



PERSONNEL AND  
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE  
4000 DEFENSE PENTAGON  
WASHINGTON, D.C. 20301-4000

APR 17 2019

The Honorable James M. Inhofe  
Chairman  
Committee on Armed Services  
United States Senate  
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report is in response to section 712 of the John S. McCain National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019 (Public Law 115-232). The report describes the reorganization of the offices of the Military Departments (MILDEPs) Surgeons General. This report also contains changes to the final plan submitted to Congress in June 2018, describing how the Department will implement section 702(e)(2) of the NDAA for FY 2017.

The organizational structures described in this report were developed by the Secretaries of the MILDEPs and reviewed by the Department of Defense. The Department provided guidance to the MILDEPs that the headquarters structures of each Surgeon General should avoid the duplication of functions and tasks that would be performed by the Defense Health Agency. Consolidating Department-wide medical functions under a single headquarters at the Defense Health Agency will result in increased efficiency by reducing unwarranted variation and duplication of effort.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the Chairman of the House Armed Services Committee.

Sincerely,

James N. Stewart

Assistant Secretary of Defense for Manpower  
and Reserve Affairs, Performing the Duties  
of the Under Secretary of Defense for  
Personnel and Readiness

Enclosure:  
As stated

cc:  
The Honorable Jack Reed  
Ranking Member



OFFICE OF THE UNDER SECRETARY OF DEFENSE  
4000 DEFENSE PENTAGON  
WASHINGTON, D.C. 20301-4000

The Honorable Adam Smith  
Chairman  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

APR 17 2019

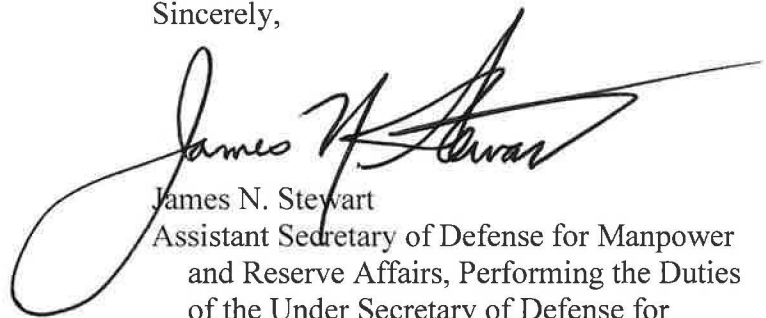
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James N. Stewart  
Assistant Secretary of Defense for Manpower  
and Reserve Affairs, Performing the Duties  
of the Under Secretary of Defense for  
Personnel and Readiness

Enclosure:  
As stated

cc:  
The Honorable William M. "Mac" Thornberry  
Ranking Member

**Report to Armed Services Committees**

**Section 712 of the John S. McCain National Defense Authorization Act  
for Fiscal Year 2019 (Public Law 115-232)**

**“Organizational Framework of the Military Healthcare System to Support the Medical  
Requirements of the Combatant Commands”**



April 2019

The estimated cost of this report or study for the Department of Defense is approximately \$11,000 for the 2019 Fiscal Year. This includes \$20 in expenses and \$11,000 in DoD labor.

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## EXECUTIVE SUMMARY

This report is in response to section 712 of the John S. McCain National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019 (Public Law 115-232), and provides the organizational structure of the office of each Surgeon General (SG) of the Armed Forces, and of any subordinate organizations of the Armed Forces that will support the functions and responsibilities of each SG. Also provided is a revised framework on the Department's transition and implementation plan (Appendix B). These revisions would require changes to current law governing the administration of the Defense Health Agency (DHA) and Military Treatment Facilities (MTFs), and the organizational framework of the Military Health System (MHS).

The organizational structures described in this report were developed by the Secretaries of the Military Departments (MILDEPs) and reviewed by the Department of Defense (DoD). The DoD provided guidance to the MILDEPs that the headquarters structures of each SG should avoid the duplication of functions and tasks that would be performed by DHA. The organizational structures for the office of each SG and the DHA are contained in Appendix A. The estimated manning levels for staffing in support of the organizational structures are described in Section 3. These documents include manning levels as of September 30, 2018 (before structural changes) and the proposed manning levels for the final organizational structures at end state as of October 1, 2021.

Consolidating Department-wide medical functions under a single headquarters at the DHA will result in increased efficiency by reducing unwarranted variation and duplication of effort. The MILDEPs have identified office of the SG personnel performing functions that will be performed by the DHA by FY 2022. The restructuring of the offices of the SGs will not adversely impact the oversight and execution of readiness requirements retained by the MILDEPs. The MILDEPs have collectively identified 2,100 positions no longer required by their offices of the SGs. Of the 2,100 positions, 457 were identified as needed to perform medical oversight functions within the MILDEPs but outside the offices of the SGs. Consolidation of functions at the DHA will require an additional 1,282 positions. The centralization of medical oversight at the DHA resulted in a net reduction of 361 positions (6 percent) performing medical headquarters oversight functions within the DoD.



## 1. INTRODUCTION

This report is submitted to the Committees on Armed Services of the House of Representatives and the Senate to fulfill the legislative requirements specified in section 712 of the NDAA for FY 2019.

The consolidation of direct and private-sector health care delivery under the DHA, including oversight and management of MTFs, means certain staff functions will no longer be needed in the offices of the MILDEP SGs. In order to quantify the number and type of potentially duplicative positions, a description of the desired end-structure of the DHA was required.

The Office of the Secretary of Defense (OSD), in collaboration with the MILDEPs, conducted a manpower requirements assessment of the DHA to determine the DHA headquarters personnel requirements. The manpower assessment described the current and future personnel requirements for the DHA, stratified by function. These functions, or work streams, provide common reference points for the transfer of functions from the MILDEPs to the DHA and facilitate identification of areas of potential duplicative effort. The results of the OSD assessment were shared with the MILDEPs to facilitate identification of functions to reduce or eliminate from their SG's offices. The MILDEPs provided OSD the information contained in this report following their analysis of the OSD assessment.

This report considers only military and civilian personnel requirements. It is assumed other ongoing medical reform efforts directed by OSD will be adopted in the final structure of the DHA.

The organizational structures described in this report conform to all requirements of 10 U.S.C. § 1073(c), sections 711 and 712 of the John S. McCain NDAA for FY 2019, and other applicable law, except as specifically outlined in Section 5 or this report.

## **2. ORGANIZATIONAL STRUCTURE OF THE OFFICES OF THE SURGEONS GENERAL [SECTION 712(F)(1)]**

### **2.A. Air Force**

#### *Background*

The Office of the Air Force (AF) SG supports the SG in the execution of title 10-specific policy and oversight functions, AF specific functions, and as a major headquarters element. The Air Force Medical Service (AFMS) operates as an integral component of the Line of the AF commands in support of AF Doctrine, rather than as a separate medical command. AFMS operational functions and current headquarters, Field Operating Agencies (FOA), Major Command (MAJCOM) Command Surgeon directorates, and MTF structures are organized accordingly. With the transfer of responsibility for the management and administration of MTF health care delivery and enterprise activities in support of MTF operations to the DHA, the AFMS is restructuring its headquarters elements to maximize the SG of the AF's ability to provide medically-ready forces and ready medical forces in support of AF and joint operational missions and National Security priorities, while eliminating duplication of effort between the AF and DHA.

#### *AFMS Transformation*

The AFMS consisted of 1 major staff element, 2 subordinate headquarters, and 647 total personnel as of September 30, 2018. The proposed final structure, to be in effect no later than October 1, 2021, has 1 major staff element, 1 subordinate headquarters, and 414 total personnel. The end state organizational structures are depicted at Appendix A, and the current and proposed future Manning levels, by functional areas, are listed in Section 3. Major changes enacted to support consolidation and eliminate unwarranted duplication are as follows:

- 1) streamlining of the Headquarters AF SG office staff;
- 2) consolidating two geographically separate FOAs into a single, integrated FOA known as the Air Force Medical Readiness Agency (AFMRA);
- 3) aligning resources for readiness, and divesting resources to support the DHA

#### *Streamlining Headquarters AF SG*

The Office of the AF SG is currently comprised of the AF SG and immediate staff with 2 subordinate Directorates and 9 subordinate Divisions, for a total of 76 staff. The AF identified nine positions in the areas of congressional/public affairs and medical resourcing as efficiencies due MTF management and administration transfer and DHA assuming additional responsibilities for enterprise functions supporting the MTFs. The remaining 67 staff are aligned to the Office of the AF SG to support existing and emerging responsibilities.

The AF SG assists the Secretary of the Air Force, other Secretariat offices, and the Chief of Staff of the Air Force in carrying out the development of policies, plans, and programs, establishing requirements, and providing resources to the AFMS pursuant to 10 USC § 8031-8038, and as

documented by paragraph 4.3 of Air Force Mission Directive (AFMD) 1, *Headquarters Air Force*, and in accordance with Headquarters Air Force (HAF) Mission Directive 1-48, *The Air Force Surgeon General*. Within his/her areas of responsibility, the AF SG prepares policies for Department of the Air Force approval and issues official guidance/procedures to ensure implementation of those policies. The AF SG also assists the Chief of Staff of the Air Force in his/her role, pursuant to 10 U.S.C. § 151, as a member of the Joint Chiefs of Staff.

Existing responsibilities for the AF SG include:

- 1) Providing guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, programs, and budgets related to carrying out the AFMS mission;
- 2) Providing recommendations as the medical staff advisor to the Secretary of the Air Force and the Chief of Staff of the Air Force;
- 3) Coordinating with the Assistant Secretary of Defense for Health Affairs on AF health and medical matters;
- 4) Primary responsibility for health matters of AF personnel; and
- 5) Providing guidance to MAJCOM Command Surgeons.

In addition to these responsibilities, the AF SG has several new statutory duties under the NDAA for FY 2019. The proposed future structure will include capability necessary to accomplish the following new duties:

- 1) Assign medical and dental personnel to MTFs for operational and training missions, during which assignment of such personnel shall be under the operational control of the MTF leader and subject to the authority, direction, and control of DHA.
- 2) Ensure the readiness for operational deployment of medical and dental personnel and deployable medical or dental teams and units.
- 3) Provide logistical support for operational deployment of medical and dental personnel and deployable medical or dental teams and units.
- 4) Oversee mobilization and demobilization of medical and dental personnel for deployment.
- 5) Carry out operational medical and dental force development.
- 6) Ensure operational Medical Readiness organizations support DHA's medical and dental readiness responsibilities.
- 7) Develop operational medical capabilities and policies to support the warfighter.
- 8) Provide health professionals to serve in leadership positions across the MHS.

