



July 2014

# DEFENSE HEALTH CARE REFORM

## Actions Needed to Help Realize Potential Cost Savings from Medical Education and Training

# GAO Highlights

Highlights of [GAO-14-630](#), a report to congressional committees

## Why GAO Did This Study

To help address DOD's escalating health care costs, in 2013 DOD established the DHA to, among other things, combine common medical services such as medical education and training. DOD trains its servicemembers for a wide variety of medical positions, such as physicians, nurses, therapists, and pharmacists. DHA's Education and Training Directorate is to oversee many aspects of DOD's medical education and training and is now expected to begin operations in August 2014. GAO was mandated to review DOD's efforts to consolidate medical education and training.

GAO examined the extent to which DOD has (1) conducted analysis to reform medical education and training to achieve cost savings and (2) determined whether the consolidation of training at METC has resulted in cost savings and designed processes to assess its effectiveness. GAO compared DHA implementation plans and METC budget information from fiscal years 2010 through 2012 with best practices and interviewed officials from the DHA, METC, and military services' Surgeons General offices.

## What GAO Recommends

GAO recommends that DOD conduct a fully developed business case analysis for the Education and Training Directorate and develop baseline cost information as part of its metrics to assess cost savings for future consolidation efforts. In comments to a draft of this report, DOD concurred with each of GAO's recommendations.

View [GAO-14-630](#). For more information, contact Brenda S. Farrell at (202) 512-3604 or [farrellb@gao.gov](mailto:farrellb@gao.gov).

July 2014

## DEFENSE HEALTH CARE REFORM

### Actions Needed to Help Realize Potential Cost Savings from Medical Education and Training

## What GAO Found

In its 2013 plans for the implementation of the Defense Health Agency (DHA), the Department of Defense (DOD) outlined the responsibilities of a new Education and Training Directorate, but has not demonstrated how its proposed reforms will result in cost savings. The National Defense Authorization Act for Fiscal Year 2013 required DOD to develop business case analyses for its shared service proposals as part of its submissions on its plans for the implementation of DHA, including, among other things, the purpose of the shared service and the anticipated cost savings. Although DOD has stated that the Directorate is a shared service that combines common services and that it will result in cost savings, DOD has not fully developed the required business case analysis for the medical education and training reforms. This is because DOD has not yet completed the first step of the process, which includes identifying the specific problems that the reform is intended to address and thereby achieve cost savings. Unlike the medical education and training reforms, other DOD shared service projects present a clear linkage between (1) a stated problem, (2) proposed process changes, and (3) an estimate of benefits, costs, and risks. For the Directorate, DOD has identified the new processes it will employ, but has not identified the concerns the proposed new processes are intended to address and how they will achieve cost savings. In addition, some officials are unconvinced that the potential cost savings will be achieved, and stated that the creation of the Directorate serves more as a functional realignment than a cost savings endeavor. Without a fully developed business case analysis, it is unclear how DOD will measure any accomplishments and hold the Directorate accountable for achieving cost savings.

DOD is unable to determine whether the consolidation of training at the Medical Education and Training Campus (METC) resulted in cost savings; however, DOD is taking action to improve some of the processes for evaluating the effectiveness of training at METC. DOD co-located medical training for enlisted medical servicemembers at METC as part of the 2005 Base Realignment and Closure Commission (BRAC) process to achieve cost savings, and subsequently, the services decided to consolidate their training. However, some officials stated they were unsure whether all funds were transferred to METC. Furthermore, due to a shortage of military service funds, the Office of the Assistant Secretary of Defense for Health Affairs provided funding for METC in addition to the services' transfers. DOD is unable to determine whether the consolidation of training at METC resulted in cost savings because it did not develop baseline cost information as part of its metrics to assess METC's success. Baseline cost information is a key characteristic of performance metrics critical to ensuring that processes achieve the desired results. Without baseline cost information prior to future course consolidation of training at METC and within the Education and Training Directorate, DOD will be unable to assess potential cost savings. DOD has designed processes to evaluate the quality of training at METC—including processes related to certification rates, accreditation, and surveys. Further, DOD has taken action to improve some processes. For example, to improve the level of feedback received from METC surveys, METC officials have begun a pilot process to conduct their own post-graduation surveys.

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## Abbreviations

ACE	American Council on Education
AETC	Air Education and Training Command
AFMC	Air Force Material Command
AMEDD C&S	Army Medical Department Center and School
BRAC	Base Realignment and Closure
CCAF	Community College of the Air Force
DHA	Defense Health Agency
DMRTI	Defense Medical Readiness Training Institute
DOD	Department of Defense
JMESI	Joint Medical Executive Skills Institute
METC	Medical Education and Training Campus
MHS	Military Health System
NMETC	Navy Medicine Education and Training Command
USAFSAM	United State Air Force School of Aerospace Medicine
USUHS	Uniformed Services University of the Health Sciences

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July 31, 2014

The Honorable Carl Levin  
Chairman  
The Honorable James M. Inhofe  
Ranking Member  
Committee on Armed Services  
United States Senate

The Honorable Howard P. "Buck" McKeon  
Chairman  
The Honorable Adam Smith  
Ranking Member  
Committee on Armed Services  
House of Representatives

The Department of Defense (DOD) operates a complex medical training network that educates both officers and enlisted servicemembers. This network consists of institutions located across the United States, with some providing training to participants from all three military services and others providing training within a single service setting. DOD trains its officers and enlisted servicemembers for a wide variety of medical positions (e.g., physicians, dentists, nurses, therapists, and laboratory technicians) and expended approximately \$655 million on such training in fiscal year 2013. This includes funds appropriated to the Defense Health Program, which provides support for education and training opportunities for medical personnel and includes resources for specialized skill training, formal educational programs outside DOD, and professional development education programs at various military sponsored schools.

Over the past decade, decisionmakers have recognized the need to transform the Military Health System (MHS) to better control rapidly escalating health care costs and take advantage of opportunities to realize savings. For example, the 2005 Base Realignment and Closure (BRAC) Commission and DOD in its 2006 *Quadrennial Defense Review* called for transforming medical education and training. Specifically, the 2005 BRAC recommended co-locating all (except Aerospace Medicine) medical basic and specialty training for enlisted servicemembers from several locations to a single site, known as the Medical Education and Training Campus (METC), in San Antonio, Texas. In implementing this BRAC recommendation, the services decided to consolidate courses where feasible to achieve cost savings and facilitate interservice training,

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and METC began training students in 2010 as a tri-service institution. In April 2012, we reported that DOD had not documented savings resulting from the creation of METC, but agency officials believed that combining several training sites into METC had saved money and that other efficiencies had been achieved.<sup>1</sup> We recommended, and DOD concurred, that DOD should employ key management practices to show both financial and nonfinancial achievements from its governance initiatives. Further, in October 2013, DOD established the Defense Health Agency (DHA) to, among other things, combine common (“shared”) medical services with the intent of achieving cost savings.<sup>2</sup> DHA’s Education and Training Directorate is intended to oversee and manage many aspects of medical education and training and is scheduled to begin operations in August 2014. Our recent report on DOD’s efforts to reform the MHS focused on the establishment of the DHA.<sup>3</sup> Specifically, in November 2013, we found that DOD lacked a thorough explanation of the potential sources of cost savings in its shared service projects, a plan to monitor potential implementation costs increases for these projects, and a current baseline assessment of MHS personnel and final staffing requirements for the DHA. As a result, we made a number of recommendations to provide decision makers with more complete information on the planned implementation, management, and oversight of DOD’s newly created DHA, and DOD concurred with our recommendations, as discussed later in this report.<sup>4</sup>

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<sup>1</sup>GAO, *Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System*, [GAO-12-224](#) (Washington, D.C.: Apr. 12, 2012).

