



UNDER SECRETARY OF DEFENSE

**4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000**

JUN 28 2018

**PERSONNEL AND
READINESS**

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

Dear Mr. Chairman:

This is the final implementation plan for section 702 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328), concerning "Reform of Administration of the Defense Health Agency and Military Medical Treatment Facilities."

Section 702 directs a major transformation of the Military Health System (MHS). Substantial challenges are inherent in implementing major reform such as that required by this legislation, not the least of which is maintaining "a ready medical force and a medically ready force." The enclosed report describes how the Department will transition to the end state of a fully integrated system of readiness and health, underpinned by a new health care delivery and management model, consistent with title 10 USC §1073c. MHS efforts focus not only on the worthy goal of reducing redundant and unnecessary headquarters overhead, but on building a structure that drives improved outcomes for readiness, health, quality and cost.

The Department's leaders, its Service members, families, and all Americans share both confidence and pride in what military medicine has achieved. Our plan boldly builds upon this success in a manner that applies science and discipline to improving mission outcomes while conserving Department resources

Thank you for your continued support of the MHS. An identical letter will be sent to the Committee on Armed Services of the House of Representatives.

Sincerely,

A handwritten signature in cursive script, reading "Robert L. Wilkie".

Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member



UNDER SECRETARY OF DEFENSE

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WASHINGTON, DC 20301-4000**

JUN 28 2018

**PERSONNEL AND
READINESS**

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

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Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

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



Final Plan to Implement Section 1073c of Title 10, United States Code

Final Report
June 30, 2018

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

The estimated cost of this report or study for the Department of Defense (DoD) is approximately \$43,250. This includes \$0 in expenses and \$43,250 in DoD labor.

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6. USD P&R Memo, Manpower Requirements Validation for the Defense Health Agency Headquarters, dated June 7, 2018
7. USD P&R Memo, Zero-Based Review of Military Department Medical Manpower, dated June 15, 2018



Recommendations for Legislative Actions

The Department has taken a deliberate and collaborative approach in establishing 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 and the military health benefit.

To accomplish the proposed implementation plan described in this report, the Department requested legislative revisions that will grant the ability to implement title 10 U.S.C. §1073c under a phased-in approach as well as grant the Secretary the authority to waive specific requirements of title 10 U.S.C. §1073c if the Secretary determines such waiver is necessary for implementation feasibility or military health readiness.

This implementation plan reflects a phased approach consistent with the Department's request for a three-year phasing period. In the event that the phasing period is required to be completed by October 1, 2020, as provided in the House-passed and Senate-passed versions of the proposed National Defense Authorization Act for Fiscal Year 2019, the Department of Defense's (DoD) phasing plan will be revised accordingly. Additionally, the Department's interim report of March 30, 2018, included features that are dependent on the grant of waiver authority to the Secretary of Defense, as contemplated by the legislative revisions requested. In the event this waiver authority is not enacted, this plan will be implemented in a manner consistent with the law in effect. Specifically, in that event, the Defense Health Agency will, under the phasing plan, assume control of every military medical treatment facility, defined as every fixed facility established for the purpose of furnishing medical and/or dental care to eligible individuals, including all operations of each such facility and all health care delivery associated with each such facility.

The Department continues to strongly recommend that Congress enact the legislative proposal to permit a three-year phase-in and to give the Secretary the authority to waive specific requirements of title 10 U.S.C. §1073c if the Secretary determines such waiver is necessary for implementation feasibility or military health readiness.



Introduction

The Military Health System (MHS) is an indispensable component of the national security fabric and is deeply engaged in support of combat forces across the globe. This system has performed superbly in combat casualty care, life-saving treatment, and long-term care and rehabilitation of our ill and injured Service members over sixteen years of sustained conflict. Working together, the MHS has achieved historic outcomes in lives saved and injury and illness prevented.

The value of “jointness” in contributing to improved outcomes on the battlefield was noted by the Deputy Secretary of Defense in 2013 when the decision was made to establish the Defense Health Agency, as part of a set of MHS Governance reforms.

Benefits from a more integrated system of care were also an important theme in the Department’s own internal review of access, quality and safety in 2014, and led to the establishment of an enterprise performance management plan and closely associated metrics in the key areas of readiness, health, health care delivery and cost.

While significant progress has been made to achieve greater integration through consensus based governance, it has come at the expense of agility and speed of decision-making. The Department has acknowledged this challenge in functions beyond health care. The 2018 National Defense Strategy states that the Department has favored “exacting thoroughness and minimizing risk” at the expense of speed of delivery and continuous adaptation. The strategy mandates bold change, stating “we must make difficult choices and prioritize what is most important to field a lethal, resilient, and rapidly adapting Joint Force.”

The National Defense Authorization Act for Fiscal Year 2017 (FY17 NDAA) directs the Military Health System to transform, highlighting the “current organizational structure (that)... paralyzes rapid decision-making and stifles innovation in producing a modern health care delivery system that would better serve all beneficiaries.” The law mandates the creation of a single agency [Defense Health Agency (DHA)] responsible for the administration of all MTFs to improve and sustain operational medical force readiness and the medical readiness of the Armed Forces, improve beneficiaries’ access to care and the experience of care, improve health outcomes, and lower the total management cost of the military health system. The National Defense Strategy directs:

“We will put in place a management system where leadership can harness opportunities and ensure effective stewardship of taxpayer resources... We must not accept cumbersome approval chains... (or) overly risk-averse thinking that impedes change. ...Department leaders will adapt their organizational structures to best support the Joint Force.”

Since December 2016, DoD civilian and military medical leaders have worked together to establish a plan that aligns with Congress’ direction. The MHS, led by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)), recognizes that success will be achieved through a disciplined and structured process of system redesign that remains true to its core strategic goals known as the Quadruple Aim: Improved Readiness, Better Health, Better Care and Lower Cost.



The DoD and MHS' role as employer, provider, health plan, and public health system brings a number of critical, structural strengths to achieving real integration in support of health readiness. Furthermore, while the MHS shares the goals of better care and lower cost with all of American medicine, DoD stands apart from the private sector by its laser focus on operational medical readiness and health of the warfighter, supporting the Secretary's priority for a more lethal force. DoD's mission demands a fighting force that achieves optimal health and readiness.

This document describes how the Department will transition to the end state of a fully integrated system of readiness and health, underpinned by a new health care delivery and management model that meets the intention of title 10 U.S.C. §1073c. MHS efforts focus not only on the worthy goal of reducing redundant and unnecessary headquarters overhead, but on building a structure that drives improved outcomes for readiness, health, and cost. To capitalize on early learnings, the Department will use a phased approach to reach the end state.

Central to this approach is the strengthening of the DHA's enterprise activities and the standardization of clinical and business processes across military medical treatment facilities (MTFs). Through this plan, the DHA will establish and issue procedural policies, exercise management responsibilities for enterprise activities to achieve efficiencies, create and expand public and private partnerships that advance the Department's mission, co-create a system of readiness and health in partnership with its patients, reduce unnecessary costs, and integrate the health delivery direct care and purchased care components of the MHS.

The structured roll-out of the Department's plan allows for the creation and maturation of management and oversight functions that ensure readiness is sustained and enhanced, culminating in a joint organizational model to allow the DHA to manage and oversee military direct and purchased care medical health services delivery in support of Combatant Commander missions and Service requirements.

Consistent with performance-based accountability, this plan includes metrics that assess our progress in each element of the Quadruple Aim and that measure our implementation of the elements of NDAA mandated transformation.

Finally, it is important to note that some of the Department's activities to implement the FY17 NDAA described in this report extend beyond just section 702. Congress expressed clear intent for greater integration across a broad range of activities, and the approach outlined here will help the Department with the comprehensive reforms directed by that legislation.

The Department's leaders, its Service members, families, and all Americans share both confidence and pride in what military medicine has achieved. Our plan builds upon this success in a manner that applies science and discipline to improving mission outcomes while conserving Department resources.

In submitting this final implementation plan, as required by title 10 U.S.C. §1073c, the Department acknowledges that under the structured roll-out, the plan will continue to be refined and enhanced to ensure successful implementation.



I. How the Secretary will carry out subsection (a) of 1073c

A. Background

In June 2017, DoD delivered an interim report to the Armed Services Committees describing a “Component Model” for implementing 10 U.S.C. §1073c. After deeper analysis and discussions, the Department decided that the Component Model did not adequately satisfy the requirements of subsection (a) of 1073c. Beginning in December 2017, the Department developed a new framework to ensure that the DHA will have direct control over military medical treatment facilities (MTFs) while the Services retain control over their uniformed personnel and non-health care delivery operational and installation-specific functions separate from MTF operations. This new framework has the advantage of allowing the Service Medical Departments to focus on their operational readiness missions while DHA strengthens its management of enterprise activities, standardizes policies and procedures to realize efficiencies and assumes authority, direction and control of the MTFs.

In February 2018, the Under Secretary of Defense (Personnel & Readiness) issued guidance on behalf of the Department, outlining the new framework for implementing 10 U.S.C. §1073c. Because the Department had only recently changed the model for satisfying subsection (a) of 1073c, and because this endeavor represents the most significant reform of the MHS in 30 years, more time was required to complete the planning to finalize the operational details of the Department’s proposed framework for the implementation of 10 U.S.C. §1073c. Therefore, the Department provided an interim report in March and now presents this final implementation plan and report.

This final report is organized according to the statutory specifications for the elements of the final implementation plan:

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

This report describes how the Secretary will carry out 10 U.S.C. §1073c using a streamlined organizational model that standardizes the delivery of care across the MHS with less overhead, more timely policy-making, and a transparent process for oversight and measurement of performance. The Department is redesigning governance, management processes and organizational design from the level of the Office of the Secretary of Defense down to MTFs.



B. Military Health System Governance

Then Deputy Secretary of Defense Ashton Carter signed a memorandum on March 11, 2013, “Implementation of Military Health System Governance Reform,” to establish governance bodies in support of MHS policy and management decision-making. Following this memorandum, the MHS leadership established a series of chartered councils, advisory groups and other intra-agency work groups to recommend and support actions by senior leaders.

The Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)), the Defense Health Agency (DHA), the Joint Staff Surgeon (JSS), and Army, Navy, and Air Force Surgeons General work collaboratively to make these decisions in the areas of clinical, financial, personnel policy and implementation of these policies. For strategic policy decisions, the senior leaders advise the Assistant Secretary of Defense for Health Affairs (ASD(HA)) in support of the ASD(HA)’s policy-making authority.

MHS Governance, as it currently stands, continues to be based on a broad set of councils, work groups, integrated product teams and other formally-chartered working groups as well as *ad hoc* working groups that often require unanimous support to advance initiatives and change. These governance bodies consume a significant amount of time and personnel resources. The result is often a sclerotic decision-making process that has the effect of demoralizing staff and other stakeholders who seek to make timely improvements in MHS policy, readiness and health care delivery. To support the reforms included in the FY17 NDAA, the Department is significantly revising its governance bodies, which will be concentrated at strategic policy levels and focus on oversight and establishing clear performance accountability vested with individuals and not committees. The DHA Director will be provided with the authority that Congress has granted to manage both enterprise support activities and MTFs.

(1) Governance Reform

MHS Governance will shift its focus from consensus-driven bodies that address both policy and management issues to a smaller, more streamlined set of oversight councils that focus on high-level, MHS-wide policy and budgetary matters. Functions pertaining to the administration and management of MTFs will be led by DHA. Functions unique to Service-specific operational readiness matters will continue to be executed by the Services. Matters that have both Service and DHA equity will be resolved by ASD(HA) with the advice and assistance of an updated MHS Governance model.

The ASD(HA) will continue to be the decisional authority and lead oversight for the Military Health System, consistent with DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs.” Only issues that require adjudication from the ASD(HA) (or higher) and input from all Components will be adjudicated through governance processes. A core principle of governance empowers decision-making by the entities with the responsibility for execution. Unanimity is not required. Decision-making authority will be vested with the responsible individuals as per Department policy.



Management and policy implementation matters related to health care delivery within MTFs will be organized and executed by the DHA. Those matters related to operational medicine and Service-managed installation functions separate from health delivery and MTF operations will be managed by the Military Medical Departments.

(2) Financial Management Reform

NDAA 2017 legislation provides the opportunity to restructure the MHS to correct long-standing deficiencies with the MHS's financial management systems, business processes, and material internal control and financial reporting that have continued to negatively affect the MHS's ability to best manage the Defense Health Program (DHP). Having sound, standardized financial management practices and reliable, useful, and timely financial and performance information is important to ensure accountability over DHP's extensive resources and efficiently and economically manage the MHS's assets and budgets.

The USD(P&R) implementation guidance issued April 25, 2018 regarding 10 U.S.C. §1073c, clarifies that the ASD(HA) will be responsible for the Planning, Programming, Budgeting, and Execution (PPBE) processes and will provide guidance to the Director, DHA, and to the Service Medical Departments. The DHA will be responsible for the PPBE portion of the DHP for both DHA operations and those of the MTFs and Intermediate Management Organizations (IMOs). MTF Directors retain flexibility to manage their DHP-budgeted allotment during the year of execution, within the DHA-provided fiscal policies and controls. The Service Medical Departments will be responsible for the PPBE portion of the DHP operational readiness activities and will retain flexibility to manage those funds under the direction and guidance of the ASD(HA) and the Military Department Secretaries. The ASD(HA) will consolidate DHP PPBE products for the Department for submission through the USD(P&R) to the Under Secretary (Comptroller) Chief Financial Officer. It is within this framework that the future resource requirements will be determined.

(a) Phase I Readiness/Healthcare Delivery Funding:

On 1 October 2018, DHP financial execution process for Phase 1 sites will be tested (Phased Implementation is described in the next section of this report). This effort required the establishment of a clear resource baseline for operational readiness and healthcare delivery to not only support the Phase 1 facilities but to also support the FY 2020-2024 Program Objective Memorandum/Budget Estimate Submission in order to systematically realign funding from the Services to the DHA. Some key assumptions made during this process include:

- (i) The DHA plans to have the ability to manage and oversee financial execution for Phase 1 MTFs starting on 1 October 2018. Only if DHA does not have full capability by then, financial distribution & execution will be through Service financial systems for Phase 1 MTFs, and responsibilities documented through a Memorandum of Agreement (MOA).
- (ii) The Services are responsible for financial execution for military manpower and operational and installation specific non-MTF associated commands of health-related activities (Readiness) and for non-Phase 1 MTFs.

