CONTINUOUS TRANSFORMATION OF OPERATIONAL MEDICINE & KEEPING PACE

- Army Medicine must prepare for the realities of LSCO while caring for our Soldiers and Families at home and abroad.
- Army Medicine has three imperatives – clear the battlefield, return Soldiers to the fight, and operate in contested environments.
- Our culture is a critical component required to enable and sustain change.
- Army Medicine must advocate for multi-domain operations requirements (mass casualty and evacuation) to instill Warfighter confidence and enable mission success.
- To ensure maneuver at speed and scale, the Army must adequately fund the Future Long Range Assault Aircraft (FLRAA) MEDEVAC variant.
- To keep pace, Army Medicine needs autonomous medical systems for timely, appropriate treatment and evacuation over greater distances and longer durations, with policies ensuring responsible technology use.
- All solutions require a Total Force and DOTmLPF-P approach to ensure well informed, effective solutions.
- A robust data infrastructure is essential to integrate medical information with the operational force Common Operational Picture and MHS Genesis.
- Army Medicine is modernizing the MEDCOM structure to meet the challenges of today and tomorrow.

TRANSFORM IN CONTACT
(TIC 1.0 / TIC 2.0)
18-24 MONTHS

DELIBERATE TRANSFORMATION
(TAA, PPBE)
2-7 YEARS

CONCEPT DRIVEN TRANSFORMATION
(DOTMLPF-P)
2030-2040

RECRUITING & RETAINING MILITARY HEALTH CARE PROFESSIONALS

- People, their development, personal and professional satisfaction, are central to everything we do.
- Army Medicine is reimagining recruiting and retaining using data informed processes to recruit, train, and retain highly competent and committed professionals.
- Army Medicine offers the maximum incentive rates outlined in the FY24 ASD, HA Health Profession Officers (HPO) Pay Plan.
- The FY24 special pay incentives budget increased by 6%, totaling $20 million.
- Effective October 2024, the Army HPO Pay Plan realigned from CY to FY, streamlining funding.
- The AMEDD Enlisted Corps offers medical specialization, degrees, and credentials with 11 degree and 10 accredited programs.

ARMY WARFIGHTER BRAIN HEALTH

- DoD and Army understanding of brain health has evolved since 2007.
- In FY24, the Neurocognitive Assessment Program shifted to a cognitive monitoring model to assess and detect brain health hazards.
- The Army's approach includes increased training, tracking, protection, monitoring, and treatment.
- The Army is committed to maintaining combat ready forces in defense of the Nation while protecting brain health.
- While blast overpressure exposure may be a contributing factor to brain injury, the human brain is extraordinarily complex with many environmental, genetic, and physical factors that affect health and performance.

ARMY MEDICINE LEGISLATIVE AFFAIRS

- Congress must provide timely, adequate, sustained, and supportive funding to ensure Army Medicine remains the Nation's premier expeditionary and globally integrated medical force, ready for the future fight.
- Government shutdowns and continuing resolutions threaten readiness, morale, and safety.

ARMY MEDICINE PRIORITIES

Army Medicine's purpose is clear – deliver *"Combat Ready Care"* at the point of need to inspire trust and to enable our Army to fight and win our Nation's wars.

Army Medicine must be ready, at scale, to provide the Army and the Joint Force, **combat ready, medically credible forces at echelon**, during campaigning and in crisis or conflict, to sustain the health of the force and our Families.

★ WARFIGHTING

COMBAT READY MEDICAL FORCES
- Realistic, threat-informed training builds cohesive, integrated medical teams
- Tactically and technically proficient

★ DELIVERING READY COMBAT FORMATIONS

SUSTAIN HEALTH
- Clear the battlefield, save lives, return Soldiers to the fight
- Deliver prevention, health promotion, force health protection and treatment

★ CONTINUOUS TRANSFORMATION

CULTURE OF CONTINUOUS TRANSFORMATION
- Build on Army Medicine's legacy of transformation in contact
- Integrate training, materiel and capability development through modernization

★ STRENGTHENING THE PROFESSION

STRENGTHEN OUR PROFESSIONS
- Medical leaders of character and competence that value Service above self
- Align authority and accountability, developing strategic leaders of integrity

LEVERAGE PARTNERSHIPS
- Leverage Joint, Combined, & Interagency partnerships to close capability gaps
- Partner with DHA to keep faith with our Families through access to care

U.S. ARMY

ARMY MEDICINE TOPLINE MESSAGES

COMBAT READY CARE ... THIS WE'LL DEFEND!

