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

PERSONNEL AND READINESS

The Honorable Roger F. Wicker
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

SEP 14 2026

Dear Mr. Chairman:

The Department's response to House Report 119–231, page 200, accompanying H.R. 3838, the Streamlining Procurement for Effective Execution and Delivery and National Authorization Act for Fiscal Year 2026, "Military Treatment Facility Trauma Centers," is enclosed.

This report provides an overview of the Defense Health Agency's efforts to establish and sustain a standardized approach to trauma readiness across the Military Health System. It identifies military medical treatment facilities currently verified by the American College of Surgeons, those meeting State-level trauma designation standards, and facilities equipped with Level III trauma capabilities.

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 Armed Services of the House of Representatives.

Sincerely,

[redacted]

Sean O'Keefe
Deputy Under Secretary of War for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

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

PERSONNEL AND READINESS

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

SEP 14 2026

Dear Mr. Chairman:

The Department's response to House Report 119–231, page 200, accompanying H.R. 3838, the Streamlining Procurement for Effective Execution and Delivery and National Authorization Act for Fiscal Year 2026, "Military Treatment Facility Trauma Centers," is enclosed.

This report provides an overview of the Defense Health Agency's efforts to establish and sustain a standardized approach to trauma readiness across the Military Health System. It identifies military medical treatment facilities currently verified by the American College of Surgeons, those meeting State-level trauma designation standards, and facilities equipped with Level III trauma capabilities.

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 Armed Services of the Senate.

Sincerely,

[redacted]

Sean O'Keefe
Deputy Under Secretary of War for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

[redacted]

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

Military Treatment Facility Trauma Centers

September 2026

The estimated cost of this report or study for the Department of War (DoW) is approximately $1830 in Fiscal Year 2026. This includes $0 in expenses and $1830 in DoW labor.
Generated on 2026Jan26 RefID: B-0D88DBC

Executive Summary

This report is in response to House Report 119–231, page 200, accompanying H.R. 3838, the Streamlining Procurement for Effective Execution and Delivery and National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2026, regarding the status of military medical treatment facilities (MTFs)[1] verified as trauma centers and the progress of additional facilities toward verification.

This report focuses on Defense Health Agency (DHA)-administered and managed MTFs. These facilities operate under the Director, DHA's authority and are responsible for delivering impatient and definitive trauma care within the direct care system.

While trauma readiness begins in operational environments (Role 1 – Role 3) under Military Department authorities, injured Service members ultimately transition into DHA-administered and managed fixed facilities or private sector care facilities for definitive surgical care, recovery, and rehabilitation. Accordingly, DHA MTF trauma capability represents the culminating institutional segment of the military trauma continuum, extending from Point of Injury (POI) through discharge.

This report addresses:

(1) the number of Military Treatment Facilities that have been verified by the American College of Surgeons as Trauma Centers;
(2) the Military Treatment Facilities that have met the "Trauma Capable" criteria established in the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328, section 703);
(3) the number of Military Treatment Facilities equipped with Level Three Trauma care capabilities;
(4) current status of efforts to obtain verification for appropriate Military Treatment Facilities as Trauma Centers; and
(5) the feasibility of recognizing Military Treatment Facilities Outside of the Continental United States Trauma Centers.

MTFs fall under American College of Surgeons (ACS) trauma center standards that the Joint Trauma System (JTS) supports.

Background

The JTS was established pursuant to section 707 of the NDAA for FY 2017 (Public Law 114–328). Among other things, the law requires the JTS to serve as the reference body for all trauma care provided across the Military Health System (MHS) and establish standards of care for trauma services provided at MTFs, making the JTS the lead organization within the Department of War (DoW) with expertise to inform the committee as requested. A full answer to these important inquiries deserves additional background information considering the

[1] Although the title of this report is "Military Treatment Facilities," pursuant to 10 U.S.C. § 1073c, the defined term is "Military Medical Treatment Facilities."

specialized nature of the terminology and processes that shape the response. While the committee's request is for information associated with MTFs, it is important to see the trauma system in the MHS as one continuum from POI, with injuries initially handled by the Military Departments in operational environments, through MTF or private sector hospital discharge. Having consistent standards and metrics ensures high quality combat casualty care throughout the entire continuum.

