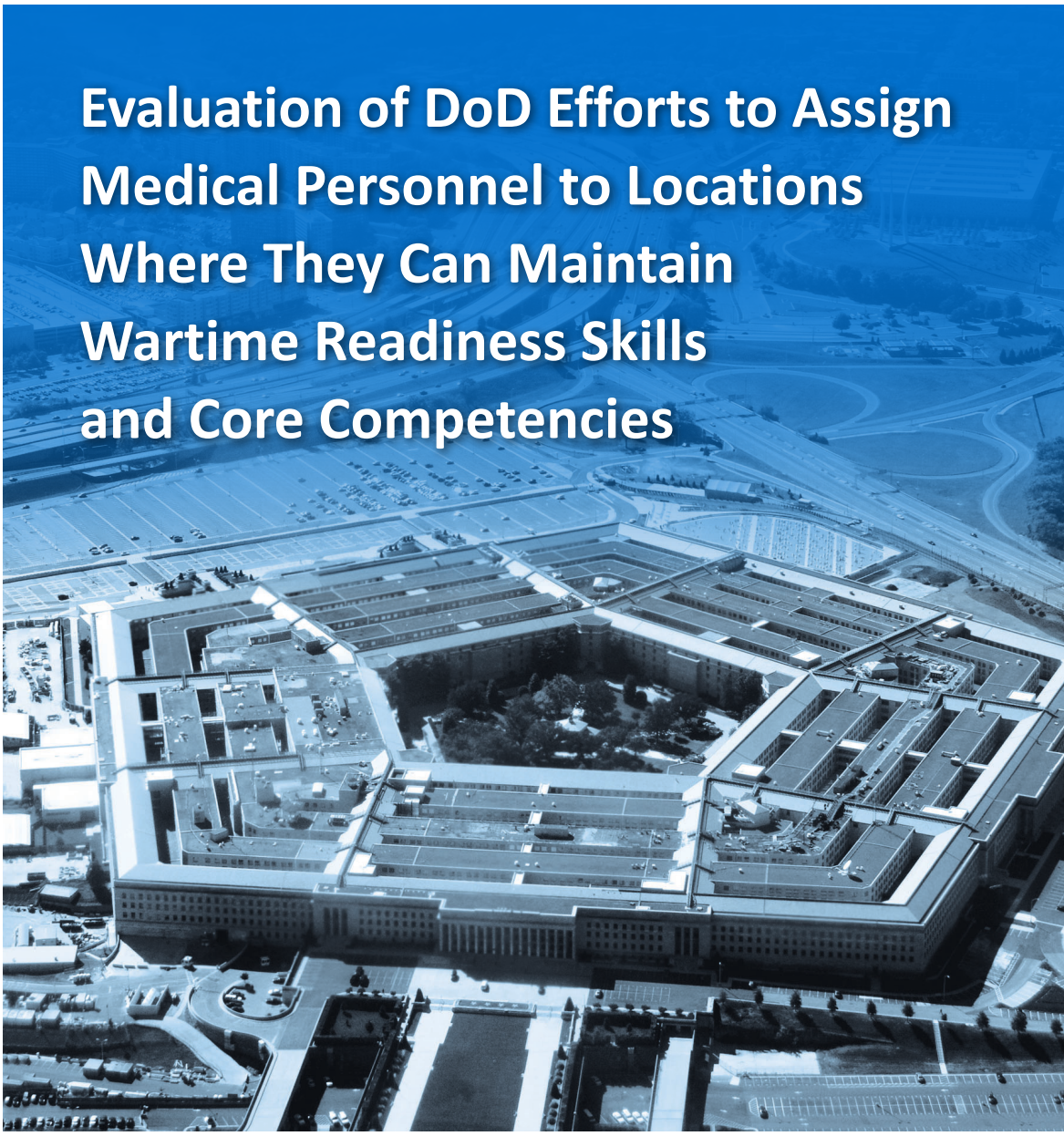
Report No. DODIG-2025-114

INSPECTOR GENERAL

U.S. Department of Defense

JUNE 13, 2025

Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies



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Results in Brief

Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies

June 13, 2025

Objective

The objective of this evaluation was to assess how effectively DoD Components assign, place, and detail wartime medical specialty personnel to locations where they can maintain their wartime medical readiness skills and core competencies.

Background

DoD policy is to maintain the critical wartime medical readiness skills of military health care personnel to maintain medical readiness. The DoD requires medical personnel's skills to be aligned with the medical functions they perform when deployed. When not deployed, active duty medical personnel are often assigned to work in military medical treatment facilities to gain opportunities that maintain their wartime medical readiness skills.

Prior studies found that military health care personnel often experience a harmful "peacetime effect" and are unable to maintain their wartime medical skills when not deployed, resulting in an unready medical force at the onset of war. For example, a 2023 Institute for Defense Analyses report found that military medical treatment facilities did not provide medical personnel with enough challenging opportunities to sustain their medical skills and maintain their medical readiness.

Finding

We determined that the Army and Navy did not effectively assign medical personnel to locations where the personnel could maintain their required wartime medical readiness skills.

Finding (cont'd)

This occurred because the Military Department policies and guidance do not require decision-makers to consider wartime readiness skill requirements, or ability to meet those requirements at their assigned location, to inform decisions about location assignments for medical personnel. In addition, Military Departments lack Defense Health Agency (DHA) support in key areas that would help inform the military medical departments and personnel commands on where to assign medical personnel.

As a result, Service members may not receive high quality, point-of-injury care from military medical personnel while deployed. Additionally, medical personnel in wartime specialties may choose to separate from the military because of their inability to obtain wartime readiness skills.

Recommendations, Management Comments and Our Response

We recommend that the Assistant Secretary of Defense (Health Affairs) direct the Military Department Surgeons General to submit an annual evaluation of each Military Department's clinical readiness assessment process. The Assistant Secretary agreed with the recommendation; therefore, the recommendation is resolved but remains open.

We also recommend that the Secretaries of the Military Departments develop and implement policy or guidance to require that information about the wartime readiness requirements for medical personnel be used when making assignment decisions. The following officials agreed with the recommendation; therefore, the recommendation is resolved but remains open—Deputy Assistant Secretary of the Army (Military Personnel and Quality of Life) and Chief of the Health Services Division of the Human Resources Command, responding for the Secretary of the Army; Surgeon General of the Air Force, responding for the Secretary of the Air Force; and Director of Special Assistant Health Affairs, responding for the Secretary of the Navy.

Additionally, we recommend that the DHA Director develop and implement a plan to assess the capacity of each military treatment facility to meet Military Department-defined

Recommendations (cont'd)

skill requirements for wartime medical readiness, generate a registry of military-civilian partnerships, and assess the performance of military-civilian partnerships. The Acting DHA Director agreed with the recommendations; therefore, the recommendations are resolved but remain open.

Please see the Recommendations Table on the next page for the status of recommendations.

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Assistant Secretary of Defense (Health Affairs)	None	3	None
Director, Defense Health Agency	None	2.a, 2.b, 2.c	None
Secretary of the Army	None	1.a	None
Secretary of the Navy	None	1.b	None
Secretary of the Air Force	None	1.c	None

Note: The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – The DoD OIG verified that the agreed upon corrective actions were implemented.


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OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

June 13, 2025

MEMORANDUM FOR SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
DIRECTOR, DEFENSE HEALTH AGENCY

SUBJECT: Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies (Report No. DODIG-2025-114)

This final report provides the results for the DoD Office of Inspector General's evaluation. We previously provided copies of the draft report and requested written comments on the recommendations. We considered management's comments on the draft report when preparing the final report. These comments are included in the report.

The following officials agreed with our recommendations; therefore, the recommendations are resolved but remain open—Assistant Secretary of Defense (Health Affairs); Acting DHA Director; Deputy Assistant Secretary of the Army (Military Personnel and Quality of Life) and Chief of the Health Services Division of the Human Resources Command, responding for the Secretary of the Army; Surgeon General of the Air Force, responding for the Secretary of the Air Force; and Director of Special Assistant Health Affairs, responding for the Secretary of the Navy.

We will close the recommendations when we receive documentation showing that all agreed-on actions to implement the recommendations are complete. Therefore, please provide us within 90 days your response concerning specific actions in process or completed on the resolved recommendations. Send your response to [redacted]

If you have any questions, please contact [redacted]

Bryan Clark

Bryan T. Clark
Assistant Inspector General for Evaluations
Programs, Combatant Commands, and Operations

Contents

Introduction

Objective

The objective of this evaluation was to assess how effectively DoD Components assign, place, and detail wartime medical specialty personnel to locations where they can maintain their wartime medical readiness skills and core competencies.[1]

We focused the evaluation on a subset of military medical personnel, including critical care physicians, critical care nurses, anesthesiologists, nurse anesthetists, emergency medicine physicians, and emergency or trauma nurses.[2]

Background

DoD Instruction (DoDI) 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," states that the DoD's policy is to maintain the critical wartime skills of medical personnel to achieve a high level of medical readiness.[3] The DoD requires that the skills of military medical personnel be aligned with the medical functions they perform when deployed. The primary mission of a ready medical force is to deliver combat casualty care, including life and limb-saving trauma care. When deployed in combat, medical personnel have opportunities to provide lifesaving trauma care. When not deployed, active duty medical personnel are often assigned to work in military treatment facilities (MTFs), which provide opportunities to maintain their wartime medical readiness skills.

However, prior studies found that military medical personnel often experience a harmful "peacetime effect," which means they are unable to maintain their wartime medical skills when not deployed.[4] This results in an unready medical force at the onset of another war. For example, a 2023 Institute for Defense Analyses report stated that the conflicts in Iraq and Afghanistan revealed significant readiness challenges with the current medical force and MTF-based training model. Specifically, the Institute for Defense Analyses found that MTFs do not provide the active duty medical personnel of combat casualty care teams with enough challenging opportunities to sustain their medical skills and maintain their medical readiness.

[1] In many cases, medical personnel in the specialties we evaluated conducted their work at the location to which they were assigned, rather than a temporarily placement or detail to another duty location. In cases when medical personnel were placed in locations different from their assigned location, we note that in the report.

