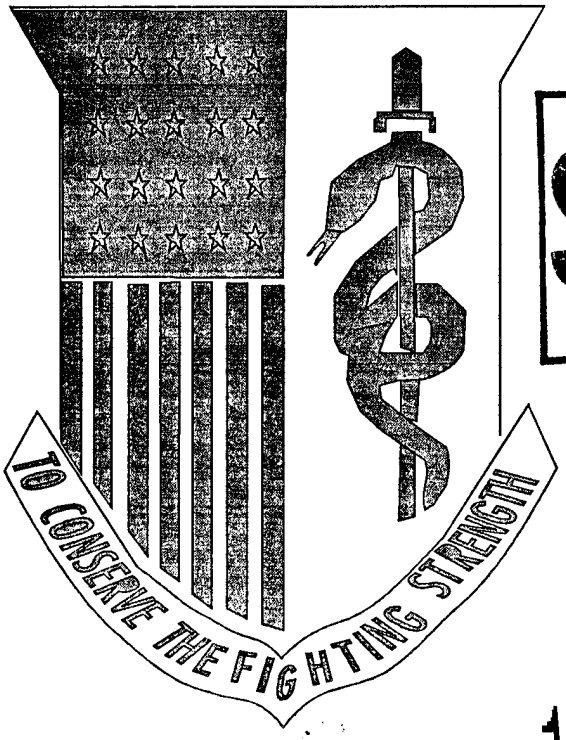
UNITED STATES ARMY MEDICAL DEPARTMENT

REORGANIZATION



VOLUME IV
ENCLOSURES 13-14

TASK FORCE AESCULAPIUS
JANUARY 1993 - JUNE 1995

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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 13

SUMMARY OF RECOMMENDATIONS
AMEDD CENTER AND SCHOOL

I. COMMAND SUITE

1. Eliminate the Office of the Assistant Commandant.

2. Chief of Staff extantly operates as the Deputy Commander. Redefine role of Chief of Staff (C/S) to that of integrator of the General Staff.

3. Establish two Brigadier General positions:

- Deputy Commanding General, Force Integration
- Deputy Commanding General, Training

II. SPECIAL STAFF

1. Historian moves to the Center for AMEDD Lessons Learned, Directorate of Evaluation and Standardization (DOES).

2. Receives TQM function from DOES.

III. DIRECTORATE OF PERSONNEL

1. Moves in its entirety to the newly created Directorate of Support (DOS).

2. No other changes recommended.

IV. DIRECTORATE OF LOGISTICS

1. Moves in its entirety to the newly created Directorate of Support (DOS)

2. No other changes recommended.

V. INFORMATION MANAGEMENT OFFICE

1. Administrative Services Division (mail, distribution, printing and publications, records management) moves to the newly created Directorate of Support (DOS).

2. Command editor realigned with the Secretary of the General Staff.

3. Information Management Officer remains on special staff reporting to the C/S. IMO retains automation management, customer support and planning functions.

4. Learning Resources Laboratory functions recognized and aligned with the newly created

Advanced Visual Information Division (AVID).

VI. DIRECTORATE OF OPERATIONS

1. International Military Student Office (IMSO) realigned to the Medical Field Service School, Academic Services Division.

2. Training Input Branch and Automated Instructional Management System (AIMS) realigned within the Academic Services Division, Medical Field Service School.

3. Registrar/Academic Records Branch realigned to the Academic Services Division, Medical Field Service School.

4. Classroom Scheduling/Facilities realigned to the Academic Services Division, Medical Field Service School.

5. Classroom Support realigned to the Academic Services Division, Medical Field Service School.

6. Security and Intelligence Branch realigned to the newly created Directorate of Support (DOS).

7. Health Sciences Media Division moves to the newly created Advanced Visual Information Division within the Directorate of Support.

8. Mobilization Branch realigned to the Directorate of Support.

9. The U.S. Army Medical Museum realigned to the Directorate of Support.

10. Move Operations Branch to DOS.

VII. CENTER BRIGADE

1. No changes were recommended.

VIII. DIRECTORATE OF TRAINING DEVELOPMENT (DOTD)

1. Unit Training Division (UTD) less Exercise Branch and DMSET Branch moves to Directorate of Combat and Doctrine Development (DCDD).

2. Deployable Medical Systems Equipment for Training (DMSET) Branch moves to DOS.

3. Exercise Branch moves to Military Science Division (School).

4. Training Literature Branch (TLB) moves to the Directorate of Combat Doctrine & Development (DCDD).

5. Performance Measurement Branch (PMB) moves to the School.

6. Individual Training Directorate less the Training Technical Branch moves to the Training Divisions of the School.

7. Training Technology Branch moves to the Audio Visual Information Division (AVID) and DOS.

8. RC-NG Plans, Policy and Training Officers move to the school.

IX. DIRECTORATE OF COMBAT DOCTRINE AND DEVELOPMENT (DCDD)

1. Establish an Operations Research Statistical Analysis (ORSA) Cell.

2. Receives the Unit Training Division (less the Exercise Branch & DMSET).

3. Receives the Training Literature Branch (TLD).

4. Receives Doctrine Division, Health Care Directorate functions from OTSG.

X. ARMY MEDICAL DEPARTMENT (AMEDD) PERSONNEL PROPONENT DIRECTORATE (APPD)

1. Moves under the Deputy Commanding General Force Integration (ACFI).

2. No other changes recommended.

XI ADVANCE VISUAL INFORMATION DIVISION (AVID)

1. Receives Health Sciences Media Division, Directorate of Operations.

2. Receives Training Technical Branch, DOTD.

3. Receives Learning Resource Laboratory functions from the IMO.

XII. DIRECTORATE OF EVALUATION AND STANDARDIZATION

1. Receives Historian from Special Staff.

2. TQM Coordinator moves to Strategic Planning Office, Special Staff.

3. Strengthen Lessons Learned Program with increased analytical capability.

XIII. DIRECTORATE OF HEALTH CARE STUDIES AND CLINICAL INVESTIGATIONS (HCSCIA)

1. Health Care Studies Division moves to the Health Care Education and Research in the School.

2. Clinical Investigation Division is combined with Graduate Medical Education (GME) when it is relocated from OTSG to the School.

3. Health Care Analysis Division moves to the Center for Health Care Education and Research within the School.

XIV. DIRECTORATE OF PATIENT ADMINISTRATION AND BIOSTATISTICS (PASBA)

1. Medical Expense & Performance Reporting System (MEPRS) Division moves back to the MEDCOM DCSRM.

2. Patient Administration Operations Division (PAD) moves to the MEDCOM Clinical Services within HCOPS.

3. DNBI, Lessons Learned projections moves to the ACFI.

4. Biostatistics Division and Patient Administration Systems Divisions move to the MSSA.

XV. DIRECTORATE OF HEALTH CARE MANPOWER MANAGEMENT SUPPORT (DHCMMS/HCMEA)

1. No longer accomplishes:

- Joint Manpower Standards

- Army Manpower Standards

- Administration & Automation Support

2. Demographic Modeling, Manpower Utilization, Working Projections moves to the MEDCOM Health Care Operations.

3. Allocations, Requirements Determinations, Equipment, Documentation moves to MEDCOM/DCSRM.

XVI. DIRECTORATE OF RESOURCE MANAGEMENT

1. Receives Central Training Program Office, Education and Training functions from OTSG.

2. No other actions recommended.

XVII. MEDICAL FIELD SERVICE SCHOOL (SCHOOL)

1. Some consolidation of Teaching Divisions.

2. Brigadier General assigned as Deputy Commanding General, Training.

3. Establish Academic Services Division.

4. Academic Services Division provides school specific support to include:

- Staff & Faculty Development
- Classroom Support
- Classroom Scheduling
- ATRRS/AIMS
- Registrar
- Library
- Extension Services Division
- International Military Student Office

5. Adds ITD (-) to teaching divisions.

6. Adds the Performance Measurement Branch, TLD.

7. Adds the Exercise Branch, UTD.

8. Adds the RC-NG Plans, Policy & Tng Officers, DOTD.

9. Adds Corps Professional Development Offices, Education and Training, OTSG.

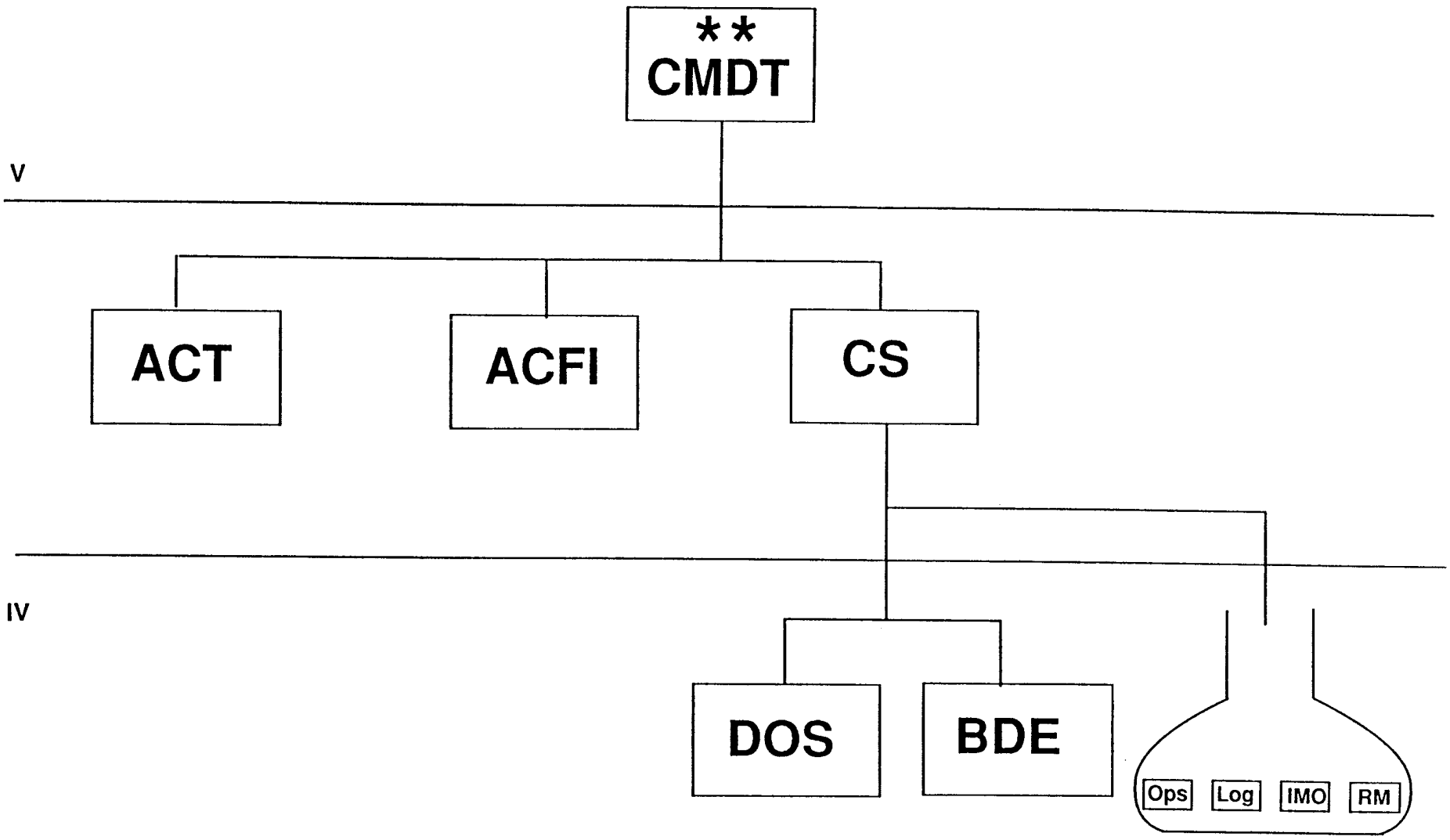
XVII. DEPUTY COMMANDING GENERAL FORCE INTEGRATION

1. Brigadier General assigned as Deputy Commanding General, Force Integration.
2. Receives Corps Chiefs Representatives.
3. Retains DCDD, Test Board, & MEDDVAC Proponency
4. Loses DOTD (-).
5. Receives APPD.

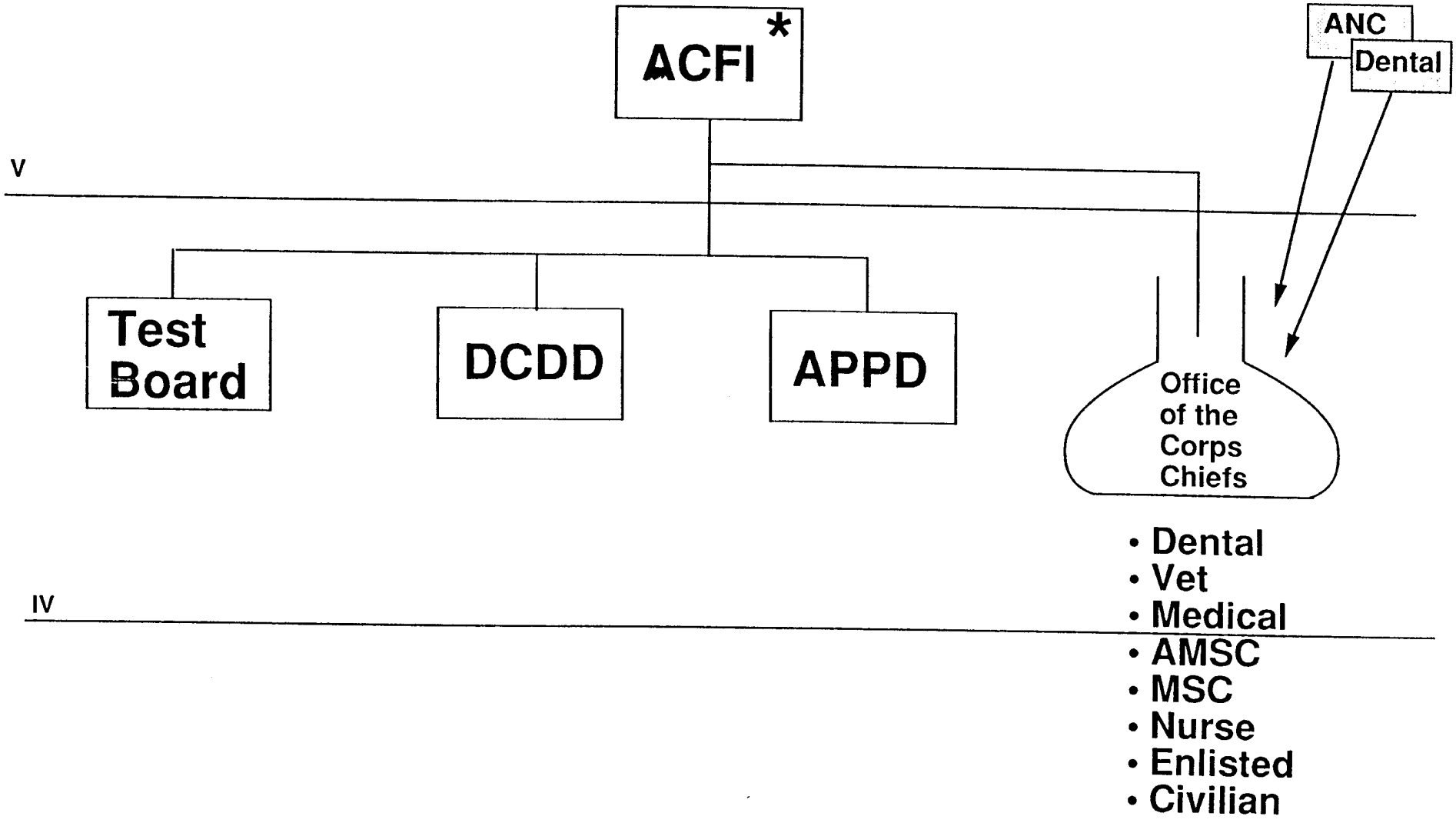
XIX. DIRECTORATE OF SUPPORT

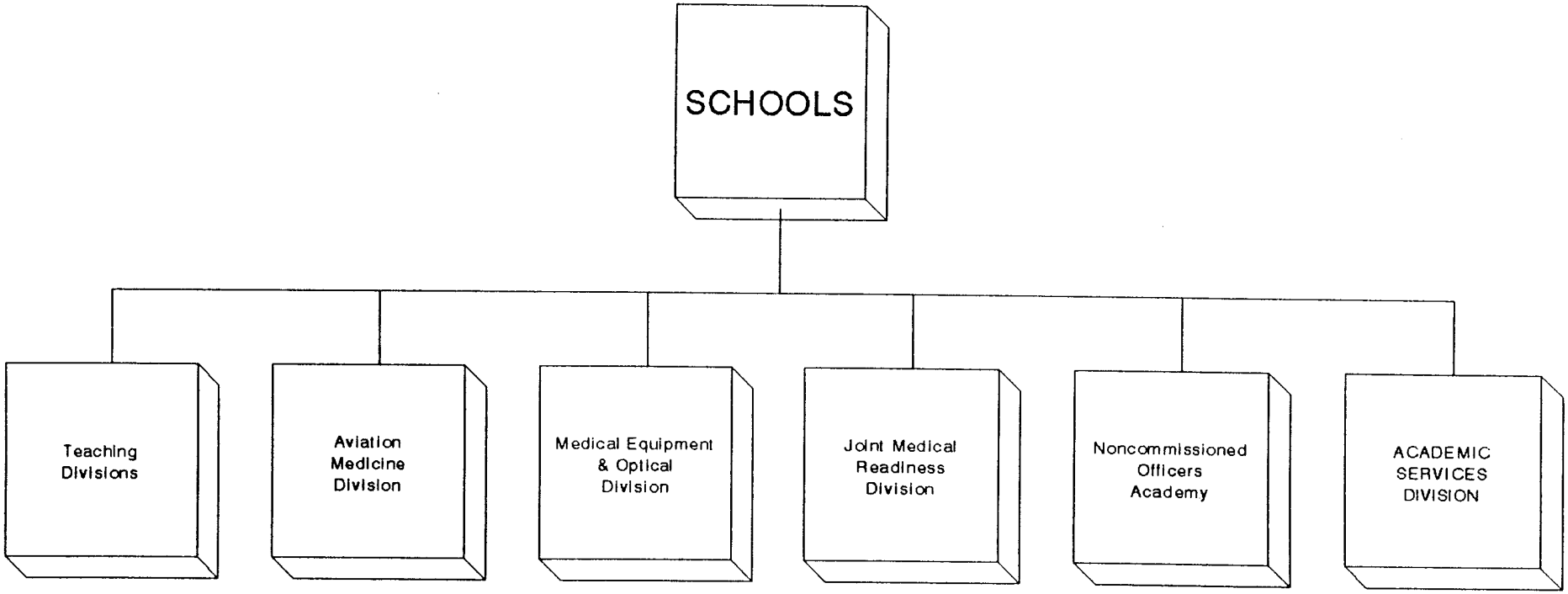
1. Receives Directorate of Logistics.
2. Receives DOES.
3. Receives Administrative Services Division, IMO.
4. Receives AVID.
5. Receives Museum, DOPS.
6. Receives DMSET, DOTD.
7. Receives Director of Personnel.
8. Receives Security & Intelligence Br, DOPS.
9. Receives Mobilization Branch, DOPS.
10. Receives Operations Branch, DOPS.

AMEDDC&S REQUISITE ORGANIZATION



ACFI REQUISITE ORGANIZATION




SCHOOLS
Teaching Divisions
Aviation Medicine Division
Medical Equipment & Optical Division
Joint Medical Readiness Division
Noncommissioned Officers Academy
ACADEMIC SERVICES DIVISION

U.S. ARMY MEDICAL DEPARTMENT AND SCHOOL

MEDICAL FIELD SERVICE SCHOOL

BACKGROUND:

The Medical Field Service School (MFSS) has undergone a number of significant organizational changes over the past several decades. The school was originally founded in 1920 at Carlisle Barracks and was initially organized as a training school for Army Medical Department personnel. Over the years the original structure underwent a number of modifications in response to a series of significant changes in the external environment. For example, in the late 1970s the school emulated the massive changes that were occurring in Training and Doctrine Command (TRADOC) at the time. During this period, an entire new focus on training design was introduced as the Army implemented the task based Instructional System Design (ISD) process. These changes led to the creation of two new directorates within the MFSS: the Directorate of Training Development and the Directorate of Training Evaluation. Throughout this same period the entire combat development process also underwent considerable change as the Army implemented the Concept Base Requirements System (CBRS) system.

