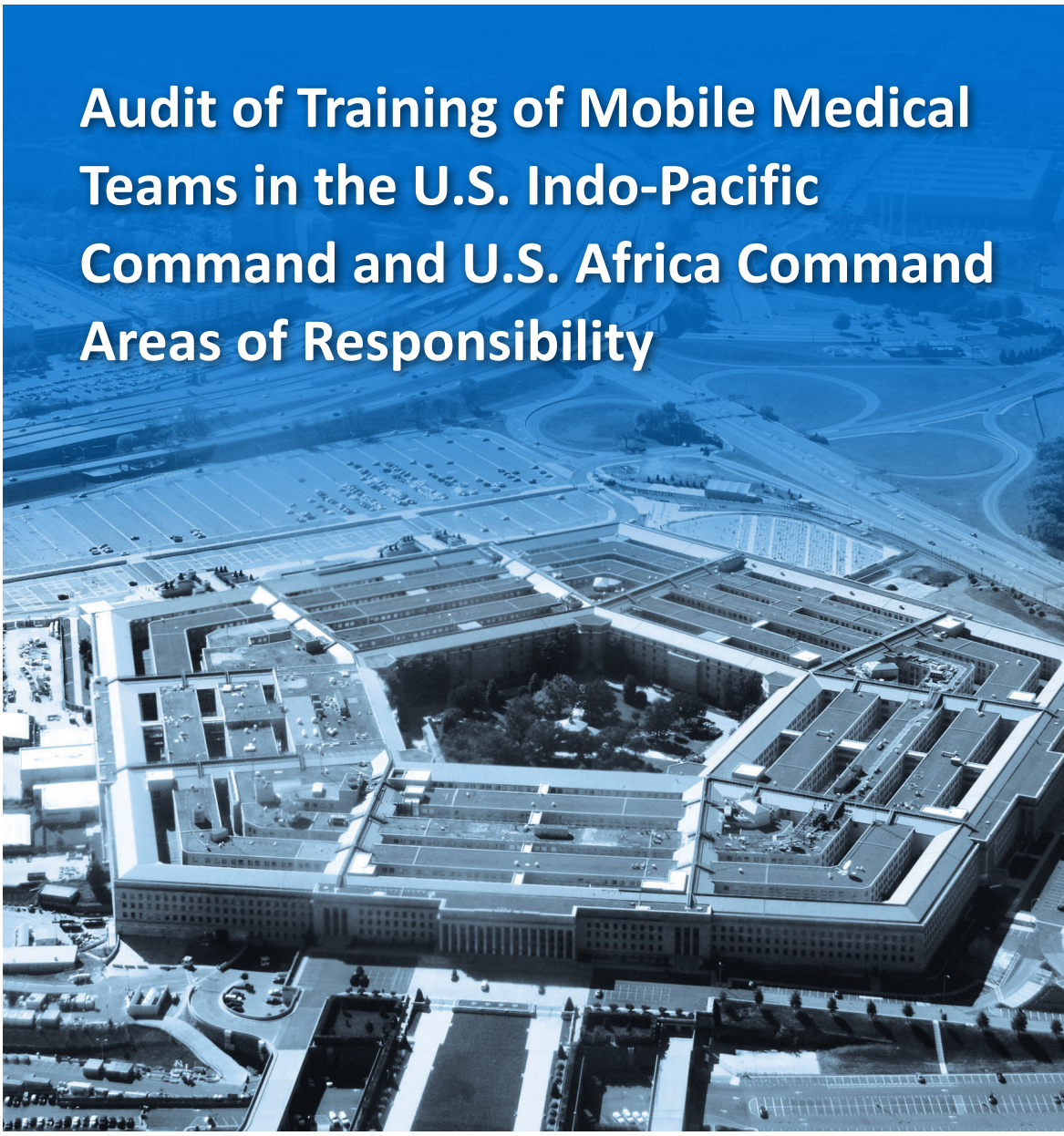
Report No. DODIG-2020-087

INSPECTOR GENERAL

U.S. Department of Defense

JUNE 8, 2020

Audit of Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility



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Results in Brief

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

Objective

The objective of this audit was to determine whether the Defense Health Agency and the Military Departments provided effective training to mobile medical teams to improve trauma care before teams deployed to the U.S. Indo-Pacific Command (USINDOPACOM) and U.S. Africa Command (USAFRICOM) areas of responsibility.

For the purposes of this report, we defined mobile medical teams as small, mobile groups of medical personnel (10 or less) operating at the tactical or intra-theater level.

Background

The Army, Navy, and Air Force employ conventional force mobile medical teams in response to combatant commander requests for forces to enable forward military operations. Mobile medical teams typically consist of a general surgeon, an emergency physician, a critical care nurse, a surgical technician, and additional trauma care professionals, to provide life-saving care, including surgery, to wounded military personnel in the field before arrival at a military medical treatment facility. Mobile medical teams need to be capable of treating trauma injuries not commonly seen at their home station military medical treatment facility, such as multiple injuries to the body that could be life-threatening. The types of trauma injuries, availability of resources, and stressors experienced by those who care for the wounded on the battlefield differ greatly from what is experienced at a military medical treatment facility. For this reason, mobile medical teams need to develop both medical skills to perform operations in austere environments and tactical skills to safely function in a combat zone.

Background (cont'd)

The Joint Requirements Oversight Council assists the Chairman of the Joint Chiefs of Staff in assessing and identifying gaps in joint military capabilities and establishing joint performance requirements that ensure interoperability between the military departments. In 2017, the Council issued a document with change recommendations and associated memorandums that identified gaps in the DoD's delivery and management of trauma care in support of deployed operations. Specifically, it stated that DoD trauma care capabilities have lacked standardization due to the absence of a single organization responsible for establishing trauma care training tools, technologies, and individual readiness standards for medical personnel across the Military Departments. To begin addressing these gaps, the FY 2017 National Defense Authorization Act (NDAA), sections 707 and 708, established requirements for the management and training of personnel providing trauma care. The FY 2017 NDAA requires the Secretary of Defense to establish, within the Defense Health Agency, both the Joint Trauma System (JTS) to organize and coordinate performance improvements in trauma care, and the Joint Trauma Education and Training (JTET) Branch to ensure units across the Military Departments are training to a common baseline for providing trauma care. Beginning in December 2016, the JTS became responsible for standardizing trauma care training for deploying mobile medical teams.

According to the Military Departments, 297 mobile medical team members either deployed or prepared to deploy to the USINDOPACOM or USAFRICOM areas of responsibility from July 2016 through July 2019. To determine the effectiveness of the training provided to mobile medical teams, we developed a 20-question survey to gather input from mobile medical team members. We provided the survey to all 297 service members and received 90 survey responses, including 29 collected during in-person interviews and 61 collected through e-mail.

Results in Brief

Audit of Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility

Background (cont'd)

In addition, we reviewed 10 post-deployment after action reports (AAR) and summaries of lessons learned that related to mobile medical team training to determine if information was collected on the effectiveness of mobile medical team training and if a standardized AAR template was used across the Military Departments.

Findings

The Military Departments provided team, environmental, and equipment training to mobile medical team members before they deployed to the USINDOPACOM and USAFRICOM areas of responsibility. Team members reported that training was generally effective.

However, based on interviews, survey results, and review of AARs and training certificates, we determined that the Military Departments need to improve surgical and tactical training to better prepare mobile medical teams for deployment to austere environments. Surgical and tactical training were not always provided to mobile medical team members prior to deployment and when provided, were often reported as ineffective. Additionally, personnel across the Military Departments stated that their home station military medical treatment facility positions did not have the trauma caseloads to prepare them to be a member of a mobile medical team. Surgical training should include treating trauma injuries on live patient models and participating in rotations to trauma centers. Tactical training should include weapons qualifications and practice on night vision equipment.

These training gaps existed because the Military Departments did not develop methods such as conducting training-specific AARs or collaborating to standardize training based on best practices. Prior to the FY 2017 NDAA, each Military Department set its own individual training requirements and was not required to collaborate with the other Departments. According to JTS and JTET Branch officials, as a part of their new responsibilities, the JTS and JTET Branch are working on standardizing mobile medical team training to be consistent across the Military Departments and incorporating trauma caseload requirements into the newly developed standardized training requirements. In addition, USINDOPACOM and USAFRICOM did not consistently identify the training and unique equipment requirements for the tactical conditions in their areas of responsibility; therefore, the Military Departments did not tailor their training to reflect combatant command requirements.

As a result of gaps in surgical training and a lack of exposure to trauma cases, mobile medical team personnel are at risk of not gaining and maintaining essential surgical experience necessary for medical readiness. Additionally, according to a USAFRICOM component command official, without better tactical training, teams may not be able to defend themselves and their patients and they may become a liability to the forces they are intended to support. Lack of standardization in training also means combatant commanders are not fully aware of the capabilities or limitations they are receiving with each type of mobile medical team.

Recommendations

We recommend that the JTET Branch Chief continue efforts to complete and implement standardized medical training, to include an austere surgical resuscitative course, in accordance with the FY 2017 NDAA and Joint Requirements Oversight Council Memorandum 125-17.

Results in Brief

Audit of Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility

Recommendations (cont'd)

We recommend that the Surgeons General of the Army, Navy, and Air Force:

- issue guidance implementing the JTET Branch's standardized training program for all mobile medical teams;
- update training curriculums at the Military medical training commands, for tactical training of mobile medical teams; and
- require all mobile medical team personnel to complete the standardized post-deployment AARs and submit them to the Joint Lessons Learned Information System.

We recommend that the JTS Chief and the JTS Performance Improvement (PI) Branch Chief develop a standardized post-deployment AAR template to gather information on the effectiveness of training provided to mobile medical team members.

Management Actions Taken

During the audit, we notified officials from the Joint Staff, Defense Health Agency and subordinate organizations, the Military Department medical training commands, USINDOPACOM, and USAFRICOM of our concerns related to the effectiveness of surgical and tactical training. All organizations agreed with our finding and recommendations and either initiated or continued ongoing corrective actions to address some of our concerns and the requirements of the FY 2017 NDAA. During the audit, JTS and JTET Branch officials stated that they had identified areas for improvement in trauma care through communication with combatant command medical personnel and the Defense Committee on Tactical Combat Casualty Care. As of October 2019, the JTET Branch had identified five standardized medical training courses that should continue to be offered and planned to develop three more. In addition, JTS PI Branch officials stated that they are working to standardize AAR template completion and submission to ensure comparable information is collected across the Services.

Management Comments and Our Response

As a result of management comments, we revised a recommendation to clarify that curriculums at Military medical training commands should be updated to ensure tactical training is provided to mobile medical teams to prepare for operations in an austere environment to ensure standardization above the unit level. While coordination with geographic combatant commands on theater specific requirements and unit level tactical training is a best practice, we believe that a portion of tactical training should be the responsibility of the Service Surgeons General, in coordination with the Military medical training commands.

The JTS Chief of Strategic Plans and Operations/Military-Civilian Partnerships agreed with our recommendation to implement standardized medical training, stating that the JTS, JTET Branch, and JTS PI Branch would work to establish baseline training standards, formulate Clinical Practice Guidelines, and serve as a basis for Joint Knowledge, Skills, and Abilities. The Chief also stated that the JTET Branch is not currently resourced or manned to meet the recommendation. We will close the recommendation once we verify that the information provided and actions taken by the JTET Branch fully address the recommendation.

The Army Surgeon General Chief of Staff and the Navy Bureau of Medicine and Surgery Executive Director agreed with our recommendation to issue guidance implementing the JTET Branch standardized training

Comments (cont'd)

program for all mobile medical teams. The Air Force Deputy Surgeon General partially agreed with our recommendation to issue guidance implementing the JTET Branch standardized training program for all mobile medical teams. However, the comments provided did not address the specifics of the recommendation; therefore, the recommendation is unresolved. We ask that the Air Force Surgeon General provide comments in response to the final report, identifying specific actions to ensure the implementation of the JTET Branch standardized training program.

The Navy Bureau of Medicine and Surgery Executive Director and the Air Force Deputy Surgeon General agreed with our recommendation to update training curriculums for tactical training of mobile medical teams. The Air Force Deputy Surgeon General stated that tactical training to meet Combatant Command theater entry requirements is not specific to mobile medical teams or to medical training, and that the Air Force Medical Service provides training to all personnel tasked to deploy within a given theater of operations in accordance to theater requirements. Comments from the Deputy Surgeon General did not address the specifics of the recommendation; therefore, the recommendation is unresolved. The intent of our recommendation is to address areas for improvements to tactical training the Air Force is already providing. We ask that the Air Force Surgeon General provide additional comments in response to the final report, identifying specific actions taken to update tactical training provided to mobile medical teams at Military medical training commands.

The Army Deputy Surgeon General disagreed with the recommendation, stating that the Surgeon General is not the proponent for updating training relating to tactical readiness, and that Army unit commanders should update relevant tactical readiness training. We disagree with the Army Deputy Surgeon General's response. The intent of our recommendation is a cross-service effort to ensure standardized training and leveraging of best practices for the improvement of additional tactical training provided as part of the Military medical training commands' programs. Therefore, this recommendation is unresolved, and we request that the Army Surgeon General provide comments on the final report to reconsider updating tactical training curriculums for mobile medical teams provided at the Military medical training command level.

The JTS PI Branch Lead agreed with the recommendation to develop a standardized post-deployment AAR template to gather information on the effectiveness of mobile medical team training.

The Navy Bureau of Medicine and Surgery Executive Director and the Air Force Deputy Surgeon General agreed with the recommendation to implement the JTS PI Branch AAR template; however, comments from the Deputy Surgeon General did not address the specifics of the recommendation, stating that post deployment AARs and lessons learned are already required. The intent of our recommendation is that the JTS standardized post-deployment AAR template be used to collect mobile medical team specific information for submission to Joint Lessons Learned Information System.

The Army Surgeon General Chief of Staff disagreed with the recommendation, stating that the Surgeon General cannot implement the recommendation because Army Regulation 11-33 mandates the process used by Army units, including mobile medical teams. We acknowledge the applicability of Army Regulation 11-33; however, the intent of our recommendation is that mobile medical teams complete the JTS PI Branch Joint standardized AAR form. Once issued, this form will be a new requirement that is not Service-specific

Comments (cont'd)

nor currently addressed in Army guidance. Therefore, the recommendation is unresolved, and we ask that the Army and Air Force Surgeons General provide additional comments in response to the final report, identifying specific actions to ensure the use of JTS PI standardized post-deployment AARs specific to mobile medical teams.

Originally, the Draft Report included a recommendation stating that the Joint Staff Surgeon should coordinate with the Command Surgeon from each geographic combatant command to define mobile medical team tactical theater entry requirements. The Joint Staff Surgeon General provided comments and cited a Secretary of Defense memorandum, dated December 19, 2019, that stated, "Effective immediately, the planning and conduct of pre-deployment training for service members and units, a statutory function of the Military Departments as Force Providers, shall be the responsibility of the Military Departments, executed in consultation with the respective Geographic Combatant Commanders." As a result, the Joint Staff Surgeon and the geographic combatant commanders are not responsible for defining any pre-deployment training requirements and the recommendation was no longer applicable; therefore, we removed the recommendation from the report.

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

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Army Surgeon General	3, 5	2	
Navy Surgeon General		2, 3, 5	
Air Force Surgeon General	2, 3, 5		
Chief, Joint Trauma System		4	
Chief, Joint Trauma Education and Training Branch		1	
Chief, Joint Trauma System Performance Improvement Branch		4	

Please provide management comments by July 8, 2020.

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** – OIG verified that the agreed upon corrective actions were implemented.

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

June 8, 2020

MEMORANDUM FOR DISTRIBUTION

SUBJECT: Audit of Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility (Report No. DODIG-2020-087)

This final report provides the results of the DoD Office of Inspector General's audit. 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.

