



OFFICE OF THE UNDER SECRETARY OF DEFENSE

**4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000**

**PERSONNEL AND
READINESS**

The Honorable Susan Collins
Chair
Committee on Appropriations
United States Senate
Washington, DC 20510

JUL 25 2025

Dear Madam Chair:

The Department's response to House Report 118–121, pages 271-272, accompanying H.R. 4365, the Department of Defense Appropriations Bill, 2024, "Military Medical Manpower," is enclosed.

House Report 118–121, pages 271-272, requests that the Defense Health Agency (DHA) submit a report providing recommendations on restructuring the DHA market structure, strengthening partnerships with community providers, and reassigning personnel to address critical access-to-care issues. DHA addressed the restructuring of the market structure by executing the DHA Advancement which consolidated DHA markets into nine Defense Health Networks. To strengthen partnerships with community providers, DHA collaborates with the TRICARE Managed Care Support Contracts to build healthcare networks. To address the reassignment of personnel, the DHA executes the Human Capital Distribution Plan annually. This report does not provide information on nurse hiring policies or vacancy rates for medical personnel; that information will be provided in separate briefings to Congress.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and their families. I am sending a similar letter to the Committee on Appropriations of the House of Representatives.

Sincerely,



Merlynn Carson, MD
Performing the Duties of the Deputy Under
Secretary of Defense for Personnel and
Readiness

Enclosure:
As stated

cc:
The Honorable Patty Murray
Vice Chair



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The Honorable Tom Cole
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable Rosa L. DeLauro
Ranking Member

Report to the Committees on Appropriations of the Senate and the House of Representatives



Military Medical Manpower

July 2025

The total estimated cost of this report or study for the Department of Defense (DoD) is approximately \$3,200.00 for the 2024 Fiscal Year. This includes \$0.00 in expenses and \$3,200.00 in DoD labor.

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Introduction

House Report 118–121, pages 271-272, accompanying H.R. 4365, the Department of Defense (DoD) Appropriations Act 2024, requests that the Defense Health Agency (DHA) submit a report to the Committees on Appropriations of the Senate and the House of Representatives containing recommendations for:

- Restructuring the DHA market structure.
- Reassigning DHA personnel to address critical access to care issues in communities deemed high risk and health shortage areas.
- Strengthening DHA partnerships with community providers especially in rural areas.

DHA restructured from geographically focused markets to nine Defense Health Networks (DHNs) to better align authority and responsibility while ensuring readiness and peacetime mission and reduce duplicative structures. Regarding the reassignment of personnel to address critical access to care, DHA coordinates with the Military Departments to execute the Human Capital Distribution Plan (HCDP) to optimize military personnel assignments.

Additionally, DHA has implemented new hiring policies and initiatives for qualified medical personnel to increase access to care. To strengthen partnerships with community providers, DHA has implemented TRICARE initiatives such as the TRICARE Managed Care Support Contracts to build healthcare networks in rural areas, DHA has also built direct partnerships with local providers to enhance access to care in rural areas. Lastly, the implementation of virtual health has shown the ability to partially overcome challenges in medically underserved communities.

The House Report 118–121 also requests information on hiring policies for nurses, and vacancy rates among military and civilian medical personnel by location and specialty, which the Department will provide in separate briefings to Congress.

