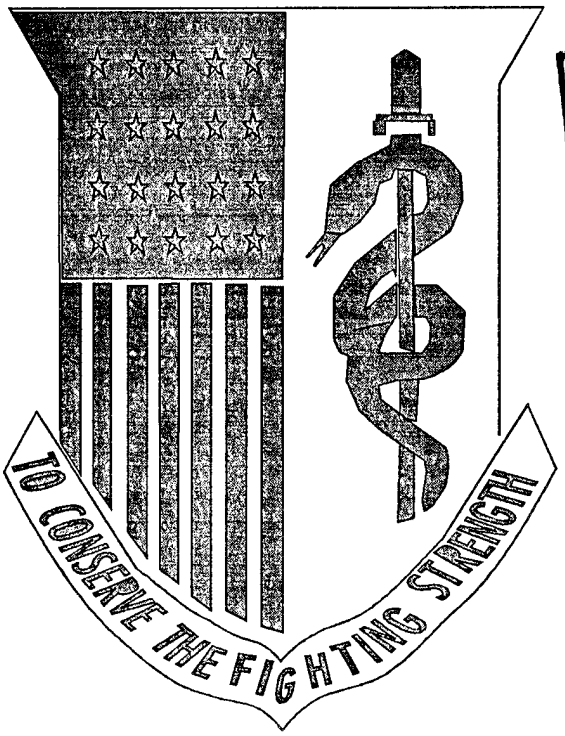
UNITED STATES ARMY MEDICAL DEPARTMENT

REORGANIZATION



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ENCLOSURES 15-17

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JANUARY 1993 - JUNE 1995

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13. ABSTRACT *(Maximum 200 words)*

This report provides a synopsis of the work surrounding the Army Medical Department (AMEDD) reorganization during the period January 1993 to June 1995. Volume I of the report documents the formation of Task Force Aesculapius; the role of Organizational Design, Incorporated; and the impact of the reorganization on other AMEDD activities. Other topics covered include background reasons for the reorganization, the analytical process, concept plan development, implementation of the concept plan, major subordinate command analyses, marketing the reorganization, and related issues. Volumes II, III, IV, and V contain enclosures which include the MEDCOM Concept Plan, Task Force charters, selected reorganization briefings, and major subordinate command reviews.

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ENCLOSURE 15

DENTAL COMMAND OVERVIEW

I. BACKGROUND:

The Dental Command (DENCOM) was activated as a major subordinate command of the MEDCOM on 14 November 1994. The formal establishment of DENCOM as a separate command represented the final step in an evolutionary process that recognized dental care as a separate product line within the medical community. Prior to this event, dental services within HSC were provided by 37 DENTACS comprised of over 150 separate Dental Clinics under the oversight of the Director of Dental Services who at one time was also dual- hatted as the Deputy Commander of HSC. A similar command relationship existed within 7th MEDCOM. Dental services were delivered by 9 DENTACS comprised of approximately 95 separate Dental Clinics under the command oversight of the Director of Professional Services, who was also dual- hatted as the Deputy Commander of 7th MEDCOM. Dental services in Japan were provided by a DENTAC reporting directing to OTSG. Dental services in Korea were organized under TOEs under the command and control of 18th MEDCOM.

In the more distant past, dental services were under the overall command and control of the local medical commander. This delivery mechanism proved to be problematic and dental services were reorganized into a separate product line in 1978 (Title 10 changed officially in January of 1979). Since that time, dental care has flourished and dental services have regularly received high marks by soldiers and commanders throughout the Army. For example, several CINCS reported nduring initial TFA interviews that, in their opinion, the quality of dental care was outstanding and the reorganization of the AMEDD would best be served if the dental care system was essentially left unchanged.

Throughout this period, all Dental Corps activities were under the watchful eye of the Dental Corps Chief who was located in Washington, D.C. The Office of the Dental Corps Chief promulgated Army dental policies and managed all interactions with the various dental professional associations and associated accrediting bodies. In addition, the Corps Chief Office designed and monitored the career development pattern of Dental Corps officers. The Corps Chief Office also managed the overall Dental Corps talent pool. With a two star Corps Chief and two one star Directors of Dental Services, the Dental Corps was admirably managed throughout this period. In many ways, this represented the "golden era" of the Dental Corps. The number of Dental officers on active duty approached 2000 and recruitment and retention problems were minimal.

The situation changed dramatically in 1989 with the fall of the Berlin Wall. As the Cold War ended, the Army underwent a significant downsizing effort. From a base force of 750,000 active duty soldiers, the Army shrunk to a post Cold War end strength of approximately 500,000 soldiers. The resultant impact on the AMEDD and the Dental Corps was significant. For example, Dental Corps end strength dropped from nearly 2000 to approximately 1200. The strains caused by the magnitude of this drawdown resulted in the AMEDD undertaking a massive restructuring effort in 1993. As a result of that effort, HSC and 7th MEDCOM were dis-established and a new MEDCOM organization was created with a worldwide medical mission.

Extantly, the Army Chief of Staff (CSA) has always held the TSG accountable for the effective provision of health care services. Unfortunately, the old AMEDD structure never provided an effective vehicle for carrying out that accountability. At the same time, the pressures generated by the magnitude of the overall downsizing effort significantly modified the way the Army intended to carry out the national military strategy. Force XXI became the new umbrella concept from which future force structure models would be derived. In the future, the Army intends to support

overseas deployments from a CONUS base force projection platform. The newly created MEDCOM was specifically designed to implement the new Force XXI strategy. A key element of the AMEDD restructuring effort was the simultaneous establishment of the DENCOM as a stand alone separate major subordinate command. For the first time, dental services were formally recognized as a separate product line. A separate command structure was subsequently established to oversee the delivery of those services.

The DENCOM organization is essentially made up of the old staff assigned to the HSC nDirector of Dental Services. The headquarters staff consisted of 12 personnel. The creation of the DENCOM did not require any additional personnel to be assigned to the command's headquarters. To oversee the 31 DENTACS and approximately 172 clinics operating throughout the world, 8 Dental Service Support Areas were created. These intermediate headquarters corresponded to the 8 Health Service Support Areas (HSSAs) which were also designed to oversee regional health care. Each DSSA was staffed by dual-hatting existing DENTAC staff personnel and by assigning one additional support staff to the headquarters. Each DSSA, in turn, was accountable for overseeing the activities of a number of DENTACS and subordinate clinic commands and clinics located within a given regional boundary.

The AMEDD reorganization effort has been underway for approximately two and one half years. In that period a number of significant changes have been implemented. Old paradigms have been shattered and new ways of thinking have emerged. The creation of the MEDCOM was the central part of this reorganization effort. A detailed analysis of the MEDCOM headquarters structure resulted in a number of significant changes to the internal staff organization. As discussed previously, an important element in the reorganization effort was to clearly differentiate between staff work and operational work. This differentiation reinforced the AMEDD decision to establish the DENCOM as a major subordinate

command. Implementation of these changes began with DA approval of the new structure. The headquarters fully activated in October 1994. A re-analysis of the MEDCOM and all of its major subordinate commands was to be carried out in FY 95. This relook of the DENCOM organization was part of that overall effort and was conducted in the March-April 1995 time frame. Conclusions from the analyses are presented below.

II. THEME:

The establishment and on-going functioning of the DENCOM is proceeding smoothly, with the command effectively meeting all existing customer dental needs.

III. FINDINGS:

- There is widespread agreement that the current DENCOM structure is effectively providing required dental services.

- The establishment of the DENCOM did not involve any increase in headquarters staffing levels.

- There is an inconsistency in the grade level of some senior enlisted staff members at the DSSA level, e.g., 1st Sgts versus SGM.

- The DSSA structure is perceived to be an efficient way of overseeing regional dental activities (the staffing of the DSSAs involved assigning minimal additional assets).

- Some Dental Corps officers reportedly call the Office of the Corps Chief directly to voice complaints and/or work "pet" issues.

- There is some confusion regarding the role of the Dental Board of Directors.

- Keeping the provision of dental services separate from other health care services is widely favored by the existing customer base.

- DSSAs vary substantially in the number and complexity of subordinate commands.

- There is a perception that some DENCOM operations are overly influenced by existing staff assigned to the office of the Corps Chief.

- Some interviewees felt that the DENCOM had too many DSSAs.

- A perception exists that the DENCOM needs a CSM to look at soldier morale and add validity to its overall command structure.

- There is a perception that the AGR Dental Officer should be assigned to the DENCOM.

- There is a widespread perception that the DENCOM is currently allocating funds in accord with mission needs more consistently and fairly than ever before. (Historically, such allocations were heretofore perceived to be primarily based on emotions and politics).

IV. ISSUES:

1. What is the best way to provide Dental Corps General Officer oversight of DENCOM activities?

2. Should all DSSAs be staffed similarly?

3. Is the Dental Corps leader development system building a sufficient junior officer "bench"?

4. Should the DENCOM have a CSM or a staff SGM?

V. DISCUSSION:

General Officer Oversight

Historically, the provision of dental services always benefited from the direct oversight of the Dental Corps Chief. Since the Corps Chief role historically constituted a "full time" position (similar to other AMEDD Corps Chiefs) this function received considerable undivided personal attention from the Corps Chief proper. The Chief of the Dental Corps throughout the recent past has always been intimately involved in all strategic level issues involving dental services and dental personnel. While the Corps Chief did not officially command existing dental activities, the reality was that he functioned extantly as the commander. The staff assigned to the Corps Chief's Office throughout this period were clearly perceived to be in a supporting role to assist him in overseeing all significant dental related issues. For example, all key policy issues were approved by the Corps Chief. Similarly, key assignments of dental personnel were always sanctioned by the Chief of the Corps. None of this should be surprising, for the Corps Chief was clearly accountable for managing the Dental Corps talent pool and overseeing all strategic issues facing the Corps.

With the dual- hatting of Corps Chief positions as an inherent part of the restructured AMEDD, the ability of the Corps Chief to devote sufficient undivided attention to Corps Chief issues has become increasingly more and more difficult. The reality is that in a restructured (downsized) Army, the AMEDD simply can no

longer afford to assign General Officers solely to oversee Corps Chief business. As a practical matter, General Officer Corps Chiefs had to be dual- hatted in other general management roles in order to retain their General Officer status (This was not an AMEDD decision but rather a CSA approved Army position). A key part of the original analysis of the MEDCOM recognized the DENCOM Commander position as a General Officer equivalent role. This recognition was due, in part, to the increased complexity of the work generated by the decision to dual-hat the Corps Chief. The net effect of the above change was to differentiate clearly between the work of the Corps Chief and that of the DENCOM commander. The Corps Chief was to concentrate on external relationship issues and career development policy issues, whereas the DENCOM commander was to focus on the operational aspects of providing dental services. There is a lingering perception, however, that the Corps Chief staff continues to attempt to perform both the external networking function, as well as the internal oversight function. Recognizing that the AMEDD (and the Dental Corps) are in a period of transition, the above perception may simply be reflective of normal growing pains. Nevertheless, the breadth of this perception is such that it warrants mention and subsequent monitoring to ensure the continued smooth transition to a full-scale stand alone DENCOM.

Basic Organizational Structure

The DENCOM extant organization (the organizational structure that reflects how work is acutally carried out) is depicted in figure 1. As illustrated, there appears to be two additional managerial layes in level IV (e.g. three separate and distinct roles). While there are in fact three roles within level IV, it is erroneous to conclude that any of these roles constitutes an unnecessary managerial layer. The underlying reasons why these three roles exist in the same managerial layer is simple. First, both the DENCOM and the VETCOM suifer from grade compression at the commander level. The work of the commander is general officer equivalent work even though the positions are currently graded at the 0-6 level. In an ideal world,

without general officer constraints, the commander role would requisitely be established as a general officer position. In today's resource constrained Army, however, it is simply not possible to assign a general officer to these roles. Current CSA guidance requires that any AMEDD general officer commanding one of the MEDCOM's new subordinate commands (e.g. DENCOM, VETCOM, USACHPPM) be dual-hatted in another senior level staff role.

Second, the DSSA role involves the exercise of comand and control over a number of separate DENTACS spread throughout a regional area. The DSSA commander has to work closely with a number of senior line commanders within his region, e.g., Corps and Division commanders. To facilitate such interactions, the DSSA commander is required to be MEL 1 qualified. Thus, the DSSA role clearly represents a solid level IV role. The DENTAC commander role, which is also aligned within level IV, is a more difficult role to understand because the complexity of that role varies widely across the DENCOM. Some DENTACS are very large and complex and, in fact, tend to almost overshadow their respective DSSAs e.g. Fort Hood and Fort Bragg (see also figure 4). Other DENTACS, while not as large, nevertheless involve establishing and maintaining complex working relationships with senior installation commanders. For example, most DENTAC commanders are rated in some fashion (intermediate or senior rated) by the senior officer assigned to the supported installation - a Major General in most cases. Even small DENTACS encompass similar working relationships. Further, DENTAC commanders exercise command and control over a number of satellite Dental clinics or Clinic Commands. The complexity required to integrate the diverse efforts of these stand-alone clinic operations is considered significant enough to warrant an O-6 commander. Thus, what appears to be "so called" layering within level IV, in fact simply represents the number and type of roles required to effectively oversee the delivery of dental services within a given geographic area (or installation).

Leader Development

As the AMEDD moves toward branch immaterial general officer positions, it is important to re-examine the career development progression of the Dental Corps officer. Figure 2 highlights the steps to the position of Corps Chief. An inherent part of an effective leader development track is to provide junior officers sufficient opportunities to command. Unfortunately, a disproportionately large number of Dental Clinic Commands are currently held by Colonels. This fact blocks needed leader development opportunities for younger Dental Corps officers and hence tends to mortgage the Corps's future. Compounding this problem is the disturbing fact that it is getting progressively more and more difficult to recruit and retain younger Dental Corps officers. This is a disturbing finding and worthy of more detailed analysis.

Laboratory Support

Existing dental laboratory support services are provided by two area dental labs (ADL) and the organic laboratories of each DENTAC. The problem with the current system is simple. The ADLs are currently under-utilized even though they are substantially more cost effective than the local labs. This economic advantage is due to more efficient work flows and a more cost effective employee salary schedule (see figure 3). The underlying rationale behind why most existing dental staff prefer to use local labs as opposed to the ADLs is simple. Most staff believe that they can exercise more control over local labs and hence achieve higher quality and more responsive service. While local labs may, in fact, be more responsive, this responsiveness comes at a high cost to the DENCOM. Further, there is no hard evidence of differences in quality between the two. Before recommending the full scale use of the ADLs, however, it is necessary to carefully evaluate the magnitude of the impact of transferring such work to the ADLs. It may well be that the ADLs

simply cannot handle the workload generated by all of the DENTACS. Irrespective, the most cost effective outcome for the DENTAC is to utilize the ADLs to their full individual capabilities.

DSSA Staffing Levels

The DSSA staffs were originally envisioned to take full advantage of dual-hatting existing DENTAC staff. One additional staff member was assigned to each DSSA to assist in the overall management of subordinate elements. It was found, however, that each DSSA varied extensively in terms of the number and type of subordinate elements contained within a given DSSA. Some DSSAs contain several DENTACS and a large number of subordinate clinics while other DSSAs contain only a single DENTAC and a small number of clinics (see figure 4). Yet each of these commands are staffed identically. It would seem prudent that staffing levels should represent the complexity of managerial work required to provide effective oversight in a given regional area. For example, the EURO DSSA oversees a large number of clinics and three separate DENTACS. In addition, many of the EURO DSSA staff are profis to TOE units. Further, the nature of the mission is such that some dependent care (including the treatment of DACs) must be provided. The complexity of this mission is in stark contrast to other DSSAs which are made up of a single DENTAC and one or two subordinate clinics. Therefore, it is recommended that the DSSA staffing levels be analyzed to determine appropriate staffing.

Inspections

A disproportionately large number of technical assistance visits are being performed by DENCOM and DSSA personnel. As the DENCOM and DSSA structure mature, inspections should decrease so these staff can effectively and efficiently function at their appropriate levels. If staff assistance visits are to continue, a thorough measure of their value-added should be performed by an independent audit.

CSM Roles

AR 611-201 authorizes a CSM for every Army unit where the incumbent is to be the principal enlisted assistant to the commander and where the commanader has authority over 300 or more enlisted soldiers. The CSM is accountable for executing established policies and standards pertaining to performance, care, conduct, appearance, personnel management, and training of enlisted personnel. The establishement of the DENCOM requisitely calls for the assignment of a CSM to carry out the above duties. The fact that the Army has not recognized such a need does not reduce the requirement for a senior NCO to perform the duties outlined above. Therefore, it is strongly recommended that the AMEDD ensure that a high potential, technically qualified, senior SGM always be assigned to the DENCOM.

It has been reported that the grade of the senior NCO at the DSSA level varies across the command. Some DSSAs reportedly have a SGM assigned where others have a 1st Sgt as their senior NCO. Since each DSSA commander is also dual-hatted as the local DENTAC commander and given that the DSSA is responsible for overseeing the provision of dental services throughout a regional area, it would seem prudent to assign a SGM to the DSSA level rather than a 1st Sgt. Having the extra rank should facilitate the accomplishment of the full range of accountabilities applicable to the DSSA command level.

VI. RECOMMENDATIONS:

1.The accountabilities and authorities relegated to the Office of the Corps Chief and those assigned to staff of the DENCOM should be clearly defined in order to eliminate any possible overlap or redundancies.

2. Recommend that DSSA staffs be analyzed to establish staffing comensurate with complexity of work.

3. Clinic Commands should be restricted to LTC commanders as an integral part of the Dental Corps overall leader development strategy.

