A STUDY TO DEVELOP

A CONCEPTUAL OUTLINE OF AN INTEGRATED CONUS MEDICAL MOBILIZATION PLAN

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Lieutenant Commander William F. Lorenzen, MSC, USN

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This study was performed as an objective endeavor to develop a conceptual outline for an integrated CONUS Medical Mobilization Plan from the perspective of the Joint Chiefs of Staff.

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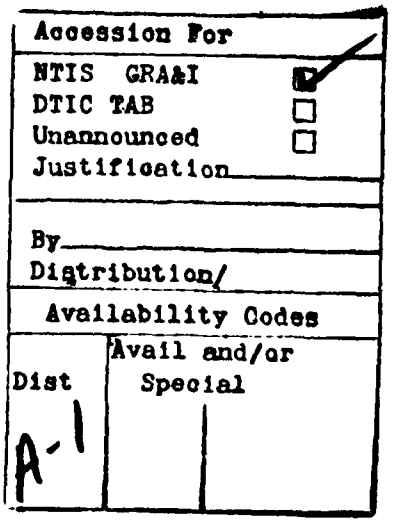


A Conceptual Outline of An Integrated CONUS Medical Mobilization Plan

Chapter I. Introduction

The inability of the military services to medically support military contingency operations has been known since a major Pentagon exercise in 1978.[1] The "Long Commission Report", which investigated the circumstances surrounding the treatment of United States Casualties in the Beirut bombing of 1982, accentuated public awareness of this critical problem.

In spite of numerous studies, heightened awareness, laudable tri-service cooperation, and increased spending there are still significant medical readiness deficits. On May 1, 1984, Assistant Secretary of Defense for Health Affairs, William Mayer, M.D., explained:

> Our wartime scenarios have predicted that, if a full scale conventional conflict broke out in Europe tomorrow, we would have sufficient medical capability to provide initial surgery for only 20 percent of the estimated casualties. . . . We are woefully short of deployable equipment and material that we do have is old and obsolete. We are still faced with critical shortages of key medical personnel who would be needed in wartime, most notably surgeons and nurses. . .[2]

The Congress has also repeatedly expressed concerns about the capability of the military services to medically support military

contingencies. Concerns range from care on the battlefield to definitive health care of casualties in the United States. The House of Representatives Appropriations Committee Report in 1985 explicitly stated why medical mobilization was receiving, and must continue to receive, emphasis:

> A trained, ready and prepared military medical system is a top priority item in any discussion of readiness of our military system. Without a means to care for our fighting forces, the United States loses its credibility with the American people, our adversaries, the military commander, and most importantly, the troops themselves.[3]

The House Armed Services Committee Report on the National Defense Authorization Act for Fiscal Year 1987 directed the Department of Defense to develop an integrated master plan for curing the ills of the wartime medical readiness system by the end of Fiscal Year 1992. On April 8, 1987, the Assistant Secretary of Defense for Health Affairs submitted to the Committee an initial draft of the Medical Readiness Strategic Plan (MRSP) which documented the Department of Defense's objectives for ensuring improved medical readiness. Included in the Medical Readiness Objectives for 1992 was the provision of health care in the Continental United States (CONUS) under a single set of policies and procedures to ensure the effective utilization of high-demand health care resources during wartime.[4]

Conditions Which Prompted the Study

Today, the Military Departments plan to operate their own

health care delivery and training systems upon mobilization. The priority for all resources is the theater of operations. This creates critical shortages in some categories of manpower and supplies in CONUS. Management of shortages is accomplished with the individual Services. Cross-Service sharing in CONUS has not been planned. Supplies are issued on a first-come, first-served basis within the existing priority structure. New manpower is allocated based upon definition of requirements of each service. Statements of military health care needs for mobilization are delineated by Service. One composite listing of needs by priority does not exist. Therefore, the Department of Defense cannot present a clear statement of aggregate health care needs in CONUS during mobilization.

Project Statement

The objective of this endeavor was to develop a conceptual outline for an integrated CONUS medical mobilization plan from the perspective of the Joint Chiefs of Staff.

Objectives

The objectives determined necessary to complete this project were as follows:

1. To identify those components of the outline plan considered by the Assistant Secretary of Defense for Health Affairs and the Joint Chiefs of Staff to be critical to CONUS

Medical Mobilization.

2. To develop a complete historical perspective on the problems encountered in developing the outline for an integrated CONUS medical mobilization plan.

3. To present the outline plan to the Joint Chiefs of Staff, achieve their approval, and commence full plan development.

Criteria

The development of any plan, particularly operational or mobilization plans is by nature, an iterative process. As such, no plan is truly complete. Futhermore, due to the highly subjective nature of this project, objective, quantifiable criteria indicative of successful plan implementation could not be obtained. However, the goal of this research project was to produce a realistic solution to an actual problem, that is - to develop a conceptual framework for an integrated CONUS medical mobilization plan outline. Therefore, for purposes of this project report, the outline is considered "completed" upon approval by the Joint Chiefs of Staff with direction for implementation of the full CONUS Medical Mobilization Plan development.

Assumptions

No specific assumptions were made regarding the approach to this project. However, during the development phase, three assumptions were made which will be addressed in the body of the study.

Limitations

No specific limitations are delineated regarding the development of this project. However, the reader may find the use of abbreviations and certain military/technical terms a limitation to understanding. To assist the reader, and help remedy what might otherwise be perplexing, a glossary of abbreviations is presented at Appendix A.

Historical Background and A Review of the Literature

The problems that exist today with medical readiness are not new. They have existed for quite some time, and have been studied by the individual Services, the Department of Defense and numerous committees of The Congress. There appears to be a general lack of closure on recommendations or initiatives advanced in previous studies of the problems. For the purposes of this study 1977 was chosen as a beginning point for delineating a proper historical perspective. A more complete review of the chronological events surrounding medical mobilization is provided at Appendix B.

Regionalization of the medical departments of the three Services is seen as a solution to interservice medical cooperation and coordination. Historically, medical regionalization,formally termed the Armed Forces Regional Health Services System, was implemented in the Continental United States in 1973 and overseas

in 1975 as a result of the Assistant Secretary of Defense policy.[5] In an effort to formalize the concept of regionalization within the Department of Defense, a tri-service regionalization work group developed and submitted a draft directive on this subject in January 1983 for review and subsequent publication. Earlier unsuccessful attempts at drafting such a regulation had been made beginning in 1977. It is interesting to note that eleven years later (1988), this regulation has yet to be published, and yet another workgroup has been formed to produce another draft directive. In accordance with the earlier policy statement, there are presently nine Regional Review Committees established in CONUS. The are composed of Commanding Officers of Military Treatment Facilities (MTFs) and are responsible for the tri-service delivery of health care in each designated geographical region. They meet periodically to consider matters of mutual interest and opportunities for cooperative improvement of health care delivery.

Among the problems associated with the present regionalization structure is that historically and currently, it has been a peacetime "coordination" activity organized into geographic regions which do not equate to other Federal Regions involved with health care or emergency preparedness in the United States such as the Department of Health and Human Service and Federal Emergency Management Agency Regions. Additionally, the current Department of Defense regionalization structure has three organizations making independent decisions voluntarily, and on a selected basis,

cooperating in joint or shared ventures. To adequately address medical mobilization, the structure would have to be realigned within an appropriate military organization - one that could integrate capabilities, and be given the authority to provide unified command, control and communications through a deliberate planning process.

The United State Senate Subcommittee on Manpower and Personnel held hearings on May 5, 1982 and May 26, 1982. During those hearings, the Subcommittee received testimony that the Department of Defense could provide emergency surgical care for only one casualty in ten who would need such care if a NATO/Warsaw Pact conflict were to occur at that point in time.[6]

In response to this testimony, the Senate Armed Services Committee (SASC) directed the Secretary of Defense to study the feasibility and beneifits to be gained by creating a Defense Health Agency modeled after existing Defense agencies.[7]

As envisioned by the SASC, the mission of the Defense Health Agency would be to function as an overall, tri-service management element of the defense health services svstem to support the mission of the military departments and the unified and specified commands under all conditions of peace and war. The Defense Health Agency would ensure an operationally responsive, single management system for all defense health services in the United States during wartime, and thereby correct a prominent deficiency in the current management scheme.

The feasibility study was concluded in April 1983, and the

final "Report For the Secretary of Defense On the Feasibility and Benefits to Be Gained from Creating The Defense Health Agency" was published on August 26, 1983. The study confirmed that:

> The SASC's concerns with medical mobilization were valid,
>
> Medical mobilization is a critical national problem,
>
> Medical readiness would be improved if the Surgeons General focused on mobilization needs, and
>
> The creation of the Defense Health Agency proposed by the Senate Armed Services Committee was feasible.[8]

The Study Team's conclusions were opposed by the Military Departments and the Joint Chiefs of Staff. In their judgement:

> The SASC's concerns were not valid,
>
> Consolidation was not needed,
>
> The Defense Health Agency would create management problems, especially during mobilization, and
>
> The current coordinating mechanisms would accomplish the SASC's goals.[9]

In previous armed conflicts the defense establihsment has had sufficient time to expand the peace-time military medical system in CONUS to care for the combat casualties. A future armed conflict could begin with little warning and rapid conflict escalation, which would not allow for the normal "gearing-up" of the medical support structure. Recognizing this situation, in May 1982, the US Congress passed Public Law 97-174, Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations; 4 May 1982.[10]

Public Law 97-174 (38 USC 5011A) mandates the VA to support the military health system during and immediately after a period of war or national emergency as declared by the President or Congress. The intent of the legislation is to designate the VA medical system as the primary backup for the military. The law permits the VA to provide priority care to active duty members of the US Armed Forces over all VA beneficiaries except the veterans with service connected disabilities. The Act also authorizes the VA to contract for community beds and to transfer nonservice-connected in-patients to civilian hospitals so as to provide more available beds at VA Medical Centers.

The Administrator of Veterans Affairs activates the VA-DoD contingency hospital system in time of war or national emergency if requested by the Secretary of Defense.

In response to the mandate of PL 97-174, the VA established a task force of VA personnel with varied backgrounds and experience in health care administration, emergency preparedness and military health services. The task force also had a representative from the Office of ASD(HA). The task force was charged with coming up with a report that would provide non-directive assistance to officials of VA medical centers and medical distrcts to develop and implement contingency plans for caring for large numbers of casualties returning from an overseas conflict as required under the VA-DoD contingency hospital system. The report of this study provides an excellent description of the organizational structures, operational aspects, patient flow, communications,

supplies and transportation arrangements of the VA-DoD system.[11]

This report, completed in May 1982, was adopted as the VA contingency plan for VA-DoD in November 1982 and provides an excellent beginning. Of particular note are the following provisions:

> The plan requires the use of the ASMRO classifications to assess and report available beds, e.g., medical, psychiatric, general surgery, burn, neurosurgery, orthopedics. . ., spinal cord.
>
> This assessment of bed-availability gives a far more realistic availability of beds, staff and supplies than a general statement of the number of acute-care beds available.
>
> The plan calls for a 45-90 day stock level of medical supplies to be maintained at each Veterans Administration Medical center, in addition to the preassembled supplies maintained for local disaster mass casualty situations.
>
> The plan also provides for a potential use of civilian hospitals not participating in NDMS to care for those VA in-patients suffering from nonservice-connected conditions, thus freeing up more VA beds.