Military Health System Reform: Strategy and Implementation Plan

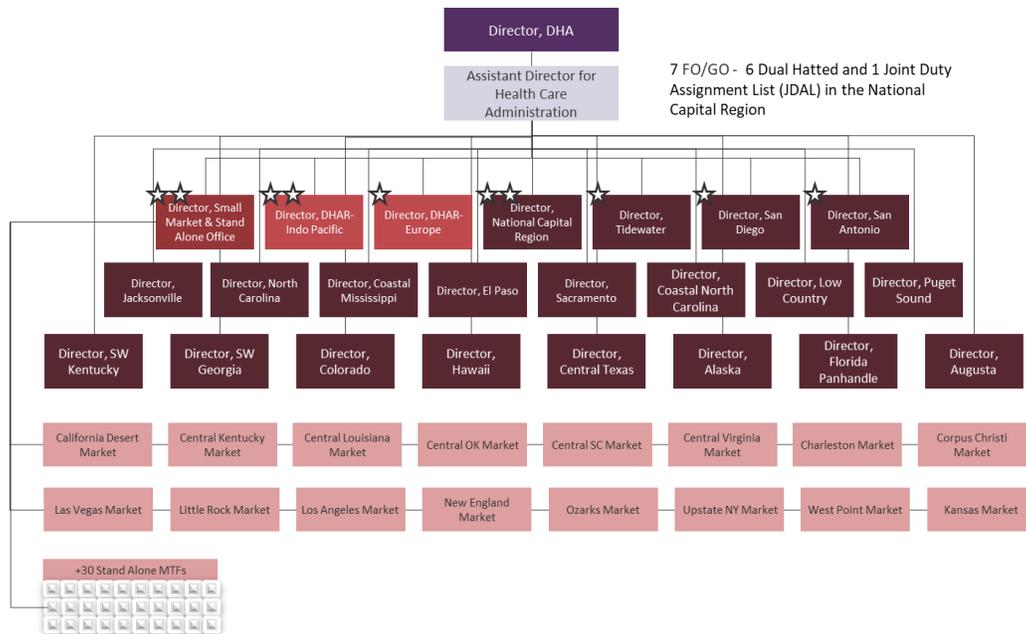
The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114–328) mandated the transfer of authority, direction, and control (ADC) of all military medical treatment facilities (MTFs) and dental treatment facilities (DTFs) from the Military Departments to DHA, thus creating a globally integrated system of readiness and healthcare. With this transfer, the Director, DHA became responsible for budgetary matters, information technology, healthcare administration and management, administrative policy and procedure, and military medical construction, among other duties. DHA successfully executed the transition of all MTFs and DTFs to DHA, consistent with the law, and has since engaged in a full strategic review of its performance and future plans.

DHA Market Structure: Origins and Limitations

DHA initially utilized a geographically focused “market” structure of Direct Reporting Organizations, which included 19 Direct Reporting Markets, the Small Market and Stand-Alone Military Treatment Facility Organization (SSO), and two DHA Regions that provided oversight and support to their aligned MTFs. In all, under this organizational structure, the Director, DHA had 23 direct reporting relationships along with other direct reports from DHA headquarters offices.

As a combat support agency, DHA must ensure that MTFs deliver high-quality care, meeting the Military Departments’ healthcare requirements, and providing the necessary clinical workload to meet the Military Departments’ medical readiness requirements, including the requirements of senior military operational commanders.

Figure 1. The DHA Market Structure



While the Market structure achieved the objectives set forth in the NDAA for FY 2017, namely, to expand the role of DHA by transferring responsibility for the administration of each MTF from the Military Departments to DHA, DoD leadership found that further improvements that also addressed the unwieldy span of control was needed. DHA’s Headquarters Assessment Team issued a report at the end of 2022 finding that, except for general officer/flag officer (GO/FO) led organizations, there were no true intermediate organizations that could coordinate healthcare delivery; most markets were legacy MTFs and their organic outlying clinics. In essence, the market structure aligned regional resources under DHA, but it was inadequate for ensuring optimal distribution of personnel and resources across the enterprise in support of the Military Departments’ requirements.

