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**Leveraging Air Force Medical Service (AFMS) Senior
Leadership Corps Diversity to Improve Efficiency**

By

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Executive Summary

Introduction

Since its inception, the AFMS has lacked professional (Corps)ⁱ diversity at the most senior levels, including both general officer (GO) positions and “stepping-stone” jobs to those GO positions. The publication of the AFMS *Flight Path*ⁱⁱ has contributed to the lack of AFMS Corps diversity in senior AFMS positions by limiting most GO positions to MC personnel. This lack of AFMS Corps diversity at senior levels runs counter to the Air Force’s diversity policy, and available data presented in this paper suggests this lack of diversity may *contribute* to AF health care cost growth.

Approach

In this paper, we examine the impact of the *Flight Path* on senior leader Corps diversity within the AFMS and opportunities for the AFMS to leverage greater Corps diversity towards becoming more efficient. In particular, this paper identifies a difference between Air Force (AF) policy regarding diversity and the AFMS *Flight Path’s* policy on AF health care executive leadership; describes how the *Flight Path* limits GO opportunities for non-MC AFMS Corps officers; suggests that members of other AFMS Corps are equally qualified and capable for executive leadership positions; explores cost growth of AF health care; provides a business case recommendation that will save an estimated \$81 million per year, while increasing AFMS Corps diversity; and proposes two options to improve Corps diversity.

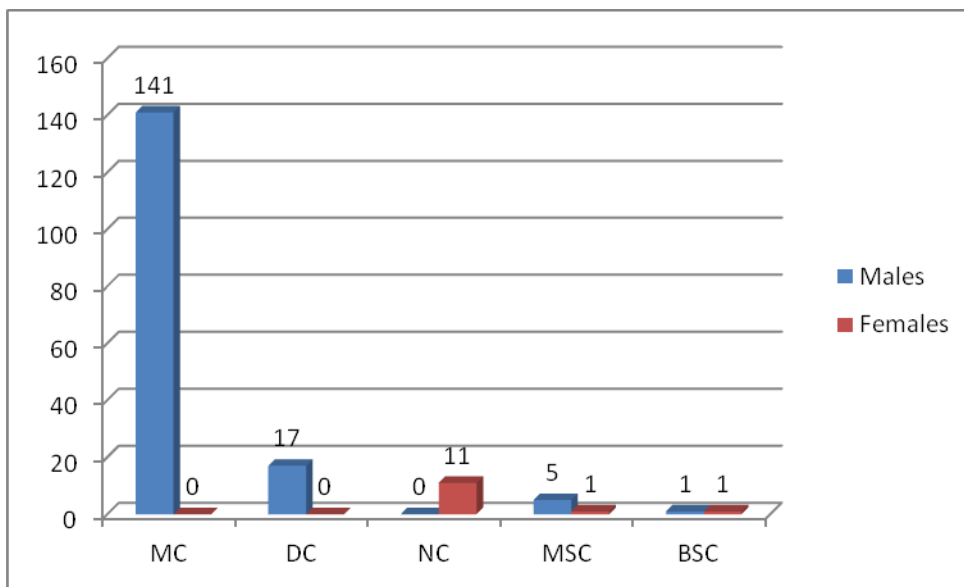
ⁱ The Air Force Medical Service (AFMS) provides health support to the United States Air Force (USAF) and Combatant Commanders and consists of five officer corps: the Medical Corps (MC), Biomedical Services Corps (BSC), Nurse Corps (NC), Dental Corps (DC), and Medical Services Corps (MSC).

ⁱⁱ In 2004, the AF mission transitioned to a more expeditionary focus, and the AFMS changed to meet that mission by developing new organizational structure guidance called the *Flight Path for the USAF Combat Wing Organization – Medical*. The overall goal of the *Flight Path* was to develop a consistent Medical Treatment Facility (MTF) structure that provided a fit and ready medical force for the expeditionary mission. The strategy to meet that goal included four objectives: provide corps-specific developmental opportunities, balance leadership teams within MTFs, provide requirements driven leadership opportunities, and provide efficient mission support at home and abroad. The *Flight Path* was published and implemented beginning in 2007.

There is a Lack of Corps Diversity within AFMS Leadership

Of the five AFMS Corps, the MC comprises 30 percent of all AFMS officers. However, since 1949, it has been the source of 80 percent (141, all male) of the 177 AFMS GOs. The historical representation of GOs from the other Corps (per Figure 1) is as follows: 17 from the DC; 11, NC; 6, MSC; and 2, BSC. All of the 21 Air Force Surgeons General (AF/SG) have been MC, as are 9 of 13 current AFMS GOs (70%).¹

Figure 1. Historical AFMS General Officer Representation by Corps and Gender



The *Flight Path* Contributes to a Lack of Corps Diversity by Limiting Key Leadership Positions to the MC

AF-level guidance (the AFMS *Flight Path*) specifies that only MC personnel will command AFMS hospitals and medical centers. Because these senior command positions are seen as stepping-stones to GO ranks, the *Flight Path's* restrictions serve to constrain the AFMS GO candidate pool.

The *Flight Path* is Inconsistent with Air Force Diversity Policy. Per AF Policy Directive (AFPD) 36-70, diversity encompasses not only race and genderⁱⁱⁱ but also education and professional experience.² In

ⁱⁱⁱ Since the MC is a less gender diverse corps (30 percent) when compared to the BSC (40 percent) and MSC corps (35 percent), the *Flight Path* has the net effect of impeding gender diversity as well.

short, the AFMS *Flight Path* runs counter to AF diversity policy by limiting professional diversity (Corps) in senior AFMS ranks.

The *Flight Path* Policy is Inconsistent with Congressional Direction

In 1991, Congress recognized that most military medical treatment facility commanders did not have the customary graduate education needed (e.g., MHA, MBA) to administer large facilities and complex health care systems. This is in contrast to civilian health care organizations, where 96 percent of Chief Executive Officers (CEOs) are non-physicians. In National Defense Authorization Act, H.R. 2521, SEC 8096, 3 June 1991, Congress required: *“None of the funds appropriated in this Act may be used to fill the commander’s position at any military medical facility with a medical doctor unless the prospective candidate is a trained professional administrator.”*³ In response to Congressional direction, a two-week administrative competency course was developed, which allowed all MTF commanders to meet the letter of the law. However, the development of the two-week course fell short of the Congressional direction for *“trained professional administrator”* associated with graduate-level credentials enjoyed by administrators of private-sector health care systems, as well as the Veterans Health Administration (VHA). In fact, the *Flight Path*’s restriction of leadership to MC personnel excludes AFMS personnel with the formal credentials most closely resembling the Congressional direction from most AFMS stepping-stone and GO positions. That exclusion is incongruent to AF diversity policy, and, as discussed below, it impacts the efficient use of human capital and business practices within the AFMS.

In 1996, Congress changed the law in Title 10, SEC 8036, *“Authority for Medical Department Officers other than physicians to be appointed as Surgeon General.”* While Congress changed the law to expand opportunities for the top job, the *Flight Path*, in effect, limits GO stepping-stone positions to only the MC. ⁴

U.S. Army and U.S. Navy Policies Resulted in Greater Senior Leadership Corps Diversity

In response to Congress' direction, the U.S. Army (USA) and U.S. Navy (USN) eliminated many limitations to diversity and allowed all Corps to compete, selecting from the "best in show" (any Corps) rather than the "best in breed" of a single Corps. As a result, LTG Patricia D. Horoho, a nurse, is the current Army Surgeon General. She previously commanded a 500-bed field hospital and the DeWitt Health Care Network, opportunities that would not have been available to her if she had been in the AF. Similarly, the Navy's current Deputy Surgeon General is an MSC officer, which would be unlikely and unprecedented in the AF under the AFMS *Flight Path*.

Costs of Limited Diversity

The AFMS' budget has increased in the last 10 years while the number of patients enrolled to MTFs has dropped by 183,000 (14 percent).⁵ Patient appointments have decreased by 16 percent in the last three years, while purchased (off base) care has increased 20 percent in the last five years.^{6 7} In addition, while overall AFMS manpower levels have remained steady, the number of AFMS headquarters personnel (AF, AFMOA, AFMSA, MAJCOMs, etc) has grown by 75 percent.⁸ There is a need for more providers at MTFs. To that end, there is a qualified pool of 600 providers currently assigned to non-patient care or administrative positions today that could serve to meet this requirement.⁹

These trends can be largely attributed to system-level AFMS management decisions and incentive structures that do not emphasize resource efficiency and that have no resultant or proportional health care quality and medical readiness effectiveness benefits. The AF would greatly benefit by reversing increased costs, while improving access and at least maintaining quality of care.

Proposed AFMS Objectives for Increasing Senior Leadership Diversity and Mission Efficiency

The AFMS needs to be able to address the senior leadership Corps diversity limitations identified and develop a strategy to become more efficient. To do so, AFMS must meet the following goals going forward:

- Remove policies that limit Corps diversity, and ensure equality in the senior leader selection process;
- Increase hospital/medical center command and GO stepping-stone positions for non-MC;
- Increase administrative competency of MTF commanders and AFMS senior leadership;
- Set a single PME standard for AFMS officers;
- Shift provider billets to patient care roles and establish new standards and metrics.

In plotting a course forward, AFMS cannot rely on continuing the status quo to increase progress toward the above goals. As such, we propose two options and discuss and evaluate them in terms of how well they meet the goals: Minor *Flight Path* Change, and Major *Flight Path* Change. Both options address the aforementioned goals with varying levels of change and disruption to the status quo. Based on an assessment of the two options, we conclude that the Major *Flight Path* Change has the greatest likelihood of achieving each of the goals and objectives by creating a leader selection process that promotes AFMS Corps diversity, increasing professional administrative competency of MTF commanders, setting a single PME standard, and by realigning human resources to increase clinical currency, medical readiness and resource efficiency. Some structural changes will need to occur to implement this plan. Also, the Air Force will incur a relatively small cost for holding a Central Selection Board (CSB) and increasing administrative professional expertise, but the potential cost savings from decreased purchased care costs of \$81 million exceed the cost of a CSB.

