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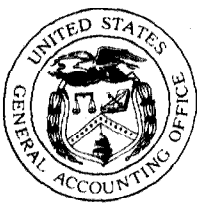
Briefing Report to the Chairman
Committee on Armed Services
House of Representatives

February 1986

DOD HEALTH CARE

Comments on a Defense Department Report on Military Podiatrists



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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

February 28, 1986

B-222161

The Honorable Les Aspin
Chairman, Committee on Armed Services
House of Representatives

Dear Mr. Chairman:

In response to a House Report 99-81 requirement, as modified in discussions with your office, we have reviewed the Department of Defense's (DOD's) December 31, 1985, report on nonphysician providers, specifically podiatrists. Our comments are summarized below and detailed in the enclosed briefing report.

In developing our comments, we attended meetings of the DOD Ad Hoc Task Force on Nonphysician Provider Requirements, which developed the December 31 report. We also interviewed active duty military doctors of podiatric medicine who serve or previously served as podiatry consultants to the Army, Navy, and Air Force Surgeons General. We discussed podiatric care issues with representatives of the American Podiatric Medical Association. We also examined selected DOD data regarding podiatry activities.

DOD's report contains information on all the areas specified in House Report 99-81. This includes information on the methods used to generate requirements for nonphysician providers in general and podiatrists specifically and the potential impact of additional authorizations for podiatrists on (1) the workload of military orthopedic surgeons and (2) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and other contract care costs.

We have three principal concerns about DOD's December 1985 report.

1. DOD's discussion of podiatrist requirements and authorizations does not distinguish between peacetime and wartime requirements and contains a conclusion that appears to be inconsistent with data previously provided by the Surgeons General regarding wartime orthopedic surgeon requirements.

2. The report's discussion of the portion of the orthopedic surgeon workload that can be assumed by podiatrists is not supported by data in the report.

3. CHAMPUS expenditures for calendar year 1984 care provided by podiatrists were significantly higher than the DOD report's estimate of CHAMPUS costs for podiatric care.

As requested by your office, we did not obtain official DOD comments on our briefing report, but we discussed its contents with officials in the Office of the Assistant Secretary of Defense (Health Affairs) who prepared the DOD report. Their comments were considered in preparing this document.

Also, as arranged with your office, unless its contents are announced earlier, we plan no further distribution of the briefing report until 10 days from its issue date. At that time, we will send copies to the Secretary of Defense and other interested parties and make copies available to others upon request.

Should you need additional information on the contents of this document, please call me on 275-6207.

Sincerely yours,

David P. Baine

David P. Baine
Associate Director

COMMENTS ON A DEFENSE DEPARTMENT REPORT ON MILITARY PODIATRISTS

INTRODUCTION

In response to a requirement in House Report 99-81 and later discussions with the office of the Chairman, House Committee on Armed Services, we have reviewed the Department of Defense (DOD) report on the (1) determination of requirements for nonphysician providers, specifically podiatrists, and (2) potential effects of additional authorizations for podiatrists on orthopedic surgeon workload and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) costs. This briefing report contains our comments on DOD's report.

DOD classifies doctors of podiatric medicine (podiatrists) as nonphysician health care providers. Podiatrists are licensed by state regulatory bodies to independently assess, diagnose, and treat, through medical and surgical means, diseases and disorders of the foot and to perform surgery to correct deformity and disability.

House Report 99-81 directed DOD to prepare a report

> ". . . delineating the process by which the requirements for non-physician providers in general, and podiatrists specifically were generated. The report should further discuss how additional authorizations for podiatrists could be used directly to reduce CHAMPUS and other contract care costs and indirectly to free up orthopedic surgeons from foot care in order to permit better utilization of scarce orthopedic resources."

DOD established an Ad Hoc Task Force on Nonphysician Provider Requirements to develop the required report, which was issued on December 31, 1985.

Objectives, Scope, and Methodology

The House report directed that we conduct a concurrent review of these issues. As a result of discussions with the office of the Chairman, House Committee on Armed Services, our review objectives were to be limited to (1) monitoring the activities of the DOD Task Force and (2) reviewing and commenting on DOD's report.

