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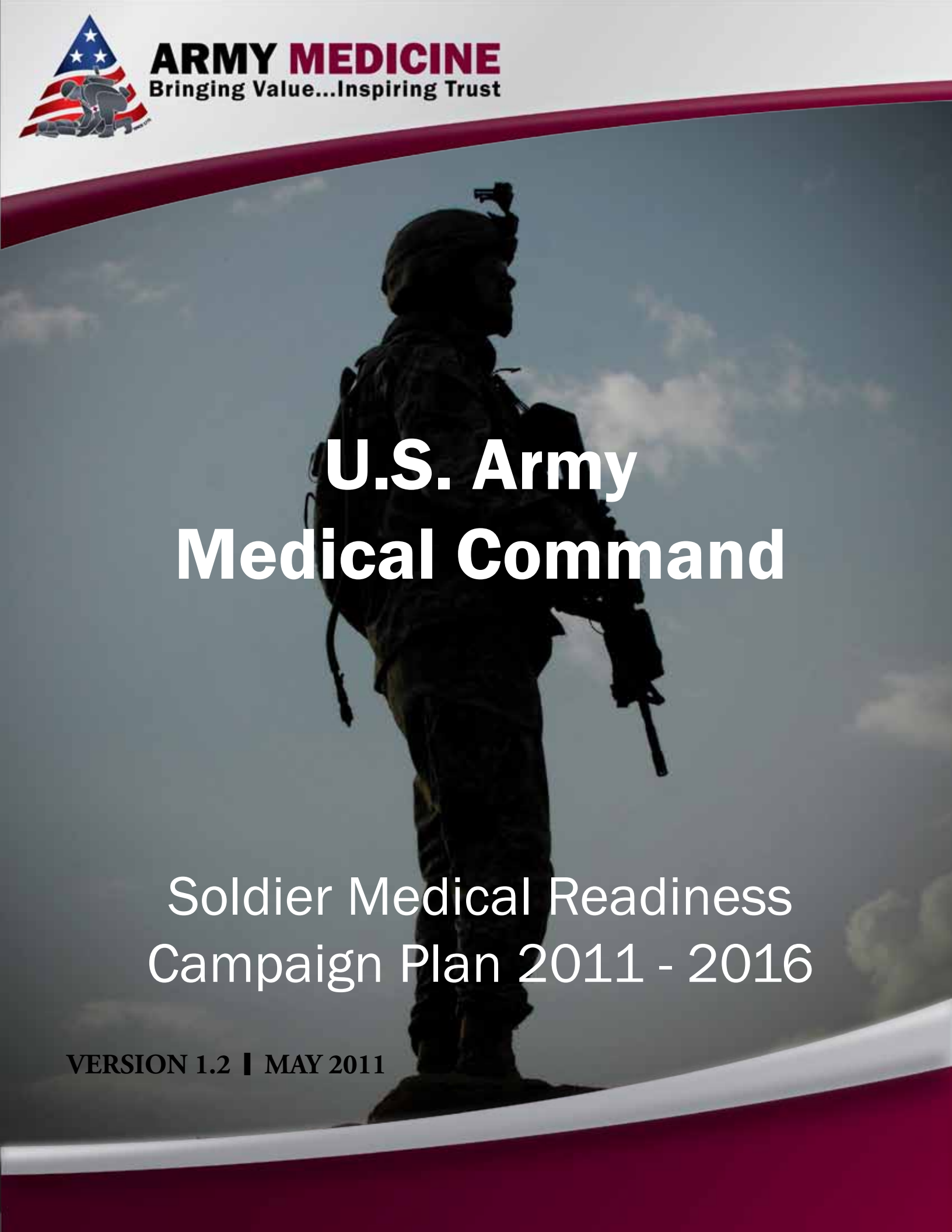

U.S. Army Medical Command

Soldier Medical Readiness Campaign Plan 2011 - 2016

VERSION 1.2 | MAY 2011

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Executive Summary

The United States Army Medical Command (MEDCOM) executes a coordinated, synchronized, and integrated comprehensive Soldier Medical Readiness Campaign Plan (SMR-CP) to support Army Force Generation in each of its phases to increase the medical readiness of the Army. The purpose of this campaign is to improve the medical readiness of the Army.

The Surgeon General has appointed the Deputy Surgeon General for Mobilization, Readiness and Reserve Affairs, MG Richard A. Stone, as the campaign lead. Additionally, senior leadership across the MEDCOM serve as campaign line of effort leads. They include the Assistant Surgeon General, Force Projection; the Deputy Commanding General (Readiness), Southern Regional Medical Command; and the Commanding General, Public Health Command (Provisional).

In these efforts, HQDA, OTSG and MEDCOM partners with U.S. Army Forces Command, U.S. Army Training and Doctrine Command, Installation Management Command, U.S. Army Reserve Command, U.S. Army Special Operations Command, Director, Army National Guard, U.S. Army Human Resource Command, HQDA G-1, and HQDA G3/5/7. We continue to partner with our Soldier beneficiaries to effectively and efficiently provide the right care at the right time to promote a healthy population and ready force.

Through the execution of this campaign, MEDCOM expects to support the deployment of healthy, resilient, and fit Soldiers; increase the medical readiness of the Army; and effectively manage the Medically Not Ready population to return the maximum number of Soldiers to deployable status.

The campaign plan seeks to improve the medical readiness of the Army through three primary lines of effort (LOE): LOE 1.0 Medically Not Ready (MNR) Soldier Identification; LOE 2.0 MNR Management Programs; and LOE 3.0 Evidence-Based Health Promotion, Injury Prevention, and Human Performance Optimization Programs. Identifying Soldiers who are medically not ready is an early success in LOE 1.0 through the increased use of MEDPROS and Electronic Profile by the Army. Once identified, LOE 2.0 initial progress has been made in the MNR management programs to include the implementation of the Medical Management Center Program, the establishment of the Reserve Component Soldier Medical Support Center, the initiation of a Medical Evaluation Board Surge plan, and the standardization of medical support to Soldier Readiness Processing sites. Regarding LOE 3.0 efforts, our quick wins include Basic Combat Training injury surveillance, implementation of military treatment facility and unit based medical management and rehabilitation programs, support to prioritized research efforts, and the coordination and support to health promotion and wellness services.

Mid-term and long-term goals have and are being developed within our SMR-CP Balanced Scorecard. The Balanced Scorecard approach provides the strategic planning and management system to execute the campaign.

Soldiers are Warriors and a Soldier on the battlefield is akin to a professional athlete at the top of his or her game. Success as a lifelong Soldier Athlete demands physical performance optimization that enables full medical readiness.

The MEDCOM, united with its Army partners, is committed to our cohesive effort to increase the medical readiness of the Army.

Introduction

Purpose.

The Soldier Medical Readiness Campaign Plan (SMR-CP) describes my vision as Commanding General, U.S. Army Medical Command (MEDCOM), and The Army Surgeon General to maintain a healthy and resilient force. The SMR-CP will align with the HQDA G1 Non-Deployable Campaign Plan to specifically address Soldier non-deployability due to medical reasons, and is a supporting effort to the Army Campaign Plan Objective, "Support Global Operations with Ready Land Power."

This Campaign Plan uses five Lines of Effort (LOEs) equally applied across active and reserve components (Figure 1 Concept of Operations):

The first LOE is the Medically Not Ready (MNR) Soldier Identification Process. The key tasks are the early and accurate

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CONCEPT OF OPERATIONS

End State: Support the deployment of healthy, resilient, and fit Soldiers and increase the medical readiness of the Army. Effectively manage the medically not ready population to return the maximum number of Soldiers to available/deployable status.

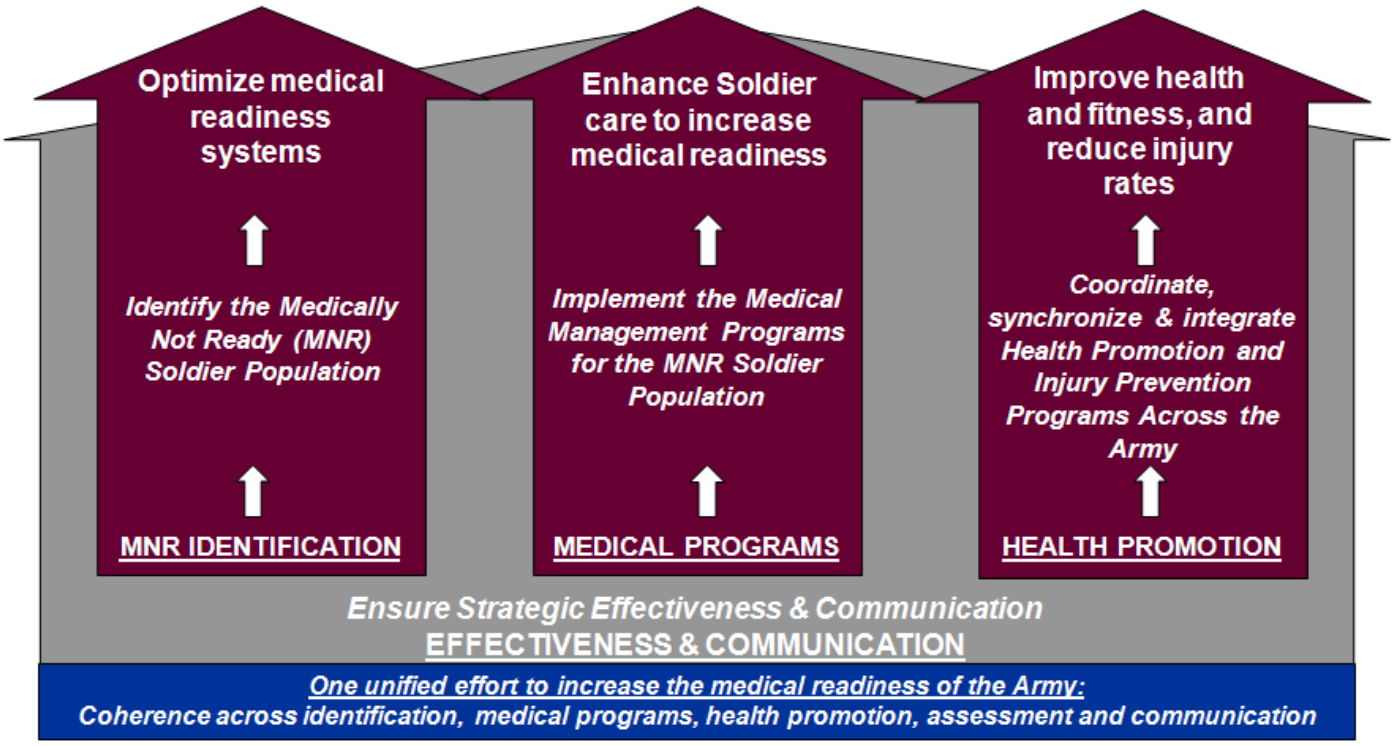


Figure 1

identification of the MNR Soldier population with an objective of optimizing medical readiness systems.

The second LOE is the MNR Management Programs. The key task is to implement medical management process for the MNR Soldier population with an objective of enhanced Soldier care to increase medical readiness.

The third LOE is Evidence-Based Health Promotion, Injury Prevention (IP), and Human Performance Optimization (HPO) Programs. The key task is to coordinate, synchronize, and integrate health promotion, injury prevention, and human performance optimization programs across the Army with an objective of improved health and fitness, and reduced injury rates.

The fourth and fifth LOEs represent performance assessment and communication processes and are integrated into LOE 1.0 - 3.0. The fourth LOE is Effectiveness of the Soldier Medical Readiness Campaign with an objective of ensuring strategic effectiveness. The fifth LOE employs Strategic Communication with an objective of effectively communicating the SMR-CP to all stakeholders.

In total, the SMR-CP is committed to the continuous application evidenced-based outcomes to drive decisions to refine or enhance Commander and Soldier programs. It will measure these programs to ensure their efficiency and viability, and will communicate to all the depth of our commitment to maintain healthy and protected Warriors.

Scope.
This plan spans a five year period – from April 2011 through September 2016 – and will be updated annually. It is applicable to all units assigned to or under the administrative control of MEDCOM. It will also inform all commands and agencies supported by MEDCOM. Detailed execution will be managed primarily through the Army Medicine Balanced Scorecard process located at the following site www.armymedicine.mil.

Mission.
Our mission is to execute a coordinated, synchronized, and integrated comprehensive SMR-CP to support Army Force Generation (ARFORGEN) in each of its phases to increase the medical readiness of the Army.

Commander's Intent.
We will execute a Soldier Medical Readiness Campaign to improve the medical readiness status of the Army. This campaign seeks to leverage and optimize all components of the Army to ensure a healthy and resilient force.

Key tasks include:

- Provide Commanders the tools, policy, regulations, and guidance to manage their Soldiers' medical requirements;
- Coordinate, Synchronize, and Integrate Health Promotion/Injury Prevention Programs across the Army;
- Identify the Medically Not Ready (MNR) Soldier population;
- Implement Medical Management Programs to reduce the MNR Soldier population;
- Identify metrics to measure outcomes and establish MNR surveillance; and
- Develop Army messages to educate and inform the force.

Endstate.
Support the deployment of healthy, resilient, and fit Soldiers and increase the medical readiness of the Army. Effectively manage the MNR population to return the maximum number of Soldiers to available/deployable status.

Who We Are

With the overseas contingency operations continuing, the spotlight justifiably is on the Army's medics, evacuation units, surgical teams and field hospitals. Army Medicine is a seamless chain of care stretching back to fixed hospitals in Europe and the United States, where Soldiers receive state-of-the-art care. Field medical units are under the command of the combatant Commanders, because their movements and work must be coordinated with those of fighting forces.

In contrast, all fixed hospitals (in the U.S. and outside the U.S.) are commanded by the MEDCOM. The challenges for Army Medicine are (1) How to provide medical leadership for field units while respecting combatant Commander's "ownership" and (2) How to integrate the work of field and fixed units.

The Army's answer is to "dual-hat" the top Army physician as both the Army surgeon general and the commanding general of MEDCOM.

As The Surgeon General (TSG) of the U.S. Army, this lieutenant general is the medical expert on the Army staff, advising the Secretary of the Army, Army Chief of Staff and other Army leaders and providing guidance to field units. As commander of the MEDCOM, he actually commands fixed hospitals and other medical commands and agencies. This dual-hatted role unites in one leader's hands the duty to develop policy and budgets as TSG and the power to execute them as the MEDCOM Commander.

This unity is reinforced by the "OneStaff" concept. This blends the Army Surgeon General's staff, located in the Washington DC area, and the MEDCOM Commander's staff at Fort Sam Houston, Texas, into a single staff for both three-star functions.

