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**HEALTH READINESS  
CONCEPT OF OPERATIONS (CONOPS)**

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## EXECUTIVE SUMMARY

For the last several years, the Military Health System (MHS) has pursued organizational transformation in concert with the Department of Defense (DOD). In October 2005, the Deputy Secretary of Defense (DepSecDef) chartered the MHS Office of Transformation to “Accelerate and enhance the quality of organizational change within the MHS by providing policy guidance and direction...” and to “Implement a strategic plan to ensure MHS programs and resources continue to support evolving needs of the DOD.”

Fundamental changes identified to transform health readiness (HR) include enhancing joint health system support capabilities, improving health service delivery capabilities, and creating joint organizational and process relationships to control and synchronize service medical capabilities. These changes can best be achieved by adopting capabilities-based planning and performance-based management principles, providing the MHS additional flexibility to provide joint capabilities when and where required without regard to platform or Service providing the new capability.

The Health Readiness Concept of Operations (HR CONOPS) describes medical capabilities designed to provide optimal health services in support of our nation’s military mission—anytime, anywhere. The explanation is clear: The HR CONOPS supports development of a capabilities-based planning system to analyze new and existing requirements; determine capability gaps, shortfalls and overmatch with appropriate Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, and Facilities (DOTMLPF) and recommends solutions for presentation and adjudication in the Joint Capabilities Integrated Development System (JCIDS).

This HR CONOPS recognizes the existing Joint Force Health Protection CONOPS with six broad capability (functional) areas as an integrating document for expeditionary HR capabilities and HR capabilities unique to Homeland Defense and Medical Stability, Security, Transition, and Reconstruction Operations. It calls for the development of two additional interdependent CONOPS—Health Service Delivery (HSD), and Health System Support (HSS)—to fully describe all medical capabilities required to support National Security Strategy. Health readiness (an overarching term that describes the broad spectrum of joint medical and health service support capabilities) integrates service transformation planning into the full spectrum of services required from the servicemember’s accession to veteran and among members of the military family by focusing on four integrated MHS mission elements:

- Casualty Care and Humanitarian Assistance
- Healthy, Fit and Protected Force
- Healthy and Resilient Individuals, Families, and Communities
- Education, Training and Research.

This HR CONOPS was reviewed by the Service Surgeons General and approved for entry into KM/DS by the Senior Military Medical Advisory Council (SMMAC) on 30 September, 2009.

The strategic construct of this concept, as developed in **Chapter 1**, describes the primary mission of the MHS to provide the continuum of health services across the range of

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military operations. This is contingent on the ability to create and sustain a healthy, fit, and protected force using the four major mission elements began with the National Defense Authorization Act (NDAA) for fiscal year 2000, Program Budget Decision (PBD) 753, *Quadrennial Defense Review*, and the *2008 MHS Strategic Plan*.

**Chapter 2** presents emerging challenges and from these challenges presents a problem statement. The joint force needs to solve the basic military medical challenge of how to more effectively ensure HR for a joint force that will operate in a complex and diverse operational environment and collaborate with other organizations, agencies, nations, and cultures. The Health Readiness Military Problem Statement is described as follows:

*The military health enterprise is not functioning as a fully integrated system and is not optimized to effectively and efficiently respond to rapidly changing economic conditions, missions, beneficiary demographics, technologies, and health education and research.*

The four MHS mission elements are accomplished through significantly enhanced interoperability within the system and use of new and enhanced capabilities.

**Chapter 3** introduces these capabilities, which are grouped into three functional areas:

- Force Health Protection (FHP)
- Health Service Delivery (HSD)
- Health System Support (HSS).

**Chapter 4** describes capabilities that enhance HR in the three functional areas. Supporting ideas include HR roles in civil-military operations, homeland defense, and full-spectrum healthcare domain from accession to veteran, as well as joint medical education and training.

**Chapter 5** presents the strategy for implementing this concept. The concept incorporates capabilities-based assessments aligned with the three HR functional areas, together with one Health Readiness Functional Capability Board Working Group, to provide integration for efforts at developing overarching joint medical capabilities and concepts. The three integrating CONOPS to this HR CONOPS will deliver the products (e.g., Initial Capabilities Documents [ICD] and Transformation Solution Recommendations), in accordance with the JCIDS processes necessary for developing required medical capabilities.

In conclusion, this document provides a conceptual foundation for future capability development activities to support HR operations envisioned to be conducted in the 2016–2025 time frame. This concept document and the other interdependent integrating HR CONOPS contain sufficient detail to initiate capabilities-based assessments supporting the JCIDS. This document outlines a medical CONOPS that collectively provides the basis for further analysis and refinements in determining potential future HR gaps and excesses.

Force readiness depends on having all warfighters and support personnel ready to conduct assigned missions and operations. A fundamental premise within the DOD and MHS is that the human being is the center of our warfighter capability; that is, the human being is the prime resource and key enabler of all warfighting systems. To keep that human resource fit and ready, the DOD requires a robust HR capability.

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*...Our nation is truly blessed that so many talented and patriotic young people have stepped forward to serve. They deserve the very best facilities and care to recuperate from their injuries and ample assistance to navigate the next step in their lives, and that is what we intend to give them. Apart from the war itself, this department and I have no higher priority. —Secretary of Defense Robert Gates, News Conference, 2 May 2007*

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## 1.0 CHAPTER 1. STRATEGIC CONSTRUCT

*The Department's greatest asset is the people who dedicate themselves to the mission. The Total Force distributes and balances skills across each of its constituent elements: the Active Component, the Reserve Component, the civilian workforce, and the private sector and contractor base. Each element relies on the other to accomplish the mission; none can act independently of the other to accomplish the mission.<sup>1</sup>*

Health readiness (HR) transformation focuses on sustaining and protecting the health and effectiveness of the human component of the American military. This is important not only for accomplishing the mission but also for meeting the expectations of military personnel, commanders, Congress, and the American people. The complexity of meeting these expectations across the range of military operations (ROMO) requires a common lexicon for medical capabilities that the Military Health System (MHS) needs for supporting service members, their families, and all those entrusted to our care.

### 1.1 PURPOSE

The primary purpose of this HR Concept of Operations (CONOPS) is to support rigorous assessment and analysis of health-related capability gaps and inefficiencies through a capabilities-based assessment (CBA) process to reach appropriate materiel and non-materiel solutions as part of the broader Department of Defense (DOD) Joint Capabilities Integration and Development System (JCIDS) effort.

This HR CONOPS will provide the analytic framework to—

- Identify a set of health-related capabilities to guide Joint Force Commanders
- Inform efforts to improve integrated HR capabilities within the context of the four mission elements and related mission outcomes that the *2008 MHS Strategic Plan* describes.
- Drive the revision of the current Joint Force Health Protection (JFHP) CONOPS and development of the Health Service Delivery (HSD) and Health System Support (HSS) CONOPS as three interdependent documents within one HR strategy.

These CONOPS will guide combatant commanders and medical communities in the development and employment of Health Readiness solutions.

### 1.2 SCOPE

The HR CONOPS broadly describes how future joint medical forces are expected to operate across the ROMO through 2016 and beyond. It examines future warfighting context and the description of how the future joint force will operate as described in the Capstone Concept for Joint Operations (January 2009) and describes future associated medical capability requirements. It presents risks and implications associated with this CONOPS as they apply to operations worldwide. HR operations are less frequently conducted unilaterally and more likely delivered in joint operations in conjunction with

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<sup>1</sup> *National Defense Strategy*, June 2008, p.19.

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multinational and interagency partners, other intergovernmental organizations (IGO), and non-government organizations (NGO).

The HR CONOPS envisions military operations conducted in accordance with the National Defense Strategy, incorporating all instruments of national power. It further focuses on describing HR capabilities for Joint Force Commanders and is applicable to geographic and functional COCOMs, military services, defense agencies, and joint staff for concept development and experimentation. The HR CONOPS integrates the JFHP, HSD, and HSS CONOPS and the four mission elements described in the *2008 MHS Strategic Plan* that drive the overall HR strategy. It considers Task Force recommendations regarding the Future of Military Healthcare, the 2005 base realignment and closure (BRAC), recommendations from the National Defense Authorization Act (NDAA) of 2008 related to the care of our wounded, ill, and injured and service-specific missions.

The essential attributes of this HR CONOPS are as follows:

- Must address the four MHS mission elements and related mission outcomes as described in the *2008 MHS Strategic Plan*.
- Must acknowledge service-unique medical missions and capabilities relative to the three integrating JFHP, HSD, and HSS CONOPS.
- Must consider MHS dimensions across the ROMO and be developed in accordance with key elements of Joint Integrating Concepts outlined in CCJCM 3010.02C, *Manual for Joint Concept Development and Experimentation* and *Manual for the Operation of the Joint Capabilities Integration and Development System (JCIDS)* (February 2009, Updated 31 July 2009).

## 1.3 CONTEXT

*The provision of health services and health benefits is an established and significant mission of each service branch of the U.S. Military. The extent and volume of healthcare services provided through military programs have grown dramatically since World War II resulting in the world's largest military healthcare system. This system serves several distinct categories of beneficiaries, including Active Duty military personnel, families of Active Duty personnel, reservists, and military retirees and their dependents. Unlike civilian healthcare systems, the Military Health System must give priority to military readiness; the Nation's engagement in a long term war on terror; the support of a conventional war, if necessary; the provision of humanitarian relief and response to natural disasters; and the achievement of other missions required by national command authorities.<sup>2</sup>*

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) serves as program manager for all DOD health and medical resources. As such, ASD(HA) will exercise authority, direction, and control over the DOD medical and dental personnel authorizations and policy, facilities, programs, funding, and other resources in the Department of Defense.<sup>3</sup>

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<sup>2</sup> *Final Report of the Task Force on the Future of Military Healthcare*, December 2007.

<sup>3</sup> Department of Defense Directive (DoDD) 5136.01, 4 June 2008.

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The *2008 Military Health System (MHS) Strategic Plan* reflects the MHS response to guidance provided by the Secretary of Defense's (SECDEF) Independent Review Group, The President's Commission on Care for America's Returning Wounded Warriors, the Task Force on the Future of Military Healthcare, the Task Force on Mental Health and the current environment of "jointness" within DOD.

The *2008 MHS Strategic Plan* provides a platform for increased collaboration with the Department of Veterans Affairs and civilian partners to improve coordinated care for Wounded Warriors and all who serve. It defines the MHS mission as follows: "Our team provides optimal Health Services in support of our nation's military mission—anytime, anywhere."<sup>4</sup>

The primary mission of the MHS is to provide the continuum of health services across the range of military operations. This is contingent on the ability to create and sustain a healthy, fit, and protected force. There are four major mission elements that support this mission: Medical Education, Training & Research; Casualty Care & Humanitarian Assistance; Healthy, Fit & Protected Force; and, Healthy & Resilient Individuals, Families & Communities.

Each MHS mission element is interdependent and cannot exist alone. Chapter 3 develops the mission elements with their overlapping nature, as illustrated in Figure 3-1, and briefly described as follows:

- An integrated and responsive research methodology and education and training system must develop a capacity that is essential to achieving improvements in operational care and evacuation.
- The most critical aspect of the system is to produce the quality of medical professionals and assemblages needed for an anytime, anywhere mission.
- Sustaining the quality of these medical professionals cannot occur without a uniformed base and beneficiary platform that produces healthy individuals, families, and communities.
- Lastly, the continuum of health services must include, when necessary, a seamless transition with the Department of Veterans Affairs (VA), civilian healthcare, and other providers.

## 1.4 ASSUMPTIONS

The HR CONOPS is based on the following (initial) assumptions.

- Success across the range of military operations depends on support of a single MHS mission with four independent but integrated, mission elements
- The MHS will follow strategies to support medical transformation as described in the *2006 and 2010 Quadrennial Defense Reviews (QDR)*.

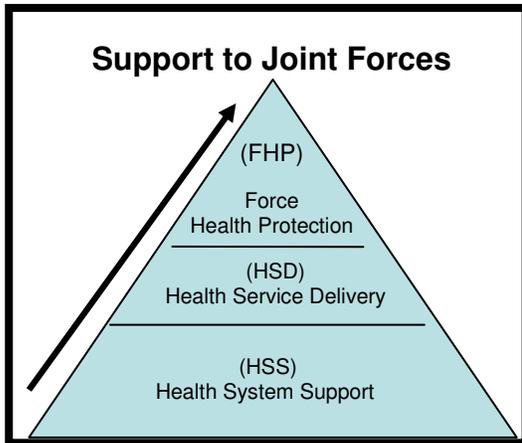
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<sup>4</sup> *2008 Military Health System Strategic Plan.*

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- Recommendations outlined in Action Memorandum for the Deputy Secretary of Defense (DepSecDef), SUBJ: Joint/Unified Medical Command Way Ahead, 27 November 2006 (listed below) remain relevant:



**Figure 1-1. Health Readiness  
Family of Capabilities**

- Take incremental and achievable steps that will yield efficiencies of operations
  - Achieve true economies of scale by combining common functions
  - Provide structural changes enabling MHS QDR Transformation initiatives
  - Preserve service-unique culture and mission support capabilities for each of the services' medical components
  - Support the principles of unity of command and effort under joint operations
- Maintain USD (P&R) and ASD(HA) oversight of the Defense Health Program
  - Facilitate consolidation of medical headquarters under 2007 BRAC law
  - Create a joint environment for the development of future MHS leaders
  - Position the MHS for further advances, and if warranted, toward more unification while ensuring that unique service medical capabilities are maintained
  - The *2008 MHS Strategic Plan* and subsequent updates will remain the roadmap for integrating HR
  - HR CONOPS will build on health system integration efforts demonstrated in the establishment of the Joint Task Force, National Capital Medical in the National Capital Region the San Antonio Military Medical Center (SAMMC), and Medical Education and Training Campus in San Antonio, TX.

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## 2.0 CHAPTER 2. MILITARY HEALTH ENTERPRISE CHALLENGE

The next quarter century will challenge US joint forces with threats and opportunities ranging from regular and irregular wars in remote lands, to relief and reconstruction in crisis zones, to sustained engagement in the global commons. During this time, the causes of conflict will vary from rational political calculation to uncontrolled passion.<sup>5</sup>

In the varied and highly uncertain security environment expected in the near future, potential adversaries will increasingly benefit from technology diffusion and access to advanced weapon systems. This environment will be defined by a global struggle against a violent extremist ideology that seeks to overturn the international state system. Beyond this transnational struggle, we face other threats, including various irregular challenges, the quest by rogue states for nuclear weapons, and the rising military power of other states<sup>6</sup>, pandemics, health care requirements associated with use of WMD, impacts of overcrowding in urban areas, lack of water, capacity-building, interagency /intergovernmental public health cooperation in education, disaster relief and reconstruction.

Internal to the DOD are the challenges associated with containing the increasing cost of providing the military health benefit as a proportion of the DOD budget. Growth in healthcare spending nationwide regularly outpaces growth of the overall economy (*The Innovator's Prescription*, page XV). America's overall healthcare bill has risen to roughly \$2.3 trillion, or about 16 percent of our total economy in 2007. Commensurately, the Defense Health Program (DHP) budget has more than doubled in the last 5 years—from \$19 billion to \$38 billion. The DHP currently represents 8 percent of total DOD spending, and it is projected to grow to 12 percent of the DOD budget, or \$64 billion, by 2015.

### 2.1 MATURE AND EMERGING CHALLENGES

The traditional battlefield has transformed into a uniquely diverse and unpredictable environment. US dominance in conventional warfare has given prospective adversaries, particularly non-state actors and their state sponsors, strong motivation to adopt asymmetric methods to counter our advantages. Our adversaries also seek to develop or acquire catastrophic capabilities: chemical, biological, and especially nuclear weapons. They also may develop disruptive technologies in an attempt to offset US advantages. For example, the development and proliferation of anti-access technology and weaponry is worrisome because it can restrict our future freedom of action. These challenges could come in the obvious forms we see today, as well as in less traditional forms of influence (e.g., manipulating global opinion using mass communications venues and exploiting international commitments and legal avenues). Meeting these challenges requires not only better and more diverse capabilities in hard and soft power but also greater flexibility and skill in employing them<sup>7</sup>. The Department will continue to emphasize the areas identified in the 2006 QDR, specifically improvements in capabilities for defeating terrorist networks, defending the homeland in depth, shaping the choices of countries at

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<sup>5</sup> *Joint Operational Environment*, page 3

<sup>6</sup> *National Defense Strategy of the United States of America*, June 2008, page 2

<sup>7</sup> *The National Defense Strategy of the United States of America*, June 2008, page 18

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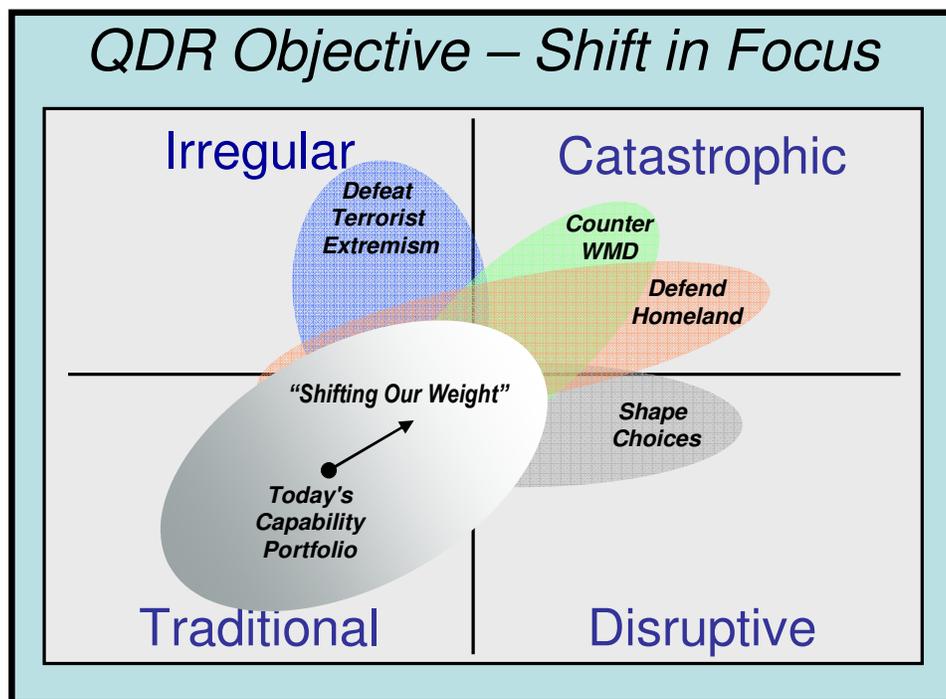
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strategic crossroads, and preventing adversaries' acquisition and use of weapons of mass destruction (WMD). Thus, the MHS must continue to focus capability models on the following array of challenges:

- **Traditional challenges**—are posed by the states employing recognized military capabilities and forces in well-understood forms of military competition and conflict.
- **Irregular challenges**—come from those employing “unconventional” methods to counter traditional advantages of stronger opponents.
- **Catastrophic challenges**—involve acquisition, possession, and use of WMD or methods producing WMD-like effects.
- **Disruptive challenges**—may come from adversaries who develop and use breakthrough technologies to negate current US advantages in key operational domains. (*National Defense Strategy of the United States of America, 2005, page 2*)

As Figure 2-1 illustrates, this future environment has significant implications for the conduct of medical operations through 2016 and beyond.

**Figure 2-1: National Defense Strategy Challenge Environments**



## 2.2 FUTURE KEY ASPECTS OF THE HEALTH READINESS ENVIRONMENT

The following key aspects of the future global environment are associated with numerous unique implications. These will influence the development of concepts and capabilities that are critical to the success of future health operations.