In supporting these responsibilities, the streamlined HAF SG staff is responsible for advising the AF SG, creating Service-specific readiness policy, and consulting with outside agencies, other DoD organizations, and Congress. As depicted in Appendix A, Figure 2, the streamlined AF SG Headquarters will continue to consist of special staff functions, Executive Services, and two directorates: Manpower, Personnel & Operational Resourcing (SG1/8) and Medical Operations (SG3/4).

The Executive Services team will directly support the SG, Deputy SG, and staff. Responsibilities will include, but are not limited to, coordinating all internal and external tasks assigned to the AF



SG, managing all SG publications, overseeing AF SG officer and enlisted promotion activities, and managing internal programs. The staff will also continue to work in close coordination with Secretary of the Air Force and HAF Directorates, DHA, AF SG Directorates, AFMRA, MAJCOMs, and other Federal and civilian health agencies to effect maximum coordination and communication between the organizations.

Functional capabilities for the AF SG will be executed by the SG1/8 and SG3/4 Directors through nine subordinate division leads:

- 1) Readiness Operations
- 2) Operational Resourcing
- 3) Capabilities Development
- 4) Aerospace and Operational Medicine
- 5) Operational Medical Logistics
- 6) Operational Support
- 7) Force Development and Management
- 8) AF Guard Representative
- 9) AF Reserve Representative

#### *FOA Consolidation*

In 2007, the AFMS established the Air Force Medical Operations Agency (AFMOA) as a means to achieve a centralized, enterprise model to oversee and support its 76 MTFs and related medical activities. This action was directed by Program Action Directive 07-13, and consolidated non-readiness MTF support functions from the MAJCOM Command Surgeon directorates worldwide to a single FOA headquartered in San Antonio, Texas. Per AFMD 35, AFMOA's current mission is:

*“to support Air Force and Joint medical missions through the execution of programs to enhance the health and performance of Airmen and members of other Department of Defense (DoD) Services through healthcare operations in Air Force Military Treatment Facilities (MTFs) and other Air Force medical units. AFMOA further supports these missions through the promotion of health and provision of healthcare for family members who are authorized DoD healthcare beneficiaries. AFMOA is the Surgeon General's primary focal point for execution and standardization of plans, practices, procedures and programs in planning, budget execution, logistics, clinical operations, clinical quality management, patient safety, family advocacy, and health promotions for the Air Force Medical Service (AFMS). AFMOA collects, validates, analyzes and presents data to users at every level of the AFMS and coordinates healthcare performance and process improvement activities in support of the AFMS strategy, and monitors national healthcare performance measures, standards and benchmarks in coordination with, and while aligning our efforts with DoD, the MHS, the DHA and our sister services.”*

Complementing AFMOA's mission and purpose to support AF MTFs world-wide, the Air Force Medical Support Agency (AFMSA) was established as a FOA in direct support of the AF SG. In accordance with AFMD 36, the AFMSA provides expert staff and processes to ensure mission success. Currently, the AFMSA performs the following major functions:

- 1) Develops and executes the strategic charter of the AFMS.
- 2) Exercises direction, guidance, and technical management of entire AFMS to capitalize on the opportunities to improve processes at all levels.
- 3) Develops policy, plans, resources, and decisions impacting AFMS operational readiness.
- 4) Works in close coordination with MAJCOMs and other health agencies, Federal and civilian, to effect maximum utilization of the nation's medical resources and services.
- 5) Directs input into the Planning Programming Budgeting and Execution (PPBE) process, such that a balanced Program Objective Memorandum (POM) is developed to meet AF Medicine needs.

To strengthen readiness and improve efficiencies, the AFMS's two FOAs, the AFMOA and the AFMSA, are being consolidated into a single FOA – the AFMRA. AFMRA's mission will be to support the AF SG in policy execution for operational medicine, while supporting the MAJCOMs and base-level unit missions. AFMRA will directly report to the AF SG and serve as a liaison to DHA in support of its mission. The FOA will be readiness-focused to enhance the oversight of AFMS medical readiness program execution, expeditionary medical capabilities, and sustain readiness-related support of AF mission requirements.

Initial Operational Capability declaration for AFMRA is tentatively set for Summer 2019 with Full Operational Capability by October 1, 2020. Subsequently, AFMSA is tentatively slated to be deactivated and AFMOA is tentatively slated to be inactivated and re-designated as the AFMRA in Summer 2019.

Once fully operational, AFMRA will oversee, set policy, plan and program operational resources, establish readiness requirements, and guide mission execution in the following functions:

- 1) Aeromedical Evacuation / Patient Movement
- 2) Aerospace and Operational Medicine
- 3) Aerospace Medicine (Mission Essential Task List - METALS)
- 4) Aerospace Physiology
- 5) Bioenvironmental Engineering
- 6) Blood Bank Operational Support
- 7) Chemical, Biological, Radiological, Nuclear, and High Explosive
- 8) Community Public Health
- 9) Controlling Status Determinations
- 10) Dental Classifications (Dental Class I-IV Determinations)
- 11) Dental Services
- 12) Deployment Health
- 13) Drug Demand Reduction Program
- 14) Education and Training for Operational Medicine and Readiness

- 15) Embedded Medical Team Program Support (Preservation of the Force and Family, Battlefield Airmen, True North and other AF specific initiatives)
- 16) Emergency and Crisis Management
- 17) Environmental Health
- 18) Facility Management of Operational Assets
- 19) Family Advocacy Program
- 20) Fitness for Duty
- 21) Accession Determinations
- 22) Duty Status Determinations
- 23) Medical Hold Programs
- 24) Flight Medicine
- 25) Flying Status Determinations
- 26) Food Protection
- 27) Force Development / Professional Development Programs
- 28) Hearing Conservation
- 29) Hyperbaric Medicine (Chamber Operations) outside the MTF
- 30) Individual Medical Equipment Issue (Gas Mask inserts)
- 31) Industrial Hygiene
- 32) Integrated Disability Evaluation System (IDES) to include Medical/Physical Evaluation Boards
- 33) Operational Logistics & War Reserve Materiel Management
- 34) Medical Support to Guard, Reserve, and Transient Personnel Units
- 35) Mental Health
- 36) Nuclear Support Programs
- 37) Occupational Health
- 38) Operational IM/IT (AF Component to Joint Operational Medical Information Systems Office)
- 39) Operational Research and Development
- 40) Optometry
- 41) Overseas Clearances (Family Member Relocation Clearances)
- 42) Personnel and Administration
- 43) Preventive Health Assessments
- 44) Public Health
- 45) Readiness Reporting and Deployment Management
- 46) Comprehensive Medical Readiness Program
- 47) Safety and Occupational Health
- 48) Substance Abuse and Prevention/Treatment
- 49) Virtual Health In Operational Settings
- 50) Wounded Warrior Programs

## *Aligning Manpower and Resources for Readiness*

Major aspects of AFMOA's mission and portions of AFMSA's mission were identified as redundant with the emerging responsibilities of the DHA. The complete divestiture and/or significant reductions of manpower and resources related to the DHA assuming responsibilities for MTF health care delivery functions can be seen in the manpower table (Section 3) in the following areas:

- 1) Business Operations
- 2) Clinical Operations
- 3) Quality and Patient Safety in the MTF
- 4) Logistics Support to MTFs for health care delivery
- 5) PPBE
- 6) Pharmacy
- 7) Quadruple Aim Performance Process (QPP)
- 8) Research and Development Related to Clinical Requirements
- 9) Resources (different than PPBE)
- 10) Strategic Communications
- 11) TRICARE (to include Health Plans and Patient Administration)

As noted previously, the AF organized its remaining headquarters' manpower and resources to maintain its ability to recruit, organize, train, and equip medical active duty personnel. As the force supplier of AF active-duty medical personnel to the MHS and the retention of administrative control of Service active duty medical personnel across the force, it was also necessary to retain manpower and resources to perform these functions. Remaining manpower and resources were organized to ensure its ability to oversee and execute aerospace/operational medical and medical readiness functions, develop operational medical capabilities, conduct and support world-wide deployed medical operations, and fulfill AF SG responsibilities for mobilization and demobilization operations.

Resources aligned to these functions are reflected in the manpower table in the areas of Dental, Education and Training, Facilities, Information Technology/Chief, Health Information Office, Logistics, Analytics (captured as QPP), Research and Development, Readiness/Mission Assurance, Resources, and Strategic Communications. These functions all have operational and expeditionary support applications and do not represent a duplication of DHA roles and responsibilities or related DHA manpower and resources.

## **2.B. Army**

### *Overview*

The combined staffs ("OneStaff") of the Office of the Army Surgeon General (OTSG) and United States Army Medical Command (USAMEDCOM) consisted of 1 major staff element, 4 subordinate headquarters, and 1,703 total authorizations as of October 8, 2018. The proposed final structure, to be in effect not later than October 1, 2021, has 1 major staff element, no subordinate headquarters, and 337 total authorizations (not validated). The (pre-decisional) proposed future OTSG organizational structure is depicted in Appendix A and the OTSG

manpower summary is contained in Section 3. The Army is also realigning 457 authorizations (estimated number pending further analysis and validation) from the current OneStaff to the existing Army Commands (ACOM) and Army Service Component Commands (ASCCs) to form Medical Readiness Directorates (MRDs) within their respective staff structures.

### *Background*

The SG is a Principal Official of the Headquarters, Department of the Army. In this role, the SG serves as the principal advisor the Secretary of the Army and the Chief of Staff of the Army (CSA) on all health and medical matters of the Army, including strategic planning and policy development related to such matters. The SG also provides technical oversight and professional supervision over all Army medical personnel.

In addition to holding responsibilities as a Principal Official of the Army Staff (ARSTAF), The SG is currently dual-hatted as the Commanding General (CG), USAMEDCOM. USAMEDCOM currently provides command and control, through its subordinate Regional Health Commands, of Army MTFs on installations worldwide.

### *Current Structure*

In 1997, The SG directed the merging of the OTSG and USAMEDCOM staff elements into the “OneStaff” in order to gain efficiencies and synergy in supporting the operational force and delivering healthcare to Army beneficiaries. Due to increasing mission requirements, the roles and responsibilities of the OneStaff have become blurred in the intervening years. With the exception of specifically directed statutory and regulatory requirements, much of the OneStaff supports both the SG and the CG, USAMEDCOM.

As part of overall modernization and reform efforts across the Army and based on changes specified in the NDAA for FY 2017 and the NDAA for FY 2019, the Army conducted a holistic assessment of medical resources and capabilities to enhance the Army’s lethality and increase readiness across the force. Army Senior Leader decisions resulting from the assessment will significantly impact OTSG’s future structure. Army transformation and reorganization efforts are ongoing as of this writing. Further analysis and key Army Senior Leader decisions are pending, which directly impacts the ability of OTSG to fully answer questions about the future Army medical staff structure. As a result, the future Army medical structures discussed in this narrative should be considered interim until further mission analysis and appropriate adjustments are conducted.

