowledge Online is

an enterprise portal system that uses advanced distributed learning technology to deliver joint courseware and learning tools that support joint training for individual warfighters involved in or preparing for integrated joint operations. The . . . portal is a fundamental part of the Joint Knowledge Development and Distribution Capability. . . . It integrates with existing DoD systems, like Army Knowledge Online and Defense Knowledge Online, to deliver joint courseware and links to other relevant training products and services. (U.S. Joint Forces Command, undated)

Assessment

Some aspects emerge as relevant for all these choices. First, a relatively large number of joint-like positions provide joint experience to health care officers, though these positions are disproportionately filled by officers of certain specialties or corps. There appears to be no logical reason to exclude medical community positions from the S-JDA other than that they have always been excluded. These positions already exist, and adding them to the S-JDA has no opportunity costs³ and only insignificant administrative costs to initially screen them through the billet qualification process and manage the promotion comparison process. We recommend that the Office of the Assistant Secretary of Defense for Health Affairs work with the Office of the Deputy Assistant Secretary of Defense for Military Personnel Policy and the Joint Staff Directorate for Manpower and Personnel (J1), and that the Joint Chiefs of Staff have the Office of the Under Secretary of Defense for Personnel and Readiness revise this outdated policy.

Second, unless the JPME II system expands significantly once again, there is little likelihood of gaining significantly more seats for medical specialties. This is the long pole in the tent for full joint qualification. Moreover, there is a significant opportunity cost to providing a year of additional joint education to clinicians, given the very high cost and long lead time to develop these officers. There are opportunities, however, for additional joint education and training of the type afforded by such courses as the Joint Medical Managers Course offered by the Defense Medical Readiness Training Institute (DMRTI),⁴ the

³ This is under the assumption that officers currently serve three-year tours in such positions as required for joint qualification. If, for example, tours were currently two years, then a particular officer would serve for another year. However, this reduces a “billet year” of potential service for a different officer. The system would contain as many joint qualifying years in either case, but fewer officers would have the qualification.

⁴ DMRTI’s mission is

to coordinate, evaluate and develop joint medical readiness training initiatives with a focus on evolving doctrine and joint operational requirements. DMRTI conducts and/or facilitates selected joint medical training programs to prepare DoD medical personnel for a wide range of Military operations. DMRTI is a Tri-Service military organization located at Fort Sam Houston in San Antonio, Texas. Staffed by professionals from

JTF Senior Medical Leader Seminar at U.S. Joint Forces Command,⁵ the Joint Medical Planners Course,⁶ and the Capstone Symposium offered by the Joint Medical Executive Skills Institute.⁷ While these courses are not part of formal JPME II instruction, they can fulfill portions of the CJCS joint learning objectives.

Third, providing joint experience and education to those with a high potential to serve in executive positions has merit across all the choices outlined here. This means that starting at the grade of O-4 and

the Army, Navy and Air Force, DMRTI conducts and coordinates training for active duty and reserve military medical personnel who provide worldwide healthcare support. (Defense Medical Readiness Training Institute, undated)

⁵ U.S. Joint Forces Command partners with DMRTI to offer the annual JTF Senior Medical Leader Seminar. The objective of the seminar is “to prepare military medical personnel for leadership roles within a JTF surgeon’s office.” Speakers include “senior medical leaders from all the military services, former JTF surgeons as well as subject matter experts in joint medical planning for medical contingency operations, interagency, and stability operations” (Pursell, 2007).

⁶ The purpose of the Joint Medical Planners Course, sponsored by the Joint Staff and offered at the Navy Medicine Manpower, Personnel, Training and Education Command and the Uniformed Service University of the Health Sciences, is

to prepare field grade officers, senior non-commissioned officers, and DoD civilians to effectively function as medical planners on Combined Commands, the Joint Staff, in Combatant Commands, Component Headquarters of Combatant Commands, Joint Task Forces, or Service Headquarters. [The course] will provide the necessary skills, familiarization, and proficiency in the concepts, procedures, and applications of joint and combined planning at the operational level of war. (Navy Medicine Manpower, Personnel, Training and Education Command, undated)

⁷ The MHS Executive Skills Capstone Course is hosted by the Joint Medical Executive Skills Institute and

has been designed to provide senior leaders of the MHS exposure to nationwide health-care industry trends, leaders in organizational change management, and federal healthcare policy makers who will offer participants a global view of how policies are formed which affect the course of the Military Healthcare System (MHS). . . . The Capstone course is designed to be a pinnacle event for recently assigned senior military treatment facility commanders, lead agents, and senior medical officers in key staff positions. . . . It provides participants exposure to the operations of the various organizations within the Department of Defense, pertinent congressional staffs, and the offices of the three Surgeons General. (Joint Medical Executive Skills Institute, 2008)

certainly by O-5, the services have to be carefully grooming certain officers to take certain positions and educational opportunities.