In summary, the existing AFMS career path paradigm, specified in the *Flight Path*, results in physician overrepresentation in senior leadership positions at a cost in AFMS Corps diversity and in dollars. In these budget-constrained times, a more appropriate model may be one in which respective education skill sets are matched to jobs that make the most sense, promoting both senior leadership Corps diversity and efficient use of resources.

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First, I'd like to thank General Larry O. Spencer, the Vice Chief of the U.S. Air Force, for speaking to and challenging the Air Force Fellows during our fellowship orientation to find more efficient and effective ways to accomplish the mission. He provided us with many examples of how he found ways to reduce mission costs without hurting mission effectiveness. Furthermore, throughout his entire career, he took professional risk, challenged the status quo, and implemented innovative ideas, which has saved millions of dollars and improved mission efficiency and effectiveness. I was and continue to be motivated and inspired by his tremendous leadership, fiscal savvy and business prowess!

I'd like to thank many friends from various Corps (NC, BSC, MSC, and DC) for inspiring this research project; nearly every one of them identified this research topic as their top concern regarding the Air Force Medical Service.

I owe a tremendous debt of gratitude to many people who provided advice, information, and analytical support. I would like to thank the many RAND researchers, AF Fellows, and all those at the Air Force Surgeon General's office who provided terrific analytical support. Finally, I'd like to thank my wife and children for their steadfast love and support.

1. Introduction

The Air Force Medical Service (AFMS) provides health support to the United States Air Force (AF) and Combatant Commanders. AF medical facilities provide health care to Department of Defense (DoD) service members, their families, and retirees at 75 military medical treatment facilities (MTFs). TRICARE supplements Air Force medical facilities with purchased health care in the civilian network.

The AFMS itself consists of 44,000 active-duty, civilian, and contract personnel and has a budget of \$6.1 billion.¹⁰ The AFMS consists of five officer Corps: the Medical Corps (MC), Biomedical Services Corps (BSC), Nurse Corps (NC), Dental Corps (DC), and Medical Services Corps (MSC). Members of the MC all have medical degrees and practice within one of the Corps' 30 specialties and 74 subspecialties. The BSC has 19 diverse specialties, all having unique educational, licensing, and board certification requirements. A few of these specialties include physician assistant, physical therapist, optometrist, podiatrist, psychologist, social worker, dietician, pharmacist, and bioenvironmental engineer. NC members have nursing degrees/credentials and include several nursing specialties, such as clinical nurse, mental health, operating room, nurse practitioner, and flight nurse. The DC members have doctor of dental medicine degrees and likewise include many specialties. Finally, the MSC members have board certification credentials and advanced degrees in health care management/administration.¹¹

In 2004, the AF mission transitioned to a more expeditionary focus, and the AFMS changed to meet that mission by developing new organizational structure guidance called the *Flight Path for the USAF Combat Wing Organization – Medical*. The overall goal of the *Flight Path* was to develop a consistent MTF structure that provided a fit and ready medical force for the expeditionary mission. The strategy to meet that goal included four objectives: provide Corps-specific developmental opportunities, balance leadership teams within MTFs, provide requirements driven leadership opportunities, and

provide efficient mission support at home and abroad. The *Flight Path* was published and implemented beginning in 2007.¹²

In this paper, we examine the impact of the *Flight Path* on senior leader Corps diversity within the AFMS and opportunities for the AFMS to leverage greater Corps diversity towards becoming more efficient. In particular, this paper identifies a difference between Air Force (AF) policy regarding diversity and the AFMS *Flight Path's* policy on AF health care executive leadership; describes how the *Flight Path* limits GO opportunities for non-MC AFMS Corps officers; suggests that members of other AFMS Corps are equally qualified and capable for executive leadership positions; explores cost growth of AF health care; provides a business case recommendation that will save an estimated \$81 million per year, while increasing AFMS Corps diversity; and proposes two options to improve Corps diversity.

2. AFMS *Flight Path* Comparison with the AF Diversity Policy

In 1996, Congress changed the law in Title 10, SEC 8036, “*Authority for Medical Department Officers other than physicians to be appointed as Surgeon General.*” Subsequently, the AF developed and implemented a formal diversity policy^{iv}.

According to Gen Norton Schwartz, the former Chief of Staff of the Air Force (CSAF), diversity is “a composite of individual characteristics, experiences, and abilities consistent with the Air Force Core Values and the Air Force Mission . . . (including) but not limited to, personal life experiences, geographic, educational, work, and socioeconomic background, cultural knowledge, language and physical abilities, philosophical/spiritual perspectives, age, race, ethnicity and gender.”¹³

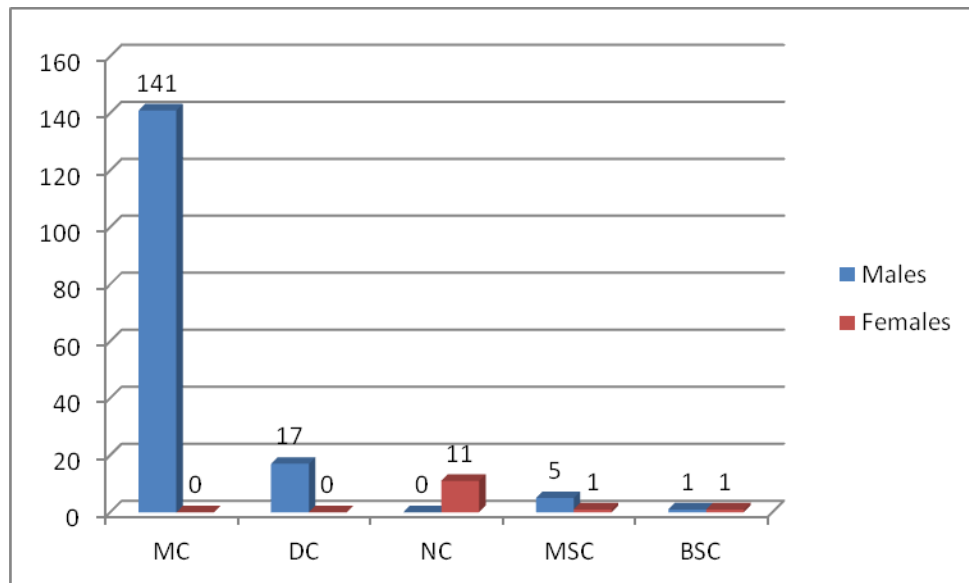
That comprehensive view of AF diversity is reflected in AFPD 36-70, *Diversity*, but it is an as-yet unrealized goal.¹⁴ In a February 19, 2010 speech, Gen Schwartz said: “[W]e still have room for yet greater diversity in the military – not because of discrimination, but because our society is replete with opportunities for our Nation’s young talent, in a wide variety of professions” and “[m]oving forward with our diversity strategic roadmap, we are taking real measures toward enduring change, especially in the senior officer and senior executive levels, where there is a noticeable lack of diversity.”¹⁵

^{iv} Senior AF leadership recognizes that diversity within the broader service is a top priority for both the Executive and Legislative branches. In their testimony to the Subcommittee on Personnel, Committee on Armed Services, United States Senate, the Honorable Daniel B. Ginsberg, Assistant Secretary of the Air Force (ASecAF) for Manpower and Reserve Affairs and Lt Gen Darrell D. Jones, Deputy Chief of Staff (DCSAF) Manpower, Personnel and Services United States Air Force on 25 Apr 2012 said the following: “Diversity remains a top priority of Air Force senior leadership. . . . In October 2011, a Declaration on Diversity signed by the [SecAF, CSAF, and Chief Master Sergeant of the Air Force (CMSAF)] was distributed across the Air Force to highlight the importance of diversity to the mission. . . . [T]he Air Force supports the Military Leadership Diversity Commission recommendations and is poised to support Executive Order 13583 (and) work with OSD to develop a plan of action and milestones to support the President’s goal of using the talents of all segments of society by enhancing our ability to recruit, hire, promote, and retain a more diverse workforce and creating a culture that encourages collaboration, flexibility, and fairness to enable individuals to participate to their full potential.”^{iv}

The AFMS *Flight Path* is not aligned with AF’s diversity policy and definition of diversity. Using standards directed in AFD 36-70, the *Flight Path’s* policy of restricting leadership positions to a single Corps limits specified diversity with respect to education and professional experience.

The Medical Corps (MC) comprises 30 percent of all AFMS officers, but since 1949, it has been the source for 80 percent (141, all male) of the 177 GO positions.^v The historical breakout for GOs in the other Corps (per Figure 1) is: 17 DC, 11 NC, 6 MSC, and 2 BSC. All the 21 Air Force Surgeons General (AF/SG) have come from the MC. MC officers also hold 9 of 13 current GO positions (70 percent).¹⁶ AF-level guidance, the AFMS *Flight Path*, specifies that only MC personnel will command AFMS hospitals and medical centers. Since these senior command positions are seen as stepping-stones to the GO ranks, the *Flight Path’s* restrictions constrain the AFMS GO candidate pool.

Figure 1. Historical AFMS General Officer Representation by Corps and Gender



Unlike the Army, Navy, Veteran’s Health Administration, or private-sector hospitals, the *Flight Path* only allows MC officers to command hospitals and medical centers. Further, the AFMS effectively

^v Since the MC is a less gender diverse corps (30 percent) when compared to the BSC (40 percent) and MSC corps (35 percent), the *Flight Path* has the net effect of impeding gender diversity as well.

prevents AFMS Corps diversity in the selection process for many senior positions by excluding all but MC officers from consideration for key leadership positions, regardless of the ability of other Corps' members to succeed in the job. Consequently, MAJCOM Surgeon and most other GO stepping-stone positions continue to be filled by MC personnel.