Legally, the Office of the Surgeon General (OTSG) and MEDCOM remain separate entities with different duties and powers (for example, OTSG explains the medical budget to Congress; MEDCOM oversees its execution). However, staff members are now dual-hatted like TSG, to eliminate duplication and improve communication. The staff totals less than 1 percent of Army Medicine strength. Three assistant surgeons general are dual-hatted as MEDCOM deputy chiefs of staff (DCS): a DCS for force management, a DCS for force sustainment, and a DCS for force projection.

Other features of the Army Medicine structure:

- Medical research is unified under a single major subordinate command, U.S. Army Medical Research and Materiel Command (USAMRMC). USAMRMC includes six research laboratories and five other commands that focus on medical materiel advanced development, strategic and operational medical logistics, and medical research and development contracting;
- Nine Army medical centers, 27 medical department activities and numerous clinics in the United States, Europe, Korea, and Japan are grouped under five major subordinate commands called Regional Medical Commands (RMC);
- Dental facilities are grouped under the U.S. Army Dental Command (DENCOM), a major subordinate command. The DENCOM is organized into five regions called Regional Dental Commands (RDCs);
- The AMEDD Center & School (AMEDDC&S) is where the Army trains medical personnel, and also serves as a 'think tank,' with a mission to envision, design and train a premier military medical force for full-spectrum operations in support of our Country;
- The Warrior Transition Command (WTC) serves as the central comprehensive source for Warrior care support policy across the Army; and
- Preventive medicine, health promotion, and veterinary services at the central, regional, and district level are grouped under the U.S. Army Public Health Command (Provisional).

The MEDCOM currently manages a $12.8 billion budget and cares for over 1.8 million beneficiaries—active-duty members of all services, retirees and their Family members. In addition to veterinary support provided to all Services, Army medical personnel are engaged in many joint-service efforts. The OTSG oversees joint field operating activities for the Secretary of Defense, and medical units participate in many multiservice deployments/exercises.

Strategic Environment

Armed conflict is the ultimate test and the ultimate justification for existence. However, when the call to rally is an enduring one, it carries a significant toll for our Warriors and their Families.

Over the past ten years, 28,000 Soldiers have been wounded, with 7,500 needing long-term care. Repetitive deployments have significantly increased the strain on our force and on its health service support requirements. And while 70% of our Total Force (Active Component, Army National Guard, and U.S. Army Reserve) is medically ready, 30% of our Total Force is Army Medicine's immediate healthcare concern. This 30% of our Force contains both a confirmed MNR Soldier population (15%), along with an additional Soldier population (15%) who require an annual exam to validate their medical readiness status.

Focusing on the Soldier also means focusing on Army Families. Army Medicine reassures Soldiers and their Families that, if injured, Soldiers will receive the best possible care and will have every chance to achieve full recovery. In addition, Army Medicine reassures deployed Soldiers that their Families will always receive high quality healthcare. This confidence in their Families' well-being at home enables Soldiers to focus on their missions around the world, making success more likely and casualties less likely.

Whatever missions may come, Soldiers risk all to protect the American people—in Afghanistan, in Iraq, and around the world. And whatever missions may come, Soldier Medics will be there to conserve the fighting strength. Therefore, it is imperative that Army Medicine help the Force manage the strain it is experiencing, ensuring the Army will be a healthy, resilient, and consistent resource for our Country.

Campaign Plan Development

The MEDCOM Commander provided guidance to his staff during a 17 November 2010 medical readiness update to develop an overarching campaign plan to reduce the MNR Soldier population, thus increasing the medical readiness of the Army. The MEDCOM Commander appointed the Deputy Surgeon General for Mobilization, Readiness and Reserve Affairs, Major General Richard Stone, as the lead in developing this campaign plan. The MEDCOM Commander also assigned each LOE to a MEDCOM General Officer.

An Action Officer Working Group (AOWG) was established to refine the CG's LOEs and Campaign Objectives. The AOWG participants included representatives from the MEDCOM/OTSG OneStaff, MEDCOM subordinate units, U.S. Army Forces Command (FORSCOM), U.S. Training and Doctrine Command (TRADOC), Installation Management Command (IMCOM), U.S. Army Reserve Command, U.S. Army Special Operations Command, Department of the Army National Guard Bureau (NGB), Human Resource Command (HRC), HQDA G-1, and HQDA G3/5/7. The AOWG identified the key tasks that MEDCOM had to accomplish to achieve the objectives and endstates.

Chapter 1 - LOE 1.0 Medically Not Ready (MNR) Soldier Identification Process

The desired endstate is to optimize medical readiness systems.

To effectively manage the MNR Soldier population we must be able to accurately identify and stratify them. Early identification allows the force to respond administratively and medically. Administratively, Soldiers awaiting a medical board should not be assigned to a Deployment Expeditionary Force (DEF), a Soldier with a temporary profile may be assigned to a DEF with a latest arrival date (LAD) greater than 120 days. Medically, early identification allows aggressive management for either return to full duty or entry into the medical board process.

The first LOE in the campaign plan is directed at the identification of MNR Soldiers. Key tasks include ensuring an effective, efficient process of medically evaluating Soldiers; an effective, efficient process for documenting medical conditions; a system of stratification by readiness category and finally; ensuring an accurate and complete medical database to serve as the sole source of medical readiness data. We will focus our efforts on three initiatives to accomplish this objective.

Initiatives:
- 1.1 Improve MEDPROS Effectiveness
- 1.2 Implement eProfile & Optimize Provider Profiling
- 1.3 Optimize Medical Screening

1.1 Improve MEDPROS Effectiveness.
Army Medicine continually strives to improve and expand the tools available for Commanders to assess the medical readiness of their Soldiers and Units. The Medical Protection System (MEDPROS) interfaces with a variety of DoD/Army databases to give Commanders the most readily available and complete medical readiness data. Commanders' visibility of accurate medical readiness data provides support to mission planning throughout the ARFORGEN cycle. There are several initiatives that will be mplemented to improve MEDPROS' effectiveness and enhance Army medical readiness.

The key tasks to achieve this objective are:

- Provide MEDPROS training;
- Define MEDPROS responsibilities;
- Establish a single reporting process for medical readiness; and
- Enable the MEDPROS capabilities.

The first step is to ensure MEDPROS users are properly trained. Each RMC headquarters and subordinate Military Treatment Facility (MTF) will establish a MEDPROS Readiness Coordinator (MRC) to advise the Director of Health Services (DHS) on the medical readiness status of Soldiers in his/her area of responsibility and coordinate with supported units. The MRCs will also facilitate training for unit Commanders and MEDPROS users at the local level.

There are medical readiness roles and responsibilities for unit leaders and their staff, healthcare providers, and the individual Soldier. We must clearly define the responsibility for MEDPROS data entry for each individual medical readiness (IMR) category and include this information in the updated Medical Readiness Leader's Guide. The MRCs will be essential to ensure Commanders and MEDPROS users at the unit and MTF understand their requirements.

Leaders across the Army are too often relying on locally-developed tracking methods to monitor Soldier and unit medical readiness. We must emphasize MEDPROS as the Army's authoritative system for medical readiness. We will work with HQDA G-1 to establish MEDPROS as the single source of medical readiness reports throughout the Army and eliminate redundant processes for reporting medical readiness. We will also coordinate with HQDA G-3 on NetUSR reporting to determine the variance of MEDPROS medical readiness reporting compared to the Commanders' medical readiness reporting to identify IMR categories that may be routinely changed in the Commander's assessment.

Finally, we will continue to enable MEDPROS capabilities to make this system more user-friendly for Commanders and Soldiers. To better assist Commanders we will develop a Commander's Portal within MEDPROS to provide a real-time view of the unit's medical readiness status. We will continue to pursue interfaces with other information technology systems such as the Armed Forces Health Longitudinal Technology Application (AHLTA) to reduce manual input.

Unit Commanders are responsible for monitoring their Soldiers' individual medical readiness and ensuring compliance with all of the combined elements of medical readiness. It is essential that we train and educate leaders across the Army on the capabilities of MEDPROS to provide medical readiness information. We will support Commanders to ensure they understand how to use MEDPROS, that MEDPROS continues to evolve to better support them, and that they are confident in the data provided.

1.2 Implement eProfile & Optimize Provider Profiling.

The Army's legacy profile practice relied on a paper system of documenting Soldiers' limitations. It depended on a manual system of routing for approval, review and manual delivery to Commanders, personnel and medical records. It also depended on manual entry into MEDPROS and this left many opportunities for omissions, errors and blind spots for Commanders.

As of 1 February 2011, the U.S. Army established the electronic profile (eProfile) as the only means of documenting limitation in physical capacity/stamina, upper extremities, lower extremities, hearing, ear, eyes, and psychiatric (PULHES) entries in MEDPROS, outside the initial Army accession physical.

The eProfile system will eliminate "pocket profiles," improve Commander-provider communication, and reduce unwarranted variance in documenting PULHES. The eProfile provides seamless routing from profiling officers to approval authority to Commander. In addition, eProfile identifies Soldiers who may require medical or administrative board action.

eProfile also leverages templates to decrease variation and standardize profiling for common conditions. It uses smart logic to prevent multiple permanent profiles or the inadvertent dropping of profile codes for previously identified conditions or administrative actions.

The MEDCOM also recognizes that the profile is a key & primary tool in our medical readiness system which starts with the provider drafting the profile. The MEDCOM has committed to the development of standard training for all profiling providers in all components to establish a baseline education requirement. Leaders across the Army agree that this is important enough to require of all providers to access the system.

The key tasks associated with this initiative are:

• MTF implementation of eProfile per MEDCOM OPORD 10-75 NLT 31 Jan 2011;
• Army wide implementation of eProfile per HQDA EXORD 055-2011 NLT 31 January 2011;
• Implementation will be monitored via metrics of both provider and Commander use of eProfile;
• Completion of Provider Profiling Course Development NLT 31 March 2011;
• FRAGO to HQDA EXORD 055-2011 to require completion of Provider Profiling Course; and
• Linking ATRRS documented completion of Provider Profiling Course to access to eProfile System.

The desired endstate is that all profiles on a DA Form 3349 are created, routed and viewed in eProfile. This will require that all units have authorized personnel to view completed DA Forms 3349.

1.3 Optimize Medical Screening.

The purpose of this initiative is to incorporate medical readiness screening into every encounter with your medical provider across all phases of the ARFORGEN cycle.

Ensuring individual Soldier medical and dental readiness is an important component in maximizing Army combat power. Soldiers considered "medically ready" are categorized as Medically Readiness Classification (MR) 1 or 2. This means they have completed their annual medical Periodic Health Assessment (PHA) and dental examination visits and have been determined to be free of a duty limiting condition (DLC).

The challenge for the medical community, Commanders, and Soldiers is to maintain medical and dental readiness by maximizing the screening across all phases in the ARFORGEN cycle.

Every contact with a provider is an opportunity to assess a Soldier's current status and identify, correct or refer a Soldier with medical deficiencies. This should be done at all provider visits, during Soldier Readiness Processing (SRP), PHAs or while undergoing a deployment or behavioral health assessment.

The Patient Centered Medical Home is the ideal setting to monitor and manage medical touch points. Each patient partners with a team of healthcare providers – physicians, nurses, behavioral health professionals, pharmacists, and others – to develop a comprehensive, personal healthcare plan. That healthcare team works with each patient over time to take care of health issues as they arise, ensure delivery of prevention screening and services, manage chronic conditions, and promote a spirit of health, wellness and trust.

The key tasks associated with this initiative are:

• Develop program changes and associated policy guidance to reduce the MNR by maximizing existing screenings to achieve MR Classification accuracy;
• Integrate medical readiness touch points into the Patient Centered Medical Home; and
• Leverage technology in healthcare systems to prompt providers to consider profiles and identifying deployment limiting conditions.

The endstate is to decrease the indeterminate MR4 population and improve overall Army medical readiness.

Chapter 2 - LOE 2.0 MNR Management Programs

The desired endstate is to enhance Soldier care to increase medical readiness.

The second LOE is the MNR management programs. The key task is to implement the medical management programs for the MNR Soldier population with objective of enhanced Soldier care to increase medical readiness. The SMR-CP LOE 2.0 will focus its efforts on ten initiatives to accomplish its objectives.

Initiatives:

- 2.1 Implement Medical Management Center Program
- 2.2 Establish Reserve Component (RC) – Soldier Medical Support Center
- 2.3 Improve Reserve Health Readiness Program
- 2.4 Improve Physical Disability Evaluation (PDES)/Integrated Disability Evaluation System (IDES)
- 2.5 Improve SRP Processing and Medical/Dental RESET
- 2.6 Assess Medical Requirements for the Operating Force
- 2.7 Optimize Active Component Brigade Surgeon Training and Selection
- 2.8 Improve Warrior Care and Transition
- 2.9 Reduce the number of Dental Readiness Class 3 and Class 4 Soldiers
- 2.10 Optimize Management of Technical Solutions

2.1 Implement Medical Management Center Program.

Medical readiness is a primary focus of the Army and the MEDCOM. In late 2010, CG, MEDCOM directed the development of a concept of operations designed to address and stem the increasing numbers of MNR Soldiers in the Army. The result of this effort was the Medical Management Center (MMC) initiative and MMC Pilot Project.

The purpose of the MMC initiative is to establish a functional framework for the consistent and command-driven management of the MNR Soldier population and associated medical readiness processes to provide for the maximum return of Soldiers to available and deployable status. The process is necessarily closely linked with medical readiness tracking and reporting by individual units and involves close communication between unit Commanders and organic unit medical personnel. Medical management describes programs and systems that focus on clinical outcomes and involves utilization management, case management and disease management. The MMC initiative is a capability and not necessarily a geographic location within the MTF. The medical management process is aligned within the Patient Centered Medical Home.

The concept of operations for MMCs is executed via the RMCs. The RMCs will establish medical management processes under the mission command of their MTFs that will provide intensive management of the MNR population. Physical Disability Evaluation System (PDES) functions are consolidated functionally in this process. Data will be collected and analyzed with best practices shared across the RMCs and MEDCOM in accordance with (IAW) the SMR-CP strategy map. All RMCs will accomplish these key tasks to enable MNR medical management: MEDPROS reconciliation with supported units monthly tied to their unit status report (USR), 100% eProfile implementation; enforcement of primary care manager by name assignment for all beneficiaries, and Soldier readiness processing standardization within the RMCs. Per OTSG/MEDCOM Policy 10-062, RMCs are directed to ensure that deploying Soldiers within 180 days prior to the date on their deployment orders are managed under enhanced Access to Care standards.

At the MTF level, the MTF Commander will assign a full time director of the medical management process for the MTF, and reporting to the MTF Commander or Deputy Commander. Supervisor/nurse case managers (NCM) will be involved in this process and will focus on establishing and maintaining a return to duty program, collaboration and communication with the healthcare team, and coordinating care needs.

