UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAR 30 2018

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is the third interim response to section 702 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328), concerning "Reform of Administration of the Defense Health Agency and Military Medical Treatment Facilities." In February 2018 the Department finalized the new framework by which it will transition Military Treatment Facility (MTF) administration and management from the Military Medical Departments to the Defense Health Agency (DHA). Detailed transition and implementation planning is well under way.

Section 702 directs a major transformation of the Military Health System (MHS). Substantial challenges are inherent in implementing major reform such as that required by this legislation, not the least of which is maintaining "a ready medical force and a medically ready force." As the enclosed report conveys, we are making significant progress toward the goal of one fully integrated Military Health Care System, with administration and management of MTFs by the DHA, which will ultimately result in increased readiness, better health, better care, and lower costs.

The final report will be submitted by June 30, 2018, and will provide additional details on our efforts to reduce the size of MHS headquarters activities through elimination of duplicative activities carried out by the DHA and Military Departments. Thank you for your continued support.

Sincerely,

Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAR 30 2018

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

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As stated

cc:
The Honorable Jack Reed
Ranking Member

Report to the Armed Services Committees of the Senate and House of Representatives

Preliminary Draft Plan to Implement 1073c of Title 10, United States Code

Interim Report

31 March 2018

In Response To: Section 702(e)(2) of the National Defense Authorization Act for Fiscal Year 2017, Public Law 114-328

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $24,675. This includes $0 in expenses and $24,675 in DoD labor.

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Recommendations for Legislative Actions

The Department has taken a deliberate and collaborative approach in establishing a transition and implementation plan for 10 USC §1073c that is consistent with Congressional intent and preserves military readiness and promotes efficient and effective delivery of health care and the military health benefit.

To accomplish the proposed implementation plan described in this report, the Department intends to request legislative revisions that will authorize a phased approach to the implement of 10 USC §1073c and would grant the Secretary of Defense the authority to waive specific requirements of 10 USC §1073c if the Secretary determines such waiver is necessary for implementation feasibility or military health readiness.

This implementation plan reflects a phased approach and includes features that are dependent on the grant of waiver authority to the Secretary of Defense, as contemplated by the legislative revisions proposed.

Background

In June 2017, DoD delivered an interim Report to Congress describing a "Component Model" for implementing 10 USC §1073c. After deeper analysis and discussions with Congress, the Department decided that the Component Model did not adequately satisfy the requirements of subsection (a) of 1073c. Beginning in December 2017, a new framework was developed to ensure that the Defense Health Agency (DHA) will have direct control over Military Treatment Facilities (MTF) while the Services retain control over their uniformed personnel and operational and installation-specific functions. This new framework has the advantage of allowing the Service Medical Departments to focus on their readiness missions while DHA standardizes policies and procedures to realize efficiencies and cost savings in the administration and management of MTFs. In February 2018, the Under Secretary of Defense (Personnel & Readiness) issued guidance on behalf of the Department, outlining the new framework for implementing 10 USC §1073c. Because the Department has only recently changed the model for satisfying subsection (a) of 1073c, more time is required to complete the planning for this enormous transformation and to finalize the operational details of the Department's proposed framework for the implementation of 10 USC §1073c. Therefore the Department is providing this interim report on progress toward implementation and will submit a final implementation plan and report not later than June 30, 2018.

This interim report provides an update on the information requested by Congress:
(A) How the Secretary will carry out subsection (a) of such section 1073c;
(B) Efforts to eliminate duplicative activities carried out by the elements of DHA and the military departments;
(C) Efforts to maximize efficiencies in the activities carried out by the DHA; and
(D) How the Secretary will implement such section 1073c in a manner that reduces the number of members of the Armed Forces, civilian employees who are full-time equivalent employees, and contractors relating to the headquarters activities of the military health system, as of the date of the enactment of this Act.

The end state goal is an integrated system of readiness and health providing agile military medical capabilities to support the United States in competing, deterring and winning conflicts across the spectrum while continuously delivering highly reliable performance with affordability and speed.

(A) How the Secretary will carry out subsection (a) of section 1073c

MTFs cannot operate in isolation from the rest of the MHS. Subsection (a) of 1073c supports enhanced integration by allowing each MHS component to focus on its primary missions: the Services ensure that their uniformed personnel are medically ready to deploy and DHA provides the platform for the readiness of military medical personnel and the health of active duty personnel and their families. Both DHA and the Service Medical Departments have a critical role in ensuring the readiness of our warfighters. This section will discuss the role of each MHS component during and after implementation of subsection (a) of section 1073c.

MHS Organizational Framework

The MHS currently operates as a federated system comprised of the Office of the Assistant Secretary of Defense for Health Affairs (ASD (HA)); the Defense Health Agency (DHA); the three Service Medical Departments: Army Medical Command (MEDCOM), the Navy Bureau of Medicine and Surgery (BUMED), Air Force Medical Service (AFMS); and the Uniformed Services University of the Health Sciences (USUHS).

The responsibilities of the ASD(HA) and the DHA are established in DoD Directives 5136.01 and 5136.13 respectively. These directives will be updated in 2018 to reflect changes in the law associated with the enactment of 10 USC §1073c and Departmental implementing guidance.

Health Affairs

The ASD(HA) is the principal advisor to the Secretary of Defense and the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) for all Department of Defense (DoD) health policies, programs and force health protection activities. The ASD(HA) ensures the effective planning and execution of the Department's medical mission, providing and maintaining readiness for medical services and support to members of the Armed Forces including during military operations; their dependents; those held in control of the Armed Forces; and others entitled to or eligible for DoD medical care and benefits under the TRICARE program. In carrying out these responsibilities, the ASD(HA)) exercises authority, direction and control over DoD medical and dental personnel authorizations and policy, facilities, programs, funding, and other resources in the DoD.

The Defense Health Program (DHP) will remain under the authority of the ASD(HA) who is responsible for allocation of funding to the DHA, the Services, and USUHS to carry out their respective responsibilities. As for the DHP appropriation, ASD(HA) will continue to be responsible for the Planning, Programming, Budgeting, and Execution (PPBE) processes and will provide fiscal guidance to:

- DHA, which is responsible for the PPBE portion of the DHP for both DHA operations as well as those of the MTFs;
- Regional Leaders and MTF Directors/Commanders, who will retain flexibility to manage their DHP-budgeted allotment during the year of execution, subject to compliance with DHA fiscal policies and controls;
- Service Medical Departments, which are responsible for their medical program PPBE portion of the DHP appropriation for military manpower, and operational and installation-specific medical requirements, including non-MTF associated commands of health-related activities.

ASD(HA) will develop consolidated DHP PPBE products for the Department, with input from DHA and the Military Departments, for submission through the USD (P&R) to the Under Secretary of Defense (Comptroller/Chief Financial Officer).

An Integrated Financial Management System

The distribution and execution of DHP funding is currently dispersed amongst multiple, disparate accounting systems. The current MHS enterprise architecture hinders the overarching

goal for audit ready initiatives and agency standard financial business processes. The solution chosen for MHS to meet these challenges is to deploy a single operational financial management system with minimal mission and business impact. This solution will also support consolidation of budgetary matters as directed by 10 USC §1073c. ASD(HA) has decided to implement General Fund Enterprise Business System (GFEBS) at the DHA and across all MTFs, which is a critical step toward moving the MHS to a single financial business system. By adopting one system we will:

- Facilitate the cost reduction of MHS Audit Readiness
- Enhance market management and operations (financial transparency and standardized business processes)
- Achieve improved management of MHS financial processes down to the MTF level
- Accomplish more effective allocation and execution of funds across Services
- Simplify Common Cost Accounting Structure (CCAS), reducing costs and becoming better stewards of resources
- Reduce the Information Technology footprint and costs
- Better support shared service goals through integrated financial, logistics, and procurement processes
- Facilitate MHS-wide asset management

During the Department's annual budget cycle, the Services will identify and communicate to ASD(HA) their known operational readiness requirements. This will enable ASD(HA) to plan for and accommodate Service-delineated needs for their uniformed personnel and also to accommodate DHA planning processes, by projecting any expected constraints, such as required training activities, affecting the availability of MTF-assigned personnel. The Services will inform DHA of any Request for Forces for contingency operations, ensuring that DHA has sufficient information to plan for any necessary backfilling of personnel or the referral of beneficiaries to the purchased care network depending on the market or geographic region.

The ultimate goal of the DHP financial management program is to transition financial operations to a platform that allows for consistency across the MHS, enabling standardized processes, data collection, reporting, and performance evaluation.

Figure 1 depicts the future state of financial management and funds distribution beginning October 1, 2018.

FIGURE 1: Defense Health Program Appropriation and Allocation Post Transition

MHS Governance

ASD(HA) is developing a new streamlined governance structure to facilitate transition and for the future-state of the MHS. The goal of MHS governance will be to provide a forum for the exchange of information to inform decision-making, ensure integration of readiness and health, and ensure standardization across the enterprise.

DHA Organizational Framework

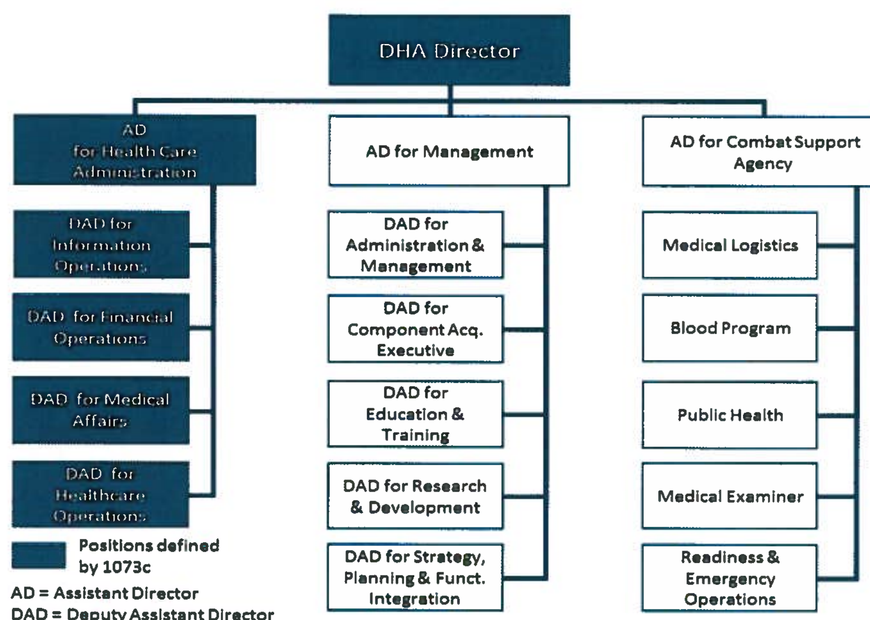
DHA Functions and Management Structure to Address Section 702

DHA's objective will be to transition to an integrated system of readiness and health – bringing together direct care MTF operations with the purchased care sector of the MHS – all under the "single agency" called for by Congress in enacting section 702. This integration objective is important in supporting the other reform provisions of the National Defense Authorization Act (NDAA) for 2017, which calls for the MHS to more closely align the direct care system to clinical functions that directly support operational medical force readiness and to rely on the purchased care system for other services for DoD health care beneficiaries. This translates to the

need for more effective patient care and referral coordination between the direct care and purchased care sectors to better support the readiness focus of MTFs and the cost-effectiveness focus of the TRICARE network. This transition process must be accomplished through a single agency that will have full management controls over both direct and purchased care sectors.

DHA has reorganized its headquarters to efficiently execute its new responsibilities, while maintaining its ongoing Combat Support Agency (CSA) and Enterprise Support Activity (ESA) functions. The DHA structure comports with the organizational structure directed in 1073c subsections (b) and (c) and the delineated positions will be filled as outlined in the statute. The DHA is currently in the process of hiring staff to fill these senior level positions per statute and anticipates completion of the hiring process by the end of calendar year 2018. As illustrated in Figure 2 below, three (3) Assistant Directors will report to the DHA Director.

FIGURE 2: Future DHA Headquarters Management Structure



- The **Assistant Director for Health Care Administration (ADHCA)** will have responsibility for establishing: priorities for health care administration and management; policies, procedures, and direction for the provision of direct care at MTFs; priorities for budgeting; policies, procedures, and direction for clinic management and operations, at MTFs; and priorities for information technology at and between MTFs.

- **The Assistant Director for Management** will have responsibility for the ongoing operation of corporate functions not related to the administration of MTFs, including the Research and Development (R&D), Education and Training (E&T), and certain other administrative and procurement functions.

- **The Assistant Director for Combat Support Agency (CSA)** will have responsibility for managing CSA functions, including the Medical Logistics (MEDLOG)

ESA, the Armed Services Blood Program Office (ASBPO), and the DHA Emergency Operations Center.

Regional Management

DHA will manage MTFs using a customized regional approach with certain functions geographically distributed, and other will be managed centrally

Table 1 outlines the functional activities that DHA is planning to execute through the regional construct. The Department's objective is to significantly reduce overall headquarters staff (military, civilian, and contractor) and ensure resources are used to streamline MTF administration and management. Final details of the regional construct and the staffing models for this approach are being developed and will be included in the final report.

Table 1: DHA Regional Construct – Proposed Functional Activities

DHA Regional Construct – Functional Activities				
Health care Operations	**Medical Affairs**	**Financial Operations**	**Information Operations**	**Other**
Clinical Operations	Quality (Patient Safety, Risk Management)	Financial Management & Comptroller	Information Technology	Logistics and Facilities
Pharmacy	Clinical Communities	Business Operations	MHS GENESIS Integration	Education and Training
TRICARE Regional Office Oversight and Integration	Clinical Analytics	Procurement and Contracting	Regional Telehealth	Clinical Investigations

Leveraging the Enhanced Multi-Service Markets (eMSMs): The Market Approach

The DHA will direct enterprise-wide programs that support standardized delivery of health care within geographic Markets and at MTFs, in order to support readiness requirements; improve health care safety, quality, and access; and more efficiently manage the resources committed to health care delivery. The enhanced Multi-Service market model used since 2013 has informed the Department's market approach going forward. The DHA will execute two major administration and management lines of effort (LOEs) related to the delivery of health care at MTFs: (1) Build Market health care delivery capability; and (2) Manage MTFs within Markets.