The VA-DoD contingency hospital system has made great progress over the past few years. In its report of December 1986, the VA notified the DoD that it can provide 17,000 beds within 72 hours of notification and a total of 32,500 beds within 30 days. The VA medical centers have identified medical personnel that have reserve obligations, and hence would not be available to the VA on mobilization. At the present, the VA medical centers have at most two weeks of medical supplies on hand. Additionally, the system has been successfully tested through participation in JCS exercises in April 1987.[12]

As noted earlier, there is no formal mobilization planning

process that incorporates all major sectors of the health care industry. Until 1980, when the DoD established the Civilian Military Contingency Hospital System (CMCHS), no sector of the civilian health care industry was included in any DoD medical mobilization plans.

Casualty estimates models and JCS exercises have demonstrated to the military medical planners that the existing DoD medical facilities would be inadequate to care for the large number of casualties from a conventional conflict in Europe. Today's medical care costs have made the maintenance and operation of a standing mass casualty capability impossible within the DoD.

Knowing that currently there is idle capacity in the civilian health sector, in 1980 DoD established the Civilian-military Contingency Hospital System(CMCHS). The CMCHS was developed on the concept that a cost-effective and rapid method of expanding DoD medical assets in wartime, would be to secure peacetime contract from private sector hospitals to guarantee a percentage of beds for military patients in war. These precommitted beds would serve as a backup to the VA-DoD hospital system in war. Although "hospital beds" were used as the unit of measure, the CMCHS contracted for beds, staff to care for the patients, supplies, and equipment. When CMCHS was discontinued on 1 January 1986, the original goal of 50,000 beds was exceeded by 13,323.[13] The basic concepts were not discarded along with the system; they are alive and well as carried over to the National Disaster Medical System (NDMS).

On December 17, 1981 the President established the Emergency Mobilization Preparedness Board (EMPB), and charged it to develop national policy and programs to improve emergency preparedness. Health program development was delegated to the Principal Working Group on Health (PWGH) chaired by the Assistant Secretary of Health and Human Services (HHS). Major members of the PWGH included: HHS/Public Health Service (PHS), DoD, VA, Health Care Financing Administration (HCFA) and the Federal Emergency Management Agency (FEMA).

Using the concept of CMCHS, the PWGH developed the National Disaster Medical System (NDMS) in response to the Present's mandate. The overall purpose of NDMS is to establish a single national medical response capability for: (1) Assisting state and local authorities in dealing with the medical and public health effects of major peacetime disasters; and, (2) providing support to the military medical system in caring for casualties resulting from overseas armed conflicts.

The NDMS is activated in three possible situations: first, when a disaster has overwhelmed the resources of a state and the governor requests assistance from FEMA resulting in Presidential activation of the system; second, when a national security incident which fills the DoD/VA beds results in the Secretary of Defense activating the system; and third, HHS/PHS activates the system directly. The three major components of the NDMS are:

1. A voluntary hospital system which will provide definitive care to disaster victims or military casualties.

2. Disaster Medical Assistance Teams (DMATs) which will be dispatched to a disaster site within the United States with necessary supplies and equipment from the country's major metropolitan areas.

3. Communication, transportation and patient regulation systems.

NDMS is organized on a regional/area concept with regard to both facilities and manpower. As of July, 1987, a total of 71 urban areas have been established with a mixture of VA and military coordinating center responsibilities. The goal of the NDMS is to have 100,000 precommitted beds to the NDMS program.[14] As of July 1988, approximately 1600 hospitals have committed over 112,000 beds to the NDMS program.[15] The NDMS is a logical extension of the CMCHS concept and has made significant progress, especially in the signing up of precommitted hospital beds, but many problems still remain primarily in the form of linkages to the existing military and VA-DoD sytems.

The Defense Authorization Act of 1986 directed the Secretary of Defense to submit a report containing a plan for revising the organizational structure of the military health care delivery system in order to streamline resource allocation, improve quality of care, reduce costs, and enhance medical readiness.[16] The report was to be prepared by the Assistant Secretary of Defense for Health Affairs. The Military Departments together with the Joint Chiefs of Staff, with input from the Unified Commands, were requested to conduct independent studies and prepare reports to be included in the report of the Secretary of Defense.

The Joint Chiefs of Staff input to the Report on the

Organization Structure of the Military Health Care Delivery System focused on areas relating to military medical readiness over which the Joint Chiefs of Staff had cognizance. The following comments summarize pertinent Unified Command comments regarding the issue of "Improving joint medical readiness planning within the Continental United States and overseas":

> "From the unified command perspective, standardization is the single most important issue that would improve medical readiness and planning. Standardization of planning factors, computer models, force structure, equipment methodology, doctrine, procedures, and reports is essential. . ."[17]
>
> ". . .a Joint Chiefs of Staff Surgeon could Coordinate nonwartime military mass casualty response planning and operations. He would serve as the staff interface for coordination with DoD, Department of State, other federal agencies, and unified commands. . ."[18]
>
> ". . .Joint medical readiness planning must be addressed within the context of joint planning throughout the entire defense organization. . ."[19]
>
> ". . .Develop a centralized control organization for medical readiness. . ."[20]
>
> ". . .In the day-to-day interface with our components and other unified commands, issues concerning joint techniques and procedures with the medical arena are often raised. . . .This multiplicity of players is difficult to assemble and orchestrate due to competition among thier own priorities. . ."[21]

The Joint Chiefs of Staff final report recommended that the role of the Organization of the Joint Chiefs of Staff (OJCS) in medical readiness matters should be strengthened, and Joint Chiefs of Staff functional responsibilities being assumed by the Assistant Secretary of Defense for Health Affairs because of

inadequate OJCS staffing should be returned to the OJCS.[22] The covering memorandum addressed to the Assistant Secretary of Defense for Health Affairs stated that:

> "The Joint Chiefs of Staff believe the structure for a responsive, professional, and practical system capable of achieving congressional goals designed to promote military medical readiness is in place today. Therefore, no substantial organizational or structural changes are required.
>
> Adjustments, changes, or fine tuning may be necessary.
>
> The Joint Chiefs of Staff oppose actions that might encroach on the ability of the Services and the CINCs to prepare balanced planning, programming, and budgeting for the materiel and manpower resources required to support strategic, logistic, and operational plans.[23]

The shortfalls and inadequacies persisted and drew further attention from the House Armed Services Committee in 1986. In their report, dated July 25, 1986, the committee noted that the Department of Defense and the Services had focused increased attention on medical readiness in recent years, yet much more remained to be done. They specifically stated that shortfalls and inadequacies continue in: manpower, equipment, logistics support, aeromedical evacuation, communications, joint planning, sharing of resources in peacetime, and wartime control of medical assets. In their report they noted that:

> "Although most agree that the medical readiness system is 'sick' agreeing on how to make the system 'well' is extremely difficult. One point on which agreement should exist, however, is that the Department of Defense must have an integrated master plan in which all of the component parts of medical readiness from all of the Services fit together to

> make the system 'well' during a certain timeframe. Unfortunately, such a master plan does not exist today. . .".[24]

Consequently, to answer the above, and to ensure that the medical system would meet the needs of the Department of Defense and the Services, the House Armed Services Committee directed the Secretary of Defense to develop an integrated master plan for curing the ills of the wartime medical readiness system by 1992.

The ASD(HA) reiterated the concerns of The Congress regarding the military medical readiness posture in his March 1986 memorandum for the Secretaries of the Military Departments and the Chairman of the Joint Chiefs of Staff. He noted that there was little coordination among the Services to determine:

> Utilization of facilities, installations, personel and equipment,
>
> Timing, location and anticipated numbers of mobilizing forces, and
>
> Plans for casualty distribution in the United States.

He went on the note that there were currently two DoD programs, the Veterans Administration/Department of Defense Resource Sharing and Emergency Operations Act, and the National Disaster Medical System which were designed to assist in hospitalizing military casualties, yet shared use of these programs among the Services required analysis and resolution. Additionally he surmised that there are policies which need to be

reviewed and agreed upon with regard to where returning casualties are hospitalized in the United States and the priority identification of which facilities require renovation or rebuilding based upon their mobilization/wartime missions. The memorandum further established the objective of producing a comprehensive, joint Service medical mobilization plan for the United States and directed the establishment of a study group to write that plan.[25]

The first draft of an Integrated CONUS Medical Mobilization Plan (ICMMP) was presented by the study group in October 1986. That plan recommended the establishment of a regionalization system in which specified medical treatment facility commanders within the nine Department of Defense Regions would exercise operational control over health care resources within their respective regions upon mobilization. The plan also allowed for a second echelon activity to control a regional area thereby allowing autonomous actions and a self supporting structure in case of a natural disaster or an attack on the continental United States. Provisions regarding medical mobilization stated that regional commanders would report to the Medical Readiness Policy Advisory Committee for matters that could not be resolved locally. [26]

The Joint Chiefs of Staff and the Services did not concur with the draft plan because of the proposed supervisory structure for CONUS medical support; the establishment of a CONUS Medical

Mobilization Office in the Office of the Assistant Secretary of Defense for Health Affairs; and the use of a committee structure for command and control.[27]

The study group forged ahead with a second draft of the ICMMP which was presented for Service staffing in March 1987. This second version provided the following recommendations:

> That a regional structure be established using the ten regional boundaries of the Federal Emergency Management Agency (FEMA).
>
> That the Services command authorities remain in place.
>
> That each Service establish a peacetime joint planning activity at both departmental and regional levels.
>
> That a joint planning activity, or Joint Health Service Planning Agency, with ten regional detachments be established which upon actual mobilization would become commands and exercise operational control over all military health care resources in CONUS, by region.[28]

The Joint Chiefs of Staff response to this version reflected the positions of each of the Services and the Unified and Specified Commands. In that response they stated the following specific objections:

> The proposed organization usurped the authority of the Chairman, Joint Chiefs of Staff, who by law was vested with the responsibility of strategic direction, contingency planning, and preparedness.
> The proposed regional structure compromised wartime control of medical assets by line commanders in that it usurped their authority to redistribute medical assets throughout their commands.