To monitor the Task Force activities, we met with the Principal Director, Medical Readiness, Office of the Assistant Secretary of Defense (Health Affairs), who was tasked by DOD to respond to the directive. We attended meetings of the Task Force between September and November 1985, except its initial meeting on September 12. We reviewed copies of documents and reports submitted to the Task Force by the military services, DOD's Office of CHAMPUS, and the American Podiatric Medical Association. We also reviewed working drafts of the Task Force's report.

In developing our comments on DOD's report, we reviewed the report and three previous DOD reports on nonphysician providers prepared since 1982. We interviewed the three active duty military doctors of podiatric medicine who currently serve as the podiatry consultants to the Army, Navy, and Air Force Surgeons General. We also interviewed the former podiatry consultant to the Army Surgeon General (1981-85), who is currently Chief, Podiatry Clinic, Evans Army Community Hospital, Fort Carson, Colorado, to obtain information he had developed on military podiatrists. We discussed with all four podiatry consultants the issues cited by House Report 99-81 and additional issues addressed by previous DOD reports.

We discussed orthopedic surgeon and podiatrist staffing issues with the Orthopedic Consultant to the Air Force Surgeon General and the Chief of Orthopedics at the Bethesda Naval Hospital. We also analyzed the latest available DOD Health Manpower Statistics (fiscal year 1984) and reviewed unclassified data on health manpower requirements and shortages submitted by the service Surgeons General to the Senate Committee on Armed Services in September 1985. We examined the Army's most recent study (Manpower Requirements Criteria for Podiatric Medicine) and reviewed the December 30, 1985, House Committee on Armed Services staff report on wartime medical readiness, which, among other things, discussed wartime physician shortages. We also discussed podiatry and orthopedic issues with the Washington representative of the American Academy of Orthopaedic Surgeons and officials of the American Podiatric Medical Association.

In reviewing DOD's discussion of potential CHAMPUS cost reductions, we examined the Task Force methodology used to derive its estimates of CHAMPUS podiatric care expenditures. We also contacted CHAMPUS officials about the accuracy of selected statements in DOD's report regarding availability of CHAMPUS data on government expenditures for services provided by podiatrists.

COMMENTS ON DEPARTMENT OF DEFENSE REPORT

We have three principal concerns about DOD's December 1985 report:

1. DOD's discussion of podiatrist requirements and authorizations does not distinguish between peacetime and wartime requirements and contains a conclusion that appears to be inconsistent with data previously provided by the Surgeons General regarding wartime orthopedic surgeon requirements.

2. The report's discussion of the potential reduction in orthopedic surgeon workload that can be assumed by podiatrists is not supported by data in the report.

3. CHAMPUS expenditures for calendar year 1984 care provided by podiatrists were significantly higher than the DOD report's estimate of these costs.

Podiatrist requirements and authorizations

The Assistant Secretary of Defense (Health Affairs) stated in his letter transmitting the report that the present authorizations for podiatrists are adequate to meet the services' needs. DOD's report stated that there were 99 authorized positions for military podiatrists and 89 assigned podiatrists (see App. I, p. 12) and that the long- and short-term costs of any increases in the number of podiatrists could be expected to exceed any savings resulting from orthopedic workload reductions. The report further stated that the amount of supplemental orthopedic workload that can be assumed by podiatrists is proportional to the number of orthopedists assigned.

DOD's report did not discuss the requirements for podiatrists on which its authorizations were based. The latest published DOD Health Manpower Statistics (fiscal year 1984) cited a DOD requirement for 141 podiatrists, a budget authorization for 97, and an on-board strength of 88 as of the end of fiscal year 1984. This represented a shortfall between requirements and on-board strength of about 37 percent. DOD's statistics also indicate that although the gap between authorizations for podiatrists and the estimated number of podiatrists on board would gradually narrow between fiscal years 1986 and 1990, the number of podiatrists on board would continue to be less than the authorizations for each fiscal year.