The DHA will establish a system of metrics and measurements to evaluate health care delivery, efficiency, and performance and will use information reported through this system to evaluate Market and MTF performance. The Director, DHA has the authority for assessing market conditions and executing actions to improve performance. The DHA may direct actions that include adjusting health care services offered by specific Market or MTFs (with attendant resource implications), implementing partnerships with other health systems, and the establishment of new programs or initiatives. The DHA Assistant Director for Health Care Administration (ADHCA) will execute Market Management with Market Managers to:

- Manage and allocate the budget.
- Establish standards for clinical and business functions.
- Optimize readiness to deploy medically ready forces and ready medical forces.
- Plan and program for the optimization of the workload at all MTFs.
- Integrate the movement of workload and workforce between or among MTFs in the respective market areas.
- Maximally integrate the direct and purchased care systems.
- Deliver patient-centered care.
- Establish military-civilian integrated delivery systems through partnerships with local regional health systems.
- Incorporate leading practices into the daily operations of MTFs to eliminate variability in health outcomes and to improve the quality of health services.
- Establish internal management controls.

DHA Responsibilities as a Combat Support Agency

The DHA is a designated Combat Support Agency (CSA) that provides direct support to all Combatant Commanders through the provision of services and resources for operating forces engaged in planning for, or conducting, military operations, including support during conflict or in the conduct of other military activities related to countering threats to U.S. national security.[1]

As a CSA, the DHA will support the requirements of 10 USC §1073c by providing the venues for military medical personnel to obtain operational clinical competencies (otherwise known as clinical Knowledge, Skills, and Abilities or "KSAs") and coordinate with the Military Departments to ensure that staffing at MTFs supports readiness requirements for Armed Forces health care personnel and members of the Armed Forces. Within the parameters of its statutory responsibilities and chartering DoD Directive 5136.13, the DHA plans for and provides operational commanders with the optimal support capabilities attainable within existing and programmed resources. The DHA Director will provide currency workload for uniformed personnel at each MTF, or, when such workload is not available, will support the Services in the identification of alternative sites at which currency can be obtained and/or maintained. In meeting the intent of 10 USC §1073c, the DHA also collaborates with the Military Departments to ensure an integrated and standardized TRICARE and health care delivery system, will coordinate with the Military Departments on matters regarding the administration of MTFs and MHS personnel, and will ensure that staffing at MTFs supports readiness requirement for members of the Armed Forces.

MTF Operations Framework

The basic elements of the model to fulfill the requirements of 10 U.S.C. § 1073c as approved by the Department on February 21, 2018 include:

All MTF clinical/health delivery services and business operations will come under the authority, direction, and control of the DHA. An MTF is defined as a fixed health care facility funded by the DHP. The DHP remains under the authority of the ASD(HA) who is responsible for

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[1] DoDD 5136.13 "Defense Health Agency (DHA)", DoDD 3000.06 "Combat Support Agencies (CSAs)"

allocation of funding to the DHA and to the Military Departments to carry out their respective responsibilities as noted below.

The Director/Commander of each MTF will exercise authority, direction and control over MTF operations and will report to the Director, DHA. The MTF leadership team will report to the MTF Director/Commander.

There will be a Military Department-specific leader responsible for the operational readiness activities of the uniformed personnel at the MTF, hereafter referred to as the "Service Commander." All MTF-based activities not involving clinical/health delivery services that are tied to organizing, training, and equipping personnel for operational readiness missions, will fall under the command of the Service Commander, together with operational and installation-specific medical functions separate from MTF health care delivery/operations. Collectively, the responsibilities of the Service Commander will be referred to, hereafter as "operational readiness." The Service Commander will report through the established Military Department chain of command. The respective duties of the MTF Director/Commander and the Service Commander are outlined in the USD(P&R) guidance memorandum found in Appendix A.

Military Departments will set readiness requirements and ensure their military medical personnel are trained and maintain their clinical KSAs. The DHA is responsible for providing the venues for military medical personnel to maintain clinical KSAs, as defined by the Military Departments within the MTFs. The Military Departments are responsible for making their military personnel available for placement at the MTFs in accordance with Service-generated readiness requirements and the capability requirements established by the DHA. DHA will coordinate with the Military Departments to ensure that staffing at MTFs supports readiness requirements.

If the DHA cannot meet Military Department readiness requirements through the MTFs, the DHA will support the Military Departments in establishing military-civilian partnerships, collaborative undertakings between the DoD and the Department of Veterans Affairs, and other appropriate practice venues to provide the clinical experience required to obtain and maintain KSAs. Pre-existing Service partnerships will be grandfathered, as appropriate, but will be subject to recurring review to ensure that each such partnership enhances appropriate KSA acquisition or sustainment or supports longstanding MTF-community relationships. Military Departments may take advantage of the MTF readiness opportunities to train to and maintain KSAs, but have autonomy to decline MTF readiness opportunities and pursue other non-military partnerships, subject to business rules to be developed.

MTFs (other than the National Capitol Region inpatient facilities) will continue to be Military Department-affiliated unless a decision is made at a later date to evolve this current construct to MTFs that are Tri-Military Department in nature, or to some other organizing construct.

The Military Department Surgeons General:

- Serve as the principal advisor to the Secretary of the Military Department concerned on all health and medical matters of the Military Department.
- Serve as the chief medical advisor of the Military Department concerned to the Director, DHA on matters pertaining to military health readiness requirements and safety of military members.
- Subject to the authority, direction, and control of the Secretary of the Military Department concerned, are responsible for recruiting, organizing, training, and equipping the military medical personnel of the Military Department concerned.

MTF civilian and contractor personnel, not directly and primarily supporting defined Military Department operational and installation-specific medical functions, are appointed, contracted for, and managed by the DHA. Uniformed personnel working within MTFs are assigned to Military Department-specific commands. The Military Departments have command and control over these uniformed personnel and have the authority to make them available for assignment to specific MTFs and to reassign them for operational missions as needed. DHA has day-to-day authority with regard to how uniformed personnel working at the MTF will be utilized, consistent with Military Department requirements to maintain operational readiness and training and to fulfill operational readiness requirements.

During the Program Objective Memorandum (budget) cycle, the Military Departments will identify and communicate to DHA the operational readiness requirements they will have for the following year, so as to enable DHA to plan for and accommodate Military Department-delineated needs for their uniformed personnel and also to outline for DHA planning purposes any expected constraints such as training activities those MTF assigned personnel may have. Military Departments will inform DHA upon receipt of any Request for Forces for contingency operations, ensuring that DHA has sufficient information with which to plan for any necessary backfilling of personnel or the referral of beneficiaries to the purchased care network, depending on the market or geographic region.

DHA will offer leadership and professional development opportunities for uniformed personnel as Regional and MTF leaders. Military Departments may opt into or decline such developmental opportunities, subject to business rules to be established later. Selection of the MTF Director/Commander will follow Military Department protocols and will ensuring nomination and selection of the highest quality candidates. The Director, DHA will monitor performance and address any performance issues with Military Department leadership and may remove the MTF Director/Commander from the position for poor performance or other good cause shown. Under this construct, the primary performance rating of the MTF Director/Commander will be conducted and issued by DHA. Military Department input into that evaluation will be dictated by the type of manning document employed.

The MTF Director/Commander will be responsible for the performance ratings of all personnel involved in DHA-led health care activities. The Service Commander will be responsible for the performance ratings of all individuals involved principally in operational and installation-specific medical functions separate from MTF health care delivery/operations.

Certain operational and installation-specific medical functions are under the direction of the Military Medical Departments because of Service specificity, Service expertise, and/or importance to Service medical operations missions. The specific functions and baseline budget allocations that will remain under Service administration and management will be specified in subsequent guidance.

Authorities and Responsibilities of MTF Directors/Commanders

MTF Director/Commander

- Execution of MTF Budget
- Authority/administration and management of MTF functional areas including:
  - Planning, Programming, Budgeting and Execution
  - Determination of manpower requirements
  - Business operations, including –coding, billing, collections
  - Patient administration, including –patient registration, patient records
  - Real property management
  - Management of medical logistics (and equipment) for MTF operations
  - Maintenance of health information technology and medical informatics
  - Clinical quality and patient safety practices
  - Medical administration of the MTF, including credentialing and privileging of medical providers
  - Risk management
  - Management of all other hospital based practices and – clinical practices
  - Clinical care of MTF patients
  - Matters pertaining to military health readiness requirements and safety of members of the Armed Forces, subject to consultation with the Service Commander
  - All other administrative responsibilities in managing a practice/clinic/hospital
- Accountability to DHA
- Serving as first line supervisor and rater for the MTF leadership team
- Primary performance evaluation for personnel involved in DHA-led activities in accordance with Service-unique evaluation processes, as applicable
  - The senior rater/reviewer will be determined based on the type of manning document employed and will follow Service policy for personnel in joint positions
- Hiring and management of civilian staffing for MTF functional activities under DHA administration and management, and management responsibility for contractor support to MTF functional activities under DHA administration and management.
- Support to operational readiness requirements and Service-specific functions
- Provide opportunities for clinical education and training for health care service providers assigned to or employed in the MTFs

Health Care Delivery Integration

The DHA Director will have overarching responsibility for integrating health care delivery performance and managing health care delivery across the Direct Care (MTFs) and Purchased Care (TRICARE) systems. In consultation with the Military Departments, the DHA Director will determine the scope of services and capacity provided by the MTFs in support of health care

operations, and will provide MTF targets for enrollment, satisfaction, access, patient safety, quality, and recapture as part of the Quadruple Aim Performance Plan (see page 41). Additionally, the DHA Director will assess utilization and capacity related to available staff within each geographic area at the provider, clinical service line, and MTF levels, to ensure the optimal distribution of personnel and facility usage. The DHA Director will also ensure that all levels—from MTFs to DHA headquarters—receive reliable performance measurement and analytics support. Finally, the DHA Director will ensure continued timely and responsive support to the Military Departments, Combatant Commands, Components, and MTFs by each of the Enterprise Support Activities (ESAs).

Service Medical Departments and Service Commands

As a military command, MTFs do far more than deliver health care—MTFs host a multitude of Service-specific medical readiness and installation support functions. The uniformed personnel assigned to MTFs represent a significant portion of the generating force for the Joint Force's medical capability, and those same uniformed personnel have mission-focused operational force responsibilities to their parent Services in areas that require medical expertise.

Each Service plays a unique operational role in support of the National Military Strategy, and, as such, each Service places unique demands on the medical support it receives in operational settings. The mission of the Service Medical Departments is to prepare uniformed military medical personnel to fully integrate into the line units they support. Deployed medical teams have proven effective in providing medical support to Joint and coalition operations, predominantly in the care of the wounded, ill and injured, and the Services and Combatant Commands have agreed on the importance of further enhancing interoperability as teams are organized, trained and equipped. However, the effective performance of operational medical support and the provision of medical advice to operational commanders requires that military medical professionals are deliberately trained and prepared for their assigned, Service-specific missions.

Using the construct presented in this report, the Department will implement standardized health care delivery processes through a single strategic approach, while allowing the Services to tailor their medical support to operational forces to meet their unique mission needs. This approach mirrors best practices in the private sector, where clinical staff are often employed by organizations separate from those that manage the facility in which they work—Kaiser-Permanente being one such example. The Department is confident that this approach will improve both readiness and health care delivery. With the divestiture of responsibility for management and administration of MTFs, the Services will turn their attention exclusively to their readiness responsibilities. Under this construct, the Service Medical Headquarters and Intermediate/Functional Commands will transfer all MTF administration and management functions to the DHA.

Assignment of MHS Functions

> **Military Departments Divest Administration and Management of the MTFs**
>
> To meet Congressional intent to improve readiness, Military Departments will divest responsibility for MTF administration and management functions and restructure their medical forces to focus on their readiness functions.

The Department identified twelve (12) overarching functions performed by headquarters elements across the MHS. The Department has determined that seven (7) functions are directly related to the administration of the MTFs and that the remaining five (5) functions are directly related to ongoing, Service-specific readiness requirements. Responsibility for the seven MTF administrative functions, together with the associated staff and capabilities will shift from the Military Departments to the DHA; the Military Departments will maintain responsibility for performing operational and installation-specific functions.

The seven MTF administration functions transferring from the Military Departments to the DHA are defined in the Table 2 below.

Table 2: Functions Transferring from the Military Departments to the DHA

Functions Transferring from the Military Departments to the DHA
Health care Administration and Management
Provide policy, procedures, guidance, direction, control and oversight to health care leaders and managers to optimize the execution of health care operations and services within health care facilities and across health care systems.
Administrative Policies & Procedures
Prepare and disseminate formal guidance, in the form of issuances, to manage or supervise the execution, use, or conduct of services and support within core business functions.
Budgetary Matters
Execute PPBE (Planning, Programming, Budgeting, and Execution) activities for DHA and MTF operations.
Military Medical Construction
Plan and implement any real property construction, alteration, development, conversion, or extension of any kind carried out with respect to MTFs.
Information Technology (IT)
Implement, manage, and sustain an integrated and secure medical information technology enterprise to ensure the right information is accessible to the right users at the right time, and in the right way, in both the installation and operational environments.
MTF and Purchased Health Care Operations
Perform, provide, or arrange services to promote, improve, conserve, or restore the mental and/or physical well-being of personnel. Services include, but are not limited to, the management of preventive and curative health measures, such as medical, laboratory, optometric services, and the management of resources, such as manpower, monies, facilities, medical supply, equipment, and maintenance, as regards the delivery of health care in the MTFs.
MTF Based Readiness
Matters pertaining to military health readiness requirements and safety of members of the armed forces, with the advice of the Service Commander (see Appendix A)

The five functions for which each Military Department will maintain responsibility are detailed below in Table 3. The Department defines these functions as functions that are not assigned by 10 USC §1073c to the DHA and are required by the Military Department to maintain and sustain the medical readiness of force or to provide responsive, ready medical capabilities. The Military Departments will provide direction through their established chains of command to the Service Commands for the execution of these functions.