This report contains recommendations that are considered unresolved because the Army Surgeon General Chief of Staff did not agree with recommendations presented in the report and the Air Force Deputy Surgeon General did not fully address the recommendations presented in the report.

As discussed in the Recommendations, Management Comments, and Our Response section of this report, the resolved recommendations may be closed when we receive adequate documentation showing that all agreed-upon actions to implement the recommendations have been completed. The unresolved recommendations will remain open until an agreement is reached on the actions to be taken to address the recommendations, and adequate documentation has been submitted showing that the agreed-upon actions have been completed.

DoD Instruction 7650.03 requires that recommendations be resolved promptly. Please provide us within 30 days your response concerning specific actions in process or alternative corrective actions proposed on the recommendations. Your response should be sent to either followup@dodig.mil if unclassified or rfunet@dodig.smil.mil if classified secret.

If you have any questions, please contact me at [redacted]

Richard B. Vasquez
Assistant Inspector General for Audit
Readiness and Global Operations

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Introduction

Objective

The objective of this audit was to determine whether the Defense Health Agency (DHA) and the Military Departments provided effective training to mobile medical teams to improve trauma care before teams deployed to the U.S. Indo-Pacific Command (USINDOPACOM) and U.S. Africa Command (USAFRICOM) areas of responsibility (AOR). See Appendix A for a discussion of the scope and methodology and prior audit coverage.

For the purposes of this report, we defined mobile medical teams as small, mobile groups of medical personnel (10 or less) on teams operating at the tactical or intra-theater level.[1] These teams may or may not be DoD programs of record directed in the Future Years Defense Program.[2] See Appendix B for more information on the mobile medical teams from each Military Department included in our scope, including their specific team structure and capabilities. We defined effective training as training that enabled mobile medical personnel to maintain readiness in resuscitative and surgical trauma capabilities that could be required to treat trauma cases typical in austere and tactical environments, which are locations that lack the comfort and luxuries of everyday life.

This report focused on active duty, conventional-force mobile medical teams in support of either conventional or special operations force missions.[3] During the audit, the DHA and its components were in the process of standardizing training; therefore, we reviewed the training requirements for each Military Department.

Background

Mobile medical teams provide life-saving care, including resuscitation, stabilization, and surgery to wounded military personnel in the field before arrival at a military medical treatment facility (MTF).[4] These medical teams are essential to provide care at the point of injury in isolated, geographically dispersed locations where an MTF is not readily available to ensure service members receive critical medical

[1] According to Joint Publication 3-0, "Joint Operations," October 22, 2018, the tactical level refers to the planning and execution of activities to achieve military objectives, to include combat. According to Joint Publication 4-02, "Joint Health Services," September 28, 2018, intra-theater level patient movement occurs between points within the theater of a combatant command.

[2] A program of record is a directed, funded effort recorded in the Future Years Defense Program, a line item of record in the budget. The Future Years Defense Program is an annually compiled program and financial plan for the DoD, containing an annual budget and a 5-year plan for cost data, manpower, and force structure.

[3] According to the DoD Dictionary, active duty conventional forces (Army, Navy, and Air Force), other than designated special operations forces, are forces on full-time duty in the active military service of the United States.

[4] According to Joint Publication 4-02, an MTF is a facility established for the purpose of providing medical care to eligible individuals.

care as soon as possible to increase survivability.[5] Mobile medical teams typically consist of a general surgeon, an emergency physician, a critical care nurse, a surgical technician, and additional trauma care professionals.

Joint Publication 4-02 defines four roles of care to describe battlefield medical and health capabilities.

- Role 1 care is unit-level medical care including self-aid or buddy aid, medic care, and combat lifesaver, beginning at the point of injury.
- Role 2 care includes continuation of resuscitation started in Role 1, advanced trauma management, and damage control surgery, often provided by mobile medical teams.[6]
- Role 3 care expands the care provided at Role 2 and includes treating patients in an MTF that is staffed and equipped to provide care from resuscitation through post–operative treatment. Role 3 also includes patient evacuation.
- Role 4 care occurs in U.S.-based hospitals and robust overseas MTFs.

Definition of a Ready Medical Force

Mobile medical teams need to be capable of treating trauma injuries not commonly seen at their home station MTF, such as multiple injuries to the body that could be life-threatening. The types of trauma injuries, availability of resources, and stressors experienced by those who care for the wounded on the battlefield differ greatly from what is experienced at an MTF.[7] For example, the treatment of an isolated ankle fracture is considerably different than the treatment of a traumatic amputated limb caused by an improvised explosive device. In addition, mobile medical teams may be required to perform in austere and unfamiliar settings, functioning with limited resources, and with teams that vary in personnel and configuration. However, unlike the peacetime setting, a team may be formed at any time and with minimal prior experience working as a team.

Health care practice within the MTF alone is only one aspect of having a ready medical force. According to military clinicians, medical readiness is the integration of medical skills with the ability to meet the psychological and environmental challenges of the battlefield. Mobile medical team readiness is the development of

[5] The point of injury is the geographic location where the injury occurred.

[6] Damage control surgery is a critical and essential capability for hemorrhage control in order to decrease preventable deaths.

[7] This report uses the term "trauma injuries" to describe physical trauma that can be caused by either blunt force trauma or penetrating trauma. According to the National Institutes of Health, blunt force trauma occurs when an object or force strikes the body, often causing concussions, deep cuts, or broken bones. Penetrating trauma occurs when an object pierces the skin or body, usually creating an open wound.

individual medical skills and specific skills for medical operations practiced outside of the MTF, familiarization with specialized field equipment, and acquisition of tactical skills to safely function in an operational environment or combat zone.

Military Health System Reform

A 2017 DoD Trauma Enterprise Doctrine, Organization, Training materiel, Leadership, Personnel, Facilities, and Policy Change Recommendation stated that DoD trauma care capabilities have lacked standardization due to the lack of a single organization responsible for establishing standards of care across the Military Departments; no individual readiness standards for medical personnel; and insufficient trauma care training tools, technologies, and facilities.[8] To begin addressing these gaps, the FY 2017 National Defense Authorization Act (NDAA), sections 707 and 708, establish requirements for the management and training of personnel providing trauma care.[9]

The FY 2017 NDAA requires the Secretary of Defense to establish within the DHA a Joint Trauma System (JTS) organization and a Joint Trauma Education and Training (JTET) Branch. Additionally, the FY 2017 NDAA states that the Secretary of Defense, through the JTET Branch, may enter into partnerships with Level I civilian trauma centers to provide mobile medical personnel exposure to a higher caseload of patients with trauma injuries.[10]

The Joint Requirements Oversight Council assists the Chairman of the Joint Chiefs of Staff in assessing and identifying gaps in joint military capabilities and establishing joint performance requirements that ensure interoperability among the Military Departments. After release of the FY 2017 NDAA, the Joint Requirements Oversight Council issued two memorandums that identified gaps in the DoD's ability to deliver and manage trauma care from point of injury through

[8] The "Joint DOTmLPF-P Change Recommendation for the Department of Defense (DoD) Trauma Enterprise (DTE)," September 21, 2017, identified gaps in the DoD's delivery and management of trauma care from point of injury through definitive care in support of deployed operations. Standardization is the process the DoD uses to achieve the closest practicable cooperation and maximum efficiency among the Military Departments through broad adoption of procedures, criteria, resources, and tactical doctrine with corresponding organizational capability.

[9] Public Law 114-328, "National Defense Authorization Act for Fiscal Year 2017," December 23, 2016. Public Law 112-239, "National Defense Authorization Act for Fiscal Year 2013," January 2, 2013, Section 731 enacts the reform of the Military Health System. The focus of this report is specific to the changes in the FY 2017 NDAA, sections 707 and 708.

[10] Level I civilian trauma centers specialize in care for every aspect of injury from prevention through rehabilitation and are a comprehensive regional resource that is a specialized medical care facility central to the trauma system. The JTET Branch selects trauma centers based on patient volume, acuity, and other factors to ensure trauma care personnel readiness.

definitive care in support of deployed operations and home MTF activities.[11] The memorandums included validated requirements addressed to the DHA and the Military Departments to review and revise trauma training courses and ensure military units across Departments are training to a common baseline for providing trauma care. Additionally, one memorandum included a recommendation addressed to the DHA and the Military Departments to establish and maintain partnerships between military MTFs and civilian academic medical centers with Level I, II, or III trauma centers.[12]

Key Players Supporting Mobile Medical Teams

The DHA and the Military Departments support mobile medical teams by serving as a source of information on trauma care, identifying training gaps for medical personnel, standardizing medical training across the Military Departments, establishing readiness standards and metrics for medical personnel, and conducting training of mobile medical teams.

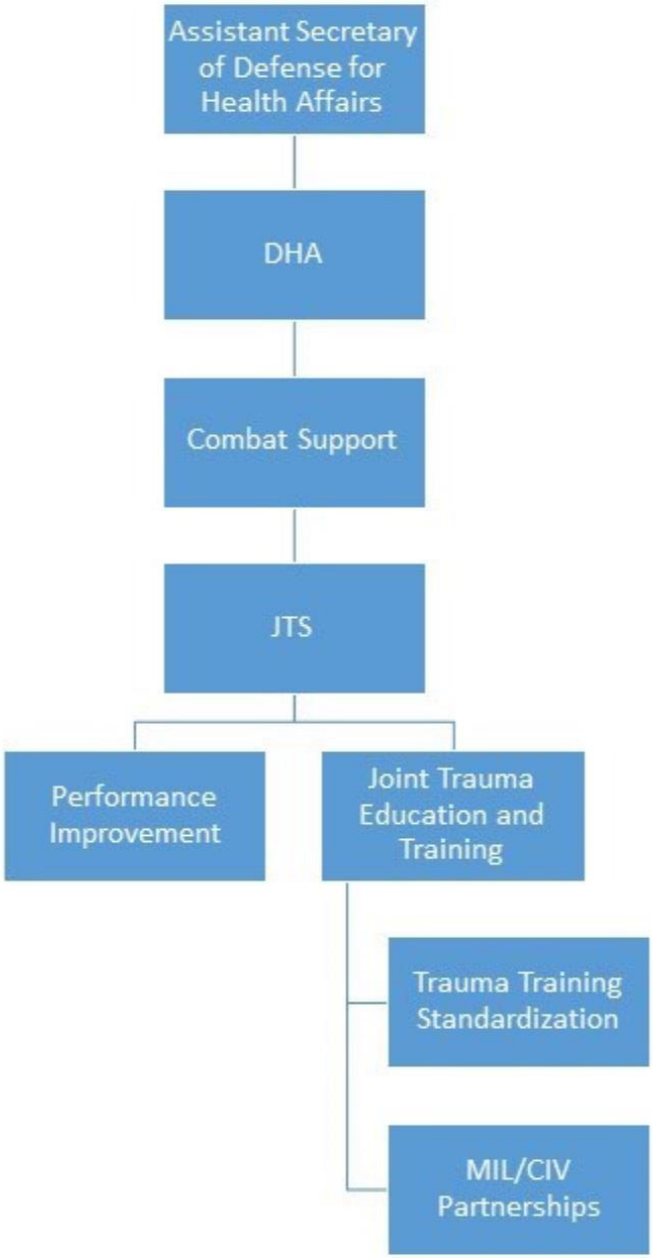
DHA Support of Mobile Medical Teams

The DHA is a joint agency that enables the Army, Navy, and Air Force medical services to provide a ready medical force to combatant commands and supports the effective execution of the DoD medical mission. Organizationally, the JTS, the JTS Performance Improvement (JTS PI) Branch, and the JTET Branch fall under the DHA. See Figure 1 for an organizational chart of the DHA and other medical stakeholder organizations.

[11] Joint military capabilities are the collective capabilities across the joint force that are available to conduct military operations. The Joint Requirements Oversight Council issued Joint Requirements Oversight Council Memorandum 125-17, "Forward Resuscitative Care in Support of Dispersed Operations DOTmLPF-P Change Recommendation," December 11, 2017, and Joint Requirements Oversight Council Memorandum 126-17, "Department of Defense Trauma Enterprise DOTmLPF-P Change Recommendation," December 11, 2017. Forward resuscitative care is provided as close to the point of injury as possible, based on operational requirements to attain stabilization, achieving the most efficient use of lifesaving and limb-saving medical treatment, and providing essential care so the patient can tolerate evacuation.

[12] A Level II trauma center is capable of starting care for injured patients, and either supplement a nearby Level I trauma center or serve as the lead trauma facility in less populated areas. A Level III trauma center is capable of surgery, resuscitation, and stabilization of injured patients, and patients may be transferred to a Level I or II trauma center for additional care.

Figure 1. DoD Medical Stakeholder Organizational Chart



Source: The DoD OIG.

The JTS is a trauma-care-focused organization aligned under the DHA Assistant Director for Combat Support and serves as the reference body for all trauma care provided across the Military Health System. The JTS organizes and coordinates performance improvements in trauma care for service members treated at an MTF or in a deployed environment. As required by section 707 of the FY 2017 NDAA, the DHA submitted the final JTS implementation plan in October 2018. The implementation plan stated that the JTS was established to fulfill the FY 2017 NDAA's requirements to serve as a source of information for military trauma care and develop standardized trauma training to ensure comparable capabilities among

deploying mobile medical teams. The JTS PI Branch is responsible for identifying gaps in training across the Military Departments and supports development of structured Combatant Command Trauma Systems, including liaisons capable of communicating areas for improvement back to the JTS.

The JTET Branch, under the JTS, is responsible for ensuring that military traumatologists maintain readiness for rapid deployment in future armed conflicts by providing standardized training curriculums and coordinating partnerships with civilian trauma centers.[13] Specifically, the JTET Branch is responsible for developing a Service-neutral, core medical training curriculum to ensure medical personnel across the Military Departments have standardized training. The JTET Branch standards require that the Military Departments deliver trauma training that meets or exceeds minimum standards set by the JTS. The JTET Branch works with the JTS PI Branch to identify gaps in training and make recommendations to the Military Departments to improve trauma care.

Section 708 of the FY 2017 NDAA stated that the Secretary of Defense was to submit the JTET Branch implementation plan no later than July 1, 2017, and the Office of the Under Secretary of Defense for Personnel and Readiness stated that the JTET Branch was to be at full operating capacity 2 years after the final implementation plan was submitted. The Office of the Under Secretary of Defense for Personnel and Readiness submitted an interim JTET Branch implementation plan to Congress in February 2018, 7 months after the FY 2017 NDAA required submission of the final plan. However, as of February 2020, the final implementation plan had not been submitted to Congress. According to the DHA, the JTET Branch has been at initial operating capacity since March 2019, but lacks the manpower and funding to develop the final implementation plan.

Military Department Support of Mobile Medical Teams

The Army, Navy, and Air Force are required to train medical personnel to maintain readiness.[14] Each Military Department has a medical training command that identifies, develops, and provides training for mobile medical teams.

- The U.S. Army Medical Center of Excellence, under the U.S. Army Training and Doctrine Command, focuses on combat casualty care and is responsible for educating and training Army medical personnel.
- The Navy Bureau of Medicine and Surgery provides policy oversight and command and control over all Navy medicine. The Navy Medicine Education, Training, and Logistics Command provides administrative

[13] A traumatologist is a physician specializing in the treatment of severe, acute physical trauma injuries sustained by individuals requiring immediate medical attention.

[14] While the Navy provides medical personnel to the Marine Corps, at the time of our audit, there were no mobile medical teams in the Marine Corps that fell within our scope.

oversight of the education and training mission for Navy medicine. The Naval Expeditionary Medical Training Institute provides training on tactical combat casualty care and Role 2 medical care for Navy personnel.[15]

- The Air Combat Command sets the requirement and curriculum for medical training courses, and the Air Force Education and Training Command develops training courses for mobile medical teams to meet Air Combat Command requirements. The Air Force Medical Readiness and Training Center provides medical training.

