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AIR COMMAND AND STAFF COLLEGE

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REDEFINING THE AIR FORCE MEDICAL SERVICE IN THE NEW
MILLENNIUM: SHOULD THE AFMS OUTSOURCE PHYSICIAN
TRAINING AND RESIDENCY EDUCATION PROGRAMS?

by

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A Research Report Submitted to the Faculty

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Preface

This paper attempts to address one of the concerns rampant in today's Air Force Medical Service. Through the early 1990s, as the Line of the Air Force optimized its requirements for warfighters and support personnel, Air Force leaders began to question the requirements for a large standing medical service to care for the decreasing numbers of active duty personnel. As a professional healthcare executive, I became curious about how the Air Force would consider privatizing medical practice while still meeting its readiness requirements. The transition of the Air Force to an Expeditionary Air Force structure has made this topic even more relevant to future commanders and medical support providers.

Special thanks are in order to Lt Col Marshall Cobb for agreeing to be my faculty advisor. Additional thanks go to the Physician Education branch at Air Force Personnel Center. The subject of physician education, training, and utilization is a complex one. Without their assistance and generous support, this paper would still be just a thought.

Abstract

As the United States Air Force enters the new millennium and reorganizes into an Expeditionary Air Force comprised of 10 Air Expeditionary Air Forces, medical support of these forces is one factor that will greatly impact military readiness. Providing the correct mix of physicians to the Air Expeditionary Forces for contingency and wartime operations will partially determine the effectiveness of the deployed forces. This paper will explore the environment of the Air Force Medical Service with regard to training physicians. It includes a historical review of training and educating Air Force physicians, as well as the organization of medical services. Further, this paper discusses the costs and benefits of outsourcing training accomplished by the Air Force Medical Service and the alternate opportunities existing in the civilian sector. Finally, this paper examines the potential impact of outsourcing on the readiness of medical units supporting the Expeditionary Air Force. Having considered the history of the Air Force Medical Service, its current training and education programs as well as the costs and benefits of outsourcing physicians, this paper concludes that a decision to outsource physicians and their training is too expensive for implementation.

Part 1

Introduction

He [General Sommervell] took the position that The Surgeon General must devise a means of dealing with all sorts of shortages and more expeditious ways of doing business.¹

— History of the Army Medical Department, 1942

The United States Air Force entered the new millennium implementing an Expeditionary Air Force comprised of 10 Air Expeditionary Forces. Medical support of these forces is one factor that will greatly impact military readiness. Force health protection for Air Expeditionary Force (AEF) personnel and their families in peacetime, humanitarian and relief operations, contingency operations, and large-scale campaigns will partially determine the effectiveness of the deployed forces. From the earliest days of military aviation, physicians have been at the forefront of improving the health and welfare of flying personnel. Former Air Force Surgeons General, Major General Malcolm C. Grow and Major General Harry G. Armstrong, both pioneers in aviation medicine, placed their own lives at risk to develop protective flying gear and aviation standards which would protect our pilots, improve aircraft designs, and meld man and machine into one fighting unit. However, in the current military and political environment, the Air Force Medical Service finds itself once again embroiled in a debate to understand the roles its medical service plays in shaping the international environment, responding to crises, and preparing for future national security needs.

This paper examines how the Air Force trains and educates physicians, how those programs have developed to enhance the science of aviation medicine, and the costs and benefits of these training programs. Further, this paper discusses the costs and benefits of outsourcing training accomplished by the Air Force Medical Service and examines the potential impact of outsourcing on the readiness of medical units supporting the Expeditionary Air Force

Background and Significance of the Problem

The Air Force Medical Service (AFMS) has several roles in its healthcare mission. It must provide healthcare to military members throughout the spectrum of conflict. The AFMS provides care for family members of military members and other beneficiaries. The AFMS is charged with providing healthcare to other people, known as third country nationals, through humanitarian relief operations and for adversaries during military operations. The plurality of the healthcare mission causes consternation over the costs of providing the care, as well as the costs of maintaining an adequate infrastructure for these tasks. Included in this confusion is the issue of how care is delivered to the beneficiary.

Realizing that the AFMS cannot provide all of the care required by our beneficiaries, it has partnered with the rest of the Department of Defense, the Veterans' Administration, and the civilian healthcare sector to develop an integrated delivery network. This network is known as TRICARE. The goal of the integrated healthcare delivery network is outstanding patient care, and the military physician is still the backbone of the network. Without the Air Force physician, military members would not receive medical care tailored to their needs as warfighters, and the close, personal relationship required by flight surgeons and aircrews would not be possible.

Consequently, the Air Force Medical Service needs to ensure that the military physician is properly trained as a diagnostician and health care provider to ensure full-spectrum force health

protection. Additionally, the Air Force Medical Service must plan to meet the healthcare needs of family members. Requirements for physician licensure and specialty certification must be addressed in order to retain qualified physicians in the Air Force Medical Service. Although there is no statutory requirement which mandates the provision of healthcare for family members or other beneficiaries, the Air Force and its medical service have philosophically agreed that providing such care benefits the military member. Through increased medical practice opportunities, physicians become more skilled diagnosticians. Reducing the psychological strain on the military member during deployment is vital to the warfighter's readiness and his ability to complete the mission. For all physicians, medical practice opportunities involving a wide variety of patients are the best way to ensure they learn and maintain proficiency in skills required for licensure and specialty certification. Therefore, training provided by military facilities, or in concert with military facilities, is necessary to ensure Air Force physicians can provide care for our beneficiary population. For military planners, then, it is imperative an adequate number of physicians receive training in specific skills and are available for worldwide deployment to care for military personnel, third country nationals, noncombatants and adversaries.

Preview of the Thesis

This paper draws together the requirements for expeditionary medicine as outlined in the Expeditionary Medical Support (EMEDS) document with the requirements for training expressed by the AFMS' Integrated Forecast Board.² Additionally, the paper considers the peacetime infrastructure required to prepare an adequate mix of trained and qualified physicians for future USAF needs based on recruiting and education and training costs. This paper focuses on and the cost of outsourcing the existing Air Force physician education and training programs

to demonstrate that the Air Force must retain physician education and training programs in order to support its personnel and warfighting needs.

Notes

¹ Link, Mae Mills, Hubert A. Coleman, *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)* (Washington, D.C.: Office of the Surgeon General, USAF, 1969) 83.

² Darr, Lt Col (Dr.) Lafon, Lt Col John Binder, “Air Force Medical Service: Concept of Operations for Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH) System.” (Paper presented to the USAF Surgeon General. Langley AFB, VA., September 1999), 80-81.

Notes, (Graduate Medical Education Selection Board. 6 December 1998), n.p.

Part 2

The Air Force Medical Service

As a result of increased performance of the newer aircraft it became apparent this [effort in selecting flyers] should be supplemented by studies concerning the effects of high performance flight on the human organism and methods of neutralizing or eliminating those factors which were detrimental to the efficiency, health or safety of flying personnel.¹

— Major General (Dr.) Harry Armstrong

For American physicians, military medical practice in the early part of the century was gained in the trenches of Europe and the Bolshevik revolution in Russia. Major General Malcolm C. Grow, former Air Force Surgeon General, wrote about the front line training he received as a physician in the Russian Army, “In a night’s work of that description a man performs more operations and treats more cases than the busiest practitioner sees in a month of private practice, and while conditions work havoc with technique, such an experience is a wonderful developer of resourcefulness.”²

Military physicians were assigned to the balloon corps and the early flying squadrons of the First World War. Following the war, these physicians were charged with refining the standards by which the Army Air Corps and Navy might select pilot trainees as well as developing specialized care for sick or injured pilots and military members. As physicians with varied specialty backgrounds, these early air surgeons were detailed into aviation medicine because of the need for physicians who understood the rigors of flight. As an early aviation specialist, General Grow drew on the resourcefulness he learned in Russia by flying multiple missions to

develop protective flight gear for aircrew personnel. He was also instrumental in establishing the first school of aerospace medicine in the US and the first medical research lab for studying important human factors affecting pilot performance.

However, the Army saw aviation medicine as an abomination to a real Army medical officer. The Air Surgeon did not have a close, personal relationship with his patients most of the time. The Air Surgeon reported through the Army's Medical Command and served in aviation medicine at the whim of the Army Surgeon. Because the specialty of aviation medicine was in its infancy, and not recognized by medical specialty board agencies, a career path leading to promotion and command did not exist.³ Therefore, physicians who desired military careers needed to stay in the more traditional specialty fields of internal medicine and surgery to be promoted. Since the ability to command was viewed through the lens of specialty practice, any physician who wanted to rise to senior command positions in the Army Medical Service needed to be a specialist whose services were required at a large general hospital. From there, he could be selected for staff duty. Air Surgeons did not have a specialty that translated easily to the care provided at large Army general facilities, so they were often viewed as "second class citizens" and suffered in the promotion boards convened by the Army Surgeon General.⁴

In the late 1930s and 1940s, physicians were in short supply all over the nation. Education was arduous, expensive and long. Salaries for student physicians and residents in the civilian sector were not all that great. They often did not make a lot more money in private practice.⁵ In fact, there wasn't much support for an aviation medicine specialty in the civilian sector until just prior to WWII.⁶ Commercial aviation was just developing, and standards used by military flight surgeons were not well documented outside military circles. It took the organization of several

groups and recognition by the American Medical Association to garner civilian support of aviation medicine as a subspecialty of preventive medicine.⁷

Over the last 50 years, medical practice both in the military and civilian sectors have changed drastically. From a largely cottage industry with few organized medical centers at the turn of the 20th century to today's large, multi-trillion dollar industry characterized by huge, centralized medical complexes, medicine has increased the availability of healthcare and healthy lifestyles to all people. However, the specialty of aviation medicine still largely relies on the physician gaining first-hand knowledge of the rigors of flight to care for aircrews and their families. The shortage of physicians who understand not only the rigors of flight, but also the intricacies of force health protection is still keenly felt.

The Uniformed Services University for Health Sciences (USUHS) sought to alleviate some of the physician shortage by educating and training physicians specifically for military service. These physicians received medical school education at the University and served a multi-year commitment in the Army or Navy and later, the Air Force, to repay their tuition costs. Today, USUHS graduates over 300 physicians each year that serve in every branch of the military services.⁸ However, even that number of physicians is not enough to meet current military requirements. In response to this shortage, each service created scholarships and financial assistance programs to directly recruit physicians from civilian universities, medical schools, and practices into military service. Many physicians also receive incentive or bonus payments to remain on active duty. These payments are approved by Congress each year and vary by specialty and length of service (see Appendices A and B).⁹ The rationale behind these payments is a belief that physicians are motivated to stay in military service when their pay and benefits are comparable to the income they could earn in private civilian practice.

Graduate medical education is the generic title for residency and fellowship training programs for physicians that occur after the physician's first year of practical experience, known as the internship. These training programs provide physicians specialized training, often lasting several years, in one medical discipline like family practice or general surgery. In the past, a physician could have a successful practice with either an internship year, or many years of training in a particular specialty. Graduate medical education is an important part of career satisfaction for Air Force physicians, and an important factor in ensuring the correct mix of physician specialists are available for care in the full spectrum of conflict.

Notes

¹ Link, Mae Mills, Hubert A. Coleman, *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)* (Washington, D.C.: Office of the Surgeon General, USAF, 1969) 56.

² Link, Mae Mills, Hubert A. Coleman, *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)* (Washington, D.C.: Office of the Surgeon General, USAF, 1969) 20.

³ Link, Mae Mills, Hubert A. Coleman, *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)* (Washington, D.C.: Office of the Surgeon General, USAF, 1969) 142.

⁴ Link, Mae Mills, Hubert A. Coleman, *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)* (Washington, D.C.: Office of the Surgeon General, USAF, 1969) 142.

⁵ Link, Mae Mills, Hubert A. Coleman, *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)* (Washington, D.C.: Office of the Surgeon General, USAF, 1969), 141.

⁶ Tuttle, Dwight W. *None But the Fit Shall Fly: Medical Service Origins*. Air Power History. Vol 38, number 1 (Spring 1991), 7.

⁷ Link, Mae Mills, Hubert A. Coleman, *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)* (Washington, D.C.: Office of the Surgeon General, USAF, 1969), 150.

⁸ General Accounting Office. *Military Physicians: DOD's Medical School and Scholarship Program* (Washington, D.C.: General Accounting Office, September 1995), 2.

⁹ Division of Medical Service Officer Assignments, guide to All Air Force Physicians, subject: Medical Officer Special Pay Information, 3 September 1999.