As noted, the MC comprises 30 percent of all AFMS officers, yet it fills 70 percent of GO positions. This uneven representation, taken alone, reveals a lack of AFMS Corps diversity. When coupled with the difference in 20-year retention rates among the AFMS Corps—approximately 10 percent for MC, 15-20 percent for BSC and NC, 25-30 percent for DC and MSC—it becomes clear that the AF selects MC officers over other AFMS officers for senior leadership positions and selects from a smaller experience pool of candidates.^{17 18}

The genesis of the lack of AFMS Corps diversity today may have started with the title of "Surgeon General." That title was developed in the 1880s when the public health service consisted of only physicians, with the senior physician holding the title of Surgeon General (prior to that "Senior Surgeon"). Over the many decades since, a wide range of health care professions have emerged to meet specific expertise requirements in a complex health care industry, most of which have been augmented into the uniformed services' health care organizations. However, the services' senior leader title—Surgeon General—did not adapt/change to be sufficiently generic, such that it would not "sound" incongruent to select the most qualified senior leader from any of a diverse range of health care professions. The centuries-old title would seem more "diversity tolerant" if it were modernized to something that reflects a more generic tone, for example, "Air Force Deputy Chief of Staff for Medical Services".¹⁹

3. *Flight Path* Development

Over the past 20 years, significant changes have occurred in how the AFMS is organized. In 1993, the AF implemented the Objective Medical Group (OMG) organizational structure and provided medics with a command and control structure similar to the Line of the Air Force (LAF). Under the OMG structure, medics shifted to a product line focus, which included designated squadrons for Medical Operations, Medical Support, Dental, and Aerospace Medicine. Proponents of the OMG reorganization assert that the reorganization enabled medics not only to gain equal standing with their LAF counterparts but that the LAF benefited by better understanding the medics as both health care professionals and leaders.²⁰

Former AF Chief of Staff Gen Jumper's May 2004 letter "*Developing Expeditionary Medic—A Flight Path*" directed the AF/SG to examine the AFMS' OMG organization, Medical Force Development, and the Medical Organizational Structure.²¹ In terms of force development, Gen Jumper tasked the AF/SG to construct a clear and effective path from Airman to Chief and from Lieutenant to Senior Officer through changes to promotions, the redefinition of medical groups, and command opportunities. In terms of promotions, Gen Jumper acknowledged that the AFMS consisted of five Corps and that only three of the five were structured to provide senior officer promotion opportunity at the GO level. Consequently, he directed a designated GO opportunity for the MSCs and BSCs. He also directed the medics to better define medical groups into four distinct categories to allow better matching of leadership and experience with unit complexity. The four categories included medical centers, hospitals, clinics, and training units. To provide the right experience and leadership mix, he directed all five Corps to have command opportunities. The letter indicated that MC would normally command hospitals and medical centers and nurses would normally command training units. Finally, group command was to be a single, three-year tour to provide a suitable test of command and stability.

In response to Gen Jumper's memo, the AFMS formed working groups to put together a plan to achieve the following objectives: ²²

Develop a streamlined, consistent Military Treatment Facility organizational structure from a Clinic to a Medical Center that:

- Provides a ready and fit force for the Air Expeditionary Force (AEF)*
- Rewards military and functional competence*
- Provides a medical power projection platform to deploy medics forward*
- Provides high quality, cost effective care*
- Create a Flight Path for the expeditionary medic that fosters:*
 - Corps-specific Force Development*
 - Requirements-driven leadership opportunity*
 - Balanced leadership teams within the MTF*
 - Compliance with military and civilian certification requirements*
 - Cost effective mission support at home and when deployed*

Two months following Gen Jumper's memo, Maj Gen Brannon, the Assistant AF/SG for Medical Force Development and Nursing Services, wrote the following on the AFMS newswire: "The guidance from General Jumper is that Medical Corps officers will normally be selected to command hospitals to afford them the opportunity to continue their practice [of medicine].....With maintaining clinical currency as a goal, some MC specialists (pathology, radiation oncology, and all surgical specialties) will only be allowed to compete for hospital command and ineligible for clinic command." Although Maj Gen Brannon stated that CSAF's guidance was to normally place MC officers in hospital command positions to continue practice, it is not the norm for MC hospital commanders to continue their practice of medicine.²³

During a certain timeframe since *Flight Path* implementation, a workload analysis was accomplished to determine the amount of patient care being delivered by 13 MC hospital and medical center commanders. The workload analysis revealed that 46 percent of hospital and medical center commanders were not providing patient care, while the other 54 percent averaged 5 patient visits per month.²⁴ Also, the AFMS keeps detailed and self-reported time sheet information that includes time spent providing patient care, readiness activities, leave, etc. The 13 MTF commanders during the same

time period self-reported spending on average less than one-half of 1 percent of their total duty time providing patient care.²⁵ Thus, the data indicates that nearly half of MC hospital and medical center commanders were not continuing their practice of medicine at all and the other half were not seeing adequate patient volume to maintain clinical skills.

Also, approximately 400 MC officers are assigned to non-MTF jobs, such as MAJCOMs or headquarters positions, which makes it difficult for them to continue practicing medicine. Given the fact that these MC officers collectively represent a significant annual investment in specialty pay, but are seeing in most cases no patients and in all other cases few patients, one must consider if this is the best use of human capital.²⁶

Does the AF benefit from limiting group command positions of in-patient hospitals and medical centers to physicians only, given the costs, sacrifices to AFMS Corps diversity, and limitations to career-path opportunities for non-MC AFMS officers?

AFDD 1-1, the AF's Basic Doctrine, states that the primary responsibility of a leader is to motivate and direct people to carry out the unit's mission successfully.²⁷ Accepting that premise, the AF will be better served by considering all AFMS officers for hospital command and selecting those who have demonstrated the best potential for mission success.

Later in MG Brannon's article, she writes "[t]hat does not mean that other Corps may not be selected for hospital command, it just means that more physicians will be selected at that level." Furthermore, MG Brannon said "General Jumper's guidance is that medical group command will generally be a one-time, three-year experience. Command of a medical center is an exception, and requires prior group command. Any officer who has completed a MDG command of at least 18 months is eligible to compete for medical center command when there is an opening."²⁸

The evolution of the *Flight Path* limits leadership opportunity for the most senior AFMS positions to only the MC. According to the 2006 *Flight Path* Implementation Guide, "Many of the

successful attributes of the OMG have been retained as the new *Flight Path* was developed. Specific changes include: ‘Medical Corps (MC) only will command medical centers’, and ‘Medical Corps (MC) normally will command hospitals’.”²⁹ When the *Flight Path* guidance was finally published in 2007, all hospitals *and* medical centers had been designated for only the MC.³⁰

The record supports the supposition that hospital and medical center command positions are linked to GO promotion or to other GO stepping-stone positions (e.g., MAJCOM surgeons). Quoting the most recent *Flight Path*, “The *Flight Path*. . . links command opportunity to senior leader requirements and focuses on functional leadership expertise throughout a career.” An interview with a key member of the AF/SG’s first *Flight Path* working group reinforces the conclusion that physicians see most GO positions as “belonging to the MC”. A key participant in the *Flight Path* working group stated that it was commonly understood in discussions with senior AFMS leaders that hospital and medical center command opportunities were limited to physicians to prepare physicians for filling most of the GO billets. Even though Title 10 does not restrict any of the AFMS’ GO positions to the MC, the working group participant stated that, except for the four GO billets set aside for each of the non-physician Corps, AFMS MC leaders treat the other nine GO billets as MC billets.³¹

While it is true that the *Flight Path* dedicated a GO billet for each Corps, in doing so, it simply raised the rank of existing Colonel positions, which were already reserved for the respective Corps Chiefs of those Corps. It did not create additional AFMS Corps diversity opportunities for non-physicians to compete for the other nine GO positions, including the top job. To the contrary, the *Flight Path* limits other Corps from holding premier leadership positions, effectively preventing non-physicians the opportunity to compete on equal ground with physicians for the other nine GO positions. Since the *Flight Path* was implemented in 2007, only physicians (MC) have held more than one GO billet at the same time.

In a study involving 57 military physician/non-physician executives, 30 civilian CEOs, and 16 VHA executive directors, the RAND Corporation found that the *Flight Path* limited leadership opportunities for non-physicians without good rationale.³² Quoting from the study:

[R]espondents criticized the Air Force policy of reserving command of medical centers and hospitals for the MC. The majority of our respondents—military, civilian, and VHA, some of whom were physicians—thought that this policy was shortsighted and that it limited without good rationale the pool from which commanders could be drawn. This policy differs from those of the Army and Navy and bucks trends in the civilian health care sector and the VHA networks and facilities, where the majority of hospital leaders are not physicians.

Another physician CEO explained why the ‘MD’ background isn’t necessary for managing a health care entity:

The answer is that, well, it’s not really a clinical entity. It’s an organizational entity. Like running a surgical service or a medical service. . . . It’s much bigger than that, because you’re dealing with finance and contracts and facility management, so, a variety of people. If you have leadership skills well developed, and whether you’re a doctor, whether you’re a non-physician, if you have those leadership skills, that will carry the day.

The RAND study recommended the following for selecting organizational leaders:

- *Consider using performance-based interviews to recruit and evaluate officers for executive-level positions.*
- *Improve diversity among those selected for leader development opportunities.*
- *Implement a policy of “best in show” rather than “best in breed.” In doing so, examine the health corps structure to ensure that all corps have equitable access to leadership opportunities.³³*

Also, the study recommended to “[p]rovide physicians with leader development opportunities along with business and management skills earlier in their careers.”

Additionally, “[w]e recognize that many of these recommendations will require structural changes and may be difficult to implement. In addition, some may require difficult trade-offs. For example, selecting physicians for early leader development opportunities requires selecting fewer of them and necessarily narrowing the pipeline.”

In addition to the *Flight Path* limiting hospital and medical center command opportunities to the MC, MAJCOM Command Surgeon positions are also limited to the MC. It seems reasonable then to compare MC members’ professional development to those in other Corps to determine whether MC members are uniquely qualified for these positions.

4. Comparing MC to non-MC Officers Leadership Development

Leadership is a skill that we learn, develop, and practice; it is not necessarily inherited nor ingrained in our DNA. . . . Leaders do not abruptly appear fully developed and ready to perform. . . . The force development process provides the means to develop leadership. . . . Leaders are created through a process of development involving education, training, and experience coupled with ongoing mentoring by more experienced leaders.

