Evaluation Report

OFFICE OF THE INSPECTOR GENERAL

PHYSICIAN RECRUITMENT AND RETENTION IN THE ARMY SELECTED RESERVE

Report No. 97-033 November 26, 1996

DEPARTMENT OF DEFENSE

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DEPARTMENT OF DEFENSE
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November 26, 1996

MEMORANDUM FOR AUDITOR GENERAL, DEPARTMENT OF THE ARMY

SUBJECT: Evaluation on Physician Recruitment and Retention in the Army Selected Reserve (Report No. 97-033)

We are providing this evaluation report for information and use. We considered management comments on a draft of this report in preparing the final report.

Comments on a draft of this report conformed to the requirements of DoD Directive 7650.3 and left no unresolved issues. Therefore, no additional comments are required.

We appreciate the courtesies extended to the evaluation staff. Questions on the evaluation should be directed to Ms. Debra B.D. Murphy, Evaluation Program Director, at (703) 604-8762 (DSN 664-8762), or Ms. Betsy Brilliant, Evaluation Project Manager, at (703) 604-8771 (DSN 664-8771). See Appendix F for the report distribution. Team members are listed inside the back cover.

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Office of the Inspector General, DoD

Report No. 97-033 **November 26, 1996**
(Project No. 6LH-9010)

Physician Recruitment and Retention in the Army Selected Reserve

Executive Summary

Introduction. We examined the recruitment and retention programs for physicians in the Army Selected Reserve to determine their effectiveness following the partial mobilization in support of Operations Desert Shield and Desert Storm. Following Operations Desert Shield and Desert Storm, the Army Selected Reserve declined from 4,391 assigned physicians in FY 1990, the height of Operations Desert Shield and Desert Storm, to 3,288 assigned physicians in FY 1995. We considered an assigned strength of 90 percent of the stated requirement as effective because a unit with that percent of fill qualifies for the highest personnel available strength rating.

Evaluation Objectives. The evaluation objective was to determine the effectiveness of physician recruitment and retention programs for the Army Selected Reserve. We also reviewed the Selected Reserve physician recruitment and retention programs in other Reserve components for "best practices."

Evaluation Results. The recruitment and retention programs for Army Selected Reserve physicians can be improved in meeting Army Selected Reserve requirements. Even when aided by congressional incentive programs and a 15-percent reduction in the number of budgeted physician positions (1990 through 1995), the Army Selected Reserve filled 71 percent of physician requirements in FY 1995.

Summary of Recommendations. We recommend that the Army establish policy guidance for the development and the implementation of a systematic, ongoing process for surveying physicians in the Army Selected Reserve; the Active Army; and the private sector, regarding the value they place on recruitment and retention incentives.

Management Comments. The Army indicated that using surveys as the key to fixing recruitment and retention problems has been disproved many times; and that recruitment and retention of Reserve physicians is not solely an Army problem, but a Tri-Service issue. The Army further stated that improving the recruitment and retention of medical personnel across all Services was being addressed by the DoD-level Medical Recruiting and Retention Working Group, established in 1991. The Army completed a major survey of physicians in May 1996, and an Army level working group was formed to focus on recruitment and retention of physicians. The Army level working group will develop and implement surveys as needed. See Part I for a discussion of management comments and Part III for the complete text.

Audit Response. The formation of the Army level working group and the recent survey meets the intent of the recommendation. No additional comments are needed.

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Part I - Evaluation Results

Evaluation Background

The primary mission of the medical components of the Military Departments is to ensure that a healthy fighting force is supported by a combat-ready health care system. The medical readiness responsibility is met with a combination of active duty and Army Selected Reserve medical personnel. The Army Selected Reserve includes the Army National Guard and the Army Reserve components. The Army medical support structure relies on the Army Selected Reserve components to provide approximately 50 percent of the total required number of Army physicians for Army wartime contingency missions. The medical mission for the Army Selected Reserve in the event of major regional contingencies consists of a range of requirements from Army Selected Reserve units backfilling (replacing active Army personnel that deployed) and augmenting the stateside medical treatment facilities (increasing an organization's capabilities) to Army Selected Reserve units mobilizing and deploying alongside active duty units.

During peacetime, 54 entities, consisting of the states, commonwealths, District of Columbia, and territories of the United States command the National Guard. Each state Adjutant General exercises command of the National Guard of that state. The President can federalize the National Guard units for national emergencies including partial and total mobilization. Combat units, such as infantry companies, are the predominant types of units in the Army National Guard. In contrast to the peacetime decentralized command structure in the Army National Guard, the Army Reserve has a centralized command structure in peacetime, the Army Reserve Command. Combat support units, such as military police companies, and combat service support units, such as combat support hospitals, are the predominant types of units in the Army Reserve.

Operations Desert Shield and Desert Storm resulted in the first call of National Guard and Reserve personnel to extended active duty, beyond 2 weeks of annual training, since the Berlin Wall crisis in 1961. The President did not activate National Guard and Reserve personnel for deployment to the Dominican Republic in 1965, Vietnam from 1961 through 1973, and Grenada in 1983. Army Reserve units did participate in Operation Just Cause in Panama in 1989. For nearly 30 years, units of the Army National Guard and Army Reserve had not been called to extended active duty for armed conflict. Operations Desert Shield and Desert Storm changed the perception of being in the Army National Guard and Army Reserve. The perception that a Reservist would be mobilized only for a major conflict has been replaced with the realization of greater Reserve component participation in peacekeeping operations. For physicians, the greater participation in peacetime missions equates to a greater risk of extended active duty, income loss, and business loss, and this adversely affects recruitment and retention in the Reserves.

In 1991, after Operations Desert Shield and Desert Storm, 435 physicians resigned from the Army Selected Reserve, compared to previous annual resignations of less than 100 physicians. In the same year, the Army Selected Reserve recruited 341 physicians compared to 703 physicians in the previous year, and physician applications for the Specialized Training Assistance Program dropped from 125 to 17.

Three recruitment incentive programs for reserve physicians of all Military Departments existed before Operations Desert Shield and Desert Storm. The programs were the Health Professional Bonus Program (formerly the Selected Reserve Bonus Test Program), Health Professional Loan Repayment Program, and Health Professional Stipend Program (also known as the Specialized Training Assistance Program). The incentive programs are still available to recruiters as marketing tools. Appendix C discusses further the incentive programs.