<sup>2</sup>According to DOD, a “shared services” concept is a combination of common services performed across the medical community. DOD identified 10 shared services it plans to implement: medical logistics, facility planning, health information technology, health plan management, pharmacy, medical education and training, medical research and development, public health, acquisition, and budget and resource management.

<sup>3</sup>GAO, *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD’s Plans and Enhance Accountability*, [GAO-14-49](#) (Washington, D.C.: Nov. 6, 2013).

<sup>4</sup>For further information on DOD medical governance issues, see: GAO, *Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure*, [GAO-08-122](#) (Washington, D.C.: Oct. 12, 2007); [GAO-12-224](#); *Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures is Needed*, [GAO-12-911](#) (Washington, D.C.: Sept. 26, 2012); and *Military Health System: Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings Testimony*, [GAO-14-396T](#) (Washington, D.C.: Feb. 26, 2014).

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The House Armed Services Committee Report accompanying the National Defense Authorization Act for Fiscal Year 2014 (H.R. Rep. No. 113-102) mandated us to review DOD's efforts to consolidate its medical training and report the results of our review to the congressional defense committees. This report examines the extent to which DOD has (1) developed plans and conducted analyses to reform medical education and training to achieve cost savings and (2) determined whether the consolidation of training at the Medical Education and Training Campus has resulted in cost savings and has designed processes to assess its effectiveness.

To determine the extent to which DOD has developed plans and conducted analyses to reform medical education and training to achieve cost savings, we obtained and reviewed documents concerning DOD's plans for the implementation of the DHA, including the Education and Training Directorate's Concept of Operations, and briefings to internal stakeholders. We compared DOD's implementation plans with best practices from GAO's *Business Process Reengineering and Assessment Guide* and DOD's shared service analysis process.<sup>5</sup> In addition, we reviewed the requirement in the National Defense Authorization Act for Fiscal Year 2013 for DOD to develop business case analyses for its shared service proposals as part of its submissions on its plans for the implementation of the DHA. We interviewed each of the service Surgeons General, and officials from the DHA and METC, concerning their understanding of the role and objectives of the Education and Training Directorate.

To determine the extent to which DOD examined whether the consolidation of training at METC resulted in cost savings, we reviewed METC's resource data from fiscal years 2010 through 2012 and best practices from GAO's *Business Process Reengineering and Assessment Guide*.<sup>6</sup> We interviewed officials responsible for the data concerning their

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<sup>5</sup>GAO, *Business Process Reengineering Assessment Guide*, [GAO/AIMD-10.1.15](#) (May 1997). To develop the *Business Process Reengineering and Assessment Guide*, we consulted with outside experts in the area of public and private sector process redesign and reengineering, reviewed literature and methodologies on process redesign and reengineering, and consulted GAO staff with relevant experience and expertise in areas such as government results and performance issues and performance measurement and benchmarking. The *Guide* is relevant because it provides a framework for assessing issues similar to those DOD faces in the establishment of the DHA.

<sup>6</sup>[GAO/AIMD-10.1.15](#).

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quality control processes, and determined that the data were sufficiently reliable for our purposes. To determine the processes that METC has designed to assess effectiveness of its training, we obtained documentation from METC about those processes, including information on certification rates, internal metrics, accreditation standards, and survey procedures. We also reviewed the cost-savings and quality-related goals of BRAC 2005 for creating METC. To obtain context, we interviewed the Commandant and other officials from METC; each of the service Surgeons General; officials from the Navy Medicine Education and Training Command, the U.S. Army Medical Department Center and School, the Air Force Air Education and Training Command, and the Health Care Inter-service Training Office concerning issues related to the establishment of METC.

We conducted this performance audit from November 2013 to July 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

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### Defense Health Agency

The National Defense Authorization Act for Fiscal Year 2013 required that DOD develop a detailed implementation plan for carrying out its health care system reform of creating the DHA, and provide the plan to the congressional defense committees in three separate submissions in fiscal year 2013. In October 2013, DOD established the DHA to assume management responsibility for numerous functions of its medical health care system, support the services in carrying out their medical missions, manage the military's health plan, oversee the medical operations within the National Capital Region,<sup>7</sup> and provide 10 shared services, including oversight of medical education and training. According to DOD, a "shared services concept" is a combination of common services performed across

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<sup>7</sup>The National Capital Region is the geographic area that includes Washington, D.C., and other specific surrounding cities and counties in both Maryland and Virginia.

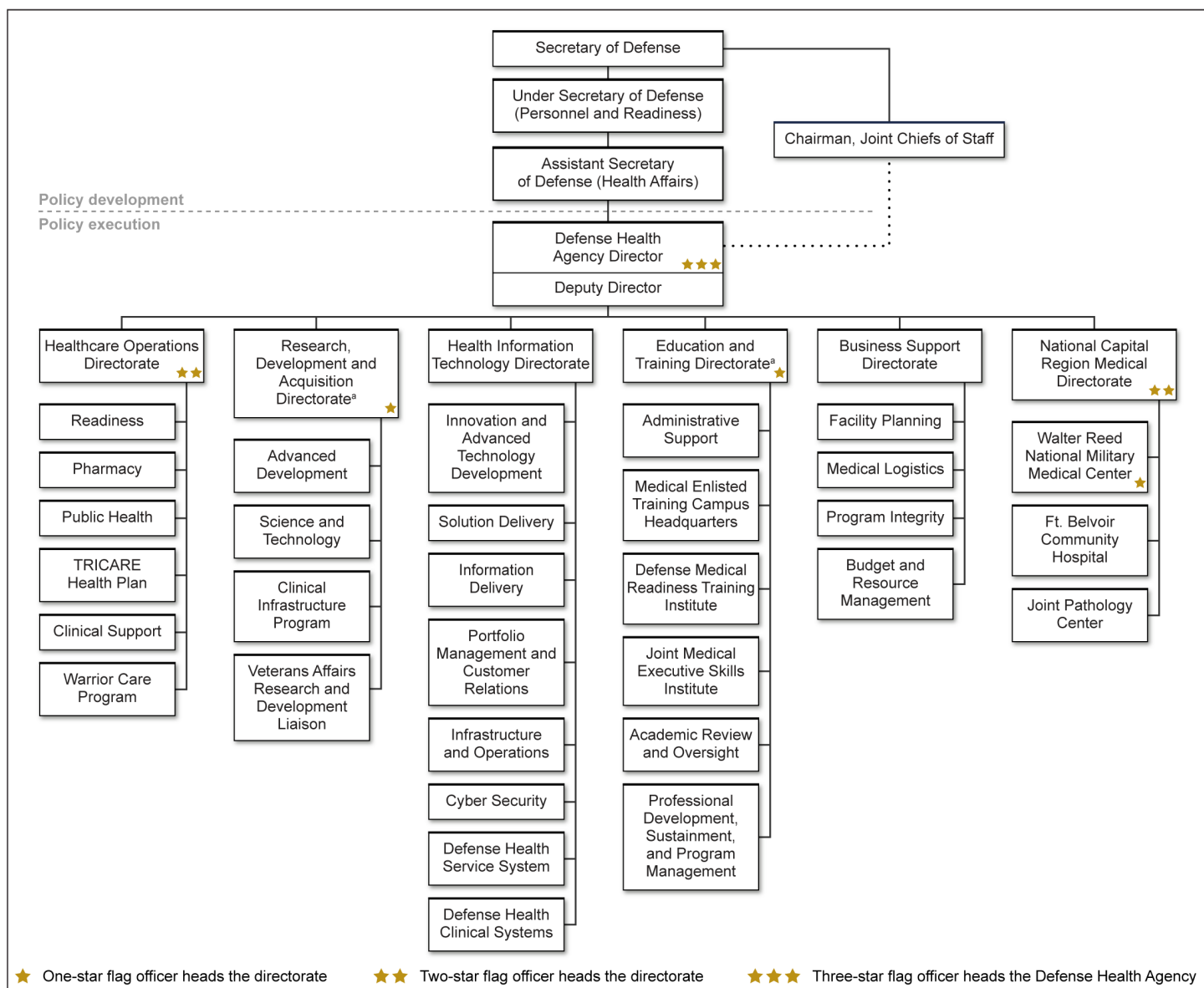
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the medical community with the goal of achieving cost savings. The DHA's Education and Training Directorate, a shared service, is scheduled to begin operations in August 2014 and, according to DOD officials, when operational, will constitute the first instance of oversight of medical education and training at the Office of the Secretary of Defense level.<sup>8</sup> While the services establish training requirements, operate their own service-specific training institutions, and provide manpower to conduct the training at tri-service institutions, such as METC, the Directorate plans to provide administrative support; academic review and policy oversight; and professional development, sustainment, and program management to the military departments' medical services, the combatant commands, and the Joint Staff. See figure 1 below for the organizational chart of the DHA.