—General Norton A. Schwartz, Air Force Chief of Staff (retired), AFDD 1-1³⁴

The AF articulates that PME is crucial to honing leadership skills and to identifying weaknesses that need to be strengthened. Squadron Officers' School (SOS) serves as Primary Development Education (PDE) for company grade officers (CGOs) and provides personal, team, and organizational leadership training. MC personnel are less likely to complete primary or intermediate developmental education than the NC, BSC, or MSC personnel. It is often said at promotion ceremonies that promotion to the next grade is not about past achievements but about future leadership potential. As evidenced by AF promotion board results, like their LAF counterparts, failure by NC, BSC, or MSC Corps officers to complete SOS is likely to result in non-promotion to the rank of Major.

Intermediate Development Education (IDE) builds on both the concepts taught in SOS and increased tenure/experience as an AF officer. For example, Air Command and Staff College (ACSC) teaches advanced concepts about effective personnel management and people skills, leading/building teams, military theory, and other competencies the AF determines as vital for success as a leader and commander. Based on past promotion rates, not completing IDE results in a near 100 percent certainty that members of the NC, BSC, or MSC will not be promoted to Lt Col.³⁵ The AF promotion criterion deems IDE so important that not completing it is an almost automatic disqualifier to lead or command in the next higher grade.

In contrast, the MC's career development guide informs AF physicians that SOS and ACSC are *not* required for promotion. Additionally, during the Air Force Management Level Review (AF-MLR)

process, the AF briefs MLR members that PDE and IDE are not required for MC members.^{36 37} One might argue that taking time to complete PDE and IDE detracts from a physician's ability to gain clinical competence and/or obtain board certification. Of note, Nurse Practitioners (in the NC) and Physicians Assistants (in the BSC) are clinical providers and have nearly identical clinical responsibilities MC members have. Given this, it is reasonable to ask why Nurse Practitioners and Physicians Assistants are not exempt from the requirement to complete PDE and IDE.

AF promotion boards view physicians without PDE or IDE as ready for promotion and increased responsibility. Alternatively, the same promotion board deems BSCs and NC clinicians without PDE and IDE as non-promotable unless they complete both. Given the value and emphasis the AF places on PME as being crucial to becoming a more effective leader, the AFMS should create an "all in" PDE and IDE requirement for all Corps.

One can argue that the not having PME and formal leadership development for MC officers is mitigated by virtue of an enhanced force development and mentorship process, but the evidence does not support that assertion either. In the late 1990s, AF Chief of Staff Gen Ryan recognized the need for better force development and launched what became known as the Force Development Initiative (FDI); in 2002, the FDI was formally approved at Corona. Subsequently, the AF authored AFI 36-2640 as formal guidance on force development.³⁸ Consequently, each Corps in the AFMS has a Functional Manager and a group of senior officers who work together through Developmental Teams (DTs) to ensure force development takes place for each member of their respective Corps. DTs meet 2–3 times per year to assess each officer's future potential and career needs and then vectors them to the appropriate education, experience, and command opportunities.

For DTs to be most effective, individual officers must participate in their own development. To facilitate force development at the local level, every MTF and headquarters department has a senior ranking Corps officer who provides mentorship and counsel. Additionally, the senior officer in each

Corps at every MTF is required (by Air Force Policy) to mentor all personnel within their respective Corps. Members, in coordination with the ranking Corps officer, play a significant role in the process by communicating to the DT through the Officer's Airman Development Plan (ADP).³⁹

The ADP is a web-based application that includes assignment, developmental, and command/leadership preferences. Once an officer completes their ADP, their senior ranking Corps officer and/or commander provides comment within the ADP. It is then transmitted to the Air Force Personnel Center for review by DTs. Because ADPs play such a significant role, all officers are highly encouraged by functional managers, commanders, and mentors to update their ADP annually. While it is difficult to measure the effectiveness of mentorship and force development other than anecdotally, the ADP completion rate serves as an indicator. Current ADP completion for the MC is less than 10 percent, while ADP completion for MSC, BSC, and NC is nearly 50 percent.⁴⁰ Consequently, the MC DT attempts to professionally develop MC personnel with 10% participation from Corps members, while the DTs for the MSC, BSC, and NC personnel are better informed when vectoring their respective Corps members to appropriate educational opportunities, squadron command jobs, and other assignments.

5. Leading and Managing AFMS Hospitals and Medical Centers

One can assert that Air Force hospitals and medical centers are organized in such a way that MC officers are uniquely qualified to lead them. However, AF hospitals and medical centers are organized in a functionally similar way to their civilian counterparts, providing the support of functional and clinical experts to hospital executive leaders. Key leadership roles specified in the *Flight Path* underscore a renewed focus on functional and clinical expertise. This mirrors the structure found in private-sector hospitals and expected by civilian health care accreditation organizations.

Key AF hospital and medical center roles include the following: SGP (Chief of Aerospace Medicine), SGD (Dental Executive), SGB (BSC Executive), SGH (Chief of Medical Staff), SGN (Chief Nurse), SGA (Administrator), and group superintendent. The SGA serves as the MTF's chief operating and financial officer. Likewise, the SGH serves as chief of the medical staff and senior advisor for standard of care issues. These functional experts reside at all clinic, hospital, and medical center command positions, and all are subordinate to the MTF commander. Therefore, the Corps affiliation of the MTF commander should not matter, because each essential functional and governance expert in all sub-elements resides outside the function of the MTF commander. In other words, the leadership and governance structure of MTFs does not require commanders to make medical decisions in their day-to-day role; it is an administrative role much like the CEO of civilian hospitals, who are primarily hospital administrators.⁴¹

In 1991, Congress recognized that most military medical facility commanders did not have the appropriate specialized graduate level administrative/business education considered to be the standard (e.g., MHA, MBA) to competently administer complex health care organizations. This is in contrast to civilian health care organizations, where 96 percent of the CEOs are non-physicians and typically would never be hired to administer health care organizations without the above specialized

education. The National Defense Authorization Act, H.R. 2521, SEC 8096, 3 June 1991, Congress required: *“None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a medical doctor unless the prospective candidate is a trained professional administrator.”*⁴² In response to the above law, a two-week overview seminar was developed, which touched on military health care administrative basics, in an attempt to satisfy the law.⁴³ Officers who attended the overview course would then be deemed “trained professional administrators.”

The typical “trained professional administrator” in the civilian health care industry has a 4-year undergraduate degree focusing on prerequisites leading to admission/completion of a two-year graduate degree specializing in business or health care management. Further, they have successfully passed a board certification exam in health care management, which covers a vast array of administrative and business competencies specific to the health care industry. Typically, a person cannot sit for the board certification exam without satisfying minimum requirements, including a graduate degree and a minimum amount of experience in the health care management career field. This is the same for physicians desiring to practice in a specific medical specialty. For physicians to be considered “trained professional specialists,” they must have the appropriate education, work experience and training (residency programs) in addition to passing a board certification exam for that specialty.

Given how complex the health care management profession is today, it is useful to consider if attending a two-week administrative overview seminar or computer based training courses would satisfy Congress’ definition of “trained professional administrator,” especially when the standard for civilian health care management involves years of education, experience, and board certification. The *Flight Path* (by policy) does not allow AFMS members who possess the credentials considered to be the national standard for “trained professional administrator” (as directed by Congress) to compete for or assigned to most senior-level positions considered stepping-stone jobs to GO, as well as to the vast majority of GO billets.

Although MTFs have a unique wartime medical readiness mission, there are many more similarities with civilian health organizations than differences. Accordingly, one might expect to see similar trends of physicians at the helm of hospitals in the private sector when compared with the AFMS. But that is not the case. Physicians did occupy the majority of CEO-like positions in the private sector 120 years ago, when the “hospital administrator” career field did not exist. But as the complexity of health care organizations increased, so did the proportion of non-physician CEOs.⁴⁴ By 1935, only 35 percent of hospitals were physician-led. Over time, as the need for hospital executive education, experience, and leadership continued to increase, hospital executive management continued to transition from physician to non-physician managers. By 2008, of approximately 6,500 U.S. hospitals, only 235 (or less than 4 percent) had physician CEOs.⁴⁵

Furthermore, physicians without proper executive skills education and experience struggle once hired into CEO positions. A recent study of 620 American College of Physician Executive members determined that almost half of physician CEOs lost their CEO jobs in the past five years. Reasons for their termination included lack of business operations involvement, inaction in task completion, poor communication skills, inability to accept criticism, and setting goals not aligned with those of the organization.⁴⁶

Finally, clinical skills gained in medical school or residency programs do not translate into management and leadership skills; thus, physicians aspiring to become CEOs have a business-management education and experience gap.⁴⁷ An MHA or MBA degree, coupled with leadership and management experience, are the two essential requirements for success in health care at the CEO level. According to a survey by Solucient and Cejka of 112 CEOs, a typical health care CEO is 53 years of age, held their first position as a CEO at age 39, has 12–15 years of CEO experience, and approximately 30 years of experience in health care. Over 90 percent have a background and education in health administration (MHA/MBA) and less than 10% had an MD, PhD, or JD.⁴⁸

Are MSC officers (or a member of any Corps) who possess an MBA or MHA equally capable as CEOs in the private sector? In the same way that not all physicians are equally experienced, educated, or competent, not all MSC personnel are equal. For MSC members to be competitive for promotion to Lt Col and Col, in addition to having an advanced degree (usually MBA or MHA), they must earn board certification from an approved and accredited executive health care organization, such as the American College of Healthcare Executives or the American Academy of Medical Administrators. To become board-certified, they must pass an exam to prove they possess the skills and knowledge necessary to succeed in health care management. Just as clinical board certification is the industry standard for physicians, health care executive board certification is the industry standard for those in civilian hospitals and medical center CEO positions.