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- **Increased emphasis and concern for survivability and longevity of care for wounded warriors.** Battlefield medicine and resuscitative and rehabilitative care have advanced to a point at which wounded warriors are surviving and recovering from battlefield injuries never before thought possible. Challenges related to the long-term health implications of survivability and reintegration continue to evolve.
- **A more complex and diverse operational environment that spans the global community and includes land, airspace, waters, space, and cyberspace.** Future conflicts will appear as hybrids comprising diverse, dynamic, and simultaneous combinations of organizations, technologies, and techniques that defy categorization.<sup>8</sup> Health Readiness must develop new capabilities to support Whole-of-Government and Global Health Engagement approaches to mitigate conflicts beyond the conventional nation state domains within all environments and in accordance with CBRN Survivability policy.
- **Healthcare operations require a combination of joint capabilities to maximize complementary and additive effects.** The services have evolved diverse sets of capabilities to operate effectively in certain situations and physical domains. The essence of joint operations is to not only match each service with its appropriate situation so that it contributes most effectively to success, but also combine service capabilities such that each enhances the effectiveness and compensates for the vulnerabilities of the others (CCJO, January 2008, page 24).
- **Technology proliferation.** Technology proliferation, including information technologies, high-resolution imagery, tele-medicine, and the electronic health record enable increased transparency and an ability to deploy leaner, more capable medical solutions requiring the development of innovative and adaptable skill sets among a diminishing healthcare workforce.
- **Increased emphasis on containing DOD health costs.** Multiple forces contribute to the unrelenting cost pressures driving tactical and transformational changes in how health services are delivered worldwide.

The MHS is not immune to the influence of these forces and must consider their effects in all operational planning and future requests for resources. The MHS also must consider other national and global health influences that are transforming how health services are delivered in planning for the future (see Figure 2-2).

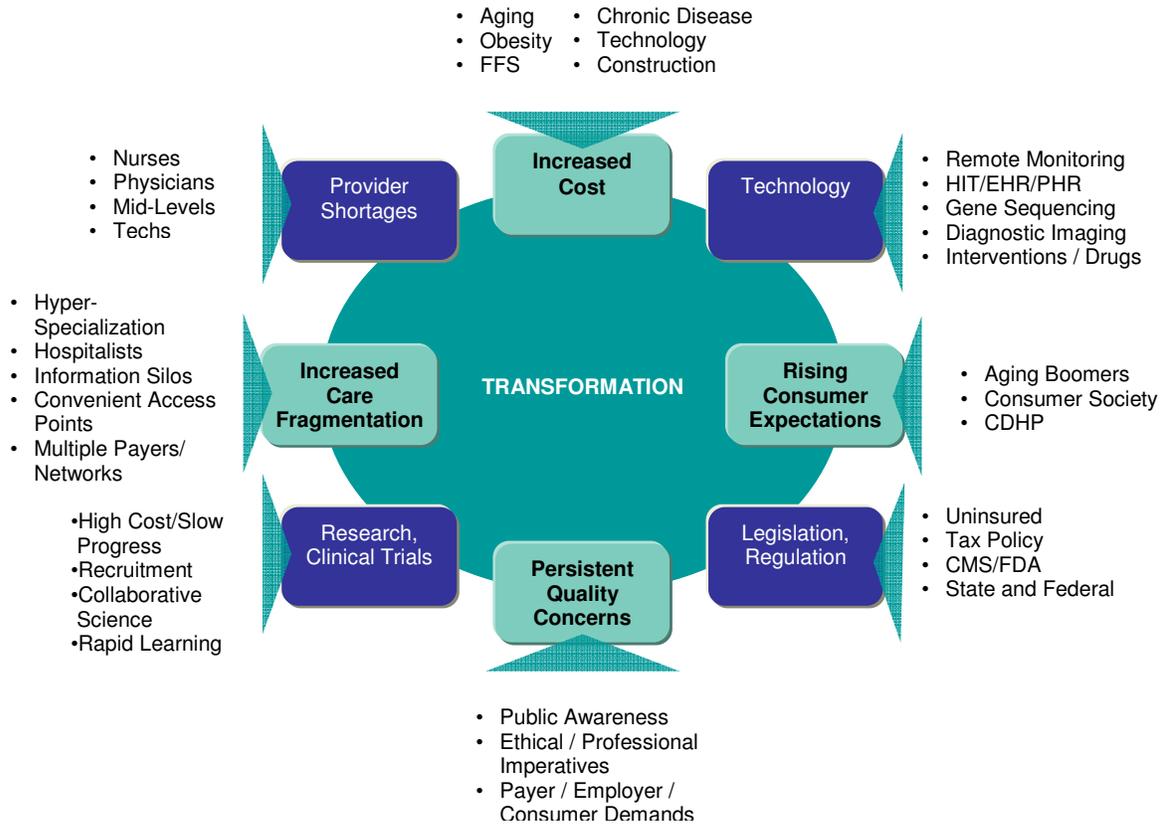
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<sup>8</sup> *Capstone Concept for Joint Operations* [CCJO], January 2009, page 8

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**Figure 2-2: Forces Bearing on Transformational Change in Health Services Delivery**



## 2.3 FUTURE JOINT FORCE OPERATIONS IMPACTING HEALTH READINESS

As noted in the 2006 *Quadrennial Defense Review Roadmap for Medical Transformation*, “transformation of the MHS has been ongoing and is significant.” Today, the medical community has an even greater opportunity to reestablish a baseline how to best care for our nation’s fighting forces; their families; and those who have served before us...more than 9 million people...by identifying challenges, shortfalls, and initiating solutions through the HR CONOPS.

Two joint operational documents—*Joint Operational Environment (JOE) 2008* and *Capstone Concept for Joint Operations (CCJO)*—guide the development of the HR CONOPS. The JOE is an excellent reference that the medical community can use to discern future challenges and implications for the joint force, whereas the CCJO provides the Chairman of the Joint Chiefs of Staff (CJCS) with vision for how the future joint force will operate in response to a wide variety of security challenges circa 2016–2028.

In the broadest sense, the JOE examines three questions that are pertinent to the line and the medical community:

- What future trends and disruptions are likely to affect the joint force over the next quarter century?

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- How are these trends and disruptions likely to define the future contexts for joint operations?
- What are the implications of these trends and contexts for the joint force? (*Joint Operating Environment*, November 2008, page 4)

Its companion document, the *CCJO*, “proposes that future Joint Force Commanders will combine and subsequently adapt some combination of four basic categories of military activity—combat, security, engagement, and relief and reconstruction—in accordance with the unique requirements of each operational situation.” (*CCJO*, January 2009, page iii). Note that the *CCJO* is the overarching concept for the Joint Operations Concepts (JOpsC) guiding the development of future joint capabilities. Other concepts in the JOpsC family of joint concepts are the Joint Operating Concepts (JOC); JFC; and Joint Integrating Concepts (JIC).

## 2.4 HEALTH READINESS ELEMENTS OF THE PROBLEM

The emerging way of war that the preceding paragraphs described sets the context for HR transformation. The following are key HR elements of this military problem that the HR CONOPS and future transformations must address:

- The lack of a fully integrated health system that includes interoperability not only between the services but also among US government; Interagencies; and non-government and commercial civilian partners. Medical forces are not sufficiently net-centric and interoperable to enable a fully integrated future health system and accelerated in its ability to know, decide, and act in real time.
- Current medical capabilities need to become more flexible, scalable, modular, as well as more survivable, sustainable, agile and rapidly deployable to meet future requirements. Medical expeditionary capabilities do not integrate new advancements in medical sciences quickly enough to ensure the most capable and most clinically appropriate care is delivered nearest to point of injury consistently across all services.
- The speed, simultaneity, and dispersed nature of future joint operations challenge medical employment concepts for forward resuscitative care, theater hospitalization, and patient movement. The future medical forces must leverage emerging medical technologies, new lift platforms, and the new employment methods evolving from these new lift platforms to sufficiently provide not only forward resuscitative care to dispersed units within the times (minutes) required to save life, limb, and eyesight; the future will also demand sustained or progressively increasing en route care while traveling to definitive treatment.
- The need to fully develop the comprehensive total life-cycle process that sustains and protects health services for all those entrusted to our care and maintains the health of all service members throughout their military service and provides definitive and rehabilitative care for injuries and/or illnesses that occur as a result of military service through and beyond reintegration and transition.
- Current medical information systems that do not fully facilitate data sharing, net-centric operations, and sense and respond capabilities.

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- Insufficient opportunities for joint medical training and shortage of medical personnel to conduct training and simultaneously meet mission requirements. Current medical training strategies and platforms cannot adequately prepare medical forces to operate in a future operational environment in which joint forces deliberately create dynamic situations that change at great speed. The future entire medical force, including planners and leaders will require joint training that matches the speed and intensity of the emerging ways of war, using joint medical doctrine that enables interdependent and mutually supporting medical operations between services.
- Processes are currently deficient or too slow in developing joint medical doctrine and joint medical standards to reflect or capture the pace of advances in medical techniques.
- The need for a more responsive medical logistics system capable of providing standardized up-to-date supplies, materiel, and equipment as medical technology changes. It must anticipate and distribute medical supplies, materiel and equipment to the right person, in the right place, at the right time.
- Medical community that lacks sufficient expertise to adequately support contingency and crisis action planning.
- Medical intelligence capability that needs to provide more timely, accurate and quantifiable data regarding medical threats within a joint operations area.
- The need to better leverage materiel and non-materiel solutions that enhance human performance.
- The need for a fully integrated patient movement system that provides visibility on all patients within the system from point of injury to final disposition.
- Current health systems and processes that lack comprehensive capabilities along the entire continuum of care, from point of injury to continental United States (CONUS) treatment and redistribution centers, and includes aspects of care across the full range of military operations.
- Current medical systems, equipment, and forces that lack capabilities to operate in all types of environments, including multinational operations, security, transition, and reconstruction operations; operations with NGOs and IGOs; medical capacity building; and public health services.<sup>9</sup>
- The growing population of persons to be treated by the MHS with more war wounded and an aging and growing retired community of veterans will increasingly challenge the ability of the MHS to provide the expected level of care.
- In an era of global engagement and conflict, elements of the joint force will be increasingly dispersed into smaller elements, operating in a distributed manner over an increasingly large area of operations. Providing support to these dispersed small units will create a significant challenge for MHS.

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<sup>9</sup> Joint Force Health Protection Concept of Operations, pages 8, 9

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## 2.5 HEALTH READINESS PROBLEM STATEMENT

The joint force must solve the medical enterprise challenge of how to enhance DOD and our nation's security by providing health support for the full range of military operations and sustaining the health of those entrusted to our care. The mission is broad and powerful; "our team provides optimal Health Services in support of our nation's military mission—anytime, anywhere." (2008 MHS Strategic Plan, page 2). This challenge must be met within the framework of four overarching mission elements (i.e., casualty care and humanitarian assistance; healthy, fit, and protected force; healthy and resilient individuals, families, and communities; and education, training, and research) for a joint force that will operate in a complex and diverse operational environment; confront a range of traditional and new adversaries and threats; employ and integrate new technologies; and collaborate with other organizations, agencies, nations, and cultures. Essentially...

*Current projections for the geo-strategic environment out to 2016 indicate an unsettled and rapidly changing world. The MHS must be prepared to support sustained military operations characterized by unconventional warfare and continuing need for humanitarian assistance. More emphasis will be placed on reigning in healthcare costs, transparency and accountability as health services are projected to consume an increasing proportion of the GDP and the DoD budget.*

*All MHS components must operate together to serve the warfighter and achieve improved population health, improved beneficiary experience and reduced per capita costs. Optimized defense-wide patient centered health services will require a highly trained total medical force equipped to provide comprehensive care to wounded, ill, and injured; promote and improve the health of the force; and manage and prevent injuries and chronic illnesses among all MHS beneficiaries. The MHS also must fully exploit information technology, infrastructure, training and research to support the full ROMO.*

*The military health enterprise is not functioning as a fully integrated system and is not optimized to effectively and efficiently respond to rapidly changing economic conditions, missions, beneficiary demographics, technologies, and health education and research.*

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## **3.0 CHAPTER 3. HEALTH READINESS CONCEPT**

### **3.1 SYNOPSIS OF THE CENTRAL IDEA: PROVIDE OPTIMAL HEALTH SERVICES IN SUPPORT OF OUR NATION’S MILITARY MISSION—ANYTIME, ANYWHERE**

The overarching purpose of the HR CONOPS is to focus MHS efforts on the core business in which we are engaged, creating an integrated medical team that provides optimal health services. The MHS will accomplish this effort through a fully integrated health system focused on four mission elements: (1) casualty care and humanitarian assistance; (2) fit, healthy and protected force; (3) healthy and resilient individuals, families, and communities; and (4) education, research, and performance improvement.<sup>10</sup> Mission outcomes will be achieved through new and enhanced capabilities in the three areas: joint force health protection, health service delivery and health system support. This concept describes the capabilities required for enhancing HR in each of these areas.

### **3.2 FOUR MISSION ELEMENTS**

Health readiness encompasses the broad spectrum of operational medical capabilities and myriad health services and health system support required to promote, protect, improve, conserve, and restore the mental and physical well-being of service members, select former service members, and their families. It represents a significant change from medical or Health Service Support concepts of the past. Military healthcare was once perceived as the responsibility of each individual service supporting largely acute, post-casualty care. Military medical capabilities are now being reshaped into more responsive, joint-centered capabilities, with greater balance between prevention and treatment.

The capabilities described in this HR CONOPS represent a homogeneous mixture of all tasks, defined in Joint Publication (JP) 4-02 as health service support. A more current decomposition of HR is described in Joint Capability Area (JCA) policy and within the four mission elements and associated mission outcomes outlined as the structure of the *2008 MHS Strategic Plan*.

JP 4-02 defines HSS as follows: “All services performed, provided, or arranged by the Services to promote, improve, conserve, or restore the mental or physical wellbeing of personnel. These services include, but are not limited to, the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; area medical support; combat stress control; and medical, dental, veterinary, laboratory, optometric, medical food, and medical intelligence services.”

Current JCA policy defines HR as the ability to enhance DOD and national security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care. All components of the former definition of Health Service Support are now applied to Health Readiness.

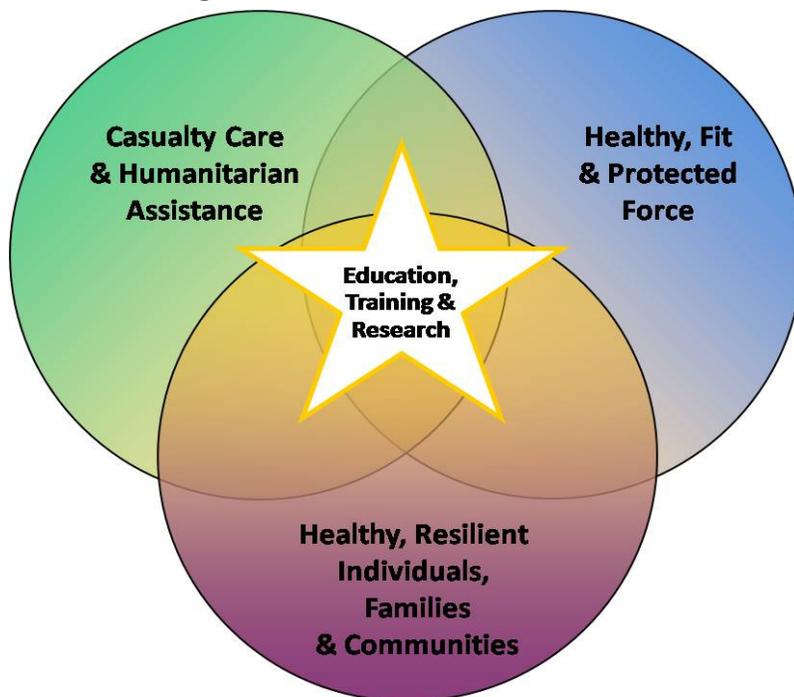
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<sup>10</sup> *2008 MHS Strategic Plan*

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The joint capabilities essential to implementing the HR strategy described in Chapter 4 were developed within the context of the four mission elements (see Figure 3-1) and mission outcomes outlined in the *2008 MHS Strategic Plan* as listed below:

**Figure 3-1: Four Mission Elements**



## 3.2.1 Mission Element 1: Casualty Care and Humanitarian Assistance

The MHS maintains an agile, fully deployable medical force and a healthcare delivery system that enables state-of-the-art health services anytime, anywhere. It uses this medical capability to treat casualties, restore function, support humanitarian assistance and disaster relief, and build bridges to peace worldwide.\*

### 3.2.1.1 Mission Outcomes

- **Reduce Combat Losses (consequences of wounds).** Service members know that if they are injured, they will be rescued immediately and afforded all the care needed to recover as quickly and completely as possible. Reducing combat losses requires a system of coordinated activities and interventions that happen from the time service members are wounded until they return to duty or enter a more extended rehabilitation period. This system includes buddy care, stabilization, medical evacuation, acute care, and initial rehabilitation.
- **Effective Medical Transition From Service and Seamless Transition From Battlefield to VA or Other Rehabilitation.** The MHS strives to build a system that service members and their families view as fair, compassionate, and competent in delivering fully integrated services among military, VA, and civilian hospitals during the transition. For those service members with severe injury or illness, the MHS must conduct a fair disability evaluation along with carefully

\* May be expanded in the future to include health engagement.

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coordinated care that effectively facilitates transition to the next phase of life. Family participation and education are critical to success.

- **Improved Rehabilitation and Reintegration.** Service members who have suffered severe physical and emotional trauma or illness deserve a commitment to compassionate, coordinated care, with a focus on full recovery whenever possible. The goal of rehabilitation is for a wounded service member to return to his or her highest achievable level of function. The DOD's health system must be able to compassionately address the most complex problems, communicate with beneficiaries in a manner that is simple to understand, and empower patients to take charge of their recovery.
- **Increased Interoperability With Allies, Other Government Agencies, and NGOs.** The MHS will maintain and improve existing relationships with other governmental agencies, NGOs (e.g., CARE) and international partners, to enhance synergies and enable more effective mission accomplishment.
- **Reconstitution of Host Nation Medical Capability.** The MHS will provide assistance to rebuild medical capabilities that are damaged or consumed in a conflict. Our objective will be to improve public health outcomes for the region, population, or country we serve. Medical Stability, Security, Transition, and Reconstruction Operations are further defined in appendices A and C and are subject to existing and future Department policy.
- **Strategic Deterrence for Warfare.** People worldwide look to the MHS following a catastrophe. Humanitarian and developmental assistance plays a critical role in winning hearts and minds. The DOD and MHS image is enhanced when host nation (HN) people report that the US military cares, protects, builds, teaches, and trusts enough to help. By building this "medical bridge to peace," the people in countries that might otherwise become hostile will be more likely to become our allies. Success translates to less violence against Americans, fewer terrorist attacks, avoidance of armed conflict, and a more positive public opinion of the United States in countries in which the DOD provided health services through the MHS.

Increased Interoperability with Allies, Other Government Agencies, and NGOs, Reconstitution of Host Nation Medical Capability and Strategic Deterrence for Warfare are part of an evolving multi-agency approach towards global stability called Whole-of-Government.

## 3.2.2 Mission Element 2: Fit, Healthy, and Protected Force

The MHS will help service commanders create and sustain the most healthy and medically prepared fighting force anywhere.

### 3.2.2.1 Mission Outcomes

- **Reduce Medical Non-Combat Loss.** Success is reflected in a reduction of preventable injury and disease. Service members must maintain their health in partnership with the MHS by participating in preventive activities, resilience building and stress training to achieve optimal physical, physiological and

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psychological fitness. Commanders are active partners in creating and sustaining a medically fit and protected force.