### *Medical Services Reform in the Army*

To form the proposed future structures and required capabilities, the Army identified and analyzed 716 tasks currently accomplished by OTSG, USAMEDCOM and its subordinate Regional Health Commands. The tasks came from 102 source documents (61 Army Regulations, 24 Department of Defense Instructions, and 17 other source documents). Of these 712 tasks, the Army identified 344 tasks that apply exclusively to the delivery of healthcare in Army MTFs. In accordance with its October 2018 Zero Based Review, the Army has identified and will transfer 543 authorizations that currently perform these tasks from the current

OTSG/USAMEDCOM OneStaff structure to the DHA. This divestiture is part of the transfer of functions to eliminate duplication of effort within the MHS.

As an enduring ARSTAF element, OTSG will remain responsible for the SG's mission as the principal advisor to the Secretary of the Army and the CSA on all health and medical matters of the Army; to organize and serve as an integrator for efforts to recruit, train, and equip medical personnel of the Army; and to provide technical oversight and professional supervision over all Army medical personnel in order to maintain the highest levels of ethical and moral behavior and professional proficiency in accordance with section 702 of the NDAA for FY 2017, and Department of the Army General Order 2017-01. Of the 716 current tasks, the Army identified 300 tasks that the future OTSG structure will need to continue to execute to achieve this mission. These tasks relate to providing technical advice and assistance to the Secretariat and the ARSTAF for matters related to readiness of the force, veterinary services, warrior transition care, medical force structure and equipping, force development, medical training and education, medical evacuation, and public health. OTSG will also represent the Army on health policies both internal and external to DoD, including with the Department of Veterans Affairs (VA). The SG will also serve as the chief medical advisor of the Army to the Director, DHA on matters pertaining to military health readiness requirements and safety of members of the Army.

The SG also has several new statutory duties under the NDAA for FY 2019. The future OTSG structure will include the required capability to accomplish these new duties:

- 1) Assign Army medical and dental personnel to MTFs for operational and training missions, during which assignment of such personnel shall be under the operational control of the MTF leader and subject to the authority, direction, and control of DHA.
- 2) Ensure the readiness for operational deployment of Army medical and dental personnel and deployable medical or dental teams and units.
- 3) Provide logistical support for operational deployment of medical and dental personnel and deployable medical or dental teams and units.
- 4) Oversee mobilization and demobilization of Army medical and dental personnel for deployment.
- 5) Carry out operational medical and dental force development for the Army.
- 6) Ensure Army operational Medical Readiness organizations support DHA's medical and dental readiness responsibilities
- 7) Develop operational medical capabilities and policies to support the warfighter
- 8) Provide health professionals to serve in leadership positions across the MHS.

The OTSG will accomplish these functions through a future organization consisting of 337 authorizations (pre-decisional), divided into five directorates (a 59-person Soldier Readiness Directorate; a 60-person Force Readiness Directorate; a 84-person Operations, Plans, and Strategy Directorate; a 71-person Resource and Program Integration Directorate; and a 27-person Credentialing and Operational Privileging Directorate), a 10-person Management Support Branch, a 6-person Reserve Affairs Advisors Branch, and a 20-person Executive Staff.

None of these Directorate authorizations represent a growth in staff supporting any individual function or workcenter retained by OTSG. When authorizations are divided into DHA Workstreams as in the Manpower Summary table in Section 3 of this report, it appears that



OTSG has growth in the areas of Business Operations (from 0 authorizations to 10 authorizations), Medical Operations and Support (from 0 authorizations to 38 authorizations), and Resources (0 authorizations to 37 authorizations). These actually represent redistribution of authorizations from other workstreams based on prior categorization during the zero-based review. The Business Operations authorizations are redistributed from the Commander/Personal Staff workstream of 76 authorizations. The Medical Operations and Support authorizations are redistributed from the Clinical Operations (170 authorizations) and Other (69 authorizations) workstreams. The Resources authorizations, consisting of Manpower and Program Analysis and Evaluation authorizations, are redistributed from the Other (69 authorizations) and PPBE (88 authorizations) workstreams.

This organization is focused solely on tasks and support related to operational medicine performed by Army field units, Soldier and unit readiness, and Army-specific programs with medical equities (such as IDES, the Army Substance Abuse Program (ASAP), and Comprehensive Soldier Fitness), with additional duties contingent on ongoing dialogue with DHA on Service roles and responsibilities.

The Army identified an additional 72 tasks for transfer from OTSG to the MRDs, with a total requirement of 457 authorizations (pre-decisional) for all seven MRDs. The MRDs are organic to the staffs of ACOMs and select ASCCs and have the mission to manage and coordinate ACOM/ASCC Commander medical readiness priorities with DHA and OTSG. The MRDs also bridge functional depth in planning and support previously provided by USAMEDCOM.

The Army will tailor the structure of MRDs to the mission and responsibilities of their respective ACOMs and ASCCs. Each MRD structure will maximize the capabilities for oversight of operational readiness, training, and/or equipping as is appropriate based on the mission of its command. Common functions and focus areas for all MRDs include:

- 1) Providing administration and management support for assigned military and civilian medical personnel
- 2) Conducting liaison activities between ACOM/ASCCs, Senior Commanders, and DHA to ensure medical services and health service support are in accordance with Army Regulations and meet unit readiness needs.
- 3) Manage medical readiness program execution not centrally managed at OTSG (such as the Holistic Health and Fitness program) with focus on execution, cost analysis, and efficacy. Further, the MRDs provide POM analysis input, impact assessments, and risk vulnerability analysis and mitigation from the perspective of their respective commands.
- 4) Current and Future Operations through developing medical input to orders, policies, plans, and other information products. The MRDs further provide oversight of readiness requirements for all medical functions to ensure that effective and comprehensive care is provided throughout the continuum of care from Point of Injury to admission into a DHA MTF or civilian institution.
- 5) Enhance and manage Training Strategy Management for ACOM/ASCC assigned medical personnel. This includes developing, maintaining, monitoring and recording mandatory and elective medical training and/or clinical Key Skills and Attributes. The MRDs also have oversight and programming for all medical Military Occupational Specialty/Area of Concentration licensure, continuing medical education, and policy oversight beyond

routine ASCC requirements. The MRDs also provide oversight of Army medical training, medical simulations, and medical exercises.

The Army will initially reorganize the remaining 366 authorizations from the original OTSG/MEDCOM OneStaff into a Provisional Medical Readiness Command (PMRC). The PMRC will manage the transition of Army MTFs and associated healthcare delivery functions from the Army Regional Health Commands and USAMEDCOM to DHA while synchronizing and integrating Army medical capabilities in support of operational force medical readiness priorities. The PMRC will also provide mission command for the remaining U.S. Army Medical Department organizations until their transition to DHA is complete, at which point the Army will conduct a conditions-based assessment for the decision to discontinue the PMRC and to determine the final disposition of its 366 authorizations. Army Senior Leaders will base their decisions from this conditions-based assessment on remaining requirements for USAMEDCOM structure and the DHA capacity to transition and manage MTFs.

The Army has identified over 50 Army-specific programs in which the future OTSG and the MRDs have responsibilities ranging from advisory to policy development to program management to monitoring and compliance. The Army is designing the OTSG and MRD future structures to ensure continued support to these programs and their readiness functions. Examples of key programs and functions performed or supported by the future OTSG and MRDs that are not duplicated by DHA include:

- 1) Administrative responsibilities within the IDES program
- 2) Medical responsibilities within the Army Holistic Health and Fitness program
- 3) Medical responsibilities within the Army Sexual Harassment Assault Response Program
- 4) Global Health Engagement/Foreign Military Sales
- 5) Warrior Care and Transition
- 6) Medical Occupational Data System/Medical Protection System for tracking Soldier medical readiness information
- 7) Medical responsibilities within the Army Exceptional Family Member Program
- 8) Army-VA policy coordination (OTSG is the Army lead agent)
- 9) Standards of Army Medical Fitness
- 10) Biosurety
- 11) Nuclear Surety
- 12) Chemical Surety
- 13) Medical provider recruiting
- 14) Organizing Army operational medical units
- 15) Army medical provider training
- 16) Equipping Army operational medical units
- 17) Medical Leader Development
- 18) Licensure for medical providers providing operational medicine with Army units
- 19) Quality Management and Safety (focus on operational medical providers)
- 20) System for Health/support to the Army Ready and Resilient Campaign
- 21) Medical Support to the Army Soldier Performance Optimization program
- 22) Mobilization Force Generation Installations medical support
- 23) Behavioral Health Readiness, pertaining to the operational force through care provided by deployable units and by Embedded Behavioral Health teams

- 24) Non-healthcare delivery medical support to the Army Family Advocacy Program
- 25) Army Substance Use Disorder Clinical Care support requirements
- 26) Army Child Development Services support (developing health standards; overseeing nutrition standard implementation; providing preventive medicine, community health nursing personnel, pediatricians and child psychiatrists; and policy staffing related to the health, nutrition, environment and sanitation aspects of child development facilities and program operations)
- 27) Medical Waiver Authority for Army Fitness Standards
- 28) Line of Duty Reviews for investigations
- 29) National Practitioner Databank Management (reporting of adverse privileging/practice actions and malpractice claims against providers)
- 30) Neurocognitive Assessment Testing for non-DHA managed health care services.
- 31) ASAP rehabilitation and counseling
- 32) Serve as the Army Medical Materiel Developer for new military medical equipment
- 33) Policy and oversight for Operational Medical Logistics
- 34) Medical Materiel Life Cycle Management for non-DHA managed medical logistics
- 35) Loan, lease and donation of Army medical materiel
- 36) Medical Materiel Release authority
- 37) Force Development (medical units)
- 38) Nutrition Management Information System
- 39) Army National Disaster Medical System Federal Coordinating Center oversight
- 40) Army Operational Health Information Technology Program Office support
- 41) Deployed Health Facility Planning
- 42) Medical Individual Training/Readiness
- 43) Health Professions Scholarship and Financial Assistance Program
- 44) Active Duty Health Professions Loan Repayment Program
- 45) Food inspections
- 46) Army Immunization program (non-clinical care)
- 47) General Officer Wellness Program (non-clinical care)
- 48) Initial Denial Authority for Freedom of Information Act requests for medical research and medical records for non-MTF activities
- 49) Army Human Immunodeficiency Virus (HIV) Program (non-clinical care)
- 50) Aviation Medicine (non-clinical care)

In accordance with Army Regulation 71-32, the Army is developing a Concept Plan for the design and approval of the new OTSG structure and for each of the MRDs. The Concept Plan process, with oversight by HQDA G-3/5/7, is designed to ensure the proposed structures have no redundancy, either within the Army or with DHA. By following its Force Management processes, the Army will ensure that it possesses the medical staff structure required to meet the Secretary of the Army's statutory responsibilities while also complying with the NDAA for FY 2017 and the NDAA for FY 2019 to streamline healthcare delivery, support DHA's responsibilities and eliminate duplication of functions assigned to DHA. At endstate, the Army and its medical staff structure will be task organized to optimally support war time requirements, operational readiness, and to execute the Secretary of the Army's statutory responsibilities throughout the Total Army without disrupting the Army's ability to provide medical support to the Joint and Multi-National Force.