It is not clear from DOD's report whether its conclusion regarding the adequacy of present podiatrist authorizations is based on wartime or peacetime needs. If the authorizations are based on wartime needs, there appears to be an inconsistency between (1) DOD's December 1985 report and (2) material submitted by the Surgeons General to the Senate Committee on Armed Services in September 1985 regarding potential orthopedic surgeon wartime shortages.

The data on wartime physician shortages for fiscal year 1986 submitted to the Senate Committee indicated that the Army, Navy, and Air Force had only 41 percent, 25 percent, and 35 percent, respectively, of the orthopedic surgeons needed during peak mobilization--a shortage of over 1,360 such physicians. In view of these data, the DOD report statement about a proportional relationship appears to be inconsistent with the report conclusion that the number of podiatrist authorizations is also adequate to meet service needs.

In discussing matters contained in this report, the officials responsible for developing DOD's report acknowledged this inconsistency and stated that they were not certain as to whether the 99 podiatrist authorizations for fiscal year 1986 were based on peacetime or wartime requirements. They also said the statement in DOD's report that a proportional relationship exists between the number of orthopedic surgeons and associated workload assumable by podiatrists was based on their observation of peacetime conditions, rather than on any quantitative analysis. They also stated they had no data to indicate whether the proportional relationship would also exist during wartime.

Potential reduction in orthopedic surgeon workload

House Report 99-81 directed DOD to assess the extent of substitution potential for podiatrists to assume a portion of orthopedic surgeon workload and to discuss in its report how additional authorizations for podiatrists could be used indirectly to free up orthopedic surgeons from foot care in order to permit better utilization of scarce orthopedic resources.

DOD's report stated that if the number of podiatrists was to be increased, any relief in workload would be felt by providers of podiatric care other than orthopedists (such as general or family practice physicians, physician assistants, nurse practitioners, nurses, medical corpsmen, and other enlisted or civilian technicians), and that increased numbers of podiatrists would have only a small effect on DOD orthopedic workload. The report also stated that "the amount of supplemental orthopedic workload that can be assumed by the podiatrist is well stated," but does not present evidence to support this statement. DOD's report contains no data to indicate (1) the extent to which orthopedists or other providers deliver care that is generally accepted as within the scope of podiatric medicine or (2) whether military podiatrists perform inpatient and outpatient surgery.

Information we obtained from the services' medical departments and podiatry consultants indicates that military podiatrists can perform foot surgery both independently on an outpatient basis and on an inpatient basis under the supervision

of orthopedic surgeons. Data developed during the Army's most recent Manpower Requirements Criteria for Podiatric Medicine study included surgical procedures that could be performed by both podiatrists and orthopedic as well as other surgeons. Also, an October 1985 Air Force fact sheet states that Air Force podiatrists can practice the full scope of military podiatric medicine, including podiatric orthopedics and surgery. The Air Force also stated that in wartime, podiatrists will perform surgical tasks and could be designated as first surgical assistants to orthopedic surgeons. The podiatry consultants to all three Surgeons General cited several examples of the types of surgery actually performed by military podiatrists.

The military podiatrists with whom we discussed this matter told us that residency-trained, surgically experienced podiatrists could assume a portion of the orthopedic workload related to foot care in both peacetime and wartime. Military orthopedic surgeons we contacted agreed, but said that such use should have only a small effect on their workload because only a small percentage of their workload involves foot surgery.

The issue concerning the extent to which podiatrists in the Armed Services can be further used to relieve orthopedic surgeon workload remains unresolved and is, in our opinion, a medical practice question that ultimately must be answered by the services' medical departments.

Potential reduction of CHAMPUS costs

House Report 99-81 stated that more comprehensive utilization of podiatrists should reduce the costs of providing care to the current beneficiary population from outside sources through CHAMPUS or other care contracted for by DOD. The Committee directed DOD's report to discuss how additional authorizations for podiatrists could be used directly to reduce CHAMPUS and other contract care costs.

DOD's report stated that it was not possible to retrieve sufficient data to determine the amount of CHAMPUS funds disbursed to podiatrists, or to other providers of podiatric medical care, without significant new (CHAMPUS) computer programs and requirements for additional information from CHAMPUS providers.