Division of Medical Service Officer Assignments, memorandum to All Air Force Physicians, subject: FY2000 Incentive Special Pay (ISP)/ Multi-Year Special Pay (MSP) Programs, 3 September 1999

Part 3

Physician Education and Training Programs

The services view GME as the primary pipeline for developing and maintaining the required mix of medical provider skills to meet wartime and peacetime care needs.¹

— Report of the Government Accounting Office, 1998

Physician Education programs are collectively called Graduate Medical Education (GME) programs. They include internships, residencies, and specialty fellowships that provide a monitored learning environment for physicians who have completed medical school. GME programs aim to prepare physicians with in-depth practical education in a single area of medicine. For Air Force physicians, training can be received at military facilities or civilian institutions in the United States. Appendix C shows which military facilities provide residency or fellowship training for Fiscal Year 2000.²

Accrediting Physician Education Programs

Air Force GME programs are held to the same standards as those of the civilian sector. A Residency Review Committee (RRC) of the Accreditation Council inspects each program for Graduate Medical Education (ACGME). This Council is a regulatory function, “jointly sponsored by the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies.”³

The RRC inspects each GME program, whether it is military or civilian. The Manual of Policies and Procedures for GME Review Committees states,

Graduate medical education programs are accredited when they are judged to be in substantial compliance with the Essentials of Accredited Residencies in Graduate Medical Education. The Essentials consist of (a) the Institutional Requirements, which are prepared by the ACGME, approved by its sponsoring organizations, and apply to all programs, and (b) the Program Requirements, which are prepared by a review committee for its area(s) of competence and approved by the ACGME. The activities of the ACGME extend only to those institutions within the jurisdiction of the United States of America.⁴

This inspection certifies that appropriate training is being delivered by the teaching institution and that the facility is not training more physicians than it can effectively teach. Additionally, the inspectors certify that appropriate specialty services are available outside the inspected program to provide an adequate education to the physician receiving training. Certification is important for military GME programs for several reasons. Certification validates training quality at a military healthcare facility, ensures the military healthcare facility has sufficient resources allocated to the residency program, and provides credibility for physician recruiting efforts.

Determining Training Programs and Selecting Physicians for Training

The Physician Education Branch at Air Force Personnel Center, Randolph Air Force Base, Texas, is responsible for ensuring that physician education and training programs offered by the Air Force Medical Service are a reflection of the requirements identified by the Air Force Surgeon General's Medical Manpower Division. Requests for training are considered at the Integrated Forecast Board. The Integrated Forecast Board consists of the Surgeon General's consultants for each medical specialty in the Air Force Medical Service. These consultants are grouped into functional panels for medical operations, medical support, and medical service

support. Each functional group considers the manpower requirements in the medical specialty, military training programs available, and the number of training positions requested for that panel's career specialties. All of the training programs and requests are ordered across the entire AFMS. Each consultant has the opportunity to explain the training programs and requests for his specialty as well as to justify the importance of the training being approved. There are currently 95 physician specialties tracked in this manner, including the number of physicians in each specialty required for peacetime operations, those required for readiness positions in deployed contingency operations, and those required to provide training to other physicians. A sample of one specialty's data is at Appendix D.⁵ Additionally, the information reflects which physician specialties sponsor training programs and the number of residents or fellows each Air Force medical facility (MHF) can train, as well as how many residents and fellows are in training and when they will complete their training and enter active duty. Training requests are approved in ranked-order until the training dollars allocated to the AFMS is exhausted.

The Integrated Forecast Board (IFB) prepares a document for the Surgeon General that identifies the number and types of Air Force-sponsored training programs that will be offered in the following two years. In 1998, this board identified 648 medical training starts for interns, residents and fellows in 20 programs offered at 12 military or sponsored locations and many civilian locations in the United States.⁶ The civilian training locations are not identified by name. Using this document, the Physician Education Branch makes applications available to all Air Force sponsored medical students and any interested active duty Air Force physicians. The Joint Graduate Medical Education Selection Board (JGMESB) reviews these applications each December. This board is comprised of the military GME directors for the Air Force, Army and Navy. These directors are grouped into the medical specialty they represent. Each panel

considers the application, the number of training slots in each program, and places physicians into the available Air Force, Army, or Navy residency or fellowship training program, or recommends for placement in a civilian training location. The selected physicians are notified in late February by the Physician Education Branch of their match for residency or fellowship on the same day that civilian physicians are notified by the National Match, the civilian sector's medical residency and fellowship directors. In both the civilian and military sectors, training for residency and fellowship begins in July.

The Physician Education Branch also advises the Air Force Surgeon General on rightsizing the Air Force Medical Corps. In 1998 and 1999, they recommended certain physicians be offered early retirement and separation in order to ensure the correct mix of physicians remained on active duty to meet the force requirements identified by the Air Force Surgeon General's Medical Manpower Division. As the Physician Education Branch makes recommendations to the Surgeon General, they also determine which physician positions the Air Force Medical Service are unable to fill through Air Force-sponsored education and training programs each year. This information is forwarded to Air Force Recruiting Service and the recruiting program is developed and sent to the Recruiting Squadrons as goals for recruitment.

Accounting for Military Graduate Medical Education Programs

Throughout the AFMS, costs are tracked in the Medical Expense Reporting System (MEPRS). MEPRS data is reported by military healthcare facility personnel to determine the costs for completed activities such as patient care, administrative time or training time.⁷ Because MEPRS relies on members' input, the Air Force Medical Service's cost for GME is not well calculated or tracked. Further, the AFMS has only begun to directly relate the GME programs to

actual military requirements in the last five years. The Government Accounting Office (GAO) reported:

In 1996, for example, DOD issued a requirement that medical force levels including GME trainee numbers be linked to each service's wartime and operation support requirements.⁸

This meant the Air Force Medical Service could no longer justify training physicians whose education did not match our operational, sustainment, or wartime requirements. The AFMS considered how best to optimize training and education programs with the Army and Navy in order to provide training to fill open active duty Air Force physician positions, while ensuring the training matched wartime and operational support requirements. However, a plan to consolidate all DOD physician training and education programs into four geographically centered military healthcare facilities was untenable to the AFMS senior leaders. The GAO reported:

Air Force officials told us that if future GME closures were driven by the four GME geographic centers concept, the Air Force would stand to lose one-third of its programs-including all programs in certain medical specialties.⁹

Costs to train physicians are based on the military personnel costs (MILPERS) reported in MEPRS, facility costs and administrative costs. MILPERS costs include expenses for trainers, who are called preceptors, and trainees (i.e. interns, residents, and fellows). Facility costs for training include the cost of providing the hospital space, equipment and supplies, as well as the maintenance of those facilities. Administrative costs include the costs for support staff who function as assistants to the preceptors, as well as the expenses of site visits by the ACGME and other inspectors.

In 1997, the GAO estimated that the cost to train physicians per year for DOD exceeded \$125 million. With 3000 physicians in training in military facilities at any given time, the estimated cost per physician exceeded \$40,000.¹⁰

The primary benefit of providing training in military healthcare facilities is a pipeline of physicians to provide care in military facilities that are highly skilled in their specialties. Another benefit of active duty Air Force physicians is in filling Aerospace Expeditionary Force deployment requirements. An active duty officer can be ordered to perform service under penalty of Uniformed Code of Military Justice (UCMJ) action.

Table 1 shows the average annual salary of a physician in the civilian sector and the MILPERS expense calculation for a military physician's annual salary. A survey accomplished in 1998 by Merritt, Hawkins and Associates, a well established physician recruiting firm indicated that a contract physician in family practice could expect an average salary of \$132,000 per year, plus forgiveness of debts, relocation allowances, continuing education expenses, and insurance benefits. Conservatively, that amount equates to an average salary of \$ 175,500.¹¹ If the Air Force Medical Service were to outsource just the Family Practice Residency Program, in effect hiring contract physicians to replace the 43 residents training in the Air Force's military GME programs, and the five program directors, each at one residency location, the annual cost could exceed \$8,424,000 per year for just 48 physicians. The entire estimated amount for Air Force GME programs was only \$27 million to train 648 physicians in fiscal year 1999.¹² My personal experience in hiring contract physicians includes negotiating both Personal Services contracts, in which the Air Force Medical Service paid all of the contract physician's expenses plus those of his office staff, and Non-personal Services contracts where the Air Force Medical Service paid only for the physician's gross salary excluding benefits. In each case, the contract physicians earned well over the average contract salary. Based on these estimates and my professional experience, outsourcing the entire Air Force GME program would be a very expensive and cost prohibitive plan.

Physician Specialty	Average Salary – Civilian	Average Salary - MILPERS
Contract physician per year	\$ 175,500.00 (includes benefits)	\$ 91,000.00
All physicians per year ¹³	\$ 102,200.00	\$ 91,000.00
Hourly Wage	\$ 49.05	\$ 43.68

Table 1. Salary Comparison Chart

Notes

¹ General Accounting Office, *Defense Health Care: Collaboration and Criteria Needed for Sizing Graduate Medical Education* (Washington, D.C.: General Accounting Office, April 1998), 1

² Notes, (Graduate Medical Education Selection Board. 6 December 1998).

³ Accreditation Council for Graduate Medical Education. *Manual of Policies and Procedures for Graduate Medical Education Review Committees*. (Chicago, IL.: Accreditation Council for Graduate Medical Education, 1994), On-line. Internet, 2 February 2000. Available from [http:// www.acgme.org](http://www.acgme.org), 5.

⁴ Accreditation Council for Graduate Medical Education. *Manual of Policies and Procedures for Graduate Medical Education Review Committees*. (Chicago, IL.: Accreditation Council for Graduate Medical Education, 1994), On-line. Internet, 2 February 2000. Available from [http:// www.acgme.org](http://www.acgme.org), 7.

⁵ Notes, (Graduate Medical Education Selection Board. 6 December 1998).

⁶ Notes, (Graduate Medical Education Selection Board. 6 December 1998).

⁷ Department of Health Services Administration. *Technical Training Study Guide* (Sheppard Air Force Base, TX.: School of Health Care Sciences, USAF, August 1987), 3.

⁸ General Accounting Office, *Defense Health Care: Collaboration and Criteria Needed for Sizing Graduate Medical Education* (Washington, D.C.: General Accounting Office, April 1998), 8.

⁹ General Accounting Office, *Defense Health Care: Collaboration and Criteria Needed for Sizing Graduate Medical Education* (Washington, D.C.: General Accounting Office, April 1998), 14.

¹⁰ General Accounting Office, *Defense Health Care: Collaboration and Criteria Needed for Sizing Graduate Medical Education* (Washington, D.C.: General Accounting Office, April 1998), 4.

¹¹ Merritt, Hawkins and Associates. *Summary Report 1998 Review of Physician Recruitment Incentives*. Dallas, TX., MHA Associates, undated. On-line. Internet, 20 March 2000. Available from <http://www.practice-net.com/surveys/report.html>.

Notes

¹² General Accounting Office, Defense Health Care: Collaboration and Criteria Needed for Sizing Graduate Medical Education,.(Washington, D.C.: General Accounting Office, April 1998) 4.

Notes. (Graduate Medical Education Selection Board. 6 December 1998).

¹³ Bureau of Labor Statistics. 1998 National Occupational Employment and Wage Estimates (Washington, D.C.: Bureau of Labor Statistics, undated), On-line. Internet, 20 March 2000. Available from <http://stats.bls.gov/oes/national/oes32102.htm>.

Carlton, MGen Paul K., Jr., "Briefing to the CSAF,." Briefing,. Office of the Surgeon General, US Air Force, Bolling Air Force Base, D.C., 20 January 2000.

Part 4

Outsourcing Physician Education and Training Programs

The medical service of an armed force is a necessary and an integral part of that force. To separate it from the force is wholly or largely to destroy its usefulness.¹

— The Committee on Federal Medical Services, 1948

The cost of outsourcing physician education and training programs is enormous. Should the AFMS decide to outsource its training and education programs, medical staffing information must be recalculated to capture the care provided by interns, residents and fellows in the course of their training, or the additional patient load must be absorbed by the TRICARE network and calculated into the reimbursement for that contract. Although the Air Force would not directly compensate civilian facilities for providing training, civilian GME programs would need to be certified by ACGME to open additional training positions for physicians.

Civilian Sector Cost in Providing Training

The American Association of Medical Colleges (AAMC) reports that more than 15,000 medical students graduate from over 125 schools of medicine each year. They also report that over 80,000 physicians are in residency at any given time, not including those in fellowship study.² If the average resident earns even \$40,000 per year, the estimated cost of training these physicians exceeds \$3 billion per year.³ Facilities incur more than just the direct cost of the residents' or fellows' salaries. Costs to the civilian medical facility are similar to costs in the

military healthcare facility for administrative and training support. A report by the Institute of Medicine, completed in 1983, stated, “Functions funded under the umbrella of medical education include construction, academic teaching, clinical teaching and experience, and research. Similarly, on the cost side the relationship is often unclear, with the cost of one function often depending on the performance of other functions.”⁴ Training facilities pay for hosting GME from monies of various sources, including federal and state governments, insurance reimbursements, and philanthropic giving. The Institute of Medicine report found that, “Operating revenues became the major source of residency financing, providing 75 percent of the \$1.4 billion cost of residency stipends and fringe benefits in 1978/79.”⁵

A significant portion of the reimbursement training facilities receive is from the federal government for providing care to indigenous persons and for providing care to citizens eligible for Medicare reimbursement. The AAMC reports that the national mean for Medicare reimbursement to teaching facilities was \$62,700 per resident.⁶ Unfortunately, this level of reimbursement is seen as too costly to continue in the future. Increases to the numbers of students and increases to the raw cost to the teaching institution will create great tumult.⁷

If military GME were to be outsourced, and the cost of resident salaries alone were absorbed, the additional cost to civilian training facilities would exceed \$25,920,000 in fiscal year (FY) 2000 alone. Additionally, civilian institutions would require increases in teaching staff to handle the increased workload, thereby incurring greater cost. The Medicare reimbursement to facilities with residents would no doubt cause action in Congress to reduce the per resident reimbursement, or to place caps on the amount of reimbursement thereby causing a negative incentive to teaching facilities.⁸

The GME program in the civilian sector is going through some drastic changes in financing. National priorities for GME reflect the same concerns as in the AFMS. The AFMS relies heavily on its GME programs to produce trained physicians for its operational, readiness, and sustainment operations.⁹ If the AFMS outsourced its training requirements to the civilian sector, the AFMS's ability to ensure recruitment of qualified physicians for active duty would be seriously degraded.

