United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Military Forces and Personnel, Committee on Armed Services, House of Representatives

June 1993

# MEDICAL READINESS TRAINING

# Limited Participation by Army Medical Personnel


GAO/NSIAD-93-205

GAO

**United States**
**General Accounting Office**
**Washington, D.C. 20548**

**National Security and**
**International Affairs Division**

B-249273

June 30, 1993

The Honorable Ike Skelton
Chairman, Subcommittee on Military
Forces and Personnel
Committee on Armed Services
House of Representatives

Dear Mr. Chairman:

In August 1992, we reported that many Army medical personnel had not trained during peacetime to perform their assigned wartime mission in Operation Desert Storm.[1] As requested by the former Chairman, we followed up on that work by reviewing the Army's medical wartime readiness training program. The objectives of this report are to provide information on the (1) training that is currently available to prepare Army medical personnel for their wartime mission, (2) factors that inhibit medical personnel's participation in this medical readiness training, and (3) steps the Army has taken to improve the medical readiness training efforts.

## Background

The Army Medical Department (AMEDD) and Army Forces Command are collectively responsible for medical readiness training. AMEDD's mission is to provide health care and support during military operations and peacetime health care services to active duty and retired military personnel and their dependents. The Army Forces Command is responsible for ensuring that medical unit personnel can perform their wartime mission, planning and evaluating all unit training activities, and providing health care during wartime.

Within AMEDD, the Health Services Command (HSC) is charged with providing peacetime health care, planning for transition to war, training medical personnel, and developing future medical concepts to support the Army. HSC operates 8 medical centers, 84 medical clinics, 38 dental clinics, and 4 dental labs in the United States, Puerto Rico, and Panama. The AMEDD Center and School develops and offers over 135 courses on medical, military, laboratory, dental science, and surgery skills; the school bases the courses on training policies established by the Army Surgeon General.

[1]Operation Desert Storm: Full Army Medical Capability Not Achieved (GAO/NSIAD-92-175, Aug. 18, 1992).

Because Army medical personnel must provide peacetime health care and prepare to perform a wartime mission, HSC and the Army Forces Command must share the Army's active duty medical personnel. During peacetime, whether they are assigned to HSC or Army Forces Command units, most clinical personnel (physicians, nurses, and dentists) and enlisted personnel work in HSC medical treatment facilities providing health care services to active duty and retired soldiers and their dependents. In the event of a conflict that requires the Army Forces Command units to deploy, the Professional Officer Filler System is used to identify and assign active Army doctors and nurses to deploying medical units. Currently, reserve medical personnel are mobilized with their assigned unit or individually and not by this system.

## Results in Brief

The AMEDD Center and School offers medical readiness training through formal classroom instruction, field exercises, and correspondence courses. The courses range from medical skills orientation and combat casualty courses to courses that introduce selected officers to strategic war-fighting tactics. In addition to the school's course offerings, hands-on training is available (and required) at the HSC hospitals, and field training exercises are conducted in each Army unit.

Although one of AMEDD's missions is to provide medical support during military operations, as of July 1992 less than half of the active duty physicians had attended key readiness training courses. Army medical personnel have limited time to participate in readiness training courses and often do not attend them because of heavy patient work loads. According to Army medical officials, peacetime health care is given priority because (1) medical facilities' operating budgets are based on the number of patients seen and diagnosed for treatment and (2) Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) has to finance health care costs when patients obtain health care in nonmilitary facilities.

AMEDD has undertaken several initiatives to increase participation in wartime mission-related training. Most of these are aimed at making training more convenient and less demanding on medical personnel's schedule. However, unless peacetime demands are balanced with the need to train for the wartime mission, these initiatives may not increase participation in medical readiness training.

## Variety of Courses Offered to Prepare Medical Personnel for Wartime Mission

The primary military courses required for medical officers include an officer basic course that provides basic training in the military skills necessary for an officer's first assignment; an officer advanced course that provides training in medical service support operations and educates officers on their duties; and a pre-command course that is structured to assist these officers in individual preparation for command by providing skill progression and refresher training. In addition, selected AMEDD officers may attend the Command and General Staff College, which introduces officers to operational and strategic war-fighting.

Enlisted medical personnel are required to attend basic and advanced noncommissioned officer courses. The basic noncommissioned officer course provides the technical, tactical, and leadership training necessary for personnel to function as members of a team or as squad leaders in support of the AMEDD mission. The advanced course stresses similar skills and prepares the soldiers to become platoon or operation sergeants.

The Joint Medical Readiness Training Center, part of the AMEDD Center and School system, offers the Combat Casualty Care and Combat Casualty Management courses for active duty and reserve health professional officers and enlisted medical personnel. The focus of both courses is on the casualty care system and providing casualty care in battlefield conditions. The Combat Casualty Care course is a 9-day training program consisting of classroom instruction and field training on the skills needed to treat combat casualties and trauma in war. The Casualty Management course is designed to prepare physicians with the skills needed to manage a medical treatment facility during combat. This course includes 7 days of classroom lecture and field training.