Types of Mobile Medical Teams

The Army, Navy, and Air Force employ conventional force mobile medical teams to deliver Role 2 medical care in response to combatant commander requests for forces to enable forward military operations.[16] Depending on the requirements included in the requests for forces, which can vary, the Military Departments provide mobile medical teams of differing structures, capabilities, and training.

Medical teams that are a program of record have established criteria and are held to common training standards and performance within their specific Military Department. Teams that are not an official program of record are established to fill a capability that does not exist in a current DoD program, as requested by combatant commanders. For example, the Army developed the Expeditionary Resuscitative Surgical Team (ERST) to fulfill a capability requested by USAFRICOM that the Army did not have established under an existing medical team program of record. See Table 1 for more detail on the structure and capabilities of mobile medical teams from each Military Department.[17]

Table 1. Army, Navy, and Air Force Mobile Medical Team Types

Service	Team	Number of Personnel Per Team	Medical Capabilities
Army	ERST	8	Surgery and postoperative care for up to 4 patients over 48 hours
Navy	Expeditionary Resuscitative Surgical System (ERSS)	9	Surgery for up to 3 patients for up to 72 hours

[15] Tactical combat casualty care is a set of trauma management guidelines customized for use in the operational setting that maintains a focus on the most common causes of preventable deaths resulting from combat. Role 2 care includes continuation of resuscitation, advanced trauma management, and damage control surgery.

[16] To enable forward military operations means supporting geographically dispersed operations, whatever the mission. Mobile medical teams provide operational flexibility for commanders to conduct forward operations in geographically dispersed areas with advanced medical capability support for a limited number of patients.

[17] Each Military Department has medical teams that are programs of record; however, if those teams had more than 10 personnel assigned, we did not include them in the scope of this report.

Table 1. Army, Navy, and Air Force Mobile Medical Team Types (cont'd)

Service	Team	Number of Personnel Per Team	Medical Capabilities
Air Force (Program of Record)	Ground Surgical Team (GST)	6	Surgery for up to 10 patients and postoperative patient holding for up to 3 patients at a time for a maximum of 12 hours

Source: The DoD OIG.

DoD and Service-Level Criteria for Training Mobile Medical Teams

DoD Instruction 6040.47 establishes policy, assigns responsibilities, and provides procedures to develop and maintain an enduring global trauma care capability that supports a full range of military operations.[18] Specifically, an enduring global trauma care capability should support trauma care research to increase readiness and analyze trauma-related data from global military operations to recommend performance improvement measures, which will ensure the appropriate treatment of injured personnel. In addition to DoD Instruction 6040.47, the Departments of the Navy and Air Force have issued service-specific criteria governing mobile medical teams. The Department of the Army has not developed specific criteria governing the mobile medical team included in our scope.

Navy Bureau of Medicine and Surgery Notice 1500 identifies the trauma training requirements for Navy personnel, which are conducted in three phases.[19] Phase I training requirements apply to personnel assigned to or deploying with an operational medical platform or sourced globally for missions across the full range of military operations. Phase II trauma training requirements include training that occurs in the environment, on the equipment, and with the unit similar to what the member is expected to encounter when deployed. Command leadership is responsible for ensuring mobile medical team members complete Phase I and II trauma training before deployment. Phase III training is mission-specific as defined by the combatant command and is provided whenever possible—usually, "just in time" to those individuals deploying to an identified AOR.

Air Force Tactics, Techniques, and Procedures 3-42.77 provides criteria to develop standardized policies, operating procedures, and training programs for the Air Force GST.[20] GST-specific training is provided in two phases. Phase I provides foundational training on how to function as a small surgical team, and focuses

[18] DoD Instruction 6040.47, "Joint Trauma System," August 5, 2018.

[19] Navy Bureau of Medicine and Surgery Notice 1500, "Phased Medical Readiness Trauma Requirements," June 19, 2018. Although the Navy ERSS teams are not programs of record, the Navy decided that the Navy Bureau of Medicine and Surgery Notice 1500 criteria is applicable to the ERSS teams.

[20] Air Force Tactics, Techniques, and Procedures 3-42.77, "Ground Surgical Team (GST)," November 16, 2018.

on cross-functional team roles and responsibilities and scenario-based training. Phase II is a field exercise providing deployment scenarios and realistic operational training linked to team mission-essential task lists.

Audit Identified Subject Areas for Mobile Medical Readiness Training

Because joint doctrine for mobile medical team training does not exist, each Military Department develops its own requirements and training programs for mobile medical teams. Based on each Military Department's training criteria and interviews with mobile medical personnel about their prior training, we identified five areas that mobile medical personnel should train in before deployment to maintain readiness and fulfill requested capabilities based on specific mission requirements.

- **Team development training** enables mobile medical teams to train together in preparation for deployment and prepares the team to work cohesively in an austere environment.
- **Surgical training** enables mobile medical team personnel to practice surgical techniques to treat trauma injuries by using mannequins, live patient models, or rotations in Level I civilian trauma centers. This training is key to practicing the treatment of trauma cases outside those normally seen at an MTF.
- **Environmental training** teaches the mobile medical teams to operate in an austere environment or outside a permanent medical facility through the use of simulations or field exercises and familiarizes personnel with medical conditions and diseases specific to the area where they are deploying.
- **Equipment set training** enables mobile medical teams to become familiar with the tools and supplies they will use during deployment.
- **Tactical training** includes weapons or other security training to ensure that medical personnel are capable of defending themselves and their patients if needed, as well as training on movement at night and in an austere environment.

Criteria for Completion of After Action Reports on Mobile Medical Team Deployments

DoD-level criteria provides guidelines and procedures for conducting after action reports (AAR) as part of the Joint Lessons Learned Program. According to Joint Publication 4-02, the primary objective of the Joint Lessons Learned Program is to enhance joint force readiness and effectiveness by contributing to

improvements in areas like training.[21] The Joint Lessons Learned Information System (JLLIS) is the DoD system of record for collecting, tracking, and sharing lessons learned from AARs. Additionally, the FY 2017 NDAA stated that the JTS must incorporate lessons learned from trauma education and training into clinical practice. DoD Instruction 6040.47 requires the Chairman of the Joint Chiefs of Staff to update and sustain DoD trauma care initiatives and medical lessons learned from each combatant command, in coordination with the JTS. DoD Instruction 1322.24 requires combatant commanders to establish processes and procedures to monitor the effectiveness of medical readiness training and report key training-related findings in the DoD system of record for lessons learned.[22]

The Army, Navy, and Air Force have issued criteria that includes overarching AAR guidance. Army Regulation 11-33 establishes policy, procedures, and responsibilities for Army-wide management of the Army Lessons Learned Program.[23] The regulation covers all tactical, operational, and strategic levels. The intent is to systematically refine and improve operations while integrating the lessons and best practices within Army concepts, doctrine, organization, training, materiel, leadership, education, personnel, facilities, and policy. According to the regulation, the Commanding General of the U.S. Army Training and Doctrine Command will ensure the Medical Center of Excellence conducts specific lessons learned collection, analysis, and dissemination. Units are required to submit AARs within JLLIS and appropriate proponents after participating in Army, joint, and combined operations and for some major training events. The format for an AAR is flexible and can be adapted to the needs of the commander.

Office of the Chief of Naval Operations Instruction 3500.37D establishes policy and assigns responsibilities for the Navy Lessons Learned Program.[24] The Navy Lessons Learned Program is intended to systematically refine and improve fleet operations while integrating lessons and best practices to inform Navy doctrine, organization, training, materiel, leadership, education, personnel, facilities, and policy. The Navy Lessons Learned Program, a subset of JLLIS, uses the Navy Lessons Learned Information System to manage and share lessons and best practices that impact fleet readiness. According to the instruction, the execution of comprehensive AARs is absolutely critical to ensuring that the Navy captures and learns from operational lessons to prepare forces for future events. Lessons and best practices are derived from actual operations, training events, and fleet activities across all levels of war (tactical, operational, and strategic).

[21] Joint Publication 4-02, "Joint Health Services," September 28, 2018.

[22] DoD Instruction 1322.24, "Medical Readiness Training," March 16, 2018.

[23] Army Regulation 11-33, Army Lessons Learned Program," June 14, 2017.

[24] Office of the Chief of Naval Operations Instruction 3500.37D, "Navy Lessons Learned Program," June 20, 2018.

The instruction states that the Commander, U.S. Pacific Fleet must provide oversight to the Navy Lessons Learned Program and standardize and publish Navy Lessons Learned Program procedures and processes in a fleet directive. Additionally, the Commander will provide fleet-wide guidance on lessons learned data collection requirements including post-deployment brief topics of interest and collection priorities. Furthermore, the Commander is required to review training and certification; review mid-deployment and post-deployment lessons learned and briefs; and when appropriate, implement corrective action for fleet-wide issues.

Air Force Instruction 10-1302 establishes guidance and procedures for the Air Force Lessons Learned Program.[25] The instruction states that timely submission of AARs is a command responsibility. Air Force Component commanders, Air Expeditionary Task Force commanders and subordinates, exercise or experiment directors, and other like commanders or directors will submit a unit-level AAR for the event (such as a deployment, contingency, or exercise) for which they are responsible. Commanders or directors will ensure that AARs for operations not supported by a continuing Air Expeditionary Forces cycle (such as contingencies and exercises) are submitted to higher headquarters no later than 45 days after the end of the event unless otherwise directed.

Selection and Review of Mobile Medical Team Training Surveys, Training Certificates, and Deployment AARs

To determine the effectiveness of training provided to mobile medical teams, we developed a 20-question survey to gather input from mobile medical team members. We requested the names of service members who deployed or prepared to deploy to the USINDOPACOM or USAFRICOM AORs from July 2016 through July 2019. According to the Military Departments, 297 service members either deployed or prepared to deploy to the USINDOPACOM or USAFRICOM AORs during that timeframe.

We distributed the survey to all 297 personnel who were identified by the Military Departments. We received 90 survey responses: 29 collected during in-person interviews and 61 collected through e-mail. However, not all 90 participants responded to every question, and as a result, the total number of participants responding to each question may differ. See Appendix A for a complete survey methodology. Table 2 shows the breakdown of the mobile medical team members who received the survey and the number of team members who responded to the survey by Military Department.

[25] Air Force Instruction 10-1302, "Air Force Lessons Learned Program," July 30, 2019.

Table 2. Survey Universe and Responses

Military Department	Number of Mobile Medical Team Members	Number of Survey Respondents
Army	49	12
Navy	122	31
Air Force	126	47
Total	**297**	**90**

Source: The DoD OIG.

In addition, using the universe of 297 mobile medical personnel, we selected a nonstatistical sample of 20 mobile medical personnel from each Military Department (60 total) and requested their training certificates for surgical training prior to deployment to identify how many had deployed without all required surgical training.

Further, we requested that the U.S. Army Medical Center of Excellence, Navy Bureau of Medicine and Surgery, and the Air Combat Command provide all AARs for mobile medical team deployments to the USAFRICOM and USINDOPACOM AORs from July 2016 through July 2019. We received 10 post-deployment AARs and summaries of lessons learned that related to mobile medical team training and reviewed them to determine if information was collected on the effectiveness of mobile medical team training, and if a standardized template was used across the Military Departments.

Review of Internal Controls

DoD Instruction 5010.40 requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and evaluates the effectiveness of the controls.[26] We identified internal control weaknesses with Military Department procedures for surgical and tactical training to prepare mobile medical teams to deploy and maintain readiness. Additionally, while DoD and Military Department criteria require AARs, there is no requirement for mobile medical team members to complete AARs using a standardized template specific to the team, surgical, environmental, equipment, and tactical training provided to mobile medical teams prior to deploying. We will provide a copy of the report to the senior officials responsible for internal controls at the Joint Staff, the DHA, the JTS, the JTET Branch, USAFRICOM, USINDOPACOM, and the Military Department Surgeons General.

[26] DoD Instruction 5010.40, "Managers' Internal Control Program Procedures," May 30, 2013.

Finding

The Military Departments Need to Improve Mobile Medical Team Training

The Military Departments provided team, environmental, and equipment training to mobile medical team members before they deployed to the USINDOPACOM and USAFRICOM AORs. Team members reported that training was generally effective. However, based on interviews, survey results, and review of AARs and training certificates, we determined that the Military Departments need to improve surgical and tactical training to better prepare mobile medical teams for deployment to austere environments. Surgical and tactical training were not always provided to mobile medical team members prior to deployment and when provided, were reported as ineffective. Additionally, personnel across the Military Departments stated that their home station MTF positions did not have the trauma caseloads to prepare them to be a member of a mobile medical team. Surgical training should include treating trauma injuries on live patient models and participating in rotations to trauma centers. Tactical training should include weapons qualifications and practice on night vision equipment.

These training gaps existed because the Military Departments did not develop methods such as conducting training-specific AARs or collaborating to standardize training based on best practices. Prior to the FY 2017 NDAA, each Military Department set its own individual training requirements and was not required to collaborate with the other Departments. According to JTS and JTET Branch officials, as a part of their new responsibilities, the JTS and JTET Branch are standardizing mobile medical team training to be consistent across the Military Departments and incorporating trauma caseload requirements into the newly developed standardized training requirements. In addition, USAFRICOM and USINDOPACOM did not consistently identify the training and unique equipment requirements for the tactical conditions in their areas of responsibility; therefore, the Military Departments did not tailor their training to reflect combatant command requirements.[27]

As a result of gaps in surgical training and a lack of exposure to trauma cases, mobile medical team personnel are at risk of not gaining and maintaining essential surgical experience necessary for medical readiness. Additionally, according to a USAFRICOM component command official, without better tactical training, teams

[27] According to Joint Publication 3-35, "Deployment and Redeployment," January 10, 2018, the Combatant Commands are responsible for identifying mission-specific training requirements, which include tactical requirements.

may not be able to defend themselves and their patients and they may become a liability to the forces they are intended to support. Lack of standardization in training also means combatant commanders are not fully aware of the capabilities or limitations they are receiving with each type of mobile medical team.

The Military Departments Provided Team, Environmental, and Equipment Training

The Military Departments provided team, environmental, and equipment training that mobile medical team members determined to be effective in preparation for deployments to the USINDOPACOM and USAFRICOM AORs. Of the 78 survey participants across the Military Departments who stated that they received team training, 68 participants (87 percent) stated that the team training helped to prepare them for deployment as a member of a mobile medical team. See Appendix C, Tables 9 and 10, for additional information about how mobile medical team members rated their team training. For example, two Navy survey participants stated that the Navy Tactical Trauma Center and Naval Expeditionary Medical Training Institute team training prepared them "to work together as a team in an environment much different than they were used to" and "incorporated all of the elements of the expected austere environment." Additionally, an Army survey participant stated that the Army's team training was invaluable in allowing members to see each other's strengths and weaknesses and that the stresses placed on the team were on pace with what was needed to prepare for deployment.

Of the 75 survey participants across the Military Departments who stated that they received environmental training and provided a rating for the training, 53 participants (74 percent) stated that the environmental training was effective in preparing them for deployment as a member of a mobile medical team. See Appendix C, Tables 11 and 12, for additional information about how mobile medical team members rated their environmental training. Collectively, Army, Navy, and Air Force survey participants stated that their environmental training mimicked real life situations and scenarios experienced during deployments, and an Army team reported in an AAR that they "gained a wealth of field experience" from their environmental training. In addition, during a site visit to Camp Bullis, Texas, we toured an Air Force training facility that included simulated smells, smoke, and sounds anticipated in an austere environment and allowed personnel to practice working in a model surgical tent.

Air Force training included simulated smells, smoke, and sound anticipated in an austere environment and allowed personnel to practice working in a model surgical tent.