- **Improve Mission Readiness.** Success is defined by increased rates of individual “deployability” and collective unit mission readiness. The MHS partners with service members to ensure that they are medically ready at all times. Throughout their military career, service members participate in health assessment and receive training and prophylaxis necessary for sustaining their personal preparedness. Unit commanders and their command surgeons are responsible for preparing these personnel for sustained deployment within myriad environments. Unit readiness officers prepare and execute readiness activities to enhance unit readiness outcomes relative to their collective medical readiness. These activities are environmental threat briefings, immunization tracking, and pre- deployment health assessments (PDHA) and post deployment health reassessments (PDHRA). Combatant and unit level commanders at all times must have full visibility of the readiness status of their personnel.
- **Optimize Human Performance.** Our goal is to enhance the medical resilience of the force. The MHS leverages medical research, technology, and an understanding of optimal human performance to enable warfighters to think more clearly, move more rapidly, withstand more emotional challenges, and return to operations more quickly than the enemy. Forces will feel more confident facing mission challenges when they know they are physically, physiologically and psychologically more fit and better prepared than enemy forces.

### 3.2.3 Mission Element 3: Healthy and Resilient Individuals, Families, and Communities

The MHS provides long-term health coaching and care for 9.2 million DOD beneficiaries. Our goal is a sustained partnership that promotes health and creates a resilience to recover quickly from illness, injury, or disease.

#### 3.2.3.1 Mission Outcomes

- **Healthy Communities/Healthy Behaviors (Public Health).** Shared accountability between the health system and patient drives improved health. Healthy behaviors improve quality of life; alternatively, unhealthy behaviors such as smoking, overeating, sedentary life style, alcohol abuse, and family violence reduce well-being and readiness. The MHS promotes success through engaging beneficiaries and enabling them to take control of their health to create a more robust and resilient military community.
- **Healthcare Quality.** Beneficiaries expect the highest standards of safety, efficacy, and evidence-based care from the MHS. The MHS achieves success when DOD hospitals, clinics, and civilian physician and hospital partners demonstrate outstanding quality and make their outcomes public.
- **Access to Care.** MHS beneficiaries deserve access to appropriate healthcare in a reasonable time frame, with no administrative hassles. They should have access to quality providers that meet their unique needs.

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- **Beneficiary Satisfaction and Perception of MHS Quality.** To achieve an effective health partnership with beneficiaries, the MHS must provide caring, compassionate, and convenient service. Healthcare system design should be built around beneficiary medical needs and customer service expectations.
- **Perception of MHS Quality by Recruitment Pool.** The MHS strives to be the best in the world through robust training programs for combat casualty care, infectious disease, psychological health, brain and eye injuries, regenerative medicine (stem cells), health IT, medical ethics, traumatic brain injury (TBI), healthcare delivery, nursing, and global public health. The MHS demonstrates that it trains not only experts and managers but also leaders. Our objective is to attract the highest caliber of medical professionals available in the industry to select the MHS as their employer of choice.

## 3.2.4 Mission Element 4: Education, Research, and Performance Improvement

Sustaining mission success relies on the MHS' ability to adapt and grow in the face of a rapidly changing health and national security environment. To accomplish this effort, the MHS must be a learning organization that values personal and professional growth and supports innovation.

### 3.2.4.1 Mission Outcomes

- **Capable Medical Workforce.** The MHS recruits and maintains a team of health professionals with the right training and skills to accomplish its wartime and humanitarian assistance missions.
- **Advancement of Medical Science.** By focusing education and research and development efforts on serving unique military missions, the MHS will inevitably make discoveries in medical science that will benefit the world. The MHS will share knowledge, devices, medicines, vaccines, new procedures, and delivery models freely. Our ability to anticipate and develop new solutions to meet warfighters' needs will simultaneously contribute to the health of society.
- **Advancement of Global Public Health.** Through global reach and surveillance, the MHS will identify and track emerging threats to human and animal health and will develop solutions (e.g., new vaccines, sanitation methods, and treatments) that will benefit the community and society at large.
- **Create and Sustain the Healing Environment (Facilities).** MHS facilities will be inviting to patients and staff. Their design will promote safety, efficient care, and patient empowerment. Their aesthetic qualities will promote healing.
- **Performance-Based Management and Efficient Operations.** The MHS will carefully define strategic value and install incentives that reward value creation. Our healthcare delivery leaders will ensure that its people have the capability to continuously improve quality and efficiency.
- **Performance-Based Focus for Joint Medical Education and Training.** The total medical force includes active, reserve, and guard service members, as well as civilian and contract staff. Medical education and training must prepare the medical force for future requirements, improving overall capabilities, and

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increasing joint medical interoperability and deployability among the services. The interface boundary with the expeditionary and institutional medical treatment facility (MTF) capabilities or Direct Care System (DCS) is equally critical in rendering care to the warfighter by honing medical professionals' skills that are applied in the JOA. The MHS is committed to unleashing the full potential of all members of the medical force by providing a joint medical education and training environment that rewards excellence and innovation.

### 3.3 ENHANCED INTEROPERABILITY AND INTERDEPENDENCE WITHIN THE MILITARY HEALTH SYSTEM

An objective of this CONOPS is to transform the medical force into a fully integrated health system that operates across the ROMO to support a dynamic joint force that decides and acts with great speed. To this end, the future medical force must support service-unique missions while operating, with an optimal degree of interoperability and interdependence, as a fully integrated HR system. The components of the future total medical force must be versatile and able to adapt quickly to collectively maintain all the capabilities required for supporting the joint force and to meet the health requirements of all MHS stakeholders and beneficiaries. In the past, the MHS capabilities largely represented the sum of independently developed service programs without maximizing opportunities for enhanced interoperability and interdependency through joint development and standardization. Current and future military strategies mandate that the medical force structure be more responsive in diverse operations, including capacity building in the civilian public health sector and providing healthcare to HN personnel, DOD contractors, deployed civilians, and all others entrusted to our care. Without compromise to service-unique missions, capabilities must be developed jointly and optimized to support HR operations across the entire ROMO.

The following definitions and discussion of the terms *interoperability*, *interdependent*, and *interchangeable*, in the context of medical capabilities provide a common lexicon for use in medical transformation. These definitions are taken from Appendix E, Part II, Glossary, and the originating sources are indicated in the parentheses.

**Interoperability.** (1) The ability to operate in synergy in the execution of assigned tasks. (JP 1-02) (2) The ability of systems, units, or forces to provide data, information, materiel and services to, and accept the same from, other systems, units or forces and use the data, information, materiel and services so exchanged, to enable them to operate effectively together. (Manual for Operation of the Joint Capabilities Integration and Development System, February 2009 (Updated 31 July 2009)) (3) The degree of interoperability should be defined when referring to specific cases. (JP 3-32)

*Interoperability* describes a condition, primarily at the tactical level, in which capabilities from more than one service can operate together to accomplish assigned tasks. As a real-world example in the Operation Iraqi Freedom JOA (as of 2007), the Army Medical Regulating Office (MRO) is responsible for managing patient evacuation from points of injury to theater hospitalization. In western Iraq, Navy corpsmen on US Marine Corps rotary wing assets are responsible for en route care from points of injury to the USAF Theater Hospital at Balad Air Base (AB). This critical process requires that services be

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interoperable in communication equipment; clinical, patient administration and MEDEVAC lexicon, techniques and procedures; and to some degree, patient movement items (PMI). The condition of interoperability should be applied with judgment so that service-specific capabilities may persist and not drive isolated characteristics that are not required in any other service/environment.

**Interdependent.** A service's purposeful reliance on another service's capabilities to maximize complementary and reinforcing effects, while minimizing relative vulnerabilities to achieve mission requirements of the Joint Force Commander. (JP1-02)

*Interdependent* describes a condition, primarily at the operational level, where capabilities from more than one service are reliant on each other to accomplish assigned missions. In the same real-world example used above, forces from all services are dependent on the Army MRO to regulate casualties from point of injury to hospitalization within Iraq. Another example of interdependence is the establishment of Joint Task Force National Capital Region Medical (JTF CapMed) in September 2007. The DepSecDef established JTF CapMed to oversee the delivery of integrated healthcare among Army, Navy, and Air Force medical treatment facilities in the national capital area, ensure readiness, and execute BRAC business plans. In this case, services depend on one another to achieve a vision of establishing a world-class medical center at the hub of the nation's premier regional healthcare system serving our military and our nation. Without this interdependency, MHS will sacrifice efficiency for service autonomy.

**Interchangeable.** The ability of systems, units, or forces to replace like systems, units, or forces that possess common capabilities and like characteristics to fulfill relevant requirements without causing unacceptable performance degradations when exchanged. (JP 1-02)

*Interchangeable* describes a condition that is applied primarily at the tactical level where a capability from one service completely replaces the capability of another. At the elemental level, interchangeability can describe equipment (e.g., patient life support items) that should be usable by medical capabilities from any service or passed seamlessly among services. At the unit or force level, interchangeability may describe a pharmacy team that can work in a theater hospital from any service, a theater hospital from any service that can provide theater hospitalization at a theater aeromedical evacuation hub, or an ability to serve the MHS beneficiary population through a series of provider encounters in which ostensibly the same health services can be obtained from military treatment facilities operated by any of the services or through a network of civilian providers. Although service medical capabilities may not always be interchangeable, they should be interoperable, and occasionally, interdependent where resources can be optimized and redundancies minimized without compromising service-unique requirements. Interoperable (service) capabilities should be, but may not always be, born joint but should be deliberately assessed during development and implementation to identify opportunities for optimizing interoperability across the full ROMO. The goal is to design joint force capabilities that increase the range of options available to the President and SECDEF.

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## **3.4 THREE FUNCTIONAL AREAS OF NEW AND ENHANCED CAPABILITIES**

The three functional capability areas comprising HR are described below and further defined in Chapter 4.

### **3.4.1 Force Health Protection**

FHP is an ability to sustain and protect the health and effectiveness of the human centerpiece of the American military. FHP is composed of activities that promote human performance enhancement; provide for a healthy, fit, and protected force; engage in health surveillance; encompass casualty management in the JOA; and enhance mission set preparedness and support to Homeland Defense/Civil Support (HD/CS) operations.

### **3.4.2 Health Service Delivery**

HSD is an ability to build healthy communities by managing and delivering the TRICARE health benefit, using military treatment facilities along with TRICARE network of healthcare providers and partnership development among health service organizations outside the DoD. HSD includes clinical preventive medicine, along with clinical diagnostics, treatment, rehabilitation, and reintegration, for all those entrusted to our care. It also includes activities associated with the health services contract development, health services contract management, and partnership development among health service organizations outside the DOD.

### **3.4.3 Health System Support**

HSS is an ability to sustain and continuously improve MHS mission effectiveness through the focused development of people, technology, infrastructure, and joint organizational culture. HSS consists of managing the total medical force, health quality and safety, health education and training, medical financial management, medical/health information management, creating and sustaining the healing environment, joint and interagency medical logistics, and medical research and development.

## **3.5 SUPPORTING IDEAS**

### **3.5.1 Homeland Defense and Civil Support**

Securing our homeland is a national responsibility requiring a partnership of organizations in which DOD is a major contributor and partnership development among health service organizations outside the DoD. Joint medical forces must be capable of supporting, integrating, and executing operations with other US Government agencies, NGOs, international partners, and state and local medical resources. The MHS must function as an integrated system to support the National Response Framework (NRF). The MHS role in Emergency Support Function 8 (Public Health and Medical support) is evolving at a rapid rate in the interagency process. Paraphrasing and applying the military problem from the 2007 *DoD Homeland Defense (HD) and Civil Support (CS) Joint Operating Concept*, MHS capabilities will affect how—

- DOD detects, deters, prevents, or if necessary, defeats external threats or aggression to the homeland

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- DOD will be prepared to respond to catastrophic incidents as appropriate or as directed
- DOD will integrate and operate with non-DoD and international partners to achieve unity of effort for HD and CS.

## **3.5.2 Medical Stabilization, Security, Transition, and Reconstruction Operations**

Per the *Military Support to Stabilization, Security, Transition, and Reconstruction Operations Joint Operating Concept (SSTRO JOC)*, the desired end state for stability operations is the achievement of full HN responsibility across mission elements. There are six major mission elements:

- Establish and maintain a safe, secure environment
- Deliver humanitarian assistance
- Reconstitute critical infrastructure and restore essential services
- Support economic development
- Establish representative, effective governance and the rule of law
- Conduct strategic communications.

Homeland Defense and Stability, Security, Transition, and Reconstruction Operations are further defined in appendices A and C respectively and are subject to existing and future Department policy.

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## 4.0 CHAPTER 4. HEALTH READINESS CAPABILITIES

Chapter 4 describes the capabilities required for operating in the manner described in the central and supporting ideas of Chapter 3.

The following functional area capabilities describe what needs to be done to deliver integrated health support. The capabilities will be further decomposed into tasks, conditions and attributes, and standards in subsequent Force Health Protection (FHP), Health Service Delivery (HSD) and Health System Support (HSS) concepts of operation. FHP capabilities integrate the capabilities of the other two CONOPS and transforms them for expeditionary operations. All three CONOPS are interdependent and enable the seamless delivery of health care to all beneficiaries whether in garrison (home-based) or in expeditionary operational environments.

### 4.1 FORCE HEALTH PROTECTION CAPABILITIES

#### 4.1.1 Joint Human Performance Enhancement Capabilities

The Joint Human Performance Enhancement (JHPE) will improve the ability of the future joint force to complete essential tasks. JHPE will extend physical and mental endurance and enhance physiological and psychological resilience to reduce injury and illness. It examines factors that stress the deployed force, and it improves warfighter success on the battlefield and between deployments. Effects should include enhanced physical resilience, enhanced physiological resilience, enhanced psychological resilience, reduced recovery time from injury, and reduced rates of injury and illnesses.

**Manage Warfighter Fatigue.** The ability to evaluate and monitor fatigue, predict and manage effects on warfighters' performance, and develop methods for countering the effects of fatigue.

**Optimize Human-Systems Integration.** The ability to support integration of the warfighter (human system) into all systems to sustain or enhance human performance, reduce warfighter morbidity and mortality, and improve mission performance.

**Enhance Warfighter Sensory, Cognitive, and Motor Capabilities.** The ability to enhance and sustain sensory capabilities; manage/control sensory inputs; enhance and sustain cognitive performance; and monitor, assess, and use the physical and mental status of individual warfighters and units to enhance commanders' decision making.

**Enhance Warfighter Learning, Communications and Decision Making.** The ability to enhance individual and team learning/training with high retention of knowledge/skills, individual and team communication, situational awareness, and decision making.

**Enhance Physiological Capability.** The ability to improve warfighter success within the physiological domain to decrease brain injury (neuroprotection), manipulate metabolic processes (related to water intake, nutrition, and waste production), and enhance the ability to withstand trauma and maintain enhanced performance despite military operations stressors.

**Provide and Maintain Ability to Operate Across the Full Range of Military Operations (ROMO).** The ability to perform in various environments: flight, kinetic,

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extreme climates (effects of temperature and altitude); space; underwater; chemical, biological, radiological, nuclear, and high yield explosive (CBRNE); and directed energy.

**Manage Warfighter Performance.** The ability to provide a healthy and fit force through effectively predicting, monitoring, evaluating warfighter performance, and taking appropriate actions to counter warfighter performance decrement.

**Enhance Psychological Resilience.** The ability to enhance warfighter resistance to and recovery from the emotional resultant outcome of combat, adversity, and trauma; prevent psychological dysfunction; and strengthen protective factors to stress and negative events.

## 4.1.2 Provide a Healthy and Fit Force (Health and Wellness)

The ability to provide and enhance a healthy and fit force from accession to veteran includes optimizing health/fitness of peacetime forces, maintaining health/fitness of deployed forces, and restoring the physical and mental health of redeployed service members.

**Access a Healthy and Fit Force.** The ability to obtain a healthy and fit force using appropriate standards for aptitudes and abilities, medical and mental conditions, as well as physical fitness to select recruits most likely to finish basic training, perform their job, and successfully complete the first term of service (generally 36 months).

**Optimize Health and Fitness of the Deployed Force.** The ability to optimize the health and fitness of deployed military and civilian through effective conduct and management of physical fitness and training programs and individual medical readiness requirements.

**Optimize Health and Fitness of the Peacetime Force.** The ability to optimize the health and fitness of military forces during peacetime or while at home station through effective conduct and management of physical fitness and training programs and individual medical readiness requirements.

**Ensure the Physical and Mental Health of the Redeployed Force.** The ability to evaluate and predict physical and mental health effects on a redeployed warfighter (routine screening and follow-up of immediate and long-term health threats); communicate effective implementation strategies to decision makers; and provide effective communication and accountability systems enabling contact between commanders, their injured warfighters, and families.

## 4.1.3 Provide Public Health/Veterinary Services

The ability to provide public health/veterinary service support to the warfighter by performing food safety operations and inspections and providing for the care and physical well-being of military working animals. Additionally, the provision of veterinary and public health services during humanitarian assistance missions is essential to HN sponsors and adds value to relationships with partner nations.

**Provide Food Safety and Inspections.** The ability to assess wholesomeness and safety of locally available foodstuffs to determine fitness for warfighter consumption. Used in conjunction with preventive medicine capabilities, proper food safety and inspections

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ensure that deployed forces receive the best and safest food available in theater. For deployed forces in remote or austere settings, food safety and inspections also are performed on foreign food production and supply chain distribution facilities using Food and Drug Administration (FDA) standards in a continuous quality program.

**Provide Military Working Animal Care.** The ability to provide medical services and healthcare to military working animals in theater to enhance force protection (FP) through detection of drugs and explosives for base and physical security.

**Provide Health-Related Education.** The ability to effectively educate DOD personnel and other beneficiaries to prevent not only the incidence of injury, disease, and chronic illness but also secondary and tertiary prevention efforts to facilitate the rapid return of personnel to duty. Health education is provided to improve and/or sustain health and is often aligned with health risk communication actions.

**Provide Public Health Sanitation, Control of Disease Vectors, and Other Health Threats.** The ability to ensure that personnel are afforded the safest environment possible in which to work and live that promotes health and well-being.

#### 4.1.4 Non-Clinical Preventive Medicine/Health Surveillance

The ability to provide comprehensive and continuous military non-clinical preventive medicine and comprehensive health surveillance to effect early intervention and control strategies for all occupational and environmental health hazards and CBRN threats, using joint technologies, practices, and procedures consistently across the military services.

**Provide Comprehensive Health Surveillance.** The ability to provide occupational and environmental health surveillance, medical surveillance, and health surveillance are important components of comprehensive health surveillance.

**Provide Medical Intelligence Preparation of the Operational Environment (MIPOE).** The ability to provide all-source medical intelligence products, including collecting and analyzing information, producing assessments and forecasts, and maintaining databases. These databases should incorporate military and civilian healthcare capabilities, endemic disease, and Occupational and Environmental Health (OEH) Operational Exposure Guidance (OEG) exposure threats and hazards on a theater- and site-specific basis.

**Anticipate and Predict Health Threats.** The ability to anticipate and predict health threats to mitigate effects of climate/environment or other OEH threats.

**Provide Health Risk Evaluation (Characterization).** The ability to characterize OEH, including infectious, endemic disease, and CBRNE hazards to determine whether they constitute a threat to the force, forecast health threats, and conduct exposure assessment are important functions needed for protecting the health of the force and ensuring mission accomplishment.

**Provide Health Risk Assessment.** (1) The ability to use exposure assessments accomplished for single or multiple health threats and to translate those exposure assessments, using recognized risk assessment methodologies (e.g., the EPA's), into

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assessments of individual health risk and unit (population) health risk. (2) The ability to understand hazard and exposure assessment results; evaluate and apply threat mitigating actions for preventing and protecting the force using cost-benefit analysis; and clearly communicate risk to the decision maker to prevent disease and non-battle injury (DNBI).

**Provide Health Risk Communications (Including CBRNE).** The ability to effectively communicate important health-related information to key stakeholders (e.g., commanders and supervisors, service members, government civilians, contractors, and family members) in a timely manner.