[2] We specifically focused on military medical personnel. For the purposes of this report, we use the term "medical personnel" to represent military medical personnel in these six specialties.

[3] DoDI 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020.

[4] Institute for Defense Analyses, "Independent Study of Force Mix Options and Service Models to Enhance Readiness of the Medical Force," June 2023.

Readiness Assessment Criteria for Military Department Medical Personnel

In accordance with DoDI 6000.19, each Military Department established a clinical readiness assessment process for maintaining wartime medical readiness skills. Specifically, each Military Department identified the required training, education, and clinical activities that each specialist must perform to maintain these skills. The Military Department requirements differ and have different names. For example, the Army uses Individual Critical Task Lists, the Navy uses Naval Medical Readiness Criteria, and the Air Force uses the Comprehensive Medical Readiness Program.

As part of their readiness assessment criteria, each Military Department requires medical personnel to conduct a minimum number of medical or surgical procedures, or see a certain number of patients, to maintain their wartime medical readiness skills. The Military Departments determine the quantity of different types of procedures or cases, with varying complexities, relevant to individual medical specialties and the type of care those specialties would provide in an operational setting. Although the Military Department requirements for procedure volume and case complexity differ, the Military Department volume thresholds are all based on a list of jointly defined procedures, known as Joint Knowledge, Skills, and Abilities (JKSAs).[5]

The Defense Health Agency (DHA) developed the JKSAs in coordination with the Military Departments to standardize skills that wartime medical specialists should maintain so they can serve in a deployed environment. In 2022, the official performing the duties of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) issued a memorandum stating that JKSAs are foundational for ensuring the clinical readiness of critical wartime specialties so that the Military Departments can organize, train, and equip ready medical personnel to meet combatant command requirements.

According to DoDI 6000.19, Military Departments should assign medical personnel to MTFs or military-civilian partnerships (MCPs) to provide the clinical opportunities that prepare them for deployment. According to federal law (discussed in the next section of this report) and DoD policy, medical personnel should first be assigned to an MTF to obtain these skills. However, if MTFs cannot provide sufficient direct patient care to meet their requirements, personnel can be assigned to an MCP.

[5] Volume thresholds include the frequency with which procedures must be performed and whether some of the procedures can be conducted through medical simulation.

Roles and Responsibilities for Assigning Medical Personnel to Maintain Wartime Readiness Skills

Multiple laws and policies establish the requirements and associated roles and responsibilities for assigning medical personnel to locations where they can maintain their wartime medical readiness skills and provide a combat-ready medical force in both peacetime and wartime.

Secretary of Defense

The FY 2017 National Defense Authorization Act (NDAA) assigned new responsibilities to the Secretary of Defense to ensure medical personnel readiness.[6] Specifically, section 725 required the Secretary of Defense to implement measures to maintain the critical skills for wartime medical readiness of health care providers in the Armed Forces. Section 725 also required the Secretary to ensure that military MTFs provide sufficient medical services to maintain the critical wartime medical readiness skills and core competencies of medical personnel.[7] Section 706 of the FY 2017 NDAA also directed the Secretary of Defense to establish military-civilian integrated health delivery systems through partnerships with other health systems. The stated purpose of establishing these partnerships is to provide additional opportunities for medical personnel to maintain their medical readiness skills.

In addition, section 708(d) of the FY 2017 NDAA required the Secretary of Defense to establish and implement a personnel management plan for certain wartime medical specialties. These specialties include emergency medical services and prehospital care, trauma surgery, critical care, anesthesiology, and emergency medicine. The DoD responded to Congress in 2021, stating that "the most important assignment criterion is that critical wartime specialists must be assigned to venues with adequate patient volume and diversity of cases to maintain those skills required to execute trauma-related and other critical wartime medical missions."[8]

Secretaries of the Military Departments

DoDI 6000.19 states that the Secretaries of each Military Department are responsible for assigning medical personnel to military MTFs, alternative training and clinical practice sites, or military-civilian training partnerships capable of providing a workload similar to MTFs. Additionally, the instruction states

[6] FY 2017 NDAA, Pub. L. No. 114-328.

[7] Critical wartime medical readiness skills and core competencies are the essential medical capabilities that are: (1) necessary for military medical personnel in the Armed Forces to maintain for national security purposes and (2) vital to providing effective and timely health care during contingency operations.

[8] Under Secretary of Defense Final Report and Implementation Plan, "Establishment of Joint Trauma Education and Training Directorate," February 14, 2018.

that the Secretaries are responsible for: (1) identifying the knowledge, skills, and abilities (KSAs) that health care providers cannot obtain in the 6 weeks before a deployment and (2) ensuring that medical personnel meet Military Department-defined medical readiness standards. DoDI 6000.19 requires the Military Departments to implement a clinical readiness assessment process for wartime medical skill maintenance and provide an annual evaluation to the ASD(HA).

Surgeons General of the Military Departments

Section 712 of the FY 2020 NDAA required Surgeons General of the Armed Forces to make assignments of medical personnel that will ensure their readiness for operational deployment.[9] Specifically, section 712 states that Surgeons General will assign medical personnel either primarily to military MTFs under the operational control of the MTF commander or director or secondarily to partnerships with civilian facilities for training activities specific to that Military Department.

Defense Health Agency

As a combat support agency, the DHA is responsible for meeting the medical readiness requirements of military operational commanders.[10] DoD implementing guidance for section 702 of the FY 2017 NDAA assigned the DHA responsibility for providing venues and opportunities at the MTFs for medical personnel to obtain and maintain their KSAs at or above minimum established thresholds.[11] The DHA is also responsible for identifying each MTF's capacity to support the clinical readiness standards established by the Secretaries of the Military Departments.[12] If the Military Department knows the capacity of the MTFs to support clinical readiness standards, it can consider assigning medical personnel to MCPs when MTF workload is insufficient to meet readiness standards.

To support the Military Department efforts to establish and evaluate MCPs, DoDI 6040.47, "Joint Trauma System," requires the DHA Director to develop and maintain a registry that tracks all military-civilian trauma partnerships and associated partnership memorandums of agreement or understanding.[13] In addition, DoDI 6040.47 requires the DHA to establish the minimum criteria

[9] FY 2020 NDAA, Pub. L. No. 116–92, § 712.

[10] FY 2019 NDAA, Pub. L. No. 114-328, § 712.

[11] Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "Construct for Implementation of Section 702," May 22, 2018.

[12] FY 2020 NDAA § 711.

[13] DoDI 6040.47, "Joint Trauma System," September 28, 2016 (Incorporating Change 2, June 14, 2022).

and goals for entering into MCPs, use data collection and analysis to assess partnership performance, and incorporate lessons learned from trauma partnerships into clinical practice. Further, DoDI 6000.19 states that all partnership agreements will include a provision for capturing the workload of medical personnel participating in the partnerships, and the process will be automated whenever possible.

The DHA's supporting role is reflected in the DHA's FY22-26 Campaign Plan.[14] The DHA included the Sustaining Expeditionary Medical Skills initiative as one of eight strategic initiatives in the plan. The DHA also included an initiative called Optimizing Skill Sustainment in its FY23-28 Strategic Plan.[15]

[14] DHA, "DHA FY22-26 Campaign Plan," January 26, 2022.

[15] DHA, "FY23-28 DHA Strategic Plan."

Finding

The Army and Navy Did Not Effectively Assign Medical Personnel to Locations Where They Could Maintain Wartime Medical Readiness Skills

Across the Military Departments, 21 of the 35 medical personnel we interviewed stated that they faced challenges maintaining their wartime medical readiness skills. Based on our analysis of Military Department personnel data, the Air Force assigned a relatively higher percent, and the Army and Navy assigned a relatively lower percent, of their medical personnel to locations that offered opportunities for them to maintain wartime readiness skills.

This occurred, in part, because the Army and Navy did not require their personnel commands to use wartime readiness requirements as criteria for making assignment decisions for medical personnel. Also, the Army and Navy did not use available wartime medical readiness skill data to inform decisions about where to assign medical personnel, in part, because of quality and completeness issues with data collected on the personnel's wartime readiness skills. Additionally, Army and Navy policies do not provide guidance on how to prioritize medical personnel's assignment to MCPs relative to MTFs and other locations. The Air Force, however, does provide this guidance.

The Military Departments also lack DHA support in key areas, such as identifying the capacity of MTFs to meet personnel readiness requirements that would help inform decisions about medical personnel assignments.[16] DHA officials stated that the DHA stopped trying to identify MTF capacity to meet clinical readiness standards in November 2023 after removing readiness-related initiatives from its strategic plan.

Because Army and Navy medical personnel are not consistently assigned where they can sustain their wartime readiness skills, they may not provide high quality, point-of-injury care to Service members during deployments. As of April 2025, Military Department data showed that medical personnel's skills often fell below readiness standards.[17] Finally, medical personnel in wartime specialties may choose to separate from the military because of their inability to obtain wartime

[16] MTF capacity refers to the clinical services an MTF can provide, which can be influenced by demand, staffing, and location.

[17] The Military Departments have dashboards showing the current clinical wartime readiness skills for medical personnel.

readiness skills. For example, Navy emergency physicians commonly cited low case volume and complexity as their reason for leaving the military, which worsens the well-documented medical personnel shortages in the Military Departments.[18]

The Army and Navy Often Assigned Medical Personnel to Locations with Limited Opportunities to Maintain Readiness Skills

The Army and Navy did not effectively assign medical personnel, such as critical care physicians, critical care nurses, anesthesiologists, nurse anesthetists, emergency medicine physicians, and emergency or trauma nurses, to locations where the personnel could maintain wartime medical readiness skills, in accordance with the FY 2017 and FY 2020 NDAAs and DoDI 6000.19. Specifically, the Army and Navy did not consistently assign medical personnel primarily to MTFs and secondarily to MCPs, which provide the most opportunities for meeting their skill requirements. Based on our observations and discussions with Army and Navy personnel, the Army and Navy assigned a higher percentage of medical personnel to low-case-volume and low-complexity locations, such as to the Navy Fleet, Marine Corps, or Army Forces Command.