Table 3: Functions Performed by Military Departments

Functions Performed by Military Departments
Identification of Operational Requirements
Identify capabilities necessary to meet warfighter requirements based on defined mission essential tasks within the projected operating environment, and identify the force structure necessary to provide the required capabilities.
Recruit, Organize, Train & Equip Medical Personnel
Recruit, organize, train and equip teams of military members that provide a capability to the Combatant Commander.
Health care Services Provided on Installations that are separate from MTF health care delivery/operations
Provide health care services performed in support of the installation to help maintain healthy people, a healthy environment, a healthy community and healthy animals, including: Occupational Health, Environmental Health, Substance Abuse Programs, Food Protection, Aerospace Physiology, Aerospace Medicine, Bioenvironmental Engineering, Nuclear Power and other Personnel Reliability Programs, Animal Medicine, Dental Care (except oral and maxillofacial surgery), Installation Emergency Response, Deployment-Related Functions, Drug Demand Reduction, Medical Logistics for operational units, Embedded Behavioral Health, and Military Aeromedical Evacuation (Patient Movement).* (*see* Appendix A).
Provide Ready Medical Forces
In relation to functions that are separate from MTF health care delivery/operations, maintain medical forces that are ready or prepared to execute assigned missions within the defined task, conditions, and standards.
Enable Medically Ready Forces
In relation to functions that are separate from MTF health care delivery/operations, optimize health, human performance, and resilience for every individual to prepare the force to meet the health challenges of the full range of military operations, and ensure every Service Member is confident that care is available anytime, anywhere.

*Implementation of some Service Command functions is dependent on the grant of waiver authority to the Secretary of Defense, as contemplated by proposed legislative revisions proposed.

Service Medical Department Structure

The Service Medical Departments will restructure to ensure that the Army, Navy, Air Force, Marine Corps, and Combatant Commands continue to receive the quality medical operational support necessary to meet the needs of the force and the nation. The Military Departments will ensure that the required military structure is in place to maintain the span of control of a geographically and functionally dispersed force and complex Military Department functions, ultimately to ensure the provision and maintenance of a ready medical force and a medically ready force. Within this construct, the Military Department Surgeons General:

- Serve as the principal advisor to the Secretary of the Military Department for all health and medical matters of the Military Department.
- Serve as the chief medical advisor of the Military Department to the Director, DHA on matters pertaining to military health readiness requirements and safety of members.
- Subject to the authority, direction and control of the Secretary of the Military Department concerned, are responsible for recruiting, organizing, training, and equipping the military medical personnel of the Military Department concerned.

Military Departments will transition to Service Command structures in coordination with the phased transition of the administration and management of MTFs to the DHA that will begin on October 1, 2018.

Service Commands

Service Commands will be linked to specific MTFs. Initially, each MTF (other than National Capital Region inpatient facilities) will continue to be aligned to, and affiliated with a particular Military Department and Service. - Over time, the Department will seek opportunities for certain MTFs to support more than one Service Commands. The Service Commands will have the operational flexibility, in collaboration with the DHA, to place medical capabilities in locations where MTFs do not provide a sufficient volume and complexity of care to meet and sustain clinical currency requirements.

Service Commander authorities and responsibilities include:

- Assignment of uniformed medical personnel to MTFs, including, but not limited to, for Service-specific training activities and for operational and training missions. This includes authority to make uniformed personnel available for assignment to specific MTFs and to reassign these personnel for operational missions as needed.
- Hiring and management of civilian and contract staff whose primary duties support operational and installation-specific medical functions that are separate from MTF health care delivery/operations
- Readiness of uniformed personnel and deployable teams/units
- Authority over operational and military-directed medical functions
    - Recruit, organize, train and equip medical personnel
- Service administrative functions with regard to uniformed personnel (e.g., fitness program monitor, leave monitoring, duty status, accountability, deployment management, drug demand reduction, pay inquiries)
- Service as primary rater for the performance evaluations of personnel whose primary duties are in operational and installation-specific medical functions
    - Performance evaluation tracking, completion, and compliance with Service requirements
- Logistical support of uniformed personnel and deployable teams/units
- Health, safety, morale, and welfare inspections
- Uniform Code of Military Justice (UCMJ)/discipline and administrative actions pertaining to uniformed personnel
- Family support, including family care plans
- Military inquiries and investigations
- Professional military education and training

- Service member preparation for promotion/selection boards and other boards
- Accountability to the designated Military Department chain of command
- Operational and military-specific functions

The Military Departments, in coordination with the DHA, will maintain responsibility for ensuring a ready medical force. Specifically, the Military Departments will coordinate with the DHA, as addressed in 10 USC § 1073c and implementing guidance, to ensure staffing at MTFs supports readiness requirements for members of the Armed Forces and military medical personnel, and will provide timely input to the DHA regarding programmatic changes to uniformed end-strength, movement of uniformed personnel due to mission and/or readiness requirements, or other Military Department directed changes.

Service Medical Department Specific Constructs

Each Service Medical Department is called upon by its parent Military Department to perform unique, specific missions aligned to the role assigned the Military Department in the National Military Strategy. As such, each Service Medical Department will take specific actions to organize and operate in a way that is supportive to both its Military Department's mission and DHA's role in administering the MTFs. The following sections, provided by the three Military Departments, detail how each Medical Department will meet Service-specific mission requirements going forward.

Army Medicine

Army Medicine, through the Surgeon General, advises the Chief of Staff of the Army (CSA) on the development, policy direction, organization and overall management of the Army Health System (AHS). Army Medicine is organized to support AHS operational priorities in four lines of effort to include: (1) Readiness and Health (Decisive Operation); (2) Health Care Delivery (Shaping Operation); (3) Force Development (Shaping Operation); and (4) Take Care of Ourselves, our Soldiers for Life, Department of the Army Civilians and Families (Sustaining Operation).

The *Health Care Delivery* line of effort is a shaping operation as it establishes the conditions for decisive operations. The health care delivery line of effort will be significantly reorganized by 10 USC §1073c. The fundamental tasks of Army Medicine will remain the promotion, improvement, conservation, or restoration of the behavioral and physical well-being of those entrusted to its care. From the battlefield to the garrison environment, Army Medicine will support the Operational requirements of Combatant Commanders. The quality health care delivered to beneficiaries, and especially families, allows the warfighter to remain ready and focused on the task at hand. Going forward, the DHA will play a vital role in ensuring MTFs perform as Health Readiness Platforms (HRPs), in which Army Medicine will train our medical personnel to support a ready force.

The *Force Development* line of effort is another shaping operation; it establishes the conditions for decisive operations by providing responsive medical capabilities within the generating and operating forces that must be premier, expeditionary and globally integrated—to an even greater degree in the future. The future of Army Medicine at the individual, organizational and enterprise levels is being determined today. We must expeditiously develop scalable and rapidly deployable medical capabilities that are responsive to operational needs and are able to operate effectively in a Joint/Combined environment characterized by highly distributed operations and minimal, if any, pre-established health service infrastructure.

Army Medicine Operational End State

The end state of the Army Medicine operational approach described above mirrors the conditions that define Army Medicine's ultimate success. To achieve this end state, Army Medicine must produce four outcomes of value to those we directly serve and to satisfy the diverse expectations of stakeholders (National Command Authority, Congress, Secretary of the Army, CSA, Supported Joint-Force and Army Commanders, Service members, Military Health System beneficiaries, and Army Medicine teammates);

Medical Readiness of the Total Army (Medically Ready Force): Army Medicine enables the medical readiness of the Total Army. Soldiers come from cultures, communities and environments that produce a variety of health and fitness outcomes. Unit commanders are responsible for Soldier readiness, but rely on Army Medicine's technical expertise and capabilities to prevent, identify, and treat health problems, while optimizing the performance of healthy Soldiers. Army Medicine will enable medical readiness by: developing Army policies and standards for expeditionary medical readiness, advising commanders on the health readiness of their Soldiers, assisting commanders to identify and reduce environmental health threats, developing knowledge and tools to positively modify physical performance and behavior, and providing responsive support to transitioning Soldiers who are medically unqualified for continued military service. The medical readiness of the Total Army ensures that our nation can rapidly and reliably project ground combat power that will physically dominate in missions across the range of military operations.

Responsive Medical Capabilities (Ready Medical Force): Army Medicine ensures it is postured to support Army commands, Service Component commands and direct reporting units, as well as supported Joint/Combined force commands with health services across the range of military operations. Static operational health service support and stove-piped medical processes will hinder our ability to integrate with supported organizations to enable the accomplishment of diverse missions. Army Medicine will develop responsive medical capabilities by: preparing for any threat environment and ensuring support to contingency and wartime requirements, improving partner nation effectiveness and interoperability, developing a cadre of operationally proficient technical experts, and organizing trained and equipped teams with advanced expeditionary tools and a common understanding of techniques. Responsive medical capabilities contribute to the supported commander's mission accomplishment and satisfaction by delivering desired health outcomes whenever and wherever required.

Quality, Outcomes-Based Care for All We Serve (Shared Accountability with DHA): Army medical personnel will train and deliver care in MTFs and will ensure the health care delivered to beneficiaries effectively produces health care outcomes that exceed national standards. Army Medicine retains direct oversight and responsibility for quality, safe outcomes in the operational environment and will ensure, by leveraging MTFs under the responsibility of DHA, that medical personnel sustain the highest level of proficiency and clinical currency as they rotate between garrison and operational missions in support of the warfighter.

Healthy and Satisfied Families and Beneficiaries: Army Medicine does its part in support of MHS policy that ensures that families and beneficiaries have access to health services required to improve their health and that they are satisfied with the methods for ensuring their wellbeing. There is interdependence between families, beneficiaries, and Army Medicine. Health services are a key benefit in the recruiting and retention of the All-Volunteer Force. Additionally, the diversity, complexity and volume of services required in the provision of this benefit enable the

training and mastery of the technical skills of personal assigned to the Army Medical Department. The Department must provide a health benefit equal to or exceeding national standards to honor the service commitment by Soldiers for Life and their families. Healthy and satisfied families and beneficiaries promote the All-Volunteer Force, conserve military resources, and sustain Army *esprit de corps*.

Army Medicine Performance Improvement

Transferring responsibility for MTF operations to DHA, will allow Army Medicine to focus on its Service Command and operational and installation-specific medical responsibilities. Army Medicine identified the following key processes in which it must excel to generate performance improvement in the outcomes required to meet stakeholder expectations. The internal processes critical to Army Medicine include:

- **Optimize Soldier Protection in all Environments:** Army Medicine leverages the principles of prevention and protection to support Army readiness. It protects Soldiers, Department of the Army civilians, and beneficiaries from potential and actual harmful exposures, while working aggressively to minimize the risks and impacts of injuries and illnesses on the Total Force. A comprehensive approach includes both the Soldier and the environment—addressing occupational and environmental health hazards; endemic communicable diseases; food-, water- and vector-borne diseases; ionizing and non-ionizing radiation; combat and operational stressors; heat, cold and altitude extremes; toxic industrial materials (TIMs); and chemical/biological/radiological/nuclear (CBRN) warfare agents; and other physical agents. Optimized protection preserves the effectiveness and survivability of Army combat power potential.
- **Improve Joint and Global Health Partnerships and Engagements:** Army Medicine develops, matures, and sustains partnerships by working side-by-side with joint and foreign medical forces to mitigate interoperability challenges, enabling responsive medical support to deployed U.S. and multi-national forces. Deliberate health partnership and engagement improves responsive medical capability and technical expertise when nested with Army Service Component Commanders' and Joint Force Commanders' intents.
- **Improve Operational Readiness:** Army Medicine develops and sustains Army Medical Department personnel and capabilities that provide premier expeditionary health services. An operationally ready Army Medical Department provides sustainable, rapidly deployable Army Health System support to the operating force. Army Medicine will: design the Army Medical Department to support no-notice, rapid deployments with mission trained personnel able to transition from garrison to an area of operation; design the Army Medical Department to quickly aggregate and disaggregate medical capabilities in response to emerging crises; design and train an Army medical Department capable of supporting missions across the range of military operations, including those in austere and non-permissive environments; ensure Army Medicine personnel are trained and equipped to deploy rapidly to support operational units; maintain institutional capacity to ensure the Army Medical Department is prepared to support the Army's required capability to mobilize rapidly and project forces in response to emerging crises; and increase Army's agility and capacity for high intensity warfare by posturing for rapid expansion of wounded warrior care.
- **Leverage Health Information Technology (HIT) to Enhance Expeditionary Medicine:** Consistent with DHA's execution of its information technology operations

statutory responsibilities, Army Medicine will deliver HIT solutions to support the health and readiness of the Army and Joint Force. HIT overcomes geographic impediments that traditionally limit health care delivery at the patient's location. To develop patient-centered HIT solutions, Army Medicine will eliminate geographic barriers to expeditionary care by leveraging global tele-consultations and other virtual health technology to link operational forces to medical support. With the support of DHA, Army Medicine will ensure the seamless passing of medical and dental information across the continuum of care by upgrading infrastructure; completing implementation training and increasing network security to increase electronic health record utilization and reliability; improve integration within the MHS by developing and executing transition plans for Army Information Technology capabilities to the DHA; and deploy secure, modernized information platforms, and enhance expeditionary health delivery outcomes by improving access to medical information and resources for Soldiers and beneficiaries, regardless of location.