PURPOSE

This Army Medicine communication tool provides topline messages to synchronize senior leader communication across all commands and COMPOS.

THE U.S. ARMY SURGEON GENERAL INTEGRATOR ROLE

- The U.S. Army Surgeon General (TSG), with dual authorities as the Commanding General, U.S. Army Medical Command (CG, MEDCOM), previously synchronized, coordinated, and integrated manning, training, and equipping functions and provided health care delivery through the CG, MEDCOM command and control (C2) role.
- As organizations and medical capabilities were reassigned to Army Commands and the Defense Health Agency (DHA), TSG's integrator role became critical.
- TSG integrator role is key to Army Medicine unity of effort and advocacy across all commands and COMPOS in support of the Army and Joint Force.
- Codifying and operationalizing TSG integrator role with Army, Joint, and international partners will deconflict the role with existing authorities and enable cohesive Army Medicine actions.
- Integration is a necessity to achieve unity of effort, with nearly 48% of the Total Army Medicine Force residing in the Reserve Components (i.e., 23% ARNG & 25% USAR); 91% in the operating force and 9% in the generating force.

ADVANCING ARMY MEDICINE – ALIGNING, MODERNIZING, AND PREPARING

TSG's / MEDCOM CG's initial assessment of the Army Medicine enterprise established a strategic direction to advance Army Medicine in support of the Army given the realities of the operating environment and Large-Scale Combat Operations (LSCO).

ALIGNING FORM & FUNCTION

- Reviewing OTSG / MEDCOM "Onestaff" Form & Function
- Codifying & Operationalizing TSG Integrator Role
- Implementing Fully the Theater Medical Commands

MODERNIZING THE HUMAN CAPITAL STRATEGY

- Employing a Data-Informed Process to Recruit, Train, & Retain
- Increasing Predictability & Professional Satisfaction

PREPARING FOR THE FUTURE FIGHT

- Assessing LSCO Plans, Requirements, & Training
- Addressing MDO Gaps
- Developing a Responsive & Predictable Individual Deployer System

ARMY MEDICINE SUPPORT TO ARMY QUALITY OF LIFE (QOL) INITIATIVES

- The Army aims to provide a supportive and enriching environment for every member of the Army Family through Army QOL Lines of Effort, including health care.
- The Nation's health care worker shortage affects Soldiers and Families, with three out of four bases in primary health care deserts also experiencing worker shortages in mental health care, maternal health care, or both; despite these realities Army Medicine and DHA are collaborating to improve access to care.
- BRAVE Telehealth offers 24/7 appointments for active duty servicemembers; the Army had 22,086 of 38,447 encounters in FY24.
- The Army is participating in the OSD Remote and Isolated Location Working Group to ensure critical services, such as health care, are available.
- The Army Disability Evaluation System (DES) processing timeline reduced 4% while accounting for 65% of the DoD caseload; cross leveling support across Medical Readiness Commands (MRCs) has contributed to a 58% decrease in narrative summary timelines.