Notes

¹ Link, Mae Mills, Hubert A. Coleman. *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)*. Washington, D.C.: Office of the Surgeon General, USAF, 1969, 256.

² Association of American Medical Colleges. *Academic Medicine: The Cornerstone of the American Healthcare System* (Washington, D.C.: Association of American Medical Colleges, undated), On-line. Internet, 2 February 2000. Available from <http://www.aamc.org/meded.edres.start.htm>.

³ Association of American Medical Colleges. *Medical Education and the Future Physician Workforce* (Washington, D.C.: Association of American Medical Colleges, undated), On-line. Internet, 2 February 2000. Available from <http://www.aamc.org/meded.edres.start.htm>.

⁴ Townsend, Jessica. "Financing Medical Education". *Medical Education and Societal Needs: A Planning Report for the Health Professions* (Washington, D.C.: Institute of Medicine, 1983), On-line. Internet, 20 March 2000. Available from http://www.ulib.org/webRoot/Books/National_Academy_Press_Books/medical_education/medi255.htm, 255.

⁵ Townsend, Jessica. "Financing Medical Education". *Medical Education and Societal Needs: A Planning Report for the Health Professions* (Washington, D.C.: Institute of Medicine, 1983), On-line. Internet, 20 March 2000. Available from http://www.ulib.org/webRoot/Books/National_Academy_Press_Books/medical_education/medi255.htm, 255.

⁶ Association of American Medical Colleges. *Medical Education and the Future Physician Workforce* (Washington, D.C.: Association of American Medical Colleges, undated), On-line. Internet, 2 February 2000. Available from <http://www.aamc.org/meded.edres.start.htm>.

⁷ Iglehart, John K. "Medicare and Graduate Medical Education." *The New England Journal of Medicine*. Vol 338, No . 6. N.p. On-line. Internet, 2 February 2000. Available from <http://www.nejm.org>.

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⁸ Iglehart, John K. "Medicare and Graduate Medical Education." *The New England Journal of Medicine*. Vol 338, No . 6. N.p. On-line. Internet, 2 February 2000. Available from <http://www.nejm.org>.

⁹ General Accounting Office. *Defense Health Care: Collaboration and Criteria Needed for Sizing Graduate Medical Education* (Washington, D.C.: General Accounting Office, April 1998), 1.

Part 5

Medical Readiness

AFSC-specific training will focus primarily on the AFSC position filled within that UTC. Additionally, each team member must be familiar with multifunctional roles.¹

— EMEDS/AFTH CONOPS

Support of the Air Expeditionary Force

Each part of the active duty Air Force physician employment cycle impacts the support the Air Force Medical Service can provide to the Expeditionary Air Force. GME programs help ensure the AFMS can support the EAF by training physicians in the specialties needed for readiness, operational, and sustainment requirements. The Force Health Protection Capstone Document states that the goal of force Health Protection is to “provide a fit and healthy force when and where the mission requires it.”² The AFMS must accurately project the manpower requirements for operational needs, deployment, and sustainment to ensure adequate physicians are available to support the service’s missions. To better provide the appropriate mix of physicians to the Air Expeditionary Forces, the Air Force Surgeon General has reorganized and reevaluated the entire contingency and wartime planning of medical response.³ He approved the Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH) system concept in 1998. This action identified changes in the physician manpower requirements and specialty mixes, thus altering training program requirements to support the AEF.⁴

Reorganization of AFMS capabilities supports the third pillar of the Joint Force Health Protection Capstone Document Casualty Care Management. This pillar is comprised of four parts, First Responders, Forward Resuscitative Surgery, Theater Hospitalization, and En Route Care, that work together in a time-phased, scalable method to provide definitive medical care to the AEF. The First Responders are responsible for setting up basic medical care while ensuring any threat to the force through airborne, waterborne, or foodborne vectors is minimized. The Forward Resuscitative Surgery portion brings in the medical personnel, equipment, and supplies required for immediate care of the sick and injured. In the Theater Hospitalization portion, assets are focused on the inpatient care of the sick and injured for short periods of time, until those warfighters either return to duty in the deployed theater or are transported out of the theater by the assets identified in the En Route Care portion of the Casualty Care and Management pillar.⁵ Just as the AEF provides a tailored force for the theater commander in chief (CINC), the EMEDS/AFTH system provides a tailored response for the force health protection required to sustain the AEF in conflict.

The Air Expeditionary Force (AEF) is lighter and leaner than the deployed forces of the early 1990s. Figure 1 illustrates the organizational structure of the AEF and Figure 2 shows the organization of EMEDS/AFTH in fulfilling the medical support role in the AEF. Strategic airlift provides the AEF an ability to transport large amounts of medical equipment and personnel into the deployed theater. Recognizing that strategic airlift will be critical, and that the build-up of forces in theater takes place over time, the EMEDS concept employs a phased build-up of medical capabilities to match the requirements of the deployed force commander, as well as enhancing their interoperability with other DOD agencies and coalition medical forces.

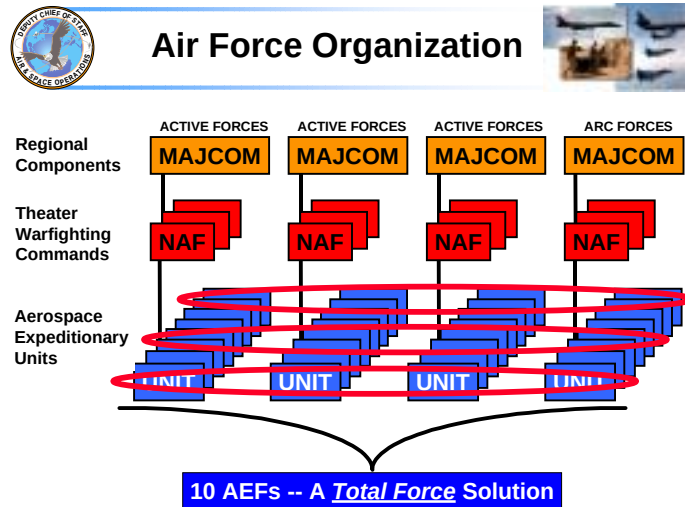


Figure 1. EAF Organization Chart

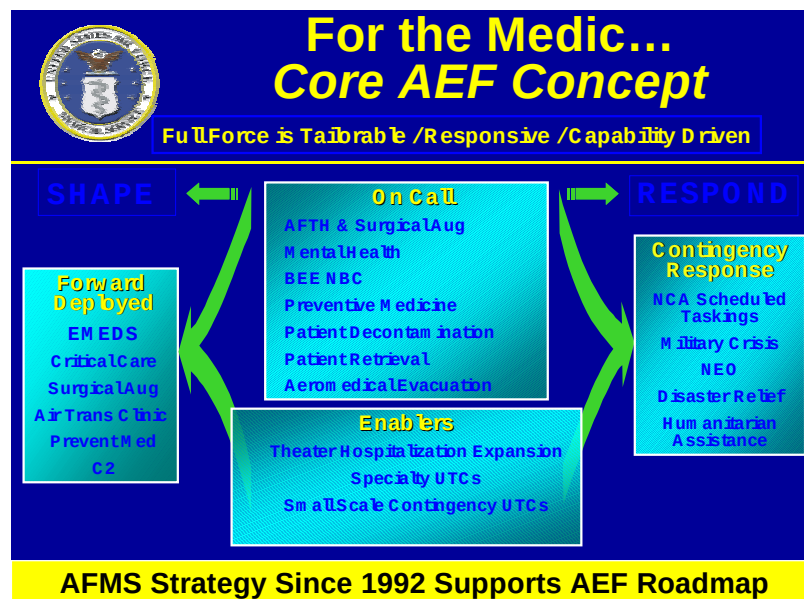


Figure 2 Medical Support for the AEF

The EMEDs defines the basic package of medical support as an Air Force Theater Hospital System (AFTH) (See Appendix E). "The role of the AFTH is to provide individual bed-down and theater-level medical/dental services for deployed forces or select population groups within the entire spectrum of Small Scale Contingencies (SSCs) through Major Theater War (MTW).⁶ By reducing the medical footprint by 66%, and relying on focused logistics and information technology, the EMEDS concept ensures adequate force health protection assets are in place and

available from the earliest stages of deployment. A breakout and illustration of the basic EMEDS/AFTH organizational structure and the largest EMEDS/AFTH configuration is at Appendix E.⁷

The Air Force Surgeon General has reorganized and re-evaluated the entire contingency and wartime planning of medical response. EMEDS/AFTH is part of that reorganization. However, the Concept of Operations Plan notes that only the larger regional facilities and medical centers will apparently have Unit Type Code (UTC) taskings to support EMEDS/AFTH in addition to the Squadron Medical Element that supports each flying unit.⁸

Major changes in the EMEDS/AFTH concepts of readiness and deployment include a focus on aeromedical evacuation of military members and smaller, lighter equipment and supply packages. The AFMS goal is to train as it deploys and provide physicians experience in forward deployed scenarios during annual Continuing Medical Readiness Training (CMRT) events.⁹ Physicians in Air Force GME programs receive training specifically addressing their roles during deployment and contingency operations. Physicians in civilian GME programs do not receive this training as part of their education and must have additional training during initial orientation, thereby reducing their ability to care for patients on entry to active duty and arrival at a military healthcare facility. An unmet training need negatively impacts a Medical Group's readiness capability, as measured by the Status Of Resources and Training System (SORTS).

Determining Readiness Capability

At the Military Healthcare Facility, the Medical Group Commander is responsible for determining the readiness capability of the Group. Medical Groups receive taskings, known as Unit Type Codes (UTC), which identify personnel, equipment, and supply requirements the Medical Group must meet during a deployment. Readiness capability is reported by the SORTS

report, annotated by tasking, and signed by the Medical Group commander to ensure that all required personnel, equipment, and supply UTCs are completed and training has been accomplished for a deployment of the tasked assets.¹⁰ Specific criteria are used to define which personnel are actually deployable and that their training is current. Additionally, medical logisticians perform inventory and testing of all equipment and supplies required for the taskings and report their findings to the commander for inclusion in the SORTS report.

The number of physicians assigned to the MHF and their levels of readiness training play into the SORTS report, as the level of staffing and mix of physicians is part of the personnel information reported. Physician training levels for wartime and contingency skills are reported as part of the readiness requirement. The commander collates all of the information on personnel, training, equipment and supplies, then makes a determination about just how ready his unit is to deploy for their wartime or contingency operations. A unit is usually downgraded in readiness status if there are not adequate numbers or types of physicians or if the training requirements have not been met. A Medical Group that routinely reports a lowered SORTS rating, called a C-rating, can expect to have increased scrutiny of its staffing levels, equipment procurement and maintenance schedules, supply fill rates, and CMRT training program. Demonstrated deficiencies during actual deployments cost the lives of the very patients the AFMS is committed to serving.

Notes

¹ Darr, Lt Col (Dr.) Lafon, Lt Col John Binder, "Air Force Medical Service: Concept of Operations for Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH) System." (Paper presented to the USAF Surgeon General. Langley AFB, VA., September 1999), 55.

² Logistics Division, Office of the Joint Chiefs of Staff, *Force Health Protection Capstone Document*. Washington, D.C.: Office of the Joint Chiefs of Staff, undated. On-line. Internet, 20 March 2000. Available from <http://www.dtic.mil/jcs/j4/divisions/mrd/index.htm>, 2.

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³ Carlton, MGen Paul K., Jr., "Briefing to the CSAF," briefing, Office of the Surgeon General, US Air Force, Bolling Air Force Base, D.C., 20 January 2000.

⁴ Darr, Lt Col (Dr.) Lafon, Lt Col John Binder, "Air Force Medical Service: Concept of Operations for Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH) System." (Paper presented to the USAF Surgeon General. Langley AFB, VA., September 1999), 1-22.

⁵ Logistics Division, Office of the Joint Chiefs of Staff, *Force Health Protection Capstone Document*. Washington, D.C.: Office of the Joint Chiefs of Staff, undated. On-line. Internet, 20 March 2000. Available from <http://www.dtic.mil/jcs/j4/divisions/mrd/index.htm>, 23-25.

⁶ Darr, Lt Col (Dr.) Lafon, Lt Col John Binder, "Air Force Medical Service: Concept of Operations for Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH) System." (Paper presented to the USAF Surgeon General. Langley AFB, VA., September 1999), 1.

⁷ Darr, Lt Col (Dr.) Lafon, Lt Col John Binder, "Air Force Medical Service: Concept of Operations for Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH) System." (Paper presented to the USAF Surgeon General. Langley AFB, VA., September 1999), 1-22.

⁸ Darr, Lt Col (Dr.) Lafon, Lt Col John Binder, "Air Force Medical Service: Concept of Operations for Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH) System." (Paper presented to the USAF Surgeon General. Langley AFB, VA., September 1999), 56-58.