The MMC Pilot initiative revealed that the ratio of NCM and the case management assistant to Soldier is varied based on the acuity of the care needs. In general, a case management assistant can track 100-150 Soldiers and a NCM can provide oversight to five case manager assistants. The supervisor case manager provides oversight and direction to the care coordinators/case manager assistants to determine proper care management needs. Supervisor case managers will work with the MMC Director and care coordinators/case manager assistants to determine if a Soldier's recovery is progressing as predicted. Care coordinators/ case manager assistants will be used to determine if a Soldier is progressing by the prescribed treatment plan and notify the supervisor case manager and Command when the Soldier is not progressing by the treatment plan; analyze information received from the patient and healthcare team to identify barriers to progress; reinforce goals for healing and transition with the Soldier, healthcare team, and Command; coordinate with the healthcare team and unit leadership to promote recovery; obtain updates of patient status; assist in coordinating services and resources needed; identify Soldiers appropriate for referral to the Warrior Transition Unit (WTU) and facilitate entry; track appointments/missed appointment statistics, and coordinate with Commanders to facilitate communication among appropriate members of the healthcare team to maximize a Soldier's recovery. RMCs and MTFs will use already-developed position descriptions for these occupations per MEDCOM OPORD 10-66.

The MMC Pilot Program, executed in 2010, completed a workflow analysis which supports this design. The source database for tracking MNR Soldiers will continue to be MEDPROS and any case management provided to a Soldier in this process will be documented in AHLTA using the standardized NCM Alternate Input Method (AIM) form.

The medical management process is controlled under the mission command of the MTF Commander as the DHS on the installation. This mission command provides the vital link between the supported unit's mission command of the Soldier and the management of the Soldier's medical recovery with the stated goals to decrease the recovery time, decrease the time a Soldier cannot perform his or her duties, decrease the time for identifying a Soldier's medical retention determination point, and optimize communication and information sharing among the healthcare team, the Soldier and the command.

The essential first step in the medical management process is identification of the MNR Soldier. The MTF along with unit Commanders will determine if a Soldier requires additional support and medical management. The definition of MNR is governed per AR 40-501 and the Army utilizes MEDPROS as the authoritative database to track, trend and report the MNR population. It is recognized that many units use home grown tracking systems to track their MNR Soldier population. These local solutions may be useful in the MMC process and will help inform future MEDPROS improvements to track, trend and report MNR data.

There are multiple means by which a Soldier will be identified as needing medical management via the MMC. These include identification by the MTF via MEDPROS or other referral sources, referral by a primary care manager (PCM), or request from unit Commanders. Each RMC/MTF will determine an approval and appeal process for assigning a Soldier to the appropriate medical management resource.

The following descriptions are helpful in understanding how a Soldier is or isn't placed in the MMC program.

1. A Commander may request medical management assistance from the MTF for a Soldier when the Commander identifies that the Soldier has a temporary profile of 3 or 4.

2. A Commander may refer a Soldier for admission into the WTU when the Soldier is active duty, and his/her recovery will take longer than six months, and he/she requires complex nurse case management or if the Soldier is RC and meets WTU entrance criteria as outlined in the Warrior Care and Transition Program (WCTP) guidelines.

3. When a Commander identifies a Soldier with a permanent profile and who has reached his/her medical retention determination point, the Soldier may be processed through a MOS/Medical Retention Board (MMRB) to determine if he/she meets retention standards. If a Soldier does not meet retention standards, then the Soldier will be referred to the PDES for a Medical Evaluation Board(MEB)/Physical Evaluation Board (PEB).

Communication between the Soldier and his/her command and the MTF Medical Management, Primary Care, SRP, and PDES personnel is an essential component of the MMC mission. The MTF Commander will establish routine means for communication among the MMC team and the Soldier and Command. The MTF Commander will also optimize the

integration of information sharing between the MMC and the Community Health Promotion Council. MMC communication will include a minimum of: A routine validation of unit MEDPROS data with unit MEDPROS personnel, validation of profile statistics with the unit medical personnel and healthcare personnel assigned as PCM teams for the unit, and routine follow-ups with Soldiers who have case management needs. The MMC Director will establish routine communication mechanisms with the MTF elements that focus on Primary Care and medical readiness support. The MMC Director will also conduct a routine assessment of case manager and case management assistant workload to ensure that MMC assets are not overwhelmed and are flexible enough to shift or surge, to satisfy the ARFORGEN needs of the supported units.

The desired steady state is that the RMCs/MTFs have appropriate medical management processes under the mission command of the MTF Commanders who provide focused management of the MNR population. Toward this end, the medical management process and PDES must collaborate functionally to reduce profile and administrative processing time and maximize the Soldiers' return to duty rate.

2.2 Establish Reserve Component Soldier Medical Support Center.

The Reserve Component – Soldier Medical Support Center (RC-SMSC) is a Vice Chief of Staff of the Army (VCSA) directed activity that will ensure standardization of medical processing of MNR Reserve Component (RC) Soldiers to either Return to Duty (RTD) or be referred to the PDES. The RC-SMSC will develop, coordinate, and integrate administrative medical management as necessary for RC wounded, ill, and injured Soldiers through centralization of MEB packet submissions. It will also provide administrative and medical subject matter expertise to the field regarding RC MEB processing.

The RC-SMSC is now operational. Follow on key tasks include the standardization of MEB requirements and processes, identification and expansion of MEB capacity throughout the MEDCOM, and development of an automated workflow system that tracks all MEB activities from initial documentation of a pre-MEB packet through final adjudication for RC Soldiers.

The desired endstate of this initiative is the reduction of MNR Soldiers with permanent (P3/P4) profiles through review and

validation of profiles or return to duty, and ensuring standardized and timely MEB entry and adjudication of Soldiers with disqualifying medical issues.

2.3 Improve Reserve Health Readiness Program.

The Reserve Health Readiness Program (RHRP) provides medical dental readiness-related services to over half a million Service members annually. The purpose of this objective is to ensure that we adequately measure the value added to all of the efforts aimed at identifying, tracking and managing funds expended by the Army for RC individual medical readiness. Through this analysis, determine the best solution from possible courses of actions such as: the RC continues to utilize the Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA) provided contract vehicle, other contract options, or use internal resources.

The OTSG will ensure that the metrics currently used by OASD/HA to measure the effectiveness and efficiency of RHRP demonstrates added value. The measurement process is tied to tracking the individual medical readiness (IMR) indicators within MEDPROS. In this objective the OTSG will evaluate the current criteria to determine a statistical model that will help guide the RC on which IMR indicators provide the most value to the Army and provide OASD/HA with data to support a course of action. In addition, the OTSG will present a business case analysis that considers an alternative delivery model that increases RC medical and dental readiness.

2.4 Improve Physical Disability Evaluation (PDES)/Integrated Disability Evaluation System (IDES).

Medical Readiness is a primary focus of the Army and the MEDCOM. To support this effort the Army made major improvements with disability processing by launching the Integrated Disability Evaluation System (IDES) in November 2007 at Walter Reed Army Medical Center. The IDES is a joint process with the Department of Veterans Affairs and by the end of fiscal year 2011 will operate at every Army MTF. Education has been key and the Army has mandated that personnel directly in support of IDES are required to receive extensive training and certification. Outreach has been done at all levels to ensure Soldiers, Families and Commanders are kept informed on all aspects pertaining to IDES.

IDES created a disability process that is easier to understand; more efficient and benefits Soldiers by reducing several months of time it once took for a Soldier to begin the disability process to receive VA benefits. Many studies were conducted that prompted the Army to move into the IDES program with the VA. The Army continues to make improvements with IDES, through feedback obtained in satisfaction surveys, town hall meetings, staff assistance visits and meetings with the VA, to ensure all Soldiers receive the same level of care and compassion regardless of their location or reason for being referred to IDES. The Army has identified success stories at Fort Riley and other installations that have effectively streamlined the overall disability processes that provided Soldiers and Families a sense of trust with the Army and VA by removing barriers for Soldiers to reach Veteran status and receive the compensation and benefits they have earned.

More work is needed and recently published results from an internal study revealed opportunities for the Army to improve in areas of medical board processing for our Soldiers in the United States Reserves and National Guard. The sole mission and purpose of the Reserve Component Soldier Medical Support Center (RC SMSC) is to eliminate the MEB backlog and set conditions for comprehensive, quality, compassionate and timely IDES processing. This center is one piece of the Army's effort to transform and improve the management of RC disability evaluation board processes, manage care for ill and injured Soldiers and standardize medical board practices with Army MTFs. The MEDCOM established the Medical Evaluation Board Tracking Office (MEBTO) that will serve as a liaison and oversight between MTFs processing medical boards and the RC SMSC. Additionally, Army MTFs will be provided supplemental personnel to ensure continuity of medical board processing and the prescribed processing timeliness are maintained.

The Army has also supported improvements with electronic information systems, with the creation of the Electronic Medical Evaluation Board (eMEB) and future systems to come, Electronic Physical Evaluation Board (ePEB). These systems have enhanced our processes and in the near future will allow for seamless transfer of medical/personal data from the Army to the VA. These enhancements will have a significant, positive impact on Soldier's when completed.

The desired endstate is to ensure that Soldiers and Family members understand the Army's commitment to provide equitable disability processing, timely reception of benefits and entitlements with a continued holistic approach to healthcare to the Army's wounded, ill and injured Soldiers.

2.5 Improve SRP Processing and Medical/Dental RESET.

The Army and MEDCOM have been executing multiple Soldier Readiness Processes (SRP) and related medical reset programs

without established standards across the installations. Multiple Army working groups and process action teams are reviewing specific deployment and mobilization processing issues which are impacted by the medical processing at these installations. A common thread across these groups is the need for a clear understanding of standardized medical and dental processes and requirements.

The purpose of this effort is to establish and document standards of practice for each portion of the SRP both at deployment and at redeployment as well as the processes conducted to support medical/dental reset.

The key tasks associated with the initiative are:

- Establish standardized procedures;
- Document the standard and metrics;
- Empower the Readiness Divisions to synchronize within their regions; and
- Develop and implement a periodic MEDCOM audit program.

Over the past ten years, MEDCOM has successfully supported Soldiers through the SRP. The requirements have evolved and expanded over time with each installation adjusting to accomplish the mission. At several installations, the medical support activity developed pilot programs to continually improve the processes. This expertise, along with existing and emerging procedures, was used as the basis for the development of a standard procedure for each process.

These standard procedures have been documented and are to be published at the MEDCOM level for common execution as well as the Army level for common understanding of the processes.

The endstate is that all Commanders will know what to expect at the SRP site and experience a standardized procedure for each part of the SRP process.

2.6 Assess Medical Requirements for the Operating Force.
The purpose of this task is to determine if current and future programmed medical capabilities within the Functional Support Brigades, Multi-Functional Support Brigades, and Special Functional Support Brigades meet requirements for managing Soldier medical readiness and MNR populations. In addition, this task will identify and validate any existing or new capability gaps.

The VCSA noted that many Functional Support Brigades, Multi-Functional Support Brigades, and Special Functional Support Brigades are not required/authorized medical personnel to assist commanders in the managing Soldier medical readiness and MNR populations and therefore face significant challenges meeting Soldier medical readiness management requirements.

The Army has approved and programmed through FY 2017, the addition of behavior health capabilities in all brigades. These additional medical capabilities along with existing medical capabilities within the Functional Support Brigades, Multi-Functional Support Brigades, and Special Functional Support Brigades are available to assist commanders in managing Soldier medical readiness. Any additional or new requirements associated with Soldier medical readiness must first be identified and validated against the current and future Operating Force and Generating Force enablers. Additionally, any future Operating

Force, Generating Force, or other enabler solutions need to be identified and factored into any solution COAs. COA development must be resource-informed and provide the required assistance to Commanders.

In addition to force structure, there are other enablers and tools currently available to assist brigade commanders in managing medical readiness. Web based enablers, such as My Medical on AKO and MEDPROS provide tools for Soldiers and unit leaders to review and manage individual medical readiness and unit medical readiness.

The desired endstate is to better assist commanders in managing Soldier medical readiness and MNR populations by reviewing the current and future medical capabilities and enablers within and in support of Functional Support Brigades, Multi-Functional Support Brigades, and Special Functional Support Brigades, to identify and validate any existing or potential capability gaps, and to recommend solutions to meet these requirements.

2.7 Optimize Active Component Brigade Surgeon Training and Selection.

Senior Officers have observed that some Battalion/Brigade Surgeons and Physician Assistants lack the experience necessary to adequately manage the complex issues associated with the MNR Soldier population. The AC Brigade Surgeon is the key to ensuring that all providers in his Brigade are properly trained and supervised to deal with the complexities of the MNR population. The AMEDDC&S offers the necessary training to properly prepare our Brigade Surgeons, but that training is underutilized. The goal is to assign the right officer with the right skills at the right time to these key Brigade Surgeon billets by ARFORGEN, the AMEDD Human Capital Distribution Plan (HCDP), and DA EXORD 015-10, Centralized Medical Care (Primary and Behavioral) at U.S. Army Installations.

HRC developed a Brigade Surgeon Initiative for the Active Component that was presented and approved by the senior leadership of the Medical Corps (MC) at the December 2010 HCDP. It will effectively increase the level of training and experience of our Brigade Surgeons. Active Component MC Officers in the grade of Major who are residency-trained specialists and have completed one tour at a MTF post-residency are eligible for assignment as Brigade Surgeons. HRC will also ensure they are graduates of the Captains Career Course and Brigade Surgeons Course. Implementation of this initiative for the 2011 assignment cycle is well underway.

Brigade Surgeons with the proper training and experience will effectively supervise other brigade providers and manage the MNR population to return the greatest number of Soldiers to deployable status in the shortest time.

2.8 Improve Warrior Care and Transition.

The transformation of U.S. Army Warrior Care began in April 2007 with the development of the Army Medical Action Plan, which outlined an organizational and cultural shift in how the Army cares for its wounded, ill and injured Soldiers. Over the past four years, the Army Medical Action Plan has evolved into the Army Warrior Care and Transition Program (WCTP).

The WCTP is an Army-wide structure that provides support and services for wounded, ill, and injured Soldiers, also called a Warrior in Transition (WT). The WCTP fully integrates Warrior Care into institutional processes across the Army and achieves the Army's goals for enhancing care and improving the transition of wounded warriors back to duty or into civilian life as productive veterans. The WCTP enables the Army to evaluate and treat WTs through a comprehensive, Soldier-centric process of medical care, rehabilitation, professional development, and achievement of personal goals, known as the Comprehensive Transition Plan (CTP).

At the heart of the WCTP is the successful establishment of 29 Warrior Transition Units (WTU) at major Army installations and nine Community Based Warrior Transition Units (CBWTUs) located regionally around the United States, which replaced the Medical Hold and Medical Holdover systems of the past. These units provide holistic care and leadership to Soldiers who have multiple conditions that require complex case management and

who are expected to require six months of rehabilitative treatment. A WTU closely resembles an Army "line" unit, with a professional cadre and integrated Army processes that build on the Army's strength of unit cohesion and teamwork. Its singular mission is to provide comprehensive care management that allows assigned members to heal and transition.