As a result of the impact of these changes, the Academy of Health Sciences was established. The school organized around 12 teaching divisions under the command and control of a Dean. In October 1992, the Academy of Health Sciences was renamed the Army

Medical Department Center and School (AMEDDC&S) and, shortly thereafter, the position of Assistant Commandant was established to complement the Dean for MFSS in an attempt to improve overall integration efforts.

Because the Army faces increased fiscal constraints, schoolhouse operations continue to be scrutinized for efficient and effective resource utilization. For example, the senior leadership of the AMEDDC&S has suggested the following initiatives be explored: (1) Combining the 12 MFSS teaching divisions into a smaller number of divisions; (2) Realigning some Directorate of Training Development (DOTD) missions and resources to the schoolhouse; (3) Establishing each teaching division as world class training leaders; and (4) Ensuring division chiefs are well informed and knowledgeable about field needs, involved in equipment and technology development efforts, and focused on integrating training and doctrine needs of Table of Distribution and Allowances (TDA) and Table of Organization and Equipment (TOE) units.

At the very least, the role of the division chief is expected to continue to expand as more and more functions originally performed at the Office of the Surgeon General (OTSG) level are transferred to the AMEDDC&S (e.g., Graduate Medical and Graduate Dental Education). Just as the role of the division chief is changing so is the role of the AMEDD General Officer Corps. For the first time, a number of General Officer billets have been identified as Corps immaterial. The magnitude of this

change is now only beginning to be felt. For example, each Corps chief will now have to rethink the leader development process in their respective Corps. One clear requirement generated by the above change is that the AMEDD in general will have to provide more command experiences as they strive to develop more senior level leaders.

The AMEDDC&S cannot escape the impact of these changes. As the AMEDD itself changes so also will the Center and School have to change. For example, the adoption of managed care as a prime health care delivery mechanism or the differentiation of separate health care product lines (e.g., Dental, Veterinary, and Public Health) suggests that the MFSS might want to reevaluate how it is structured to support such programs.

1. THEME: There appears to be too many roles contained within the executive management level of the school portion of the AMEDDC&S.

FINDINGS:

A. The perception of the division chiefs is that there are too many management layers between the division chiefs and the Commandant. Currently O6 division chiefs must go through three (sometimes four) other O6s to obtain a decision or guidance from the Commandant (see enclosure 1).

B. The Chief of Staff role functions extantly as a management role and not as a staff integration role.

C. The Secretary of the General Staff (SGS) role is perceived by some division chiefs to function de facto as an additional layer in the MFSS work flow process.

D. The Commandant travels extensively and relies on the Chief of Staff to keep things running smoothly in his absence.

E. The role of the Deputy Commandant has been widely perceived as adding to the confusion described above.

F. Both the Assistant Commandant and the Dean are doing work in the same organizational layer.

G. The division chief role appears to be compressed into to low a level (i.e., Level III) - although much of the work of the division chiefs is in fact appropriate to that level.

H. The role of the Assistant Commandant tends to focus on external customers while the role of the Dean is primarily oriented around the teaching divisions.

I. The work of division chiefs, the Dean, and the Assistant Commandant is not clearly differentiated from one another, thereby contributing to a general feeling of overlap and unnecessary bureaucracy.

ISSUE: The roles of the senior executive level are poorly defined and contain considerable overlap and duplication of accountabilities.

DISCUSSION: The work performed by and the responsibilities assigned to the Dean and Assistant Commandant for Training, the

SGS, and to lesser extent the Chief of Staff appear duplicative and result in unneeded staffing, supervision, and oversight.

RECOMMENDATIONS (see enclosure 2):

A. Combine the work of the Assistant Commandant for Training and the Dean's work into a single role.

B. Upgrade the position described above to Brigadier General by adding work appropriate to Level V.

C. Refocus the Chief of Staff role on staff integration work, not Deputy Commandant work.

2. THEME: There is a generalized concern that the current organizational structure of the MFSS is inadequate to meet the future training and education needs of the AMEDD.

FINDINGS:

A. The perception of the Dean and the MFSS division chiefs is that the MFSS is currently optimally organized.

B. MFSS division chiefs report that they perform the following tasks (work): serve as the senior Subject Matter Experts (SMEs) for their areas of responsibility; mentor officer students; direct graduate, undergraduate, and technical training and education for professionals and paraprofessionals (officer, enlisted, civilian); spearhead initiatives such as tri-service training; manage affiliations with professional accrediting

bodies; conduct professional short courses; and review and approve student recycle, relief, and elimination actions.

C. The Dean and various MFSS division chiefs have divergent opinions as to whether or not the MFSS teaching divisions could be combined/consolidated.

D. More and more MFSS training programs are facing increasing accreditation demands.

E. Division chiefs believe organizing by academic disciplines is the best way to meet accreditation requirements.

F. Some teaching divisions deliver course content into a variety of training courses operating at all levels.

G. Some savings appear to be possible by consolidating some branches and sections within MFSS's teaching divisions.

H. Division chiefs generally do not concern themselves with long-range planning for the future, integrating concepts and doctrine, and other training tasks appropriate for an individual functioning at Level IV. Most division chiefs spend the majority of their time involved in the daily operation of their division.

ISSUE: What is the best MFSS structure to meet future AMEDD training and education requirements?

DISCUSSION:

The MFSS has successfully conducted business for many years under its present configuration of 12 teaching divisions and

subordinate functional branches. In fact, the present organization has produced many outstanding products which are nationally recognized for excellence. However, the current fiscally constrained operating environment dictates that the command explore alternate organizational designs that not only save resources but also maintain the quality of the Center and School's various products.

There are several possible design alternatives that offer potential savings. One option is to organize by process instead of function. Organizing by process is a popular design strategy in industry today. This organizational design strategy is a marked departure from how the MFSS currently operates and is focused on streamlining the organization, reducing non-value added activities, and focusing on the Military Occupation Specialty (MOS) producing process instead of functions.

The process option implies reorienting the entire training function around the natural environment a student would face in the field (i.e., under the direct supervision of his/her normal supervisor. This approach would not organize the schoolhouse around an academic discipline (e.g., Behavioral Science), a medical area (e.g., Laboratory Science), or a Corps (e.g., Dental). A process reorientation would have the supervisor responsible for not only teaching the skills and knowledge required on the job, but also for providing soldier care and feeding throughout the training cycle. In other words, a 91B soldier would have an Noncommissioned Officer (NCO) primary

instructor who would teach all of the required skills and tasks while simultaneously leading the student in all non-MOS related tasks (i.e., Physical Training, study halls, etc.). The supervisors of the NCOs would be the normal supervisor in a field/work setting, in this example, a physician assistant (PA) or a nurse.

This approach would in turn mean that the PA/nurse would also command the unit that the soldiers are assigned to. The argument that the PA/nurse has insufficient experience to command is a fallacious one, especially in view of the increasing number of nurses who are assessed from ROTC programs where they receive the same leadership experiences and training as their combat arms counterparts (see enclosures 3 and 4).

The biggest problem with organizing the school in the above fashion is that it requires a completely new mind set and a totally different organizational structure. In many regards, the process option is similar to the merger of the 232d Medical Battalion and the Combat Medical Specialist Division (CMSD) that was made effective on 12 April 1993. Given that a reorganization along process lines for the entire school is somewhat radical, it might be wise to hold off total program implementation pending an objective evaluation of the 232d/CMSD merger.

A second option involves organizing the schoolhouse around major product lines (i.e., officer, preventive medicine, ancillary medical services, etc.). The number of product lines can be derived from analyzing the primary health care delivery

systems. Discrete MOSs do not constitute a delivery system, rather they simply make up a portion of one.

Under this proposal, MFSS could reduce its teaching divisions from 12 to a lesser number, possibly four or five, thereby saving some administrative overhead associated with the consolidation. Under this strategy the new division chiefs (O6 level) would be considered "product line managers" and would be responsible for a portfolio of similar products. For example, an Ancillary Medicine/Community Specialty Division could be established and be responsible for conducting the following training programs: MOSs 91S, 91E, 42D, 91R, 91T, and others. Reporting to the division chief would be a series of "product managers" (O5 level) who are directly responsible for a specific MOS product (i.e., MOS 91S). Manpower savings from such an arrangement would come from a consolidation of branches and a bottoms-up assessment of the resources required to produce a given product. The following proposal aligns the existing MFSS divisions into four broad "product line" orientations consistent with the proposed restructuring of the Medical Command (MEDCOM) (see enclosures 5 and 6).

1. Health Services Operations Division:
   - All current Health Care Administration (HCA) Division Courses (less the Baylor Course and Patient Administration Branch)
   - All current Military Science Division Courses
2. Ancillary Medicine/Community Specialty Division:

- All current Veterinary Science Division Courses
- All current Dental Science Division Courses
- Courses taught in the Behavioral Science Division's Special Subjects, and Alcohol and Drug Training Branches*
- All current Preventive Medicine Division Courses

3. Allied Health/Hospital Specialty Division:
   - All current Medicine and Surgery Division Courses
   - All current Laboratory Science Division Courses
   - Courses taught in the Army Medical Specialist Corps Division's Physical Therapy, Occupational Therapy, Physical Therapy and Nutrition Care Branches
4. Nursing Science Division:**
   - All current Nursing Science Division Courses
   - Behavioral Science Specialist (91G) Course currently taught in Behavioral Science Division***

Note: Teaching divisions comprised of more than one Corps should be assigned a Corps immaterial division chief (Colonel). A rotation policy should be established to ensure equitable distribution of assignments between the Corps. Branch Chiefs should be Lieutenant Colonel or Major.

* Psych/Neuro Branch of the current Behavioral Science Division would move to Combat Development/ACFI.

** It can be argued that Nursing Science would "fit" into the newly created Allied Health/Hospital Specialty Division.

However, it is recognized that the nursing practice arena spans both inpatient (hospital) and outpatient clinic areas.

*** The 91F Course (currently Nursing Science Division) and the 91G Course (Currently Behavioral Science Division) are scheduled to begin the Interservice Training Review Organization (ITRO) process this Fiscal Year. Since the Air Force and Navy have only one psychiatric technician course, the Army may have to consolidate their psychiatric courses to facilitate interservice training and standardization.

The above mentioned proposal requires the judicious application of some basic design principles in order to avoid unnecessary layering. For example, if the Allied Health Division Chief (an O6) hired additional O6s in the laboratory science, medicine and surgery, and occupational/physical therapy areas, then the consolidation would have achieved no real savings. In this case, Colonels would still work for Colonels and each major functional area would still retain its required administrative overhead. In fact, the layering problem uncovered at the senior organizational level would be replicated at a lower level. However, if the subordinate elements to the division chief are all O5s then the correct situation would be retained. The real issue is not layers themselves, but rather what is the nature of the work required to produce a given training product or a trained soldier.

The number of required organizational layers is a function of the complexity of the work to be performed in producing a given product or service. Thus, to construct the most effective schoolhouse structure requires that one build it from the bottom up. Employing a bottoms-up approach, however, requires the application of some fundamental design principles if one is to overcome parochial interests or entrenched traditional thinking. These principles are:

(1) The teaching of skills or knowledge simply requires that the instructor be an expert in a given area.

(2) The design of instruction requires an individual with the skills and knowledge to operate one full level above the student. Design, by its very nature, requires the integration of skills and knowledge into a comprehensive set of principles which permit the student to effectively cope with a variety of situations. This design process requires an individual who is capable of operating one full organizational layer above the student. Having a separation of this magnitude also facilitates the synthesis of discrete actions into a comprehensible total perspective capable of solving a wide range of problems extant at a given level.

(3) The approval of curriculums and/or Programs of Instruction (POIs) requires an individual with the cognitive capacity to function two full layers above the targeted level. This separation is required because it provides the approving authority with the experience of having occupied most, if not

all, of the roles contained at the level of the designing individual.

(4) Sign-off authority for curricula (or doctrine) needs to reside at the third level above the targeted audience. Thus, most MFSS POIs should be signed-off by the division chief of a given area. For example, 91B POIs should be signed-off by the division chief, whereas, medical doctrine appropriate to the company level should be signed-off by the ACFI.

A second set of design principles also needs to be considered. While the first set of principles focused on cognitive capacity (problem solving capacity), the second set focuses on the maximum number of soldiers an individual is capable of providing "value added" leadership. For highly routinized work with everyone performing the same task(s), the maximum number of subordinates a leader can "add value" to is sixty. As work becomes more complex, this number drops considerably. For example, at the 91B level the PA/nurse should be able to lead sixty soldiers. This number assumes that there are sufficient NCOs to provide expert training, as well as, oversee the soldiers during their non-training time. At the other extreme is the Army Baylor HCA course which is a graduate level course requiring a faculty capable of teaching at the graduate level. Again, the same principles apply for technically related knowledge. Technical expertise is required irrespective of rank. For integration, however, a Major or Lieutenant Colonel is required. Course approval requires an O6, PhD, former Deputy

Commander for Administration. To do a full scale bottoms-up design for the entire MFSS requires the judicious application of the above mentioned design principles.

One of the underlying reasons why consolidation has become an attractive option is that there is evidence that some of the division chiefs are not operating at the level where they should be. In other words, not all division chiefs are working on tasks appropriate to their respective position in the organizational hierarchy. For example, an appropriate task for a division chief is to integrate outcomes and products generated by the CBRS system into their respective product line areas, and subsequently translate these requirements into future course adjustments and POI and faculty development changes. This study uncovered little evidence that division chiefs were performing this type of integration effort. Enclosure 7 illustrates the changing nature of work at each successive layer in the schoolhouse. Perhaps, if this work were being performed, pursuing manpower savings by consolidating teaching divisions would not receive as much attention.

OPTIONS:

1. Study the feasibility of organizing the entire schoolhouse around the student natural work process (option one).

2. Evaluate the short-term feasibility of reorganizing the existing teaching divisions around the major product lines that the AMEDD at large is organized around (option two).

3. Maintain the status quo pending the complete integration of the activities being transferred from the OTSG and the formal establishment of the MEDCOM.

RECOMMENDATION: Further evaluate options one and two pending the resolution of tri-service (ITRO) initiatives and the integration of OTSG Education and Training functions into the MFSS organizational structure. In addition, consider the impact Graduate Medical Education and Graduate Dental Education will have on future division chief work. Possibly, the best approach is to pursue a combination of both options one and two. Pursue a process design in areas where it is feasible/do-able (i.e., 232d/CMSD merger) and in other areas pursue a bottoms-up approach based on the level of work (i.e., Allied Health Science Division).

3. THEME: Assigning training development responsibilities to MFSS teaching divisions may reduce duplication of efforts and improve some overall training products.

FINDINGS:

A. Teaching divisions currently provide SMEs to DOTD to assist in the training development process.

B. The teaching divisions report that much of the training literature developed by DOTD needs to be revised and rewritten when it is staffed through the appropriate SME.

C. Job Task Analysis Work Sheet (JTAWS) is perceived as marginally productive at best by Individual Training Division (ITD), DOTD and of low-value added by the teaching divisions.

D. MFSS staff perceive that DOTD staff view the SAT process format as more important than course substance.

E. Division chiefs report that DOTD adds little value to the teaching divisions.

F. (See also ITD write-up.)

ISSUE:

A. Would DOTD training developers be better utilized if they were assigned to MFSS teaching divisions?

B. Should resources be taken from DOTD and transferred to the Military Science Division to coordinate and execute AMEDDEX?

DISCUSSION:

To properly carry out the training development process DOTD must rely on MFSS teaching divisions to provide SMEs in each area. Therefore, MFSS teaching division chiefs tend to view DOTD's training development mission as primarily one of formatting instructional materials since the preponderance of instructional materials are actually written by SMEs. The resulting coordination between DOTD and the divisions is perceived by the MFSS Division Chiefs as time-consuming and superfluous. Also, in the area of training literature development, literature which has been developed by DOTD writers

and staffed through the respective SMEs is often determined by the SME to be unneeded, incomplete, inaccurate, and/or in need of major revisions. If the MFSS teaching divisions were responsible for developing the training, it was felt that such duplication could be avoided. Moreover, Division Chiefs may be aware of and recommend that some training materials be purchased from the private sector, thereby generating significant cost savings.

MFSS suggests that some efficiencies may be realized by assigning training developers from DOTD's Individual Training Division to the MFSS teaching divisions. DOTD is concerned, however, that the training development process, including the standardization and integration of doctrine and concepts might be compromised and/or subjugated to the platform instruction process if such development responsibilities are shifted to the MFSS teaching divisions.

Historically, DOTD has coordinated, developed, and executed AMEDD exercises (e.g., AMEDDEX, FPLEX). Recently, MFSS's Military Science Division has been assigned responsibility for coordinating and executing FPLEX. The Military Science Division feels that the appropriate resources associated with the above function needs to be transferred to the Military Science Division.

RECOMMENDATION: Transfer the assets from the Individual Training Division, DOTD to the teaching divisions.

4. THEME: The Formal Training Development Process (i.e., SAT) is cumbersome, lengthy and may add little value.

FINDINGS: MFSS teaching divisions report that the SAT process makes it very difficult to obtain approval and formalize new courses of instruction. Division Chiefs report that in many instances training could be developed as effectively using the internal Branch Chiefs and selected AMEDD active duty and civilian personnel. One division chief disclosed that he routinely circumvents the SAT process by not disclosing changes to a POI's course focus or objectives. Rather, the division chief makes the changes and when the annual curriculum committee convenes, he gets the POI approved as if it were simply being updated. Applying the formalized SAT process to all courses is not felt to be necessary. For some courses, the SAT process could be eliminated or significantly modified.

ISSUE: Does the SAT process significantly improve all training products?

DISCUSSION: The goal of systematically developing training is to ensure that all training is: (1) driven by the actual tasks and work to be accomplished and the needs of the field (i.e., customer based), (2) standardized and evaluated, and (3) consistent and based on current doctrine and coordinated with the latest concepts being developed.

RECOMMENDATION: Review the SAT process to determine its applicability to Area of Concentration (AOC), MOS, and Warrant Officer courses.

5. THEME: Assigning technically competent and appropriately experienced staff to MFSS teaching divisions significantly enhances the ability of these divisions to accomplish their mission.

FINDING: Many MFSS division chiefs indicated that an enhancer to getting their work done was having the authority to choose instructors or at least pick from a slate of instructors. Conversely, having the ability to veto the assignment of active duty staff that they did not see as competent or experienced was equally beneficial.

ISSUE: Should MFSS division chiefs be given increased authority to select (or veto) their Officer and Enlisted staff?

DISCUSSION: Most division chiefs felt that they were informally empowered to select and/or veto the assignment of Officer personnel. However, they report having little control over the assignment of Enlisted personnel. There is a critical need to have top notch staff assigned to the teaching divisions since they serve as mentors, models, and teachers for the entire AMEDD.

RECOMMENDATION: Develop a process whereby division chiefs have the authority to veto the assignment of an individual (both Officer and Enlisted) to their team. If veto procedures are too difficult to achieve, provide a mechanism where it is relatively easy for a division chief to initiate the removal of a member from his or her team. This action should be coordinated with APPD and the Corps chiefs.

6. THEME: The structure of the AMEDDC&S must reflect the manner in which health care is delivered.

FINDINGS:

A. The Commandant stated that the structure of AMEDDC&S may need to reflect the changes (such as coordinated care) currently underway throughout the AMEDD.

B. Currently, there is a very limited focus on coordinated care within MFSS.

ISSUE: Should the structure of AMEDDC&S reflect coordinated care initiatives and other changes in health care delivery?