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<sup>8</sup>The DHA and the Education and Training Directorate are expected to reach full operational capability no later than October 1, 2015.

**Figure 1: Defense Health Agency (DHA) Organizational Chart**



Source: Defense Health Agency. | GAO-14-630

Notes: This is an updated DHA organization chart from the one that we published in November 2013 in [GAO-14-49](#).

Under the DHA, the services' Surgeons General (three-star flag/general officers) will continue to head their respective medical organizations.

<sup>a</sup>This directorate has not yet reached Initial Operating Capability as of July 2014.

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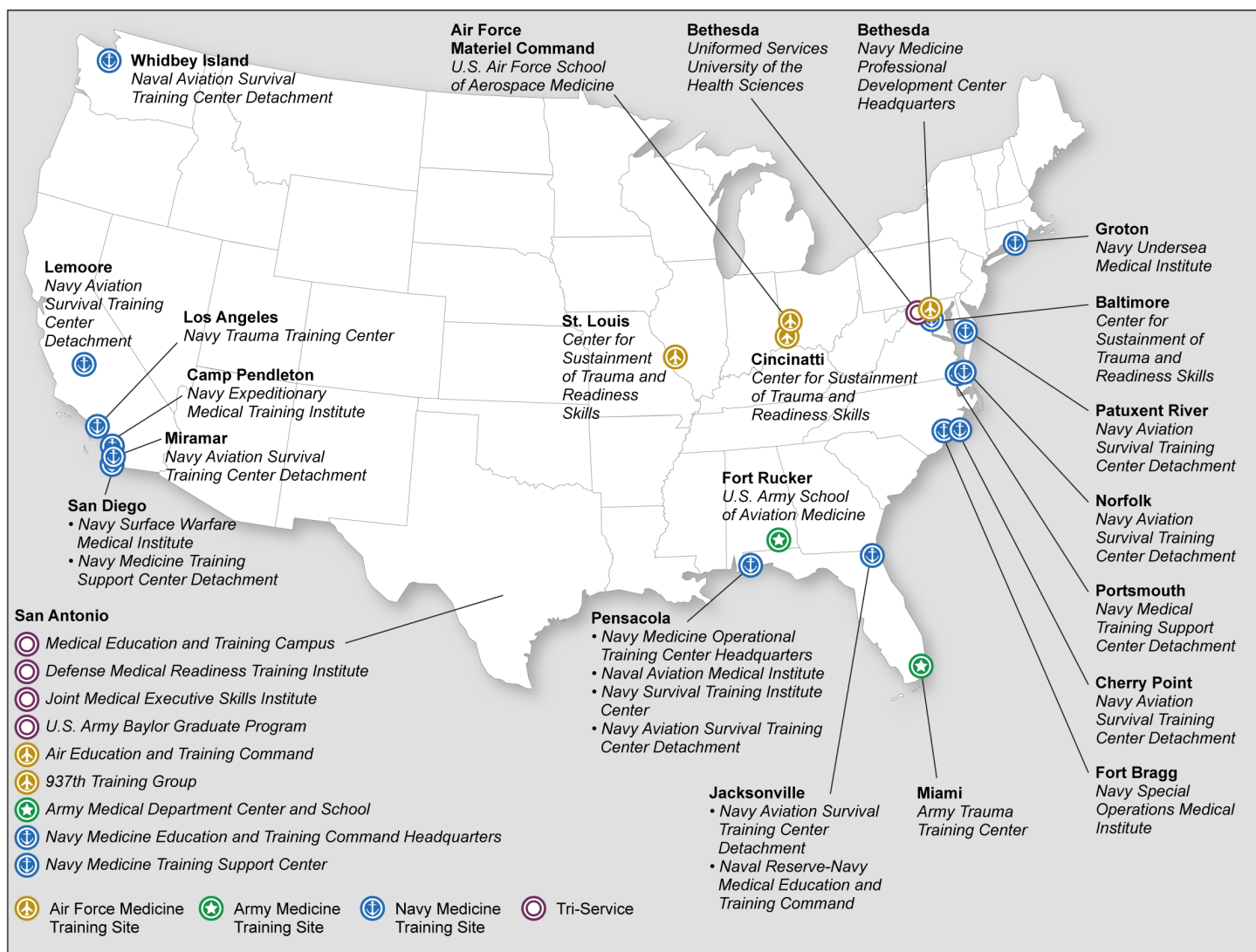
## DOD's Medical Training Network

Medical personnel receive training throughout their careers to develop and enhance their skills. Examples of the types of medical training they can receive include

1. initial training for enlisted servicemembers, which results in a new occupational classification;
2. sustainment training for enlisted servicemembers, which does not result in a new occupational classification but refreshes or augments initial training;
3. operational or readiness skills training, which provides training to perform in operational situations throughout the world and includes such training as burn and trauma care as well as emergency and Chemical, Biological, Radiological, Nuclear, and Explosive preparedness; and
4. executive skills training for enlisted servicemembers, officers, and civilians, which provides military health care leaders with executive management and professional administrative skills.

These training courses can be presented in shared or service-specific settings that involve varying degrees of a consolidated approach to course curricula, faculty instruction, equipment, and facilities. Figure 2 depicts the locations of this training and whether it is shared ("tri-service") or service-specific training.

**Figure 2: Tri-Service and Service-Specific Department of Defense Medical Training Sites**



Source: GAO analysis of Department of Defense information; Map Resources (map). | GAO-14-630