## **2.C. Navy**

### *Overview*

The Bureau of Medicine and Surgery (BUMED) headquarters must align with the expeditionary requirements of the Navy and Marine Corps missions. While BUMED's end state must retain a headquarters structure to provide optimal mission support, it will decrease from 1,189 to 688, a reduction of 42 percent (Section 3, table, and Appendix A: Organizational Structures, A-3 Navy, Figure 1 and 2). In FY 2019, BUMED anticipates additional reductions that will result in fewer military positions, and a reduction in civilian personnel dollars. Final details will be included in the President's Budget for FY 2020. The Navy and the DHA will execute the transfer of 325 positions (military and civilian) to DHA identified during FY 2018. The goal of BUMED's efforts is to divest itself of the functions associated with management and administration of the MTFs to the DHA and redirect focus on warfighter readiness.

### *Background*

Restructuring BUMED must account for two factors that are unique to the Department of the Navy (DON): DON contains two Services -- the Navy and Marine Corps -- with all of the uniformed medical assets belonging to the Navy; DON is expeditionary in nature, not garrison-based. As a result, it does not task-organize around the installation. These factors require BUMED, on behalf of the DON, to centrally manage medical assets, as opposed to aligning all medical capabilities within line elements (Appendix A: Organizational Structures, A-3 Navy, Figure 1).

Presently, the SG of the Navy, as the Chief, BUMED (a MAJCOM element within the Navy) must ensure personnel and materiel readiness of shore activities as assigned by the Chief of Naval Operations (CNO) and Commandant of the Marine Corps (CMC). This mandate includes the development and oversight of health care policy for all shore-based and operating forces of the Navy and Marine Corps.

The SG of the Navy has multiple roles within the Department. As codified in 10 U.S.C. § 5137, the SG is an advisor to Secretary of the Navy (SECNAV), CNO, and CMC on all health care policy. In addition, the SG serves as the chief medical advisor of the Navy and Marine Corps to the Director, DHA. The SG, acting under the authority, direction, and control of SECNAV, recruits, organizes, trains, and equips medical personnel of the Navy and the Marine Corps. Finally, the SG also serves as Chief, BUMED, commander of the echelon II command.

Section 702 of the NDAA for FY 2017 transferred the management and administration of MTFs from the MILDEPs to the DHA. To meet congressional intent, the Navy SG's headquarters structure and related Service commands will focus on readiness that is related to all Navy and Marine Corps operational activities, while transferring to the DHA the administration and management of the MTFs.

## *Navy Medicine Transformation*

BUMED is an echelon II shore activity with three subordinate echelon III commands consisting of 1,189 military and civilian personnel as of October 1, 2018 (Appendix A: Organizational Structures, A-3 Navy, Figure 1). The proposed final framework will have one echelon II major headquarters command and no more than three echelon III subordinate commands and consist of 688 personnel (military and civilian) – a decrease of over 40 percent (Appendix A: Organizational Structures, A-3 Navy, Figure 2). The echelon III commands will be aligned in support of Navy (Fleet Forces Command, Pacific Fleet) and Marine Corps (Marine Expeditionary Forces) line commands, and the third will align with the Navy's training command. This framework will be refined based upon the evolution of reform and transition efforts.

Throughout the process to plan and implement as codified in 10 U.S.C. § 1073c, the Navy is identifying and eliminating duplicative activities within its medical headquarters functions. The DHA and the Navy SG are working concurrently to define requirements, eliminate duplicate functions, and transfer to the DHA military and civilian end strength positions to support the transition effort. The DHA, with input from the Navy, will further strengthen common services, activities, and clinical and business functions, including those located outside of the National Capital Region, into a headquarters for all functions and responsibilities as directed in 10 U.S.C. § 1073c.

The Navy will divest from functions aligned with the administration and operations of the MTFs, as dictated by the NDAA for FY 2017 to support DHA efforts. The following are representative examples:

- 1) All delivery of (non-operational) healthcare tasks
- 2) MTF Facility Management
- 3) MTF-Based Quality/Safety of Healthcare
- 4) MTF Medical Personnel Management (military and civilian)
- 5) Safety, risk assessment, performance improvement of health care delivery
- 6) Programming, Planning, Budgeting and Execution for health care delivery functions
- 7) Uniform Business Office functions
- 8) Performance planning for health care delivery
- 9) Health Facilities planning agency
- 10) High Reliability Organization initiatives in the MTF
- 11) Medical Logistics for health care delivery in the MTF
- 12) Managed Care execution
- 13) Clinical Quality Management
- 14) Sustainment, restoration, and modernization of the MTF

As Navy Medicine continues transformation, it has done a deliberate review of present mission, functions and tasks, and those that will be needed in the future state. To the extent consistent with the Final Implementation Plan, the NDAA for FY 2019, and Section 5 of this report, missions, functions, and task requirements for BUMED's end-state construct include, but are not limited to, the following requirements:

- 1) Medical responsibilities within IDES
- 2) Medical responsibilities within the Navy and Marine Corps Health and Fitness program
- 3) Medical responsibilities within the Navy and Marine Corps Sexual Harassment Assault Response Program
- 4) Medical responsibilities for the Warrior Transition Program
- 5) Medical responsibilities within the Navy Exceptional Family Member Program
- 6) Navy – Veterans Affairs policy coordination
- 7) Licensure for medical providers providing operational medicine
- 8) Quality Management and Safety (focus on operational medical providers)
- 9) System for Health/support to the Navy Resiliency Program
- 10) Mental Health Readiness, pertaining to the operational force through care provided by deployable units and by Embedded Behavioral Health teams
- 11) Neurocognitive Assessment Testing (Traumatic Brain Injury testing)
- 12) Navy National Disaster Medical System Federal Coordinating Center oversight
- 13) Navy Immunization program
- 14) Initial Denial Authority for Freedom of Information Act requests for medical research and medical records
- 15) Navy HIV Program
- 16) Aviation Medicine
- 17) Undersea Medicine
- 18) Independent Duty Corpsman
- 19) Navy and Marine Corp Public Health (non-MTF)
- 20) Medical Logistics and Acquisition (non-MTF)
- 21) Facilities Management (non-MTF)
- 22) Radiation Health
- 23) Antiterrorism/Force Protection (non-MTF)
- 24) Physical Security Program (non-MTF)
- 25) Mission-focused research and development, and oversight and direction to Naval Medical Research and Development activities.
- 26) Develop strategy and policy for defensive medical capabilities, countermeasures, and technologies to enhance medical surveillance, detection and protection against pandemics, public health issues, chemical, biological, radiological, and nuclear weapons risks through biomedical research programs.
- 27) Oversight of force manning, manpower, personnel, and individual training and education policies, requirements, processes, programs, and alignments affecting active, reserve, and civilian personnel in support of medical fleet readiness.
- 28) Oversight of operational readiness exercises and ensure certification recommendations for deployable medical teams and units.
- 29) Responsible for, deployability, assignability, and employability, dwell, and home tempo to of Navy Medical Forces to meet operational requirements.



- 30) Oversight of medical and dental services for the Fleet, Combatant Commanders and Naval Installation medical functions separate from MTF clinical/health care services and business operations for Navy and Marine Corps personnel, and other uniformed services personnel.
- 31) Maintains cognizance of the Navy's global health engagement activities and requirements to support DoD's security cooperation strategies to build capabilities and cooperative relationships with allies and other international partners.

Navy Medicine's end state organizational structure will not be defined by the MTF, but rather on the needs of the supported line units and the operational medical platforms. The organizational structure that will operationalize this future construct will be through Navy Medicine Readiness Training Commands (NMRTC). These NMRTCs will allow focused efforts on meeting the medical readiness needs of the operational units as well as more proactive, deliberate facilitation of the development of clinical and operational currency and competency of the Medical Force (Expeditionary Medicine). In addition, the structure supports force development requirements to continue to train and develop Navy Medicine leaders to meet future expeditionary medicine requirements. Finally, the organization fulfills the requirements of a Navy Command and the responsibilities and programs mandated by Service instructions.

Navy Medicine's future state results in improved efficiency and effectiveness in readiness, removes duplication in work or functions with the DHA, and working with DHA ensures the delivery of medical readiness maintenance for Navy medical personnel, medical readiness evaluation and treatment for all Navy and Marine Corps personnel, and healthcare to DoD beneficiaries. Furthermore, to meet the goals of both the NDAA for FY 2017 and the NDAA for FY 2019, this construct maintains a strong interface between the MTF and the Services.

NMRTCs affiliated with larger commands will support installations and operational commanders across the Navy and Marine Corps, regardless of the existence of an MTF on the installation, to execute Service-required medical readiness functions for those installations and commands. The NMRTC will serve as the single point of contact in support of installation and operational commanders, providing medical information, support and overall medical cognizance of the active duty force. It will increasingly employ information technology, analytics, and research and development to support the DON's increased emphasis on readiness requirements. The use of data-driven analytics will support the DON's objective of a more proactive health care model to support Sailors, Marines, and Commanding Officers in optimizing their readiness and performance in achieving their assigned missions. It also will improve situational awareness and understanding of the real-time readiness for Commanding Officers, Line community medical assets and allow for a more tailored approach to meet the medical readiness requirements of their platforms. NMRTC organizational structure is designed to maintain DON equities within the MHS transformation:

- 1) Command and Control of Navy Military Personnel
- 2) Command Structure Through the Navy
- 3) Maintains good order and discipline in garrison and deployed environments
- 4) Continues Sailorization and Navy lifelines for our Sailors and their families
- 5) Agility to Rapidly Deploy Medical Personnel
- 6) Control and Oversight of Resources for Department of Navy missions

- 7) Specific to readiness missions for which Navy and Marine Corps are responsible and accountable
- 8) Flexibility in MTF Operations to Support Operational Tempo
- 9) Single Navy Medicine Point of Contact for Fleet/Fleet Marine Force Line Commanders

The DON believes the proposed structure offers the best and most viable solution to ensuring the Navy and Marine Corps have the medical support they need. It strengthens the relationship between the SG and the SECNAV, CNO, and CMC. It also provides a single interface between the DON and DHA as it supports the Services in executing their readiness mission (Appendix A: Organizational Structures, A-3 Navy, Figure 3). The DON remains committed to the success of the MHS and the DHA and will continue aggressive efforts toward that end state.