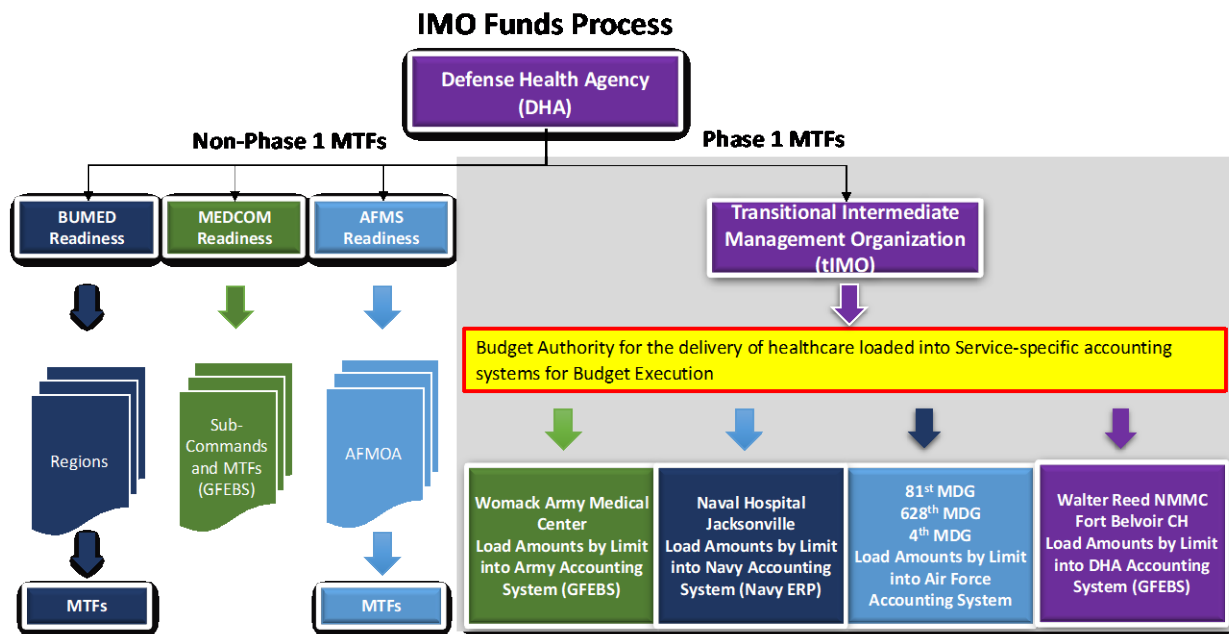


- (iii) The DHA will be responsible for financial execution for MTF activities (Healthcare Delivery & Operations).
- (iv) The DHA will assume management responsibilities for civilian employees and contractor personnel performing health care delivery functions and operations in accordance with the phasing plan. They will transition from Service documented and support systems to DHA manpower documents and civilian support and contract management.
- (v) The Medicare Eligible Retiree Health Care Fund (MERHCF) level of effort will remain the same. MTFs will not increase over-65 patient empanelment without prior approval from DHA.

(b) DHP Funds Flow

The goal in redesigning funds flow was to make the process as simple as possible at the MTF level and sustainable for future phases. In keeping with desired end state of operating MTFs through an Intermediate Management Organization (IMO) structure the following funds flow was developed to facilitate this concept. **FIGURE 1** depicts this high-level funds flow.

FIGURE 1: IMO Funds Process for Phase I facilities



For more details on the new PPBE processes, see the Financial Concept of Operations, **APPENDIX 1**.



C. Defense Health Agency (DHA) Management and Administration of MTFs

On March 20, 2018, the USD(P&R) directed the ASD(HA) to lead the development of the Department’s integrated implementation plan, unifying authority and accountability for implementation of 10 U.S.C. §1073c. On May 22, 2018, USD(P&R) in a memorandum titled “Construct for Implementation of section 702” provided clear direction to the Military Departments, Office of the ASD (HA) and the DHA on the foundation of this plan. The complete memo is provided at **APPENDIX 2**. Specific elements from that memorandum are excerpted in the following sections.

In developing the internal Implementation Plan, leaders from the Office of the Secretary of Defense (OSD) and the Military Departments arrived at a set of principles that informed the final organizational structure and decision-making process. Certain seminal principles pertain to all affected officials, organizations, and personnel, in all geographic locations, and in all circumstances, as follows:

- The drive for operational readiness and support of operational and war fighting missions take primacy over the delivery of clinical/health care services and the execution of business operations in an MTF. To this end, each Military Department will have unrestricted access to its military medical personnel for all validated war fighting and operational requirements, including both planned and unplanned deployments, military operations, and exercises. DHA consent is not required to deploy uniformed military medical personnel assigned to a position on a Service Manpower Document but allocated against a manpower requirement on a DHA MTF Joint Table of Distribution (JTD) with duty at the MTF, and DHA will fully support the deployment of such personnel. Each Military Department will exercise due care in establishing clinical and non-clinical training requirements applicable to military medical personnel and will provide as much advance notice to DHA as practicable of any requirement that uniformed military medical personnel assigned to a position on a Service Manpower Document but allocated against a billet on a DHA MTF JTD with duty at the MTF, participate in such training. DHA will work to facilitate Military Department access to uniformed military medical personnel for such purposes.
- In the interests of achieving and sustaining operational readiness and ensuring quality, access, and continuity in the delivery of clinical/health care services to members of the Armed Forces and other authorized beneficiaries, MTFs will be the default choice for the assignment, allocation, detail, or other utilization of military medical personnel for purposes of generating operational medical readiness. Such default is subject to the capacity of the MTF to afford military medical personnel opportunities to obtain and maintain currency in the clinical Knowledge, Skills, and Abilities (KSAs) associated with their medical specialties and communities, at or above minimum established thresholds. Consistent with congressional direction in section 706 and 708 of NDAA17, if operational medical readiness needs are unable to be met through the MTF, the DHA Director will establish military and civilian partnership as may be necessary and appropriate for military medical personnel to obtain and maintain currency and clinical KSAs associated with their medical specialty. All military personnel of the Military Department concerned will be assigned to the Service Manpower Document.



- The Secretaries of the Military Departments and the USD(P&R), together with the officials, organizations, and personnel subordinate to them, will take all necessary and appropriate actions to ensure that their exercise of duties, authorities, and responsibilities, and their relationships, are marked by all due collaboration, coordination, and consultation, in the best interests of a “ready medical force” and a “medically ready force,” the MHS enterprise, and the national defense.

Key features of the DoD approach to this implementation are:

(1) Phased Implementation

In light of the enormity of the changes required by 10 U.S.C. §1073c, Department leaders determined that a phased approach will introduce less risk and provide an opportunity to adjust as the implementation progresses. The Department has requested legislative revisions that will grant the ability to implement 10 U.S.C. §1073c under a phased implementation approach as well as grant the Secretary the authority to waive specific requirements of 10 U.S.C. §1073c if the Secretary determines such waiver is necessary for implementation feasibility or military readiness. Transfer of authority, direction and control (ADC) of the MTFs will be accomplished through a three-year, phased approach. Beginning October 1, 2018, all MTFs within the MHS, whether under Service command or DHA administration and management, will adhere to the same DHA-established policies, procedures, and standard clinical and business processes. In the absence of published DHA issuances, current Military Department (MILDP) policies and procedures will remain in effect until superseded by the appropriate DHA issuance. DHA is now consolidating separate Service policies and is in the process of establishing and prioritizing common standards, policies, and procedures. This process is described in more detail in Section III of this report.

The phases and timelines identified in the following section reflect “no later than” dates. If the Department can accelerate transition timelines, based on DHA meeting conditions set by the Department to assume ADC over MTFs, the completion dates may be pushed forward.

1. Phase 0 – Shape (Present to 30 September 2018): This phase is defined as the activity required for DHA to assume administration for all MTFs, and the transfer of ADC for specified MTFs to the DHA (i.e., authority, direction & control). The following MTFs have been identified as the first transitioning MTFs (tMTFs) that are either already under DHA ADC or directly transitioning to DHA management on 1 October 2018.
 - i. Walter Reed National Military Medical Center
 - ii. Fort Belvoir Community Hospital – and associated clinics (Dumfries Health Center, Fairfax Health Center, DiLorenzo (Pentagon) TRICARE Health Clinic).
 - iii. Womack Army Medical Center and all associated clinics (Bragg Clinic, OHC NSG Off-Sunny Point, Troop & Family Med Clinic-Bragg, WAMC-VA Fay Rehab Clinic-Bragg, CBMH Fayetteville-Bragg, CBMH Hope Mills-Bragg, CBMH Linden Oaks-Bragg, EBH East Bragg Clinic-Bragg, EBH West Bragg Clinic-Bragg, NICOE-Intrepid Spirit-Bragg, Robinson Clinic-Bragg, Joel Clinic-Bragg, and Clark Clinic-Bragg).

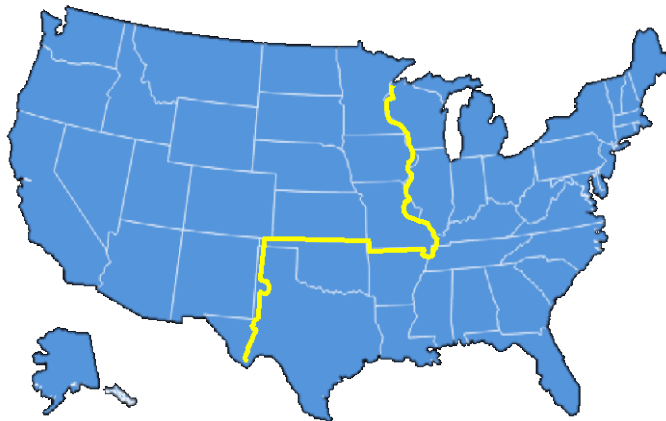


- iv. Naval Hospital Jacksonville and all associated clinics (Navy Branch Health Clinic (BHC) Albany, BHC Jacksonville, BHC Key West, BHC Kings Bay and BHC Mayport).
- v. 81st Medical Group (Keesler AFB - Biloxi, MS)
- vi. 628th Medical Group (Joint Base Charleston - Charleston, SC)
- vii. 4th Medical Group (Seymour-Johnson AFB - Goldsboro, NC).

DHA will guide its administrative and management responsibilities through the transitional DHA IMO, hereafter referred to as tIMO that will support the Phase 1 MTFs (tMTFs). DHA will execute administration and management through the issuance of standardized, enterprise-wide policies, processes and practices for clinical/health delivery services and business operations within the MTFs. All Service policies and procedures will remain in effect until such time they are superseded by DHA issuances as appropriate.

- 2. Phase 1 – Initial Transition (1 October 2018 to 30 September 2019): This phase is defined as the tMTFs coming under the ADC of the DHA. During this year, there may be some MTF functions administered by the DHA with support from the Services. The transition planning for the remaining MTFs that reside in the “East Region,” to include establishing IMOs in the East Region, will begin at this time. A map depicting the East and West Regions in the US is shown at **FIGURE 2**. The regional break-out is aligned with the TRICARE regions (with the exception of Hawaii). Phase 2 MTFs (i.e., the remainder of the MTFs in the East Region) will develop a Quadruple Aim Performance Plan (QPP) in the first quarter of FY19 to assist with the transition of performance plans, programs, and budgets. This QPP will be the basis for funding when these MTFs transition to the DHA in FY20. The DHA will establish its IMOs over the remaining East Region MTFs. The Services will utilize existing protocols to appoint MTF Directors, who will generally be dual-hatted as MTF Director and Service Commander. During Phase 1, DHA will increase its functional capability with the support of the Services to such time as that Service support is no longer needed and functions are fully executed by DHA. The organization of IMOs is described further in the next section of this report (Section I.C.(2)), DHA Headquarters and Intermediate Management Organizations).

FIGURE 2: EAST and WEST REGION



3. Phase 2 – East Region Transition (NLT 1 October 2019): This phase was previously described in the March 2018 interim report as transfer of MTFs from “MHS Regions 1, 2, and 3”. Phase 2 is defined as full implementation IMO oversight of all MTFs in the East Region (~60 percent of U.S. MTFs) to DHA ADC, and the beginning of planning and execution for the transition of MTFs and establishing required IMOs in the West Region. The East Region IMOs will be established by this date. Phase 2 MTFs will have developed a Quadruple Aim Performance Plan (QPP) in the first quarter of FY19 to assist with the transition of performance plans, programs, and budgets. The QPP will be the basis for funding when these MTFs transition to the DHA. The Services will utilize existing protocols to appoint MTF Directors.
4. Phase 3 – West Region Transition (NLT 1 October 2020): This phase was previously described in the March 2018 interim report as MHS Regions 4 and 5 and is now called the “West Region.” Phase 3 MTFs will have developed a Quadruple Aim Performance Plan (QPP) in the first quarter of FY20 to assist with the transition of performance plans, programs, and budgets. This phase is defined as full implementation of the IMOs oversight of MTFs in West Region, thus completing the full implementation of DHA ADC over all MTFs in the United States and the achievement and sustainment of the desired end state as provided in 10 U.S.C. §1073c.
5. Phase 4 – Outside United States Transition (NLT 1 October 2021): This phase is defined as full implementation of the IMOs oversight of all MTFs outside the United States and the achievement and sustainment of the desired end state as provided in 10 U.S.C. §1073c. All DoD will have developed a Quadruple Aim Performance Plan (QPP) in the first quarter of FY21 to assist with the transition of performance plans, programs, and budgets. (The date of 1 October 2021 referred to in this paragraph assumes the enactment of legislation allowing such a date.)

(2) DHA Headquarters and Intermediate Management Organizations

The Director, DHA is responsible for the administration and management of all MTFs, including the delivery of clinical/health care services and business operations in support of both operational readiness and beneficiary care. The DHA will reconfigure to accept the added responsibilities called for in 10 U.S.C. §1073c while continuing ongoing operations as a Combat Support Agency in accordance with DoD Instruction 3000.06, Combat Support Agencies.

The DHA serves as the headquarters for the administration and management of the MTFs, bringing direct and purchased care into a single integrated healthcare system. The Director of the DHA will be responsible for the administration of each MTF through DHA-established IMOs with respect to budgetary matters, information technology, health care administration and management, administrative policy and procedure, military medical construction, and all other MTF operations.

The DHA Director has designated three Assistant Directors: Assistant Director for Health Care Administration (HCA) (AD(HCA)), Assistant Director for Management (AD(M)), and Assistant Director for Combat Support Agency operations (AD(CSA)).