4. The DENCOM should continue to pursue obtaining an authorization for a CSM.

DENCOM EXTANT ORGANIZATION

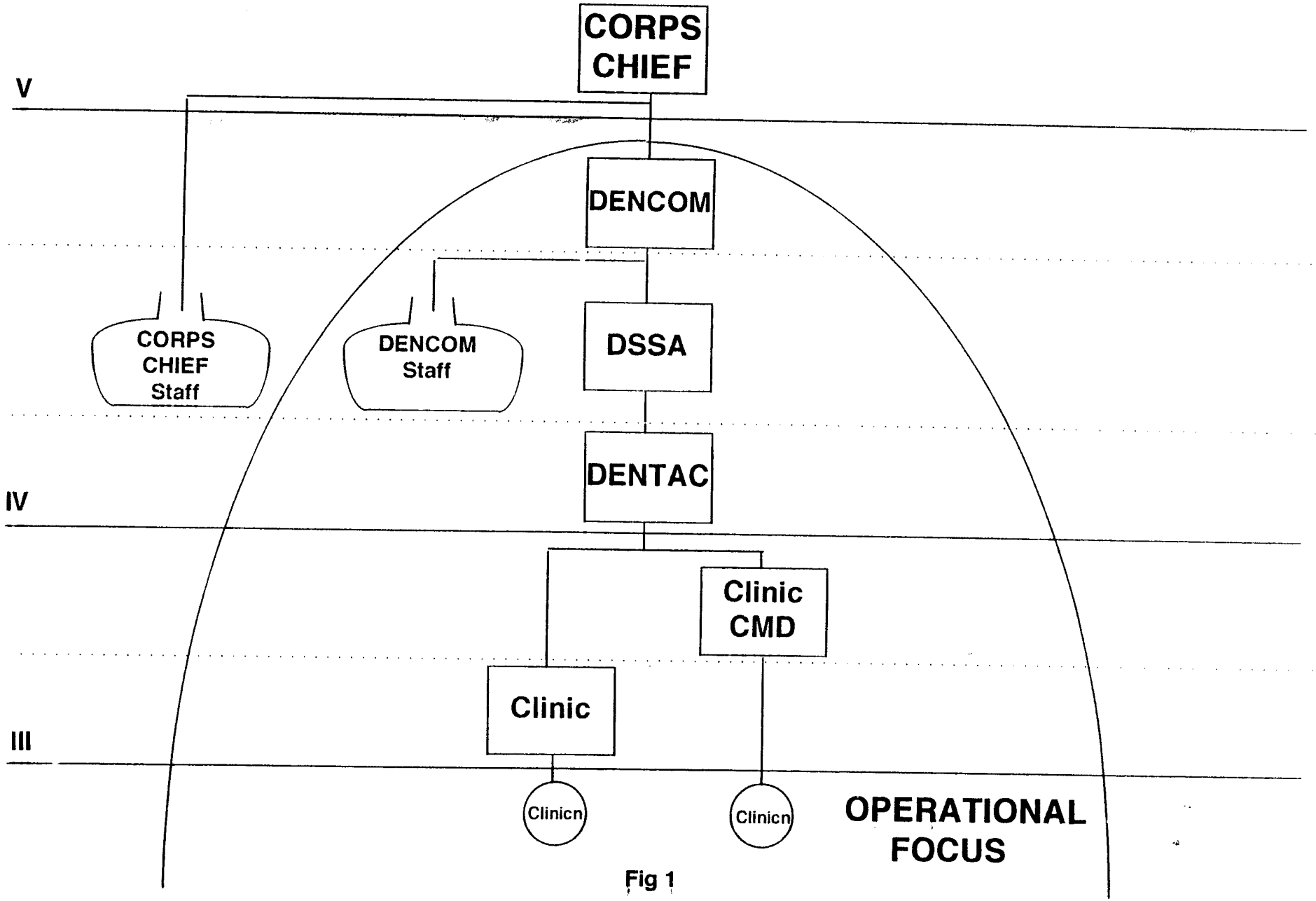


Fig 1

DENCOM LEADER DEVELOPMENT

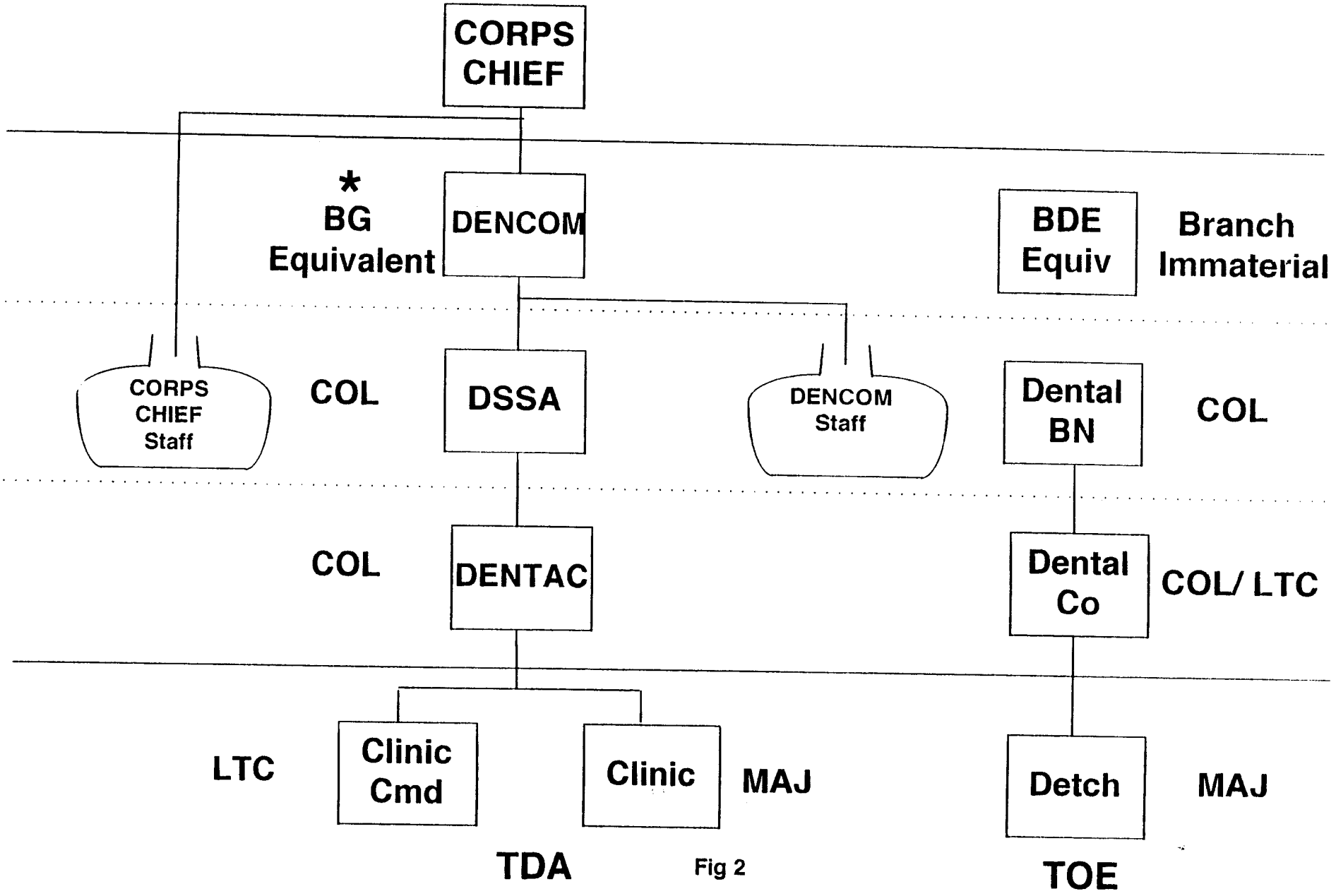
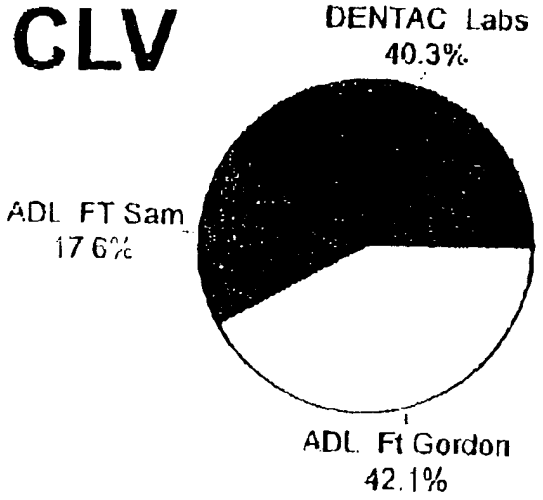


Fig 2

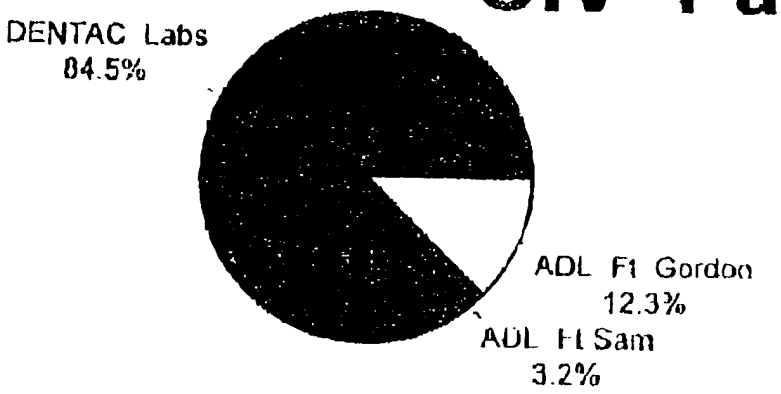
DENTAL LABORATORIES

FY 93

CLV



CIV Pay



	CLV	CIV Pay
DENTAC Labs	1,183,433	$ 5,879,420
ADL FSHTX	519,840	225,766
ADL Gordon	1,239,699	585,900
TOTAL	2,942,972	$ 6,969,086

DSSA COMPLEXITY

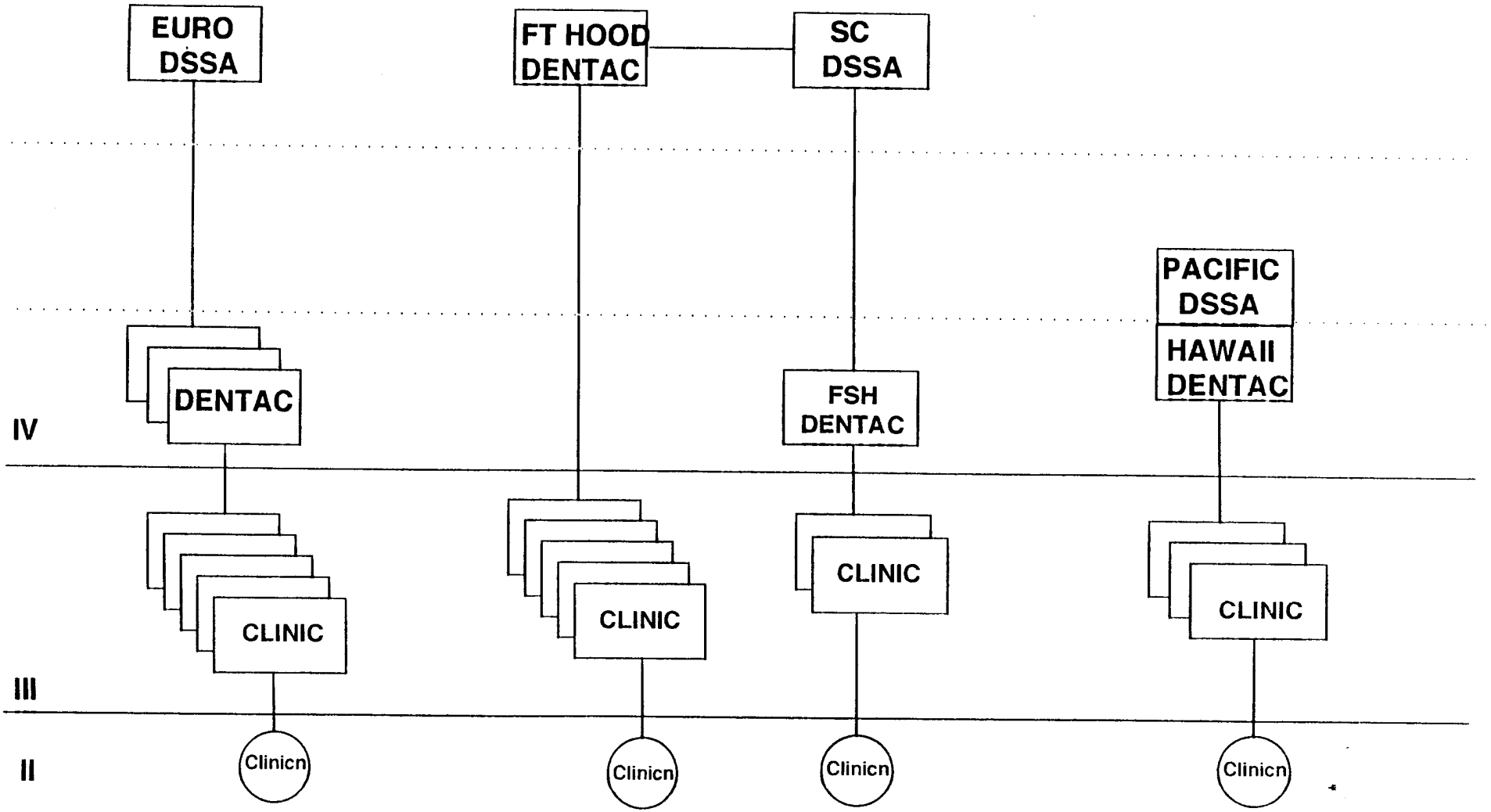


Fig 4

ENCLOSURE 16

VETERINARY COMMAND
OVERVIEW

I. BACKGROUND:

The Veterinary Command (VETCOM) was activated as a major subordinate command of the MEDCOM on 15 November 1994. The command was organized to reflect the unique product line of veterinary services (versus medical and dental), enhance readiness, and ensure an overall capability of providing high quality accessable veterinary services throughout DoD. The Army Veterinary Service has served as the DoD Executive Agent for Veterinary Services since 1981. As a result of that expanded mission and in accord with lessons learned from operation Desert Storm/ Desert Shield, the Veterinary Service Directorate strengthened an existing, albeit weak, regionalization concept. The VETCOM VSSA's formalize the regional organization and provide the flexibility needed to meet the requirements imposed by numerous DoD mission deployments, changes in operational procedures (e.g. prime vendor) and expanded use of animals in operational missions and in research and development programs. Regionalization allows the VSSAs to reconcile personnel imbalances within large areas of responsibility. The VETCOM structure also improves the readiness of the AMEDD through shortened chains of command, increased coordination in joint training efforts with TOE and RC units, and effective personnel movements during mobilization.

In 1981, the Secretary of the Army was designated the Executive Agent for all DoD Veterinary Services. This mission included the provisioning of uniform use of veterinary services throughout the Department of Defense. The Executive Agent was to provide the following services:

- Control of animal diseases communicable to man
- Veterinary care for government-owned animals supported by appropriated funds

- Provision of military veterinarians for research and development, when required by the Military departments
- Food safety and quality assurance for DoD activities

The formal establishment of the VETCOM as a separate command represented the final step in an evolutionary process that finally recognized veterinary services as a separate product line within the medical community. Prior to this event, the provisioning of veterinary services in CONUS was provided by regions and branches under the oversight of the HSC Director of Veterinary Services. A similar command relationship existed within the 7th MEDCOM. Veterinary services were delivered by detachments and branches under the oversight of theAssistant Chief of Staff for Veterinary Services.Veterinary services in the Pacific were overseen by the regional Veterinarian in Hawaii. TOE veterinary units reported to their respective commanders.

Throughout this period, all Veterinary Corps activities were also under the general oversight of the Veterinary Corps Chief who was located in Washington, D.C. The office of the Corps Chief managed all interactions with the various professional associations and associated accrediting bodies. In addition, the Corps Chief Office actively designed and monitored the career development pattern of Veterinary Corps officers worldwide. Additionally, the Corps Chief managed the overall Veterinary Corps talent pool. With a Brigadier General Corps Chief the Veterinary Corps was adequately represented throughout this period.

All of this changed dramatically in 1989 with the fall of the Berlin Wall. As the "cold war ended", the Army struggled with the pressures generated by a significant downsizing requirement. From a base force of 750,000 active duty soldiers, the Army shrunk to a post cold war end strength of approximately 500,000 soldiers. The resultant impact on the AMEDD and the Veterinary Corps was significant. The

strains caused by the magnitude of this drawndown resulted in the AMEDD undertaking a massive restructuring effort in 1993. As a result of that effort, HSC and the 7th MEDCOM were dis-established and a new MEDCOM organization was established with a worldwide medical mission. A key element of that restructring effort was the simultaneous establishement of the VETCOM as a stand alone separate major subordinate command. For the first time ever, Veterinary Services were formally recognized as a separate product line and a separate command structure was established to oversee the delivery of those services.

The VETCOM headquarters was essentially made up of the old staff assigned to the HSC, Directorate of Veterinary Services. The headquarters staff consisted of 23 personnel. The creation of the VETCOM did not involve assigning any additional personnel to the headquarters. To oversee the existing veterinary districts and corresponding branches, 7 Veterinary Service Support Activities were created. These headquarnters corrsdponded to the 7 Health Service Support Activities (HSSAs). European operations were treated separately. Each VSSA was accountable for overseeing the activities of a number of districts and subordinate branches located within their respective regional boundaries.

The AMEDD reorganization effort has been underway for approximately two and one half years. In that period a number of significant changes have been implemented. Old paradigms have been shattered and new ways of thinking have emerged. The creation of the MEDCOM was the central part of this reorganization effort. A detailed analysis of the headquarters structure resulted in a number of significant changes to the internal staff organization. Implementation of these changes began with DA approval of the new structure. The headquarters fully activated in October 1994. A re-analysis of the VETCOM structure was conducted in the March- April 1995 time frame. Conclusions from this analysis are presented below.

II. THEME:

The VETCOM organization is effectively carrying out all DoD assigned missions.

III. FINDINGS:

- There is widespread agreement that the current VETCOM structure is effectively providing all required veterinary services.

- The establishement of the VETCOM did not involve any increase in headquarters staffing levels.

- All veterinary assets in Europe are assigned to the 100th Med Det (VS HQ).

- The 100th MED DET mission encompases both TOE and Theater (TDA) missions.

- The 41 civilians organic to the 100th MED DET are documented on the EURO HSSA TDA.

- There is some indication that the alignment of all European Veterinary assets into a TOE structure is causing a degradation in theater support.

- The VETCOM commander is currently dual-hatted as the Director of the DoD Veterinary Activity.

- The VSSA structure is perceived to be an efficient way of overseeing regional veterinary activities (the staffing of the VSSAs involved minimal additional assets).

- Keeping the provisioning of veterinary services separate from other health care services is widely favored by the existing customer base.

• VSSAs vary substantially in the number and complexity of subordinate commands.

• Some Veterinary officers believe that the DoD VET Activity should be aligned separately from the VETCOM.

• The day-to-day working interactions with DoD customers who are located in the NCR requires a veterinary presence in the Washington area.

• There exists a perception that because the VETCOM does not have a worldwide mission, the DoD Veterinary Activity needs to function as an autonomous operation.

• Veterinary Corps staff are currently assigned to a variety of units throughout the world e.g. CENCOM; FORSCOM; 5th Corps; DLA; AAFES; DeCA, Naval Supply Systems Command, etc. None of these assets currently fall under the operational control of the VETCOM.

• There are approximately 30 Veterinary Corps positions in Joint Activities.

• There continues to be overlap between the Air Force food inspection mission and the AMEDDC&S Veterinary training program e.g. food inspection training.

• The Director of the Food Safety and Public Health staff element is currently dual hatted as the Deputy Commander of the VETCOM.

• There is a perception that the MEDCOM staff holds too many "non-value added" meetings involving VETCOM personnel.

• The Non-appropriated Fund Veterinary Activity is perceived to be an effective way to provide needed veterinary services.

• There is some confusion over the functions appropriate to the Office of the Assistant Corps Chief in the AMEDDC&S and the Veterinary Corps Chief's office.

• The personnel system has not caught up with the establishment of the VETCOM e.g. UCMJ authority is missing because the SIDPERS system has yet to officially recognize the command.

IV. ISSUES:

1. What is the best way to provide VETCOM oversight over all DoD supported activities?

2. Is there a requirement to establish a VSSA in Europe?

3. Should all VSSAs be staffed similarly?

4. Is there a need to maintain a DoD VET Activity separate from the VETCOM?

V. DISCUSSION:

Integration of Corps Chief, DoD Veterinary Activity and VETCOM

From the inception of the DoD Veterinary Activity, the Veterinary Corps Chief was dual-hatted as the Director of the Activity, located in Washington D.C. The Director of the Activity functioned as the senior Veterinary Officer for all DoD issues. Consequently, the Veterinary Corps Chief functioned as the senior Army

veterinarian. There existed a limited working relationship between the DoD Activity and VETCOM. It was felt that the work of the two agencies differed significantly, hence there was no attempt to integrate existing staffs. VETCOM, at the time, did not have a worldwide mission, whereas the DoD Activity was chartered to oversee all Veterinary operations throughout DoD.

The nature of existing working relationships between OTSG and HSC (MEDCOM) changed dramatically with the restructuring of the AMEDD in 1993. With the formal establishment of the MEDCOM and the dual hatting of the TSG as the Commander, it was now possible for the TSG/ MEDCOM Commander to exercise operational oversight over all AMEDD assets worldwide. The MEDCOM was never envisioned to assume command and control over TOE medical units, although it was expected to exert persuasive influence, through the respective CINC, over such units. At the same time, the AMEDD began to shift it's center of gravity from the NCR area to San Antonio (the home of the MEDCOM). A key design feature of the restructured AMEDD was to dual-hat all Corps Chief roles. It was also intended to centralize the day-to-day operational work of the Corps Chiefs in the AMEDD Center and School. For those Corps which felt a necessity to maintain an NCR presence because of required working interactions with specific accrediting bodies or other NCR customers, such a presence was to be an adjunct activity of the Corps Chief Office located within the AMEDDC&S.

The creation of the MEDCOM and the designation of the new Veterinary Corps Chief as the Commander of the VETCOM provided an opportunity for the AMEDD to further integrate the operations of the DoD Veterinary Activity and the VETCOM. Previously, these were two separate activities. However, the changes described above permitted the AMEDD (and the Army) to capitalize on futher synergies between these two functional areas. While the VETCOM does not enjoy command and control oversight over all veterinary activities worldwide, extantly the

Commander was expected to monitor and influnce such efforts, as required. A primary vehicle for implementing such influence was the authority which flowed logically from the Corps Chief's proponency role. The Corps Chief role encompasses some aspects of proponency but not all. For example, the Corps Chief is clearly the branch proponent and the functional proponent for all branch related issues. The Corps Chief, however, is not the personnel proponent, although he must work closely with the proponent i.e., APPD. To fully understnd the rationale behind the decision to integrate the DoD VET Activity with the VETCOM, one needs to first understand the key elements of proponecy as outlined below:

Functional proponency - oversight over all aspects of the worldwide health care (veterinary) delivery system. Extantly, the CSA holds the TSG accountable for the effective provisioning of all health care services. (The presence of this extant accountability is the primary reason why the CSA permitted the establishment of a MEDCOM with the TSG dual-hatted as the commander). Similarly, the Secretary of the Army (acting as the DoD Executive Agent) holds the Veterinary Corps Chief (through TSG) accountable for all Veterinary operations.

Branch Pronponency - Each Corps Chief is responsible for overseeing all unique branch matters. The branch proponent should be expected to adopt a parochial position visi-a-vis his or her branch, although such a position should be tempered with compromise, as the situation demands.

Personnel Proponency - Overseeing all force management issues based on analysis and studies consistent with the life-cycle management philosophy espoused by the DA-DCSPER.

Specified Proponency - Accountable for developing concepts, doctrine, training and educational programs.

The Veterinary Corps Chief operates extantly as the branch, functional and specified proponent for all veterinary related activities. It is the authority which flows from the Corps Chief role which facilitates the exercise of influence over those veterinary units not under the direct control of the VETCOM. For example, by recommending doctrinal changes (a specified/branch proponency accountability), the Corps Chief is able to influence existing operating procedures in all veterinary commands (TDA and TOE) worldwide.

The dual-hatting of the VETCOM Commander (the existing Corps Chief) as the Director of the DoD Veterinary Activity eliminates any possible confusion over who is extantly in charge of veterinary operations worldwide. Further, it facilitates the complete integration of the two activities thereby generating additional personnel savings and operational synergies. Mentoring a split staff (i.e., VETCOM staff in San Antonio and DoD VSA staff in the NCR) with a dual-hatted Commander/ Director follows the OTSG/MEDCOM model and appropriately recognizes the current focus of the two staffs. However, as the VETCOM continues to mature, the requirement for a searate DoD VSA staff needs to be periodically reevaluated. There is potential synergy associated with consolidation of the two stafffs.

Basic Organizational Structure

The VETCOM extant organization (the organizational structure that reflects how work is acutally carried out) is depicted in figure 1. As illustrated, there appears to be an additional managerial layer in level IV (e.g. two separate and distinct roles). While there are in fact two roles within level IV, it is erroneous to conclude that either of these roles constitutes an unnecessary managerial layer. The underlying reasons why these two roles exist in the same managerial layer is simple. First, both

the DENCOM and the VETCOM suffer from grade compression at the commander level. The work of the commander is general officer equivalent work even though the positions are currently graded at the 0-6 level. In an ideal world, without general officer constraints, the commander role would requisitely be established as a general officer position. In today's resource constrained Army, however, it is simply not possible to assign a general officer to these roles. Current CSA guidance requires that any AMEDD general officer commanding one of the MEDCOM's new subordinate commands (e.g. DENCOM, VETCOM, USACHPPM) be dual-hatted in another senior level staff role.

Second, the VSSA role involves the exercise of comand and control over a number of separate districts and branches spread throughout a wide regional area. The VSSA commander has to work closely with a number of senior line commanders within his region e.g. Corps and Division commanders. To facilitate such interactions, the VSSA commander is required to be MEL 1 qualified. Thus, the VSSA role clearly represents a solid level IV role.