**Provide for Medical Countermeasures.** The ability to minimize the incidence or the severity of disease or illness, including the protection of US personnel against rare or exotic diseases or against chemical or biological warfare agents through the application of medical countermeasures.

**Provide for Non-Medical Countermeasures.** The ability to employ non-medical actions or materiel to prevent or control spread of disease or mitigate the effects of CBRNE related exposure. Non-medical countermeasures may include measures to avoid contact with the threat or to limit contact with the threat, thus reducing the opportunity for adverse health effects to develop.

**Archive and Retrieve Health-Related Documents and Data.** The ability to provide effective laboratory and information management systems and procedures for documenting, compiling, storing, and archiving germane non-clinical preventive medicine and health surveillance data, including deployment and in-garrison OEH- and CBRNE-related data in usable and actionable formats that enable retrieval, strategic communication, and future reference. Includes the ability to create longitudinal exposure records which include individual exposures recorded in medical records and archived OEH and CBRNE monitoring data critical for the short- and long-term health protection of the force.

## 4.1.5 Global Patient Movement

The ability to evacuate injured and ill personnel with appropriate enroute care. This includes all activities related to CASEVAC, MEDEVAC, aeromedical evacuation (AE), enroute care, patient movement planning, medical regulating, patient staging facilities, patient movement items, and patient in-transit visibility. Also included are all activities related to maintaining DOD's Global Patient Movement Network.

**Aeromedical Evacuation (AE).** The ability to provide movement of regulated patients under medical supervision to and between MTFs by USAF fixed-wing organic or commercial assets. Civil Reserve Air Fleet may also be used. (JPM FNA Report)

**Casualty Evacuation (CASEVAC).** The ability to provide unregulated movement of casualties aboard non-dedicated, non-standardized platforms (vessels, vehicles, or aircraft), including movement to and between MTFs. (JPM FNA Report)

**En Route Care.** The ability to provide continuation of healthcare for critically injured/ill warfighters accompanied by trained medical providers while being moved to increased

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medical care capabilities or to a site for final disposition or RTD (JP 1-02). En route care, which is a shared capability with casualty management, requires detailed coordination, standardization and synchronization. This includes the capability to direct and manage a patient movement safety program which allows for evaluation of the quality of care standards and process improvement.

**Manage Patient Movement Items.** The ability to manage medical equipment, supplies, and patient movement items (PMI) required to support patient movement. This includes activities related to managing theater resources, preventive maintenance and repair, and supporting information systems.

**Medical Evacuation (MEDEVAC).** The ability to provide timely, efficient PM and en route care of the wounded, injured, or ill persons from the point of injury to an MTF; from one MTF to another MTF; or from an MTF to a contingency aeromedical staging facility (CASF). This is performed by dedicated, standardized medical evacuation platforms, with trained medical professionals (JPM FNA Report).

**Medical Regulation.** The ability to coordinate intra-theater and inter-theater patient movement. This includes patient movement policies, medical regulating authorities, patient movement requirements centers, supporting information systems and patient movement enablers such as the Joint Patient Movement Teams.

**Patient Movement Planning, C2.** The ability to provide command and control for all units involved in patient movement. The ability to provide patient movement planning.

**Provide Patient Reception, Staging and Re-distribution.** The ability to manage patients at staging facilities and provide transitory care. This includes evacuation related activities at casualty collection points, helicopter evacuation stations, AE staging facilities, and the federal coordinating centers.

**Staging and Management of Patient Movement Teams.** The ability to stage and manage teams and units to sustain, with no degradation, the standards of care as patients move through the continuum of care. This includes activities related to MEDEVAC crews, AE crews, critical care air transport teams, aeromedical staging facilities, and specialty care teams such as the Army's Burn Flight Team.

## 4.1.6 Casualty Management

The ability to provide a continuum of timely, responsive medical and surgical care that incorporates the latest technologies and advancements in medical science. This care begins with the first responder and proceeds through forward/resuscitative care and theater hospitalization in the joint area of operations. Health Service Delivery addresses definitive care at a CONUS-based rehabilitative facility.

**First Responder Care.** The ability to provide initial medical care at or near the point of injury by the individual or medical and/or non-medical personnel. This may include preparing the casualty for transportation to the next medical capability, as required.

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**Forward Resuscitative Care.** The ability to provide expedient healthcare at the point of injury to salvage life, limb, or eyesight and relieve pain. This care includes stabilizing the warfighter in preparation for transportation to the next higher medical capability, as required.

**Organic and Area Medical Support in Theater.** The ability to provide resuscitative care, sick call, and patient holding for up to 72 hours within a specified area of operations.

**Theater Hospitalization.** The ability to provide capabilities that medical personnel require to repair, restore, stabilize, or rehabilitate casualties within the theater, including preparation for strategic transport, return to duty, or rehabilitation. The utilization of telemedicine in this setting is a force multiplier.

**Medical Care in a CBRNE Environment.** The ability to manage patient care and response in the event of an emergency resulting in casualties generated by WMD, mass casualty incidents, and/or terrorism events including the ability to perform medical operations in a contaminated environment, decontaminate patients, and mitigate CBRNE medical effects.

## **4.1.7 Shared Situational Understanding and Awareness**

The ability to capture and share timely, accurate, interoperable medical all-source data. This data provides medical asset visibility, coordination, and decision support management and enables information-rich visualization and execution monitoring.

## **4.1.8 Support to Security, Stability, Transition, and Reconstruction Operations**

The ability to provide complementary health capabilities to achieve CCDR Security, Stability, Transition, and Reconstruction Operations (SSTRO) theater engagement objectives.

## **4.1.9 Support to Homeland Defense and Civil Support Operations**

The ability to provide reinforcing health support to the homeland if the nation were to endure a natural or technological catastrophic event.

## **4.1.10 Detainee Medical Care**

The ability to provide medical care and safeguard the health of detained personnel in compliance with the provisions of the Geneva Convention, international law and our nation's stance on human rights.

## **4.1.11 Operational Medical Logistic Support**

The ability to orchestrate and synchronize the provision of integrated medical logistics support (e.g., medical supplies, medical equipment, and its maintenance, blood, optical, medical facilities, medical services, and/or medical contracting) for HR support to the joint force in a designated operational area.

**Medical Logistics Integration.** The ability to synchronize and integrate the provision of medical logistics for HR support to the joint force in a designated operational area.

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**Medical Logistics Management.** The ability to manage and maintain visibility of medical logistics for HR support to the joint force in a designated operational area.

## 4.2 HEALTH SERVICE DELIVERY CAPABILITIES

The ability to provide acute or long-term primary or specialty care capabilities to all eligible beneficiaries outside the theater in either the direct or purchased care system.

### 4.2.1 Define the Health Benefit

The ability to identify and plan for specific healthcare needs associated with a population of eligible beneficiaries and continuously measure, monitor, and positively influence health and wellness through evidenced-based preventive and interventional healthcare services. This care delivery model maintains a healthy, worldwide deployable force (and associated medical support component) to achieve US national objectives and improves overall health, wellness, and satisfaction for all beneficiaries by managing access and demand, promoting healthy lifestyles, and controlling future healthcare costs.

**Health Quality and Safety.** The ability to gain and maintain awareness of advances in proven healthcare delivery practices and technologies; promote infusion into the scope of care; and use measurable approaches with outcome monitoring to enhance the quality of health and attain desired health outcomes. Safety includes the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of healthcare. Health safety also involves the ability to establish operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them so that they will not occur. Health quality and safety includes quality assurance, quality improvement, and risk management.

### 4.2.2 Clinical Preventive Medicine and Public Health Laboratory Services

The ability to provide effective methods to reduce overall disease burden in a population and potentially reduce non-battle injuries for warfighters. Preventive medicine includes preventive medical and dental services, occupational health services, and public health laboratory services. Commonly used approaches are vaccination, counseling to modify high-risk behaviors, screening, and proactive treatments for chronic disease processes to establish early control and medical management.

**Preventive Medical Services.** The ability to conduct health promotion and disease prevention strategies to reduce death, disability, and suffering. This ability includes identifying and managing disease processes before they become problematic, identifying and treating asymptomatic conditions, and limiting negative effects of disease processes already under way. Emphasis is placed on health promotion and disease prevention through examinations, immunizations, screening tests, health counseling, and community health education.

**Preventive Dentistry Services.** The ability to maintain the normal masticating mechanism by fortifying structures of the oral cavity against damage and disease using primary (fluoride gel), secondary (dental restoration) or tertiary (fixed bridge) prevention.

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**Occupational Health Services.** The ability to protect the safety, health, and welfare of the warfighter, civilian employees, and contractors in the workplace includes occupational medicine, occupational (or industrial) hygiene, public health, safety engineering, chemistry, health physics, ergonomics, toxicology, epidemiology, environmental health, industrial relations, public policy, sociology, and occupational health psychology.

**Public Health Laboratory (PHL) Services.** The ability to provide services to test and monitor the environment; assess the population's health status; investigate and control disease outbreaks; detect and track communicable diseases; act as a reference laboratory for private laboratories; and assure the safety of food and water.

## 4.2.3 Diagnosis

Capabilities that assist clinicians in their ability to identify a medical or dental condition, disease, or injury. Diagnostic procedures are complimentary to relevant history, signs and symptoms, and results of physical examination.

**Ambulatory Diagnostic Services (Medical).** The ability to apply medical examinations and capabilities on an outpatient basis (return home the same day) without admission to a hospital.

**Ambulatory Diagnostic Services (Dental).** The ability to apply dental examinations and capabilities on an outpatient basis (return home the same day) without admission to a hospital.

**Inpatient Diagnostic Services.** The ability to apply diagnostic examination and capabilities that require or support an admission to a hospital. Examples are diagnostic laboratory and radiological services before or after inpatient surgery.

**Laboratory Diagnostic Services.** The ability to provide chemical, hematological, microscopic, microbiologic, immunologic, or pathologic study of secretions, discharges, blood, or tissue sections to help diagnose a medical or dental condition or disease.

**Radiology Diagnostic Services.** (1) The ability to use various radiological techniques, mostly noninvasive, to diagnose an array of medical conditions using x-rays, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, and ultrasound. (2) The ability to provide oral and maxillofacial imaging techniques (e.g., bitewing, peri-apical, and occlusal radiographs; ultrasound, cone beam CT, MRI) and special tests (e.g., sialograph) to help diagnose oral or maxillofacial conditions or disease.

## 4.2.4 Treatment

The ability to administer or apply remedies to a patient for a disease or injury, including medicinal and surgical management, therapy, or combinations, intervention radiology and to provide for palliative and end of life care.

**Emergency Services.** The ability to provide the initial evaluation, diagnosis, treatment, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care. Emergency services may be provided in a hospital-based or freestanding emergency

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department (ED), in an urgent care clinic, in an emergency medical response vehicle, or at a disaster site.

**Routine Ambulatory Care (Medical).** The ability to provide ambulatory (out-patient) primary and specialty diagnosis, observation, treatment, and rehabilitation for symptoms and conditions for which non-urgent or non-emergent intervention is required.

**Routine Ambulatory Care (Dental).** The ability to provide examination and assessment of teeth and supporting oral structures routine prophylactic treatment and care to restore integrity of the teeth and maintain dental health.

**Surgery (Ambulatory).** Ambulatory surgery procedures that require the patient to remain in the medical treatment facility less than 24 consecutive hours following completion of the procedure.

**Medical Management (Chronic Illnesses).** The ability to provide an integrated managed care model that promotes utilization management, case management, and disease management programs as a hybrid approach to managing patient care. This ability includes evidence-based, outcome-oriented management of populations with common conditions emphasizing the integration of clinical practice guidelines and monitoring patient outcomes.

**Inpatient Non-Surgical Treatment.** The ability to provide all non-surgical medical care and services to treat patients admitted to a hospital for at least one overnight stay.

**Intensive Care.** The ability to provide comprehensive and highly specialized, life-saving methods and equipment with continuous monitoring and care to seriously ill or injured patients with specially trained provider, nursing, and technical staff.

**Surgery (Inpatient).** The ability to treat disease or injury, improve or restore form or function, or close a previously sustained wound through surgical intervention. Inpatient surgery requires that the patient remain in the medical treatment facility for more than 24 consecutive hours following the completion of the procedure to recover from the procedure.

**Pharmacy Services.** The ability to support clinical activities in all environments through expert clinical consultation, patient education, and appropriate handling and dispensing of drugs and other medical supplies to patients or family members.

**Therapeutic Radiology Services.** The ability to apply ionizing radiation to treat patients with cancer and other diseases.

**Mental Healthcare.** The ability to provide patients with tools to achieve a state of subjective well-being and successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, an ability to adapt to change and cope with adversity, decreased negative stigma associated with a warfighter seeking mental health, and mitigated risks for post-traumatic stress disorder (PTSD). Activities include prevention, early intervention, and clinical treatment.

**Substance Abuse Care.** The ability to provide medical and/or psychotherapeutic treatment for dependency on illegal drugs and prescription or over-the-counter drugs or

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alcohol or other mind altering substances to enable the patient to avoid psychological, physical, legal, financial, social, and job-related consequences.

## 4.2.5 Rehabilitation

The ability to restore skills to a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible. Rehabilitation addresses the patient's physical, psychological, social, vocational, educational, and environmental needs. Family members often are involved actively in the patient's rehabilitation program.

**Physical Rehabilitation.** The ability to use therapeutic measures and reeducation to the restoration of physical, psychological, social, vocational, speech, and educational potential consistent with neurological or anatomical impairment.

**Amputee Care.** The ability to assist patients who will experience, or have experienced, amputation and/or limb deficiency at any point along the continuum of care, including preoperative assessment, surgery, acute hospitalization, rehabilitation, outpatient services, prosthetics, and life-long management.

**Burn Care.** The ability to apply highly specialized medical training, resources, and technologies to manage, treat, and heal patients with deep burn injuries.

**Occupational Rehabilitation.** The ability to help a patient regain the ability to perform normal everyday tasks and activities by restoring old skills or teaching new skills to adjust to disabilities using adaptive equipment, orthotics, and modification of the patient's home or work environment.

## 4.2.6 Reintegration

The ability to provide a system of resources designed to assist severely ill or injured warfighters transition back to active duty or to civilian status and to their families, jobs, school, and community. The ability to assist and involve families in the transition process is a critical component to reintegration success.

**Disability Counseling and Coaching.** The ability to provide severely injured or ill service members and families access to a network of professional counseling, information and resources that provide personal support and assistance from injury to reintegration, separation or medical retirement.

**Disability Evaluation.** The ability to evaluate service members who have achieved the optimal medical benefit from available treatment options against medical retention standards.

**Transitional Services.** The ability to provide severely ill or injured warfighters who are transitioning to civilian life and possibly civilian or VA healthcare with the guidance and support to make the passage as seamless and trouble-free as possible.

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## 4.3 HEALTH SYSTEM SUPPORT CAPABILITIES

The ability to perform healthcare administrative and support related functions to sustain and continuously improve MHS mission effectiveness through focused development of people, technology, infrastructure, and joint organizational culture.

### 4.3.1 Health Services Contract Development

The ability to identify, accurately assess, and develop a plan to acquire “patient-centered” health services or capabilities defined in the military health benefit, which are not readily available via organic military medical capabilities or are more cost effectively provided by a network of health industry partners.

**Contract Development.** The ability to provide contract strategies that deliver “best value” balance between vendor performance and deliverable quality and cost through collaboration with medical service delivery leadership.

**Contract Modifications.** The ability to alter specification, delivery, contract period, price, quantity, or other provisions of an existing contract through unilateral action in accordance with a contract provision (change order), or by mutual action of the parties to the contract (contract amendment). It includes administrative changes, notices of termination, field orders, and notices of exercise of a contract option and contract extensions.

### 4.3.2 Health Services Contract Management

The ability to manage administrative activities associated with contracts (e.g., invitations to bid, bid evaluation, award of contracts/task orders, contract implementation, measurement of work completed, and verification and computation of payments).

**Medical Services Acquisition.** The ability to perform health-related acquisition activities to develop or purchase MHS requirements not readily available via organic military medical capabilities or more cost effectively provided through health industry partners.

**Monitoring.** The ability to monitor contract relationships, addressing related problems, incorporating necessary changes or modifications in the contract, ensuring both parties meet or exceed each other’s expectations, and actively interacting with the contractor to achieve the contract’s objective(s).

**Beneficiary Services.** The ability to understand and deliver all patient customer service requirements through initial and ongoing health plan benefit education, enrollment, assistance with accessing care and services, claims administration, and payment.

**Claims Payment.** The ability to provide reimbursement to contributing medical/non-medical resources for healthcare products and services provided to eligible patients in properly documented manner and in accordance with all associated payment rules and regulations.

### 4.3.3 Partnership Development

The ability to explore collaborative clinical and/or business arrangements with potential health industry partners to provide required healthcare and healthcare services so that

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patients receive the best possible care and services that will result in the best possible medical outcome.

## **4.3.4 Total Medical Force (Medical Professionals)**

The ability to effectively manage the total medical force by determining manpower requirements, necessary skill mix, conducting career transition and succession planning, and ensuring that the right people are in the right place at the right time at the right cost.

**Total Medical Force Recruiting.** The ability to effectively recruit and retain the highest quality military, federal civilian, and contractor medical professionals to support the MHS across the full ROMO.

**Credentialing and Privileging.** (1) *Credentialing:* The ability to confirm the qualifications of healthcare providers, including collection, verification, assessment and interpretation of practitioner information and documents such as appropriate education, training, licensure, experience, and expertise. (2) *Privileging:* The ability to grant permission and assigning responsibility to a healthcare provider to independently provide specified or delineated healthcare within the scope of his or her license, certification, or registration. Clinical privileges define the scope and limits of practice for individual providers and are based on the capability of the healthcare facility and on the licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations regarding the healthcare provider.

## **4.3.5 Joint and Service Medical Education and Training**

The ability to provide dynamic, capabilities-based training for the joint and service medical forces in support of national security requirements across the full range of integrated operations. Joint and service medical education and training will provide the common framework for preparing medical personnel for current and future operational mission requirements, thereby enhancing joint medical interoperability and deployability. Key components of a successful program will include an effective joint and service-specific military healthcare personnel education and training process; an adaptive and efficient environment in which to support military medical education and training; an effective joint and service-specific medical leader preparation process; transformed military medical readiness training that enhances integrated operations and the ability to leverage recruiting and retention incentive programs to ensure total medical force capability.

**Basic and Specialty Medical Education and Training Programs.** The ability to provide basic medical education and training programs to officers and enlisted and specialty medical education and training programs to officers, enlisted and civilian personnel to meet the training and certification requirements for their military specialty code(s) and civilian position(s).

**Medical Readiness Training.** The ability to provide courses, hands-on training programs, and exercises designed to develop and enhance survival skills and maintain military medical skills. Medical readiness training includes individual, collective, and unit training, initial and sustainment, required for ensuring healthcare personnel and units are capable of performing operational missions.

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**Staff Development.** The ability to provide training for personnel to attain skills, knowledge, personal and professional development, and career advancement. This effort is accomplished through facilitated learning opportunities ranging from college degrees to formal coursework, professional credentialing/licensing, conferences and seminars, and informal learning opportunities.

**Continuing Health Education.** The ability to provide medical professionals with specific continuing health education to maintain competence and currency regarding new and developing areas of study and practice. Educational forums include live, virtual, and constructive events; modeling and simulation; written publications; online programs; and audio, video, or other electronic media. These forums are developed, reviewed, and delivered by experts in their clinical and operational areas.

**Health Professional Degree Granting Programs.** The ability to plan, conduct, and properly document formal education programs that result in the issuance of healthcare professional degrees to students who successfully complete all prescribed program requirements.

**Graduate Medical Education.** The ability to plan, conduct, and properly document graduate medical education obtained while serving as an intern, resident, or fellow after graduation from medical school.