The DOD Task Force extrapolated 1984 CHAMPUS outpatient diagnostic code data to estimate about $4.26 million in government payments for all foot and ankle conditions. DOD then estimated that $1.42 million was paid under CHAMPUS during calendar year 1984 for treating those conditions most commonly treated by a podiatrist. The report also said that the bulk of these expenditures would have been paid to emergency rooms, clinics, and providers other than podiatrists.

DOD concluded that it is likely that the addition of more podiatrists would result in a minimal decrease in CHAMPUS expenditures because (1) active duty personnel (who are not eligible for CHAMPUS benefits) would have first claim on additional military podiatric services; (2) CHAMPUS eligible beneficiaries are not required to use military treatment facility services and do not need approval from a military treatment facility to obtain CHAMPUS eligible outpatient services, such as podiatric care; and (3) routine foot care is not an authorized CHAMPUS benefit.

Contrary to DOD's statement in its report regarding the nonavailability of data concerning CHAMPUS expenditures by type of private sector provider, the Office of CHAMPUS does have such data readily available in its data base. CHAMPUS officials provided this data to us. For calendar year 1984, billings to CHAMPUS by solo-practice podiatrists totaled about $6.35 million. Government expenditures related to those billings amounted to about $3.07 million. (CHAMPUS beneficiaries and/or their private insurers paid the remaining $3.28 million in accordance with CHAMPUS payment regulations.) CHAMPUS officials also provided us comparable data for fiscal year 1985, which they estimated to be about 90 percent complete as of February 1986. These data show that billings to CHAMPUS by solo-practice podiatrists amounted to about $7.18 million, of which about $3.57 million was estimated to be government expenditures to those providers. The estimates of government expenditures to solo-practice podiatrists do not include CHAMPUS payments to podiatric group practice organizations or to multispecialty groups that may include podiatrists.

The officials responsible for developing DOD's report told us that, in their opinion, despite the $3.07 and $3.57 million government costs cited above, the amount of CHAMPUS workload and associated government expenditures in any specific geographic area served by a military treatment facility may not warrant additional podiatrist authorizations at that facility. However, they offered no data to support their opinion. They said that an analysis of CHAMPUS podiatric workload and associated government expenditures on a geographic specific basis would be needed to determine the amount of CHAMPUS cost reduction that might be achieved by assigning additional military podiatrists.

DOD'S DECEMBER 31, 1985, REPORT ON NONPHYSICIAN PROVIDERS

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

31 DEC 1985

Honorable Les Aspin
Chairman
Committee on Armed Services
House of Representatives
Washington, D.C. 20510

Dear Mr. Chairman:

This is in response to the Committee on Armed Services report on the 1986 Defense Authorization Act that requires the Department of Defense to report on the generation of requirements for non-physician providers and the effect of additional authorizations.

Enclosed is the report which delineates the process by which the requirements for non-physician providers, specifically podiatrists, are generated. The report further discusses how new additional authorizations for podiatrists would affect CHAMPUS and other contract care costs as well as the orthopedic resource workload. Based on the evaluation of the report, we feel the present authorizations were properly developed and are adequate to meet the needs of the Services.

Non-physician providers are an essential part of our military medical establishment and the podiatrist is an integral member of that team.

Sincerely,

Bud Mayer

William Mayer, M.D.

Enclosure

APPENDIX I

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

31 DEC 1985

Honorable Barry Goldwater
Chairman
Committee on Armed Services
U. S. Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This is in response to the Committee on Armed Services report on the 1986 Defense Authorization Act that requires the Department of Defense to report on the generation of requirements for non-physician providers and the effect of additional authorizations.

Enclosed is the report which delineates the process by which the requirements for non-physician providers, specifically podiatrists, are generated. The report further discusses how new additional authorizations for podiatrists would affect CHAMPUS and other contract care costs as well as the orthopedic resource workload. Based on the evaluation of the report, we feel the present authorizations were properly developed and are adequate to meet the needs of the Services.

Non-physician providers are an essential part of our military medical establishment and the podiatrist is an integral member of that team.

Sincerely,

Bud Mayer

William Mayer, M.D.