Leader development

As the AMEDD moves toward implementing branch immaterial general officer positions, it is important to re-examine the career development progression of Veterinary Corps officers. Figure 2 highlights the steps to the position of Corps Chief/ VETCOM Commander. An inherent part of that development is to provide junior officers sufficient experience to command veterinary districts and/or detachments. It is absolutely paramount, from a leader development perspective, that over- graded veterinary officers should not be permitted to command lower level units. To do so denies sufficient opportunities for younger Veterinary Corps officers and hence tends to mortgage the Corps's future.

European VSSA

There is some evidence emerging that the alignment of all (TOE and TDA) European Veterinary assets into the 100th MED DET (VS HQ) is causing a degradation in some subordinate elements ability to perform required theater support missions. For example, sometimes 5th Corps training requirements disrupt the efficient scheduling of veterinary support efforts to non-Corps units. It is only natural for a Corps Commander to want all of his subordinate units fully trained and ready to deploy. Such a concern posses no real problems for combat arms units. Obviously, readiness is an operational Corp's number 1 priority. But readiness does not come free, part of the cost is always expressed in valuable training time. Sometimes this training time comes at the expense of providing necessary support to non-Corps units. Since all veterinary assets in Europe are an organic part of the Corps, even though they are supporting a theater mission, it is difficult for a subordinate district or section commander to reprioritize (or re-program) required training initiatives. What invariably happens is that both missions are pursued, often over-stressing existing personnel or providing a lower level or quality of service.

The genesis of this situation is understandable. When the U.S. Army MEDCOM was originally established, and the 7th MEDCOM dis-established, the original guidance from Department of the Army was interpreted to mean that "the MEDCOM would not oversee any TOE assets". The intent of this guidance was directed primarily toward FORSCOM units. In the case of Europe, however, this guidance was interpreted to mean that all Veterinary units had to be either TOE or TDA; there was no supposed middle ground. At the time, the 5th Corps commander had to be persuaded to accept all Veterinary assets, including those with a theater mission or he would lose direct control over existing organic TOE units.

In subsequent conversations with the DCINC, it has become apparent that such a descision should be revisited. From the DCINC's perspective, both the theater mission and 5th Corps' mission need to be accomplished. There are times when the primary focus of the Corps may not be the primary focus of the theater. For example, to deploy the CSH hospital out of Wurzburg would likely seriously disrupt the concurrent health care delivery throughout the Wurzburg regional area. Sometime such deployments require compromise and sometimes they do not. It was for this very reason that the CINC preferred that the European HSSA commander not be dual-hatted as the 30th MEDICAL Brigade Commander.

A similar argument could be made regarding the 100th MED DET (VS) commander. By placing all assets in the Corps, compromise is made more difficult. Alternatively, by creating a European VSSA and dual-hatting the VSSA commander as the 100th MED DET commander, competing mission requirements can be more effectively reconciled. The critical issue to the DCINC is that so long as all TOE VET units are trained and ready to deploy, it is inconsequential whether they are assigned to the 100th MED DET or to the VSSA and "PROFISed" to their respective TOE units. The alignment issue should reflect the best choice for providing service to both the Corps as well as to the theater. Given the fact that the civilian workforce assigned to the 100th MED DET (VET) is currently documented on the HSSA TDA, creation of a VSSA would permit the realignment of these assets into their true organization. Therefore , it is recomended that creation of a VSSA and dual-hatting the commander as the 100th MED DET commander be discussed with the CINC in the near future.

VSSA Organization and Staffing

The VSSA organizational structure was originally patterned after the HSSA structure. Seven VSSAs were established (Europe has been discussed above), each co-located with their respective HSSA. The regional boundaries for each VSSA

generally corresponds with the respective HSSA boundaries. Each VSSA was staffed identically due to comparable missions. It was found, however, that each VSSA varied extensively in terms of the number and type of subordinate elements contained within the VSSA boundaries. Some VSSAs contain several districts and a large number of subordinate branches while other VSSAs contain only two districts and a small number of branches. Yet each of these commands are staffed identically. It would seem prudent that staffing levels should represent the complexity of the managerial work indigenous to a given region.

The recent MEDCOM decision to reduce the number of HSSAs from six to four in CONUS should be similarly implemented by the VETCOM. This decision, in turn, permits the VETCOM to realign existing districts into the remaining VSSA structure, thereby achieving a more effective overall balance.

CSM Roles

AR 611-201 authorizes a CSM for every Army unit where the incumbent is to be the principle enlisted assistant to the commander and where the commanader has authority over 300 or more enlisted soldiers. The CSM is accountable for executing established policies and standards pertaining to performance, care, conduct, appearance, personnel management, and training of enlisted personnel. The establishment of the VETCOM requisitely calls for the assignment of a CSM to carry out the above duties. The fact that the Army has not recognized such a need does not reduce the requirement for a senior NCO to perform the duties outlined above. Therefore, it is strongly recommended that the AMEDD ensure that a high potential, technically qualified, senior SGM always be assigned to the VETCOM.

VI. RECOMMENDATIONS:

1. Fully integrate the DoD VET Activity with the VETCOM.

2. Establish a EURRO VSSA; dual-hat the commander of the 100th MED DET as the VSSA commander and align TDA theater assets under the VSSA.

3. Reduce the number of VSSAs in accord with the realigned HSSA structure and staff each VSSA according to the complexity of their respective missions.

4. The VETCOM and MEDCOM should continue to pursue obtaining an authorization for a CSM.

VETCOM EXTANT ORGANIZATION

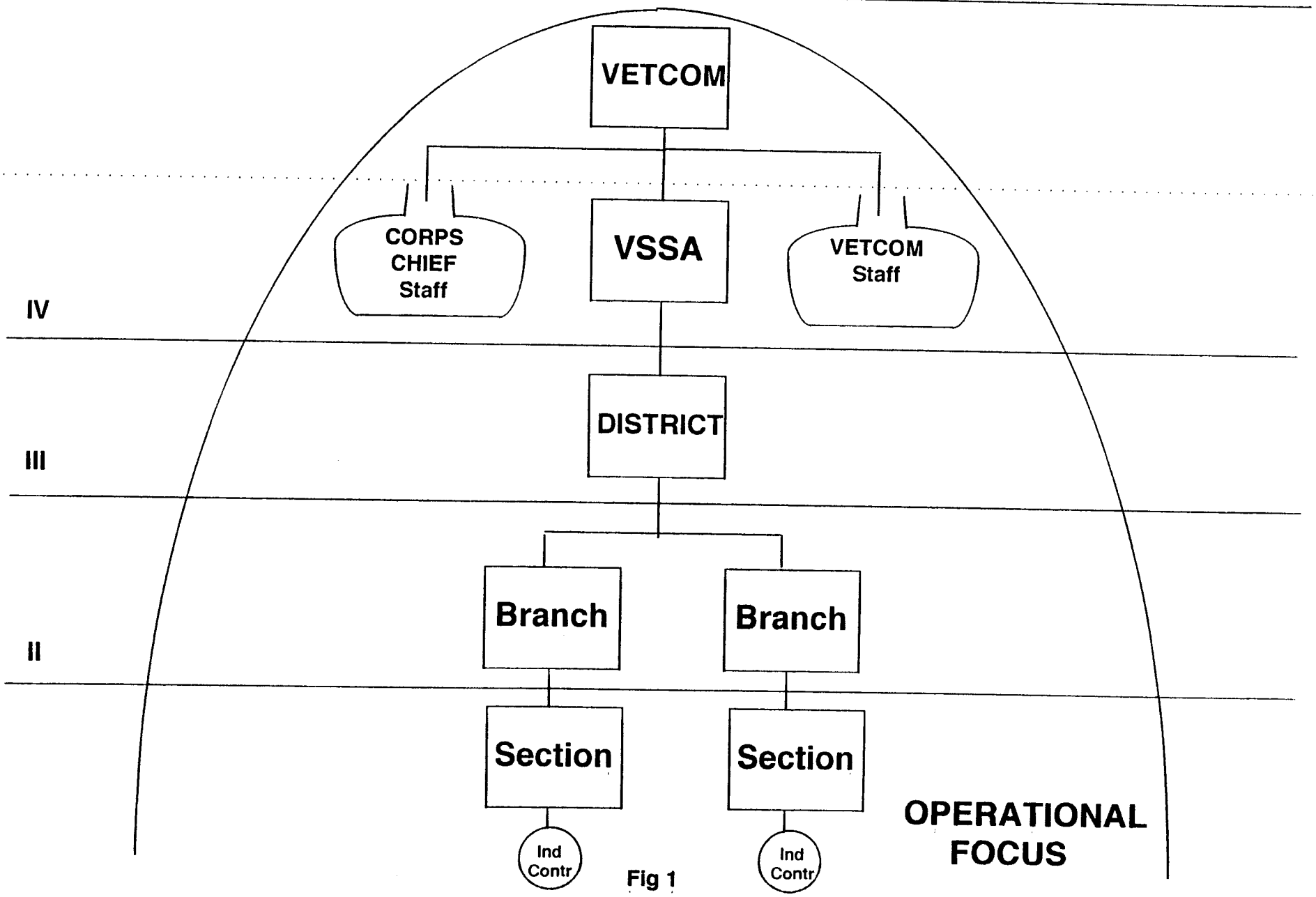


Fig 1

VETCOM LEADER DEVELOPMENT

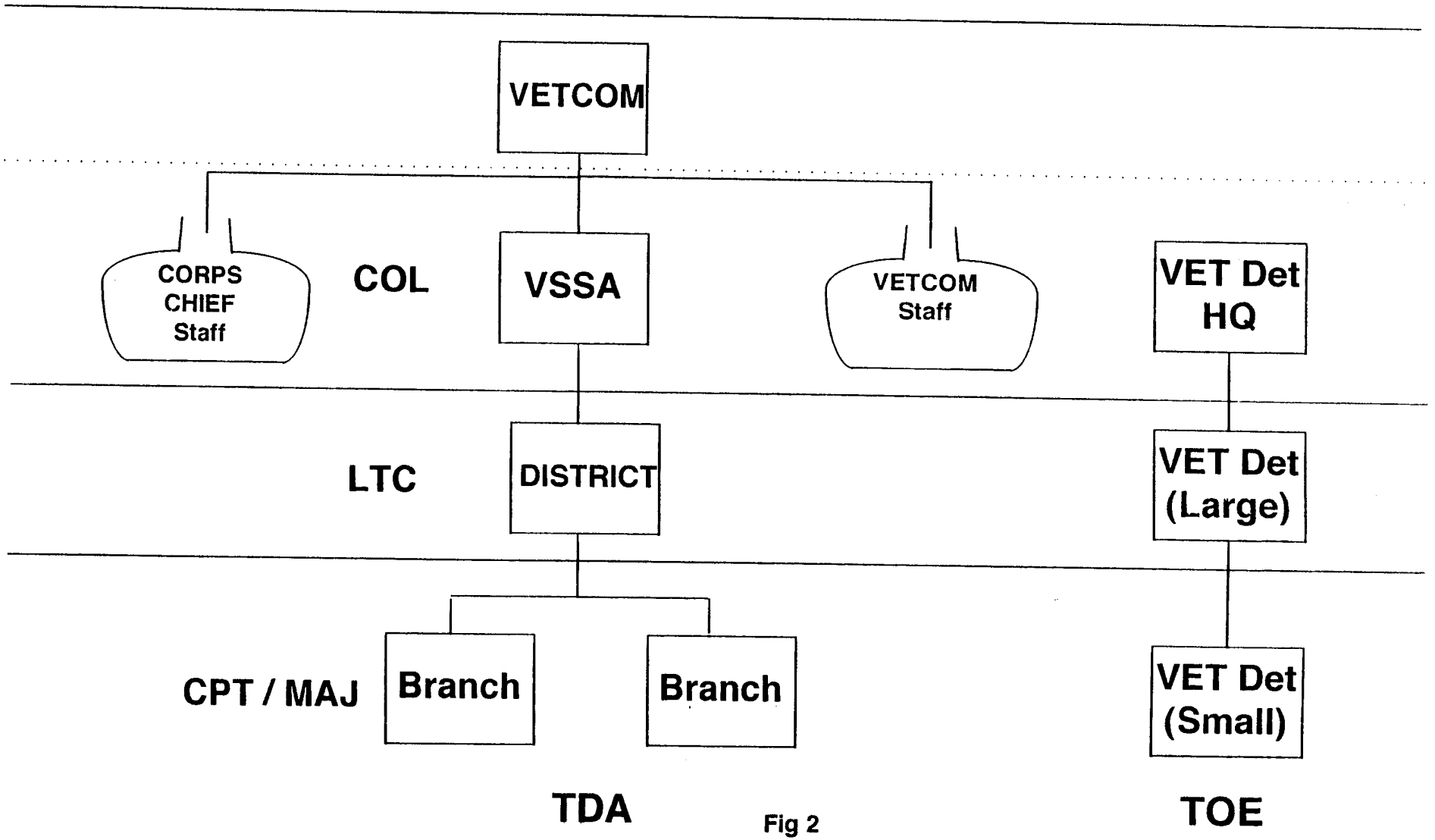


Fig 2

ENCLOSURE 17

U.S ARMY CENTER FOR HEALTH PROMOTION AND PREVENTIVE MEDICINE (PROVISIONAL)

ORGANIZATIONAL DESIGN REVIEW
17 MAY 1995

U.S. ARMY CENTER FOR HEALTH PROMOTION AND PREVENTIVE MEDICINE (PROVISIONAL)

ORGANIZATIONAL DESIGN REVIEW

TAB 1

ENCLOSURE 17

U.S. Army Center for Health Promotion and Preventive Medicine (Provisional)

OVERVIEW

I. BACKGROUND

The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) lineage can be traced back over fifty years to the Army Industrial Hygiene Laboratory. That organization was established at the beginning of World War II and was under the direct jurisdiction of the Army Surgeon General. It was originally located at the John Hopkins School of Hygiene and Public Health, with a staff of three and an annual operating budget not to exceed three thousand dollars. Its mission was to conduct occupational health surveys of Army operated industrial plants, arsenals, and depots. These surveys were aimed at identifying and eliminating occupational health hazards within the Department of Defense's (DOD) industrial production base and proved to be beneficial to the Nation's war effort.

More recently, the organization has been nationally (and internationally) known as the U.S. Army Environmental Hygiene Agency or AEHA. Its mission, by this time, had been expanded to support the worldwide preventive medicine programs of the Army, DOD and other Federal Agencies through consultations/supportive services, investigations and training.

Today, the organization has been further redesigned to the U.S. Army Center for Health Promotion and Preventive Medicine.

USACHPPM's mission is to provide worldwide technical support for implementing preventive medicine, public health and health promotion/wellness services into all aspects of America's Army and the Army community, anticipating and rapidly responding to operational needs and adaptable to a constantly changing world environment.

The professional disciplines represented at the Center include chemists, physicists, engineers, physicians, optometrists, audiologists, nurses, industrial hygienists, toxicologists, entomologists, veterinarians, and many others as well as subspecialties within these professions.

The organization's quest has always been one of excellence and continuous quality improvement. It is fiercely proud of its history, yet equally excited about its future. CHPPM's vision is to become a nationally recognized Center for Health Promotion and Preventive Medicine. To achieve that vision, CHPPM subscribes to the following values which are steeped in its rich heritage:

- Integrity is the foundation
- Excellence is the standard
- Customer satisfaction is the focus
- Its people are the most valued resource
- Continuous quality improvement is its pathway.

The organization is currently being totally restructured with a provisional organizational structure under the command and control of its first General Officer leader. New programs are being added related to health promotion/wellness, soldier fitness

and disease surveillance. As always, the mission focus is centered upon the Army's existing imperatives which are oriented around readiness for war and operations other than war.

The forementioned reorganization increased the number of directorates from five to seven to facilitate the center's new mission. Traditional directorates were also reorganized. The content of this paper focuses on each directorate mission, customers, work process, plan or strategy, and their products and services.

1. The Directorate of Epidemiology and Disease Surveillance (DEDS) is a new directorate. Their mission is to establish and operate a central epidemiologic resource for the Army; analyze, interpret and disseminate information regarding the status, trends, and determinants of health and fitness of America's Army; and identify and evaluate obstacles to medical readiness.

DEDS products/services are surveillance activities, routine reports, epidemiologic consultation/outbreak investigation, deployment surveillance/PDA participation, coordination and training; teaching/training of residents, USUHS, AMEDD C&S, other oral presentations and publications; committee, working and advisory group presentations such as HHS: Advisory Committee on Injury Prevention and Control, Consumer Products Safety Advisory Committee, DOD Injury Surveillance and Prevention Working Group; AFEB Injury Work Group; and the Army (DCSPER) Injury PAT.

Epidemiology services ongoing or planned include assessment of leading causes of morbidity/mortality and assessments of

leading types of causes of illness and injury. In addition, asthma and chronic respiratory disease surveillance, injury surveillance pilot projects, clinical preventive services assessments, smoking cessation pilot project, and a longitudinal soldier surveillance project are or will be ongoing.

2. The Health Promotion and Wellness Directorate (DHPW) is another new directorate. Their mission is to provide expertise to integrate health promotion and wellness initiatives into the Total Army by recommending policy, planning programs, providing training guidance, assisting in research and development, and disseminating information.

The DHPW customers are installations and line commanders, soldiers, civilian employees, retirees, family members, health care providers, RC/NG, DENTACs, MEDDACs, MEDCENs, TOE medical units, WRAIR, Army Community and Family Support Center, Army Physical Fitness School, Henry M. Jackson Foundation, DA Staff, MACOMs, DOD, COE, OTSG, and Child Development Services.

The DHPW products and services fall into six major categories: training, technical services, health promotion information management, functional services, preventive coordination, and liaison.

3. The Field Preventive Medicine Directorate (DFPM) is the third new directorate. Their mission is to protect warfighter health through defining environmental health threats, promoting countermeasures, and evaluating outcomes.

The DFPM key operational strategies are nonspecific and

brief. They include defining health threats, identifying threat countermeasures, promoting countermeasures, performing medical surveillance and evaluation, and coordinating deployment planning initiatives.

4. The Directorate of Clinical Preventive Medicine (DCPM) consists of programs from the former Occupational and Environmental Health Directorate. Their mission is to provide consultation and services to DOD, MEDCOM, HSSAs, MTFs, OTSG, and other MACOMs in the areas of: occupational medicine, occupational health nursing, vision conservation, hearing conservation, environmental noise, infectious disease control, and environmental medicine.

They operate the fully-accredited Army Occupational Medicine Residency.

DCPM also manages the funding, equipment, and software purchase and fielding, and related training for the Occupational Health Management Information System (OHMIS).

In addition, they provide functional support for the Hearing Evaluation Automated Registry System (HEARS) and Medical Information Module (MIM) of the OHMIS.

The DCPM customers are USACHPPM (Prov), MEDCOM, and its subordinates, i.e.; HSSA's, MTF's, MRMC, AMEDD C&S, other MACOMs and their installations; OTSG, DCSPER, DCSOPS, OCLL, Army Safety Center, Corps and Division Surgeons, DOD, DOD (HA), JCS; J4, unified commands, AFIP, AFEB, AFPMB, USUHS, Navy and Air Force; Federal Agencies such as NIOSH, OSHA, CDC, USPHS, and other

agencies such as academia, allied forces, private industry, and the media.

The DCPM work strategy is to focus on the following five areas:

a. Readiness: Maintain deployable people who are properly trained in military unique issues (e.g., chemical agents or propellant exhaust exposure) and who can respond to emergencies immediately by telephone or in person.

b. Develop, implement, guide, and provide management data from DA/DOD systems such as HEARS, MIM, the Civilian Recourse Conservation Program and the MEDCOM Managed Care in Occupational Medicine Program.

c. Develop CHPPM related proposals for medical policies and long range medical programs for MEDCOM, OTSG, & DOD.

d. Conduct planned training courses, consultations and surveys.

e. Participate in professional committees and in professional programs, and publish scientific work to provide peer review, give the Army a voice in the development of national policy and standards, and develop the CHPPM as a nationally and internationally respected organization.

5. The Directorate of Laboratory Services (DLS) mission statement is to provide comprehensive laboratory science assessments of occupational and environmental health risks associated with Army and DOD operations worldwide.

The DLS customers fall into two categories; Direct mail-in

customers (samples) and CHPPM program managers. Almost all CHPPM programs are DLS customers. Other customers include DLA, COE, MEDDACs, MEDCENs, health clinics, Aberdeen Proving Ground Support Activity and AEC.

Services and products include extensive organic, inorganic, and radioisotope analytical method development and sample analysis, toxicological and health risk evaluations of chemical substances, document review, basic and applied chemical health effects research, DOD chlorinesterase testing, and expert consultation.

6. The Directorate of Occupational Health Sciences (DOHS) is a consolidation of the former Directorate of Industrial Hygiene and several programs from the Directorate of Radiation and Entomological Sciences. Their mission is to support the warfighter and the industrial base by providing occupational health expertise in the anticipation, recognition, evaluation, and control of chemical, physical, and entomological stressors.

Their customers include other CHPPM assets, MACOMs, Installations, COE, OTSG, AEC, DA Staff, DLA, DOD, FUDS, DSA, BRAC sites, ATSDR, USACAMDA, State Department, Defense Contractors and universities, and colleges.

Their work process is quite variable, focusing primarily on providing required support to the industrial base.

Their products and services are both internal and external to USACHPPM.

7. The Directorate of Environmental Health Engineering (DEHE) is

a long standing directorate. Their mission is to provide worldwide technical preventive medicine guidance and evaluation focused on military environmental health issues. This support is provided to Army and DOD leaders and decision makers charged with the responsibility for the environmental health of military and civilian service members and the general public.