- **Improve Disability Evaluation System (DES) Processing:** Army Medicine expedites DES processing, while ensuring outcomes that equitably balance the needs of Soldiers, units, and the Army. Army Medicine will: encourage leadership engagement to achieve positive outcomes; address DES performance gaps to increase efficiency; partner with the Department of Veterans Affairs to further improve the DES process, increase efficiency, and improve outcomes; prevent backlogs in Medical Evaluation Boards by meeting or exceeding DoD/Army processing goals; leverage HIT interoperability across the civilian sector and in DoD to facilitate the exchange of medical information; and standardize DES staff training to ensure accurate and consistent processing for all Soldiers. Improved DES processing positively impacts Army readiness and takes care of Soldiers for Life.
- **Improve Healthy Behaviors, Communities, and Environments:** Army Medicine supports the readiness and health of the Army, its commands, and Joint/Combined forces' commands, through its System for Health. The System for Health nests with the National Prevention Strategy, DoD's Total Force Fitness Strategy, the Army Human Dimension Concept, and the Army Ready and Resilient Campaign. The System for Health integrates services across the care continuum through MTFs, Army Wellness Centers, Community Health Promotion Councils and operational health care capabilities. Army Medicine partners with Army entities to influence strategic, operational, and tactical policy and environments. Army Medicine will: improve, strengthen and maintain the health readiness of the Total Army through the System for Health Programs with a view to shifting the current culture from a "find and fix disease" model, to a "prevent and predict" model in partnership with the Soldier; mitigate preventable disease, illness, and injury through integrated strategies, and attack medical readiness issues by preventing musculoskeletal injury, obesity, tobacco and substance abuse; promote a culture of wellness and personal health responsibility through scientifically grounded strategies and policies to ensure readiness and empower Soldiers, Department of the Army civilians, families, and retirees to choose healthier lifestyles. Health promotion improves health readiness, conserves resources, and fulfills our commitment to the Army Family.
- **Leverage Medical Research, Development and Logistics Management:** Army Medicine leads the advancement of military medicine and transforms Army Medical Logistics business processes into a capability to enable warfighter readiness and better align with Army-wide sustainment systems. Through Research and Development, Army Medicine will: project and sustain a healthy and medically protected force; be the agent

of transformation for the future medical force; enhance the care of Service members and the military family; discover, develop, and field cost effective medical knowledge and materiel in order to optimize the effectiveness of the Armed Forces; and amplify Joint Force access to cutting edge medical knowledge and materiel by capitalizing upon Army executive agent responsibilities. Through Army Medical Logistics Transformation, Army Medicine will: improve master data management; integrate logistics with health information technology; improve business standardization and auditability; achieve total asset visibility; and align medical logistics management systems and processes to seamlessly interact with Army and Joint Force sustainment systems. Synchronization of medical research and development and global logistics management encourages a ready, effective, and efficient Army Medical Logistics Enterprise.

Army Medicine Reorganization to Service Command Structure for Readiness

Based on 10 USC §1073c, Army Medicine will reorganize to a Service Command construct to focus on Title 10 responsibilities (recruit, organize, train, and equip) to enable continuous improvement in the medical readiness of the Total Army through quality, outcomes-based care with Soldiers for Life, and will improve the force development and force generation of responsive medical capabilities to support the Army and Joint Force evolving operational requirements of the Army and the Joint Force. Army Medicine's organizational structure will be aligned and integrated as inseparable components of the Army Force structure, from the Service headquarters, Medical Department headquarters, and down through the Service structure and chain of command to the execution level Service Command.

In the current organizational construct, Army Medicine utilizes multi-disciplinary Regional Health Commands aligned to support Army Corps and Army Service Component Commands for readiness (operating force) and health care delivery (generating force) requirements. In the future organizational construct to implement 10 USC §1073c, Army Medicine will reorganize readiness functions into a Service Command structure at strategic, operational and tactical levels. The Service Command structure will be optimized for readiness support to the Army and the Joint Force. These reorganization efforts will enhance Army Medicine's focus on readiness and enable a single agency, DHA, to focus on MTF health care operations, including both MTF direct care and TRICARE network purchased care performance improvement efforts.

The design of the Army Medicine Service Command structure affords is a significant opportunity to focus on Army readiness. The Army Medicine Service Command structure will be streamlined and incorporate process improvements to enhance both effectiveness and efficiency in how Army Medicine delivers readiness and integrates with DHA. To support the redesign, Army will transfer functions and personnel to DHA at the strategic, operational and tactical levels to enable an integrated system of readiness and health.

Navy Medicine

The Navy Medicine organizational construct and its operating concept, the Future Care Model, guided by the focus areas defined below, describes how Navy Medicine will provide medical capabilities best to meet the needs of its operational commanders, Sailors, and Marines.

Navy Medicine historically balanced serving the needs of both active duty service members and beneficiaries. The focus on beneficiary care, while important, forced Navy Medicine to shift and dedicate significant resources to treating patients and conditions that may not have significantly enhanced operational readiness. Moving forward, Navy Medicine will enhance its focus on its readiness mission. This shift in focus will enable Navy Medicine to become more agile and

responsive to the specific needs of Operational Commanders and active duty military personnel, including a focus on prevention, resilience, and performance optimization. This shift will also provide the medical force with greater opportunities to obtain relevant clinical experience, develop medical capabilities required in operational settings, and enable Navy Medicine to maintain the highest levels of survivability in any conflict.

Navy Medicine Headquarters Organizational Construct

It is the responsibility of the Navy Medicine headquarters to ensure the personnel and material readiness of forces (organize, man, train, equip), as assigned by the Chief of Naval Operations (CNO) for command, develop health care policy for all operating forces of the Navy and Marine Corps, and provide technical support in the operating forces of the Navy and Marine Corps. At the same time that the DHA is structuring itself and design its operating construct to meet the requirements of 10 USC §1073c, the Services must also restructure their organization and operating constructs to meet their missions. Navy Medicine will restructure its medical forces to be focused on Military Department functions and activities while transferring responsibilities for the administration and management of the MTFs to the DHA. Navy Medicine will ensure that the required military structure is in place to determine operational requirements, provide policy and procedure, direction and oversight, and exercise command and control to maintain the span of control of a geographically and functionally dispersed force and the complexity of Military Department functions—ultimately to ensure the provision and maintenance of a ready medical force and a medically ready force. This will include a restructuring of Navy Medicine's current headquarters and intermediate/regional commands for both geographic and functional commands. Through the analysis supporting the implementation of 10 USC §1073c, resources are being identified for allocation against validated requirements of both the DHA and the Military Departments. The Department of the Navy will continue to evaluate and refine these calculations to ensure that DHA and Military Department/Service Commands are properly staffed to execute their assigned missions and preserve the following Service equities:

- Command and control of uniformed Navy personnel with authority to reassign them for operational missions as needed to:
  - Agilely respond to emergent operational requirements;
  - Maintain good order and discipline in garrison and deployed environments; and
  - Continue Sailorization and maintain Navy lifelines
- Control and oversight of Navy and Marine Corps readiness mission budgetary resources allocated to Navy Medicine via the PPBE process discussed above in this report.
- Flexibility in MTF Operations to support changing installation and operational tempo needs
- Maintenance of a single Navy Medicine contact point for operational commanders

Navy Medicine "Service Commands" Organizational Construct: Navy Medicine Readiness and Training Commands Concept

DoD has determined that within the future organizational and management construct associated with the implementation of 10 USC §1073c, the Military Departments will establish Service Commands separate and distinct from DHA managed MTFs. In accordance with this direction, Navy Medicine has developed the concept for Navy Medicine Readiness and Training Commands (NMRTCs), and will continue to evaluate options for the Navy's future construct that will ultimately be approved by the Chief of Naval Operations and the Secretary of the Navy. In the short term, NMRTCs will be co-located within the current direct care MTFs. The NMRTCs

will be responsible for executing Navy's operating concept, the Future Care Model (FCM). The FCM vision emphasizes Navy Medicine's readiness mission and its commitment to supporting Service members across all environments. The future for Navy Medicine is not defined or confined within the walls of a MTF, but rather seeks to meet the medical readiness needs of Sailors and Marines where they live, work, and play. Embracing emerging virtual health capabilities and embedding care to increase convenience, while maintaining the highest standards for quality medical care and supporting readiness, the FCM prioritizes preventive medicine and performance optimization to develop Service member resilience and evolve from a reactive to a proactive health care model. The FCM prioritizes the needs of Navy Medicine's Commanding Officers and supports their ability to execute their missions with a medically-ready, resilient force.

NMRTCs will facilitate the mutually supportive relationship between the development of medical skills within the medical force to meet the needs of operational medical platforms while working with the commands aligned to the installation to meet the medical readiness needs of their Sailors and Marines. NMRTCs will serve as the single point of contact for all things medical for an operational line commander to improve efficient response. While MTFs will still serve an important role in the facilitation of this relationship, when medical readiness needs are not optimized solely through MTF operations or an MTF does not provide sufficient case load or patient throughput to meet operational medical platform requirements for skill currency and competency for its assigned personnel, NMRTCs will identify other mechanisms (e.g., partnerships, non-MTF based care) to meet those requirements.

In addition, with respect to functions not assigned to DHA, NMRTCs will increasingly employ information technology, analytics, and research and development to support Navy Medicine's increased emphasis on readiness requirements. The use of data-driven information will support Navy Medicine's objective of a more proactive health care model to support Sailors, Marines, and Commanding Officers in optimizing their readiness and performance to achieve their assigned missions. It also will improve situational awareness and understanding of real-time readiness for Commanding Officers and Line Medical Assets, and allow for more tailored approaches to meet the medical readiness requirements of their platforms.

Ready Medical Force

To maintain high levels of survivability and meet the operational demands of the future, Navy Medicine will no longer assume that its medical force develops and maintains clinical currency and competency solely through operating within traditional care settings. NMRTCs will proactively track and facilitate the development of the medical force both within and outside of traditional care settings, and coordinate with Medical Operational Platforms to ensure they meet the readiness requirements for their operational missions. Shifting in focus from beneficiary care to readiness and employing analytics to support decision making will ensure Navy Medicine maintains an agile force able to support U.S. interests throughout the world.

Align Training to Operational Requirements

The ability to analyze, define, and measure the operational medical capabilities required to support the operational force will be a key component of the NMRTC. The resulting knowledge, skills, and abilities (KSAs) must be aligned to the needs of operational units and medical platforms. As a learning organization, the NMRTCs will constantly ensure alignment of medical force KSAs with requirements provided by Medical Operational Platforms, analysis of necessary medical capabilities in operational settings, lessons learned, innovation from Navy Research Commands, and identified gaps in medical force performance based on data analytics. As the liaison between Navy Medicine and operational units, NMRTCs will ensure medical KSAs driving training requirements are updated to reflect changes in medical readiness requirements, and will proactively align KSAs to anticipated future requirements.

Medically Ready Force

Increased emphasis on supporting the development of individual and unit medical readiness requires Navy Medicine to better understand the unique needs of the units assigned to an installation and to implement modernized programs to best meet their medical readiness requirements. NMRTCs will support unit commanders in maximizing the medical readiness of their Sailors and Marines through the improved alignment of medical resources to meet their needs and the use of technology and analytics to increase situational awareness of medical readiness and inform decisions.

Align Medical Resources to Meet Service Member Medical Needs

The FCM vision provides flexibility to NMRTC Commanders to identify the needs within the active duty population they serve and identify the best platforms to accommodate Sailor and Marine requirements where they work, live, and play. NMRTCs will maintain dashboards of unit medical readiness to facilitate a more proactive approach in meeting the needs of the units aligned. Based on those needs, Navy Medicine will facilitate programs that provide care access within MTFs, but also at work centers, in gym facilities, and near barracks to increase access on-base; as well, Navy Medicine will support virtual health capabilities to provide means for medical asset engagement when Sailors and Marines are off-base.

Support to Navy Installations

NMRTCs will maintain Navy Medicine's current role in supporting Navy and Marine Corps installations, including occupational and environmental health, force health protection, and public health requirements. In addition, based on the missions supported by the installation, NMRTCs will maintain the capabilities to provide the required additional services tailored to installation needs (e.g., nuclear field duty and special duty screenings, range-safety and response requirements). These missions are specifically tailored to Navy and Marine Corps needs and require Navy Medicine's support for safe and effective execution.

Performance Measurement

For NMRTCs to be successful in their mission, a shift in focus of performance management is necessary. Current methods of assessing Navy Medicine performance focus primarily on access and productivity metrics. While readiness missions were met, the full weight of Navy Medicine's capabilities were not fully-applied to assure optimized capability, in contrast to the importance applied to MTF productivity. In the future, NMRTCs will be measured on their success in meeting the medical readiness requirements of the operational units aligned to their installation(s) and their operational medical platforms.

Air Force Medicine

As directed by 10 USC §1073c, the Air Force Medical Service (AFMS) will implement program planning and transition existing structures to directly support operational readiness and installation-specific medical functions. This section will focus on the high- level AFMS structure transition and key functions necessary to support the Air Force's operational readiness missions. Further adjustments will be made as Air Force Medicine collaboratively develops plans with the DHA, other MHS partners, and line counterparts. This transition of administrative authority is occurring at the same time our nation is facing global disorder and a security environment more complex and volatile than any we have experienced in recent memory, as described in the Secretary of Defense's 2017 National Defense Strategy. Rapidly evolving trans-regional, multi-domain, and multi-functional threats require a more lethal, resilient, and rapidly innovative Joint Force, combined with a robust constellation of allies and partners, and reform of current processes. Medically ready Airmen are the foundation of a credible combat forward presence and implementation of the Dynamic Force posture, which necessitates further changes to AFMS operational responsibilities. These substantive changes in roles, responsibilities, and DoD strategy create unique opportunities for the continued improvement of AFMS operations.

AFMS Reform Overview

The AFMS is not structured as a medical command, but rather as an integral component of its line commands. As such, its operational functions and current headquarters, field operating agencies, Major Commands (MAJCOMs), and MTF structures are distinctly different than those of the other services. With the transfer to DHA of responsibility for the management and administration of health care delivery at the MTFs, the AFMS will undergo significant reform to align fully to the operational medical mission.

In accordance with Title 10 of the U.S. Code, the Department of the Air Force, via the AFMS, will continue to execute all of its specified and implied missions as delineated in Air Force doctrine, Joint Publications (specifically JPs 4.0 and 4.02) and DoD Instructions and Directives in its new construct.

The AFMS will apply Military Department authorities to reengineer its management processes to develop a medical force and provide operational capabilities aligned to the National Defense Strategy. As the reengineering progresses, the organizational structure and alignment of responsibilities under the Air Force Surgeon General, as described below, will undergo some adjustment.

Headquarters

The Air Force Surgeon General headquarters will consist of two directorates, SG1/8 and SG3/5, and the Surgeon General's Executive (SGE) Services. The Air Force Medical Support Agency (AFMSA) is co-located with the Air Force Surgeon General headquarters.