Enclosure

APPENDIX I

Generation of Requirements for Non-Physician Providers (Including Podiatrists)

The House Armed Services Committee included language in its report on the FY 1986 Defense Authorization Bill (Report No. 99-81) as follows:

> "The Committee, therefore, directs the department to prepare a follow-on report delineating the process by which the requirements for non-physician providers in general, and podiatrists specifically, were generated. The report should further discuss how additional authorizations for podiatrists could be used directly to reduce CHAMPUS and other contract care costs and indirectly to free up orthopedic surgeons from foot care, in order to permit better utilization of scarce orthopedic resources."

A DoD Task Force was established for the purpose of developing this report. The Task Force consisted of representatives from each Service.

The report which follows is organized into three sections: (1) a narrative description of the requirements generation process for each Service, (2) discussion of effects of additional podiatry authorizations, and, (3) an evaluation.

The Requirements Generation Process for Each Service

Each of the services develops its requirements for non-physician providers in a different manner, although all are based on the application of a formula or model to known factors.

Although somewhat different techniques for determining requirements are used, the proportion of the various skills to the size of the medical system of each armed service are similar.

The Army derives its requirements for podiatrists (and all other personnel requirements) by determining the medical force structure necessary to support approved Army missions; this structure is staffed as determined by various force structuring models and published in the Table of Organization and Equipment (TO&E) and the Table of Distribution and Allowances (TDA). While this technique is used to establish initial requirements in support of the Army committed to combat, peacetime requirements are based on a minimum active duty readiness baseline modified by periodic on-site manpower surveys of active treatment facilities. The later technique establishes the level of personnel needed to support the day-to-day health care delivery mission.

The Navy develops requirements from a series of planning models, staffing standards, platform requirements and manning documents for its various elements and activities. The basic model is the Medical Planning Model (MPM) formula of the Joint Operational Planning System. This formula takes forces at risk times casualty rates to give the number of beds required to treat anticipated casualties. The bed determination is then processed through a series of data interpretations to provide the numerical requirement for physicians. Once the number of beds and physicians to be supported are identified, ancillary support manpower resource requirements are developed. Podiatrists are considered ancillary support manpower resources for the purposes of these calculations. Recognized staffing standards and platform requirements are applied to the bed and physician requirements determined by use of the planning models and requirements by skill of ancillary personnel are derived. These procedures, as well as the staffing standards and other guides are periodically reviewed to ensure they remain accurate and appropriately reflect anticipated requirements.

The Air Force determines its requirements for nurse practitioners, optometrists, physician assistants, podiatrists, psychologists, social workers, occupational therapists and physical therapists by use of applications of the Provider Requirements Integrated Specialty Model (PRISM). PRISM is an interactive decision support system used to plan health care provider requirements for each of the Air Force treatment facilities throughout the world. PRISM is a tool to determine facility specific peacetime health care manpower requirements for beneficiaries expected to use Air Force facilities and the facility specific quantity and mix of medical care providers (both physicians and non-physicians) necessary to satisfy peacetime requirements. PRISM II utilizes output from the Medical Planning Model of the Joint Operational Planning System as a requirement for generating data for wartime manpower needs. PRISM is computer based and utilizes a computer modeling process to develop medical manpower requirements.

Podiatry Strengths for each of the services as authorized and assigned are:

	Army	Navy	Air Force	Total
Authorized	42*	25* **	32*	99
Assigned	37*	19*	33*	89

* Includes one podiatric residence.
** Includes 5 newly established billets creasted in September 1985.

Discussion of Effect of Additional Podiatry Authorizations

A review of CHAMPUS data available indicates that it is not possible to retrieve the amount currently being disbursed to podiatrists, or to providers other than podiatrists for care that is generally accepted as within the scope of podiatric medicine without significant new computer programs and probable changes in data submission requirements. Available data does indicate that the amount of CHAMPUS expenditures that could be recaptured through additional podiatry authorizations cannot be determined with accuracy since:

- CHAMPUS does not code payments by podiatric conditions. Payments made are categorized by three digit diagnostic codes from International Classification of Diseases, Volume 9. The majority of diagnoses treated by podiatrists, according to the American Podiatry Medical Association, could only be identified by adding a fourth digit representing a sub-category to a three digit code. The four digit code for a particular medical condition is not exclusive to the foot and ankle and may categorize that same medical condition in another body part or area.

