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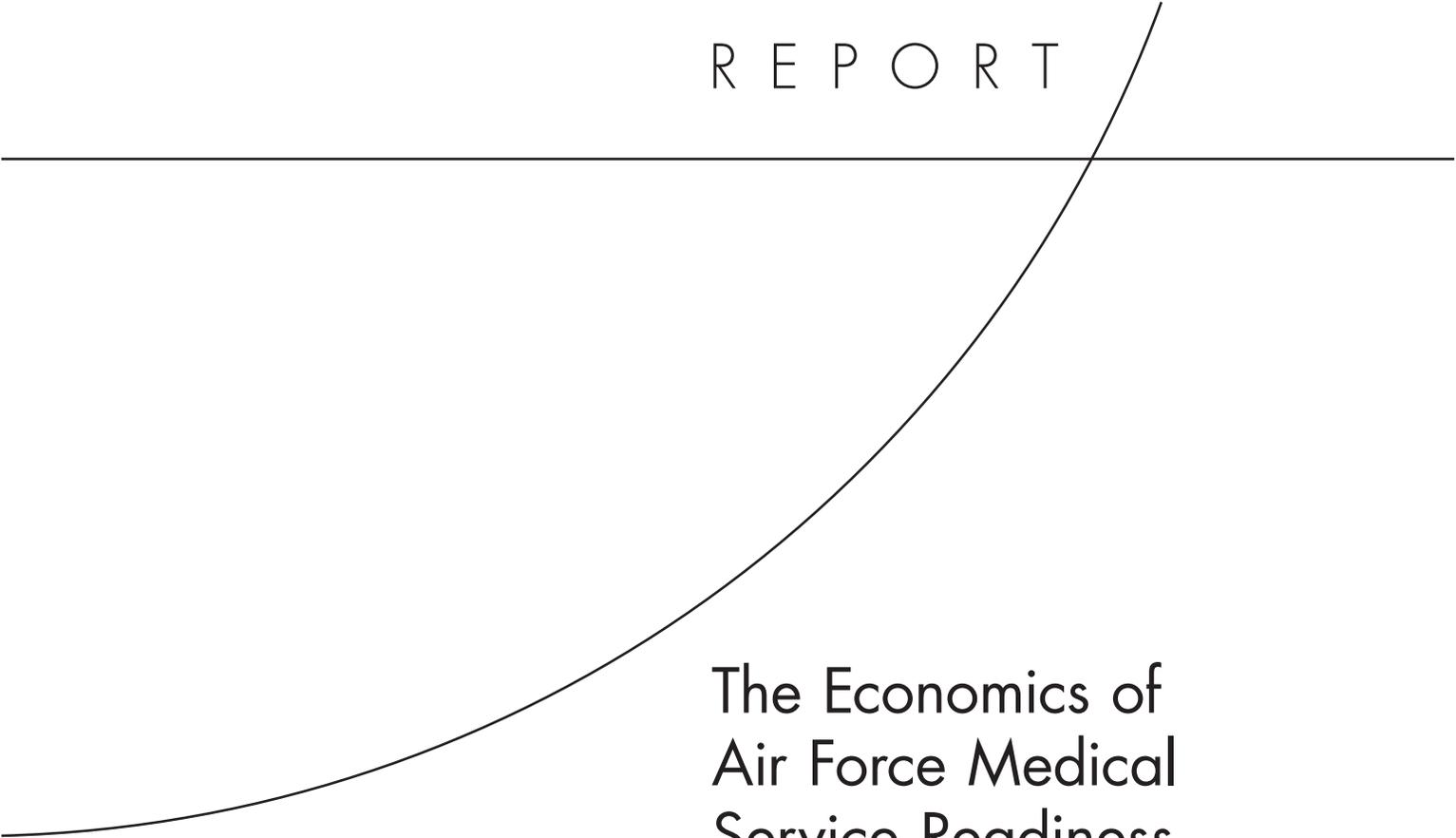
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R E P O R T

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# The Economics of Air Force Medical Service Readiness

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## Summary

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AFMS is facing a challenging environment. As key providers of medical support for operations Iraqi Freedom and Enduring Freedom, AFMS personnel operate three theater hospitals that provide health care to deployed forces from all four services. Much of this health care is provided to severely injured or wounded U.S. personnel, as well as to civilians in Iraq and Afghanistan. At the same time, they have continued the mission of stabilizing wounded and injured patients and providing expeditious aeromedical evacuation of personnel out of theater.

Although AFMS has been successful in meeting these requirements, the operation of in-theater hospitals is an added responsibility that was not envisioned when the Air Expeditionary Force concept for sizing and training for AFMS deployment capabilities was established in the late 1990s. Under this concept, AFMS was structured to support Air Force units deployed in theater and to provide aeromedical evacuation for all the services.

The care of the severely injured and wounded depends on teams of critical-care specialists, including surgeons, operating room and intensive care nurses, and surgical technicians. To stay ready for wartime and maintain their surgical skills in peacetime, these AFMS teams must operate on patients with a wide variety of health needs. While replicating the severity of combat wounds and injuries in peacetime is difficult, regular surgery at least provides these teams with the surgical experience necessary to maintain their technical proficiency. Also known as *currency opportunities*, assignments that allow the teams to maintain surgical skills in a hospital and surgical environment are referred to as the *inpatient workload* in this report.<sup>1</sup> (See p. 46.)

To scope the currency situation and the ability of the Air Force to function as a provider of medical services and the issues it faces in accomplishing these goals, we interviewed a wide variety of medical and support personnel within AFMS, the Army and Navy medical services, and the Office of the Assistant Secretary of Defense, Health Affairs (OASD[HA]) and gathered data on currency opportunities, workload accomplishments, and funding. Although we found a widespread commitment to providing quality medical care to DoD beneficiaries, we also noted a variety of opinions about how AFMS and other services' medical care systems should address many of the issues they face.