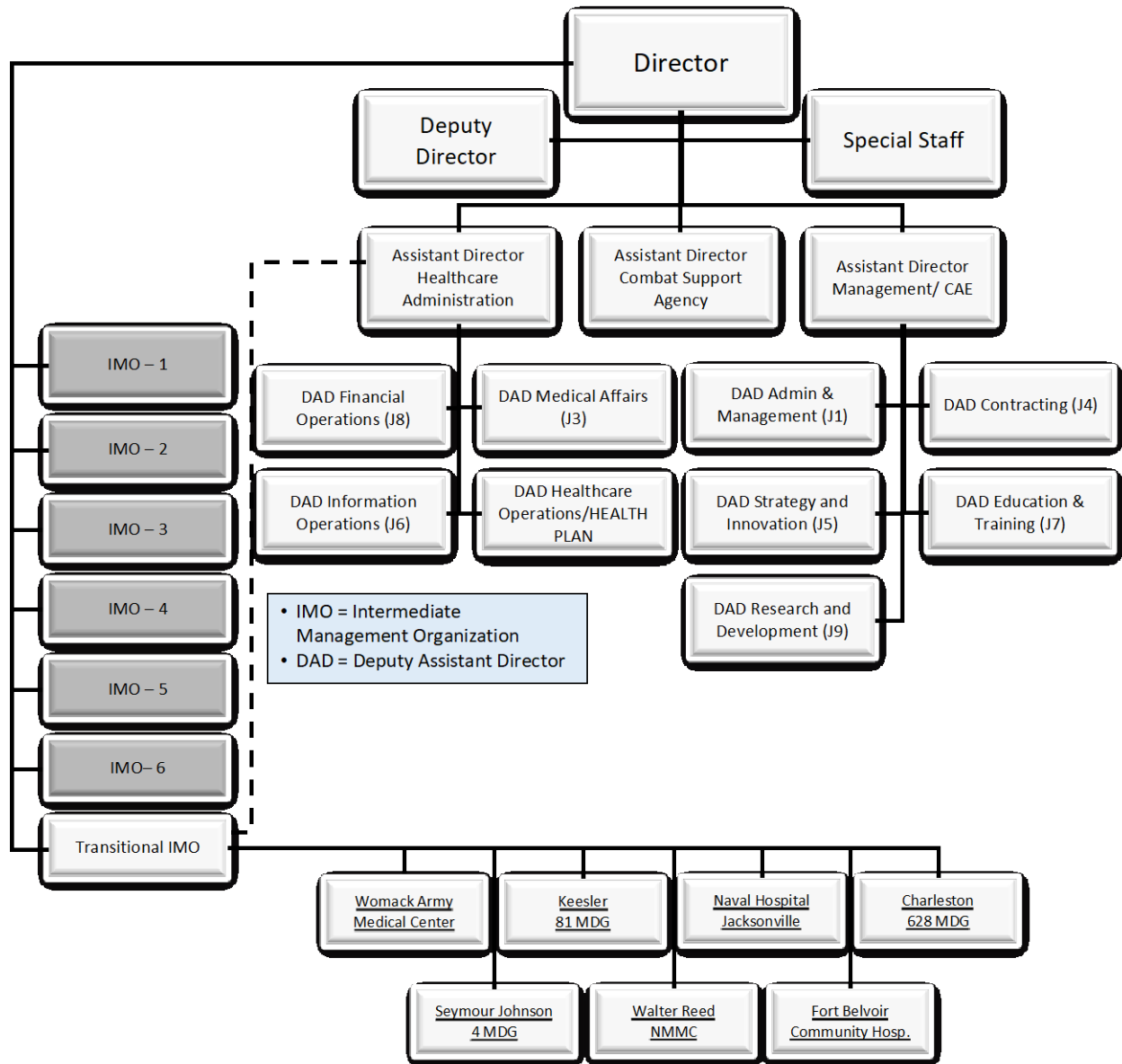
The DHA Director will exercise authorities through the three ADs to meet the DHA’s missions and will retain direct control and accountability over the leadership of the designated IMOs and the MTF Directors under DHA’s control.

The AD(HCA) has four Deputy Assistant Directors, as stipulated in 10 U.S.C. §1073c, along with other staff necessary for the AD(HCA) to meet congressional intent, and enable the oversight and management of all MTFs under the authority, direction, and control of the DHA Director.

All MTFs within the MHS, whether under Service command or DHA administration and management, will be required to adhere to the same policies, procedures, and standard clinical and business processes as these are established, beginning not later than October 1, 2018. In the absence of published DHA issuances, current Military Department (MILDEP) policies and procedures will remain in effect until superseded by the appropriate DHA issuance. Development of these healthcare system-wide standards, policies, and procedures is the responsibility of the DHA. The DHA organizational structure to direct enterprise support activities and manage transitioning MTFs in Phase 1 is depicted at **FIGURE 3**.



FIGURE 3: DHA Organizational Chart (Phase 1)



DHA is establishing IMOs to assist with span of control in the management and administration of MTFs. The IMOs will be tailored by the health care services delivered in the medical facilities consistent with the categorization in section 703 of FY17 NDAA (i.e., medical centers, hospitals, clinics) and then by geographic region. The two types of IMO are Market/Platform IMOs and Community IMOs:

- Market/Platform IMOs manage MTFs that deliver comprehensive specialty and subspecialty inpatient and ambulatory health care services to support medical readiness.

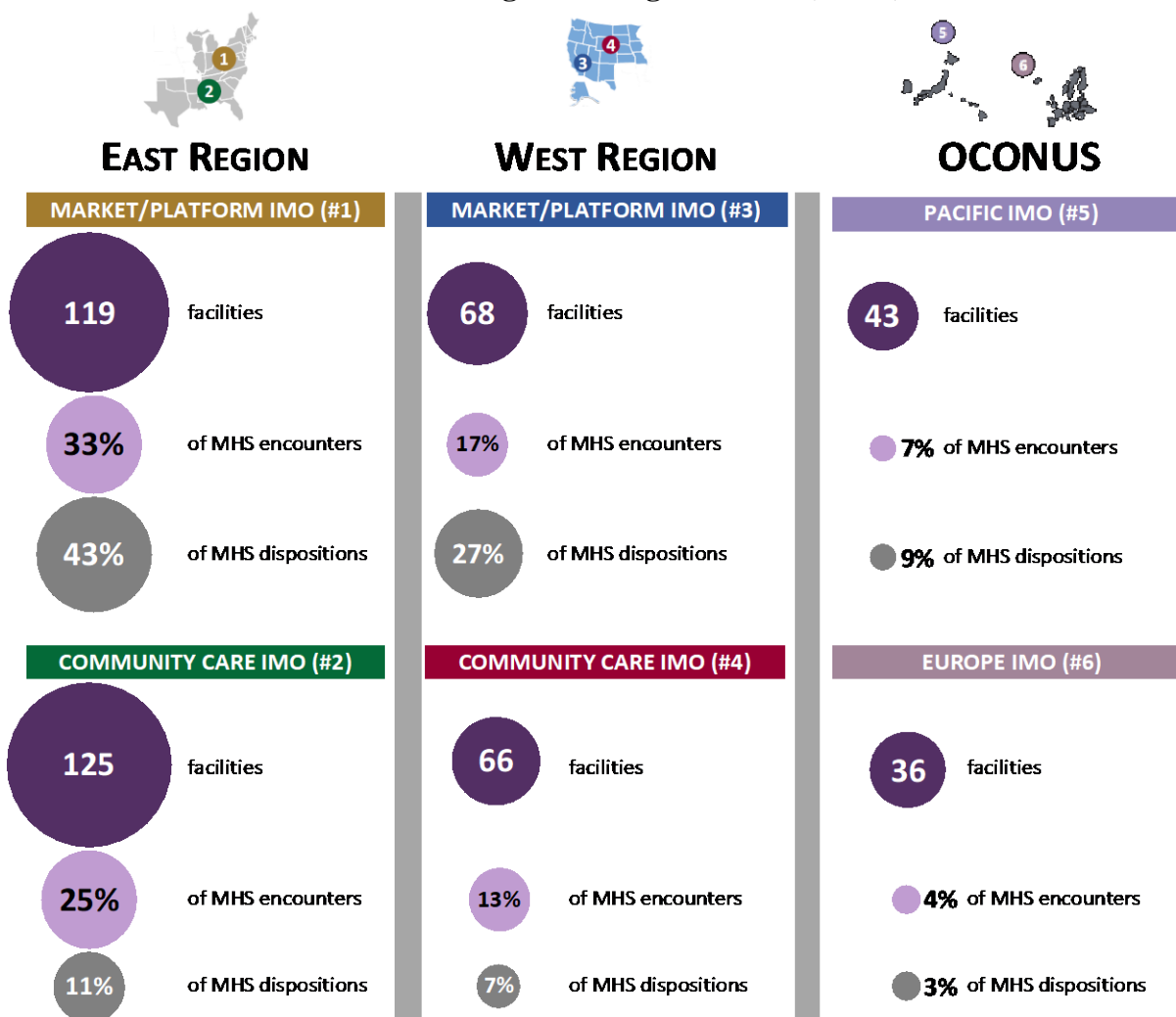


- Community IMOs manage MTFs that deliver ambulatory and limited specialty and inpatient health care services to support medical readiness of beneficiaries outside of Medical Center markets with greater reliance on purchased care for specialty services.

DHA will phase-in six IMOs during the course of the transition. The six IMOs consist of a Market IMO and Community Care IMO in both the East and West regions as well as two OCONUS IMOs, one within the Indo-Pacific Command (INDOPACOM) and one within the European command (EUCOM)/Africa Command (AFRICOM)/Central Command (CENTCOM) regions. SOUTHCOM, where there are no MTFs, will be managed directly from DHA headquarters. This model will facilitate management specialization, oversight and support to groups of MTFs with similar functions and geographic region. DHA HQ and IMO manpower requirements will be documented on Joint Tables of Distribution.

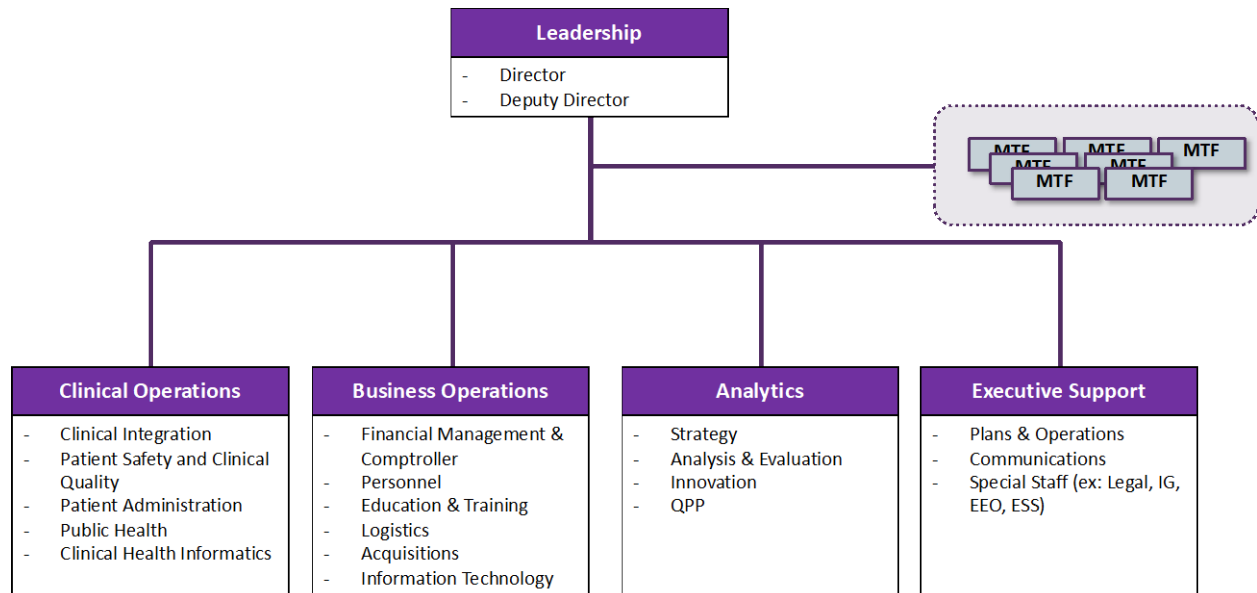
The phased IMO final structure is shown below in **FIGURE 4**. A comprehensive listing of MTFs assigned to each IMO is provided in **APPENDIX 3**.

FIGURE 4: DHA Intermediate Management Organizations (IMOs) at End State



In order to minimize headquarters overhead growth during the transition period, DHA’s National Capital Region Medical Directorate (NCR MD) will be organized to perform the IMO functions during Phases 0 and I for those MTFs currently under or transitioning to DHA administration and management. The tIMO will be located at Walter Reed National Military Medical Center. The planned IMO structure for Phase 1 is shown in **FIGURE 5**.

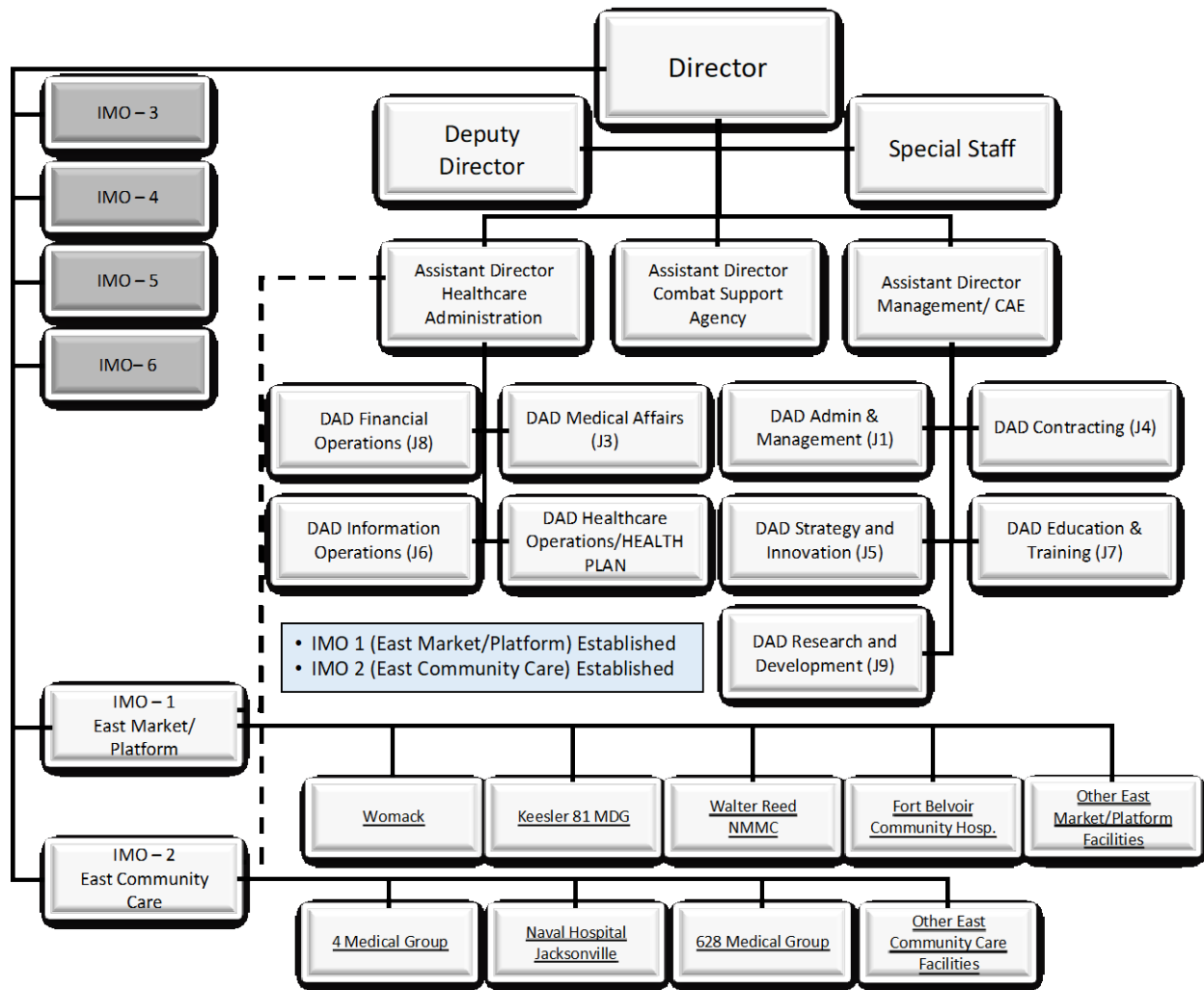
FIGURE 5: IMO Organizational Chart



As the transition further unfolds, the DHA organizational oversight of the MTFs will mature. Beginning in FY19, a new IMO for Community Care will be established, and other medical centers from the East Region will be aligned under the IMO-1 (Market Platform). (**FIGURE 6**).