⁹ Darr, Lt Col (Dr.) Lafon, Lt Col John Binder, "Air Force Medical Service: Concept of Operations for Expeditionary Medical Support (EMEDS)/Air Force Theater Hospital (AFTH) System." (Paper presented to the USAF Surgeon General. Langley AFB, VA., September 1999), 56-58.

¹⁰ Department of Health Services Administration. *Medical Readiness Handout* (Sheppard Air Force Base, TX.: School of Health Care Sciences, USAF, August 1987), 155-156

Part 6

Conclusion and Recommendation

To maintain combat effectiveness it was necessary that each individual be able to attend his duties, and it fell to the Surgeon to circumvent his being absent because of preventable sickness and to assure his return to duty within as few hours as possible.¹

— Mae Mills Link and Hubert A. Coleman

The military must have a robust readiness capability, including its medical forces, to continue the level of operational effectiveness that the Air Force has enjoyed over the past decade. The early aviation medicine specialists clearly understood the value of organic medical assets to the Air Force's ability to fight and worked hard to ensure the Air Force would gain and retain the unity of effort and command and control benefits garnered in an organic medical service.

Based on a review of the available data for military GME program costs, the costs of civilian GME programs, the costs of hiring civilian physicians to provide the care currently captured by physicians in military GME programs, and the readiness needs of the AFMS, outsourcing military GME programs is not fiscally feasible. Military GME programs must be retained within the AFMS to ensure the future needs for force health protection can be met by qualified physicians.

Current joint medical planners have embraced the view espoused by Joint Vision 2010 in their Force Health Protection Capstone Document, and AFMS planners have molded the

EMEDS/AFTH systems to respond to the needs of AEF commanders, thus supporting the National Military Strategy and National Security Strategy. By taking advantage of military, medical, and technological innovations, the AFMS has significantly changed medical support to deployed commanders and altered basic concepts of field medical care.

This paper reviewed the historical importance of an organic medical service for the Air Force and examined the potential effects on the Graduate Medical Education program and operational readiness of outsourcing this education and training program to the civilian sector. This paper also examined the civilian sector's current turmoil regarding Graduate Medical Education programs and compared the costs of outsourcing GME to the civilian sector with those required for maintaining an organic service. Outsourcing the physician education and training programs currently maintained by the Air Force will have a huge impact in the money needed to recruit, train, and retain physicians for future military service.

This paper is limited to an overview examination of SORTS reporting in order avoid discussing classified information. The forms and calculations for SORTS reporting are not included in this study. This paper is also limited in its discussion of the costs of GME programs because the data is unclear for both the military and civilian sectors. Because there are so many forms of funding GME in the civilian sector and because the cost factors are not clearly delineated in military and civilian sectors, exact cost information was not available for this discussion. Although cost information for a specific GME program at a specific civilian training facility is available, the data is not generalizable to the larger discussion of total GME program costs. However, comparisons of estimated aggregate and average cost data that is available for both civilian and military GME programs, as well as salary data from MILPERS, the Bureau of

Labor Statistics, and Merritt, Hawkins and Associates, demonstrated the fiscal drawbacks to outsourcing Graduate Medical Education programs.

Implications of analysis for future plans

In the future, the Air Force Medical Service must come to terms with rightsizing not only the numbers of physicians on active duty, but the specialty of the physician as well. As the AFMS implements the EMEDS/AFTH system and transitions into full integration with the AEF, senior leaders will need to carefully monitor the physician specialists recruited, trained, and employed to ensure the needs of warfighting commanders are met. Strict attention to matching GME requirements with readiness and operational requirements will mean increased emphasis on primary care physician specialties, while other specialties will not be required in large numbers on active duty.

Consolidation of military GME programs to increase the effectiveness of training received by resident physicians should be carefully studied to ensure the requirements for ACGME certification are met. Credibility in physician education is just one factor in recruiting and retaining physicians for active duty that cannot be ignored without creating adverse effects on military physicians.

Recommendations

Further study must be accomplished to better define actual medical education costs in the Air Force Medical Service. Additionally, the USAF Surgeon General must continue efforts to map training requirements to readiness and sustainment requirements. Continued emphasis on matching recruiting and training programs to the needs of the operational AFMS will ultimately provide the correct mix of physicians for active duty service. The USAF must maintain its

organic medical service to ensure our beneficiaries are treated in a timely and appropriate manner under the entire spectrum of conflict.

Notes

¹ Link, Mae Mills, Hubert A. Coleman. *A History of the Origin of the U.S. Air Force Medical Service (1907-1949)* (Washington, D.C.: Office of the Surgeon General, USAF, 1969), 3.

Appendix A

Physician Special Pay Information

MEDICAL OFFICER **SPECIAL PAY INFORMATION**

The purpose of this guide is to provide information concerning the special pays for which physicians may be eligible. The following special pays are in addition to base pay entitlements.

Creditable service determines the amount of monthly bonuses. The creditable service received for special pays differs from the credit received for base pay.

Creditable service for special pay includes:

- a. All periods (year for year credit) spent in medical internship, residency or fellowship training while not on active duty as a Medical Corps officer. For example, one year internship and two years Family Practice residency is three years of creditable service.
- b. All periods (year, month and day credit) of active service, for a duration of one year or more; in the Medical Corps of the Army, Navy, Air Force, or Public Health Service.

MEDICAL SERVICE PAY DATE (MSPD).

The date derived by adding all periods of creditable service and subtracting the sum from the date entered into the active duty Medical Corps. For example, three years creditable service subtracted from 1 July 1999 (date entered active duty) equals a MSPD of 1 July 1996. Physicians have two pay dates—a base pay date for promotions and a MSPD for bonuses.

VARIABLE SPECIAL PAY (VSP).

Payable monthly to all physicians on active duty. The Air Force Personnel Center (AFPC/DPAMF1) initiates VSP upon entry on active duty. No contract or other action is required. Please refer to the chart below for VSP rates.

<u>YEARS OF CREDITABLE SVC</u>	<u>ANNUAL AMT</u>	<u>MONTHLY AMT</u>
Internship	\$ 1,200	\$ 100.00
Less than 6	5,000	416.66
6 to 8	12,000	1,000.00
8 to 10	11,500	958.33
10 to 12	11,000	916.66
12 to 14	10,000	833.33
14 to 18	9,000	750.00
18 to 22	8,000	666.66
22 or more	7,000	583.33
General Officers	7,000	583.33

BOARD CERTIFIED PAY (BCP)

Payable monthly to physicians who have achieved appropriate board certification. A copy of the board certificate or notification letter must be provided to AFPC/DPAMF1, 550 C Street West, Suite 27, Randolph AFB TX 78150-4729. Please refer to the chart below for BCP rates.

<u>YEARS OF CREDITABLE SVC</u>	<u>ANNUAL AMT</u>	<u>MONTHLY AMT</u>
less than 10	\$ 2,500	\$ 208.33
less than 12	3,500	291.66
less than 14	4,000	333.33
less than 18	5,000	416.66
18 or more	6,000	500.00

ADDITIONAL SPECIAL PAY (ASP).

Medical Corps officers of any grade who are not in internship or initial residency training are eligible for ASP with an annual lump sum payment of **\$15,000**. To receive ASP, the officer must sign a written agreement to remain on active duty for 12 months. The officer may not enter into an agreement that would extend beyond a mandatory release date. The ASP anniversary date will be the date of entry on active duty, or the date following completion of internship or initial residency training. Physicians initial ASP agreements will be completed while attending the Commissioned Officer Training (COT) or prepared by the Military Personnel Flight (MPF) Career Enhancement. Thereafter, a report of individual personnel (RIP) entitled "Medical Corps Officer Eligible for Additional Special Pay (ASP)" will be generated through the personnel data system approximately 150 days prior to the effective date. After the agreement is approved by the medical group commander, forward to AFPC/DPAMF1 (at least 30 days prior to anniversary date to ensure timely payment). Signature of acceptance on a ASP agreement constitutes authorization to extend the date of separation to match the ASP active duty service commitment date. ASP agreements are binding as of the date of the provider's signature.

SINGLE-YEAR INCENTIVE SPECIAL PAY (ISP)

Residency trained or board certified physicians practicing in specialties designated as critical by Assistant Secretary of Defense (Health Affairs) who are below the grade of 07, may receive ISP. The rates and eligible specialties are subject to change from year to year. Physicians become eligible for ISP the fiscal year (1 October) following initial residency training completion. Physicians who complete subspecialty fellowship programs are eligible to receive ISP effective the date they enter active duty. Physicians on active duty who complete a subspecialty training program are offered the opportunity to sign a new ISP contract upon completion of the program only if the ISP increases. When the subspecialty rates remain the same as the generalist rate, physicians will not be allowed to sign new ISP contracts. Signature of acceptance on a single-year ISP agreement constitutes authorization to extend the date of separation to match the ISP active duty service commitment date. The effective date of the ISP agreement is the date physicians become eligible to receive ISP. If that date plus 30 days has passed, the effective date of the agreement is the date it is signed. The MPF/Career Enhancement Unit prepares a written agreement for signature. After the agreement is approved by the medical group commander, forward to AFPC/DPAMF1. ISP agreements are binding as of the date of the provider's signature.

MULTI-YEAR SPECIAL PAY (MSP)

To be eligible for MSP, medical corps officers must be below the grade of 07 who:

- a. Have at least eight years of creditable service, or have completed any active duty service commitment incurred for medical education and training;
- b. Have completed initial residency training (those physicians who are board certified under a grandfather clause meet this requirement), or is scheduled to complete initial residency training before September 30 of the fiscal year in which the officer enters into the MSP written service agreement.

MSP agreements can be renegotiated at any time as long as the physician has the required retainability. Signature of acceptance of MSP constitutes authorization to extend the date of separation (DOS) to match the MSP ADSC. MSP agreements are binding as of the date of the provider's signature.

MULTI-YEAR INCENTIVE SPECIAL PAY (MISP)

Guidelines for Multi-year incentive special pay are the same as single-year ISP. However, MISP is linked to MSP and physicians applying for MSP must apply for MISP in the same specialty. There is no provision for mixing MSP and ISP specialties. Physicians eligible for ISP who sign MISP agreements will continue to receive those rates for the duration of the agreements. If pay rates for MSP or ISP should increase in the future, you may elect to sign new agreements in order to qualify for the higher rates.

Appendix B

Physician Incentive Special Pay Rates



**DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR FORCE PERSONNEL CENTER
RANDOLPH AIR FORCE BASE TEXAS**

3 Sep 99

MEMORANDUM FOR ALL AIR FORCE PHYSICIANS

FROM: HQ AFPC/DPAM
550 C Street West Suite 25
Randolph AFB TX 78150-4727

SUBJECT: FY00 Incentive Special Pay (ISP)/Multi-Year Special Pay (MSP) Programs

The Assistant Secretary of Defense (Health Affairs) has announced the FY00 ISP and MSP programs. Annual MSP and ISP agreement amounts beginning FY00 (1 Oct 99) are indicated in Attachment 1. **In order for agreements to be effective 1 Oct 99, they must be received by this office NLT 30 Nov 99. Agreements received after 30 Nov 99 will be effective the date they are signed.**

MULTI-YEAR SPECIAL PAY (MSP): MSP rules remain the same as before. To receive MSP, physicians must have either eight years of creditable service, based on their medical service pay date (MSPD), or have no active duty service commitment (ADSC) for medical education or training, and be below the grade of brigadier general. Physicians must have completed initial residency training (those physicians who are board certified/experienced under a grandfather clause meet this requirement). Physicians may complete an agreement for two, three or four years for any specialty for which they are currently credentialed and privileged; however, the MSP and Multi-Year Incentive Special Pay (MISP) specialty must be the same. The ADSC associated with MSP will be added to any existing ADSC for medical education and training.

Physicians with an existing MSP contract may terminate that contract to enter into new MSP contract with an equal or longer contract obligation than the original contract in effect at the time of execution of the new MSP contract. Any unearned portion of the terminated agreement shall be recouped. For example, if a physician is under an existing three year MSP, they may only terminate current contract to request a new 3 or 4 year MSP contract.

If physicians have training commitments when they enter into an MSP agreement, they **must** still serve that training commitment. The commitment for MSP is added to their training commitment. As in previous programs, physicians are not required to be currently practicing in their specialty in order to receive MSP. For physicians who do not have sufficient retainability to cover the length of a multi-year special pay agreement, signature of acceptance on the MSP agreement constitutes authorization for use of the agreement as a source document to extend their date of separation (DOS). Specified-Period-of-Time Contracts (SPTCs) are no longer required to extend their DOS for pay. Submission of an MSP agreement does not guarantee extension of DOS, but a DOS extension will be accomplished if it is determined to be consistent with the needs of the Air Force. Physicians must hold RegAF status to remain on active duty beyond 20 years. Physicians must take action to extend their DOS to remain beyond age 60 before they can receive their special pay. A delay in submitting DOS extension paperwork will cause a delay in special pay payments. HQ AFPC/DPAM retains authority to change DOS for medical special pay agreements.