Evaluation Objectives

The evaluation objective was to determine the effectiveness of physician recruitment and retention programs for the Army Selected Reserve. We also reviewed the Selected Reserve physician recruitment and retention programs in other Reserve components for "best practices."

See Appendix A for a description of the evaluation process. Appendix B summarizes prior coverage related to the evaluation objectives, Appendix C describes existing recruitment incentive programs, and Appendix D contains a summary of suggestions recorded from interviews.

Recruitment and Retention of Physicians in the Army Selected Reserve

The recruitment and retention programs in the Army Selected Reserve needed improvement in meeting the physician manning requirements of the medical support structure. The recruitment and retention programs lacked a systematic, continuous process for identifying what will attract individuals to both join and remain in the Army Selected Reserve. As a result, even when aided by congressional incentive programs and a 15-percent reduction of the physician force structure requirements, from FY 1990 through FY 1995, the Army Selected Reserve filled 71 percent of the physician requirements in FY 1995.

Guidance on Army Selected Reserve Recruitment and Retention

Several Army regulations provide guidance affecting the recruitment of physicians into the Reserves. Army Regulation 135-101, "Appointment of Reserve Commissioned Officers for Assignment to Army Medical Department Branches," July 15, 1979, prescribed grade determination and professional requirements for appointments. The regulation affected the direct commissioning process of physicians into the Selected Reserve. Army Regulation 601-132, "Army Medical Department Officer Procurement," April 4, 1977, prescribed functional responsibilities in the physician recruitment process. This regulation is still listed as current, although the recruitment mission of the Army Surgeon General had been transferred to the U.S. Army Recruiting Command, effective October 1, 1995. In accordance with Army Regulation 601-132, the Surgeon General is responsible for developing and recommending physician recruitment policies to the Headquarters, Department of the Army, Office of the Deputy Chief of Staff for Personnel. Army Recruiting Command is responsible for non-physician Army Medical Department recruitment programs. Army Regulation 135-7, "Incentive Programs," September 1, 1994, designates the Deputy Chief of Staff for Personnel responsibility for the policy governing the various Army National Guard and Army Reserve incentive programs. Among the 13 incentive programs described in the regulation, 2 applied to recruiting physicians into the Selected Reserve.

- Health Professional Loan Repayment Program
- Health Professional Stipend Program

The Chief, National Guard Bureau, supervises and manages incentive programs as they pertain to Army National Guard soldiers. The Chief, Army Reserve, exercises staff supervision and management of the incentive programs as they pertain to Army Reserve soldiers.

Physician Incentive Programs

Recruiters have three physician incentive programs available to recruit physicians into the Army Selected Reserve. The Health Professional Bonus Program provides up to $30,000 bonus for physicians with critical wartime specialties for joining the Selected Reserve. The Health Professional Loan Repayment Program provides up to $3,000 a year to pay for medical school loan expenses for physicians with critical wartime specialties. The third incentive program, the Health Professional Stipend Program provides a $865 monthly stipend for physicians who are obtaining specialized training in critical wartime specialties, in return for obligated service in the Selected Reserve. See Appendix C for additional information.

Effectiveness of Recruitment and Retention Programs

The lack of a systematic, continuous process, for identifying what will attract individuals to both join and remain in the Army Selected Reserve, contributes to not meeting the physician manning requirements.

Army Survey Process. The Army had an unstructured physician recruitment and retention survey process. The primary recruitment effort within the Army Recruiting Command has been focused on senior high school students (generally from 17 to 19 years old) to meet the needs of the Active Forces. The recruitment of physicians (generally from 23 to 27 years old) for the Army Selected Reserve has received less emphasis. In 1995, the Army had 31 dedicated physician recruiters. Physician recruiters, however, did not have a structured process for surveying the physician target groups to assist in identifying the effectiveness of their recruitment approaches and what incentives and experiences attract and retain physicians. Instead, physician recruiters learned on the job, networking with other medical recruiters, networking with medical schools and residency programs to develop their understanding of the physician target group, and identifying potential recruits.

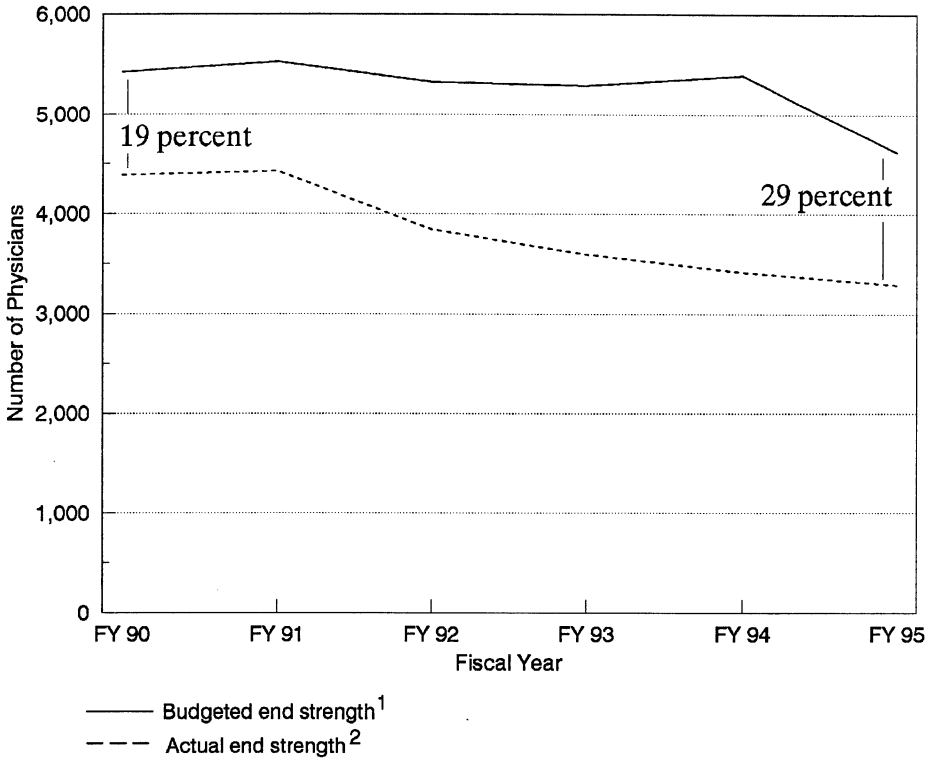
The recruiters had incentive programs to assist in attracting wartime critical specialties for non-prior service physicians. However, the recruiters did not have incentives for attracting physicians who were specialty qualified or in training for specialities not on the critical wartime specialty list, or for attracting prior service physicians. Physicians completing their active duty commitments have not been a significant source for recruiting physicians into the Selected Reserve. Physician recruiters did not have a structured process for surveying the active duty physician target groups to assist in identifying what incentives and experiences will attract and retain physicians in the Selected Reserve.