Army and Navy Medical Personnel Are Often Assigned to Locations Without Direct Patient Care Opportunities

Based on data provided by the Military Departments' personnel commands, the Army and Navy are more likely than the Air Force to assign their medical personnel to locations that do not provide opportunities for direct patient care. As a result, Army and Navy medical personnel likely have fewer opportunities to maintain wartime readiness skills. For example, as of FY 2024 and in contrast to the FY 2020 NDAA and DoDI 6000.19 guidance that requires medical personnel to be assigned first to an MTF and secondarily to an MCP, only 25 percent of Army and 52 percent of Navy emergency physicians were assigned to MTFs or MCPs. However, the Air Force assigned 81 percent directly to MTFs or MCPs, locations that offer opportunities for direct patient care. Table 1 demonstrates the distribution of medical personnel assignments to MTFs, MCPs, and other locations for the six medical specialties we evaluated for each Military Department. Specifically, Table 1 shows that medical personnel are often assigned outside of an MTF, and few are assigned to MCPs. Additionally, the table further illustrates that the Army and Navy do not prioritize assigning medical personnel to MTFs or MCPs.

[18] According to Report No. DODIG-2024-033, "Management Advisory: Concerns with Access to Care and Staffing Shortages in the MHS," November 29, 2023, the DoD OIG received multiple hotline complaints related to staffing shortages across medical departments. Additionally in the report, the Naval Inspector General stated that the Navy did not have enough active duty physicians to meet current requirements because of unprecedented attrition and operational requirements.

Table 1. Percent of Medical Personnel Assigned to MTFs, MCPs, and Other Locations (by Specialty and Service)

Specialty	Service	Total Personnel[1]	Percent MTF Assigned	Percent MCP Assigned	Percent Other[2]
Emergency Medicine Physicians	Army	250	25	2	72
	Navy	199	52	1	47
	Air Force	222	81	4	16
Critical Care Physicians	Army	56	70	0	30
	Navy	31	90	0	10
	Air Force	62	69	31	0
Anesthesiologists	Army	91	85	2	13
	Navy	149	72	1	26
	Air Force	140	86	6	9
Emergency Medicine Nurses	Army	225	37	3	60
	Navy	273	71	1	28
	Air Force	210	86	4	10
Critical Care Nurses	Army	448	17	2	81
	Navy	395	68	0	32
	Air Force	303	84	7	9
Certified Nurse Anesthetists	Army	205	33	2	65
	Navy	175	78	1	21
	Air Force	102	89	1	10

Note: Due to rounding, overall percents may not equal 100 percent.

[1] Excludes students.

[2] Includes all assignments to non-MTF or non-MCP locations.

Source: The Army Human Resources Command, Navy Bureau of Medicine and Surgery, and Air Force Medical Readiness Agency.

In Table 1, the Army and Navy medical personnel not assigned to MTF or MCP positions may also spend some time at an MTF providing direct patient care. According to Army policy, some medical personnel assigned to operational units are loaned to MTFs and required to spend 88 percent of their duty time at the MTF.[19] We did not confirm that medical personnel met this policy requirement, however. Being on loan to the MTF provides skill sustainment opportunities for these personnel and opportunities to meet Army medical readiness requirements. However, a significant percentage of Army medical personnel still do not have opportunities to provide direct patient care related to their specialty. After

[19] Headquarters Department of the Army Execute Order 115-23, "Administrative Guidelines for MTOE Assigned Personnel Soldiers and TDA Units," January 5, 2023.

accounting for the medical personnel who practice medicine at an MTF, 58 percent of emergency medicine providers, 45 percent of emergency medicine nurses, and 43 percent of critical care nurses still do not spend their time providing direct patient care at MTFs or MCPs.

According to Navy Bureau of Medicine and Surgery (BUMED) officials, some Navy providers assigned to Marine Corps units also work partially at an MTF. BUMED officials provided data showing that 41 percent of Navy medical personnel assigned to Marine Corps billets reported duty time at an MTF.

Medical Personnel Stated That MTFs Do Not Provide Enough Opportunities for Direct Patient Care

In our interviews with 35 medical personnel in all three Military Departments in the six specialties listed in Table 1, 21 stated that they faced challenges sustaining wartime readiness skills at their assigned location, including those providing direct patient care at an MTF. Our interviews included medical personnel across all Military Departments who were assigned to an MTF and concerned that they could not obtain the required procedure volume and complexity to maintain the skills necessary to provide care in an operational setting. One critical care physician assigned to the largest MTF in the Military Health System (MHS) stated that they independently conducted only 10 procedures at that MTF since 2018. In contrast to the MTF, the physician independently conducted 950 procedures while voluntarily participating in off-duty employment at a civilian hospital and during a 9-month deployment. Although the physician did supervise medical residents and fellows at the MTF, they stated that, to feel ready to care for Service members in a deployed environment, personally completing procedures is important, not supervising others or completing the procedures in simulation. Many medical personnel who faced challenges sustaining their wartime skills at an MTF recommended expanding MCPs to increase opportunities for providers and nurses to sustain their wartime readiness skills.

Based on interviews with medical personnel working at MCPs, we determined that MCPs typically provide more procedure volume and complexity than MTFs and may provide more opportunities for medical personnel to meet their wartime readiness skill requirements. Medical personnel working in a civilian hospital as part of an MCP told us that they received significantly higher case volume and more complex cases than they would at an MTF, which better prepared them to provide care in a deployed setting. We interviewed eight medical personnel currently working at MCP locations, and only two expressed concerns about obtaining the case volume and acuity required to maintain their skills.

In a 2021 congressionally directed report, the Institute for Defense Analyses found that MTFs alone cannot meet procedure volume requirements for military readiness and that the Military Departments should expand partnerships with civilian hospitals. DoDI 6000.19 clearly reflects that recommendation, stating that although an MTF is the default choice for assignment, the DoD will establish MCPs when personnel cannot maintain wartime medical readiness skills at MTFs. Despite the requirement to establish MCPs, the Military Departments permanently assigned only a small percentage of medical personnel to MCPs.

Army and Navy Policies and Guidance Do Not Require That Wartime Readiness Skill Requirements Be Factored into Medical Personnel Assignment Decisions

Army and Navy policies do not require information about medical personnel's readiness skill attainment to inform assignment decisions, nor do the policies include guidance about how to prioritize assignment to MCPs relative to other locations. Furthermore, the data the Army and Navy collected about medical personnel's attainment of wartime readiness skills may not yet be complete or accurate enough to inform assignment decisions.

Military Department Policies Do Not Require Attainment of Wartime Readiness Skills to Factor into Assignment Decisions

Army and Navy policies and guidance do not require that information about an individual's compliance with wartime readiness skill requirements, or their ability to meet those requirements at the assigned location, be considered during medical personnel assignments. The lack of a requirement to consider these skills when assigning personnel is inconsistent with the DoD's response to section 708(d) of the FY 2017 NDAA, when the DoD stated that "the most important assignment criterion is that critical wartime specialists must be assigned to venues with adequate patient volume and diversity of cases to maintain those skills required to execute trauma-related and other critical wartime medical missions."

In addition, although the Air Force does primarily assign providers to MTFs and MCPs, as shown in Table 1, its policies, like the Army's and Navy's, do not require information about an individual's compliance with wartime readiness skill requirements to inform assignment decisions. Without using information about these skill requirements to inform assignment decisions, the Military Departments cannot effectively weigh all medical readiness and mission requirements to make risk-informed decisions about where to assign providers.

Army and Navy Policies Do Not Identify the Relative Importance of Military-Civilian Partnerships

Army and Navy policies also do not include guidance about how to prioritize MCP positions relative to other open positions. In response to section 708(d) of the FY 2017 NDAA, all Military Departments acknowledged that the solution to low procedure volume at MTFs was to assign more critical wartime medical specialists to partnerships to obtain skill sustainment opportunities. However, unlike the Air Force, Army and Navy policies do not contain information about how to prioritize MCPs. The Air Force policy requires that 80 percent of MCP positions be filled as part of its 2023 Air Force Medical Service Officer Staffing Prioritization Plan.

An Army Medical Command official stated that assignment policy does not identify how to prioritize assignments to MCPs because no Army execute order mandates the use of MCPs to sustain readiness. Therefore, assignment to an MCP is voluntary, and the Military Departments infrequently use MCPs to maintain medical personnel readiness. Although Navy personnel guidance does state that continental U.S., non-headquarters positions, such as MTFs, should be filled at a minimum of 65 percent, it does not specifically define how MCPs should be prioritized relative to other positions.

Data on the Attainment of Wartime Readiness Skills May Not Be Accurate Enough to Inform Assignment Decisions

Although the Army and Navy collected data about the wartime readiness skill attainment of medical personnel, we determined that the data may not yet be complete or accurate enough to inform assignment decisions. Officials from each of the Military Departments stated that inaccurate and incomplete data prohibited them from using wartime readiness skill data to inform assignment decisions. For example, an official from the Army Medical Command told us that the data was still in a developmental phase and not complete enough for the Army to use the data to inform medical personnel assignment decisions. A BUMED official stated that a primary objective of efforts to collect data on medical personnel's clinical workload is to help inform personnel assignment decisions. However, BUMED officials stated that this cannot be done until BUMED addresses known limitations in the data, which is complicated by inaccurate medical provider information in the electronic health record.[20]

[20] The electronic health record focuses on the total health of a patient and contains information from all of the medical personnel involved in the patient's care.

DHA officials and officials from the military medical departments expressed concerns with the accuracy of data for wartime medical readiness because of data quality issues with the MHS Electronic Next Generation Integrated Services and Electronic System (MHS GENESIS), the MHS' electronic health record. For example, a DHA official provided us with an analysis showing that MHS GENESIS produces duplicative data and assigns KSAs to the wrong provider. The official stated that these problems can lead to both overcounting and undercounting of the actual clinical workload for medical personnel. To overcome issues with MHS GENESIS, the Military Departments often rely on medical personnel to self-report clinical workload data. However, an Air Force official told us that they did not feel the Comprehensive Medical Readiness Program data is always accurate because the data is a result of human input, and BUMED officials encountered challenges with collecting clinical data directly from medical personnel.