The Army is committed to this mission and has dedicated more than 3,900 permanent cadre and staff to oversee approximately 10,100 wounded, ill and injured Soldiers and their Families. Each WT receives a Triad of Care, consisting of a Primary Care Manager (PCM) (normally a physician), a Nurse Case Manager (NCM) and a Squad Leader. This triad directs and supervises the individual healing and transition process. Cadre members are selected based on specific criteria and rigorous standards and are trained at the AMEDDC&S Fort Sam Houston, Texas, to ensure that cadre members have the skills necessary to successfully assist WTs through the transition process.

The focal point for the WCTP is the CTP. Instead of solely focusing on the injury or illness, the CTP fosters a holistic approach to a Soldier's rehabilitation and transition. This is accomplished through the collaboration of a multidisciplinary team of physicians, case managers, specialty care providers, occupational therapists, social workers, behavioral health specialists, and WTU leaders at all levels. This team helps the Soldier to develop individually-tailored goals that emphasize the transition back to duty or to civilian life through the domains of career, physical, emotional, social, spiritual, and Family.

The most severely wounded and injured Soldiers are enrolled in the Army's Wounded Warrior (AW2) Program. These Soldiers have or are expected to receive an Army disability rating of at least 30% in one or more specific categories or a combined rating of 50% or greater for conditions that are the result of combat or are combat related. An AW2 advocate provides personalized assistance with day-to-day issues that confront these Soldiers and Families, including benefits counseling, educational opportunities and financial and career counseling. Currently AW2 assists over 7,700 severely wounded Soldiers and their Families, wherever they are, for as long as it takes – including after retirement or separation from the Army.

Within the context of the Soldier Medical Readiness Campaign, it is key to note that WTs are a small population within the larger Army structure, and as such, are still bound by the same processes and procedures for medical evaluation, boards and

accountability. The U.S. Army Warrior Transition Command (WTC) continues to refine, improve, standardize and align the WCTP by participating in several working groups that are reforming the way the Army manages, tracks and processes Soldiers with medical issues across all Service components. To ensure that we support this specific population, the WTC is leading the effort to manage the recommendations identified in the 2 November 2010 Department of Army Inspector General (DAIG) inspection of the WCTP. The WTC conducts quarterly tables of distribution and allowances (TDA) right-sizing to ensure the proper mix and numbers of cadre personnel are available at each WTU location. Over the next 48 months the WTC will be restructuring the remote care system, which will merge the current regionally-focused CBWTUs with the installation-based WTUs to facilitate the management of the program across the board. Lastly, there are continuous improvements being made to the formal implementation of the WCTP to include: drafting and publication of a WCTP Army Regulation and DA Pamphlet; changes and refinements to the Cadre Training Courses and CTP Policy and Guidance; and implementing automated solutions to facilitate process improvement and execution of the CTP.

2.9 Reduce the Number of Dental Readiness Class 3 and Class 4 Soldiers.

The Active Army Dental Care System (AADCS) operated by DENCOM through its Dental Treatment Facilities (DTFs) provides sufficient access to AC Soldiers and eligible active duty status RC Soldiers to meet dental readiness requirements. The Army Selected Reserves Dental Readiness System (ASDRS) provides sufficient access to non-active duty status RC Soldiers to

meet dental readiness requirements throughout the RC ARFORGEN cycle. Unit Commanders and individual Soldiers are responsible for accessing the AADCS and the ASDRS to attain a dental ready status per Army Regulations 40-501, 40-3, 40-35, HA Policy 06-001 and the PPG. The campaign initiative will focus on a single source Dental Readiness Information Center (DRIC) using an online portal. The DRIC will contain specific guidance and documents for Commanders and Soldiers of each Army Component describing how to access current dental readiness delivery care systems. DRIC will update documents/programs on a real time basis to minimize confusion for Commanders and Soldiers. Campaign efforts will focus on Army leadership providing information to Commanders and Soldiers on how to access the DRIC and implement their dental readiness requirements.

The key tasks associated with the initiative are:

• Use current AKO "My Medical Readiness Status" link with "My Dental" subsection as initial draft of the DRIC product;
• Refine DRIC product through cooperation with NGB, USARC, RHRP, FORSCOM, TRADOC dental stakeholders through the Dental All Army Working Group (DAAWG). Build DRIC as "one stop shop" for all dental readiness information and link to stakeholder web sites;
• Determine location(s) of DRIC and align with MEDCOM single source information center;
• Direct unit Commanders and Soldiers to access DRIC and implement dental readiness as a condition of employment or condition of AT, once DRIC is functional; and
• Identify ownership/resource of maintaining DRIC portal with most current information.

The endstate is to improve dental readiness with the following goals:

Improve Dental Ready Status			
YEAR	AC	ARNG	USAR
1	91% to 95%	69% to 80 %	73% to 80%
2	95%	80% to 85%	80% to 85%
3	95%	85% to 90%	85% to 90%
* Using Baseline MEDPROS data as of 3 JAN 2011			

2.10 Optimize Management of Technical Solutions.
The purpose of optimizing management of technical solutions is to support all members of the SMR-CP workgroup to find Information Management/Information System (IM/IT) solutions that improve their current business processes or facilitate accomplishing their mission more efficiently.

The key tasks associated with the initiative are:

• Define and analyze functional requirements;
• Analyze existing systems across the DoD that may be leveraged to fulfill those requirements;
• Provide guidance regarding the acquisition methodologies for modifying existing systems or developing new systems; and
• Provide guidance regarding a) IM/IT development and acquisition funding source, b) the MEDCOM IM/IT governance process, and c) the MEDCOM and TRICARE Management

Activity (TMA) system certification requirements.
As a member of the SMR-CP AOWG, the Assistant Chief of Staff for Information Management (ACSIM), will strive to maintain full situational awareness of all AOWG's initiative requirements, and will constantly lean forward to identify opportunities to leverage IM/IT solutions to fill these requirements. Once opportunities are identified, the ACSIM will work hand-in-hand with the AOWG's identified functional proponents to clearly identify the requirements, and then look across the DoD for possible existing system solution to fill these requirements, or work through the IM/IT governance process to vet new requirements. ACSIM will also simultaneously advise and work with the functional proponents on the proper procedures when acquiring correct funding and required certifications (e.g. Certificate of Net worthiness-CON, Defense Information Assurance Certification and Accreditation Process-DIACAP, Defense Business Certification/Defense Business Transformation-DBC/DBT).

The desired endstate is that IM/IT solutions are identified and IM/IT requirements are properly staffed through the ACSIM governance process. The development and implementation of IM/IT solutions are executed according to the most current DoD and MEDCOM mandates and governing procedures. The SMR-CP AOWG members are confident that the recommended IM/IT solution is the most viable solution possible. The recommended IM/IT solutions are developed and implemented in a timely manner, and the recommended solutions are in alignment with MEDCOM and TMA IM/IT strategic plan.

The desired endstate is to improve health and fitness, and reduce injury rates.

The third LOE will address two major factors that impact Soldier medical readiness: injuries and physical fitness/performance. Within the SMR-CP, injuries and physical fitness will be targeted through a combination of evidence-based health promotion, injury prevention, and human performance optimization efforts. The key task is to coordinate, synchronize, & integrate health promotion, injury prevention, and human performance optimization programs across the Army with an objective of improved health and fitness, and reduced injury rates.

Injuries and behavioral health conditions are leading causes of MNR. The MEDCOM Comprehensive Behavioral Health System of Care Campaign Plan is poised to address behavioral health issues, and coordination between campaign plans will occur. In addition, the SMR-CP's focus on injuries and physical fitness serves to build physical resiliency, a key focus area of the Army's Comprehensive Soldier Fitness program. These MEDCOM and Army initiatives address unique and complimentary aspects of readiness to ensure Soldiers are both healthy and resilient.

The SMR-CP LOE 3.0 will focus its efforts on four initiatives to accomplish its objectives.

Initiatives:
- 3.1 Coordinate and Support Health Promotion and Wellness Services
- 3.2 Support Injury Prevention & Human Performance Optimization Initiatives
- 3.3 Implement MTF & Unit Based Medical Management & Rehabilitation Programs
- 3.4 Support Prioritized Research Efforts

3.1 Coordinate and Support Health Promotion and Wellness Services.

Mission and medical readiness are directly linked to wellness. To optimize their readiness, it is critical that Soldiers engage in lifestyles and live in communities that promote their health and wellness. Army health promotion is any combination of health education and related organizational, social, and economic interventions designed to facilitate changes conducive to the health and well-being of the Army community. A goal of Army health promotion is to provide primary prevention programs and initiatives that enable healthy lifestyle choices and eliminate preventable health issues that contribute to illness and injury. The purpose of this initiative is to coordinate and support best practices and evidence-based health promotion and wellness services that enhance physical fitness and performance while reducing the risk of injuries.

As part of this campaign, health promotion and wellness services will strive to improve the Army's status on key national health indicators directly associated with reduced risk of injury and enhanced physical fitness. Specific efforts will concentrate on increasing the proportion of Soldiers who maintain a healthy weight, engage in regular physical activity, and live tobacco free. By focusing health promotion efforts on these areas, it is expected that Soldier medical readiness, warfighting ability, work performance and wellness will be supported and optimized across all stages of the ARFORGEN cycle.

The key tasks for this initiative include first identifying and prioritizing existing and promoting health promotion and wellness programs and services that address physical activity, healthy weight, and tobacco free living. Subject matter experts and program evaluators will review and compile the evidence base to identify successful programs, policies, and initiatives poised for greatest impact on the Army community and to identify gaps in current public health practice. This evidence will be used to influence and integrate programs and offerings at Army Wellness Centers. Similarly, Community Health Promotion Councils and Health Promotion Officers across the enterprise will coordinate and synchronize services with IMCOM to promote adoption of evidence-based best practices in the areas of weight management,

physical activity, and tobacco use prevention, and ensure integration and coordination of these practices occurs across installations. Leaders of this initiative will continually collaborate and coordinate with DoD, military, professional, civilian, academic, and community-based organizations to avoid redundancy, provide state of the art public health and prevention practice, and improve the health and wellness of our Soldiers.

The endstate of this initiative will provide all Soldiers, Commanders, and the military community with coordinated and integrated evidence-based health promotion and wellness practices, programs, and policies that support the development and maintenance of a healthy, physically fit, and injury-free force.

3.2 Support Injury Prevention & Human Performance Optimization Initiatives.

The MEDCOM continually strives to improve and expand the tools available for Commanders to address the physical fitness and readiness of their Soldiers and units. Training and mission planning throughout the ARFORGEN cycle can enhance the physical capabilities of the Soldier. The key tasks to achieve this objective are: identify ongoing programs, evaluate best practices, target training and education, implement policy and provide oversight resulting in reduced injury rates, improved overall health and optimized performance.

The first step is to identify subject matter experts, best practices, ongoing initiatives, appropriate assets and requirements. This process includes determining those personnel, practices at MTFs, standardized wellness centers, community agencies and medical services aligned with operational units. Identifying these assets will facilitate coordination of ongoing initiatives and implementation of new projects in the most efficient manner to address gaps, overlaps/redundancies and voids.

Using a proactive, coordinated effort across the spectrum of care in collaboration with DoD, military, professional, civilian and academic organizations will provide evidence-based, state of the art practice and information. Unit leaders and their staff, health care providers, health promotion staff and the individual Soldier must synchronize efforts on local initiatives to enhance physical fitness and performance, and to reduce risk of injury. Programs such as the TRADOC Initial Entry Training Soldier Athlete Initiative and 4th Infantry Division Iron Horse Performance Optimization illustrate ongoing collaborative efforts between MEDCOM, TRADOC, and FORSCOM units to maximize readiness.

As with any mission, ensuring a clear understanding of the requirements and providing appropriate training are the keys to success. Focused training for leaders, medical and health promotion personnel, as well as individual Soldiers provides consistent information vertically and horizontally specific to the individual tasks and ultimately unit mission. Appropriate guidance at all levels results in efficient use of resources, improved Soldier medical readiness and enhanced war-fighting capabilities.

Translating objective information garnered from identification of best practices, program evaluations and research into actionable items for unit Commanders and health care providers is critical to standardization, incorporation and policy changes. Provide Commanders withreal-time usable injury and performance data to tailor their health and fitness programs, and policies and practices specific to their mission throughout the ARFORGEN cycle.

The endstate is for Commanders to use evidence-based programs and policies to manage the MNR population and to develop healthy and fit Soldiers to maximize readiness.

3.3 Implement MTF & Unit Based Medical Management & Rehabilitation Program.

Musculoskeletal injuries continue to increase throughout the Army. Proper management requires early identification and treatment of injuries, appropriate rehabilitation and expeditious re-integration. Using this approach facilitates either the Soldier's return to duty or transition into productive roles within society. The key tasks to accomplish this objective are: review current tools, prioritize evidence-based best practices, provide guidance, implement policy, and provide oversight resulting in standardized care and efficient management of injuries to optimize quality of life for Soldiers.

The first step is to examine current standards of care, best practices, clinical protocols and management guidelines, ongoing initiatives, appropriate assets and requirements to maximize Soldier function.

Collaboration with DoD, military, professional, civilian and academic organizations is critical in the establishment of an evidence-based review of current programs and prioritization of practices, tools, and future programming. Unit leaders and their staff, healthcare providers, and the individual Soldier must synchronize efforts on local initiatives to improve early identification of musculoskeletal injuries, enhance recovery and reconditioning and expedite transition to an active lifestyle.

Providing integrated guidance is essential, including training and education, from the frontline medic to the specialized healthcare provider and ancillary fitness professionals. This includes synchronizing programmatic efforts across the installation, MTF and unit to maximize efficiency and meet the Soldiers' needs.

Transforming this information into useful knowledge and applicable tasks for unit Commanders, healthcare providers, and fitness professionals is a key task. Finally,

defining the impact of the programs at all levels (Unit, Installation, MTF) by monitoring outcomes and metrics is part of this process. This information can be used by Army leaders to identify policies and programs that support development of an enterprise solution for managing Soldiers before, during, and after injury/rehabilitation events.

3.4 Support Prioritized Research Efforts.

There are a wide variety of research programs that aim to improve Soldier medical readiness, reduce physical training-related injuries, and optimize performance. Within the USAMRMC there are five research programs- Military Operational Medicine, Military Infectious Diseases, Combat Casualty Care, Clinical and Rehabilitative Medicine, and Medical Chemical Biological Defense. Of these, the Military Operational Medicine Research Program (MOMRP) has the most relevance to the SMR-CP. The purpose of this initiative is to raise the visibility of existing MOMRPs, identify research programs outside of USAMRMC that are relevant to the SMR-CP, and improve communication between USAMRMC, the OTSG, and PHC.

The concept of operations for this initiative will involve identifying existing research programs internal and external to the MOMRP to raise stakeholders situational awareness of these programs and foster improved communication regarding on-going research efforts.