Fourth, there appears to be enough JPME II seats (with careful selection for attendance) and potential JDAL positions to provide a large enough pool to be selective for consideration for general or flag rank, but not all general and flag positions may require such experience and education as a prerequisite. For promotion to O-9, the requirement for significant experience does exist. Continuing waivers of the requirement for promotion to O-7 allows promising officers who may not have had the opportunity to gain joint experience through the grade of O-6 to gain it at the grade of O-7 or O-8 through the new process for obtaining joint experience qualifications.

Recommendations

We recommend a blended approach to JOM for health care officers: Use processes similar to those used for line officers where it makes sense (i.e., experience) and develop separate processes that make sense for joint education. This would require the following:

- *Validating joint experience for health care officers through the S-JDA formal process or through individual certification as allowed in the current DoDI and CJCSI:* It is obvious from the numbers of health care positions that are potentially joint and from the experiences of health care officers serving in operational venues that not-insignificant numbers of health care officers are receiving qualifying joint experience. There are few costs from implementing this recommendation. The impact of this recommendation would be to allow joint experience qualification based on existing positions and not to expand positions providing such qualification.
- *Developing a system of joint education and training that fits the requirements of and is targeted to the medical professions, either as permanent policy or as a step toward full JPME II requirements:* While some health care officers do attend JPME II, there are so few seats available to them that the vast majority of health care

officers will not have the opportunity. Moreover, there are significant costs to expanding formal JPME II opportunity for a year for such officers. The medical community should validate shorter-term training and education opportunities of the type outlined earlier or consider blended learning courses to ensure that officers receive sufficient joint training and education.

Comments of Health Care Officers: 2005 JOM Census Survey

Table A.1 presents a selection of verbatim comments provided by health care officers responding to the 2005 JOM Census survey. Note that some identifying details in the comments included here have been blanked out to maintain the privacy of the respondents.

Table A.1
Verbatim Comments of Health Care Officers, by Billet Type and Billet Pay Grade

Billet Pay Grade	Billet Category	Verbatim Comments Appended to Survey
O-5	JDAL billet	Joint credit should be received for all who serve in joint billets. There should not be a three year minimum to get credit.
O-4	Non-JDAL billet in external organization	As an Army medical department officer, I am not eligible for joint service credit. I believe the rules should change to allow any military personnel serving in a joint billet receive joint service credit in their military record.
O-5	Non-JDAL billet in external organization	As a Medical Service Corps Officer JPME is not offered, though I feel it would be helpful. When I was part of the JTF [. . .] I was on my third joint tour. There are issues that will never come up in a JTF that are needed in a well rounded Joint Officer. When on a JTF staff you are accomplishing a mission, not evaluating the merits of joint doctrine, policy, plans, force structure, etc. Understanding the broader picture of the military as only one implement of national power is a valid requirement for a Joint Specialty Officer.
O-5	Non-JDAL billet in external organization	Joint Experience is essential for continued growth.
O-5	Non-JDAL billet in external organization	Medical personnel serving in Joint Billets should be given the same opportunity and requirement as the rest of the services. Medical planners and operations personnel perform the same functions without the benefit of this training.
O-5	Non-JDAL billet in external organization	Yes. As a medical staff officer in the Joint Environment, we should be able to become JPME trained and qualified as "Joint Qualified" officers. If medical isn't the modal for joint then I don't know what is. . . . It seems ridiculous that I have served over four years in the Joint environment (will have potentially over 7 years joint following this assignment) and I will not be "Joint Qualified" because Joint Qualification only applies to the the [sic] line (DOPMA [Defense Officer Personnel Management Act]) officers.

Table A.1—Continued

Billet Pay Grade	Billet Category	Verbatim Comments Appended to Survey
O-5	Non-JDAL billet in external organization	This position needs to be awarded the recognition of joint service credit. I've worked with officers from the other three services on many issues and am required to have an understanding of their processes.
O-5	Non-JDAL billet in external organization	Thank you for the opportunity to comment. Being a medical person, I believe Joint Credit should go for medical positions as well as line positions. I'll be finishing this Joint Staff assignment [sic] (total of 4 years, 1 yr internship, 3 permanent) with no "on-paper" "JOINT" credit, while line colleagues who serve far less time, and work no harder, get Joint credit on their records. I am a strong believer in Joint assignments. I've learned a lot from my Army, Navy and Marine counterparts. Many of them have far more experience and relevant training than I do. Of all the Services, the USAF does the worst in preparing officers for Joint assignments. The USAF is too committed to it's [sic] own doctrine and philosophy, and has a reputation of "not playing well with others" that is common knowledge in the Joint Community. I believe the USAF should commit more strongly to being part of the Joint Community.
O-6	Non-JDAL billet in external organization	It has been a combination of previous joint assignments, "out of my service" schools, and deep understanding of my own service that provided me with the experience to be immediately successful in this position.
O-6	Non-JDAL billet in external organization	Give all personnel in joint jobs at COCOMs JOINT CREDIT Make joint service a requirement [sic] for all specialties Expand joint military education opportunities Mandate joint experience for all specialties [sic] Mandate documentation of joint tours and duty on FITREP [fitness reports]
O-3	Service-nominated billet	To be successful in my position, one requires a knowledge of joint service interaction as well as the possession of a tactical medical background.