After BUMED officials identified issues and concerns related to the completeness and accuracy of clinical data, they made progress collecting data directly from medical personnel about their skill sustainment. BUMED officials provided documentation showing that, as of March 2025, 85 percent of Navy expeditionary medical platform personnel submitted data about the volume of procedures they completed and the care they provided as part of the Navy's Clinical Activity Data Capture process.[21] BUMED officials also provided documentation showing that they used this data to help decide which providers to place in MCP locations and highlighted ongoing efforts to develop a model that uses this data to help inform assignment decisions that maximize the number of skill sustainment opportunities available to medical personnel. However, as of May 2025, BUMED only collects this data for medical personnel assigned to BUMED billets and aligned to an expeditionary medical platform. BUMED officials stated that they have plans to expand these data collection and analysis efforts to other medical personnel in the future but did not indicate plans to expand the initiative to include personnel assigned to the Navy Fleet or Marine Corps.

Therefore, we recommend that the Secretaries of the Military Departments update and implement policy or guidance requiring personnel commands to use information about wartime readiness requirements for medical personnel when making assignment decisions, as well as clearly identify how personnel commands should prioritize MCP assignment locations relative to other locations.

[21] Navy Medicine expeditionary platforms are medical capabilities to support distributed maritime operations, such as casualty receiving treatment ships, expeditionary medical facilities, and expeditionary medical units.

The DHA Did Not Meet Statutory Requirements That Support Military Department Wartime Readiness Objectives

The DHA did not support the Army, Navy, and Air Force in key areas that would help inform where the Military Departments assign medical personnel, as required by law and DoD policy. Section 711 of the FY 2020 NDAA requires the DHA to determine each MTF's capacity to support the clinical readiness standards the Secretaries of the Military Departments established. In addition, DoDI 6000.19 and DoDI 6040.47 require the DHA to maintain a registry that tracks all MCPs and associated memorandums of agreement and collect and analyze data to assess partnership performance.[22]

The DHA Did Not Determine MTF Capacity to Support Medical Readiness Standards

The DHA did not determine the capacity of each MTF to support the medical readiness standards the Military Departments established. The DHA, in coordination with the Military Departments, established annual procedure volume targets, known as JKSAs, that helped the Military Departments determine if medical personnel have the skills to conduct these types of procedures in a deployed environment. Based on the demand for these procedures at MTFs, the DHA began an initiative to determine each MTF's capacity to meet JKSA targets for two of six specialties in the scope of this evaluation—emergency and critical care providers. As part of this initiative, the DHA developed a pilot visualization tool for the Military Departments and MTFs, known as the KSA Demand Model. However, we found that this DHA initiative is no longer active, and the DHA does not currently meet the FY 2020 NDAA requirement to determine each MTF's capacity to support the clinical readiness standards the Secretaries of the Military Departments established.

The DHA Did Not Track and Assess Military-Civilian Partnerships

The DHA did not track or assess MCP performance in accordance with the FY 2020 NDAA, DoDI 6000.19, and DoDI 6040.47. The JKSA Working Group tracks MCPs through a makeshift application; however, an official from the JKSA Program Management Office told us that the Joint Trauma System Manager's MCP application is not actively maintained. We verified that the application does not maintain the memorandums of agreement with the MCPs.

[22] DoDI 6040.47, "Joint Trauma System," September 28, 2016 (Incorporating Change 2, June 14, 2022).

Furthermore, the DHA did not collect data or establish metrics to assess MCP performance, which would allow Military Departments to make informed decisions about when and where to assign medical personnel to MCPs. DHA officials and military personnel told us that the DHA previously had a contract to collect, process, and upload data for work performed at the MCPs, but the contract lapsed in 2023. Personnel in the JKSA Working Group collect and analyze MCP data on a by-request basis, but this is not part of their official duties. These officials told us that the Military Departments have not devoted any resources to assessing the performance of all MCPs across the Military Departments.

DHA Officials Stated That DHA Strategic Initiatives Changed

Officials from the JKSA Program Management Office stated that in November 2023, the DHA Director approved the FY23-28 DHA Strategic Plan, which removed readiness-related initiatives. DHA leadership then stopped their initial efforts to identify MTF capacity to meet clinical readiness standards and develop an MCP registry. According to DHA officials, the purpose of the initiative, known as the Sustain Expeditionary Medical Skills initiative, was to develop the DHA's strategy for maintaining the medical personnel wartime skills deemed highly perishable and mission essential.

Without DHA support assessing the capacity of the MTFs, the Military Departments cannot effectively determine the maximum number of personnel they can assign to an MTF while still meeting the skill requirements for wartime medical readiness, nor can the Military Departments make informed decisions about when and where to establish MCPs to increase the number of skill sustainment opportunities. Furthermore, without the DHA's support assessing the extent to which MCPs contribute to skill sustainment, the Military Departments cannot effectively assign medical personnel to the highest-performing MCPs.

Therefore, the DHA Director, in coordination with the Military Departments, should develop and implement a plan to determine the capacity of each MTF to meet Military Department-defined medical readiness assessment requirements. The DHA should also coordinate with the Military Departments to develop and implement a plan to generate a complete MCP registry and assess the performance of all MCPs.

Medical Personnel May Lack Skills Needed to Execute Critical Wartime Medical Missions and May Separate from the Military

If medical personnel are not assigned to locations where they can sustain their wartime readiness skills, they may not provide high quality, point-of-injury care to Service members during deployments. Military Department data collected to assess wartime readiness skills shows that individual medical personnel often fall below the established Military Department threshold for procedure volume and acuity and, therefore, may not have the skills required to execute trauma-related and other critical wartime medical missions.

Each Military Department requires their medical personnel to perform different types and frequencies of procedures to meet readiness skill requirements. For example, the Army requires critical care physicians to place two arterial lines per year while the Air Force requires 10, and the Navy requires physicians to meet JKSA thresholds that assign arterial lines a numeric score that is combined with the scores of other required procedures. Like arterial line placements, other procedures deemed critical for maintaining wartime readiness skills are assigned a required frequency, and personnel must meet all of the procedure and volume requirements. Based on data the Military Departments provided, only 9 percent of Army physicians, 25 percent of Navy physicians, and 41 percent of Air Force physicians met their respective Military Department annual threshold for procedure volume and acuity. The Air Force has significantly higher compliance with their Comprehensive Medical Readiness Program's procedure and volume requirements than the Army and Navy have to their respective Service-defined procedure and volume requirements.

Additionally, medical personnel in wartime specialties may choose to separate from the military because of their inability to obtain wartime readiness skills. In September 2021, the DoD provided a response to section 708(d) of the FY 2017 NDAA, stating that the low volume and complexity of cases in MTFs was a primary reason for low retention rates. A January 2024 Medical Corps Retention and Burnout Study, conducted for BUMED to survey emergency medicine physicians, found that concerns about skill degradation is the number-one factor contributing to junior officer attrition.[23] A medical Service member from the survey said, "My biggest reason for wanting to get out is simply because I desire to do emergency medicine." In addition, according to documentation the Army's critical care consultant

[23] The Voice of the Customer Analysis Learnings, "Medical Corps Retention and Burnout Study," January 2024.

provided, the overall retention rate for Army Medical Corps personnel decreased 7 percent since 2015, which is attributed, in part, to a low volume of KSA opportunities in the MHS.

Based on the findings in this report, we recommend that the ASD(HA) require the Surgeons General of the Military Departments, in coordination with the DHA, to submit an annual evaluation to the ASD(HA) on the Departments' clinical readiness assessments. The evaluation should identify, at minimum, the:

- Department's progress toward implementing its assessment process for wartime clinical readiness;
- data quality and collection issues preventing the Department from accurately measuring adherence to standards for wartime clinical readiness;
- percent of medical personnel, by specialty and assignment location, that meet the Department's established thresholds for clinical readiness;
- percent of medical personnel that meet the Department's established thresholds for clinical readiness through assignment to MCPs; and
- the assigned locations where the Department's medical personnel are at greatest risk of clinical skill degradation.

Management Comments on the Finding and Our Response

The Deputy Assistant Secretary of the Army (Military Personnel and Quality of Life), responding for the Secretary of the Army, made several comments on the Finding. The Deputy Assistant Secretary stated that Army medical personnel assigned to MTFs use simulation and training aid devices to supplement their required medical readiness skills training and increase proficiency in specific skills. They also stated that Army medical personnel assigned to units such as field hospitals and forward resuscitative surgical detachments are required by policy to perform duty at MTFs, which facilitates repetitive training on Individual Critical Tasks. The Deputy Assistant Secretary stated that the findings do not account for the personnel that are administratively assigned to operational units but have duty at the MTFs and, by policy, these officers are required to spend a minimum of 88 percent of their time working in the MTF. Additionally, they stated that if these personnel are accounted for, all but one of the six critical wartime specialties have over half of their personnel working at MTFs.

Our Response

We acknowledge that Army medical personnel may conduct some procedures using simulation to help meet their readiness assessment thresholds, which we note in our report. We also recognize that some Army medical personnel administratively assigned to operational units spend time at MTFs, which could provide skill sustainment opportunities. When we collected personnel assignment data for this report, Army Human Resources Command officials stated that the authoritative manpower data sources did not allow them to identify the individual personnel who were administratively assigned to operational units but spend time at the MTF. Rather, the officials could only identify the authorizations (positions) to which the personnel could be assigned. Army Human Resources Command personnel told us that the issue with the data source was resolved, and they provided data that identified, at an individual level, medical personnel assigned to operational units with duty at an MTF. Although we referenced this Army process in our draft report, we updated the final report to indicate the extent to which some operationally assigned personnel have opportunities to provide direct patient care at an MTF.

Recommendations, Management Comments, and Our Response

Recommendation 1

We recommend that the following Secretaries of the Military Departments update and implement policy or guidance requiring personnel commands to use information about wartime readiness requirements for medical personnel when making assignment decisions and clearly identify how military-civilian partnership assignment locations should be prioritized relative to other assignment locations.

a. Secretary of the Army

b. Secretary of the Navy

c. Secretary of the Air Force

Secretary of the Army Comments

The Deputy Assistant Secretary of the Army (Military Personnel and Quality of Life) and the Chief of the Health Services Division of the Human Resources Command, responding for the Secretary of the Army, agreed and stated that as the collaboration with the ASD(HA) to implement a comprehensive medical personnel assignment process matures, the Army will be able to match medical

personnel training requirements to training opportunities at MTFs. The Deputy Assistant Secretary and Chief stated that they will use existing mechanisms in the Active Component Manning Guidance to further prioritize MTF assignments for critical wartime specialties. The Chief also stated that they will update manning guidance or the Army Talent Alignment Process Policy to ensure Army specialty consultants have informed assignment decisions based on readiness data provided by the DHA and Army Office of the Surgeon General.