SINGLE-YEAR INCENTIVE SPECIAL PAY (ISP): In order to receive ISP, physicians must have completed an initial residency, be privileged to the basic standard of the specialty, have a current state license, and be engaged in the practice of the specialty for a sufficient time during the agreement period to allow for the full maintenance of professional skills in that specialty. Service Secretaries now have authority to approve ISP agreements when physicians are fully qualified and assigned to a position requiring a substantial portion of time performing military unique duties:

- (1) Under adverse conditions, or
- (2) in remote OCONUS locations, or
- (3) that preclude the ability to spend appropriate time in a clinical setting

The agreement for members fitting the criteria above must be endorsed by the AF Surgeon General and should be mailed to HQ USAF/SGWF, 110 Luke Avenue, Suite 400, Bolling AFB DC 20332-7050. Additional documentation required consists of:

- (1) a valid state license,
- (2) proof of current CME

Signature of acceptance on a single-year ISP agreement constitutes authorization for use of the agreement as a source document to extend their DOS to match their ISP ADSC. Submission

of an ISP agreement does not guarantee extension of DOS, but a DOS extension will be accomplished if it is determined to be consistent with the needs of the Air Force.

In light of the increase in FY2000 pediatric and internal medicine subspecialty ISP rates, pediatric subspecialists (44KX) and internal medicine subspecialists (44MX) who previously executed ISP agreements in the 44K and 44M generalist rate, are eligible to renegotiate MSP/MISP agreements for pediatrics and internal medicine subspecialty rates. Subspecialists who choose to remain under previous FY generalist MSP/MISP agreements will be susceptible to utilization, to include PCS assignments, as pediatric and internal medicine generalists.

For purposes of pay, critical care specialists are identified as internal medicine subspecialists of gastroenterology, nephrology and pulmonary medicine, and pediatric subspecialists of cardiology, gastroenterology, neonatology, and pulmonary medicine. Surgical subspecialties are identified as adult cardiology (44MB), cardio-thoracic surgery, colon and rectal surgery, oncology surgery, pediatric surgery, plastic surgery and vascular surgery. Although not a surgical subspecialty, adult cardiology (44MB) will draw the surgical subspecialty rate.

NOTE: Physicians who are currently under a previous FY MSP and multi-year incentive special pay (MISP) and wish to renegotiate to the FY00 special pay rates must sign both the MSP and MISP agreements. For example, a family practice physician currently under previous FY multi-year agreements, whose ISP was increased from \$12,000 to \$13,000, must renegotiate both the MSP and MISP agreements in order to receive the higher ISP rate.

Physicians with an existing single-year ISP agreement may terminate that agreement on or after 1 Oct 99 in order to enter into a new single-year ISP agreement only when the new agreement will result in a higher ISP rate than the ISP agreement being terminated. This provision is not intended to allow medical officers to arbitrarily terminate an ISP agreement solely for the purpose of changing the anniversary date to coincide with an Additional Special Pay (ASP) agreement or a resignation/release from active duty date.

MULTI-YEAR INCENTIVE SPECIAL PAY (MISP): MISP is linked to MSP. Physicians applying for MISP must apply for MSP in that same specialty. There are no provisions for mixing MSP and MISP specialties. The same practicing clause applies to physicians applying for MISP as to single-year ISP. Physicians will receive the same ISP amount for the duration of their MSP/MISP agreement. Single-year ISP cannot be linked with MSP agreements. If pay rates for MSP or ISP should increase in the future, the physicians may sign new agreements, however, they must follow the guidance for renegotiating MSP (see above).

The Air Force considers physicians board certified by the American Osteopathic Board of Family Practice as family practice physicians for ISP and MSP purposes. Additionally, residency trained or board certified physicians practicing as flight surgeons may receive ISP and MSP in their specialized fields.

ENDORSEMENT OF SPECIAL PAY CONTRACTS: The following guidance is provided for the endorsement of special pay agreements:

- a. Medical Treatment Facility Commanders are the final approving authority for special pay agreements within their organization.
- b. Medical Center Vice Commanders may be designated as approving officials.
- c. Medical Treatment Facility Commanders should have their agreements endorsed by their supervisor.
- d. Members entitled to special pays and who are assigned in staff agencies should have their agreements endorsed at the Director level in their organization, i.e., MAJCOMs, TRICARE Agencies, etc.
- e. Directors and MAJCOM Surgeons should have their agreements approved by their supervisor.
- f. Members assigned to Air Force Element positions should have their agreements approved by the Commander, Air Force Medical Operations Agency (AFMOA) which is located at 110 Luke Avenue, Room 400, Bolling AFB, DC 20332-7050.
- g. Flight Surgeons assigned to Squadron Medical Elements should have their line squadron commander approve their agreements with suggested coordination by the local Medical Treatment Facility Commander.
- h. Members attending PME in residence should have their commander approve their agreements.
- i. Members assigned to AFIT positions should have their agreements forwarded to AFIT/CIM, 2950 P Street, Wright Patterson AFB, OH 45433-7765 for approval.
- j. Under no circumstance will a subordinate approve agreements.
- k. This guidance should cover most eligible members. The rule of thumb is whoever would be the OPR for recommending termination or withholding of special pays should be the approving authority.
- l. Agreements must include the approving authority's typed or stamped signature block indicating their duty title. Agreements that do not have the above mentioned level of approval authority or lack signature blocks will be returned for reaccomplishment.

SPECIAL PAY CONTRACTS: Annual Medical Corps ASP agreements generate from the PCIII System within the Commander Support Staff function at medical treatment facilities. ISP and MSP-MISP agreements are generated by the member. All medical special pay agreements are available on the AFPC Web Page, www.afpc.randolph.af.mil. Choose the

Medical Officer Information option from the main menu and look for the FY2000 Special Pay Program icon.

We recommend each physician take the time to review the available options. Be advised FY00 amounts remain in effect until 30 September 2000. Please direct questions to the Medical Special Pay Branch (DPAMF1), DSN 665-2377 or via E-MAIL at edward.keating@afpc.randolph.af.mil; henrietta.lowak@afpc.randolph.af.mil; or jerry.savoy@afpc.randolph.af.mil.

D. CREAGER BROWN, Col, USAF, MSC
Chief, Medical Service Officer Mgt Div
Directorate of Assignments

Attachment:
FY 00 MSP/ISP Amounts

FY2000 MSP/ISP AMOUNTS

AFSC	AFS	FY00 ISP	TWO YEAR MSP	THREE YEAR MSP	FOUR YEAR MSP
44D	Pathologist	\$16,000	\$6,000	\$7,000	\$8,000
44DA	Path, Hematology	\$16,000	\$6,000	\$7,000	\$8,000
44DB	Path, Cytology	\$16,000	\$6,000	\$7,000	\$8,000
44DC	Path, Gynecology	\$16,000	\$6,000	\$7,000	\$8,000
44DD	Path, Forensic	\$16,000	\$6,000	\$7,000	\$8,000
44DE	Neuropathology	\$16,000	\$6,000	\$7,000	\$8,000
44DF	Pediatric	\$16,000	\$6,000	\$7,000	\$8,000
44DG	Transfusion Medicine	\$16,000	\$6,000	\$7,000	\$8,000
44DH	Microbiology	\$16,000	\$6,000	\$7,000	\$8,000
44DJ	Immunology	\$16,000	\$6,000	\$7,000	\$8,000
44DK	Dermatology	\$16,000	\$6,000	\$7,000	\$8,000
44EA	Emergency Medicine Sp	\$22,000	\$6,000	\$7,000	\$8,000
44F	Family Physician	\$13,000	\$9,000	\$10,000	\$14,000
44H	Nuclear Med Phys	\$31,000	\$6,000	\$7,000	\$8,000
44K	Pediatrician	\$11,000	\$8,000	\$9,000	\$10,000
44KA	Adolescent Med	\$14,000	\$6,000	\$7,000	\$8,000
44KB	Ped Cardiology	\$23,000	\$6,000	\$7,000	\$8,000
44KC	Developmental Peds	\$14,000	\$6,000	\$7,000	\$8,000
44KD	Ped Endocrinology	\$14,000	\$6,000	\$7,000	\$8,000
44KE	Neonatology	\$23,000	\$6,000	\$7,000	\$8,000
44KF	Ped Gastroenterology	\$23,000	\$6,000	\$7,000	\$8,000
44KG	Ped Hematology	\$14,000	\$6,000	\$7,000	\$8,000
44KH	Ped Neurology	\$14,000	\$6,000	\$7,000	\$8,000
44KJ	Ped Pulmonology	\$23,000	\$6,000	\$7,000	\$8,000
44KK	Ped Infec Disease	\$14,000	\$6,000	\$7,000	\$8,000
44KL	Medical Genetics	\$14,000	\$6,000	\$7,000	\$8,000
44KM	Ped Nephrology	\$14,000	\$6,000	\$7,000	\$8,000
44M	Internist	\$13,000	\$6,000	\$7,000	\$8,000
44MA	Oncology	\$14,000	\$6,000	\$7,000	\$8,000
44MB	Cardiology	\$36,000	\$6,000	\$7,000	\$8,000
44MC	Endocrinology	\$14,000	\$6,000	\$7,000	\$8,000
44MD	Gastroenterology	\$23,000	\$6,000	\$7,000	\$8,000
44ME	Hematology	\$14,000	\$6,000	\$7,000	\$8,000

Atch 1 (1 of 3)

FY2000 MSP/ISP AMOUNTS

AFSC	AFS	FY00 ISP	TWO YEAR MSP	THREE YEAR MSP	FOUR YEAR MSP
44MF	Rheumatology	\$14,000	\$6,000	\$7,000	\$8,000
44MG	Pulmonary Disease	\$23,000	\$6,000	\$7,000	\$8,000
44MH	Infect Diseases	\$14,000	\$6,000	\$7,000	\$8,000
44MJ	Nephrology	\$23,000	\$6,000	\$7,000	\$8,000
44N	Neurologist	\$13,000	\$6,000	\$7,000	\$8,000
44P	Psychiatrist	\$14,000	\$9,000	\$10,000	\$14,000
44PA	Child Psychiatrist	\$14,000	\$9,000	\$10,000	\$14,000
44R	Diagnostic Radiology	\$31,000	\$6,000	\$7,000	\$8,000
44RA	Neuroradiology	\$31,000	\$6,000	\$7,000	\$8,000
44RB	Spec Procedures	\$31,000	\$6,000	\$7,000	\$8,000
44S	Dermatologist	\$14,000	\$6,000	\$7,000	\$8,000
44SA	Dermatologic Surg	\$14,000	\$6,000	\$7,000	\$8,000
44SB	Dermato Pathologist	\$14,000	\$6,000	\$7,000	\$8,000
44T	Radiotherapist	\$31,000	\$6,000	\$7,000	\$8,000
44Y	Critical Care Medicine	\$23,000	\$6,000	\$7,000	\$8,000
44YA	Ped Crit Care	\$23,000	\$6,000	\$7,000	\$8,000
44Z	Allergist	\$14,000	\$6,000	\$7,000	\$8,000
45A	Anesthesiologist	\$29,000	\$6,000	\$7,000	\$8,000
45B	Orthopedic Surgeon	\$36,000	\$9,000	\$10,000	\$14,000
45BA	Hand Surgery	\$36,000	\$9,000	\$10,000	\$14,000
45BB	Ortho, Pediatrics	\$36,000	\$9,000	\$10,000	\$14,000
45BC	Biomechanics	\$36,000	\$9,000	\$10,000	\$14,000
45BD	Sports Medicine	\$36,000	\$9,000	\$10,000	\$14,000
45BE	Spine Surgery	\$36,000	\$9,000	\$10,000	\$14,000
45BF	Oncology	\$36,000	\$9,000	\$10,000	\$14,000
45BG	Repl Arthroplasty	\$36,000	\$9,000	\$10,000	\$14,000
45E	Ophthalmologist	\$28,000	- NO MSP	-NO MSP	- NO MSP
45EA	Oculoplastics	\$28,000	- NO MSP	- NO MSP	- NO MSP
45EB	Cornea Ext Disease	\$28,000	- NO MSP	- NO MSP	- NO MSP
45EC	Glaucoma	\$28,000	- NO MSP	- NO MSP	- NO MSP
45ED	Neuro-opt	\$28,000	- NO MSP	- NO MSP	- NO MSP
45EE	Pathology	\$28,000	- NO MSP	- NO MSP	- NO MSP
45EF	Stra-Peds	\$28,000	- NO MSP	- NO MSP	- NO MSP

Atch 1 (2 of 3)