Of 81 survey participants across the Military Departments, 68 participants (84 percent) stated that they received equipment set training in preparation for deployment. See Appendix C, Tables 13 and 14, for additional information about equipment set training. Collectively, Army, Navy, and Air Force survey participants stated that their equipment training was effective enough to meet mission needs, and Navy survey participants also stated that they receive opportunities to re-familiarize themselves with their equipment sets 3 to 4 times every year. An Army AAR reported that a team member "learned how to do trauma surgery using minimal equipment and supplies," and that it was "very good training." Based on the survey results and team member comments we determined that, collectively, Army, Navy, and Air Force team members believe their team, environmental, and equipment training effectively prepared them for deployment.

Surgical and Tactical Training to Prepare for Deployment Needs Improvement

Based on interviews, survey results, and review of AARs and training certificates, the Military Departments need to improve the surgical and tactical training to better prepare mobile medical teams for deployment to austere environments. Surgical and tactical training were not always provided to mobile medical team members prior to deployment and when provided, were reported as ineffective. Additionally, personnel across the Military Departments stated that their home station MTF positions did not have the trauma caseloads to prepare them to be a member of a mobile medical team. Surgical training should include treating trauma injuries on live patient models and participating in rotations to trauma centers. Tactical training should include weapons qualifications and practice on night vision equipment. See Appendix C for more information on survey participants' responses related to the surgical and tactical training they received, divided by Military Department.

Surgical Training for Mobile Medical Teams Needs Improvement

The Army, Navy, and Air Force Medical Commands all require that surgical training be provided to mobile medical teams; however, we identified gaps where surgical training was not always provided, or when provided, was not effective. Additionally, according to JTS component officials, surgical training is not standardized across the Military Departments, and there is a lack of access to caseloads specifically for trauma care experience.

Our review of training certificates for 40 mobile medical team personnel who deployed to USAFRICOM and UNINDOPACOM showed that 19 personnel (48 percent) did not receive at least one of their required surgical courses prior to deployment. For a breakdown by Military Department of the training certificates reviewed, see Appendix C, Table 15. Additionally, according to audit survey results of 79 mobile medical team personnel who received surgical training and provided a rating for their training, 26 personnel (33 percent) stated that the surgical training did not prepare them for deployment; and 59 of the 89 personnel (66 percent) who rated their home station MTF positions stated that their home station MTF positions did not have the trauma caseloads necessary to prepare them to provide trauma care in an austere environment. For a breakdown of responses by Military Department, see Appendix C, Tables 5 and 6.

19 personnel (48 percent) did not receive at least one of their required surgical courses prior to deployment.

Some examples from the audit survey and our review of AARs included Army team members stating that preparing for deployment with mannequins and live tissue models was not effective.[28] An Army mobile medical team member felt that the surgical training they received should have included real human trauma management, and that the lack of caseloads at the home station MTF was the main cause for the degradation of their trauma skills. Also in response to the survey, Air Force team members stated that the surgical training they received did not provide trauma experience and that some mobile medical team members felt unprepared to perform surgery on open cavities caused by traumatic blast wounds often seen during deployments.

A team member felt that surgical training should have included real human trauma management, and that a lack in caseloads leads to trauma skills degradation.

Further, 35 survey participants from all of the Military Departments stated that they received minimal trauma cases at their home station MTF, and that the lack of trauma cases did not prepare them for deployment. Some expressed a need for more trauma center rotations to practice necessary skills to prepare for deployment, such as performing surgery on open cavities caused by traumatic blast wounds. According to our survey responses and reviewed AARs, the Military Departments can better prepare mobile medical teams for deployment by increasing trauma center rotations though civilian-military partnerships, in line with section 708 of the FY 2017 NDAA.

[28] Live tissue training describes the use of anesthetized animals for medical education and training.

In February 2020, the Office of the Under Secretary of Defense for Personnel and Readiness issued DoD Instruction 6000.19, which assigned responsibilities in maintaining the readiness and core competencies of medical personnel.[29] Specifically, the Military Departments establish knowledge, skills, and abilities metrics for medical personnel, and the DHA, in coordination with the Secretaries of the Military Departments, establishes civilian-military partnerships to ensure the medical readiness of medical personnel. If workload is insufficient to meet requirements, the Secretary of the Military Department concerned, will identify alternative training and clinical practice sites for uniformed medical personnel, and may establish civilian-military training partnerships to provide such workload. Because the Military Departments already took action to address utilizing civilian-military training partnerships to provide additional trauma caseloads, we will not be making a recommendation in this area.

Mobile Medical Team Tactical Training Needs Improvement

Mobile medical teams must assess and develop their basic combat skills to shoot, move, communicate, navigate, and survive. For example, personnel must be able to defend themselves and be able to move tactically in the event that ground or air platforms are unavailable. However, we determined that the Military Departments did not always provide tactical training to mobile medical team members prior to deployment to the USINDOPACOM and USAFRICOM AORs, and when provided, the tactical training was reported as ineffective.

Through a review of survey results for 90 mobile medical team members, we identified that 25 Army, Navy, and Air Force survey participants (28 percent) did not receive tactical training. In addition, when tactical training was received, 25 of 64 survey participants (39 percent) found it ineffective. Specifically, 4 of 10 (40 percent) Army, 5 of 18 (28 percent) Navy, and 16 of 36 (44 percent) Air Force survey participants who received tactical training did not believe it prepared them for deployments.

Team members were required to defend themselves while engaging in convoy operations within 500 meters of enemy combatants that were directing fire at the convoy.

Some examples from the survey responses and reviewed AARs included Army team members being required to engage in convoy operations when fire was directed at the convoy on two occasions, within 500 meters of enemy combatants. Army team members stated that in these situations, mobile medical team members are required to defend themselves. Army team members

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

also stated that they were not provided training to operate a tactical weapons system, such as the Common Remotely Operated Weapon Station, which was used 50 percent of the time during night security.

In addition, Navy team members stated that they had to rely on the units they supported for protection, which could have been a burden to those units, and that they could not fulfill a mission tasker due to not having tactical training.[30] Other Navy team members stated that, while they received tactical training, it did not effectively prepare them for deployment and could have been improved with additional tactical movement exercises, shooting and weapons handling, and patrolling.

Further, Air Force team members stated they were also refused for missions because they were believed to be a liability to operations. Other Air Force team members stated that they were not provided night vision training, which was necessary when they had to drive an ambulance to meet a patient, or to retrieve necessary supplies at night. Additionally, Air Force team members reported that a lack of night vision training led the team to injure a pedestrian while transporting medical supplies.

Military Departments Did Not Develop Methods to Identify Best Practices and Potential Gaps in Training

The gaps in surgical and tactical training for mobile medical teams existed because the Military Departments did not develop methods, such as AARs, identify best practices and potential training gaps, or collaborate to standardize training based on best practices. Prior to the FY 2017 NDAA, each Military Department set its own individual training requirements and was not required to collaborate with the other Departments. According to JTS and JTET Branch officials, as a part of their new responsibilities, the JTS and JTET Branch are standardizing mobile medical team training to be consistent across the Military Departments and incorporating trauma caseload requirements into the newly developed standardized training requirements. Therefore, the JTET Branch Chief should continue efforts to complete and implement standardized medical training in accordance with the FY 2017 NDAA and Joint Requirements Oversight Council Memorandum 125-17, to include an austere medical course. In addition, once the

The JTS and JTET Branch are standardizing mobile medical team training to be consistent across the Military Departments and include trauma caseload requirements.

[30] These statements represents the opinions of the service members who responded to the survey. Because we collected this information through an electronic survey, we were not able to corroborate the statements with officials who made the decision.

JTET Branch publishes the standardized medical training, the Military Department Surgeons General should issue guidance implementing the standardized JTET Branch training program for all mobile medical teams.

In addition, USAFRICOM and USINDOPACOM did not consistently identify the training and unique equipment requirements for the tactical conditions in their areas of responsibility; therefore, the Military Departments did not tailor their training to reflect combatant command requirements. In response to the Draft Report, the Joint Staff Surgeon General cited the Secretary of Defense memorandum, "Military Service Pre-deployment Training in Support of Geographic Combatant Commander Theater-entry Requirements," December 19, 2019, that stated, "Effective immediately, the planning and conduct of pre-deployment training for service members and units, a statutory function of the Military Departments as Force Providers, shall be the responsibility of the Military Departments, executed in consultation with the respective Geographic Combatant Commanders." Therefore, the Surgeons General of the Army, Navy, and Air Force should update training curriculums at the Military medical training commands for tactical training of mobile medical teams.

The Military Departments have issued criteria requiring mobile medical teams to complete AARs for the purposes of the Joint Lessons Learned Program. However, the Army does not specify the information that must be gathered on an AAR, and the Navy only states that a post-deployment brief is required. The Air Force standardized questionnaire provides a framework to collect lessons learned related to deployment preparation and training; however, it does not specifically require teams to document the effectiveness of specific types of training, such as surgical training. Although criteria for the Army, Navy, and Air Force require AARs, there is no requirement to use a standardized template to collect post-deployment training feedback from mobile medical teams specific to the effectiveness of team, surgical, environmental, equipment, and tactical training provided before their deployments. Therefore, the Military Departments have limited to no framework for documenting the effectiveness of training provided to mobile medical teams. We confirmed this through our review of 10 AARs that addressed inconsistent topic areas, did not focus on training effectiveness, and were not submitted to JLLIS.[31] For example, AARs did not consistently focus on the quality of surgical and tactical training of mobile medical teams.

In addition, our survey of mobile medical team members identified issues that were not captured on AARs, such as personnel deploying without experience in trauma care, convoy operations, or weapons systems, but then being required to meet these capabilities while deployed.

[31] We received 38 AARs; however, only 10 were related to mobile medical team deployments to the USINDOPACOM and USAFRICOM AORs and included feedback on training.

Had these issues been recorded on standardized AARs and submitted to JLLIS, the Military Departments would have had the opportunity to identify and address the concerns. Specifically, existing surgical and tactical training could have been modified, or new surgical and tactical training courses developed to ensure team personnel were more effectively trained.

Had these issues been recorded on standardized AARs and submitted to JLLIS, the Military Departments would have had the opportunity to identify and address the concerns.

To meet their mission of identifying challenges to and improving DoD medical readiness, JTS PI Branch officials stated that they searched JLLIS to identify opportunities to improve medical training. However, JTS PI Branch officials stated that their search did not result in any useful data because of weaknesses in the type of system searches that can be done. To assist in obtaining standardized feedback on mobile medical team training, the JTS Chief and the JTS PI Branch Chief should develop a standardized post-deployment AAR template. Specifically, the template should assist with gathering information on the effectiveness of team, surgical, environmental, equipment, and tactical training provided to mobile medical team members prior to their deployment. In addition, the Military Department Surgeons General, in coordination with the USINDOPACOM and USAFRICOM Command Surgeons, should require all mobile medical team personnel to complete the standardized post-deployment AAR before redeploying to their home station, and submit them to JLLIS.

Mobile Medical Teams May Not Be Prepared to Meet Surgical and Tactical Mission Requirements

As a result of gaps in surgical training and a lack of exposure to trauma cases at home station MTFs, mobile medical team personnel are at risk of not gaining and maintaining essential surgical experience necessary to prepare for deployment and maintain medical readiness. For example, deployed teams may be required to operate on traumatic blast wounds without prior experience or knowledge of how to treat them and may have little to no experience treating trauma cases on live human patients. Additionally, Air Force team members stated that the surgical training they received did not provide trauma experience and that some mobile medical team members felt unprepared to perform surgery. These medical readiness skills are necessary for teams deploying to an austere environment where trauma care is required to treat patients until transport to an MTF.

In addition, as long as mobile medical team personnel are operating in a forward, austere environment, tactical training is necessary to ensure teams can provide self-protection and operate at night to fulfill their mission. For example, Army team members were required to defend themselves when fire was directed at the convoy on two occasions, within 500 meters of enemy combatants. According to a USAFRICOM component command official, without more tactical training, teams will not be able to defend themselves and their patients, and may become a liability to the forces they support. Further, due to each Military Department's differing training and culture, each mobile medical team delivers a different and sometimes inconsistent capability to combatant commanders. The inconsistency results in a capability that is not reproducible and reliable when one team deploys to replace the other and combatant commanders are not fully aware of the capabilities or limitations they are receiving with each type of mobile medical team.

Due to each Military Department's differing training and culture, each mobile medical team delivers a different and sometimes inconsistent capability to combatant commanders.

Military Department and Defense Health Agency Branches' Management Actions Taken

During the audit, we notified officials from the Joint Staff, JTS and JTS PI Branch, JTET Branch, the Military Department medical training commands, USAFRICOM, and USINDOPACOM of concerns related to the effectiveness of surgical and tactical training. All organizations agreed with our finding and recommendations and either initiated or continued corrective actions to address some of our concerns and the requirements of the FY 2017 NDAA. During our audit, JTS and JTET Branch officials stated that they had identified areas for improvement in trauma care through communication with combatant command medical personnel and the Defense Committee on Tactical Combat Casualty Care.[32] In October 2019, the JTET Branch identified the following five medical training courses that should continue to be offered.

- Tactical Combat Casualty Care Course is the DoD standard of care for first responders (medical and non-medical) and the All Service Member Tactical Combat Casualty Care course replaces Service trauma skills currently taught in first aid and self-aid buddy care courses.

[32] The Committee on Tactical Combat Casualty Care is composed of subject-matter experts in trauma, battlefield medicine, pre-hospital medicine, and experience in the deployed combat environment. The committee provides recommendations for training and equipment for service members.

- Combat Casualty Care Course is a 3-day course designed to enhance medical readiness and provide knowledge of Role I and Role II care in an austere combat environment.
- Emergency War Surgery Course consists of trauma lectures that cover war wounds and the management of injuries, such as spine trauma injury, abdominal trauma, and amputations. The course also covers field critical care principles, triage principles, and burn management.
- Trauma Nurse Care Course is 2-day course that provides knowledge of early care of trauma patients and information and skills to identify life-threatening injuries associated with the care of patients.
- Advanced Trauma Life Support is a 2 ½-day course that prepares medical providers to identify and respond to life-threatening traumatic injuries.

In September 2019, the JTET Branch, through the DHA, issued guidance requiring the Tactical Combat Casualty Care course. As of February 2020, they had not finalized the other four courses and did not have an estimated timeframe to do so.

The JTET Branch plans to develop three additional courses.

- Austere Resuscitative Surgical Care Course
- EnRoute Casualty Care Course
- Prolong Field Care Course

The JTET Branch does not have an estimated timeframe to develop these courses and the associated objectives. In addition, JTS PI Branch officials stated that they are working to standardize mobile medical team deployment AAR completion and submission to ensure comparable information is collected.

To address surgical training gaps, the JTET Branch is developing procedures to enter into civilian-military partnerships to increase team member exposure to trauma cases and shift the full time active duty role for mobile medical team members to be primarily trauma care-focused. The NDAA established a deadline of not later than July 1, 2017, for a final implementation plan that includes a subsection for entering into partnerships; however, more than 2 years after the deadline, the JTET Branch has not submitted a final implementation plan. Additionally, the NDAA does not specify a timeline for establishing partnerships with Level I civilian trauma centers. The JTET Branch expects to issue memorandums of understanding between the Military Departments and the Level I civilian trauma centers. Finally, the JTET Branch is establishing goal-based criteria for entry into partnerships with civilian trauma centers and performance metrics for these partnerships.

Management Comments on the Finding and Our Response

Joint Trauma System Comments on the Military Departments' Need to Improve Mobile Medical Team Training

The JTS Chief, Strategic Plans and Operations/Military-Civilian Partnerships, agreed with our finding, and stated that while mobile medical team members may report team-based, environmental, and equipment training as effective immediately after completing training, the lack of standardized AARs following deployment makes understanding the true effectiveness of training unclear. Additionally, the Chief stated that the lack of standardized team training and variability in team member composition among the Military Departments could negatively impact the interoperability and exchangeability of teams. The Chief corrected a statement included in the Management Actions Taken section of the Draft Report which stated that the JTET Branch developed five standardized medical training courses. The Chief explained that the JTET Branch itself has not developed any courses to date and does not have academic support personnel assigned to it to perform this function, rather the Branch had identified courses that should continue to be offered.