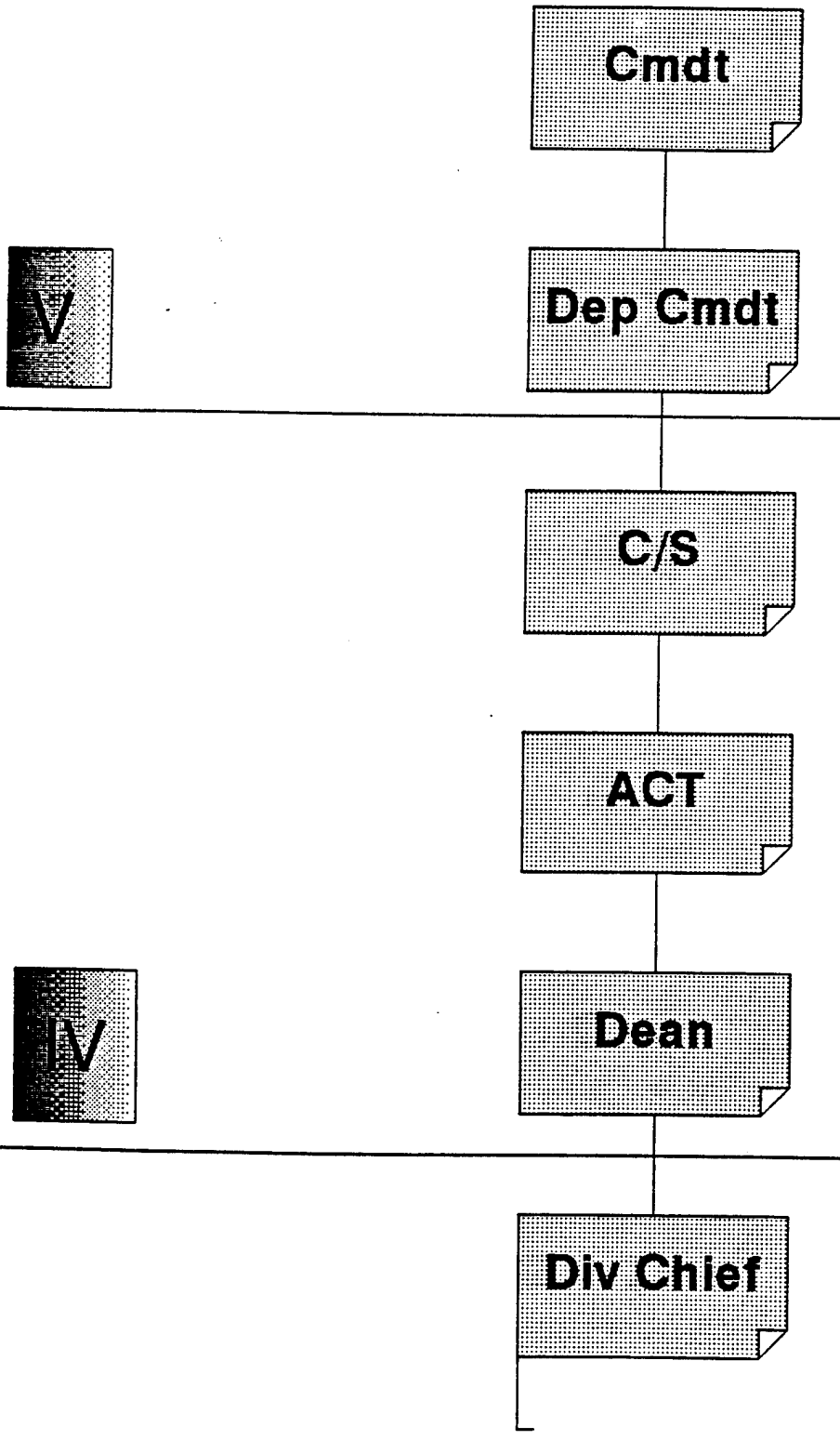
DISCUSSION: The Deputy Chief of Staff for Operations (DCSOPS) of the new AMEDD MEDCOM will combine peacetime and wartime health care delivery operations. Coordinated care will consume extensive AMEDD resources. Medical Treatment Facilities (MTFs)

will be reorganized differently. Combining the Military Science Division and Health Care Administration Division under the umbrella of a Health Care Operations Division may facilitate the integration of peacetime and wartime training missions and minimize the disparity between training for both peacetime and wartime missions.

RECOMMENDATION: Consolidate portions of HCAD (i.e., the Human Resources Branch and the Logistics Branch) into Military Science Division. Retain the remainder of HCAD and combine with the Health Care Studies element of Health Care Systems Support Activity.