The key tasks associated with the initiative are:

- Conduct inventory to identify existing USAMRMC IP/HPO research activities that enhance Soldier medical readiness;
- Coordinate with stakeholder/customers to identify gaps and perceived needs for research by Commanders and decision makers;
- Establish subject matter expert derived consensus for a prioritized list for IP/HPO research activities that should be considered for funding;
- Conduct research on selected IP/HPO research activities; and
- Communicate IP/HPO research activities and results across USAMRMC/PHC/OTSG.

The endstate will provide visibility for injury prevention/human performance optimization research efforts and enhance dissemination of evidence-based lessons learned to the Commanders, policy makers, and the health promotion community, ultimately contributing to the reduction in the number of MNR Soldiers.

Chapter 4 - LOE 4.0 Effectiveness of the Solider Medical Readiness Campaign Across All Lines of Effort

The desired endstate is to ensure strategic effectiveness.

Introduction.
The Balanced Scorecard (BSC) strategic management framework has been and continues to serve as the centerpiece of the MEDCOM enterprise-wide strategic management system. MEDCOM uses the BSC as the principal tool by which to guide and track the command to improve operational and fiscal effectiveness, and better meet the needs of our patients, customers, and stakeholders. The BSC is used to drive top-to-bottom organizational understanding and strategic alignment, focus day-to-day efforts, and enable mission achievement. Similarly, we will use the BSC to assess and monitor effectiveness of the SMR-CP and better enable its mission achievement.

Balanced Scorecard Overview.
Every BSC has two components: (1) the Strategy Map, and (2) the Scorecard. The Strategy Map communicates the mission and vision statements, and the means and ways on which to focus performance to best attain the ends important to mission accomplishment. The Scorecard provides the necessary details to turn strategy in action: Objective Statements, Measures, Measure Targets, and resourced Initiatives to resolve performance gaps to improve strategic performance.

The BSC's main driver is the organization's Mission and Vision. The BSC then defines the Strategic Themes or the critical "pillars of excellence" by which the organization intends to execute its strategy to achieve the mission and vision.

Through four perspectives then the organization's strategy is viewed and measured: (1) Patient/Customer/Stakeholder Perspective (Ends)…those products and services of value; (2) Internal Process Perspective (Ways)…those critical processes that must be performed well to deliver products and services of value; (3) Learning and Growth Perspective (Means)…those organizational capabilities which enable those critical processes, and (4) Resource Perspective (Means)…resource stewardship enabling the strategy.

Within each of these four balanced perspectives, the organization identifies the specific Strategic Objectives to fully achieve the Strategic Theme outcomes, and thus, the mission. The BSC is a dynamic, living document that will be refined due to mission and priority changes, organizational learning, as well as target achievement. Periodic reviews are conducted to ensure proactive change.

The Soldier Medical Readiness Campaign BSC.
ANNEX B to this Campaign Plan contains the SMRC BSC. Figure 2 is our SMRC Strategy Map by which we communicate our campaign strategy, and Figure 3 is our SMRC Scorecard by which we assess, monitor, and improve the effectiveness of our campaign strategy. The SMRC BSC is directly aligned to and supports Army Medicine's BSC Strategic Objectives CS 3.0, "Improved Health and Protected Warriors" and IP 10.0, "Optimize Medical Readiness."

Prominent on the top of the SMRC Strategy Map is the campaign's Mission Statement and Vision Statement.

The SMRC BSC's three Strategic Themes directly reflect the campaign's first three Lines of Effort: LOE 1.0, Medically Not Ready (MNR) Soldier Identification Process; LOE 2.0, MNR Management Programs; and LOE 3.0, Evidence-Based Health Promotion (HP), Injury Prevention (IP), and Human Performance Optimization (HPO) Programs. Enablers of these previous three Lines of Effort are LOE 4.0, Effectiveness of the SMR-CP; and LOE 5.0, Strategic Communication, both reflected at the bottom of the SMRC Strategy Map.

The initiatives within each of the first three LOEs explained in this Campaign Plan's Chapters 1, 2, and 3 are directly reflected on the Strategy Map as Strategic Objectives or as finite Initiatives (projects) document in the Scorecard in the far right "Initiatives" column.

MEDCOM will assess and monitor the effectiveness of this campaign plan's strategic performance using the SMRC BSC, conducting quarterly performance reviews to MEDCOM leaders.

Surveillance.
In addition to utilizing the BSC as a tool to assess the effectiveness of the SMR-CP, LOE 4.0 includes the development and implementation of ongoing, routine surveillance of the MNR Soldier population across all Army components. Surveillance is a public health tool used to assess the magnitude of a health concern, monitor trends over time, and assist in evaluating the effectiveness of interventions, programs, and policies designed to address that concern. Using data collected through MEDPROS, eProfile, and other sources as they become available, this surveillance will assist in identifying, monitoring, and reporting of specific health behaviors and outcomes that are barriers to Soldier Medical Readiness (e.g, injury, tobacco use) over time. This knowledge will enable establishment of clinical and prevention efforts focused on the leading barriers to Soldier Medical Readiness.

Chapter 5 – LOE 5.0 Strategic Communication Across All Lines of Effort

The desired endstate is to effectively communicate the SMR-CP to all stakeholders.

Introduction
Army Medicine strategy to communicate efforts related to the SMR-CP integrates information across all functions and engage key audiences/stakeholders to promote awareness and achieve desired effects based on the strategic objectives and initiatives in the Army Medicine Balanced Scorecard. Our strategic communication efforts are twofold:

a. To communicate specific aspects of the SMR-CP to Army Medicine personnel.

b. To educate and inform our external audiences and key stakeholders. Our external audiences and key stakeholders are:

– Soldiers
– Commanders
– Army and DoD Leaders
– Family Members
– Family Readiness Groups
– TRICARE Partners
– Congress
– Military and Veterans Service Organizations
– American Public
– Media

Army Medicine Overarching Themes
Army Medicine's core themes are synchronized with the overall Army Campaign Plan "America's Army: Strength of the Nation" and are intended to communicate Army Medicine's vision to key audiences /stakeholders; America's Premier Medical Team Saving Lives, Fostering Healthy and Resilient People, and Inspiring Trust Army Medicine…Army Strong!

Key Themes: Key themes, focused on desired outcomes, provide a roadmap for planning the appropriate communication strategy. Key themes for the SMR-CP Communication Strategy include:

• Optimize Medical Readiness Systems
• Enhance Soldier Care to Increase Medical Readiness
• Improve Health and Fitness, and Reduce Injury Rates

Key Messages: Strategic communication messages are derived from the key themes and form the basis for communicating at all levels, enabling a synchronized and consistent messaging campaign. These messages have been coordinated with the Army Medicine staff and key stakeholders to ensure accuracy, consistency, and integration with other Army Medicine innovations and programs. Key messages are:

• Everything Army Medicine does is about building and sustaining a healthy and resilient force.
• Army Medicine is partnering with Commanders and key stakeholders to develop tools to optimize Soldiers' health, resilience and human performance.
• We will standardize best practices across the Army to optimize Soldiers' health, resilience and human performance.

Strategic Objectives:

• **Line of Effort 1.0** – Medically Not Ready (MNR) Soldier Identification Process

Specific Messages:
- Improve Medical Protection System (MEDPROS) effectiveness; thereby, enabling Commanders to assess their Soldiers medical readiness.
- Improve global tracking of Soldiers who have a temporary or permanent condition that may render them medically not ready to deploy through the electronic profile (eProfile).
- Maximize medical screening across all phases in the ARFORGEN cycle to increase medical readiness.

• **Line of Effort 2.0** – Medically Not Ready Management Programs

Specific Messages:
- Focus on clinical outcomes, utilization management, case management and disease management to return of Soldiers to an available and deployable status.
- Standardize medical processing of MNR Reserve Component (RC) Soldiers to reduce Soldiers with P3/4 profiles.
- Examine Physical Disability Evaluation System (PDES)/ Integrated Disability Evaluation System (IDES) to decrease processing time to ensure Soldiers receive Veteran's benefits without delay.
- Standardize Soldier Readiness Processing and medical/dental reset upon redeployment.
- Analyze current processes to determine best methodology to assist brigades in managing Soldiers' medical readiness and MNR population.
- Increase training for Active Component Brigade Surgeons; "assign the right officer with the right skills at the right time."

- Integrate and institutionalize processes across the Army to improve transition of Wounded Warriors back to duty or into civilian life as productive veterans.
- Reduce Dental Readiness Class 3 and Class 4 Soldiers using the Dental Readiness Information Center (DRIC).

• **Line of Effort 3.0** – Evidence-Based Health Promotion (HP), Injury Prevention (IP), and Human Performance Optimization (HPO) Programs

Specific Messages:

- Provide evidence-based health promotion programs and services to enable healthy lifestyle choices and eliminate preventable health issues contributing to MNR Soldiers.
- Implement, support, and evaluate promising injury prevention and performance optimization best practices.
- Capture existing best practices, assess the evidence base, and evaluate incorporation of standardized best practices to improve management of injuries and optimize Soldier Medical Readiness.
- Identify research programs within Army Medicine that contribute to injury prevention/performance optimization, and communicate evidence-based lessons learned from these studies.

• **Line of Effort 4.0** – Effectiveness of the Soldier Medical Readiness Campaign Across All Lines of Effort

Specific Message:

- Assess and continually improve the Soldier Medical Readiness process through use of the Balanced Scorecard.
- Continuously monitor Medical Readiness of all COMPOs through MEDPROS.
- Develop and implement surveillance to assess specific barriers to Soldier Medical Readiness.

• **Line of Effort 5.0** – Strategic Communication Across All Lines of Effort

Specific Messages:

- Develop strategic messages and communication tools to inform and educate internal and external audiences and key stakeholders.
- Continuously inform and educate the Force using the following communication forums and venues:

Communication Forums and Venues

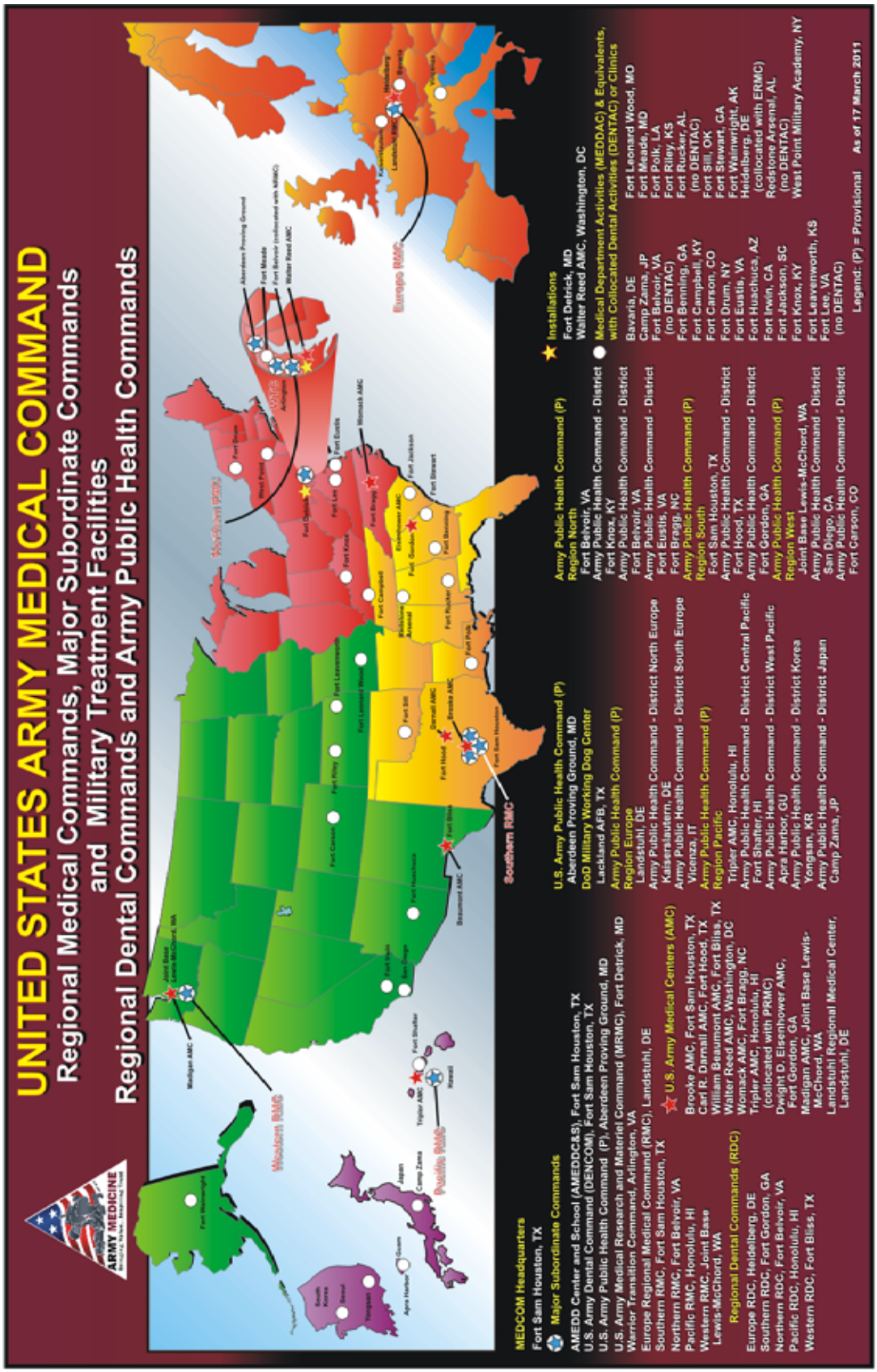
Tool	Audience	Responsibility
Marquees at Installations	Soldiers, Family member, Retirees and their Families, and the local Military Community	Local MTF PAO
Town Halls - Use Talking Points	Internal Workforce	MEDCOM Chief of Staff, RMC and MTF Commanders
Installation newspapers - Press Release Template	Soldiers, Family members, Retirees, and the local Military Community, and American Public	STRATCOM & RMC/MTF Public Affairs
TSG Email	Army Medicine Team, Army & DoD Senior Leaders	Lead: SME Assist: STRATCOM
TSG Letter	FORSCOM, TRADOC, and IMCOM Commanders, Garrison Commanders, Company Commanders, and Family Readiness Groups	Lead: SME Assist: STRATCOM
Media Releases	Soldiers, Families, Retirees, and the American Public	STRATCOM/Regional/ MTF
TSG Letter	Congress	STRATCOM
Stand up Banners at MTFs, Fitness Centers, Wellness Centers, etc.	Soldiers, Family members, Retirees, and the local Military Community	STRATCOM/SME