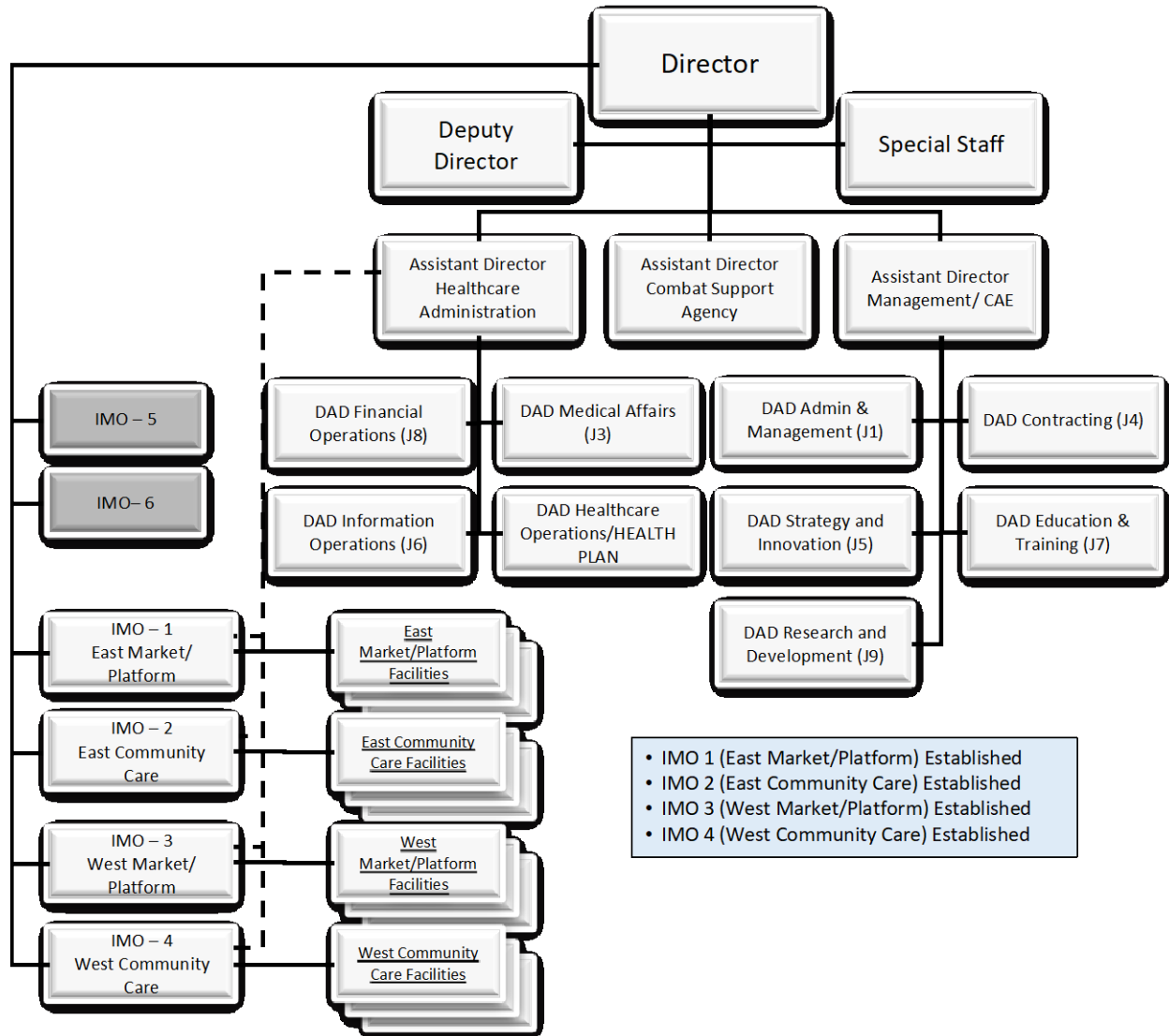


FIGURE 6: DHA Organizational Chart (Phase 2)



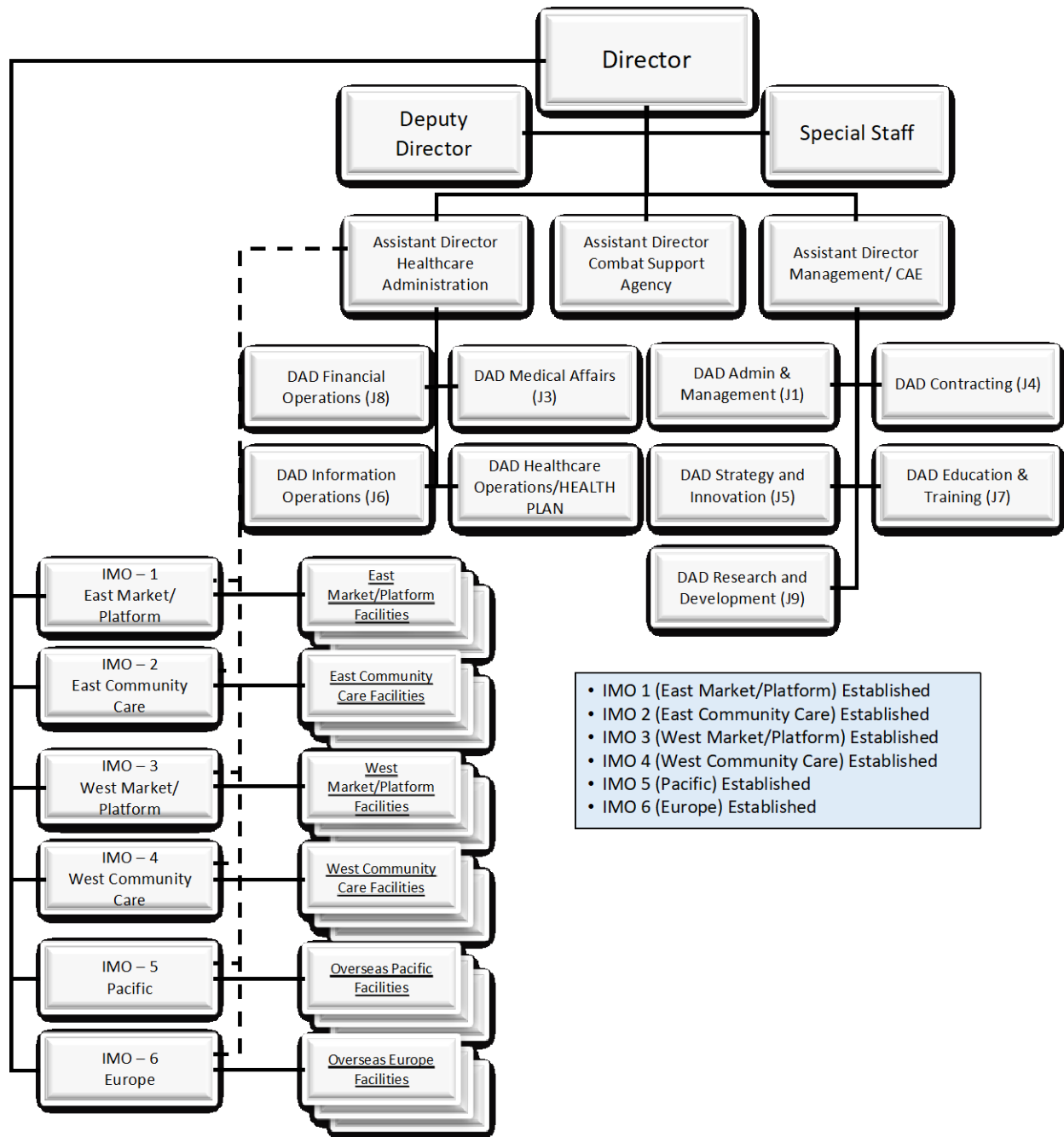
In FY20, all remaining US-based MTFs will transition to the DHA, and two IMO s will be established in the West for Market and Community-based platforms (FIGURE 7).

FIGURE 7: DHA Organizational Chart (Phase 3)



By October 1, 2021, all MTFs will have fully transitioned to the DHA. IMOs for Europe and Pacific will be established and finalized (FIGURE 8).

FIGURE 8: DHA Organizational Chart (Phase 4 / Final)



(3) Service Headquarters and Intermediate Management Commands/Organizations

The Services understand the criticality and value of partnering with DHA to ensure successful transition of administration and management of all MTFs and to realize efficiencies to the greatest extent possible. The Services continue to finalize the specific structure and staffing of their headquarters and intermediate commands in collaboration with DHA. Organizational restructuring will optimize command and staff structures within the Services to meet operational requirements while supporting the transfer of MTF-based roles and responsibilities to DHA.

At the end state, the Services will have transitioned all MTF-associated health care delivery functions to DHA, achieved efficiencies by eliminating duplicative headquarters activities, and restructured Service intermediate commands to best support operational imperatives for its line commanders.

Work continues by the Services to finalize these structures. Health Affairs, DHA and the Services have been closely coordinating their respective Concepts of Operations (CONOPS) to ensure alignment with Department policies, congressional direction, and Service doctrine. The final state of Service intermediate commands and headquarters described in this report may be adjusted as planning and implementation continues. The following sections outline evolving Service intermediate commands and their relationship to the DHA headquarters and DHA IMOs.

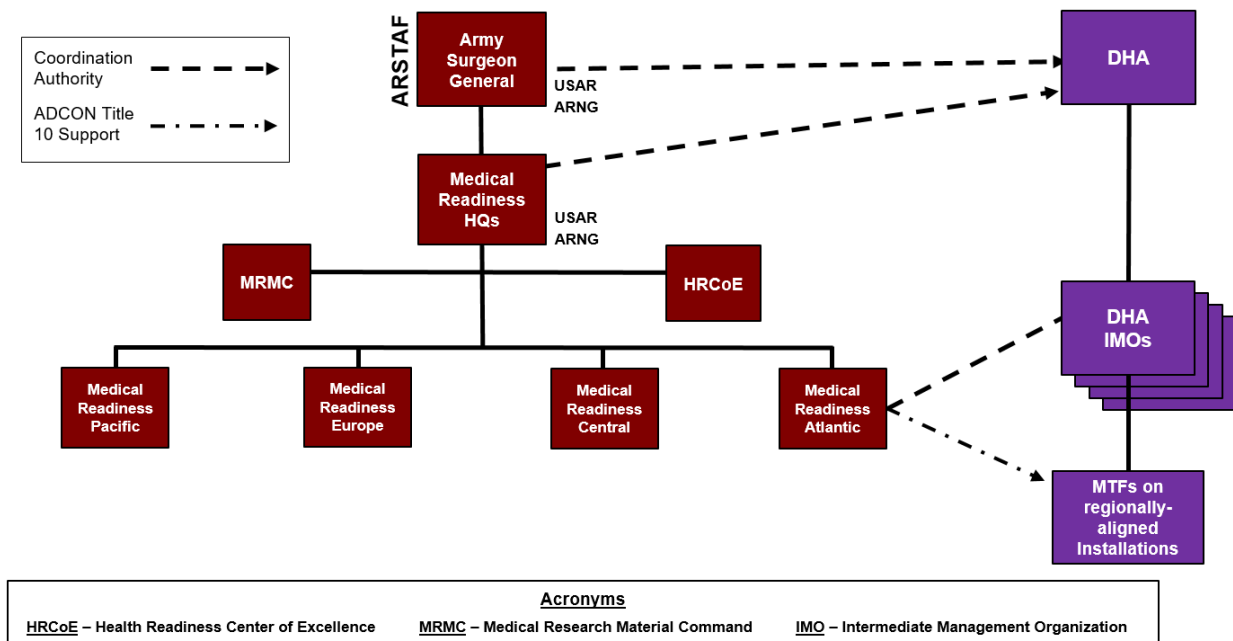
(a) Army Medicine

The Army's objective is to maximize Service readiness by transforming each echelon in a manner that balances the Secretary of the Army's responsibilities and DHA objectives. DHA IMOs will subsume Army Regional Health Command (RHC) responsibilities for oversight, administration, and management of MTFs and healthcare delivery while Army's medical headquarters, Medical Command (MEDCOM) staff will downsize to align with the change to its roles, responsibilities, and authorities. Moreover, RHCs will transform and realign to best support Headquarters, Department of the Army (HQDA) priorities and the Army Reform Initiative with direct support to applicable Army organizations allows for a flexible, tailored approach to medical support to the Total Force with varying needs and requirements. The Army will continue to reorganize the medical structure to support the Total Force under the Army Reform Initiative.

FIGURE 9 is the initial proposed composition of the Office of the Surgeon General (OTSG), Medical Readiness Command, and subordinate organizations after divestiture of health care delivery activities to DHA.