FY2000 MSP/ISP AMOUNTS

AFSC	AFS	FY00 ISP	TWO YEAR MSP	THREE YEAR MSP	FOUR YEAR MSP
45EG	Viterous/Retina	\$28,000	- NO MSP	- NO MSP	- NO MSP
45G	OB/GYN	\$31,000	\$6,000	\$7,000	\$8,000
45GA	OB/GYN Endocrin	\$31,000	\$6,000	\$7,000	\$8,000
45GB	OB/GYN Oncology	\$31,000	\$6,000	\$7,000	\$8,000
45GC	OB/GYN Pathology	\$31,000	\$6,000	\$7,000	\$8,000
45GD	Maternal Fetal Med	\$31,000	\$6,000	\$7,000	\$8,000
45N	Otolaryngologist	\$30,000	\$6,000	\$7,000	\$8,000
45P	Physical Med Phys	\$11,000	\$8,000	\$9,000	\$10,000
45S	Surgeon	\$26,000	\$9,000	\$10,000	\$14,000
45SA	Thoracic Surgeon	\$36,000	\$6,000	\$7,000	\$8,000
45SB	Colon/Rectal Surg	\$36,000	\$6,000	\$7,000	\$8,000
45SC	Cardiac Surgeon	\$36,000	\$6,000	\$7,000	\$8,000
45SD	Pediatric Surgeon	\$36,000	\$6,000	\$7,000	\$8,000
45SE	Peripher Vasc Srg	\$36,000	\$6,000	\$7,000	\$8,000
45SF	Neurological Surg	\$36,000	\$8,000	\$9,000	\$10,000
45SG	Plastic Surgeon	\$36,000	\$6,000	\$7,000	\$8,000
45SH	Oncology Surg	\$36,000	\$6,000	\$7,000	\$8,000
45SJ	Multi Organ Trans	\$36,000	\$6,000	\$7,000	\$8,000
45U	Urologist	\$28,000	\$6,000	\$7,000	\$8,000
45UA	Urology, Peds	\$28,000	\$6,000	\$7,000	\$8,000
45UB	Urology, Oncology	\$28,000	\$6,000	\$7,000	\$8,000
45UC	Uro, Kidney Trans	\$28,000	\$6,000	\$7,000	\$8,000
48A	Aerospace Med Sp	\$11,000	\$8,000	\$9,000	\$10,000
48E	Occupatnl Med Sp	\$11,000	\$8,000	\$9,000	\$10,000
48F	Family Practice Spec	\$13,000	\$9,000	\$10,000	\$14,000
48P	Preventive Med Spec	\$11,000	\$8,000	\$9,000	\$10,000

Atch 1 (3 of 3)

Appendix C

Medical Corps Approved Training

Below are listed the approved training starts for Medical Corps officers for FY 99 and preselects for FY 00. These positions were recently approved at the Integrated Forecast Board (IFB 98). Notes and abbreviations are listed at the end of the training listings. Applications for the 98 GME Selection Board are available from HQ AFPC/DPAME, 550 C Street West, Suite 27, Randolph AFB, TX 78160; DSN 487-6331, commercial 210-662-6331, or from the Director of Medical Education at teaching facilities. Questions may be addressed to DPAME, the clinical consultants or program directors.

Training	Number/Training Status/Location	Length	Start
Aeromedical Services			
Residency, Aerospace Medicine	17-Sponsored; (civilian/USAFSAM)	36	Jul-99
Residency, General Preventive Medicine	1-USUHS; 2-Civilian Sponsored	24	Jul-99
Residency, General Preventive Medicine (Note 4)	1-USUHS	24	Jul-00
Residency, Occupational Medicine	2-Civilian Sponsored	24	Jul-99
Fellowship, Hyperbaric Medicine	1-USAFSAM	12	Jul-99
Allergy			
Fellowship, Allergy-Immunology	2-WHMC	24	Jul-99
Anesthesia			
Residency, Anesthesia (PG1)	15-Deferred	48	Jul-99
Residency, Anesthesia (Preselect-Note 1)	8-WHMC/BAMC	48	Jul-00
Residency, Anesthesia (PG2)	2-WHMC/BAMC; 2-Def/Rdef	36	Jul-99
Fellowship, Critical Care Anesthesia	1-WHMC	12	Jul-99
Fellowship, Neuroanesthesia	1-Deferred	12	Jul-99
Fellowship, Pain	2-Deferred	12	Jul-99
Fellowship, Obstetrical Anesthesia	1-Deferred	12	Jul-99
Dermatology			
Residency, Dermatology (PG2)	3-WHMC/BAMC	36	Jul-99
Fellowship, Dermatologic Surgery	1-Civilian Sponsored	12	Jul-99
Emergency Medicine			
Residency, Emergency Medicine (PG1)	4-WP/WS; 15-Deferred	36	Jul-99
Residency, Emergency Medicine (PG2)	5-WHMC/BAMC	36	Jul-99
Family Practice			
Residency, Family Practice (PG1)	7-Scott/St Eliz; 8-Eglin; 10-DGMC; 10-MGMC; 4-EB/UNeb; 61-Deferred	36	Jul-99
Residency, Family Practice (PG2)	3-EB/UNeb	24	Jul-99
Fellowship, Family Practice Sports Medicine -Note 5	1-Deferred	12	Jul-99
Transitional Medicine	6-WHMC; 4-DGMC; 10-MGMC	12	Jul-99
General Surgery			
Residency, General Surgery	4-WHMC/UTHSC; 3-WP/WS; 2-DGMC; 4-Keesler; 12-Deferred	60	Jul-99
Preliminary Year, General Surgery (PG1 Only)	9-WHMC/BAMC; 4-WP/WS; 4-DGMC; 4-Keesler	12	Jul-99
Research, General Surgery	1-WHMC/BAMC; 1-DGMC; 1-Keesler	12	Jul-99
Research, General Surgery	1-WHMC/BAMC; 1-DGMC; 1-Keesler	12	Jul-00

Training	Number/Training Status/Location	Length	Start
Fellowship, Trauma/Critical Care Surgery	2-Civilian Sponsored	12/24	Jul-99
Fellowship, Trauma/Critical Care Surgery	2-Civilian Sponsored	12/24	Jul-00
Fellowship, Laparoscopic Surgery	1-Deferred	24	Jul-99
Fellowship, Laparoscopic Surgery	1-Civilian Sponsored	24	Jul-00
Fellowship, Thoracic Surgery	1-Keesler	12	Jul-99
Fellowship, Colorectal Surgery	1-Deferred	12	Jul-99
Fellowship, Colorectal Surgery	1-Civilian Sponsored; 1-Def/RDEF	12	Jul-00
Residency, Neurosurgery	1-Deferred	72	Jul-99
Internal Medicine			
Residency, Internal Medicine	16-WHMC; 6-DGMC; 8-WPMC;	36	Jul-99
	10-Keesler; 30-Deferred		Jul-99
	2-Civilian Sponsored PG2	24	Jul-99
Preliminary Year, Internal Medicine	7-WHMC	12	Jul-99
Fellowship, Hematology/Oncology	3-WHMC/BAMC; 2-Deferred	36	Jul-99
Fellowship, Cardiology	3-WHMC/BAMC; 3-Deferred	36	Jul-99
Fellowship, Cardiac Electrophysiology	1-Civilian Sponsored	24	Jul-99
	1-Civilian Sponsored	24	Jul-00
Fellowship, Endocrinology	2-WHMC	24	Jul-99
Fellowship, Gastroenterology	2-WHMC/BAMC; 2-Civ. Spon, 2-Deferred	36	Jul-99
Fellowship, Rheumatology	2-WHMC	24	Jul-99
Fellowship, Pulmonary/Critical Care Medicine	3-WHMC/BAMC; 2 Deferred	36	Jul-99
Fellowship, Infectious Disease	2-WHMC/BAMC; 2-Deferred	24	Jul-99
Fellowship, Nephrology	1-WHMC/UTHSC	24	Jul-99
Neurology			
Residency, Neurology (PG2)	1-WHMC	36	Jul-99
Residency, Neurology (PG1 or PG2)	1-Deferred	36/48	Jul-99
Residency, Neurology (Preselect - Note 2)	2-WHMC	36	Jul-00
Fellowship, Neuromuscular	1-Civilian Sponsored	12	Jul-99
OB/GYN			
Residency, OB/GYN	3-WHMC/BAMC; 3-DGMC; 3-Keesler	48	Jul-99
	3-WP/WS		
Fellowship, Reproductive Endocrinology	1-Civilian Sponsored	36	Jul-00
Ophthalmology			
Residency, Ophthalmology (PG2)	3-WHMC/BAMC	36	Jul-99
Fellowship, Oculoplastic/Reconstructive Surgery	1-Deferred	12	Jul-99
Fellowship, Glaucoma	1-Deferred	12	Jul-99
Fellowship, Strabismus/Pediatric Ophthalmology	1-Civilian Sponsored	12	Jul-99
Orthopaedic Surgery			
Residency, Orthopaedic Surgery (PG1)	38 Deferred	60	Jul-99
Fellowship, Orthopaedic Sports Medicine	1-Civilian Sponsored	12	Jul-00
Fellowship, Orthopaedic Hand Surgery	1-Civilian Sponsored; 1-Def/Rdef	12	Jul-00

Training	Number/Training Status/Location	Length	Start
Otorhinolaryngology			
Residency, Otorhinolaryngology (PG2)	2-WHMC/BAMC	48	Jul-99
Residency, Otorhinolaryngology (PG1)	20-Deferred	60	Jul-99
Pathology			
Residency, Pathology	2-WHMC/BAMC; 7-Deferred	60	Jul-99
Fellowship, Hematopathology	1-Deferred	12	Jul-99
Fellowship, Cytopathology	1-WHMC/BAMC; 1-Deferred	12	Jul-99
Fellowship, Neuropathology	1-Deferred	24	Jul-99
Fellowship, Transfusion Medicine	1-Deferred	12	Jul-99
Fellowship, Dermatopathology	1-Deferred	12	Jul-99
Pediatrics			
Residency, Pediatrics	8-WHMC/BAMC; 6-DGMC; 6-WP/WS; 8-Keesler, 32-Deferred	36	Jul-99
Fellowship, Pediatric Cardiology	1-Civilian Sponsored; 2-Deferred	36	Jul-99
Fellowship, Developmental Pediatrics	2-Army	36	Jul-99
Fellowship, Neonatology	2-WHMC/BAMC; 1-Deferred	36	Jul-99
Fellowship, Pediatric Gastroenterology	1-USUHS; 1-Deferred	36	Jul-99
Fellowship, Pediatric Neurology	2-Civilian Sponsored; 1-Deferred	36	Jul-99
	1-Civilian Sponsored	36	Jul-00
Psychiatry			
Residency, Psychiatry	6-WHMC/UTHSC; 5-WP/WS	48	Jul-99
Combined Residency, Family Practice/Psychiatry	3-MGMC	60	Jul-99
Fellowship, Child & Adolescent Psychiatry	1-WP/WS; 1-Deferred	24	Jul-99
Fellowship, Forensic Psychiatry	1-Deferred	12	Jul-99
Radiology			
Residency, Diagnostic Radiology (Preselect-Note 1)	2-WHMC/BAMC; 1-DGMC	48	Jul-00
Residency, Diagnostic Radiology	15-Deferred	60	Jul-99
Residency, Diagnostic Radiology (PG2)	6-WHMC/BAMC; 1-DGMC	48	Jul-99
Fellowship, Neuroradiology	1-Deferred	24	Jul-99
Fellowship, Interventional Radiology	1-WHMC/BAMC; 3-Deferred	12	Jul-99
Fellowship, Pediatric Radiology	1-Deferred	12	Jul-99
Fellowship, Nuclear Radiology	1-WHMC/UTHSC	12	Jul-99
Fellowship, Musculoskeletal Radiology	1-Deferred	12	Jul-99
Transitional Medicine			
Transitional Medicine	6-WHMC; 4-DGMC; 10-MGMC	12	Jul-99
Urology			
Residency, Urology (PG2)	1-WHMC	60	Jul-99
Residency, Urology (Preselect-Note 3)	2-WHMC/BAMC; 3-Deferred	72	Jul-00
All Medical Corps			
Fellowship, Clinical Genetics/Cytogenetics	1-Deferred	36	Jul-99

Training	Number/Training Status/Location	Length	Start
Note 1: Trainees selected for anesthesia and radiology must complete a preliminary year in General Surgery, Internal Medicine, or Transitional Medicine.			
Note 2: Trainees selected for neurology must complete a preliminary year in Internal Medicine.			
Note 3: Trainees selected for urology must complete a preliminary year in General Surgery.			
Note 4: Trainees selected for preventive medicine must complete a preliminary year in Transitional Medicine.			
Note 5: Open to physicians who are 44F, 44K, 44M.			
Abbreviations:			
USAFSAM - USAF School of Aerospace Medicine, Brooks AFB, TX			
WHMC - Wilford Hall Medical Center, Lackland AFB, TX			
DGMC - David Grant Medical Center, Travis AFB, CA			
WPMC - Wright Patterson Medical Center, Wright-Patterson AFB, OH			
MGMC - Malcolm Grow Medical Center, Andrews AFB, MD			
EB - Ehrling Bergquist Hospital, Offutt AFB, NE			
BAMC - Brooke Army Medical Center, Ft Sam Houston, San Antonio, TX			
WRAMC - Walter Reed Army Medical Center, Washington, D.C.			
St Eliz - St Elizabeth's Hospital, Belleville, IL			
UNeb - University of Nebraska, Omaha, NE			
UTHSC - University of Texas Health Science Center, San Antonio, TX			
WS - Wright State University, Dayton, OH			

Appendix D

Sample Integrated Forecast Board Worksheet

Worksheet for Family Practice Physicians

MANPOWER/READINESS MODEL		Rank/Name	
		Consultant:	Lt Col Michael Spatz
		Assignments Officer:	Maj Paul Goven
		Education Officer:	Lt Col Toni Beumer
Isolated/OCONUS UTCs	11	Product Line Chp(s):	Lt Col Michael Spatz
CONUS UTCs	65		Lt Col Elvin E. Maxwell
Rotation/Sustainment	175		Lt Col Kevin Mulligan
TOTAL	251		Lt Col Cheri Maney