During the same timeframe, the Government Accountability Office (GAO) found in its report, GAO-23-105441, “DEFENSE HEALTH CARE: DOD Should Reevaluate Market

Structure for Military Medical Treatment Facility Management,” that DHA faced challenges mitigating shortfalls of military medical personnel in MTFs. These challenges predated the transition because of factors such as deployments and training. In addition, personnel requirements for the market and regional offices that manage the MTFs were not linked to workload information, sometimes creating a disconnect with budgetary needs. The consolidation of many aspects of the MHS under DHA, shifted the Military Departments’ mission sets to focus more intensely on their own readiness requirements such as deployments and duty assignments outside MTFs, and consequently reduced Military Departments’ attention towards staffing MTFs. GAO noted several steps that DHA had undertaken to mitigate shortfalls, such as authorizing markets and regions to move civilian providers. It also pointed towards a need for a new oversight mechanism that rebalanced manpower and human capital distribution decisions, while also consolidating the data needed to understand and address the root causes of staffing shortages.

In early 2023, the incoming Director, DHA’s initial 90-day assessment of DHA operations and structure cited a shared belief across DoD leadership that DHA should reduce the number of direct reports and realign DHA management structures to improve the interface between DHA and the Military Departments. Understanding that the Services and DHA share a common labor pool, reorganizing DHA to better align to Service medical management structures would improve coordination and decrease response time.

Change to the Network Structure

Responding to internal assessments, GAO findings, and the Director, DHA’s initial assessment, the DHA initiated a large-scale organizational initiative to reduce the number of direct reports and eliminate duplicative and overlapping organizations. DHA engaged with key stakeholders across the agency and conducted an analysis of functional support and alternative organizational models to inform the development of what is now known as the DHN model.

The Director, DHA’s initial assessment was followed by more detailed discussion with the Military Department Surgeons General on specific alignment of MTFs and Military Department leadership with the understanding that the MHS and healthcare delivery in DoD are not microcosms of other health delivery systems (whether Department of Veterans Affairs or private sector). Discussions also highlighted that the DoD health system is part of a larger mission and organizational structure and needs to be organized optimally to support that mission. In addition to reducing direct reports, the group determined that important criteria for reorganization included:

- Better aligning authority and responsibility.
- Dual-hatted network leaders with authority to address and resolve military medical personnel movements.
- Ensuring readiness and peacetime mission.
- Less emphasis on geographic alignment over decision making alignment, except where it is consistent with decision-making.

Table 1. Comparison of Market and Network Structures

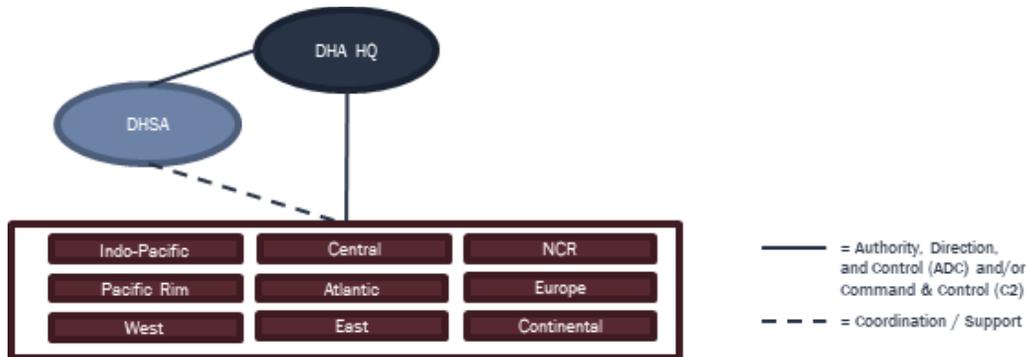
	Market Structure	Network Structure
Organizational Rationale	Regional/geographically based healthcare delivery model Aligned with geographic location of beneficiaries	Military resource-based healthcare delivery model Aligned with Military Department command structures
Reporting Structure	19 Large Markets 1 SSO 17 Small Markets 40 Stand-alone MTFs 2 Overseas DHA Regions	4 Regional Defense Health Support Activities (DHSAs) at DHA headquarters 9 DHNs
Leadership Structure	Some dual-hatted O-6, some dual-hatted GO/FOs	All dual-hatted GO/FOs
Leader Authorities	ADC over MTF policy, business planning and resourcing decisions	<u>No change</u> : ADC over MTF policy, business planning and resourcing decisions
Relationship with Service Command	Varies by market and Military Department affiliation of market director	Influence and input into military personnel and staffing through Military Department command authority
MTF Business Planning and Financial Management	Driven by standardized market business plans	<u>No change</u> : Driven by standardized market business plans