Air Force Survey Process. In contrast to the Army Selected Reserve's unstructured physician recruitment and retention survey process, the Air Force Reserve Recruiting regions developed profiles of physicians from survey data of physicians in the Air Force Reserve. Those profiles were shared with recruiters of other Air Force Recruiting regions. One profile was developed from a January 1996 survey of Reserve physicians already assigned to a Reserve unit. The survey asked how the physician learned of the Air Force Reserve, what the physician's most important reasons were for joining, which incentives were important in that decision, what could be done to recruit other physicians, what the physician enjoyed most about serving in the Reserve, and what could have been done to improve the satisfaction of physicians to cause them to continue service in the Air Force Reserve. Regionally collected data were augmented with tabulated data from all Air Force Reserve and Air National Guard physicians who were attending their Military Indoctrination for the Medical Service Officer Course. The Air Force Reserve Recruiting office used local recruiters as well as headquarters staff to collect the data during the indoctrination course. Questions were added to the survey to determine what improvements could be made to the recruitment and accession processing. The information was conveyed to all Air Force Reserve recruiters; and it was the impetus for reviewing and shortening the Air Force Reserve accession processing time from an average of 359 days to less than 199 days. Another example of data collection was the recruiter interview with active duty physicians before their release from active duty. Again, the data were tabulated and shared among recruiters. The Air Force Reserve also showed us surveys of physicians in the Active Forces. However, as with the Army Reserve, none of the Air Force Reserve surveys targeted physicians in the private sector who are not affiliated with the Reserve.

Staffing Levels

The effectiveness of the recruitment and retention programs are reflected in the actual end strength of the physicians in the Selected Reserve. We compared the Army and the Air Force budgeted and actual end strength for FY 1990 through FY 1995. The gap between the budgeted and actual end strength for the Army significantly increased while the Air Force had a significant decrease.

Army Selected Reserve Staffing Levels. The Army Selected Reserve had not been effective in meeting its physician manpower requirements. We considered a 90-percent fill rate to be an effective program because a unit with that percentage of fill qualifies for the highest personnel availability strength rating. As shown in Figure 1, the gap between the budgeted end strength and the actual end strength increased from 19 percent in FY 1990 to 29 percent in FY 1995. The increased gap occurred even though the budgeted end strength decreased by 15 percent.

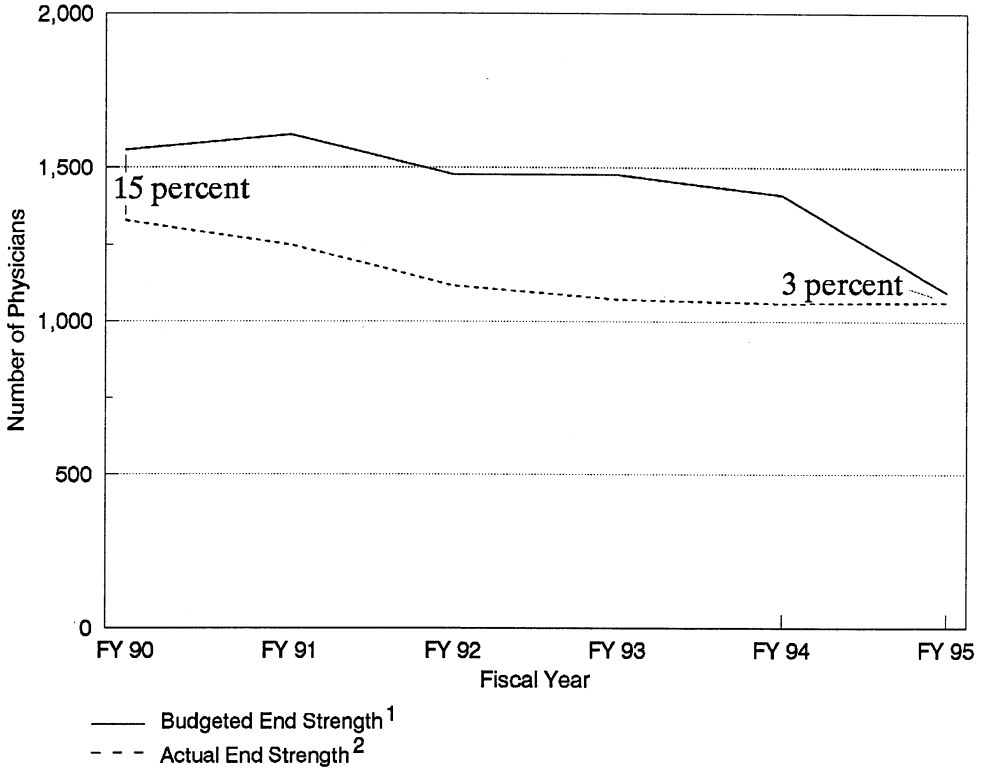


[1]Source: Defense Manpower Requirements Reports FYs 1990, 1991, 1993, 1995, and 1996.
[2]Source: Defense Manpower Data Center FYs 1990 through 1995.

Figure 1. Comparison of Physician Budgeted End Strength to Actual End Strength in the Army Selected Reserve

In FYs 1990 through 1995, the combined budgeted end strength for the two components of the Army Selected Reserve, representing medical support force requirements, decreased by 15 percent, from 5,421 physicians to 4,623 physicians. During the same period, the combined actual end strength, representing assigned physicians, decreased 25 percent, from 4,391 to 3,288 physicians. From FY 1993 through FY 1995, the Army Selected Reserve recruited fewer physicians each year than it lost, which resulted in a 9-percent drop in the actual end strength, and a physician fill of only 71 percent in FY 1995. Approximately two-thirds of the gap between the budgeted end strength and actual end strength is in the wartime skills listed as critically short in FY 1995.