Tool	Audience	Responsibility
Social Media (i.e. Facebook, Twitter, Text marketing, email, and snail mail)	Senior Leaders, Soldiers, Family members, Retirees, and American Public	STRATCOM/SME
OPD/NCOPD/Commanders Call/Family Readiness Groups	Senior Leaders, Soldiers, Family members, and Staff	MTF Commanders/CSM Company Commanders/1SG
RMC and Local MTF Websites	Senior Leaders, Soldiers, Family members, Retirees, and American Public	RMC & MTF Commanders
Local newspapers, Army Times, Television, and Radio	Internal/External Audiences	Lead: SME Assist: STRATCOM
TRICARE Service Center	Soldiers, Family members, Retirees	MTF
Installation Senior Enlisted Council	Installation Senior NCOs	MTF CSM
Army Medicine Homepage http://www.armymedicine.army.mil/index.cfm	Army and MEDCOM Leadership, Soldiers, Families, and workforce	Lead: SME Assist: STRATCOM
STRATCOM Army Knowledge Online (AKO) Homepage https://www.us.army.mil/suite/page/608996	Army and MEDCOM Leadership, Soldiers, and workforce (must have AKO access)	Lead: SME Assist: STRATCOM
Congressional Hearings and visits	Congress and key staffers	STRATCOM
Media Roundtables and interviews with Army Medicine Leaders	Media, American Public, Soldiers, Families, and Retirees	STRATCOM & RMC/MTF PAOs
STAND-TO	Soldiers, Families, Retirees, and the American Public	Lead: SME Assist: STRATCOM
TSG Blog/Social Media	Senior Leaders, Soldiers, Family members, Retirees, and American Public	Lead: SME Assist: STRATCOM
Army Medicine Exhibit's at National Conferences (Army Medical Symposium, etc.)	Senior Leaders, Soldiers, Family members, Retirees, and American Public	STRATCOM
Health Fairs	Senior Leaders, Soldiers, Family members, and Retirees	MTF Commander
Knowledge Management	Army Medicine and other Army/DoD personnel (must have AKO access)	SMEs and AMEDDC&S
Defense Media Activity	Internal/External Audiences	Lead: SME Assist: STRATCOM
Community Health Promotion Councils	Installation Commanders	Senior Mission Commander/ Health Promotion Officer

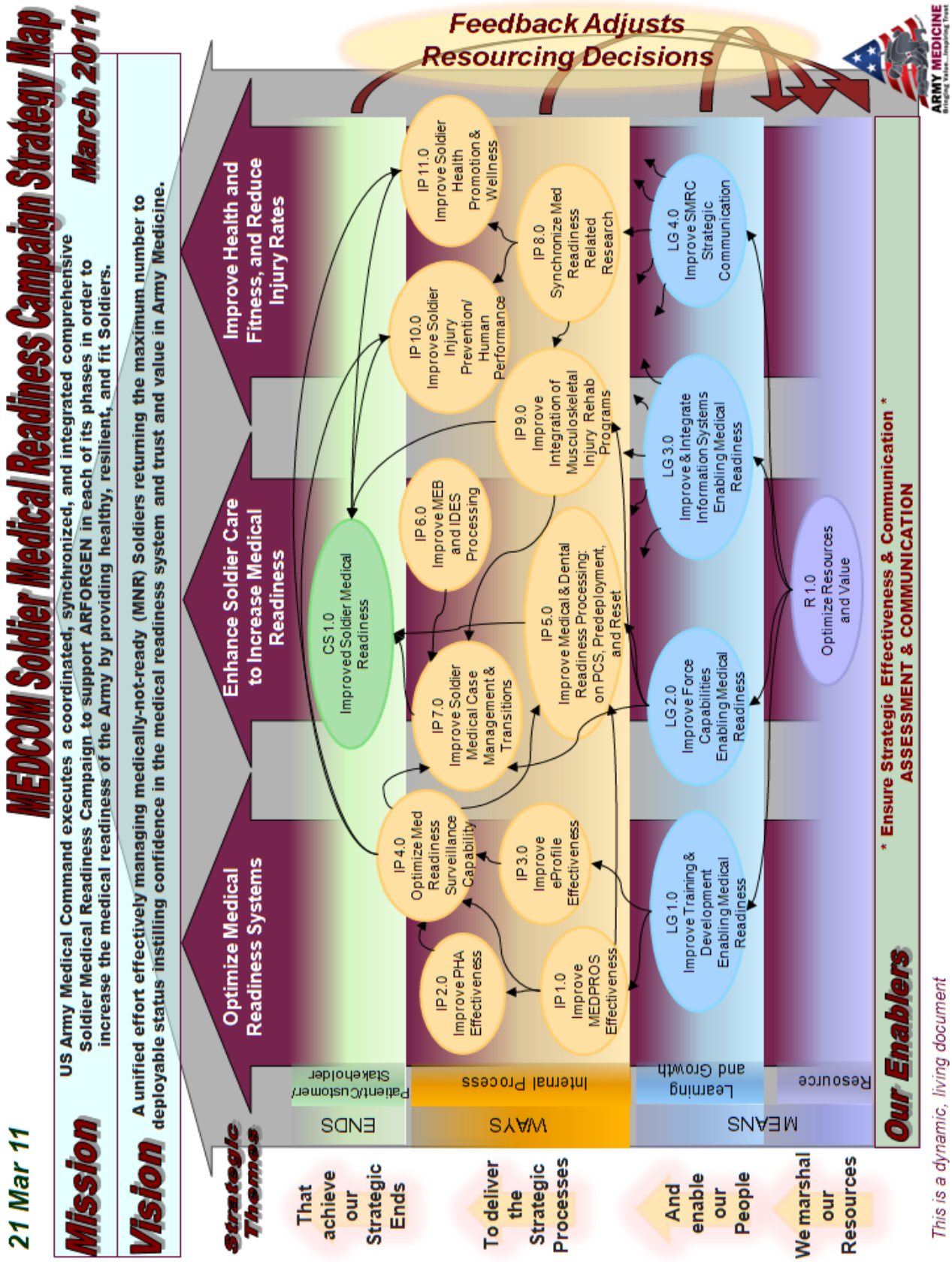
Chapter 6 - Summary

The SMR-CP is an initiative to coordinate, synchronize, and integrate all OTSG/MEDCOM efforts to deliver a fully medically ready Army. This campaign encompasses multiple initiatives developed and implemented to establish policy, processes and programs to reduce the MNR population, increase individual medical readiness, and increase sustained confidence in the medical readiness system. This campaign includes efforts to improve overall health and physical fitness while reducing injury rates throughout the Army with focused emphasis on the Initial Entry Training Soldier population and Soldiers in the ARFORGEN cycle. This effort is also supportive of our overall effort to improve wellness, knowledge of healthy lifestyle decisions, and ensure a more resilient force. This campaign is designed to inform and support Commanders and to provide them with tools, in the form of policies and programs, to assist them in managing their Soldiers' readiness requirements. This will help reduce Soldier recovery times, and will allow Commanders to have both visibility and control of their MNR Soldier population through all phases of the ARFORGEN cycle. We realize that all Soldiers heal differently and at different rates. It is our intent to ensure that every Soldier receives the healthcare needed to progress toward the goals established by a care plan.

The enduring effort of this campaign is to support the deployment of healthy, resilient, and fit Soldiers and increase the medical readiness of the Army. Integration of all medical readiness processes, programs and policies helps us to effectively manage and track the MNR population to optimize health in our Soldiers and return the maximum number of Soldiers to available/ deployable status.


UNITED STATES ARMY MEDICAL COMMAND
Regional Medical Commands, Major Subordinate Commands and Military Treatment Facilities
Regional Dental Commands and Army Public Health Commands
Western RMC
Pacific RMC
Southern RMC
Northern RMC
Europe RMC
MEDCOM Headquarters
Fort Sam Houston, TX
Major Subordinate Commands
AMEDD Center and School (AMEDDC&S), Fort Sam Houston, TX
U.S. Army Dental Command (DENCOM), Fort Sam Houston, TX
U.S. Army Public Health Command (P), Aberdeen Proving Ground, MD
U.S. Army Medical Research and Materiel Command (MRMC), Fort Detrick, MD
Warrior Transition Command, Arlington, VA
Europe Regional Medical Command (RMC), Landstuhl, DE
Southern RMC, Fort Sam Houston, TX
Northern RMC, Fort Belvoir, VA
Pacific RMC, Honolulu, HI
Western RMC, Joint Base Lewis-McChord, WA
Regional Dental Commands (RDC)
Europe RDC, Heidelberg, DE
Southern RDC, Fort Gordon, GA
Northern RDC, Fort Belvoir, VA
Pacific RDC, Honolulu, HI
Western RDC, Fort Bliss, TX
U.S. Army Medical Centers (AMC)
Brooke AMC, Fort Sam Houston, TX
Carl R. Darnall AMC, Fort Hood, TX
William Beaumont AMC, Fort Bliss, TX
Walter Reed AMC, Washington, DC
Womack AMC, Fort Bragg, NC
Tripler AMC, Honolulu, HI
(collocated with PRMC)
Dwight D. Eisenhower AMC, Fort Gordon, GA
Madigan AMC, Joint Base Lewis-McChord, WA
Landstuhl Regional Medical Center, Landstuhl, DE
U.S. Army Public Health Command (P)
Aberdeen Proving Ground, MD
DoD Military Working Dog Center
Lackland AFB, TX
Army Public Health Command (P)
Region Europe
Landstuhl, DE
Army Public Health Command - District North Europe
Kaiserslautern, DE
Army Public Health Command - District South Europe
Vicenza, IT
Army Public Health Command (P)
Region Pacific
Tripler AMC, Honolulu, HI
Army Public Health Command - District Central Pacific
Fort Shafter, HI
Army Public Health Command - District West Pacific
Apra Harbor, GU
Army Public Health Command - District Korea
Yongsan, KR
Army Public Health Command - District Japan
Camp Zama, JP
Army Public Health Command (P)
Region North
Fort Belvoir, VA
Army Public Health Command - District
Fort Knox, KY
Army Public Health Command - District
Fort Belvoir, VA
Army Public Health Command - District
Fort Eustis, VA
Fort Bragg, NC
Army Public Health Command (P)
Region South
Fort Sam Houston, TX
Army Public Health Command - District
Fort Hood, TX
Army Public Health Command - District
Fort Gordon, GA
Army Public Health Command (P)
Region West
Joint Base Lewis-McChord, WA
Army Public Health Command - District
San Diego, CA
Army Public Health Command - District
Fort Carson, CO
Installations
Fort Detrick, MD
Walter Reed AMC, Washington, DC
Medical Department Activities (MEDDAC) & Equivalents, with Collocated Dental Activities (DENTAC) or Clinics
Bavaria, DE
Camp Zama, JP
Fort Belvoir, VA
(no DENTAC)
Fort Benning, GA
Fort Campbell, KY
Fort Carson, CO
Fort Drum, NY
Fort Eustis, VA
Fort Huachuca, AZ
Fort Irwin, CA
Fort Jackson, SC
Fort Knox, KY
Fort Leavenworth, KS
Fort Lee, VA
(no DENTAC)
Fort Leonard Wood, MO
Fort Meade, MD
Fort Polk, LA
Fort Riley, KS
Fort Rucker, AL
(no DENTAC)
Fort Sill, OK
Fort Stewart, GA
Fort Wainwright, AK
Heidelberg, DE
(collocated with ERMC)
Redstone Arsenal, AL
(no DENTAC)
West Point Military Academy, NY
Legend: (P) = Provisional
As of 17 March 2011

Annex B
Soldier Medical Readiness
Campaign Plan Balanced Scorecard



Annex B Figure 2

MEDCOM Soldier Medical Readiness Campaign Balanced Scorecard
As of 29 Apr 11

Mission: US Army Medical Command executes a coordinated, synchronized, and integrated comprehensive Soldier Medical Readiness Campaign to support ARFORGEN in each of its phases in order to increase the medical readiness of the Army by providing healthy, resilient, and fit Soldiers.

Vision: A unified effort effectively managing medically-not-ready (MNR) Soldiers returning the maximum number to deploy-able status instilling confidence in the medical readiness system and trust and value in Army Medicine.

Strategic Themes & Results:

IDENTIFY AND ASSESS	MANAGE SOLDIER CARE	OPTIMIZE HEALTH & HUMAN PERFORMANCE		
Results: Optimize systems and processes which provide Commanders and Healthcare Providers routine visibility of Medically-Not-Ready (MNR) Soldiers and an assessment of their health needs to maintain individual health readiness.	Results: Optimize systems and processes managing Soldier medical and dental care to return MNR Soldiers to optimal medical readiness quickly, and transition those who cannot meet individual health readiness standards to optimal functioning in civilian life and future care.	Results: Coordinate, synchronize, and integrate health promotion, injury prevention, and unit-based musculoskeletal rehabilitation programs across the Army to improve Soldier health, fitness, resilience and reduced injury rates.		

