Family Practice in the US Air Force

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The United States Air Force Medical Service is well suited for family practice because of its early identification with the small community hospital. A plan was originally developed in 1968 to bring family practice to every Air Force member. This paper traces the progress of the program, identifies problem areas, specifies the planning factors and implementation plan, and gives the final goal for full family practice in the USAF.

The US Air Force Medical Service is well suited for family practice because it is designed to center on the concept of the community hospital. Medical treatment facilities are, for the most part, hospitals of fewer than 100 beds or clinics that concentrate on primary care medicine. Most hospitals have a mean of 25 to 50 beds, are represented by all the primary specialties, and have 300 to 600 outpatient visits per day. The standard clinic facility is staffed with family physicians and general medical officers (GMOs), with a pediatrician and internist also assigned at larger clinics.

The population served is relatively fixed and usually stable in its assignment for a period of three years. The population varies from almost all active-duty personnel and their dependents, with the total beneficiaries being 6,000 to 10,000 people, to areas with large retired populations with an area population of 65,000 to 135,000. The active-duty families are young, stressed by separation from their roots, and at many bases have the added stress of frequent, short, or prolonged family disruptions because of temporary duty and the Air Force worldwide flying mission. Family practice fits the needs of the Air Force, although the great variation in facilities and populations makes central planning difficult.

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Historical Background

Initial planning for family practice was accomplished by Col Edwin Turner, who formed the first Air Force Family Practice Clinic at Homestead AFB, Florida, in 1968. He was instrumental in developing military training programs at Andrews AFB, Wright-Patterson AFB, and Scott AFB. In the early 1970s, the Air Force was faced with the loss of physicians because of discontinuation of the physician draft. Lt Gen Towner, then Surgeon General, saw this loss as an opportunity for transition into family practice and directed that as a goal the Medical Service provide a family physician for all flyers and their families. The Health Professions Scholarship Program (HPSP) then came into existence, and through this, Col Ed Turner and his replacement, Col Rod Hoch, began a program to provide family physicians for all Air Force families.

Residency Programs

There are now Air Force training programs at Malcolm Grow USAF Medical Center, Andrews AFB; David Grant USAF Medical Center, Travis AFB; Scott USAF Medical Center; Carswell USAF Regional Hospital; Eglin USAF Regional Hospital; and a training site at Ehrling Berquist USAF Regional Hospital, Offutt AFB, associated with the Creighton University Family Practice Residency Program. Each residency has one family physician staff member for every four residents and a psychiatrist or social worker, and some have an associated community health nurse. Family

practice residency programs in the USAF now graduate about 42 family practice residents annually. All medical students under the HPSP program who wish to be deferred in family practice residencies are allowed to do so. This means the input of residency-trained family physicians is 75 to 80 annually.

Module Identification

Opening new family practice clinics is dependent on the turnover of family physicians to include the number of residents who graduate from training. The Air Force is recruiting no physicians in the primary care specialties (unless by exception); therefore, the number of incoming residents is known about 12 to 18 months before they are in place at their base of assignment. Physician attrition is determined about a year prior to opening new modules, and after each existing clinic is brought as close to provider requirements for an integrated specialty model as possible within manpower limitations (eg, facility constraint), the number of physicians in excess of present requirements is determined. Medical treatment facilities (MTFs) with large turnovers of physicians or with serious staff problems are identified as sites for new modules, and inputs to primary clinics are frozen. Since assignments are tentatively given in early winter for the coming summer, the new clinics are identified from six to nine months before they open. An attempt is made to place an experienced military family physician at each new module, but this is not often possible because of the relative youth of the specialists. The average time of service out of residency is now about two to three years and is gradually increasing.

Progress

In the summer of 1983, the US Air Force had 289 board-certified, residency-trained family physicians, and modules in 67 of the 118 USAF medical treatment facilities. Almost every overseas base has at least one family physician, an achievement of particular importance because of the large number of small, isolated clinics overseas. Stateside, 46 of the 65 hospitals have family practice modules, which have been located in commands with more stressful missions and in the more isolated locations. The USAF projects to have 417 family physicians by 1986, all of which could be placed in family practice modules by 1990. The USAF family physicians have established their credibility and at most bases are practicing full family practice and doing very well.