All the services must continue providing superior care to the wounded and injured from combat and normal military operations as a first priority, but they must also provide quality peacetime care to beneficiaries, conduct health-care operations as efficiently as possible, and

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<sup>1</sup> We use inpatient workload as a proxy for evaluating overall opportunities to retain surgical currency. Some of the outpatient workload at ambulatory surgical centers (ASCs) could also provide currency opportunities, depending on the particular surgical specialty. However, for severe combat injuries, which require more-invasive surgery, an inpatient stay would align more closely with that currency opportunity.

maintain the currency of their health-care providers. To do this, they must recruit, train, and retain a highly skilled, deployable medical force by providing professional opportunities that help attract high-quality medical personnel. Graduate medical education and military-unique specialized training are critical to accomplishing these goals and supporting medical readiness. Yet all this must happen in the context of the increasing costs of medical care and the focus on reducing forecast cost increases. Our description of these challenges and our recommendations are based in part on these interviews and our analysis of the data provided.

Over the past two decades, AFMS has faced a major reduction in its inpatient workload for a number of reasons. The primary reason has been a decline in the number of AFMS hospitals (where inpatient procedures are performed), from 76 in 1992 to 15 in 2008, a decrease of 80 percent. This contraction was due both to hospital closures (many were shuttered as Air Force bases were closed after the end of the Cold War) and to the conversion of many hospitals into stand-alone clinics or ASCs.

The reasons for converting hospitals to stand-alone clinics and ASCs are complex. In some instances, AFMS elected to convert smaller hospitals because they lacked the workload to keep their surgical teams trained, creating concern about the quality of care they provided. Others were converted because of external decisions, such as a 2005 Base Realignment and Closure direction to convert five AFMS hospitals to clinics or ASCs. (See pp. 8–10.)

In addition to the reduction in the number of facilities capable of inpatient procedures, the AFMS surgical workload, along with those of the Army and Navy medical departments, has decreased because of the passage of the TRICARE for Life legislation, which essentially eliminated any financial incentive for Medicare-eligible DoD beneficiaries to use military hospitals. Previously, these beneficiaries had to pay part of the cost of their care if they elected to use a civilian physician. The decreased workload from this older DoD beneficiary population was significant because it provided a substantial percentage of the inpatient workload critical for surgical teams to maintain readiness. (See pp. 52–54.)

At the same time, OASD(HA), facing rising health-care costs throughout the military community, established budget-allocation processes that linked a portion of the services' funding to their patient workloads. These methodologies were designed as incentives for the military medical departments to maintain or increase their annual workloads or to risk budget reductions. The rationale was that, if DoD was purchasing an increasing proportion of health care from the civilian sector, the service medical departments' should decrease commensurately to account for the decreased workload.

Under this budget-allocation process, the inpatient workload is vital because payments for inpatient work can be more than 150 times higher than for outpatient visits.<sup>2</sup> However, retaining or increasing the inpatient workload is more difficult when surgical teams deploy from MTFs because, under current workload reporting policies and systems, the teams earn no workload credit for procedures they perform elsewhere. So, unless reservists or civilians can be found to fill in for deployed medical personnel, the home MTFs are less able to handle the normal workload. Thus far, the savings in pharmacy costs and additional funds and supplemental appropriations passed annually since fiscal year 2002 for the global war on terror have mitigated the resource implications of this lost workload somewhat. (See pp. 17–32.)

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<sup>2</sup> This difference is driven primarily by the facility cost portion of the procedures, not the professional services costs.

In addition to the factors described above, AFMS will face some very significant challenges in the future. In response to a 2005 Base Realignment and Closure decision, AFMS's flagship hospital, Wilford Hall Medical Center (WHMC), is being converted into an ASC. WHMC performed more than 40 percent of AFMS's inpatient procedures and was also the only Level I trauma and emergency room referral center in AFMS. The center also served as a training and currency platform for a wide variety of surgical and nonsurgical skills, including training for future AFMS leadership. Although AFMS personnel will continue to perform much of WHMC's surgical work at the new Air Force–Army San Antonio Military Medical Center (SAMMC), the identification and documentation of the AFMS workload may be jeopardized, possibly resulting in the misperception that the workload decreased further, which could affect recruitment or the very existence of AFMS inpatient capabilities. It is also currently unclear how medical resources at SAMMC will be allocated between the U.S. Air Force and U.S. Army. To ensure that AFMS gets both the resources and the recognition for its SAMMC workload, we recommend that the AFMS leadership advocate that OASD(HA) suspend the current workload-based funding methodologies at SAMMC until experience is gained with the new organization. (See pp. 41, 91–97.)

To maintain a cadre of critical-care specialists ready for wartime deployment, AFMS may have to increase its inpatient workload at AFMS hospitals or find alternatives for training critical-care specialists at non-AFMS hospitals. Training alternatives could include assignments to other services' hospitals, partnerships with the U.S. Department of Veterans Affairs hospitals or civilian hospitals, or greater use of Air National Guard or Air Force Reserve medical personnel in wartime. Solutions to these challenges are essential for AFMS to meet its wartime critical-care responsibilities; to ensure proper resourcing under OASD(HA)'s "pay-for-performance" metrics; and to be viewed as a vibrant, viable medical service offering interesting work to potential medical professionals.<sup>3</sup> (See pp. 57–67.)

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<sup>3</sup> AFMS commissioned a subsequent RAND study to investigate these workload enhancing options further.