## Tri-Service Medical Training

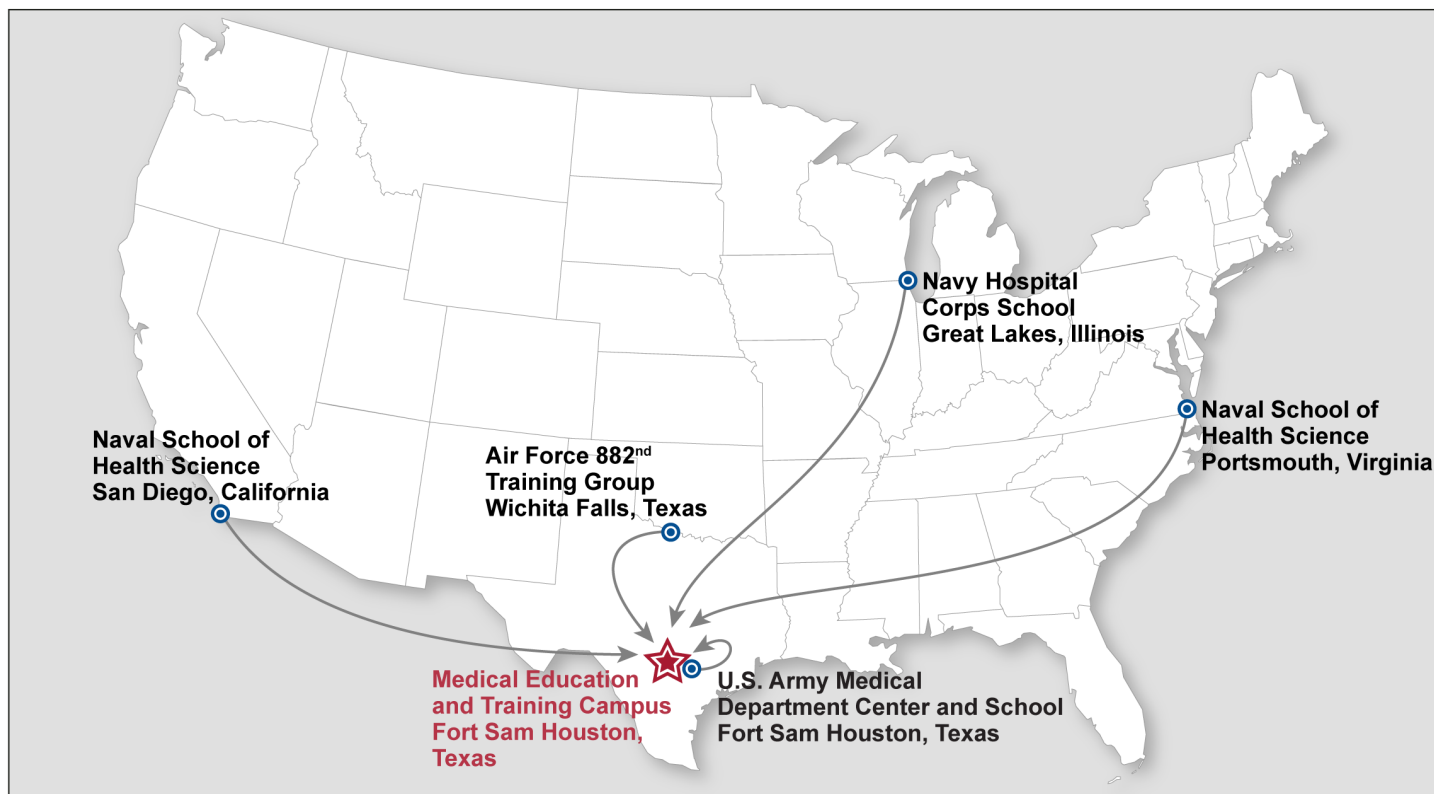
Four DOD institutions offer medical training to servicemembers from all three services. These institutions vary in size and subject matter, and include the following:

- *Uniformed Services University of the Health Sciences (USUHS):* DOD-funded medical school in Bethesda, Maryland, with a fiscal year 2015 budget estimate of about \$146 million. This university provides

medical training to health professionals dedicated to a career as a physician, dentist, or nurse in DOD or the U.S. Public Health Service.

- *Medical Education and Training Campus (METC)*: Provides initial skills training to most medical enlisted servicemembers in about 50 areas such as pharmacy, laboratory, and dental technology; combat medics, basic hospital corpsmen, basic medical technicians; and a number of advanced medical training courses. METC resulted from a 2005 BRAC recommendation to establish a medical education and training complex that collocated medical enlisted training being conducted at five different locations by each of the military services into one location at Fort Sam Houston, Texas. (See fig. 3.)

**Figure 3: Service-Specific Medical Basic and Specialty Enlisted Department of Defense (DOD) Training Sites Relocated to Form the Medical Education and Training Campus (METC) in Fort Sam Houston, Texas**



Source: Department of Defense; Map Resources (map). | GAO-14-630

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Since first becoming operational in 2010, METC has created 14 new consolidated courses while 22 of its courses were consolidated prior to METC's creation. METC trains, on average, about 20,000 students annually and is estimated to cost almost \$27 million in fiscal year 2015.<sup>9</sup> See appendix I for a list of courses taught at METC and course participants.

- *Defense Medical Readiness Training Institute (DMRTI)*: Tri-service organization that is staffed by servicemembers from the Army, the Navy, and the Air Force as well as Department of the Army civilians and according to officials, had a \$1.4 million budget in fiscal year 2013. This organization offers resident and nonresident joint medical readiness training courses as well as professional medical programs that enable military medical personnel, both active duty and reserve, to better perform a wide range of medical and health support missions they face throughout the world. Courses include trauma care, burn care, public health emergency preparedness, humanitarian assistance, and emergency response to chemical, biological, nuclear, and other events. During fiscal year 2013, approximately 3,600 students participated in 122 course iterations in 51 different locations. According to officials, besides providing medical readiness training to U.S. servicemembers, DMRTI has provided this training to officials in 38 countries at the request of a combatant command.
- *Joint Medical Executive Skills Institute (JMESI)*: Tri-service organization that provides military health care leaders with executive management skill programs, products, and services that are designed to enhance their performance as managers and leaders in the military healthcare environment. The training JMESI provides centers on the Core Curriculum which is a collection of 35 executive administrative competencies required of a military hospital commander that tri-service senior leaders are responsible for reviewing and updating every 3 years. Each year approximately 200 managers graduate from JMESI's Healthcare Management Seminar and MHS Capstone Symposium, and nearly 20,000 students participate in its online, distance learning program.

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<sup>9</sup>This figure does not include costs for civilian compensation.

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## Service-Specific Medical Training

In addition to tri-service training, each of the services operates its own education and training entities that provide additional training to their medical servicemembers. The Army and Navy education and training entities are constituent commands of the Army Medical Command and the Bureau of Medicine and Surgery, respectively, which are headed by Surgeons General. The Air Force education and training entities conduct a wide variety of training, including nonmedical training, and do not report directly to the Air Force Surgeon General. These organizations include the following:

- *Army Medical Department Center and School (AMEDD C&S)*: Army training headquarters located at Fort Sam Houston, Texas. The center formulates the Army Medical Department's medical organization, tactics, doctrine, and equipment. The school educates and trains Army medical personnel. More specifically, the Academy of Health Sciences is the "school" and is part vocational institution, part community college, and part major university. The Academy of Health Sciences includes 361 programs of instructions, with 41 of them taught at METC; 2 levels of officer leader development programs; 6 Masters Degree programs; 7 Doctoral Degree programs; 94 professional postgraduate programs; as well as pre-deployment training within three main centers and a graduate school. First, the Center for Health Education and Training consists of 10 departments whose primary mission is to instruct advanced or specialty courses enhancing and building upon the initial training that enlisted soldiers receive from METC and officers receive after finishing their basic courses. Second, the Center for Pre-Deployment Medicine analyzes, designs, and develops individual pre-deployment training courses and products and provides professional expertise and pre-deployment training to increase the technical and tactical abilities of physicians, nurses, and other healthcare professionals. Third, the Leader Training Center provides professional education, doctrinal, and individual leadership training to execute Army missions across a full spectrum of military operations. Additionally, aviation medicine classes are taught at the US Army School of Aviation Medicine, in Fort Rucker, Alabama, and forward surgical teams preparing for overseas deployment go through training at the Army Trauma Training Center in Miami, Florida.
- *Navy Medicine Education and Training Command (NMETC)*: Consists of four centers that provide education, training, and support for Navy medical personnel. The first center is the Navy Medicine Professional Development Center headquartered in Bethesda, Maryland, which offers educational programs such as the Naval Postgraduate Dental

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School as well as leadership and specialty courses that focus on the practice and business of military medicine in both the operational and hospital settings delivered via in-person classes and online. The second center is the Navy Medicine Training Support Center headquartered in San Antonio, Texas. It serves as the Navy's component command for METC students and instructors to provide administrative and operational control of Navy personnel assigned to METC. The third center is the Navy Medicine Operational Training Center, which is headquartered in Pensacola, Florida, and consists of six detachments and nine training centers at 14 locations throughout the country that teach such areas of Navy medicine as undersea, aviation, expeditionary, special operations, and survival training. Fourth, another section of the NMETC provides medical education and training to the reserve components.