Air Force Selected Reserve Staffing Levels. In contrast to the Army Selected Reserve, the Air Force Selected Reserve decreased its gap from 15 percent to 3 percent of budgeted end strength to actual end strength, as shown in Figure 2, resulting in a physician fill of 97 percent in FY 1995. The significant feature was the increased number of physician recruitments each successive fiscal year since FY 1992 to maintain a relatively consistent actual end strength.



[1]Source: Defense Manpower Requirements Reports FYs 1990, 1991, 1993, 1995, and 1996.
[2]Source: Defense Manpower Data Center FYs 1990 through 1995

Figure 2. Comparison of Physician Budgeted End Strength to Physician Actual End Strength in the Air Force Selected Reserve

Like the Army Selected Reserve, the Air Force Selected Reserve is composed of two components, the Air National Guard and the Air Force Reserve. From FY 1990 through FY 1995, the combined physician budgeted end strength for the two Air Force Reserve Selected Reserve components, representing medical support force requirements, decreased by 30 percent, from 1,557 physicians to 1,096 physicians. The combined actual end strength, representing assigned physicians, decreased during the same period by 20 percent, from 1,329 physicians to 1,063 physicians. The Air Force Selected Reserve recruited an increased number of physicians each year since FY 1992. The Air Force Selected Reserve recruited 128 physicians in FY 1992, 140 physicians in FY 1993, 152 physicians in FY 1994, and 170 physicians in FY 1995. The success of the Air Force recruitment and retention programs from FY 1993 through FY 1995 resulted in a leveling of the actual physician end strength.

We are not attributing the success of the Air Force physician recruitment and retention solely to the use of an effective survey, because an individual chooses a course of action for any number of reasons. However, a survey can be used effectively to identify needed changes in the work environment, such as additional readiness training or less administrative workload, and increased incentives.

Surveys of Physicians

Items for a Survey. We collected suggestions from 37 current and previous recruiters on their perceptions on what could improve recruitment and retention of physicians. Of the six most frequently recorded suggestions, four addressed changes to the current incentive programs and the pending business protection insurance program (see Appendix D).

Health Professional Loan Repayment Program. An increase in the entitlement of the Health Professional Loan Repayment Program for physicians from $3,000 to $7,500 per year could increase recruitment. The $3,000 per year payment has successfully recruited nurses into the Army Selected Reserve. However, the loan repayment incentive program has not attracted physicians in significant numbers. With medical school loan amounts exceeding $50,000, the annual repayment limit is insufficient to pay the interest on educational loans. A survey could determine the number of medical school students receiving financial assistance, the amount of financial assistance, and the potential that a higher amount would be a significant recruitment incentive.

Business Protection Insurance for the Reserve Components. An increase in the business protection insurance could increase recruitment and retention. In response to the 1995 RAND study, "Insuring Reservists Against Economic Losses: An Overview," Congress enacted business protection insurance for the Reserve components that addressed complaints of many reservists who were activated for Operations Desert Shield and Desert Storm and suffered income losses because of their Reserve commitment. The RAND study, reported that the overwhelming majority of reservists lost income as a result of mobilization. It further reported that the reservists expected their losses to be less than $50,000 per year and desired business protection insurance for amounts of $5,000 or less a month. The business protection insurance for the Reserve components is available at the rate of $1.00 per $100 of coverage per month for a maximum of $5,000 per month. For physicians, the $5,000 per month is not sufficient. According to the Medical Group Management Association, a family practice physician incurs monthly operational expenses of about $18,300. That includes about $8,000 for monthly salaries of support staff. When mobilized, the family practice physician's office revenues cease. The willingness of a

physician to risk business losses or to purchase protection insurance for an amount greater than $5,000 per month could be measured by a survey. With the survey results, an informed decision could be made on whether the protection is a significant feature for physician recruitment and retention and whether a higher ceiling for the insurance should be considered.

Summary

The Army Selected Reserve developed its understanding of the recruitment and retention market place through individual recruiter experience and through shared information from the other Reserve components. The major tools the Army Selected Reserve had to assist in its recruitment and retention mission were legislatively enacted incentive programs. It had no systematic, continuous process for identifying incentives that were most effective in attracting and retaining physicians. Having filled only 71 percent of its physician requirements in FY 1995, the Army Selected Reserve recruitment and retention program failed to meet its mission goals. A survey targeted at physicians in the Army Selected Reserve, Active Army, and private practice could provide information on the relative merits of existing and proposed recruitment and retention incentives.

Recommendation, Management Comments, and Audit Response

We recommend that the Deputy Chief of Staff for Personnel, Department of the Army, establish policy guidance for development and implementation of a systematic, ongoing process for surveying physicians in the Army Selected Reserve; Active Army; and private sector, regarding the value they attach to recruitment and retention incentives. The initial survey of physicians in private practice should include questions to measure the relative value of increasing the repayment amounts for the Health Professional Loan Repayment Program and the insurance protection amounts for the business protection insurance of the Reserve components.

Management Comments. The Army stated that using surveys as the key to fixing recruitment and retention problems has been disproved many times; and that recruitment and retention of Reserve physicians is not solely an Army problem, but a Tri-Service issue. The Army further stated that improving the recruitment and retention of medical personnel across all Services was being addressed by the DoD-level Medical Recruiting and Retention Working Group, established in 1991. It is a forum where survey findings are shared, required surveys are developed, and needed changes to the health profession program are developed.

The Army also stated it completed a major survey in May 1996, of Selected Army Reserve physicians. In conjunction with the survey, the Army set up an Army level working group to implement an integrated plan for recruiting and retaining medical personnel. The responsibilities of the group include conducting further surveys, as needed.

Audit Response. Army actions satisfy the intent of the recommendation and further comments are not needed.

Part II - Additional Information

Appendix A. Evaluation Process

Scope and Methodology

Assessment Parameters. We focused our assessment on the Army's implementation of the Selected Reserve physician recruitment and retention programs.

