

Roundtable Discussion

Meeting Manpower Requirements In The Military Health System

Stressed by the demands of the long conflicts in Iraq and Afghanistan, the Military Health System (MHS) is a \$47 billion enterprise facing shortages and maldistribution of its professional staff.

Participants in a roundtable discussion sponsored by the nonprofit Institute of Federal Health Care outlined potential steps to help mitigate the effects of these lengthy deployments – now exceeding eight years — including more flexibility in hiring civilian staff, greater understanding of the contracting and other personnel tools available to commanders for meeting gaps in staffing, and use of technologies such as telehealth.

Roundtable participants included representatives of federal agencies, beneficiary groups, academia and the private sector.

Concern was expressed during the discussion that the increasing percentage of the Defense Department budget devoted to medical care has made it a target in the struggle for personnel and resources by siphoning money from military operations and construction: “The issue is, who gets the billets.”

An unknown hovering over the MHS — and all of federal medicine — is the outcome and impact of health care reform efforts. Participants noted that the MHS has “something to offer” in the health care debate, in that it is “primary care-centric,” while civilian medicine is driven by specialty care, which increases cost.

However, the conflicts abroad have hindered the ability to deliver primary care by uniformed providers: “Our problem is having so many primary care docs deployed. We are brought to our knees.”

Satisfaction = Access

A complex issue facing the MHS is the ever greater focus on beneficiary satisfaction, which in some respects has replaced cost as the number one concern of hospital commanders: “We are now held account-

able for patient satisfaction statistics. We’ve begun doing the same things being offered in civilian medicine, and it’s done to compete for patients.”

To most beneficiaries, satisfaction is equated with access, continuity of care and good customer service — factors adversely affected by the current long deployments. While beneficiaries recognize the difficulties posed by these conflicts, they find it frustrating not to be able to book an appointment or receive followup care

From the discussion ...

- **While staffing levels in military treatment facilities may be at or near authorized strengths, demand often exceeds those authorized strengths: “Our budgeted end-strength does not match our documented requirements.”**
- **The long tours of duty in Iraq and Afghanistan complicate the staffing of medical treatment facilities at home. Except for subspecialists, physicians face year-long tours — twice as long as the norm in previous conflicts. The ability to maintain skills and engage in graduate medical education — retention issues for physicians — is adversely affected by the length of these conflicts.**
- **The MHS consists of a team of military, civilian and contract staff, “yet they all play under different rules.” The contracting system for civilian staff is “klunky,” and there is not a good training program for the civilian workforce.**
- **Medical and dental benefits are a prime reason individuals remain in military service, making sufficient staffing “germane to national defense.”**
- **The character of military medicine has changed, with greater focus in the past decade on cost-efficiency and business practices. “We have become business-centric.”**
- **Having sufficient support staff is a significant issue in some areas and specialties.**
- **The combined Walter Reed Army/Bethesda Navy medical center under development on the Bethesda campus provides an opportunity to “see if we can combine efficiencies” and extrapolate them to a unified medical command.**

upon referral, and they don't want to be told the reason their care is being directed to a military facility is to provide a good patient mix for graduate medical education, or that accepting care disruptions in time of conflict is their "patriotic duty."

There is a generation gap among beneficiaries that colors their views on care provided by the MHS: retirees tend to seek military culture and prefer treatment in the direct-care system, whereas younger spouses and family members are more concerned with access than with where care is provided.

The "medical home model," in which patients have an ongoing, stable relationship with clinic staff, including their own physicians — usually civilian providers — has proven highly successful in enhancing beneficiary satisfaction at the large military treatment facilities where it is being tested, but adopting this expensive model in areas with small facilities is not feasible.

Further, it was observed, military medicine cannot deliver the luxuries offered at places such as the Mayo and Cleveland clinics. "We can't compete with valet parking and cappuccinos."

These highly esteemed civilian systems can "cherry-pick" their patients and do not face the need to support a fighting force.

Flexibility Paramount

"We do not have an agile way to staff military treatment facilities."

"Optimizing" care delivery is hampered by the high turnover rate in medical personnel — 15 to 30 percent annually — and by the inability to shape the personnel structure for maximum efficiency. Tools

are available to allow more expeditious hiring and contracting for civilian staff, but commanders and supervisory personnel often are not aware of them. Better ways are needed to ensure this information is disseminated to commanders in the field.

Some participants urged revising the system for promotion in the Medical Corps. The current requirement for time in administrative positions to reach the 0-6 level is "archaic" and takes focus away from clinical issues at the leadership level.

Contract organizations such as Team Health have the ability to hold staff accountable and focus on productivity — and to adapt to advances younger physicians expect, such as social networking.

An innovative program pays spouses of active-duty personnel \$6,000 to train in fields that can be transported as the service member changes duty stations; a majority choose health-related jobs.

The VA Experience

The Veterans Health Administration — which does not face the demands of deployment — has a low staff turnover rate (average of 9.4 percent in 2008). Attempting to provide civilian-type concierge care, VA consistently is ranked at the top of patient satisfaction surveys.

Team care is emphasized, as is shared decisionmaking, a process in which the patient is included. VA's electronic record system, VISTA, enables care coordination and continuity across the entire system.

Among the innovative programs in use or under development in the VA medical system: using kiosks for patient scheduling and information; giving nurses new roles, including a

clinical nurse leader; a pilot "travel corps" program in which a staffing pool is sent to areas with shortages.

VA also makes "comprehensive" use of telehealth — for consults, for mental health services, for diagnostics and for other ways of augmenting clinical services.

Purple and Deep Purple

Optimizing care in the MHS will occur through joint operations — the "purple suit" — participants acknowledged. Some suggested that even greater integration is needed through a "deep purple" merger of the VA and military health care systems, warning that their combined budgets of \$100 billion are a "flashing neon sign" that more economies will be demanded in a time of burgeoning federal deficits.

Participants in this roundtable: James Andrews of the Army Surgeon General's Office; Ronald Blanck of Martin-Blanck Associates; Dan Blum; Sherman Boss of the National Naval Medical Center; Donald Bradsaw; Frank Capocchia, Jr. of the Air Force Surgeon General's Office; Barbara Cohoon of the National Military Family Association; Jerri Curtis of the National Capital Area GME Consortium; Rick Erdtmann of the Institute of Medicine; Ronald Hamilton of the Army Surgeon General's Office; Ada Sue Hinshaw of USUHS; Mark Kobelja of the National Naval Medical Center; Michael Kussman; Joel Labow of the National Naval Medical Center; Denise Lew of the U.S. Air Force; Lynn Massingale of Team Health; Steve Mirick of AMSUS; Matthew Nathan of the National Naval Medical Center; Joyce Raezer of the National Military Family Association; Stephen Sears of the National Naval Medical Center; Carol Thompson of the U.S. Air Force; George Tracy of Spectrum Healthcare Resources; Maureen Vial of the DoD Health Affairs Office; Randy Williamson of the Government Accountability Office.

The roundtable was moderated by the Hon. P.T. Henry, IFHC Managing Director is Nancy Tomich (www.fedhealthinst.org).