FIGURE 9: Proposed Army Medical Readiness Command HQ Organizational Structure



Medical Readiness Organizations will initially consolidate their functions in place and examine collocating with supported organizations. The Medical Readiness Command-Atlantic will be located initially at Fort Belvoir, VA. The Medical Readiness Organization-Central will be located initially at Joint Base San Antonio (JBSA), TX. Both organizations will work with the Surgeon Cells at U.S. Army Forces Command (FORSCOM), Training and Doctrine Command (TRADOC), Army Materiel Command, and Army Futures Command. Medical Readiness Organization-Europe will be located at Sembach Kaserne, Germany and Medical Readiness Organization-Pacific will be located at Fort Shafter, HI and Joint Base Lewis McChord (JBLM).

The intermediate Army Medical Readiness Organizations have coordinating authority with the respective DHA IMO and are in direct support of their corresponding Army commands. Army Medicine will project and communicate readiness requirements derived from training and operational plans to DHA to deconflict personnel demands. The Army will use its liaison function with DHA to actively communicate these requirements as quickly as possible. The Surgeon General (SG) will continue to serve as the principal advisor to the Secretary of the Army and the Chief of Staff of the Army on all health and medical matters of the Army, including strategic planning and policy development. The SG, acting under the authority, direction, and control of the Secretary of the Army Title 10 will recruit, organize, train, and equip, medical personnel of the Army. The SG and staff will coordinate operational requirements with DHA and advise the Director of the DHA on matters pertaining to military health readiness requirements and safety of members of the Army.



(b) Navy Medicine

Navy Medicine (NAVMED) will transform from the current medical treatment facility (MTF) centric paradigm into a mission focused Navy Medical Readiness and Training Command (NMRTC) construct and operating model. This construct will ensure:

- Command and Control (C2) of Navy Military Personnel
- Command Structure Through the Navy
- Agility to Rapidly Deploy Medical Personnel
- Control and Oversight of Resources for Department of Navy missions
- Flexibility in MTF Operations to Support Operational Tempo
- Single Navy Medicine Point of Contact for Fleet/Fleet Marine Force Line Commanders

The Service medical department structure at the intermediate command level will be an interim structure required to support the NMRTC and current MTF functional requirements until those current functions (and associated resources) related to administration and management of the MTFs are transferred to DHA according to the transition phasing. After divestiture of administration and management responsibilities of MTFs, the headquarters and intermediate commands will be streamlined, with a smaller footprint, to optimize the effectiveness of the Service in executing Service specific functions and missions. Navy will continue to identify efficiencies as planning and transition progresses.

The organizational structure is focused on meeting the medical readiness needs of the operational units (Warfighter Optimization) as well as more proactive, deliberate facilitation of the development of clinical and operational currency and competency of the Medical Force (Expeditionary Medicine). The foundation of the construct will be the Quadruple Aim Performance Plan, an agreement between the DHA and the Service that details the functions, and that will document the workload that will be available to the NMRTC to maintain currency of their personnel. These Service directed commands will be responsible and accountable for the following functions:

Warfighter Optimization - NMRTCs will support the Line Commanders in maximizing lethality of the warfighter by improving medical readiness of their Sailors and Marines aligning the appropriate medical resources to meet their needs.

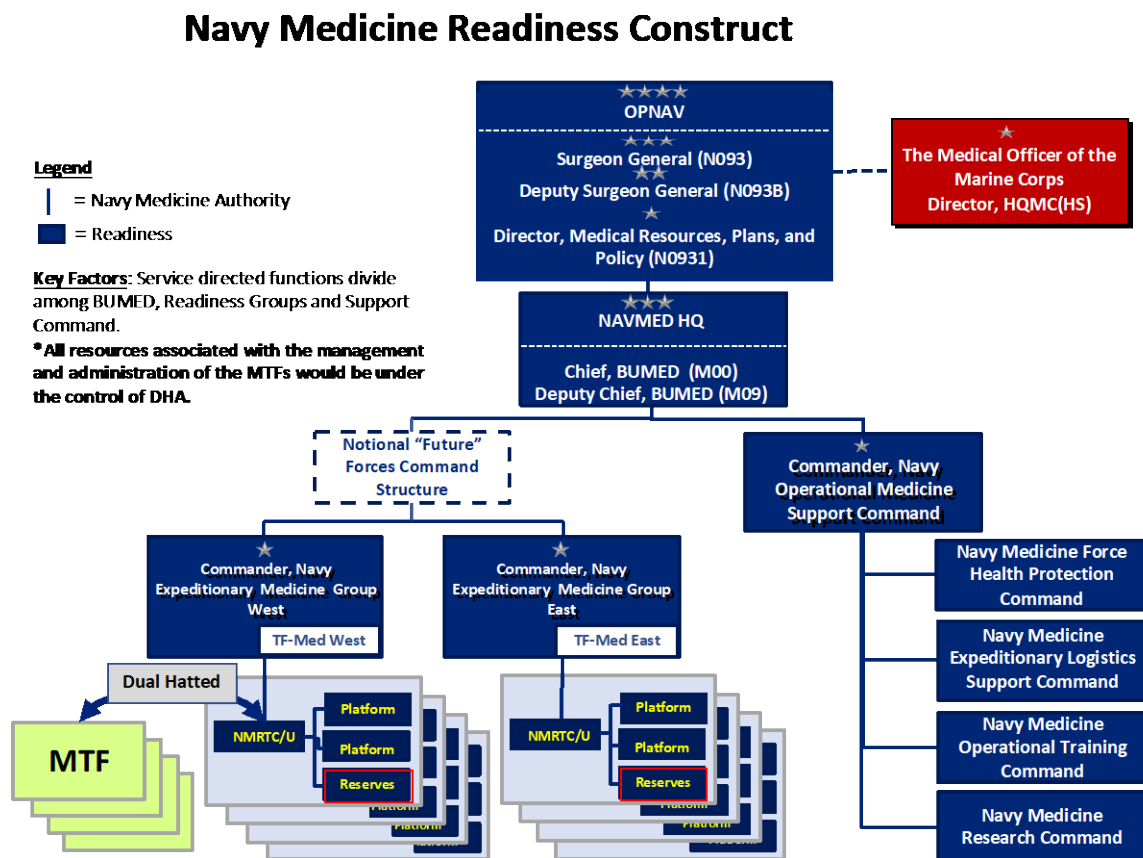
Expeditionary Medicine - To maintain high levels of survivability and to meet the operational demands of the future, Navy Medicine will prioritize MTFs as its readiness platforms ensuring that its Medical Force develops and maintains clinical currency and competency. Navy Medicine, through DHA, will explore partnerships with civilian institutions if an MTF cannot provide sufficient caseload to maintain clinical currency.

All military personnel will be assigned to NMRTCs. Select civil service and contract personnel currently only performing readiness related activities separate from MTF operations and health care delivery functions will be assigned to the NMRTCs.



Initially, Navy Medicine will re-organize current Navy Medicine Regional Commands into interim Navy Expeditionary Medicine Groups at the intermediate level and consolidate appropriate functions to optimize the readiness of NMRTCs. This structure will change as the needs and requirements of the MTFs and NMRTCs evolve and current administration and management of MTF functions transfer to the DHA throughout the phases of implementation. Additionally, this organizational structure may allow the regionalization of certain support elements of the NMRTC allowing more efficient and effective use of resources. The future state organizational construct for Navy Medicine is provided at **FIGURE 10**.

FIGURE 10: Proposed Notional Chain of Command Structure for Navy Medicine



(c) Air Force Medicine

The Air Force Medical Service (AFMS) is not structured as a medical command, but rather as an integral component of Air Force (AF) Line commands in support of AF Doctrine. As such, AFMS operational functions and current headquarters, field operating agencies, Major Commands (MAJCOMs), and MTF structures are distinctly different than those of the other Services. With the transfer of responsibility of the management and administration of MTF health care delivery to the DHA, the AFMS will undergo significant reform to maximize its ability to provide medically-ready forces and ready medical forces in support of Air Force operational missions and National Security priorities.



After reorganization, the Headquarters Air Force Surgeon General (SG) will consist of three directorates: Executive Services, Medical Manpower Personnel and Resourcing, and Operational Medicine and Research.

The SG’s Executive Services Directorate will directly support the Surgeon General, Deputy Surgeon General and AF/SG staff. The Directorate will be responsible for coordinating all internal and external tasks assigned to AF/SG, managing all SG publications, overseeing AF/SG officer and enlisted promotion activities, and managing internal programs. The Directorate will continue to work in close coordination with Secretary of the Air Force (SAF) and Headquarters Air Force (HAF) Directorates, DHA, AF/SG Directorates and Field Operating Activities (FOAs), MAJCOMs, and other federal and civilian health agencies, to effect maximum coordination and communication between the organizations.

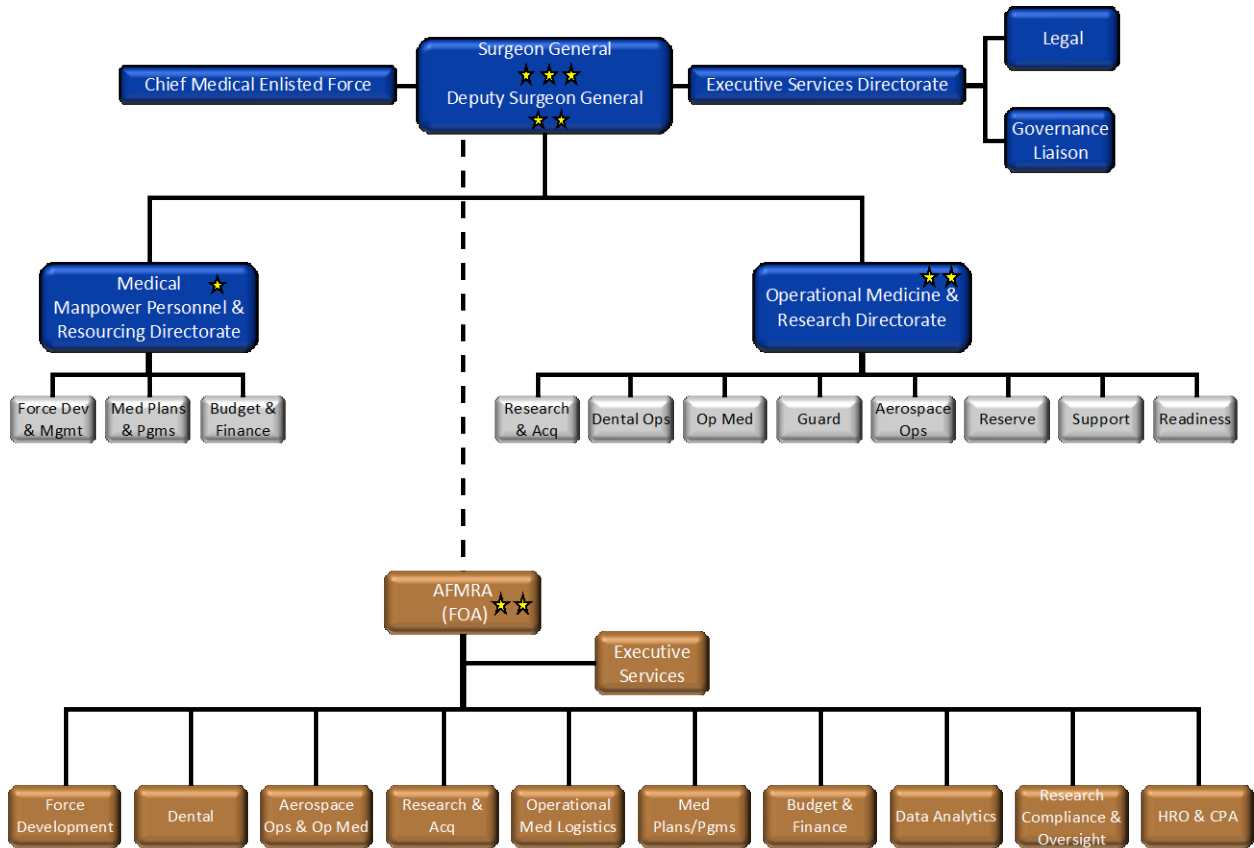
The Air Force Medical Manpower Personnel and Resourcing Directorate will be the primary directorate for Medical Force Development, Strategy, Plans and Programs, and Budget and Finance. This directorate: creates and influences policy and strategic direction for military and civilian medical accession, retention, force management and force development; builds AFMS strategic programs; analyzes AFMS core mission areas and reviews legislative, policy and operations as they relate to the total force to create a more unified AFMS that is fully integrated with Air National Guard and Air Force Reserve; provides financial execution of military manpower, operational and installation specific medical requirements to include non-MTF associated commands of health-related activities of the operational mission platform.

The Air Force Medical Operations and Research Directorate will be the primary staff office for defining and executing operational medicine and readiness. This Directorate will be the primary advisor to the Air Force Surgeon General on operational capability, requirements and the utilization of Air Force Medical Service personnel. This Directorate integrates emergency and contingency operations support to the SG via the Medical Operations Center (MOC), which will provide 24-hour emergency operations capability as the medical representative to the Air Force Crisis Action Team (CAT).

The Air Force Medical Services will reduce its headquarters/intermediate command “footprint” by creating one consolidated FOA consisting of the Air Force Medical Operations Agency (AFMOA) and the Air Force Medical Support Agency (AFMSA) to perform and execute the Service readiness and operational support functions. The single FOA, to be called the Air Force Medical Readiness Agency (AFMRA) pending approval from HAF/A1, will result in improved readiness, effectiveness, and efficiencies in cost and full time equivalents. AFMRA will liaise with DHA in order to provide direct Service support to MTFs in the execution of AFMS and DHA policies and programs, in coordination with, and while aligning efforts with MTF Directors, MAJCOM Command Surgeons, the MHS, other service branches and key mission partners. AFMRA will also support the AF/SG and the MAJCOMs in the execution of the operational medical mission, provide program support for a medically-ready force and medical force readiness in support of the Air Expeditionary Force construct, Joint Staff taskings, and related Request for Forces from Combatant Commands. The future, end state headquarters organization for the Air Force Surgeon General is provided at **FIGURE 11**.