Locations Visited. To accomplish the evaluation objectives, we interviewed recruiters, Reserve unit members, and headquarters personnel in the recruitment and retention functions of the five Reserve components. Included among the interviewees were 37 current or former recruiters. A complete list of organizations visited or contacted is in Appendix E.

Data Sources. We obtained Selected Reserve authorization and assignment data for FY 1990 through FY 1995 from the Defense Manpower Data Center, Monterey, California, from the Office of the Assistant Secretary of Defense (Health Affairs), and from the Office of the Assistant Secretary of Defense (Reserve Affairs). Problems existed in some of the Health Personnel Manpower Data System statistics reported through the Defense Manpower Data Center. For example, the Naval Reserve listed 0 authorizations for physicians in FY 1994, whereas another data source, the Defense Manpower Requirements Report reported that the Naval Selected Reserve budgeted end strength for physicians in FY 1994 was 1,626. Numerical discrepancies were in the authorization data the Army Selected Reserve reported through the Defense Manpower Data Center and the budgeted end strength data of the Health Personnel Manpower System contained in the Department of Defense Manpower Requirements Reports for FYs 1990, 1991, 1993, 1995, and 1996. However, the number of assigned physicians reported by the Defense Manpower Data Center and the actual end strength reported in the Defense Manpower Requirements Reports were consistent. Given questionable aspects of some of the available data, we used the Military Departments' Reserve component physician budgeted end strength numbers as the Reserve components' requirement for physicians in the Selected Reserve on the last day of the specified fiscal year.

Additional deficiencies were in the Health Personnel Manpower Data System data relating to the number of physician gains, physician losses, recipients of the stipend program, and recipients of the loan repayment program. We used the annual reports from the Reserve Force Policy Board and data provided by the recruiting functions and incentive management offices of the Military Departments to fill in the data gaps.

Civilian Physician Data. The American Medical Association provided data on the number and specialities of physicians in the United States. The Group Management Association provided data on the operating expenses for a family practice physician operating as a small business.

Standard of Effectiveness. Our ultimate measure for effectiveness of the physician recruitment and retention efforts of the Army Selected Reserve was the fill percentage of personnel calculated by comparing actual physician end strength to budgeted physician end strength for the same fiscal year. We considered a fill of 90 percent or higher as effective. We selected 90 percent as the standard because a unit with at least a 90-percent fill of personnel qualifies for the highest personnel available strength rating (Army Regulation 220-1, "Unit Status Report," July 31, 1993). The evaluation also included a limited review of recruitment and retention practices in the Naval Reserve, Air Force Reserve, and Air National Guard in search of potential best practices.

Evaluation Period and Standards. The program evaluation was performed from August 1995 through May 1996 in accordance with Standards issued and implemented by the Inspector General, DoD.

Appendix B. Prior Audits and Other Reviews

General Accounting Office

General Accounting Office (GAO) Report No. HEHS-95-244 (OSD Case No. 1017), "Military Physicians: DOD's Medical School and Scholarship Program," September 29, 1995, concluded that the Uniformed Services University of the Health Sciences (USUHS) is a more costly way to educate and retain military physicians when considering DoD and total Federal costs. The GAO indicated that when costs are distributed over the expected years of military physicians' service, USUHS remains more costly when DoD costs are considered. When all Federal costs are considered, USUHS is almost equal to the cost of the Health Professions Scholarship Program and lower than the cost of the Deferred Scholarship Program. According to GAO, the difference is that the USUHS graduates are expected to have much longer military careers. Also USUHS receives much less non-DoD Federal support than civilian medical schools. The GAO also reported that USUHS provides a medical education comparable to that of any other U. S. medical school. Finally, GAO reported that, given the changes in operational scenarios and the DoD approach to delivering peacetime health care, new assessments of the military physician needs and the means to acquire and retain such physicians are in order. The GAO submitted matters for congressional consideration regarding the determination of wartime medical support requirements. The matters are part of an ongoing medical requirements determination process that Army medical personnel commonly refer to as the 733 study.

The GAO Report No. NSIAD 93-80 (OSD Case No. 9253), "Army Force Structure: Future Reserve Roles Shaped by New Strategy, Base Force Mandates, and Gulf War" December 15, 1992, concluded that to the extent that a reassessment of the Army wartime requirements permits the Army flexibility in adjusting its Active and Reserve mix, the Army could consider certain opportunities to expand or modify Reserve roles in its Total Force. Since the end of the Cold War, the Army has planned a future force smaller than any since just before the Korean War. Congress has approved the reductions in the Army Active forces, but has approved less than half of the proposed reductions in the Reserve force, believing that a greater reliance on Reserves is necessary. GAO recommended that the Army increase the role for Reserve support in the Army contingency force, determine whether the missions of forces inactivated from Europe could be shifted to the Reserves and evaluate the merits of restructuring one or more of the latest deploying National Guard combat divisions into smaller combat and additional support units. The Army has responded to the recommendations by restructuring the combat forces in the Army National Guard and increasing the participation of Army Reserve and Army National Guard units in operations.

GAO Report No. HRD-90-1 (OSD Case No. 7946-A), "Defense Health Care: Military Physicians Views on Military Medicine," March 22, 1990, concluded that the probability of physicians leaving the Services can be reduced most substantially by increasing salaries and by decreasing hours spent on non-physician tasks. Other factors, such as ability to maintain proficiency, unwanted changes of duty station and readiness training indicated a somewhat reduced effect on a physician's decision to leave the Service. In keeping with the GAO desire for impartiality, no recommendations were offered.

Inspector General, DoD

Inspector General, DoD, Report No. 93-INS-13, "Medical Mobilization Planning and Execution," September 30, 1993. One major finding of the report was that insufficient training affected the availability of DoD medical personnel during contingencies. The report recommended that the Assistant Secretary of Defense (Health Affairs), the Assistant Secretary of Defense (Reserve Affairs), and the Secretaries of the Military Departments ensure that medical personnel comply with requirements for officer basic training and field training, and that training requirements for medical sustainment and burn care be identified and funded. The Assistant Secretary of Defense (Health Affairs) essentially agreed with the recommendations and included the training requirements as important points in the medical strategic plan for the year 2001 and beyond.