Supporting the Army Chief of Staff's 4 Imperatives: SUSTAIN, PREPARE, RESET, TRANSFORM

Our Enablers : " Ensure Strategic Effectiveness & Communication " ASSESSMENT & COMMUNICATION "

Strategic Objective	Objective Statement	Measure	Measure Status	Target	Initiatives
		BSC Crosswalk to Campaign Plan Index			
	Measure Status Legend: G Met goal or on target to meet goal A Between goal and warning R Below warning level				
CS 1.0 IMPROVED SOLDIER MEDICAL READINESS	Maximize the deployability of the Total Army Force through a Soldier Medical Readiness System that maximizes value in health services.	CS 1.1 % COMPO 1 Soldiers Medical Readiness Classification (MRC) 1 & 2 CS 1.2 % COMPO 2 Soldier MRC 1 & 2 CS 1.3 % COMPO 3 Soldiers MRC 1 & 2 CS 1.4 % of BCT Soldiers Not Deployable at LAD Due to Medical		CS 1.0 85% COMPO 1 NLT 30 Sep 11 CS 1.2 75% COMPO 2 NLT 30 Sep 11 CS 1.3 75% COMPO 3 NLT 30 Sep 11 CS 1.4 4.0% NLT 31 Dec 12	
IP 1.0 IMPROVE MEDPROS EFFECTIVENESS	Optimize MEDPROS effectiveness and utility for Commanders, Army leaders, and Soldiers in tracking and providing visibility and transparency of individual Soldier and unit medical readiness. Better ensure accuracy and timeliness of MEDPROS data through effective interfaces with Army and DoD information systems of record.	IP 1.1 % RMC HQs and MTFs w/ hired MRCs IP 1.2 % variance in data on NetUSR from MEDPROS reported compared to commander-reported medically ready		IP 1.1 100% of MTFs w/assigned MRCs in 180 days of SMRCP published date. IP 1.2 Defined Target TBD after determining measure baseline	- IP(i) 1.1 Publish updated MEDPROS Leaders Handbook - IP(i) 1.2 Develop Commanders' portal in MODS/MEDPROS - IP(i) 1.3 Establish bi-directional AHLTA interface - IP(i) 1.4 Hire MEDPROS Readiness Coordinators at each RMC HQ and each MTF

Patient/Customer/Stakeholder Perspective

Annex B Figure 3

Internal Process

Strategic Objective	Objective Statement	Measure	Measure Status	Target	Initiatives
IP 2.0 LEVERAGE ARMY HEALTH ASSESSMENT TOOLS	Maximizing the use of health assessment screenings across all phases in the Army Force Generation (ARFORGEN) Cycle to ensure early identification and treatment of deployment limiting conditions. Optimize the effective use of the Army health assessments (Pre-DHA, PHA, PDHA, & PDHRA) to decrease the indeterminate population, facilitate early identification and improve overall Army medical readiness.	IP 2.1 % MR4 by component IP 2.2 % of Soldiers deployed in support of contingency operation who completed a PDHRA within the 90 to 180-day window following a PDHA.		IP 2.0 MR4 < 5% for AC Soldiers and MR4< 11 % for RC Soldiers NLT 31 Dec 11 IP 2.2 85% NLT 31 Dec 11	- IP(i) 2.1 Publish MEDCOM SRP OPORD - IP(i) 2.2 Publish new PHA guidance - IP(i) 2.3 PHA Reset during demobilization
IP 3.0 IMPROVE MEDICAL PROFILING	Optimize Profile effectiveness and utility for Commanders, Army leaders, and Soldiers in tracking and providing visibility and transparency of individual Soldier profiles. Implement ePrfofile and develope standard training for all profiling providers in all components to establish a baseline education requirement. To ensure accuracy and timeliness of profile data through effective interfaces with Army and DoD information systems of record.	IP 3.1 % profiles viewed by unit leaders by UIC IP 3.2 % of PULHES with source of eProfile		IP 3.1 85% of profiles are viewed by unit leaders by UIC in eProfile NLT 31 Jan 12 IP 3.2 100% of PULHES in eProfile NLT 31 Jan 12	- IP(i) 3.1 MEDCOM enterprise eProfile Implementation
IP 4.0 OPTIMIZE MEDICAL READINESS SURVEILLANCE CAPABILITY	Develop and implement ongoing, routine surveillance of the Medically Not Ready (MNR) Soldier population. Using data collected through MEDPROS, eProfile, disability, and other sources as they become available, this surveillance will assist in identifying, monitoring, and reporting specific health behaviors and outcomes that are barriers to Soldier Medical Readiness (e.g., injury, tobacco use) over time. This knowledge will enable establishment of clinical and prevention efforts focused on the leading barriers to SMR.	IP 4.1 % of BCT/OSUT installations with company-level injury surveillance IP 4.2 % of MNR 3B cases (MEDPROS) able to be sub-classified as injury vs. other medical conditions.		IP 4.1 100% NLT 30 Sep 11 IP 4.2 70% NLT 31 Dec 11 and 80% NLT 31 May 12	- IP(i) 4.1 Establish BCT/OSUT injury surveillance - IP(i) 4.2 Identify, acquire, and link existing data sources necessary to determine specific reasons for MNR 3B classification (e.g., injury, behavioral) - IP(i) 4.3 Develop and implement surveillance plan for monitoring medical readiness, injuries, and other barriers to medical readiness
IP 5.0 IMPROVE MEDICAL AND DENTAL READINESS PROCESSING: ON PCS, PREDEPLOYMENT, AND RESET	Improve medical and dental readiness processing through documented standards of practice for each portion of Soldier Readiness Processing and upon redeployment medical/dental reset actions. Empower the Regional Medical Commands to provide regional synchronization of the application of these standards of practice through the Regional Medical Command Readiness Divisions. Optimize dissemination of dental readiness information and improve Soldier utilization of existing dental readiness examination/treatment programs.	IP 5.1 % dental class 1 & 2 all COMPOS IP 5.2 % Medical Indeterminate Soldiers IP 5.3 % of compliance of standardized SRP procedures determined during OIP		IP 5.1 NLT 31 Dec 11 AC Target 95%, ARNG Target 80%, USAR Target 80% IP 5.2 No greater than 10% indeterminate NLT 30 Sep 12 IP 5.3 100% NLT 31 Dec 11	- IP(i) 5.1 Publish MEDCOM SRP OPORD - IP(i) 5.2 Improve RC Soldier Health Readiness Program - IP(i) 5.3 Establish DRIC portal - IP(i) 5.4 First Term Dental Readiness Program - IP(i) 5.5 Improve In and Out-Processing
IP 6.0 IMPROVE MEB AND IDES PROCESSING	Enhance current partnerships and practices to ensure equitable disability processing, timely reception of benefits and entitlements and a continued holistic approach to health care for the Army's wounded, ill and injured Soldiers.	IP 6.1 % Soldier Satisfaction with MEB/IDES Processing IP 6.2 % of Soldiers Processed meeting Referral Phase timeline IP 6.3 % of Soldiers Processed meeting MEB Stage timeline (NARSUM) IP 6.4 % MEB Return Rate from PEB		IP 6.1 50% Satisfaction NLT 30 Sep 11 IP 6.2 AC = 10 days, RC = 30 days IP 6.3 AC/RC = 35 days IP 6.4 No Greater than 10% NLT 30 Sep 11	- IP(i) 6.1 Implement IDES at every MEDCOM MTF - IP(i) 6.2 RC SMSC - IP(i) 6.3 Execute MEDCOM MEB Surge Initiative - IP(i) 6.4 Implement eMEB at each MEDCOM MTF
IP 7.0 IMPROVE SOLDIER MEDICAL CASE MANAGEMENT & TRANSITIONS	Improve MNR Soldier case management to support processes to decrease Soldier recovery time, decrease the length of time Soldier cannot perform their duties and decrease the timeline for identifying a Soldier's medical retention decision point. This leverages the Warrior Transition Command's execution of and knowledge learned from the Warrior Care and Transition Program (WCTP) managing the care of WII Soldiers assigned to WTUs	IP 7.1 % reduction in MNR Soldiers w/i 180 dys of MNR entry and entered into MEDPROS IP 7.2 % of MTFs in initial roll out (defined in FRAGO 1 to OPORD 10-66) reporting FOC implementing MMC concept/program w/in 60 dys NLT 15 Apr 11 IP 7.3 % of remaining MTFs at remaining installations supporting troop populations in ARFORGEN reporting FOC implementing MMC concept/program w/i 180 dys (NLT 15 Aug 11)		IP 7.1 95% of MNR Soldiers as entered into MEDPROS are returned to fully medically ready within 180 days. (Green: 95%-100% , Amber: 80%-94%, Red: below 80%) IP 7.2 100% of MTFs in initial roll out with MMCs implemented w/i 120 dys (Green: 90%-100% , Amber: 80%-89%, Red: below 80%) IP 7.3 100% of remaining MTFs w/MMCs implemented in 180 days(Green: 90%-100% , Amber: 80%-89%, Red: below 80%)	- IP(i) 7.1 Execute MMC Pilot - IP(i) 7.2 Establish MMC capability at each MTF - IP(i) 7.3 WCTP implementation - IP(i) 7.4 Publish updated WTPG

Annex B Figure 3

Strategic Objective	Objective Statement	Measure	Measure Status	Target	Initiatives
IP 8.0 SYNCHRONIZE MEDICAL READINESS RELATED RESEARCH	Communicate commanders' and public health research needs, collaborate with Army partners on injury prevention/human performance optimization projects, and enhance communication of evidence-based lessons learned to the Commanders, policymakers, and the health promotion community, ultimately contributing to the reduction in the number of MUR Soldiers	IP 8.1 # of publications on musculoskeletal injury (MSI) IP 8.2 # of presentations on MSI IP 8.3 # of current agreements that leverage Army partners		IP 8.1 >50% of papers on MSI per FY in peer-reviewed publications IP 8.2 5 talks/presentations per FY specifically on MSI research IP 8.3 1 agreement with an Army partner to disseminate MSI research lessons learned NLT 30 Sep 11	- IP(i) 8.1 Complete research inventory - IP(i) 8.2 Compile list of suggested future IP/HPO research - IP(i) 8.3 Develop communication/coordination strategy
IP 9.0 IMPROVE INTEGRATION OF MUSCULOSKELETAL INJURIES REHAB PROGRAMS	Synchronize, coordinate, and improve unit-based and MTF-based musculoskeletal injury rehabilitation programs to enable Soldier medical readiness.	IP 9.1 Number of Soldier profile days due to musculoskeletal injury (MSI) in FORSCOM units evaluated		IP 9.1 15% decrease in profile days due to MSI in FORSCOM units evaluated	- IP(i) 9.1 Unit-based medical management - IP(i) 9.2 Unit-based rehab program - IP(i) 9.3 Musculoskeletal Action Plan - IP(i) 9.4 Aquatic Rehabilitation Pilot Program - IP(i) 9.5 Aquatic Warrior Exercise Program Standardization
IP 10.0 IMPROVE SOLDIER INJURY PREVENTION/HUMAN PERFORMANCE	Coordinate and synchronize evidence-based Injury Prevention/Human Performance Optimization policies and programs that support ARFORGEN in each of its phases in order to improve the medical readiness of the Army.	IP 10.1 % pass APFT in FORSCOM units evaluated IP 10.2 % Soldier injury rate in FORSCOM units evaluated IP 10.3 Recommendations for injury prevention provided to FORSCOM units evaluated		IP 10.1 >85% pass rate on current APFT in FORSCOM units evaluated 30 Jul 11 IP 10.2 15% decrease in injury rate in FORSCOM units evaluated 30 Jul 11 IP 10.3 Recommendations for injury prevention targets provided to FORSCOM units evaluated (2SD, 2/4BD) NLT 30 Sep 11	- IP(i) 10.1 Conduct inventory of ongoing Army IP/HPO programs & initiatives - IP(i) 10.2 Conduct review of evidence-based support for IP/HPO initiatives & ID best practices and gaps - IP(i) 10.3 Implement support, review, and evaluate promising Army IP/HPO initiatives - IP(i) 10.4 IET Soldier Athlete initiative - IP(i) 10.5 101st Eagle Tactical Athlete Program Research Study - IP(i) 10.6 4th ID Iron Horse Performance Optimization MEDCOM/FORSCOM - IP(i) 10.7 USASOC THOR3 Initiative - IP(i) 10.8 USASOC Ranger Athlete Warrior Program - IP(i) 10.9 25th ID Advanced Tactical Athlete Condition Initiative - IP(i) 10.10 Implement policy and guidance, education and training and incorporate these into Army IP/HPO initiatives
IP 11.0 IMPROVE SOLDIER HEALTH PROMOTION & WELLNESS	Optimize the medical readiness of the Army by increasing the proportion of Soldiers who participate in regular physical activity, maintain a healthy weight, and live tobacco free, thereby improving their physical fitness and reducing risk of injury.	IP 11.1 % of signatures on MOA IP 11.2 % of indicators for which data source, metric, and baseline have been determined IP 11.3 % of installations with standardized Army Wellness Center at full operation capacity IP 11.4 % of FORSCOM installations with Health Promotion Officer to facilitate CHPC process IP 11.5 % Soldiers Passing APFT IP 11.6 % Soldiers Maintaining a Healthy Body Weight IP 11.7 % Soldiers Tobacco Free in Selected Units		IP 11.1 100% signatures NLT 30 Jun 11 IP 11.2 100% determined NLT 30 Jun 11 IP 11.3 33% NLT 30 Sep 11 IP 11.4 100% NLT 30 Sep 11 IP 11.5 2% improvement over baseline NLT 30 Sep 12 IP 11.6 2% improvement over baseline NLT 30 Sep 12 IP 11.7 3% improvement over baseline NLT 30 Sep 12	- IP(i) 11.1 Obtain signatures on MOA regarding Community Health Promotion Councils and Army Wellness Centers on Army installations - IP(i) 11.2 Determine Soldier population metric, data source, and baseline for healthy weight, regular physical activity, and tobacco free living across all COMPOs - IP(i) 11.3 Phased execution of standardized Army Wellness Centers - IP(i) 11.4 Utilize Health Promotion Officers to facilitate Community Health Promotion Council process on installations - IP(i) 11.5 Conduct comprehensive literature review, review existing initiatives based on evidence, and select promising programs and policies improving physical activity, healthy weight and tobacco free living for phased implementation and evaluation

Internal Process

Annex B Figure 3

Strategic Objective	Objective Statement	Measure	Measure Status	Target	Initiatives
LG 1.0 IMPROVE TRAINING AND DEVELOPMENT ENABLING MEDICAL READINESS	Optimize training, development, and assignment experience to perform duties and provide skills enabling maximized Soldier Medical Readiness.	LG 1.1 % MEDPROS users w/formal training LG 1.2 % Assigned Bde Surgeons filled by a Field Grade MC Officer LG 1.3 % of assigned Bde Surgeons residency trained and board certified MC Officer LG 1.4 % Assigned Bde Surgeons w/at least 1 yr post-residency clinical experience jP 1.5 & Assigned Bde Surgeons having completed the Bde Surg orse prior to or within 90 days of arrival to unit		LG 1.1 Defined Target TBD after determining measure baseline LG 1.2 40% NLT 30 Sep 11; 60% NLT 30 Sep 12 LG 1.3 90% NLT 30 Sep 11; 95% NLT 30 Sep 12 LG 1.4 40% NLT 30 Sep 11; 60% NLT 30 Sep 12 LG 1.5 80% NLT 30 Sep 11; 90% NLT 30 Sep 12	- LG(i) 1.1 AMEDDC&S Brigade Surgeon Course Enhancements - LG(i) 1.2 Brigade Surgeon Assignments Management - LG(i) 1.3 BCT Physical Therapists training and guidance improvement - LG(i) 1.4 MEDPROS User Training - LG(i) 1.5 Initiative to Build User Training Tracking Tool NLT 30 Sep 11
LG 2.0 IMPROVE FORCE CAPABILITIES ENABLING MEDICAL READINESS	Improve Force Capabilities in Multi-Function Support Brigades, Functional Support Brigades, and Special Functional Support Brigades with the right medical capabilities enabling Soldier medical readiness	LG 2.1 % Improvement in Force Medical Readiness Capabilities IAW Assessment Result		LG 2.1 Defined Target TBD after determining measure baseline	- LG(i) 2.1 Focus on Multi-Functional Spt Bdes, Functional Spt Bdes, and Special Functional Spt Bdes - LG(i) 2.2 Functional Area Assessment - LG(i) 2.3 Functional Needs Assessment - LG(i) 2.4 Functional Solutions Analysis
LG 3.0 IMPROVE INFORMATION SYSTEMS ENABLING MEDICAL READINESS	Implement an integrated and user-friendly family of information systems that is responsive and reliable to better and seamlessly support the continuum of healthcare, healthcare personnel, and efficient practices to optimize the Soldier Medical Readiness System across the full spectrum of operations: DoD, VA and the civilian healthcare network.	LG 3.1 % Satisfaction with Clinical Info Systems and Technologies Improving MEDCOM Employees' Ability to Do Their Job (from Q 36, MEDCOM Speaks! Employee Satisfaction Survey)		LG 3.1 Defined Target TBD after determining measure baseline	- LG(i) 3.1 Assist in PDHA and AHLTA Interface SCR process - LG(i) 3.2 Define MEDPROS and AHLTA interface requirements - LG(i) 3.3 Define the SMART Technology requirements - LG(i) 3.4 MMC pilot assessment support for data collection and quality - LG(i) 3.5 Reserve Affairs support to ID and deploy an MED management system - LG(i) 3.6 Spt HP&S/MR&S to track referral during PDHA sessions
LG 4.0 IMPROVE SMRC STRATEGIC COMMUNICATION	Improve Strategic Communication with various communication tools and strategies to integrate information across all functions and engage key audiences/stakeholders to promote awareness and achieve the desired effect of the Soldier Medical Readinesss Campaign Plan.	LG 4.1 % SMRCP Strategic Communication Plan executed LG 4.2 Outcome Measure TBD		LG 4.1 100% Executed NLT 31 Dec 11 LG 4.2 Defined Target TBD	- LG(i) 4.1 Develop, publish, and implement SMRCP Strategic Communication Plan - LG(i) 4.2 Educate the force on the new PHA process
R 1.0 OPTIMIZE RESOURCES AND VALUE	Effectively forecast requirements, program, allocate and execute all available resources to achieve TSG,MEDCOM Commander priorities in Soldier Medical Readiness and deliver maximum value to Americal taxpayers. Promote a culture of effects-based results, fiscal stewardship and personal accountability.	R 1.1 Measure TBD		R 1.1 Defined Target TBD	- TBD

Learning & Growth

Resource

Annex B Figure 3

Annex C
Terms of Reference

The following terms of reference are applicable to the MEDCOM SMR-CP.