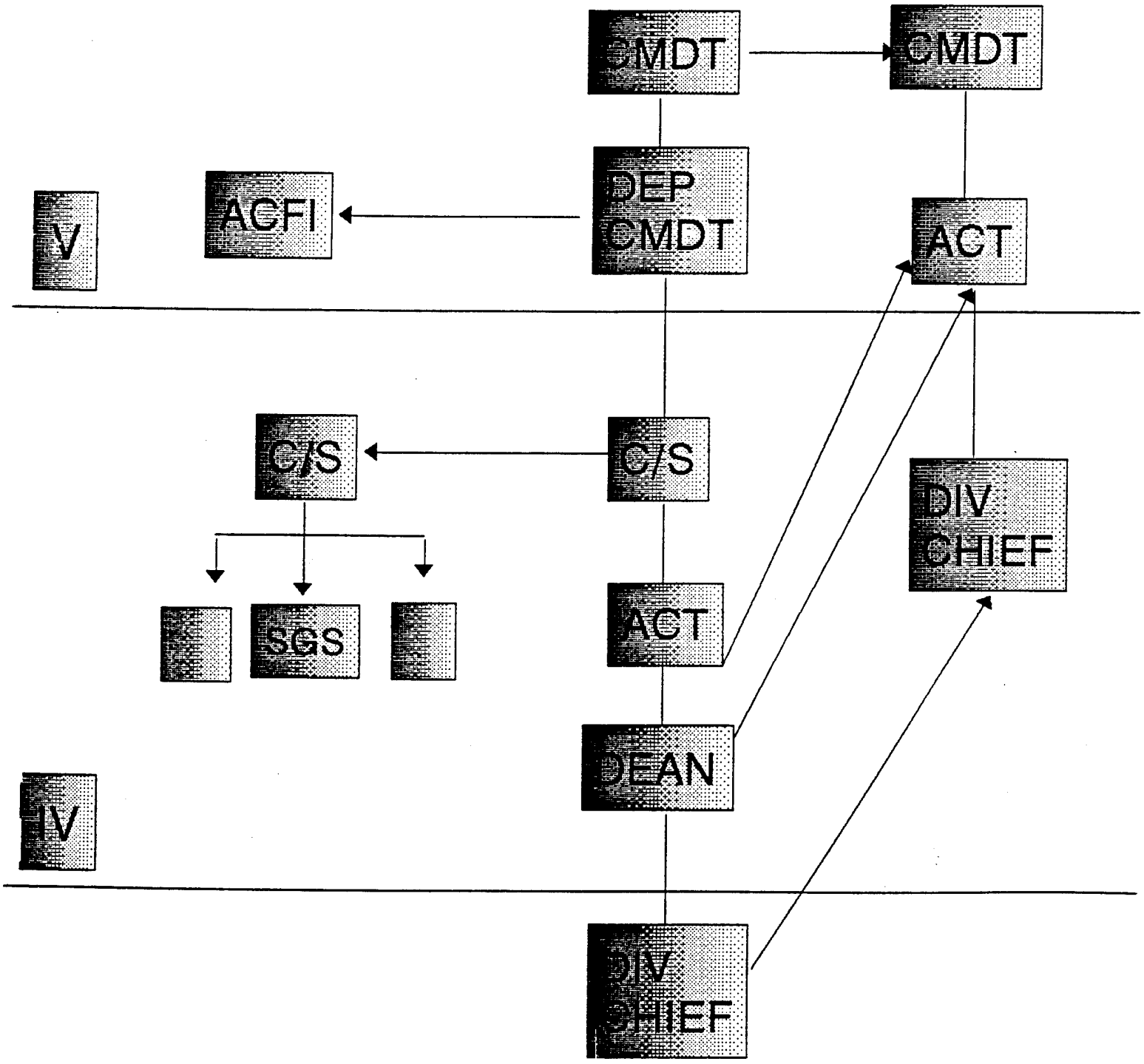
SENIOR LEADERSHIP ROLES

Extant Situation



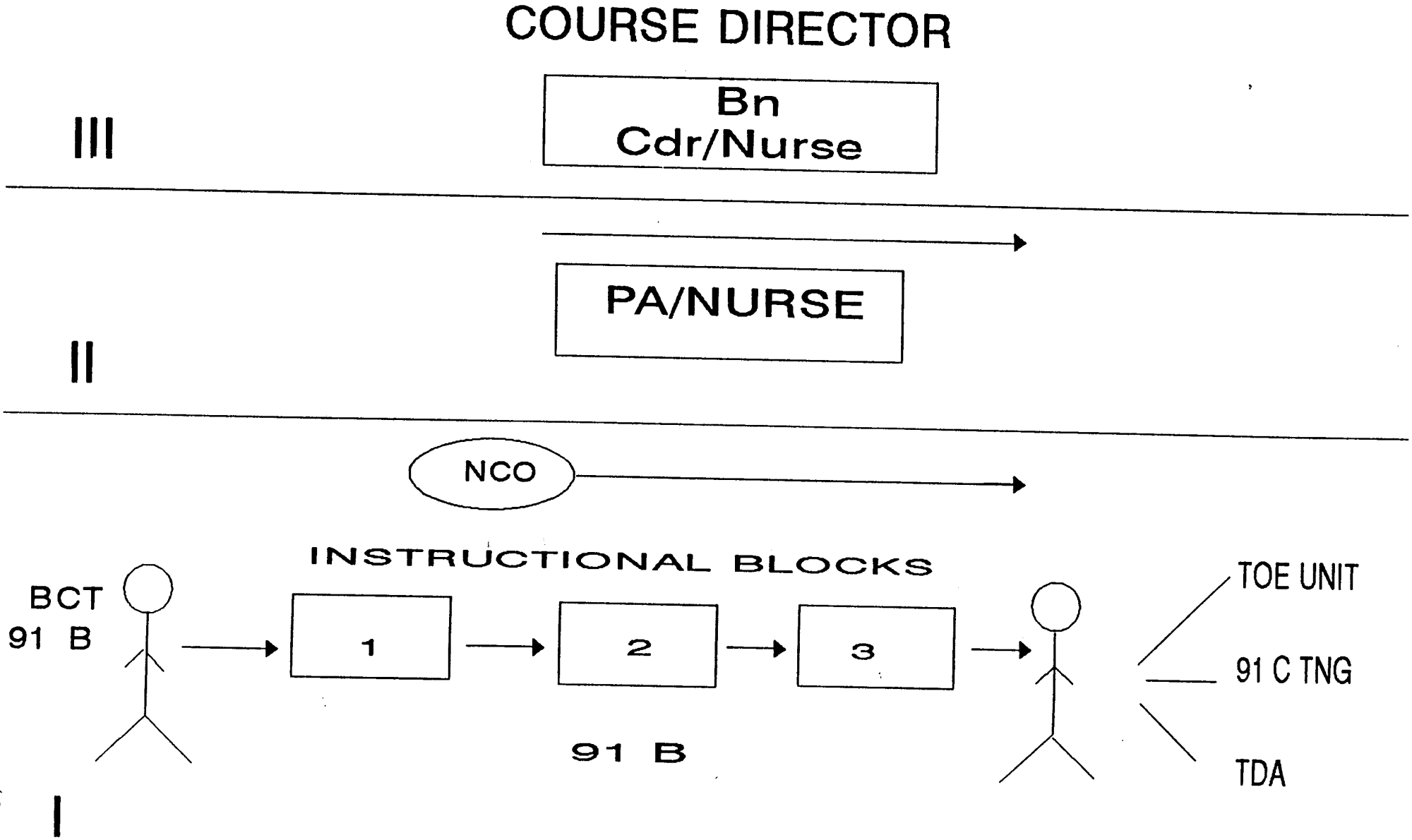
ENCL 1

SENIOR LEADERSHIP ROLES
REQUISITE SITUATION



ENCL 2

PROCESS ORIENTATION

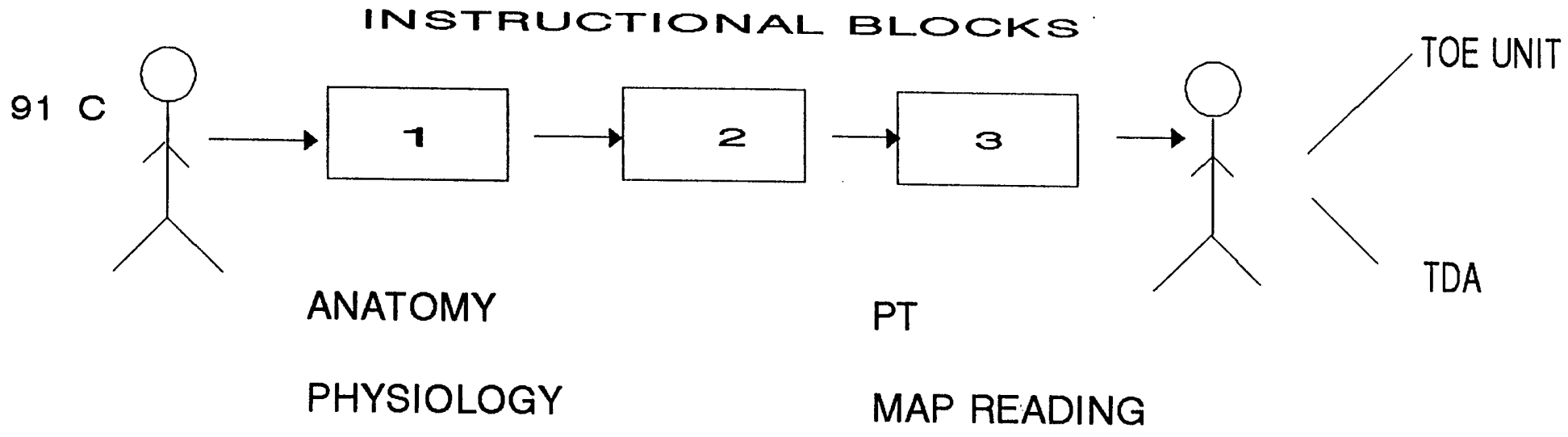


ENCL 3

PROCESS ORIENTATION

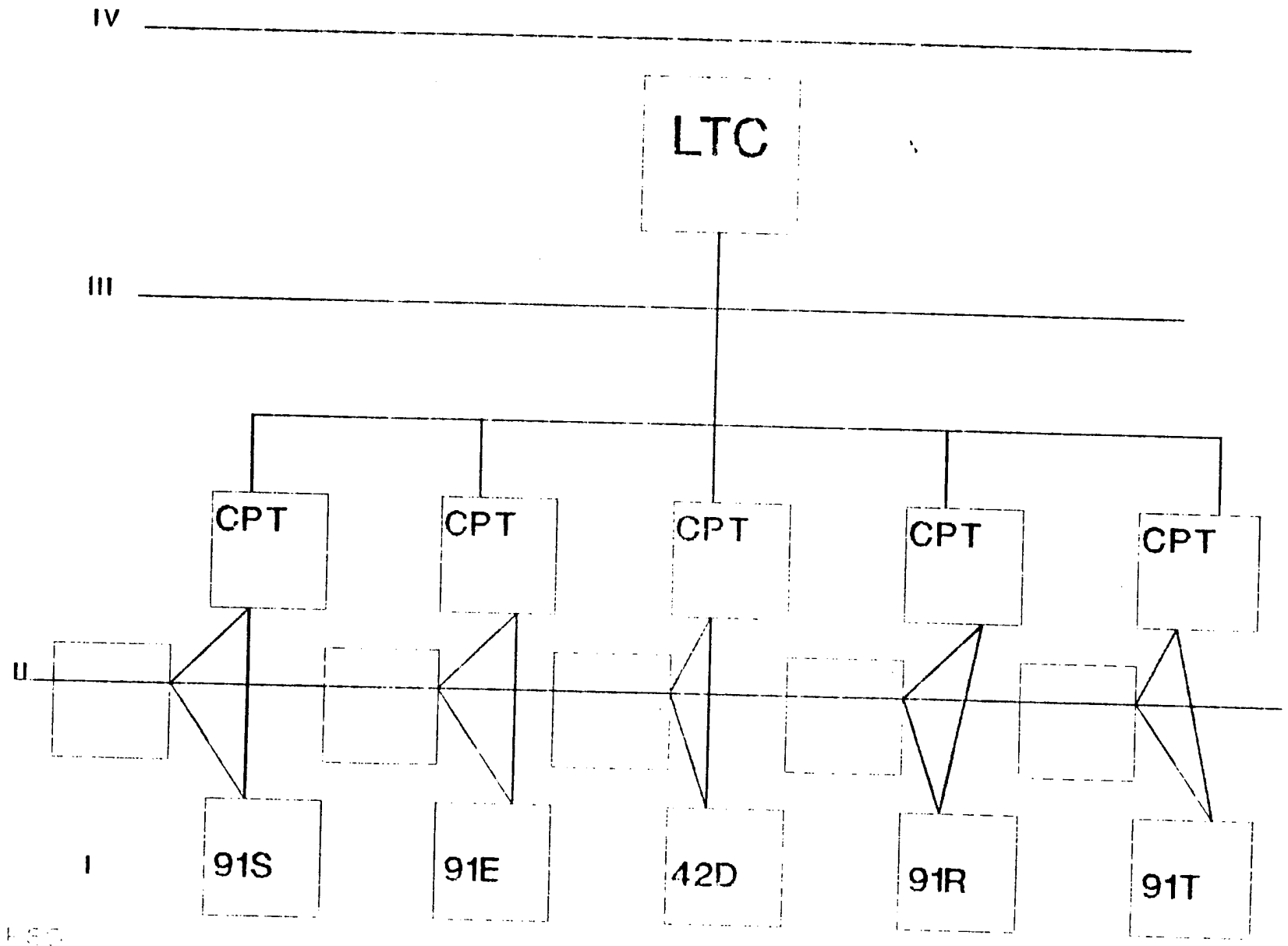
COURSE DIRECTOR

NURSE



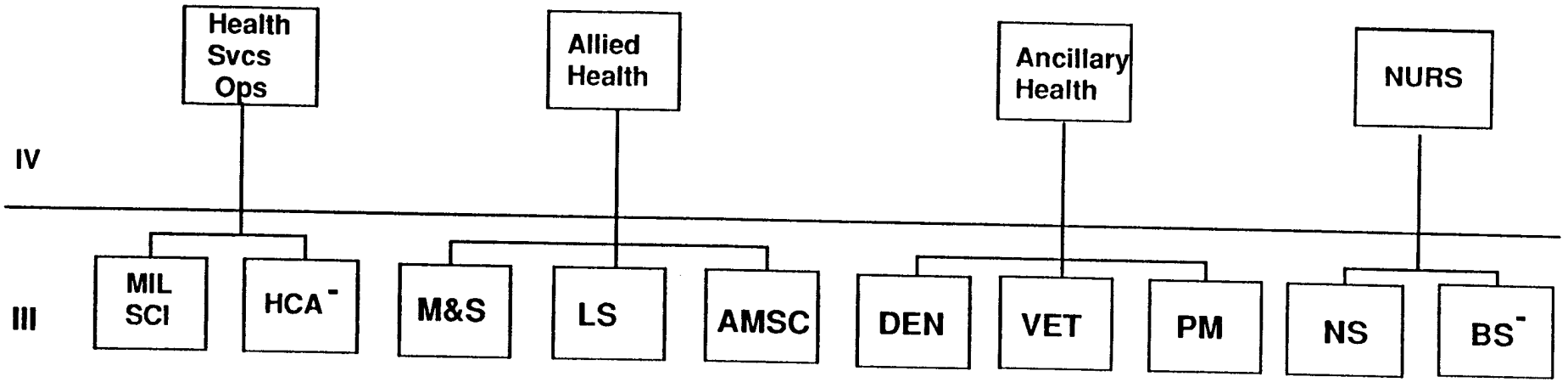
ENT 1

PRODUCT MANAGER



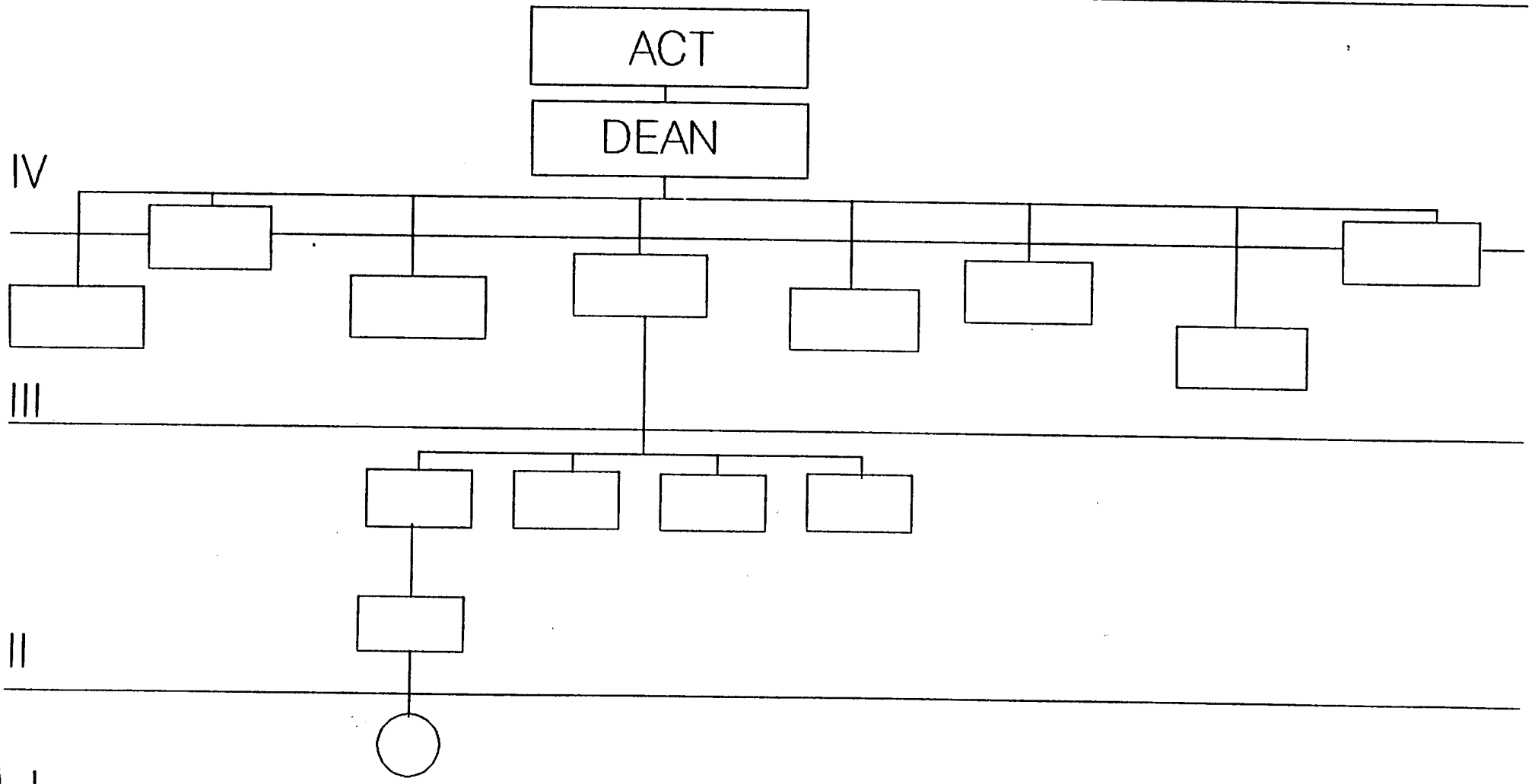
ENCLS

POSSIBLE DIVISION ALIGNMENT



ENCL 6

DIVISION CHIEF ROLES
Extant Situation



ENCL

ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF SUPPORT

I. THEME: Currently a variety of support services are scattered throughout the Army Medical Department Center and School.

II. FINDINGS:

A. Elements of Directorate of Training Development (DOTD) share in the training technology that Health Science Media is exploiting. This technology needs to support the school house if it desires to become a world center in the education of allied health science personnel.

B. It is felt that the Information Management Office (IMO) should focus on the planning for and execution of requirements that will provide the Center and School with a world class information processing capability.

C. Currently the use of a "learning resource lab" is limited in utilization by the student population. The primary users appear to be staff and faculty and Baylor students.

D. Health Science Media is viewed as a world class facility operating with apparent minimal guidance and not responsible to any one single command control element within the Center and School.

E. The Directorate of Personnel is viewed as being aligned with the requirements commensurate with its function.

F. The Historian is a knowledgeable and capable individual.

He is an asset of Health Services Command. He could be far better utilized as the Center and School's Lessons Learned point of contact in the Directorate of Evaluation and Standardization (DOES).

III. ISSUES:

A. Conceptually, what is the best alignment of those elements that are customer oriented and exist to provide a service as opposed to a product for the Center and School?

B. What plans need to be communicated in order to alleviate realignment/dissolution concerns within the DOTD?

C. How should the support elements be organized to best support the Center and School?

D. With the dissolution of Directorates of Training Development (DOTDs) within Training and Doctrine Command (TRADOC), are there any existing elements of DOTD that are of a value added nature which should be saved and utilized?

IV. DISCUSSION:

Creating a Directorate of Support would consolidate all resource sustainment functions for the Center and School into a single support activity. Staff roles would continue to assist the Commander in carrying out his work and not be burdened with overseeing the provisioning of day-to-day services. The proposal will retain the DOES and Directorate of Logistics in their current configuration. In addition, the inclusion of training technology

elements that reside in the Directorate of Training and Development and DOES, the Health Science Media Division, and the "Learning Resource Lab" would roll up into Advanced Visual Information Division (AVID). This Directorate of Support as envisioned would be the locus for support across the Center and School.

Revisiting a Directorate of Support and aligning elements that currently exist within other agencies will meet with strong opposition. To place a variety of service support agencies under one flagship will require that the position of Director be filled at the 06 level.

Alignment of Health Science Media under the Directorate of Support will help "reign in" and focus the media division, simulation, "learning resource lab" and training technology branch in their divergent methods of providing enhanced video support to the training base.

V. RECOMMENDATIONS:

A. Create a Directorate of Support (DOS).

B. Align Director of Evaluation and Standardization and the Historian under DOS.

C. The DOES Lessons Learned mission should be a charter of the Historian.

D. Create an Advanced Visual Information Division spearheaded by Health Science Media.

E. Place the mailroom, distribution, printing and publications, and record management in a new Administrative Services Division under DOS.

F. Place the security and intelligence functions along with mobilization planning under DOS.

G. Place taskings for the Center and School, to include Camp Bullis, under DOS.

H. Align the Deployable Medical System Exportable Training (DMSET) with the current Directorate of Logistics under DOS.

I. Align the Directorate of Personnel under the Directorate of Support.

U.S. ARMY DEPARTMENT CENTER AND SCHOOL

ARMY MEDICAL DEPARTMENT PERSONNEL PROPONENT DIRECTORATE

BACKGROUND:

The Army Medical Department Personnel Proponent Directorate (APPD) was established in the late 70s in response to a series of MOS distribution problems extant within the Army at the time. Originally APPD encompassed only the enlisted personnel function. The basis for creating an enlisted proponency function was related to structural changes made at the Training and Doctrine Command (TRADOC) level which affected grade "maldistribution" within various Military Occupational Specialties (MOSs). As a result, of the distribution problems, a Specialty Proponency Program was established for each TRADOC school including all associated schools (e.g., the Medical Field Service School (MFSS) - The former Academy of Health Sciences). The Specialty Proponency Program was assigned to the Directorate of Training Development (DOTD) under the Program Management Division following the TRADOC model in existence at the time.

TRADOC allocated 4 - 5 authorizations to each Service School in order to properly resource the Personnel Proponency functional area. Originally Health Services Command (HSC) diverted these resources from the proponent function and utilized them in other functional areas. In late 1983, it became apparent to the then AMEDD leadership that the Proponent function needed to be resourced at the original program level. The first studies involving

enlisted proponency, including changes to Career Management Field (CMF) 91, were generated shortly thereafter.

By 1985 the Speciality Proponency Branch was transferred to PRACTO which was the precursor of the current Assistant Commander, Force Integration (ACFI). In 1987, the Specialty Proponency Branch became a Special Staff of the Deputy Commandant and the Officer Personnel Proponency Branch (OPPB) was authorized and formed. Representatives from each of the six AMEDD corps were identified and assigned to the proponent activity. In 1992, the division was transformed into a directorate. Today APPD is an integral part of the AMEDDC&S; however, because of its AMEDD-wide mission it continues to work directly for the Office of the Surgeon General (OTSG) through the Army Personnel Proponency Steering Committee (APPSC) under a new Memorandum of Understanding (MOU).

There are four main components within the Army proponency area: (Branch, Specified, Functional, Personnel). Accountability for these components are as follows:

Branch - AMEDD Corps Chiefs

Specified - AMEDDC&S

Functional - TSG

Personnel - Corps Chiefs/APPD

Enlisted - Office of Corps Chiefs

Civilian - Corps Chiefs

In addition, APPD is responsible for eight life-cycle functions (acquisition, distribution, deployment, professional development, structure, individual education and training,

sustainment, and separation). The various proponent functions together with the life-cycle management functions cut across all facets of the AMEDD including the essence of Corps Chief work. Over the years the role of the Corps Chief has evolved into a prestigious and powerful position, yet one that continues to be widely misunderstood. Much of the misunderstanding can be traced to a lack of clarity regarding the basic accountabilities associated with the role. Additionally, the nature of the working relationships between the Corps Chief role and a host of external roles (e.g., consultant) was also poorly defined thereby adding to the confusion. For example, the Officer Personnel Proponent Division (OPPD) of Personnel Command (PERSCOM) communicates directly with the various Corp Chiefs currently assigned at OTSG. On the other hand, the enlisted branch of the Health Services Division at the PERSCOM communicates directly with the Enlisted Personnel Proponent Division (EPPD) of the APPD.

Thus, considerable confusion exists throughout the AMEDD (and the Army) regarding the overlapping roles of the Corps Chiefs, the Proponency Activity (APPD) and the AMEDDC&S. Given the fact that the AMEDD is currently undergoing a massive restructuring, this would seem to be an opportune time to resolve this issue.

I. THEMES:

A. The APPD organization is viewed by many interviewees as an activity that is "out-of-control" and subject to little or no regulatory control. Many respondents reported that the APPD organization reported to no one. This confusion has contributed to

the lack of understanding as to how the APPD organization interfaces with the Assistant Commandant for Force Integration (ACFI).

B. It is also perceived that there are insufficient open lines of communication between APPD and other AMEDD activities.

C. A number of leader development issues have been identified as central to the AMEDD's long-term success. The Corps Chiefs and APPD are expected to play a central integrating role in all leader development initiatives. To date, however, it remains unclear as to how this integration effort is to occur, especially given the likely probability that the Office of the Corps Chiefs activities will relocate to the AMEDDC&S.

II. FINDINGS:

General: Requirements for active duty and civilian manning levels are established as a byproduct of the Total Army Analysis (TAA) process which identifies the resource requirement (equipment + personnel) necessary to meet the projected threat. The personnel requirements generated by the TAA process are detailed in The Army Authorization Document System (TAADS). The Officer Personnel Proponent Division (OPPD) "scrubs" each document received from The Army Authorization Documentation System (TAADS). During the scrub process a growth model is created for specific situations.

A. The Enlisted Personnel Proponent Division (EPPD) works with the enlisted medical Military Occupation Series (MOSs) on matters pertaining to each enlisted area such as 91B, 42C, etc.

B. The Leadership Development Division (LDD) is tasked

to develop a leadership career management path (CMP) designed to meet future needs. To date the CMP development process is widely misunderstood by many AMEDD personnel.

C. The internal development and training of personnel within APPD is a slow process. Current estimates are that it takes at least two years to "grow" an analyst. Required training must include the knowledge needed to work with other proponent units in the field.

D. APPD has initiated actions sufficient to give them update responsibility for the Army Training Requirements and Resources System (ATRRS). This acquired responsibility has in turn reportedly usurped the ATRRS system manager and blocked the modification capabilities of that position. Consequently, updates are not currently being made for courses which produce either a MOS or an Additional Skill Identifier (ASI) that are listed in DA Pam 351-4, U.S. Army Formal Schools Catalog.

E. Each area within the APPD reportedly marches to a different "drummer" and reports to a different "customer."

F. Funding in APPD is sufficient to provide state-of-the-art computer equipment (LAN network) and software programs which include "heavy-duty" databases.

III. ISSUES:

A. How can APPD be better integrated into the day-to-day operations of other key AMEDDC&S organizational elements (ACFI, DCD, DOTD)?

B. If Corp Chiefs are moved to the AMEDDC&S, how will

APPD's daily operations be affected?

C. How can APPD gain "managerial responsibility" over a system not managed within their Directorate? Has the ATTRS system been maintained to protect its credibility or has it been so neglected as to jeopardize the total picture?

IV. DISCUSSION:

A. The APPD community is widely perceived to be an activity working outside the regulatory constraints adhered to by other AMEDD activities. Although they are not a Field Operating Agency (FOA), they nonetheless tend to view themselves as a FOA but even then they do not work under normal FOA guidelines.

B. Because of the confusion surrounding the proponency issue (e.g., who is accountable for what component of proponency) and because the TSG retains overall regulatory accountability for AMEDD functional proponency, APPD has had to develop a complicated working relationship with the Corps Chiefs, (the AMEDD Personnel Proponency Steering Committee (APPSC), representing the Corps Chiefs) and the AMEDDC&S.

C. This lack of clarity regarding how APPD is expected to work with its current customer base has contributed to the perception that it "reports to no one." With the impending creation of an Office of the Corps Chiefs and its subsequent alignment under the AMEDDC&S, it is now possible to revisit the mission and working relationship of not only APPD but also the Corps Chief office and DCDD. Since justification for all uniform AMEDD assets begins with the readiness issue and since readiness

itself starts with the combat development process, all of the above activities are perhaps best integrated under the auspicious of the ACFI. Since AMEDD personnel are assigned to two parallel manning systems, e.g., the Table of Organization and Equipment (TOE) and Table of Distribution and Allowances (TDA) systems, integration of competing requirements accessing both systems clearly constitutes "general officer" work. Further, given the changing picture of future AMEDD general officer requirements, and the corresponding leader development experiences necessary to produce tomorrow's generals, it is natural that such integration occur in the AMEDDC&S.

V. RECOMMENDATIONS:

A. APPD should be closely aligned under the auspices of the Assistant Commander Force Integration (ACFI). The ACFI will provide APPD with the planning guidance and context required for a cohesive and focused organization.

B. Managerial responsibility for ATRRS needs to be returned to the Directorate of Operations where it can be maintained in a timely manner.

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF EVALUATION AND STANDARDIZATION

BACKGROUND:

The Directorate of Evaluation and Standardization (DOES) serves as the principle advisor to the Commandant regarding the quality and effectiveness of AMEDD training and training products. They are also responsible for AMEDD "lessons learned" data collection and the AMEDDC&S Total Quality Management (TQM) program. The directorate is comprised of two divisions: the Evaluation and Standardization Division, and the Analysis and Technology Support Division. The Chief, DOES is a lieutenant colonel and reports to the Assistant Commandant, Academy of Health Sciences (AHS).

DOES has not always been organized and staffed in its current configuration. In fact, DOES was understaffed in the mid-1980's which resulted in both Inspector General (IG) and U.S. Army Audit Agency (USAAA) documented deficiencies. The 1987 IG report concluded "the DOES lacks the authority and resources to perform its assigned mission." Similarly, the 1988 USAAA report stated that the reason for identified deficiencies in training evaluations and the Systems Approach to Training (SAT) process was due to staffing shortages which resulted in DOES being "...essentially closed down during ten months of a twenty-one month period that ended 31 July 1987."

Because of the noted deficiencies in training evaluations,

the Commandant, AHS (then MG LaNoue) decided to strengthen DOES staffing in 1988. However, it took some time before DOES was fully operational because the newly assigned personnel required a train-up period before they were effective in their jobs. As a result, a fully staffed DOES has only been an integrated part of the AMEDDC&S for the last couple of years.

I. THEMES:

A. There is a general lack of understanding in the AMEDDC&S regarding the roles and responsibilities of DOES.

B. There is a perceived lack of cooperation between DOES and the Directorate of Training Development (DOTD).

C. There is a general feeling that DOES should be independent from AHS and work directly for the Commander, AMEDDC&S.

D. There is a perception that many DOES products are not "value added" and that some programs, like lessons learned, are broken altogether.

II. FINDINGS:

A. Many interviewees indicated a lack of understanding regarding DOES functions and responsibilities. Instructors, in particular, tended to view DOES as merely "the people who sit in back of the classroom." Other comments suggested that the DOES evaluation methodology "was not based on scientific analysis."

B. There is a conflict between DOES and DOTD on some

training development responsibilities.

C. DOES is required to conduct impartial evaluations of all AMEDD training programs and training products. A potential conflict of interest exists by having DOES remain part of the AHS.

D. DOES is inadequately resourced to effectively perform the lessons learned program.

E. The DOES TQM cell is misplaced within the organization. It appears the TQM function was assigned to DOES because there was no other logical place to put it.

F. DOES has a need for an analyst with the ability to process large amounts of information into a condensed/summarized form. This type of work is typically performed by a Historian (GS-170).

III. ISSUE: How should DOES be integrated into the AMEDDC&S to better facilitate internal and external evaluations of AMEDD training programs and products?

IV. DISCUSSION:

DOES is often misunderstood in the AMEDDC&S (typically by personnel assigned to lower levels of the organization), nonetheless, the DOES activity performs a critical function in both the delivery of medical training and in the development of medical proponency. DOES's evaluation program enables the Commandant to make informed decisions on continuous process

improvement of AMEDDC&S products. In addition, the evaluation program enhances the integration of doctrinal, combat, and training development efforts in support of the Concept Based Requirement System (CBRS) and the SAT process.

The conflict between DOES and DOTD centers around a perceived duplication of duties in regards to training development. In the interviews, there were implications that DOTD, for whatever reason, believed they should evaluate their own training development material. Whether this is a valid claim or not is uncertain. However, it is reasonably certain that this problem causes a strained relationship between DOTD and DOES. In the existing situation, DOTD must submit training development products to DOES for validation. Often, this causes problems between DOTD and DOES because they frequently disagree on the outcome of the evaluation. As a result, DOTD becomes reluctant to staff any documents through DOES because there is a perception that DOES is unfairly critical of their work (hence, DOTD believes they should evaluate their own products).

The conflict described above may be attributable more to an organizational design and structure problem than to a "personality" based problem. There are some indications that lack of role clarity and clearly articulated working relationships specified in terms of clear authority levels may be the root cause behind evaluation and standardization problems within the AMEDDC&S. First, the DOES is not really an "independent" advisor to the Commandant since the Chief, DOES is

rated by the Assistant Commandant for Training (ACT). This may cause personal conflict when DOES is required to "impartially" evaluate other organizations that belong to the ACT. Second, DOES conducts evaluations and provides feedback not only to the ACT but also to the Assistant Commandant for Force Integration (ACFI). DOES provides ACFI "lessons learned" data which, in turn, feeds CBRS. If DOES is assigned to one organization or the other (ACT or ACFI), it may hinder their efforts to support the various missions and responsibilities of the AMEDDC&S as a whole.

After considering the issues and findings, the Process Action Team (PAT) considered two organizational design options to address DOES issues. Under both options, DOES staffing would be increased to improve their mission capability. Specifically, the extra staffing would be used to strengthen the lessons learned program. The PAT felt strongly that the lessons learned program should be given increased staffing to ensure the AMEDDC&S has a viable customer feedback mechanism for continuous improvement of AMEDDC&S products and services. Also, under both options, the TQM function would be removed from DOES and placed in the organization as an independent contributor to the AMEDDC&S commander (supervised by the Chief of Staff).

The first organizational design option is to divide DOES into two parts consistent with the two AMEDDC&S strategic business units (ACT and ACFI). The function of training evaluation and input to the SAT process would belong to the schoolhouse (ACT) and the function of providing input to CBRS

through lessons learned would belong to ACFI. This arrangement would align both functional areas more closely with the organization they support (e.g. their customer base). In addition, if the plan to create two brigadier general positions (one overseeing training and one overseeing force integration efforts) comes to fruition, the function of evaluation and standardization would be strengthened and enhanced by working directly for a general officer.