The primary DEHE customer base includes MACOMs, DA, DLA, operating agencies and military field units. Requests for work are generated through environmental staff personnel, preventive medicine personnel, and others. More specific examples of their customer base includes:

Medical Command - Staff, MEDCENs/MEDDACs and other installations

Army Material Command - Staff, ammunition plants, depots, and other facilities

TRADOC, FORSCOM and other MACOM installations, tenant activities and staffs

Defense Logistics Agency

U.S. Army Environmental Center

U.S. Army Chemical Demilitarization and Remediation Activity

U.S. Forces Korea and U.S. Army Europe

HQDA - The Surgeon General, Army Secretariat, and ODEP

The DEHE focal point for support requests and subsequent execution of work within the DEHE is the Program Manager (PM). The DEHE has seven PMS who report to the Director. These Pms and their employees interface directly with the field.

Tasking occurs on a planned and a quick response basis. The need for planned, scheduled services is identified through direct contact and marketing and, to a lesser extent, the 1383 Report and the annual Mission Services Meeting held by the Center. Projects of large scope which extend over several years are generally formalized in an Interagency Support Agreement detailing scope of work, schedule, and funding. Major undertakings such as support for the DERA Program and DLA are the subject of work plans which detail activities and funding on an annual basis. Quick response support is most frequently precipitated by a phone call from a wide variety of sources. These requests come directly to the pertinent PM or may come down through Command Channels.

Based upon guidance from the DEHE, the PM prioritizes work requests and commits the resources necessary to accomplish the requested work. Services are prioritized based upon overall environmental health impact, regulatory priority, and the value added by the service to the Army's mission.

Quick response tasks and unplanned technical consultations are frequently high priority and are accommodated by the PM on a case-by-case basis.

The PM monitors technical progress through direct interaction with the project officer and/or through oversight by senior engineers/team leaders/section chiefs. Depending on the project, both the PM and the project officer update the customer on progress. For projects of larger scope, quarterly IPRs may be

held to keep the customer informed. Reports prepared by project officers are reviewed by senior engineers/team leaders/section chiefs. The PM further reviews and approves the final report. Financial oversight is also provided by the PM with assistance from program analyst resources.

Generic DEHE services include consultations, environmental health studies, training, quick/emergency response and health risk assessments. The DEHE also provides direct staff support to The Surgeon General/MEDCOM regarding policy development, response to Congressional inquiries, media inquiries, representation in meetings, and other areas as requested.

II. THEME

The USACHPPM reorganization effort has resulted in instability and perceptions of image problems and valued customer loss.

III. FINDINGS

1. The reorganization of USACHPPM was swift and decisive, however, resourcing new directorates appears inadequate and their subsequent development has proceeded slowly.
2. Relating existing programs to the new directorates is in some cases inadequate. This results in the new directorates playing catch-up.
3. The missions of the DCPM Disease Control and Prevention Program and the DEDs is unclear. Redundancy may be occurring.

4. Some Directorates have retained division chiefs while others have eliminated them.

5. Serious concern was expressed by several interviewees about the lack of USACHPPM stability during this period of change.

6. Some respondants expressed concern that long standing customers may or do feel that USACHPPM can't provide the services USAEHA provided.

IV. ISSUES

1. What is the best way to resource the new CHPPM program areas?

2. Is there overlap between the DCPM Disease and Prevention programs and similar programs within DEDS?

3. Does the Division Chief layer add value?

IV. DISCUSSION

The continued survival and growth of USACHPPM appears to depend on the command's ability to relate their services and products to support the warfighter. Some of the services provided and customers supported do not appear to directly support this effort (although many of the services provide indirect support). The performance of these peripheral services provides USACHPPM with reimbursable and/or supplemental funding. This presents a dilemma to the command, however. The supplemental/reimbursable funding is extremely important to the maintenance and continued growth of CHPPM. It is important that these efforts continue, provided they support the CHPPM mission.

It appears that the change generated by the reorganization has resulted in increased staff anxieties, as expressed by a number of staff members. The instability of the existing structure coupled with the unknowns related to the protracted change of the command as a whole combined with the present climate within the Army have further fueled these increased anxieties. Therefore, it is incumbent upon the command's senior leadership to develop, communicate and act upon an overall strategy of moving CHPPM toward a more stabile existence where employees may focus on their technical tasks.

Resourcing and staffing the new directorates is also paramount to establishing their credibility as well as the credibility of CHPPM as it relates to carrying out the new mission. The new directorates appear to have done a good job developing strategies, ascertaining warfighter and customer needs, and developing action plans to meet those needs. Now is the time to ensure resourcing is provided. This will help to establish credibility with external customers who are anticipating the mission change. It will also assist in establishing internal credibility of the new directorates.

V. RECOMMENDATIONS

1. Prioritize staffing and resourcing of the new directorates. This may be done in one of two ways. First, transfer some personnel resources from existing programs which indirectly support the warfighter to the new areas. Inter-

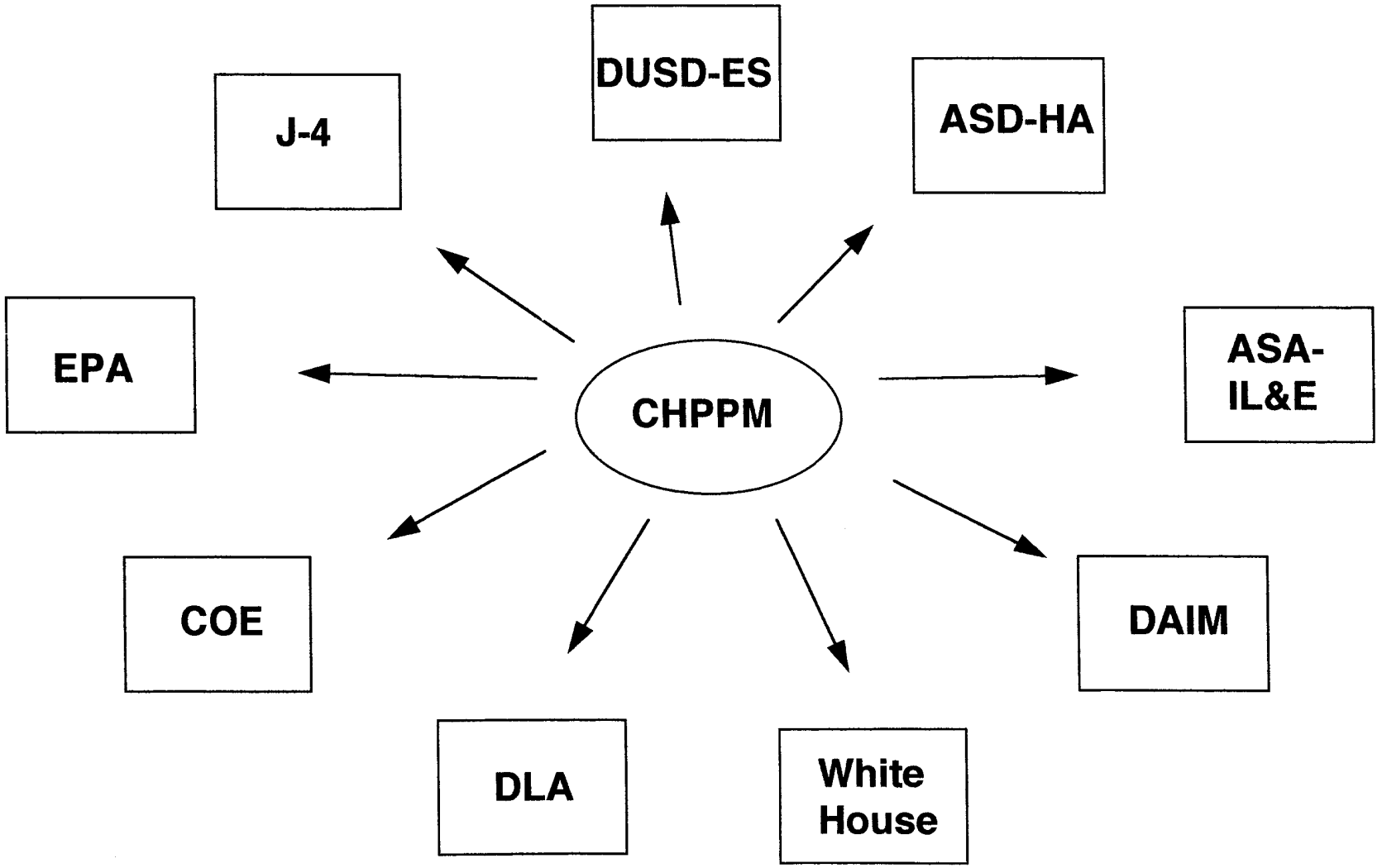
program relocations serve to diversify personal experiences while conserving overall CHPPM resources. Second, divert a percentage of reimbursable/supplemental funds to support resourcing the new directorates and programs. The presence of this additional funding will facilitate growth of the new programs. In addition, such a strategy permits the continued provisioning of services to existing customers while simultaneously allowing for expansion and growth of a new customer base.

2. Re-look the need for both a DCPM Disease and Prevention Program and the DEDs. If they are redundant, eliminate one or integrate them.

3. The need to keep (or eliminate) division chiefs appears to be tied to the amount of work required to be carried out at the Directorate level. Consider providing an executive/assistant director to eliminate some of the administrative load at the director level.

4. Senior leadership must develop, communicate, and act on their strategy to propel the organization from USAEHA to USACHPPM. This action must be swift and decisive to minimize existing turmoil and anxiety.

CHPPM CUSTOMERS



TAB 2

ENCLOSURE 17

U.S. Army Center for Health Promotion and Preventive Medicine

RESOURCE MANAGEMENT

I. BACKGROUND

Typically resource management offices perform four main functions: budgeting, analysis, programming, and manpower. Prior to the formation of the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM), the Army Environmental Hygiene Agency (AEHA) relied heavily upon the Office of the Surgeon General (OTSG) for resource management support. Personnel with preventive medicine expertise assigned to OTSG performed most of the programming and management analysis functions for AEHA. OTSG personnel were also able to program preventive medicine resources on behalf of the entire Army Medical Department. The OTSG staff was able to champion AEHA's cause and ensure that specific funding was obtained. Hence, AEHA did not have to directly compete with medical treatment facilities for funds. The resource management office within AEHA concentrated mainly on manpower and budget execution functions.

II. THEME

The USACHPPM needs a sophisticated resource management capability to support the development and execution of successful business plans.

III. FINDINGS

1. The USACHPPM resource management office currently has two branches; the Manpower Management Branch and the Program and Budget Branch. There is a lack of emphasis on resource programming and management analysis functions.

2. The Preventive Medicine Planning and Integration Office has a stated function of developing business plans that include resource programming and force integration issues. It reportedly lacks personnel with the necessary expertise to perform those functions.

IV. ISSUE

What is the optimal mechanism to provide USACHPPM with fully developed resource management capabilities?

V. DISCUSSION

Implementing successful business plans demands a full range of resource management capabilities. There is a need for highly developed management analysis skills in the resource management office. Sophisticated economic analyses need to be performed to ensure that resources are allocated as efficiently and effectively as possible. There is a need for program analysis and evaluation skills to serve as CHPPM's honest broker. In light of CHPPM's new increased emphasis on prevention and wellness coupled with the lack of any significant resource increases, difficult decisions need to be made concerning where

to place existing resources. Some existing programs may need to be reduced or eliminated in order to properly resource new prevention and wellness programs.

There is also a need for increased budget programming expertise. The OTSG staff no longer has the mission of developing long range budget needs. Expertise within CHPPM's resource management office is needed to ensure that current and future funding requirements for prevention and wellness programs are clearly identified and communicated to the Medical Command Program and Budget Office for inclusion in the Program Objective Memorandum submissions.

VI. RECOMMENDATIONS

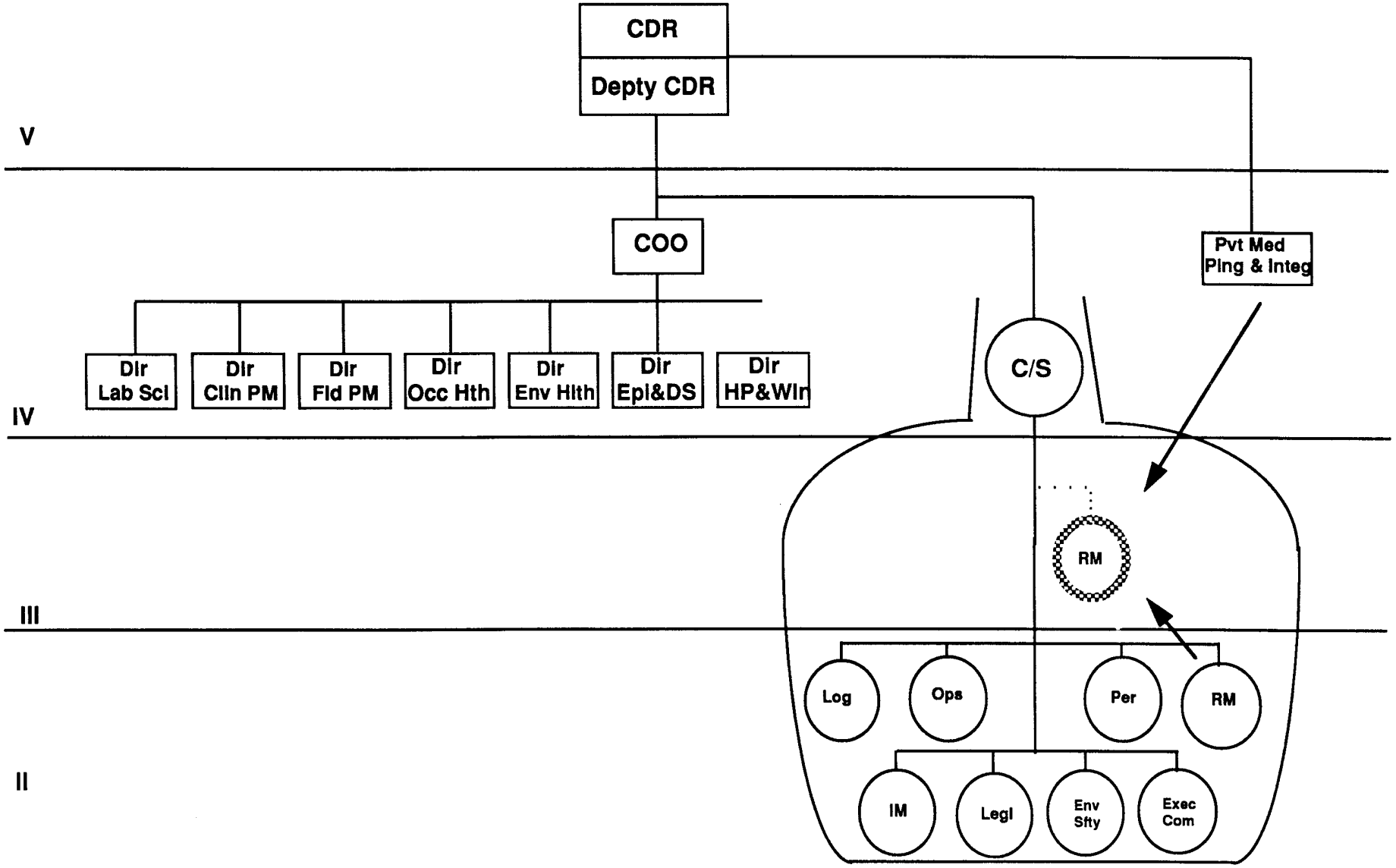
1. The resource management office should be enhanced to provide more management analysis capability.

2. The resource management office should also be enhanced to provide expanded programming capability.

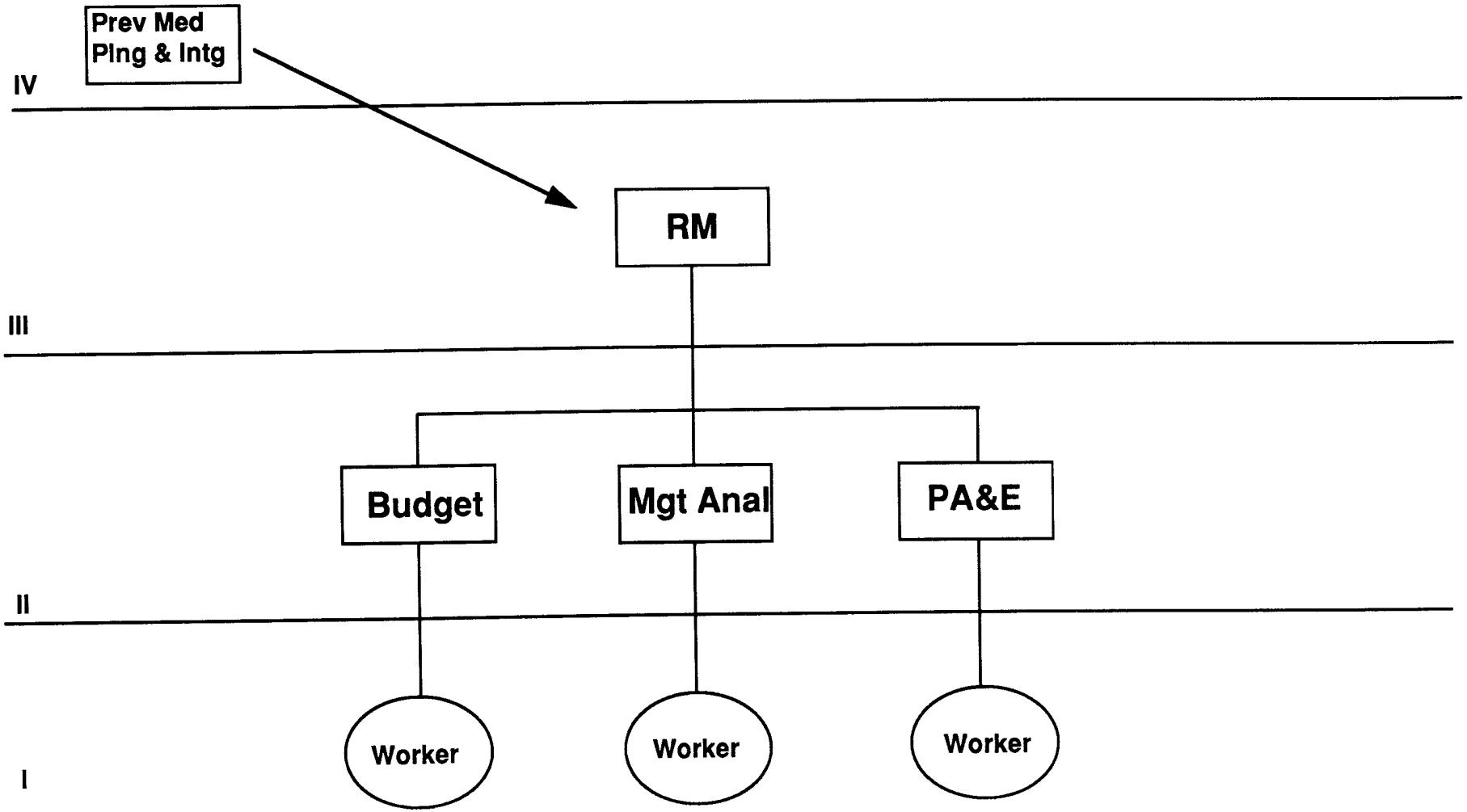
3. The Preventive Medicine Planning and Integration Office's intended function of resource programming should be placed in the resource management office.

4. A military comptroller should be assigned to the Command similar to other MEDCOM major subordinate commands. An active duty comptroller would bring new experiences and perspectives to the Center while the existing civilian staff would ensure continuity.

Resource Management



REQUISITE RM STAFF ORGANIZATION



TAB 3

ENCLOSURE 17

U.S. Army Center for Health Promotion and Preventive Medicine

SUPPLEMENTAL FUNDING

I. BACKGROUND

The USACHPPM (as USAEHA) was once totally funded by the parent MACOM (now MEDCOM) to perform mission work. As the customer base and need expanded while traditional mission dollars shrank, USAEHA found that customers were willing to pay to receive services. A business decision by senior USAEHA management was made to accept funds from customers for the performance of requested services. This allowed USAEHA to meet existing customer needs, develop new market niches, expand support facilities, position for future growth in anticipated technical areas, and develop into a national leader in the environmental and occupational health area.

Today the USACHPPM receives a mix of operating funds (e.g., labor, travel and per diem, administrative overhead, laboratory, facilities, consumables, etc.) from three sources: core or programmed funds (e.g., P84 through MEDCOM), reimbursable funds, and supplemental funds. The terms "reimbursable" and "supplemental" have been used interchangeably within USACHPPM for many years. These terms are further defined in the paragraphs below to explain subtle differences in operational use within the command.

Reimbursable funds can be defined as funds paid by a customer for a particular but finite service that core dollars, if available, would be used to fund. The recipient of the reimbursable funds, for the most part, is the particular USACHPPM program performing the service. The Chief of Staff may receive an administrative "handling charge" or overhead from the reimbursable fund (20 percent) for accounting and other costs to the USACHPPM. The individual program can charge an overhead fee in the amount of 15 percent (total overhead charge equaling 35 percent). If two or more programs coordinate to perform the service, the 15 percent program overhead is divided on a per program net funding percentage basis.

Acceptance of a reimbursable project is the decision of the individual program manager. The decision is based on many factors, including: prioritization of request against current mission impact goals (e.g., support to readiness, health, regulatory, political or public relations, national security, etc.), manpower availability, subordinate training needs, scheduling conflicts, and funding shortfalls. Reimbursable services are usually of a quick response nature and can be performed with current program staffing. Staffing may be from either USACHPPM-main, a DSA, or a combination of the two with the reimbursable funds distributed on a percentage basis between the participants. Analytical support can be provided with inhouse resources or through the use of outside contractors. The

individual program manager can determine the operating parameters for which reimbursable funds are requested (e.g., expenses only; combination expenses and labor; combination expenses, labor, overhead; expenses and analytical; expenses, labor, analytical, overhead; etc.).