Administrative Control: Direction or exercise of authority over subordinate or other organizations in respect to administration and support, including organization of service forces, control of resources and equipment, personnel management, unit logistics, individual and unit training, readiness, mobilization, demobilization, discipline, and other matters not included in the operational missions of the subordinate or other organizations.

Army Community Hospital (ACH): An MTF that provides definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of primary care, internal medicine, surgery, and PM/PH Services. An ACH may also discharge the functions of an outpatient clinic. When a MEDDAC has a hospital, the ACH is the primary MTF of that MEDDAC and is separately identified in the TDA of the MEDDAC.

Army Disability Program: An Army program implemented in concert with federal law to ensure the timely, independent, impartial determinations of potentially disabling conditions experienced by Soldiers.

Army Force Generation (ARFORGEN): The structured progression of increased unit readiness over time, resulting in recurring periods of availability of trained, ready, and cohesive units prepared for operational deployment in support of civil authorities and combatant commander requirements.

Army Health Centers (AHCE): An MTF that is organized, staffed, and equipped to provide preventive, primary, and specialty outpatient services. AHCEs may provide acute care, routine ambulatory care, same day surgery, and observation care. Both same day surgery and observation care are generally for care that will be completed within 24 hours, but may be extended to 48 hours if needed. Observation beds are used for care of patients who cannot be cared for on an outpatient status, but who do not require hospitalization. An AHCE also provides the full range of ambulatory (outpatient) pharmacy services and limited laboratory and radiology services. AHCEs are not subordinate to another MTF.

Army Health Clinic (AHC): A MTF designed, equipped, and staffed to provide ambulatory health services to eligible personnel. It normally has general radiology, laboratory, and pharmacy capabilities and offers specialty care in one or more of the subspecialties. Services provided depend on the availability of space and facilities and the capability of the assigned professional staff. An AHC may be a stand-alone facility or subordinate to a MEDCEN or MEDDAC and may provide medical administrative and logistical functions when authorized.

Army Wellness Centers (AWCs): A facility focused on prevention and sustaining healthy lifestyles to improve the overall well-being for the Army community. Standardized AWCs expand the community reach of the MTF by providing and promoting health assessment, physical fitness, healthy nutrition, stress management, general wellness education and tobacco education. AWCs strive to identify populations "at risk" for negative health outcomes and tailor services to mitigate or prevent these risks from developing further. Services are available for Soldiers and retirees, Family members and DoD civilians.

Balanced Scorecard (BSC): The BSC strategic management framework has been and continues to serve as the centerpiece of MEDCOM's enterprise-wide strategic management system. MEDCOM uses the BSC as the principal tool by which to guide and track the command to improve operational and fiscal effectiveness, and better meet the needs of our patients, customers, and stakeholders.

Campaign Plan: A plan for a series of related tasks aimed at achieving strategic or operational objectives within a given time and space.

Case management: A mechanism for periodic clinical tracking/ ongoing case management of at-risk individuals who do not participate in the prospective surveillance system.

Commander's Intent: A concise expression of the purpose of the operation and the desired endstate.

Community Health Promotion Council (CHPC): The CHPC will be organized to provide a comprehensive approach to health promotion, and be concerned with the environment and its relationship to people at the individual, organizational, and community levels. All tenant organizations fall under the CHPC for health promotion policy and programs. As the designated

representative of the senior commander, the garrison commander, through the CHPC, will provide comprehensive health promotion policy and programs that are applicable to all garrison residents. For more information see AR 600–63 (Army Health Promotion) dated May 2007/RAR 7 September 2010.

Comprehensive Soldier Fitness Program: The Army's premier program for building resiliency in the force.

Concept of Operation: A verbal or graphic statement that clearly and concisely expresses what the commander intends to be accomplished.

Contingency Expeditionary Force: Army General Purpose Force units designated during the ARFORGEN Synchronization Process and given an Available Force Pool Date (AFPD) to execute a contingency mission, operational plan or other Army requirement.

Course of Action: Any sequence of activities that an individual or unit may follow.

Deployment Expeditionary Force: Army General Purpose Force units assigned or allocated during the Global Force Management and ARFORGEN Synchronization Processes and having the responsibility to execute assigned missions, designated by having a Latest Arrival Date (LAD).

Direct Reporting Unit (DRU): An Army organization comprised of one or more units from the operating or generating force, designated by the Secretary of the Army, normally to provide broad general support to the Army in a single, unique discipline not otherwise available elsewhere in the Army. DRUs report directly to a Headquarters, Department of the Army principal and/or Army Command.

Director of Health Services (DHS): The DHS is the principal advisor to the installation commander and staff on matters concerning the delivery of healthcare and public health services. The MTF Commander for a given health service area (HSA) is the DHS for all active, Army Reserve, state-operated, and inactive installations within that HSA (see MEDCOM Reg 40-21 for listing of HSAs).

Dwell: That period of time when a unit is not deployed for a directed or assigned mission outside the United States.

Endstate: The set of required conditions that defines achievement of the commander's objectives.

Fiscal Year: Term used to differentiate a budget or financial year from the calendar year. It is commonly abbreviated as FY.

Full Spectrum Operations: The Army's operational concept of Full Spectrum Operations: Army forces combine offensive, defensive, and stability or civil support operations simultaneously as part of an independent joint force to seize, retain, and exploit initiative, accepting prudent risk to create opportunities to achieve decisive results. They employ synchronized action – lethal and nonlethal – proportional to the mission and informed by a thorough understanding of all variables of the operational environment. Mission command that conveys intent and an appreciation of all aspects of the situation guides the adaptive use of Army forces.

Health promotion: Any combination of health education and related organizational, social, and economic interventions designed to facilitate behavioral and environmental changes conducive to the health and well-being of the Army community.

Health Service Areas (HSAs): The HSA assigned to each MEDCEN, MEDDAC/U.S. Army Dental Activity (DENTAC) is outlined as a geographical area of responsibility in chapter 2 of MEDCOM Regulation 40-21 (Regional Medical Commands and Regional Dental Commands Health Service Areas). Typically, an RMC/RDC consists of two or more HSAs and includes all medical treatment facilities and dental treatment facilities located within the HSA's geographical boundaries.

Installation Management Command (IMCOM): IMCOM, headquartered in San Antonio, Texas, oversees all facets of installation management such as construction; barracks and Family housing; Family care; food management; environmental programs; well-being; Soldier and Family morale, welfare and recreation programs; logistics; public works and installation funding.

Installation Senior Medical Council: Installations will develop and implement an installation specific health services plan for the management of health care providers and services with the goals of improving professional and technical skills and improving access to care for Soldiers and Family Members while maintaining medical support of the ARFORGEN Cycle. For more information see HQDA EXORD 015-10, Centralized Medical Care (Primary and Behavioral) at US Army Installations.

Line of Effort (LOE): Links multiple tasks and missions using the logic of purpose-cause and effect- to focus efforts toward establishing operational and strategic conditions.

MEDCOM SMR-CP Time Horizon: Short Term: Fiscal Years 2011-2012; Mid Term: Fiscal Year 2013 Long Term: Fiscal Years 2014, 2015, and 2016.

Medical Department Activities (MEDDAC): An organization that includes ACHs, AHCEs, and those AHCs that are not subordinate to another MTF; and all of which encompass associated activities responsible for providing health services to authorized beneficiaries within an assigned HSA. It normally has mission command over Army Medicine facilities, activities, or units (other than TOE units) located within its HSA.

Medical Readiness Class 1 (MR1): All medical requirements met.

Medical Readiness Class 2 (MR2): Medically ready within 72 hours (any deficiencies correctable during final Soldier Readiness Program (SRP)). Deficiencies may include immunizations, Dental Class 2 conditions, lack of medical warning tags, need HIV or DNA lab tests, or optical prescription on file but eye equipment not ordered.

Medical Readiness Class 3A (MR3A): Soldiers with a medical or dental condition expected to be resolved in less than 30 days.

Medical Readiness Class 3B (MR3B): Medical requirements will take more than 30 days to correct. Deficiencies may include temporary profiles exceeding 30 days, and Permanent P3 or P4 profiles.

Medical Readiness Class 4 (MR4): Medical readiness requirement deficiencies are considered in an indeterminate status. Deficiencies may include: No current periodic health assessment (PHA) or no current dental exam.

Medical Management Center (MMC): The MMC falls under the mission command of the MTF on that installation. The MMC provides the vital link between the mission command of the Soldier and the medical management of the Soldier's medical recovery to decrease the recovery time after injury or illness, decrease the length of time a Soldier cannot perform their duties and decrease the timeline for identifying a Soldier's medical retention determination point.

Medically Ready: A Soldier who, IAW the medical/dental fitness standards established in AR 40-501, is not restricted by medical reasons from deploying individually or with his unit for most planned contingencies and envisioned operational scenarios either immediately or within 72 hours after completion of final SRP requirements. This includes MR1 and MR2 categories.

Measure of Effectiveness: A criterion used to assess changes in system behavior, capability, or operational environment that is tied to measure the attainment of an end state, achievement of an objective, or creation of an effect.

Measure of Performance: A criterion used to assess friendly actions that are tied to measuring task accomplishment.

Military Treatment Facilities (MTFs): The umbrella term for uniformed services MEDCENs, ACHs, AHCEs, clinics or other facilities that are authorized to provide medical, dental, or veterinary care.

Mission: The task, together with the purpose, that clearly indicates the action to be taken and the reason therefor.

Mission Command: The exercise of authority and direction by the commander using mission orders to enable disciplined initiative within the commander's intent to empower agile and adaptive leaders in the conduct of full spectrum operations. It is commander-led and blends the art of command and the science of control to integrate the warfighting functions to accomplish the mission.

National Guard Bureau: The NGB is a joint activity within the DoD. It is the focal point at the strategic level for National Guard matters that are not under the authority and direction of the Secretaries of the Army and Air Force, including joint, interagency, and intergovernmental matters where NGB acts through other DoD officials. The NGB is the channel of communications on all matters pertaining to the National Guard between the Army and the Air Force, and the several States.

Objective: The clearly defined, decisive, and attainable goal toward which every operation is directed.

Office of Coordinating Responsibility: The organization or staff office(s) responsible for providing input / support to the Office of Primary Responsibility as required.

Office of Primary Responsibility: The organizations or staff office(s) primarily responsible for preparing and executing the task.

Operation Order (OPORD): A directive issued by a commander to subordinate commanders for the purpose of effecting the coordinated execution of an operation.

Operations Tempo (OPTEMPO): A measure of the pace of an operation or operations in terms of missions conducted and a measure of equipment and vehicle usage.

Prevention: A proactive process which empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

Regional Medical Commands (RMCs): The RMCs are MEDCOM Major Subordinate Commands (MSCs) and operate under the supervision of the RMC commander. The RMC commander provides mission command over the MEDCEN, MEDDAC, and MTF commanders located within his or her respective RMC.

RESET: When viewed in all capital letters, RESET refers to the Army imperative that will systematically restore deployed units -- CEF units as well as DEF units -- to an appropriate level of equipment, Soldier, and Family readiness in preparation for future deployments and contingencies. RESET encompasses those tasks required to re-integrate Soldiers and Families, then organize, man, equip, and train a unit.

Senior Commander: Command of Army installations is exercised by a Senior Commander (SC). The SC is designated by Senior Army leadership. The SC's command authority over the installation derives from the Chief of Staff of the Army (CSA) and Secretary of the Army's (SA) authority over installations. This is a direct delegation of command authority for the installation to the SC. The SC's command authority includes all authorities inherent in command including the authority to ensure the maintenance of good order and discipline for the installation.

Strategic Communication: The process Army Medicine uses to integrate information across all functions and engage key audiences/stakeholders to promote awareness and achieve desired effects based on our strategic objectives and initiatives in the Army Medicine BSC. Strategic communication includes effective messaging both internal and external to the organization.

U.S. Army Forces Command (FORSCOM): The largest Army Command (ACOM) and the Army Service Component Command (ASCC) of U.S. Joint Forces Command (JFCOM). As ASCC to JFCOM, the joint force provider, FORSCOM is responsible for sourcing the combatant commanders' requests for conventional land forces.

U.S. Army Reserve Command: The U.S. Army Reserve Command is a direct reporting unit to Headquarters, Department of the Army. Its mission is to provide trained and ready units and individuals to mobilize and deploy in support of the national military strategy. The U.S. Army Reserve Command is responsible for all of the operational tasks involved in training, equipping, managing, supporting, mobilizing and retaining Soldiers under its command.

U.S. Army Warrior Transition Command (WTC): The WTC is a one-star command under the U.S. Army Medical Command (MEDCOM) that was created to provide a central comprehensive source for warrior care support. WTC's mission is to develop, coordinate and integrate the Army's Warrior Care and Transition Program (WCTP) for wounded, ill and injured Soldiers, Veterans and their Families or caregivers and to promote success as they transition back to the Army or to civilian life thorough a comprehensive program of medical care, rehabilitation, professional development and personal goals. WTC additionally supports Army Force Generation by ensuring everything possible is done to retain and return to duty Soldiers that are fully fit for duty.

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