The DHN model provides influence and input into military personnel and staffing through Military Department command authority, whereas within the market model the relationship with the Service command varied by market and Military Department affiliation of the Market Director, leading to challenges with interfacing with the Military Departments. The DHN model aligns all MTFs under nine GO/FO led DHNs. In this model, MTFs are aligned to a DHN primarily by Military Department Command, though a majority of DHNs are multi service. This alignment capitalizes on GO/FO authorities, leadership, and decision-making to enhance personnel and resource sharing across the organization, simplify relationships, and improve internal communication. DHN directors are dual-hatted, exercising authorities delegated to them from the Director, DHA and authorities inherent in their Military Department leadership roles. As statutorily mandated, DHA, through its DHN directors, maintains ADC over MTF budgets, information technology, healthcare administration and management, administrative policy and procedure, military medical construction, and any other matters the Secretary of Defense determines appropriate.

To determine whether the interface between DHA and the Military Departments has improved under the DHN organizational structure, DHA conducted assessments 2 weeks, 30 days, 90 days, and 180 days after initial operating capability. MTFs have indicated that dual-hatted GO/FO leadership has led to streamlined decision-making, increased support/responsiveness to MTFs, a clearer hierarchy, and a single commander/director of the medical readiness command and the DHN.

At this time, formal input has not been requested from the Military Departments on how aligning the DHNs with their service medical management structure affects their ability to execute their mission for supporting medical readiness. However, informal feedback from Military Departments to DHA senior leaders occurs regularly.

Figure 2. The Defense Health Network Model



In addition to restructuring, a DHSA was established to provide functional support to the DHNs, streamline communications, and track network support requests to completion.

In response to section 714 of the NDAA for FY 2024 (Public Law 118–31), GAO initiated report GAO-25-107432, “DEFENSE HEALTH CARE: Actions Needed to Address Long-Standing Management Challenges with Medical Facilities,” regarding DHA’s plans for achieving consolidation of business functions across MTFs under the DHN structure, as well as analyses on the network model decision making process.

Military Medical Manpower

On December 6, 2023, the then-Deputy Secretary of Defense issued the memorandum, “Stabilizing and Improving the Military Health System.” This memorandum recognizes that the realignment of medical personnel, coupled with a challenging healthcare economy and ambitious private sector care (PSC) capacity assumptions, led to chronically understaffed MTFs and DTFs that at times cannot deliver timely care to beneficiaries or ensure sufficient workload to maintain and sustain clinical skills. As a result, beneficiaries are routinely referred to the private sector for services that MTFs and DTFs should be able to deliver, with the Military Departments increasingly turning to the private sector for clinical skills sustainment opportunities for uniformed medical personnel.

Senior leadership determined the most effective way to take care of people, support the National Defense Strategy, increase clinical readiness, mitigate risks to requirements, and reduce long-term cost growth in PSC is to reattract beneficiaries to MTFs and maximize medical education and training pipelines. However, the memo recognizes that reattracting care to MTFs and DTFs requires a stable, predictable workforce sufficiently staffed, trained, and routinely available to provide healthcare to MHS beneficiaries. Maintaining a ready medical force and medically ready force under resource constraints has required wholesale change to policy and procedures, new oversight, and careful consideration of partnerships with Network and local providers.

Policy Changes

DHA and the Military Departments’ Medical Services collaborated on a plan to understand, account for, and analyze the duty requirements at the MTF and DTF level to ensure availability of military medical personnel to support readiness and the delivery of care. The then-Official Performing the Duties of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) issued Directive-Type Memorandum 24-003, “Military Health System Manpower Requirements Determination, Resourcing and Assignment,” to begin codifying this shared responsibility.

