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Maintaining Military Medical Skills During Peacetime

Outlining and Assessing a New Approach

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Prepared for the Office of the Secretary of Defense

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Summary

This monograph examines the feasibility of a new model for maintaining the clinical skills of the military medical force. Under the model, active-duty personnel would be assigned to civilian settings during peacetime. The study on which this monograph is based explored the feasibility of this model from a civilian perspective, focusing on civilian receptiveness to the proposed arrangement and identifying potential barriers and concerns. The study found that civilian medical organizations are generally receptive to the idea of such a model and that DoD could consider conducting a pilot study to assess the effectiveness of the model in improving military medical readiness.

Background

Currently, most military medical personnel are stationed at military treatment facilities (MTFs), where they maintain their clinical skills by treating beneficiaries of TRICARE, the military health care program. Yet the medical skills required during deployment are likely to differ significantly from those required in MTFs. Specifically, the most frequent diagnoses during deployment relate to wounds, fractures, and acute conditions such as febrile illness. By contrast, the most frequent diagnoses at MTFs relate to obstetric care and conditions associated with aging.

Consequently, alternative arrangements for maintaining medical skills for deployment may be needed. One alternative would be to station some military medical personnel in nonmilitary settings in which

the case mix more closely resembles the expected case mix under deployment, such as emergency rooms or trauma centers. For the model to work, civilian organizations must be willing to accommodate military medical personnel despite the risk of deployment and—preferably—to share the cost with DoD. Would civilian medical organizations accept this partnership?

Study Purpose and Approach

This analysis explored the feasibility of using DoD medical personnel in nonmilitary medical settings, focusing on the civilian perspective. We conducted the analysis in two steps. First, we worked with DoD's Office of Program Analysis and Evaluation to develop a straw-man scenario under which DoD personnel could be stationed at civilian facilities. This model proposed a five-year initial period of service that would follow graduate medical education. Once medical personnel entered military service, they would be stationed at civilian locations on a semipermanent basis. During a typical year, medical personnel would be at their civilian stations for approximately eight months and deployed for day-to-day operations or in military-specific training for four months. Second, we used the straw-man model to gauge civilian reactions to the proposed arrangement. To do this, we interviewed nine civilian health care organizations to determine their willingness to consider the proposed arrangements. The interviews focused on concerns about potential deployment, malpractice liability, cost sharing, compensation, and workforce management issues.

Findings

The analysis found that civilian organizations overall had positive views about accommodating DoD personnel and would be willing to consider sharing the cost of assigning military health care providers to civilian facilities. Civilian organizations felt that the model made the most sense for occupations that perform acute, short-term care. In

general, the civilian organizations thought that the model was feasible. However, three reservations about feasibility emerged: (1) if the civilian counterpart job is unionized, the model would be difficult to implement; (2) enlisted DoD medical personnel are occasionally given more responsibility than their civilian counterparts are legally allowed; and (3) the labor market for enlisted medical occupations can be relatively slack. The study results also indicated the following:

- The risk of deployment and liability issues were, somewhat surprisingly, not a major concern.
- Of greater concern were personnel policy issues. In particular, some respondents wondered whether civilian organizations could exert sufficient control over military personnel and accept or reject specific appointments based on organizational needs.
- Three additional questions about personnel policy also arose: Would civilian employers be able to discipline or fire military employees who were not performing adequately? How would legal issues such as sexual harassment and workers' compensation be handled? Would civilian employers have the flexibility to reallocate DoD personnel across geographic locations as needed?
- All the organizations except one (a fire department) expressed a willingness to share the cost of using military medical personnel. There were concerns, however, about the complexity of compensation under dual-payer arrangements. There were also concerns about whether the civilian organizations would need to share the costs of benefits as well as salaries.

Potential Advantages and Disadvantages to DoD

Adding a new category of health care providers—active-duty personnel stationed at civilian facilities—can contribute to readiness. This new category could also increase the military's flexibility by allowing DoD to employ virtually any mix of medical personnel without having to sustain them in MTFs. This flexibility would be useful for employing specialties or maintaining skills that are required for deployment

but are seldom used to fulfill DoD's benefits mission. Although reservists can provide this flexibility to a degree, there is no guarantee that the work that reservists are doing in their civilian jobs matches the skills required by DoD during deployment. Further, active-duty personnel stationed in civilian settings could be called up more easily than reservists.

While this increased flexibility represents a benefit, the new category of providers could also increase DoD's costs. If MTF providers currently engaged in beneficiary care are shifted to the civilian sector, DoD would have to expend more resources replacing the care they would otherwise provide to TRICARE beneficiaries, perhaps by turning to the civilian sector. The study found that civilian organizations may be willing to provide permanent-duty stations for military medical personnel and that they may even be willing to cost share for these personnel. If so, this cost sharing would at least partially offset additional costs that DoD might incur under the new model, making it more attractive from DoD's standpoint.

Given the relatively positive reaction of civilian organizations, DoD could consider conducting a pilot study to assess the model's effect on readiness, retention, and morale and to determine whether the benefits of the program appear to outweigh the costs. We anticipate that a meaningful pilot study would involve at least five to seven civilian sites, allowing DoD to have sufficient perspective on the hurdles and contingencies that might arise when negotiating contracts with civilian organizations.