- *Air Force:* There is no specific Air Force organization focused exclusively on medical training. The Air Force Surgeon General assists Air Force leadership in developing policies, plans, and programs, establishing requirements, and providing resources to the Air Force Medical Service, while the Air Force's Air Education and Training Command (AETC) and the Air Force Material Command (AFMC) provide medical training. AETC, which is headquartered at Joint Base San Antonio—Randolph, Texas, oversees a wide variety of medical and nonmedical training. AETC is responsible for 114 medical-related courses: 35 initial skills courses conducted mostly at METC; 73 sustainment or skills progression courses conducted at METC and other various locations; and 6 medical readiness courses taught at a military training site near San Antonio, Texas. AFMC, which is headquartered at Wright-Patterson Air Force Base, Ohio, includes the Air Force School of Aerospace Medicine (USAFSAM). USAFSAM is a center for aerospace medical education and training, and offers a series of courses comprising the initial qualification training for flight surgeons, including hyperbaric medicine, occupational medicine, aviation mishap prevention, and other unique aeromedical issues pertinent to the flight environment. The school trains 6,000 students annually.

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## DOD Has Outlined the Responsibilities of the New Directorate, but Has Not Conducted a Business Case Analysis to Demonstrate How It Will Achieve Cost Savings

DOD has outlined the areas of responsibility for its Education and Training Directorate, including consolidation and management of a number of activities currently performed by the services. However, in its plans, DOD has not demonstrated through a fully developed business case analysis how creating a shared service for education and training will result in cost savings.

According to DOD's third submission<sup>10</sup> to Congress on its plans for the implementation of the DHA in October 2013, DOD proposed a number of projects or "product lines" for its shared service Education and Training Directorate.<sup>11</sup> Specifically, DOD identified three product lines for the directorate, which involve (1) management of professional development, sustainment, and related programs, including the METC, the Defense Medical Readiness and Training Institute, and the Joint Medical Executive Skills Institute; (2) academic review and policy oversight functions, including management of online courses and modeling and simulation programs; and (3) management of academic and administrative support functions, such as training and conference approval processes. According to DOD's second submission to Congress, the overall purpose and core measure of success for all shared services is the achievement of cost savings. This focus differentiates the objective of establishing shared services from the six other objectives outlined in DOD's plans for the implementation of the DHA.<sup>12</sup> However, in its plans, DOD has not demonstrated how its Education and Training Directorate projects will

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<sup>10</sup>The National Defense Authorization Act for Fiscal Year 2013 required that DOD develop a detailed implementation plan for carrying out its health care system reform of creating the DHA, and provide it to the congressional defense committees in three separate submissions in fiscal year 2013.

<sup>11</sup>Department of Defense, *Plan for Reform of the Administration of the Military Health System: Third Submission under Section 731 of the National Defense Authorization Act for Fiscal Year 2013* (Oct. 25, 2013).

<sup>12</sup>The seven goals of the DHA include: (1) promote more-effective and more-efficient health care operations through enhanced enterprise-wide shared services; (2) deliver more-comprehensive primary care and integrated health services using advanced patient-centered medical homes; (3) coordinate care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems; (4) match personnel, infrastructure, and funding to current missions, future missions, and population demand; (5) establish more interservice standards and metrics, and standardize processes to promote learning and continuous improvement; (6) create enhanced value in military medical markets using an integrated approach specified in 5-year business performance plans; and (7) align incentives with health and readiness outcomes to reward value creation.

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result in cost savings through a fully developed business case analysis, including an analysis of benefits, costs, and risks. In its third submission to Congress on its implementation plans for DHA, DOD presented estimates of costs and cost savings for two “sub-product lines” concerning modeling and simulation and online learning. However, these projects do not represent the core of the directorate’s mission, but rather a portion of the academic review and policy oversight project. Further, these projects overlap with DHA’s contracting and information technology shared services. Specifically, while cost savings for modeling and simulation are allocated to the Education and Training Directorate, implementation costs are to be incurred by the DHA contracting shared service. In addition, the savings for the online learning project are found within the DHA information technology shared service portfolio. Aside from these projects, DOD did not present information concerning the cost savings of its other shared service projects within the Education and Training Directorate.

*GAO’s Business Process Reengineering Assessment Guide* states that a business case begins with (1) measuring performance and identifying problems in meeting mission goals, which is then addressed through (2) the development and selection of a new process.<sup>13</sup> As noted above, the primary stated purpose of the DHA’s shared service projects is to achieve cost savings. The *Guide* further states that as a project matures, the business case should be enlarged and updated to present a full picture of the benefits, costs, and risks involved in moving to a new process. Such analysis is to provide a sound basis to proceed with the reengineering process. DOD’s own process for developing its shared services, outlined in its second submission on implementation of the DHA, states that after an assessment of the current state of performance and measures of effectiveness have been identified, performance improvement and cost reduction opportunities should be identified. It also states that new processes and initiatives are to be developed to address these challenges, along with associated implementation costs. Further, the National Defense Authorization Act for Fiscal Year 2013 required DOD to develop business case analyses for its shared service proposals as part of its submissions on its plans for the implementation of the DHA, including, among other things, the purpose of the shared service and the anticipated cost savings.

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<sup>13</sup>GAO-AIMD-10.1.15.

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DOD does not have a fully developed business case analysis for medical education and training because it has not yet completed the first step of that analysis, which is to identify specific problems, which, given the stated purpose of shared services, should be directed toward the achievement of cost savings. Several of DOD's other shared service projects present a clear linkage between (1) a stated problem, (2) proposed process changes, and (3) an estimate of benefits, costs, and risks. For example, DOD's third submission<sup>14</sup> on the implementation of DHA, states that the pharmacy shared service will address rising costs due to variation in drug purchasing, staffing, and formulary management (the problem) through the introduction of MHS-wide standards and business rules (the new processes), which will result in cost savings. Similarly, the plan states that the contracting shared services will address rising costs due to fragmentation in its acquisition strategy (the problem) through a common approach to acquisition planning, program management, contract execution, management, and administration (the new processes). In contrast, DOD listed the new processes the Directorate will employ, but it did not explain the problem its proposed new processes will address, and how they will achieve cost savings.

DOD officials stated that they believe that a central problem for the Directorate to address is unnecessary variation of practice between the services, and they believe that efficiencies could be generated through the consolidation of training. However, in its official plans for the Directorate, DOD has not identified this issue or any other challenge related to cost savings as the problem its shared service will address. DOD also lacks the information to assess its current performance to then identify a problem. Specifically, DOD officials stated that they lack data on the cost of DOD's education programs and potential redundancy within its portfolio of courses, which would allow them to identify a problem and develop processes to address these challenges. In fact, officials stated they have identified the need for developing a baseline of current medical education and training courses and associated spending as a goal for the Directorate, and therefore have acknowledged the lack of such information. In addition, some officials cast doubt on the potential cost savings that could be achieved. Several DOD officials told us that the creation of the Directorate represents a logical step in the course of

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<sup>14</sup>Department of Defense, *Plan for Reform of the Administration of the Military Health System: Third Submission under Section 731 of the National Defense Authorization Act for Fiscal Year 2013*.

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further cooperation among the services in the area of medical training. However, senior service officials stated that the Directorate was unlikely to achieve significant savings and that its creation serves more as a functional realignment than a cost savings endeavor. For example, officials stated that the Directorate provides an opportunity to assign a parent agency to METC, JMESI, and DMRTI, which they described as “orphan” agencies that lack a parent organization. Officials made similar comments during our 2012 review,<sup>15</sup> in which we found that DOD was not able to demonstrate potential financial savings from the creation of METC, but agency officials stated at the time that they believed combining several training sites into the formation of METC had saved money and that other efficiencies had been achieved.