The second option is to move DOES under the newly created Directorate of Support (DOS). This option has the benefit of strengthening the impartiality of DOES by not placing them in either the ACT or ACFI. In addition, this option enables the DOES to maintain synergy of effort by staying together as a team.

V. RECOMMENDATIONS:

A. Provide DOES with additional staffing to strengthen the lessons learned program. Assign the Command Historian to DOES to assist in this program.

B. Realign the DOES (less TQM) to the newly established Directorate of Support.

C. Make the TQM function an independent contributor to the AMEDDC&S Commander under the supervision of the Chief of Staff.

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF OPERATIONS

BACKGROUND:

In October 1992 the Directorate of Support was reorganized into two separate directorates: Directorate of Operations and Directorate of Logistics. Basically, the functions were distributed according to the design principle that "if a function were not logistics it belonged to operations." For example, the International Military Student Office (IMSO), a nonlogistics functional area, was realigned under the Directorate of Operations.

The Plans & Operations Division constitutes the heart and soul of the Directorate of Operations. Numerous changes, however, are planned for the Operations Directorate. First, the military chief's position is to be converted to a civilian position effective 1 October 1993. Second, the Training Input Branch is likely to become a separate division with the pending realignment of the Education & Training function/mission from Office of the Surgeon General (OTSG). It is envisioned that the Army Training Requirements Resources System (ATRRS) function, OTSG Education & Training Division will be consolidated with the ATRRS and the Army Instructional Management System (AIMS), AMEDDC&S. This new division will include all resources for personnel, facilities, and mobilization, etc., for all training resources/requirements.

The Health Sciences Media Division encompasses a broad functional area and has mission ties with the Army's Audio Visual

Command. There is extensive use of information related technologies employed by the Information Management Office (IMO).

I. THEMES:

A. The Directorate of Operations performs essential support functions that may require realignment.

B. Considerable concern was expressed about ATRRS, AIMS and OTSG consolidation.

II. FINDINGS:

A. Protocol/political issues generate considerable taskings which consume valuable time and are widely perceived to be of "low value."

B. Civilianization of various positions/jobs should enhance the overall performance of the Directorate.

C. The Health Sciences media Division should be further analyzed to explore the possibility of realigning the function/mission to better serve the existing customer base.

D. Reorganization/consolidation of the OTSG Education & Training Division into the AMEDDC&S will impact significantly on the Directorate of Operations - in particular the Army Training Requirements & Resources System (ATRRS) and the Army Instructional Management System (AIMS). The magnitude of integration is likely to cause this functional area to become a full-fledged Division within the Operations Directorate.

E. The IMO staff element is perceived to be not supporting the ATRRS/AIMS mission. Operations personnel stated that the ATRRS function needs critical resource support in three different areas:

Technical, Network Management, and Data Communications.

F. It is felt that the Security Branch with a Military Police (MP) Specialist assigned constitutes a low value added effort.

III. ISSUE:

What is the most effective way to provide operational support services (i.e., media, scheduling classrooms, AIMS, ATRRS, operations, mobilization, IMSO support) to AMEDD Center and School?

IV. DISCUSSION:

The merging of two major scheduling resource systems into one Army Training Requirements Resources System (ATRRS) and Army Instructional Management System (AIMS) is expected to be a complicated undertaking requiring a carefully executed plan (no written plan exists as of this date).

It is anticipated that the AMEDDC&S will receive increased mobilization mission requirements in the near future, especially as more command mobility functions are realigned from OTSG to the AMEDDC&S.

Training for 91Bs will be relocated to Camp Bullis when the new Medical Center Complex is completed. The relocation of 91B training will force major changes in scheduling/bussing students on a daily basis.

The mission of the Health Sciences Media Division is widely misunderstood. Several respondents indicated that they felt that the division reported to no one and that the questions relating to the long-term support mission of the Media Division should be clarified.

V. RECOMMENDATIONS:

A. International Military Student Office (IMSO) realigned to the Medical Field Service School, Academic Services Division.

B. Training Input Branch and Automated Instructional Management System (AIMS) realigned within the Academic Services Division, Medical Field Service School.

C. Registrar/Academic Records Branch realigned to the Academic Services Division, Medical Field Service School.

D. Classroom Scheduling/Facilities realigned to the Academic Services Division, Medical Field Service School.

E. Classroom Support realigned to the Academic Services Division, Medical Field Service School.

F. Security and Intelligence Branch realigned to the newly created Directorate of Support (DOS).

G. Health Sciences Media Division moves to the newly created Advanced Visual Information Division within the DOS.

H. Mobilization Branch realigned to the DOS.

I. The U.S. Army Medical Museum realigned to the DOS.

J. Operations Branch realigned to the DOS.

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF COMBAT AND DOCTRINE DEVELOPMENT

BACKGROUND:

The overall mission of the Directorate of Combat and Doctrine Development (DCDD) is to define the future warfighting requirements facing the Army Medical Department (AMEDD). DCDD is the manager of change for the Army Medical Department (AMEDD) in five basic combat domains: Doctrine, Training, Leader Development, Organizations, and Materiel (DTLOM). The directorate is organized into five operational activities: Clinical Consultants Office, Concepts and Analysis Division, Material and Logistics Systems Division, Organization and Personnel Systems Division, and Doctrine Literature Division. Central to DCDD's mission is to define and forecast the AMEDD's role in support of a national defense strategy away from that of forward-based forces to one of force projection. Concomitant with this mission shift is a corresponding requirement to accomplish the above amidst significant budget reductions. These budget pressures are in turn causing extensive reexamination of existing AMEDD doctrine, training, and leader development practices. The directorate is one of a limited number of AMEDD activities which is funded under P2 funds (mission funding), as opposed to P8 funding which is primarily medical in nature and encompasses the majority of AMEDD activities. Since over 95% of DCDD's funding is derived from the P2 funding stream, there is

potential for significant future cuts as the Army's mission area (P2) comes under increased scrutiny.

Clinical Consultants Office: The Clinical Consultants Office works directly for the Director as an integrating activity for the entire Directorate of DCDD. Its responsibilities include review of the Directorate's output to insure recommendations and staff actions from the DCDD activities are clinically sound. Additionally, the office refers research and development projects to the Medical Research and Development Command (MRDC) and also controls the termination of Research and Development (R&D) projects before completion, if necessary. Some R&D projects which the office oversees are being accomplished in a seven to ten year time frame while some other ventures take as long as twenty years. The current chief of the Clinical Consultant's Office, by virtue of his longevity within the Directorate, is performing a de facto role of Deputy Director. This provides both continuity and an historical perspective which are considered essential given the rapid turnover of active duty military directors.

Concepts and Analysis Division: The Concepts and Analysis Division currently has two major branches: Concepts Branch which is responsible for the design and formulation of medical concepts to support the Force Projection Army, and an Operations Analysis (OA) Branch which supports concepts formulation in terms of force structure requirements as well as the construction of models in terms of hospital design and bed mix (i.e., the number of Intensive Care Unit beds, medical and surgical beds). A third function, the

former Threat Branch, is staffed by a single independent contributor and is being absorbed into the Concepts Branch as an additional function. A fourth function, the Force Structure Branch, is due to receive work load transferred from the Health Care Operations of the Office of the Surgeon General (OTSG) in June 1993. Because the redesign and realignment of the Force Structure Branch has not been accomplished at this time, current plans are to retain the Force Structure Branch under the Concepts and Analysis Division. Most concept papers developed in this area extend out one year in duration with the noticeable exception of the Total Army Analysis (TAA) process. The OA Branch deals heavily in the TAA process which follows a normal two year cycle.

The OA Branch currently maintains large data bases as well as simulation models to include the Workload Patient Generator model and the Global Requirements Estimation for Wartime Medical Support (GREWMS) model. The OA Branch has several customers outside of the directorate with whom it communicates directly to include Health Care Operations at the OTSG; Medical Research and Development Command; Air Force and Naval Operations; and Supreme Headquarters Allied Powers, Europe (SHAPE). Additionally, the branch is also responsible for providing, upon request, data and information to at least three different civilian contractors who are conducting independent studies for Department of the Army and Department of Defense agencies. Additionally, the OA Branch communicates freely with other divisions and branches within the directorate and provides them with information and data as requested.

Prior to June 1992, the OA Branch was a separate entity under the Director of DCDD. With the anticipated funding reductions from Health Services Command, all military Operations Research Analyst (ORSA) officers, who typically hold the Area of Concentration of 67D, were to be replaced on the Table of Distribution and Allowances (TDA) by civilians with those skills. However, the funding to allow the hiring of these 'technomanagers' has not been approved in the projected budget. The current projected TDA does not allow for any active duty individuals to be assigned after Fiscal Year 1994. In the absence of appropriate analytical assets in the OA Branch, the branch was placed subordinate to the Concepts Division creating the new Concepts and Analysis Division. This decision was predicated upon two main points: (1) the director of DCDD did not have the resources to effectively manage the OA Branch as a separate division and monitor its workload and output and (2) some military supervision was required because the assigned civilian personnel could not provide the "reality check" needed to determine if the simulation and modeling of military operations were sound and consistent with normal standards.

Organization and Personnel Systems Division: The Organization and Personnel Systems Division (OPSD) is divided into two branches: Tables of Organization and Equipment (TO&E) Branch and Manpower Requirements Criteria (MARC) Branch. The TO&E Branch develops, designs, and documents AMEDD TO&E to reflect current doctrine and equipment Basis of Issue (BOI) requirements for AMEDD and Non-medical TO&E that contains medical assets. It also develops,

reviews, updates and coordinates Basis of Issue Plan (BOIP) on medical equipment entering the supply system. The OPSD Division chief, however, indicated that the TO&E building process actually commences well in advance of the completed concepts paper, as the division encourages assigned personnel to coordinate with Concepts Branch from the very inception of a concept, thereby having practical input into its formulation. Upon receipt of a formal concepts paper, the TO&E Branch builds the objective through the base TO&E which includes the mission statement, dependency, Basis of Allocation, assignment, and mobility, as well as a complete listing of all personnel and equipment requirements. This product includes Incremental Change Packages which documents, in advance, approved changes in modernization to the TO&E and all other notes and explanations on how the TO&E was constructed. Within the TO&E Branch, this process takes an average of six months to accomplish, but can vary significantly depending upon the TO&E's degree of developmental complexity. When this product is completed internally, it is sent forward to the TO&E Review Board at the Combined Arms Center (CAC) and subsequently to Department of the Army for approval. This external review process takes approximately twelve months but again the actual development time can vary significantly depending upon the product's overall complexity level.

The Manpower Requirements Criteria Branch is responsible for conducting studies on the amount and type of medical personnel requirements needed to staff medical and non-medical TO&Es. The

studies are conducted within given functional areas and focus on defining requirements for all echelons of care from the combat medic to hospital wards. Each of the AMEDD's TO&E are comprised of one or more of the 38 personnel functional areas and each functional area must be evaluated at least once every three years. The studies require significant coordination with various interested third parties to include the Combined Arms Service Command (CASCOM), OTSG consultants, Corps Chiefs and MACOMS. After coordination the study is boarded for approval at CAC and forwarded to the United States Army Force Integration Support Agency (USAFISA) for DA approval. Approved MARCs are published in AR 570-2. MARC studies generally average 12 months in duration from the time they are initiated to when a given study is approved by USAFISA; however, controversial studies such as the Nursing Staff Study have taken substantially longer (e.g., eight years) to coordinate and staff and ultimately gain approval.

Material and Logistics Systems Division: The Material and Logistics Division represents the combat soldier through the development, procurement, and issue of medical items. The division coordinates with MRDC for the development of new medical items and Army Material Command (AMC) regarding the fielding of new non-medical items. The division also accomplishes the Program Objective Memorandum (POM) planning for all TO&E material issues affecting the AMEDD. The Material and Log Systems Division spends an inordinate amount of time defending Class VIII (medical

material) at meetings involving CAC and CASCOM and issues involving the TO&E based medical logistics deployment.

The division currently is heavily involved in the AMEDD Center and School's participation within the Enhanced Concept Based Requirements System (ECBRS) which is a complex, interactive, and analytic process focusing on key modernization issues affecting the AMEDD. The entire multiphase process has a two year time frame. As ECBRS was initially perceived as a material based modernization system, the lead agent for this process was the Material and Log Systems Division within DCDD; however, with the AMEDD's participation within ECBRS becoming more sophisticated, it has become apparent that this system encompasses all five domains of DTLOM.

The ECBRS methodology centers on refinement of concepts and identification and prioritization of capabilities within the five domains of DTLOM. Within the process, there is an early and continuous integration of science and technology. Requirements identified through the ECBRS process will ultimately ensure maximum return on investment (ROI) on the battlefield.

Inherent in the ECBRS process is the evolving concept of "battle laboratories" or battle labs. Battle labs allow the commander's energies to be focused on integration of requirements and second order consequences generated by the rapidly changing dynamics of the battlefield. Several different battle labs have been established in which the AMEDD has a varying degree of involvement including the Combat Service Support battle lab located

at CASCOM, Fort Lee, VA. Battle labs are organized as task forces, located with troops and tied to the technology base. They prioritize and integrate requirements across the combined arms force as well as have the ability to explore new ideas and experiment with new technologies through the employment of advanced computer simulations, virtual prototypes, and hands-on tests with soldiers on ranges and maneuver areas. To be employed to their full potential, battle labs will require new simulations and virtual prototype tools which replicate the battlefield with greater accuracy. In order to be effectively executed, battle labs require extensive analytic capabilities as potential technologies are identified, demonstrated, exploited, and assessed for payoff. For the AMEDD to maintain a dynamic edge in the battle labs arena, it is essential that an increasing number of operations research analysts (both active duty and civilian) become extensively involved throughout the battle labs process as it continues to evolve.

THEMES, FINDINGS, ISSUES, AND RECOMMENDATIONS

1. THEME: Without a specific career development track in the combat development arena, many senior positions within the directorate require an incumbent to train for significant periods of time before they are qualified to deal effectively with complex combat development issues.

FINDINGS:

A. The complexity of the duties within each division requires significant amounts of training time for the individual to become proficient as a combat developer. Without a specific combat developer track for AMEDD officers, the professional development for these officers to accomplish these roles is severely limited.

B. Department of the Army civilians have filled the Combat Development (CD) void due to their relative permanence within their respective functional areas.

C. Within the Material and Logistics Systems Division there is duplication of effort with Defense Medical Standardization Board which comes under the auspices of Department of Defense (DoD) Health Affairs and works for the standardization of level 3 and level 4 hospital on the tri-service level. This board has increased its charter by becoming the material developer for the services to include the U.S. Army.

D. There is some confusion over the Battle labs concept and how its implementation will be accomplished within the AMEDD. Battle labs have been described conceptually as the TO&E equivalent to the Gateway to Care (GTC) program. However, the Battle labs, similar to the GTC in its infancy, suffer from a lack of understanding and information on their implementation as well as to what products are to be derived from their utilization.

ISSUE: Is there a need for a career development track for combat development?

RECOMMENDATION: Assign the combat developer career development issue to a Process Action Team consisting of Proponency and Corps chief representatives for study and resolution.

2. THEME: There is a need for a larger Operations Research and Analysis Cell within DCDD with OR trained active duty officers assigned to this cell. The configuration of the OA cell is deemed not adequate to meet the current needs of DCDD.

FINDINGS:

A. The Concepts and Analysis Division has had five different division chiefs in the last year. This lack of continuity has allowed the OA acting branch chief to perform in a relatively unsupervised role. This managerial issue is further complicated by the OA Branch's functioning in a realm of highly technical expertise in which the division chief and directorate have little or no experience.

B. Several respondents stated that while the OA Branch is extremely proficient technically; the existing branch personnel, nonetheless, still do not comprehend the full extent of the AMEDD's Operations Research and Systems Analysis requirements both now and in the immediate future. Conversely, the OA Branch perception is that most customers utilize the models strictly to validate preconceived concepts and decisions, and not as a true analytic tool.

C. Within the OA Branch, taskings and requests for assistance from outside the directorate continue to be directly received, thereby bypassing the division chief and director of DCDD.

ISSUES:

A. Is the OA current structure able to meet the analytical needs of DCDD and the AMEDD Center and School?

B. Where within the current organizational design should this analytical cell be located?

RECOMMENDATION: Increase the number of operations research (OR) and systems analysts (both active duty and civilian) within the Operations Analysis Cell. These individuals must be OR trained; computer programmers, or information management individuals cannot be substituted as convenient. Make this cell subordinate to the Director of DCDD as a stand alone division. If the OA cell cannot be assigned military Operations Researchers, the Operations Analysis cell must be led by a carefully selected, competent civilian director with extensive experience in the combat development area.

3. THEME: The TO&E Review Board at CAC is not perceived as "adding value" to the TO&E development process.

FINDING: The TO&E Review Board, located at CAC, consists of four individuals who have no functional medical expertise. These

individuals are currently responsible for review of all TO&E changes within the U.S. Army, and because of the workload generated by this wide ranging responsibility, they are severely backlogged. This board is perceived as an impediment by AMEDD Combat Development personnel because it is both slow and incapable of making an informed decision on the clinical value of a given TO&E.

RECOMMENDATION: Allow the AMEDD Center and School the executive authority over medical TO&E changes. This would accelerate the time required to implement change.

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF TRAINING DEVELOPMENT

BACKGROUND:

Directorates of Training Development were organized in Training and Doctrine Command (TRADOC) in the mid-1970s in response to a demand for greater rigor and organization in approaches to training and training development. In 1980, General Pixley, the Surgeon General, mandated the Army Medical Department (AMEDD) to implement a Directorate of Training Development (DOTD) similar to those in TRADOC. To staff DOTD, positions were initially taken from various resources including the Medical Field Service School (MFSS), reduction in force (RIF) personnel from local San Antonio Air Force bases, and from excess personnel made available by the partial closure of Gorgas Army Hospital.

Prior to the formation of DOTD, individual training was haphazardly designed throughout the TRADOC community by instructors and course directors who often interposed their own personal agendas into existing training programs. No systematic approach to training design existed and the concept of designing training around job related critical tasks was an unknown concept throughout the training community. Documentation on training content was sketchy with most documentation maintained solely by the individual instructor teaching a given course.

To further fix accountability and systemize training development throughout Department of Defense (DoD), Congress mandated an organized approach to training be developed. The Inter-Service Procedures for Training Development (ISD), the precursor to the current Systems Approach to Training (SAT) was developed by TRADOC with experts from Florida State University. The ISD process was time consuming and purportedly confusing, hence, the SAT process evolved as a more streamlined and understandable method of training development.

The SAT process is key to the tasks of DOTD and especially, ITD. It has been characterized as supporting uniformity of military training needs, allowing for revisions and improvements of both existing training and new courses and ensuring that training programs and support materials are developed to match the doctrine, equipment, and organizational needs. SAT processes include analysis (to include Job Task Analysis Worksheets (JTAWS)), design, development, execution and evaluation. The SAT process is currently taught to AMEDD Center and School (C&S) teaching staff through courses such as the SAT Course, The Faculty Development Course, and the Executive SAT Course.

The Directorate of Training Development at the AMEDDC&S is organized into three divisions: Individual Training Division (ITD), Training Literature Division, and Unit Training Division. The ITD includes the Enlisted Training Development Branch, Officer Training Development Branch, Training Operations Branch (to include functional course development and design),

Distributed Training Branch and Training Technologies Branch. Training Literature Division is comprised of the Training Literature Branch and Performance Measurement Branch. Unit Training Division includes an ARTEP Branch, Force Modernization Training Branch, Exercise Branch, New Organization Training Branch and DMSET.

I. THEMES:

A. Some work related activities of DOTD are perceived to be "non-value added" and duplicative of efforts routinely occurring within the teaching divisions.

B. Some efficiencies were felt to be obtainable if portions of the DOTD individual training division were realigned with the teaching divisions.

II. FINDINGS:

A. DOTD was developed to set the azimuth for training in the AMEDD.

B. The mission of DOTD is reportedly not clearly understood by everyone outside of DOTD. There is a reported lack of clarity and definition to the functions of DOTD.