Assistant Secretary of Defense (Health Affairs)

Logistics Management Institute, "The Selected Reserve Health Care Professionals Bonus Test," August 1993. The Assistant Secretary of Defense (Health Affairs) contracted with the Logistics Management Institute to study the effect of a bonus test program, initiated in August 1989, that offered a $10,000 annual bonus to physicians and nurses in wartime critical specialties for joining the Selected Reserve. The study concluded that the bonus offered to anesthesiologists, general surgeons, orthopedic surgeons, and nurse anesthetists attracted greater numbers of those professionals than expected. Additionally, a $6,000 bonus offered to operating room and other nurses attracted a very large number. The bonus test program involved bonuses of not more than $10,000 per year for a maximum of 3 years affiliation as a member of the Selected Reserve in one of the five Reserve components to which health care personnel were assigned. The study recommended that the bonus test program be converted to a regular incentive program and a determination made as to the numbers and types of critical-skill specialists needed for the Selected Reserve. The study also recommended a determination of whether bonuses were needed

as an additional recruiting tool based on the severity of need and whether a national Selected Reserve bonus policy was needed. Based on the recommendations and results of the study, Congress approved extending the incentive nationally for the 2-year period beginning FY 1996. The incentive is known as the Health Professional Bonus Program.

Appendix C. Recruitment Incentive Programs

Army Reserve recruiters rely on Selected Reserve recruitment incentive programs to help meet their recruitment goals.

Incentive Programs

A total of three incentive programs are available to the Reserve components for recruiting physicians possessing specific wartime specialty qualifications with critical shortages. To be eligible for the incentive, the individual's speciality must be on the list, and the particular Reserve component must have a shortage in that specialty. As shown in Table C, the specialty list was expanded in 1995 to include nonsurgical specialties.

Table C. Wartime Specialties With Critical Shortages

February 1990	March 1995
Anesthesiology	Anesthesiology
Surgery	Diagnostic Radiology
Cardiac/Thoracic	Primary Care
Colon/Rectal	Family Practice
General Surgery	Emergency Medicine
Neurosurgery	Internal Medicine
Orthopedic	Surgery
Pediatric	Cardiac/Thoracic
Peripheral/Vascular	Colon/Rectal
Plastic Surgery	General Surgery
	Neurosurgery
	Orthopedic
	Peripheral/Vascular
	Urology

Health Professional Loan Repayment Program. The Health Professional Loan Repayment Program provides up to $20,000 for repayment of educational loans for physicians possessing certain critical wartime specialties who are serving in the Selected Reserve. For each year of Selected Reserve service, the Reserve component will provide up to $3,000 to the loaning institution. Physicians in the Selected Reserve may serve in an Army Reserve Troop Program Unit or in the Individual Mobilization Augmentee Program.

The Army Reserve and Army National Guard do not have ready access to data that isolate the number of physicians from other health professionals enrolled in the Health Professional Loan Repayment Program. Instead, both rely on records of the number and amount of payments made under the program to track program activity. For example, in FY 1995, the Army Reserve provided 1,459 payments totaling $2.8 million for all health professionals in the loan repayment program.

Health Professional Stipend Program. The Health Professional Stipend Program, also known as the Specialized Training Assistance Program, pays a stipend (approximately $865 per month) to physicians enrolled in an accredited residency training program. Participation in the program requires a 2-year obligation in the Army Selected Reserve for each year of financial assistance. The Army National Guard uses the stipend program to attract residents for service obligation and refrains from mobilizing physicians in residency training. The Army Reserve encourages the stipend recipients to join the Individual Ready Reserve instead of the Selected Reserve while in residency training to avoid possible activation during Presidential Selected Reserve Call-ups. The service obligation of stipend recipients in the Army Selected Reserve commences following residency training. The Health Professional Stipend Program was responsible for providing more physicians in critical wartime specialities to the Army Selected Reserve than any other incentive program. It has been a significant source for anesthesiologists and general surgeons for the Army Reserve. Since 1988, the program has enrolled 374 anesthesiology residents and 427 general surgery residents.

Health Professional Bonus Program. The Health Professional Bonus Program provides a recruitment bonus up to $30,000 to nonprior service physicians who are board certified or board eligible and join the Army Selected Reserve. The bonus is paid in three annual lump-sum increments of $10,000. The Army National Guard had only four participants in this incentive program, with the last enrollment in FY 1991. The Army Reserve has had more success in enrolling physicians with critical wartime specialties. Because the bonus is limited to 3 years, it is a short-term solution.

Appendix D. Results of Interviews

Based on interviews with 37 various current and previous recruiters and personnel responsible for managing the Military Departments' physician recruitment program, several recurring suggestions were proposed to improve the recruitment and retention of physicians. The six most frequently recorded suggestions listed in descending order, from most frequent to least frequent were:

o fund physician attendance at one continuing health education conference annually,

o increase the repayment amounts for physicians in the Health Professional Loan Repayment Program,

o credit annual training periods while in the Health Professional Scholarship Program toward qualifying years for Reserve retirement,

o survey physicians to determine the factors of importance to them,

o increase the amount of coverage available in the business protection insurance, and

o continue funding of the Health Professional Stipend Program.

Most of the suggestions entail a resource expense without a supportable expectation that the change would result in additional physician recruitments or extended physician retention. However, a survey could document the physicians' perceived value of existing and proposed incentives.