Our Response

Comments from the Deputy Assistant Secretary and Chief addressed the specifics of the recommendation. Therefore, the recommendation is resolved but will remain open. We will close the recommendation when we obtain and verify information on the actions that the Army takes to fully address the recommendation, including: (1) the updated manning guidance or associated policy that demonstrates the prioritization of MTF assignments for all critical wartime specialties and (2) the updated guidance or policy to ensure Army specialty consultants make informed decisions based on readiness data provided by the DHA and the Army Office of the Surgeon General.

Secretary of the Air Force Comments

The Air Force Surgeon General, responding for the Secretary of the Air Force, agreed and stated that the Air Force Surgeon General will update and implement policy requiring personnel commands to use information about wartime readiness requirements for medical personnel when making assignment decisions and clearly identify how MCP assignment locations should be prioritized relative to other assignment locations. The Surgeon General stated that the estimated completion date is December 12, 2025.

Our Response

Comments from the Air Force Surgeon General addressed the specifics of the recommendation. Therefore, the recommendation is resolved but will remain open. We will close the recommendation when we obtain and verify information on the actions the Air Force takes to fully address the recommendation, including the updated policy requiring personnel commands to use wartime readiness requirement information when making medical personnel assignments, supporting documentation demonstrating the policy's implementation, and clear identification of how MCP assignment locations are prioritized above other medical personnel assignments.

Secretary of the Navy Comments

The Director of Special Assistant Health Affairs, responding for the Secretary of the Navy, agreed and stated that the Navy Personnel Command will incorporate the recommended updates to guidance in their 2026 Officer Manning Plan.

Our Response

Comments from the Director of Special Assistant Health Affairs addressed the specifics of the recommendation. Therefore, the recommendation is resolved but will remain open. We will close the recommendation when we obtain and verify information on the actions the Navy takes to fully address the recommendation, including the updated 2026 Officer Manning Plan.

Recommendation 2

We recommend that the Defense Health Agency Director, in coordination with the Military Departments, develop and implement a plan to:

a. Determine the capacity of each military treatment facility to meet Military Department-defined assessment requirements for wartime medical readiness.

Defense Health Agency Comments

The Acting DHA Director agreed and stated that the DHA completed modeling and validating manpower requirements for each MTF and coordinated with the Military Departments to integrate the military and civilian mix of requirements in October 2024. They further stated that the DHA meets the DoD Office of Inspector General's recommendation by leveraging the MHS Business Rules for the Human Capital Distribution Planning (HCDP) and Manpower Requirements Determination. The Acting Director stated that the HCDP is an annual planning process to produce a detailed and accurate forecast of military medical personnel assignments, including the projected staffing gaps, and inform the DHA's business plan for civilian and contractor staffing for the upcoming fiscal year. To do so, the HCDP references accurate manpower requirements when determining the distribution of military personnel to MTFs and enables the Military Departments to place military personnel in MTFs best suited to generate clinical currency for wartime medical readiness.

Additionally, the Acting Director stated that the DHA is improving the Manpower Requirements Determination model to refresh and revalidate manpower staffing requirements for each MTF. The refreshed assessment will identify the existing clinical workload of each MTF, and then the DHA will analyze demand for patient care at each MTF. Lastly, the Acting Director stated that the DHA will use joint

clinical activity thresholds, developed in coordination with the Military Departments, to identify how many military medical personnel the MTFs could support given historical workload. The Acting Director stated that the DHA and Military Departments should work toward expanding the slots available in MCPs to sustain clinical competency, particularly in verified trauma centers.

Our Response

Although we disagree with the Acting Director's statement that the DHA currently meets the recommendation through leveraging the MHS Business Rules for the HCDP and Manpower Requirements Determination process, the Acting Director's planned actions to revalidate the DHA's manpower staffing requirements and identify how many military medical personnel can support each MTF fully address the specifics of the recommendation. Therefore, the recommendation is resolved but will remain open. We will close the recommendation when we obtain and verify the information on the actions the DHA takes to fully address the recommendation, such as: (1) completing the revalidation of its MTF manpower staffing requirements model and using the joint clinical activity thresholds to identify how many military medical personnel each MTF can support based on historical workload and (2) determining how many military medical personnel each MTF can support, based on the Military Department clinical assessment requirements (Army Individual Critical Task Lists, Naval Medical Readiness Criteria, and Air Force Comprehensive Medical Readiness Program).

b. Generate a complete registry of military-civilian partnerships.

Defense Health Agency Comments

The Acting DHA Director agreed and stated that the DHA supports creating a single, enterprise-wide registry of all MCPs. The Acting Director further stated that an enterprise-wide registry will allow the MHS to track and analyze all MCPs and other external agreements where military medical personnel may perform clinical workload in support of their expeditionary scope of practice requirements.

Our Response

Comments from the Acting Director addressed the specifics of the recommendation. Therefore, the recommendation is resolved but will remain open. We will close the recommendation when we obtain and verify information on the actions the DHA takes to develop an enterprise-wide registry that allows the MHS to track and analyze all MCPs.

c. Assess the performance of all military-civilian partnerships.

Defense Health Agency Comments

The Acting DHA Director agreed and stated that the DHA will assess the clinical readiness activity achieved at MCPs and other external agreements using the jointly developed expeditionary scope of practice metrics described in the response to recommendation 2.a. They also stated that the comprehensive external agreements and partnerships registry described in the response to recommendation 2.b will enable the JKSA Project Management Office to validate data completeness and ensure complete data reporting to produce a more complete picture of clinical readiness activity across the MHS.

Our Response

Comments from the Acting Director addressed the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation when we obtain and verify information on the actions the DHA takes to fully address the recommendation. Because the Acting Director stated that the JKSA Program Management Office will rely on a complete MCP registry to ensure a complete picture of clinical readiness activity across the MHS, this recommendation will only be closed after Recommendation 2.b. is resolved and closed.

Secretary of the Army Comments

Although not required to respond, the Deputy Assistant Secretary of the Army (Military Personnel and Quality of Life) and the Chief of the Health Services Division of the Human Resources Command agreed and stated that the Army must have a comprehensive assessment of the case volume, complexity, and civilian staffing at each MTF so that the Army can make decisions on where to assign Army medical personnel to maximize clinical skill sustainment. The Deputy Assistant Secretary also acknowledged that the MHS faces significant resource constraints resulting in a loss of MTF capabilities, which has forced each Military Department to explore MCPs.

Recommendation 3

We recommend that the Assistant Secretary of Defense (Health Affairs) require the Surgeons General of the Military Departments, in coordination with the Defense Health Agency, to submit an annual evaluation to the Assistant Secretary of Defense (Health Affairs) on the Departments' clinical readiness assessments. The evaluation must, at minimum:

- **Provide the Department's progress toward implementing its assessment process for wartime clinical readiness.**
- **Provide the data quality and collection issues preventing the Department from accurately measuring adherence to wartime clinical readiness standards.**
- **Provide the percent of medical personnel, by specialty and assignment location, meeting the Department's established clinical readiness threshold.**
- **Provide the percent of medical personnel meeting the Department's established clinical readiness thresholds through assignment or placement in military-civilian partnerships.**
- **Provide the assigned locations where the Department's medical personnel are at greatest risk of clinical skill degradation.**

Assistant Secretary of Defense (Health Affairs) Comments

The Acting ASD(HA) agreed and stated that they will issue a memorandum no later than October 31, 2025, directing the Surgeons General of the Military Departments, in collaboration with the DHA, to submit an annual readiness evaluation. Specifically, the evaluation will address:

- progress toward implementing the wartime clinical readiness assessment process;
- current challenges affecting data quality and accuracy in measuring adherence to clinical readiness standards;
- percentage of medical personnel meeting established readiness thresholds, detailed by medical specialty and assignment location;
- percentage of personnel achieving readiness standards through MCPs; and
- identification of assignment locations with the highest risk for clinical skill degradation among medical personnel.

Additionally, the memorandum will direct the DHA, in coordination with the Military Departments, to develop a standardized reporting template and data collection procedures no later than 60 days from the issuance of the memorandum. The Acting ASD(HA) also stated that these actions will ensure transparency, accountability, and continuous improvement in sustaining the readiness of military medical personnel.

Our Response

Comments from the Acting ASD(HA) addressed the specifics of the recommendation. Therefore, the recommendation is resolved but will remain open. We will close the recommendation when we verify that the information provided and actions the ASD(HA) takes fully address the recommendation, including: (1) issuance of the ASD(HA) memorandum directing the Surgeons General of the Military Departments, in collaboration with the DHA, to submit an annual readiness evaluation that includes the specific bulleted items in the recommendation and directing the DHA to develop a standardized reporting template and data collection procedures; (2) the standardized reporting template and data collection procedures; and (3) a post-memorandum annual readiness evaluation.

Defense Health Agency Comments

Although not required to respond, the Acting DHA Director agreed and stated that the ASD(HA) will establish this formal evaluation process. The Acting Director further stated that the DHA memorandum, "Specialty-Specific Emergency War Surgery Course Transition from Pre-Deployment to Sustainment Training," January 26, 2022, provides additional standardization of clinical readiness requirements across the Military Departments and that the complete implementation of this memorandum will fulfill the formal Joint Capabilities Integration and Development System requirement.

Secretary of the Army Comments

Although not required to respond, the Deputy Assistant Secretary of the Army (Military Personnel and Quality of Life) and the Chief of the Health Services Division of the Human Resources Command agreed with the recommendation.

Appendix

Scope and Methodology

We conducted this evaluation from December 2023 through January 2025 in accordance with the "Quality Standards for Inspection and Evaluation," published in December 2020 by the Council of the Inspectors General on Integrity and Efficiency. Those standards require that we adequately plan the evaluation to ensure that objectives are met and that we perform the evaluation to obtain sufficient, competent, and relevant evidence to support the findings, conclusions, and recommendations. We believe that the evidence obtained was sufficient, competent, and relevant to lead a reasonable person to sustain the findings, conclusions, and recommendations.

