This product is part of the RAND Corporation monograph series. RAND monographs present major research findings that address the challenges facing the public and private sectors. All RAND monographs undergo rigorous peer review to ensure high standards for research quality and objectivity.

Qualifying Military Health Care Officers as "Joint"

Weighing the Pros and Cons

Sheila Nataraj Kirby, Harry J. Thie

Prepared for the Office of the Secretary of Defense

Center for Military Health Policy Research

A JOINT ENDEAVOR OF RAND HEALTH AND THE
RAND NATIONAL DEFENSE RESEARCH INSTITUTE

The research described in this report was prepared for the Office of the Secretary of Defense (OSD). The research was conducted in the RAND National Defense Research Institute, a federally funded research and development center sponsored by the OSD, the Joint Staff, the Unified Combatant Commands, the Department of the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community under Contract W74V8H-06-C-0002.

Library of Congress Cataloging-in-Publication Data is available for this publication.

ISBN 978-0-8330-4625-3

Published 2009 by the RAND Corporation
1776 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138
1200 South Hayes Street, Arlington, VA 22202-5050
4570 Fifth Avenue, Suite 600, Pittsburgh, PA 15213-2665
RAND URL: http://www.rand.org
To order RAND documents or to obtain additional information, contact
Distribution Services: Telephone: (310) 451-7002;
Fax: (310) 451-6915; Email: order@rand.org

Summary

The unprecedented challenges facing the U.S. military at home and abroad have highlighted the need for officers to be educated and trained in joint matters[1] so that they are prepared to take on the new roles and responsibilities that the current environment demands. In his 2005 *Vision for Joint Officer Development*, Chairman of the Joint Chiefs of Staff (CJCS) Peter Pace emphasized the need for *all* colonels and Navy captains to be educated and experienced in joint matters (U.S. Joint Chiefs of Staff, 2005). There is increasing recognition that the roles that the Military Health System (MHS) is being asked to play—especially with respect to national emergencies (such as pandemic influenza) and reconstruction operations—require working strategically with other nations, other militaries, and other agencies. The 2006 Quadrennial Defense Review (QDR) highlighted the importance of preparing health care leaders to succeed in joint, performance-based

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

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

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

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

Exclusion of Professional Specialties from Joint Officer Development

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

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

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

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

New Evidence on Types of Billets Staffed by Health Care Officers

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

Defining a Potential JDAL for Health Care Officers

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

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

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

Table S.1—Continued

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

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

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

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

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

Barriers to Extending Joint Duty Requirements to Health Care Officers

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

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

Recommendations

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

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