Appendix E. Organizations Visited or Contacted

Office of the Secretary of Defense

Deputy Director Reserve Affairs, Deputy Assistant Secretary of Defense (Health Services Operations and Readiness), Office of the Assistant Secretary of Defense (Health Affairs), Washington, DC
Accessions Policy Directorate, Deputy Assistant Secretary of Defense (Military Personnel Policy), Office of the Assistant Secretary of Defense (Force Management Policy), Washington, DC
Assistant Secretary of Defense (Reserve Affairs), Washington, DC
- Personnel Policy, Deputy Assistant Secretary of Defense (Manpower and Personnel), Office of the Assistant Secretary of Defense (Reserve Affairs), Washington, DC
- Reserve Medical Readiness Directorate, Deputy Assistant Secretary of Defense (Manpower and Personnel), Office of the Assistant Secretary of Defense (Reserve Affairs), Washington, DC

Department of the Army

Office of the Chief of the Army Reserve, Rosslyn, VA
- Medical Affairs, Office of the Chief of the Army Reserve, Washington, DC
- Personnel Management Division, Office of the Chief of the Army Reserve, Washington, DC

Headquarters, Army Medical Command, Fort Sam Houston, TX
- Army National Guard Advisor, Directorate of Operations, Army Medical Command, Fort Sam Houston, TX
- Army Reserve Advisor, Directorate of Operations, Army Medical Command, Fort Sam Houston, TX
- Center for Health Care Education Studies, Army Medical Department Center and School, Fort Sam Houston, TX
- Deputy Chief of Staff for Readiness and Force Integration, Great Plains Health Service Support Area, Fort Sam Houston, TX
- Program, Analysis and Evaluation Directorate, Army Medical Command, Fort Sam Houston, TX
- Personnel Operations Branch, Deputy Chief of Staff Personnel, Army Medical Command, Fort Sam Houston, TX
- Quality Assurance Division, Directorate of Clinical Operations, Army Medical Command, Fort Sam Houston, TX

Department of the Army (cont'd)

Headquarters, Army Recruiting Command, Fort Knox, KY
- Health Services Directorate, Army Recruiting Command, Fort Knox, KY
- Program, Analysis and Evaluation Directorate, Army Recruiting Command, Fort Knox, KY
- Marketing Research Division, Program, Analysis and Evaluation Directorate, Army Recruiting Command, Fort Knox, KY
- United States Army Reserve Medical Detachment, 1st Brigade, Army Recruiting Command, Fort Meade, MD
- United States Army Reserve Medical Detachment, 3rd Brigade, Army Recruiting Command, Fort Knox, KY
- United States Army Reserve Medical Detachment, 6th Brigade, Army Recruiting Command, Aurora, CO

Headquarters, Army Reserve Command, Atlanta, GA
- Documentation Section, Manpower Division, Army Reserve Command, Atlanta, GA
- Office of the Surgeon, Headquarters, Army Reserve Command, Atlanta, GA
- Personnel Management Branch, National Army Medical Department Augmentation Detachment, Atlanta, GA
- Quality Improvement Branch, National Army Medical Department Augmentation Detachment, Atlanta, GA
- 2290th Reserve Army Medical Hospital, Rockville, MD
- 5502nd Army Medical Hospital, Fitzsimons, CO

Office of the Surgeon General, Department of the Army, Falls Church, VA
- Reserve Personnel Policy Advisor, Directorate of Personnel, Office of the Surgeon General, Falls Church, VA
- Mobilization and Reserve Affairs, Directorate of Operations, Office of the Surgeon General, Falls Church, VA

Headquarters, Department of the Army, Deputy Chief of Staff for Personnel, Washington, DC
- Analysis and Strength Management Branch, Officer Division, Directorate of Military Personnel Management, Deputy Chief of Staff for Personnel, Headquarters, Department of the Army, Washington, DC
- Reserve Component Accessions, Officer Division, Deputy Chief of Staff for Personnel, Headquarters, Department of the Army, Washington, DC

Specialized Training Assistant Program Management Office, Army Reserve Personnel Center, St. Louis, MO

Medical Recruiting and Retention Branch, Recruiting and Retention Division, Personnel Directorate, Army National Guard Readiness Center, Arlington, VA

Department of the Navy

Manpower Directorate, U.S. Navy Reserve Force, Naval Support Activity, New Orleans, LA
Personnel Strength, Plans and Community Management Branch, U.S. Navy Reserve Force, Naval Support Activity, New Orleans, LA

Department of the Air Force

Headquarters, Air Force Reserve Personnel Center, Denver, CO
- Health Services Individual Reserve Programs Directorate, Air Force Reserve Personnel Center, Denver, CO
- Recruiting Liaison/Health Professions Recruiting Branch, Air Force Reserve Personnel Center, Denver, CO

Headquarters, Air Force Reserve, Office of the Command Surgeon, Washington, DC
Health Professions Recruiting Division, Air Force Reserve Command, Robins Air Force Base, GA
Medical Readiness Evaluations, Directorate of Medical Services, Office of the Air Surgeon, Air National Guard Readiness Center, Andrews Air Force Base, MD
Officer Accessions, Directorate of Manpower and Personnel, Air National Guard Readiness Center, Andrews Air Force Base, MD
Recruiting Accessions and Force Analysis Branch, Office of the Air Force Reserve, Washington, DC
Surgery Clinic, Wilford Hall Medical Center, Lackland Air Force Base, TX

Appendix F. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense for Acquisition and Technology
  Deputy Under Secretary of Defense (Logistics)
  Director, Defense Logistics Studies Information Exchange
Under Secretary of Defense (Comptroller)
  Deputy Chief Financial Officer
  Deputy Comptroller (Program/Budget)
  Director, Program Analysis and Evaluation
Under Secretary of Defense for Personnel and Readiness
  Deputy Under Secretary of Defense (Readiness)
Assistant Secretary of Defense (Command, Control, Communications and Intelligence)
Assistant Secretary of Defense (Health Affairs)
Assistant Secretary of Defense (Reserve Affairs)
Assistant to the Secretary of Defense (Public Affairs)

Joint Staff

Director, Joint Staff
Director for Operations, Joint Staff
Inspector General, Joint Staff

Department of the Army

Deputy Chief of Staff for Operations and Plans
Deputy Chief of Staff for Personnel
Auditor General, Department of the Army
Inspector General, Department of the Army
Surgeon General of the Army
Chief, Army Reserve
Surgeon, Army Reserve Command
Commander, Army Recruiting Command
Chief, National Guard Bureau
Surgeon, Army National Guard Bureau

Department of the Navy

Deputy Chief of Naval Operations (Plans, Policy, and Operations)
Assistant Secretary of the Navy (Financial Management and Comptroller)
Auditor General, Department of the Navy
Inspector General, Department of the Navy
Surgeon General of the Navy
Commander, Naval Reserve Force Command