Supplemental funds can be defined as dollars paid by a customer for multi-year support in a specific program area. These funds are generally multi-year dollars for which a customer has committed long-term to use USACHPPM services. Supplemental dollars may be used to hire additional personnel (e.g., government employees, contractors) or pay for shortfalls in existing labor funds. For example, Defense Logistics Agency (DLA) has provided manpower authorizations and funding for multi-year support. Other expenses are also included. Analytical support can be provided with inhouse resources or outside contractors. As with reimbursables, the Chief of Staff receives an administrative overhead charge from the supplemental fund (20 percent) for accounting and other costs to the USACHPPM. The individual program charges an overhead fee in the amount of 15 percent (total overhead charges equal 35 percent). If two or more programs (including DSAs) coordinate to perform the service, the 15 percent program overhead is divided per program (or DSA) based on net funding percentage to the supplemental job order.

Acceptance of a supplemental project within USACHPPM-main is the

decision of the individual program manager, associated program managers, and the USACHPPM chain of command (directors and Commander). All expenses are considered when costing out supplemental funds. Supplemental funds earned by one program may be used to support the operation of another program which does not have adequate funding (this is decided at the level of director). The DSAs can market services and procure reimbursable and supplemental funding sources separate from the USACHPPM-main programs.

Customer commitment to provide supplemental funds flows primarily to the environmental programs which can "buy" manpower support from other USACHPPM directorates (e.g., DOHS, DLS). Reimbursable funds are received primarily within the DOHS, DLS and DEHE. Customers making long term supplemental commitments with USACHPPM include USAEC and other MACOM environmental offices, and DLA. DLA also procures occupational health supplemental services from DOHS, DLS and DCPM. Reimbursable customers include installations, MACOM HQs, other services (e.g., Navy, Air Force, NSA, State Department), and HQDA.

Many USACHPPM programs support the "warfighter" (e.g., CINCs, USARC, FORSCOM, TRADOC) or other MEDCOM assets (e.g., HSSA, MEDDAC or installation preventive medicine) for which the USACHPPM and MEDCOM have the directed mission. These support efforts are primarily funded with core dollars. The services

provided are value added and USACHPPM is the appropriate delivery platform.

Supplemental and reimbursable funding allows profitable programs to transfer their core dollars to support programs that have less money making potential but still have high value added to the Army.

II. THEME

The USACHPPM is not adequately core funded to meet the current level of service being requested by the customer base. Some customers are willing to pay reimbursable funds and make long term supplemental funding commitments to offset expenses and manpower in order to receive a "world class" product in a timely fashion. Supplemental and reimbursable funds are required to maintain current program support levels. In addition, with the stand up of the new USACHPPM directorates (and programs) supplemental and reimbursable funds constitute the primary funding vehicle to allow these programs to operate in support of the Army's needs.

III. FINDINGS

1. Past attempts have been made to define the handling of funds not considered core dollars. For example, a draft USAEHA Regulation 5-XX, entitled "Supplemental Services Management", defines supplemental service as <u>any work funded by an entity</u>

other than the Agency. The draft was developed and staffed in November 1993 and has yet to be finalized.

2. Considerable confusion exists regarding the amount and use of overhead charges levied on all reimbursable or supplemental funding sources.

3. Not all personnel within USACHPPM understand how cross-leveling of funds occurs throughout the command.

IV. ISSUES

1. Should the USACHPPM operate like a business and rely on customers to provide total program funding?

2. Should USACHPPM maintain a mix of core, supplemental and reimbursable funding? If so, is there a proper mix or does mix depend on FY core funding with any differences made up from existing supplemental fund commitments and potential reimbursables from the customer base?

3. How does the USACHPPM fund anticipated expenses in a new FY while other government customers are awaiting their annual budgets to determine commitments to the USACHPPM?

V. DISCUSSION

USACHPPM, like the rest of the MEDCOM, needs to operate like a business. Performing like a business may include finding niche customers who are willing to pay dollars in exchange for services. Sometimes providing services to niche customers is consistent with USACHPPM's mission and sometimes it is not. Generally, service organizations should "stick to the knitting" and concentrate their efforts on primary customers only. But the policy of serving niche customers is complicated by the funding issue described previously. As long as the command is not fully funded to provide the broad array of services implied by their overall mission statement, then niche customers offer a source of additional (reimbursable) funding that can assist in meeting mission needs. Reimbursable funds can be used to optimize overall service levels through the judicious use of cross-leveling of those funds. Thus performing like a business may, in fact, indirectly support the needs and/or priorities of the Army and mission of MEDCOM.

If USACHPPM is to operate as a business, then the issue of profits becomes germane. A basic question to be answered is should USACHPPM make a profit? Businesses make profits to pay for research and development, technical improvements, or to improve shareholder value. As a government entity, CHPPM is, by definition, a non-profit organization. Nevertheless, when profits are plowed back into advanced business development

efforts (e.g. developing new wellness/health promotion programs), such profits don't evoke the same negative connotations. If CHPPM is to continue to grow and develop new products and services it must be funded to do so. In an era of constrained central funding, the command must have the flexibility of seeking such funds from profits generated by existing programs.

Further, if CHPPM is to operate as a business then the source of non-core funding needs to be defined. Terms like reimbursable and supplemental funding should be clearly defined and understood throughout the command. The proposed definitions described in the background section seem to be a good place to start.

Pricing should also be standardized within USACHPPM. The current "handling charge" or overhead of 35 percent seems appropriate. The programs receiving additional funds should receive some portion of the 15 percent previously identified. The commitment to accept supplemental and reimbursable funds should be the decision of the USACHPPM-main program managers and command staff. Additionally, it seems reasonable that the DSAs be able to market and procure funds separately from USACHPPM-main. The real value of the HQ Staff is to conduct periodic audits and financial analyses so as to better manage the entire supplemental/ reimbursable funding area.

A fundamental challenge facing the command is to determine if the

new USACHPPM directorates and programs have a sufficient customer base to constitute reimbursable and supplemental funding sources. The likely answer is no. Therefore, the real underlying question is, can existing programs with reimbursable and supplemental funding capabilities facilitate the transfer of core funds to the new programs to allow them to grow and develop?

The current method of using successful money making programs to fund less successful money making ones is a sound business technique. Further, having Directors responsible for the decisions involved in transferring funds appears to underpin the success of USACHPPM in meeting mission needs and providing overall support to the Army. The close interrelationship between money sources, however, could be jeopardized by inadvertent "tinkering". The potential always exists to lose current level core funding by raising the nature of success USACHPPM has in obtaining reimbursable and supplemental funding to the MEDCOM PBAC.

VI. RECOMMENDATIONS

1. Clearly articulate the definitions of reimbursable and supplemental funding throughout CHPPM and the MEDCOM.

2. Continue the policy of transferring funds from reimbursable sources to non-funded areas.

3. Price services such that reasonable profits and all associated overhead costs are recovered.

4. Maintain Chief of Staff overwatch of all reimbursable programs (assign the accountability to the PA&E element in DCSRM).

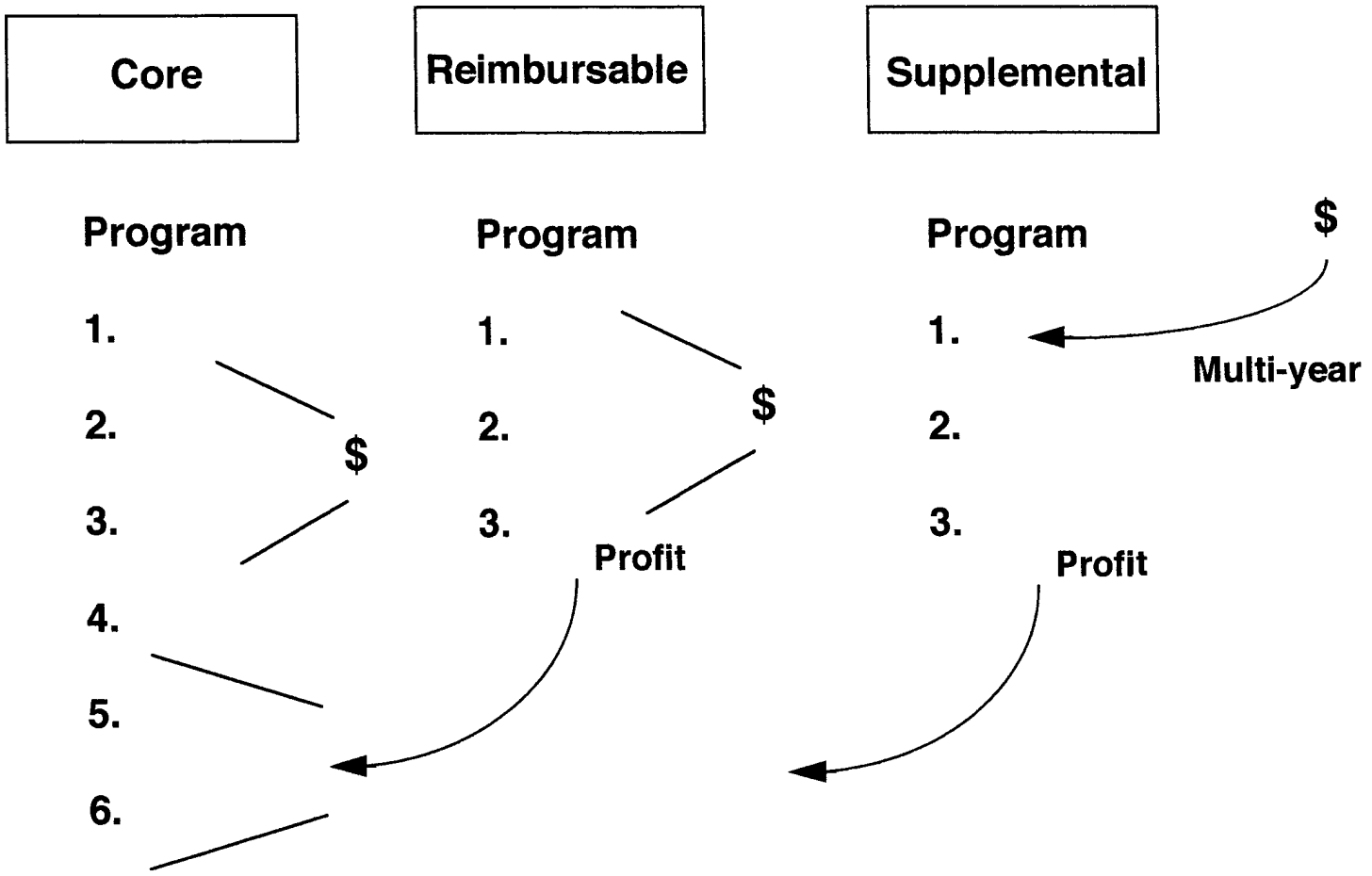
FUNDING DEFINITIONS

- **Reimbursable - Funds paid by customer for a particular service**

- **Supplemental - Funds paid by a customer for multi-year support for a specific program**

- **Core - Annual operating funds provided by the MEDCOM as a normal part of the business process**

FUNDING IMPACT



TAB 4

ENCLOSURE 17

U.S. Army Center for Health Promotion and Preventive Medicine

QUALITY SYSTEMS/TRAINING OFFICE

I. BACKGROUND

In 1991 a civilian position of Scientific Advisor was established. The purpose of this position was to provide the commander with the latest scientific information available and to keep AEHA/CHPPM in the forefront of technology. In addition, in 1993, a decision was made to perform all Toxicological work at AEHA/CHPPM under Good Laboratory Practices(GLP). Because of this decision, an internal assessment was performed to aid AEHA in their conformance to GLP. One finding of this audit was that there was no independent check on the performance of GLP practices. As a result of this finding, the Quality Assurance Office(QAO) was created and placed under the Chief of Staff(COS) in the organizational structure. Around the same time, the Total Army Quality Office(TAQ) was established to aid AEHA/CHPPM efforts in the area of total quality management(TQM).

II. FINDINGS

1. The scientific advisor spends a great deal of time on training, including both corporate and professional development. In addition, he seems to be given tasks that none of the directors want. Confusion exists as to the duties and responsibilities of the scientific advisor.

2. One of the prime responsibilities of the TAQ is to suggest and implement training in the area of quality.

3. The QAO is responsible for monitoring quality within CHPPM and to conduct quality training for the center as needed.

4. The training office manages the paperwork trail for all center training and aides the scientific advisor, TAQ and QAO in both determining center training requirements and setting up the actual training.

III. ISSUES

1. Where should the Quality Systems and Training Office be located in the organization?

2. Does the Center need a science advisor or a technical director?

IV. DISCUSSION

Several of the training functions being performed by the scientific advisor and the QAO are necessary due to certification requirements or by OPM. In addition, there are both quality and training functions being performed by the TAQ office in support of the TQM initiative being implemented by DA. While all of these functions need to be performed, coordination is lacking and duplication of effort is apparent. To have a more efficient

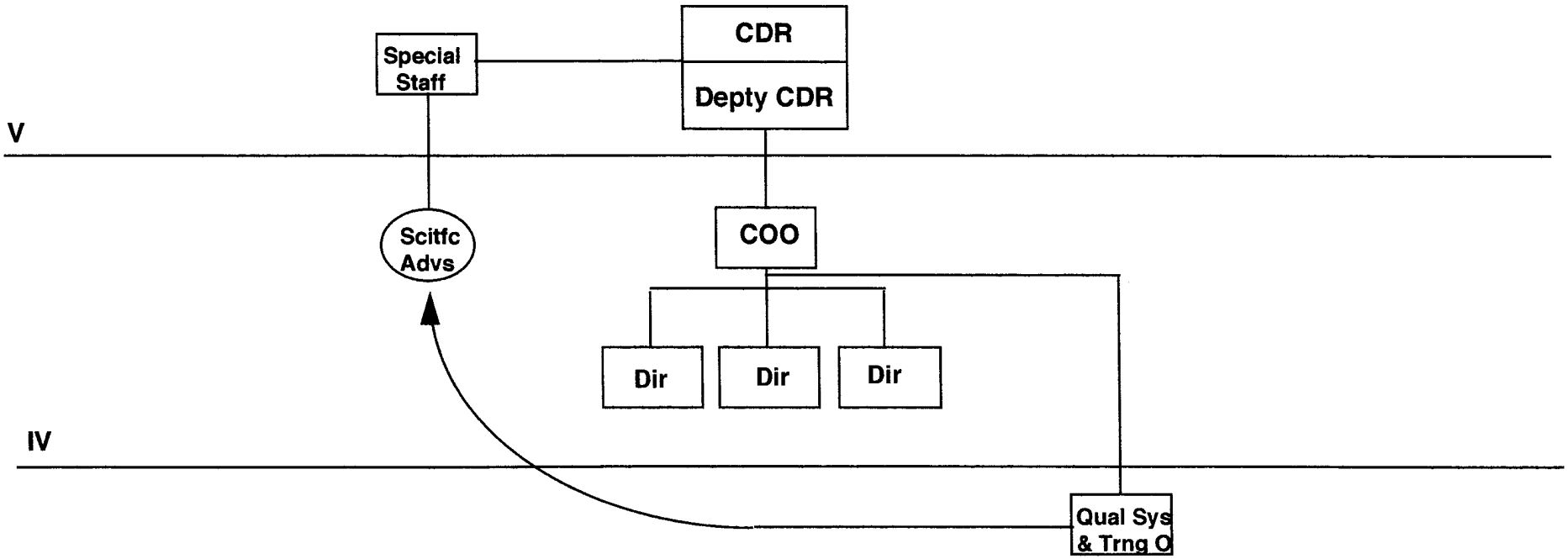
operation, these operations need to be streamlined.

V. RECOMMENDATIONS

1. The assets and responsibilities of the scientific advisor position, QAO, TAQ and the training office should be combined into one functional group.

2. This group should be assigned to the special staff in the center's organizational structure.

QUALITY SYSTEMS TRAINING OFFICE



- TAQ
- QA
- Cont. Trng

TAB 5

ENCLOSURE 17

U.S. Army Center for Health Promotion and Preventive Medicine

DLS ANALYTICAL CHEMISTRY LABORATORIES

I. BACKGROUND

The Directorate of Laboratories Sciences (DLS) provides analytical support to a variety of USACHPPM environmental and occupational health programs. In addition, DLS provides similar support for DA, and DOD programs as well as other federal government agencies. This support ranges from sample analysis, method development, consultation to document review and readiness issues.

II. FINDINGS

1. There is a lack of clarity with regard to DLS turnaround time requirements and goals.

2. DLS turnaround time seems excessive.

III. ISSUES

1. What is the current DLS turnaround status?

2. How should the Theater Army Medical Laboratory (TAML) be best integrated into USACHPPM?

IV. DISCUSSION

During interviews conducted at USACHPPM, the turnaround time of DLS laboratories was mentioned several times. In addition, there seems to be a lack of clarity, in some cases, as to the

turnaround time requirements for the samples received. Management also needs to decide the primary focus of DLS. Should they be a production laboratory, method development laboratory or a combination of both?

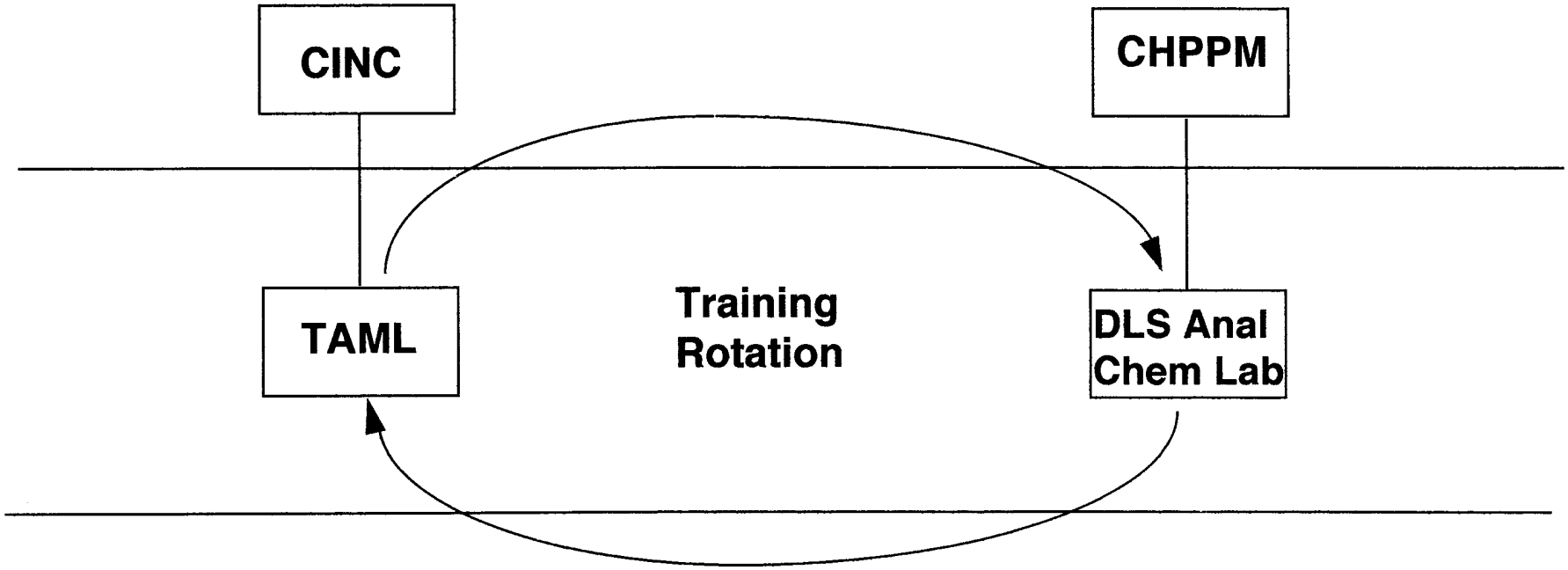
A unique challenge facing USACHPPM is how best to meet the training requirements of personnel assigned to the TAML. The TAML training mission is scheduled for transfer to USACHPPM. Initial discussions involved rotating people through the CHPPM laboratories in Edgewood for training in the various analytical procedures that constitute the required knowledge base when the TAML is fully operational.

V. RECOMMENDATIONS

1. Management must decide the primary focus of the DLS laboratories.

2. DLS personnel should rotate through the TAML doing some of the work that will be transferred back to the main labs from the DSA's. This will provide realistic training in tasks expected to be performed in field laboratory settings.

THEATER ARMY MEDICAL LABORATORY



TAB 6

ENCLOSURE 17

U.S. Army Center for Health Promotion and Preventive Medicine

DIRECT SUPPORT ACTIVITIES

I. BACKGROUND

There are 3 USACHPPM Direct Support Activities (DSAs) that provide customers with an expanded level of routine occupational and environmental health services. These DSA services augment and go beyond the capabilities of the assets at the HSSA and MEDDAC level. By comparison, services provided by USACHPPM-main are either an expanded level or considered extraordinary requiring a high level of technical and programmatic competence. Some overlap of second echelon service capabilities exists between the DSAs and the USACHPPM-main, depending on the program in question.

The DSAs are located at Ft Meade (USACHPPM-North/DSA-N), Ft McPhearson (USACHPPM-South/DSA-S) and Fitzsimons Army Medical Center (FAMC) (USACHPPM-West/DSA-W). FAMC is on the BRAC list and plans are underway to move DSA-W to Fort Lewis, WA sometime in FY 96. Each DSA has a specific regional support area but can cross regional boundaries when needs dictate. DSA-S and DSA-W have analytical laboratories though not as extensive as USACHPPM-main.

USACHPPM-main and the DSAs have developed service-oriented projection platforms based on customer oriented program support

strategies. The projection platform strategy for USACHPPM-main provides general or third level echelon support to the installation, post and MEDDAC level customer and services directly requests for support from higher levels of DA and DOD such as the DA Secretariat. The DSA platform provides a direct or second level echelon support to the installation, post and MEDDAC level customer.

The inception of the DSAs occurred in February 1974, when the USAEHA Directorate of Regional Activities was formed and tasked to develop plans to integrate the mission services offered by the five Continental United States Army Medical Laboratories (AML) into USAEHA. In June the tasking was expanded to plan for the incorporation of the AML's personnel assets into the USAEHA TDA (approximately 113 positions). In July 1974, USAEHA was tasked to plan consolidation of the five existing AML's at Ft Meade, Ft McPherson, Ft Sam Houston, St Louis MO and Ft Baker CA into the three sites currently staffed as separate commands.