We identified and reviewed the following Federal laws and DoD policies to address the objective of this evaluation.

- FY 2017 NDAA, Pub. L. No. 114-328
- FY 2019 NDAA, Pub. L. No. 115-232
- FY 2020 NDAA, Pub. L. No. 116-92
- DoD's Response to the House Report 117-397, "Report to the Committee on Armed Services of Senate and the House of Representatives Sustainment of Critical Medical Skills," December 2023.
- DoDI 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020.
- DoDI 6040.47, "Joint Trauma System," September 28, 2016 (Incorporating Change 2, June 14, 2022).
- Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy and Oversight of the Minimum Standardized Threshold of Readiness Currency for Knowledge, Skills, and Abilities," February 26, 2019.
- Deputy Secretary of Defense Memorandum, "Requirements and Readiness for the Medical Force," February 28, 2018.
- ASD(HA) Policy Memorandum, "Establishment of a Knowledge, Skills, and Abilities Program Management Office," May 14, 2018.
- Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "Construct for Implementation of Section 702," May 22, 2018.
- ASD(HA) Information Memorandum, "Progress of the Establishment of the Knowledge, Skills, and Abilities Program and Program Management Office," July 15, 2018.

- Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy and Oversight of the Minimum Standardized Threshold of Readiness Currency for Knowledge, Skills, and Abilities," February 26, 2019.
- ASD(HA) Memorandum, "Sustainment of the Military Health System Joint Knowledge, Skills, and Abilities Clinical Readiness Program," April 7, 2022.

During the evaluation, we obtained and reviewed the following evidence and documentation to support our conclusions.

- A spreadsheet of Army personnel data from the Army Human Resources Command and extracted from the Army Integrated Personnel and Pay System as of January 2024
- A spreadsheet of Navy personnel data from BUMED and extracted from the Navy Standard Integrated Personnel System as of January 2024
- A spreadsheet of Air Force personnel data from the Air Force Medical Readiness Agency and extracted from the Military Personnel Data System as of September 2024
- Data from military medical department officials showing the number of medical personnel permanently assigned to MCPs
- Army, Navy, and Air Force assignment policies and guidance to determine the extent to which wartime medical readiness skills are taken into account when making assignment decisions
- Emails from DHA officials highlighting strategic planning decisions related to the DHA's role as a combat support agency
- Documents from each of the military medical departments highlighting issues related to retention of medical personnel

During the evaluation, we conducted interviews with and received information from the following stakeholders.

- Military Departments
  - 35 medical personnel across the three Departments
  - 10 specialty consultants and specialty leaders across the three Departments (7 Army, 2 Navy, and 1 Air Force)
- DHA
  - DHA Headquarters and the ASD(HA)
  - DHA Manpower and Personnel (J1)
  - DHA Joint Trauma System Operations (J3)
  - DHA Analytics and Evaluation (J5)
  - JKSA Program Management Office

    - DHA JKSA MCP Working Group
    - DHA JKSA Working Group
- Army
    - Army Human Resources Command
    - Army Military-Civilian Trauma Team Training Program
    - Army Medical Command Manpower
    - Army Medical Command Director of Medical Health Assessments Governance
    - Army Deputy Force Command Surgeon
    - Army Medical Command Office of the Surgeon General
- Navy
    - Navy Personnel Command
    - Navy Personnel Command Career Management Department
    - Navy BUMED Command
    - Navy Director of Manpower and Personnel
- Air Force
    - Air Force Personnel Center
    - Air Force Medical Readiness Agency
    - Air Force Branch Chief of the Medical Manpower and Personnel Division
    - Air Forces Chief of Medical Career Management

Use of Computer-Processed Data

We used computer-processed data to identify the assigned location of medical personnel. The Military Departments extracted and provided to us the assignment data from personnel and manpower data systems. Each Department extracted the personnel assignment data from the following systems they use to track medical personnel assignments.

- Army Human Resources Command using the Army Integrated Personnel and Pay System
- BUMED using the Navy Standard Integrated Personnel System and the Total Force Manpower Management System
- Air Force Medical Readiness Agency using the Military Personnel Data System

Based on interviews with Military Department officials knowledgeable of the data systems, a review of data system documentation, and an assessment of the completeness of key data elements, we determined that the data the Military Departments provided was sufficiently complete and accurate for use in this evaluation. Each Military Department provided data from authoritative personnel and manpower data systems. Data system documentation indicated that internal controls are in place to ensure that complete and accurate data is collected. The Military Departments provided data that included the source system, date of extraction, and key variable definitions. We assessed the data for completeness and obtained additional information from stakeholders to ensure the data was reliable.

Prior Coverage

During the last 5 years, the Government Accountability Office (GAO) issued two reports assessing medical force readiness. The DoD Office of Inspector General (DoD OIG) issued one report evaluating the effectiveness of DoD training for mobile medical teams to improve trauma care before teams deployed to the U.S. Indo-Pacific Command and U.S. Africa Command areas of responsibility. In a report to Congress, the Institute for Defense Analyses provided an independent assessment of readiness-enhancing training models, including the use of MCPs.

Unrestricted DoD OIG reports can be accessed at http://www.dodig.mil/reports.html/.

Unrestricted GAO reports can be accessed at http://www.gao.gov.

Unrestricted Institute for Defense Analyses reports can be accessed at https://www.ida.org/en/research-and-publications/.

DoD OIG

Report No. DODIG-2020-087, "Audit of Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility," June 8, 2020

> The DoD OIG audited whether the DHA and Military Departments provided effective training to mobile medical teams to improve trauma care before teams deployed to the U.S. Indo-Pacific Command and U.S. Africa Command areas of responsibility. The DoD OIG found that, according to personnel across the Military Departments, their home station military MTF positions did not provide the trauma caseloads to prepare them to be a member of a mobile medical team. The report made five recommendations to the DoD to implement a standardized medical training program for the mobile medical teams with standardized post-deployment after-action reports to gather information

on the effectiveness of the team training provided before their deployment. We did not follow up on these recommendations because they were outside the scope of this evaluation.

GAO

Report No. GAO-21-337, "Defense Health Care: Actions Needed to Define and Sustain Wartime Medical Skills for Enlisted Personnel," June 17, 2021

This report examined the extent to which: (1) the Military Departments defined, tracked, and assessed enlisted personnel's wartime medical skills, and (2) the DoD developed plans and processes to sustain these skills and assessed risks associated with implementing them. The GAO found that the Military Departments did not fully define, track, and assess wartime medical skills for enlisted medical personnel. The GAO also found that the DoD did not fully develop plans and processes to sustain the wartime medical skills of these personnel. The report made thirty recommendations. We did not follow up on these recommendations because they were outside the scope of this evaluation.

Report No. GAO-19-206, "Defense Health Care: Actions Needed to Determine the Required Size and Readiness of Operational Medical and Dental Forces," February 21, 2019

The GAO reviewed the DoD's efforts to address requirements from the FY 2017 NDAA about required medical and dental personnel and wartime readiness. The GAO found that the DoD did not use complete, accurate, and consistent data that fully demonstrate results. More so, the GAO identified concerns with the DoD's metric to assess physician clinic readiness. The GAO made six recommendations to the DoD, including a recommendation to identify and mitigate the limitations in a clinical readiness metric for medical providers. We did not follow up on these recommendations because they were outside the scope of this evaluation.

Institute for Defense Analyses

Project BE-7-4920, "Independent Study of Force Mix Options and Service Models to Enhance Readiness of the Medical Force (NDAA-21 Sec 757)," June 2023

This report provides the congressionally directed, independent assessment of readiness-enhancing training models, including the use of MCPs and alternative force mix options that would place a higher share of combat casualty care teams in the Reserve Component. The Institute for Defense Analyses conducted four analyses, and the study had three main findings: the MTF-based training model does not support personnel readiness for key combat casualty care teams, MCP-based training models appear to be highly effective for supporting the readiness of these personnel, and an MCP expansion targeting these personnel is feasible and would not impact the majority of the force. The report made four key recommendations to change the policy. We did not follow up on these recommendations because they were outside the scope of this evaluation.

Management Comments

Secretary of the Army

DEPARTMENT OF THE ARMY
OFFICE OF THE ASSISTANT SECRETARY
MANPOWER AND RESERVE AFFAIRS
111 ARMY PENTAGON
WASHINGTON DC 20310-0111

SAMR-MP (500A) MAY 5, 2025

MEMORANDUM FOR U.S. Army Audit Agency, Audit Coordination & Follow-up Office

SUBJECT: Army Response to DoDIG Draft Report: Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies (Project No. D2024-DEVOPB-0022.000)

1. The Army has carefully reviewed the Draft Report and concurs with the findings and three specific recommendations. This memorandum provides some technical comments on clarity and accuracy as well as detailed responses to each recommendation.

2. The following comments are offered for consideration of improving clarity and accuracy in the report:

a. Page 2, last paragraph. Army medical personnel assigned to MTFs supplement required medical readiness skills training through utilization of MTF simulation laboratories for assigned critical tasks. Furthermore, proficiency is reinforced through repetitive training leveraging Training Aid Devices, Simulators, and Simulations (TADSS) available in Live, Virtual, Constructive, and Gaming (LVC-G) environments at additional locations.

b. Page 7, First paragraph. Army personnel assigned to Modified Table of Organization and Equipment (MTOE) units – including Field Hospitals (FHs) and Forward Resuscitative Surgical Detachments (FRSDs) – may experience limited patient flow when not deployed. To maintain proficiency, these MTOE-assigned personnel (MAP) are required by policy to perform duty at Military Treatment Facilities (MTFs), facilitating repetitive training on Individual Critical Task Sets (ICTs). These personnel are also eligible for consideration for MCP.

c. Page 8, Table 1 “Percent of Medical Personnel Assigned to Military Treatment Facilities (MTF), Military-Civilian Partnerships, and Other Locations by Specialty and Service.” The findings do not account for personnel in the selected AOCs that are administratively assigned to operational units with duty at the MTF. By policy, these officers are required to spend a minimum of 88% of their time working in the MTF. If these personnel are accounted for, all but 1 critical wartime specialty listed has most personnel assigned and working in the MTF (60N at 90.2%; 60X at 85%; 62A at 42.8%; 66F at 60.1%; 66S at 57.1%; and 66T at 55%).