Problems

The first major problem, and one of the greatest unsolved obstacles, is the lack of space for the Family Practice Clinic. Historically each hospital had a primary care section with two to three general medical officers, with all other care provided by the other specialty services. By providing family practice, the room requirement may increase up to and exceed 500 percent, and the number of rooms may dictate the number of family physicians assigned. Correction of this problem may require pre-engineered buildings, some of which are being constructed. In facilities to be constructed, adequate space has been designed into the facility, but total space improvements at all Air Force bases may take up to 15 years.

The second major problem has been the lack of support staff. Family practice modules have been formed when family physicians become available for assignment, and usually the number of new sites cannot be identified until about eight months before a new module is created. Support staffing for a much larger Family Practice Clinic than the former Primary Care Clinic may take four to six years to be in place. In 1980, program-objective memorandums were prepared and sent to Congress for family practice support. The personnel to provide that support have already started to arrive.

The third significant problem has been the lack of experienced family physicians. Because family practice has grown so fast, new modules have been formed using residents directly out of training. It takes about 18 months after a family practice module is created before true family practice is occurring at the medical treatment facility because of the lack of administrative experience in the clinics.

An internal problem has been the formation of special clinics, created as a result of the expertise of family physicians in other specialty areas. These specialty clinics have placed the family physicians on multiple call rosters, creating additional duties that take the physician from the Family Practice Clinic and interfere with the organization of the clinic schedule.

The final problem is the same as that experi-

enced in any civilian community where family practice becomes a new entity. Other specialists and hospital commanders may be unfamiliar with the concept and bring fixed ideas about family practice into discussions on privileges, scope of responsibility, and clinic operation.

Planning

There have been two major central contributions in planning for full implementation of the family practice concept; the provider requirements for an integrated specialty model (PRISM), and the Family Practice Implementation Plan.

The PRISM concept was developed by the Professional Services Directorate and the Manpower Division of the Plans and Programs Directorate of the USAF Surgeon General's Office. PRISM I was created to model the physician requirement within present resources to provide family practice to all active-duty personnel and their dependents. PRISM II was developed to model the physician requirement for readiness, and PRISM III, to identify the model to be used as physician resources are increased to take care of all active-duty, dependent, or retired personnel and other beneficiaries.

The PRISM model used family physicians and physicians' assistants or nurse practitioners in two-person teams to provide care for specific populations. PRISM has since been refined to account for care to an age-sex–defined population to produce 22 to 24 outpatient visits per average clinic day and provide time for inpatient care. The plan includes incorporation of an additional primary care clinic at all larger facilities and will include general medical officers at bases at a ratio of four family physicians to one general medical officer. Some smaller facilities will have no general medical officers. The total required number for board-certified, residency-trained family physicians will be about 500 for the family practice modules, with an additional 200 for flight medicine offices. Flight medicine has been excluded from planning until most modules have been formed to take care of the nonflying population.

The central guidance involves impanelment, access, manning, appointments, clinic operation, space, and support requirements. The document also defines operation of primary care and the emergency room, since the three areas of operation are closely connected.

All active-duty personnel and their dependents may be impaneled, except at medical centers where there is a large transient population. Impanelment is to be by squadron for active-duty personnel so that in addition to providing continuity of family care, the physician also becomes aware of job-related problems that are common for all members of a squadron. This awareness improves squadron morale and increases the familiarity of the physician with problems common to Air Force personnel.

The second major planning document, the Family Practice Implementation Plan, has been the result of three years' work by the Consultant in Family Practice, the Surgeon General's Manpower Division, and the Air Force Medical Management Engineering Team (MEDMET). The implementation plan began as an attempt to determine the manpower needs for family practice to include the total support package. The study was undertaken first at 15 operative family practice sites and finally at five varied family practice clinics. The findings showed that each clinic was being operated completely differently, and none totally followed the concepts of family medicine. It was then determined that central guidance was necessary if family practice was to be effective.

The appointment system is to be a modified wave system with appointments held open for acute patients on each day. The system is designed to provide 24 appointments, or a lesser number, depending on the visit length required for particular procedures (eg, vasectomies).

The plan, which sets up space criteria to be used in facility design and identifies all manpower requirements for the three clinic areas, was released to the field in May 1983.

Conclusions

Family practice is growing rapidly in the US Air Force to a projected strength of about 700 board-certified, residency-trained family physicians. The growth of this specialty has not been without pain to the physicians making up the force because of the lack of facilities, support, experience, and understanding of "what family practice is and does" by other medical personnel. Experience with family physicians is improving, their credibility is proved, and the future of family practice in the Air Force is assured because it answers a proven need by the people.