> That the "operational control" and the wartime "command and control structure" in the plan were different from existing peacetime structures.[29]

Concurrent with the evolution of the two versions of the ICMMP noted above, the Department of Defense was also in the process of developing the Medical Readiness Strategic Plan (MRSP). This plan was published in February 1988 and incorporated as one of the strategic action plans a provision pertaining to CONUS medical mobilization. The objectives of the CONUS Medical Mobilization Strategic Action Plan may be summarized as:

> The establishment of a Joint Service organization, responsive to the Office of the Joint Chiefs of Staff, to develop joint policies and procedures for the effective and efficient utilization of the health care resources of the military medical departments in CONUS, to facilitate coordination and utilization of health care resources of the Veterans Administration and the National Disaster Medical System in the event of a national security emergency, and to complete a detailed, integrated medical mobilization plan for the United States by June 1989.[30]

During staffing of the Medical Readiness Strategic Plan, and following the staffing of the second version of the Integrated CONUS Medical Mobilization Plan, the Joint Staff, in conjunction with the Assistant Secretary of Defense for Health Affairs and the Services created a subcommittee of the Medical Steering Committee. Under the auspices of the Medical Mobilization

Steering Committee a work group was formed to attempt development of an alternative to the ICMMP that would be agreeable to all concerned.

This work group provided its report to the Medical Mobilization Steering Committee on November 3, 1987 and recommended that:

> A central activity be established to serve as the focal point for medical mobilization planning and that regional liaison offices be established to assist in that planning.[31]

The Joint Chiefs of Staff met on December 23, 1987 to discuss the Medical Mobilization Steering Committee Report. Their decision resulted in the establishment of a Joint Medical Mobilization Office (JMMO) within the Joint Staff Directorate for Logistics (J-4), and provided further direction to establish a planning cell within the JMMO to:

> Develop an Integrated CONUS Medical Mobilization Plan outline,
>
> Determine CONUS regional input requirements and the most cost effective method of developing, implementing and maintaining regional plans,
>
> Verify JMMO staffing requirements,
>
> To activate a fully staffed JMMO and regional liaison activities upon approval of staffing, and,
>
> Produce the Integrated CONUS Medical Mobilization Plan and forward to the Services and the Assistant Secretary of Defense for Health Affairs.[32]

Endnotes

[1]Henry Mohr, "Will America Be Able to Treat Its Battlefield Wounded?" Heritage, Backgrounder, December 18, 1984, p. 2.

[2]U. S. Congress, House, Committee on Appropriations, Subcommittee on Defense, May 1, 1984.

[3]U. S. Congress, House, Committee on Appropriations, Department of Defense Appropriation for 1986, Committee Report #183-23, October 24, 1985, p. 90.

[4]The Department of Defense Medical Readiness Strategic Plan, Office of the Assistant Secretary of Defense (Health Affairs), February 1988, p. 6.

[5]Deputy Secretary of Defense Memorandum, "Regionalization of Peacetime Military Health Services Support," September 5, 1973.

[6]U. S. Congress, Senate, Subcommittee on Manpower and Personnel, Medical Activities, Hearings (Washington: U. S. Govt. Print. Off., 1982), p.776.

[7]U. S. Congress, Senate, Armed Services Committee, Department of Defense Authorization for Appropriations for 1982, (Washington: U. S. Govt Print. Off. 1982), p. 738.

[8]"Report for the Secretary of Defense on the Feasibility and Benefits to be Gained from Creating The Defense Health Agency," ASD(HA) Memorandum of Transmittal, September 20, 1983, p. 8.

[9]Chairman, Joint Chiefs of Staff, letter "Defense Health Agency Report," October 28, 1983.

[10]Public Law 97-174, 38 USC 5011, Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, May 4, 1982.

[11]"Report to Congress on the Veterans Administration Bed Capacity in Support of Department of Defense Contingency Planning," May 30, 1982, p. 22-25.

[12]Veterans Administration Contingency Operations Office Report, "Veterans Administration Bed Capacity in Support of Department of Defense Contingency Planning," December 14, 1986, p. 15-19.

[13]National Disaster Medical System, "Facts on the National Disaster Medical System," Rockville, MD, p. 1.

[14]Ibid, p. 2.

[15]National Disaster Medical System, Directorate Staff Memorandum, "NDMS Update", July 15, 1988, p. 2.

[16]U. S. Congress, Department of Defense Authorization for Appropriations, 1986, (Washington: U. S. Govt. Print. Off. 1986), p. 299-300.

[17]U. S. Commander-in-Chief, Atlantic, letter Ser: J3-475-87, of 2 April 1986, Subject: Organizational Structure of the Military Health Care System.

[18]U. S. Commander-in-Chief, Central Command, letter Ser: J-1-248-87, of 28 March 1986, Subject: Structure of the Military Health Care System.

[19]U. S. Commander-in-Chief, European Command, letter Ser: J1-126-87, of 4 April 1986, Subject: Organizational Structure of the Military Health Care System.

[20]U. S. Commander-in-Chief, Pacific, letter Ser: J3-478-87, of 3 April 1986, Subject: Organizational Structure of Military Health Care.

[21]U. S. Commander-in-Chief, Forces Command, Ser: J1-388-87, of 9 April 1986, Subject: Organizational Structure of the Military Health Care System.

[22]Joint Chiefs of Staff, "Report on the Organizational Structure of the Military Health Care System", 24 May 1986, Executive Summary, p. 2-3.

[23]Joint Chiefs of Staff Memorandum, JCS 1865/95-1, of 26 May 1986, Subject: "Report on the Organizational Structure of the Military Health Care System.

[24]U. S. Congress, House, Armed Service Committee, Report: Medical Readiness, (Washington: U. S. Govt. Print. Off., 1986), p. 202.

[25]Assistant Secretary of Defense (Health Affairs) Memorandum, Subject: Study Directive for the Integrated CONUS Medical Mobilization Plan, 25 March 1986.

[26]Office of the Assistant Secretary of Defense (Health Affairs), "Integrated CONUS Medical Mobilization Plan", October 1986.

[27]Vice Chairman, Joint Chiefs of Staff, Memorandum, VCJCS 1945/86-1 of 15 November 1986, Subject: First Draft of the Integrated CONUS Medical Mobilization Plan.

[28]Assistant Secretary of Defense (Health Affairs), "Integrated CONUS Medical Mobilization Plan", March 1987.

[29]Vice Chairman, Joint Chiefs of Staff, Memorandum, VCJCS 1249/87-1 of 2 May 1987, Subject: Integrated CONUS Medical Mobilization Plan".

[30]Office of the Assistant Secretary of Defense (Health Affairs), "The Department of Defense Medical Readiness Strategic Plan", February 1988, p. 45.

[31]Medical Mobilization Steering Committee Report, November 3, 1987, p. 18.

[32]Joint Chiefs of Staff, Memorandum for the Assistant Secretary of Defense (Health Affairs), JCSM-12-88, Subject: Medical Mobilization Steering Committee Report, Appendix B.

Chapter II. Discussion

This chapter relates the experiences of the actual development of an Integrated CONUS Medical Mobilization Plan Outline.

Organizational survival and prosperity necessitate the use of an integrated planning process wherein operating executives and managers "think strategically and act operationally."[1] Integrated planning among the military services, although achieved with difficulty due to Service parochialism, has been a hallmark of the overall military preparedness of the United States. Admiral William J. Crowe, Jr., at his swearing-in ceremony noted that the ". . . need for 'joint' operations, 'joint' thinking, and 'joint' leadership has never been greater as we meet the global challenges and in order to get the most out of our finite resources."[2]

In approaching the development phase of this study from an operators viewpoint a general direction was required to initiate further strategic thinking. This general direction was found in the basics of what was expected, what assumptions would be necessary to continue, what were the objectives to be, what analysis would be needed, and finally what structure would be used to accomplish the final development and implementation of an integrated CONUS medical mobilization plan. With these thoughts in mind, each was approached individually.

Expectations

Expectations in the military world, as in the civilian marketplace, can be equated to that of the mission of the organization. Briefly stated, that mission of the Joint Medical Mobilization Office, as stated succinctly by the Assistant Secretary of Defense for Health Affairs, and expanded upon by the Joint Chiefs of Staff is to:

> Assess medical assets identified for mobilization to assure adequate medical resources are available during all stages of war and monitor the implementation of medical capabilities in CONUS.[3,4]

Incorporated in the global mission statement above are several specific elements which require further refinement during the actual implementation phase. However, the mission statement being completed, the next step was then to derive any assumptions that would be made during the outline phase.

Assumptions

Three hypotheses were derived from an experiential base and from the guidance given by the Joint Chiefs noted in Chapter I, these are noted as:

> Medical [generically] should be treated the same as other combat service support functions

Existing organizational structures should be preserved and utilized

CONUS should be considered a theater of operations for planning purposes.

The first assumption, medical should be treated the same as other combat service support functions, is derived from the individual medical department position of each of the Services that medical is different, and requires separate logistics functions, separate equipment functions, separate personnel functions. It, medical, can almost be likened to a Service within a Service, and has resulted in many cases with a duplication of functions and requirements. This first assumption therefore, merely asks the question why this is so, and baring any cogent answer, states that it isn't so - we [medical] are no different than all the rest of those vitally necessary combat service support functions.

The second assumption, existing organizational structures should be preserved and utilized, evolves from the requirement to develop an organization that provides for the most cost effective means of efficiently and effectively utilizing the medical resources in CONUS. It stems also from the denial by the Services and the Joint Chiefs of Staff of those proposals which created a new and different organizational structure.

The third assumption, CONUS should be considered as a theater of operations for planning purposes, allows for the conceptual and actual planning framework for the purposes of Military Support to

Civil Defense and the Land Defense of CONUS. Both of these programs are well established and, in fact, have specific plans. However each of these programs does not incorporate the medical aspects. Additionally this assumption will allow for the addressal of resources specifically to support a theater from within the Services.

Objectives

The objectives were derived from the taskings, recommendations and reports of the various work groups that have been addressed previously and preceded this effort. The objectives are broadly grouped into the overall general categories of structure, planning, and coordination.

Structure refers to the specifc objective of utilizing existing structures which will achieve a more cost-effective program than creating new structures and organizational relationships. It also pertains to the concept of centralized guidance and review and decentralized planning and execution which is a hallmark of military organizations, and finally, it also refers to the maintenance of a system which incorporates a flexible response to a variety of contingency situations and levels of conflict/need.

Planning refers to the overall objective of producing an integrated CONUS medical mobilization plan which will be established in peacetime and facilitate a transition to war, and

also be responsive to national emergencies.