Our Response

We acknowledge the Chief's response to the finding and appreciate the explanation of the impact the lack of standardized training and AARs can have on mobile medical teams. In response to the Chief's correction of the Draft Report statement, we updated the section to state that the JTET Branch has identified five medical training courses that should continue to be offered to mobile medical teams.

Recommendations, Management Comments, and Our Response

Deleted and Renumbered Recommendations

The Draft Report included a recommendation stating that the Joint Staff Surgeon should coordinate with the Command Surgeon from each geographic combatant command to define mobile medical team tactical theater entry requirements. As a result of comments received from the Joint Staff Surgeon General, we deleted Draft Report Recommendation 3 to the Joint Staff Surgeon General of the Joint Chiefs of Staff, in coordination with the Surgeon General from each Geographic Combatant Command. We renumbered Recommendations 4, 5, and 6 as Recommendations 3, 4, and 5.

The Joint Staff Surgeon General cited the Secretary of Defense memorandum, "Military Service Pre-deployment Training in Support of Geographic Combatant Commander Theater-entry Requirements," December 19, 2019, that stated, "Effective immediately, the planning and conduct of pre-deployment training for service members and units, a statutory function of the Military Departments as Force Providers, shall be the responsibility of the Military Departments, executed in consultation with the respective Geographic Combatant Commanders." As a result, the Joint Staff Surgeon and the geographic combatant commanders are not responsible for defining any pre-deployment training requirements and the recommendation was no longer applicable.

Revised Recommendation

As a result of management comments, we revised Draft Report Recommendation 4 (Recommendation 3 of the Final Report) to clarify that curriculums at Military medical training commands should be updated to ensure tactical training is provided to mobile medical teams to prepare for operations in an austere environment to ensure standardization above the unit level. While coordination with geographic combatant commands on theater specific requirements and unit level tactical training is a best practice, we determined that for the purposes of this report the recommendation should require that a portion of tactical training be the responsibility of the Service Surgeons General to coordinate with the Military medical training commands.

Recommendation 1

We recommend that the Chief of the Joint Trauma Education and Training Branch continue efforts to complete and implement standardized medical training, to include an Austere Surgical Resuscitative Course, in accordance with the Fiscal Year 2017 National Defense Authorization Act and Joint Requirements Oversight Council Memorandum 125-17.

Joint Trauma Education and Training Branch Comments

The JTS Chief, Strategic Plans and Operations/Military-Civilian Partnerships, agreed with the recommendation, stating that the JTET Branch would work with the JTS PI Branch to establish baseline training standards, using processes already in place by the JTS to collect, analyze, and process theater injury data that is used to formulate Clinical Practice Guidelines and serve as the basis for Joint Knowledge, Skills, and Abilities. The Chief further stated that the JTS and JTET Branch could work with DoD sister organizations that maintain academic support functions, such as the Uniformed Services University and the Medical Education and Training Campus, to design, build, implement, and validate specific courses to meet evolving

theater requirements. The JTS, with the input of its Defense Committees on Trauma, could then exercise its role as the final reference body for the DoD Trauma Enterprise in accordance with the FY 2017 NDAA Section 707, by serving as the final endorsement authority for all courses, regardless of their origin, based on standards previously set forth by the JTET Branch. However, the Chief stated that the JTET Branch is not currently resourced or manned to meet Recommendation 1, and that to date, the JTET Branch has been operated by active duty volunteers who have taken on JTET Branch roles in addition to their full-time duties.

In addition, the Chief requested that we revise Recommendation 1 to include that the JTET Branch should collaborate with government and civilian partners to develop courses that assist in continued efforts to standardize mobile medical team training and sustainment. Furthermore, the Chief requested we revise the recommendation to state that the JTET Branch, in coordination with the Military Health System Strategic Partnership with the American College of Surgeons, develop baseline criteria for civilian-military trauma partnerships and develop strategies to effectively measure the success of these partnerships. The Chief also requested we recommend the DHA take immediate steps to fully resource previously approved manning requirements and funding increases to the JTS/JTET Branch that will enable accomplishment of these directives in accordance with the FY 2017 NDAA and the Joint Requirements Oversight Council Memorandum 125-17.

Our Response

Comments from the Chief addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify that the JTET Branch has issued baseline training standards for mobile medical teams. We acknowledge that the ability to close the recommendation is contingent on the JTET Branch acquiring adequate resources and manning. We also acknowledge the Chief's request to revise the recommendation; however, we did not make any revisions because it is not the intent of the recommendation to be prescriptive in how the JTET Branch completes and implements standardized training.

Recommendation 2

We recommend that the Surgeons General of the Army, Navy, and Air Force issue guidance implementing the Joint Trauma Education and Training Branch's standardized training program for all mobile medical teams.

Army Surgeon General Comments

The Army Surgeon General Chief of Staff, responding for the Army Surgeon General, agreed with the recommendation, stating that once the JTET Branch approves and issues guidance, the Army Surgeon General will take action to ensure the timely rollout and implementation of a standardized training program as directed.

Our Response

Comments from the Chief of Staff addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify that the Army Surgeon General has directed the implementation of JTET's standardized training program.

Navy Surgeon General Comments

The Navy Bureau of Medicine and Surgery Executive Director, responding for the Navy Surgeon General, agreed with the recommendation and requested we revise the recommendation to state that implementation of the JTET Branch standardized training program follow Service review and acceptance of the program. The Executive Director stated that this addition would ensure Service equity in program development, review, and implementation

Our Response

Comments from the Executive Director addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation once we verify that the Navy Surgeon General has directed implementation of JTET's standardized training program. We acknowledge the Executive Director's requested revision to the recommendation; however, it is not the intent of the recommendation to be prescriptive on the process for how JTET coordinates with the Services while developing a standardized training program.

Air Force Surgeon General Comments

The Air Force Deputy Surgeon General, responding for the Air Force Surgeon General, agreed with the recommendation stating that the Air Force Medical Service agrees that the DHA establishes standards to ensure those delivering trauma care have the knowledge, skills, and abilities to do so, are following established procedures, and are provided with the requisite experience to be considered current in the medical field. The Deputy Surgeon General further stated that the Air Force Medical Service does not agree with the interpretation that the DHA will standardize readiness training, as this is a Service responsibility. The Deputy Surgeon General did state; however, that Air Force mobile medical teams are already following agreed-upon joint standards and guidelines.

Our Response

Although the Deputy Surgeon General partially agreed with the recommendation, the comments provided do not address the specifics of the recommendation; therefore, the recommendation is unresolved. We acknowledge that the Services are responsible for readiness training; however, section 708 of the FY 2017 NDAA states that the Secretary of Defense shall establish the JTET Branch to ensure that Service traumatologists maintain readiness and are able to be rapidly deployed for future armed conflicts. The NDAA further states that the duties of the JTET will include developing standardized combat casualty care instruction for all members of the Armed Forces, including the use of standardized trauma training platforms. We ask that the Air Force Surgeon General provide additional comments in response to the final report, identifying specific actions to ensure the implementation of the JTET Branch standardized training program.

Recommendation 3

We recommend that the Surgeons General of the Army, Navy, and Air Force update training curriculums at the Military medical training commands for tactical training of mobile medical teams.

Army Surgeon General Comments

The Army Surgeon General Chief of Staff, responding for the Army Surgeon General, disagreed with the recommendation, stating that the Surgeon General is not the proponent for updating training curriculum relating to tactical readiness, including basic combat skills to shoot, move, communicate, navigate, and survive; training to operate tactical weapons systems; and night vision training. The Chief of Staff further stated that per Headquarters, Department of the Army, Executive Order 114-19, the unit commander is responsible for developing and executing pre-deployment training.[33]

Our Response

Comments from the Chief of Staff did not address the specifics of the recommendation; therefore, the recommendation is unresolved. We agree that unit commanders are responsible for developing and executing pre-deployment training, including tactical training; however, some pre-deployment training for mobile medical teams is also performed by the Military medical training commands, such as the U.S. Army Medical Center of Excellence. The intent of our recommendation is to address the effectiveness of tactical training that is already being provided by

[33] Headquarters, Department of the Army, Executive Order 114-19, "Theater Entry Pre-Deployment Training in Support of Geographic Combatant Commands, April 2019.

all of the Military medical training commands. Specifically, we identified where each of the Military medical training commands provided limited tactical training relevant to mobile medical teams above the unit level. For example, the Army medical training command began incorporating night vision goggle and specialized weapons training for mobile medical teams in response to post-deployment after action reports. While mobile medical teams should continue to receive tactical training required by unit commanders as part of pre-deployment readiness, the intent of our recommendation is a cross-service effort to ensure standardized training and leveraging of best practices for the improvement of additional tactical training provided as part of the Military medical training commands' programs. Therefore, we request that the Army Surgeon General provide comments on the final report to reconsider updating tactical training curriculums for mobile medical teams provided at the Military medical training command level.

Navy Surgeon General Comments

The Navy Bureau of Medicine and Surgery Executive Director, responding for the Navy Surgeon General, agreed with the recommendation and requested a revision to the recommendation which states that the Service will update training curriculums or processes that fulfill tactical theater entry requirements once the area of operations is known. The Executive Director explained that Services may utilize other than Service-specific training programs which would require a process update, rather than a curriculum update. Additionally, the Executive Director stated that tactical skills are specific to the theater, not the capability, so the training for these skills is typically completed "just in time" when a team is activated to deploy to a given area of operations.

Our Response

Comments from the Executive Director addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close this recommendation after we verify that the Navy has updated its curriculum or processes for tactical training of mobile medical teams. We acknowledge the Executive Director's requests to revise the recommendation; however we did not make the requested revisions because it is not the intent of the recommendation to be prescriptive on when in the pre-deployment process the training is conducted, and the Service's plan to update processes rather than specific training curriculum would still meet the specifics of the recommendation once processes are appropriately documented and provided to the DoD OIG as support for closing the recommendation. We did, however, revise the recommendation to clarify that curriculums should be updated at the Military medical training commands for tactical training of mobile medical teams.

Air Force Surgeon General Comments

The Air Force Deputy Surgeon General, responding for the Air Force Surgeon General, agreed with the recommendation. The Deputy Surgeon General stated that while tactical training to meet Combatant Commander theater entry requirements is not specific to mobile medical teams or to medical training, the Air Force Medical Service provides training to all personnel tasked to deploy within a given theater of operations that is in accordance with that theater's requirements.

Our Response

Comments from the Deputy Surgeon General did not address the specifics of the recommendation; therefore, the recommendation is unresolved. Although the Deputy Surgeon General stated that the Air Force Medical Service provides training to all personnel tasked to deploy, the intent of our recommendation is to address areas for improvements to tactical training, such as increased weapons and night vision training, that the Air Force is already providing. We ask that the Air Force Surgeon General provide additional comments in response to the final report, identifying specific actions that will be taken to update tactical training provided to mobile medical teams at Military medical training commands.

Recommendation 4

We recommend that the Chief of the Joint Trauma System and the Chief of the Joint Trauma System Performance Improvement Branch develop a standardized post-deployment after action report template to gather information on the effectiveness of team, surgical, environmental, equipment, and tactical training provided to mobile medical team members prior to their deployment.

Joint Trauma System and Joint Trauma System Performance Improvement Branch Comments

The JTS PI Branch Lead, on behalf of the JTS Chief and JTS PI Branch Chief, agreed with the recommendation, stating that the JTS PI Branch is actively addressing the need for a standardized AAR that will be used to evaluate the effectiveness of pre-deployment training to achieve readiness, and be uploaded to JLLIS. The JTS PI Branch Lead stated that a JTS module has been established in JLLIS and that it will be populated with data for evaluation once the AAR has been aligned with the Role 2 Readiness Report approved by the JTS Committee for Surgical Combat Casualty Care, and is finalized by the estimated completion date of August 1, 2020.

Our Response

Comments from the JTS PI Branch Lead addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close this recommendation after we verify that JLLIS includes a JTS module with information on the effectiveness of team, surgical, environmental, equipment, and tactical training provided to mobile medical team members.

Recommendation 5

We recommend that the Surgeons General of the Army, Navy, and Air Force, in coordination with the Command Surgeons of the U.S. Indo-Pacific Command and U.S. Africa Command, require that all mobile medical team personnel individually complete standardized post-deployment after action reports, using the Joint Trauma System Performance Improvement Branch template, before redeploying to their home station, and submit them to the Joint Lessons Learned Information System for the purposes of the Lessons Learned program.

Army Surgeon General Comments

The Army Surgeon General Chief of Staff, responding for the Army Surgeon General, disagreed with the recommendation, stating that the Surgeon General cannot implement the recommendation because Army Regulation 11-33, "Army Lessons Learned Program," mandates the process used by Army units, including mobile medical teams, to submit lessons learned. Therefore, the Chief of Staff recommended directing the recommendation to the Army Deputy Chief of Staff G-3/5/7 as the Army Lessons Learned Program involves many Army organizations at all levels of command, which ensures relevant knowledge is provided to the operational force.

Our Response

Comments from the Chief of Staff did address the specifics of the recommendation but not the intent of the recommendation; therefore, the recommendation is unresolved. We agree that Army Regulation 11-33, "Army Lessons Learned Program," mandates processes for submitting lessons learned; however, the intent of our recommendation is that mobile medical teams complete the JTS PI Branch joint standardized AAR form, once issued. When the JTS PI Branch issues this form it will be a new requirement that is not Service-specific nor currently addressed in Army guidance. Additionally, the form will ensure documentation of mobile medical team specific information and submission to JLLIS for purposes of JTS PI efforts. Therefore, we request that the Army Surgeon General provide comments on the final report to reconsider issuing guidance, which could be done in coordination with the Army Deputy Chief of Staff G-3/5/7, requiring use of the JTS standardized post-deployment AAR for mobile medical teams, once issued, and submission of completed AARs to JLLIS.

Navy Surgeon General Comments

The Bureau of Medicine and Surgery Executive Director, responding for the Navy Surgeon General, agreed with the recommendation, stating that Navy policy will be updated to match standardized post-deployment AAR requirements following publication of the JTS template.

Our Response

Comments from the Executive Director addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close this recommendation after we verify that the Navy Surgeon General has updated policy to require completion of the JTS template.

Air Force Surgeon General Comments

The Air Force Deputy Surgeon General, responding for the Air Force Surgeon General, agreed with the recommendation, stating that post-deployment AARs and lessons learned are already required.

Our Response

Although the Deputy Surgeon General agreed with the recommendation, comments from the Deputy Surgeon General did not address the specifics of the recommendation. Without requiring the use of the JTS standardized post-deployment AAR template, the Air Force cannot ensure the completion and submission of the new mobile medical team-specific information into JLLIS. Therefore, the recommendation is unresolved. We ask that the Air Force Surgeon General provide additional comments in response to the final report, identifying specific actions to ensure the completion of JTS standardized post-deployment AARs specific to mobile medical teams.

Appendix A

Scope and Methodology

We conducted this performance audit from April 2019 through March 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our scope included mobile medical teams, defined as small, mobile groups of medical personnel (10 or less) from the Army, Navy, and Air Force operating at the tactical or intra-theater level.

Criteria Governing Mobile Medical Team Training

To gain an understanding of DoD and Military Department mobile medical team training and AAR requirements, we reviewed the following criteria.