Every military conflict across history results in improvements in trauma care. Emerging lessons from World War II, Korea, and Vietnam resulted in the publication of a National Academy of Sciences' report in 1966, "Accidental Death and Disability: The Neglected Disease of Modern Society," which improved trauma care and developed trauma systems in the United States. Leaders in the MHS accelerated the application of the trauma system concept in DoW during the conflicts in Afghanistan and Iraq through the formation of the Joint Theater Trauma System (JTTS, forerunner of the JTS), resulting in historically low death rates in the history of war and conflict. There are four principles to a trauma system—ensuring that the right patient gets to the right place at the right time and receives the right care. While this sounds simple, the amount of coordination, communication, integration, and leadership to execute an effective trauma system is not simple.

The private sector healthcare system embraced the concept of trauma systems after the Vietnam War with key leadership from the ACS. The ACS developed a robust list of standards that established the policies, procedures, processes, and personnel that separate a trauma center from non-trauma centers, and they also established a process to validate the presence of these standards in a facility to achieve verification as a trauma center. The ACS Committee on Trauma (CoT) collaborated with DoW throughout the maturation of the JTTS in Afghanistan and Iraq; however, the trauma standards and verification system that the ACS developed are specific to U.S. hospitals that the Joint Commission or similar accrediting body accredits. DHA contracts with the Joint Commission to accredit its MTFs, as the law requires their accreditation. The JTS partnered with the ACS to support MTFs that wish to pursue ACS trauma center verification.

The ACS assesses healthcare facilities for compliance with its standards which results in a notice of "verification," a quality program of the ACS. Private sector healthcare facilities and DHA seek verification by the ACS as trauma centers consistent with the mission and vision of their leadership teams. Formal authorization to participate as trauma centers in State trauma systems is a public sector regulatory program known as a "designation." Several MTFs were successful in achieving ACS verification and trauma center designation in their State trauma systems. Additional factors leading to the decision to achieve ACS's verified trauma center status include commitment to skills sustainment, maintaining in-patient volume and support for graduate medical education programs. The JTS's Trauma System Support & Consultation Branch (TSS&CB) partners with and support staff at MTFs that strive to achieve and maintain ACS verified trauma center status. DHA established the TSS&CB in 2022 to work within the MTFs to support MTFs that wish to pursue ACS trauma center verification. This Branch mentors MTF directors, trauma medical directors, and trauma program nurse managers through the complex ACS trauma center verification process.

Outside of ACS's well-described trauma center standards and its verification process, there are no alternate accepted standards that suggest a private sector hospital or MTF is "trauma capable" they are either met (by meeting ACS verification standards), or they are not. Other than seeking verification from ACS, there is no Department or DHA policy or instruction that identifies defined standards for an MTF to be "trauma capable."

ACS Verified MTFs

The ACS CoT, as the national leader in trauma center standards, publishes a list of standards characterizing the policies, procedures, processes and personnel to provide optimal care for severely injured patients. The standards characterize three levels of trauma centers where Level I and Level II centers demonstrate the capability to provide care for the most complex injuries, and Level III trauma centers provide less complex care. Upon request, the ACS CoT performs surveys of hospitals to assess compliance with these standards and issue a statement of verification to hospitals that meet these standards. ACS verified the following eight MTFs as trauma centers at the noted levels:

Table 1. List of MTFs Verified by the ACS

MTF Name	Location	ACS Verified Level
Brooke Army Medical Center	San Antonio, TX	Level I
Tripler Army Medical Center	Honolulu, HI	Level II
Landstuhl Regional Medical Center	Landstuhl, Germany	Level II
Alexander T Augusta Military Medical Center	Fort Belvoir, VA	Level III
Navy Medical Center Camp Lejeune	Camp Lejeune, VA	Level III
William Beaumont Army Medical Center	Fort Bliss, TX	Level III
Womack Army Medical Center	Fort Bragg, NC	Level III
Mike O'Callaghan Military Medical Center	Las Vegas, NV	Level III

There are some MTFs that have not sought assessment against the ACS standards but instead requested to be surveyed solely against State-determined designation standards. The following three MTFs met criteria established by their State trauma system, but the ACS has not assessed them.

Table 2. List of MTFs Designated by State Level Authority

MTF Name	Location	State Verified Level
Navy Medical Center Portsmouth	Portsmouth, VA	Level II
Madigan Army Medical Center	Joint Base Lewis-McCord, WA	Level II
Carl R Darnall Army Medical Center	Fort Hood, TX	Level III

MTFs Meeting the "Trauma Capable" Criteria per the NDAA for FY 2017

Section 1073d(b)(3)(D) of title 10, U.S. Code, directs that DoW medical centers shall have "Level one, level two, or level three trauma care capabilities;" however, there is no further guidance in this section defining the term "capabilities." The JTS, as the reference body for care of the injured in the DoW, is best positioned to support MTFs to meet the elements needed for ACS verification and to perform surveys to assess whether MTFs meet those criteria prior to the MTF undergoing a formal ACS verification survey.

The JTS, through the process of medical performance optimization, identifies gaps in the military trauma system and works to close those gaps since the inception of the JTTS, now the JTS.

When deployed Service members suffer injuries on the battlefield, they enter a system of care—the "military trauma system"—which has standards set by the JTS from POI until they arrive at an MTF. On arrival at the MTF, the JTS still governs the standards which align with the standards set by the ACS. It is all one interconnected system from POI through discharge from an MTF, but this system considers the deployed trauma system and a challenging, kinetic environment that servicemembers operate in. In summary—the principles of the JTS-governed military trauma system: *right patient, right time, right place, right care,* apply from POI through MTF or private sector care hospital discharge. JTS assesses the operational environment. JTS assesses and verifies MTFs that meet ACS's requirements as a trauma center.

MTFs Equipped with Level III Trauma Care Capabilities

Level III trauma centers can provide the initial resuscitation and evaluation of all injured patients but are limited to providing definitive care to those with complex injuries. Level III trauma centers can stabilize patients and provide expeditious transfer to higher level centers for patients with complex injuries. This is the ACS standard, and the same standard that the JTS aligns with. The result of the absence of a definition of "trauma capable" status is that there are no MTFs that are "trauma capable." One should align the standard for "trauma center capable" with the ACS standard for a Level III trauma center. Using a different standard from the ACS's risks the MHS's capability to ensure high quality trauma care at MTFs. Table 3 lists the four MTFs that are pursuing ACS's status as a Level III trauma center.

Table 3. List of MTFs Seeking Level III Trauma Center Designation

MTF Name	Location
Brian Allgood Army Community Hospital	Korea
Naval Hospital Guam	Guam
Naval Hospital Okinawa	Okinawa, Japan
Naval Hospital Yokosuka	Yokosuka, Japan

Status of Efforts to Obtain Verification for MTFs

The decision to seek and achieve verification as a trauma center by any MTF rests with the MTF leadership teams. Ensuring the MTFs meet the ACS standards for verification is vital to ensure the MHS provides quality care to all trauma patients. The work continues within the Department amongst the stakeholders to determine which MTFs should pursue a designation as a trauma center. Currently, as noted in Table 3 above, there are four MTFs seeking trauma center designation.