In response, the then-Assistant Secretary of Defense for Health Affairs initiated the HCDP to optimize military personnel assignments across the MHS. The HCDP contains business rules that establish a collaborative process between the Military Departments and DHA for planning and programming the uniformed medical and dental workforce within MTFs and DTFs. Central to this effort was the establishment of an annual cadence under which Military Department assignment cycles are reconciled with DHA manpower requirements to inform future year programming and resource decisions.

Table 2. HCDP Responsibilities

Director, DHA	Secretaries of the Military Departments
(1) Prioritize DHA MTF/DTF staffing for military authorizations, as outlined in the Program Objective Memorandum manpower requirements process, by location and military occupational specialty.	(1) Review DHA’s prioritized staffing plan to inform assignments for military personnel for the upcoming fiscal year.
(2) Submit HCDP staffing requests to the Military Services to ensure sufficient time for planning and response to such requests.	(2) Determine availability of staffing to meet DHA requirements based on their respective distribution processes.
(3) Coordinate with the Secretaries of the Military Departments to place uniformed medical and dental personnel in DHA MTF/DTFs to meet the DHA military medical and dental personnel requirements.	(3) Provide the DHA with a written estimate of the breakdown of military personnel by location and military occupational specialty to perform healthcare delivery in MTF/DTFs to meet the DHA’s staffing plan within 90 days of completion of the HCDP executive conference.
(4) Support the Secretaries of the Military Departments by ensuring systems are in place to collect data and measure compliance with the HCDP business rules.	(4) Coordinate with DHA annually to coincide with Military Department assignment cycles.
(5) Provide the Secretaries of the Military Departments with updates on Service member, civilian employee, and contractor personnel staffing to communicate a complete staffing perspective.	
(6) Coordinate with the Secretaries of the Military Departments at an annual executive conference in August, to coincide with Military Departments assignment cycles.	

Hiring Policies for Qualified Medical Personnel

The December 6, 2023 Deputy Secretary of Defense memorandum also directed the USD(P&R) to prioritize implementation of chapter 74 of title 38, U.S. Code, which grants authorities to improve recruitment and retention of healthcare personnel.

To date, DHA has taken a series of steps to implement special salary rates for Registered Nurses, and is pursuing redelegation of authorities between DoD and the Office of Personnel Management for all eligible healthcare occupations.

Changes to hiring practices are occurring at the MTF level as well. As an example, Brooke Army Medical Center (BAMC) is spearheading a Rapid Hiring Initiative to streamline, shorten, and simplify the hiring experience from application to start date in the San Antonio Market. By working closely with the Army's Civilian Human Resources Agency, performing certain administrative actions in advance, and reducing the number of steps to hire, BAMC has begun to show measurable results and is now working with San Diego and the National Capital Region to help them stand up their own rapid hiring Initiatives.

Quarterly Reporting

DHA maintains an enterprise-wide Civilian Hiring Dashboard that provides rolling and monthly views on overall time to hire for clinical positions, numbers onboarded in a given month, and average numbers of days it takes applications to move from one step of the process to another, and gains and losses by profession, all discernable at the DHN and MTF levels. DHA's long-term goal is to achieve a 60-day standard for total recruitment time. DHA also tracks overall turnover rates of positions, as well as the number of open hiring actions as permitted by manpower requirements and authorizations. To date, DHA has seen a 5.2 percent increase in civilian employees since September 21, 2022.

Strengthening Partnerships

Over 60 percent of healthcare delivered through the MHS is provided by civilian providers in the local community. Maintaining and ultimately strengthening clinical partnerships requires careful planning both at the headquarters level as well as the DHN and local levels. PSC is managed through the TRICARE Program, a set of health plans offered to military beneficiaries worldwide. At DHA headquarters, oversight of the TRICARE Program and the Managed Care Service Contractors (MCSCs). MCSCs create and maintain the civilian provider networks, ensure that PSC delivery networks are adequate to meet all beneficiaries' clinical needs in a timely and convenient manner. At the DHN and MTF levels, DHA leadership works continuously to build relationships with community providers that benefit MHS clinicians' knowledge, skills, and abilities, and to expand access to care for service members, families, and retirees located in their communities.