II. THEME

The DSAs provide valuable second echelon support to Army installations and MEDDACs within given geographical regions.

III. FINDINGS

1. Currently there are no clear lines of differentiation between the level of support the DSAs and USACHPPM-main provide to the

field.

2. Customers can request services by contacting either the DSA or USACHPPM-main program manager which can be confusing for a customer.

3. The DSAs offer command billets for three Preventive Medicine Officers. The DSAs also offer management opportunities for military and civilian development below the command level.

4. DSAs reportedly provide better response and access to customers from their respective regional hubs.

5. DSAs provide needed technical expertise in the areas of environmental and occupational health.

6. Some conflicts exist between program managers and DSA Commanders. Program Managers design programs but hand them off to DSA Commanders for execution. DSA Commanders, in turn, reprioritize execution in accord with their respective regional needs.

7. The DSAs reportedly provide a value-added degree of independence to the Command.

IV. ISSUES

1. Customer Services

a. Should the level of services provided by the DSAs be clearly different from those of the USACHPPM-main?

b. Should all requests for services be routed to the USACHPPM-main program managers for consideration of support? Does the current mechanism of customer contact with either the DSA or USACHPPM-main support the Army adequately? Are customers

confused?

2. Required number of DSAs

a. How many DSAs are required to provide adequate second echelon support to the Army? Could the USACHPPM-main supporting third level and some second level echelon work and a large DSA with CONUS responsibilities for second echelon support service the Army adequately? Could USACHPPM-main and two DSAs (located at Ft Meade and Ft McPherson) supporting the center of mass of Army customers (northeast to southeast CONUS) provide adequate support? Are maintaining the DSAs at Ft Meade and Ft McPherson appropriate? Should DSA-N and DSA-S be relocated to better support two centers of mass of Army customers? Could the lines of regional responsibilities be redefined for two DSAs and what would be the boundaries?

b. Does moving DSA-W to Ft Lewis provide easy access to other regional customers from this location? Is Ft Lewis near a "hub" transportation center for quick customer support? Where are the AC and RC customers' "centers of mass" for DSA-W if located at Ft Lewis? Is standing down DSA-W and moving the authorizations back to USACHPPM-main more appropriate to the AMEDD and USACHPPM's expanded mission given the BRAC imperative at FAMC?

c. What is the rational for retaining three DSAs? What is the rational for more than one DSA?

3. Command and Leadership Opportunities

a. Does having the DSA command billets and lower level management positions benefit the AMEDD and Army?

b. How many (and what percentage) of command billets exist for the AMEDD preventive medicine MOSs given the current downsizing?

V. DISCUSSION

The AMLs were located to support the then established area Armys. When five AMLs were consolidated into three DSAs with regional support responsibilities, the reason for maintaining DSAs was direct customer support with quick response access from "hub" locations. The DSAs (and AMLs) were also the only source of professional expertise in the areas of environmental and occupational health (e.g., preventive medicine, industrial hygiene) because individual assets were not yet assigned to all installations or posts. Today the ability to respond quickly from a regional "hub" is as timely as traveling across country from a single point "hub". In addition, more AMEDD assets have been assigned to individual installations and posts to provide day to day support. Quick response requests are not as numerous with on sight assets handling the day-to-day issues and appropriately interpreting need for off-site support. With the advent of overnight delivery services, regional response is not as essential as once required for analytical support.

The program manager is technically accountable for operation of individual programs. The program manager can advise the DSA commander on technical matters. The DSA commanders are accountable for the execution of programs at the DSA level within the constraints imposed by available assets. Conflicts arise between program managers and the DSAs when coordination and communication is poor and program interests are made secondary to DSA funding interests. For example, when DSA assets obtain separate funding (e.g., reimbursable and supplemental funds) which obligates DSA manpower from one program area or project to support another program area or project, the affect is that some core services are shifted at USACHPPM-main or the other DSAs to cover what might be obligated core funded support. This has happened on a limited basis. However, coordination and communications is personality driven and not based on a structured operating procedure.

A major difference between third and second level echelon support is the quick response to high visibility issues usually required to support third echelon customers verses second level customers. Third level support to the DA Secretariat, for example, is politically driven with high potential for negative feedback if suspenses are not met. This requires a constant shifting of daily priorities to meet third level customer expectations. In responding to such customers (third level) sometimes second level customer priorities are shifted and missed. To avoid shifting

all technical resources to third echelon support, there needs to be at least one DSA organization that is physically separated from USACHPPM-main to support the second echelon customer base.

A major void in the current provisioning of USACHPPM related services pertains to the existing RC sites. The active duty installations have organic CHPPM assets to meet their first echelon services needs. The RC sites, on the other hand, have virtually no organic capability of addressing their CHPPM related needs. Currently the DSAs are organized to provide second echelon support to existing active duty installations.

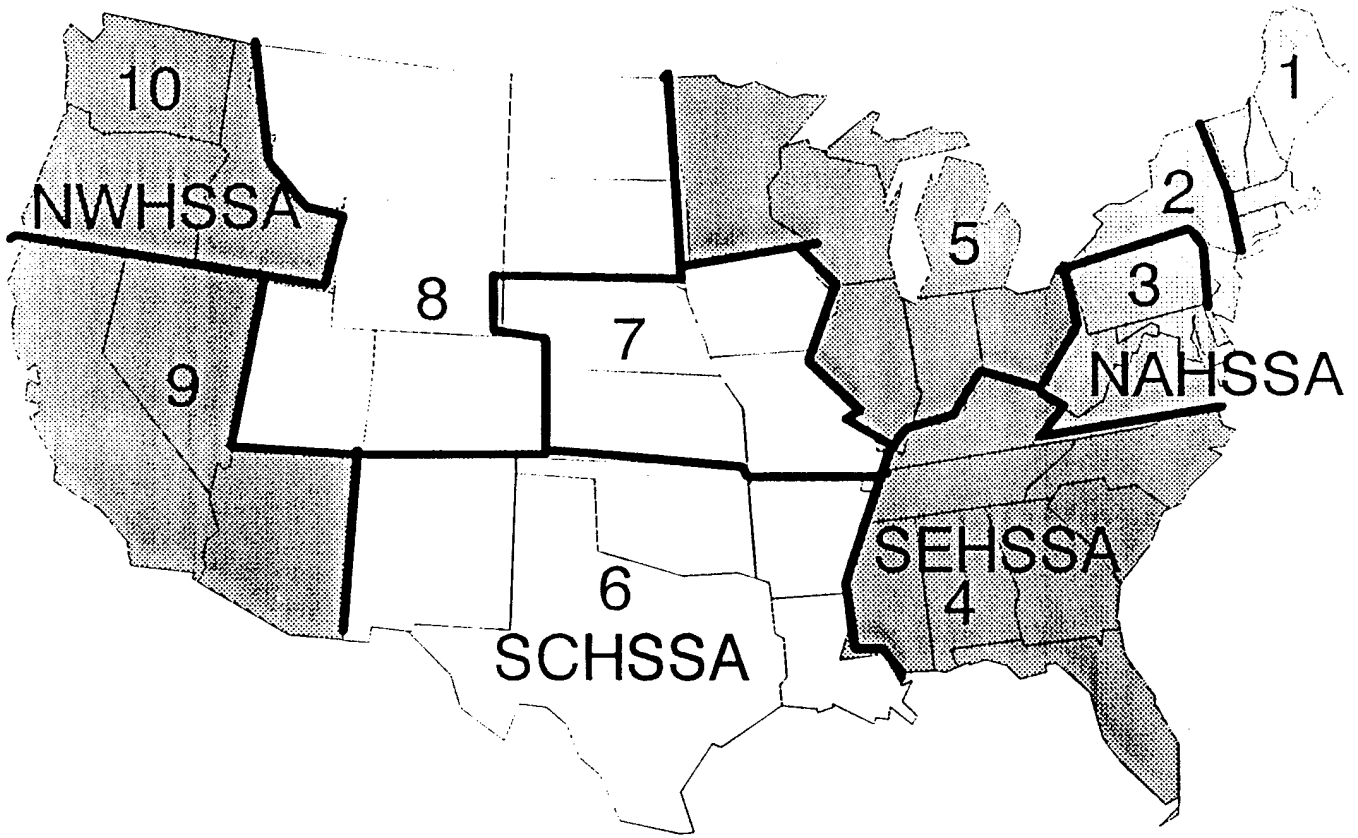
Perhaps a more appropriate mission for the DSAs to undertake is to routinely provide first echelon services to RC installations within their given geographical area. Figure 1 depicts the ten RC readiness regional support groups (RSG). As depicted, these RSGs are currently aligned with the four MEDCOM HSSAs in order to optimize the readiness status of each RSG. By adopting a similar approach, the RSGs could be aligned with two DSAs, one in the east and one in the west. Since the BRAC process has identified Fitzsimons Army Medical Center for closure, (the current home of the DSA-west), this DSA should be relocated, most logically to Ft. Sam Houston, TX. The rationale behind choosing Ft. Sam Houston as opposed to Ft. Lewis is its central proximity to the bulk of the AC/RC sites within this combined geographic area. In addition, Ft. Sam Houston has become the center of gravity of

AMEDD operations. Relocating DSA-West there further solidifies this desired outcome. Finally, by relocating a DSA to Ft. Sam Houston, potential synergies with the AMEDD Center and School become feasible. DSA-North should be closed. Personnel savings from its closure should be transferred to other CHPPM unresourced programs or to reinforce the TAML. DSA-South (redesignate DSA-East should refocus its priorities on the RC and assume oversight for all installations within RSGs 1-5 depicted in Figure 1.

VI. RECOMMENDATIONS

1. Close DSA-North. Reinvest the assets, or a portion thereof, in the new CHPPM program areas.
2. Relocate DSA-West to Ft. Sam Houston, TX.
3. Refocus DSA attention on providing support to the RC.
4. Appoint a PAT to clearly differentiate the work (both products and services) of DSAs from both CHPPM-main and the local installation level. The PAT should also address the preferred customer contact process, e.g., with DSAs or with program managers.

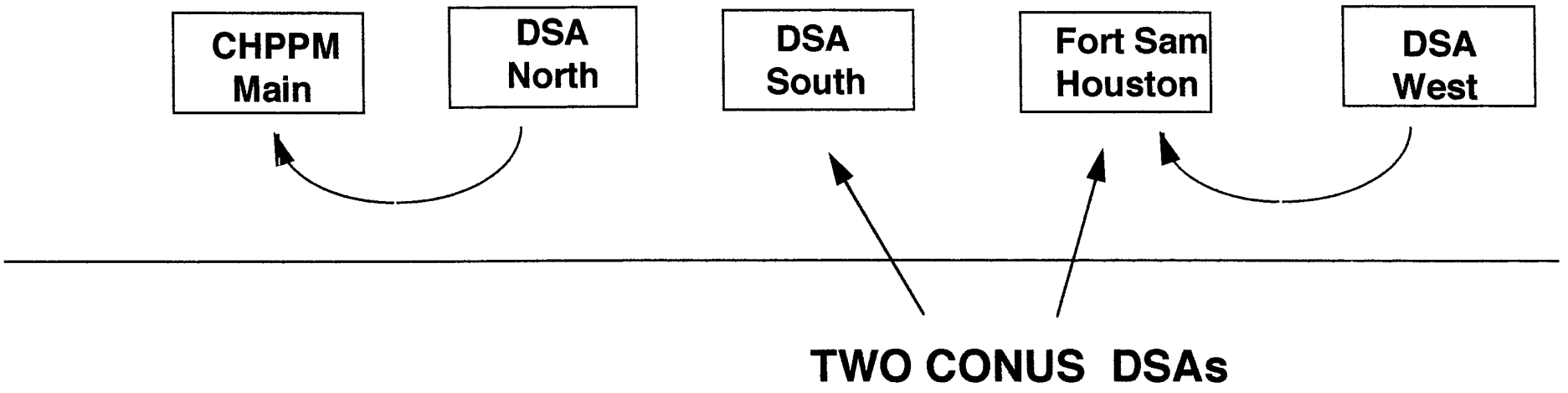
MEDCOM XXI--RC READINESS
REGIONAL SUPPORT COMMAND/GROUPS
WITH PROPOSED HSSAs



NOTES: a) Western boundary of SEHSSA is also the boundary between the CONUSAs.

b) ARCOM geographic/state boundaries coincide with HSSA boundaries.

DSA CONSOLIDATION



TAB 7

ENCLOSURE 17

U.S. Army Center for Health Promotion and Preventive Medicine

DSA ANALYTICAL CHEMISTRY LABORATORIES

I. BACKGROUND

The Army Environmental Hygiene Agency direct support activities (DSA) were formed in 1974 as regional divisions under the directorate of regional activities. At that time, the analytical chemistry laboratories were part of the Environmental Engineering Branch at DSA-South and DSA-West. In 1976, the analytical laboratory at DSA-West became a separate branch and the same thing was done at DSA-South by 1982. The purpose of these laboratories was to provide analytical support to the environmental engineering divisions in the regions. Support for DSA-North was provided by the main laboratory at Edgewood.

II. FINDINGS

1. DSA-South's analytical costs are reportedly more cost effective than those at Edgewood or DSA-West.
2. There is some overlap in analytical procedures across existing laboratories (e.g., all the labs perform metals and industrial hygiene solvent analysis).
3. Many of the more difficult routine analyses done by the Directorate of Laboratory Science (DLS) at Edgewood are not done by the DSA's.
4. There is considerable transhipping of samples among the three laboratories.

III. ISSUES

1. Is there a need for analytical chemistry laboratories in the DSA's?

IV. DISCUSSION

The DSA laboratories were originally set up to provide analytical support to the environmental and industrial hygiene missions of the regional activities. A key rationale underlying that decision was a desire to reduce sample transport time to the main laboratory at Edgewood. While this may have been a valid reason in the past, the evolution of rapid, highly sophisticated shipping services today obviates that problem.

There is overlap among all three laboratories; metals and some industrial hygiene work are common to all. This overlap is deemed necessary for the following reasons: 1) CHPPM laboratories in Edgewood support the work of DSA-North divisions in addition to the divisions at Edgewood. 2) There are similar multiple support requirements relevant to several engineering programs. In addition, the main CHPPM laboratories routinely perform a much more comprehensive list of analytical methods. Any analysis needed by DSA personnel for which the DSA analytical laboratories do not have the capability are sent back to the CHPPM main laboratory at Edgewood. The DSA labs also perform backup routine analysis for the Edgewood labs if their capacity is not exceeded. This results numerous transhipments of samples.

Given the recent BRAC decision to close Fitzsimons Army Medical Center, home of the DSA-West laboratory, the whole issue of maintaining regional laboratories needs to be revisited. In addition, the full scale integration of the TAML organization into the CHPPM mission needs to be factored into any decision pertaining to the regional labs. In an era of cost constrained resourcing, every effort must be made to consolidate similar functions when such consolidation leads to personnel and dollar savings without jeopardizing laboratory quality. It is alleged that the analytical lab at DSA-South is more cost efficient than other CHPPM labs. The numbers presented suggest that a detailed cost analysis needs to be conducted by an independent auditor. Pending the outcome of this study, the analysis to date suggests that the labs should be fully consolidated at Edgewood Arsenal. Such a consolidation should also take into account a proper role for training TAML personnel. Perhaps an operational field laboratory should be established at Edgewood to train Theater Army Medical Laboratory (TAML) personnel while simultaneously assisting the main CHPPM laboratory in handling the increased workload generated by such a consolidation. In addition to providing a unique, readiness-oriented training function, an operational field lab would solve the dilemma of "no more vents on the roof of the Headquarters building".

V. RECOMMENDATIONS

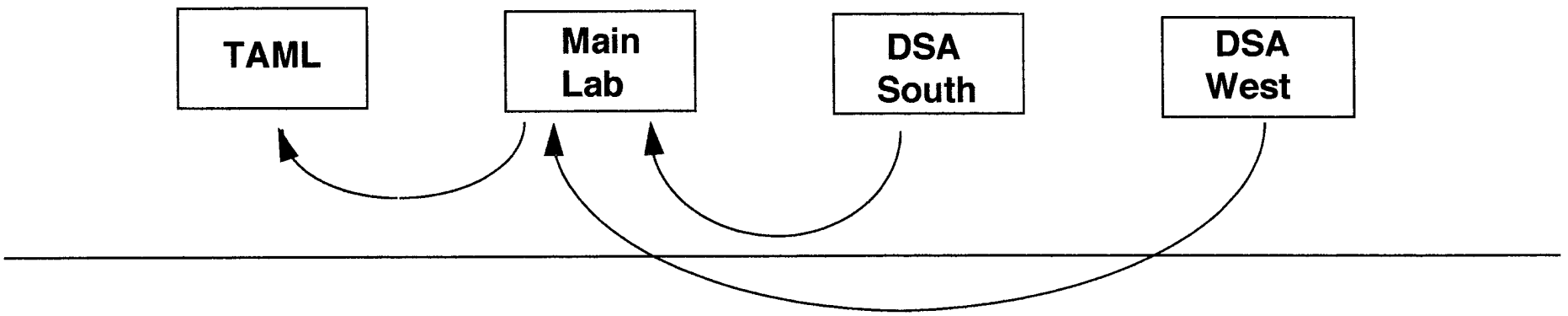
1. A detailed cost analysis of analytical work at DSA-South

should be conducted by an independent auditor.

2. Pending the outcome of 1. above, the DSA analytical chemistry laboratory function and their resources should be consolidated into the main laboratory at Edgewood.

3. Establish an operational field laboratory at Edgewood.

LABORATORY CONSOLIDATION



U.S. Army Center for Health Promotion and Preventive Medicine

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III. ISSUES

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IV. DISCUSSION

The DSA laboratories were originally set up to provide analytical support to the environmental and industrial hygiene missions of the regional activities. A key rationale underlying that decision was a desire to reduce sample transport time to the main laboratory at Edgewood. While this may have been a valid reason in the past, the evolution of rapid, highly sophisticated shipping services today obviates that problem.

There is overlap among all three laboratories; metals and some industrial hygiene work are common to all. This overlap is deemed necessary for the following reasons: 1) CHPPM laboratories in Edgewood support the work of DSA-North divisions in addition to the divisions at Edgewood. 2) There are similar multiple support requirements relevant to several engineering programs. In addition, the main CHPPM laboratories routinely perform a much more comprehensive list of analytical methods. Any analysis needed by DSA personnel for which the DSA analytical laboratories do not have the capability are sent back to the CHPPM main laboratory at Edgewood. The DSA labs also perform backup routine analysis for the Edgewood labs if their capacity is not exceeded. This results numerous transhipments of samples.

Given the recent BRAC decision to close Fitzsimons Army Medical Center, home of the DSA-West laboratory, the whole issue of maintaining regional laboratories needs to be revisited. In addition, the full scale integration of the TAML organization into the CHPPM mission needs to be factored into any decision pertaining to the regional labs. In an era of cost constrained resourcing, every effort must be made to consolidate similar functions when such consolidation leads to personnel and dollar savings without jeopardizing laboratory quality. It is alleged that the analytical lab at DSA-South is more cost efficient than other CHPPM labs. The numbers presented suggest that a detailed cost analysis needs to be conducted by an independent auditor. Pending the outcome of this study, the analysis to date suggests that the labs should be fully consolidated at Edgewood Arsenal. Such a consolidation should also take into account a proper role for training TAML personnel. Perhaps an operational field laboratory should be established at Edgewood to train Theater Army Medical Laboratory (TAML) personnel while simultaneously assisting the main CHPPM laboratory in handling the increased workload generated by such a consolidation. In addition to providing a unique, readiness-oriented training function, an operational field lab would solve the dilemma of "no more vents on the roof of the Headquarters building".

V. RECOMMENDATIONS

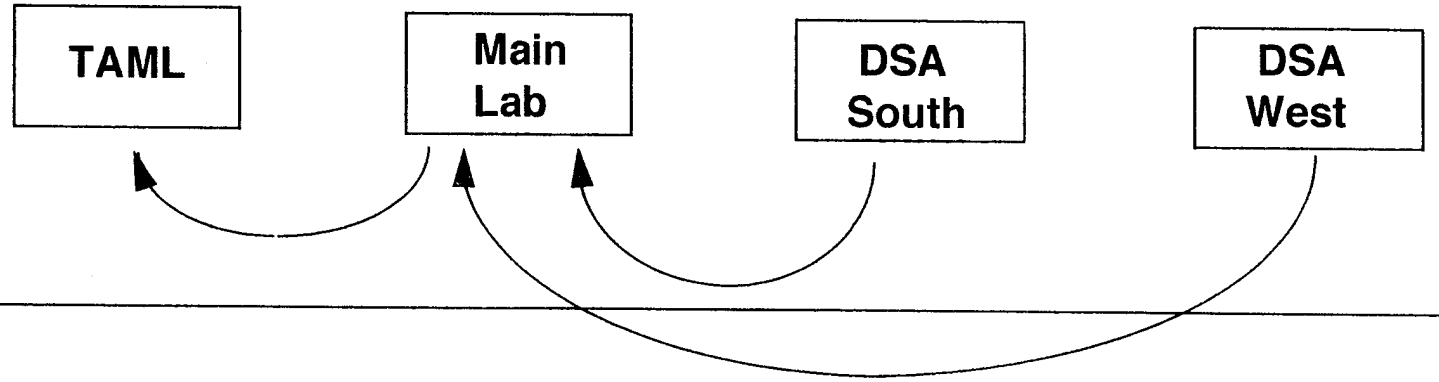
1. A detailed cost analysis of analytical work at DSA-South

should be conducted by an independent auditor.

2. Pending the outcome of 1. above, the DSA analytical chemistry laboratory function and their resources should be consolidated into the main laboratory at Edgewood.