SG1/8, Headquarters Air Force Medical Manpower Personnel and Resourcing, is the primary directorate for Medical Force Development; Strategy, Plans and Programs; and Budget and Finance. The SG1/8 creates and influences policy and strategic direction for military and civilian medical accession, retention, force management, and force development; builds AFMS strategic programs based on leadership decisions, ensuring integration into AFMS Program Objective Memorandum submissions, of the d resources required to execute worldwide medical operations in support of air, space and cyber requirements; analyzes AFMS core mission areas and reviews legislative, policy and operations as they relate to the Total Force to create a more unified AFMS that is fully integrated with the Air National Guard and Air Force Reserve; provides financial execution of military manpower, operational and installation-specific medical requirements, to include non-MTF associated health-related activities associated with the operational mission platform.

SG3/5, Headquarters Air Force Medical Operations and Research, is the primary staff office for defining and executing operational medicine and readiness through strategic planning and policy development and issuance. The Directorate is the primary advisor to the Air Force Surgeon General on operational capability, requirements, and the utilization of AFMS personnel. The SG3/5 integrates emergency and contingency operations support to the Surgeon General via the Medical Operations Center (MOC), which provides 24-hour emergency operations capability as the medical representative to the Air Force Crisis Action Team (CAT); leads the Aerospace and Operational Medicine Enterprise, consisting of health services and activities that directly support execution of the Air Force mission, including aviation medicine (specifically non-MTF-health care for aviation personnel); operational medicine; biomedical engineering; deployment-based force health readiness and protection; medical support to the nuclear enterprise and other reliability communities; human performance sustainment, optimization, and enhancement; medical response to aviation and operational mishaps and to chemical, biological, radiological, or nuclear (CBRN) events; and delivery of medical services in operational settings. The SG3/5 provides oversight for AFMS Mental Health policy, including Post-Traumatic Stress Disorder, Deployment Mental Health, and Sexual Assault Response, as well as oversight for AFMS Wounded Warrior and Invisible Wounds Program; provides guidance and operational support to military medical research, materiel development, and acquisitions capabilities to ensure warfighter readiness and support of the Air Force mission; plans, programs, and executes dental activities and produce policies and guidance to optimize dental readiness.

SGE is the Directorate that directly supports the Surgeon General, Deputy Surgeon General, and Air Force Surgeon General's staff. The Directorate is responsible for coordinating all internal and external tasks assigned to the Air Force Surgeon General, managing all Surgeon General publications; overseeing Air Force Surgeon General officer and enlisted personnel promotion activities; and managing programs including security, the Freedom of Information and Privacy Acts, protocol, records management, and vehicle control, as well as internal budget and contracts. SGE will continue to work in close coordination with Secretary of the Air Force and Headquarters Air Force Directorates, DHA, other air Force Surgeon General Directorates and Forward Operating Agencies, MAJCOM Command Surgeons, and other federal and civilian health agencies, to effect maximum coordination and cross-organizational communication.

Air Force Medical Support Agency (AFMSA)

AFMSA is a Field Operating Agency that supports Headquarters Air Force and the Air Force Surgeon General. The AFMSA commander is responsible for administration, training, and readiness of assigned forces. Together with AFMSA's execution of Air Force Surgeon General policies, AFMSA supports the Department of the Air Force's full spectrum readiness capability, defined as ensuring that medical Airmen are prepared and able to execute the full spectrum of military medical operations (e.g., Current/Future Combat & Stability Operations, Global Health Engagement (GHE) and Humanitarian Assistance/Disaster Relief (HA/DR), Homeland Defense, New and Evolving Mission Operations).

AFMSA will develop policy, plans, and resources, and make decisions impacting the AFMS. It maintains communication with the Service Commanders through the Functional Area Manager program. AFMSA personnel both directly support the headquarters operations for the Air Force Surgeon General and the AFMS by exercising guidance, direction, and technical management to capitalize on the opportunities to improve processes at all levels.

AFMSA will work in close coordination with DHA, MAJCOMS, the Air Force Medical Operations Agency (AFMOA), medical wings, and other health agencies—federal and civilian sector—to effect maximum utilization of the nation's medical resources and services.

Air Force Medical Operations Agency (AFMOA)

AFMOA is a Forward Operating Agency that reports to the Air Force Surgeon General and liaises with DHA in order to provide direct MTF support in the execution of AFMS and DHA policies and programs, in coordination and while aligning efforts with, AFMSA, MAJCOM Command Surgeons, the MHS, sister Services, and key mission partners. AFMOA served as the centralized execution arm of the AFMS after Air Force Program Action Directive 07-13 was approved in 2007. This directive required the centralization of clinical and health care support operations oversight of Air Force MTFs in the AFMS and eliminated these oversight capabilities at the MAJCOM level. Over the past decade, the AFMS has refined this model to achieve significant efficiencies and has realized an ability to standardize clinical and health care support operations processes across 76 MTFs and deployed medical unit locations worldwide.

AFMOA will refocus its mission and capabilities and transform to provide support of Air Force Surgeon General medical readiness priorities, while serving as a direct liaison to DHA for identifying medical readiness skill requirements in the MTF setting. This refocused mission will enhance the oversight of AFMS medical readiness program execution, mature expeditionary medical capabilities, and sustain readiness-related support of Air Force mission requirements.

AFMOA supports the Air Force Surgeon General and the MAJCOMS in the execution of the operational medical mission, provides program support for a medically ready force, and medical force readiness in support of the Air Expeditionary Force construct, Joint Staff taskings, and related Requests for Forces from Combatant Commands. In doing so, it provides enterprise level management and oversight of medical readiness programs, strategic partnerships, operational medical logistics, dental operations, aerospace medicine liaison to integrated operational medical support capabilities, oversight of the clinical aspects of medical operations in the deployed environment, and support to programs unique to the Air Force mission. As the primary focal point for determining and measuring medical personnel readiness skills, AFMOA retains the capability to analyze clinical and administrative operations in Air Force MTFs, with the goal of identifying gaps in readiness skills and generating recommendations for how best to achieve

those skills at the MTF, in other federal health care facilities, or through partnerships in the public and private sector. AFMOA will support and provide oversight of the Comprehensive Medical Readiness Program (CMRP) for the AFMS. AFMOA will also be a source of determining military staffing requirements and overall force mix at MTFs to preserve AFMS Critical Operational Readiness Requirements (CORR). In executing this new role, AFMOA will engage with the Air Force Line, the Air Force Surgeon General, AFMSA, MAJCOM Command Surgeons, DHA, and numerous external partners, including the Department of Veterans Affairs.

Major Commands (MAJCOMs)

MAJCOM Command Surgeons and related staff will remain as principal functional advisors to MAJCOM Commanders and Air Force Line staff agencies. MAJCOM Command Surgeons will primarily focus on supporting the Service Commanders at each base in the areas of medical readiness and operational medicine. MAJCOM Command Surgeons will continue to rely on Air Force Surgeon General agencies, enumerated herein, for strategic policy, plans, and programming guidance for medical readiness and operational medicine requirements. MAJCOMs will provide more effective and efficient support given their expertise in understanding the unique requirements and factors that impact diverse MAJCOM operations. In general, MAJCOMs are currently sized properly to support the new construct and the Service Commanders.

MAJCOMs will ensure that medical units are properly organized, trained, and equipped to carry out all aspects of their expeditionary and home station missions. Major responsibilities include executing the Global Force Management Process, functioning as the Manpower and Equipment Force Packaging (MEFPAK) Responsible Agency, and providing management and oversight to the Aeromedical Evacuation program. These are Air Force Line functions and must remain at the MAJCOM level.

MAJCOMs will also provide Aerospace and Operational Medicine oversight and support to the Service Commanders in relation to their responsibilities for aviation medicine; occupational, environmental, and operational medicine; industrial hygiene; public health; force health readiness and protection; medical support to the nuclear enterprise; health promotion; human performance sustainment, optimization, and enhancement; medical response to aviation and operational mishaps and to chemical, biological, radiological, or nuclear (CBRN) events, and Aerospace Operations Physiological Training (AOPT). Flight Medicine will continue to approve/disapprove waivers for personnel in their command. MAJCOM Flight Medicine staff is expert in the unique factors associated with their rated Service members.

MAJCOM Bioenvironmental Engineering is responsible for supporting bases and higher headquarters on a vast array of operational issues, many of which are MAJCOM specific. These include occupational health programs, MEFPAK Responsible Agency roles, and unique roles such as support to the Joint CBRN defense program as a MAJCOM's Medical Combat Developer. Staff will also provide reach back capability to support embedded mental health, substance abuse, and patient safety standards and evaluation programs.

Some MAJCOMs will have additives to their staff due to unique requirements such as larger than normal occupational health programs and Personnel Reliability Programs (PRP).

Service Command Structure

The DHA Director will assume responsibility for the management of, and exercise authority, direction, and control of an MTF, whereas the Service Commander will have responsibilities and authorities aligned to the line Wing/Installation Commander.

The Service Commander will ensure all active duty Service members assigned to the MTF or to readiness currency duty locations outside the MTF Operational Platform, whether aligned to DHA-led health care activities or operational readiness activities, remain current. The Service Commander, with support from MAJCOMs and AFMOA, will communicate currency requirements and gaps to the MTF Director. Active duty Service members that cannot meet currency requirements inside a DHA MTF will be provided a work center in an appropriate alternate setting, as agreed upon by the MTF Director/Commander and the Service Commander.

The organizational structure of the operational readiness component under the Service Commander will be capability based and scalable to required size across the AFMS. Furthermore, the structure will be formed in such a way as to meet Chief of Staff of the Air Force priorities for the revitalization of squadrons to maximize combat capability; improve readiness, retention, and morale; and reinforce our Air Force culture.

The Service Commander's staff will include a Chief of Aerospace Medicine and appropriate operational readiness staff, as may be required to meet the Installation Commander's operational readiness requirements and support personnel aligned to the Service Commander. The organizational structure will be complementary to MAJCOM and Wing capability requirements. Service Commanders may be at Group or Squadron level, dependent on Wing requirements and number of authorizations.

Conclusion

The AFMS will undergo a significant transition as the Department implements changes in the management and leadership of MTFs. It is clear that more specificity and adjustments will be required as planning evolves across the MHS. While Airmen progress through this paradigm shift together, it is essential that all MHS Components adhere to high reliability organization (HRO) principles, work together as a team with the DHA and other Services, and focus on efficiencies in providing an operational mission platform with gleaming success. As an HRO, Trusted Care is what the Air Force is about—the fabric of its culture; medical readiness and operational medical support is what Air Force does.

(B) Efforts to eliminate duplicative activities carried out by the elements of the DHA and the Military Departments

The Department has identified those functions within each Service's medical departments that are in support of the administration and management of MTFs. Those Service functions that will no longer exist when transition of these functions to DHA is complete were identified in Table 2.

As the Department is completing its implementation strategy, ensuring the reduction of the overall medical headquarters footprint while improving the capability of the Department to administer standardized clinical and business functions is a primary goal. Planning for these reductions began soon after the National Defense Authorization Act for Fiscal Year 2017 was

signed by the President, with reductions of headquarters Full-Time Equivalents (FTEs) programmed into the budget cycle. Table 4 details the initial savings from resource reductions, by year, between now and Fiscal Year 2023. The MHS will achieve a 25% reduction in personnel assigned to medical headquarters across the enterprise. However, during the transition, the Department will identify further reductions as the consolidation and transfer of functions from Service medical departments to DHA proceeds. The "Total" column in the chart below reflects the total number of reductions across the Future Years Defense Program (FYDP). The reductions in Table 4 reflect savings achieved through planned elimination of duplicative activities at the headquarters level.

Table 4: Programmed MHS Headquarters Reductions

MHS Headquarters Reductions	FY19	FY20	FY21	FY22	FY23	Total
Programmed Reduction in DHP Operations &Maintenance ($M)	-$27.0	-$35.8	-$45.6	-$46.5	-$47.6	**-$202.5**
Programmed Reduction in Military Personnel End-Strength (FTEs)	0	-8	-16	-20	-25	**-25**
Programed Reduction in Civilian Full-Time Equivalents (FTEs)	-42	-76	-115	-130	-140	**-140**

Throughout the process of planning and implementing 10 USC §1073c, the Department is identifying and eliminating duplicative activities. The DHA and the Service medical departments are working together to define requirements, eliminate duplicate functions, and transfer to the DHA, as part of the Fiscal Year 2020-2024 budget, the military end strength and civilian FTEs needed to support the jointly-manned DHA headquarters. The DHA, with input from the Service medical departments, will further strengthen common services, activities, and clinical and business functions, including those located outside of the National Capital Region, into a restructured headquarters designed to carry out the new responsibilities associated with managing the MTFs.

As the Military Departments provide a complete accounting of existing headquarters, and both Service Commands and the DHA staffing models are completed, the Department will apply its rigorous manpower and PPBE processes to formalize final staffing for both DHA and Service Commands. The final requirements will be coordinated with the Office of Management and Budget, and included in the President's Fiscal Year 2020 Budget submission. Additional details on the staffing and resourcing of the DHA headquarters and the Service medical departments will be provided in the final report.

As important as the reduction in headquarters staff, however, is the downstream value of increased agility in decision-making and execution, as well as the standardization of clinical and business policies across the MHS. These changes will improve and accelerate the ability of the Department to gain further management efficiencies in support of the Department's mission.

Enterprise-wide contracting support provides and apt example of a function as to which the timely, disciplined execution of ESAs can produce enhanced support and accelerated savings.

In 2017, the DHA awarded an enterprise-wide contract to acquire professional medical services (e.g., physicians, nurses, and other allied health professionals). This contract is available to all DHA and Service-led MTFs.
An example where the timely, disciplined execution of ESAs can produce enhanced support and accelerated savings is in enterprise-wide contracting support. In 2017, the Defense Health Agency awarded an enterprise-wide contract to acquire professional medical services (e.g., physicians, nurses, and other allied health professionals). This contract is available to all DHA and Service-led MTFs.