FISCAL YEAR	FY99	FY00	FY01	FY02	FY03
Imapct Year					
Beginning Workforce	555	538	533	511	500
Training Output - "L" Coded	108	110	91	87	104
Transfers to 48F	36	35	35	20	20
Recruits	3	0	0	0	0
Workforce Losses	90	77	77	77	77
Losses to Training - "L" Coded	2	3	1	1	1
Ending Workforce	538	533	511	500	506
Mission Support Plan Auth	547	525	502	502	502
OVERAGE/SHORTAGE	-9	9	9	-2	4

EDUCATIONAL PROGRAMS			NOTES
Program Length: 3 years (limited 2 year)			1. Current UMD - 587
In-house Training Starts			2. 36 transfers to 48F's or 48G's
Facility	PG1	PG2	3. Training billets - 120
David Grant	10		4. Beginning workforce numbers include 15 SGH's.
Eglin	8		5. Requests 100 starts:
Ehrling-Bergquist	4	4	39 sponsored in-house PG1 starts
Malcolm Grow	10		61 deferred PG1 starts
Scott	7		4 sponsored in-house PG2 starts
Total	39	4	2 sponsored (1 civilian, 1 USHUS) fellowships in Sports Medicine
Training Output: Family Practice Sports Medicine, 2-2000			1 sponsored (Army) FP Faculty Development fellowship

Appendix E

EMEDS/AFTH System

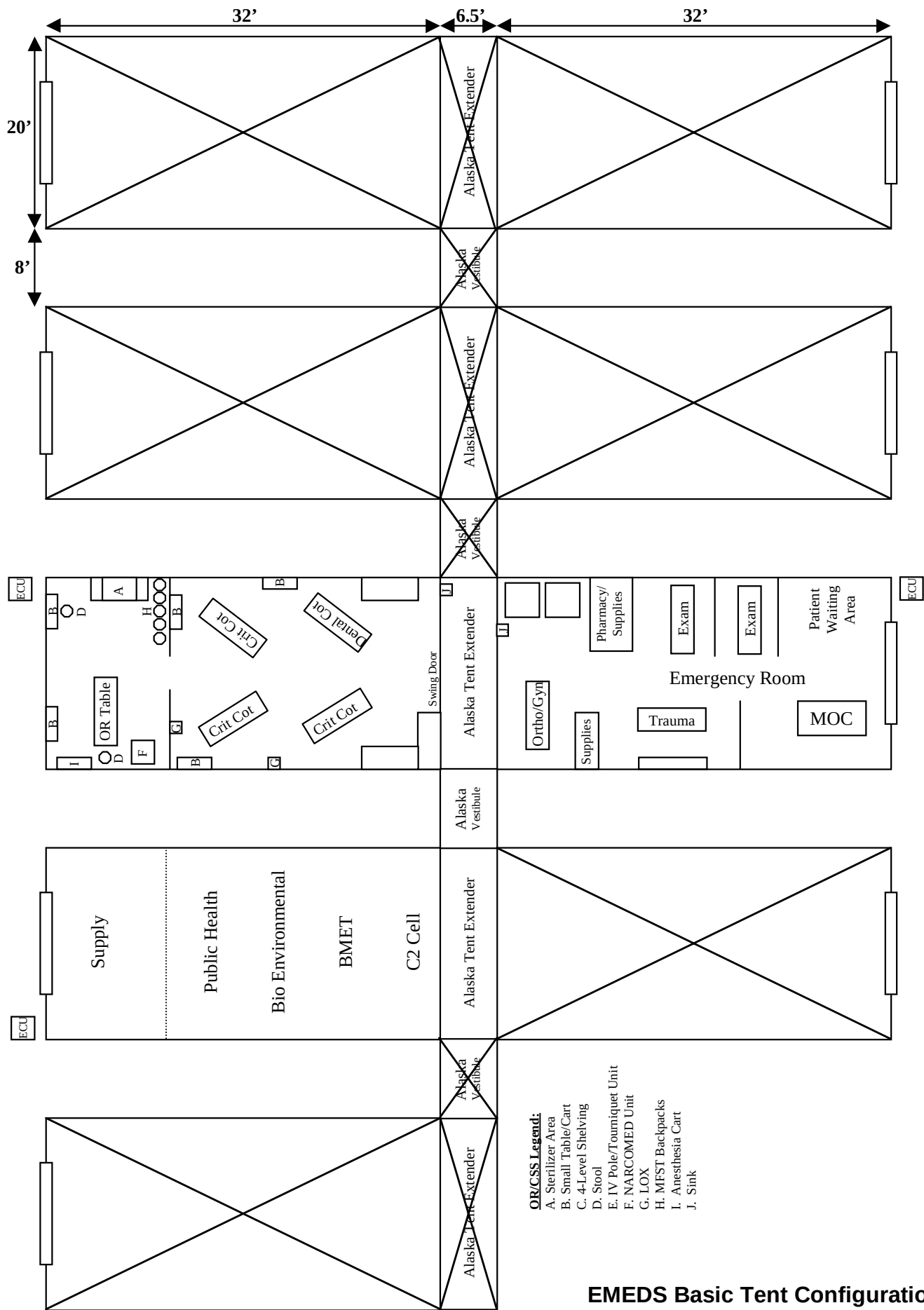
Manual 23-110, *USAF Supply Manual, Volume V, AF Medical Materiel Management System*, provides guidance for WRM assets, outlining when commanders may loan and use WRM assets. WRM program taskings are published annually by HQ USAF/SGXR in the AFMS Medical Resource Letter, which identifies personnel and equipment UTC taskings and storage locations. Medical materiel for EMEDS/AFTH deployable assets is identified in the appropriate AS.

Allowance Standard (AS) and Corresponding Unit Type Code (UTC)

AS	AS Title	UTC	MEFPAK	Pilot Unit	Pilot Unit Base	WRM Project Codes
901	Infectious Disease Team	FFHA2	AFMC	74 MDG	Wright-Patterson	JA - JC
917A	Mental Health Augmentation Team	FFGKU	AMC	89 MDG	Andrews	JD - JI
917B	Mental Health Rapid Response	FFGKV	AMC	89 MDG	Andrews	JJ - JQ
915	Prevention and Aerospace Medicine	FFGL2/3	ACC	1 MDG	Langley	JR - JV
SP07	BEE Nuclear/Chemical/Biological (NBC) Team	FFGL1	ACC	509 MDG	Whiteman	IN - IQ
SP10	Ancillary Augmentation	FFANC	ACC	1 MDG	Langley	LU - LW
SP11	Critical Care Air Transport Team(CCATT)	FFCCT	AMC	59 MDW	Lackland	UA - UX
SP12	Primary Care	FFPRM	AFSPC	45 MDG	Patrick	LR - LT
SP14A	Endodontics	FFEND	AETC	59 MDW	Lackland	KD - KF
SP14B	Periodontics	FFPER	AETC	59 MDW	Lackland	KG - KH
SP18	Air Transportable Dental Clinic	FFF0C	USAFA	10 MDG	Academy	KA - KC
SP23	Pedodontics	FFPDD	AETC	59 MDW	Lackland	KI - KJ
SP25A	ENT Augmentation	FFENT	AETC	59 MDW	Lackland	LA - LC

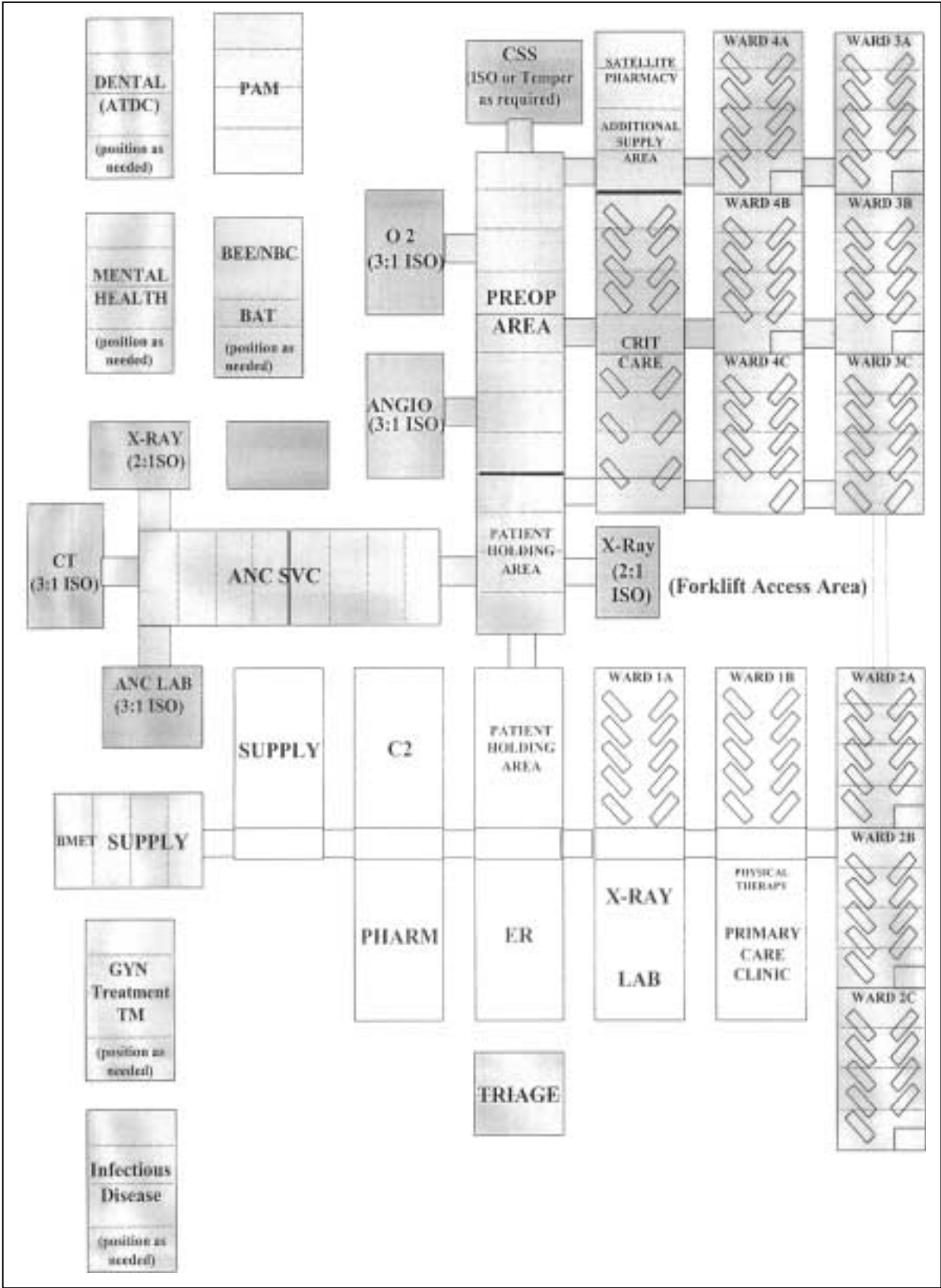
AS	AS Title	UTC	MEFPAK	Pilot Unit	Pilot Unit Base	WRM Project Codes
SP25B	Ophthalmology Augmentation	FFEYE	AETC	59 MDW	Lackland	LD - LF
SP25C	Oral-Maxillofacial Surgery	FFMAX	AETC	59 MDW	Lackland	KK - KM
916	Neurosurgical Augmentation	FFNEU	AETC	59 MDW	Lackland	KN - KP
SP27	Thoracic & Vascular Surgery	FFGKT	AMC	60 MDG	Travis	KQ - KS
SP28	Urology Augmentation	FFPPP	AFMC	74 MDG	Wright-Patterson	LI - LK
SP30A	Radiology Augmentation Team	FFRAD	AFMC	74 MDG	Wright-Patterson	KU - KV
SP30B	CT Scan Team	FFHA4	AFMC	74 MDG	Wright-Patterson	KT
SP33B	Gynecology Augmentation Team	FFGYN	PACAF	3 MDG	Elmendorf	LG - LH
SP33A	Obstetrics Augmentation Team	TBD	PACAF	3 MDG	Elmendorf	TBD
892	Pediatric Team	FFPED	USAFE	48 MDG	Lakenheath	LO - LQ
SP39A	Telemedicine Forward	FFTMF	AFMC	70 LS	Brooks	KW
SP39B	Telemedicine Suite	FFTEL	AFMC	70 LS	Brooks	KX
SP43	Critical Care Augmentation	FFCCU	AETC	59 MDW	Lackland	LL - LN
896	Air Transportable Hospital (ATH)	FFGKA	ACC	1 MDG	Langley	VA - VC, VE-VG, VI-VK, VM-VO, VQ-VS
TBD	EMEDS Equipment – Increment 1	FFEE1	ACC	1 MDG	Langley	TBD
TBD	EMEDS Equipment – Increment 2	FFEE2	ACC	1 MDG	Langley	TBD
TBD	EMEDS Equipment – Increment 3	FFEE3	ACC	1 MDG	Langley	TBD
TBD	EMEDS Resupply – Increment 1	FFEE4	ACC	1 MDG	Langley	EA-EF
TBD	EMEDS Resupply – Increment 2	FFEE5	ACC	1 MDG	Langley	EG-EO