- DoD Instruction 1322.24, "Medical Readiness Training (MRT)," March 16, 2018.
- DoD Instruction 6040.47, "Joint Trauma System (JTS)," August 5, 2018.
- Chairman of the Joint Chiefs of Staff Instruction 3150.25F, "Joint Lessons Learned Program," June 26, 2015.
- Joint Publication 3-0, "Joint Operations," October 22, 2018.
- Joint Publication 3-35, "Deployment and Redeployment Operations," January 10, 2018.
- Joint Publication 4-02, "Joint Health Services," September 28, 2018.
- Army Regulation 11-33, "Army Programs: Army Lessons Learned Program," June 14, 2017.
- Navy Bureau of Medicine and Surgery Notice 1500, "Phased Medical Readiness Trauma Training Requirements," June 19, 2018.
- Office of the Chief of Naval Operations Instruction 3500.37D, "Navy Lessons Learned Program," June 20, 2018.
- Air Force Instruction 10-1302, "Operations: Air Force Lessons Learned Program," July 30, 2019.
- Air Force Instruction 41-106, "Health Services: Medical Readiness Program Management," June 9, 2017.
- Air Force Tactics, Techniques, and Procedures 3-42.77, "Tactical Doctrine: Ground Surgical Team (GST)," November 16, 2018.

We identified requirements from the FY 2017 through 2019 NDAAs for the establishment of the JTS within the DHA, and processes for creating standardized training curriculums for a joint service training program. The team then compared those requirements to what the JTS and JTET Branch had done to date to implement standardized training across the Military Departments.

Additionally, we reviewed the following Joint Requirements Oversight Council Memorandums to determine actions taken to meet the requirements in the NDAAs.

- Joint Requirements Oversight Council Memorandum 025-15, "Combat Casualty Care Medical Research and Development Doctrine, Organization, Training materiel, Leadership, and Education, Personnel, Facilities, and Policy Change Request," March 12, 2015.
- Joint Requirements Oversight Council Memorandum 125-17, "Forward Resuscitative Care in Support of Dispersed Operations Doctrine, Organization, Training materiel, Leadership, and Education, Personnel, Facilities, and Policy Change Recommendation," December 11, 2017.
- Joint Requirements Oversight Council Memorandum 126-17, "Department of Defense Trauma Enterprise Doctrine, Organization, Training materiel, Leadership, and Education, Personnel, Facilities, and Policy Change Recommendation," December 11, 2017.

Background Site Visits

To gain an understanding of the current and future processes for mobile medical team training, we conducted a site visit to four bases in San Antonio, Texas: Joint Base San Antonio-Fort Sam Houston, Joint Base San Antonio-Lackland, Joint Base San Antonio-Randolph, and Camp Bullis. We interviewed military medical officials from the following organizations:

- JTS
- Defense Medical Readiness Training Institute
- U.S. Army Medical Command
- U.S. Army Medical Center of Excellence
- Navy Bureau of Medicine and Surgery
- Navy Medicine Education, Training, and Logistics Command
- Air Force Medical Operations Agency
- Air Force Air Education and Training Command
- Air Force Medical Readiness and Training Center

In addition, during the site visit to the Air Force Medical Readiness and Training Center at Camp Bullis, we observed a portion of the Expeditionary Medical Support training, which is a larger 97-person Air Force team that the GST can be part of. We also toured the GST-specific training facilities, including a simulator and model surgical tent.

We also conducted interviews with officials from USAFRICOM, USINDOPACOM, and the DHA to discuss roles and responsibilities for training mobile medical teams.

Survey and Related Site Visits

With input from the DoD OIG's Qualitative Methods Division (QMD), we developed a 20-question survey to determine the types of training conducted and their effectiveness in preparing mobile medical teams to deploy to the USINDOPACOM and USAFRICOM AORs. The survey included questions on the types of teams personnel were assigned to; the effectiveness of team, surgical, environmental, equipment, and tactical training in preparation for deployment; and how well respondents' home station MTF job prepared them for deployment on a mobile medical team. See Appendix D for a copy of the full mobile medical team survey.

To conduct the survey, we requested a universe of personnel who were assigned to a mobile medical team from July 2016 through July 2019 from the Army, Navy, and Air Force. The U.S. Army Medical Command deferred to U.S. Army Forces Command to provide the names of members of the Army's Forward Resuscitative Surgical Teams; however, U.S. Army Forces Command was unable to provide this information. As a result, we removed Forward Resuscitative Surgical Team members from our scope.

The survey universe included 297 personnel—49 Army, 122 Navy, and 126 Air Force. However, we could not verify that 297 personnel comprised the complete universe of personnel who served on Army ERST, Navy ERSS, and Air Force GST teams from July 2016 through July 2019. For example, we requested a list of the names of all GST team members assigned to Nellis Air Force Base, which was compared to the universe we received from the Air Combat Command, and found that 26 of the 35 people on the Nellis Air Force Base list were not included in the universe provided by Air Combat Command.

We also requested to meet with mobile medical team personnel to conduct the survey in person. Based on the number of mobile medical teams and personnel available, we visited Elmendorf Air Force Base, Alaska; Nellis Air Force Base, Nevada; and Navy Medical Center San Diego, California, to conduct interviews. We interviewed 21 Air Force GST members during site visits to Elmendorf Air Force Base and Nellis Air Force Base, and 8 Navy ERSS personnel during a site visit to Navy Medical Center San Diego.

During the site visit to Elmendorf Air Force Base, we administered the survey to 13 Air Force GST personnel and refined the survey questions based on feedback. During the site visit to Navy Medical Center San Diego we interviewed eight ERSS personnel. All eight personnel were included in the original e-mailed survey universe. During the site visit to Nellis Air Force Base, we interviewed eight GST personnel. Five personnel were included in the original e-mailed survey universe. The remaining three personnel were referred to us by the Nellis Air Force Base contact, and all three personnel met our criteria.

We closed the survey on October 8, 2019, and received a total of 90 completed surveys (either in-person interviews or electronic). Specifically, 12 Army, 31 Navy, and 47 Air Force mobile medical team members completed the survey. See Appendix C for a breakdown of results from the survey analysis.

Selection and Review of Training Certificates

We requested a universe of personnel assigned to a mobile medical team from July 2016 through July 2019, and selected a nonstatistical sample of 20 mobile medical team members from each of the three Military Departments, for a total of 60 team members. We used the random number function in Microsoft Excel and chose the first 20 names for each Military Department. We requested records for the required training for mobile medical team members, specific to their deployment on a mobile medical team. We determined, based on the information provided by the Military Departments for all 60 individuals, whether training was completed before deploying to the USINDOPACOM and USAFRICOM AORs. See Appendix C for a breakdown of results from the certificate analysis.

Review of AARs

We requested all AARs for mobile medical team deployments to the USAFRICOM and USINDPACOM AORs from July 2016 through July 2019 from the Military medical training commands. We reviewed 10 AARs and summaries of lessons learned to determine if information was collected on the effectiveness of mobile medical team training, and if a standardized template was used across the Military Departments.

Use of Computer-Processed Data

We did not use computer-processed data to perform this audit.

Use of Technical Assistance

We received assistance during the audit from members of QMD. QMD assisted in developing the questionnaire and selection of survey type.

Prior Coverage

During the last 5 years, the Government Accountability Office (GAO) issued three reports discussing the JTS' and DHA's implementation of FY 2017 NDAA requirements. Unrestricted GAO reports can be accessed at http://www.gao.gov.

GAO

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

> The DoD has not determined the required size and composition of its operational medical and dental personnel who support the wartime mission, or submitted a complete report to Congress, as required by the FY 2017 NDAA. The GAO found that the Military Departments applied different planning assumptions in estimating required personnel, such as the definition of "operational requirements." Until the DoD establishes joint planning assumptions for developing medical and dental personnel requirements, including a definition of operational requirements, and a method to assess options for achieving joint efficiencies, the DoD will not know whether it has the optimal requirements in place to train mobile medical team personnel to achieve its missions.

Report No. GAO-19-102, "Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce," November 2018

> The GAO found that the Military Departments have their own processes to determine their operational medical personnel requirements; however, their planning processes to meet those requirements do not consider the use of all medical personnel or the full cost of military personnel. The DHA has not developed a strategic workforce plan. Without developing this plan, the DHA may continue to face the same challenges experienced by the Military Departments in executing an appropriate and efficient workforce mix at its MTFs.

Report No. GAO-18-300, "New Trauma Care System: DOD Should Fully Incorporate Leading Practices into Its Planning for Effective Implementation," March 2018

The GAO assessed whether the DoD's implementation plan for a new JTS included the four required elements from the FY 2017 NDAA. The GAO found that the supplemental planning documents prepared to date do not fully incorporate leading practices for planning. The GAO found that two of the elements were partially incorporated and two elements were not incorporated. The GAO determined that by not fully incorporating leading practices into its planning documents, the DoD may be missing opportunities to ensure that its efforts to implement a new JTS are effective, and help reduce trauma-related deaths and injuries across the Military Services.

Appendix B

Military Department Mobile Medical Team Structure and Capabilities

During the audit, we identified mobile medical teams from each of the Military Departments to gain an understanding of their structure, size, and capabilities. We provided a brief summary of the teams included in our scope in the table below.

Table 3. Military Department Mobile Medical Team Structure and Capabilities

Service	Team	Number of Personnel Per Team	Medical Capabilities
Army	ERST	8	Developed in response to a USAFRICOM request for medical forces. Provides far-forward damage control resuscitation and surgery, and stabilizes up to 4 patients for medical evacuation for up to 48 hours of continuous operations.[1]
Navy	ERSS	9	Provides emergency resuscitation and damage control surgery close to the point of injury. Operates afloat and ashore. Performs surgery for immediate life- and limb-saving needs, trauma care, and medical evacuation. Surgery for up to 3 patients for up to 72 hours.
Air Force (Program of Record)	GST	6	Smallest deployable Air Force module for delivery of advanced emergency medical and surgical care. Team deploys with man-portable field packs configured to support rapid setup. Stabilizes and prepares patients for casualty evacuation. Capable of performing up to 10 surgical interventions and providing postoperative patient holding for up to 3 patients at a time for a maximum of 12 hours without resupply.

Source: The DoD OIG.

[1] Damage control resuscitation includes non-surgical capabilities, such as whole blood transfusions and advanced airway care.

Appendix C

Survey and Training Certificate Sample Results

This appendix provides a breakdown of responses to questions in the survey and a breakdown of the analysis conducted on the sample of training certificates collected.

Survey Results

Ninety mobile medical team members across the Military Departments participated in our survey: 12 Army participants, 31 Navy participants, and 47 Air Force participants. However, not all 90 participants responded to every question, and as a result, the total number of participants responding to each question may differ. In addition, our survey contained 20 questions, and 7 of those questions are relevant to our audit analysis. For a complete list of all survey questions administered to mobile medical team personnel, see Appendix D.

Surgical Training

Table 4. Did you receive surgical training? (Survey question 6)

	Army	Navy	Air Force	Total
Yes	12	29	43	84
No	0	2	4	6

Source: The DoD OIG.

Table 5. If you stated that you received surgical training, rate your surgical training. (Survey question 11)

Rating	Army	Navy	Air Force	Total
0 – Did not receive this training in preparation for deployment	0	0	1	1
1 – Received training but it was insufficient in preparation for deployment	1	3	4	8
2 – Training was partially sufficient in preparation for deployment	0	4	13	17
3 – Training was sufficient in preparation for deployment	5	14	13	32
4 – Training was more than sufficient in preparation for deployment	5	6	10	21
Subtotal	**11**	**27**	**41**	**79**

Table 5. If you stated that you received surgical training, rate your surgical training. (Survey question 11) cont'd

Rating	Army	Navy	Air Force	Total
No response	1	2	2	5
Total	**12**	**29**	**43**	**84**

Source: The DoD OIG.

Table 6. Rate your home/duty station position as preparation for your deployed position. (Survey question 16)

Rating	Army	Navy	Air Force	Total
0 – Duty station position did not prepare at all for deployment	3	1	10	14
1 – Duty station position was insufficient preparation for deployment	2	8	11	21
2 – Duty station position was partially sufficient preparation for deployment	3	12	9	24
3 – Duty station position was sufficient preparation for deployment	0	5	12	17
4 – Duty station position was more than sufficient in preparation for deployment	4	5	4	13
Subtotal	**12**	**31**	**46**	**89**
No response	0	0	1	1
Total	**12**	**31**	**47**	**90**

Source: The DoD OIG.

Tactical Training

Table 7. Did you receive tactical training? (Survey question 6)

	Army	Navy	Air Force	Total
Yes	10	18	37	65
No	2	13	10	25

Source: The DoD OIG.

Table 8. If you stated that you received tactical training, rate your tactical training. (Survey question 13)

Rating	Army	Navy	Air Force	Total
0 – Did not receive this training in preparation for deployment	0	1	6	7
1 – Received training but it was insufficient in preparation for deployment	1	1	2	4
2 – Training was partially sufficient in preparation for deployment	3	3	8	14
3 – Training was sufficient in preparation for deployment	2	9	12	23
4 – Training was more than sufficient in preparation for deployment	4	4	8	16
Subtotal	**10**	**18**	**36**	**64**
No response	0	0	1	1
Total	**10**	**18**	**37**	**65**

Source: The DoD OIG.

Team Training

Table 9. Did you receive team development training? (Survey question 6)

	Army	Navy	Air Force	Total
Yes	12	28	38	78
No	0	3	9	12

Source: The DoD OIG.

Table 10. If you stated that you received team development training, rate your team development training. (Survey question 9)

Rating	Army	Navy	Air Force	Total
0 – Did not receive this training in preparation for deployment	0	0	0	0
1 – Received training but it was insufficient in preparation for deployment	0	0	0	0
2 – Training was partially sufficient in preparation for deployment	0	3	7	10
3 – Training was sufficient in preparation for deployment	6	13	21	40

Table 10. If you stated that you received team development training, rate your team development training. (Survey question 9) cont'd

Rating	Army	Navy	Air Force	Total
4 – Training was more than sufficient in preparation for deployment	6	12	10	28
Subtotal	**12**	**28**	**38**	**78**
No response	0	0	0	0
Total	**12**	**28**	**38**	**78**

Source: The DoD OIG.

Environmental Training

Table 11. Did you receive environmental training? (Survey question 6)

	Army	Navy	Air Force	Total
Yes	10	27	38	75
No	2	4	9	15

Source: The DoD OIG.

Table 12. If you stated that you received environmental training, rate your environmental training. (Survey question 10)

Rating	Army	Navy	Air Force	Total
0 – Did not receive this training in preparation for deployment	0	0	1	1
1 – Received training but it was insufficient in preparation for deployment	0	3	2	5
2 – Training was partially sufficient in preparation for deployment	2	4	7	13
3 – Training was sufficient in preparation for deployment	5	16	21	42
4 – Training was more than sufficient in preparation for deployment	2	3	6	11
Subtotal	**9**	**26**	**37**	**72**
No response	1	1	1	3
Total	**10**	**27**	**38**	**75**

Source: The DoD OIG.

Equipment Set Training

Table 13. Did you receive equipment set training? (Survey question 6)

	Army	Navy	Air Force	Total
Yes	12	25	31	68
No	0	6	7	13

Source: The DoD OIG.

Note: Although overall, 47 Air Force mobile medical team members participated in our survey, 38 of those answered this question. We did not ask nine of the participants from the Alaska site visit the equipment set question. See Appendix A for additional details about the survey methodology.

Table 14. If you stated that you received equipment set training, rate your equipment set training. (Survey question 12)

Rating	Army	Navy	Air Force	Total
0 – Did not receive this training in preparation for deployment	0	0	0	0
1 – Received training but it was insufficient in preparation for deployment	1	4	2	7
2 – Training was partially sufficient in preparation for deployment	1	8	6	15
3 – Training was sufficient in preparation for deployment	4	7	16	27
4 – Training was more than sufficient in preparation for deployment	6	5	4	15
Subtotal	**12**	**24**	**28**	**64**
No response	0	1	3	4
Total	**12**	**25**	**31**	**68**

Source: The DoD OIG.