6. Comparing the AFMS to the Army and Navy

The Army, Navy, and AF each have hospitals and medical centers with similar missions. The Army's approach is quite different than the AF's as it affords leadership development and hospital and medical center command opportunities for all Corps. Approximately 15 years ago, the Army moved away from a physician-centric command screening and selection process. The Army employs the Command Selection System (CSS) to select officers for commands that are on the Command Select List (CSL). This program is under the Chief of Staff of the Army and is managed by the Command Management Branch at US Army Human Resources Command. The system employs a centralized selection board convened at the Department of the Army Secretariat. Only Army Medical Department (AMEDD) officers can compete for AMEDD commands, but the membership of the selection board includes both medical and non-medical personnel.⁴⁹

The majority of AMEDD commands are coded to be filled by any AMEDD officer. Personnel from all Corps compete against each other for command opportunities. The goal of the command selection process is to select the best qualified officers. Under some circumstances, command positions are limited to a specific Corps, such as limiting command of a dental clinic to a dentist. Also, health care facilities are categorized by size and complexity as level one and level two. To command a level-two hospital, one must first successfully command at a level-one clinic or hospital.⁵⁰

An additional structure being used to prepare officers for CSL Command and to develop talent in Army Medicine is the Non-CSL Advisory Board, which selects officers to fill smaller facilities or units that still require a Lt Col- or Col-level leader. The Non-CSL program closely resembles the CSL program in structure. This process also allows officers from all Corps to compete for the same commands. So, unlike the AFMS's "best in breed" (MC only) approach to hospital or medical center command, the Army's uses the "best in show" (all Corps) approach.⁵¹

The Army's command screening and selection process has successfully brought about AMEDD Corps and gender diversity at the executive leadership levels. For example, Lt Gen Patricia D. Horoho, a nurse, is the current U.S. Army Surgeon General. She previously commanded a 500-bed field hospital at Fort Gordon, Georgia, and commanded the DeWitt Health Care Network—opportunities she would not have had if she had been a nurse in the AFMS.⁵²

The Army's approach has fostered command opportunities for other Corps too. As of Oct 2012, health care administrators commanded ten hospitals/medical centers, physicians commanded nine, nurses commanded three, and a dentist commanded one. The fact that the Army is allowing non-physicians to lead as hospital and medical center commanders, as well as Command Surgeons, is paving the way for promotion and leadership opportunities not seen in the Air Force. In fact, while the majority of Army GO medical positions are from the MC, there are 2 MSC, 2 NC, and 1 DC GOs.⁵³

Like the Army, the Navy allows non-physicians to command hospitals and medical centers. The Navy's medical service consists of four Corps, including the MC, DC, NC, and MSC. The MSC includes 31 subspecialties, including allied health clinicians and health care administrators.⁵⁴ Unlike the U.S. Army, the Navy's Medical Department Command Screening Board is managed by medical personnel. The board screens officers to serve as Navy Medicine Executive Officers (XO) and commanding Officers (CO).

Naval officers in the rank of Captain must submit an application to be considered. Additionally, the Navy has a Council of Corps Chiefs. The Council gathers, screens applicants, and recommend specific personnel for specific CO or XO positions for each clinic, hospital, and medical center to the Navy SG. The Navy SG reviews and has final approval authority for the list. While the majority of hospitals and medical centers are commanded by MC personnel, four are commanded by MSCs, three are commanded by dentists, and one is commanded by a nurse. Just as hospital and medical center command positions are GO stepping-stone positions for the Army, they are stepping-stone positions for Navy health care executives. Presently, while the majority of GO officer positions are from the MC,

there are 3 MSC, 2 NC, and 2 DC GOs. Additionally, the Navy's Deputy Surgeon General is an MSC officer.⁵⁵

7. Increasing AFMS Corps Diversity Could Improve Efficiency

“Health-care costs are eating the Defense Department alive, rising from \$19 billion a decade ago to roughly \$50 billion.”

“What it takes is the political will and willingness, to make hard choices—choices that will displease powerful people both inside the Pentagon and out. . . . [S]avings must stem from root-and-branch changes that can be sustained and added to over time. . . . [E]very dollar squandered on waste is one denied to the warfighter.”^{vi}

—SECDEF Robert M. Gates, 8 May 2010⁵⁶

Let’s now look at one area where increasing Corps diversity may result in more careful management of human and fiscal resources. More specifically, greater AFMS Corps equality and representation could influence incentive structures resulting in optimal resource efficiency. By including greater Corps diversity (all Corps), and placing greater emphasis and incentivizing efficient use of human and fiscal resources, great efficiency could be achieved. At the present time, leaders are drawn from populations that don’t necessarily have adequate medical administration skills, and may be causal to less efficient management of resources as outlined below.

To fully explore decisions that were made regarding resources in the paragraphs below, it is important to provide some context. At present, most AF MTFs do not have sufficient patient populations to meet surgical currency requirements. Therefore, AF surgeons sometimes maintain surgical currency by practicing at civilian health care facilities. In such instances, the AFMS may not capture or benefit from the workload. Under such circumstances, one should expect the AFMS to perform less efficiently than private-sector hospitals. Additionally, the medical readiness mission requires a tremendous investment of time and resources, further reducing the efficiency of “provider productivity” in the AFMS health care system. The AFMS has placed great emphasis on clinical currency and medical readiness over the past decade. With that in mind, the following paragraphs explore

^{vi} Remarks as Delivered by Secretary of Defense Robert M. Gates at the Eisenhower Library regarding Defense Spending, May 08, 2010.

opportunities for the AFMS to become more efficient, while continuing to place great emphasis on clinical currency and medical readiness.

Over the past several years DoD has placed a greater emphasis on the Military Health System (MHS) becoming more efficient because of the rapid increase in health care costs, while simultaneously maintaining clinical currency and readiness capability.^{57, vii, 58} From 2001 to 2006, total costs for DoD health care rose by over 100 percent. Today, 50 percent (\$32.2 billion) of DoD's military personnel-related costs are medical, as outlined in DoD's most recent budget proposal.⁵⁹ Personnel cost growth at the current rates will result in DoD personnel cuts of 82,000 by 2021. However, if cost growth is reduced by 1.9 percent, personnel end strength cuts can be avoided altogether. If nothing changes to personnel growth cost rates, the entire defense budget will be consumed by paying for health care and other personnel benefits by 2039.⁶⁰

Despite the *Flight Path's* emphasis on "cost-effective care" and growing Congressional and AF emphasis on controlling health care costs over the past decade, health care costs continue to increase rapidly.⁶¹ In 2008, the Air Force Audit Agency (AFAA) determined that during a 3-month period at 12 MTFs "[n]early 14,000 appointments went unfilled while, at the same time, over 19,000 patients were referred to the private sector." The audit found that when a patient's primary care manager did not have available appointments, patients were referred off base for costly care, rather than to providers who had open appointments within the military's clinic (known as "cross-booking"). The AF/SG concurred with the report's findings and said the AFMS was taking steps to fix the problems. Additionally, the auditors found that, of the clinics they audited, most were operating well below enrollment capacity.⁶²

^{vii}The AFMS has three major missions: maintaining a healthy and deployable active-duty force, ensuring the readiness of AFMS personnel for medical support during wartime, and delivering peacetime health care. To be prepared to accomplish the wartime mission, it is vital that physicians and support staff maintain clinical or surgical currency.⁵⁹

At nearly the same time as the AFAA audit, the AF/SG began adapting a Patient-Centered Medical Home (PCMH) model from the private sector to be used in the AFMS. The PCMH model, typically led by a physician, is supposed to reduce the incentive for face-to-face care. Better coordination of patient care is supposed to lead to better primary care access and lower costs (such as are incurred at urgent care or emergency room visits). To date, however, there is little evidence PCMH achieved improved effectiveness.⁶³

The PCMH working group consisted of the Deputy Surgeon General (MC), the AFMS Family Practice consultant (MC), 5 Family Practice physicians (MC), 2 nurses (NC), 2 medical technicians, and 1 group practice consultant (MSC).⁶⁴ While the team composition included many clinical views, it did not have much financial/business expertise. When the AFMS implemented PCMH, it placed a great deal of emphasis on continuity of care—making sure patients received care from their own PCM team versus another MTF provider. In fact, when PCMH was implemented, cross-booking was highly discouraged. This went against the AFAA’s recommendations. Per the Air Force Medical Operations Agency (AFMOA), one of the four main tenants of PCMH includes “cross booking—NONE”, and in an AFMOA PCMH talking paper “cross-booking—eliminated”.^{65 66} The AFMOA recently softened its position on cross-booking, but it is still discouraged. The fundamental issue is not whether continuity of care is important. The principal issue is that PCMH was implemented using metrics and incentives as explained below, which discourage efficient use of resources (unused appointments) and result in significant and unnecessary health care costs (purchased care instead of cross-booking and using the MTF’s unbooked appointments).

MTFs receive quarterly financial award funding based on their PCMH performance metrics/rankings. In addition to instructive guidance from the AF/SG to avoid cross-booking, the continuity-of-care metric has the most impact of all the metrics (40 percent weighting) in AFMS-wide PCMH rankings and serves to discourage cross-booking.⁶⁷ When cross-booking occurs within an MTF,

continuity metrics take a negative hit. However, when patients receive care at an off-base doctor's office, continuity metrics are not negatively impacted, despite additional costs. Also, when patients are referred off base, TRICARE funding, not the MTFs' funding, is used to pay for the care. In other words, MTFs are insulated from the costs of purchased care and are financially incentivized (quarterly award funding) when they do not follow the AFAA's recommendation to cross-book appointments and instead use TRICARE funds to purchase medical care from off-base private doctors.

Regarding incentives, one AFMS MTF that consistently ranks in the top few MTFs for PCMH metrics and also ranks high for primary care referrals off base is able to achieve stellar PCMH rankings and, consequently, a sizable financial award by purchasing off base care for patients instead of scheduling patients with another military MTF provider, thereby avoiding the additional off base cost. One can also imagine that even if a patient being cross-booked to another military provider impacts continuity, it does so less than an off base referral, because the military providers are steps away from each other to consult. In addition, record-keeping remains with the military system.

A 2012 market analysis of a certain geographic area containing both Army and AF MTFs determined that of all the MTFs (Army and AF), adjusted for enrollment, the AF's MTFs referred the most patients to off base care. MTF providers can select one of two types of off base referrals. "Evaluate Only" (EO) referrals allow the MTF's primary care provider to provide the medical care following an evaluation by a purchased care provider. The other type of off base referral, an "Evaluate and Treat" (E&T), does not allow the MTF's primary care provider to provide the care, because the purchased care provider is authorized to treat the patient following the evaluation.