TRICARE Initiatives

To strengthen partnerships with community providers, especially in rural areas, DHA collaborates with the TRICARE MCSCs to build robust networks in rural communities. In situations where there are not enough local providers to meet the requirements of a rural community, both DHA and the MCSCs have several tools at their disposal to mitigate these challenges to timely access to care.

First, both DHA and MCSCs utilize telehealth capabilities to bridge the gap for the beneficiaries. To ensure telehealth capabilities for all beneficiaries moving forward, the current contract, known as T-5, that began healthcare delivery on January 1, 2025, requires the MCSCs to create a comprehensive telehealth implementation plan for coverage to rural, remote, and isolated areas.

Financial incentives are in place as well. Reimbursement is permitted up to 115 percent of the TRICARE allowed charge when DHA determines it is necessary to meet network requirements. Other T-5 changes involve new measures of PSC availability, easier transfers of referrals when beneficiaries move, increased beneficiary support for PSC appointments, and more accurate and current provider directories.

Under T-5, MCSCs have strengthened integration of care between the Direct Care and PSC delivery systems by way of contractor award fee incentives and full interoperability between MHS GENESIS and Health Information Exchanges to streamline the referral process and provide seamless information exchange between providers wherever they are located.

Direct Partnerships Between MTFs and Local Providers

Beyond working with MCSCs, DHA and MTFs have built direct partnerships with local providers that have enhanced access to care in rural, remote locales and in some cases, provide valuable clinical skills training for military providers. For example, when the nearest network hospital, Ridgecrest Regional Hospital, announced the closure of labor and delivery services in March 2024, the Branch Health Clinic China Lake successfully assisted TRICARE-eligible beneficiaries to find alternative birthing clinics in the China Lake-Ridgecrest area. The clinic's referral nurse educates patients on options and tracks them throughout their pregnancy to ensure their healthcare needs are met. The clinic also coordinates referrals for basic prenatal services such as ultrasound and labs to be done locally, saving patients several hours of driving.

China Lake and the Department of the Navy have also established a partnership with Ridgecrest Regional Hospital, an essential community provider that has been under financial stress. DoD has been coordinating with the Department of Health and Human Services and the State of California on improving cash flow for the hospital. The Naval Air Warfare Center Weapons Division recently awarded a contract to Ridgecrest for standby medical services including labor and delivery, which provide crucial support to China Lake's military and civilian populations.

In San Antonio, Texas, the San Antonio Military Civilian Trauma Consortium (SAMCTC) is a collaborative organization that brings together military and civilian healthcare providers to improve trauma care and outcomes for patients. This consortium focuses on sharing knowledge, resources, and best practices between military and civilian trauma systems. Key features and value include:

- **Collaboration:** SAMCTC fosters partnerships between military healthcare facilities and civilian hospitals, enhancing the exchange of information and techniques in trauma care.

- **Research and Innovation:** The consortium promotes research initiatives that aim to improve trauma treatment protocols and patient outcomes, leveraging the unique experiences of both military and civilian settings.
- **Training and Education:** It provides training opportunities for healthcare professionals, ensuring they are equipped with the latest knowledge and skills in trauma care.
- **Resource Optimization:** By pooling resources and expertise, SAMCTC aims to optimize patient care and streamline processes in trauma management.
- **Community Impact:** The consortium not only benefits military personnel but also enhances trauma care for the local civilian population, thereby improving overall community health outcomes.
- **Support for Service Members and Veterans:** It addresses the specific needs of veterans who may require specialized trauma care due to their unique experiences and injuries.