DOD’s reform of medical education and training reflects prior similar problems we have identified with DOD initiating major changes to the MHS without a clear understanding of how cost savings will be achieved. In its 2011 analysis of options to reform the MHS, DOD stated it anticipated \$46.5 million in personnel savings as a result of the establishment of the DHA. However, in our November 2013 report,<sup>16</sup> we found that DOD did not know how the establishment of the DHA would affect total MHS staff levels. We recommended that DOD develop a baseline assessment of the current number of military, civilian, and contractor personnel currently working within the MHS headquarters and an estimate for the DHA at full operating capability, including estimates of changes in contractor full-time equivalents. DOD concurred with our recommendation and stated that it planned to conduct a baseline assessment of headquarters staffing levels and submit a revised estimate of its staffing needs in the department’s third and final implementation plan submission. However, as we testified in February 2014,<sup>17</sup> DOD did not include this information in its third and final submission. In that testimony, we noted that DOD continued to lack discrete cost savings estimates for the various functions it had identified as part of its 10 shared service projects, and it had not clarified its plan to monitor implementation costs. DOD’s reform of medical education and training now risks similar challenges to those DOD had encountered in establishing the DHA. In

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<sup>15</sup>[GAO-12-224](#).

<sup>16</sup>[GAO-14-49](#).

<sup>17</sup>[GAO-14-396T](#).

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particular, given that DOD continues to lack an understanding of how the establishment of the DHA will affect staff levels, its challenges in identifying cost savings and a clear mission for its education reforms could result in increases in staff levels without any savings. As we noted in our reviews of DOD's plans for the implementation of the DHA,<sup>18</sup> DOD's submissions did not include critical information necessary to help ensure that DOD achieves the goals of its reform of the MHS. Accordingly, in a recent report, the House Committee on Armed Services has expressed concern<sup>19</sup> regarding DHA's staffing requirements, cost estimates, performance metrics, and medical education and training shared service.

Without a business case analysis that links (1) a stated problem, (2) proposed process changes, and (3) an estimate of benefits, costs, and risks, the role of the Directorate remains ambiguous, and it is unclear how DOD will measure its accomplishments and hold the Directorate accountable for achieving cost savings by sharing training and education services. Without such information, the Directorate also potentially risks increasing staff levels without achieving any cost savings.

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## DOD Cannot Determine Whether the Consolidation of Training at METC Has Resulted in Cost Savings but Is Taking Action to Improve Some Processes for Evaluating Training Effectiveness

DOD established METC as part of the 2005 BRAC process to provide interservice training for enlisted service members and to achieve cost savings. However, DOD is unable to determine whether the consolidation of medical education and training for enlisted personnel at METC has resulted in cost savings because it did not establish a baseline for spending on education and training prior to METC's establishment. METC has designed processes to assess the effectiveness of its training and is taking action to improve them.

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<sup>18</sup>[GAO-14-49](#) and [GAO-14-396T](#).

<sup>19</sup>*Report of the Committee on Armed Services, House of Representatives, on the National Defense Authorization Act for Fiscal Year 2015*, H.R. Rep. No. 113-446, at 168 (2014).

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## DOD Officials Cannot Demonstrate Whether the Consolidation of Training at METC Has Resulted in Cost Savings

DOD cannot demonstrate whether the consolidation of training at METC has resulted in cost savings. However, officials stated that while they could not document cost savings, they believe that the consolidation of training at METC has led to cost savings because of (1) increased equipment sharing; (2) personnel reductions; and (3) cost avoidances, such as those associated with the closure of medical education facilities that were service-specific. In contrast, officials also identified areas where the consolidation of training at METC may have resulted in cost increases because of, for example, (1) the construction of new facilities; (2) relocation of students to METC;<sup>20</sup> and (3) replacement of personnel within their organizations who had been transferred to METC.

To fund training at METC, the services transferred funding to a single METC budget managed by the Air Force over 3 years from fiscal year 2010 through fiscal year 2012. The services continue to fund compensation for military instructors at METC. Civilian funding was transferred to the Air Force, and officials told us that this funding is likely to be transferred to the DHA.

When METC was established, the services transferred funding for their enlisted medical programs being consolidated at METC into a single METC budget. However, some officials stated they are unsure whether the services' transfers were representative of their true costs for the transferred programs prior to the creation of METC. Additionally, the funding transfers from the services were not sufficient to fund training at METC, and the Office of the Assistant Secretary of Defense for Health Affairs provided additional funding to cover this shortfall. For instance, of the total METC budget of \$26.6 million in fiscal year 2012, Health Affairs provided 28 percent; the Air Force, 22 percent; the Army, 36 percent; and the Navy, 14 percent. Table 1 shows the funding amounts transferred by each service to fund METC, from fiscal year 2010, the first year in which the services transferred funds, until fiscal year 2012, when the services completed a permanent transfer of their funds to METC.

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<sup>20</sup>Officials stated that although the cost of relocating students is mostly incurred by the Navy, it is still an additional cost incurred by DOD. Officials stated that prior to the establishment of METC, Navy enlisted servicemembers completed basic training at Great Lakes Naval Station and would then complete the Navy's enlisted medical training at a nearby location. Since the establishment of METC, enlisted servicemembers complete basic training at Great Lakes Naval Station and are then transferred to METC in the San Antonio, Texas, area to complete enlisted medical training.

**Table 1. Amounts Transferred by Each Service to Fund the Medical Education and Training Campus (METC), by Fiscal Year**

Nominal dollars			
Organization	Fiscal year 2010	Fiscal year 2011	Fiscal year 2012
Air Force	\$612,000	\$2,284,000	\$5,862,000
Army	273,000	4,051,000	9,462,000
Navy	272,000	1,757,000	3,828,000
Health Affairs	315,000	10,146,000	7,500,000
<b>Total</b>	<b>\$1,472,000</b>	<b>\$18,238,000</b>	<b>\$26,652,000</b>

Source: Department of Defense (DOD). | GAO-14-630

GAO's *Business Process Reengineering Assessment Guide* states that performance measures are a critical part of a comprehensive implementation process to ensure that a new process is achieving the desired results.<sup>21</sup> Additionally, through our prior work on performance metrics, we have identified several important attributes of these assessment tools, including the need to develop a baseline and trend data to identify, monitor, and report changes in performance and to help ensure that performance is viewed in context.<sup>22</sup> By tracking and developing a performance baseline for all measures, agencies can better evaluate progress made and whether goals are being achieved, such as cost savings targets.

DOD did not establish and monitor baseline cost information as part of its metrics to assess performance to ensure that the establishment of METC provided costs savings. Officials told us that their focus in establishing METC was to ensure that DOD met the BRAC recommendation to co-locate enlisted medical training, not to ensure that this consolidation led to

<sup>21</sup>GAO-AIMD-10.1.15.

<sup>22</sup>GAO, *Tax Administration: IRS Needs to Further Refine Its Tax Filing Season Performance Measures*, [GAO-03-143](#) (Washington, D.C.: Nov. 22, 2002); *GPRA Performance Reports*, [GAO/GGD-96-66R](#), (Washington, D.C.: Feb. 14, 1996); *Missile Defense: Opportunity to Refocus on Strengthening Acquisition Management*, [GAO-13-432](#) (Washington, D.C.: Apr. 26, 2013); *Performance Measurement and Evaluation: Definitions and Relationships*, [GAO-11-646SP](#) (Washington, D.C.: May 2011); and *Agency Performance Plans: Examples of Practices That Can Improve Usefulness to Decisionmakers*, [GAO/GGD/AIMD-99-69](#) (Washington, D.C.: Feb. 26, 1999).