Secretary of the Army (cont'd)

SAMR-MP
SUBJECT: Army Response to DoDIG Draft Report: Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies (Project No. D2024-DEVOPB-0022.000)

3. Each Draft Report Recommendation and Response is provided below:

a. Recommendation 1: We recommend that the Secretaries of the Army, Navy, and Air Force update and implement policy or guidance requiring personnel commands to use information about wartime readiness requirements for medical personnel when making assignment decisions and clearly identify how military-civilian partnership assignment locations should be prioritized relative to other assignment locations.

b. Response to Recommendation 1: Concur. the Army's reform efforts are underway. Over the previous 18 months, ASD(HA) in collaboration with the military departments implemented a comprehensive military medical personnel assignment process, the Human Capital Distribution Plan (HCDP). The HCDP occurs annually and is synchronized with the Army's annual assignment process. We agree that as the process matures, senior MHS leaders will be able to match a healthcare professional's training requirements with training opportunities at a Military Treatment Facility (MTF) or military-civilian partnership location. Additionally, the MHS has also formalized a centralized manpower database to track requirements, authorizations, and assignments for each of the services. The ASD(HA) staff is required to provide a quarterly update to the MHS Governance executive body to ensuring synchronization and oversight.

c. Recommendation 2**:** We recommend that the Defense Health Agency Director, in coordination with the Military Departments, develop and implement a plan to:

- Determine the capacity of each medical treatment facility to meet Military Department-defined assessment requirements for wartime medical skills.
- Generate a complete registry of military-civilian partnerships.
- Assess the performance of all military-civilian partnerships.

d. Response to recommendation 2: Concur. As a precondition to improving the HCDP, the Army must have a comprehensive assessment of the case volume, complexity, and civilian staffing at each MTF. The Defense Health Agency is the only DoD organization with access and analytical expertise to provide this information to each Service Surgeon General. This information is essential for the Army Surgeon General to make a sound decision on where to assign Army Medical personnel to maximize clinical skill sustainment. The Army recognizes the Military Health System faces significant resource constraints resulting in a loss of capability at the MTFs. Since 2019, there has been a 25%-38% capability loss at the largest 9 MTFs since FY2019. This loss of capability has forced each Military Department to explore military-civilian partnerships. To improve transparency and collective opportunity, the Army concurs with the DHA keeping a performance-based registry of military-civilian partnerships for each service to utilize.

Secretary of the Army (cont'd)

SAMR-MP
SUBJECT: Army Response to DoDIG Draft Report: Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies (Project No. D2024-DEVOPB-0022.000)

e. Recommendation 3: We recommend that the Assistant Secretary of Defense (Health Affairs) require the Surgeons General of the Military Departments, in coordination with Defense Health Agency, to submit annual evaluation to the Assistant Secretary of Defense (Health Affairs) on the Departments' clinical readiness assessment. The evaluation must, at a minimum:

- Provide the Department's progress toward implementing its assessment process for wartime clinical readiness
- Provide the data quality and collection issues preventing the Department from accurately measuring adherence to wartime clinical readiness standards.
- Provide the percent of medical personnel, by specialty and assignment location, meeting the Department's established clinical readiness threshold.
- Provide the percent of medical personnel meeting the Department's established clinical readiness thresholds through assignment or placement in military-civilian partnerships.
- Provide the assigned locations where the Department's medical personnel are at greatest risk of clinical degradation.

f. Response to recommendation 3: Concur. This recommendation is congruent with current DoD policy. The MHS has already established a multi-service governance structure, which could accommodate this reporting requirement.

4. The POC for this memorandum is [redacted]

STONEBURG.JOH[redacted] Digitally signed by STONEBURG.JOHN.HENRY.IV.[redacted]
JOHN H. STONEBURG
Deputy Assistant Secretary of the Army
(Military Personnel and Quality of Life)

3

Secretary of the Army (cont'd)

DEPARTMENT OF THE ARMY
HEADQUARTERS, US ARMY HUMAN RESOURCES COMMAND
1600 SPEARHEAD DIVISION AVENUE, DEPARTMENT 250
FORT KNOX, KENTUCKY 40122-5205

AHRC-TAH 2 May 2025

MEMORANDUM FOR Office of the Inspector General

SUBJECT: Response to DOD IG Project No. D2024-DEVoPB-0022.000

1. References

a. Memorandum, Office of Inspector General, Department of Defense, Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies (Project No. D2024-DEV0PB-0022.000), 04 December 2023.

b. Inspector General, DODIG Draft Report: (CUI) Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies (Project No. D2024-DEV0PB-0022.000), 21 April 2025.

c. Headquarters Department of the Army, AR 600-3 The Army Personnel Development System, 14 May 2023.

d. Headquarters Department of the Army, HQDA EXORD 241-21 ISO Army Talent Alignment Process, 30 September 2021.

2. The U.S. Army Human Resources Command (HRC) reviewed the DoD Inspector General (IG) draft report (reference 1b) and provides comments on those recommendations impacting HRC. HRC concurs with recommendation 1. Clarifying comments are listed below:

a. Recommendation 1: Recommend that the Secretaries of the Army, Navy, and Air Force update and implement policy or guidance requiring personnel commands to use information about wartime readiness requirements for medical personnel when making assignment decisions and clearly identify how military-civilian partnership assignment locations should be prioritized relative to other assignment locations.

b. Response to Recommendation 1: Concur with comment

c. Justification for Response: The findings fail to acknowledge MTOE assigned personnel (MAP) as "primarily assigned" to military treatment facilities (MTFs). MAP personnel are assigned to MTOE units with "duty at" MTFs, and by policy are required to spend a minimum of 88% of time in the MTF. If MAP personnel are accounted for, all but 1 critical wartime specialty listed has a majority of personnel assigned and working

Secretary of the Army (cont'd)

AHRC-TAH
SUBJECT: Response to DOD IG Project No. D2024-DEVoPB-0022.000

in the MTF (60N at 90.2%; 60X at 85%; 62A at 42.8%; 66F at 60.1%; 66S at 57.1%; and 66T at 55%).

Existing mechanisms can be utilized to further prioritize MTF assignments for critical wartime specialties. AR 600-3, para 2-9 assigns authority for executing personnel management to the Surgeon General, in coordination with HRC. HRC assigns personnel against existing force structure and prioritizes fill based on Active Component Manning Guidance (ACMG), provided by the Chief of Staff of the Army. Active Component Manning Guidance is updated periodically and is the mechanism by which the Army can prioritize assignments based on current mission and emerging requirements. The ACMG process allows the Army to prioritize assignments based on the total mission requirement, both in the operational force as well as the generating force (MTF). Manning guidance for MTFs can be adjusted if directed. This alternate course of action allows Army Senior Leaders to maintain flexibility as requirements change.

Additionally, Army G-1 ATAP policy allows Health Services Division, HRC "to communicate with and receive feedback from TSG's AOC Consultants regarding skill mismatches." (reference 1d). Utilizing this mechanism, we recommend Consultants inform slating decisions based on readiness data provided from DHA and OTSG to identify duty locations that are best suited to maintain competencies for the AMEDD's "wartime medical specialty personnel".

d. Timeline for Implementation: ACMG is updated as required, which has occurred approximately annually over the past few years.

3. The point of contact for this action is [redacted]

WALTERS.KATR[redacted] Digitally signed by WALTERS.KATRINA.EAKER.
INA.EAKER[redacted]
[redacted]

KATRINA WALTERS
COL, MC
Chief, Health Service Division

Secretary of the Air Force

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

21 May 2025

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL

FROM: HQ USAF/SG
7700 Arlington Blvd
Falls Church, VA 22042

SUBJECT: Department of the Air Force Response to DoD Office of Inspector General Draft Report, "Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies" (Project No. D2024-DEV0PB-0022)

1. This is the Department of the Air Force response to the DoDIG Draft Report, "Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies" (Project No. D2024-DEV0PB-0022). The DAF agrees with the report as written and welcomes the opportunity to improve wartime readiness reporting requirements.

2. The AF/SG will correct issues identified in this report, and develop and implement a corrective action plan outlined in the following recommendations:

RECOMMENDATION 1: The DODIG recommends that the Air Force update and implement policy or guidance requiring personnel commands to use information about wartime readiness requirements for medical personnel when making assignment decisions and clearly identify how military-civilian partnership assignment locations should be prioritized relative to other assignment locations.
DAF RESPONSE: The Commander concurs with the recommendation, stating that AF/SG will update and implement policy requiring personnel commands to use information about wartime readiness requirements for medical personnel when making assignment decisions and clearly identify how military-civilian partnership assignment locations should be prioritized relative to other assignment locations.
Estimated Completion Date: 12 Dec 2025.

3. The AF/SG point of contact is [redacted]

DEGOES.JOHN.J[redacted] Digitally signed by DEGOES.JOHN.J[redacted]
JOHN J. DEGOES
Lieutenant General, USAF, MC, FS
Surgeon General

Secretary of the Navy

DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

May 27, 2025

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Request for Responses to DODIG Draft Report "Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies" (D2024-DEV0PB-0022.000)

The Department of the Navy concurs with recommendation 1 in the Department of Defense Inspector General (DoDIG) draft report, "Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies." The Bureau of Medicine and Surgery (BUMED) and Navy Personnel Command (NPC) submitted the following responses for your consideration.

BUMED is requesting amendments to the draft report that reflect ongoing efforts to accurately measure clinical readiness, and its initiatives to forecast wartime knowledge, skills, and abilities (KSA) for individuals based on location and specialty. For your consideration, the attachments submitted by BUMED include a response to specific sections in the draft report, a recently published BUMED instruction on KSA, dashboards highlighting KSA metrics across BUMED organizations, a KSA predictive modeling brief, and a brief to realign billets supporting the University of Pennsylvania military-civilian partnership for trauma training.