Table A.1—Continued

Billet Pay Grade	Billet Category	Verbatim Comments Appended to Survey
O-3	Service-nominated billet	The Joint Blood Program (JBP) is the perfect microcosm of jointness. While aircraft, ships, tanks etc. tend to be service specific . . . blood resources are the one truly joint operational asset that all services require. The JBP has been practicing jointness long before this became vogue. Many lessons can be learned from their established joint structure and daily interactions. I've had the experience of a lifetime working in a joint operational setting.
O-3	Service-nominated billet	Depnding [sic] on the activities within the position and the OPTEMPO [operation tempo] the military takes on. This position could very well require greater Joint type training in the future.
O-4	Service-nominated billet	A variety of knowledge of med . . . AE [aeromedical evacuation], logistics, preventive med, med capabilites [sic] of different services is helpful. The Joint Medical Planners course at Bethesda was helpful as was my prior SOF [special operations force] and joint experiences. I believe I am making a difference by being here and providing the Air Force capabilites [sic] to assist in planning SOF missions.
O-4	Service-nominated billet	A person serving in my billet interacts with all us military services, us embassy, host country armed forces, local host country civilian health care organizations and other host country govenmental [sic] organizations.
O-4	Service-nominated billet	The Defense Medical Standardization Board operates in the Joint-environment exclusively. [. . .] We focus entirely on supporting deployed forces.
O-4	Service-nominated billet	The [sic] are unique medical activities that are truly joint in organization/function and personnel in those billets should be formally recognized with joint credit.
O-5	Service-nominated billet	Prior joint experience at the tactical or operational level whould [sic] enhance the job. PME [professional military education] helps fill the information void where actual work in a joint environment is not available.

Table A.1—Continued

Billet Pay Grade	Billet Category	Verbatim Comments Appended to Survey
O-5	Service-nominated billet	Two things would help the next officer in this position: (1) They should have a background in DoD acquisitions [. . .].
O-5	Service-nominated billet	Apart from my current assignment, I have served in a CTF [combined task force] and JTF deployed prior to 2001 as well as assigned to Landstuhl Regional Medical Center where Air Force and Army medics worked side by side in the provision of daily medical care. If the health services community is to be given Joint Credit for our close workings with sister Service and other nations’ medical communities while in garrison or deployed, then what is Joint Duty needs to be amplified to include these activities [sic]. Thank you for the opportunity to complete this survey.
O-5	Service-nominated billet	I certainly recognize the need to place key personnel in joint billets, and to that end there should be a better mechanism to capture those individuals’ skillsets, but why not a closer examination of those who with relevant prior or multi-service experiences, especially multiple AFSCs [U.S. Air Force specialty codes]/MOSs [military occupational specialties] etc. They bring a lot to the table. Do you know why there is a mandated multiple MOS requirement for Special Forces Warrant Officers? Obviously, it’s for that eclectic skill set that such experience encompasses. Beyond that, there are a wealth of service backgrounds which would facilitate placing better qualified personnel in joint billets, but that doesn’t seem to happen, and many troops with practical experience aren’t in the running, since they didn’t have the academic sponsorship. On another note . . . there is no mention of language proficiency for multinational operations, and that area is one in which our military continues to fall behind. Frankly, I could care less whether the billet is joint . . . I just want the best qualified personnel in those positions, and it appears that we’ve constructed another group of joint billet ring-knockers. If you truly want to “fix the system,” there needs to be a better set of qualifiers based on experience, and not the self-fulfilling prophecy of special-ed academics and joint placement mentorship.