Training Certificates Results

Table 15. Military Department Surgical Training Certificate Results

Military Department	Sampled Individuals	Deployed Individuals	Individuals Deployed Without Surgical Training	Percentage
Army	20	20	11	55%
Navy	20	8	8	100%
Air Force	20	12	0	0%
Totals	**60**	**40**	**19**	**48%**

Source: The DoD OIG.

Appendix D

Mobile Medical Team Survey

Survey of Mobile Medical Personnel Training

Project No. D2019-D000RJ-0143.000

POC: [redacted]

Audit Objective

We are performing a DoD OIG audit to determine the effectiveness of training provided to mobile medical teams prior to deploying to the U.S. Indo-Pacific Command (USINDOPACOM) and U.S. Africa Command (USAFRICOM) areas of responsibility (AOR).

Survey Objective

This survey will help us gather valuable input from personnel who have deployed (or are eligible to deploy) to the USINDOPACOM and USAFRICOM AORs on how well they were prepared for the team, environmental, medical/surgical, equipment, and tactical capabilities required of them during deployment.

Survey Time Expectations

The survey should take approximately 20 minutes.

Classification and Anonymity

All answers to the survey must be UNCLASSIFIED. Responses will be compiled and used anonymously in an unclassified audit report, ensuring no responses can be tied back to a specific individual. Your responses will not be shown to any personnel outside the audit team.

Personally Identifiable Information (PII)

Please do not include PII in any of your responses. If you have any concerns, please contact the DoD OIG Hotline (https://www.dodig.mil/Components/Administrative-Investigations/DoD-Hotline/).

Mobile Medical Team Definition

We define a mobile medical team as a mobile, small (about 5–10 personnel, depending on mission requirements) group of medical personnel, on either doctrinal or non-doctrinal teams, operating at the tactical/intra-theater level and providing Role 1 and/or Role 2 care before the patient arrives at a medical treatment facility.

Deployment Information

1. **From the drop-down menus at right, select which team(s) you have been assigned to. Choose all that apply.**

Army FST/FRST	Yes / No
Army ERST	Yes / No

1

Mobile Medical Team Survey (cont'd)

Navy FST	Yes No
Navy ERSS	Yes No
Navy DCST	Yes No
AF GST	Yes No
AF MFST	Yes No
Other (please indicate in comment box below)	Yes No
Comments	

2. From the drop-down menu at right, select the AOR(s) that you deployed to between July 2016 and July 2019.	USINDOPACOM USAFRICOM Both USINDOPACOM and USAFRICOM N/A (did not deploy to either AOR)
3. From the drop-down menu at right, select the number of times you have deployed on a mobile medical team to the USINDOPACOM and/or USAFRICOM AOR(s) between July 2016 and July 2019.	0 1 2-3 4+
4. From the drop-down menu at right, select the reason(s) you deployed to the USINDOPACOM and/or USAFRICOM AOR(s).	Exercise Mission-related (HA/DR, OCO, etc) Both exercise and mission-related Other (please specify below) N/A (did not deploy to either AOR)
Comments	

| 2

Mobile Medical Team Survey (cont'd)

5. **From the drop-down menu at right, select the number of trauma cases you worked on during your deployment to the USINDOPACOM and/or USAFRICOM AOR(s) between July 2016 and July 2019.**

0
1
2-5
6+
N/A (did not deploy to either AOR)

Training

Team Development Training Definition
Training as a mobile medical team in preparation for deployment.

Environmental Training Definition
Any training or simulations to operate in a more austere environment/outside of a permanent medical facility.

Medical/Surgical Training Definition
Any training on mannequins, live patient models, or rotations to trauma centers (including civ-mil partnerships) to practice treating trauma cases outside your normal work at your home station.

Mobile Equipment Set Training Definition
Training on the specific equipment that would be used during deployment.

Tactical Training Definition
Weapons or other security training, as necessary for the mission.

6. **Did you receive training in the following subject areas as you prepared for deployment? Select "yes" or "no" from the drop-down menus at right.**

If you received training in a subject area, select the year of training from the drop-down menus.

Team Development

Yes
No

3

Mobile Medical Team Survey (cont'd)

Year of most recent team development training	2015 2016 2017 2018 2019 N/A (did not receive training)
Environmental	Yes No
Year of most recent environmental training	2015 2016 2017 2018 2019 N/A (did not receive training)
Medical/Surgical	Yes No
Year of most recent medical/surgical training	2015 2016 2017 2018 2019 N/A (did not receive training)
Mobile Equipment Set	Yes No
Year of most recent mobile equipment training	2015 2016 2017 2018 2019 N/A (did not receive training)
Tactical	Yes No

| 4

Mobile Medical Team Survey (cont'd)

Year of most recent tactical training	2015 2016 2017 2018 2019 N/A (did not receive training)
7. For the training(s) you did not receive (as marked in Question 6), which training(s) would have been beneficial as you prepared for deployment? Select all that apply.	Yes, would have been beneficial No, would have not been beneficial N/A (received this training)
Team Development	Yes, would have been beneficial No, would have not been beneficial N/A (received this training)
Environmental	Yes, would have been beneficial No, would have not been beneficial N/A (received this training)
Medical/Surgical	Yes, would have been beneficial No, would have not been beneficial N/A (received this training)
Mobile Equipment Set	Yes, would have been beneficial No, would have not been beneficial N/A (received this training)
Tactical	Yes, would have been beneficial No, would have not been beneficial N/A (received this training)
8. When you deployed to the USINDOPACOM and/or the USAFRICOM AOR(s), was the mobile equipment set the same as the mobile equipment set you trained on?	Yes No N/A (did not deploy to either AOR)
Comments	

| 5

Mobile Medical Team Survey (cont'd)

9. From the drop-down menu at right, rate your team development training you received in preparation for deployment. Provide comments as necessary below your rating.

- 0 - Did not receive this training in preparation for deployment
- 1 - Received training but it was insufficient in preparation for deployment
- 2 - Training was partially sufficient in preparation for deployment
- 3 - Training was sufficient in preparation for deployment
- 4 - Training was more than sufficient in preparation for deployment

Comments

10. From the drop-down menu at right, rate your environmental training you received in preparation for deployment. Provide comments as necessary below your rating.

- 0 - Did not receive this training in preparation for deployment
- 1 - Received training but it was insufficient in preparation for deployment
- 2 - Training was partially sufficient in preparation for deployment
- 3 - Training was sufficient in preparation for deployment
- 4 - Training was more than sufficient in preparation for deployment

Comments

11. From the drop-down menu at right, rate your medical/surgical training you received in preparation for deployment. Provide comments as necessary below your rating.

- 0 - Did not receive this training in preparation for deployment
- 1 - Received training but it was insufficient in preparation for deployment
- 2 - Training was partially sufficient in preparation for deployment
- 3 - Training was sufficient in preparation for deployment
- 4 - Training was more than sufficient in preparation for deployment

Comments

6

Mobile Medical Team Survey (cont'd)

12. **From the drop-down menu at right, rate your mobile <u>equipment set training</u> you received in preparation for deployment. Provide comments as necessary below your rating.**

0 - Did not receive this training in preparation for deployment
1 - Received training but it was insufficient in preparation for deployment
2 - Training was partially sufficient in preparation for deployment
3 - Training was sufficient in preparation for deployment
4 - Training was more than sufficient in preparation for deployment

Comments

13. **From the drop-down menu at right, rate your <u>tactical training</u> you received in preparation for deployment. Provide comments as necessary below your rating.**

0 - Did not receive this training in preparation for deployment
1 - Received training but it was insufficient in preparation for deployment
2 - Training was partially sufficient in preparation for deployment
3 - Training was sufficient in preparation for deployment
4 - Training was more than sufficient in preparation for deployment

Comments

Position Information

14. **What is your duty station/home medical treatment facility position?**

15. **What is/was your mobile medical team position?**

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Mobile Medical Team Survey (cont'd)

16. From the drop-down menu at right, rate how well your duty station position prepared you for experiences during deployment or potential deployment. Provide comments as necessary below your rating.

- 0 - Duty station position did not prepare at all for deployment
- 1 - Duty station position was insufficient preparation for deployment
- 2 - Duty station position was partially sufficient preparation for deployment
- 3 - Duty station position was sufficient preparation for deployment
- 4 - Duty station position was more than sufficient in preparation for deployment

Comments

17. From the drop-down menu at right, rate how effective was your mobile medical team's ability to document trauma cases during deployment. If you have not deployed, rate how well your training has prepared you for documenting trauma cases. Provide comments as necessary below your rating.

- 0 - Team could not document trauma cases effectively at all
- 1 - Team could insufficiently document trauma cases
- 2 - Team could partially sufficiently document most trauma cases
- 3 - Team could sufficiently document most trauma cases
- 4 - Team could sufficiently document all trauma cases

Comments

Final Comments

18. If not already described in your responses to questions 9–13, please provide examples of how your training did or did not prepare you for deployment.

8

Mobile Medical Team Survey (cont'd)

19. Please provide any additional information you would like for us to know about the training and preparation you had prior to deploying on a mobile medical team, as well as any information you would like to provide about your experience during deployment. Are there any areas of improvement specific to mobile medical teams and training that you recommend?

20. If you deployed to an AOR other than USINDOPACOM and/or USAFRICOM as part of a mobile medical team, please provide any relevant information about those deployments.

| 9

Management Comments

Joint Staff Surgeon

THE JOINT STAFF
WASHINGTON, DC

30 April 2020

MEMORANDUM FOR: Department of Defense Office of the Inspector General (DoD OIG)

FROM: Joint Staff Surgeon (JSS)

SUBJECT: Office of the Joint Staff Surgeon (OJSS) response to DoD OIG recommendations in report Project No. D2019-D000RJ-0143.000.

1. The DoD OIG made six recommendations in Project No. D2019-D000RJ-0143.000: Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility.

2. Recommendation #3 of the report states, "The Joint Staff Surgeon, Joint Chiefs of Staff, in coordination with the Command Surgeon from each Geographic Combatant Command (GCC), should define the tactical theater entry requirements for mobile medical team personnel."

3. The 19 Dec 19 DoD policy memo[1] states that the authority and responsibility for determining theater entry training requirements resides with the Services in coordination with the CCMDs and the Office of the Secretary of Defense. The OJSS recommends that these requirements should be informed by ongoing work by the Joint Trauma System leveraging work collected over the past 10 years to develop evidence-based recommendations.

   a. The Memo stipulated that the planning and conduct of pre-deployment training for Service members and units, a statutory function of the Military Departments as Force Providers, shall be the responsibility of the Military Departments.

   b. GCCs may recommend unit training requirements they believe will promote success. However, the Force Providers are ultimately responsible for the training and readiness requirements of their units.

4. My point of contact for this memorandum is [redacted]

PAUL FRIEDRICHS
Brigadier General, MC, USAF
Joint Staff Surgeon

[1] Secretary of Defense Memorandum (Dec 19 2019) "Military Service Pre-deployment Training in Support of Geographic Combatant Commander Theater-entry Requirements"

Army Surgeon General

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042-5140

DASG-CS

22 APR 2020

MEMORANDUM FOR Department of Defense Inspector General, Audit Readiness and Global Operations, ATTN: [redacted] 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Reply to DODIG Draft Report, Audit of Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility (Project No. D2019-D000RJ-0143.000)

1. Thank you for the opportunity to review this draft report.

2. Our comments are enclosed for your consideration.

3. Our point of contact is [redacted] Internal Review and Audit Compliance Office, [redacted] or email: [redacted]

FOR THE SURGEON GENERAL:

Encl

RICHARD R. BEAUCHEMIN
Chief of Staff

Army Surgeon General (cont'd)

U.S. Army Medical Command (MEDCOM) and
Office of the Surgeon General (OTSG)

Comments on DODIG Draft Report
Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and
U.S. Africa Command Areas of Responsibility
(Project No. D2019-D000RJ-0143.000)

RECOMMENDATION 2: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force issue guidance implementing the Joint Trauma Education and Training Branch's standardized training program for all mobile medical teams.

RESPONSE: Concur. When guidance is approved and issued by the Joint Trauma Education and Training Branch, The Surgeon General will take action to ensure a timely rollout and implement as directed. Until then, existing Service guidance will be followed and updated as needed to ensure combatant command requirements are met.

RECOMMENDATION 4: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force update training curriculums to train mobile medical team personnel in accordance with the tactical theater entry requirements identified by the geographic combatant commands.

RESPONSE: Non-concur. The Surgeon General is not the proponent for updating training curriculum relating to tactical readiness training as discussed in the report, including basic combat skills to shoot, move, communicate, navigate, and survive; training to operate a tactical weapons system; and night-vision training. Per HQDA EXORD 114-19 (attachment 1), the unit commander is responsible for developing and executing pre-deployment training. Therefore, updates to relevant tactical readiness training curriculum should be executed by unit commanders as part of the mission analysis process.

However, The Surgeon General will update medical training curriculum in accordance with Joint Staff Surgeon Office guidance which identifies requirements focused on areas which the medical training community can impact.

RECOMMENDATION 6: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force, in coordination with the Command Surgeons of the U.S. Indo-Pacific Command and U.S. Africa Command, require that all mobile medical team personnel individually complete standardized post-deployment after action reports, using the Joint Trauma System Performance Improvement Branch template, before redeploying to their home station, and submit them to the Joint Lessons Learned Information System for the purposes of the Lessons Learned program.

Encl

Army Surgeon General (cont'd)

RESPONSE: Non-concur. Army Regulation (AR) 11-33, Army Lessons Learned Program (ALLP), mandates the process used by Army units, including mobile medical teams, to submit lessons learned. The ALLP is a collaborative process involving many Army organizations at all levels of command, which ensures relevant knowledge is provided to the operational force at the right time within the Sustainable Readiness Model process.

The Surgeon General is not the proponent for AR 11-33 or the ALLP, and therefore cannot implement the recommendation. Recommended changes to the ALLP should be directed to the Department of the Army Deputy Chief of Staff, G-3/5/7 as the proponent for AR 11-33.

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Navy Surgeon General

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH VA 22042

IN REPLY REFER TO
April 26, 2020

MEMORANDUM FOR INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE

SUBJECT: Response To Report D2019-D000RJ-0143.000

Pursuant to the March 16, 2020 draft report, Audit of Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility, Navy Medicine concurs with the applicable recommendations (2, 4, and 6) and provides the following commentary and rationale for each:

Recommendation #2: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force issue guidance implementing the JTET Branch's standardized training program for all mobile medical teams:

Comment: Add, "… following Service review and acceptance of said program" at the end of the recommendation. Service guidance will be published after training program delivery.

Rationale: The standardized training program does not yet exist. Adding the above comment assures Service equity in program development, review and implementation.

Recommendation #4: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force update training curriculums to train mobile medical team personnel in accordance with the tactical theater entry requirements identified by the geographic combatant commands.

Comment: Reword to "… update training curriculums or processes to assure mobile medical team personnel receive training that fulfills tactical theater entry requirements … combatant commands once the area of operations is known." Service curriculum and/or processes will be updated to meet tactical theater entry requirements.

Rationale: (1) Services may utilize other than Service-specific training programs to fulfill this requirement; thus, this would be a training process update versus training curriculum update and (2) Tactical skills are specific to the theater, not the capability, so the training for these skills is typically completed "just in time" when the team is activated to deploy to a given area of operations.

Navy Surgeon General (cont'd)

Recommendation #6: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force, in coordination with the Command Surgeons of the U.S. Indo-Pacific Command and U.S. Africa Command, require that all mobile medical team personnel individually complete standardized post-deployment after action reports, using the Joint Trauma System Performance Improvement Branch template, before redeploying to their home station, and submit them to the Joint Lessons Learned Information System for the purposes of the Lessons Learned program.