Since 2008 and following implementation of PCMH, primary care E&T referrals (annualized enrollment adjusted for referrals) have increased by approximately 25 percent for one AF MTF and approximately 18 percent at the other AF MTF compared to less than 10% for the Army MTF.⁶⁸ The report concludes that:

“Patient Centered Medical Home (PCMH) policy/implementation for the Air Force locations appears to be contributing to the increase in primary care referrals. Meanwhile, MTFs are cautioned against cross-booking a patient to another PCM outside of their team in order not to destabilize continuity of care for other teams. This may have evolved into never cross-booking policy, resulting in frequent referrals to off base purchased care and greater cost to the DoD. Customer satisfaction data bears out dissatisfaction with access to their PCM.”⁶⁹

Echoing the findings from the 2008 AFAA audit, the report also noted that “[b]ased on the most recent performance snapshot, an additional 1,044 appointments per month (a 44% increase) were possible if converted and booked.”⁷⁰ In other words, proper appointment management within the military system can prevent the additional expense of approximately \$1 million per year in off base medical appointments at the few MTFs that were part of the market analysis.

In recent research regarding PCMH, RAND found a slight decrease in specialty care referrals (not statistically significant). Also, it found increased use of Emergency Departments (not statistically significant) and Urgent Care Centers (statistically significant), the opposite effect of the desired results. RAND also found that off base Emergency Department and Urgent Care utilization increased over time following PCMH implementation. RAND explained the increase in emergency room visits as a consequence of longer wait time for scheduled appointments at MTFs.⁷¹

The PCMH model was intended to reduce purchased care off base, but data suggest an increase in off base purchased care. Also, implementing PCMH required a tremendous investment in providers (Physicians, Nurse Practitioners, and Physician Assistants) at the expense of other mission areas. PCMH drove a 20 percent increase in providers, from 67 providers/100,000 enrollees to 80 providers/100,000 patients) because of reducing the number of patients enrolled to each panel. Prior to PCMH, a family

practice provider maintained a patient panel size of 1,500 enrollees per provider, and had approximately 100 bookable appointments per week.⁷²

With the implementation of PCMH, the AF/SG reduced panel size by 16.7 percent to 1,250 patients, and reduced bookable appointments by 10 percent from 100 to 90 per week. As a point of reference, the average off base family practice physician has a panel size of 2,100 patients.⁷³ While Air Force family practice physicians have 18 bookable appointments per day, they average 14–15 visits because patients do not show up for appointments and cancel appointments with little warning, while others go unfilled, often times as a result of cross-booking policies. The AF productivity rate is 60 percent of the U.S. national average of 25 patients per day.⁷⁴

PCMH providers have three direct-care support staff per provider, which is nearly double the national average of 1.6 direct-care support staff per provider, an inverse relationship to PCMH providers' lower productivity. The DoD's electronic medical record (EMR) system is inefficient, which also helps explain why patient care is less efficient. While the DoD's EMR system may not be optimal, non-DoD physicians would counter that their greater productivity occurs in an environment that is equally inefficient, one that requires electronic medical records and dealing with insurance companies, prescription denials, and insurance billing paperwork. In fact, non-DoD physicians reported spending nearly 3-weeks per year interacting with health plans.⁷⁵

One might assume that deployments cause MTFs clinical personnel shortages, contributing to increased purchased care costs. To maintain the ability to see patients at home when active-duty medical personnel deploy, the AFMS provides funding to backfill deploying staff members with contractors and civilians. The AFMS has on staff hundreds of personnel to backfill deployed members. In fact, the AFMS budgeted \$130 million in FY12 to backfill medical personnel with contract/civilian replacements. However, in some instances, medical backfills cannot be acquired.⁷⁶

Finally, one might suggest there is a provider shortage in the AFMS, but data suggest otherwise. From 1975 to 2012, the supply of physicians in the United States increased from 1 physician per 599 people to 1 physician per 417 people. Since 1975, the size of the active-duty force has decreased by 61 percent, yet the AF physician population has increased by 6 percent. The current physician-to-active-duty-member ratio is approximately 100 service members per 1 physician; including Air Force contract and civilian physicians, the AFMS has a total of 3,737 physicians for a ratio of 1 physician for every 285 enrollees (which includes family members). This is a more favorable physician-to-patient ratio than the U.S. average of 1 physician per 417 people.⁷⁷

When one includes physician extenders (physician assistants/nurse practitioners), the AFMS ratio is 1 provider for every 228 enrollees. Even with a favorable provider to enrollee ratio, the AF still pays over \$1.7 billion for off base purchased care, which is partly the result of nearly 600 physicians and physician extenders being placed in non-patient care or administrative positions, both inside the MTF and in other non-MTF locations.⁷⁸

8. Management and Overhead Cost Growth

“Another category ripe for scrutiny should be overhead—all the activity and bureaucracy that supports the military mission.”

“Going forward, some questions to be considered should be: How many of our headquarters and secretariats are primarily in the business of reporting to or supervising other headquarters and secretariats, as opposed to overseeing activity related to real-world needs and missions? . . . How many commands or organizations are conducting repetitive or overlapping functions . . . and could be combined or eliminated altogether?”

—SECDEF Robert M. Gates, 8 May 2010⁷⁹

Most civilian-sector medical providers spend the majority of their time in direct patient care. Conversely, although the AFMS invests in (cost-avoiding) revenue-producing providers, it sustains a corporate structure that places 15 percent of medical providers (at any one time) in varied administrative roles that do not involve patient care. That cost is borne by hiring redundant capability or by referring care off base. It would be analogous to the AF investing heavily in pilots and then placing so many of them in administrative roles that it must hire contractors to fly over half their sorties. To describe it in those terms, the AFMS contracts out nearly \$1.7 billion in “medical sorties” per year (72 percent) and executes \$652 million (28 percent) of sorties using AFMS providers.

It seems reasonable to evaluate whether it makes fiscal sense to have nearly 600 providers (not including medical students) in dedicated non-MTF positions and/or administrative roles rather than in MTFs to help mitigate the high cost of purchased care. This is not to say that providers in dedicated non-MTF positions or administrative roles do not have a valuable role or that their roles can be altogether eliminated. For example, the AFMS has 33 providers dedicated to CSTARs, a group that trains Air Force trauma teams, crucial training that advances critical care and readiness skills that providers will need in a deployed environment. Although realigning more providers to direct care in MTFs will not translate to meeting all patient care demands for the enrolled population, efficiencies can be realized in the AFMS. The AFMS should further explore opportunities within its existing diversity of professions to

leverage the best balance of human capital to meet patient care needs, and administrative requirements

Even though the AFMS has fewer MTFs and enrollees, it has increased administrative personnel not assigned to MTFs. In 1990, the AFMS had 121 MTFs, and in 2012 there are 75 MTFs. In FY 2003, the AFMS supported a total of 375,062 military personnel and 1,249,837 total enrollees. By September 2012, the number of active-duty supported dropped to 328,896, with 1,062,082 total enrollees including family members.⁸⁰

Despite a 12 percent decrease in the quantity of active-duty personnel supported and a 15 percent drop in total enrollees since 2003, manpower authorizations for headquarters support agencies, such as AFMOA, AFMSA, MAJCOMs, etc., have increased by 75 percent from 839 in 2003 to 1,470 in 2013.⁸¹ Some of the manpower authorization increases are a result of Air Force level decisions (e.g., the establishment of Air Force Global Strike Command, Air Force District of Washington, etc.). Others are a result of AFMS decisions and priorities (e.g., net growth at Headquarters, Air Force Medical Operations Agency and MAJCOMs). National security concerns changed from 2003 to 2013, making some of the added headquarters positions necessary. However, a more Corps-diverse AFMS can manage the complex, diverse considerations needed to more efficiently balance non-MTF personnel positions.

9. A Business Case for AFMS Corps Diversity

“The greatest fiscal threat to the military is not declining budgets, Hagel warned, but rather ‘the growing imbalance in where that money is being spent internally.’ In other words, money dedicated to health care or benefits is money that's not spent on preparing troops for battle or pilots for missions.”⁸²

The AFMS will benefit from determining innovative ways to accomplish its core mission more efficiently, especially with looming budget cuts, and expanding AFMS Corps diversity within the most senior positions could be a first step. A more Corps diverse AFMS team at the most senior level, similar to what exists in the civilian sector, the other services, and the VHA, will yield benefits (e.g., a highly trained focus on balancing the business of delivering health care with meeting readiness requirements, clinical currency, Graduate Medical Education programs, and so on).

Considering the \$6.1 billion AFMS budget, it is important to develop/implement best business practices to most effectively execute those resources. Allowing more blue-suit clinicians to practice medicine instead of assigning them to administrative positions can save millions of dollars in purchased care (TRICAE funds) off base and significantly reduce the funding spent on clinical contractors. This is not to suggest that MC personnel be limited or restricted from leadership opportunities, but rather to increase mission capability at MTFs. Also, leveraging clinical currency requirements for those providers who must be assigned to non-MTF administrative roles will benefit the AFMS by increasing MTF patient access, thereby reducing civilian purchased care costs.

The difference in annual personnel costs between officers in the MSC, BSC, and NC and MC is considerable. Most MSC, BSC and NC officers enter active duty as lieutenants. Most physicians enter the service as Captains, but it is possible for them to come on active duty as a Majors or Lt Cols depending on their civilian medical experience. Additionally, administrators typically progress in rank at a slower pace. For instance, at 20 years of service, approximately 75 percent of physicians are

promoted to O-6 while less than 25 percent of NC, BSC, or MSC personnel are promoted to O-6. In addition to extra pay from higher rank, physicians receive up to 6 types of special pay. The Line of the Air Force (MILPERS) pays \$271 million per year to fund special pays for the MC, NC, BSC, and DC.⁸³ For instance, a family practice physician with ten years of service receives \$20,000 in Incentive Special Pay, \$15,000 in Additional Special Pay, \$11,000 in Variable Special Pay, and \$3,500 in Board-Certification Pay. In addition, they are eligible for retention bonuses up to \$38,000 per year for a four-year service commitment. In all, the annual cost difference between an administrator and family practice physician at the 10-year mark is between \$60,000 and \$95,000.^{84 85} For a specialist, such as an anesthesiologist, radiologist or an orthopedic surgeon, the special pay can exceed \$100,000.⁸⁶

The pay differences expose an important and expensive opportunity cost by having clinicians in administrative roles that do not specifically require clinicians, instead of taking advantage of their valuable clinical training in the MTFs. To illustrate, moving one family practice physician from an administrative role back to a clinical role can reduce private-sector care cost by at least \$275,000 (based upon historical AFMS productivity levels). For a specialist, the savings are greater. Many physician extenders can also be moved from administrative roles back into clinical roles and yield savings. Finally, all providers (physicians and extenders) who serve in clinical roles are more likely to meet AF clinical competency standards than those in administrative positions and, therefore, are better prepared to use their clinical skills in a deployed environment.