C. MFSS staff perceive that bringing individual training development into the teaching divisions would yield savings and give synergy to the efforts of training students.

D. It was reported by DOTD staff that there will be extreme difficulty in coordinating all of the tasks currently done by

DOTD, if ITD or any other part of DOTD is moved to the teaching divisions.

E. Without an ITD, according to some interviewees, it was felt that instructors and directors will not apply the rigors of the SAT process to course design which could eventually erode the quality of instruction.

F. JTAWS, a part of the SAT process, is perceived as marginally productive at best by ITD and of low "value added" by many in the teaching divisions. MFSS staff perceive that DOTD staff view the format of the SAT process as more important than course substance.

G. The presence of too much layering in the AMEDDC&S adds to the inherent difficulties perceived in implementing such processes as SAT and in obtaining approval of documents from DOTD to teaching divisions and vice versa.

H. Division Chiefs have reportedly lost touch with subject matter. The Senior Leadership of the AMEDDC&S believes that division chiefs should be more actively involved in development of training and equipment needs to include active involvement in Concept Based Requirements System (CBRS).

I. Changes in doctrine and equipment drive all training requirements, therefore the primary role of the Assistant Commandant for Force Integration (ACFI) is to act as a facilitator of communication and integrator for information in DCDD, DOTD, and the AMEDD Board. It was reported by the Senior Leadership that if DOTD were to reorganize under other than the

ACFI, communication and integration problems could easily escalate. However, the Senior Leadership also perceived that the Individual Training Division (ITD) functions of DOTD could easily be realigned into the teaching divisions.

J. The Senior Leadership perceived the mission of DOTD to be ill defined and dependent almost totally on taking Subject Matter Experts (SMEs) out of the teaching areas. They felt that the MFSS teaching divisions could perform some DOTD functions more effectively.

K. SMEs are generally located in the teaching divisions, not DOTD.

L. The ITD has 20 managers/education specialists for 30 enlisted MOSs and one per officer corps.

M. Division Chiefs in MFSS report that their instructors currently develop lesson plans and slides for their classes and that DOTD adds little value to the teaching divisions.

N. Teaching staff feel that they best know the needs of their students and hence, are in a better position to develop lesson plans based on these needs.

O. The Senior Leadership of the AMEDDC&S felt that ITD should be placed in appropriate functional areas of Academy of Health Sciences (AHS) but that quality could not decrease as a result. It was recognized that if tasks were transferred to teaching divisions, then each Division may require more support, (i.e., Training Development experts assigned to division chiefs).

P. Staff outside of DOTD perceive the SAT process to be cumbersome, lengthy, and of no value added. Some DOTD personnel view part of the SAT process, JTAWS, to be marginally productive due to the amount of time and resources required.

Q. The mission of ITD is to assure consistency and equitable distribution of training development resources throughout the schoolhouse, enhance communication of changes in training development needs, and to supervise the utilization of education specialists. DOTD staff believe that the AMEDDC&S could not become a center of excellence if all training development assets were to be distributed throughout the teaching divisions resulting in a lack of unity of effort in training development.

R. It is the opinion of DOTD staff that if DOTD is dismantled, the work that they are currently performing will nevertheless still be required. According to DOTD personnel, while the teaching and administrative staff of MFSS may perceive the dissolution of DOTD as initially positive since the teaching divisions themselves stand to gain additional personnel, eventually, however, they will come to realize that there remains a need for coordination of training development efforts and that an organization similar to DOTD will simply be recreated. Some DOTD staff suggest that training development remain separate from the teaching divisions but that the agency for training development be reorganized (see chart 1).

S. Having education specialists in DOTD as opposed to Teaching Divisions assures their currency of knowledge in doctrine and training according to DOTD. In 1983, TRADOC attempted to move education specialists back into teaching divisions and the quality of training development was reportedly compromised. Movement of the education specialists out of DOTD was viewed by a previous Dean, MFSS to be a short term solution that could result in long term problems with the integrity of training development compromised.

T. DOTD acknowledged that the process for approval of training materials both to and from teaching branches was in fact time consuming due to too many layers of bureaucracy at the AMEDDC&S (see diagram 2).

U. Training at the AMEDDC&S can not be compared to civilian colleges. Civilian colleges do not have a need for centralized training development due to a stable teaching staff that are supposedly experts in the fields of both training development and instruction. This is often not the case at the AMEDDC&S. Also, in a civilian college the tenured faculty are accountable for instruction whereas in the AMEDDC&S the Dean of MFSS is accountable for instruction.

V. The Training Literature Division of DOTD has staffing responsibility for non-AMEDD training literature products as well as development of AMEDD training literature products such as Field Manuals (FMs), Training Manuals (TMs), Soldiers Manuals (SMs), Training Circulars, Department of the Army pamphlets, etc.

The Training Literature Division of DOTD has numerous interagency relationships DoD-wide with Combined Arms Support Command (CASCOM), TRADOC, Office of the Surgeon General (OTSG), AMEDD Personnel Proponent Directorate (APPD) as well as the AMEDDC&S. Other products of DOTD that are required by TRADOC include ARTEPs, Doctrinal Manuals, MQS manuals, POIMMS, Graphic Training Aids (GTAs) and Reserve Component Configured Courseware.

W. DOTD staff reported that some information required by TRADOC on short notice was simply "busy work" with low value added (i.e., requests for the number of hours a specific subject is taught at the AMEDDC&S).

X. ITD focuses on U.S. Army Reserves (USAR) as well as active component training. Downsizing of active duty troop strength does not affect the training needs of the USAR. In addition to USAR, ITD is involved in developing training products for agencies outside of the DoD to include the Federal Bureau of Investigation.

Y. Although it is surmised that DOTD provides a centralized location for all training products, this is not always true. An example of this is the Medical Surgical Division of MFSS which has produced a "Refresher Manual" for Physician Assistants in Emergency Medicine that is currently distributed Army-wide by Extension Services. There is no evidence that DOTD has any awareness of this training aid.

Z. It is the opinion of DOTD and MFSS teaching staff that there is a problem with the current process of DOES evaluating existing instruction.

AA. DOTD perceives that they are under-resourced in analytical capability.

BB. The Training Technology Branch of ITD focuses on reviewing new technologies to determine usefulness for training. There is supposed duplicity and fragmentation of this Technology evaluation effort with Health Science Media as they are organized outside of DOTD in the Directorate of Operations.

III. ISSUES:

A. Can the MFSS maintain high quality training and training development and move the AMEDDC&S toward a world class center of training excellence if DOTD is dismantled and assets and responsibilities put into teaching divisions?

B. Can some or all of ITD functions be moved to teaching divisions without compromising the integrity of training and training development?

C. Is a major source of the teaching divisions' current dissatisfaction with some of the DOTD processes (e.g., the SAT process) due to poorly defined communication efforts or to unnecessary duplication due to overlapping work?

D. Are there too many layers of bureaucracy currently involved in the approval process of training products?

E. If DOTD (or part of DOTD) is dismantled, would a new"organization" for training development emerge to deal with unmet training development needs?

F. Is the Directorate of Standardization and Evaluation (DOES) the most effective agent/directorate for evaluating training?

G. How can training technologies be better evaluated, planned and utilized?

IV. DISCUSSION:

As the AMEDDC&S continues to adapt to shrinking resources and growing demands, the effective provisioning of quality training and supporting training development efforts becomes paramount. The current structure and processes of DOTD and the ongoing interface which DOTD has with the teaching divisions is not perceived by MFSS teaching staff as meeting the needs of the teaching divisions. Some of this "disconnect" between DOTD and the teaching divisions appears to be due to an inadequately understood or communicated mission and role of DOTD to the MFSS staff. If DOTD in its current form is to remain and if teaching divisions are to realize the value of DOTD, greater "marketing" is needed by DOTD.

Many of the functions of ITD appear to "fit" more easily into the existing teaching divisions (e.g., Officer and Enlisted training). If such a realignment were to occur, Division Chiefs would become more involved with their respective subject matter

material and division staff would benefit from having training developers/education specialists within each division. It can be argued, however, that there are not enough existing education specialists to properly service the 30 Military Occupation Specialty (MOS) courses currently being supported. Thus, some additional education specialist positions might need to be created. The corresponding argument that education specialists would not receive the latest in training and doctrine information could be countered by having mandatory, regularly scheduled training meetings for all education specialists.

Detriments to placing ITD functions within the teaching divisions must be discussed and weighed against corresponding benefits. For example, having dispersed education specialists throughout the teaching divisions would make it difficult to aggregate them into small groups to work on a specific project as required. This is not an insurmountable problem, however, for when a need for a project group of education specialists was identified, the Dean of MFSS could assign specific education specialists to such a project, whether or not a teaching division chief wanted to temporarily loose his/her education specialist. The issue of moving education specialists into teaching divisions appears workable and of assistance to teaching divisions and ultimately, to improving the timeliness and quality of training provided to students.

The larger issue of moving the remaining ITD (or all DOTD functions) to teaching divisions is less realistic. Putting all

current ITD (instead of only Officer and Enlisted training branches of ITD as described in the above paragraph) and/or DOTD functions in MFSS teaching divisions could quickly compromise the integrity of training and training development. Even with additional administrative assistance, it would be difficult for teaching divisions to produce all of the training literature now produced in DOTD, continue to review new training technologies and interface and meet the externally imposed demands of all agencies including TRADOC, that is currently demanded of DOTD.

The SAT process as it is currently implemented, is perceived by many instructors to be a major road block toward timely implementation of changes to curriculums. Although the SAT process is valuable in systematically approaching training development needs, the existing process is felt to be too cumbersome and time consuming. Instructional staff believe a revision to the SAT process is required in order to shorten time frames for overall course development and to minimize the effort spent on cumbersome processes such as JTAWS. A curriculum change process should be designed to more easily respond to changes extant in the external environment. Recognition should be given that the instructor, branch chief and division chief in a given specialty area are apt to best know what is needed to keep curriculum current. The existing methods of how changes are implemented and who approves these changes need revision.

A consolidation of all training technology expertise is needed within the AMEDDC&S. The functions of Health Science

Media and Training Technology need to be melded into a single organization for better utilization and centralization of all such resources.

The role of DOES in evaluating instruction needs to be examined. Currently, DOTD and teaching division staff perceive little value in the information they receive from DOES. Some DOTD staff have proposed that there be an external evaluation division as an integral part of any reorganization of training at the AMEDDC&S. Recognition must be given to the value of evaluations performed outside of either the teaching divisions or DOTD but such evaluations are useful only if the information provided is relevant.

Finally, if DOTD is to be dismantled, many staff express a concern that a new but similar "agency" could easily arise to meet needs that could not or were not met by the teaching divisions. If such an agency were to arise, this would be tantamount to recreating what currently exists which would constitute a waste of manpower and other resources in the dismantling and then rebuilding process.

V. RECOMMENDATIONS: There is a need to more closely integrate the expertise of education specialists (currently in DOTD) and MFSS teaching divisions to enhance the quality of training and training materials while simultaneously reducing costs. Recommendations must also take into account the impact of any proposed changes on the civilian workforce. Two options are

given with the first option having the least impact on the civilian workforce.

A. Option 1

1. Move the ITD functions and assets of Officer Training Branch, Enlisted Training Branch and Training Operations Branch to MFSS teaching divisions by creating support cells under each teaching division. Teaching Division Chiefs will be held accountable for all course design.

2. Move the Training Technology Branch of ITD to a newly created Advanced Visual Information Division (AVID) that includes assets currently in Health Sciences Media under the newly created Directorate of Support (DOS).

3. Move the remainder of DOTD (Training Literature Division, Unit Training Division and the Distributed Training Branch and RC issues of ITD) to a Support Cell under the ACT.

B. Option 2: Option 2 includes all the recommendations in Option 1 with two additional changes. Option 2 would result in all DOTD functions redistributed throughout MFSS and the DCDD.

1. Move the Training Literature Division of DOTD into the DCDD with the Doctrine Literature Division.

2. Download Unit Training Division functions into MFSS Teaching Divisions.

C. In addition to the above options, the following recommendations are made:

1. That the process of developing courses and revising curriculums be streamlined to meet the needs of changes in specialties in a more timely manner than occurs currently.

2. That the "layers" in the chain of approval for training related documents be decreased and approval authority be delegated to the lowest possible level to maintain quality training products.

3. That the process of evaluation of instruction by DOES be examined by a multi-disciplinary task force of teaching staff (to include Faculty Development Staff) and training developers to assure that evaluations produce relevant information for all concerned in the instruction of students.

4. That an External Evaluation Division within the Support Cell under the ACT, be identified to assure a clear "tracking and linkage" of all training products (i.e., Soldier Manuals, LPs/POIs, correspondence courses, etc.).

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

STUDENT/SOLDIER DAY

BACKGROUND:

Training and Doctrine Command (TRADOC) Regulation 350-6 states that the goal of Individual Enlisted Training (IET) is to produce motivated, disciplined, and physically fit soldiers who are trained in basic combat skills, Military Occupational Specialty (MOS) technical skills, and capable of taking their places in the ranks of the field Army. New soldiers are expected to learn basic skills/tasks in Basic Combat Training (BCT) and One Station Unit Training (OSUT). Regulations require that common task skills be reinforced in Advanced Individual Training (AIT) and unit training. The Army Medical Department Center and School (AMEDDC&S) Brigade follows Army and TRADOC regulatory guidance and ensures that basic combat skills are reinforced during AIT/MOS technical training.

I. THEME:

A. A perception exists within the Medical Field Service School (MFSS) staff and faculty that the Brigade's emphasis on solderization, common task reinforcement, and other duties prevents students from adequately studying and preparing for classes. Brigade personnel interpret their current mission IAW TRADOC Regulation 350-6 which charges them with assuring that soldiers receive reinforcement training in common task, physical

fitness, and other solderization skills. Therefore, many students face a day with competing demands (i.e., academic vs solderization). The net effort of the above incongruence is that the student often suffers from an inadequate amount of sleep. (Typical student hours are from 0430-2200.)

B. The distinction between the responsibilities and roles of the instructors and the Drill Sergeant may contribute to the above competing demands. There is a perception that having Drill Sergeants serve as instructors and having instructors assist with solderization training would give greater understanding and more compassion for the competing demands (See Encl 1).

II. FINDINGS:

A. Soldiers/students are required to conduct common task and solderization training after a nine period academic day and on weekends. At the same time students must prepare/study academic subjects after the nine period academic day ends. Remedial instruction (reteach/retest) must also be conducted outside of the academic day (See Encl 2).

B. The typical AIT student/soldiers' day consists of a 42 period week of MOS technical training plus a minimum of three periods of PT per week. Periods of reteach, retest, and mandatory study halls are also conducted outside of the already crammed 42-47 period week.

C. Limited training time and lack of time to study may be a contributing factor to the high academic relief/recycle rates in

some courses.

D. Most drill sergeants do not serve as instructors and many AMEDDC&S instructors do not assist with solderization efforts.

E. Mandated and required military training is not documented in most AMEDDC&S Program of Instructions (POIs).

F. The decision has been made to consolidate the 232d Bn and the Combat Medical Specialist Division (CMSD, 91B MOS). The school Dean will be the intermediate reviewer for the Battalion Commander, 232d Med Bn, who in turn is accountable for 91B training, common task reinforcement, and solderization tasks. Drill sergeants are to serve as instructors.

III. ISSUES:

A. How can the AMEDD maintain an environment that allows for achieving a proper balance between academic training and solderization?

B. Should the AMEDDC&S strictly comply with Army and TRADOC regulations on solderization, lengthen courses of instruction, or relax some solderization requirements, limit academic hours or reduce the soldier's rest and personal time?

C. Will revised TRADOC regulation requirements and/or the merge of the 232d Bn and CMSD resolve the issue?

IV. DISCUSSION:

There appears to be a "we" "they" attitude between instructors and drill sergeants. There is also a conflict

between the Table of Distribution and Allowances (TDA) and Table of Organization and Equipment (TOE) training requirement of AMEDD soldiers/students. The lack of unity on this issue appears to be causing conflicting demands and may require further leadership decisions. The ultimate decision may be to lengthen all courses and allow for a shorter academic day with adequate time for Common Task Training (CTT) and other solderization tasks. In the past, MFSS has attempted to lengthen courses, but Office of the Surgeon General (OTSG) only approved lengthening if resources were provided by AMEDDC&S.

TRADOC Regulation 350-6, 1989, states that AIT commanders and service schools must find innovative ways to merge their responsibilities for training to achieve better unity of effort for AIT training. Commanders must provide input to training developers and ensure that AIT graduates are proficient in their technical and common skills, as well as be responsible for soldiers welfare, discipline, physical training, and other related areas. Academic instructors must assist in solderization efforts of the training chain of command.

TRADOC is in the process of revising the regulations that provide common military training and mandatory training requirements. Efforts are on-going to combine TRADOC Regulation 350-6, 351-10, 351-12, and 351-17 into a single source document. The draft required common military training (CMT) subjects/method of presentation matrix is continued at Encl 3. The current requirements are listed at Encl 4.

V. RECOMMENDATIONS:

A. Have drill sergeants serve as instructors in all AIT courses and have instructors assist with solderization efforts, as stated in TRADOC Regulation 350-6, 1989.

B. Continue to follow Army Regulation 350-15 on physical training and at the same time, if requirements are not valid/realistic and can not be met during AIT, work within the Army chain of command to change the policy.

C. Work with TRADOC to revise the new regulations that require mandatory common training to be documented in the Program of Instruction (POI). Documentation/identification of periods/hour of required training would clarify requirements during and after the academic day. Once the TRADOC Regulation is revised, AMEDDC&S must follow the regulation.

D. If A through B cannot be accomplished, recommend increasing the length of high density, priority courses to allow adequate time for technical training and solderization. This could possibly be resourced by eliminating low priority courses.

Soldier's Day from a Drill Sergeant/Instructor's Perception

Background:

I have experienced both aspects of soldierization. I was assigned here originally at the Academy of Health Sciences as a Cadre Sergeant in D-Co 232d. The responsibilities and role of the cadre sergeant are basically the same as the Drill Instructors (DIs). We are responsible for the soldiers once they arrive here on Fort Sam Houston from Basic Training as well as the Reserves and National Guardsmen who were coming from home and elsewhere.

The cadre sergeant in-processes the soldiers and makes sure they are administratively squared away, i.e., financial, personal, etc. The cadre sergeant is responsible for waking them up, doing physical training, marching them to and from class, holding formations and anything else in between until they were put to bed. I did this for approximately 2 years, day-in-and-day-out, 7 days a week. This was the most stressful job that I had ever done because of the large responsibility that was placed on me as a cadre sergeant. I could never think of myself as an individual because of always thinking about the fraternization rules and threat of a student's accusation, whether guilty or not. Also I didn't have the time because of being burdened with multiple problems from as many as 100 soldiers per cycle, i.e., those who bring unacceptable habits and behavior into the Army, gang activities, those initial entries who no longer want to be in the Army, reclassified soldiers who find it hard to be in an AIT student status, continuing the physical building of former couch potatoes, and assisting those with overwhelming personal problems from civilian life.

The soldierization was actually broken into two aspects - instructors and the cadre sergeant. There were constant complaints from the instructors that the soldiers were not studying enough and concentrating more on housekeeping as opposed to what they were actually here for which is to become a medic. There were constant complaints from instructors that the cadre sergeant didn't care about anything except the barracks maintenance. There was always an incident where the student would play the cadre sergeant against the classroom instructor.

Ironically, for some reason, I came down on orders from the Department of the Army to attend Drill Sergeant School. (as if I needed more gray hairs and stress in my life!)

Being a professional soldier, I thought - thanks, but no thanks! I felt as though I had done my time - 2 years of pure hell. I felt I didn't deserve this action therefore, I sought to get out of those orders, but to no avail. I was told that if I did not go then I would be barred from re-enlistment.

By the way, all cadre sergeants, once they have done 2 years, will go on to become instructors. So, off to Drill Sergeant school at Fort Knox, Kentucky . I attended the school for approximately 10 weeks. More stress and gray hairs. I gave it my best, hoped and prayed that I could conquer and graduate from the course.