### 3. MANNING DOCUMENTS IN SUPPORT OF THE ORGANIZATIONAL STRUCTURE [SECTION 712(F)(2)]

The manning requirements, by workstream, for the organizational structures of the offices of the SG and the DHA before and after transition are presented in the table below. The personnel requirements for the pre-transition state are as of September 30, 2018. The numbers in the table do not include contracted personnel requirements. The post-transition personnel requirements are based on the zero-based review conducted by the Office of the Under Secretary of Defense for Personnel and Readiness.

*Table—pre and post transition manning requirements (military and civilian only)*

Work Stream	Air Force		Army		Navy		DHA	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Acquisition	0	0	9	1	4	3	158	525
Business Operations	27	19	0	10	73	22	19	19
Clinical Ops/Quality/Patient Safety	73	10	170	27	68	18	81	171
Commander/Personal Staff	46	37	76	12	20	17	43	27
Dental	13	13	17	2	2	2	0	22
Education & Training	8	15	43	12	8	8	518	536
Facilities	41	3	23	2	19	9	91	353
IT/CHIO	8	8	54	20	41	17	878	849
Legal/Risk Mgmt	0	0	55	2	14	8	75	158
Logistics	82	56	61	11	13	12	33	414
Medical Operations and Support	0	0	0	38	0	0	0	0
Other	17	0	69	0	69	26	186	206
Personnel	36	37	108	20	257	149	55	39
Pharmacy	2	0	13	1	1	1	48	61
PPBE	10	7	88	21	16	12	63	207
Public Health	8	8	33	15	12	5	172	145
Quadruple Aim Performance Plan	18	16	82	2	4	1	77	3
Research & Development	40	29	9	8	13	12	141	141
Readiness/Mission Assurance	111	130	89	88	96	95	36	99
Resources	69	23	0	37	72	53	5	53
Strategic Communications	6	3	22	8	9	7	22	19
Subordinate Commands	0	0	657	0	375	211	0	0
TRICARE	32	0	25	0	3	0	279	215
Totals	647	414	1703	337	1189	688	2980	4262
Net		-233		-1366		-501		+1282

#### **4. RECOMMENDATIONS FOR LEGISLATIVE OR ADMINISTRATIVE ACTION [SECTION 712(F)(3)]**

The reforms directed in 10 U.S.C. § 1073c, coupled with other reforms required by the NDAA for FY 2017 and the NDAA for FY 2019, represent the most significant changes to the MHS in over 30 years. The Department has taken a deliberate and collaborative approach in executing a transition and implementation plan for title 10 U.S.C. § 1073c that is consistent with congressional intent and preserves military readiness and promotes efficient and effective delivery of health care. However, DoD leadership has determined that for the MILDEPs to be best positioned to carry out their readiness responsibilities and DHA to be best positioned to administer and manage MTFs effectively, the Department needs to revise its transition and implementation plan.

The revisions to the plan are reflected in the framework outlined in the March 27, 2019 memorandum in Appendix B. The purpose of these revisions is to reaffirm the primary role of the MILDEPs in military medical readiness. Specifically, the revisions would preserve the authority of the Secretary of Defense to assign MHS roles and responsibilities for financial operations, medical affairs, and supporting the needs of installation operational commanders so as best to support health care delivery and medical readiness. They also would preserve MILDEP responsibility for clinical sites on installations that are not constructed primarily for health care, sites generally proximate to operational units and focused on supporting readiness. The revisions include matters regarding the assignment of military personnel on installations and their command and control, as well as the role of DHA in supporting the MILDEPs in their primary responsibility for medical readiness. Further, the revisions affirm a policy against unnecessary duplication of functions and tasks between the DHA and the SGs of the MILDEPs.

These revisions to the Department's transition and implementation plan would require changes to current law governing the administration of the DHA and military medical treatment facilities and the organizational framework of the MHS. As such, the Department intends to seek from Congress legislative revisions that will grant the ability to implement title 10 U.S.C. § 1073c consistent with the framework described in the memorandum in Appendix B.

## 5. UPDATES TO FINAL DHA IMPLEMENTATION PLAN

As required by section 702(e)(2) of the NDAA for FY 2017, the Department submitted a final implementation plan June 30, 2018. Subsequent to that submission, Congress made a number of statutory amendments necessitating revisions to the final plan, and DoD has approved other changes to the plan. In furtherance of section 702(e)(2), the following advises of significant revisions to the final plan:

### *Market Construct:*

The final implementation plan from June 2018 described the establishment of six intermediate management organizations (IMOs) to assist with span of control in the management and control of MTFs (final implementation plan pp. 12-18). The IMO construct has been replaced by a market management approach as described below.

DHA will manage the MTFs through a Market Construct. A Market is a group of MTFs that operate as a system: sharing patients, providers, functions, budgets, etc., across facilities in order to improve the delivery and coordination of health services to drive value for beneficiaries. DHA is currently identifying Markets and associated Market Offices to stand up. Thus far, 19 Markets have been identified to report to DHA, 13 of which are located in the East Region and will be falling under DHA authority in Phase 2 of the transition. The value of the Market approach lies in its ability to create an integrated system of readiness and health by supporting and holding accountable assigned MTFs to optimize delivery of the Quadruple Aim, as well as implementing DHA initiatives designed to optimize Health Care delivery and operations at the MTFs (e.g., purchased care).

Market Office functions consist of core functions and unique subfunctions that are particular to the demand signals of a specific Market. Core functions of Markets are common to all Market Offices and will be scaled depending on the complexity of the Market; these are identified and are shown in **Figure 1**.

**Figure 1: Core Market Functions**

Market Functional Structure			
Clinical Operations	Administrative Operations	Analytics	Executive Support
<ul style="list-style-type: none"><li>Clinical Operations</li><li>Clinical Integration</li><li>Patient Safety &amp; Quality</li><li>Nursing</li><li>Patient Administration</li><li>Public Health</li><li>Clinical Health Informatics Office</li></ul>	<ul style="list-style-type: none"><li>Facilities / Logistics / Acquisitions</li><li>Personnel</li><li>Financial Management</li><li>Information Technology</li></ul>	Analytics/Quadruple Aim Performance Plan	<ul style="list-style-type: none"><li>Plans &amp; Operations</li><li>Public Affairs Office/Strategic Communications</li><li>Education &amp; Training</li><li>Special Staff</li></ul>

DHA will align MTFs into Large Markets, Small Markets and stand-alone facilities, or OCONUS regions. The Markets will each have a Market Office that manages and executes strategic and operational functions at the MTFs, including the optimization of health care

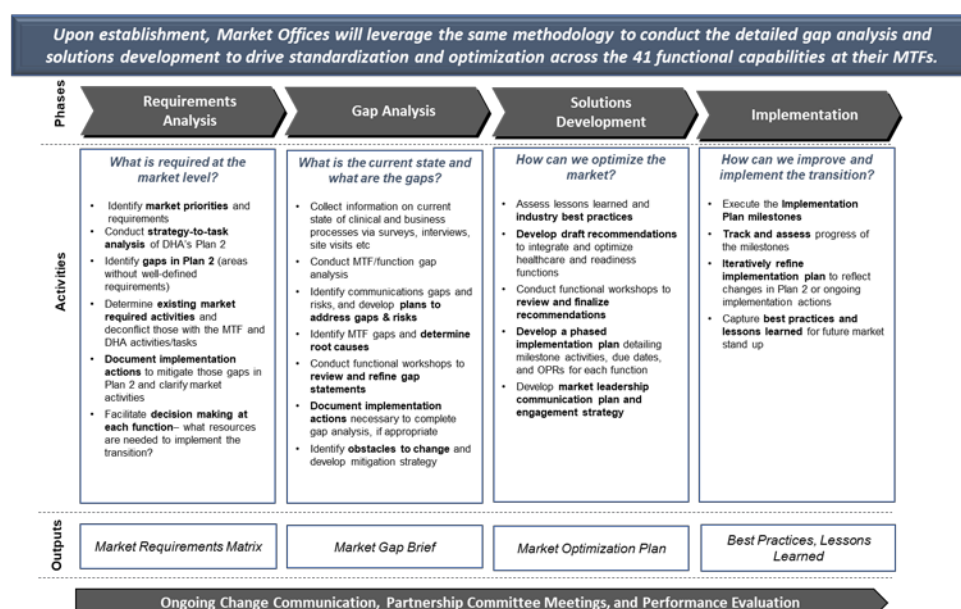
delivery, promoting readiness, and ensuring performance of administrative operations. Prior to stand-up, the Markets will each go through a certification process that consists of a current state assessment and gap analysis; training to address gaps, learn DHA transformation and optimization applications, and the implementation tools and checklist; and the final certification inspection.

The small and stand-alone MTFs will collectively be managed by the Small and Stand-Alone Office (SSO), a specialized Market Office whose purpose is to serve as a learning organization that performs optimization functions similar to Market Offices for the small and stand-alone MTFs. The SSO will also analyze small Markets and stand-alone facilities for potential future integration into Markets and functional re-scoping.

Onboarding Market Offices will be accomplished through training, knowledge transfer, and provision of tools necessary to achieve Market Office proficiency. A Market Training Symposium was conducted March 18<sup>th</sup>-22<sup>nd</sup> at the DHA Headquarters to prepare leaders for implementation of Markets and transitioning to the new operating model. The tIMO, through the Market Development Office (MDO), will onboard and stand up the four initial Markets: National Capitol Region, Womack, Jacksonville, and Keesler. Thereafter, the Markets will be onboarded along a gradient of complexity using conditions-based criteria by the MDO.

Market Office training will take place through Market Symposia. Service subject matter experts and current training venues are being incorporated into the Market Symposia training plan. Symposia training will be completed on-site, one-on-one, and be tailored to the requirements of the Market to support the implementation of a unified Market using tested and proven standardized tools and best practices. Following the establishment of the Markets, each Market Office will follow the approach described in **Figure 2** to continue to identify gaps and improve MTF operations.

**Figure 2: Approach for Continued Optimization of the Markets**





*Composition of the Service Medical Headquarters and Intermediate Management  
Commands/Organizations:*

The final implementation plan from June 2018 described the establishment of each of the Service Medical headquarters and Intermediate Management Commands (final implementation plan pp. 19-32). The structures described in Sections 2 and 3 of this report replace that section of the final implementation plan.