3. Establish an operational field laboratory at Edgewood.

LABORATORY CONSOLIDATION



TAB 8

ENCLOSURE 17

U.S. Army Center for Health Promotion and Preventive Medicine

Summary

I. BACKGROUND

The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) has been reorganized as part of the Army Medical Department's overall organizational restructuring effort initiated in July 1992. To date a number of significant changes have been implemented throughout the AMEDD as part of an overall effort to more clearly and rationally differentiate policy and strategic level work from operational and tactical work. The impact of these changes on USACHPPM has been dramatic.

First, the basic mission of the organization has been significantly altered. Several new program areas have been added; i.e., health promotion and wellness; preventive medicine; and epidemiology and disease surveillance. Second, the organizational alignment of the institution has similarly changed. Today, USACHPPM is aligned as a separate major subordinate command of the MEDCOM. Third, managerial oversight for program development and execution has now been assigned to a general officer. Fourth, command responsibility now extends to subordinate elements worldwide, e.g. USAPACEHA in Japan and the former 10th Med Lab in Europe.

In addition to the above changes, the nature of existing working

relationships at the local installation level further compounds work effectiveness. While programs are developed centrally (at CHPPM), execution occurs at the installation level by functional experts who are assigned to the local MEDDAC/MEDCEN commander. While much "lip service" is paid regarding the importance of preventive health care measures (and programs), the reality is that when resources get constrained these programs are often the first to suffer. The leadership challenge created by this extant situation is indeed significant.

A primary intent of the original restructuring effort was to reanalyze each AMEDD major subordinate command approximately one year after the changes of the initial study were implemented. The first evaluation of AEHA (now USACHPPM) was a cursory one. The intent of this analysis was to scrutinize the command in much greater detail. Conclusions from this reanalysis are presented below.

II. THEME

USACHPPM is struggling in its attempt to cope with the integration of new mission areas and significant organizational changes.

III. FINDINGS

1. Many CHPPM employees report that the command is currently experiencing high levels of anxiety and frustration due to the

many uncertainties associated with the existing restructuring effort.

2. Many staff members feel that new program and mission areas exist in name only and are not resourced adequately.

3. Considerable resistance to change exists within the command regarding the new mission areas that have been added. Many staff members long for the "old days."

4. There is some concern that some existing programs are not adequately meeting customer's needs.

5. Some traditional customers reportedly believe that they are not being provided the same high quality service that they received in the past.

6. Because the commander is dual-hatted as the ASG and does not reside permanently at APG; some personnel believe that this situation creates unnecessary turmoil and confusion.

7. Confusion exists throughout the command regarding the different types of funding streams; i.e., programmed, reimbursable and supplemental.

8. The command does not receive enough programmed money to

properly execute all current missions.

9. Some staff members expressed concern (including resentment) over the Chief of Staff's "tax" assessed on supplemental funds.

10. CHPPM personnel report that most attempts to receive additional programmed funding for Health Promotion programs is routinely rejected by the HSSA Chiefs of Staff in PBAC voting.

11. The decision making process within Headquarters, CHPPM appears to be consensus driven even it this means sacrificing timeliness.

IV. ISSUES

A. Internal organizational structure:

1. Does the command need a full-time General Officer in residence as Commander?

2. Does USACHPPM need a Deputy Commander for Operations?

3. Where should the Quality Systems and Training office be located within the organization?

4. Does the Center need a science advisor or a technical director? (Presently the Center has a Science Advisor).

5. Should the Center have a separate marketing office? If not, how could those duties best be handled?

6. Should the Center retain divisions in the mission directorates?

7. Where (organizationally) should be Preventive Medicine Planning and Integration Office (PMPIO) be?

8. Should the position of Chief, Occupational Health Management Information System (OHMIS) be civilian or military?

B. External organizational issues:

1. Do we need both Direct Support Activities (DSA's) and HSSA's? Are the HSSA's better positioned to do the PM and DSA work?

C. Operational issues:

1. If there is a need for DSA's, what should the force structure and function be?

2. Is there a need for analytical chemistry laboratories in the DSA's?

3. What is the best location for GME? Do we need Madigan, USACHPPM and WRAIR GME?

4. What should we use as our operational definition of supplemental funding?

V. DISCUSSION

1. <u>ORGANIZATIONAL ANALYSIS</u> - The manifest and extant organizations are depicted in Figures 1 and 2. As illustrated, there exists some non-value added layering. For example, within level IV there exists two separate and distinct roles, the COO role and the Department Director role. When one considers that

the Deputy Commander role also exists and that, defacto, the Deputy is really running the day-to-day operations of the Center, then we have a situation where a Colonel works for a Colonel who also works for a Colonel. This layering is unnecessary and dysfunctional.

The Deputy Commander role is necessary because the Commander is dual-hatted as the ASG and currently does not reside full time at APG. Even if the commander were to move to APG, the Deputy role is required because of the dual-hatted nature of the GO role. It is strongly recommended that the Commander reside at CHPPM and travel to Washington to carry out the work of the ASG role. This is especially necessary in the period of transition and growth of the new CHPPM organization. The Commander and Deputy Commander roles, in reality, are already functioning at level V. The presence of the COO role is perplexing, however. This role appears to represent non-value added layering in the overall structure. The actual work of the COO role is heavily focused on implementing special programs, e.g., ISO 9001 and TQM. While this work is important, it constitutes staff work and not operational command and control work.

Similarly, the continued presence of divisions and program directors within level III also appears to represent non-value added layering. The underlying issue behind the two roles appears to be an on-going requirement to provide Department heads

with additional staff assistance to help them manage a diverse set of programs. The best way to do this is to create required staff support roles within level III and not add an additional managerial layer.

Figure 3 illustrates the mainstream production centers of USACHPPM. As shown, the DSAs, USACHPPM-Europe (formerly 10th Med Lab), and USAPACEHA are operational support activities. The Laboratory Science Directorate is a general support activity.

2. STAFF ORGANIZATION - The extant staff organization is depicted in Figure 4. As illustrated the staff is generally operating one full layer below the required level. This finding does not imply that the staff is not capable of operating at the next higher level. Rather, it simply points out that the current environment has not reinforced nor demanded that they do so. The whole staff needs to operate at the next higher organizational layer.

3. PROGRAMS - Considerable anxiety exists within the Center regarding the prioritization and future management of existing programs and services. Generally, these services and programs have evolved individually over the years in response to a specific customer need or as a result of program development advances in a given functional area. Each program has developed its own advocate (i.e., the program managers and/or a given

customer) and each program delivers a useful product. The problem, however, is that programs have grown and expanded over the years. With the ability to receive supplemental and reimbursable funds, some programs flourished and grew. Internal transfers of funds (through the Chief of Staff's "tax" system) permitted other program areas to also continue operating. It does not appear that any significant evaluation of program and service outputs has occurred on a routine basis (e.g. there is no existing PA&E function within the headquarters). As new mission areas have been added without new funding sources, the ability of the command to adjust and develop new services and programs has been difficult. No existing advocate wants to give up anything. This is not surprising. Hence, it has been difficult to reprioritize overall Center efforts. What is missing is a process that periodically validates (or cancels) existing program efforts. The challenge is that the command now faces a situation where more is expected of it than it has been resourced to provide. Tough trade-off decisions need to be made. This is the work of the proposed PA&E cell.

To assist in any reprioritization effort, it is useful to clearly differentiate between services, programs and directorates.

Service - A specific product to a given customer; e.g., radiation protection survey.

Program - A grouping of like services that seem to fit together; e.g., develop imaging equipment training programs

(train the local radiation protection officer).

Directorate - A management node of related programs; e.g., Occupational Health Directorate.

As described previously, many programs and services have evolved serendipitously over the years. Sometimes strong program managers pushed their program areas whereas, at other times, customers pulled the CHPPM staff in a given direction. Today, it appears that too many programs and too many services exist. The Command is in need of an overall functional mission area analysis. This should be a major undertaking of the new PA&E cell and the headquarters staff. Stringent valuative criteria will have to be developed from a detailed analysis of the Center's new mission statement. Hard choices must be made. Recommend a formal FAA be held in the fall time frame (see also discussion below).

4. COMMUNITY BASED WELLNESS PROGRAMS - The average installation provides a variety of health promotion, prevention and wellness programs. Typically these programs are managed as separate entities, each of which is under the watchful oversight of a singularly focused product champion. Sometimes these product champions are located on the MEDCOM staff e.g. HRD programs while at other times the champion resides on the DA staff (e.g., DCSPER). Most programs that fit into the general wellness/ prevention category tend to be managed as "stove pipe"

operations. Rarely are these diverse efforts integrated into a single comprehensive program. Consequently, much duplication and overlap tend to occur. Complicating the integration problem further is the fact that the same customer base tends to enroll or utilize multiple programs simultaneously. This multiple use tends to inflate total customer utilization rates. In other words, the combined output of these programs tends to affect a much smaller number of participants than the aggregate numbers suggest.

Integration and rationalization is sorely needed and CHPPM is in a natural position to drive such an initiative. In the 1970s, the Army reportedly made an attempt to improve overall customer satisfaction by co-locating many of these programs in a single building e.g. a "help center." Unfortunately, this initiative was never fully implemented Army wide.

In today's constrained resource environment, the time has come to achieve true functional integration. USACHPPM should take the lead in this endeavor. With a well rounded staff consisting of a dietician, clinical psychologist, social worker, community health nurse, in addition to a compliment of other health care professionals e.g. nurses, physicians, PTs, dentists, etc., CHPPM is uniquely postured to do so. The Directorate of Health Promotion and Wellness, with concurrence of CHMPPM and MEDCOM, should coordinate with the DA DCSPER to schedule a functional

area analysis (FAA) embracing this entire area.

In order to facilitate the overall integration of diverse program efforts, the soldier fitness and ADAPC programs should be part of the FAA process. The likelihood is that additional synergies are possible if programs such as these are merged under one overall integrator. For example, previous recommendations have suggested that the AMEDD Center & School drastically revise existing Alcohol and Drug Abuse training programs. The intent is that the AMEDDC&S will no longer offer annual certification courses. This logic needs to be extended to the entire scope of the Alcohol and Drug Abuse program area (and other similar areas). After a thorough analysis, concrete recommendations need to be presented to the DA DCSPER regarding the whole family of programs that fall into this general area.

Finally, it is expected that a primary delivery mechanism of health promotion and wellness programs in the future will be the Army education system. While program content and planning may be developed centrally, program execution in many respects is a personal decision. If an individual chooses not to adhere to program standards that is their own concern and they must be prepared to live with the consequences.

5. <u>PM WORKING RELATIONSHIPS AT THE MEDCOM LEVEL</u> - The Director of PM services within the MEDDAC is accountable for overseeing

the delivery of all PM related products/services within the MEDDAC's area of operation. Currently, the PM Director works for the DCCS like all other clinical directors. Unfortunately, this working relationship reinforces the notion that PM programs are similar to other clinical programs and hence must vie with these programs for increasingly scarce resources. Because some PM programs often have little or no immediate impact, the ability to compete for scarce dollars is made even more difficult. A more effective working relationship would be to align the PM function directly under the Commander. Currently, each MEDDAC commander is also the Director of Health Services for a given geographic region. By realigning the PM directly under the Regional Health Service mission, competitive pressures for scarce clinical dollars would be reduced. This alignment would also obviate an existing problem with the DCCS who is generally perceived as a non-value added managerial layer.

6. MARKETING - The ability of CHPPM to develop and deliver new products and services to the Army (and to other government customers) requires an aggressive marketing function. Such a function is particularly important because the command has the ability to sell services to customers and use the profits generated therein to fund other necessary programs which are currently under-funded. The marketing activity should analyze the overall market; identify specific niche markets where existing services could be profitability delivered; identify

customer needs in new market areas (e.g., the health promotion and wellness areas); and develop and monitor pricing strategies for all external customers. Additionally, the marketing activity should take overall responsibility for developing appropriate advertising strategies and related product/service literature. As a full scale marketing function is developed, the external communication staff activity should be folded into the marketing area. The marketing function as described above is not a staff element but rather a manistream production function.

7. CHPPM SERVICE ECHELONS - CHPPM services are delivered by three different activities; the organic support provided to the installation by the internal assets of the MEDDAC/MEDCEN, second echelon support within a given regional area PROVIDED by the appropriate DSA organization; and tertiary support from CHPPM-main. Figure 5 highlights the overlapping nature of these services. Current levels of support to RC sites and installations have been covered in a separate paper (see DSA paper). That paper concluded that RC support was generally inadequate and that the DSA should consider refocusing their efforts in that respect. Such a refocus then leaves the question of how best to provide 2d echelon support to the active component installations. The general areas of support at the MEDDAC level are illustrated in Figure 6. Also shown are the corresponding functional areas at the DSA and CHPPM-main levels. As illustrated, there currently exists some duplication or overlap

of functions and some totally new functional program areas. Further, there is some inconsistency across DSAs themselves. The issue here is what constitutes the proper level of support at the 2nd and 3rd echelons; more in-depth expertise regarding local functional areas, new program areas, or a combination of the two, see Figure 7. At the very least, the nature of the 2nd and 3rd echelon support work should be consistently addressed across the entire command.

8. ADVANCED BUSINESS DEVELOPMENT FUNCTION - The very nature of CHPPM's mission suggests that for the command to remain viable over the long haul, new programs and new initiatives have to be continuously developed. The analog to this effort in private industry is the continuous requirement to aggressively seek out advanced business development opportunities. Because any business has only so much investment capital available at any given time, care must be taken as to how best to employ such investment capabilities. Old programs and services must be continually reevaluated. Costs associated with providing such services must continually be reduced in order to fund new development initiatives. Such a business strategy and focus must also apply to CHPPM. Existing programs need to be continually evaluated and costs associated with such programs, need to be continually examined and reduced wherever possible. Old programs must be abandoned when necessary and or program execution down-loaded to the customer base or to external contractors.

9. LEADER DEVELOPMENT - As the AMEDD moves toward implementing branch immaterial general officer positions, it is important to reexamine the career development progression of officers assigned to all corps. Such a reevaluation is particularly important to 68 series MSC officers because the number of leader development positions is severely limited across the AMEDD. Currently, 68 series MSC officers command the DSAs including CHPPM - Europe (10th Med Lab) and USAPACEHA. A previous recommendation was made to eliminate one DSA in light of the forming of the TAML. The net effect of these changes is no overall reduction in leader development positions. However, if other corps officers are to compete for these billets, then perhaps this issue could become significant.

10. SENIOR NCO LEADERSHIP - The establishment of CHPPM requisitely called for the assignment of a senior NCO who is accountable for ensuring that all enlisted soldiers within the command adhere to established policies and standards pertaining to performance, care, conduct, personnel management and training. In this regard, the responsibilities of the senior NCO are not much different from those of a CSM. Therefore, it is recommended that the AMEDD ensure that a high potential, technically qualified senior SGM always be assigned to CHPPM.

11. GME - GME is provided from three separate sites: USACHPPM,

Walter Reed Army Institute of Research, and Madigan Army Medical Center. The residency programs are designed to have from nine to eleven starts each year. This year there were only eight starts. There is a question as to whether operating three distinct GME sites with all associated overhead is cost effective. The majority opinion was that at least one, if not two of the sites should be consolidated. However, there was considerable controversy on which of the sites offered the best program. This is most likely reflective of internal parochialism related to each of the programs. Without an "honest broker", external review and analysis of this issue, there will likely be an impasse within the current CHPPM staff.

12. LOGISTICS - There were a number of problems reported in the logistics area. There are perceptions that Aberdeen Proving Grounds consistently provides poor support to CHPPM. Staff members reported a number of problems such as a lack of feedback on the status of orders, cancellation of orders without follow-up notification and substitutions being made without customer approval. Most of these problems seem to point to a lack of communications. The problem most likely could be lessened by improved communications among Aberdeen Proving Grounds, the CHPPM logistics division, and the CHPPM staff.

13. OHMIS CHIEF - The USACHPPM OHMIS office is presently staffed by three individuals. The chief (program manager) is a military

04, the operations manager is a GS 13, and the Program Support Assistant is a GS 06. Historically, the OHMIS office has required an individual with a broad-based background of preventive medicine experience to understand and operationalize the diverse OHMIS initiatives. In addition, this individual needed user experience to serve as a reminder of why OHMIS exists. A military program manager has served these purposes well.

Recent evolutions of the OHMIS office have minimized the need for the program manager to have the broad-based background of preventive medicine experiences. Functional area responsibility is now relegated to the respective functional areas within CHPPM. The absence of a military program manager will not hinder the current OHMIS initiatives.

Many of the OHMIS initiatives require 18-24 months to be realized. The current 3-4 year military tour does not facilitate the continuity of operations for most of these initiatives. Strong leadership and continuity are important requirements for the next generation of OHMIS.

As described above, the need to have a field user's perspective still exists. Military still serve this purpose well. Nevertheless, it is recommended that a civilian OHMIS program manager be assigned subsequent to the incumbent's departure.

This recommendation based is on the long-term need to maintain for project continuity. We also recommend a military officer (0-3 or 0-4) be assigned for a career development assignment as well as to provide first hand field user's perspective to the program.

VI. RECOMMENDATIONS

1. Eliminate the COO role.
2. Eliminate the Division Chief role. Assign adequate support staff to the Directorate level as required.
3. Ensure that all primary staff roles function at Level III.
4. Establish a criteria and/or standard for evaluating all existing programs. Have the PA&E evaluate each program area and prioritize them according to their mission focus.
5. Realign the PM chief of the MEDDAC level to report directly to the MEDDAC Commander/Director of Area Health Services.
6. Establish a fully functioning PA&E cell.
7. Establish a CHPPM marketing activity.
8. Coordinate with the DCSPER and host an FAA involving all Army elements/activities involved in community, health promotion, and wellness related programs.
9. Consolidate GME into one or two sites as recommended by an external review and analysis.
10. Appoint a civilian to head the OHMIS office.