## 4.3.6 Medical Financial Management

The ability to effectively forecast, budget, allocate, execute, analyze, balance, and document funds required for financing healthcare operations.

**Develop and Manage DHP.** The ability to effectively forecast, budget, allocate, execute, analyze, balance, and document funds appropriated by Congress exclusively for the healthcare needs of our active and retired servicemembers and other eligible beneficiaries and their families in a fiscally responsible manner for helping enhance the efficiency and effectiveness of the overall DOD budget.

**Manage the Medicare Eligible Retiree Healthcare Fund.** The ability to pay for Medicare-eligible retiree healthcare.

**Manage DHP Military Personnel (MilPers) by End Strength.** The ability to receive, analyze, and staff the military services to comply with MilPers end strength prescribed in strategic resource planning and budgeting guidance. This effort includes either increasing recruiting and training pipelines to grow projected end-strength requirements for needed skills, or designing personnel strategies to draw down MilPers end strengths where needed to meet planned staffing needs.

**Manage Pay for Performance and Prospective Payment Programs.** The ability to create new MHS cost models and use associated efficiencies to form a “reserve fund” to reward innovation and exemplary medical performance; align systemic and healthcare provider team performance incentives; improve the ability to analyze, forecast, and partially fund each medical service based on future workload projections to drive accountability for the healthcare needs of eligible and enrolled populations.

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## 4.3.7 Medical Information Management

The ability to define, categorize, collect, organize, store, protect, and analyze health-related data and collaborate among the Services, other federal agencies and private sector partners.

**Health Information Technology Requirements and Development.** The ability to identify, validate, plan, resource, develop, test, produce, and sustain IT products and services that meet validated MHS requirements.

**Health Information Performance Assessment.** The ability to measure strategic value (in the eyes of the relevant user community) of fielded health information products, systems, and services to enable portfolio governance and balance investment decisions.

## 4.3.8 Create and Sustain the Healing Environment

The ability to program, design, and build health and medical research facilities that promote safety, efficient care delivery, patient empowerment, and promote healing through aesthetic qualities (includes the ability to fully sustain existing health and research facilities to ensure a consistent level of reliable infrastructure and systems operations),

**Portfolio Management.** The ability to conduct health system planning; provide critical infrastructure asset visibility; perform MHS asset capability assessments; collaborate with federal partners on planning processes and capital asset projects; research best practices and collaborate with national organizations and industry; manage MHS capital asset decision processes and models; and maintain the Medical Infrastructure Portfolio Investment Tracking System (MIPITS).

**Health Facility Construction.** The ability to manage development and defense of the DOD medical facilities portions of the military construction (MILCON) program objective memorandum (POM), budget estimate submission, and President's Budget; provide facilities acquisition budget planning and financial management; and coordinate programming and execution of all major construction, minor construction, and planning/design funding.

## 4.3.9 Medical Logistics

The ability to organize and provide life-cycle management of medical products and services, to include devices and equipment, required to support HR requirements across the range of military operations.

**Medical Materiel.** The ability to organize and provide life-cycle management of medical materiel, including pharmaceuticals, medical supplies, medical assemblages, and medical gases.

**Blood.** The ability to organize and manage the provision of blood and blood products.

**Medical Equipment and Technology.** The ability to organize and provide life-cycle management of medical equipment, including the assessment and integration of medical technology.

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**Medical Maintenance.** The ability to organize and manage the maintenance of medical equipment.

**Optical.** The ability to organize and manage the fabrication and delivery of spectacles and prescription protective eyewear.

**Medical Facilities.** The ability to organize and manage the provision of life-cycle management for medical facilities.

**Medical Logistics Services.** The ability to provide medically unique services and functions essential to the provision of HR support of the joint force.

**Medical Contract Management.** The ability and authority to organize and manage the provision of contract support to acquire medical products and services in support of HR requirements.

## 4.3.10 Medical Research and Development

The ability to not only advance the state of medical science, technologies, and practices in those areas of most pressing need and relevance to today's battlefield experience but also ensure that the most promising and expedient medical solutions are developed and fielded for the future joint force. Medical research and development is conducted under a continuum of broad categories reflecting different levels of technological effort and dependent upon the technological maturity of those efforts. Briefly, these broad categories of medical research are:

- Basic Medical Research Science provides support for basic medical research directed toward greater knowledge and understanding of the fundamental principles of science and medicine that are relevant to the improvement of Force Health Protection.
- Applied Biomedical Technology is conducted to refine concepts and ideas into potential solutions to military health and performance problems with a view towards evaluating technical feasibility.
- Medical Technology Development supports promising candidate solutions that are selected for initial safety and efficacy testing in small scale human clinical trials regulated by the U.S. Food and Drug Administration (FDA) prior to licensing for human use.
- Advanced Component Development supports the development of medical products that are regulated by the U.S. Food and Drug Administration (FDA) and the accelerated transition of FDA licensed and unregulated products and medical practice guidelines to the military operational user through clinical and field validation studies.
- Medical Systems Development supports development and demonstration of medical commodities delivered from Advanced Component Development efforts that are directed at meeting validated requirements prior to full-rate initial production and fielding, including initial operational test and evaluation and clinical trials.

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- Medical Systems Sustainment supports enhancement activities for fielded medical products and the pre-planned improvement of fielded medical products, including information management/information technology (IM/IT) systems

## **4.4 RISKS AND MITIGATION ASSOCIATED WITH HR CAPABILITIES**

This section addresses three primary potential risks that are associated with following this concept as opposed to other alternatives. The section does not address the operational risk of failure inherent in conducting any particular mission.

### **4.4.1 Anticipated Advanced Technologies Will Be Neither Developed Nor Acquired**

If anticipated advanced technologies are neither developed nor acquired, the result will be less than optimal level of HR. The risk may be mitigated by less ambitious operations, acceptance, and continuation of training medical forces at all echelons to use currently available technologies.

### **4.4.2 Increasing Dependence on Information Processes**

Systems and technologies add potential vulnerabilities that must be defended. As with any failure of technology, this will require maintaining the ability to conduct HR operations in a less than optimal information environment.

### **4.4.3 System Inertia**

System inertia will forestall attempts to break down service insularity (or stovepipes) to achieve anticipated horizontal and vertical full-spectrum integration. This effort may limit the ability to maximize inter-service synergism and reduce unnecessary redundancies. With operations focused on future leadership of the MHS community, increasing joint training and education may mitigate the risk.

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## 5.0 CHAPTER 5. STRATEGY FOR HEALTH READINESS IMPLEMENTATION

### 5.1 ROLE OF HEALTH READINESS TRANSFORMATION

The Global War on Terrorism brings operational challenges to the forefront. DOD has seen a wave of transformation spread throughout the organization as it attempts to respond to these challenges. The MHS' transformation initiatives blend policy guidance, medical readiness, and business practices to improve the effectiveness and efficiency of the MHS.<sup>11</sup>

Transforming HR is essential for meeting the future challenges and achieving the United States' commitment to a peaceful world. Identifying and attaining fully integrated HR capabilities and providing trained and ready forces to accomplish them during joint operations are critical to reaching these goals. The complexity of meeting these expectations across ROMO requires a common lexicon for medical capabilities that MHS needs (see Chapter 4) for supporting service members, their families, and all those individuals entrusted to our care. Successful MHS transformation will require a fully integrated strategy with clear objectives, and effective implementation of the strategy will require commitment and attention from DOD's senior leadership and clearly assigned roles and responsibilities.

Effective MHS implementation will enable specific definition of transformation investments among capabilities that address future risks and balance against the other risk areas identified in the 2006 QDR and future reviews.

### 5.2 GUIDANCE FOR IMPLEMENTING MHS TRANSFORMATION

To achieve a true transformation and the breakthrough performance we desire, we must transform our culture profoundly. Our culture is defined by the assumptions and mental models we use to understand the world and guide our behaviors.<sup>12</sup> We intend to change those assumptions in ways shown in Table 5-1.

**Table 5-1: Changing the Way We Think and Act**

Old Paradigm		New Paradigm
Why should we...	To	Why couldn't we...
Two competing missions: healthcare delivery and force health protection	To	One mission, three interdependent themes
Service-specific infrastructure	To	Jointly staffed facilities
Budget and rules based	To	Performance-based management
End year with no money left	To	End year with savings; meet performance goals
Beneficiary satisfaction surveys	To	Customer relationship building
Provider centered	To	Patient control and accountability
Direct care system of MTFs and network of civilian providers	To	Integrated health delivery team with shared accountability
Proprietary information	To	Data sharing
Fixed-fee contracts	To	Performance-based contracting

<sup>11</sup> *Military Health System Office of Transformation (MHS-OT), Final Report, July 2007 (1-1).*

<sup>12</sup> *2008 Military Health System Strategic Plan, A Roadmap for Medical Transformation (6).*

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Old Paradigm		New Paradigm
Active duty, reserve, guard, civilians, and contractors managed separately	To	Total force and team development

DOD and MHS continue to pursue transformational business and planning practices such as adaptive planning and a more entrepreneurial future-oriented, capabilities-based resource allocation planning process. They also are pursuing accelerated acquisition cycles built on spiral development, output-based management, and a reformed analytical support agenda. It is imperative that DOD and MHS leadership foster innovation and adaptation of information age technologies and concepts within organizational and functional areas. With increased reliance on civilian-based contract support for delivering medical care, greater attention to the optimization of the direct care system with contractor support must be balanced with a priority of focus directed to the sustainment of expeditionary capabilities.<sup>13</sup>

To this end, the MHS recognizes ongoing DOD efforts in capability and portfolio management and acknowledges that intermittent evaluations are necessary for capturing modifications. To facilitate these processes, an HR Working Group (WG) will operate as a conduit for addressing HR issues and capabilities to the Force Support FCB (FS FCB). The HR WG is responsible for organizing, analyzing, and prioritizing HR joint warfighter capability proposals.

The HR WG will identify and consider alternatives for joint warfighter needs in the capability area of HR. The HR WG also is responsible for addressing material and nonmaterial solutions to HR capability gaps and is the lead coordinating body ensuring HR priorities are appropriately represented through the Joint Capabilities Integration and Development System (JCIDS) process and existing MHS governance structure.

### 5.3 INTEGRATION OF HR ELEMENTS INTO THE MHS OF TOMORROW

As detailed throughout this document, the three functional areas also set the stage for new and existing HR capabilities entry into the formal JCIDS process for review; discussion; and when necessary, approval. The initiatives introduced here will follow the construct in Figure 5-1 and be developed through three supporting CONOPS: Force Health Protection, Health Services Delivery, and Health System Support. These HR functions all fall under Force Support, Tier II JCA, Health Readiness, for conducting CBAs. This process should lead to any required Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, and Facilities (DOTMLPF) changes, the development of mission outcome measures, submission of ICDs and follow-on JCIDS documents and assessment of the DOTMLPF, thus allowing MHS to successfully prepare for the challenges and responsibilities that joint warfighters will face in 2016 and beyond.

Our nation's leaders provide the resources to sustain the MHS. In return, they expect the best medical support for the warfighter. The SECDEF, service secretaries, Joint Chiefs of Staff, CCDRs, and Congress expect the MHS to simultaneously accomplish six interconnected outcomes in balance. We create value by delivering the following:

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<sup>13</sup> *Joint Force Health Protection Concept of Operations*, July 2007 (29).

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- Fit, healthy, and protected force
- Lowest possible deaths, injuries, and diseases during military operations, superior follow-up care, and seamless transition with VA
- Humanitarian and disaster relief at home and abroad
- Healthy and resilient individuals, families, and communities
- Advances in medical education and research
- Effective management of healthcare costs.

To succeed, the MHS must serve two customer groups that have somewhat different expectations:

- **Commanders and Service Members**—partner with us to achieve individual medical readiness and enhanced performance. They expect and deserve responsive, capable, coordinated medical services anytime, anywhere. In addition to combat operations and peacekeeping, the nation calls on us to provide humanitarian assistance, disaster relief, and support for HD. Often, no other healthcare system in the world can provide what the MHS must provide. Because we face a rapidly changing national security environment, the MHS must excel at developing and deploying innovative products and services that meet mission requirements.
- **Our Beneficiaries**—desire high-quality, convenient health services tailored to their individual health needs. A major part of our success will be doing simple things well every time. If our beneficiaries are delighted with us every time they “touch” our system, they will be much more likely to help us help them manage their health over the long term.<sup>14</sup>

Today’s HR strategy is designed to ensure that the MHS can simultaneously accomplish all six interconnected outcomes, addressing the needs of our two major customer groups, and balancing them with other MHS stakeholders. The strategy encompasses three functional areas that represent the ability to accomplish the following:

- Sustain and protect the health and effectiveness of the human centerpiece of the American military
- Build healthy communities by managing and delivering the TRICARE health benefit, using military treatment facilities and the TRICARE network of healthcare providers
- Sustain and continuously improve the MHS mission effectiveness through the focused development of people, technology, infrastructure, and joint organizational culture.

The functional areas above will further translate into formal capability-based assessments; identification of needed DOTMLPF changes; and the creation of new health-related capabilities that the MHS must examine and pursue to achieve the DOD’s transformation goals and mission.

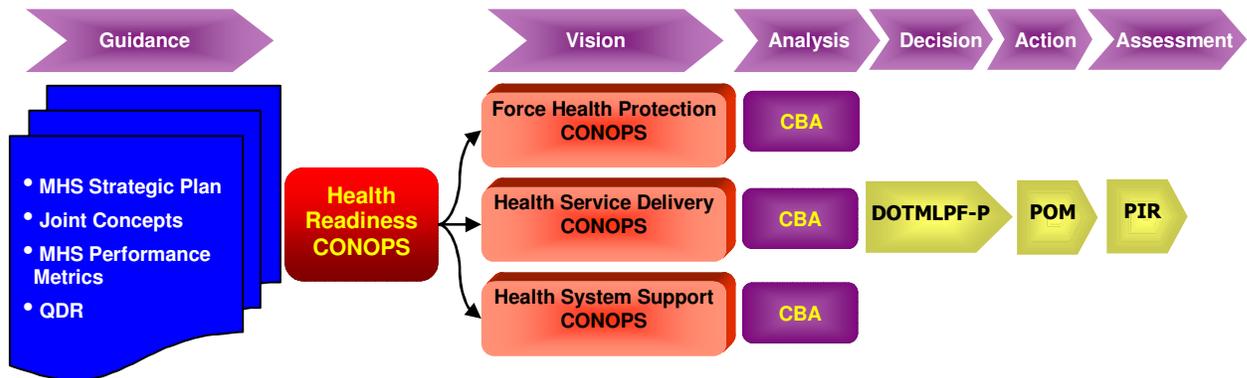
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<sup>14</sup> The 2008 Military Health System Strategic Plan, A Roadmap for Medical Transformation (7)

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Figure 5-1: Health Readiness Implementation Plan Structure



## 5.4 CONCLUSION

As MHS leaders, America has given us a humbling responsibility: To care for our country's fighting forces, their families, and those who served before us...more than 9 million in all. Our healthcare team has performed exceptionally. During this conflict, military medicine has achieved unprecedented and truly remarkable outcomes. We have achieved these results from a foundation of a vibrant military medical culture—one based on innovation, service to others, and an unrelenting persistence to achieve excellence.

Those within and outside our system know well and acknowledge our clinical excellence and achievements. We will continue to improve health care delivery across the full spectrum of operations in service to our warriors. The senior OSD and Joint Staff medical leadership, the Surgeons General, and staffs reexamined our fundamental purpose and vision of the future, and explored strategies to achieve that vision. This HR CONOPS focuses these efforts on the mission in which we are engaged: creating an integrated medical team that provides optimal health services in support of our nation's military mission—anytime, anywhere.

Fundamental changes in HR transformation include enhancing joint health system support capabilities, improving health service delivery capabilities, and creating joint organizational and process relationships to synchronize the medical capabilities of all services. These changes can best be achieved by not only adopting capabilities-based planning and performance-based management principles but also giving the MHS additional flexibility to provide capabilities when and where required without regard to the platform or service providing the capability.<sup>15</sup>

Capabilities defined in this HR CONOPS provide the Joint Force Commander with an ability to build fully integrated, joint medical systems for service-unique operations and missions. These capabilities specifically include components for implementing the HR

<sup>15</sup> Military Health System Office of Transformation (MHS-OT) Final Report, July 2007 (6-3)

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strategy consisting of four mission elements: (1) casualty care and humanitarian assistance; (2) fit, healthy, and protected force; (3) healthy and resilient individuals, families, and communities; and (4) education, research, and performance improvement.

Success is dependent on integrating many of the MHS' facets into future military operations. Future operations will require solutions to project and sustain joint forces conducting distributed simultaneous operations in multiple theaters or in multiple locations within a theater, and across the full range of military operations. Future operations will demand adaptable, flexible, and modular medical capabilities and forces. They also will require responsiveness and adaptability from the MHS and its interagency and multinational partners.

The HR role in supporting the DoD's mission includes preserving, protecting, and promoting the health of our military and civilian personnel, contractors, interagency and multinational partners, and other eligible beneficiaries. Given that military operations are likely to be conducted increasingly at distant locations in a non-contiguous and distributed manner, HR will remain a critical consideration for our warfighters, force projectors, and sustainers.

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## APPENDIX A: LINKAGE OF HEALTH READINESS WITH JOINT CONCEPTS

Appendix A describes the relationship between the functional elements of the health readiness (HR) concept and other selected concepts of the Joint Operations Concepts (JOpsC) family.

### **A.1 Combating Weapons of Mass Destruction JIC, Version 1.0, 10 December 2007**

The *Combating Weapons of Mass Destruction (CWMD) Joint Integrating Concept (JIC)*, version 1.0, describes how a Joint Force Commander, who has responsibility for a joint operations area (JOA), will conduct future (2015–2027) operations to combat WMD development, proliferation, acquisition, and employment. The Joint Force Commander will employ capabilities enabling CWMD operations within a joint, interagency, and multinational context integrated with other key elements of national power: diplomatic, information, military, economic, financial, intelligence, and law enforcement (DIMEFIL).

CWMD capabilities provide essential services and activities for managing and mitigating damage resulting from using CBRN weapons or release of toxic materials or contaminants and determining appropriate follow-up actions are taken as a result of these effects. The activities may include population evacuation, decontamination, transportation, communications, public works and engineering, firefighting, information and planning, mass care, resource support, health and medical services, urban search and rescue, hazardous materials, food, and energy.

CWMD capabilities obtain operationally important information on battlefield damage assessment, munitions effects (lethal and non-lethal), medical assessments, and hazards such as CBRN contamination to conduct mission assessment. The JFC must obtain information regarding the reaction of the enabling WMD networks to the operations, exploit the reaction of the network in support of further operations, and establish how the network is adapting to the attack. As a result of these capabilities, attribution is established to warrant the cooperation of the host nation (HN) or the international community and to determine the impact of the operations on the deterrence decision-making calculus of the adversary.

CWMD operations will be fully networked and collaborative by developing and exercising command and control structures to integrate components such as medical; logistics; engineering; security; and command, control, communications, and computers (C4); and joint/multinational and interagency support. Military disaster control capabilities support provision of life's essentials (e.g., water, food, sanitation, weatherproof shelter, medical care). These capabilities facilitate the successful delivery of humanitarian assistance, mitigate human suffering, and lead to stability.

### **A.2 Joint Urban Operations Joint Integrating Concept (JIC), Version 1.0, 23 July 2007**

The *Joint Urban Operations JIC*, version 1.0, provides working-level descriptions of joint plans to be conducted across the range of military operations where adjacent natural terrain, manmade construction, or the density of noncombatants are dominant features.

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In an ever-changing environment, Joint Urban Operations enables commanders to plan and execute rapid medical evacuations and force extractions with agility and precision. Especially in austere, anti-access environments, Joint Urban Operations also enables HR to employ precision-delivery platforms with sufficient range to rapidly move forces and provide sustainment to these highly distributed deployed forces.