## APPENDIX A: ORGANIZATIONAL STRUCTURES

### A-1 Air Force

Figure 1 – Overview of AF Surgeon General Future (End State) Structure

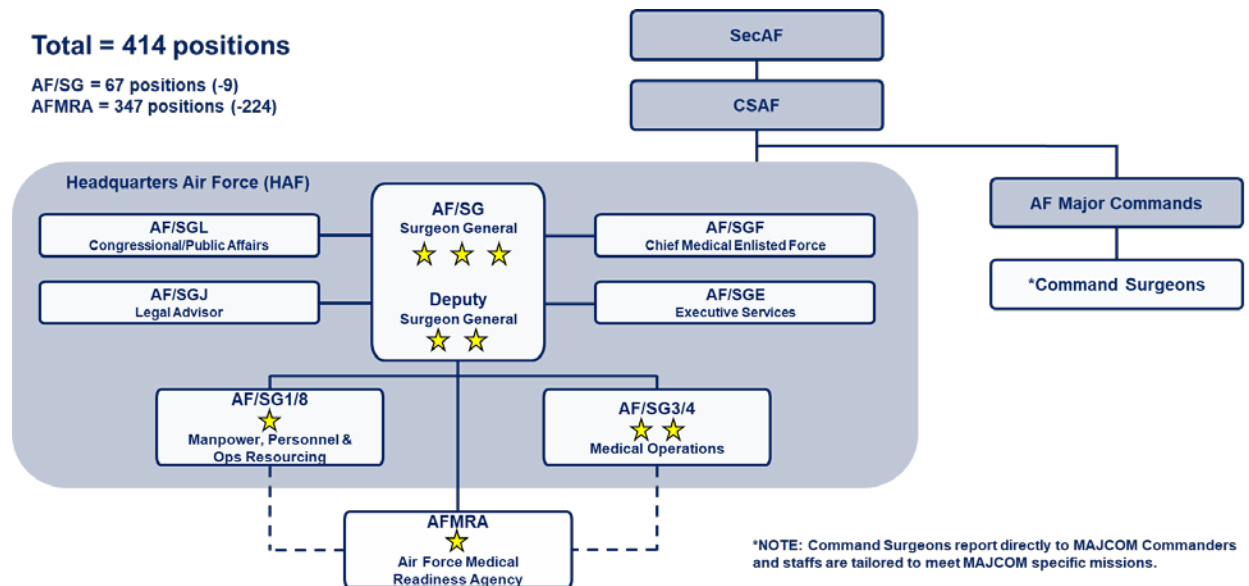
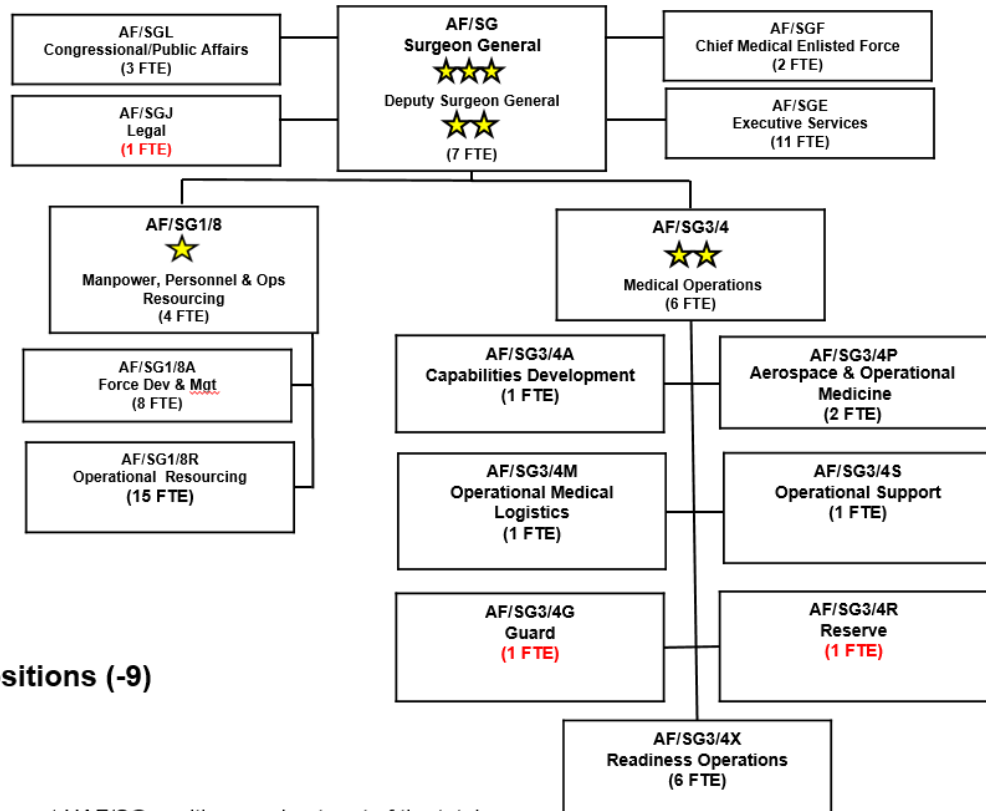


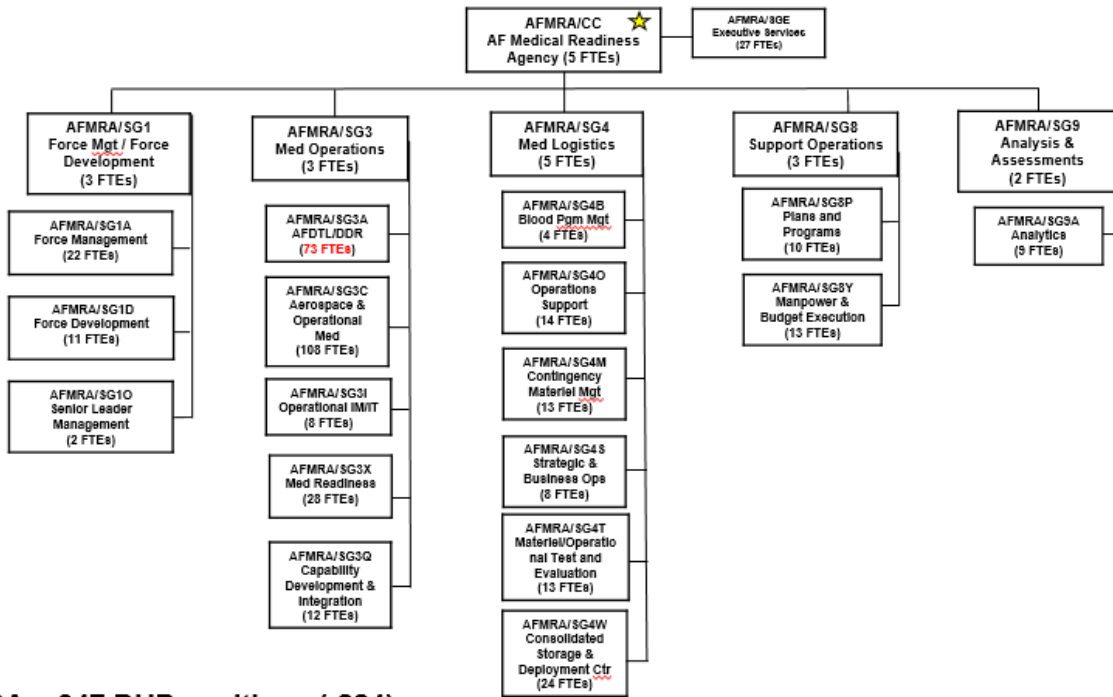
Figure 2 – AF/SG Future (End State) Structure: HAF/SG



**AF/SG = 67 positions (-9)**

Note: Items in red are not HAF/SG positions and not part of the total

Figure 3 – AF/SG Future (End State) Structure: AFMRA



**AFMRA = 347 DHP positions (-224)**

Note: Items in red are not AFMRA DHP positions and not part of the total

## A-2 Army

Figure 1: Current Surgeon General Headquarters

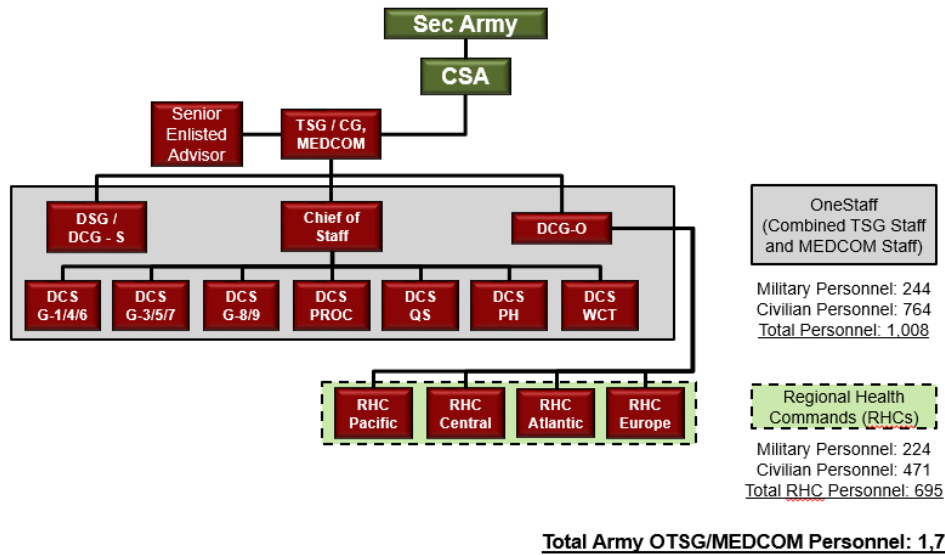
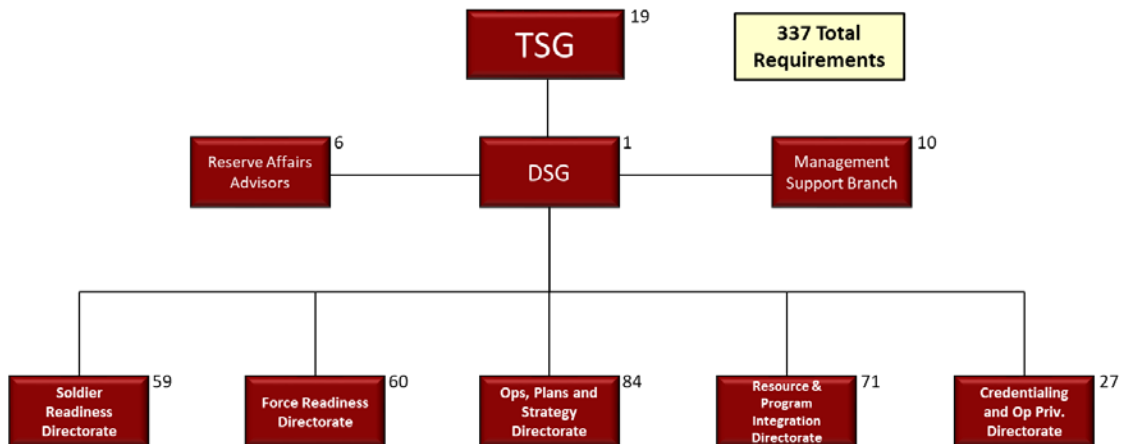