Coordination is that objective which is envisioned as the most difficult to achieve. It refers to the development of joint policies and procedures applicable to all the Services Medical Departments particularly in facilitating joint use of military medical resources (manpower, facilities, material and equipment) where appropriate, and incorporating the Veterans Administration and National Disaster Medical System programs fully into the response capability of the military.

Analysis

The analysis phase resulted in the completion of an exhaustive research of correspondence, directives, instructions, and publications to establish a firm foundation knowledge in the medical mobilization arena. A complete detailed review of this research may be found at Appendix C, however at this point I will merely summarize the cogent facts.

Several key directives and publications are pertinent to the issues at hand. Paramount among them is, the National Security Decision Directive (NSDD), Number 259 of 4 February 1987 which establishes the ground work for National Emergency Planning., This decision states that the civil defense program will provide the all hazard integrated emergency management system for CONUS. Based on this decision the Under Secretary of Defense for policy has called for a rewrite of all Department of Defense Directives

that pertain to emergency management. Included are DoD Directives 3025.1, the Use of Military Resources During Peacetime Civil Emergencies within the United States, Its Territories and Possessions, 3025.10, Military Support of Civil Defense (MSCD), and 5030.45, DoD Representation on Federal Emergency Management Agency (FEMA) Regional Preparedness Committees (RPCs) and Regional Field Boards (RFBs). Together these directives currently provide the policy guidance and DoD structure for the Services planning and response to specific scenarios. The importance of NSDD Number 259 is that these programs are now all tied together under one umbrella.

The DoD structure to meet the goals and objectives of these references is described in DoDD 3025.10. In this directive, the Joint Chiefs of Staff have overall responsibility for Military Support to Civil Defense and the Commander In Chief, Forces Command (CINCFOR) has been given the responsibility for planning and execution of that program. CINCFOR is required to decentralize the planning and execution to the Continental US Armies (CONUSAs) and State Area Commands (STARCs) to include proper coordination with other uniformed services.

Department of Defense Directive 5030.45 describes the system for military claims for civil resources during war or national emergency. The key to this system is the Continental US Armies. The CONUSAs will provide the DoD representation to the FEMA Regional Field Board, which is the resource allocation body within each federal region. The other Services will channel their

requests through the CONUSAs to the Regional Field Board. Decisions on resources not available within a region will be made on a national level. All Services have current implementing instructions that recognize the structures identified in these two directives and describe the individual Service implementation.

The analysis phase also pointed out that the Services currently have programs which call for the Military Support to Civil Defense and Disaster Preparedness. Army Regulations 500-60 and 500-70, Air Force Regulation 355-11, and Department of the Navy Instruction 3440.16A are all concerned with the military response to civil authorities for support during disaster situations and for military support to civil defense. In addition these directives utilize a consistent structure which is already established.

Structure

Central to this existing coordination structure, as noted above, is CINCFOR, flowing down to the CONUSAs and the STARCs. CINCFOR, a Specified Command of the Joint Chiefs of Staff, through regulation is tied both to the FEMA national Headquarters and the Principal Planning Agents of the Services. The CONUSAs are tied directly to the FEMA regions and to the Services' Regional Planning Agents. Underneath the CONUSAs are the STARCs which tie directly to the Service installations and to the State Offices of Emergency Serivces. It is interesting to note that research

pointed out that twenty-three of the State Offices of Emergency Services are collocated in the STARC for those states. A schematic representation of the coordination structure described above is noted as Appendix D.

Executive Order 11490 assigns FEMA the role of coordinator in the emergency preparedness of Federal Agencies and Departments. The cognizant agency for federal medical preparedness is the Dpeartment of Health and Human Services. It is envisioned that the JCS interface with FEMA and Health and Human Services for the purposes of identifying the military requirements for medical mobilization will the Joint Medical Mobilization Office. It will also be the focal point for interfacing national policy with the military and ensuring that all plans developed by HHS meet the needs of DoD. Executive Order 12656, replacing Executive Order 11490, was signed by the President in late 1988 and strengthens the responsibilities of FEMA and other Federal Agencies in national emergency preparedness planning.

As described, both a military and civilian structure exists for both planning and resource claimancy. Although the military structure exists, no resources have been allocated to perform the medical mobilization planning mission. The military structure is the Joint Chiefs of Staff, to CINCFOR, a Specified Command, to the CONUSAs and subsequently to the STARCs. The civilian structure rests with FEMA and the State Offices of Emergency Services. The coordination and support channels between all active participants is already established and operational.

The implementation of this structure for medical mobilization is straightforward and requires minimal resources with no substantial organizational or structural changes. Through CINCFOR and the CONUSAs current mission of Military Support of Civil Defense and their attendant role in mobilization, the framework, without resources, exists to institute the planning and implementation methodology within an existing network. Two items were needed to formalize the placement of the medical mobilization mission under CINCFOR's responsibility: a clear tasking, and the resources to perform that tasking.

The tasking requires a change to ANNEX N of the Joint Strategic Capabilities Plan which would designate the Joint Medical Mobiliation Office as the focal point for Integrated CONUS Medical Mobilization Planning and incorporation of the utilization of the VA and NDMS. Additionally the change would task CINCFOR with planning, coordination, and implementation responsibilities to incorporate integrated CONUS medical mobilization planning into the Joint Command Readiness Program, and require the delegation of regional planning, coordination and execution responsibilities to the CONUSAs, calling for the integration of the individual Services' Medical Mobilization Plans.

The resources to perform the new taskings noted above at the JCS, CINCFOR, and CONUSA levels is achieved through an assessment of the functions required to develop, implement and maintain a plan. A complete detailed listing of the functions required is noted at Appendix E. The JCS staffing level is an issue which is

solely the purview of the Director of the Joint Staff. As noted in the Background, the Joint Medical Mobilization Office has been created by the Joint Chiefs of Staff. The decision to resource that office resulted in the provision of a total of seven officers and one civilian. The Joint Medical Mobilization Office is required within the Joint Staff to make the structure operational. It will provide liaison on the national level with DoD, Federal, and civilian agencies, such as the US Transportation Command, Department of Transportation, FEMA, VA HHS/PHS, and the NDMS. Additionally, this office will provide guidance to CINCFOR for developing the integrated CONUS medical mobilization plan; serve as a focal point for Joint Staff coordination; and review Joint Service resource capabilities to perform the medical mobilization mission within CONUS.

The functions noted at Appendix E, though similar, are not redundant to the regional functions of CINCFOR. It is also important to note that none of the assigned functions shall infringe on the prerogatives of the Military Departments/Services or on their assigned responsibilities to provide independent logistical support to their Forces.

The manpower resource decision of the Joint Chiefs of Staff resulted in the provision of three medical planning officers and one civilian at CINCFOR and at each of the CONUSAs.

Chapter III. Conclusions

This project, to have successfully achieved it purpose, was required to fulfill the three objectives stated earlier, and to present a conceptual outline for an integrated CONUS medical mobilization plan.

The components of the outline plan were shown to be both complex and convoluted from the perspective of the depth and breadth of the impact of these components on the Services, other federal agencies and civilian organizations. Achieving commonality of goal among the Services is a difficult endeavor at best. To also incorporate the requirements of other federal agencies such as the Veterans Administration, the Department of Health and Human Services, and the Federal Emergency Management Agency, with their ingrained politically directed decision making processes, merely compounds the difficultness of the task at hand. However, to produce an outline plan which addressed the Department of Defense as a single entity would not achieve the goal. Mobilization and specifically medical mobilization is more than the Department of Defense component. It incorporates all the nation's resources toward a common goal of national response to an emergency.

The historical perspective of creating the outline plan demonstrated both the issues that had been previously addressed, and the methodologies tried with which fault had been found for various reasons. The exhaustive historical research resulted in

the ability to focus on central issues in a manner which had not been attempted previously, and to avoid those pitfalls which had caused others to fail.

The final objective, and perhaps the most telling, was that of actual presentation of an outline plan to the Joint Chiefs of Staff, achieving their approval, and commencing full plan development. The outline plan, comprised of the structure, resources to implement the structure, and specific functions to be carried out by the structure have been presented in this project. On September 30, 1988, the Joint Chiefs of Staff approved this conceptual outline and directed full development of the integrated CONUS medical mobilization plan once full staffing was achieved.

This project is therefore considered to have met the criteria established for successful completion. However, as noted earlier, the development of any plan is an iterative process and can never truly be completed. This has been found to be true as the actual plan development phase was entered into. The basic tenets of the outline have not been found to be at fault, but the depth and breadth of the various facets of the plan have continued to grow and form additional aspects.

Endnotes

[1]Below, Patrick J., Morrisey, George L., and Acomb, Betty L. The Executive Guide to Strategic Planning. Josey - Bass, San Francisco, 1987. p. xvi.

[2]Admiral William J. Crowe, Jr., USN, Remarks at his swearing-in ceremony as Chairman, Joint Chiefs of Staff, September 30, 1985.

[3]Office of the Assistant Secretary of Defense (Health Affairs), "The Department of Defense Medical Readiness Strategic Plan", February 1988, p. 10.

[4]Joint Chiefs of Staff, JCSM-12-88, of 16 January 1988, Subject: Medical Mobilization Steering Committee Report, Appendix B.

APPENDIX A

ACRONYMS

AFR	Air Force Regulation
AFRHSS	Armed Forces Regional Health Services System
AR	Army Regulation
ASD	Assistant Secretary of Defense
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASMMO	Armed Services Medical Mobilization Office
CHAMPUS	Civilian Hedalth and Medical Program of the Uniformed Services
CINC	Commander-in-Chief
CJCS	Chairman, Joint Chiefs of Staff
CMCHS	Civilian-Military Contingency Hospital System
CONUS	Continental United States
CONUSA	Continental United States Army, becomes a JRDC upon mobilization
DDMM	Deputy Director for Medical Mobilization, Joint Staff
DG	Defense Guidance within the PPBS
DHA	Defense Health Agency
DHC	DOD Health Council
DOD	Department of Defense
DRB	Defense Resources Board
EMPB	Emergency Mobilization Preparedness Board
FEMA	Federal Emergency Managment Agency
FORSCOM	U. S. Army Forces Command
HEW	Department of Health, Education and Welfare
HHS	Department of Health and Human Services
ICMMP	Integrated CONUS Medical Mobilization Plan
JCS	Joint Chiefs of Staff, supported by the Joint Staff
JHSPA	Joint Health Services Planning Agency
JMMO	Joint Medical Mobilization Office
JRDC	Joint Regional Defense Command
JSAC	Joint State Area Command
JSCP	Joint Strategic Capabilities Plan
JSPD	Joint Strategic Planning Document
J-4	Logistics Directorate, Joint Staff
MHCS	Military Health Care System
MHHS	Military Health Services System
MMSC	Medical Mobilization Steering Committee
MRSP	Medical Readiness Strategic Plan
MSCD	Military Support to Civil Defense
MTF	Medical Treatment Facility
NCA	National Command Authority
NDMS	National Disaster Medical System
NSC	National Security Council
OASD(HA)	Office of the Assistant Secretary of Defense Health Affairs
OCONUS	Outside the Continental United States
OPCON	Operational Control
OSD	Office of the Secretary of Defense

PPBS	Programming, Planning and Budgeting System
PWGH	Principal Working Group on Health
SASC	Senate Armed Services Committee
SECDEF	Secretary of Defense
SG	Surgeon General
STARC	State Area Command, becomes a JSAC upon mobilization
VA	Veterans Administration

APPENDIX B

CHRONOLOGY OF EVENTS IN MEDICAL MOBILIZATION

FEB 1955 — The second Hoover Commission considered military health care as part of its study of federal organization. This study recommended that medical and hospital services be modified into a much more closely coordinated pattern; that the government develop a voluntary contributory plan of medical care and hospital insurance for dependents.