The MC and DC are similar in terms of education, recruitment, importance of retaining them for readiness and patient care, attrition concerns, bonuses paid, and so on. Thus, it makes sense to compare the two career fields with respect to how they balance patient care and leadership. Both career fields receive significant specialty-pays to adequately compensate and retain them. All medical providers performing duties in MTFs are required to submit a timesheet showing how their time is spent. The tables below show how time is spent for MC and DC members (by rank) who submitted a

timesheet at an MTF in FY12. When considering the quality of DMHRI data, it's important to keep in mind the data are based on personnel self-reporting the breakout of their time.

The tables below reflect data of MC and DC personnel assigned to MTFs, as well as those assigned to non-MTF jobs but who provided some patient care at an MTF. Any provider who sees patients in an MTF is required to complete a timesheet, whether they are assigned to the MTF or not. The data reveals that 90 percent of DC personnel (883 of 986) report spending time at an MTF compared to only 76 percent of MC personnel (2,529 of 3,328). As stated previously, there are more AF physicians assigned to non-MTF billets than there are dentists in the AFMS. It seems logical, though, that all providers should see patients at MTFs to maintain their clinical competency.⁸⁷

MC and DC personnel in the Captain grade are most likely to be in board certification/residency programs that can negatively impact time spent in patient care. Therefore, only field-grade (FG) MC and DC personnel are compared. Of 2,148 MC FG physicians, 297 did not complete timesheets, presumably because they did not provide any patient care, compared to only 16 of 538 FG dentists. The AFMS can potentially avoid millions of dollars of purchased civilian care by requiring providers who are not assigned to MTFs to spend more time providing patient care at MTFs, if they are assigned close to one. Additionally, from a business-case perspective, it seems reasonable to look at the AFMS billets that do not require current clinical skills and whether those billets require a clinical background at all.

Of the physicians and dentists who reported spending time at MTFs, there were noteworthy differences in how that time was spent, especially at the field grade level. For example, 180 O-6 dentists spent an average of 46 percent of their time providing patient care, compared to 224 O-6 physicians, who spent 30 percent of their time providing patient care. The gap occurred with Lt Cols as well, where dentists spent 63 percent of their time performing patient care compared to 52 percent for physicians.

It's also worth noting that Lt Col and Col physicians reported spending more time performing administrative duties (e.g., flight or squadron command) than did dentists. O-6 physicians reported

spending 46 percent of their time in administrative roles compared to 39 percent for O-6 dentists. Lt Col physicians reported spending 23 percent of their time in administrative roles, compared to 19 percent for Lt Col dentists. Replacing more of physicians' administrative time with patient care time will have multiple benefits; it will help maintain/improve their clinical competency, increase AFMS patient access, improve readiness, and reduce civilian purchased care by millions of dollars.

Table 1. How MC Members Allocate Their Time on Timesheets

FY12 MC DMHRSI	Patient Care	Administration	Education	Readiness or Deployments
Capt	58.20%	3.45%	29.91%	8.43%
Maj	67.84%	6.91%	12.75%	12.50%
Lt Col	51.86%	23.27%	12.34%	12.53%
Col	30.11%	46.46%	12.73%	10.69%

Based on AFMS FY12 Defense Medical Human Resources System Internet (DMHRSi).

Table 2. How DC Members Allocate Their Time on Timesheets

FY12 DC DMHRSI	Patient Care	Administration	Education	Readiness or Deployments
Capt	72.21%	2.04%	18.83%	6.93%
Maj	68.48%	7.60%	15.20%	8.71%
Lt Col	62.96%	19.16%	8.94%	8.94%
Col	45.98%	39.27%	7.55%	7.20%

Based on AFMS FY12 Defense Medical Human Resources System Internet (DMHRSi).

Especially in the health care environment today, it makes sense to develop more balance where specific costly/scarce resources are targeted to meet specific needs. Although it may result in fewer senior leader opportunities for physicians makes sense in today's business-entered environment. The risk that doing so will cause more physicians to separate from the AF seems unlikely and may actually help retention. For example, lack of senior leader positions has not impacted retention of dentists; as noted, O-6 dentists spend a greater percentage of their time seeing patients than their physician counterparts, yet retention rates for dentists are higher. In fact, physicians separating from the AF sometimes cite not wanting to be moved from a clinical role to a non-clinical/administrative job

as the reason for separating. A recent RAND study found that some physicians choose to leave the Air Force to continue practicing medicine rather than filling leadership positions.⁸⁸

The argument is not that clinicians should be placed at a disadvantage from holding leadership positions by virtue of being clinicians. However, it makes sense for any organization to apply its diverse teams' skills to positions team members are prepared for, including the most senior levels, and especially when not doing so costs the organization millions of dollars. The AFMS should aim to find a healthy balance of leadership opportunities, while retaining sufficient providers to meet the health care needs of the patient population.

A position-by-position review would reveal opportunities to realign physicians and physician extenders from non-clinical positions to clinical ones at MTFs. Additionally, the AFMS should consider increasing the ratio of time spent by MTF providers performing patient care versus administrative functions. When appropriate, administrative functions should be transferred to others. Reducing headquarters manpower authorizations from 1,470 to closer to the 2003 end strength of 839 will also free up hundreds of personnel to return to MTFs or to backfill physicians in administrative roles.

Increasing emphasis and promotion opportunity for those who choose to remain in clinical roles (instead of administrative or leadership roles) may increase provider satisfaction and retention. Since the number of physicians in field-grade rank is not limited, promotion opportunities for physicians do not have to suffer for those who remain in clinical practice, though there may necessarily be fewer non-clinical leadership jobs.

Finally, reading from the AFMS' mission brief, it states that: "readiness is job #1: we exist to deploy clinically current medics and keep AF personnel deployable! Delivering the health benefit underpins readiness, and the peacetime health delivery system is the main platform from which we maintain clinical skills to do Job #1".⁸⁹ It seems reasonable then to ensure the clinical currency of the nearly 600 providers in administrative roles or to assess which of the administrative billets actually

require providers. The potential to save tens of millions of dollars in contractor and/or civilian purchased care costs is impetus for a renewed emphasis on providers seeing patients, further enhancing the AFMS’ #1 mission, readiness.

Table 3 estimates potential savings by realigning 200 providers from administrative to clinical functions. It also estimates aggregate full-time equivalents (FTEs) by increasing the percentage of time spent by Lt Col and Col MC personnel to match the percentage of time spent in clinic by those of equal rank in the DC per Tables 1 and 2. Finally, Table 3 estimates the FTEs and savings of ensuring all providers not assigned to MTFs spend five percent of their time (one day per month) in patient care. The table below indicates a total annual savings of \$81.7 million; this assumes no unplanned or unexpected external factors.

Table 3. How Realigning Providers Can Save \$81 million

Change	Net FTE Increase	* Estimated Savings (\$M)
**Realign 200 administrative providers to clinical roles	200	55.0
Increase MC Lt Cols clinic time by 10% (those assigned to MTFs)	60	16.5
Increase MC Cols Clinic Time by 15% (those assigned to MTFs)	22	6.1
MC not assigned to MTFs provide patient care 5% of time	15	4.1
Total	297	81.7

* Assumes \$275,000 savings per FTE

** Includes all provider types, such as physicians, NPs, PAs, etc.

There was insufficient data to determine the potential savings by eliminating the PCMH policy which discourages cross-booking and the total cost of unbooked appointments. However, based upon the 2007 AFAA audit findings, the potential cost savings are estimated at over 10 million per year. We recommend the AFMS change policy to allow cross-booking to maximize use of AFMS resources. Echoing the AFAA’s findings, we recommend the AFMS consider increasing enrollment at MTFs, which could save millions more.

By realigning up to 200 primary care providers back to MTFs, the AFMS could increase enrollment by up to 250,000 patients, which would save tens of millions in TRICARE funding for primary care visits, ancillary services (pharmacy, laboratory, diagnostic imaging, physical therapy, etc.), and surgical cases. Furthermore, the AFMS struggles with having adequate surgical cases for surgeons to maintain their surgical currency/skills. Increasing enrollment would benefit surgeons by providing them with more surgical workload.

10. Key Problems and Potential Options for a Path Forward

What is required going forward is not more study. Nor do we need more legislation. It is not a great mystery what needs to change. What it takes is the political will and willingness, as Eisenhower possessed, to make hard choice—choices that will displease powerful people both inside the Pentagon and out.^{viii}

—SECDEF Robert M. Gates, 8 May 2010⁹⁰

In this section, we summarize some of the key problems identified in this paper, discuss what the goals should be in addressing those problems, and then evaluate courses of actions (COAs) that could help meet those goals to address the problems. Table 5 summarizes the key problems that were identified throughout this paper and how to address the problem.