Joint Medical Readiness Training Center personnel have developed nonresident casualty care training courses to increase participation by reserve personnel. Active duty personnel usually attend the courses at the joint training center facility at Camp Bullis, Texas. Training center personnel can travel to a reserve unit's home station to teach the courses during the unit's annual training period. Army medical personnel stated that the combat casualty courses are the best introduction to treating injuries in a wartime environment for medical personnel.

Army Forces Command regulations require all active and reserve enlisted medical personnel to work in HSC hospitals and medical treatment facilities to obtain hands-on training related to their military occupational specialty. The Army Forces Command regulations require that active duty

medical personnel train in the HSC facilities at least 60 days each year. Reservists are required to work in these facilities during one annual training period (2 weeks) every 4 years.

Army medical personnel at all levels are also required to participate in field training exercises with their unit to prepare for their wartime mission. For example, HSC and the Army Forces Command require that physicians and nurses who will be assigned to deploying medical units during wartime receive field training to ensure that they are familiar with field medical operations. According to medical unit commanders, field training is important for the medical personnel (particularly physicians) to learn their role in the unit, gain familiarity with the equipment used in combat, and practice survival skills and methods of deployment. The commander decides the length and frequency of the unit's training on the basis of the unit's wartime mission and an assessment of the unit's ability to perform that mission.

## Peacetime Health Care Requirement Limits Time Available for Training

Each officer is required to take the AMEDD Center and School's officer basic and advanced courses before attending other senior officer courses or schools. Until January 1993, the officer advanced course was a 20-week course consisting of classroom lecture and field training. According to AMEDD officials, the officer advanced course has been the most difficult course for active duty physicians to attend because of the length of the course and the impact on peacetime health care. As of July 1992, 25 percent of the active Army physicians had attended the officer advanced course. Reserve physicians have had similar difficulty attending the officer advanced course because their annual training period is only 2 weeks. Other courses also have low participation rates among physicians. For example, as of July 1992, only 47 percent of the active physicians had attended the Combat Casualty Care course and only 3 percent had attended the Combat Casualty Management course. According to Army medical officials, medical personnel have limited time to participate in and often do not attend readiness training due to heavy patient work loads, budgetary constraints, and efforts to contain CHAMPUS costs.

Within AMEDD, the HSC medical personnel's mission during peacetime is to provide health care to over 3.5 million active duty personnel, retirees, and their dependents. In 1956, Congress passed the Dependents' Medical Care Act, as amended, authorizing health care for dependents of active duty personnel and retirees at military medical facilities. Under the law, active

duty personnel are given priority in receiving health care at military medical facilities. The dependents of active duty personnel are entitled to health care at these facilities on a space available basis. Military retirees and their dependents are not entitled to health care at a military medical facility but may be provided health care at these facilities on a space-available basis.

Within HSC's facilities, each commander is required to manage personnel training within the practical constraints of providing peacetime health care. According to AMEDD officials, HSC facilities' operating budgets are based on the number of patients seen and diagnosed for treatment, in accordance with Department of Defense guidelines. As a result, the hospital's operating budget may be reduced to the extent that physicians' participation in readiness training displaces patient work load. Thus, the medical treatment facility commanders must decide if personnel will fulfill the immediate priority of providing peacetime health care instead of attending training courses for wartime missions.

Army medical officials stated that CHAMPUS costs are another reason that medical treatment facility commanders limit the time physicians participate in field and classroom training. As provided for by the Military Medical Benefits Amendments of 1966, as amended, CHAMPUS serves as an insurance plan for active duty dependents and military retirees and their dependents to receive health care for medical services not available in the military treatment facilities. CHAMPUS costs are incurred when patients must obtain health care outside the military facilities, such as when their physicians may be unavailable due to training.

Although HSC medical personnel must be prepared to deploy for war to provide medical support, medical officials believe efforts to contain CHAMPUS costs often preclude physicians from participating in training. These costs continue to rise as the number of retirees and dependents increase each year, along with health care costs in the civilian community. CHAMPUS costs have increased from $1.4 billion in fiscal year 1985 to an estimated $3.9 billion in fiscal year 1993. Hospital officials at one medical center told us that amounts beyond budgeted CHAMPUS expenditures must come from its direct care operating budget. AMEDD officials stated that since the hospital commanders are accountable for the facility's CHAMPUS costs, the number of physicians participating in wartime readiness training will be limited.

## AMEDD Has Undertaken Several Initiatives to Improve Training Opportunities

AMEDD has several initiatives underway—such as regional training sites, training course revisions, and caretaker hospitals—that may allow easier access to training facilities and increase participation in training by both active and reserve personnel. Most of these initiatives are in the early stages of implementation, so it is too early to determine whether they will increase participation in medical readiness training.

### Regional Training Sites Established for Easier Access to Training

Six regional training sites have been established in an effort to provide both active and reserve component units with facilities where they can conduct medical readiness training exercises. The regional training sites are operated by the National Guard Bureau and the Army Reserve Command. The first two sites were established by the National Guard at Camp Shelby, Mississippi, and Fort Indiantown Gap, Pennsylvania, in 1989. The Army Reserve established its first site at Fort Devens, Massachusetts, in April 1991 and by July 1992 had established three additional sites at Fort Gordon, Georgia; Fort McCoy, Wisconsin; and Camp Parks, California. An additional reserve site at Fort Chaffee, Arkansas, is scheduled to become operational during fiscal year 1994.