1956 — Responding to Hoover Commission and DOD recommendations, Congress enacted what was to be later known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

1958 — Under a Presidential directive, Dr. Fred Collier, of the University of Michigan, conducted a study to evaluate the notion of a single manager for health. He concluded that there was no real problem, that coordination had achieved much and would continue to be suitable, and that the Military Departments could overcome their personnel problems and maintain the quality of care with a residency system with the medical centers of University caliber, that were then in operation.

1966 — Congress expanded the CHAMPUS to cover retiered personnel and their dependents and the dependents of deceased personnel. Other services were added and payment mechanisms were established to induce beneficiaries to use military facilities whenever possible.

By extending to beneficiaries a right to health care instead of just a space-available opportunity, Congress created a new mission for the Military Health Care System, i.e., providing health care for beneficiaries. This additional mission competes for resources with the primary mission of providing medical support to military forces in combat.

1970 — A Presidential Blue Ribbon Panel recommended the establishment of an Office Director of Defense Medicine and Health that would be repsonsible for eliminating waste, duplication, and redundancy by reviewing and approving budgets and manpower for all DOD health programs, and by consolidation all programs for research, supply and equipment, professional services, intelligence, construction, and other matters. The Panel's recommendations included decisive authority for the Director in areas pertaining to consolidation. No action was taken on the recommendations.

1971 U.S. Comptroller General examined the CHAMPUS program and determined that the organizational structure (executive agent delegated to Surgeon General (SG) was too cumbersome; that policy decisions were not implemented in a timely manner; and occasionally lost their original intent as they were transmitted through the intermediate agencies.

JUL 1972 The Secretary of Defense (SECDEF) discontinued the executive agent arrangement of CHAMPUS, and responsibility was given to the Assistant Secretary of Defense - Health Affairs (ASD)(HA)).

SEP 1973 The Deputy Secretary of Defense issued a memorandum directing coordinated tri-service implementation of an Armed Forces Regioonal Health Srvice System (AFRHSS) in CONUS and overseas for the purpose of improving the delivery of health care to DOD beneficiaries and patient referral techniques. Tri-Service Regional Coordinating Committees were formed to achieve economies in resource utilization and to improve productivity.

DEC 1975 A study of the Military Health Care System (MHCS) jointly conducted by the Office of Managment and Budget, DOD, and the Department of Health Education and Welfare (HEW), was undertaken as a result of concern about anticipated physician shortages with the end of the draft; quality of system planning, management and evaluation; and increasing overhead and support cosats throughout the DOD. The report of the study recommended that a central entity within DOD be establsihed to manage the DOD medical regionalization concept. This entity, the DOD Health Council (DHC) would serve as a coordinating mechanism for planning and allocating resources for health care delivery within CONUS and overseas.

DEC 1976 DHC, chaired by ASD(HA), was established by the Secretary of Defense. The council was established to meet need for a central entity within DOD to serve as the coordinating body for health care delivery in CONUS, including CHAMPUS. the council was to advise ASD(HA) on DOD health matters by providing a forum for consultation, discussion, and advise on DOD health plans, policies, and related issues.

1979 Responding in part to the President's request for a "search organizational review" of Defense resource management issues, a report was prepared by RAND Corporation. The principle observation was that the two primary missions of the Defense Medical Health CAre system pull in opposite directions. Consolidation or even creation of a single DOD health care agency seemed attractive when considering the benefit mission. But the

decentralized system seemed better for the readiness mission since it is more closely linked to the deploying forces. With the realization that desirable objectives can often conflict, the study opts for a more concerted effort to pursue both missions through the current structure.

1981 The Surveys and Investigations Staff of the House Appropriations Committee evaluated the organizational structure of the Military Health Care System and concluded that ASD(HA) does not have the capacity to monitor the activities of the military departments; ASD(HA) does not have direct line authority over the military medical activities; DOD has rejected all recommendations for more centralized management of medical programs; DOD has taken action to define its medical mobilization requirements, but has not clearly defined its peacetime medical mission; DOD still has no consistent basis for determining resource requirements for the military direct care system; and the military services lack standard criteria for staffing medical facilities.

MAY 1982 Mobilization exercises sponsored by the Joint Chiefs of Staff and the Office of the Secretary of Defense in 1978, 1980, and 1982, demonstrated the limited ability of the Services to respond to various scenarios. The Senate Armed Services Subcommittee (SASC) on Manpower and Personnel held hearings to address the specific areas of medical readiness, management of peacetime health care delivery, and quality assurance. One result of those hearings was a directive to the Secretary of Defense to study the feasibility and benefits to be gained by creating a Defense Health Agency (DHA).

JUM 1982 President Reagan established the President's Private Sector Survey on Cost Control (Grace Commission). One of the 36 task forces established reported on federal hospital management. Among their recommendations was the dismantling of the Defense Health Council and Tri-Service regionalization program and the creation of a centralized Health Agency under the ASD(HA); establishing facility planning guides and freezing construction funding for small hospitals and for larger hospitals with less than 60% occupancy; exploring sharing opportunities and incentives more actively and appointing a Director of Shared Health Resources in both DOD and VA; accelerating implementation of the Tri-Service Medical Information System (TRIMIS) and Uniform Chart of Accounts (UCA); and phasing out VA supply depots. Another task force studied DOD health care costs for which OSD as responsible. Among this group's recommendations was that DOD should

consolidate military health care management under a Defense Health Agency.

AUG 1983 The Report for the Secretary of Defense on the feasibility and Benefits to be Gained from Creating the Defense Health Agency was submitted by Systems Research and Applications Corporation (SRA). This report found no legal impediments to the transfer of health functions from the Military Departments to a Defense Health Agency, and concluded that if well-managed and fully supported by the Military Departments, a DHA would function effectively, improve mobilization capability, ensure high equality health care, and provide effective cost control with substantial savings to help fund the health care resources needed for mobilization. The Services had many unfavorable comments, and SRAs savings claims were strongly questioned. The study team agreed with the Service commentors that many of the cost efficiencies could theoretically be achieved through better cooperation without a DHA, but found that after years of effort most of the potential efficiencies had yet to be achieved.

APR 1984 National Disaster Medical System (NDMS) is established as recommended by the Emergency Mobilization Preparedness Board.

JAN 1985 The Conference Committee Report of the Military Construction Authorization Act of 1985 directed the establishment of a Blue Ribbon Panel of health care experts from outside DOD to review the criteria for sizing military hospitals and to determine if expanded use of available civilian health care facilities could be cost effective. the Panel recommended that: medical readiness requirements should be the primary criterion for determining the size and composition of peacetime active duty medical force and of the facilities in the direct care system; current estimates of wartime requirements should be refined; and Management Information Systems (MISs) in development should be implemented without delay and that an integrated analytic force sizing methodology based on those requirements and MISs should be adopted for sizing and staffing all DOD medical treatment facilities (MTF); review of MTF construction projects should be consolidated and streamlined; sizing/construction time gap should be closed; and firm guidelines be developed to ensure the Military Health Ssytem make full use of civilian or other fovernmental capacity to provide care to its beneficiaries. The Military Health Services System must adopt workload measurements and other resource allocation mechanisms that reward the cost effective provision of

quality care and that eliminate incentives for over-utilization of services.

SPR 1985 — Congressional Military Construction Committees requested consolidated (tri-service) plan for use of medical facilities in CONUS; ASD(HA) expanded plan to include all CONUS medical resources. Plan to be developed by task force under ASD(HA).

DEC 1985 — Dr. Mayer (ASD(HA)) briefs SECDEF that an integrated plan would be developed addressing Tri-Service CONUS medical requirements and capabilities.

1986 — DOD Authorization Act directed the SECDEF to submit a plan for revising the organizational structure of the Military Health Care Delivery System in order to streamline resource allocation, improve quality of care, reduce costs, and enhance medical readiness.

MAR 1986 — ASD(HA) forms a task force to develop the Integrated CONUS Medical Mobilization Plan (ICMMP) and a General Officer Advisory Committee was established to guide the task force in its efforts.

MAY 1986 — ASD(HA) Report to Congress on the Organizational Structure of the Military Health Care Delivery System identifies three options:

1. Strengthen and centralize management of medical programs within existing systems;
2. Create a single DOD health budget; and
3. Create a DOD Health Agency.

ASD(HA) selected the first option, but proposed a drastic revision to the medical portion of the Planning Programming and Budgeting System (PPBS). The Services objected and SECDEF made a decision which established a Medical Program Review Committee (MPRC) to draft Defense Medical Guidance, review DOD medical programs, and resolve medical program issues. The ASD(HA) plan left the DOD Health Agency as an option if this did not work.

NOV 1986 — Task Force presents initial draft ICMMP to Services for comment.

DEC 1986 — Services non-concur with ICMMP first draft. Services object to having planning office in OASD(HA) and use of committee structure (DHC) for command and control; constructive criticism by Services forwarded to ASD(HA).

General Winkler, Deputy Assistant Secretary of Defense - Health Affairs (Medical Readiness) (DASD-HA(MR)) forms

the Medical Readiness General Officer Working Group to address the Service's objections to the ASD(HA) porposal.

JAN 1987 — Medical Readinedss General Officer Working Group presents the Services Armed Serivces Medical Mobilization Office (ASMMO) concept to the ASD(HA) for consideration as an alternative structure to implement the ICMMP.

FEB 1987 — Medical Readiness General Officer Working Group discusses alternatives to ASMMO. General Winkler decides to present three organizational alternatives to ASD(HA):

1. A planning and coordinating office, i.e., the Joint Health Services Planning Agency (JHSPA) during peace and war, as endorsed by the three Services;

2. A planning and coordinating office (JHSPA) for peacetime with regional and national Operational Control (OPCON) upon mobilization; and

3. A Defense Health Agency for peace and war.

ASD(HA) selects option two, the JHSPA, for the organizational structure to present to the Services for formal staffing. This decision was contrary to what the Services had endorsed.