For those of you who have never attended Drill Sergeant school, it's like going to basic training again. The instructors treat you as if you are a new recruit. I feel the reasoning behind this mentality hopefully, is to give a better understanding with feelings that you can train but be firm and fair. I graduated and was still assigned to Co D-232d for another 2 years.

The scenario had not changed at all except hopefully now I was formally trained to help a civilian become a soldier. The same complaints were still hitting the companies hard from instructors, especially since most of the instructors were formerly cadre sergeants. This brought a lot of envy and apathetic behavior by the classroom instructors because the DIs were on board and they were doing the exact job they had done as cadre sergeants but getting paid for it. Also that the soldiers were not listening to them because they were intimidated by the DI's hat. To me, the hat served the same purpose as the big gold belt that we wore as cadre sergeants to identify us.

Nonetheless, I felt that the hat carried more weight and respect. At one time or another, every soldier wants to become a DI since seeing them in basic training. The hat signifies power and authority and they realize that not everyone could fit the bill. Meanwhile, the complaints kept pouring in that the soldiers were being disruptive, and would not listen to the instructors because they were not DIs.

Once again, it was re-enforced to the soldiers that they would maintain their bearing in the classrooms and that they were still dealing with NCOs who had the same authority as the DIs. The companies support this to the fullest.

It was a different element for Fort Sam Houston to adapt to TRADOC programs because this was the first time DIs had been in a medical AIT. So the whole concept was to bring the school on line with TRADOC programs. This encountered some changes because military skills in CTT are more difficult under TRADOC programs because of the time structure whereas before as cadre sergeants, we did CTT essentially as a Round Robin - anytime we wanted to. Sometimes we did not have time to do it.

TRADOC dictates the format and structure IAW the guidelines. The same complaints about soldiers not having enough time to study were rampant and we were more concerned with barracks maintenance.

It was mandatory that once the DI came on board in 232d Med Bn that throughout their rigorous schedule that they would get certified on CPR, EMT and any other courses they needed and become Assistant Instructors with platform time so that this could help the student once they were dismissed from class with their academics. Also it would relieve burden on Instructors coming over for study halls in the evenings. This worked out well because the Instructor saw the DI as being helpful and gave them more time for themselves. It was mandatory that if a student is having an exam the following day they would have mandatory study hall the night before. There would be no GI parties nor anything else except studying. This study hall would be supervised by the DIs to ensure soldiers were, in fact, studying.

My tour of duty was up recently as a DI as the 232d and CMSD were to merge. Perhaps this would be beneficial to both sides so that they could see hands-on what goes on in a student/soldier day.

91B
Typical Day
M - F

1. 1800-0400 - E1 & E2 will pull 2 hrs as fireguard 6 times in 10 weeks (course length); E3 & E4 will pull ACQ 6 times in 10 weeks ; E4 and above every will pull headcount every 10 days.

2. 0400 - unofficial wakeup to prepare barracks for daily inspection

3. 0430 - wakeup for PT

4. 0450 - PT formation

5. 0600 - Released from PT to shower, prepare barracks for inspection, and eat breakfast

6. 0750 - Formation, march to class

7. 1150-1250 - Lunch, to include being marched to and from dining facility

8. 1700- Released to cadre, marched to company area, kept in company formation for dissemination of information, mail call

9. 1800 - Released for supper

10. 1900-2000 - Assigned details in barracks or company area or inspection conducted by cadre

11. 2000-2100 - Study time but also time to prepare uniforms/boots for next day

NOTE: Parade Practice and Parade (2 hours each) at least once per month. Some months students nust participate in several parades ie. Change of Command, Fiesta. Classroom hours missed have to be made up prolonging the duty day and leaving even less time for study and barracks preparation for inspections.

91B
Typical Day
Weekend

1. 0001-2400 - E1 & E2 will pull 2 hrs as fireguard 7 times in 10 weeks (course length); E3 & E4 will pull ACQ 2 times in 10 weeks ; E4 and above every will pull headcount every other weekend.

Saturday

2. 0800-1300 - CTT training 1st 4 weeks and remedial PT

3. 1700 Recall Formation (varies by Drill Instructor)

Note: Some students are given overnight passes starting at 1400 until recall on Sunday from 5th week on (varies by company- at discretion of drill instructor)

Sunday

1. 1700 - Recall formation and/or march by practice (1-1/2-2) hrs) varies by company)

2. 1800-2000 GI Party to make barracks 'spotless'

3. During the 8th week major preparation for command inspection takes up most of weekend time

NOTE: Each company sets its own policy with regard to recall formations etc. Some have a lot others have few. No standardization of how soldiers are handled.

DRAFT

DEPARTMENT OF THE ARMY

HEADQUARTERS UNITED STATES ARMY TRAINING AND DOCTRINE COMMAND
FORT MONROE, VIRGINIA 23651-5000

ATTENTION OF

ATTG-I (351)

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Mandated and Required Common Military Training (CMT) Subjects in TRADOC Resident Training Courses

1. Mandated and required Common Military Training (CMT) was a briefing topic during the Assistant Commandants' Conference at Fort Leavenworth, KS. Confusion exists about which CMT subjects are mandated/directed by HQDA, TRADOC, and the proponents for IET, NCOES, and OES. Additionally, confusion exists with regard to how much POI time is devoted to each CMT subject.

2. CMT subjects are found in AR 350-41, Army Forces Training, TRADOC Regulation 351-10, Guidelines for the Development of Enlisted Training, BNCOC and ANCCC Mandatory Training Annexes for Common Leader Training published by USASMA, and MQS II Common Core Summaries published by USACAC.

3. Have provided appropriate matrices that address CMT required in TRADOC resident courses (Encl 1); IET (Encl 2); NCOES (Encl 3); and OES (Encl 4). These matrices address all mandated, directed CMT requirements that must be included in your POIs. Enclosures 2 through 4 show all CMT additions to AR 350-41 to date.

4. Mandated/directed CMT subjects that are "Programmed" must be identified in the POI with the number of hours directed for the instruction. You are responsible to determine best approach and amount of POI time for CMT subjects presented via Integrated, Awareness, or Reinforced instruction.

5. Proponents designated for CMT subjects are responsible to identify critical tasks through application of Systems Approach to Training (SAT), and design, develop, and distribute training support packages (TSP) to users conducting resident IET, NCOES, WOES, and OES training courses.

6. Effort is on-going to combine TRADOC Regulations 350-6, 351-10, 351-12, 351-17, and 351-XX to provide a one source document for IET, NCOES, WOES, and OES policy. Anticipate a draft for your review and comment within the next 120 days.

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ATTG-I
SUBJECT: Mandated and Required Common Military Training (CMT) Subjects in TRADOC Resident Training Courses

7. Recommend you review your POI mandatory training annexes for all courses to ensure compliance with mandated/directed training and take steps to decrease POI time by eliminating subjects no longer relevant to a Force Projection Army.

8. POC is Mr. Morrison, DSN 680-5637, Profs MON1(MORRISOS).

FOR THE COMMANDER:

4 Encls

DENNIS P. MALCOR
Major General, GS
Deputy Chief of Staff
for Training

DISTRIBUTION:
Commander,
U.S. Army Training Centers
U.S. Army Combined Arms Command and Fort Leavenworth
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Commandant,
TRADOC Service Schools
U.S. Army Sergeants Major Academy
Academy of Health Sciences

REQUIRED COMMON MILITARY TRAINING (CMT) SUBJECTS/METHOD OF PRESENTATION IN TRADOC RESIDENT COURSES

SUBJECT	TRADOC PROPONENT	REFERENCE	\A RCT/OSUT	\A AIT/OSUT	\B PLDC	\B BNCOC	\B ANCOC	\C SMC	\C WOBC	\C WOAC	\C WOSC	\C OBC	\C OAC	\C CAS3	\C CGSC
PHYSICAL READINESS:															
Alcohol/Drug Abuse	USASSC	AR 600-63	P	R	A	A	A	P	P	P	P	P	I	I	I
Battlefield Stress	AHS	MED SPR	-	-	I	I	I	I	-	-	-	P	P	I	I
Health Benefits Awareness	USAIS/ AHS	AR 600-63	P	A	A	A	A	P	A	A	A	A	A	A	A
Physical Fitness Tng	USAIS	AR 350-15	P	R	P	P	P	P	P	P	P	P	P	I	I
Suicide Prevention	AHS	AR 600-63	A	A	I	I	I	P	I	I	I	I	I	I	I
Tobacco Usage	USAIS	AR 600-63	A	A	A	A	A	A	-	-	-	A	A	A	A
WEAPONS TRAINING:															
Weapons Qualific'n	USAIS	AR 350-4	P	-	-	-	-	-	-	-	-	P	-	-	-
Marksmanship Train the-Trainer (MTT3)	USAIS	AR 350-4	-	-	P	P	P	-	-	-	-	P	-	-	-
Ammo Accountability, Safety & Security	USAOMMCS	DAIG IPR	I	-	A	I	I	-	-	-	-	I	-	-	-
LEGAL AWARENESS:															
Bfts of Hon Dis	USASSC	AR 350-21	I	-	-	-	-	-	-	-	-	-	-	-	-
Code of Conduct/ SERE	TJAGSA/ JFKSWC	AR 350-30	P	R	R	R	R	I	P	R	-	P	R	-	-
Equal Opportunity/ Sexual Harassment	USASSC	AR 600-20	P	-	P	P	P	I	P	P	P	P	P	-	P
Geneva-Hague Conv	TJAGSA	AR 350-216	P	-	-	-	P	P	P	P	-	P	P	P	P
Info Scty/SAEDA	USAISC	AR 381-12	P	-	-	-	-	-	A	A	A	A	A	-	A
Info Sys Scty	USASIG	AR 380-19	-	P	-	-	-	-	-	-	-	-	-	-	-
Military Justice	TJAGSA	AR 27-10	P	-	-	-	P	P	P	P	-	P	P	-	-
Stnds of Conduct	TJAGSA	AR 600-50	P	R	R	R	R	R	-	-	-	P	-	-	-
LEADING SOLDIERS:															
Leadership	USACAC	FM 22-100	-	-	P	P	P	P	I	I	I	I	I	-	I
Military History	USACAC	CTA 150 11			P	P	P	P			•	P	P	P	P
Quality of Life	USASMA	CSA Dir	-	-	P	A	A	A	-	-	-	A	A	-	-
Reprisal Training	TJAGSA	DA Msg	-	-	I	R	R	I	-	-	-	I	I	-	-
Total Army Quality	DCSPER	AR 5-1	-	-	I	I	I	I	I	I	I	I	I	I	I

P=Programmed, I=Integrated, A=Awareness, R=Reinforced;

\A, Encl 2, CMT in TPT; \B, Encl 3, CMT in NCOPE; \C, Encl 4 CMT in OES

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REQUIRED COMMON MILITARY TRAINING (CMT) SUBJECTS/METHOD OF PRESENTATION IN TRADOC RESIDENT COURSES, CONT'D

SUBJECT	PROPONENT REFERENCE		BCT/OSUT \A	AIT/OSUT \A	PLC \B	BNCOC \B	ANCOC \B	SSC	WOC	WWO1	WWO2	WWO3	CAS3	CGS
SOLDIER SAFETY/ [illegible]														
Directed Energy Warfare (DEW) Safety Awareness	USAOMMCS	CMMCS TSP	I	I	I	I	I	-	-	-	-	-	-	-
Electromagnetic Environmental Effects (E3)	USAOMMCS	DA Msg	-	I	I	I	I	I	-	-	-	-	-	-
Fratricide Prev'n	USACAC	TRAP	I	I	I	I	I	I	O	O	O	A	-	-
Hazardous Communication	DCST	CG Dir	A	A	A	A	A	A	A	A	A	A	-	A
Heat, Cold, & Hearing Injury Prevention	USAIS/ ARS	AR 40-5	P	I	I	I	I	I	I	-	-	I	-	-
Safety-in-Training, Risk Assessment/ Risk Management	TRADOC CSO/DCST	AR 385-10	I	I	I	I	I	I	I	I	I	I	I	I
Thermal Ordnance Safety Awareness	USAOMMCS	VCSA Task	A	A	A	A	P	A	-	-	-	-	-	-
OPERATIONAL TECHNIQUES: [illegible]														
Environmental Awareness Tng	USAES	Army ET Mstr Plan	I	I	I	I	I	I	I	I	I	I	I	I
First Aid	USAIS/ARS	FM 21-11	P	-	-	-	-	-	-	-	-	-	-	-
NBC Defense/ MOPP 4 Posture	USACMLS	AR 350-42	P	R	P	P	P	I	P	P	-	P	P	I	I
Threat/OPFOR	USACAC	AR 350-2	P	I	I	I	P	P	I	I	I	I	I	I	I
Operations Scty	USACAC	AR 530-1	I	I	I	I	I	-	I	I	I	I	I	I	I
PMCS	USAOCS	DA GOSC	-	I	P	I	I	-	-	-	-	-	-	-	-

METHOD OF PRESENTATION: P = Programmed, I = Integrated, A = Awareness, R = Reinforced

A, Encl 2, CMT in IET; \B, Encl 3, CMT in NCOES; \C, Encl 4, CMT in OES

CMT subject proponent determines number of hours Programmed Instruction, determines primary subject for Integrated Instruction and provides training support packages as indicated in Chapter 4, TRADOC Reg 351-10.

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COMMON MILITARY TRAINING (CMT) SUBJECTS
INITIAL ENTRY TRAINING

CMT SUBJECTS REQUIRED FOR IET COURSES BY AR 350-41, SEP 86	REG'N REQU'MENT	BCT/ OSUT	AIT/ OSUT	RMKS
Weapons Qualification	P	P62	-	
Physical Fitness	P	P33	R	
SAEDA	A	P 1	-	
Military Justice	P	P 2	P 2	\1
Alcohol/Drug Abuse	P	P 1	R	
Heat/Cold/Hearing Injury	I	I	I	
NBC Training	P	P 8	R	
OPFOR/Threat	I	P 1	I	
Prev Motor Veh Accidents	I	I	I	
OPSEC	I	I	I	
Benefits of Hon Discharge	A	I	-	
Code of Conduct/SERE	P	P 1	R	
Geneva-Hague Conventions	P	P 1	-	
EO/SH	P	P 1	-	
Health Benefits Awareness	A	P 1	A	
Standards of Conduct	-	P 1	R	
Army Safety Program (Safety-in-Training)	A	I	I	
CMT SUBJECTS DIRECTED BY DA FOR IET COURSES AFTER SEP 86				
Ammo Acc't/Safety/Scty	I	I	-	
Environmental Aware Tng	I	I	I	
Suicide Prevention	I	A	A	
CMT SUBJECTS DIRECTED BY HQ TRADOC FOR IET				
Risk Assess/Risk Mgm't	I	I	I	
Fratricide Prevention	I	I	I	
MOPP 4 Posture	I	I	I	
Hazardous Communication	A	A	A	
Tobacco Usage	A	A	A	
CMT Subj Programmed Hours		113	2	\1

P = Programmed, I = Integrated, A = Awareness, R = Reinforced

Number of POI hours (1, 2, 8, etc) shown for Programmed Instruction method.

\1 Article 137, UCMJ, rebriefing required in AIT courses over 4 months in length.

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COMMON MILITARY TRAINING (CMT) SUBJECTS
NCOES

CMT SUBJECTS REQUIRED FOR RESIDENT TRAINING BY AR 350-41, SEP 86	REG'N REQU' MENT	PLDC	BNCOC USASMA PH I CLT	BNCOC BRANCH PH II MOS	ANCOC USASMA PH I CLT	ANCOC BRANCH PH II MOS	
Physical Fitness	P	I	I	I	I	I	
Leadership	I	P27	P11	I	P 8	I	
Military Justice	-	-	-	-	P 1	-	
Alcohol/Drug Abuse	P	A	A	A	A	A	
Heat/Cold/Hearing Injury	I	I	I	I	I	I	
NBC Training	P	P 1	P 5	I	-	I	
Threat/OPFOR	I	I	-	-	I	I	P
Prev Motor Veh Accidents	I	I	-	I	-	I	
OPSEC	I	I	I	-	I	-	
Code of Conduct/SERE	I,R	R	-	R	-	R	
Geneva-Hague Conventions	P	-	-	-	P 1	-	P
EO/SH	P	P 1	P 5	I	P 6	I	
Health Benefits Awareness	A	A	A	A	A	A	P
Standards of Conduct	-	R	R	R	R	R	
Army Safety Program (Safety-in-Training)	A	I	I	I	I	I	
CMT SUBJECTS DIRECTED BY DA FOR RESIDENT TRAINING AFTER SEP 86							
Ammo Acc't/Safety/Scty	I	I	I	-	I	-	-
Battlefield Stress	I	I	I	-	I	-	I
Directed Energy Warfare	I	I	I	-	I	-	I
E3	I	I	-	I	-	I	I
Environmental Aware Tng	I	I	I	-	I	-	I
PMCS	I	P 2	-	I	-	I	-
Quality of Life	A	I	A	A	A	A	A
Reprisal Training	R	I	R	-	R	-	I
Suicide Prevention	I	I	I	-	I	-	P
Total Army Quality	I	I	I	-	I	-	P
UXO Safety Awareness	A,P	A	A	-	P 1	-	A
CMT SUBJECTS DIRECTED BY HQ TRADOC FOR RES TNG							
BRM/Train-the-Trainer	P	P 8	P16	-	P20	-	-
Master Fitness Training	P	P13	P18	-	P11	-	P 6
Military History	P	P 1	-	P2	-	P3	P18
Risk Assess/Risk Mgm't	P	P 1	P 1	-	P 2	-	P 2
Fratricide Prevention	I	I	I	I	I	I	I
MOPP 4 Posture	I	I	I	I	I	I	-
Hazardous Communication	A	A	A	-	A	-	A
Tobacco Usage	A	A	A	A	A	A	A
DA/TRADOC CMT SUBJ HOURS		54	56	2	50	3	113

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COMMON MILITARY TRAINING (CMT) SUBJECTS
NCOES, CONT'D

CMT SUBJECTS REQUIRED FOR RESIDENT TRAINING at AR 350-41, SEP 00	REG'N REQU'MENT	PLDC	BNCOC USASMA PH I CLT	BNCOC BRANCH PH II MOS	ANCOC USASMA PH I CLT	ANCOC BRANCH PH II MOS	SMC
Army Writing Program	P	-	P7	-	P15	-	-
Combat Orders	P	-	P4	-	P2	-	-
FM 101-5 Diagnostic Test	P	-	-	-	P3	-	-
NCO ER	P	-	P2	-	-	-	-
Platoon Tactical Opns	P	-	-	-	P6	-	-
Property Accountability	P	-	P3	-	-	-	-
Squad Tactical Opns	P	-	P4	-	-	-	-
Training the Force	P	-	P6	-	P6	-	-
PHASE 1 CLT Examination	P	-	P4	-	P4	-	-
USASMA Directed Hours			30	-	36	-	
Total CMT Subj Prog Hours		54	86	2	86	3	113
METHOD OF PRESENTATION							

P = Programmed, I = Integrated, A = Awareness, R = Reinforced

Number POI hours (1, 16, 20, etc) shown for Programmed Instruction method.