Figure 2: Surgeon General Headquarters after transition complete



### A-3 Navy

Figure 1: Navy Medicine Headquarters Baseline

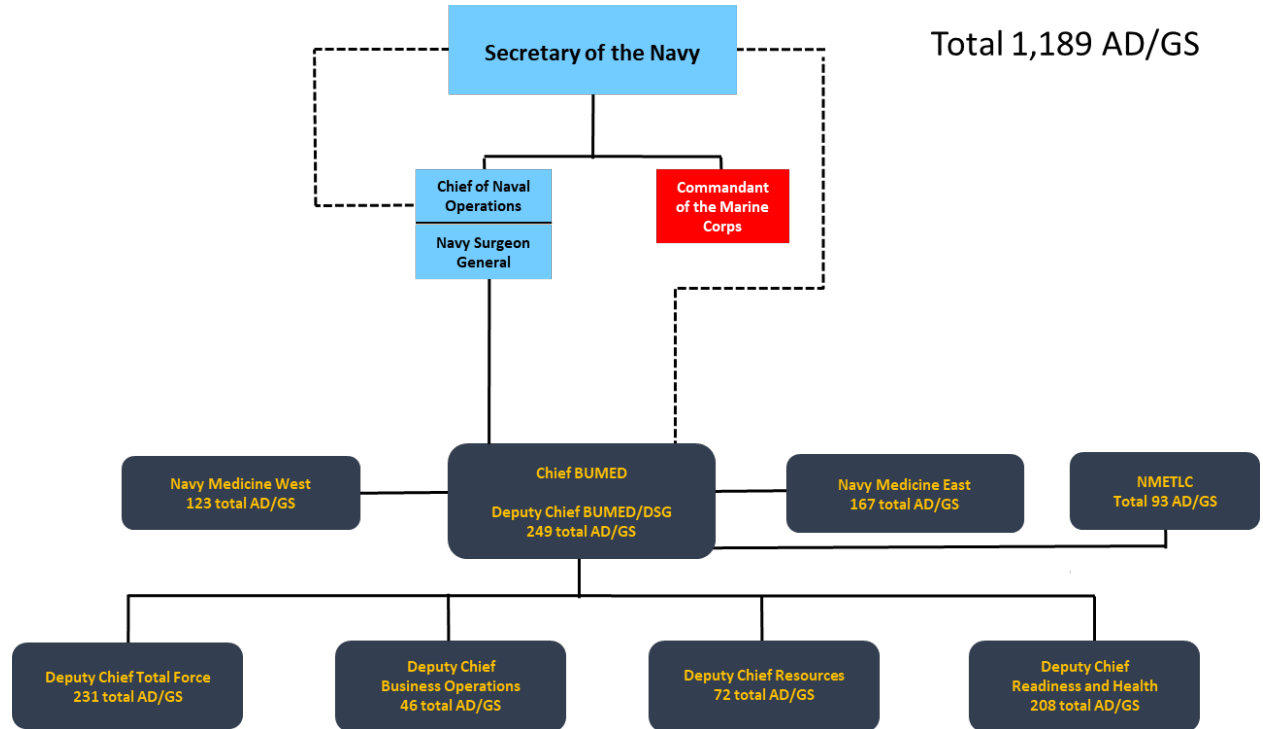


Figure 2: Navy Medicine Headquarters Future State

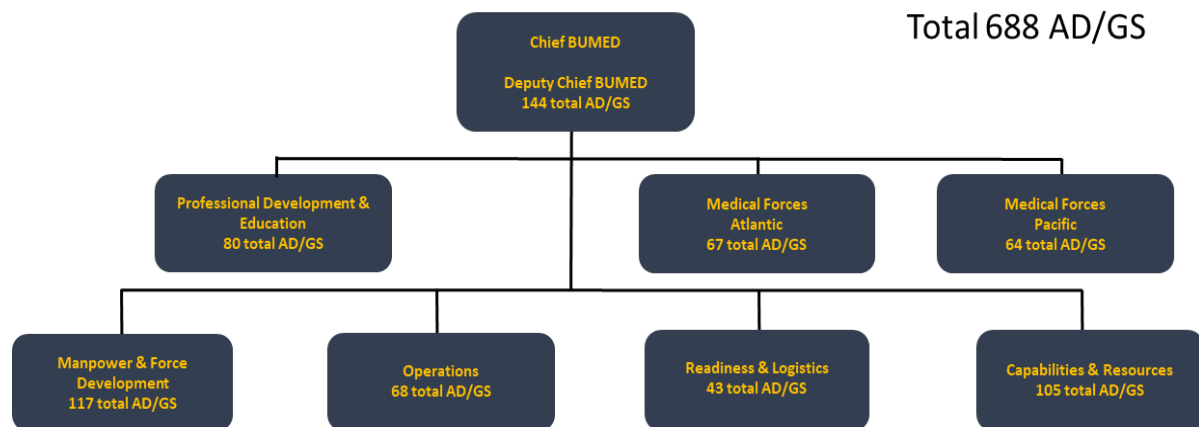
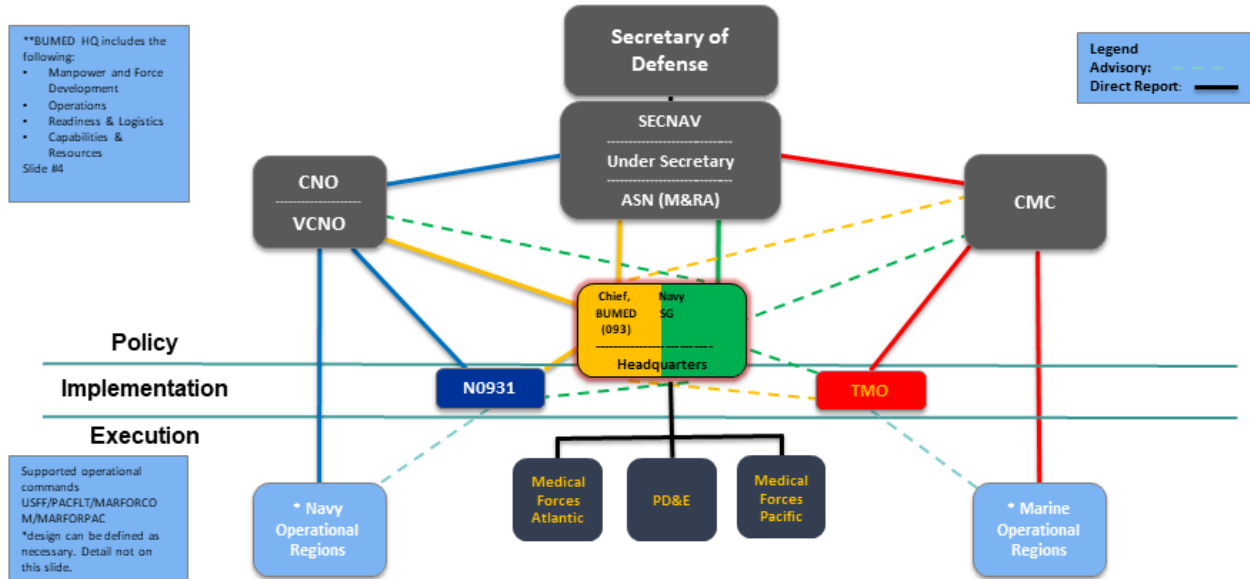




Figure 3: Department of the Navy as it relates to Navy Medicine Headquarters Structure



## APPENDIX B: PROPOSED AMENDED ORGANIZATIONAL FRAMEWORK



OFFICE OF THE UNDER SECRETARY OF DEFENSE  
4000 DEFENSE PENTAGON  
WASHINGTON, D.C. 20301-4000

27 MAR 2019

MEMORANDUM FOR UNDER SECRETARY OF THE ARMY  
UNDER SECRETARY OF THE NAVY  
UNDER SECRETARY OF THE AIR FORCE  
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS  
VICE CHIEF OF STAFF OF THE ARMY  
VICE CHIEF OF NAVAL OPERATIONS  
VICE CHIEF OF STAFF OF THE AIR FORCE  
DIRECTOR, DEFENSE HEALTH AGENCY

SUBJECT: Alignment of Operational and Installation-Specific Medical Functions and Responsibilities with Section 702 of the National Defense Authorization Act for Fiscal Year 2017, and Sections 711 and 712 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019

References: (a) Under Secretary of Defense for Personnel and Readiness memorandum, "Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments," February 21, 2018  
(b) Under Secretary of Defense for Personnel and Readiness memorandum, "Construct for Implementation of Section 702," May 22, 2018  
(c) Final Plan to Implement Section 1073c of Title 10, United States Code (Final Report to the Armed Services Committees of the Senate and House of Representatives), June 30, 2018

This memorandum clarifies the Department's current plan for implementing 10 U.S.C. § 1073c and sections 711 and 712 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019. Specifically, it addresses roles and responsibilities of the Military Departments, the Assistant Secretary of Defense for Health Affairs (ASD(HA)), and the Defense Health Agency (DHA) regarding operational and Military Treatment Facility (MTF) specific medical functions. This memorandum revises, reiterates or supplements previous guidance in references (a), (b), and (c); to the extent that any guidance is inconsistent, guidance in this memorandum shall govern. Some elements of the Department's current implementation plan outlined below may be supplemented by additional actions in the next 2 years, or may represent the end state of the organizational reform, contingent on Congress adopting statutory changes that DoD will recommend this year.

Each Military Department is responsible for:

- Manning, organizing, training, equipping, their military personnel (including medical personnel), for medical individual and collective readiness, and setting requirements for services DHA provides in support of the Services to include care of uniformed

personnel.