CHPPM MANIFEST ORGANIZATION

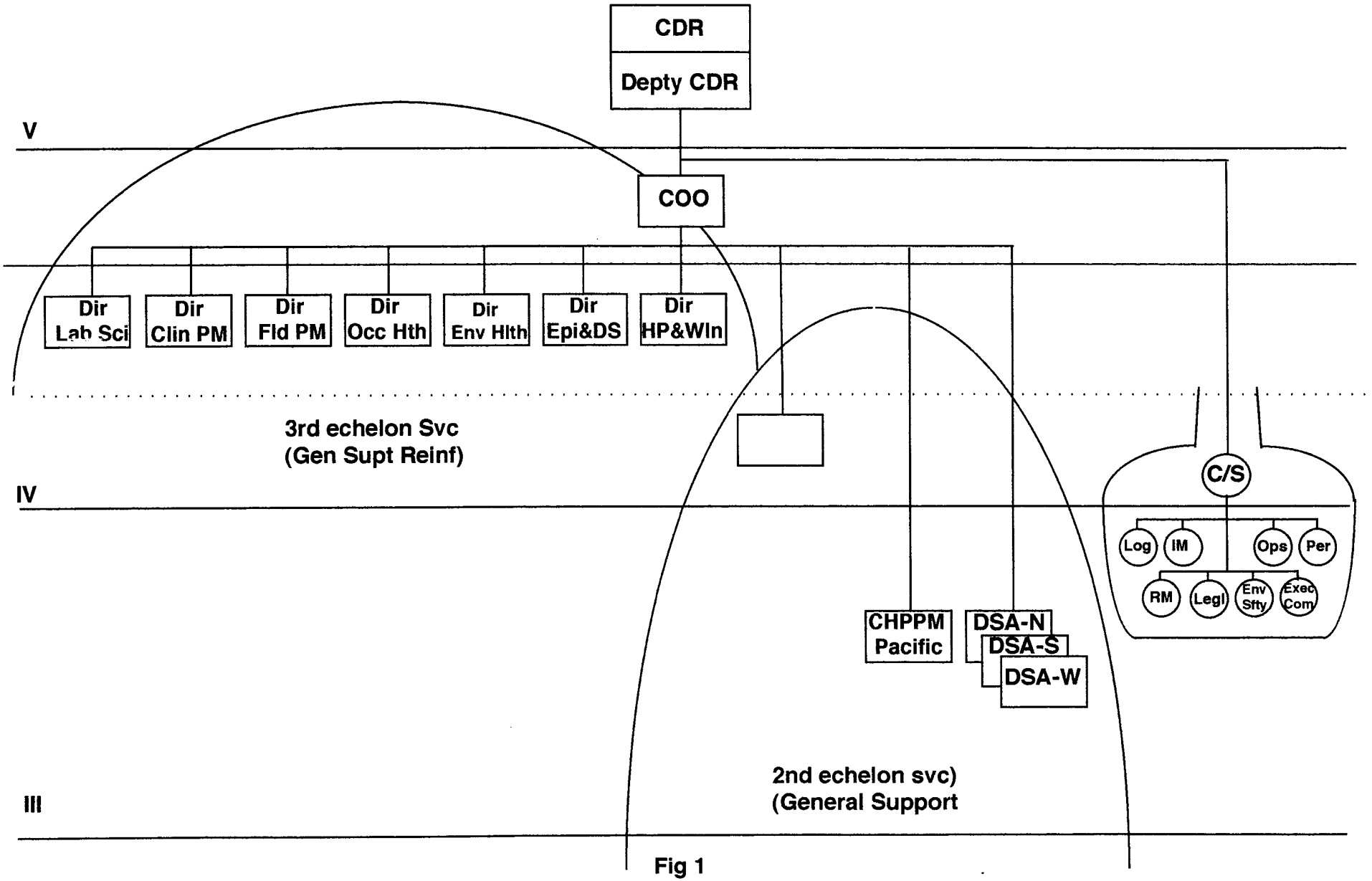


Fig 1

CHPPM EXTANT ORGANIZATION

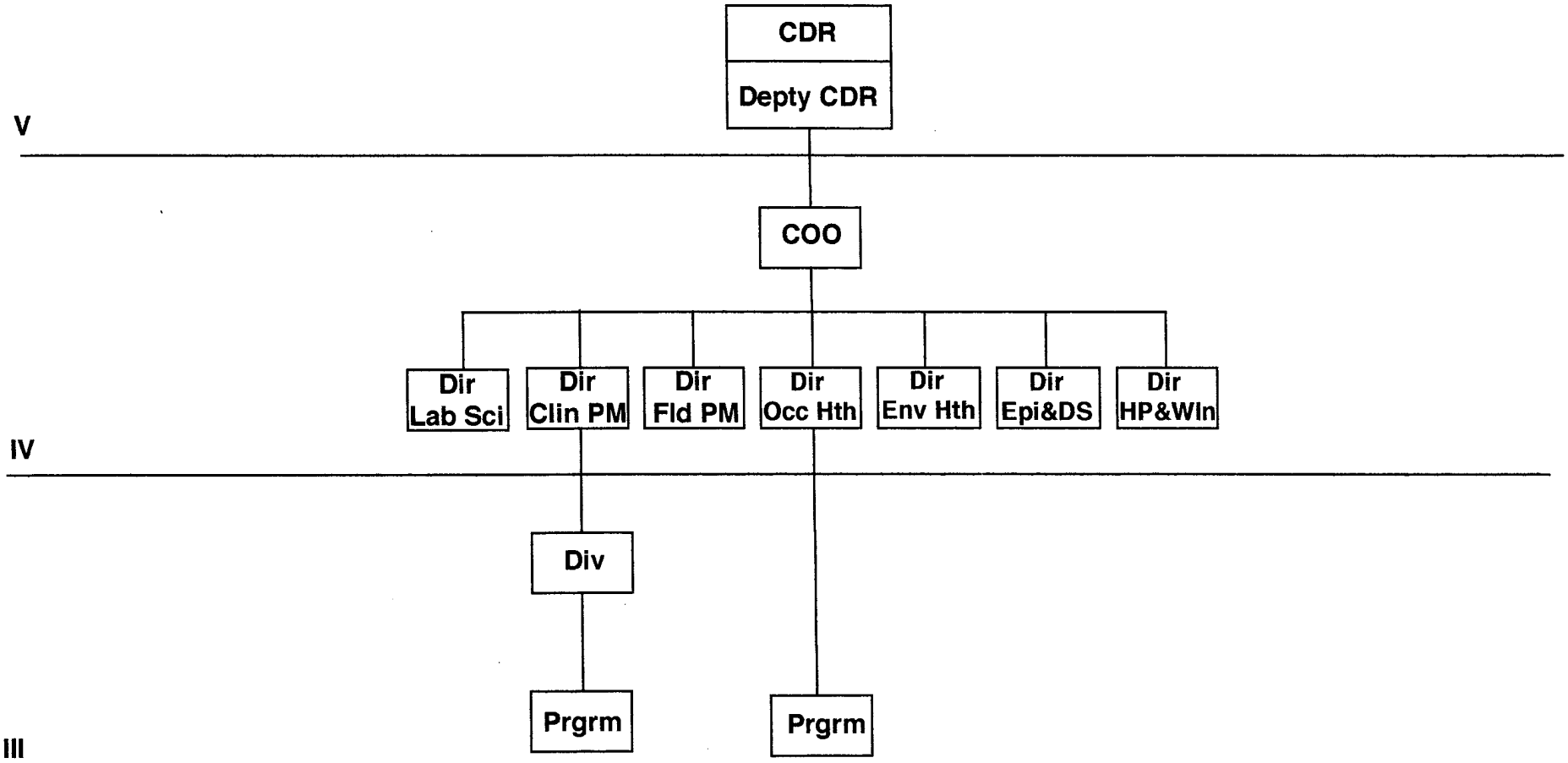


Fig 2

CHPPM MANIFEST ORGANIZATION

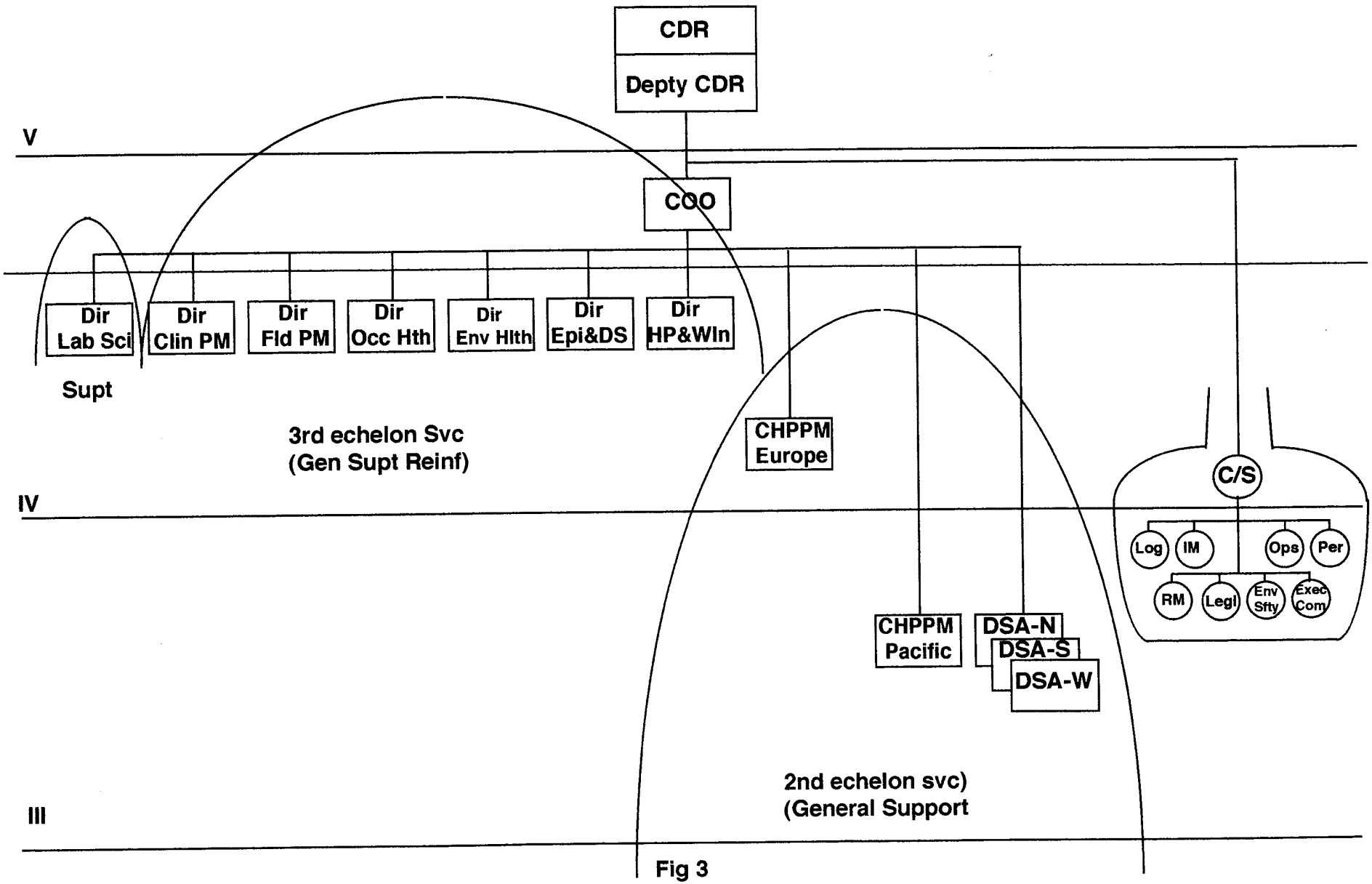


Fig 3

EXTANT STAFF ORGANIZATION

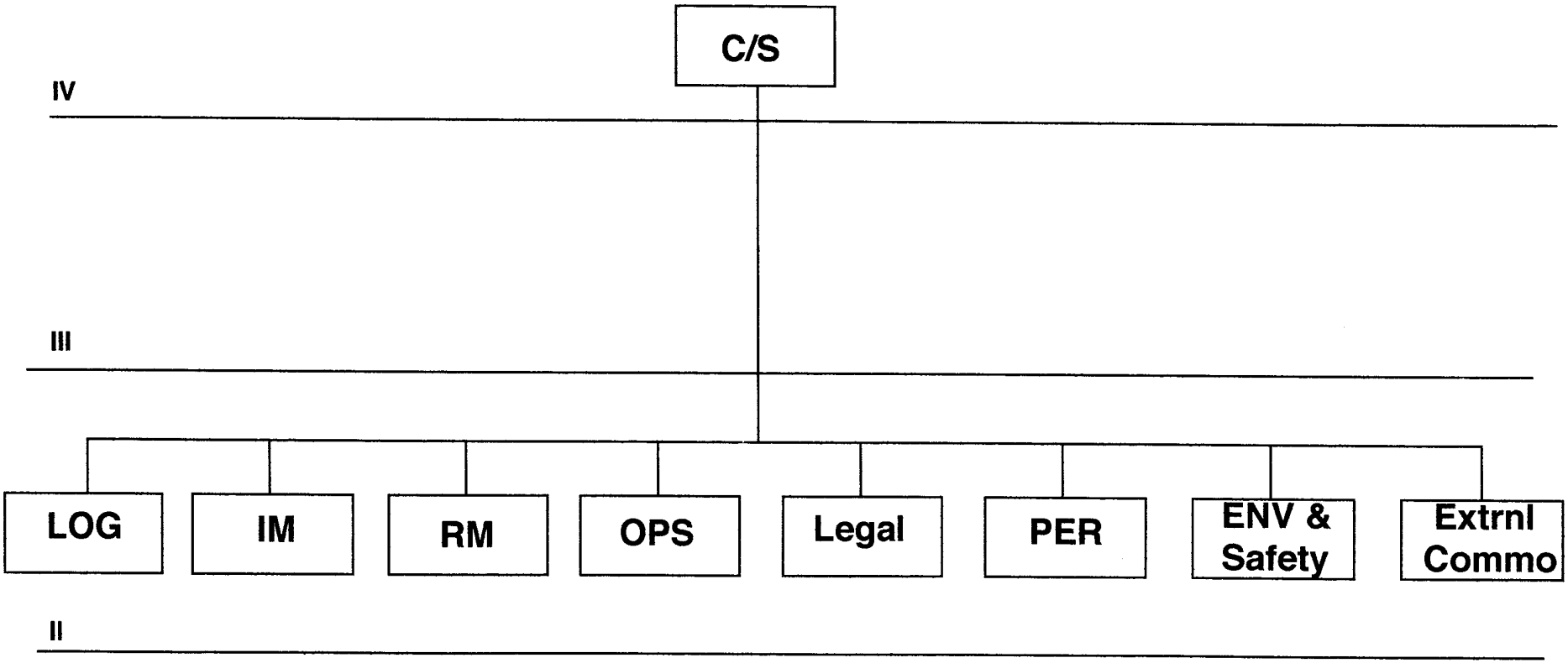


Fig 4

CHPPM SERVICES

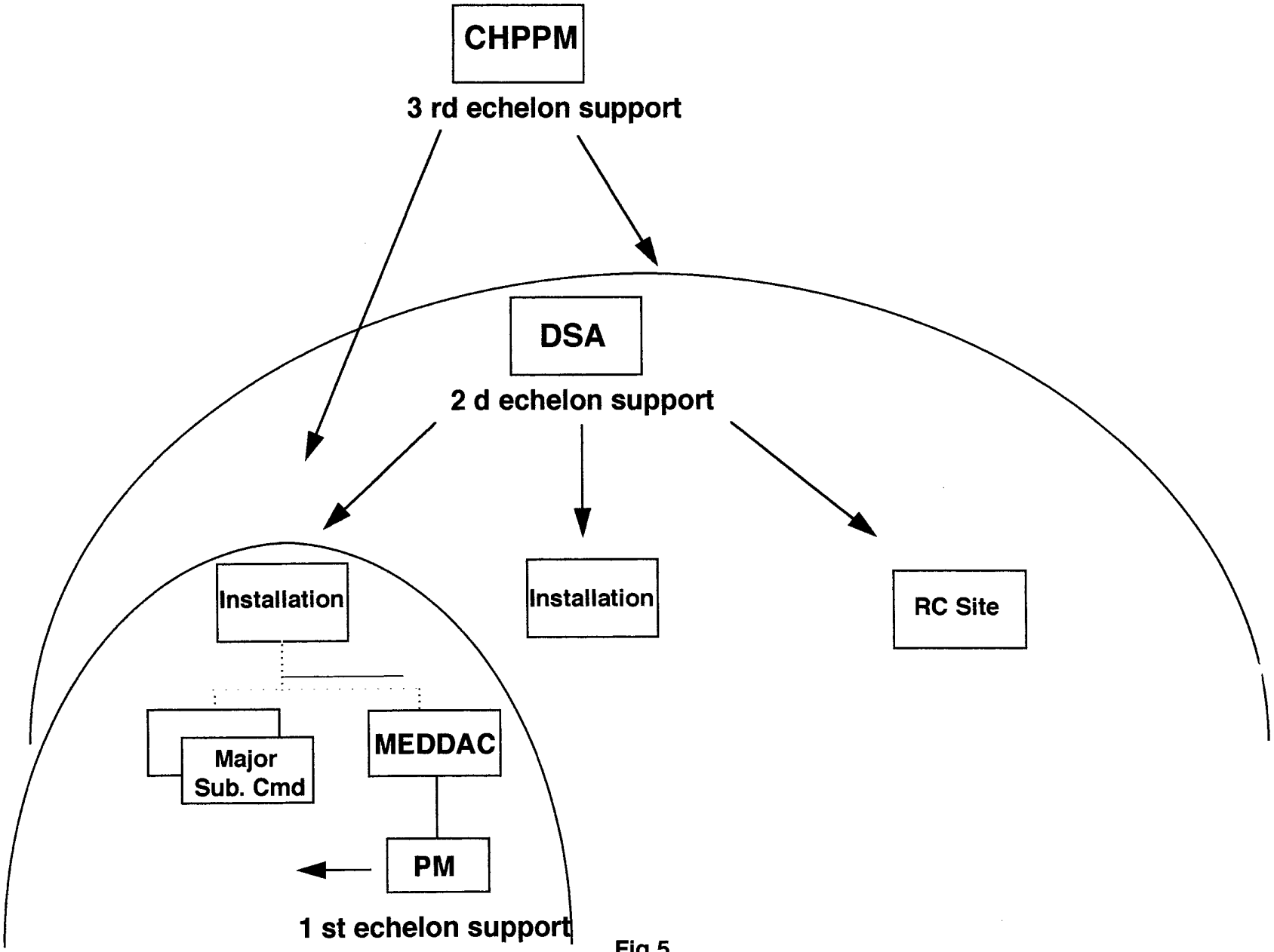


Fig 5

CHPPM WORK

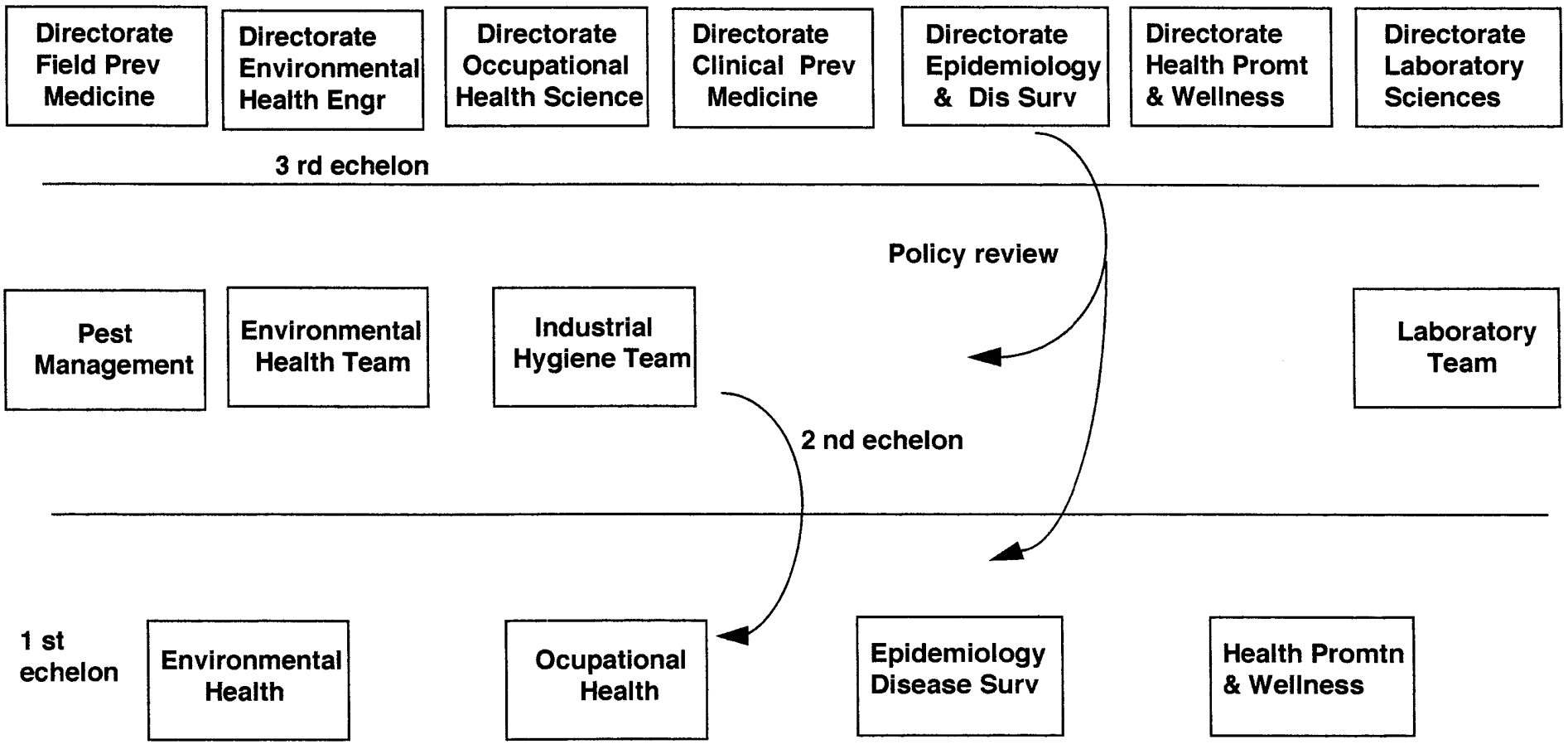


Fig 6

CHPPM WORK

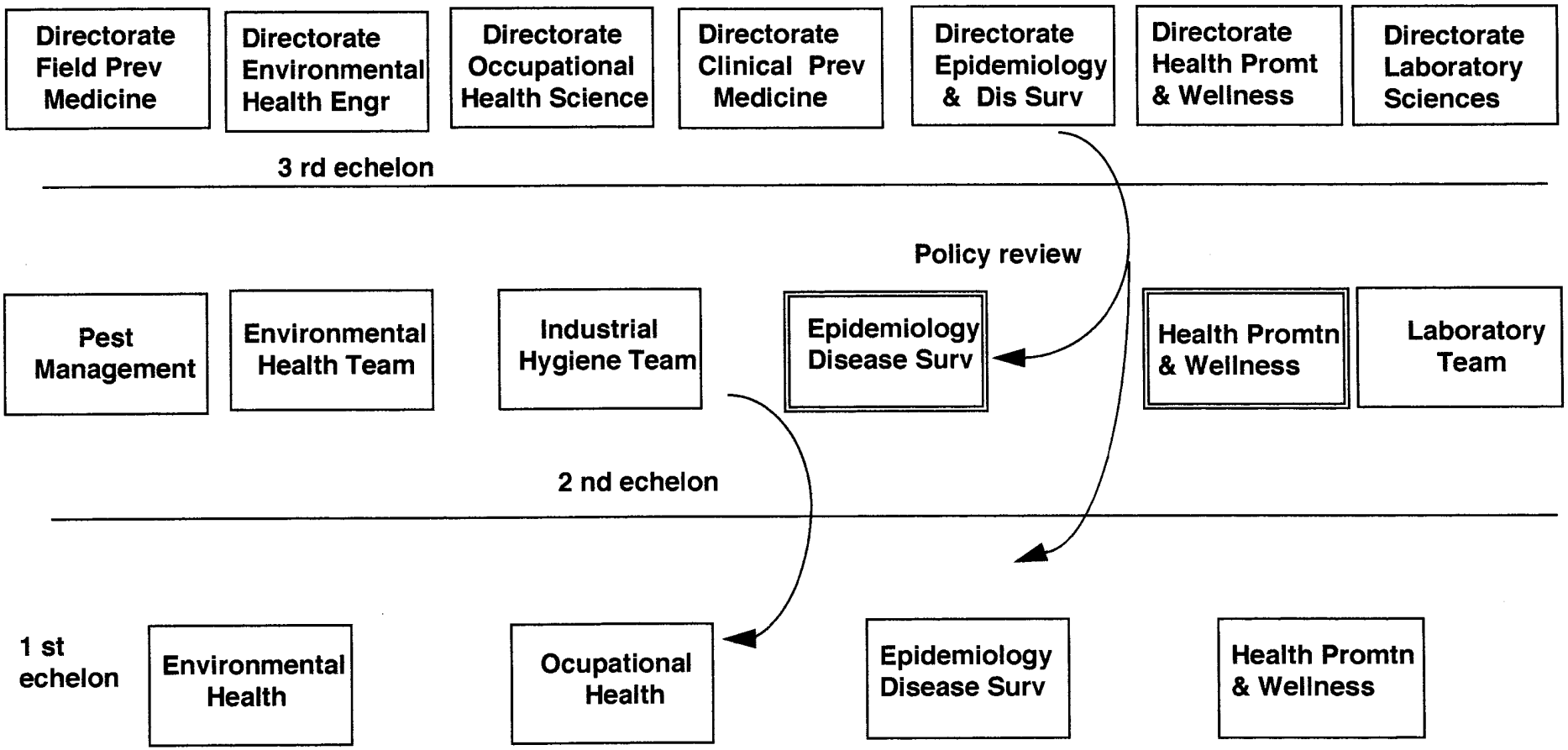


Fig 7