Table 4. Problems Identified and How to Address Them

Problem Identified	How to Address It (Objectives)
1. There is poor Corps diversity in AFMS senior ranks because of an institutional policy and <i>Flight Path</i> ; lack of Corps diversity runs counter to AF policy	1. Remove policies that limit AFMS Corps diversity, and ensure equality in the senior leader selection process
2. MC-only hospital and medical center commanders and majority-MC GOs leave no advancement path beyond Corps Chief positions for other AFMS Corps – negatively impacts morale and advancement for other Corps	2. Equal opportunity for non-MC to command hospitals/medical centers and fill GO stepping-stone positions
3. MC as MTF commanders and GOs has not resulted in efficient business operations for AFMS because they are not trained or certified for health care administration tasks; AFMS leadership policy results in costly health care business decisions and is not aligned with the will of Congress	3. Increase administrative competency of MTF commanders and AFMS senior leadership
4. Inconsistent AF PME standards; lack of PME prevents honing leadership skills and identification of weaknesses that need to be strengthened	4. Set a single PME standard for AFMS officers
5. Too much overhead cost growth, including headquarters growth of 75 percent; many MC officers are diverted to non-clinical tasks and PCMH is poorly adapted for AFMS use; patients are diverted to off-base care, increasing cost	5. Shift provider billets to patient care roles and establish standards and metrics for patient visits

Because the status quo results in the problems shown in Table 4, an option continuing along that path will not adequately address those problems. So, below we consider two options that address the

^{viii} Remarks as Delivered by Secretary of Defense Robert M. Gates at the Eisenhower Library regarding Defense Spending, May 08, 2010.

problems in different ways: The Minor *Flight Path* Change and Major *Flight Path* Change. As the titles imply, both options involve varying levels of change to the *Flight Path* in order to address problems. The Minor *Flight Path* Change is a less comprehensive change, yet improves upon the Status Quo in each of the problem areas. The Major *Flight Path* Change provides a more comprehensive and far-reaching approach to addressing the problems.

Minor *Flight Path* Change

1. Remove policies that limit AFMS Corps diversity, and ensure equality in the senior leader selection process. In this COA, the AFMS will set aside 30–35 of the clinic group commands to be divided up amongst the five Corps, and the larger clinics and smaller hospitals will become Corps-neutral. All graduated group commanders will be allowed to compete for more complex hospital and medical center command positions, and medical wing command positions will remain Corps-neutral. Additionally, the AFMS will align their senior MAJCOM and AFMS leaders' titles with equivalent MAJCOM directorates and AF Deputy Chiefs of Staff, change the position title of "MAJCOM Surgeon" to "Director, Medical Services Directorate," and change the name of "AF Surgeon General" to "AF Deputy Chief of Staff for Medical Services". We assess this COA partially achieves objective 1 by increasing opportunity for all Corps to compete for commanding clinics, hospitals and medical centers. By making position titles more Corps neutral, it seems more likely that non-MCs will be considered for other AFMS senior leadership positions. In order to fully meet objective 1, it will need to allow for equal opportunity to compete for all clinics, hospitals, and medical centers instead of just 30-35.

2. Equal opportunity for non-MC to command hospitals/medical centers and fill GO stepping-stone positions. This COA is linked to COA 1 and serves as a mechanism for allowing equal opportunity to high-potential senior leader positions. To help promote Corps equality, the AFMS will develop a "high-potential senior leader position list," which will include those positions that have historically served as GO stepping-stone positions, including hospital and medical center command and MAJCOM

Surgeons. Further the AFMS process for filling each high-potential senior leader position will mirror the process employed by the Army. The records of all Corps personnel selected to compete for key senior leadership positions will meet a CSB, which will consist of at least 50 percent line officers and an even distribution for members of each Corps. This COA has proven effective at increasing professional diversity within the Army. Therefore, we assess COA will fully achieve the objective 2.

3. Increase administrative competency of MTF commanders and AFMS senior leadership. In this COA, the AFMS will require all AFMS MTF commanders and those in GO positions to meet the national board certification standards for “trained professional administrators,” just as the AFMS currently requires all clinical personnel to meet national clinical certifying standards. Therefore, we assess this COA will fully achieve objective 3.

4. Set a single PME standard for AFMS officers. The AF determined PME is critical to developing officers most effectively. Therefore, in this COA, the AFMS will require all AFMS officers to complete PME appropriate for their rank. Ensuring that all officers complete PME will ensure honing of leadership skills and identification of weaknesses that need to be strengthened. Therefore, we assess this COA will fully achieve objective 4.

5. Shift provider billets to patient care roles and establish standards and metrics for patient visits. In this COA, the AFMS will require AFMS providers not assigned to MTFs, but at locations within 25 miles of an MTF, to spend a minimum of 5 percent of their time in patient care, which is approximately one duty day per month. In rare circumstances, waivers will be granted to exempt providers from patient care. Metrics will be established to measure compliance, and special pays will be linked to compliance with patient care. PCMH metrics will be changed to reward MTFs that use resources the most efficiently. For example, the AFMS will decrease emphasis on continuity metrics and will increase emphasis on maximizing MTF resources, such as better appointment utilization, increased provider productivity, etc. While this COA makes more efficient use of existing resources, it does not

realign providers from administrative positions to patient care positions. Therefore, we assessed this COA as partially achieving objective 5.

Major *Flight Path* Change

The Major *Flight Path* Change includes COAs similar to the Minor *Flight Path* Change that are in certain instances more extensive and disruptive to the Status Quo.

1. Remove policies that limit AFMS Corps diversity, and ensure equality in the senior leader selection process. In this COA, the *Flight Path* will be changed to eliminate all Corps designations for group/wing command (including hospital and medical center command) and other senior GO stepping-stone positions, such as MAJCOM Surgeons. To help promote Corps equality, the AFMS will develop a “high-potential senior leader position list,” which will include those positions that have historically served as GO stepping-stone positions. As recommended by the RAND Corporation, the AFMS will also take steps to identify high-potential physician leaders sooner and will narrow the physician-leader pipeline. Doing so will provide a more deliberate and effective approach to developing MC leaders to include business and management education and experience. Also, the AFMS will place greater focus on the functional/clinical path, allowing MC to advance in rank within the functional/clinical path. Finally, the AFMS will align their senior MAJCOM and AFMS leaders’ titles with equivalent MAJCOM directorates and AF Deputy Chiefs of Staff, change the position title of “MAJCOM Surgeon” to “Director, Medical Services Directorate,” and change the name of “AF Surgeon General” to “AF Deputy Chief of Staff for Medical Services.” We assess this COA will fully achieve objective 1 by increasing opportunity for *all* Corps to compete for *all* high-potential senior leader positions. Further, by making position titles more Corps neutral, it seems more likely that non-MCs will be considered for other AFMS Senior Leadership positions.

2. Equal opportunity for non-MC to command hospitals/medical centers and fill GO stepping-stone positions. In this COA, the AFMS process for filling each high-potential senior leader position will

mirror the process employed by the Army. The records of all Corps personnel selected to compete for key senior leadership positions will meet a CSB, which will consist of at least 50 percent line officers and an even distribution for members of each Corps. A board process consisting of majority representation from line officers will help ensure line-officer influence and diversity and will help promote Corps equality. This COA has proven effective at increasing professional diversity within the Army. Therefore, we believe this COA will fully achieve the objective 2.

3. Increase administrative competency of MTF commanders and AFMS senior leadership. In this COA, the AFMS will require all AFMS MTF commanders and those in GO positions to meet the national board certification standards for “trained professional administrators,” just as the AFMS currently requires all clinical personnel to meet national clinical certifying standards. Therefore, we assess this COA will fully achieve objective 3.

4. Set a single PME standard for AFMS officers. The AF determined PME is critical to developing officers most effectively. Therefore, in this COA, the AFMS will require all AFMS officers to complete PME appropriate for their rank. Ensuring that all officers complete PME will ensure honing of leadership skills and identification of weaknesses that need to be strengthened. Therefore, we assess this COA will fully achieve objective 4.

5. Shift provider billets to patient care roles and establish standards and metrics for patient visits. In this COA, the AFMS will decrease the quantity of personnel at headquarters locations, returning to 2003 levels of approximately 846 personnel. Also, the quantity of providers in administrative positions will be reduced from 600 to 400. All providers assigned to MTFs, including those in administrative roles, will be required to perform patient care. The overall ratio of time spent in patient care by MC personnel will increase to levels similar to the DC. The AFMS will require AFMS providers not assigned to MTFs, but at locations within 25 miles of an MTF, to spend a minimum of 5 percent of their time in patient care. In rare circumstances, waivers will be granted to exempt providers

from patient care. Metrics will be established to measure compliance. PCMH metrics will be changed to reward MTFs that use resources the most efficiently. For example, the AFMS will decrease emphasis on continuity metrics and will increase emphasis on maximizing MTF resources, such as better appointment utilization, increased provider productivity, percentage of time spent in patient care versus administration, Evaluate and Treat versus Evaluate Only referrals, meeting patient enrollment goals, decreasing (TRICARE) purchased care for services available at MTFs, etc. Both financial rewards and penalties will be assessed based on performance metrics. The total estimated savings impact of this COA is \$81 million. We assess this COA will fully achieve objective 5 by realigning and reallocating human capital to achieve greater efficiency and savings.

Table 5. summarizes how the two options deal with the identified problems. The *Major Flight Path Change*, while more disruptive than the *Minor Flight Path Change*, has the greatest likelihood of realizing each of the objectives. Some structural changes will need to occur to implement this plan. Also, the Air Force will incur a relatively small cost for holding a CSB and increasing administrative professional expertise, but the potential cost savings of \$81 million per year to the Air Force through decreased purchased care costs exceed the cost of a CSB. The data is already available for creating the suggested metrics and will require minimal effort to implement.

Table 5. Summary Evaluation of Two Options

Problem	No Senior Development Path for Non-MC	Corps Diversity Limitation/Lack of Diversity in Senior AFMS	Lack of Professional Administrative Expertise in Senior AFMS Positions	Lack of Single AF PME Standard	Administrative Overhead Cost Growth/Use of AFMS Resources
Way to Address It	Improves Advancement/ Development Path for Non-MC	Increases AFMS Senior Level Corps Diversity	Increases Professional Administration Skill of AFMS Senior Leadership	Ensures Same PME Standard Applied to all AFMS Officers	Decreases Overhead Costs/Increases Utilization of Clinicians/Reduces Off-base Care Expenditure
Minor Flight Path Option	+	++	++	++	+
Major Flight Path Option	++	++	++	++	++

Does not meet objective -- - 0 + ++ Meets objective

Conclusion

In summary, the existing AFMS career path paradigm, specified in the *Flight Path*, results in physician overrepresentation in senior leadership positions at a cost in AFMS Corps diversity and in dollars. In these budget-constrained times, a more appropriate model may be one in which respective skill sets are matched to the jobs that make the most sense, promoting both senior leadership diversity and efficient use of resources.

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