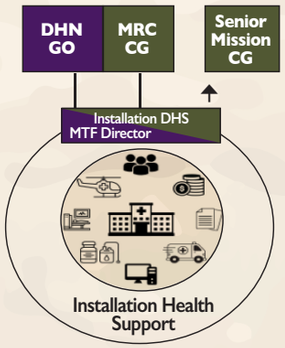
MILITARY HEALTH SYSTEM (MHS) STABILIZATION & INTEGRATION

- Army Medicine is implementing the Deputy Secretary of Defense's (DSD) December 2023 guidance aimed at maximizing health care capacity in the direct care system, reattracting care to the Military Treatment Facilities / Dental Treatment Facilities (MTFs / DTFs), balancing operational requirements, and enhancing clinical competencies.
- In September 2024, the Military Departments (MILDEPS) and the DHA launched the first annual Human Capital Distribution Plan (HCDP) to allocate uniformed medical and dental personnel to MTFs / DTFs.
- The Army is collaborating with MHS stakeholders on a manpower analysis study and risk management process to ensure operational responsiveness and support MHS stabilization.
- The MILDEPS and DHA are mitigating operational risk by prioritizing resources to increase clinical capacity at large MTFs while maintaining some excess capacity at small MTFs.
- A $13.2 billion funding shortfall identified in the MHS Review (May 2022-June2023) is affecting access to care, civilian hiring, contracting actions, and other activities across the MHS.
- The unified medical budget (UMB) is falling behind health care expenditures, shrinking to 7% of the DoD's $842 billion budget request, with per capita spending at roughly $6,400 compared to the national average of $15,900 and the Veterans Health Care Administration's $10-13,000.

"The Department relies on the Military Health System to provide medically ready forces and ready medical forces, and to deliver high quality care to our beneficiaries, including military family members and retirees."

~ HON Kathleen H. Hicks

INSTALLATION HEALTH SERVICE SUPPORT (IHSS)



- Typically, one Colonel or Lieutenant Colonel serves as the MTF Director, the Army Service Commander, and the Director of Health Services (DHS), synchronizing, coordinating, integrating, and optimizing the Army Health System within the health service area; this includes Army readiness and QOL programs with Army Medicine functions and responsibilities.
- The MTF Director executes health care delivery under the authority, direction, and control of the DHA, ensuring access to care for our Soldiers and Families.
- The Army Service Commander and DHS roles are executed under the C2 of the MRC and include, integrating health service support and aligning efforts within the health service area.
- The MRC CG generally has dual authorities as the Defense Health Network Director, ensuring unity of effort and command.
- TSG advocates for Army health policies and readiness requirements and assesses Assistant Secretary of Defense, Health Affairs (ASD, HA) and DHA policies and programs.
- OTSG / MEDCOM tracks outcomes and costs for over 50 areas of IHSS to assess effectiveness and efficiency, while highlighting operational risk.

TIMELINE

1973. The Health Services Command is established, positioning TSG as the integrator of health matters.

1986. The Goldwater-Nichols Act reorganizes the DOD and changes command structure.

1991. Soviet Union collapses ending the Cold War. Massive budget cuts and the U.S. Armed Forces mission focus is peace keeping and peace enforcement.

1994. MEDCOM is established. AMEDD TDA organizations are placed under one command while TSG integrates medical support to the operating force.

Late 1990s. Medical force structure cuts with low threat operationing environment. CSH conversions for efficiency and elimination of Role 4 theater medical support.

2001. 91W MOS is established. Medics are required to train to EMT-Basic, with competencies in emergency care, evacuation, medical force protection, and primary care.

2001. TRICARE is established, improving access to care for beneficiaries.

2006. 68W MOS is established with changes to administration but not training.

2009. The Warrior Transition Command is established to oversee programs for wounded warriors.

2010. The U.S. Army Public Health Command (USAPHC) is established, integrating the VETCOM and the U.S. Army Center for Health Promotion and Preventive Medicine.

2016. All deployable hospitals begin conversion to Hospital Centers and Field Hospitals reducing total bed capacity.

2016. RHCs are established. Regional Dental Health, Public Health, and Medical Commands merge. DENCOM and USAPHC disestablished.

2017. NDAA is passed, DHA has authority, direction, and control of MTFs / DTFs.

2018. MEDCOM transfers 1,685 PROFIS TDA authorizations to MTOE.

2019. Army aligns AMLC to AMC, MRDC to AFC, and MEDCoE, formally AMEDD C&S, to TRADOC.

2020. COVID Response

Operation Warp Speed; support to civilian hospitals and civilian vaccination operations; preventing, testing, treating, and contact tracing efforts; CL VIII management.

2022. RHCs redesignated as MRCs.

2023. DHA transitions to nine DHNs.

2024. MHS GENESIS fully deployed.

1973 1986 1991 1994 2001 2006 2009 2010 2016 2017 2018 2019 2020 2022 2023 2024