AS	AS Title	UTC	MEFPAK	Pilot Unit	Pilot Unit Base	WRM Project Codes
TBD	EMEDS esupply – Increment 3	FFEE6	ACC	1 MDG	Langley	EP-EU
TBD	Ambulance Augmentation Package	FFAMB	ACC	55 MDG	Offutt	WS-WZ
TBD	Mobile Field Surgery Team	FFMFS	AETC	59 MDW	Lackland	DK-DO
890K	ATH Resupply	FFGKG	ACC	1 MDG	Langley	VD, VH, VL, VP, VT
TBD	Chemically Hardened ATH	FFCHA	ACC	1 MDG	Langley	WA-WR
900C	Hospital Surgical Expansion Package (HSEP)	FFEET, FFEES, FFEEW	ACC	1 MDG	Langley	HF - HK
890I	HSEP Resupply	FFLAE	ACC	1 MDG	Langley	HF-HK
TBD	Biological Augmentation Team	FFBAT	ACC	1MDG	Langley	IJ-IM
902A	Patient Decontamination Augmentation Set	FFGLA	ACC	49 MDG	Holloman	IA – ID



**EMEDS Basic Tent Configuration
(not to scale)**

Notional EMEDS +114 Bed AFTH



Deployable Medical Teams and Corresponding UTCs

Deployable Medical Teams and Corresponding Unit Type Codes (UTCs)			
EMEDS Basic UTCs			
Mobile Field Surgery Team: FFMFS	Ground Critical Care Team: FFEP1	EMEDS Command and Control: FFEP2	EMEDS-Basic Resupply: FFEE4
Prevention and Aerospace Medicine Tm 1: FFGL2	Air Transportable Clinic: FFDAB	EMEDS Equipment – Increment 1: FFEE1	EMEDS - Basic Nursing Augmentation: FFEP6
Prevention and Aerospace Medicine Tm 2: FFGL3			
EMEDS+10 Bed AFTH UTCs			
EMEDS Medical Team 2: FFEP3	EMEDS Equipment – Increment 2: FFEE2	Prevention and Aerospace Medicine Tm 3: FFGL4	EMEDS+10 Resupply: FFEE5
EMEDS+25 Bed AFTH UTCs			
EMEDS Medical Team 3: FFEP4	EMEDS Surgical Augmentation: FFEP5	EMEDS Equipment – Increment 3: FFEE3	EMEDS+25 Resupply: FFEE6
Core Base Medical Support UTCs			
Patient Decontamination Equipment: FFGLA	Patient Decontamination Personnel: FFGLB	Bioenvironmental Engineering NBC Team: FFGL1	
Patient Retrieval Team: FFGLE		Mental Health Rapid Response Team: FFGKV	
Medical Augmentation UTCs			
Ancillary Augmentation Team: FFANC	Hospital Medical Expansion Package (HMEP): FFEW1, FFEW2, FFEW	Hospital Surgical Expansion Package (HSEP): FFEST, FFEES	Surgical Augmentation Team: FFGK6
Pediatric Module - ATH: FFPED	Laboratory Augmentation: FFBU2	Biomedical Lab Officer: FFBU3	Gynecological Treatment Team: FFGYN
Critical Care Team – CCU: FFCCU	10-Bed ICU Expansion Unit: FFCCV	Urology Augmentation Team: FFPPT	Thoracic Vascular Surgical Team: FFGKT

Primary Care Augmentation Team: FFPRM	Biological Augmentation Team: FFBAT	Infectious Disease Team: FFHA2	Infectious Disease Augmentation Team: FFHA5
Ophthalmology Augmentation Team: FFEYE	Neurosurgical Augmentation Team: FFNEU	Ear, Nose and Throat Augmentation Team: FFENT	Oral Surgery Augmentation Team: FFMAX
CT Scan Team: FFHA4	Fluoroscopy/ Angiography Augmentation Team: FFRAD	Mental Health Augmentation Team: FFGKU	Obstetrics Augmentation Team: FFGYM
Dental Augmentation UTCs			
Pediatric Dentistry Team: FFPDD	Endodontic Augmentation Team: FFEND	Air Transportable Dental Clinic: FFF0C	Periodontic Augmentation Team: FFPER
Non-Medical Augmentation UTCs			
AFTH Command and Control Augmentation Team: FFC2A	Medical Management Augmentation: FFAAT	Admin Enlisted Augmentation: FFAAS	Admin Officer Augmentation: FFAAR
AFTH Patient Movement Element: FFPME	Medical Logistics Personnel Augmentation Team: FFLG1	Biomedical Equipment Maintenance Team: FFBMM	Systems Augmentation Team: FFSYS
Ambulance Augmentation Team: FFAMB	Telemedicine Team: FFTEL	Telemedicine Forward: FFTMF	
AF Theater Support UTCs			
Radiation Assessment Team: FFRA1	Radiation Assessment Team: FFRA1	Radioanalytical Assessment Team: FFRA3	Theater Epidemiology Team: FFHA1

EMEDS Basic, EMEDS+10 and +25 Bed AFTH Manpower Matrix

AFSC	Rank	Title	EMEDS Basic (PAR 500-2000)		EMEDS + 10 Bed AFTH (PAR 2000-3000)			EMEDS + 25 Bed AFTH (PAR 3000-5000)			Authorized Substitute	Comments
			QTY	UTC	ADDED	UTC	TOTAL	ADDED	UTC	TOTAL		
040C0	0-5	Commander	1	FFEP2			1			1	C4XXX	Corps Neutral. No less than 0-5. Note: If commander is RAM trained, can decide that SME RAM is not required
041A3	0-3	Health Services Admin	1	FFEP2			1			1	04XXX	IM/IT corps neutral officer
041A3	0-4	Health Services Admin						1	FFEP4	1		
042B3	0-3	Physical Therapist						1	FFEP4	1		
43A3	0-4	Aerospace Physiologist			1	FFGL4	1			1		
43E3A	0-4	Bioenvironmental Engineer	1	FFGL3			1			1	4B071	
043H3	0-4	Public Health Officer	1	FFGL2			1			1	4E071	If 43E3A deploys on FFGL2, 043H3 must deploy on FFGL3
043P3	0-3	Pharmacist						1	FFEP4	1		
043T3A	0-3	Biomedical Lab Scientist						1	FFEP4	1		
044E3A	0-3	Emergency Medicine Specialist	1	FFMFS			1			1	044F3	Family Practice Physician MFST Trained
044F3	0-4	Family Physician			1	FFEP3	1			1		
044F3	0-3	Family Physician						1	FFEP4	1	042G3 or 46N3H	Physician Assistant or Family Nurse Practitioner
044M3	0-3	Internist	1	FFEP1			1			1		
045A3	0-4	Anesthesiologist	1	FFMFS			1			1	046M3	Nurse Anesthetist
045B3	0-4	Orthopedic Surgeon	1	FFMFS			1			1		
045S3	0-4	General Surgeon	1	FFMFS			1	1	FFEP5	2		
046M3	0-3	Nurse Anesthetist						1	FFEP5	1	045A3	If 046M3 deploys on FFMFS, 045A3 must deploy on FFEP5
046A3	04-5	Nursing Admin						1	FFEP4	1	046A3	Requires appropriate clinical expertise
046N3	0-4	Clinical Nurse			1	FFEP3	1			1		Requires appropriate clinical expertise
046N3	0-3	Clinical Nurse	1	FFEP6	2	FFEP3	3	4	FFEP4	7		
046N3E	0-3	Critical Care Nurse	1	FFEP1	2	FFEP3	3			3		
046S3	0-3	OR Nurse	1	FFMFS			1			1		
046S3	0-4	OR Nurse						1	FFEP5	1		
047G3C	0-4	Dentist						1	FFEP4	1	047G3A	047G3A is mandatory at EMEDS+25 if EMEDS Basic is an 047G3C
047G3A	0-4	Comprehensive Dentist	1	FFEP2			1			1	047G3C	General Clinical Dentist
048A3	0-5	Aerospace Medicine Specialist	1	FFGL2			1			1		
048F3	0-4	Aerospace Medicine (Family Practice)	1	FFDAB	1	FFEP3	2			2	048G3	Aerospace Medicine Physician
4A051		Health Services Management Journeyman			1	FFEP3	1	3	FFEP4	4		
4A071		Health Services Management Craftsman			2	FFEP3	2			2		One 4A071 requires one year systems experience and network mgmt training
4A151		Medical Materiel Journeyman			1	FFEP3	1	1	FFEP4	2		
4A171		Medical Materiel Craftsman	1	FFEP2			1			1		
4A251		Biomedical Equipment Repair Journeyman						1	FFEP4	1		
4A271		Biomedical Equipment Repair Craftsman	1	FFEP2			1			1		

AFSC	Rank	Title	EMEDS Basic		EMEDS + 10 Bed AFTH			EMEDS + 25 Bed AFTH			Authorized Substitute	Comments
			(PAR 500-2000)		(PAR 2000-3000)			(PAR 3000-5000)				
			QTY	UTC	ADDED	UTC	TOTAL	ADDED	UTC	TOTAL		
4B051		Bioenvironmental Engineer Journeyman			1	FFGL4	1			1		
4B071		Bioenvironmental Engineer Craftsman			1	FFGL4	1			1	043E3A	
4D071		Dietary Craftsman						1	FFEP4	1		
4E051		Public Health Journeyman			1	FFGL4	1			1		
4E071		Public Health Craftsman			1	FFGL4	1			1	043H3	
4F051		Aeromedical Services Journeyman	1	FFDAB			1			1	4N051	Medical Services Journeyman
4F071		Aeromedical Services Craftsman	1	FFDAB			1			1	4N071	Medical Services Journeyman
4H071		Cardiopulmonary Lab Craftsman	1	FFEP1			1			1	4N071-487	Medical Services Craftsman
4N051		Medical Services Journeyman	4	FFEP6	8	FFEP3	12	3	FFEP4	15	4F051	
4N071		Medical Services Craftsman			1	FFEP3	1	2	FFEP4	3		
4F071-496		Independent Duty Medical Craftsman	1	FFGL3	1	FFEP3	2			2	4N071-496	Independent Duty Medical Technician
4N091		Medical Services Superintendent						1	FFEP4	1		
4N151		Surgical Services Journeyman			1	FFEP3	1	2	FFEP5	3		
4P071		Pharmacy Craftsman			1	FFEP3	1			1		
4R051		Radiology Journeyman						1	FFEP4	1		
4R071		Radiology Craftsman			1	FFEP3	1			1		
4T051		Medical Laboratory Journeyman						1	FFEP4	1		
4T071		Medical Laboratory Craftsman			1	FFEP3	1			1		
4Y071		Dental Craftsman			1	FFEP3	1			1		
		Totals:	25		31		56	30		86		

Appendix F

Glossary

Acute. Health conditions requiring quick attention to return a person to full health

Beneficiaries. People eligible to receive medical care from the Air Force Medical Service, including sponsors, family members, and retired military members and their family members, as well as those people designated to receive medical care by the Secretary of the Air Force.

Billet. A position.

Chronic. Health conditions which are not curable, but which can be managed by medical treatment over time and are usually of a complex nature.

Civilian Facility. A clinic, community hospital or medical center in the civilian community.

Contingency Operations. Specific actions taken by the military during a conflict that is not a total war.

Contract Physician. A physician who is hired directly by a military healthcare facility.

Education. Didactic, academic programs for physicians to learn required information.

Evacuation Operations. Specific actions taken by the military to remove people from a location during natural disasters, civil unrest or other military operation.

Fellow: A physician who has completed a residency program and who is continuing training in a single area of medicine.

Graduate Medical Education. Training and education programs designed to teach physicians a single area of medicine (GME).

Humanitarian Relief Operations. Specific actions taken by the military to relieve suffering and distress due to natural disasters or other military operations in a location.

Intern. A physician who has completed medical school and is in the first year of post-graduate training.

Medical Corps. Physicians who are members of the Air Force Medical Service.

Medical Officer. A physician.

Medical Operations. Those areas of healthcare which are directly centered on the person receiving medical care.

Medical Service Officer. All commissioned officers in the Air Force Medical Service.

Medical Service Support. Those areas of healthcare which provide administrative, logistical, or technical assistance to personnel in direct patient care.

Medical Support. Those areas of healthcare which assist in the diagnosis or treatment of patients.

Military Healthcare Facility. A clinic, community hospital, or medical center owned and operated by the United States Air Force. (MHF)

Military Operations Other Than War. Specific military actions taken to quell an uprising or respond to a national threat that do not include total war. (MOOTW).

Outsource. Transfer of a program from military resources to civilian resources

Primary Care. Medical care initially provided to a person to diagnose and treat acute health problems.

Post Graduate Year One. The first year of medical training following graduation from medical school. Also, the internship year (PG1).

Post Graduate Year Two. The second year of medical training following graduation from medical school. Also, resident year (PG2).

Resident. A physician who has completed the first year of post-graduate training and who is studying one specific area of medicine.

Specialty Care. Medical care provided by a physician for certain chronic medical conditions and complicated health problems.

Spectrum of Conflict. A continuum from peacetime to engagement in total war, including humanitarian relief operations, contingency operations, evacuation operations, military operations other than war, and wartime operations.

Sponsor. The military member

Training. Practical, vocational programs for physicians to learn required skills.

Unit Manning Document. A list of military and government positions and persons assigned to a particular military healthcare facility.

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