MAR 1987 — Serivces receive second draft of ICMMP for staffing.

APR 1987 — OJCS develops alternative proposal for joint approval.

MAY 1987 — Services non-concur with rewrite of ICMMP; Army sends reply to ASD(HA) nonconcurring with plan, but supporting OJCS alternative proposal (ASD(HA) is willing to take the Service non-concurrences to SECDEF and recommend the implementation of a DHA).

JUL 1987 — SECDEF Medical Strategic Program Report on Health Care: SECDEF approved a Vice Chairman Joint Chiefs of Staff (VCJCS) proposal to establish the Medical Mobilization Steering Committee (MMSC) to address how a Joint Health Service Planning Agency would be formed, supervised, resourced, and phased into operation.

1987 — ICMMP presented to SECDEF.

1987 — Study Task Force dissolved.

AUG 1987 — DHC plan submitted to the Services regarding the revitalization of the Armed Forces Regional Health Care System. Action was met with strong resistance from the Services.

NOV 1987 Medical Mobilization Steering Committee (MMSC) renders their Report, presenting twenty-six problems findings the most significant of which were four problems requiring new organization:

1. No integrated CONUS medical mobilization plan;
2. No mechanism to implement an integrated plan;
3. No CONUS MTF medical readiness reporting system; and
4. No CONUS medical requirements/capabilities determination.

DEC 1987 The Joint Chiefs of Staff (JCS) in a "Tank" session considers MMSC Report. JCS approves, in concept, MMSC Report but Joint Staff was directed to develop an addendum to reflect a phased approach using planning cell.

JAN 1988 Addendum to MMSC Report developed within the Logistics Directorate, J-4 and Service concurrence received.

FEB 1988 The Joint Medical Mobilization Office established with two officers and a planning cell of six officers within the Logistics Directorate, J-4. Tasked with developing and ICMMP Outline, staffing requirements for full JMMO implementation, and regional framework and staffing requirements.

NOV 1988 Executive Order 12656, Assignment of Emergency Preparedness Responsibilities, signed by President Reagan.

DEC 1988 DODD 6010.17, National Disaster Medical System, signed by SECDEF.

APPENDIX C

REFERENCES

DODD 3025.1, MAY 23 1980 - USE OF MILITARY RESOURCES DURING PEACETIME CIVIL EMERGENCIES WITHIN THE UNITED STATES, ITS TERRITORIES, AND POSSESSIONS

- Establishes policies, assigns responsibilities, and furnishes guidance for DoD support to civil authorities under peacetime civil emergency conditions within the United States.
- Assigns Secretary of the Army as DoD Executive Agent, who shall:
  - -- Provide policy and direction concerning plans, procedures, and requirements to all DoD components,
  - -- Plan, conduct, and coordinate DoD responses to civil emergency situations,
  - -- Task appropriate DoD components for necessary resources
  - -- Exercise, through designated military commanders, the direction of military resources committed,
  - -- Establish and maintain liaison with FEMA for DoD with respect to military support
- Chairman, Joint Chiefs of Staff shall:
  - -- Provide policy guidance and assign responsibility to, and establish procedures for commanders responsive to the Joint Chiefs of Staff to conduct civil emergency relief operations anywhere in the United States.
  - -- Provide recommendations to the DoD Executive Agent on planning and using military resources for civil emergency relief operations.
- Heads of DoD Components shall:
  - -- Develop contingency plans for civil emergency relief operations, and ensure that military commanders coordinate such plans with FEMA regions and appropriate civil authorities at state and local levels.

DODD 3025.10, JULY 22, 1981 - MILITARY SUPPORT OF CIVIL DEFENSE

Directive establishes DoD policies and responsibilities for DoD support of the national civil defense program under the proponency of the Federal Emergency Management Agency (FEMA).

Pertinent extracts of the directive include:

- The JCS shall have overall responsibility for providing military support of civil defense.
- Accomplishment of the military support of civil defense mission requires coordination between the DoD and FEMA at the national and regional levels.
- DoD commanders charged with planning and execution responsibilities shall coordinate plans and procedures with FEMA regional offices.
- Subject to JCS approval, the Military Services and Defense Agencies shall make available to state or local authorities during a civil defense emergency those resources not otherwise committed to current or planned military operations or to other priority missions.
- The Commander in Chief, U.S. Readiness Command (Now USFORSCOM) has military support of civil defense planning and execution responsibilities for the CONUS.
- Commanders at appropriate echelons may provide interim emergency assistance in coordination with and supplementary to the capabilities of state and local governments to include, but not limited to:
  - -- Rescue, evacuation, and emergency medical treatment or hospitalization of casualties, recovery of critical medical supplies, and safeguarding of public health.
- JCS shall: In consultation with Director, FEMA, and the Military Services, issue instructions for the conduct of military support of civil defense to Commanders of Unified Commands and other designated commanders. Such instructions shall provide for establishment of liaison with FEMA
- FORSCOM was reorganized as a specified command reporting to the Secretary of Defense through the Chairman of the Joint Chiefs of Staff with an activation date of 1 July 1987.
- FORSCOM is required to centralize planning and decentralize execution to the CONUSA/STARC levels, with particular interest in establishing proper coordination with the other uniformed services at these levels.

DODD 5030.45, NOVEMBER 29, 1983 - DOD REPRESENTATION ON FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) REGIONAL PREPAREDNESS COMMITTEES (RPCs) AND REGIONAL FIELD BOARDS (RFBs)

The Secretary of the Army, as the DoD Executive Agent for DoD participation in the RPCs and RFBs, shall designate a principal regional military emergency coordinator (RMEC) for each RPC and RFB.

- During civil defense emergencies, the RMECs shall be guided by the principle that FEMA regions, acting on behalf of FEMA and in accordance with civil emergency preparedness guidance, will adjudicate resource claimancy matters for their respective regions for civil resources necessary for state and local civil defense activities. This does not automatically include DoD resources.

- During national emergency or war, DoD claims for civil resources available within a FEMA region shall be channeled through the respective RPC or RFB.

DODD 5100.1, SEPTEMBER 25, 1987 - FUNCTIONS OF THE DEPARTMENT OF DEFENSE AND ITS MAJOR COMPONENTS

Promulgates statements of the functions of the Department of Defense and its major components.

- The Chairman, JCS, functions within the chain of command by transmitting to the Commanders of the Unified and Specified Combatant Commands the orders of the President or the Secretary of Defense.

- The JCS shall in part:

  -- Prepare joint logistic and mobility plans to support those strategic plans and recommend the assignment of logistics and mobility responsibilities to the Armed Forces in accordance with those logistic and mobility plans.

  -- Establish and maintain a uniform system for evaluating the preparedness of each Unified and Specified Command.

  -- Develop and establish doctrine for all aspects of the joint employment of the Armed Forces.

  -- Formulate policies for coordinating the military education and training of members of the Armed Forces.

  -- Provide military guidance for use by the Military Departments, the Military Services, and the Defense Agencies in the preparation of their respective detailed plans.

UNIFIED ACTION ARMED FORCES - JCS PUB. 2

- Includes direction for the preparation of joint logistic and mobility plans to support those strategic plans and recommends the assignment of logistic and mobility responsibilities to the Military Services in accordance with those logistic and mobility plans.

- It also states that in unified or specified commands the CINC is responsible for coordination of medical and dental services within the command.

JOINT LOGISTIC POLICY AND GUIDANCE - JCS PUB. 3

- States that it is the duty of the Joints Chiefs of Staff to prepare joint logistic plans and assign logistic responsibilities to the Military Services and the Defense Logistics Agency in accordance with those plans.

- Determine the headquarters support, such as facilities, personnel, and communications, required by CINCs, and recommend the assignment to the Military Departments of the responsibilities for providing such support.

- Prevent unnecessary duplication or overlapping among the Services by using the personnel, intelligence, facilities, equipment, supplies, and services from any or all Services from all cases where military effectiveness and economy of resources will thereby be increased.

- To the maximum extent practicable, assignment of logistic responsibilities should be the same during peacetime and emergency conditions to provide adequate training and an orderly transition in an emergency.

- Ascertain the logistic support available to execute the general war and contingency plans of the CINCs.

- Review and recommend to the Secretary of Defense appropriate logistic guidance for the Military Services that, if implemented, will result in logistic readiness consistent with the approved strategic plans.

- Directs the preparation of integrated plans for military mobilization.

ORGANIZATION AND FUNCTIONS OF THE JOINT CHIEFS OF STAFF - JCS PUB. 4

- Highlights the direction to prepare guidance and policies relating to military support of civil defense and matters relating to civil defense.

MOBILIZATION - JCS PUB. 21

- Identifies responsibilities and procedures for mobilization planning to be used when preparing mobilization plans.
- The Logistics Directorate acts as the OJCS point of contact with OSD, the Services, unified and specified commands, and Defense agencies for mobilization matters.
- Included is the responsibility to make recommendations for coordinating military mobilization with related civil mobilization efforts, and to assess medical assets identified for mobilization to assure adequate medical resources are available during all stages of war and monitor the implementation of medical capabilities.

FORSCOM REG 10-5

- Maintains liaison with other services, Government agencies, and HQDA commands and agencies for developing domestic emergency plans (AR 500-60)
- Develops plans, policies, and procedures to employ forces and resources of all military services to assist Federal, State, and local civil authorities during natural disasters or domestic emergencies (AR 500-60)
- The FORSCOM command surgeon advises CINC on all medical matters. Advises on the medical portions of plans for Land Defense of CONUS. Coordinates with other Services on medical plans for same.
- FORSCOM, War Plans Division, provides support and office or record for the FEMA liaison officer. Plans, coordinates, and conducts national level CINCFOR sponsored civil/military coordination conferences. Conducts liaison with state department, CONUSAs, State Area Commanders, and the Ten FEMA regions on the mission of military support of civil defense and land defense of CONUS.
- Basically, the FORSCOM, CONUSA, STARC and State Military Support Office (SMSO) organization results in one DOD voice asking for resource support from Federal, State and local authorities.

AR 500-60, 1 AUGUST 1981 - DISASTER RELIEF

Regulation prescribes policy and procedures and assigns responsibilities for disaster relief activities.

- Upon Presidential declaration of an emergency or major disaster, under Public Law 93-288, the FEMA Director or Regional Director may direct any Federal agency to assist State and local governments.

- The Secretary of the Army is designated the DoD Executive Agent for: Military Support in Presidentially declared major disasters and emergencies within the United States.

- The Secretary of the Army has delegated the authority for the conduct of disaster relief operations in CONUS to the CG, FORSCOM, with authority to further delegate this authority to CONUS Army commanders, but no lower.