Department of the Air Force

Assistant Secretary of the Air Force (Financial Management and Comptroller)
Deputy Chief of Staff for Plans and Operations
Auditor General, Department of the Air Force
Inspector General, Department of the Air Force
Surgeon General of the Air Force
Surgeon, Air Force Reserve
Commander, Air Force Reserve Personnel Center
Surgeon, Air National Guard Bureau

Other Defense Organizations

Director, Defense Contract Auditing Agency
Director, Defense Information Systems Agency
  Inspector General, Defense Information Systems Agency
Director, Defense Logistics Agency
Director, National Security Agency
  Inspector General, National Security Agency
Inspector General, Defense Intelligence Agency

Non-Defense Federal Organizations and Individuals

Office of Management and Budget
General Accounting Office
  National Security and International Affairs Division
    Technical Information Center
  Health, Education, and Human Services

Non-Defense Federal Organizations and Individuals (cont'd)

Chairman and ranking minority member for each of the following congressional committees and subcommittees:

Senate Committee on Appropriations
Senate Subcommittee on Defense, Committee on Appropriations
Senate Committee on Armed Services
Senate Committee on Governmental Affairs
House Committee on Appropriations
House Subcommittee on National Security, Committee on Appropriations
House Committee on Government Reform and Oversight
House Committee on National Security, International Affairs, and Criminal Justice, Committee on Government Reform and Oversight
House Committee on National Security

Part III - Management Comments

Department of the Army Comments

DAPE-MPA (SAAG-PMF-E/17 Sep 96) (36-2b) 1st End LTC Youngquist
DSN 225-3037
SUBJECT: Evaluation Report on Physician Recruitment and Retention in the Army Selected Reserve (Project No. 6LH-9010)

HQDA (DAPE-MPA), Washington, DC 20310-0300

10 OCT 1996

THRU ~~Director of the Army Staff~~ KIM LINDAHL, MAJ, GS, ADECC 15/10
~~Assistant Secretary of the Army (M&RA)~~ 11/21/96

FOR Inspector General, Department of Defense, ATTN: Logistics Support Directorate, 400 Army Navy Drive, Arlington, VA 22202-2884

1. The DOD study presents some interesting findings. Major emphasis is placed on the role of surveys. Page 9 provides a disclaimer, "We are not attributing the success of the Air Force physician reenlistment and retention to the use of an effective survey, because an individual chooses a course of action for any number of reasons." Yet, the final and single recommendation is that the Army establish an ongoing process for surveying physicians in the Army Selected Reserve, Active Army, and private sector. The logic espoused in the study is that the Air Force Selected Reserve medical officer assigned against authorized percentage is higher than the Army Selected Reserve due to surveys.

2. To say that surveys are the key to fixing recruiting and retention problems is logic many times disproved. As one example, for several years, the U.S. Army Reserve (USAR) has conducted survey after survey of personnel who are both currently assigned to the USAR and those who have left to ascertain why people attrit. Yet for the last eight years, the attrition has remained in the 30% to 35% range. If surveys were the answer, attrition would be fixed.

3. Recruiting and retention of doctors is not only an Army issue but, more broadly, a Tri-Service issue. Since 1991, a DOD level Medical Recruiting/Retention Working Group (MEDWG) has been operational. This group has representatives from each service, both Active and Reserve. Their purpose and focus is to improve recruiting and retention of medical personnel across all services. A key part of this is sharing results, both successes and failures, with sister services. This includes any surveys. One example of their accomplishments is submitting a change, enacted by Congress in FY97, which increases the Health Professionals Loan Repayment Program (HPLRP) repayment amount from $3,000 (per year) and $20,000 (total) to $7,500 and $50,000 respectively. The MEDWG collectively found $3,000 per year was not effective in enticing physicians, nurses, dentists, and physician assistants in the critical skills short within the Reserve components.

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SUBJECT. Evaluation Report on Physician Recruitment and Retention in the Army Selected Reserve (Project No. 6LH-9010)

4. In May 1996, the USAR completed a major survey of 835 Selected Reserve physicians. The actual survey was done by AmerInd, a civilian contractor. In conjunction with this survey, the Chief, Army Reserve directed the organization of a working group within the USAR to implement an integrated plan for recruiting and retaining medical personnel. This is similar to the DOD level MEDWG. Responsibilities include conducting any further surveys as needed.

5. An issue not addressed in the DOD survey is the fact that generally, reasons for the recruiting shortfalls and high attrition are well known. These reasons were restated again by those 835 doctors who participated in the USAR survey:

- The Reserve Components cannot compete with the civilian sector in dollars.
- In many cases, mobilization equals loss of private practice.
- The average RC physician loses income when attending drills and annual training.
- Medical doctors, for the most part, are willing to mobilize for a national emergency but not for "active duty conveniences," "political expediency," or "peacekeeping" missions.
- Over 80% cannot be mobilized over 90 days without serious impact on their practice.
- Over 80% echo the need for an income insurance plan for protection during periods of mobilization (effective 1 Oct 96). However, it is also well know that the current $5,000 limit is not sufficient for a majority of medical doctors.
- A majority of doctors attrit due to either the financial impact of mobilization or potential for mobilization. As one doctor succinctly stated, "Our needs and responsibilities to our community are unique. When we are gone, we can't tell people not to get sick until we get back."
- The USAR must compete with other programs for medical officers such as the National Health Service Corp (national program) or, as an example at state level, the Wisconsin Physician Loan Assistance Program.

6. Medical recruiting and retention is a DOD-wide issue, both Active and Reserve. The focus should be looking at solutions to problems from the Tri-Service level. The OSD-level MEDWG has and continues to meet regularly to address medical recruiting and retention issues. It is a forum where survey findings can be shared, required surveys can be developed, and needed changes to the Health Professionals Recruitment Bonus Program, Health Professional Stipend Program, and HPLRP can be articulated and passed

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to Congress for approval. Working groups at the various service component level, like the one recently formed by the USAR, are helpful. However, issues/suggestions/solutions should be brought to the Tri-Service level to benefit all services.

7. The HQDA point of contact is LTC Youngquist, DSN 225-3037.

FOR THE DEPUTY CHIEF OF STAFF FOR PERSONNEL:

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CF:
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OCAR, ATTN: DAAR-MA (LTC LaFantasie)
NGB, ATTN: ARP-H (LTC Redd)
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