Comment: Concur as written. Service policy will be updated to match standardized post-deployment after action report requirements following publication.

There are no Freedom of Information Act concerns associated with this draft report.

My point of contact for this effort is [redacted] who can be reached at [redacted] or [redacted]

M. P. MALANOSKI
Executive Director

Air Force Surgeon General

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

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL

FROM: HQ USAF/SG
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Air Force Response to DoD Office of Inspector General Draft Report, "Audit of Training of Mobile Medical Teams in the U.S. Africa Command and U.S. Indo-Pacific Command Areas of Responsibility" (Project No. D2019-D000RJ-0143.000)

1. This is the Department of the Air Force response to the DoDIG Draft Report, "Audit of Training of Mobile Medical Teams in the U.S. Africa Command and U.S. Indo-Pacific Command Areas of Responsibility" (ect No. D2019-D000RJ-0143.000). The Air Force Surgeon General (AF/SG) concurs with comment with the report as written and welcomes the opportunity to provide clarifying comments below.

2. The AF/SG, in coordination with Air Combat Command (ACC), will appropriately address issues identified in this report, and, as necessary, develop and implement a corrective action plan outlined in the following recommendations:

RECOMMENDATION 2: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force issue guidance implementing the Joint Trauma Education and Training Branch's standardized training program for all mobile medical teams.

AIR FORCE RESPONSE: Concur with comment. The Air Force Medical Service (AFMS) concurs that the DHA establishes standards to ensure those delivering trauma care have the knowledge, skills, and abilities to do so; are following established procedures (clinical practice guidelines); and are provided with the requisite experience, in-garrison, to be considered current. However, the AFMS does not agree with the interpretation that DHA will standardize unit type code (UTC) training platforms. The provision of specific unit type code training (Readiness Training) is a Service responsibility. In the Air Force, the management process for Unit Type Codes (UTCs) and responsibilities are outlined IAW AFI 10-401, Air Force Operations Planning and Execution.

ECD: N/A; Already implemented. AFMS teams are already following established clinical practice guidelines, and agreed upon joint standards of currency. The AFMS intends to retain service-specific UTC readiness training.

RECOMMENDATION 4: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force update training curriculums to train mobile medical team personnel in accordance with the tactical theater entry requirements identified by the geographic combatant commands.

AIR FORCE RESPONSE: Concur with comment. Tactical training to meet Combatant Commander Theater Entry Requirements is not specific to Mobile Medical Teams or to medical

Air Force Surgeon General (cont'd)

training in general. The AFMS provides training to all personnel tasked to deploy within a given theater of operations that is in accordance with that theater's requirements.

ECD: N/A; Already implemented. This is not specific to medical teams, and the AFMS provides up-to-date training to all personnel tasked to deploy IAW a given theater's requirements.

RECOMMENDATION 6: We recommend that the Surgeons General of the U.S. Army, Navy, and Air Force, in coordination with the Command Surgeons of the U.S. Indo-Pacific Command and U.S. Africa Command, require that all mobile medical team personnel individually complete standardized post-deployment after action reports, using the Joint Trauma System Performance Improvement Branch template, before redeploying to their home station, and submit them to the Joint Lessons Learned Information System for the purposes of the Lessons Learned program.

AIR FORCE RESPONSE: Concur without comment.

ECD: N/A; Already implemented. Post deployment AARs/lessons learned are already required.

MURPHY.SEA N.LEE. [redacted] Digitally signed by [redacted]

SEAN L. MURPHY
Major General, USAF, MC, FS
Deputy Surgeon General

Joint Trauma System

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

31 Mar 2020

JTS/JTET comments in response to Draft Report on Mobile Medical Teams in the US Indo-Pacific Command and US Africa Command AORs

Dear [redacted]

Thank you for providing the draft document for our review. Please accept the following comments in response to your findings, and our recommendations for the final report:

The JTS is in agreement with the IG's findings with respect to the relative ineffectiveness and lack of availability for standardized mobile medical team training prior to deployment, particularly with regard to surgical training and the lack of exposure to high acuity trauma cases performed in most military treatment facilities. The JTS recognizes that while some team based, environmental, and equipment training may be subjectively reported as effective by team members immediately after completing the training, the lack of standardized after-action reports following actual deployment makes the true effectiveness of this training unclear. The JTS further contends that the lack of standardized team training curricula creates teams with disparate abilities to carry out their missions. Combined with the significant variability in team member composition between and even within the Services, this lack of standardization could negatively impact the interoperability and exchangeability of mobile medical teams based on the particular Service providing the team, as well as the ability for the teams to fulfill their missions within the previously established "Golden Hour." The IG's finding that USINDOPACOM and USAFRICOM did not consistently identify the training and unique equipment requirements for the tactical conditions in their AORs further compounds this problem. Mobile medical teams serve as risk mitigation to line commanders, however it is impossible to know from a quantitative or qualitative perspective how effective these teams will be without a baseline standard for training. The JTS believes that this baseline standard for trauma training and sustainment must exist and supports current efforts underway by the Joint Knowledge, Skills, and Abilities Program Management Office (JKSA PMO) and the Military Strategic Partnership with the American College of Surgeons (MHSSPACS). These efforts are focused on the development of cognitive assessments, psychomotor skills training, and team based training programs toward achieving that end state. Additionally, the JTS strongly recognizes the need for thoughtful collaboration between military and civilian trauma systems, which likely could benefit from expansion beyond the myriad of currently uncoordinated and unstandardized military-civilian partnerships into more integrated health care delivery "learning trauma" systems (NDAA 17 Sec 706, National Academy of Science, Engineering, and Medicine report, "Zero Preventable Deaths," 2016).

Additionally, while the JTS and JTET agree in principle with Recommendation 1, the JTET is currently not resourced or manned to meet this recommendation. The IG correctly ascertained that the IOC of the JTET occurred in March 2019, however, to date it has been largely manned with active duty "volunteers" who have taken on their JTET roles as additional duties. Furthermore, the JTET has had no funding specifically allocated to its contractor positions, which have been "borrowed" from the JTS to meet the most basic of JTET functional responsibilities as outlined in NDAA 17 Sec 708. The lack of consistent funding and subsequent job instability inherent in these positions have led to significant contractor turnover, which has significantly limited the JTET's effectiveness. Additionally, the JTET has relied on the

Joint Trauma System (cont'd)

JKSA PMO, the MHSSPACS, and the Defense Medical Readiness Training Institute (DMRTI) for its training standardization efforts. The IG report's finding on page 23 that the JTET has "developed...five standardized medical training courses" is factually incorrect. In fact, the JTET itself has developed no courses to date, and has no academic support personnel assigned to it to perform this function. Specifically, the Tactical Combat Casualty Course All Service Member course was developed by a Health Affairs chartered Tri-Service working group chaired by the former chief of DMRTI, at that time under DHA J-7, and funded by DHA J-9 Research and Development dollars under the Leadership, Strategy, Tactics, and Technology Program. The Combat Casualty Care Course (C4) has existed since the 1980's and is also managed by the DMRTI, as is the Emergency War Surgery Course. The Trauma Nurse Core Course, administered as a stand-alone course as well as in conjunction with C4, is owned and maintained by the Emergency Nurses Association (ENA). Similarly, the Advanced Trauma Life Support Course is owned by the American College of Surgeons (ACS). In order for the JTET to develop curricula and build courses, including the other three undeveloped courses mentioned in the IG report, it would need a full academic support branch, which is likely unnecessary. Instead, a more cost effective approach that would eliminate redundancy may be possible if, working closely with the JTS Process Improvement Branch, the JTET were to instead focus on establishing baseline training standards. The JTS already has effective processes in place to collect, analyze, and process theater injury data, which it then uses to formulate Clinical Practice Guidelines which serve as the basis for the JKSA's. DHA Combatant Command liaisons can further aid the JTET in identifying training gaps in peace time, and Combatant Command Trauma Systems can be rapidly stood up similar to the CENTCOM Joint Theater Trauma System (JTTS, Operation Iraqi Freedom, 2003) in times of conflict. In fact, it was the original JTTS in CENTCOM that led to the formation of the current JTS. The JTS/JTET could then work with other DOD sister organizations with already in-place academic support functions such as the Uniformed Services University, the Medical Education and Training Campus, and other professional societies such as the ACS to design, build, implement, and validate specific courses to meet evolving theater requirements. The JTS, with the input of its Defense Committees on Trauma, could then exercise its role as the final reference body for the Department of Defense Trauma Enterprise in accordance with NDAA 17 Sec 707 by serving as the final endorsement authority for all courses, regardless of their origin, based on the standards previously set forth by the JTET.

Finally, the JTET has only very recently assumed primary responsibility for military-civilian partnerships, with plans to establish a DHA sponsored tri-service working group aimed at addressing key elements for entry criteria based on ACS soon to be published standards (the "blue book") and strategies for measuring partnership effectiveness. Pilot programs are currently being designed to look at military civilian integrated trauma networks as directed by NDAA 20 Sec 743. ***The IG could significantly aid the JTS/JTET by expanding its recommendation 1 to include their immediate and full funding so that they can meet the functional requirements assigned to them in the NDAA, the JROCM's, and DOD policies referenced in the IG report.***

Suggested change to recommendation 1:

We recommend that the Chief of the Joint Trauma Education and Training Branch continue efforts to standardize mobile medical team training and sustainment, including collaboration with government and civilian partners to develop courses that achieve that end. We also recommend that the JTET, in coordination with the MHSSPACS, develop baseline criteria for military-civilian trauma partnerships and develop strategies to effectively measure the success of these partnerships in achieving a ready medical

2

Joint Trauma System (cont'd)

force. The DHA should take immediate steps to fully resource previously approved manning requirements and funding increases to the JTS/JTET that will enable it to accomplish these directives in accordance with the Fiscal Year 2017 National Defense Authorization Act and Joint Requirements Oversight Council Memorandum 125-17.

The JTS fully supports Recommendation 5 as written. Furthermore, the JTS will continue to develop work products that support the Services in their Title X responsibilities and that align with its plans to refine and expand the DOD Trauma and other registries.

Respectfully submitted,

Michael T. Charlton, Col, USAF, MC, FS
Chief, Strategic Plans and Operations/Military-Civilian Partnerships
Joint Trauma System

2

Joint Trauma System Performance Improvement Branch

7 April 2020

MEMORANDUM for: DoD Office of the Inspector General
SUBJECT: Response to "Audit of Training of Mobile Medical Teams in the U.S. Indo-Pacific Command and U.S. Africa Command Areas of Responsibility) Project No. D2019-D000RJ-0143.000

In response to recommendation number 5: "*the Military Department Surgeons General, in coordination with the USINDOPACOM and USAFRICOM Command Surgeons, should require all mobile medical team personnel to complete the standardized postdeployment AAR before redeploying to their home station, and submit them to the Joint Lessons Learned Information System (JLLIS) (Recommendations 5 and 6).*"

The JTS Performance Improvement team agrees with the Recommendation above, and is actively addressing the need for a standardized Role 2 After Action Report (AAR) to upload to JLLIS. To achieve a comprehensive tool, we will align the AAR with the Role 2 Readiness Report that was approved by the JTS Committee for Surgical Combat Casualty Care (CoSCCC). This tool will eventually be used to validate team readiness prior to deployment, and the AAR to evaluate the effectiveness of the pre-deployment training to achieve readiness. We have a draft AAR that will be converted into a DOTMLPF-P format to align with the DHA Joint Lessons Learned Program required by the Chair of the Joint Chiefs of Staff Instruction CJCSI 3150.25G. The Joint Lessons Learned Information System module for the JTS has been established and will be populated with the R2 AAR data and reports will be generated to evaluate adherence to best practices. The estimated completion of the draft R2 AAR will be 1 August 2020, and interim pilot testing with re-deploying teams will be conducted.

Please let me know if you have further questions or would like additional clarification.

Best regards-
[redacted]

MANNSALINAS.ELIZABETH.ABBEY.[redacted] Digitally signed by [redacted]

Elizabeth Mann-Salinas, PhD, RN, FCCM, (Ret), US Army
Performance Improvement Lead
Contractor, STS Systems Support (SSS)
Joint Trauma System: A Defense Center of Excellence (CoE) DHA AD Combat Support
3698 Chambers Pass
Fort Sam Houston, TX 78234-6315
Office: [redacted]
Cell: [redacted]

Acronyms and Abbreviations

AAR	After Action Report
AOR	Area of Responsibility
DHA	Defense Health Agency
ERSS	Expeditionary Resuscitative Surgical System
ERST	Expeditionary Resuscitative Surgical Team
GST	Ground Surgical Team
JLLIS	Joint Lessons Learned Information System
JTS	Joint Trauma System
JTS PI	Joint Trauma System Performance Improvement
JTET	Joint Trauma Education and Training
MTF	Military Medical Treatment Facility
NDAA	National Defense Authorization Act
USAFRICOM	U.S. Africa Command
USINDOPACOM	U.S. Indo-Pacific Command

Glossary

Active Duty Conventional Forces. Forces (Army, Navy, and Air Force), other than designated special operations forces, on full-time duty in the active military service of the United States.

Austere. Living conditions or a way of life with no comforts or luxuries. Conditions of limited personnel and equipment resources.

Damage Control Resuscitation. Non-surgical capabilities such as whole blood transfusions and advanced airway care.

Damage Control Surgery. A critical and essential capability for hemorrhage control in order to decrease preventable deaths.

Enable Forward Military Operations. Use in support of geographically dispersed operations. Whatever the mission set, mobile medical teams provide operational flexibility for commanders to conduct forward operations with the support of an advanced medical capability for a limited number of patients.

Forward Resuscitative Care. Care provided as close to the point of injury as possible based on current operational requirements to attain stabilization, achieve the most efficient use of lifesaving and limb-saving medical treatment, and provide essential care so the patient can tolerate evacuation, which is known as Role 2 care in NATO doctrine.

Future Years Defense Program. An annually compiled program and financial plan for the DoD, containing an annual budget and a 5-year plan for cost data, manpower, and force structure.

Intra-theater. Within the theater of a combatant command; for the purposes of this report, refers to patient evacuation.

Level I Trauma Center. A Level I trauma center is a comprehensive regional resource that is a specialized medical care facility central to the trauma system and is capable of providing total care for every aspect of injury from prevention through rehabilitation.

Level II Trauma Center. A Level II trauma center is capable of starting care for injured patients, and either supplements a nearby Level I trauma center or serves as the lead trauma facility in less populated areas.

Level III Trauma Center. A Level III trauma center is capable of surgery, resuscitation, and stabilization of injured patients, and patients may need to be transferred to a Level I or Level II trauma center for additional care.

Live Tissue Training. Live tissue training describes the use of anesthetized animals for medical education and training.

Military Medical Treatment Facility. A facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

Point of injury. The geographic location where the injury occurred. Role 1 medical care begins at the point of injury.

Program of Record. A program of record is a directed, funded effort recorded in the Future Years Defense Program and is a line item of record in the budget.

Standardization. The process by which the DoD achieves closest practicable cooperation and maximum efficiency among the Military Departments through broad adoption of procedures, criteria, resources, and tactical doctrine with corresponding organizational capability.

Tactical Combat Casualty Care. A set of trauma management guidelines customized for use in the operational setting that maintains a focus on the most common causes of preventable deaths resulting from combat.

Tactical Level. The planning and execution of activities to achieve military objectives, to include combat.

Trauma Injuries. This report uses the term injuries to describe physical trauma that can be caused by either blunt force trauma or penetrating trauma. Blunt force trauma occurs when an object or force strikes the body, often causing concussions, deep cuts, or broken bones. Penetrating trauma occurs when an objective pierces the skin or body, usually creating an open wound.

Traumatologist. A physician specializing in the treatment of severe, acute physical trauma injuries sustained by individuals requiring immediate medical attention.


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