- FORSCOM will Coordinate and control disaster relief efforts of all DoD components, appoint a DoD military representative as Disaster Control Officer, and control DoD resources furnished for disaster relief.

- CG, US Army Health Services Command will provide professional filler personnel as required to staff FORSCOM AMEDD MTOE units employed in disaster relief operations.

- DOMS is the DoD point of contact with Director, FEMA and other Federal agencies or department in all matters related to military assistance during major disasters or emergencies.

- FEMA Regional Directors and FCOs will submit requests for DoD resources to the CONUS Army or unified commander through the DCO.

- AR 500-60 calls for the reporting of casualties and fatalities of both military and civilian personnel.

AR 500-70, 1 OCTOBER 1982 - MILITARY SUPPORT OF CIVIL DEFENSE (MSCD)

MSCD is a mission of all DoD components.

- Within DoD, the JCS has overall responsibility for providing MSCD. It is authorized to use DoD services and agencies to provide MSCD.
- The USCINCRED (now USCINCFORSCOM) coordinates the planning and execution of MSCD in CONUS under the overall direction of JCS.
- FORSCOM and the CONUSAs form the basic structure through which MSCD is planned and executed in CONUS.
- FORSCOM will -- coordinate and control, at CONUSA and state levels, how all available military capabilities and resources will be used in preattack and postattack phases.
- FORSCOM will -- decide the most effective way to use resources that are provided by the Departments of the Navy and Air Force and other DoD agencies.
- Military plans for emergency assistance will include the providing of rescue and evacuation services and emergency medical treatment; hospitalizing casualties; and using preventive measures to control the spread of infectious diseases.
- Regional Preparedness Committees will:
  - -- Consider DoD claims for civilian resources that will be available within a FEMA region during national emergency conditions.

AFR 355-11, 7 NOVEMBER 1986 - DISASTER PREPAREDNESS

- Regulation recognizes FEMA, RPCs, and CONUSAs and calls for the AF support and coordination of same.
- Notes the Numbered Air Forces that will support specific states under the US Air Force military support to civil authority - emergency or natural disaster relief operations.
- Notes the Military Support of Civil Defense and Land Defense of CONUS and specifies the coordination required with FORSCOM, CONUSAs, and STARCs.

OPNAVINST 3440.16A - DEPARTMENT OF THE NAVY CIVIL DISASTER ASSISTANCE PROGRAM

- Instruction notes that the same planning, skills and material required to prevent, minimize, or recover from peacetime civil disasters, emergencies or disturbances will be required to recover from enemy attack.
- The instruction also notes the coordination and planning required with FEMA, FORSCOM, CONUSAs, and STARCs.
- Instruction delineates that Military Support of Civil Defense (MSCD) is the wartime version of peacetime military support to civil authorities. The difference is that the JCS uses the Unified Command Structure to plan for and execute the MSCD mission.

PUBLIC LAW 93-288 - DISASTER RELIEF ACT OF 1974

- Identifies federal response subsequent to Presidential declaration of a major disaster.
- Under Section 305, the Director, FEMA may in any emergency arrange for aid to save lives and protect the public's health and safety. FEMA may direct appropriate federal agencies to perform emergency work essential to saving lives or protecting and preserving public health and safety -- including the delivery of medicine and emergency medical care.
- It calls for the appointment of a Federal Coordinating Officer to act on-scene for the President to provide coordination for the overall Federal response and managing the delivery of Federal response program.
- Organized into ten regional areas, FEMA provides technical and planning guidance for state and local emergency preparedness.

EXECUTIVE ORDER 11490

- Assigns to FEMA the role of coordinator in the emergency preparedness of federal agencies and departments -- including functions related to medical and health services.
- It does not intend that FEMA compete with or duplicate the work assigned to HHS and other lead-agencies, but rather requires all departments to maintain a process for determining areas of separate and interrelated action.
- HHS is assigned as the cognizant agency for federal medical and health preparedness.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

- Responsibilities include the assurance that medical care is available to the mobilizing population, and returning military casualties.
- Ensures that activities are coordinated with other agencies such as the DoD, VA, FEMA, etc.

EXECUTIVE ORDER 11490, SECTION 1101 et seq.

- HHS is charged to prepare national emergency plans and preparedness programs covering health services, civilian health manpower and health resources.
- Section 1103 states that HHS will cooperate in the development of Federal support procedures through jointly planning with other departments and agencies.
- Further explanation of CONUS planning responsibilities is contained in the HHS Emergency Manual in Chapter 3-00-00.

42 USC - PUBLIC HEALTH SERVICE ACT

The Public Health Service (PHS) is the health component of HHS and under the PHS Act (42 USC) has broad responsibilities in national health care including:

- Assistance to states in developing and providing adequate health care and preventing/controlling communicable/chronic diseases
- Maintainance of a national quarantine system to prevent communicable diseases from entering the U.S.
- Lead Federal agency for coordinating national assistance, technical advice, guidance, medical and public health personnel, supplies and equipment to state/local authorities during civil disasters
- Participation in development of State and local disaster plans
- Management of a commissioned corps of several thousand health professionals.

42 USC SECTION 215

- Authorizes the Secretary of HHS to detail officers of the PHS to other Departments.
- Historically, in peacetime, war, or a Presidential declaration of a national emergency, PHS Commissioned officers have been mobilized and employed to augment DoD health care activities under:
  - -- Section 217 which provides for the President to constitute the PHS Corps a branch of the land and naval forces of the U.S.
  - -- Section 216 which provides for the President to declare the Corps a military service under the uniform Code of Military Justice.
  - -- Section 203 which authorizes mobilization of the PHS reserves.
  - -- Section 211 which authorizes recall of retired officers.
- Through national, regional, State and locally assigned commissioned officer and civil service staff, PHS meets its responsibilities as manager of civil sector health resources and plays a key role in medical and public health responses to disasters and national emergencies with the VA, FEMA, and other Federal, State, local officials.

PUBLIC LAW 97-174 - VETERANS ADMINISTRATION AND DEPARTMENT OF DEFENSE HEALTH RESOURCES SHARING AND EMERGENCY OPERATIONS ACT

The Public Law provides for sharing arrangements between federal medical agencies.

- One of VA's missions is to serve as the primary health-care backup to the DoD health care system in the event of war or national emergency as declared by the President or Congress.
- Directs that local contingency plans make full use of available VA health care resources, including the use of VA medical centers, outpatient clinics, supply services, communications systems, education and other medical resources.
- The VA has 71 medical centers which should be established as primary receiving centers for the treatment of sick and wounded military personnel needing immediate care upon return from an overseas conventional war.
- Also included is the establishment of VA secondary support centers for accepting transfers from and/or sharing resources with the primary receiving centers so as to maximize the availability of VA beds.

PLAN FOR FEDERAL RESPONSE TO A CATASTROPHIC EARTHQUAKE - FEMA

The Plan is primarily based on the authorities of P.L. 93-288, the Disaster Relief Act of 1974 which provides for a presidential declaration of a major disaster based upon a governor's request, and delivery of federal assistance to meet state and local needs.

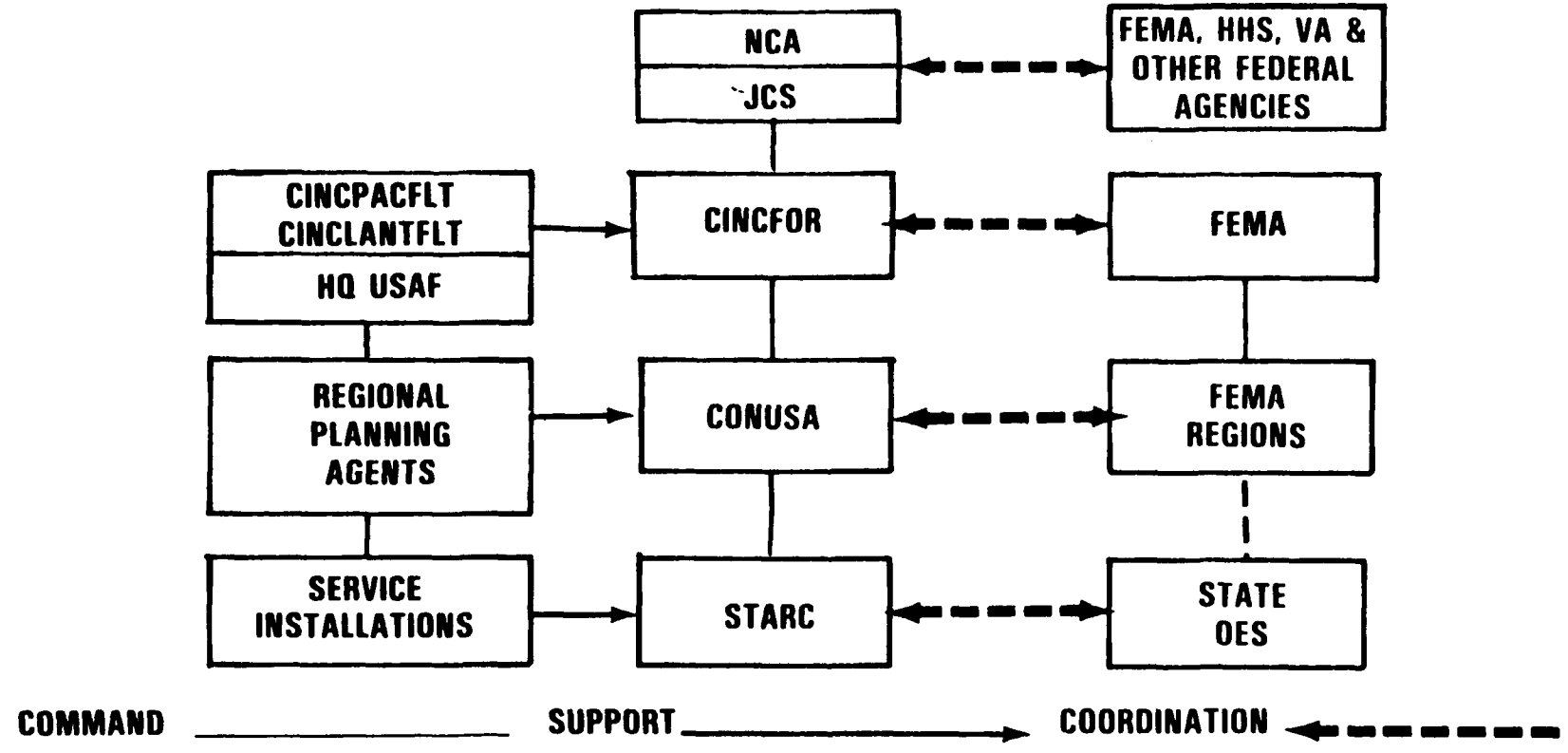
- The Plan applies to all federal departments and agencies which may be required to provide effective support to state and local requirements.
- The plan identifies 25 federal departments and agencies, but does not limit response solely to those identified.
- The Federal coordinating officer, appointed by the President, has the authority under P.L. 93-288 to task any federal department or agency he deems necessary.