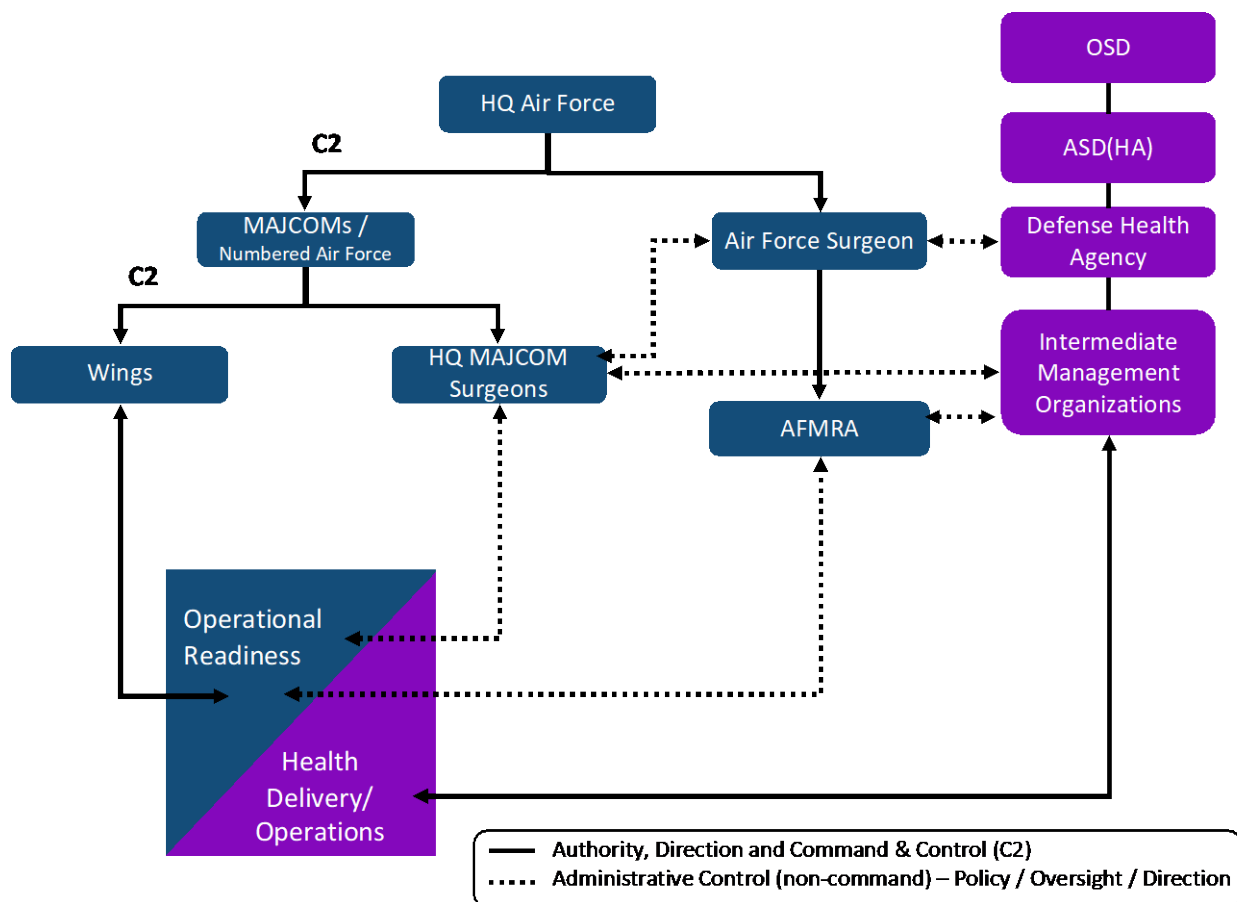
FIGURE 11: AF Surgeon General with AFMRA (End State with Single FOA)



The reporting and communications lines between MTFs on AF installations to both line leaders and the DHA structure are depicted in **FIGURE 12**.



FIGURE 12: AFMS and DHA Official Communication Flow (End State)



(4) MTF Management and Organizational Structure

The DHA will ensure the Military Departments (MILDEP) retain access to uniformed personnel working at MTFs to support the Services’ deployment and mission requirements. The Department established a comprehensive summary of structures, authorities and responsibilities, personnel rating relationships, and manpower documentation for MTF Directors and other personnel assigned to the MTFs. This document is included in the USD(P&R) Memorandum at **APPENDIX 2**. The significant policies regarding management of personnel include:

- As a general rule, at each MTF there will be a single military officer who will be dual-hatted as the MTF Director and the Service Commander. This dual-hatted officer will be referred to as the “MTF Director,” except when acting solely in his/her capacity as Service Commander, in which case, the officer will so state and will execute documents and issue direction over the title of “Service Commander.” The DHA Director, with the concurrence of the ASD(HA), may authorize exceptions to this general rule, including to permit a civilian employee to serve as an MTF Director; to make appropriate arrangements in jointly staffed National Capital Region MTFs; or upon request of the Secretary of the Military Department concerned, supported by a CONOPS that reflects



appropriate constraints on the number of staff supporting the Service Commander, to permit the positions of the MTF Director and Service Commander to be single-hatted (i.e., a different officer is assigned to each position).

- The dual-hatted MTF Director will be supported by, and exercise authority, direction, and control over a leadership team and staff in numbers and capabilities appropriate to the totality of his/her duties, authorities, and responsibilities. The leadership team and staff will report to the MTF Director.

(a) The Military Departments:

- Select the highest quality candidates for nomination to be an MTF Director and a Service Commander, in accordance with MILDEP policies and procedures, and consults with the Director, DHA to vet MTF Director nominees.
- After consultation with the Director, DHA, may remove the Service Commander from that position and/or relieve him/her of the authority to act in that capacity, in accordance with MILDEP policies and procedures.

(b) The Director, DHA:

- Consults with the Secretary of the MILDEP concerned to vet nominees submitted by the Secretary to be an MTF Director.
- With advance notice to the Secretary of the MILDEP concerned, may remove the MTF Director from that position, and/or relieve him/her of the authority to act in that capacity, in accordance with DHA policies and procedures.
- Acting by and through the MTF Director, determines the capacity of each MTF required to support both operational readiness and quality, access, and continuity in the delivery of clinical/health care services to members of the Armed Forces and other authorized beneficiaries.
- Acting by and through the MTF Director, exercises authority, direction, and control of all MTF operations and of all personnel assigned, allocated, detailed to, or otherwise utilized to perform duties and functions associated with MTF operations, including the delivery of clinical/health care services and MTF business operations.

(c) Manpower Documentation

There will be at least two manpower documents at each MTF: the DHA MTF Joint Table of Distribution (JTD) (i.e., the statement of MTF manpower requirements) and the Service Manpower Document.

The DHA MTF JTD will be generated by DHA. Subject to validation of enumerated requirements, authorizations, and force structure through appropriate processes, the JTD is the authoritative manpower document for the establishment and documentation of all DHA MTF manpower requirements and authorizations—including military manpower, uniformed service personnel (e.g., members of the U.S. Public Health Service), and civilian employees, in the numbers and capabilities required—associated with MTF operations, including but not limited to



the delivery of clinical/health care services and MTF business operations, at the capacity required, as determined by the Director, DHA.

The Service Manpower Document (e.g., Table of Distribution and Allowances, Activity Manpower Document, Unit Manpower Document) will be generated by the MILDEP concerned. Subject to validation of enumerated requirements, authorizations, and force structure through appropriate processes, the Service Manpower Document is the authoritative manpower document for the establishment and documentation of all MILDEP manpower requirements and authorizations—both military manpower and civilian employees, in the numbers and capabilities required—associated with the MILDEP’s execution of operational and installation-specific medical functions separate from the delivery of clinical/health care services in the MTF and MTF business operations, at the capacity required, as determined by the MILDEP concerned. All military personnel of the MILDEP concerned will be assigned to the Service Manpower Document.

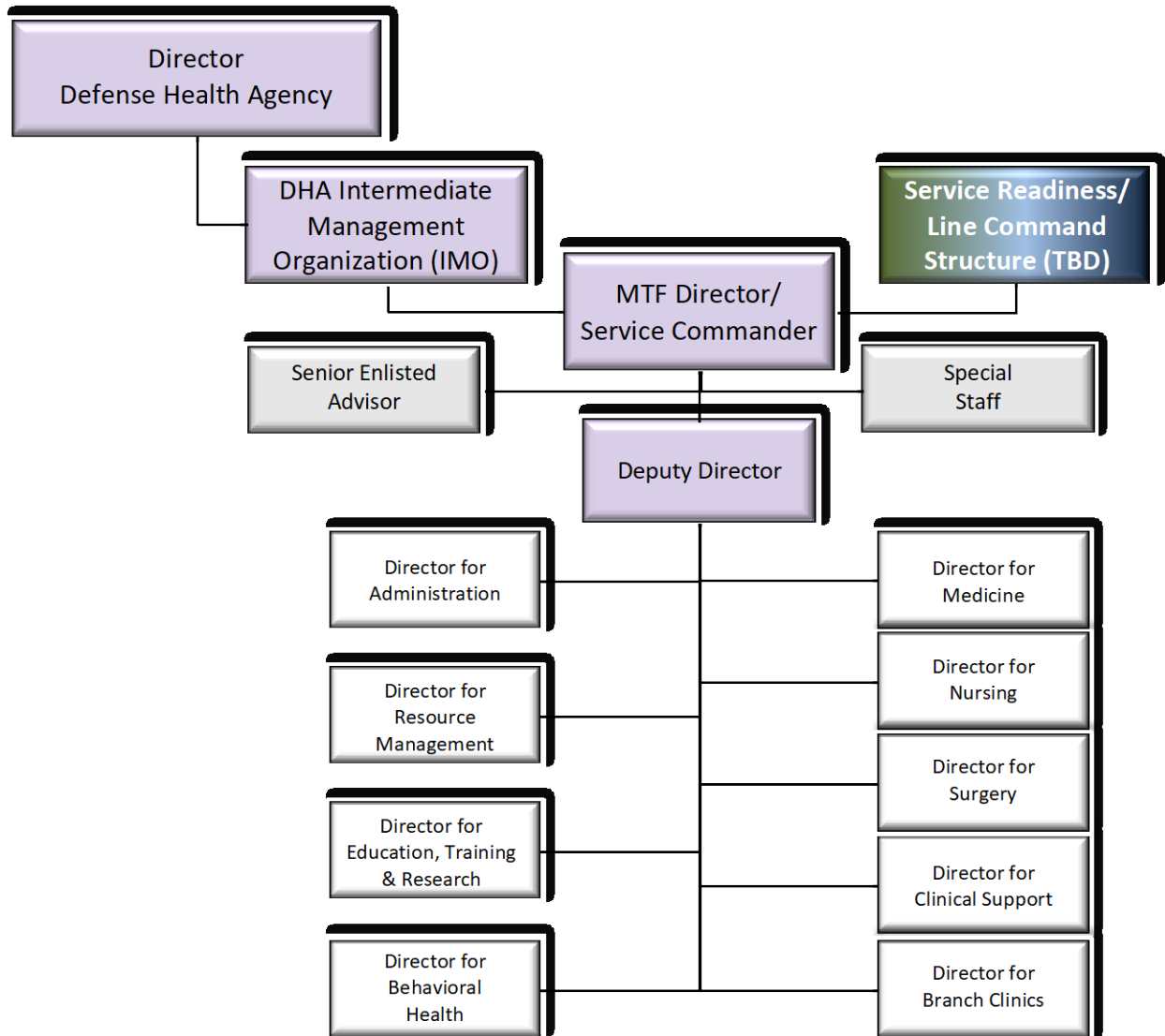
The MILDEPs will work with the DHA to ensure that, to the greatest extent practicable, the pool of military medical personnel assigned to a position on a Service Manpower Document and available for allocation against a position on the DHA MTF JTD, with duty at the MTF, are sufficient to meet Service readiness requirements (currency and competency). The Director, DHA will determine MTF capacity requirements reflected in the DHA MTF JTD manpower requirement structure for military medical personnel.

The DHA MTF JTD and Service Manpower Document will be reviewed and updated regularly to reflect MTF mission and capacity requirements, and MILDEP operational medical force readiness requirements, respectively. Over time, all manpower documents will be refined to reflect application of the single DoD process for defining the military medical and dental personnel requirements necessary to meet operational medical force readiness requirements, as required by section 721 of the NDAA for FY17. The DoD Program Budget Review will determine that more or fewer military manpower requirements and/or different capabilities are needed to execute DHA MTF or MILDEP missions to the required capacity, in a cost-effective and efficient manner.

On October 1, 2018, the MTFs being organized under the DHA will have structures that reflect their current Service command models. Over the phased implementation period, the DHA will develop a standardized MTF organizational structure that is adapted for medical center, hospital and clinic operations. The notional starting point for this MTF organizational structure is shown in **FIGURE 13**. The organizational charts for each tMTF in Phase 1 is provided at **APPENDIX 4**.



FIGURE 13: Notional Model MTF Organizational Structure



II. Efforts to eliminate duplicative activities by the elements of the DHA and the Military Departments

The Department is undertaking a comprehensive, validated analysis of the functions that will be performed at DHA and the MILDEPS, as well as the number of military and civilian medical personnel working at both headquarters and intermediate command organizations.

Eliminating duplicative activities at medical headquarters while improving the capability of the Department to more efficiently and effectively administer standardized clinical and business functions is an integral goal of this reform effort. The DHA and the Services have delineated the functional requirements that will reside at the DHA headquarters and those at the Services Medical Department headquarters removing duplication at the DHA and the Services Medical Department headquarters.

FIGURE 14 outlines the tasks to be performed by specific organizations. Tasks to “Nest” are those that should be nested with DHA IMO operations but still managed by the Services in phases 0 and 1. Tasks to “Divest” should be moved entirely out from the Services intermediate command organizations and managed by another organization (DHA HQ or IMO). Tasks to “Transform” should be reformed to meet the new medical constructs that DHA and Service Medical Department develop and may be managed at the Service medical intermediate or HQ level.



FIGURE 14: Function transitions between Service IMOs and DHA IMO

Nest	Divest	Transform	
Civilian Personnel functions for Civilians (HR)	All delivery of Health Care tasks	Public Health Command	MOEs for clinical and ISA sustainment
Liaison cell for Operations logistics, personnel, finance	All Facility management for MTFs	Simulations, expeditionary, virtual training	PPBE functions and cost accounting for readiness
Training Program management in MTF	Quality/Safety for Health Care	Distribution, control, accounting for funding to ensure a medically ready force and ready medical force	Quality and safety for healthcare in operational setting
FAP, EFMP, Substance Abuse integration	MTF Personnel Management (MIL & CIV)	Management of external agency MIL/CIV partnerships; manage medical training agreements with civilian trauma centers	Health facility planning in line with operational requirements and integration with DHA MILCON activities
Emergency planning and preparation	Safety, risk assessment, performance improvement of HCD	Forecasted/unforecasted unit based training, deployment, PTDOs	Credentialing and privileging for deploying providers
Integrate readiness requirements with regional performance plan	PPBE for healthcare delivery functions	Strategy and Innovation (Readiness function QPP)	Quality, safety and occupational health support PHC and Dental
	Uniform Business office functions	Evaluation of operational requirement and training strategy management	
	Performance planning for HCD	Civilian Personnel oversight	
	Retention (probable)	Enlisted training/skill sustainment	
	Health Facilities planning agency and facility management	Operational logistics	
	HRO initiatives	Liaison functions with DHA	
	Healthcare Delivery MEDLOG	Liaison functions with ACOMs	
	IM/IT	Warrior Transition and Care	
	Managed care execution		
	Clinical quality management (CQM)		
	Sustainment, restoration, modernization (SRM)		

In Phases 1-2 of the transition, some residual MTF functions will reside in both the DHA and Service Medical Departments. **FIGURES 15** and **16** show the functions for which each organizational entity at both the HQ and IMO levels will be responsible.