- CHAMPUS does not code payments by the type of provider. Gross extrapolation of CHAMPUS outpatient expenditures by four digit category which would include most conditions of the foot and ankle yields CHAMPUS payments of about 4.26 million dollars. Further analysis of those conditions most commonly treated by a podiatrist yields payments of 1.42 million. The estimate includes strains, sprains, and other emergency conditions. Service reviewers contend that the bulk of these expenditures would have been paid to emergency rooms, clinics, and providers other than podiatrists.

- CHAMPUS payments for outpatient care cannot be displayed by catchment areas for the three Services. Analysis of available data does not permit identification of the most ideal place to locate additional podiatrists to maximize recovery of CHAMPUS funds, if any.

Despite the inability to precisely define CHAMPUS payments for podiatry care, it is likely that the addition of more podiatrists would result in a minimal decrease in CHAMPUS expenditures since:

- Active duty personnel are not authorized care under CHAMPUS and would have first claim on any additional services made available in service medical treatment facilities.

- Outpatient care under CHAMPUS does not require prior approval by a military treatment facility. There is no requirement for CHAMPUS eligible beneficiaries to use services available in military facilities.

- Routine foot care is not an authorized CHAMPUS benefit.

A possible indicator of the extent of CHAMPUS utilization for podiatric service is contained in a report by the American Podiatric Medical Association stating the revenue sources for reimbursed care. This report reflects no reimbursement by CHAMPUS of sufficient size as to be statistically significant. The Services report only one contract for podiatric service from local civilian sources due to a shortage of military podiatric providers requested for the Fiscal Year 1985 in the amount of $17,280. Although routine podiatric care is not an authorized CHAMPUS reimbursement, there are doubtless services provided to beneficiaries by podiatrists that are part of a billing submitted by the primary provider who may be a physician, a clinic or other facility that does not identify the podiatric service by specialty.

Each of the Services sponsors one podiatric residency annually. Residency training is conducted in service facilities, civilian training programs (by contract), and Veterans Administration hospitals. Services report sufficient numbers of podiatrists who have completed residencies available. Procurement of podiatrists with graduate training from the civil sector has not been a problem in recent years.

In the absence of a podiatrist, podiatric care, when sought, is normally obtained from providers other than orthopaedic surgeons. Alternative providers would include physicians (general or family practitioners), physician assistants, nurse practitioners, nurses, medical corpsmen and other enlisted or civilian technicians as well as self care by the patient. If the number of podiatrists were to be increased, any relief in workload would be felt by those providers other than orthopaedists.

A survey of contemporary podiatry conducted by the Virginia Polytechnic Institute and State University indicate that approximately 55 percent of podiatrists hold hospital staff appointments and approximately 58 percent of those holding hospital appointments have surgical privileges. Most civilian practices are office based from an outpatient population while all military podiatrists are on the staff of a hospital or treatment facility and also treat an exclusively outpatient population. The civilian practitioners make relatively few referrals to physicians (both MD and DO) while military podiatrists, as full time staff members, have a considerably greater interchange with physicians.

APPENDIX I

Evaluation

There are differences between the military and civilian practice of podiatry. The greatest is that military podiatry is exclusively hospital based (albeit predominantly outpatient) with the podiatrist working as part of a health care delivery team alongside or under the supervision of a physician. The amount of supplemental orthopaedic workload that can be assumed by the podiatrist is well stated and is proportional to the number of orthopaedists assigned. The process to determine requirements is long standing and proven. These processes provide for an increase in the number of all health care providers should the potential patient population increase by reason of numbers or risks. This increase would, again, be proportionate. There is, however, no indication that any increase in the number of existing podiatric residencies would meet any service need or alter the current workload distribution of podiatric care.

It appears that any increases in the numbers of podiatrists would have a negligible effect on CHAMPUS or contract care costs as far as can be determined and some small effect on the workload of the orthopaedist. The long and short term costs of such an increase could be expected to exceed any savings in either dollar or skill assets.

(101309)

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