Table A.1—Continued

Billet Pay Grade	Billet Category	Verbatim Comments Appended to Survey
O-5	Service-nominated billet	I think that this billet should be reclassified as a joint assignment because it is a unique situation where the three services work together to manage joint service programs and collaborate on joint dental health issues that drive joint policies and doctrine.
O-5	Service-nominated billet	I spend most of my time working Army and AF issues to include teaching members of all services about the medical management of CBRNE [chemical, biological, radiological, nuclear, and high-yield explosives] casualties. We prepare units for deployment. We also train Public health and civilian providers. We primarily focus on training as opposed to operations. It is a very joint position [. .].
O-5	Service-nominated billet	DoD activities, like the Defense Medical Standardization Board (DMSB), work hand in hand on a daily basis with each of the Services, DLA [Defense Logistics Agency]/DSCP [Defense Supply Center Philadelphia], JFCOM Surgeon, DoD(HA [Health Affairs]), the Joint Staff Surgeon, and various interdepartmental/multi-national POCs [points of contact]. We as [sic] as "purple" as you can get. [. .]
O-5	Service-nominated billet	I believe that the Navy, specifically Navy Medicine needs to do better in understanding the need for support of Navy Personnel and their counterparts from their sister services who are working hand in hand to produce Special Operations Corpsmen and Medics. The billets at my current duty station [. .] trains "All" Special Forces Medics and Corpsmen (Green Beret, SEALs, Force Reconnaissance [sic] and other foreign country Special Forces Medics). Because of the limited Joint Billets available, these billets are not listed as Joint Billets, but in actuality are functioning as such in a Joint Environment. They do not receive the support they need to reduce the critical short falls for all Special Forces Medics and Corpsmen. Lack of continuity of effort by the Navy damages the Joint Special Operations effort in producing the finest Special Warfare Corpsmen and Medic[s].

Table A.1—Continued

Billet Pay Grade	Billet Category	Verbatim Comments Appended to Survey
O-6	Service-nominated billet	<p>[I] work in a joint environment but billet’s not designated as joint. “[H]ome base” only if broadly defined, assigned on paper to AF Element but not duty-stationed there.</p> <p>[Survey] tool viewed tasks as if they occur in distinct isolation, no way to show concurrent task accomplishment, i.e. health services is the overarching task in which strategic direction is provided overall—survey is more oriented to the line side perspective.</p>
O-6	Service-nominated billet	<p>I work [. . .] in the Military Health System, Office of the Assistant Secretary of Defense for Health Affairs [sic]. I work daily with Army, Navy, AF active duty, DoD civilians and contractors. [. . .], only a select few are considered joint (DoD) billets, though all of us perform joint duties.</p>
O-6	Service-nominated billet	<p>My base is a model of joint and combined service cooperation. I interact with member of other US military service and host nation military daily but my position is not considered a joint billet.</p>
O-6	Service-nominated billet	<p>This survey is tailored to line-officer joint positions and not medical corps, joint positions. These require unique knowledge of medical care operations, personnel and medical care standards, most of which are similar across all 3 Services. This skill/knowledge set is the essential, and single most important factor in medical officers entering Service-level and Joint Service-level positions. Closely following in importance is experience in working with other Service components and knowledge of their unique missions and capabilities; and closely following that, experience and knowledge in formulating and implementation of DoD(HA [Health Affairs]) policies. Most likely, an O-6 medical officer would have gained that experience by the time he/she assumes such a position.</p>

Table A.1—Continued

Billet Pay Grade	Billet Category	Verbatim Comments Appended to Survey
O-6	Service-nominated billet	The organization I work in on a daily basis is part of the OSD and employs officers from every branch of the service including the US Coast Guard. We all deal with interservice coordination, contracting, and cooperative support issues to deliver healthcare to all combatant and non-combatant eligibles and their families on a dialy [sic] basis, and now under the new healthcare contracts this is all done in an even larger geographical area. However none of the service branches consider our billets for Joint Service Credit under OSD. This billet gave me the opportunity to collaborate with my sister services and to be on the same team. I have a deep respect for their roles in wartime and peacetime and for our unified force health protection interests. Receiving Joint Credit would be great to record that I was here and reflect the true Joint nature of what I accomplished here for my military.
O-6	Service-nominated billet	Although having never served in a permanent joint duty billet, I have served in a temporary joint duty billet for 3 months since 11 Sep 2001. In addition, I’ve served on the AF component staff of EUCOM [U.S. European Command] (USAFE [U.S. Air Forces in Europe]), on various JFACC [joint force air component commander] and AFFOR [Air Force forces] staffs prior to 2001.
O-6	Service-nominated billet	Please support the use of Joint Meritorious Service Medals. There are some organizations whose members work in a joint environment 100% of the time but do not get recognized with a joint medal.
Flag officer	Service-nominated billet	JPME is not currently required for medical department officers. It should be. Joint experience is not required for promotion for medical department officers—nor is it given any weight in promotion precepts. It should be. Problems with training and assignment opportunities aside—if we do not behave as though it is important it will never be given credence.

Table A.1—Continued

Billet Pay Grade	Billet Category	Verbatim Comments Appended to Survey
Flag officer	Service-nominated billet	I currently wear five hats: three Service [. . .] and two joint [. . .]. The joint hats are becoming increasingly important and I am devoting an increasing portion of my time and energy to them, as I should.

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