Feasibility of Recognizing MTFs Outside the Continental United States (OCONUS)

It is feasible. The JTS can assess OCONUS MTFs, or by external Agencies such as the ACS. The ideal scenario is that JTS's TSS&CB engages with the MTF and identifies, in advance, gaps precluding ACS verification. The goal would be to close the gaps and pursue ACS trauma center if it is feasible and acceptable for the MTF to become an ACS verified trauma center. The TSS&CB assessment is done using Possible (feasible), Acceptable, Suitable and Sustainable (PASS) criteria detailed in the figure below:

Figure. PASS Criteria

Possible	Is it possible and feasible for ACS verified trauma center to exist at the MTF? Is there a patient reception area (helicopter landing zone), operations (OR) capacity, Emergency Department (ED) infrastructure, and appropriate professional staff. If it is not possible or feasible, there is no need for a TSS-CB assessment.
Acceptable	Would the trauma center be acceptable in the community? Does it meet a community need? Is there support from the regional trauma system for the MTF to become a trauma center?
Suitable	Would verification as a trauma center support the theater operational plan? Is it suitable for the CCMD O-Plan? Is there support from the CCMD to pursue trauma center verification?
Sustainable	Will military departments, Commands, and the DHA support in the future with staffing, specialty needs, leadership support/buy-in. Is trauma center status sustainable at the MTF from a personnel and resourcing perspective.

Recognition by the ACS is important because it signifies that MTFs are on equal footing with private sector care facilities, which is important for regional trauma systems even in OCONUS environments. For example, as an ACS verified Level II trauma center, staff at Landstuhl Regional Medical Center (LRMC) can see civilian German trauma patients. Even among the MTFs there exists certain challenges in the OCONUS facilities that create inequalities so that comparison to private sector hospitals is less meaningful. Typically, the ACS limits its verification surveys to private sector hospitals in the continental United States because their standards relate to U.S. mainland training paradigms (U.S. medical school standards, U.S. physician resident training standards, etc.). These are often absent in the staff of private sector hospitals OCONUS. The ACS agrees to assess MTFs against its standards, if requested.

Therefore, it is feasible for the ACS to recognize OCONUS MTFs as trauma centers. In fact, ACS currently verified two MTFs (Tripler Army Medical Center and LRMC) as trauma centers with the additional four listed in table 3 above as also seeking verification.

Conclusion

The purpose of this report is to answer the congressional inquiry regarding the status and progress of MTFs becoming verified trauma centers. Additionally, the report expands on the purpose of the Combatant Command Trauma System (CTS) to ensure Congress is aware of the role the JTS has in assessing operational environments that are not MTFs to ensure the Department meets trauma care standards to support the highest battlefield survivability possible in the military's trauma system. In summary, this report confirms that the DoW has successfully integrated several of its key MTFs into the national trauma system through verification by the ACS, the recognized civilian standard-bearer. This achievement: 1) improves the quality of trauma care in the MHS; 2) improved national readiness and preparedness for large scale combat operations, 3) enhanced graduate medical education; 4) improved clinical volume in other surgical service lines when MTFs become trauma centers as systems are in place to support other medical/surgical services; and 5) supported high-level clinical readiness at these specific centers. There is still much work to be done to support the MTFs to ensure high quality trauma care, such as increasing overall clinical volume.

Furthermore, there is risk in not aligning with the trauma center standards developed by the ACS and adjusting MTF standards by defining "trauma capable" outside of the formal ACS process. This risk is in a "strategic drift" to use an unvalidated MTF standard that does not align with the validated high-quality standards set by the ACS and that JTS supports.

In terms of operational environments, the JTS will continue to implement the CTS to ensure operational environments meet the highest standards to deliver high-quality battlefield trauma care but note the responsibility is with the respective Military Department to implement and maintain the standard. DoW has a unique mission to deliver trauma care from POI in any operational environment through MTF or private sector hospital discharge—this care ranges across time, space, and through different Combatant Commands. Having validated standards for trauma care delivery in any environment ensures a commitment to battlefield survivability improving clinical outcomes from injury for all Service members and DoW beneficiaries.