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cost savings. However, the METC business plan,<sup>23</sup> developed in response to the BRAC recommendation, noted that the intent of establishing METC was to reduce costs while leveraging best practice training programs of the three services. We found in April 2012<sup>24</sup> that DOD was unable to provide documented savings associated with the establishment of METC. We recommended that DOD employ key management practices in order to show the financial and nonfinancial outcomes of its reform efforts, and DOD concurred with our recommendation. DOD noted that it would employ key management practices in order to identify those outcomes; however, as of June 2014, DOD officials have not documented the financial outcome of the establishment of METC.

DOD justified its request for the 2005 BRAC round in part based on anticipated savings. For example, DOD submitted to the 2005 BRAC Commission a recommendation for the consolidation of 26 military installations operated by individual military services into 12 joint bases to take advantage of opportunities for efficiencies arising from such consolidation and elimination of similar support services on bases located close to one another. However, we found in 2012 that DOD did not have a plan for achieving cost savings.<sup>25</sup> For example, during our review of DOD's effort to implement this BRAC recommendation, joint base officials provided us with anecdotal examples of efficiencies that had been achieved at joint bases, but it was unclear whether DOD had achieved any significant cost savings to date, due in part to weaknesses in such areas as DOD's approach to tracking costs and estimated savings. Specifically, it did not establish quantifiable and measurable implementation goals for how to achieve cost savings or efficiencies through joint basing. We recommended that DOD develop and implement a plan that provides measurable goals linked to achieving savings and efficiencies at the joint bases and provide guidance to the joint bases that directs them to identify opportunities for cost savings and efficiencies.

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<sup>23</sup>Department of Defense, *Appendix B of San Antonio Business Plan 172*, Commission and DOD Recommendation Number: MED-0016, (Feb. 23, 2011).

<sup>24</sup>[GAO-12-224](#).

<sup>25</sup>GAO, *2013 Annual Report: Actions Needed to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, [GAO-13-279SP](#) (Washington, D.C.: Apr. 9, 2013) and GAO, *DOD Joint Bases: Management Improvements Needed to Achieve Greater Efficiencies*, [GAO-13-134](#), (Washington, D.C.: Nov. 15, 2012).

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DOD did not concur with our recommendation, and we noted that this position contradicts DOD's position that joint basing would realize cost savings. Similarly, the co-location and consolidation of training at METC was, in part, premised on the achievement of cost savings, but DOD did not establish baseline costs as part of its metrics for assessing performance.

It is now likely not possible to develop baseline cost information for fiscal year 2009 to determine the extent to which the establishment of METC resulted in cost savings. However, without developing baseline cost information before undergoing future course consolidation of training at METC and within the Education and Training Directorate, DOD will be unable to accurately assess cost savings in the future.

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### DOD Has Designed Processes for Evaluating the Effectiveness of Training and Is Taking Action to Address Accreditation and Survey Response Issues

METC has designed quality assurance processes to provide continuous, evaluative feedback related to improvements in education and training support, and is taking action to address issues regarding course accreditation and the post-graduation survey process.

### METC Has Established Quality Assurance Processes

- *Certification Rates:* METC monitors the national certification exam pass rates of its students, both to meet national requirements and to make comparisons with national averages. According to METC officials, certification rates are generally higher since the consolidation of training at METC. Currently, certification rates for seven programs exceed the national average.<sup>26</sup>
- *Internal Metrics:* According to METC officials, METC regularly monitors a number of internal metrics, such as attrition, course repetition, and graduation rates. To manage performance information for all of their courses, officials produce a monthly snapshot of these data to track trends in performance over time. Additionally, all of METC's courses are to be reviewed through a comprehensive program review process conducted by the Health Care Interservice

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<sup>26</sup>We did not verify the accuracy of these figures.

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Training Office.<sup>27</sup> This office is to review 30 specific standards to help ensure, for example, that all service and accreditation requirements are met; that faculty meet all required qualifications; and that internal and external surveys are conducted, analyzed, reported, and acted on according to policy.

- *Accreditation Standards:* METC is institutionally accredited by the Council on Occupational Education and is officially an affiliated school within the Community College of the Air Force (CCAF). Most METC courses are accredited by a relevant external accrediting body, such as the American Council on Education (ACE) or the CCAF.
- *Surveys:* The METC Memorandum of Agreement states that METC and the services will conduct external evaluations to document program efficacy and to facilitate curriculum review, by gathering feedback to measure whether the training received was relevant and to determine whether the graduates are proficient in their job duties. METC solicits this feedback through surveys sent by the services to the supervisors of METC graduates at the gaining commands to gauge satisfaction with the training they received at METC. These surveys ask such questions as whether the graduates have the cognitive skills necessary to do their jobs, whether they have met the entry-level practice requirements of their organizations, and whether any job tasks should be added to the METC curriculum for their programs of study.

#### METC Is Taking Action to Address Issues Related to Course Accreditation and the Post-Graduate Survey Process

METC officials told us that some training courses were awarded fewer recommended credits by the ACE than similar service-run courses had received prior to METC's consolidation.<sup>28</sup> Officials also stated that the consolidation of service-run curricula into single programs at METC was conducted by a contractor, and that these consolidated curricula could be improved. METC officials further noted that the ACE review of METC's consolidated curricula occurred after a change to that body's process for

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<sup>27</sup>The Health Care Interservice Training Office serves as a facilitating and coordination support office and as the point of contact on health care interservice training for all military services. It is one of five Interservice Training Offices under the Interservice Training Review Organization.

<sup>28</sup>The ACE reviews METC courses and recommends the number of credits that outside colleges, universities, and training programs should accept for completion of courses at METC.

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recommending credits, and that they are unaware whether the decrease in the number of recommended credits was due to the consolidated curricula or changes to ACE's process. METC officials told us that they are attempting to improve their programs through their regular process of curriculum review ahead of future ACE reviews of recommended credits for their courses.

METC officials also told us that the post-graduate survey process has been ongoing since before METC was established; however, these surveys have historically exhibited low response rates. For instance, one sample survey provided by METC officials had a 14 percent student response rate and a 0 percent supervisor response rate. To improve the level of feedback received from these surveys, METC officials have begun a pilot process to conduct their own post-graduation surveys, using an online survey program that can be sent directly to the students' and supervisors' personal email addresses. Depending on the success of the pilot, METC officials plan to extend the process throughout all of METC.

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## Conclusions

DHA's Education and Training Directorate is scheduled to begin operations in August 2014 to oversee medical education and training reform, but DOD does not have key information necessary to assess its progress in realizing the reform effort's goal of achieving cost savings. When DOD responded to the 2005 BRAC recommendation to relocate some medical education and training programs for enlisted servicemembers at METC, DOD similarly did not have key information necessary to determine whether the consolidation of training there had resulted in cost savings. Although DOD's plans for the implementation of the DHA acknowledge the benefits of conducting business case analyses, it has not done so for its medical education and training reforms. DOD's inability to demonstrate that cost savings had resulted from the consolidation of training at METC risks being repeated on a larger scale in the reform effort of the DHA's Education and Training Directorate. Specifically, absent analysis demonstrating how the Directorate's efforts will result in cost savings, the creation of the Directorate could increase costs by increasing staff levels without achieving any cost savings. In addition, without baseline cost information prior to future course consolidation of training at METC and within the Education and Training Directorate, DOD will be unable to assess potential cost savings. The risk of cost growth also exists for any future consolidations of training at METC, which could require significant investment of time and resources without any long-term efficiencies.

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## Recommendations for Executive Action

To help realize the reform effort's goal of achieving cost savings, we recommend that the Assistant Secretary of Defense for Health Affairs direct the Director of the DHA to conduct a fully developed business case analysis for the Education and Training Directorate's reform effort. In this analysis the Director should

- identify the cost-related problem that it seeks to address by establishing the Education and Training Directorate,
- explain how the processes it has identified will address the cost-related problem, and
- conduct and document an analysis of benefits, costs, and risks.