The Military Civilian Medical Partnership at Fort Drum, New York, is similarly a collaborative initiative aimed at enhancing healthcare delivery for military personnel and their families by integrating civilian medical resources with military healthcare services. This partnership seeks to improve access to care, streamline services, and ensure that both military and civilian providers can effectively meet the health needs of the community. Key Features and Benefits include:

- **Integrated Care:** The partnership combines military and civilian healthcare systems, allowing for a more coordinated approach to patient care. This integration helps ensure that service members receive comprehensive support across various medical specialties.
- **Access to Services:** By leveraging civilian medical facilities, the partnership increases access to specialized care that may not be available within military hospitals. This is particularly beneficial for families and veterans who may require ongoing medical attention.
- **Resource Sharing:** The collaboration enables sharing of resources, including medical expertise, technology, and facilities, which enhances the overall quality of care provided to patients.
- **Community Engagement:** The partnership fosters strong ties between the military and civilian communities, promoting health awareness and education initiatives that benefit both populations.
- **Research and Training:** The partnership often involves collaborative training programs and research initiatives aimed at improving medical practices and

addressing specific health challenges faced by military personnel.

There are hundreds of other collaborative partnerships between DoD and civilian health systems in the United States and around the world that help improve access to care; help DoD sustain its clinical skills; and contribute to effective shared advances in healthcare delivery.

Emerging Virtual Health Capabilities

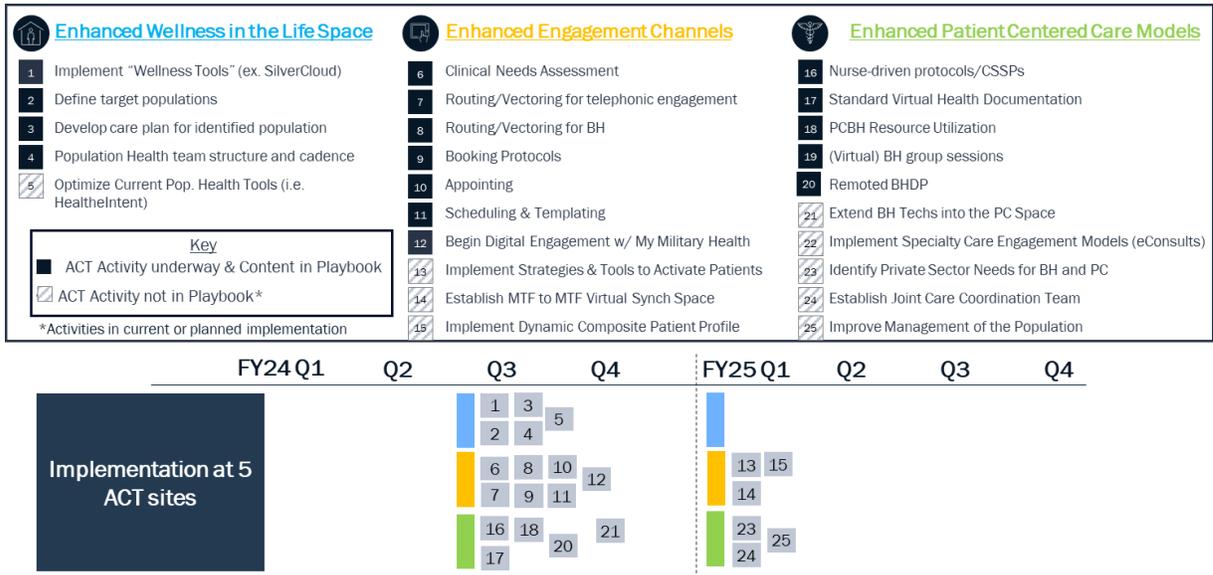
Early evidence on virtual health has shown its ability to partially overcome challenges in medically underserved communities. Care collaboration tools are under development for providers to communicate more easily between each other. New payment flexibilities on telehealth for primary, specialty and behavioral care are coming online to overcome local access challenges wherever possible.