- Delivering operational clinical services under the operational control of Combatant Commands; on ships or planes; and on installations outside of MTFs (as defined below). Each Military Department will act as the Privileging/Scope of Practice/Clinical Quality Management authority for providers conducting such operational clinical services.
- Setting medical readiness standards, subject to DoD minimum standards and metrics established by the ASD(HA), and ensuring that their military medical personnel are trained in and maintain their clinical readiness skills. The Military Departments will maintain readiness standards at the MTF or through non-MTF partnerships with civilian institutions established by the DHA or the Military Departments. All partnerships will include a provision for capturing and reporting workload.
- Coordinating with DHA on a Service Manpower Document that identifies military medical personnel assigned to MTFs, by location, skill set, and clinical availability. Each Military Department will exercise administrative control of military personnel assigned to MTFs, to include personnel assignments and the issuance of military orders. In situations where military personnel, not under the authority, direction, and control of the MTF Director, provide health care services in the facility, the DHA will maintain oversight for the provision of care delivered by these individuals through MTF policies and procedures and the privileging responsibility of the MTF.
- Establishing policies for assessment of the employability, deploy-ability, and assignability of their personnel, laying out requirements, where appropriate, to assure proper evaluation of employability, deploy-ability, and assignability, and executing administrative and personnel management aspects of these assessments.
- Developing Defense Health Program (DHP) resource requirements and submitting them through appropriate Military Health System (MHS) governance processes to the ASD(HA).

The ASD(HA) is responsible for conducting oversight of the MHS as detailed by DoD Directive 5136.01, Secretary of Defense policy and statute, and especially:

- Allocating DHP funding to the Military Medical Departments and the DHA with a priority placed on readiness requirements.

The DHA is responsible for:

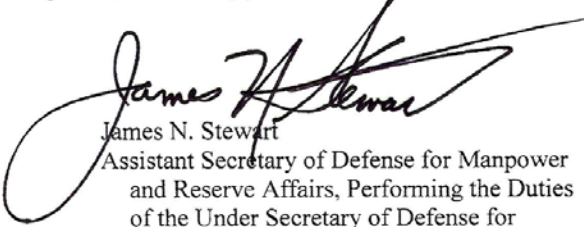
- Conducting clinical services and business functions within the MTFs in support of healthcare delivery, and especially providing facility, medical supply, equipment, and other clinical support as needed for all activities within the MTF. The DHA will act as the Privileging/Scope of Practice/Clinical Quality Management authority for all care within an MTF. For purposes of distinguishing DHA responsibilities for delivery of health care services inside an MTF from Military Department responsibilities for delivery of health care services outside an MTF, an MTF is defined as any DoD facility, outside of a deployed environment, constructed primarily for health care or as otherwise determined by the Secretary of Defense to be

a MTF. With respect to budgetary responsibilities, the operation and maintenance of MTFs will be funded through the DHP appropriation.

- The provision of care within the MTF to include care in support of medical readiness. The Military Departments will set medical readiness requirements for Active Duty care (what is needed, when, and where) for DHA implementation.
- Identifying the capacity of each MTF to support Military Department or ASD(HA) established clinical readiness standards.
- Coordinating with each Military Department on a Service Manpower Document that identifies military medical personnel assigned to MTFs, by location, skill set, and clinical availability.
- Providing sufficient capacity within the MTF or DHA established non-MTF partnerships to meet Military Department clinical readiness requirements.
- Developing DHP resource requirements and submitting them through appropriate MHS governance processes to ASD(HA).

Tables 1 and 2 attached provide a distribution of responsibilities for planning and executing the requirements. The Military Departments, ASD(HA), and DHA will work collaboratively to monitor effectiveness and efficiency of support.

This guidance will be updated, as needed, to address on-going issues and business rules associated with implementation of this important organizational reform of the MHS. Except as modified by this memorandum and future updates, reference (c) remains in effect.



James N. Stewart  
Assistant Secretary of Defense for Manpower  
and Reserve Affairs, Performing the Duties  
of the Under Secretary of Defense for  
Personnel and Readiness

Attachments:  
As stated

cc:  
Chief Management Officer of the Department of Defense  
Under Secretary of Defense (Comptroller)/  
Chief Financial Officer  
Director of Cost Assessment and Program Evaluation



**TABLE 1. READINESS FUNCTIONS IN THE MTF WITH PROVISION OF CARE**

Readiness Functions in the MTF with Provision of Care	Provision of Care within the MTF*	Assessment (D/A/E) Requirements**
Aerospace and Operational Medicine	Y	Y
Care for Uniformed Personnel (Not involving assessment D/A/E)	Y	N
Community Public Health	Y	Y
Dental Classifications (Dental Class I-IV Determinations)	N	Y
Dental Services (includes operational assets)	Y	Y
Deployment Health	N	Y
Family Advocacy Program	Y	Y
Flight Medicine	Y	Y
Hearing Conservation	Y	Y
Medical Support to Guard, Reserve, and Transient Personnel Units	Y	Y
Nuclear Support Programs (Personnel Reliability Program, etc.)	Y	Y
Occupational Health	Y	Y
Operational/Embedded Mental (Behavioral) Health (in the MTF)	Y	Y
Optometry	Y	Y
Pain Management	Y	Y
Polypharmacy	Y	Y
Preventive Health Assessments (PHA)	Y	Y
Sports Medicine	Y	Y
Substance Abuse and Prevention/Treatment	Y	Y
Traumatic Brain Injury Program	Y	Y
Virtual Health (for operational & expeditionary settings)	Y	Y
Wounded Warrior Programs (Line supported in some cases)	Y	Y

\* Y means this is a DHA responsibility; N means it is not a DHA responsibility, but a Service responsibility.

\*\* Y means it is a Service responsibility for policy involving deployability, assignability, or employability; N means this area does not involve deployability, assignability, or employability."

**TABLE 2. READINESS FUNCTIONS IN THE MTF WITHOUT PROVISION OF CARE**

Readiness Functions in the MTF without Provision of Care	Provision of Care within the MTF*	Assessment (D/A/E) Requirements **
Administrative Support for Medical Evaluation Boards	N	Y
Aeromedical Evacuation / Patient Movement (ASF, AES, CASF and Pat Admin related functions)	N	Y
Aerospace Medicine (Mission Essential Task List - METALS)	N	N
Aerospace Physiology	N	Y
Anti-Terrorism and Force Protection/Operations Security (Line supported in some cases)*	N - DHA responsible for Standalone facilities	Y
Bioenvironmental Engineering	N	Y
Blood Bank (Jointly managed capability; aspects may be Service led)	Y = MTF Banks N = Deployed	Y
Chemical, Biological, Radiological, Nuclear, and High Explosive (CBRNE)	N	N
Controlling Status Determinations	N	N
Drug Demand Reduction/Testing	N	Y
Education and Training for Operational Medicine and Readiness	N	Y
Emergency and Crisis Management (supporting installation response outside the MTF)	N	Y
Environmental Health	N	N
Facility Management of Operational Assets (WRM Warehouses, non-MTF facilities)	N	N
Fitness for Duty/Accession Determinations/Duty Status Determinations/Medical Hold Programs	N	N
Flying Status Determinations (DNIF, Up Chit/Down Chit, etc....)	N	Y

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Readiness Functions in the MTF without Provision of Care	Provision of Care within the MTF*	Assessment (D/A/E) Requirements **
Food Protection	N	Y
Force Development/Professional Development (ADCON; OT&E related)	N	Y
Ground Evacuation (CASEVAC)	N	N
Hyperbaric Medicine (Chamber) outside the MTF	N	N
Immunization Status (IMR specific)	N	Y
Independent Duty Medic/Medical Technician/Corpsman Programs	N	Y
Individual Medical Equipment Issue (Gas Mask inserts)	N	Y
Industrial Hygiene	N	Y
Integrated Disability Evaluation System (IDES) to include Physical Evaluation Boards	N	Y
Laboratory Test Status (IMR specific)	N	Y
Medical Materiel (Operational Logistics & War Reserve Materiel Management)	N	Y
Mental Health Baseline Assessments (ANAM; pre/post deployment)	N	N
Operational IM/IT (HIT; JOMIS support at Services level)	N	Y
Operational Research and Development	N	N
Overseas Clearances (Family Member Relocation Clearances)	N	N
Personnel and Administration	N	Y
Readiness Reporting and Deployment Management	N	Y
Readiness Training Program Oversight & Management (CMRP, ICTLs, KSAs)	N	N
Religious Support / Pastoral Care (Line supported in some cases)	N	N
Safety and Occupational Health outside the MTF (for installation mission support)	N	N
Veterinary Public Health (to include Animal Health)	N	Y

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## APPENDIX C: ACRONYMS

<b>ACOM</b>	<b>Army Commands</b>
<b>AF</b>	Air Force
<b>AFMD</b>	Air Force Mission Directive
<b>AFMOA</b>	Air Force Medical Operations Agency
<b>AFMRA</b>	Air Force Medical Readiness Agency
<b>AFMS</b>	Air Force Medical Service
<b>AFMSA</b>	Air Force Medical Support Agency
<b>ARSTAF</b>	Army Staff
<b>ASAP</b>	Army Substance Abuse Program
<b>ASCC</b>	Army Service Component Commands
<b>BUMED</b>	Bureau of Medicine and Surgery
<b>CG</b>	Commanding General
<b>CMC</b>	Commandant of the Marine Corps
<b>CNO</b>	Chief of Naval Operations
<b>CSA</b>	Chief of Staff of the Army
<b>DHA</b>	Defense Health Agency
<b>DoD</b>	Department of Defense
<b>DON</b>	Department of Navy
<b>FOA</b>	Field Operating Agency
<b>FY</b>	Fiscal Year
<b>HAF</b>	Headquarters Air Force
<b>HIV</b>	Human Immunodeficiency Virus
<b>IDES</b>	Integrated Disability Evaluation System
<b>IMO</b>	Intermediate Management Organization
<b>MAJCOM</b>	Major Command
<b>MDO</b>	Market Development Office
<b>MHS</b>	Military Health System
<b>MILDEPs</b>	Military Departments
<b>MRD</b>	Medical Readiness Directorate
<b>MTF</b>	Military Treatment Facility
<b>NDAA</b>	National Defense Authorization Act
<b>NMRTC</b>	Navy Medicine Readiness Training Command
<b>OSD</b>	Office of the Secretary of Defense
<b>OTSG</b>	Office of the Surgeon General
<b>PMRC</b>	Provisional Medical Readiness Command
<b>POM</b>	Program Objective Memorandum
<b>PPBE</b>	Programming, Planning, Budgeting and Execution
<b>QPP</b>	Quadruple Aim Performance Process
<b>SECNAV</b>	Secretary of the Navy
<b>SG</b>	Surgeon General
<b>SSO</b>	Small and Stand-Alone Office
<b>USAMEDCOM</b>	United States Army Medical Command
<b>VA</b>	Department of Veterans Affairs