Specific Efforts to Eliminate Duplicative Activities and Achieve Efficiencies by the Military Departments

Army Medicine

Army Medicine will divest from all aspects related to the delivery of the health care benefit. In doing so, Army Medicine will transfer resources and functions to the DHA to facilitate a smooth and effective transition of health care delivery to the DHA. Army Medicine is actively reviewing the additional assets that the DHA will require to establish the headquarters capabilities and structure sufficient to effectively manage the extensive mission portfolio of MTF health care delivery.

The following discussion of initial plans and supporting analyses illustrate the deliberate Army and DHA planning efforts currently underway to develop a phased, risk-adjusted plan. The plan will smoothly transition resources and responsibilities to the DHA and realign Army capabilities and resources in support of the Army's "man, train, and equip" responsibilities, while fully supporting the readiness of the Joint Force.

Army Medicine is reviewing all documented positions, all contracts, and all over hires related to MTF operations, as reflected on the four Regional Health Command (RHC) headquarters tables of distribution and allowances (TDAs). These reflect RHC headquarters resources that remain after several previous rounds of efficiency exercises. These RHC headquarters provide the necessary command and control structure to support the span of control and time and distance issues related to a world-wide network of health care delivery, plus readiness, public health, and veterinary operations. Army Medicine is assessing every position on the four RHC TDAs to determine the number and type of staff, funding, and functions that support MTF operations. Army Medicine will be making recommendations related to the number of positions (spaces), personnel (faces), and resources (dollars) to be transitioned to the DHA to meet the span of control, time, and distance issues DHA will face.

Army Medicine has already completed several prior transfers of staff, funding, and functions to the DHA. These transfers have been associated with Health Information Technology (HIT), facilities, contracting, and public health. Army Medicine has already realized reductions in headquarters FTEs as part of the initial 25 percent reduction in MHS headquarters reflected in the Fiscal Years 2019-2023 Program Objective Memorandum. In addition to these prior transfers and reductions, Army Medicine is identifying additional FTEs to be transferred to the DHA to comply with 10 USC §1073c. Army Medicine continues to review all Army Medical Command headquarters positions and funding and is specifically focusing deep dive reviews on the elements of Army Medical Command headquarters that have been associated, partially or fully, with MTF operations or delivery of the health care benefit.

In accordance with the Department's model for implementation of 10 USC §1073c, Army Medicine is proceeding with a thorough review of all remaining staff, funding, and functions associated with the DHA-led effort to review headquarters structure. Army Medicine will continue to work to finalize the readiness related staff, funding, and functions to accomplish these mission requirements.

Navy Medicine

Over the past five years, in support of the establishment and continued success of the DHA, Navy Medicine has transferred FTE authorizations to the DHA. Additionally, as part of an initial analysis associated with the implementation of 10 USC §1073c, Navy Medicine identified both resources to be transferred to the DHA and resources that reflected unwarranted duplication, to be eliminated as part of the initial 25 percent reduction in MHS headquarters.

The remaining FTEs associated with the Navy's headquarters and Intermediate/Regional commands across the Navy enterprise will be restructured into a future state between the headquarters and two Regional Commands, aligned and integrated into the Fleet and Fleet Marine Force organizational constructs, focusing on Expeditionary Medical Force Optimization and Warfighter Optimization. This shift in focus will maximize warfighter performance through optimized medical readiness tailored to operational requirements, while enhancing the readiness of the medical force to sustain expeditionary medical capability.

Air Force Medicine

The Air Force Medical Service (AFMS) recognizes the imperative and opportunity to restructure management headquarters activities with a focus on readiness, operational support, force development, and support to priorities established by the Secretary of the Air Force. For those functions transferring to the DHA, the AFMS will divest its management staff that supports the administration and management of the MTFs for health care delivery. Major Headquarters Activities consist of resources from Headquarters Air Force Surgeon General, the Air Force Medical Support Agency (AFMSA), Air Force Medical Operations Agency (AFMOA) and nine MAJCOMs.

In August 2017, the AFMS performed a billet-by billet analysis, to determine those activities that are accomplishing management oversight for Service operational and installation support activities and those resources supporting health care delivery functions at the MTF level. Within the Major Headquarters Activity, the AFMS has identified the authorizations directly associated with providing management and administration of health care delivery to the MTFs. Additional authorizations other than Major Headquarters Activities provide oversight and direction for MTF management and the administration of health care delivery, and may be identified to fill validated DHA requirements to accomplish newly established responsibilities and authorities as directed by 10 USC §1073c. These authorizations do not include the positions already provided to the DHA by the AFMS that are tied to Enterprise Support Activities, or the efficiencies associated with the initial 25 percent reduction in MHS headquarters undertaken in response to 10 USC §1073c.

AFMS management-level authorizations not directly tied to MTF health care delivery remain responsible to the Military Department for meeting readiness requirements by giving directions to the Service Commands on all non-health care delivery functions. Examples include, but are not limited to, non-MTF delivery/operation aspects of the following functions: occupational health, environmental health, substance abuse programs, food protection, Aerospace Physiology,

Aerospace Medicine, family advocacy, bioenvironmental engineering, nuclear power and other Personnel Reliability Programs, animal medicine, dental care (except oral and maxillofacial surgery), Installation Emergency Response, deployment-related functions, drug demand reduction, Medical Logistics for operational units, embedded behavioral health, and Military Aeromedical Evacuation (patient movement). Dependent on the grant of waiver authority to the Secretary of Defense, as contemplated by the legislative revisions proposed. Service Command responsibilities may be further expanded.

(C) Efforts to maximize efficiencies in the activities carried out by the DHA

Budgetary Matters

The standardization of the budgeting process will allow for identification of areas of duplication and opportunities to achieve efficiencies through elimination of unnecessary redundancies. With regard to operational and installation-specific medical functions, the Department is identifying operational resources (funding and manpower) within the Defense Health Program (DHP) appropriation. Operational activities are identified in Attachment A.

During Phase I (*see* page 36), Military Treatment Facility (MTF) Health Care Delivery and Operations, the Department is identifying and realigning for Phase I facilities those functions moving from the Service medical departments to the DHA. The Department is identifying the civilians and military within the MTFs for transfer from the Services to the DHA for Phase I. The Department will defer the formal realignment of civilian personnel to DHA until any potential human resources and manpower issues are resolved and processes are established to ensure successful transfer. Finally, the Department will also identify Fiscal Year 2019 funding for the Phase I MTFs that will realign to DHA beginning on October 1, 2018.

For the remaining MTF health care delivery and operations, the Department will identify the resources (funding and manpower) supporting the remaining MTF facilities, to include those located outside the 50 United States, within the DHP appropriation. For programs supporting both operational readiness and MTF Health delivery/operations, the Department will identify programs and associated resources (funding and manpower) that support, directly or indirectly, both operational and MTF health care delivery. These resources will require further review and adjudication during subsequent cycles.

Information Technology

All DHP-funded information technology functions and resources within the Service medical departments are being consolidated into the DHA/Information Operations portfolio. The DHA will optimize information technology infrastructure to support the military's new electronic health record (EHR), MHS GENESIS. These efforts include consolidating four separate Information Technology environments into a single Medical Community of Interest (MED-COI) prior to further MHS GENESIS deployment. This consolidation will result in improved network availability, cybersecurity, customer resolution, and reduced costs. In conjunction with DoD's zero-based review of Information Technology systems, the DHA will further eliminate duplication by shutting down or consolidating legacy systems. The DHA will also develop and implement enterprise standards for EHR workflows, content, and system configuration, ensuring seamless transition to MHS GENESIS. This will standardize the health care experience for both patient and provider and lead to an overall reduction in variation across the system.

Health care administration and management

By the end of the last phase of transition, all health care and administration functions and resources related to MTF health care operations within the Service medical departments will be transferred to the DHA. The DHA has completed an analysis of required policies and procedures to manage and administer the MTFs, identify where current DHA policy exists, and areas where policy gaps may occur. Additionally, the Services are working with DHA to identify their policies and procedures, and where unnecessary duplication exists between DHA and Service policy and procedures, Service policy and procedures as they relate to the administration and management of MTFs, can be rescinded. DHA will, over time, streamline four stovepipes of similar policies and procedures to one.

Military medical construction

The DHA will ensure application of an enterprise approach to military medical construction that considers upcoming/ongoing restoration and modernization investments to ensure the most efficient use of limited resources.

Any other matters the Secretary of Defense determines appropriate

The Department will closely monitor progress and adjust where necessary to meet the intent of the National Defense Authorization Act for Fiscal Year 2017.

(D) How the Secretary will implement section 1073c

Implementation Background

Because DoD's current medical transformation is so complex and involves changes to both DHA and Service components, close, ongoing coordination among Service medical department and DHA leadership is critical to ensure an integrated MHS-wide transition plan. The Department recognizes that planning for each of these distinct, but interdependent, missions must be fully integrated to ensure that our readiness and health care delivery missions are coordinated and successfully executed. As such, the Under Secretary of Defense (Personnel & Readiness) has directed the ASD(HA) to lead the development of the Department's integrated implementation plan, unifying authority and accountability for implementation of 10 USC §1073c. During the transition planning process, the MHS will leverage the best clinical and business practices among the Services. For example, Army Medical Command is noted for its detailed business planning. The Air Force Medical Operations Agency uses peer group comparisons of its MTFs, while Navy's Bureau of Medicine has distinguished itself in health care quality activities. Using already existing infrastructures and processes will offer opportunities to accelerate standardization and facilitate the transition of MTFs to DHA administration and management.

Phased Implementation

The Department proposed a phased approach to implement parts of 10 USC §1073c and recognize that this is contingent on enactment of legislative relief. Department leaders determined that a phased approach would introduce less risk and provide an opportunity to learn and adjust as the implementation progresses.

The Department has proposed a phased approach to implement parts of 10 USC §1073c, recognizing that the approach is contingent on enactment of legislative relief. Department

leaders determined that a phased approach would introduce less risk and provide an opportunity to learn and adjust as the implementation progresses.

1. Authority, direction, and control of the MTFs will be transitioned through a three-year, phased approach. However, beginning on October 1, 2018, all MTFs within the MHS—whether under Service command or DHA authority, direction, and control—will adhere to the same DHA-established policies, procedures, and standard clinical and business processes. DHA is now consolidating disparate Service policies and is in the process of establishing and prioritizing common standards, policies, and procedures.
2. Phase I: This transition phase occurs on October 1, 2018.
   a. All ESA functions will move to the DHA no later than October 1, 2018.
   b. The following MTFs will be under DHA authority, direction, and control no later than October 1, 2018:
      - National Capital Region:
        - Walter Reed National Military Medical Center
        - Fort Belvoir Community Hospital
        - Dumfries Health Center
        - Fairfax Health Center
        - DiLorenzo (Pentagon) TRICARE Health Clinic
      - Additional Phase I MTFs:
        - Army: Womack Army Medical Center and all associated clinics (Bragg Clinic, OHC NSG Off-Sunny Point, Troop & Family Medical Clinic-Bragg, WAMC-VA Fay Rehab Clinic-Bragg, CBMH Fayetteville-Bragg, CBMH Hope Mills-Bragg, CBMH Linden Oaks-Bragg, EBH East Bragg Clinic-Bragg, EBH West Bragg Clinic-Bragg, NICOE-Intrepid Spirit-Bragg, Robinson Clinic-Bragg, Joel Clinic-Bragg, and Clark Clinic-Bragg).
        - Navy: Naval Hospital Jacksonville and all associated clinics (Navy Branch Health Clinic (BHC) Albany, BHC Jacksonville, BHC Key West, BHC Kings Bay and BHC Mayport).
        - Air Force: 81st Medical Group (Keesler AFB, Biloxi, MS), 628th Medical Group (Charleston AFB, Charleston, SC) and the 4th Medical Group (Seymour-Johnson AFB, Goldsboro, NC).
3. Phase II: This phase will include transfer of authority, direction, and control over all MTFs in MHS Regions 1, 2, and 3 to DHA by October 1, 2019.
4. Phase III: This phase will include the transfer of authority, direction, and control over all MTFs in Regions 4 and 5 to DHA by October 1, 2020
5. Phase IV: This phase includes the transfer of authority, direction, and control over all MTFs outside the United States to DHA by October 1, 2021.

Figure 4 shows the geographic regions as they will be defined for purposes of a phased process to align MTFs under the DHA.

Figure 5 describes the phased approach, together with the major activities that will unfold at each major milestone date.

Metrics have been identified to monitor the transition (see Figure 6). An evaluation of Phase I transition will be initiated six months after the commencement of Phase I in order to determine areas for increased attention and provide lessons learned to inform subsequent phases.