## **A.3 Joint Logistics (Distribution) Joint Integrating Concept (JIC), Version 1.0, 07 February 2006**

The *Joint Logistics (Distribution) JIC*, version 1.0, suggests a set of capabilities and corresponding tasks, conditions, and standards to potentially guide how a future JFC will integrate joint distribution activities to enhance joint operations. This concept will help drive joint, service, and multinational experimentation and influence science and technology efforts.

To achieve HR logistical objectives, the capabilities within the Joint Logistics (Distribution) JIC enhance the ability to plan and execute rapid medical evacuations and force extractions with agility and precision. Success depends on acknowledgment of security environment challenges, conduct of simultaneous operations, and improved trust and confidence in the distribution system.

## **A.4 Net-Centric Operational Environment Joint Integrating Concept (JIC), Version 1.0, 31 October 2005**

The *Net-Centric Operational Environment (NCOE) JIC*, version 1.0, provides a conceptual framework for enhancement of overall warfighter performance in support of a JTF and includes the JTF Commander, JTF mission partners, and warfighters at the “first tactical mile.”

The NCOE JIC recognizes the critical nature of exchanging information among partners while leveraging information assurance (IA) and security capabilities to prevent unauthorized use. Security capabilities will provide real-time access to multiple sources within any medical infrastructure that can be inhibited by the constantly evolving and complex operational environment. These capabilities will provide HR a vision of a fully integrated network that will allow for more effective information access, discovery, and collaboration.

The collaboration of medical communities of interest (COI) is important to fulfilling the objectives of HR. The WMD/medical COIs provide an NCOE collaborative presence to local and JTF-level medical assets on treatment and evacuation priorities on WMD casualties. The WMD/medical COI advises on mission-oriented protective posture (MOPP) measures, decontamination procedures, and helps solve problems as they arise in collaboration with local users. Access to this information and collaboration among COIs contributes to effective knowledge sharing throughout the Joint Force.

As a result of the NCOE JIC, IA will be expanded to role-based, risk-managed user access. This will require policy changes and increased responsibility for IA personnel. On the other hand, emerging technologies (e.g., distributed key management) will likely reduce the current quantity of IA tasks.

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## **A.5 Command and Control Joint Integrating Concept (JIC), Version 1.0, 01 September 2005**

The C2 JIC promotes development of C2 capabilities for agile, decisive, and integrated force employment in all phases of combat and supporting operations, as required by the National Military Strategy (NMS) 04.

HR interoperability in a fully networked environment will be essential to the full functionality of Joint Health Surveillance, Intelligence, and Preventive Medicine (JHSIPM) today and in the future. All HR capabilities maintain information and decision superiority in net-centric operations. Each capability is responsible for sharing information and monitoring service and command relationships to not only provide seamless interoperable force health protection and casualty care but also develop and maintain shared situational awareness and understanding.

The C2 JIC emphasizes the broad information sharing and collaboration within the joint, interagency, and multinational communities that will require such capabilities be made available for experimentation. Interagency and multinational participation in joint experimentation will be essential, as will conducting experimentation scenarios to test the agility of prototype C2 capabilities across various missions, threats, and conditions.

This joint medical C2 construct will achieve the required attributes for HR; provide effective mitigation of health risks to joint, multinational, and other supported populations at risk; and enable further reduction in morbidity and mortality among combat casualties without increasing the overall medical footprint in the theater.

## **A.6 Global Strike Joint Integrating Concept (JIC), Version 1.0, 10 January 2005**

The *Global Strike Joint Integrating Concept (JIC)*, version 1.0, describes a concept for conducting Global Strike (GS) operations during the Seize The Initiative (STI) phase of a major combat operation (MCO) in 2015 while identifying effects, capabilities, tasks, attributes, conditions, and standards for conducting future GS operations.

The GS JIC is written to focus the capabilities-based assessment (CBA) within the functional area, across functional areas, and across various JICs. Within each individual functional area, a functional capabilities board (FCB) is assigned to review a list of tasks and assess any additional tasks deemed appropriate. This process helps ensure that each FCB provides the GS capabilities needed from their individual Joint Functional Concept. To ensure end-to-end interoperability and integration of capabilities needed for GS operations, each FCB identifies critical capabilities across two or more Joint Functional Concepts. The specification of capabilities provides insight into common capability needs concerning various concepts.

## **A.7 Homeland Defense and Civil Support (Version 2.0)**

The *Homeland Defense and Civil Support (HD/CS)*, version 2.0, Joint Operating Concept (JOC) describes how the future joint force will plan, prepare, deploy, employ, and sustain the force in detecting, deterring, preventing, or if necessary defeating, attacks against the homeland; provide defense support of civil authorities; and plan for emergencies while identifying potential areas for joint experimentation in the 2012–2025 time frame.

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A critical threat facing HD/CS is CBRNE attacks or emergencies. This threat presents an extreme danger to the population and could adversely affect HR capabilities. The construction of a organized, trained, and equipped force able to detect, assess, contain, quarantine, evacuate, and provide FP and medical surge capabilities will result in the management of CBRNE risk on future medical services, therefore establishing a secure environment.

## **A.8 Stability Operations: Military Support to Stabilization, Security, Transition, and Reconstruction Operations (Version 2.0)**

The *Military Support to Stabilization, Security, Transition, and Reconstruction Operations (SSTRO)*, version 2.0, JOC is to recommend an operational-level solution for a very challenging future military problem: how the joint force can more effectively prepare for and conduct SSTRO to help governments or regions under serious stress as well as describe how the future JFC will provide military support for stabilization, security, transition, and reconstruction operations within a military campaign in pursuit of national strategic objectives in the 2014–2026 time frame.

SSTRO enables the effective functioning of transportation, power, waste management, electric, education, housing, and health infrastructure customary for the local region. SSTRO provides an ability to refurbish or construct primary healthcare clinics, administrative buildings, and hospitals that the host nation can sustain. The desired effects are achieved without dependence on existing facilities or delays to building infrastructure.

SSTRO provides communities with flexible and agile joint medical forces capable of conducting sustained operations in multiple locations. The personnel of medical forces are given instruction to enhance their cognitive thought and leadership skills for SSTRO.

As a result of educated personnel and practical facilities, SSTRO facilitates an ability to obtain and redistribute essential supplies, food, and medicine and to provide timely emergency medical treatment and prophylaxis rapidly and effectively.

## **A.9 Irregular Warfare (Version 1.0)**

*Irregular Warfare (IW)*, version 1.0, JOC describes how future JFCs could conduct protracted IW to accomplish national strategic objectives in the 2014–2026 time frame. The JOC will guide development and integration of DOD military concepts and capabilities for waging protracted IW globally or regionally against hostile states and armed groups.

HR plays an integral comprehensive role in providing nation assistance to foreign states, organizations, or groups to support and assist in the political, economic, and social development of a friendly or occupied state or other political entity. Consequently, local populations can access and receive essential services (e.g., food, potable water, power, waste management, medical care, education, law enforcement, firefighting, transportation, commerce, communications, and agriculture).

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## APPENDIX B: APPENDIX B: QUADRENNIAL DEFENSE REVIEW CONSIDERATIONS

The *Quadrennial Defense Review* (QDR) was designed as a process catalyst for service adaptation and reorientation to produce a truly integrated joint force displaying greater agility, deployability, and capability against a wide range of threats. Through a process of continuous improvement, constant reassessment, and application of lessons learned, changes based on QDR reviews will continue over time. Transforming health readiness via the Military Health System (MHS) is specifically addressed in 2001 and 2006 QDRs. The 2001 QDR addresses the MHS under the heading, Revitalizing the DOD Establishment, which states:

*To create a world class health system, DoD has initiated a comprehensive review of all Defense and Service health agencies, management activities, and programs; and strengthened the TRICARE system to ensure better management and accountability. A coordinated, integrated, and adequately resourced healthcare system with an improved organizational structure will ensure the availability of contingency medical capabilities for active forces. It also will administer medical benefits to dependents and retirees in order to meet the needs of the force and expectations of the broader Service family.*<sup>16</sup>

The 2006 QDR further addresses the MHS under the heading, Reshaping the Defense Enterprise, which states:

*New breakthroughs in science and health, and new innovations in prevention and wellness, offer the opportunity to develop a 21st century Military Health System that will improve health and save both lives and money. This transformation in health and healthcare parallels other transformations in the Department of Defense. It is the Department's goal to have a lifetime relationship with the entire Department of Defense family which maximizes prevention, wellness and personal choices and responsibility. As with other areas related to the Department enterprise, the QDR recommends aligning medical support with emerging joint force employment concepts. Building on recent improvements in new purchased care contracts and the streamlining of regional TRICARE management structures, the QDR recommends continuing to shift toward a market-driven, performance-based investment program. It also recommends improving planning processes and the transparency of information, while leveraging the recent launch of the Department's electronic health record system. This new system is needed to effectively manage MHS by adopting a more flexible financing process. Above all, the Department's military and civilian senior leaders endorse the need to modernize the TRICARE benefit structure for those customers who are not on Active Duty. The intent is to promote longer and healthier retirement lives by encouraging self-responsibility for their own and their family's health and the use of health resources to achieve the longest, healthiest lives at the lowest cost. Doing so will require changes in legislation and rules to adjust TRICARE cost-sharing features so that they restore the balance Congress created in establishing the TRICARE program in the 1990's...*<sup>17</sup>

To ensure that the MHS, services, and joint staff developed the QDR and related initiatives in an effective and integrated manner, the DepSecDef chartered the Military Health System Office of Transformation (MHS-OT) in October 2005. The MHS-OT

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<sup>16</sup> 2001 *Quadrennial Defense Review Report*, 30 September 2001 (51).

<sup>17</sup> 2006 *Quadrennial Defense Review Report*, 6 February 2006 (72).

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provided strategy and planning guidance for the long-term process owners responsible for planning the implementation of 19 QDR transformation initiatives.

Table B-1 shows QDR Initiatives listed in the QDR Roadmap for Medical Transformation, organized into four sections: Transform the Force, Transform the Infrastructure, Transform the Business, and Sustain the Benefit.

**Table B-1: Quadrennial Defense Review Initiatives**

Initiative Number	Description
<b>Transform the Force</b>	
1	Medical Readiness Review (Establish ongoing capability assessment)
2	Interoperability and Agility of Operational Medical Capabilities
3	Homeland Defense and Medical Civil-Military Operations
4	Healthy, Enhanced, and Protected Force
5	Joint Medical Education and Training Focused on Performance-Based Mgmt.
6	Shaping Future Joint Medical Force
7	Integrate Graduate Medical Education
<b>Transform the Infrastructure</b>	
8	Transform the Infrastructure
19	Implement Base Realignment And Closure (BRAC)
<b>Transform the Business</b>	
9	Process Improvement
10	Performance-Based Planning
11	Performance-Based Finance
12	Eliminate Utilization Barriers
13	Management of Jointly Operated Facilities and Full Use of Personnel
14	IM/IT Alignment
15	Contracting for Healthcare Services
16	Contracting for Professional Services
<b>Sustain the Benefit</b>	
17	Effective Patient Partnerships
18	Sustain the Benefit

The sections below present brief descriptions of each QDR Initiative described in the MHS-OT Final Report and other related documents.

## **B.1 Transform the Force**

**Medical Readiness Review (MRR).** Develop permanent, integrated departmental process to annually review medical readiness capabilities, in conjunction with warfighter transformation efforts, using the analytical agenda process.

**Interoperability and Agility of Operational Medicine Capabilities.** Improve joint capabilities, agility, and interoperability of the medical force across a range of military operations (ROMO). In the past, the MHS capabilities largely represented the sum of independently developed service programs, resulting in reduced interoperability and interdependency. Future military strategies mandate that the medical force structure be more responsive in diverse operations, including capacity building in the civilian public health sector and providing healthcare to host nation personnel, DOD contractors, and other civilians. Without compromise to service-unique missions, these capabilities must

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be developed jointly and optimized to support joint health service operations across the entire ROMO.

**Homeland Defense and Medical Civil-Military Operations.** Align MHS capabilities to meet the requirements of DOD Homeland Defense, civil support, and medical civil-military operations. Currently, the MHS is organized to support military forces during military operations and to provide beneficiary healthcare from fixed military treatment facilities. At present, the scope of the requirements for support to homeland defense and other missions is not yet developed because the MHS' role in these operations has been neither fully defined nor analyzed. This initiative calls for actions to define the mission of the MHS in these areas, conduct a capabilities-based analysis to determine MHS mission requirements, and incorporate them into the MHS.

**Healthy, Enhanced, and Protected Force.** Define standards and resource requirements for a healthy, enhanced, and protected force as a key component of HR. Although commanders are ultimately responsible for the health and protection of deployable personnel and may individually develop and implement standards, uniform minimum standards to measure health, enhancement, and protection status of deployed personnel do not exist. In collaboration with command and human resource authorities, the MHS will address this gap by developing joint, commonly applied minimum standards for all deployable personnel while protecting the prerogatives of commanders at all levels to develop additional, more stringent standards based on mission, equipment, tactics, training, and time requirements.

**Joint Medical Education and Training Focused on Performance-Based Management.** Prepare healthcare leaders to succeed in joint, performance-based environments, including expeditionary medicine and beneficiary care missions. Although most healthcare-oriented leader training programs are service-centric, leaders throughout the MHS must be able to take advantage of best practices from the private healthcare sector, Overseas Contingency Operations (OCO), TRICARE system, and operational lessons learned from among the service medical departments. Medical education and training must prepare medical personnel for future requirements, improving overall capabilities and increasing joint medical interoperability and deployability among the services. Civilian contractor/providers and MTFs must have a seamless interface for efficient and effective flow of the patients in the Direct Care System and must be supported by processes and tools that allow for seamless and effortless transition of the beneficiary and their related healthcare documentation, among MTFs and to civilian, Department of Veterans Affairs (VA), or other interagency partner facilities rendering care, rehabilitation, and reintegration.

**Shaping Future Joint Medical Force.** Shape the future Joint Medical Force by providing the required mix and number of medical personnel needed to meet projected wartime missions and deliver effective beneficiary healthcare. The MHS will benefit from enhancing its ability to recruit, retain, reward, and manage medical personnel and developing joint medical personnel management policies that eliminate service competition for scarce healthcare human resources; improve the use of medical personnel in a cross-service, joint environment; meet service-specific requirements for force health

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protection; make use of external medical resources in federal and civilian environments; and allocate available medical personnel resources cost effectively and equitably.

**Integrate Graduate Medical Education.** Optimize graduate medical education (GME) training capabilities without compromising the services' ability to meet those training requirements. Establish a joint forecasting capability for GME requirements that identifies internal excess capacity, builds on the successes of the Joint DOD-VA Pilot Program for providing GME and training for physicians, and ensures that civilian training programs are used only when appropriate.

## **B.2 Transform the Infrastructure**

**Transform the Infrastructure.** Employ the Health Facility Steering Committee with cross-service representation to review existing MHS policies for replacement with industry standards; link military construction (MILCON) decisions to MTF business plans; develop metrics to monitor performance of capital investments and operations and sustainment; and leverage private industry expertise to enrich the solution set.

**Implement Base Realignment and Closure (BRAC).** Employ the Resource Management Steering Committee (RMSC) and Health Facility Steering Committee (HFSC) with cross-service representation to develop a plan that gives the MHS the capability to leverage BRAC actions to the fullest extent possible and synchronize BRAC actions with each other and within the context of other MHS Transformation Road Map initiatives.

## **B.3 Transform the Business**

**Process Improvement.** Employ the Strategy Management Working Group (SMWG) with cross-service representation to review current service approaches to process improvement and develop an MHS solution set most appropriate for the military health enterprise. Provide leaders with the knowledge, skills, and abilities to successfully implement process improvement methods and ensure a consistent understanding and commitment to the process improvement "vision" among all stakeholders. Implement the selected process improvement method, and facilitate adaptation of information systems, reporting processes, change management and organizational development, human resource development, and other affected domains, as necessary.

**Performance-Based Planning.** Develop and implement an MHS-wide performance-based planning process that standardizes format and processes for the development and submission of business plans; creates a standard business plan for use as a basis for the MHS Joint Business Plan; and develops a process for capturing workload performed in MTFs, the private sector, or other clinical environments for use in justifying programming and budgeting requirements to support approved business plans.

**Performance-Based Finance.** The MHS must accomplish the following: (1) Change its funding allocation to a system based on the value of those mission-essential services for readiness (military-unique) missions and provide the health benefit. (2) Develop an implementation plan for a decision support system, and implement a programming and allocation system that allocates funds in accordance with performance-based financing. (3) Develop an actuarial model for determining funding requirements for the health

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benefit, and establish a reserve fund. (4) Undertake an innovation investment process, and establish a board of directors that will vote on investments and establish payback requirements.

**Eliminate Utilization Barriers.** Enhance the cross-agency commitment among the MHS, the Department of Health and Human Services, and the Department of Veterans Affairs and increase interaction between the MHS direct care system and private health industry; to accomplish this effort, the MHS must eliminate barriers that prevent the full utilization of uniformed and government civilian personnel across services, government agencies, and the private sector. The MHS must review completed pilot studies that have explored new ways for military medical personnel to work with federal and civilian partners.

**Management of Jointly Operated Facilities and Full Use of Personnel.** Use existing Medical Cross-Service Flag Level Steering Group to stand up integrated process teams (IPT) with cross-service and OSD representation to develop recommendations for standardization of governance structures and business rules for jointly staffed facilities that are consistent with MHS practices without compromising readiness; evaluate existing jointly staffed models; and identify and apply supporting performance-based management tools and resources.

**Information Management/Information Technology (IM/IT) Alignment.** The QDR mandates a focused examination of current IM/IT governance and the development of a plan for improvement so that the MHS can better leverage IM/IT to achieve strategic goals and add stakeholder value. The Portfolio Management Oversight Committee (PMOC) and supporting structure were chartered to accomplish IM/IT alignment; however, concern exists that the business process redesign and improvement are not optimally aligned with the implementation of major new IM/IT systems and that advocacy for IM/IT systems is suboptimal. The PDASD, MHS CIO, and DASD HB&FP with other DASD and service representatives will conduct a gap analysis of current IM/IT governance and recommend improvements to the Senior Military Medical Advisory Council (SMMAC) for approval.

**Contracting for Healthcare Services.** The MHS will stand up a work group to discuss best approach (e.g., Demonstration projects) and conduct a business case analysis to serve as a catalyst for developing and implementing new initiatives and a strategy for acquiring contracts for selected ancillary services. This working group will leverage any work from other similar initiatives (e.g., Military Health System Executive Review [MHSER] Local Authorities Working Group [LAWG]) and contracts currently in place across the services and will conduct market analysis to identify industry trends, supply and demand levers, potential new suppliers, negotiation levers, and available contract vehicles for acquisition of selected health services.

**Contracting for Professional Services.** Based on a recommendation from the DOD Inspector General, the ASD (Health Affairs) chartered the Army Surgeon General to lead a DOD-Wide Strategy Council to develop a coordinated strategy for acquiring direct care medical services, including the implementation of the centers of excellence concept. The

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Strategy Council, chaired by a representative of the Army Surgeon General, included representation from all three services and the TRICARE Management Activity (TMA).

## **B.4 Sustain the Benefit**

**Effective Patient Partnerships.** Improve the MHS' ability to manage chronic disease via strong patient partnership (e.g., patient empowerment, self-care management), and leverage the partnership to achieve evidence-based medicine, improve health outcomes, improve patient satisfaction, and reduce escalating costs.