PUBLIC HEALTH SERVICE DISASTER RESPONSE GUIDES

- Describes the Public Health Service Agency disaster responsibilities covering Technological Hazards, Natural Disaster, Repatriations, Immigration, Energy and Material Shortages, and War.

- Each guide defines the incident, response, and organization for lead and supporting agencies as they correlate to normal Public Health Service program authorities and activities.

CONUS COORDINATION CHANNELS



APPENDIX E

FUNCTIONS ASSIGNED TO THE JOINT MEDICAL MOBILIZATION OFFICE

1. Establish and manage the activities of the Joint Medical Mobilization Office (JMMO) in accordance with the policies, plans, programs, standards, and procedures established by OSD and the Joint Chiefs of Staff.

2. Provide guidance to CINCFOR for the development, maintenance, and execution of the Integrated CONUS Medical Mobilization Plan to ensure maximum effective and efficient use of residual CONUS medical resources during and following mobilization.

3. Provide liaison on the national level with Federal and civilian agencies, such as FEMA, the Veterans Administration (VA), the Department of Health and Human Services/Public Health Service (HHS/PHS), and the National Disaster Medical System.

4. Provide guidance to CINCFOR for assessing whether DOD Health Care Regions can facilitate medical mobilization planning. Any recommendations provided to OSD on this subject will be coordinated with the Services and CINCFOR.

5. Recommend CONUS medical mobilization priorities for the Joint Chiefs of Staff to prevent duplication or overlapping among the Services; to increase effectiveness and economy of medical resources; and to identify and resolve, through coordination with the Services, issues and conflicts involving CONUS medical mobilization.

6. Monitor the Services' CONUS medical mobilization planning and execution through exercise participation and evaluation.

7. Continually review joint Service resource capabilities to provide health care services in CONUS during mobilization and provide assessments to the Joint Chiefs of Staff and the Military Departments.

8. Review and evaluate the CONUS medical portions of the Military Departments' Program Objective Memorandums. The JCS representative to the Medical Program Review Committee will be provided with detailed information concerning CONUS medical mobilization requirements for the Five Year Defense Plan.

9. Review theater operations plans and projected CONUS medical mobilization workloads to monitor CONUS medical requirements and residual medical resource capabilities.

10. Review Service requirements for CONUS medical military construction and provide advice to DMFO and the Services regarding CONUS medical readiness priorities, including the use of nonindustrial facilities and execution of contingency medical

facility construction plans.

11. Coordinate with Service medical logistics agencies and DLA for wartime requirements and assess their capabilities to provide required medical supplies and equipments during mobilization. Appropriate input will be provided to the Joint Industrial Mobilization Planning Process.

12. Ensure development of a standard medical materiel (Class VIII) requirements model that can be used for CONUS and overseas theaters and ensure that medical logistic systems are designed for expansion to meet peak loads in an emergency.

13. Determine Service medical mobilization-related joint training requirements; review medical readiness training initiatives; recommend potential areas for joint sharing; and coordinate joint medical mobilization training with FEMA, VA, HHS/PHS, and the Inter-Service Training Reivew Organization.

14. In coordination with USTRANSCOM and the appropriate military and Federal agencies, ensure that CINCFOR and the Continental U.S. Armies (CONUSAs) identify primary and alternate airports and seaports to which returning casualties may be directed and at which supplies and equipment designated for theater medical operations can be staged and uploaded.

15. Ensure that CINCFOR and the CONUSAs coordinate CONUS patient evacuation and movement plans and issues with appropriate agencies.

16. Coordinate, through the JCS executive agents, the activities of the Armed Services Medical Regulating Office and the CONUS mobilization activities of the Armed Services Blood Program Office.

17. Develop, in coordination with Services, a standardized CONUS medical treatment facility readiness reporting system.

18. Prepare and submit consolidated CONUS medical readinesss reports to the Services and OSD; prepare and disseminate annually a CONUS medical readiness requirements and capabilities analysis report; and provide recommendations on actions to correct shortfalls.

19. Assess and recommend adjustments, as necessary, to standardized communications and management information systems to incorporate all aspects of medical mobilization.

20. Through CINCFOR, confirm annually the participant status of each VA and NDMS facility and provide reports to OSD and the Military Services.

21. Prepare, with the Military Services, a general plan for the mobilization and employment of PHS-designated commissioned corps officers in DOD health care facilities, including priorities for

employment, time-phased requirements and availability, C2 responsibilities, and requirements for definitive plans.

FUNCTIONS ASSIGNED TO CINCFOR

1. Perform medical mobilization activities in accordance with the policies, plans, programs, standards, and procedures established by OSD and the Joint Chiefs of Staff.

2. Assist the Joint Medical Mobilization Office (JMMO) in coordinating with Federal and civilian agencies, such as FEMA, the VA, HHS/PHS, and NDMS.

3. Through the CONUSAs, confirm annually the participant status of each VA and NDMS facility and provide reports to JMMO.

4. Develop and maintain the Integrated CONUS Medical Mobilization Plan (ICMMP) to ensure maximum effective utilization of residual CONUS medical resources during and after mobilization.

5. Review and approve regional medical mobilization plans developed by the CONUSAs and forward to the JMMO.

6. Assess and provide recommendations on the use of DOD Health Care Regions to facilitate the medical mobilization planning process, in accordance with policy and guidance provided by JMMO.

7. Provide direct access for the CINCFOR Surgeon to the JMMO on all matters related to the development, maintenance, or execution of the ICMMP.

8. Identify and resolve, through coordinatino with the Services*, issues and conflicts involving medcial mobilization and refer issues that cannot be resolved to the JMMO.

9. Provide recommendations on all CONUS medical mobilization priorities and issues to the JMMO.

10. Provide guidance in the execution of regional medical mobilization plans to ensure integrated health care operations.

11. Monitor regional CONUS mobilization planning and execution through joint exercise participation and evaluation.

12. Continually review regional resource capabilities to provide health care services in CONUS during mobilization and provide assessments to the JMMO.

13. Coordinate with the Services* to review projected CONUS medical planning workloads to determine CONUS requirements and residual

resources and recommend priorities to the JMMO.
14. Review requirements for CONUS medical military construction and provide advice to the JMMO regarding medical readiness priorities, including execution of contingency medical facility construction plans and the use of nonindustrial facilities.

15. Coordinate with the Service medical logistics agencies and DLA for wartime requirements and the assessment of the capabilities of agencies and industries to provide required CONUS medical supplies and equipment during mobilization, and procie recommendations to the JMMO regarding appropriate input to the Joint Industrial Mobilization Plan.

16. Review medical mobilization-related joint training requirements and medical readiness training initiatives; recommend to the JMMO potential areas for joint training; and coordinate medical mobilization training with regional representatives for FEMA, VA, and HHS/PHS.

17. In coordination with CONUSAs, HQ MAC, Military Traffic Management Command, Military Sealift Command, USTRANSCOM, the Department of Transportation, HHS/PHS, and the VA, identify primary and alternate airports and seaports to which returning casualties may be directed and at which supplies and equipment designated for theater medical operations can be staged and uploaded.

18. Coordinate CONUS patient evacuation and movement plans and issues with the Air Force, HQ MAC, USTRANSCOM, and other appropriate agencies.

19. In conjunction with the JCS executive agent and the Armed Services Medical Regulating Office, ensure that a joint medical regulating liaison officer position is established at CINCFOR and that a reigonal joint medical regulating office is established in each CONUSA for use furing wartime or national emergency.

20. Provide recommendations to the JMMO on actions to correct shortfalls in medical support.

21. Assure a system exists to track military patients through the entire CONUS health care delivery system to ensure expedient personnel returns to duty.

FUNCTIONS ASSIGNED TO CONUSAs

1. Coordinate and approve, after Services* review, medical mobilization planning performed by the State Area REgional Commands (STARCs) in accordance with direction provided by CINCFOR.

2. Provide coordination on the regional level with Federal and

civilian agencies, such as FEMA, HHS/PHS, VA and NDMS.

3. Through the NDMS Federal Coordinators, within their regional areas of responsibility, confirm annually the participant status of each VA and NDMS facility and provide reports to CINCFOR.

4. Develop and maintain regional medical mobilization plans that have been reviewed by Services* to ensure maximum effective utilization of residual CONUS medical resources during mobilization and forward plans to CINCFOR for approval.

5. Review the medical mobilization plans of DOD medical faciliteis within the region and make recommendations for changes to ensure compatibility with regional mobilization plans.

6. Assess whether the DOD Health Region structure facilitates the medical mobilization planning process, in accordance with policy and guidance provided by CINCFOR and provide recommendations to CINCFOR.

7. Provide the Senior Medical Advisor direct access to the CINCFOR Surgeon on all matters related to the development, maintenance, or execution of regional, state, and local medical mobilization plans.

8. Identify and resolve, through coordinatinno with local, state, and regional agencies, issues and conflicts involving medical mobilization and refer issues that cannot be resolved at the regional level to CINCFOR.

9. Coordinate with the Services* on all regional medical mobilization priorities and issues prior to providing recommendations to CINCFOR.

10. Provide guidance in the execution of regional and state medical mobilization plans to ensure integrated health care operations.

11. Exercise regional plans through joint and major exercise participation.

12. Continually review regional and state resource capabilities to provide health care services during mobilization and provide assessments to CINCFOR.

13. Review projected regional and state medical workloads to determine medical requirements and residual medical resources and recommend medical priorities to CINCFOR.

14. Review regional military construction requirements and provide adivce to CINCFOR regarding medical readiness priorities, including the use of nonindustrial facilities and execution of contingency medical facility construction plans.

15. Coordinate medical mobilization-related common training

requirements with regional and state representatives of FEMA, VA, and HHS/PHS.

16. In coordination with USTRANSCOM and the appropriate military and Federal agencies, ensure that STARCs identify primary and alternate airports and seaports to which returning casualties may be directed and at which supplies and equipment designated for theater medical operations can be staged and uploaded. This information should be provided to CINCFOR and Services*.

17. Coordinate regional patient evacuation and movement plans and issues with appropriate agencies.

18. In conjunction with ASMRO establish a regional joint medical regulating office for use during wartime or national emergency.

19. Provide recommendations to CINCFOR on actions to correct shortfalls.

20. Track military patients within the region.

21. Plan for the implementation of procedures for expeditious return to duty of military patients within the region.

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* Refers to the Principal and Regional Planning Agents and other major commands designated by the Services.