FIGURE 15: Phase 1 DHA and Service HQ Functional Responsibilities

DHA Director	AD Healthcare Admin.	AD Management	AD Combat Support Agency
Governance	DAD MA CMO	DAD Admin & Management (J-1)	EA Management
Program Executive Office	<i>Clinical Quality Management</i>	<i>DHA & Regional Staffing</i>	Public Health EA
Office of Inspector General	<i>Clinical Operations</i>	<i>CIVPER Management</i>	Population Health
Equal Employment Opportunity	DAD IO (J-6)	<i>SHARP/SAPR</i>	MEDLOG EA
Other Special Staff	<i>Health IT</i>	<i>MILPER Management</i>	
	DAD FO (J-8)	<i>Mission Assurance</i>	
	<i>PPBE</i>	DAD CAE (J-4)	
	<i>Facilities ESA</i>	<i>Acquisition EA</i>	
	DAD HCO	DAD Strategic Planning (J-5)	
	<i>Healthcare Operations</i>	<i>QPP</i>	
	<i>Clinical Labs</i>	<i>Analytics</i>	
	<i>Pharmacy</i>	DAD Education & Training (J-7)	
	<i>MHS GENESIS</i>	<i>Education and Training EA</i>	
	DAD TRICARE (J-10)	DAD R&D (J-9)	
	<i>Health Plan (TRICARE) EA</i>	<i>Research & Development EA</i>	

ARMY HQ Functions		Navy HQ Functions		Air Force HQ Functions	
Governance	RCM	Governance	Education & Training	Governance	Education & Training
Strategic Comms	EO/EEO	Strategic Comms	R&D	Strategic Comms	R&D
CIVPER Management	Administrative	CIVPER Management	RCM	CIVPER Management	RCM
DHA & Regional Staffing	Pastoral/ Chaplain	Public Health	EO/EEO	DHA & Regional Staffing	EO/EEO
Acquisition EA	MILPER Management	Acquisition EA	Facilities & Environmental Readiness	Acquisition EA	Administrative
Population Health	Global Health Engagement	Population Health	Administrative	Population Health	
Public Health	Patient Admin	DHA & Regional Staffing	Global Health Engagement	Public Health	
MHS GENESIS	Plans and Programs	MHS GENESIS		MHS GENESIS	
Clinical Operations		Clinical Operations		Clinical Operations	
Education & Training					
R&D					

- Functional Requirement aligned to DHA Functional Capabilities (Workstreams)
- Service Functional Requirement that does not align into DHA Functional Capabilities (Workstreams)



FIGURE 16: DHA IMO Functional Responsibilities

Phase 1 - DHA IMO Functional Requirements

Clinically-Oriented Functions	Administratively-Oriented Functions	Other Functions
Clinical Integration	Financial Management & Comptroller	Legal
Patient Administration	Communications	
Patient Safety & Clinical Quality	Logistics & Facilities	
Health Informatics Office	Plans & Operations	
	Personnel	

Phase 1 - Service Regional Functional Requirements

ARMY Regional Functions		Navy Regional Functions		Air Force Regional Functions	
Governance	Health IT	Governance	Health IT	MILPER Management	Airman Family Division
Strategic Comms	IG	MILPER Management	Mission Assurance	Education & Training	Aviation Management
MILPER Management	OGC	CIVPER Management	Administration	Public Health EA	Doctrine
CIVPER Management	EO/EEO	Education & Training	DIR Admin	Revenue Cycle Management EA	Human Factors
Manpower	Patient Safety	MEDLOG EA	Special Assistants	Enterprise Activities (EA) Management	Modernization
PPBE	Chaplain	PPBE		Health Plan (TRICARE) EA	Physical STDs
MEDLOG EA	FAM Advocacy	Revenue Cycle Management EA		MHS GENESIS	Physio Programs
Public Health EA	OFC of Soldier's Council	Healthcare Operations		Mission Assurance	Surgeon
Healthcare Ops	OFC of the Commander	Facilities EA and Environmental Readiness		Administration	
Clinical Quality Management	OFC TRP CDR	Clinical Operations		Executive Services	
Facilities EA	Patient Administration (PAD)			Aeromedical Evac Ops	
Clinical Operations				Aerospace Medicine	

Functional Requirement aligned to DHA Functional Capabilities (Workstreams)

Service Functional Requirement that does not align into DHA Functional Capabilities (Workstreams)

By October 1, 2020, functional responsibilities for all MTFs will have transferred to the DHA.



III. Efforts to maximize efficiencies in the activities carried out by the DHA

As important as the realignment of headquarters activities is the downstream value of increased agility in decision-making and execution, and the standardization of clinical and business processes across the MHS. These changes will accelerate the ability of the Department to improve health care delivery, more effectively support Service readiness requirements, improve the patient experience, and gain further management efficiencies in support of the Department’s mission.

There are three principal efforts underway aimed at maximizing efficiencies in the MHS and improving performance: (a) the redesign and standardization of business and clinical processes to achieve greater efficiencies across the enterprise; (b) the development and implementation of DHA-established Procedural Instructions (DHAPIs); and (c) the establishment of the Quadruple Aim Performance Plan (QPP). This section addresses the activities underway in each area.

A. Clinical and business process redesign

When the DHA was established in 2013, the Deputy Secretary of Defense outlined the expectation for its performance in his March 11, 2013 memorandum:

“The centerpiece of the reform is the establishment of a Defense Health Agency (DHA) to assume responsibility for shared services, functions, and activities of the MHS and other common clinical and business processes... We must operate the MHS in the same manner that medical support of operational forces has been so effectively provided in our recent conflicts: jointly. We must also be responsive to the fiscal challenges facing the nation by achieving a sustainable health program budget. In doing so, we must attain greater integration of our direct and purchased healthcare delivery systems, essential to accomplishing the quadruple aim of the MHS...”

Since its establishment, the DHA, in close collaboration with the MILDEPS, has undertaken comprehensive business case analyses and business case redesign efforts in order to streamline clinical and business processes, principally focused on the initial ten enterprise activities for which it was responsible: medical logistics, health IT, pharmacy programs, TRICARE health plan, health facility planning, medical research and development, public health, acquisition, budget and resource management, and medical education and training.

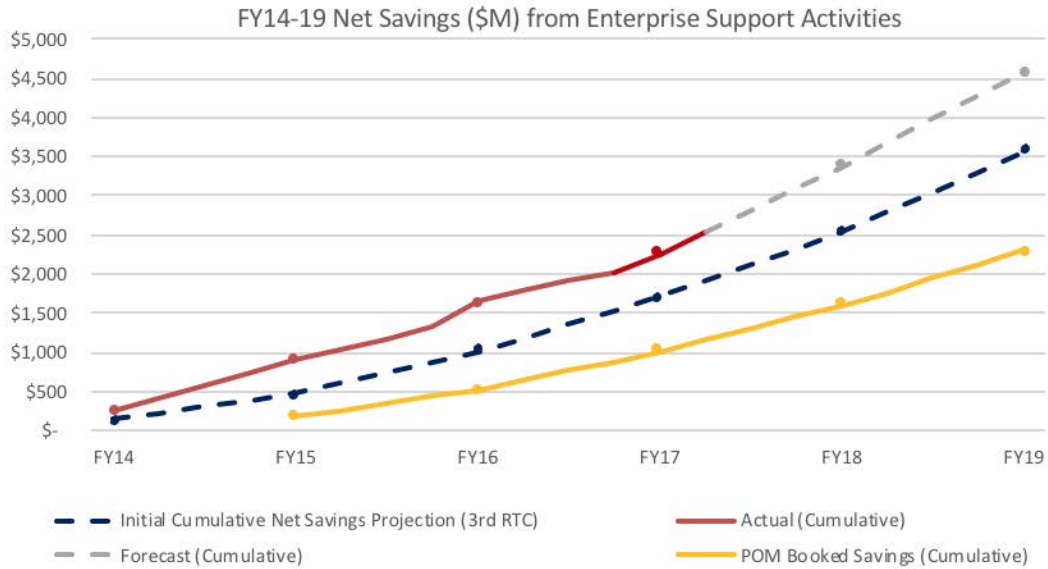
These redesign efforts led to the budgeted reduction of \$2.3 billion in DHP funding over the FY15-19, Future Years Defense Program (FYDP). The actual performance of the MHS over this period exceeded the \$2.3b projected savings, and the Department achieved these in savings by 2017 – two years earlier than anticipated -- as depicted in **FIGURE 17**.

It is important to note that these savings only capture reductions in the DHP. Several initiatives that led to these cost reductions, particularly in the area of pharmacy programs also produced \$658 million in savings for the Medicare Eligible Retiree Health Care Fund (MERHCF).



Because the MERHCF is an accrual fund, managed by the Department of the Treasury, savings achieved in this area accrue both to the Department of Defense and the taxpayer.

FIGURE 17: MHS-Driven Defense Health Program Savings (FY15-19)



Over the last two years, the Department has identified additional efficiency opportunities across 10 reform initiatives with potential, conservative savings approaching more than \$760 million annually by FY 23 when fully implemented. The business case analyses require further validation, but work is progressing across each of the following business lines: Access to Care; Purchased MTF support services (to include housekeeping, dietary services, and professional services); Revenue Cycle Management; Medical Facilities; Medical Logistics; Pharmacy; Laboratory; Radiology; TRICARE Support Contracts, and Value Based Purchasing. Brief descriptions of these initiatives are outlined in **FIGURE 18**.



FIGURE 18: FY19-23 Initiatives to Achieve Greater Efficiencies

Initiative	Description	Projected Annual Savings (End State)*
Access to Care	Standardized management and oversight to optimize specialty appointments to recapture specialty care	\$60M
Purchased Services	Single contract/program management office for MTF support services including medical support, housekeeping, laundry, dietary and other services	\$75M
Revenue Cycle Management	Standardize and centralize policies/management for all back-office functions across direct and purchased care, to include collection of non-TRICARE health insurance for beneficiaries with dual coverage	\$72M
Medical Facilities	Implement enterprise-wide facility planning standards, investment strategies and processes; centralize support of MTF Sustainment, restoration and modernization (SRM) and leasing at DHA level to coordinate enterprise requirements for MTFs.	\$45M
Medical Logistics	Establish Defense Medical Materiel Support Center (DMMSC) to drive standardization; establish materiel and services acquisition strategy in collaboration with DLA (to include Cyber Logistics Center of Excellence - essential for MHS GENESIS)	\$80M
Pharmacy	Establish DHA Pharmacy authority over pharmacy enterprise-wide, to include staffing, formulary management, and clinical pharmacy services across inpatient and outpatient settings; a standardized staffing model; establish structure and process for direct care medical benefit medication standardization and quality management; centralize equipment purchasing authority at DHA-level	\$79M
Laboratory	Reduce leakage to commercial sector where capacity exists; invest in urine drug screen for long-term opioid therapy (LOT), to reduce costs, morbidity and mortality by monitoring the inappropriate use of opioids; reduce tests with questionable clinical indication in lab / pathology; implement utilization management tools	\$12M
Radiology	Establish Radiology Management Structure at DHA to oversee and manage across the enterprise; implement “hub and spoke” radiology model across the MHS, and establish civilian tele-radiology partnerships; standardize equipment purchasing order sets, and staffing models	\$20M
TRICARE Contracts	Changes in administrative fee award structure; updates to retiree cost-sharing; adoption of CMS rates for long-term care and rehab; improve payment integrity and audit functions	\$260M
Value-Based Purchasing	Design and launch pilots for two initiatives: Episode-Based (bundled) Payments; Welvie Surgical Decision Support to assist patients with surgeon selection	\$60M

*Savings includes cost avoidance in the Revenue Cycle Management initiative; savings are low-end estimates.



Although these opportunities include specific actions across a broad array of health care services, there are features common to many initiatives that are enabled through the implementation of 10 U.S.C. §1073c: the use of centralized contract support functions; common purchasing; standardized staffing models; the smart use of automation afforded by the introduction of MHS GENESIS; and the completion/implementation of DHA Interim and Final Procedural Instructions. Implementation plans for these reform initiatives will be integrated with implementation plans for MTFs and deliberately phased in over time to mitigate risk to the MHS during transition.

In addition to the consideration of these initiatives, additional cost savings totaling \$1.7 billion annually by FY23 are already programmed and include: changes in the administrative fee award structure for the TRICARE contract partners; updates to retiree cost-sharing enabled by the TRICARE Interim Final Rule; adoption of Centers for Medicare and Medicaid Services (CMS) rates for long-term care hospitals and inpatient rehabilitation facilities; further savings from IT rationalization, standardization and consolidation and standardization of the purchasing of medical Internet Protocol (IP) Connectable devices.

B. DHA Procedural Instructions

As part of its responsibility to manage and administer MTFs, the DHA, together with the Services, has identified multiple, critical areas that either have Service-specific regulations or policies that require a common, DHA Procedural Instruction (PI), or that represent a gap for which a PI is needed.

It will take time to develop, coordinate, publish, disseminate and implement DHA PIs for all areas. **FIGURE 19** represents the current priority PIs to be published prior to Oct 1, 2018. The list and publication status of all currently planned PIs is provided at **APPENDIX 5**.