**Sustain the Benefit.** The MHS financial structure is unsustainable in the long term. Congressional Budget Office (CBO), Office of Management and Budget (OMB), Comptroller estimates, and expert studies predict MHS' budget increasing from \$19 billion in 2001 to \$64 billion in 2015. Inside DOD, this equates a growth from 4.5 percent of its budget in 1990 to 12 percent in 2015, thereby reducing DOD's ability to fund priority mission-essential capabilities. Congress did not act on the DOD proposal in the FY07 President's Budget to increase healthcare costs for working age military retirees, but it did direct a task force to review the MHS, including the "beneficiary and government cost sharing structure." The DOD planned to propose a set of TRICARE benefit changes for retirees under age 65 upon receiving the recommendations from the task force. To date, no benefit changes have occurred, and this initiative was closed in December 2007.

Overall, the MHS has made significant progress since stand-up of MHS Office of Transformation in October 2005. Most of the QDR Roadmap Initiatives described above have been either completed or transitioned to the MHS Tactical Plan. Only initiatives 10 and 11 remain for continued tracking and referral to the next QDR.

*Without a doubt, reshaping the defense enterprise is difficult. The structures and processes developed over the past half-century were forged in the Cold War and strengthened by success in it. However, the strategic landscape of the 21st century demands excellence across a much broader set of national security challenges. With change comes turmoil, and achieving a desired vision requires determination and perseverance within the Department and, importantly, cooperation with the Congress. As we emphasize agility, flexibility, responsiveness and effectiveness in the operational forces, so too must the Department's organizations, processes and practices embody these characteristics if they are to support the joint warfighter and our Commander in Chief.<sup>18</sup>*

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<sup>18</sup> 2006 Quadrennial Defense Review Report, 6 February 2006 (72).

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## APPENDIX C: HOMELAND DEFENSE AND MEDICAL STABILITY, SECURITY, TRANSITION, AND RECONSTRUCTION OPERATIONS

Using Military Health System (MHS) resources to support civil-military operations (CMO) has proven to be a valuable asset. Medical civil-military operations (MCMO) support US national interests and are applicable in Defense Support of Civil Authority, Stability Operations, and Major Combat Operations. MCMO supports the geographic combatant commanders' (CCDR) theater security cooperation strategy and US embassy objectives. MCMO must be coordinated with US embassy plans, associated US Government agencies, multinational partners, and non-governmental organizations (NGO) in response to the needs and leadership of the host nation (HN).<sup>19</sup>

### C.1 Future Operational Environment

Complex humanitarian emergencies, poverty, and disease will continue to undermine social controls, destabilize governments and nations, and create conditions that lead to civil unrest, crime, insurrection, war, and terrorism.<sup>20</sup> To effectively address the future operational environment, the MHS must resolve existing challenges and address new challenges associated with the elements of homeland defense (HD) and medical stability, security, transition, and reconstruction operations.

### C.2 Military Transformation Challenges

Joint medical forces have historically planned and executed MCMO largely on an ad hoc basis. Historical lessons learned, strategic knowledge, and copious civilian experience have not been translated into joint medical Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, and Facilities (DOTMLPF) changes leading to comprehensive planning and efficient collaborative execution of these operations.<sup>21</sup>

Warfighters traditionally have a cultural and psychological focus on major combat and an aversion to peacekeeping, CMO, and following the lead of another US Government agency; however, the lines of distinction in recent and future operations are less defined and more variable. Diplomacy, special operations, multilateral efforts, and consideration of second order effects are essential for warfighter success in the face of complex geopolitical interests. The lack of a common framework, terminology, or shared understanding of CMO<sup>22</sup> also affects the joint medical community.

Before concluding their work, the MHS-OT established the *Quadrennial Defense Review Roadmap for Medical Transformation* containing 4 broad categories and 19 initiatives. Initiative 3 under "Transform the Force" required a study to determine the scope of the MHS role in DOD HD, civil support (CS), and medical civil-military operations. The study also concluded that responsible parties should use the Joint Capabilities Integration and Development System (JCIDS) to conduct a capabilities-based analysis to determine the MHS DOTMLPF for these operations.

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<sup>19</sup> *Joint Force Health Protection Concept of Operations*, July 2007 (E-1).

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

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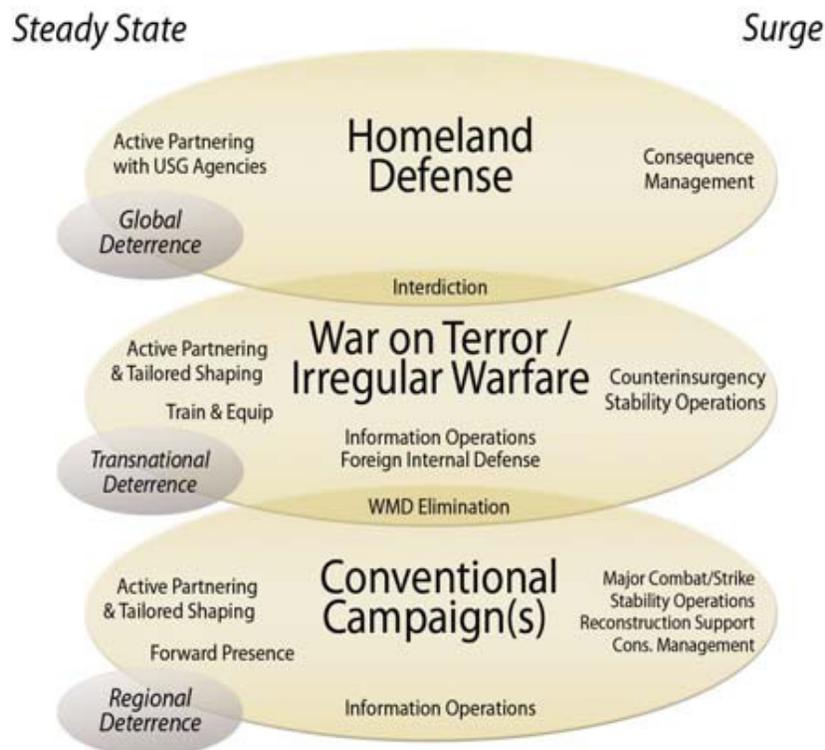
The US Northern Command (USNORTHCOM) drafted the *Homeland Defense and Civil Support: Military Health System* and *Stability Operations: Military Health System* Joint Capabilities Documents (JCD) in July 2008 to effect the requirements. Although these draft documents were not formally staffed through the Knowledge Management/Decision Support (KM/DS) system for Joint Readiness Oversight Council (JROC) approval, the capability gap analysis and associated insights gained were incorporated in the *Joint Force Health Protection Concept of Operations Functional Solutions Analysis*.

## C.3 Elements of Homeland Defense

### C.3.1 Homeland Defense

The HD approach to leveraging MHS capabilities is best characterized by the 2006 QDR which refined the Department's force planning construct (see Figure C-1) into three objective areas: Homeland Defense, War on Terror/Irregular (Asymmetric) Warfare, and Conventional Campaigns. Per the 2006 QDR, for each area, planning efforts and associated force structures are divided into continuous DOD efforts in the area (steady-state) and episodic activities (surge).

**Figure C-1: 2006 QDR Force Planning Construct**



During steady-state operations, service-deployable medical assets support normal force generation, sustainment, and training activities. Service medical treatment facility assets provide routine health services to DOD beneficiaries. Planning and coordination for HD missions occur at the joint level with limited assets. When surge activities are required to support enhanced deterrence, decisive operations, and restoration operations, service

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deployable medical assets and, to a limited extent, installation assets may be required to support joint operations under the command and control (C2) of the combatant command.

## C.3.2 Civil Support (CS)

By its very nature, providing support to civil authorities is a surge activity under the QDR construct. Most, if not all, of the MHS capabilities required to support the DOD HD mission will be requested by civil authorities in catastrophic incident response. Exceptions occur when the Federal Government takes time-critical action absent local requests (e.g., catastrophic events). Figure C-2 shows capability requirements for a catastrophic incident relative to time with capabilities building from immediate local response to national asset availability.

**Figure C-2: Capability Requirements and Generation as a Function of Time**

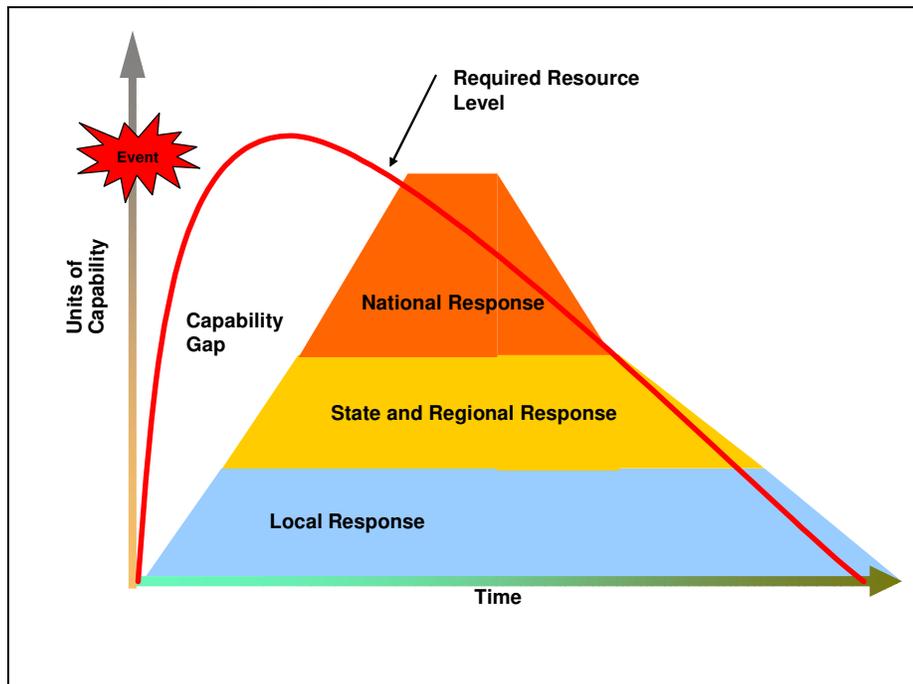


Figure C-1 also illustrates the importance of time-critical requirements. Mobilization to an affected area outside the region further complicates requirements.

DoD CS is executed under the auspices of the NRF. Although installation commanders may provide support to local civil authorities under Immediate Response Authority or mutual aid agreements, no DOD standards exist for installation support agreements that address the extent of reliance on civil authorities or the provision of assistance to civil authorities.

## C.4 Elements of Medical Stability, Security, Transition, and Reconstruction Operations

The doctrinal support for stability operations is general, vague, and piecemeal. The JFHP CONOPS groups stability operations and homeland civil support under the heading of Civil-Military Operations. Expectations and some guidance regarding medical stability

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operations are in the following JPs: JP 3-07.1, *Joint Tactics, Techniques, and Procedures for Foreign Internal Defense* ; JP 3-07.3, *Joint Tactics, Techniques, and Procedures for Peacekeeping Operations* ; JP 3-13.3, *Operations Security* ; JP 3-27, *Homeland Defense* ; JP 3-28, *Civil Support* ; JP 3-40, *Combating Weapons of Mass Destruction* ; JP 3-41, *Chemical, Biological, Radiological, Nuclear, and High-Yield Explosives Consequence Management* ; JP 3-57, *Civil-Military Operations* ; and JP 4-02, *Health Service Support* ; however, these publications do not bring these missions together with clarity. In fact, they divide the functions among “Stability Operations and Crisis Response,” “Civil-Military Operations,” and “Multinational Operations.” To provide clarity, the analysis team developing the *Stability Operations: Military Health System JCD* developed the following definitions:

## **Medical Security Cooperation**

Medical security cooperation is the health/medical component of theater security cooperation activities that geographic CCDRs conduct. These are ongoing, day-to-day, peacetime/preconflict operations shaping the medical environment in the area of responsibility. Medical security cooperation may include activities such as medical HA/DR, Medical Civic Action Programs (MEDCAP), and Medical Readiness Training Exercises (MEDRETE). Medical security cooperation also includes disease surveillance programs through overseas laboratories and the Global Emerging Infections Surveillance and Response System (GEIS). Medical security cooperation activities are conducted in coordination with other US Government agencies, international NGOs, and host nation (HN) counterparts.

## **Medical Capacity Building**

Medical capacity building ranges from preconflict peacetime security cooperation to post-conflict stability operations. The focus is on building an HN sustainable medical system by improving military and civilian healthcare capabilities. Peacetime examples include the DOD Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Prevention Program (DHAPP) and the Defense Institute for Medical Operations disaster preparedness and response training programs for foreign militaries. Ongoing efforts to establish the medical components of the Afghan National Army and the Iraqi Security Forces are examples of military-to-military stability operations capacity building. Another example occurred in Rwanda under US Air Forces in Europe (USAFE) in December 2006. Among other training, the USAFE team provided seminars on medical operational planning for disaster preparedness and Humanitarian Relief Operations (HUMRO) events.

## **Health Sector Stabilization and Reconstruction**

Medical stability operations focus on supporting the missions of the joint/multinational force, with particular emphasis on local and provincial health sector efforts. Medical stabilization includes small-scale activities that respond to urgent humanitarian relief and reconstruction requirements that immediately will assist the indigenous population through the execution of nonconstruction and construction activities. Medical capacity building is the strengthening of local healthcare institutions, promotion of appropriate policies, and transfer of required medical skills to local authorities. The Commander’s

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Emergency Response Program (CERP) funds such projects, including healthcare, water and sanitation, and education. MHS health sector stabilization efforts range from direct care and assistance to HN health sector capacity-building. For example, DOD and MHS supported US Government agencies, multinational organizations, and NGOs to help stabilize the Afghan health sector.

Medical reconstruction entails support to the HN and to provincial and local health sectors. Health sector reconstruction is a complex, long-term process requiring cooperation with other US Government agencies, multinational organizations, NGOs, and most importantly, HN medical organizations. Ongoing health sector reconstruction efforts in Iraq provide a current example of DOD/MHS support to health sector reconstruction.

## **International Humanitarian Assistance and Disaster Response**

MHS international HA/DR efforts range from immediate direct care and assistance to longer term health sector restoration and capacity building. Examples are the support provided in response to the 2004 Indonesian Tsunami disaster and the 2005 Pakistani earthquake.

### **C.5 Conclusion**

The MHS is organized to support military forces during military operations and provide beneficiary healthcare from fixed military treatment facilities or via a network of civilian and interagency partner providers. At present, the scope of the requirements for MHS support to HD, SSTRO, and other missions is not yet developed because the MHS' role in these operations has not been fully defined and analyzed. This HR CONOPS provides the framework for defining the MHS mission in these areas and conducting a capabilities-based analysis to determine MHS mission requirements for incorporation across the MHS.

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Joint Publication, JP 3-57, *Civil-Military Operations*, 8 July 2008.

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## APPENDIX E: GLOSSARY

### Part I. Acronyms

AB	Air Base
AE	Aeromedical Evacuation
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BA	Battlespace Awareness
BI	Business Intelligence
BRAC	Base Realignment and Closure
C2	Command and Control
C4	Command, Control, Communications, and Computers
CASEVAC	Casualty Evacuation
CBA	Capabilities-Based Assessment
CBO	Congressional Budget Office
CBRNE	Chemical, Biological, Radiological, Nuclear, and High Yield Explosive
CCDR	Combatant Commander
CCJO	Capstone Concept for Joint Operations
CDHP	Consumer-Directed Health Plan
CERP	Commander's Emergency Response Program
CJCS	Chairman of the Joint Chiefs of Staff
CMS	Centers for Medicaid and Medicare Services
COI	Community of Interest
CONOPS	Concept of Operations
CONUS	Continental United States
CS	Civil Support
CT	Computed Tomography
CWMD	Combating Weapons of Mass Destruction
DCS	Direct Care System
DepSecDef	Deputy Secretary of Defense
DHAPP	Department of Defense HIV/AIDS Prevention Program
DHP	Defense Health Program
DIMEFIL	Diplomatic, Information, Military, Economic, Financial, Intelligence, and Law Enforcement
DNBI	Disease and Non-Battle Injury
DOD	Department of Defense
DODD	Department of Defense Directive
DOTMLPF	Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel and Facilities
ED	Emergency Department
EHR	Electronic Health Record
FCB	Functional Capability Board
FDA	Food and Drug Administration
FFS	Fee-For-Service
FHP	Force Health Protection
FP	Force Protection

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FRC	Forward Resuscitative Care
FRS	Forward/Resuscitative Surgery
FS	Force Support
GDP	Gross Domestic Product
GEIS	Global Emerging Infections Surveillance and Response System
GME	Graduate Medical Education
GS	Global Strike
HA/DR	Humanitarian Assistance/Disaster Response
HD	Homeland Defense
HFSC	Health Facility Steering Committee
HIT	Health Information Technology
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
HN	Host Nation
HR	Health Readiness
HS	Homeland Security
HSD	Health Service Delivery
HSS	Health System Support
HUMRO	Humanitarian Relief Operations
IA	Information Assurance
ICD	Initial Capabilities Document
IGO	International/Agency Government Organization
IM/IT	Information Management/Information Technology
IT	Information Technology
IW	Irregular Warfare
JCA	Joint Capabilities Area
JCD	Joint Capabilities Document
JCIDS	Joint Capabilities Integration and Development System
JFC	Joint Functional Concept
JFHP	Joint Force Health Protection
JHPE	Joint Human Performance Enhancement
JHSIPM	Joint Health Surveillance, Intelligence, and Preventive Medicine
JIC	Joint Integrating Concept
JP	Joint Publication
JMROC	Joint Medical Readiness Oversight Committee
JOA	Joint Operations Area
JOC	Joint Operating Concept
JOE	Joint Operational Environment
JOpsC	Refers to the Family of Joint Operations Concepts
JROC	Joint Requirements Oversight Council
JTF CapMed	Joint Task Force National Capital Region Medical
KM/DS	Knowledge Management/Decision Support
LAWG	Local Authorities Working Group
MCO	Major Combat Operation
MEDCAP	Medical Civic Action Program
MEDEVAC	Medical Evacuation

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MEDRETE	Medical Readiness Training Exercises
MHS	Military Health System
MHSER	Military Health System Executive Review
MHS-OT	Military Health System Office of Transformation
MILCON	Military Construction
MilPers	Military Personnel
MIPITS	Medical Infrastructure Portfolio Investment Tracking System
MIPOE	Medical Intelligence Preparation of the Operational Environment
MOPP	Mission-Oriented Protective Posture
MRI	Magnetic Resonance Imaging
MRO	Medical Regulating Office (Army)
MTF	Medical Treatment Facility
NCOE	Net-Centric Operational Environment
NDAA	National Defense Authorization Act
NGO	Non-Governmental Organization
NMS	National Military Strategy
NRF	National Response Framework
OCO	Overseas Contingency Operations
OEG	Operational Exposure Guidance
OEH	Occupational and Environmental Health
OLAP	Online Application Processing
OMB	Office of Management and Budget
PBD	Program Budget Decision
PDHRA	Post-Deployment Health Readiness Assessment
PHL	Public Health Laboratory
PHR	Personal Health Record
PM	Patient Movement
PMI	Patient Movement Item
PMOC	Portfolio Management Oversight Committee
PMR	Patient Movement Request
POM	Program Objective Memorandum
PTSD	Post-Traumatic Stress Disorder
QDR	<i>Quadrennial Defense Review</i>
RMSC	Resource Management Steering Committee
ROMO	Range of Military Operations
SAMMC	San Antonio Medical Center
SAR	Search and Rescue
SECDEF	Secretary of Defense
SMMAC	Senior Military Medical Advisory Council
SMWG	Strategy Management Working Group
SSTRO	Stability, Security, Transition, Reconstruction, and Operations
TBI	Traumatic Brain Injury
TMA	TRICARE Management Activity
USAFE	United States Air Forces in Europe
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USNORTHCOM	United States Northern Command

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VA Department of Veterans Affairs  
WG Working Group  
WMD Weapons of Mass Destruction

## Part II. Glossary

**Board.** An organized group of individuals within a Joint Force Commander's headquarters, appointed by the commander (or other authority), that meets with the purpose of gaining guidance or decision. Its responsibilities and authority are governed by the authority that established the board. (JP 3-33)

**Capability.** The ability to execute a specified course of action. (A capability may or may not be accompanied by an intention.) (JP 1-02.) It is defined by an operational user and expressed in broad operational terms in the format of an initial capabilities document or a DOTMLPF change recommendation. Also called capabilities.