My Military Health (MMH) represents the next phase of enhanced virtual capabilities. MMH prioritizes delivering healthcare services primarily through digital channels and technologies. This includes leveraging telehealth, online consultations, electronic health records, mobile health applications, and remote monitoring as the primary methods for patient care and interaction. The goal of MMH is to enhance accessibility, efficiency, and patient outcomes by reducing the dependence on in-person visits and traditional paper-based processes, transforming healthcare delivery to be more proactive, patient-centric, and technologically integrated.

MMH has three main components: Converge, SilverCloud, and Conversa. Converge is used to schedule remote and on demand visits, including tools such as a visit readiness companion, customized intake workflows, pre and post visit instructions, and providing benefits such as ease of provider access and low barrier patient experience. Conversa automates care with highly personalized, automated, and trusted conversations. The system identifies at-risk patients and provides digital triage to higher levels of care for those patients like phone calls, telehealth, e-visits, or scheduling in-person consults when necessary. SilverCloud offers digital mental health solutions using evidence-based Cognitive Behavioral Therapy based content, interactive tools, and relatable user videos - available anytime, anywhere on a user's smartphone, tablet, or computer.

The capabilities under MMH are currently deployed at 5 Venture Sites across the continental United States under a program known as Accelerate Care Transformation.

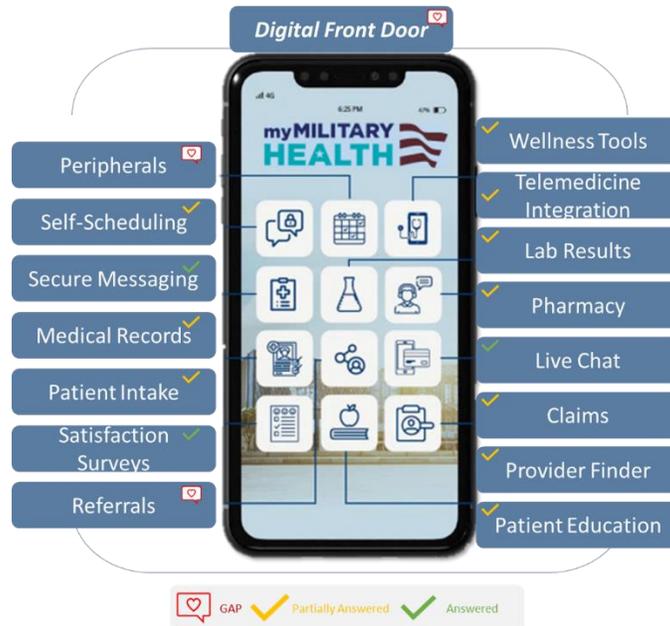
Figure 3. Accelerating Care Transformation Timeline and Capabilities



Since its launch in March, the Venture Sites have significantly increased the availability and use of virtual appointments, with some primary care clinics achieving virtual appointing rates of over 50 percent.

DHA plans to expand the activities taking place at the Venture Sites enterprise-wide under a Digital Front Door (DFD) program. The initial phase of DFD begins in FY 2025, integrating virtual primary care and behavioral healthcare model changes, as well as implementation of scheduled virtual visits using the Converge platform. Final rollout of these aspects of DFD, including the rollout to outside the continental United States sites, will conclude over the course of FY 2026.

Figure 4. Capabilities of the MHS Digital Front Door at Full Capacity



Conclusion

The MHS is at an inflection point and faces risks and challenges that are not only unique to military medicine, but also reflect overall healthcare challenges in the United States. These challenges include increased utilization of high-cost services; shortages of nurses, technicians, and physicians; rapid and costly changes in technology; and access challenges for individuals living in remote and medically underserved communities.

The MHS recognizes that it cannot sustain the readiness of the medical force in its present operating model. The accelerating shift in healthcare to digitalization, patient-centeredness, and hyper-specialization requires the DHA to adapt or face risks of diminishing readiness of the medical force, deteriorating retention of medical staff, and reductions in direct care capability and capacity that will be almost impossible to reverse. This report is intended to highlight some of the ways DHA has addressed this problem set.