The regional training sites are equipped with deployable medical systems and provide the opportunity for hospital units to train on prepositioned equipment closely resembling their go-to-war set. The sites are staffed with a cadre of trainers and support personnel who provide new equipment and sustainment training, as well as site and subject matter expertise to assist in both unit and individual training. The site personnel also provide an evaluation capability in accordance with the Army Training and Evaluation Program. In addition to training conducted at the site, site personnel can provide mobile training teams to conduct training at the unit's location.

### Courses Revised to Increase Participation

The AMEDD Center and School has shortened the officer advanced course for active duty personnel and developed courses that reserve personnel may take at their home station. According to AMEDD officials, the officer advanced course for active duty physicians has been shortened from 20 to 8 weeks to limit the time that physicians will have to be away from their patients. Pilot courses were held in September 1991 and January and September 1992, and the course was integrated into the individual training plan in September 1992. The first course offered under the plan began in January 1993.

For reserve personnel, the AMEDD Center and School has developed an officer advanced course that can be taken at the officer's home station. An officer can complete this course in two phases. The first phase is a 127-hour correspondence course completed on a self-paced basis at the officer's home station. The second phase is completed at the AMEDD Center and School during the officer's 2-week annual training period. The Individual Training Division of the AMEDD Center and School is also developing similar courses for the officer basic and pre-command courses for the reserve component personnel. However, AMEDD Center and School officials stated that the pre-command course will not be available until late 1993 and the officer basic course will not be available until 1995.

## Establishment of Caretaker Hospitals May Increase Participation in Readiness Training

The Army Forces Command has 14 active hospital units available to deploy in wartime but plans to convert 6 of the deployable hospital units to "caretaker" status—a change that may benefit medical readiness training.[2] In a caretaker hospital unit, the majority of the assigned medical personnel work in a nearby HSC facility to provide peacetime health care, while a small cadre of personnel (the "caretakers") are assigned to maintain the Army Forces Command unit's equipment and perform administrative tasks. Perhaps the most significant change that comes with the caretaker concept is the designation of reserve hospital units and personnel as replacements for the active duty personnel deploying with caretaker hospital units at the HSC facilities. Specifically, in the event of a deployment these reserve units are to replace the caretaker hospital units, and peacetime health care operations would not be interrupted.

While the main reason for designating reserve units as replacements is to ensure that active duty unit personnel working in HSC facilities are available for immediate deployment, medical readiness training could also benefit from this arrangement. Each caretaker hospital unit is required to participate in 2 weeks of medical readiness field training each year. According to one AMEDD official, having designated reserve units to staff the HSC hospitals should enable all caretaker medical personnel to participate in this field training. It will also allow the designated reserve units to train for their wartime mission in their assigned medical treatment facility during their 2-week annual training period.

[2]Forces Command converted its Fort Bliss, Texas, hospital unit to caretaker status in August 1992. Hospitals at Fort Sam Houston and Fort Hood, Texas, were converted in October and December 1992, respectively. Forces Command plans to convert the remaining three hospitals to caretaker status by the end of fiscal year 1995.

## Other Efforts to Improve Participation in Training

In January 1992, the Assistant Secretary of Defense (Health Affairs) issued guidance advising the Army to establish programs to ensure that all health care personnel are provided, at a minimum, 2 weeks of training every 3 years to maintain and sustain combat medical skills. However, according to the Army's Director of the Plans and Operations, Division of the Office of the Surgeon General, as of February 1993, no specific programs had been developed to implement this guidance.

## Scope and Methodology

We interviewed officials of and collected information from the Army HSC and the AMEDD Center and School, Fort Sam Houston, Texas; the U.S. Army Forces Command and U.S. Army Reserve Command, Fort McPherson, Georgia; and the Office of the Army Surgeon General and the Chief Surgeon, National Guard Bureau, Alexandria, Virginia. We also observed a medical training exercise sponsored by the California National Guard at Camp Roberts, California, and visited the Regional Training Site and Eisenhower Army Medical Center at Fort Gordon, Georgia.

As requested, we did not obtain official agency comments. However, we discussed the contents of this report with responsible officials from the Office of the Assistant Secretary of Defense (Health Affairs), the Army Surgeon General, the Army's HSC and have included their comments as appropriate. They generally agreed with the information presented. Our review was conducted from June 1992 to February 1993 in accordance with generally accepted auditing standards.

We are sending copies of this report to the Chairmen of the Senate and House Committees on Armed Services and on Appropriations, the Secretaries of Defense and the Army, and the Director of the Office of Management and Budget. We will also make copies available to other interested parties on request.

This report was prepared under the direction of Henry L. Hinton, Jr., who may be reached on (202) 512-4126 if you or your staff have any questions concerning this report. Other major contributors to this report are listed in appendix I.

Sincerely yours,

Henry L. Hinton Jr.

for Frank C. Conahan
Assistant Comptroller General

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