NPC will incorporate the DoDIG recommendations in the 2026 Officer Manning Plan. Additionally, PERS-4415 will update standing 2025 Officer Manning Plan guidance to incorporate this change. The 2025 changes will be maintained within PERS-4415, the 2025 Officer Manning Plan will not have a revision; this is like all other updates within the calendar year.

My point of contact for this matter is [redacted]

PINER.THOMAS.JEFFERSON[redacted] Digitally signed by PINER.THOMAS.JEFFERSON[redacted] Date: 2025.05.27 09:50:48 -04'00'

Thomas J. Piner
Captain, Medical Service Corps, U.S. Navy
Director, Special Assistant Health Affairs

Attachment:
As stated

Defense Health Agency

DEFENSE HEALTH AGENCY
7700 ARLINGTON BOULEVARD, SUITE 5101
FALLS CHURCH, VIRGINIA 22042-5101

MEMORANDUM FOR THE DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Response to Department of Defense Inspector General Draft Report "Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies" (Project Number D2024-DEV0PB-0022.000)

The Defense Health Agency's (DHA) response to the Department of Defense Inspector General (DoDIG) project number D2024-DEV0PB-0022.000 is attached. The DHA concurs with the recommendations provided by the DoDIG that are assigned to DHA in the report "Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies".

My point of contact for this matter is [redacted]

SMITH.DAVID.J[redacted] Digitally signed by SMITH.DAVID.[redacted]

David J. Smith, M.D.
Acting Director

Attachment:
As stated

Defense Health Agency (cont'd)

DOD IG DRAFT REPORT
D2024-DEV0PB-0022.000

"Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies"

DEFENSE HEALTH AGENCY RESPONSE
TO THE DOD IG RECOMMENDATIONS

RECOMMENDATION 2: We recommend that the Defense Health Agency Director, in coordination with the Military Departments, develop and implement a plan to:

a. Determine the capacity of each medical treatment facility to meet Military Department-defined assessment requirements for wartime medical readiness.

(U) DHA RESPONSE: Concur. The Military Health System (MHS) supports both clinical readiness and beneficiary healthcare from one set of resources. These interdependent missions create resourcing efficiencies for the MHS. The Defense Health Agency (DHA) meets this recommendation by leveraging MHS Business Rules for the Human Capital Distribution Planning (HCDP) and Manpower Requirements Determination. These rules are currently in use by DHA and the Military Departments (MILDEPs).

In Oct 2024, DHA completed modeling and validation of manpower requirements for each MTF and coordinated with the MILDEPs to integrate the military/civilian mix of requirements. DHA is currently documenting these requirements in the Fourth Estate Manpower Tracking System (FMTS).

(U) The HCDP is an annual planning process to produce a detailed and accurate forecast of military medical personnel assignments. The outputs of HCDP identify projected staffing gaps and informs DHA's business plan for civilian and contractor staffing for the upcoming fiscal year. DHA is improving the Manpower Requirements Determination Business rule to refresh and revalidate manpower staffing requirements for each Military Treatment Facility (MTF). Additionally, a formal process has been established which routinely reconciles DHA and MILDEP manpower documents to ensure an accurate accounting of military personnel requirements and authorizations.

There are two components to determining MTF capability to meet wartime medical readiness assessment requirements: available workload (demand) and MTF capacity (supply). The DHA's calculations of available workload (demand) and MTF capacity (supply) inform the manpower models that generate the overall the manpower staffing requirement in each MTF. In doing so, the HCDP is referencing accurate manpower requirements when determining the distribution of military personnel to MTFs and enables MILDEPS to place them in MTFs best suited to generate clinical currency for wartime medical readiness.

Defense Health Agency (cont'd)

(U) The refreshed assessment by DHA will first identify the existing clinical workload of each MTF and geographic area, defined using the DHA's "geo-cluster" framework. The DHA will analyze demand for patient care from beneficiaries enrolled at each MTF or receiving care in each geo-cluster. The DHA will also work with the Veterans Health Administration (VHA) to identify clinical readiness-related workload provided to Veterans through the community care network potentially capturable by DHA MTFs.

The DHA will use the joint clinical activity thresholds developed in coordination with the Military Departments to identify how many military medical personnel each MTF and geo-cluster could support given its historical workload. The DHA and MILDEPS should assess a 'blended practice' and expanding the slots available within military-civilian partnerships (MCPs) to sustain clinical competency, particularly those supporting American College of Surgeons-verified trauma centers. To bolster other efforts, including the Integrated Continental U.S. Medical Operations Plan, MCP expansion could focus on civilian facilities near designated casualty receiving facilities.

b. Generate a complete registry of military-civilian partnerships.

(U) Concur. DHA supports the creation of a single, enterprise-wide MCP Library from which a comprehensive listing of all MCPs (inclusive of details such as specialty types and number of personnel) can be sorted and filtered. This will allow the MHS to track and analyze all MCPs and other external agreements where military medical personnel may perform clinical workload in support of their Expeditionary Scope of Practice (ESP) requirements.

c. Assess the performance of all military-civilian partnerships.

(U) Concur. The DHA will assess the value of clinical readiness activity achieved at MCPs and other external agreements through the same metrics it uses to assess performance of MTFs in the Direct Care system, described in Recommendation 2a. Jointly developed ESPs and scoring methodologies are unique to each specialty and are applicable at any venue where military medical personnel within the specialty perform clinical workload. Assessing MCP performance with the clinical readiness activity threshold metric allows for a comparison to DHA MTFs. The comprehensive external agreements and partnerships registry described in Recommendation 2b will enable the Joint Knowledge, Skills, and Abilities Project Management Office to validate data completeness by tracking existing external agreements and partnerships and ensuring complete data reporting. Accurate and complete data reporting will produce a more complete picture of clinical readiness activity across the MHS.

RECOMMENDATION 3: We recommend that the Assistant Secretary of Defense (Health Affairs) require the Surgeons General of the Military Departments, in coordination with the Defense Health Agency, to submit an annual evaluation to the Assistant Secretary of Defense (Health Affairs) on the Departments' clinical readiness assessments. The evaluation must, at minimum:

- **Provide the Department's progress toward implementing its assessment process for wartime clinical readiness.**

Defense Health Agency (cont'd)

- **Provide the data quality and collection issues preventing the Department from accurately measuring adherence to wartime clinical readiness standards.**
- **Provide the percent of medical personnel, by specialty and assignment location, meeting the Department's established clinical readiness threshold.**
- **Provide the percent of medical personnel meeting the Department's established clinical readiness thresholds through assignment or placement in military-civilian partnerships.**
- **Provide the assigned locations where the Department's medical personnel are at greatest risk of clinical skill degradation.**

(U) DHA RESPONSE: Concur. The January 26, 2022 DHA Director Memorandum "Specialty-Specific Emergency War Surgery Course Transition from Pre-Deployment to Sustainment Training" provides additional standardization of clinical readiness requirements across the MILDEPs. Completing the implementation of this memorandum will fulfill the formal Joint Capabilities Integration and Development System requirement. ASD(HA) will establish this formal evaluation process.

Assistant Secretary of Defense (Health Affairs)

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MEMORANDUM FOR INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE

SUBJECT: Response to Department of Defense Inspector General Draft Report, "Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies" (Project No. D2024-DEV0PB-0022.000)

I have reviewed the Department of Defense (DoD) Inspector General Draft Report, "Evaluation of DoD Efforts to Assign Medical Personnel to Locations Where They Can Maintain Wartime Readiness Skills and Core Competencies" (Project No. D2024-DEV0PB-0022.000) and provide the following response for the following recommendation within my purview.

Recommendation 3: We recommend that the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) require the Surgeons General of the Military Departments, in coordination with the Defense Health Agency (DHA), to submit an annual evaluation to the ASD(HA) on the Departments' clinical readiness assessments.

- Provide the Department's progress toward implementing its assessment process for wartime clinical readiness.
- Provide the data quality and collection issues preventing the Department from accurately measuring adherence to wartime clinical readiness standards.
- Provide the percent of medical personnel, by specialty and assignment location, meeting the Department's established clinical readiness threshold.
- Provide the percent of medical personnel meeting the Department's established clinical readiness thresholds through assignment or placement in military-civilian partnerships.
- Provide the assigned locations where the Department's medical personnel are at greatest risk of clinical skill degradation.

Response: We agree with Recommendation 3. The ASD(HA) will direct the Surgeons General of the Military Departments, in collaboration with the DHA, to submit an annual clinical readiness evaluation. This evaluation will specifically address progress toward implementing the wartime clinical readiness assessment process; current challenges affecting data quality and accuracy in measuring adherence to clinical readiness standards; the percentage of medical personnel meeting established readiness thresholds, detailed by medical specialty and assignment location; the percentage of personnel achieving readiness standards through military-civilian partnerships; and identification of assignment locations with the highest risk for clinical skill degradation among medical personnel. These steps will ensure transparency, accountability and continuous improvement in sustaining the readiness of military medical personnel. This

Assistant Secretary of Defense (Health Affairs) (cont'd)

memorandum will be issued no later than October 31, 2025. The DHA, in coordination with the Military Departments, will develop the standardized reporting template and data collection procedures no later than 60 days of the initial memorandum. The first annual clinical readiness evaluation report will be submitted to the ASD(HA) no later than 30 days after receiving the first annual report.

My point of contact for this matter is [redacted]

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USAN[redacted]

Stephen L. Ferrara, M.D.
Acting

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Acronyms and Abbreviations

ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BUMED	Bureau of Medicine and Surgery
DHA	Defense Health Agency
DoDI	DoD Instruction
HCDP	Human Capital Distribution Planning
JKSA	Joint Knowledge, Skills, and Abilities
KSA	Knowledge, Skills, and Abilities
MCP	Military-Civilian Partnership
MHS	Military Health System
MHS GENESIS	Military Health System Electronic Next Generation Integrated Services and Electronic System
MTF	Military Treatment Facility
NDAA	National Defense Authorization Act


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Legislative Affairs Division
703.604.8324

Public Affairs Division
public.affairs@dodig.mil; 703.604.8324

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4800 Mark Center Drive
Alexandria, Virginia 22350-1500
www.dodig.mil
DoD Hotline 1.800.424.9098