**Capstone Concept for Joint Operations (CCJO).** The overarching concept of the Joint Operational Concepts family of documents that guides the development of future joint capabilities. It applies to operations worldwide conducted unilaterally or in conjunction with multinational military partners and other government and non-government agencies.

**Casualty.** Any person who is lost to the organization by having been declared dead, duty status—whereabouts unknown, missing, ill, or injured. (JP 1-02.) See also Casualty Category; Casualty Status; Casualty Type; Duty Status—Whereabouts Unknown; Hostile Casualty; Non-Hostile Casualty.

**Casualty Evacuation.** The unregulated movement of casualties that can include movement to and between medical treatment facilities. Also called CASEVAC. See also Casualty; Evacuation; Medical Treatment Facility. (JP 1-02)

**Cell.** A subordinate organization formed around a specific process, capability, or activity within a designated larger organization of a Joint Force Commander's headquarters. A cell is usually part of a functional and traditional staff structure. (JP 3-33)

**Combatant Command.** A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense, and with the advice and assistance of the Chairman of the Joint Chiefs of Staff. Combatant commands typically have geographic or functional responsibilities. (JP 1-02)

**Combatant Commander.** A commander of one of the unified or specified combatant commands established by the President. Also called CDR. (JP 1-02)

**Compatibility.** The ability of systems, equipment, devices, and materiel to operate in their intended operational environments without suffering unacceptable degradation or without causing unacceptable performance interactions or responses. It involves the application of sound system, equipment, device, and materiel design configurations that ensures interference free operation, and clear concepts that maximize operational effectiveness. (JP 1-02)

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**Concept.** A notion or statement of an idea; an expression of how something might be done. See Joint Concept. (Source: JFHP CONOPS)

**Countermeasures.** A form of military science that, by the employment of devices and/or techniques, has as its objective the impairment of the operational effectiveness of enemy activity. (JP 1-02) Includes all types of therapeutic, clinical, and non-medical interventions that negate effects of threats or reduces risks (regardless of source) by minimizing or eliminating detrimental effect on mission success.

**Definitive Care.** Care rendered to conclusively manage a patient's condition. It includes the full range of preventive, curative, convalescent, restorative, and rehabilitative medical care. This normally leads to rehabilitation, return to duty, or discharge from the service. (JP 4-02)

**Effect.** (1) The physical or behavioral state of a system that results from an action, a set of actions, or another effect. (2) The result, outcome, or consequence of an action. (3) A change to a condition, behavior, or degree of freedom. (JP 3-0)

**End of Life Care.** The care that patients and their families receive when patients are dying or near death. It incorporates multiple forms of care, including supportive care, hospice care and palliative care.

**En Route Care.** Continuation of the provision of care during movement (evacuation) between the health service support capabilities in the continuum of care, without clinically compromising the patient's condition. (JP 4-02)

**En Route Care Capability.** The ability to provide uninterrupted medical care from the point of injury or initial illness until patients arrive at a medical facility or between capabilities in the continuum of essential care, without compromise to the patient's condition. See also En Route Care. (JP 4-02)

**Evacuation.** (1) Removal of a patient by any of a variety of transport means (air, ground, rail, or sea) from a theater of military operation, or between health service support capabilities, for the purpose of preventing further illness or injury, providing additional care, or providing disposition of patients from the military healthcare system. (2) The clearance of personnel, animals, or materiel from a given locality. (3) The controlled process of collecting, classifying, and shipping unserviceable or abandoned materiel, US or foreign, to appropriate reclamation, maintenance, technical intelligence, or disposal facilities. (4) The ordered or authorized departure of noncombatants from a specific area by the Department of State, DOD, or appropriate military commander. This refers to the movement from one area to another in the same or different countries. The evacuation is caused by unusual or emergency circumstances and applies equally to command or non-command sponsored family members. See also Evacuee; Noncombatant Evacuation Operations. (JP 4-02)

**First Responders.** Primary healthcare providers whose responsibility is the provision of immediate clinical care and stabilization in preparation for evacuation to the next health service support capability in the continuum of care. In addition to treating injuries, they treat service members for common acute minor illnesses. (JP 4-02)

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**First Responder Capability.** The healthcare capability that provides immediate clinical care and stabilization to the patient in preparation for evacuation to the next health service support capability in the continuum of care. (JP 4-02) It involves several tiers of first responders with training in field sanitation and preventive medicine; highly proficient medical teams and organic medical structures that support combat formations and operational units that provide treatment of battlefield trauma within the first few minutes after injury; and those organic preventive medicine units/teams and medical biological detection teams that provide prevention and protection support to the force from natural, environmental, occupational, operational, industrial, behavioral, and nuclear-biological-chemical warfare health threats.

**Force Health Protection.** Joint healthcare capabilities and measures to promote, improve, conserve and restore the mental and physical wellbeing of deployed forces. FHP includes preventive, protective, restorative and rehabilitative medical and dental care for injuries and illnesses from health hazards and threats within a Joint Operational Area (JOA). FHP activities sustain a healthy and fit force, and include all measures taken by commanders, supervisors, individual service members, as well as the Military Health System (MHS) to support all beneficiaries and ensure the success of joint warfighters across the range of military operations. FHP activities are enabled by the integration of Health Service Delivery (HSD) and Health System Support (HSS) capabilities as applied to expeditionary task force operations. (See also HSD and HSS)

**Foreign Humanitarian Assistance (Abroad).** Programs conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions such as human pain, disease, hunger, or privation that might present a serious threat to life or that can result in great damage to or loss of property. Foreign humanitarian assistance (FHA) provided by US forces is limited in scope and duration. The foreign assistance provided is designed to supplement or complement the efforts of the host nation civil authorities or agencies that might have primary responsibility for providing FHA. FHA operations are those conducted outside the United States, its territories, and possessions. Also called FHA. See also Humanitarian Assistance. (JP 1-02)

**Forward Resuscitative Care.** Care provided as close to the point of injury as possible based on current operational requirements to attain stabilization and achieve the most efficient use of life, limb, and eyesight saving medical treatment. Forward resuscitative care typically provides essential care for stabilization to ensure that the patient can tolerate evacuation. Also called FRC. See also Essential Care (JP 4-02) (Normally provided by medical personnel and also includes efforts to relieve pain and administer Forward/Resuscitative Surgery [FRS] care capabilities.)

**Healthcare Provider.** Any member of the Armed Forces, civilian employee of the DOD, or personal services contract employee under 10 United States Code (USC) 1091 authorized by the DOD to perform healthcare functions. The term excludes any contract provider who is not a personal services contract employee. Also called DOD Healthcare Provider. (JP 4-02)

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**Health Service Delivery.** The ability to provide acute or long-term primary or specialty care capabilities to all eligible beneficiaries outside the theater in either the direct or purchased care system.

**Health System Support.** The ability to perform healthcare administrative and support related functions to sustain and continuously improve MHS mission effectiveness through focused development of people, technology, infrastructure, and joint organizational culture.

**Health Surveillance.** The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential risks to health, thereby enabling timely interventions to prevent, treat, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance. (JP 4-02 and approved for next edition of JP 1-02.)

**Health Threat.** A composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of nuclear, biological, and chemical weapons (e.g., weapons of mass destruction) that have the potential to affect short- or long-term health (e.g., psychological impact) of personnel. (JP 4-02)

**Homeland Defense.** The protection of United States sovereignty, territory, domestic population, and critical infrastructure against external threats and aggression or other threats as directed by the President. Also called HD. (JP 3-0)

**Homeland Security.** As defined in the National Strategy for Homeland Security, a concerted national effort to prevent terrorist attacks within the United States, reduce America's vulnerability to terrorism, and minimize the damage and recover from attacks that do occur. The DOD contributes to homeland security through its military missions overseas, homeland defense, and support to civil authorities. Also called HS. (JP 3-26)

**Hospital.** A medical treatment facility capable of providing inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well as the necessary supporting services required to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic. (JP 1-02)

**Humanitarian and Civic Assistance.** Assistance to the local populace provided by predominantly US forces in conjunction with military operations and exercises. This assistance is specifically authorized by title 10, USC, section 401, and funded under separate authorities. Assistance provided under these provisions is limited to (1) medical, dental, and veterinary care provided in rural areas of a country; (2) construction of rudimentary surface transportation systems; (3) well drilling and construction of basic sanitation facilities; and (4) rudimentary construction and repair of public facilities. Assistance must fulfill unit training requirements that incidentally create humanitarian benefit to the local populace. Also called HCA. See also Foreign Humanitarian Assistance. (JP 3-05.1)

**Humanitarian Assistance.** Programs conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions (e.g., human pain, disease, hunger, or

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privation) that might present a serious threat to life or that could result in great damage to or loss of property. Derived from Foreign Humanitarian Assistance (FHA) (JP 3-05.1) See also Humanitarian and Civic Assistance (JP 1-02, JP 3-07.6)

**Humanitarian Relief.** Material or logistical assistance provided for humanitarian purposes, typically in response to humanitarian crises. The primary objective of humanitarian relief operations is to save lives, alleviate suffering, and maintain human dignity. It therefore may be distinguished from development aid, which seeks to address the underlying socioeconomic factors that might have led to a crisis or emergency.

**Interchangeable.** The ability of systems, units, or forces to replace like systems, units, or forces that possess common capabilities and like characteristics to fulfill relevant requirements without causing unacceptable performance degradations when exchanged. (Definitions for the purpose of HR CONOPS)

**Interdependent.** A service's purposeful reliance on another service's capabilities to maximize complementary and reinforcing effects, while minimizing relative vulnerabilities to achieve mission requirements of the Joint Force Commander. (Definitions for the purpose of HR CONOPS)

**Interoperability.** (1) The ability to operate in synergy in the execution of assigned tasks. (JP 1-02) (2) The ability of systems, units, or forces to provide data, information, materiel and services to, and accept the same from, other systems, units, or forces and use the data, information, materiel, and services so exchanged to enable them to operate together effectively. (Manual for Operation of the Joint Capabilities Integration and Development System, February 2009 (Updated 31 July 2009)) (3) The degree of interoperability should be defined when referring to specific cases. (JP 3-32)

**In-Transit Visibility.** The ability to track the identity, status, and location of DOD and non-unit cargo (excluding bulk petroleum, oils, and lubricants) and passengers; medical patients; and personal property from origin to consignee or destination across the range of military operations. Also called ITV. (JP 1-02)

**Joint.** Connotes activities, operations, organization, etc., in which elements of two or more military departments participate. (JP 0-2)

**Joint Concept.** Links strategic guidance to the development and employment of future joint force capabilities and serve as "engines for transformation" that may ultimately lead to doctrine, organization, training, materiel, leadership and education, personnel and facilities (DOTMLPF) and policy changes (This term and its definition modify the existing term and its definition and are approved for inclusion in JP1-02. Source CJCSI 3010.02) . (CJCSI 5120.02)

**Joint Force.** A general term applied to a force composed of significant elements, assigned or attached, of two or more military departments, operating under a single Joint Force Commander. (JP 1-02)

**Joint (Force) Commander.** A general term applied to a combatant commander, subunified commander, or joint task force commander authorized to exercise combatant command (command authority) or operational control over a joint force. Also called JFC.

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(JP 1-02) Note: Concept documents also use JFC for the name of a series of Joint Functional Concept documents, as defined below. (Note: To avoid confusion, the term “joint commander” without the acronym is used throughout this document.)

**Joint Functional Concept.** An articulation of how a future Joint Force Commander will integrate a set of related military tasks to attain capabilities required across the range of military operations. Although broadly described within the joint operations concepts, they derive specific context from the joint operating concepts and promote common attributes in sufficient detail to conduct experimentation and measure effectiveness. Also called JFC. Per CJCSI 3010.02B, a JFC is one of a series of concept documents that apply elements of the CCJO solution to describe how the joint force, 8 to 20 years into the future, will perform an enduring military function across ROMO. It identifies the operational-level capabilities required and the key attributes necessary to compare capability or solution alternatives. (Note: JFC also is the JP 1-02 acronym for Joint Force Commander; however, but to avoid confusion with joint functional concepts documents referenced throughout this concept document, only the term “joint commander” is used.)

**Mass Casualty.** Any large number of casualties produced in a relatively short time period, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack that exceeds local logistical support capabilities. See also Casualty. (JP 1-02)

**Materiel.** Equipment and supplies in military and commercial supply chain management. In a military context, materiel relates to the specific needs of a force to complete a specific mission. The term also is used often in a general sense (“men and materiel”) to describe the needs of a functioning army.

**Medical Civil-Military Operations.** All health-related activities in support of a Joint Force Commander that establish, enhance, maintain, or influence relations between the joint or multinational force and host nation, multinational governmental and nongovernmental civilian organizations and authorities, and the civilian populace to facilitate military operations, achieve US operational objectives, and positively impact the health sector. Also called MCMO. (JP 4-02)

**Medical Intelligence.** A category of intelligence produced from the collection, evaluation, and analysis of information concerning the medical aspects of foreign areas that have immediate or potential impact on policies, plans, and operations; it includes the observation of the fighting strength of enemy forces, occupational and environmental information, and formation of assessments of foreign medical capabilities in the military and civilian sectors. Also called MEDINT. (JP 2-01)

**Medical Intelligence Preparation of the Operational Environment.** A systematic continuing process that analyzes information on medical and disease threats, enemy capabilities, terrain, weather, local medical infrastructure, potential humanitarian and refugee situations, transportation issues, and political, religious, and social issues for all types of operations. Medical intelligence preparation of the operational environment is a component of the health service support mission analysis process, and the resulting statistics are used as a basis for developing health service support estimates and plans. It includes defining the operational environment, describing the operational environment

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effects on health service support operations, evaluating the operational environmental threats, and determining courses of action to meet actual and potential threats. Also called MIPOE. Previously called Medical Intelligence Preparation of the Battlefield (MIPB). (JP 4-02)

**Medical Regulating.** Actions and coordination necessary to arrange for the movement of patients through different levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities, ensures that bed space is available (JP 1-02) and allocates appropriate en route care resources (teams and PMI) to accompany patients.

**Medical Surveillance.** The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population's health, well-being, and performance. (JP 4-02)

**Military Health System (MHS).** A health system that supports the military mission by fostering, protecting, sustaining, and restoring health. It also provides the direction, resources, healthcare providers, and other means necessary for promoting the health of the beneficiary population. These include developing and promoting health awareness issues to educate customers, discovering and mitigating environmentally based health threats, providing health services, including preventive care and problem intervention, and improving the means and methods for maintaining the health of the beneficiary population by constantly evaluating the performance of the healthcare services system. (JP 4-02 and approved for next edition of JP 1-02.)

**Multinational.** Between two or more forces or agencies of two or more nations or coalition partners. See also Alliance; Coalition. (JP 5-0)

**Natural Disaster.** Effect of a natural hazard (e.g., flood, volcanic eruption, earthquake, or landslide) that affects the environment and leads to financial, environmental, and/or human losses.

**Occupational and Environmental Health (OEH) Surveillance.** The regular or repeated collection, analysis, archiving, interpretation, and dissemination of occupational and environmental health-related data for monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury when determined necessary. (JP 4-02 and approved for next edition of JP 1-02)

**Operational Capability.** The ability to effectively employ a system, a weapon, or an item of equipment of approved specific characteristics that is staffed or operated by an adequately trained, equipped, and supported military unit or force. See also Initial Operational Capability. (JP 1-02)

**Palliative Care.** A comprehensive approach to treating serious illness that focuses on the physical, psychological and spiritual needs of the patient. Its goal is to achieve the best quality of life available to patients and their families by relieving suffering and controlling pain and symptoms.

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**Patient.** A sick, injured, wounded, or other person requiring medical/dental care or treatment. (JP 1-02)

**Preventive Medicine.** The anticipation, communication, prediction, identification, prevention, education, health risk assessment, and control of communicable diseases, illnesses and exposure to endemic, occupational, and environmental threats. These threats include non-battle injuries, combat stress responses, WMD, and other threats to the health and readiness of military personnel. Communicable diseases include arthropod-, vector-, food-, waste-, and waterborne diseases. Preventive medicine measures include field sanitation, medical surveillance, pest and vector control, disease/health risk assessment, environmental and occupational health surveillance, waste (e.g., human, hazardous, and medical) disposal, food safety inspection, and potable water surveillance. Also called PVNTMED. (JP 4-02)

**Quality Assurance.** Planned and systematic production processes that provide confidence in a product's suitability for its intended purpose.

**Rehabilitative Care.** Therapy that provides evaluations and treatment programs using exercises, massage, or electrical therapeutic treatment to restore, reinforce, or enhance motor performance and restores patients to functional health, allowing for their return to duty or discharge from the service. Also called Restorative Care. (JP 4-02)

**Resuscitative Care.** Advanced emergency medical treatment required for preventing immediate loss of life or limb and attaining stabilization to ensure that the patient could tolerate evacuation. (JP 4-02)

**Risk Communication.** The process of adequately and accurately communicating the magnitude and nature of potential environmental and occupational health risks to commanders and to service members. (Source: N/A)

**Risk Management.** The process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risk cost with mission benefits. Also called RM. See Risk. (JP 3-0)

**Seriously Ill or Injured.** The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that there is cause for immediate concern, but there is not imminent danger to life. Also called SII. See also Casualty Status. (JP 1-02)

**Seriously Wounded.** A casualty whose injuries or illness are of such severity that the patient is rendered unable to walk or sit, thereby requiring a litter for movement and evacuation. (JP 1-02)

**Slightly Wounded.** A casualty whose injuries or illness are relatively minor, permitting the patient to walk and/or sit. (JP 1-02)

**Stable.** One who, in the best clinical judgment of the responsible physician, can withstand a bed to bed evacuation of up to 12 hours for intratheater movement and 48 hours intertheater, and is unlikely to require intervention beyond the scope of standard en-route care capability during the evacuation. (Source: N/A)

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**Stability Operations.** An overarching term encompassing various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. (JP 3-0)

**Standardization.** The process by which the DOD achieves the closest practicable cooperation among the services and DOD agencies for the most efficient use of research, development, and production resources, and agrees to adopt on the broadest possible basis the use of a (1) common or compatible operational, administrative, and logistic procedures; (2) common or compatible technical procedures and criteria; (3) common, compatible, or interchangeable supplies, components, weapons, or equipment; and (d) common or compatible tactical doctrine with corresponding organizational compatibility. (JP 4-02)

**Telemedicine.** Rapid access to shared and remote medical expertise by means of telecommunications and information technologies to deliver health services and exchange health information for the purpose of improving patient care. (JP 4-02)

**Theater Hospitalization Capability.** Essential care and health service support capabilities to either return the patient to duty and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the theater. It includes modular hospital configurations required to support the theater (emergency medical services, surgical services, primary care, veterinary services, dental services, preventive medicine, and combat and operational stress control, blood banking services, hospitalization, laboratory and pharmacy services, radiology, medical logistics and other medical specialty capabilities as required). (JP 4-02)

**Total Asset Visibility.** The capability to provide users with timely and accurate information on the location, movement, status, and identity of units, personnel, equipment, materiel, and supplies. It also includes the capability to act on that information to improve overall performance of DOD's logistic practices. Also called TAV. See also Automated Identification Technology; In-Transit Visibility; Joint Total Asset Visibility. (JP 4-01.8)

**Wounded.** See Seriously Wounded; Slightly Wounded. (JP 1-02)

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