To help ensure that DOD has the necessary information to determine the extent to which cost savings result from any future consolidation of training within METC or the Education and Training Directorate, we recommend that Assistant Secretary of Defense for Health Affairs direct the Director of the DHA to develop baseline cost information as part of its metrics to assess achievement of cost savings.

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## Agency Comments

We provided a draft of this product to DOD for comment. The Acting MHS Chief Human Capital Officer provided DOD's comments in an email dated July 21, 2014. In that email, DOD concurred with the draft report's findings, conclusions, and recommendations. Additionally, noted in the email was that Medical Education and Training is the only shared service that has never had any type of oversight by the Office of the Assistant Secretary of Defense for Health Affairs or the pre-DHA TRICARE Management Activity. Further, in that email, DOD noted that that much credit goes to the sub-working group which has worked numerous hours over the past 2 years to put this shared service together so the MHS can realize efficiencies and garner maximum value, exploit best practices from the services, and achieve standardization where it makes sense.

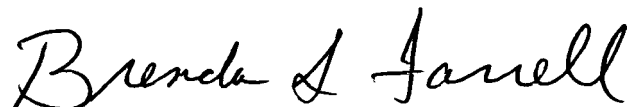
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We are sending copies of this report to the appropriate congressional committees; the Secretary of Defense; the Assistant Secretary of Defense for Health Affairs; the Director, DHA; and the Surgeons General of the Army, the Navy, and the Air Force. In addition, the report is available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-3604 or [farrellb@gao.gov](mailto:farrellb@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last

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page of this report. GAO staff who made major contributions to this report are included in appendix II.

A handwritten signature in black ink that reads "Brenda S. Farrell". The script is cursive and fluid, with the first letters of each word being capitalized and prominent.

Brenda S. Farrell  
Director  
Defense Capabilities and Management

# Appendix I: Medical Education and Training

## Campus Courses and the Course Participants

The Medical Education and Training Campus (METC) is the result of the 2005 Base Realignment and Closure (BRAC) Commission legislation that required the bulk of enlisted medical training in the Army, Air Force, and the Navy to be co-located at Fort Sam Houston, Texas. As a result, four major learning institutions for Navy and Air Force relocated to Fort Sam Houston, where the Army was already training its enlisted medical force under the Army Medical Department Center & School’s (AMEDD C&S) Academy of Health Sciences. The Naval School of Health Sciences in San Diego, California; Naval School of Health Sciences in Portsmouth, Virginia; Navy Hospital Corps School in Great Lakes, Illinois; and the 882nd Training Group (now the 937th Training Group) at Sheppard Air Force Base moved to Fort Sam Houston, Texas. METC is now the largest military medical education and training facility in the world.

METC started operating on June 30, 2010. Its initial training course was radiography specialist. Other courses were phased in throughout the rest of the year and into 2011. METC became fully operational on September 15, 2011. The longest program offered is cytology, which is the study of cells, at 52 weeks; and the shortest, at 4 weeks, is patient administration. METC offers about 50 medical training programs, which are listed in table 2 along with the course participants.

Table 2: Service Participation in Medical Education and Training Campus (METC) Programs			
Program and course title	Army	Navy	Air Force
<b>Ancillary Training Department</b>			
- Diet Therapy Fundamentals			✓
- Nutrition and Diet Therapy	✓		✓
- Nutrition in Prevention			✓
- Occupational Therapy	✓	✓	
- Pharmacy	✓	✓	✓
- Pharmacy Craftsman			✓
- Physical Therapy	✓	✓	✓
<b>Basic Medical Technician Corpsman Department</b>			
- Basic Medical Technician/Corpsman		✓	✓
<b>Combat Medic Department</b>			
- Combat Medic	✓		
<b>Dental Services Department</b>			
- Advanced Dental Laboratory		✓	
- Advanced Porcelain Technician	✓	✓	✓

**Appendix I: Medical Education and Training  
Campus Courses and the Course Participants**

<b>Program and course title</b>	<b>Army</b>	<b>Navy</b>	<b>Air Force</b>
- Dental Assistant (Air Force only)			✓
- Dental Assistant (Army only)	✓		
- Dental Assistant (Navy only)		✓	
- Dental Laboratory Basic	✓	✓	✓
- Fixed Prosthodontics	✓	✓	✓
- Removable Prosthodontics		✓	✓
<b>Diagnostic Services Department</b>			
- Cytotechnologist	✓		
- Electroneurodiagnostic		✓	✓
- Histopathology		✓	✓
- Medical Laboratory (Air Force only)			✓
- Medical Laboratory	✓	✓	
- Nuclear Medicine	✓	✓	✓
- Radiographer	✓	✓	✓
<b>Healthcare Support Department</b>			
- Advanced Field Medical Systems	✓	✓	✓
- Advanced Sterilization Systems	✓	✓	✓
- Biomedical Equipment Management	✓	✓	✓
- Biomedical Equipment Technician	✓	✓	✓
- Biomedical Officer Management Orientation			✓
- Computed Tomography	✓	✓	✓
- Computer Based Medical Systems	✓	✓	✓
- Mammography Imaging Systems	✓	✓	✓
- Medical Expense/Performance Reporting System			✓
- Medical Logistics	✓		✓
- Medical Materiel Supervisor			✓
- Patient Administration	✓		✓
- Radiographic Acceptance Procedures	✓	✓	✓
- Radiographic /Fluoroscopic Imaging Systems	✓	✓	✓
- Telemedicine	✓	✓	✓
- Ultrasound Imaging Systems	✓	✓	✓
<b>Nursing and Specialty Medical Training Department</b>			
- Cardiopulmonary			✓
- Cardiovascular Technologist	✓	✓	
- Independent Duty Medical Technician			✓
- Ophthalmic	✓		✓
- Orthopedic	✓	✓	✓

**Appendix I: Medical Education and Training  
Campus Courses and the Course Participants**

<b>Program and course title</b>	<b>Army</b>	<b>Navy</b>	<b>Air Force</b>
- Otolaryngology Technologist	✓		✓
- Respiratory Therapy	✓	✓	
- Surgical Technologist	✓	✓	✓
- Urology		✓	✓
Public Health Services Department			
- Behavioral Health	✓	✓	✓
- Preventative Medicine	✓	✓	

Source: METC. | GAO-14-630.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

Brenda S. Farrell, (202) 512-3604 or [farrellb@gao.gov](mailto:farrellb@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Lori Atkinson, Assistant Director; Rebecca Beale; Jeffrey Heit; Mae Jones; Carol Petersen; Michael Silver; Adam Smith; and Sabrina Streagle made key contributions to this report.

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# Related GAO Products

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*Military Health System: Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings.* [GAO-14-396T](#). Washington, D.C.: February 26, 2014.

*Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability.* [GAO-14-49](#). Washington, D.C.: November 6, 2013.

*Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed.* [GAO-12-911](#). Washington, D.C.: September 26, 2012.

*Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System.* [GAO-12-224](#). Washington, D.C.: April 12, 2012.

*2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue.* [GAO-12-342SP](#). Washington, D.C.: February 28, 2012.

*Follow-up on 2011 Report, Status of Actions Taken to Reduce Duplication, Overlap, and Fragmentation, Save Tax Dollars, and Enhance Revenue.* [GAO-12-453SP](#). Washington, D.C.: February 28, 2012.

*Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue.* [GAO-11-318SP](#). Washington, D.C.: March 1, 2011.

*Military Personnel: Enhanced Collaboration and Process Improvements Needed for Determining Military Treatment Facility Medical Personnel Requirements.* [GAO-10-696](#). Washington, D.C.: July 29, 2010.

*Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure.* [GAO-08-122](#). Washington, D.C.: October 12, 2007.

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