FIGURE 19: Publications to Be Completed by October 1, 2018

Urgent Publications (to be implemented by 30 SEP 18)	
Medical Logistics Enterprise Activity (EA) (2 publications; MOA and/or MEDLOG PI)	Education & Training Procedures and Administrative Guidance for the MHS
Public Health Enterprise Activity (EA)	Facilities Enterprise Activity (EA)
Management Standards for Medical Coding of DoD Health Records	Problematic Substance Use by DoD Personnel
Medical Expense Reporting System (MEPRS) Manual (Vols. 1 & 2)	Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)
Procurement Enterprise Activity (EA)	DoD Patient Bill of Rights and Responsibilities in the MHS
Health Information Technology Enterprise Activity (EA) (Enterprise DAD-IO)	Behavioral Health Treatment and Outcomes Monitoring
Joint Medical Executive Skills Development Program	Joint System Trauma Lexicon
Pharmacy Programs Enterprise Activity (EA)	PCM Empanelment
Medical Ethics	



C. Quadruple Aim Performance Plan (QPP)

The MHS leadership has adopted the QPP as the centerpiece around which it will establish and monitor MTF performance across the linked objectives of readiness, health, quality and cost. The MHS believes that improvement in performance across this spectrum of activities all contribute to better outcomes and increased efficiencies. For example, improvements in patient safety can lead to fewer health care related complications, fewer hospitalization readmissions, and to reductions in other resource-intensive activities that can lead to lower overall health care costs while improving the health of our beneficiary population.

The QPP supports the MHS integrated system of readiness and health. It applies across both direct care and purchased health services. The purpose of the QPP is to:

- Align market or MTF activities with the Military Health System Quadruple Aim;
- Promote system learning and continuous improvement;
- Support a smooth transition of administration and management of MTFs to DHA;
- Demonstrate measurable improvement in seven critical initiatives and associated measures against baseline performance; and
- Enable enhanced enterprise performance balanced across the Quadruple Aim.

Processes disseminated to all MTFs establish how plans will be reviewed and approved, and how performance will be monitored beginning in FY19.

This approach is aligned with the phased transition of MTFs and guidance has been customized for Phase One MTFs and all others, as follows:

1. All Phase One MTFs will:
 - a. Be evaluated using the approved set of QPP enterprise measures and will address a selection of the seven MHS Critical Initiatives in their QPPs. An MHS Critical Initiative is an activity or set of activities that are critical to the overall performance of the enterprise and to an MTF. The MHS Critical Initiatives for FY19 are described at **FIGURE 20**, and aligned with the Quadruple Aim as outlined here:
 - i. Deployability (Medically Ready Force)
 - ii. Improve Medical Force Readiness (Ready Medical Force)
 - iii. Encourage Healthy Behaviors (Health)
 - iv. Optimize and Standardize Access (Access)
 - v. Improve Condition Based Quality Care (Quality)
 - vi. Achieve Zero Patient Harm (Safety)
 - vii. Improve Effectiveness and Efficiency of Direct Care Platform
 - b. The complete QPP can be found at: (<https://go.usa.gov/xnzKk>).
 - i. Will be reviewed by the DHA and approved by the Director, DHA.
 - ii. Will undergo monthly performance reviews by DHA.
 - c. MTFs not included in Phase One will continue to use planning templates, approval processes, and monitoring currently executed by MILDEPs. These MTFs are encouraged to use the new planning template with the support of their chain of command.



The performance of *all* MTFs in the MHS will be monitored using the MHS QPP measures, beginning 01 October 2018. Performance will be shared throughout the MHS, captured at the MHS Dashboard located on the internal CarePoint website, the Military Health System's Population Health Portal. Internal stakeholders will be able to compare performance across MTFs and markets, and when applicable against measures also used by the broader American medical community, consistent with direction in FY17 NDAA, section 726. Where appropriate, and consistent with congressional direction regarding public transparency, measures will also be shared on the MHS external website dedicated to public display of performance at the MTF and enterprise level.

Each QPP shall include a set of Local Critical Initiatives (1-3 year efforts) supported by near term projects (to be completed in FY19). Local Critical Initiatives will be comprised of:

- a. Three to seven Local Critical Initiatives aligned with the seven MHS Critical Initiatives:



FIGURE 20: Quadruple Aim Performance Plans (QPP) Domain

Quad Aim	Critical Initiatives (CI)	Working Definition of FY 19 Critical Initiatives
Readiness	Deployability (Medically Ready Force)	Anything that contributes to the deployability of the active, reserve or guard force, including care, screening, prevention, or improvements to access for uniformed personnel. This is done in support of Service requirements (i.e., readiness demand signal).
	Improve Medical Force Readiness (Ready Medical Force)	All MTF activities that ensure the medical force is ready to deploy anywhere, anytime in support of the full range of military operations. It includes efforts to increase readiness-related caseload that supports clinical knowledge skills and abilities within MTFs or through partnerships (i.e., readiness demand signal).
Better Health	Encourage Healthy Behaviors (Health)	About 50% of health outcomes are related to behaviors. As we shift from healthcare to health we intend to help patients achieve better health by making the healthy choice the easy choice. This is particularly important with regard to nutrition, activity, tobacco use, substance abuse, and self-management of chronic illness (i.e., health demand signal).
Better Care	Optimize & Standardize Access (Access)	Patients should not have to wait for help when they need our help. This initiative is about reducing waiting time for appointments, but it is also about creating alternatives that get help to people without a visit to a hospital or clinic. It is also about reducing time that people have to wait for answers (i.e., health care demand signal)
	Improve Condition Based Quality Care (Quality)	Our clinical communities are developing pathways of care that will specify the best known way to deliver care for common conditions like low back pain and normal childbirth. While piloting these efforts, we will implement evidence based care and make the right choice the easy choice for the health team in common conditions (e.g., diabetes, low back pain screening, pharyngitis).
	Achieve Zero Patient Harm (Safety)	We will achieve zero harm by identifying zero events (e.g., wrong site surgery, post-operative infection) and preventing them with always events (e.g., checklists, care bundles) This will require changing the culture, training and rigorous process management.
Lower Cost	Improve Effectiveness & Efficiency of DC Platform	Increasing productivity will be accomplished by eliminating the wasteful processes that prevent our team from performing at full capacity. We will work smarter, not harder and apply the principles of high reliability to eliminate wasteful procedures, re-work and wasted capacity.

- b. Three to seven Local Critical Initiatives chosen by local leadership and based on local needs or opportunities for significant improvement.

As management and administration of MTFs is transitioned to the DHA, the QPP template will be fully standardized across the MHS.



IV. How the Secretary will implement subsection 1073c in a manner that reduces the number of members of the Armed Forces, civilian employees, and contractors relating to the headquarters activities of the military health system

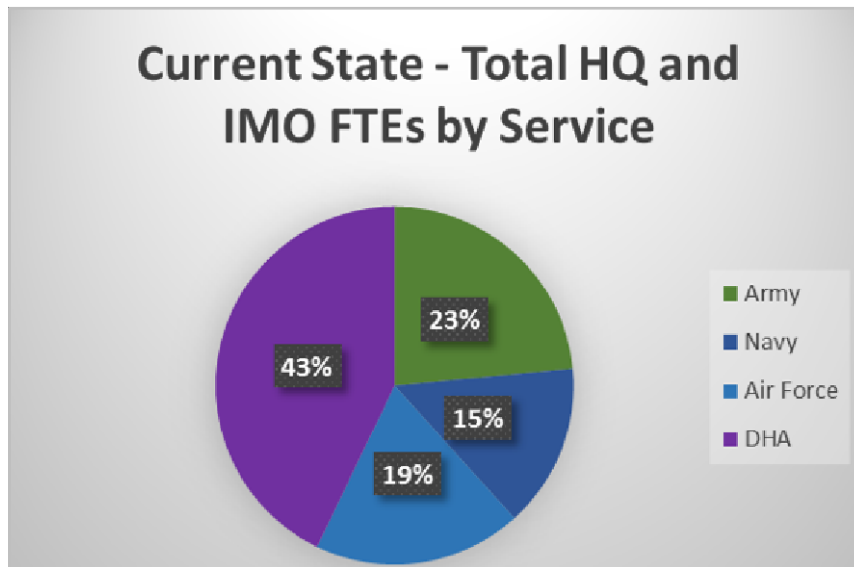
As 10 U.S.C. §1073c is being implemented over the next three years, the overall medical manpower requirements in DoD medical headquarters will be reduced and therefore the Department is planning for headquarters personnel reductions including military, civilian, and contractor personnel.

Planning for these reductions began in the 2015 budget cycle and accelerated after the NDAA 2017 was signed. The Department has already programmed a 25 percent reduction in manpower positions aligned to medical headquarters across the enterprise, and programmed a \$202.5 million reduction in DHP costs commensurate with that effort.

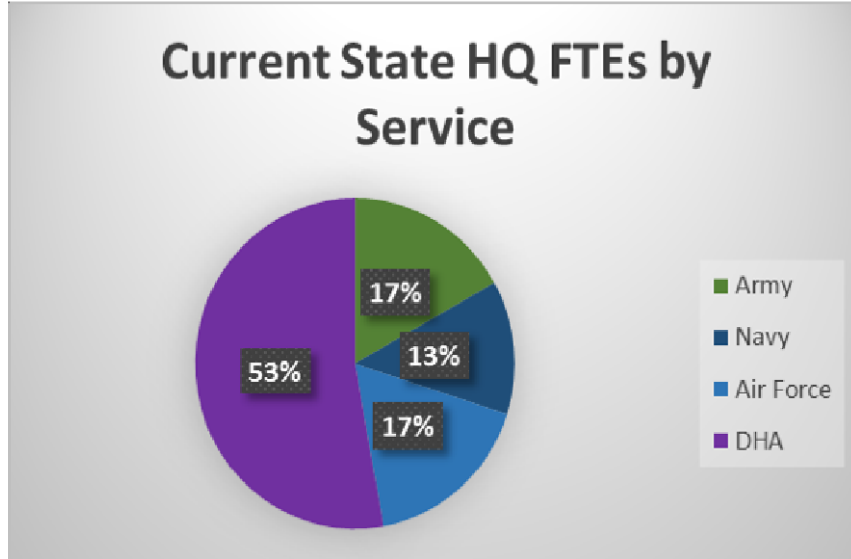
Further manpower reductions are being planned. To begin the process of identifying Full Time Equivalents (FTEs) for reduction, the Department has compiled the number of military and civilian full-time positions currently aligned to DHA and Service headquarters. **FIGURE 21** details the current baseline information on DHA and Service Medical Department headquarters staffing provided to the DoD Chief Management Officer’s Reform Modernization Group (RMG) by the Services and DHA.

FIGURE 21: Current Total Headquarters and Intermediate Command Staffing

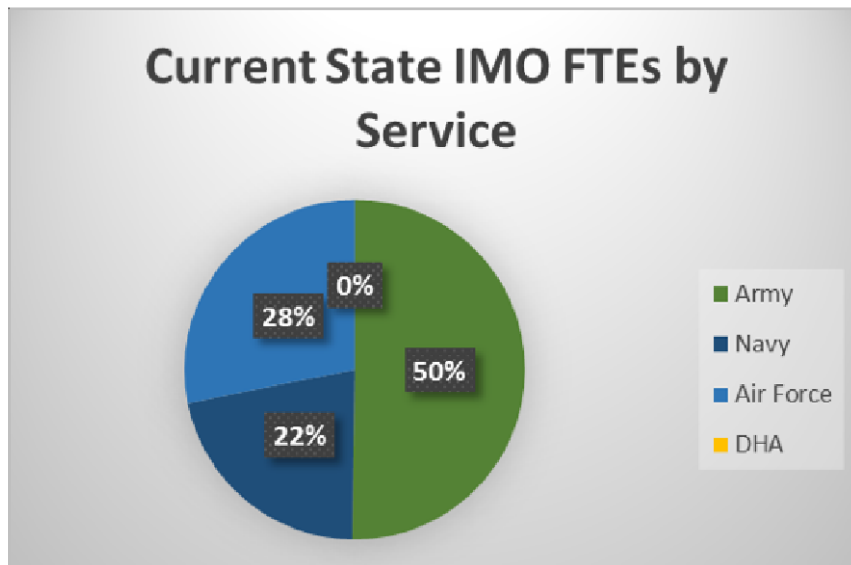
Current State - Total Service HQ and IMO FTE Levels					
	Army	Navy	Air Force	DHA	Total
FTEs	1632	1029	1307	2980	6948



Current State - Service HQ FTE Levels					
	Army	Navy	Air Force	DHA	Total
FTEs	952	737	926	2980	5595



Current State - Service IMO FTE Levels					
	Army	Navy	Air Force	DHA	Total
FTEs	680	292	381	0	1353



Because the Services will be supporting the transition of administration and management of MTFs to DHA, during Phase 0 and Phase 1 (FY2018-2019), the Department does not anticipate major reductions in headquarters manpower beyond the 25 percent reduction already



programmed in order to ensure a smooth transition as DHA’s new responsibilities are being established.

The DHA will experience incremental growth in staffing during the transition in order to undertake its new responsibilities and with each subsequent phase will continue to effect incremental growth until it has full responsibility for all MTFs.

By the end of 10 U.S.C. §1073c implementation, however, the Department will further reduce overall combined headquarters manpower FTEs by an additional 10 percent from the current state. Overall military and civilian manpower requirements in both Service and DHA medical headquarters and intermediate activities will be reduced by *at least* 695 positions from today’s baseline levels summarized in Figure 20.

In June 2018, the USD(P&R) directed the DHA and the Military Departments undertake zero-based reviews of their “above MTF” support functions proposed at end state to validate requirements needed to successfully support operational demands, using independent manpower engineering teams (**APPENDIX 6 and 7**).

The Office of the Secretary of Defense Cost Analysis and Program Evaluation and USD(P&R) have created a Manpower Working Group to oversee this work. The team will ensure the appropriate sizing of all “above MTF” level medical activities within the Military Departments, identify additional medical functional areas for inclusion in the ongoing manpower analysis, review the results of the manpower assessment of DHA and Military Department’s headquarter activities, and analyze any other critical areas as determined by the issue team leads. This effort will ensure that the DHA has the appropriate level of resourcing to carry out its new responsibilities and that the Military Departments’ medical headquarters appropriately reflect their narrowed scope of responsibility in the end state. At end state, the Military Departments will have minimal or no management responsibility over the MTFs and the DHA will need to see some level of resource growth, we fully expect current Military Department medical headquarters activities to be reduced substantially to allow for modest DHA growth after internal efficiencies resulting in a net savings across the MHS of greater than 10 percent.

The results of both of these zero-based efforts are due September 1, 2018, and reductions will be incorporated into the Department’s FY20 Program Budget Review, and will be submitted to Congress along with the final results of the NDAA 17, section 721 manpower review in January 2019.

One other point of personnel efficiency that occurs below the headquarters level is the decision to dual-hat the MTF Director /Service Commander roles. This management action reduces the need for two entirely separate command and management functions to be established, and helps integrate the readiness and health missions at the point of patient care.

The actions outlined in this report represent a path to the MHS’ continued pursuit of the Quadruple Aim. We look forward to keeping our stakeholders in Congress apprised of our progress and informed on any course adjustments we make over the coming transition period.