FIGURE 4: MHS REGIONS

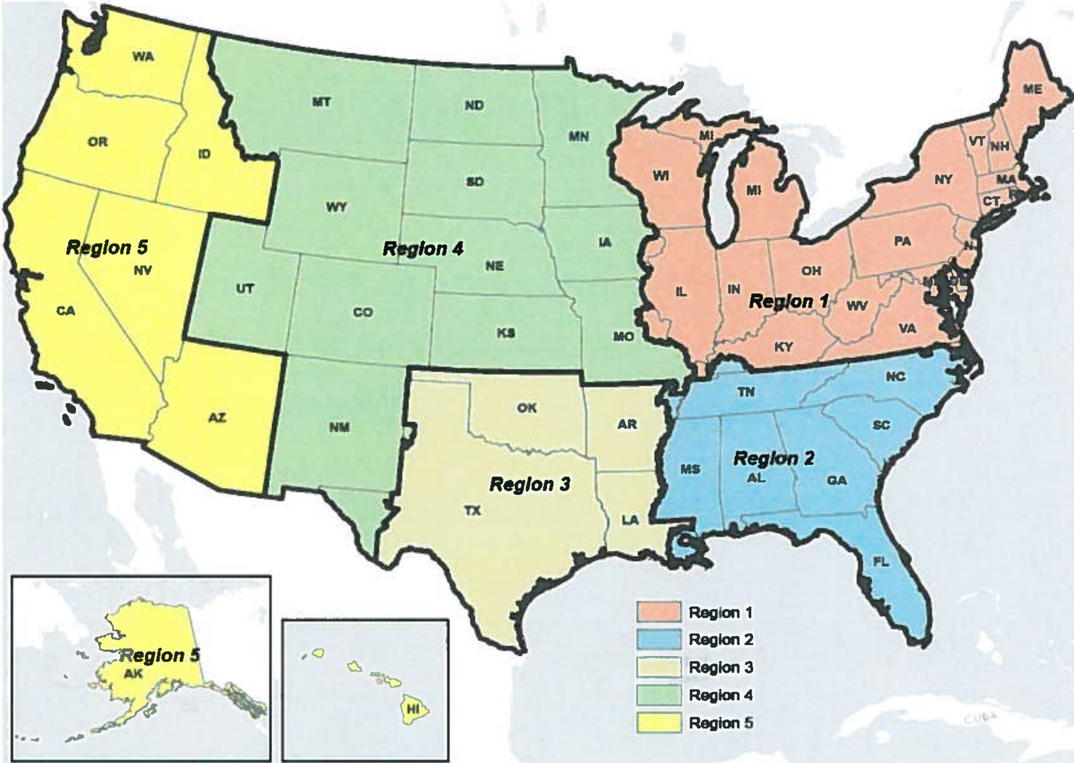
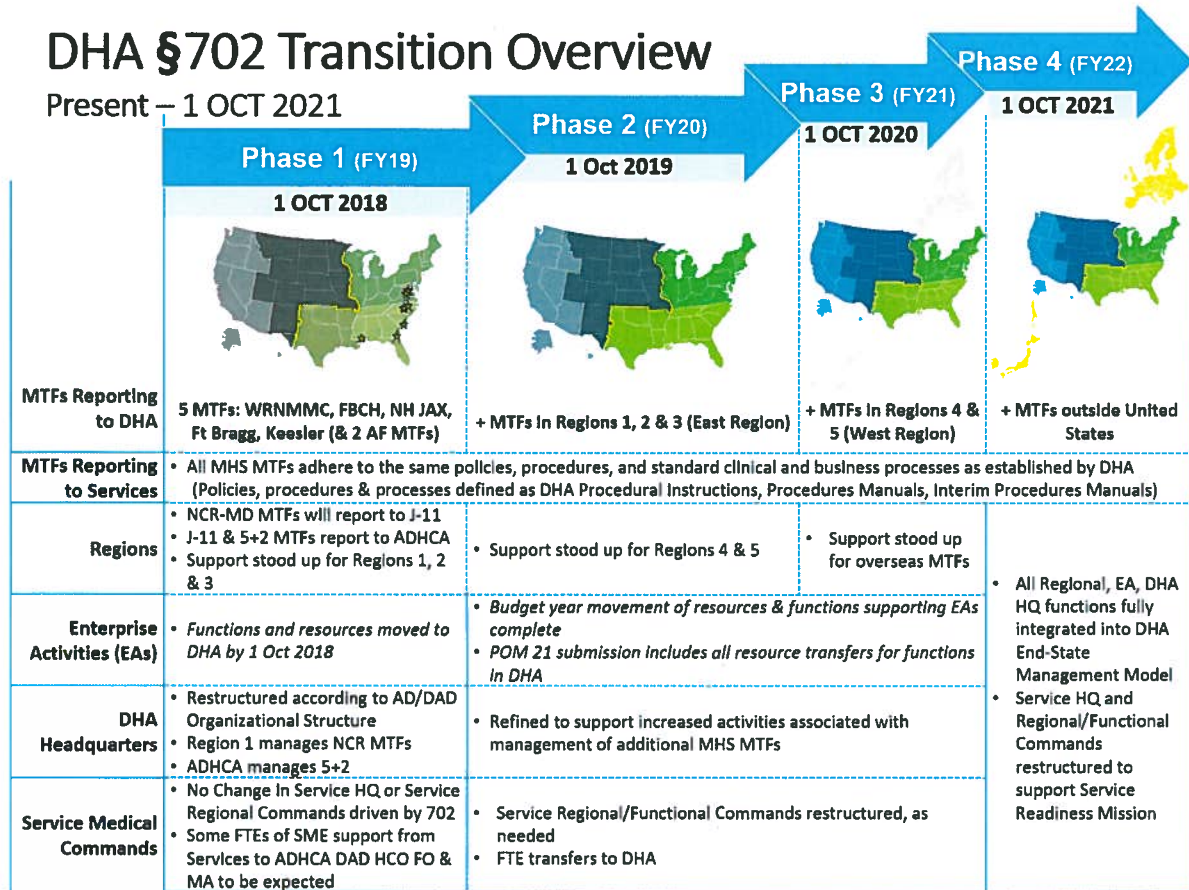


FIGURE 5: Phased Approach to Transition of MTFs to DHA Administration and Management



Quadruple Aim Performance Plans as the Tool for Standardizing Business Planning Processes

Since 2009, the MHS Quadruple Aim has served as the strategic framework for the alignment of priorities across the Army, Navy, Air Force, and DHA. The Quadruple Aim guides the MHS to increase readiness, better health, better care, and lower overall costs.

The Director of the DHA will use the Quadruple Aim to develop performance goals and metrics and will prepare a Quadruple Aim Performance Plan (QPP) for each MTF that: (1) supports performance goals and metrics; and (2) supports an overall market QPP, including integration of direct care and purchased care services in a given market. The DHA will ensure mission targets for enrollment, readiness requirements, access, satisfaction, quality, and recapture for each MTF are reflected in the QPP and that the QPP addresses both DHA and Military Department functions. MTF Leaders will ensure QPP submission timelines are met, and that MTF and market performance goals are incorporated in the QPP.

The QPP will translate strategy to action and further the shift from health care to health, by standardizing market, MTF, and TRICARE performance improvement initiatives, building and sustaining an integrated system of readiness and health. The DHA incorporates the National

Defense Strategy and National Military Strategy in shaping the DHA strategy, which is then used to build the QPP and define performance metrics for delivering an integrated system of readiness and health.

In support of the QPP, a portfolio of measures will be provided to the MTFs to help each determine its focus for performance improvement plans. Measures within the QPP will build on the Partnership for Improvement (P4I) measures as the foundation. The MTFs will be able to choose areas for improvement from this portfolio of measures, and each MTFs will receive a unique and dynamic scorecard tailored to its own performance.

QPPs will include seven priority areas for improvement, with initiatives in each plan aligning to these priorities. The seven areas are:

1. Access
2. Safety
3. Effectiveness (i.e., condition-based care)
4. Productivity
5. Medical force readiness
6. Total Force deployment
7. Healthy behaviors

Procedural Instructions as the Tool to Standardize Administration and Management of MTFs

Procedural Instructions (PI) are critical to the sounds administration and management of the MTFs. The DHA will continue to develop, review, and publish all critical PIs required for transition to DHA administration of MTFs by October 1, 2018. This list consists of a set of prioritized policies that will be expeditiously published and monitored for effectiveness in facilitating the administration and management of MTFs under 10 USC §1073c criteria, including: budgetary matters, Information Technology, health care delivery, administration and management, administrative policy and procedures, military medical construction, and "any other matters the Secretary of Defense determines appropriate." DHA PIs will be disseminated as they are completed and monitored until fully implemented.

Progress to Date

The MHS has made significant progress in planning for DHA to assume responsibility for the administration and management of MTFs. Accomplishments include:

- Identified Phase I MTFs for transition by October 1, 2018
- Established parameters of subsequent Phases to complete transition of all MTFs to the DHA by October 1, 2021
- Issued Department policy directing the framework and business rules for implementation of 10 USC §1073c
- Determined a standardized business planning process (Quadruple Aim Performance Plans)
- Began implementing a standardized accounting system across the MHS

- Inventoried and prioritized DHA PIs for immediate and near-term issuance and implementation
- Drafting and disseminating DHA procedural instructions (DHA PIs)
- Hosted a MHS Senior Leadership Symposium on March 13-15, 2018, with more than 200 attendees, for the purpose of training MTF leaders on the Quadruple Performance Plans process, receiving input from the field, and communicating the transition process for Phase I MTFs
- Drafted transition concept of operations (CONOPS)
- Developed measures to monitor the transition

Key Implementation Milestones

- March 31, 2018 – Submit Interim Report to Congress on the implementation of section 702 of the National Defense Authorization Act for Fiscal Year 2017
- April 30, 2018 – Submit initial detailed transition plan to the USD(P&R)
- June 30, 2018 – Submit Final Report to Congress on the implementation of section 702 of the NDAA for Fiscal Year 2017
- August 2018 – Finalize metrics for monitoring the phased transition of the administration and management of the MTFs from the Services to the DHA
- October 1, 2018 – Five inpatient facilities with associated clinics and two ambulatory centers transition to the authority, direction, and control of the DHA
- October 1, 2018 – DHA develops and issues policies and procedures addressing the following matters for implementation in all MTFs:
  - budgetary matters
  - information technology
  - health care administration and management
  - administrative policies and procedures
  - military medical construction
- October 1, 2019 – Additional MTFs in geographic regions 1, 2, and 3 (in the northeast, southeast, and Texas) transition to the authority, direction, and control of the DHA
- October 1, 2020 – All MTFs in the United States (geographic regions 4 and 5) transition to the authority, direction, and control of the DHA
- October 1, 2021 – All MTFs outside the United States transition to the authority, direction, and control of the DHA
- Transition of MTFs outside the 50 United States will be the last phase of transition. An alternative framework may be considered for these facilities at a later date.

Transition Metrics

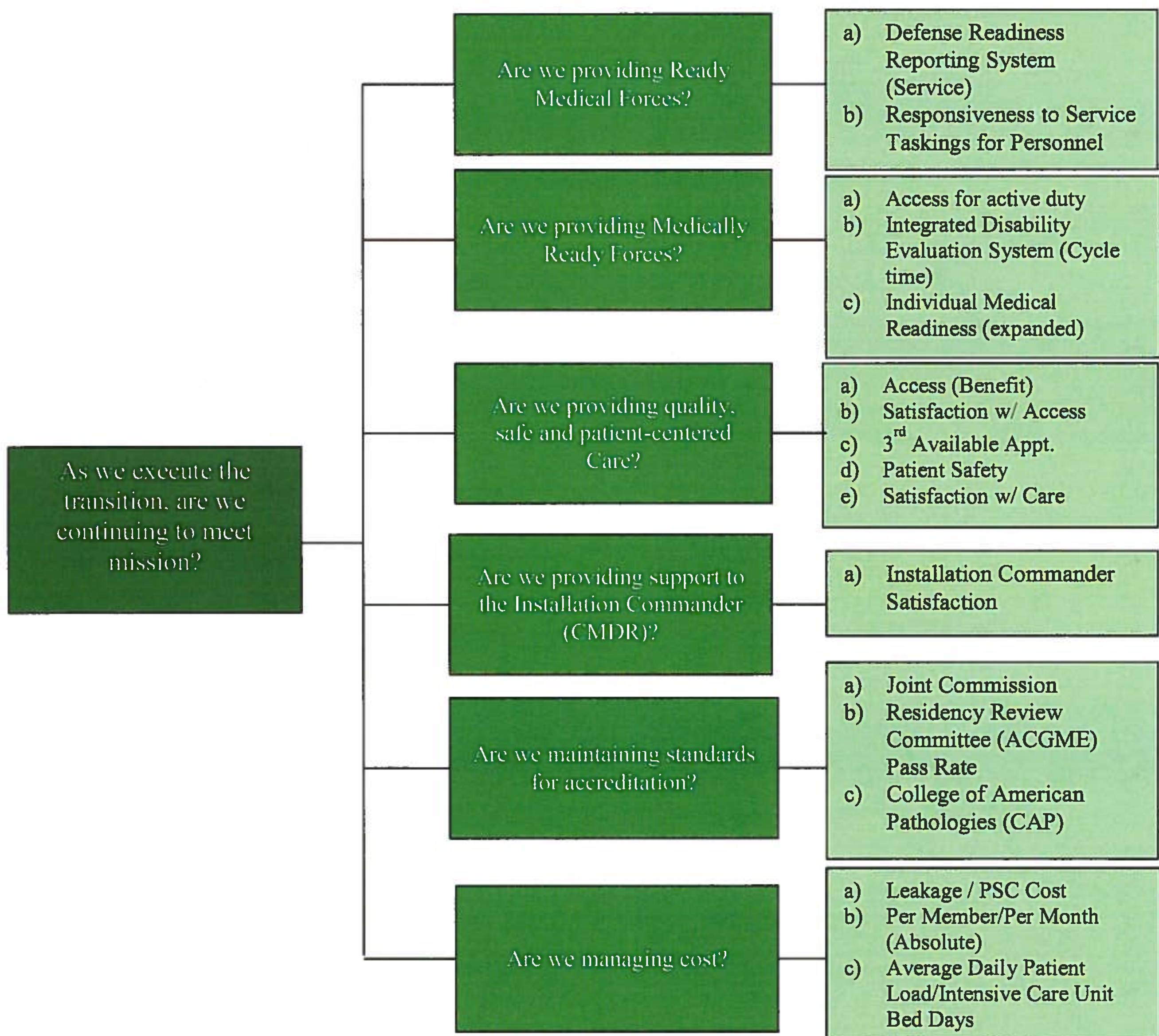
Over the past four years, the MHS has made substantial progress in establishing and operating a comprehensive system of measures to evaluate its performance against the Quadruple Aim. This performance measurement system, Partnership for Improvement (P4I), has played a critical role in system-wide improvements. Enterprise core quality metrics for health outcomes, quality of care, and safety are assessed with the goal of eliminating undesired variability and improving quality through evidence-based best practices. The Department will leverage P4I as a

foundational element in measuring the progress the MHS makes in transitioning MTF administration and management responsibilities from the Military Departments to the DHA.

Separately, to ensure a trained and ready health system to support the Joint Force, the DHA and the Military Departments are working collaboratively to establish a measurable definition of medical readiness. Additional measures will be tracked to evaluate DHA enterprise support functions and efficiencies resulting from business process re-engineering. To provide a full picture of progress throughout the 10 USC §1073c implementation process, the Department will report regularly on metrics across six broad categories, described below.

Measures have been identified to ensure that the MHS continues to meet DoD missions throughout this complex evolution. The purpose is to take any corrective actions early in the process to enable MHS leaders to make adjustments. Figure 6 below lists the initial measures the Department plans to use to assess performance and progress during the transition:

FIGURE 6: Transition Metrics



Conclusion

The Secretary of Defense fully supports efforts to reform the Military Health System as required by 10 USC §1073c and has directed the Department to take focused and determined action to ensure effective, timely, and efficient implementation. Where opportunities for more expeditious implementation and early attainment of milestones present, the Department will incorporate those opportunities into the implementation strategy and accelerate the overall timeline at every possible opportunity. Throughout this effort, the Department will continue to communicate with full transparency, maintaining an open dialogue with appropriate oversight Committees in discussing the Department's progress in bringing this important initiative to fruition.

Appendix A – USD(P&R) Guidance on the Framework for Section 702

PERSONNEL AND READINESS

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

FEB 21 2016

MEMORANDUM FOR UNDER SECRETARIES OF THE MILITARY DEPARTMENTS
DIRECTOR OF COST ASSESMENT AND PROGRAM EVALUATION

SUBJECT: Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments

10 U.S.C. § 1073c, as added by section 702 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114–328), "Reform of administration of the Defense Health Agency and military medical treatment facilities" requires that, beginning October 1, 2018, the Director, Defense Health Agency (DHA) shall be responsible for the administration of each military medical treatment facility (MTF), including with respect to budgetary matters, information technology, health care administration and management, administrative policy and procedures, military medical construction and any other matters the Secretary of Defense determines appropriate.

In accordance with section 702 of the NDAA for FY 2017 and 10 U.S.C. § 1073c, the Department has established a model and plan to transition administration and management responsibilities of the MTFs from the Military Medical Departments to the DHA, under the guidance and direction of the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

1. The basic elements of the model to fulfill section 702 of the NDAA for FY 2017 and 10 U.S.C. § 1073c include:
   a. All MTF clinical/health delivery services and business operations will come under the authority, direction, and control of the DHA. An MTF is defined as a fixed healthcare facility funded by the Defense Health Program (DHP). The DHP remains under the authority of the ASD(HA) who is responsible for allocation of funding to the DHA and to the Military Departments to carry out their respective responsibilities as noted in the framework below.
   b. The Director/Commander of each MTF will exercise authority, direction and control over MTF operations and will report to DHA. The MTF leadership team will report to the MTF Director/Commander.
   c. There will be a Military Department-specific leader responsible for the operational readiness activities of the Uniformed Personnel at the MTF, hereafter referred to as "Service Commander." All MTF-based activities not involving clinical/health delivery services, that are tied to organizing, training, and equipping personnel for operational readiness missions, will fall under the command of the Military Department Commander, together with operational and installation-specific medical functions separate from MTF health care delivery/operations (outlined below*), hereafter, "operational readiness." The Service Commander will report through the established Military Department chain of command.
   d. The respective duties of the MTF Director/Commander and the Service Commander are outlined in the attached authorities and responsibilities.

e. Military Departments will set the readiness requirements and ensure their military medical personnel are trained and maintain their clinical Knowledge, Skills, and Abilities (KSA). The DHA is responsible for providing the venues for military medical personnel to obtain clinical KSAs as defined by the Military Departments within the MTFs. The Military Departments are responsible for making their Service personnel available for placement at the MTFs in accordance with Service-generated readiness requirements and the capabilities established by the DHA. DHA shall coordinate with the Military Departments to ensure that staffing at MTFs supports readiness requirements.
f. If the DHA cannot meet Military Department readiness requirements through the MTFs, the DHA will support the Military Departments in establishing military-civilian partnerships, Department of Defense (DoD)/Veterans Affairs collaborations and any other appropriate practice venues that provide the required experience to maintain KSAs. Pre-existing Service partnerships will be grandfathered, if appropriate, and subject to recurring review to ensure the partnerships enhance appropriate KSA acquisition or to support longstanding MTF-community relationships.
g. Military Departments can take advantage of the MTF readiness opportunities to train to and maintain KSAs but have autonomy to decline and pursue other non-Military partnerships subject to business rules defined in paragraph e and f above.
h. MTFs (other than the National Capitol Region inpatient facilities) will continue to be Military Department-affiliated unless a decision is made at a later date to evolve this current construct toward MTFs becoming Tri-Military Department in nature or some other organizing construct.
i. The Military Department Surgeons General:
   1. Serve as the principal advisor to the Secretary of the Military Department concerned on all health and medical matters of the Military Department.
   2. Serve as the chief medical advisor of the Military Department concerned to the Director, DHA on matters pertaining to military health readiness requirements and safety of members.
   3. Subject to the authority, direction, and control of the Secretary of the Military Department concerned, are responsible for recruiting, organizing, training, and equipping military medical personnel of the Military Department concerned.
j. MTF civilian and contractor personnel, not directly and primarily supporting the defined Military Department operational and installation-specific medical functions, are appointed, contracted for, and managed by the DHA.
k. Uniformed Personnel working within MTFs are assigned to Military Department-specific commands. The Military Departments have command and control over these personnel and have the authority to make them available for assignment to specific MTFs and to reassign these personnel for operational missions as needed.
l. DHA has day-to-day authority with regard to how Uniformed Personnel working at the MTF will be utilized, contingent on Military Department requirements to maintain operational readiness and training and to fulfill operational readiness missions. .
m. During the Program Objective Memorandum cycle, the Military Departments will identify and communicate to DHA the operational readiness requirements they will have for the following year, so as to enable DHA to plan for and accommodate Military Department-delineated needs for their Uniformed Personnel and also to outline for DHA planning purposes any expected constraints such as training activities those MTF assigned personnel may have. Military Departments will inform DHA upon receipt of any Request for Forces for contingency operations to ensure DHA has sufficient information with which to plan for any necessary backfilling of personnel.

n. DHA will offer leadership and professional development opportunities for Uniformed Personnel as Regional and MTF leaders, which Military Departments can opt into or decline subject to business rules to be collectively established later.
o. Selection of the MTF Director/Commander will follow Military Department protocols ensuring the highest quality candidates. Director, DHA will monitor performance and address any performance issues with Military Department leadership and can remove this individual from position for poor performance
p. Under this construct, the primary performance rating of the MTF Director/Commander will be conducted by DHA. Military Department input into that evaluation will be dictated by the type of manning document employed.
q. MTF Director/Commander will be responsible for the performance ratings of all personnel involved in DHA-led healthcare activities. The Service Commander will be responsible for the performance ratings of all individuals involved principally in operational and installation-specific medical functions separate from MTF health care delivery/operations.*

2. Implementation Timeline for Framework
   a. Transition of administration and management of the MTFs will be effected through a phased approach (because statute currently requires that beginning October 1, 2018, the Director, DHA shall be responsible for the administration of each MTF, this is contingent upon Congress making legislative changes). All MTFs within the Military Health System (MHS), whether under Service command or DHA administration and management, will be required to adhere to the same policies, procedures, and standard clinical and business processes by October 1, 2018. Development of these system-wide standards, policies, and procedures will be the responsibility of the DHA.
   b. Phase One/Initial Operating Capability of the transition will be completed by October 1, 2018. Phase one will include Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, Dumfries Health Center, Fairfax Health Center, and DiLorenzo Tricare Health Clinic. Each Military Department will recommend to DoD Senior Leadership which medical center/hospital in the Southeast should be included in Phase One. Those clinics affiliated with the selected Army and Navy medical centers/hospitals will be included in Phase One. Air Force will recommend 2-3 ambulatory centers.
   c. Transition of MTFs outside the 50 United States should be the last phase of transition. An alternative framework may be considered for these facilities at a later date.
   d. Metrics will be developed, with input from the Military Departments, to monitor the transition prior to October 1, 2018. A comprehensive evaluation of phase one transition will be initiated six months after commencement of phase one.
   e. The detailed transition plan will be developed under the direction of the ASD(HA) and is subject to time limits established by Congress.

3. Resource management guidance:
   a. For the DHP, ASD(HA) will be responsible for the Planning, Programming, Budgeting, and Execution (PPBE) processes and will provide fiscal guidance to:
      i. DHA – responsible for the PPBE portion of the DHP for both DHA operations as well as those of the MTFs; Regional Leaders and MTF Directors/Commanders retain flexibility to manage their DHP-budgeted allotment during the year of execution, within DHA fiscal policies and controls

ii. Military Medical Departments – responsible for their medical program PPBE portion of the DHP appropriation for military manpower, and operational and installation-specific medical requirements* to include non-MTF commands

b. ASD(HA) develops consolidated DHP PPBE products for the Department, with input from the Military Departments and DHA, for submission through the Under Secretary of Defense for Personnel and Readiness to the Under Secretary (Comptroller) Chief Financial Officer.

c. MHS governance structure will be configured to support this PPBE process.

4. The Department intends to seek legislative change to 10 USC 1073c to grant the Secretary of Defense waiver authority to permit Military Department management of an MTF health service that is primarily focused on a Service member's health, performance, and qualification for a special operational readiness role; health services in this category would need to be integrated with an MTF's overall health care operations and utilize the policies and processes developed by the DHA in exercising its authority, direction, and control over the MTF. As the MHS phases in DHA's direct responsibility for all MTFs across the system, the delineation of operational and installation-specific medical functions that are separate from MTF health care delivery/operations may require clarification. This legislative change would enable such modifications without additional requests for statutory changes from Congress.

5. The point of contact for this memorandum is Tom McCaffery, Acting ASD(HA). Mr. McCaffery may be reached at (703) 697-2111 or Thomas.P.McCaffery.civ@mail.mil.

Robert L. Wilkie

Attachment:
As stated

cc:
Director, Defense Health Agency
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Joint Staff Surgeon

*Operational and installation-specific medical functions that are separate from MTF health care delivery/operations include, as determined by ASD(HA), non-health care delivery/operations functions under the following activities: Occupational Health, Environmental Health, Substance Abuse Programs, Food Protection, Aerospace Physiology, Aerospace Medicine (specifically non-MTF health care for aviation personnel), Bioenvironmental Engineering, Nuclear Power and other Personnel Reliability Programs, Animal Medicine, Dental Care (except oral and maxillofacial surgery), Installation Emergency Response, Deployment-Related Functions, Drug Demand Reduction, Medical Logistics for operational units, Embedded Behavioral Health, and Military Aeromedical Evacuation (Patient Movement).

Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments

MTF Director/Commander	Service Commander

• Execution of MTF Budget
• Authority/administration and management of MTF functional areas including:
    o Planning, Programming, Budgeting and Execution
    o Determination of manpower requirements
    o Business operations – coding, billing, collections
    o Patient administration – patient registration, patient records
    o Real property management
    o Management of medical logistics (and equipment) for MTF operations
    o Maintenance of health IT and medical informatics
    o Clinical quality and patient safety practices
    o Medical administration of the MTF including credentialing and privileging of medical providers
    o Risk management
    o Management of all other hospital based practices – clinical practices
    o Clinical care of MTF patients
    o Matters pertaining to military health readiness requirements and safety of members of the armed forces, with the advice of the Service Commander
    o All other administrative responsibilities in managing a practice/clinic/hospital
• Accountability to the Director, Defense Health Agency (DHA)
• First line supervisor and rater over MTF leadership team
• Primary performance evaluation for all personnel involved in DHA-led activities in accordance with Service-unique processes
    o Senior rater/reviewer will be determined based on manning document and will follow Service policy for personnel in joint positions
• Hiring and management of civilian and contract
	• Movement of uniformed medical personnel to MTFs, including (but not limited to) for Service specific training activities and for operational and training missions
	• Hiring and management of civilian and contract staff whose primary duties are for supporting operational and installation specific medical functions that are separate from MTF health care delivery/operations
	• Readiness of uniformed personnel and deployable teams/units
	• Authority over operational and installation specific medical functions
	    o Programming, Planning, Budgeting and Execution for the defined operational and installation-specific (non-MTF) medical care requirements, readiness commands and other Service functions
	    o Recruit, organize, train and equip medical personnel
	• Service administrative functions (e.g. fitness program monitor, leave monitoring, duty status, accountability, deployment management, drug demand reduction, pay inquiries) with regard to uniformed and civilian personnel (whose primary duties are in operational and installation-specific medical functions)
	• Primary performance evaluation (primary rater) for uniformed and civilian personnel whose primary duties are in operational and installation-specific medical functions
	• Logistical support of uniformed personnel and deployable teams/units
	• Performance evaluation tracking, completion, and compliance with Service requirements
	• Health, safety, morale and welfare inspections
	• UCMJ/discipline over uniformed personnel
	• Family support, including family care plans

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<td rowspan="2">staffing for MTF functional areas under DHA administration and management
• Support to operational readiness requirements and Service-specific functions
• Provide opportunities for clinical education and training for Service providers in the MTFs</td>
<td>• Military inquiries and investigations
• Professional military education and training
• Service Member board preparation
• Accountability to chain of command
• Operational and installation-specific medical functions that are separate from MTF health care delivery/operations include, as determined by ASD-HA, non-health care delivery/operations functions under the following activities: Occupational Health, Environmental Health, Substance Abuse Programs, Food Protection, Aerospace Physiology, Aerospace Medicine (specifically non-MTF health care for aviation personnel), Bioenvironmental Engineering, Nuclear Power and other Personnel Reliability Programs, Animal Medicine, Dental Care (except oral and maxillofacial surgery), Deployment-Related Functions, Drug Demand Reduction, Medical Logistics for operational units, Embedded Behavioral Health, and Military aeromedical evacuation (patient movement).</td>
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<tr>
<td><u>Military Departments</u>

• Assignment of uniformed medical personnel to duty locations including MTFs
• Mobilization/demobilization of uniformed personnel
• MTF Director/Commander performance evaluation input, based on Service specific processes
• Service Commander performance evaluation
• Establish readiness requirements
• Force development
• Other Service specific functions not delivered under the authority of the DHA including (may not be functions of all Services):
    o Oversight of the Exceptional Family Member Program
    o IDES (Administration of the medical personnel Evaluation Boards)</td>
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	- WTU clinical support (specifically Army) - Embedded Behavioral Health - Family Advocacy Program Support