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COMMON MILITARY TRAINING (CMT) SUBJECTS
OES

CMT SUBJECTS REQUIRED FOR RESIDENT TRAINING BY AR 350-41, SEP 86	REG'N REQU'MENT	OBC CC	OBC BR TNG	OAC CC	OAC BR TNG	CAS3	CGSC
Weapons Qualification	P	P8	-	-	-	-	-
Physical Fitness	P	P5	I	P5	I	I	I
NBCDA	A	-	A	-	A	-	A
Leadership	I	I	I	I	I	-	I
Military Justice	P	P3	-	P3	-	-	-
Alcohol/Drug Abuse	P	P1	A	A	A	I	I
Heat/Cold/Hearing Injury	I	I	-	-	-	-	-
NBC Training	P	P25	I	P8	I	I	I
Threat/OPFOR	I	I	I	I	I	I	I
Prev Motor Veh Accidents	I	I	I	-	-	-	-
OPSEC	I	I	I	I	I	I	I
Code of Conduct/SERE	P	P1	R	R	R	-	-
Geneva-Hague Conventions	P	P1	-	P1	-	P1	P5
EO/SH	P	P5	I	P6	I	-	P5
Health Benefits Awareness	A	A	A	A	A	A	A
Standards of Conduct	-	P1	R	R	R	R	R
Army Safety Program (Safety-in-Training)	A	I	I	I	I	I	I
CMT SUBJECTS DIRECTED BY DA FOR RESIDENT TRAINING AFTER SEP 86							
Ammo Acc't/Safety/Surv	I	I	-	-	-	-	-
Battlefield Stress	I	P2	-	P3	-	I	I
Environmental Aware Tng	I	I	I	I	I	I	I
Quality of Life	A	-	A	-	A	-	-
Reprisal Training	R	I	-	I	-	-	-
Suicide Prevention	I	I	I	I	I	I	I
Total Army Quality	I	-	-	-	I	I	I
CMT SUBJECTS DIRECTED BY HQ TRADOC FOR OES RESIDENT TRAINING							
BRM/Train the Trainer	P	P4	-	-	-	-	-
Military History	P	P6	I	P10	I	P14	P76
Risk Assessm't/Risk Mgm't	P	P1	I	P2	I	-	-
Fratricide Prevention	I	I	I	I	I	-	-
MOPP 4 Posture	I	I	I	I	I	-	-
Hazardous Communication	A	A	-	A	-	-	A
Tobacco Usage	A	A	A	A	A	A	A
CMT Subj Programmed Hrs		63	-	38	-	15	86

P = Programmed, I = Integrated, A = Awareness, R = Reinforced

Number POI hours (1, 6, 14, etc) shown for Programmed Instruction method.

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Appendix D

Common Tasks Selected for Reinforcement Training and Evaluation in AIT

D-1. This appendix establishes the BCT tasks to be reinforced and evaluated in AIT units.

D-2. TRADOC has a responsibility to ensure those skills gained by the soldier in BCT do not deteriorate to an unacceptable level prior to their graduation from IET. Therefore, selected skills trained in BCT are required to be reinforced and evaluated in AIT. (These tasks are listed in table D-1.)

D-3. Tasks will be evaluated during the final 4 weeks of AIT. Tasks for which individuals receive "No-Go" will be reinforced and evaluated again prior to graduation. The goal is to ensure all soldiers demonstrate the ability to perform those tasks prior to departing IET. For long AIT course lengths, skill decay for many tasks may approach a point where time required to bring the individual back up to standard equals 50 percent of the original training time. To preclude that, units will schedule periodic refresher training. To assist in that effort, refresher training increments suggested by skill retention data to maintain 90 percent proficiency are listed at table D-1. A side benefit of the skill retention work was the identification of those steps within a task which were the prime causes for failure. Where applicable, those steps have been listed by task at table D-2. Unit cadre will pay special attention to those steps during refresher training.

Table D-1
Common tasks selected for reinforcement/evaluation in AIT and minimum reinforcement increment

Reinforce Every	TP 600-4 or STP-21-1-SMCT Number	TITLE
4 wks	031-503-1002	Put On, Wear, and Remove your M17-Series Protective Mask with Hood
4 wks	031-503-1003	Store your M17-Series Protective Mask with Hood in Carrier
4 wks	031-503-1007	Decontaminate your Skin and Personal Equipment
4 wks	081-831-1030	Administer Nerve-Agent Antidote to Self (Self Aid)
16 wks	031-503-1019	Recognize and React to a Chemical/Biological (CB) Hazard
16 wks	031-503-1018	React to Nuclear Hazard
4 wks	081-831-1016	Put on a Field or Pressure Dressing
4 wks	081-831-1017	Put on a Tourniquet
8 wks	081-831-1005	Prevent Shock
4 wks	081-831-1034	Splint a Suspected Fracture
4 wks	071-326-0502	Move Under Direct Fire
4 wks	071-326-0511	React to Flares
8 wks	071-329-1001	Identify Terrain Features on the Map
4 wks	071-329-1002	Determine the Grid Coordinates of a Point on a Military Map Using the Military Grid Reference System
4 wks	071-329-1003	Determine a Magnetic Azimuth Using a Lensatic Compass
8 wks	071-326-0010	Report to an Officer (Indoors)
4 wks	071-326-0014	Identify Rank
4 wks	071-326 0012	React to an Approaching Officer
4 wks	071-326-0013	React to an Approaching NCO
4 wks	071-331-0050	React to an Inspecting Officer
8 wks	071-331-0801	Use Challenge and Password
4 wks	071-331-0052	Challenge Unknown Persons (Night)
4 wks	071-331-0051	Summon Commander of Relief
8 wks	113-571-1016	Send a Radio Message
4 wks	071-326-0030	Execute Drill Movements with Arms (Stationary)
4 wks	071-326-0031	Execute Drill Movements with Arms (Marching)
4 wks	071-311-2025	Maintain an M16A1 M16A2 Rifle
4 wks	071-311-2026	Perform a Function Check on an M16A1 or M16A2 Rifle
8 wks	071-311-2027	Load an M16A1 or M16A2 Rifle
8 wks	071-311-2028	Unload an M16A1 or M16A2 Rifle
8 wks	071-311-2029	Correct Malfunctions of an M16A1 or M16A2 Rifle
4 wks	071-318-2210	Prepare an M72A2 Light Antitank Weapon for Firing
4 wks	071-318-2211	Restore an M72A2 Light Antitank Weapon to Carrying Configuration
4 wks	071-318-2203	Perform Misfire Procedures on an M72A2 Light Antitank Weapon

Reinforce Every	TP 600-4 or STP-21-1-SMCT Number	TITLE
4 wks	071-325-4425	Employ an M18A1 Claymore Mine
4 wks	071-325-4401	Perform Safety Checks on Hand Grenades
4 wks	071-325-4407	Employ Hand Grenades

Table D-2

Key task performance measures to emphasize

TP 600-4 Task Number	Key Performance Measures
031-503-1002	7
031-503-1007	1i, 1j, 1s
081-831-1030	3c, 3d, 5a, 7b
081-831-1016	3b
081-831-1034	1, 4
071-311-2025	1
071-325-4412	2d, 2e, 3b, 3c, 3d
071-318-2203	1a, 1b
071-326-0502	2b, 3c
071-329-1001	1 thru 8
071-329-1002	1
071-326-0012	1
071-326-0030	1. 2

Appendix E

Training Records

E-1. This appendix provides samples of training records for BCT, OSUT, and AIT and supplements the guidance in chapter 3 for completing the records. The training records are comprised of DA forms and, with the exception of overprinting training subjects in the appropriate sections, cannot be modified by TRADOC or its subordinate commands. HQ TRADOC will coordinate changes to the forms that comprise the training records with HQDA.

E-2. DA Form 5286-R.

a. Information concerning individuals who receive new starts will be recorded in item 6.

b. The results of the APFT will be recorded in item 7c.

c. The SAEDA training (item 7e) has been deleted from the BCT POI but may be presented in OSUT or AIT.

d. Civil disturbance training (item 7j) is not presented in IET.

e. The data required in item 11 by paragraph 3-7e(4) may be overprinted on this form.

E-3. DA Form 5286-1-R is a continuation sheet and may be overprinted to record the required training subjects for IET.

E-4. DA Form 5286-R will include records of all formal training received by the soldiers in IET. DA Form 705 will also be included in the TRTJ.

E-5. The sample training records are as follows:

a. For BCT, sample ITR is figure E-1 and the TRTJ is figure E-2.

b. For AIT, sample ITR is figure E-3 and the TRTJ is figure E-4.

c. For OSUT, sample ITR is figure E-5 and the TRTJ is figure E-6.

Appendix F

Health and Hygiene Training in IET

F-1. This appendix establishes TRADOC guidance for health and hygiene training/education in IET.

F-2. Commanders will develop their own programs which fully integrate this philosophy, appropriate POI instruction, and unit activities.

F-3. Historically, in every conflict in which the United States has been involved, only 20 percent of all hospital admissions were from combat injuries. The other 80 percent were from diseases and nonbattle injuries (DNBI). For this reason, it is imperative that our soldiers learn and develop good health and hygiene habits early in their training. Good health and hygiene habits are preventive countermeasures to DNBI. These countermeasures are generally simple, common sense actions that every soldier should know and perform.

F-4. While performing good health and hygiene habits is an individual responsibility, and environment that fosters the development of these habits is a leadership responsibility. This leadership responsibility is executed through–

a. Leader training. Cadre training POIs (Drill Sergeant School, Cadre Training Course, Pre-Command Course, etc.) and NCO/officer development programs should emphasize the leader's role in the education/habit development process. This is best accomplished by training in such areas as:

(1) Individual Preventive Medicine Countermeasures (FM 21-10).

(2) Unit Preventive Medicine Countermeasures (FM 21-10).

(3) Inspection/Early Detection Techniques (FM 21-10).

(4) Healthy Life Style Habits (FM 210-20).

RULES AT AMEDDC&S

The mission of the AMEDDC&S is to provide command, control, and administrative and logistical support to personnel assigned or attached to the AMEDDC&S; prepare brigade mobilization and contingency planning; administer the training program for all permanent party personnel; and coordinate and supervise support requirements.

The brigade commander has been given a free hand in running the brigade; however, he is expected to coordinate vertically and horizontally in establishing and implementing all policies affecting AMEDDC&S personnel. While the above mission contains no explicit statement charging the brigade with accountability for the "soldierization" of AIT personnel, the staff has, nevertheless, accepted such a mission as implied. In fact, this study uncovered an unofficial brigade charter stated as follows: "to produce soldiers, if not the best medics." This charter, however, is not agreed upon by everyone at the AMEDDC&S. Current difficulties in "soldierization" and academic training relate directly to who makes the rules.

Under the structure of the brigade, the leadership believes and insists on having the freedom to establish policies, guidelines, and procedures to accomplish the stated mission. The TRADOC model agreed upon in an MOU between the AMEDDC&S and TRADOC is followed in meeting the mandated and required common military training subjects in resident training. Although the TRADOC model is being used, data indicates that how and to what degree it is implemented by the AMEDD has some flexibility. It appears that no rules have been established on what things will not be tolerated when dealing with soldiers. Of course, the brigade has SOPs and policy files. However, there are no basic rules on how the soldiers enter the walls of the AMEDDC&S and go through the gauntlet of the brigade requirements and the academic requirements of the school, and come out of this experience capable of performing in a TOE unit or in a TDA hospital. Information uncovered in this study indicates that no one happens to be handling the integration of the requirements between technical proficiency (MOS) and military custom (soldierly skills).

The finding indicates that the brigade and schoolhouse insist on following the regulations and requirements for their areas of accountability. The AMEDDC&S Deputy Commander is the individual needed to integrate the requirements and to establish a set of common sense rules.

The statement "Soldier Medic" implies soldier first and a medic second. The data indicates that this simple statement is interpreted differently in the brigade and in the school.

Recommend the Deputy Commander, AMEDDC&S, review the role of the brigade and school and establish common rules to be followed.

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

PATIENT ADMINISTRATION SYSTEMS AND BIOSTATISTICS ACTIVITIES

(PASBA)

BACKGROUND:

The Office of the Surgeon General (OTSG) is the proponent for the worldwide medical data bases. PASBA is its agent for management of these biomedical statistical data and has a world-wide mission. Data is collected for all active military treatment facilities (MTF) both Fixed and Non-Fixed (Table of Organization and Equipment (TOE)).

PASBA was created as a Field Operating Activity (FOA) of Health Services Command (HSC) and chartered to provide the MACOM with aggregated patient history data. PASBA currently collects patient history data from all medical treatment facilities world-wide. Originally, data collected was intended to track individual patient histories as well as provide the necessary information to identify specific costs associated with a given treatment protocol. However, because of the magnitude of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) portion of military health care costs, Department of Defense-Health Affairs (DoD HA) has increasingly relied on PASBA data and analytical supporting efforts in their attempts to more effectively manage the health care system.

The PASBA was transferred from HSC (as a Field Operating Activity (FOA)) to the U.S. Army Medical Center and School (AMEDD

C&S) on 2 October 1992 where it currently resides as a directorate. Additionally, as a result of Army Management Headquarters Account (AMHA) reductions to HSC the Patient Administration (PAD) Operations Section was transferred to PASBA. The Medical Expense and Performance Reporting System (MEPRS) Division was transferred to PASBA 1 October 1991; it was moved from the Deputy Chief of Staff for Resource Management, Headquarters, U.S. Army Health Services Command (HSC). The MEPRS data system appears to have been transferred to PASBA for the same reason as the PAD Operations Section.

I. THEME: PASBA provides a number of routine and customized statistical reports which provide MTF Commanders with a wealth of patient data that enhances their decision making capability regarding the provision of health care in their facility.

II. FINDINGS:

A. The Patient Administration Operations Division was recently moved from Health Services Command to PASBA.

B. PASBA performs a wide range of recurring and special reports to DoD and civilian agencies; the cost of these reports is not incurred by the requestor.

C. There is a perception among the commanders of the Medical Treatment Facilities (MTFs) that the Medical Expense Performance Report System (MEPRS) provides minimal value.

D. There is a perception on the part of the PASBA staff that the development of regions under the Medical Command may require downloading of PASBA assets to those regions, particularly in support of third party payments systems.

E. The Chief of the Patient Administration Division at OTSG feels that two spaces are needed on the ARSTAF, and that a PAD cell should be developed under the Medical Command (MEDCOM) that combines elements of OTSG PAD and the Operations Branch of the PASBA.

F. MEPRS was not designed to be a cost accounting system. It is felt that the MTF commanders are using MEPRS but do not fully understand the capabilities of the system and area unwilling to confirm the extent that they use MEPRS.

G. The Chief of the Patient Administration Division at OTSG feels that a regional PAD Headquarters is needed.

H. The Biostatistics Division provides biomedical statistical analysis worldwide. Computerized worldwide databases are maintained for inpatients, patients issued nonavailability statements, medical summary information, Blood Bank Operational Report, and the HSC database for Social Work Activities.

I. The PAD Systems Division operates the Individual Patient Data System (IPDS) and the Army Central Registry of Child & Spouse Abuse for the Army Family Advocacy Program System (AFAPS).

J. Release of information and/or data involves consideration and proper handling of: Privacy Act Data, Sensitive Data (i.e.,

AIDS, Psychiatric, Drug and Alcohol, Abortions, Cosmetic Surgery, etc.), and Combat related data.

K. PASBA conducts projects on external databases (i.e. databases for which PASBA is not the proponent's agent): Health Risk Appraisal data base; Retrospective Case Mix Analysis System (RCMAS); Meals Ready To Eat (MRE) data; active duty strength data; the NEWSLEADER questionnaire data; Standard Inpatient Data Record in the Automated Quality of Care Evaluation Support System (AQCESS); and the Composite Health Care System (CHCS).

L. PASBA has both a peacetime and wartime mission.

III. ISSUE: What is the best way to organizationally align PASBA in the Medical Command?

- As a staff element in Health Care Operations, MEDCOM?
- As a standalone support office in the Medical Support and Services Activity (MSSA)?
- Download the current function to the regions maintaining only a small cell in the MSSA?

IV. DISCUSSION:

With the realities of reduced funding and the emphasis on the delivery of cost effective health care it is imperative for the MTF Commander to have timely access to Individual Patient Data System (IPDS) information. PASBA provides a wealth of patient data to it's customers. Customers include: MTFs; OTSG; HQ 7th Medical Command, Europe; HQ 18th Medical Command, Korea; and the Department

of the Army. Additionally, the Air Force and Navy biometrics offices rely on PASBA for assistance and technical expertise with regards to data management and programming functions. PASBA performs a wide range of recurring and special reports to DoD and civilian agencies, however, the cost of these reports is not incurred by the requestor. Most of the work that PASBA performs lends itself to fee for service; the AF has expressed an interest in receiving services from PASBA. The Chief of PASBA confirms that fee for service will validate the value of PASBA reports.

As a result of Army Management Headquarters Account (AMHA) reductions to HSC the PAD Operations Division was transferred to PASBA. Interviews revealed that there is a perception in PASBA that the PAD Operations Division is performing work primarily for HSC. Review and analysis of the functions performed by this division are those associated with the Medical MACOM (MEDCOM). The functions performed by this division include: implementation of policy; providing guidance to Army MTFs on patient administration; and providing technical guidance and assistance on medical eligibility, entitlements, business office operations, casualty reporting, decedent affairs, medical disability, procurement of civilian medical services, and sharing of facilities with other Federal medical facilities.

The Medical Expense and Performance Reporting System (MEPRS) Division was transferred to PASBA from the Deputy Chief of Staff for Resource Management, Headquarters, U.S. Army Health Services Command (HSC). The MEPRS data system appears to have been

transferred to PASBA for the same reason as the PAD Operations Section (aforementioned). This division is the Headquarters, HSC functional proponent for the MEPRS for Fixed Military Medical and Dental treatment Facilities (directed by DOD 6010.13-M). MEPRS merges data from the Expense Assignment System (EAS) Version 3 and the Composite Health Care System (CHCS). MEPRS serves as system to account for the costs (i.e., costs of items such as wards, and bed days) associated with the delivery of health care in military fixed facilities. The functions (i.e., reporting of expenses, workload, and manpower data) performed by this division are resource management focused.

V. RECOMMENDATIONS:

A. Align the Patient Administration Operations Division with the Health Care Operations, MEDCOM.

B. Align the MEPRS Division with the Deputy Chief of Staff for Resource Management, MEDCOM.

C. Align the remainder of PASBA with the MSSA as an office and operate on a "fee for service" basis.

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF HEALTH CARE MANPOWER MANAGEMENT SUPPORT

BACKGROUND:

The Health Care Management Engineering Activity (HCMEA) was established approximately three years ago as a Field Operating Activity (FOA) for the Headquarters (HQ), Health Services Command (HSC). The primary functions of HCMEA were developing both Army unique and Joint Tri-Service Health Care manpower staffing standards (and requirements determination for joint standards); managing the HSC Commercial Activities (CA) Program; and managing the HSC Defense Region Interservice Support (DRIS) Program.

Approximately one year ago, in an attempt to cope with Army Management Headquarters Account (AMHA) reductions, the HQ, HSC manpower function was split into operations and policy. The policy function was staffed with four positions and remained on the HQ, Deputy Chief of Staff for Resource Management (DCSRM) Table of Distribution and Allowances (TDA). The remainder of the Manpower Division (Allocations and Requirements Determination) functions were consolidated with HCMEA and the corresponding positions were transferred to the HCMEA TDA. The 06 Manpower Division Chief was dual-hatted as the Chief for Manpower Policy and Director for the consolidated FOA. Last Fall the consolidated FOA was transferred to the AMEDDC&S because it appeared that MACOM HQ FOAs were under scrutiny by HQ Department of the Army (DA) for potential manpower cuts. The Health Care Manpower and Management Engineering Activity

is currently known as the Directorate of Health Care Manpower Management Support (DHCMMS).

During the Organizational Design Study of HQ, HSC the Manpower Policy function was studied. Because manpower requirements determination and allocation functions were closely related (and are also the work of the Major Army Command (MACOM) DCSRM) the manpower allocations and requirements functions performed by HCMEA was also analyzed (refer to the HSC Manpower write-up). Other functions (e.g., Commercial Activities program management), while constituting MACOM functions, were not studied at that time because HCMEA (along with other HSC FOAs) was officially assigned to the AMEDDC&S and that organization was to be analyzed during a later phase of this study. However, during the Organizational Design Study of the Office of the Surgeon General (OTSG) manpower and CA functions were included.

I. THEME: The majority of the work which the Directorate of Health Care Manpower Management Support performs constitutes MACOM level functions normally associated with a MACOM DCSRM.

II. FINDINGS:

A. Although this organization was aligned with the Army Medical Department Center and School (AMEDDC&S) last fall, it is performing work which is properly that of the MACOM HQ.

B. DHCMMS's primary customers are Medical Treatment Facility (MTF) commanders; secondary customers are DA, Department of Defense (DoD), and HSC.

C. The HSC DCSRM Chief of Manpower Policy is dual-hatted as Chief, DHCMMS.

D. The Chief, DHCMMS is attempting to eliminate work associated with joint standards, CA, and TDAs (equipment and civilian manpower documentation).

E. The Chief, DHCMMS believes that relationships need to be built laterally between the proposed Medical Command (MEDCOM) and AMEDD Personnel Proponency.

F. DHCMMS's CA Division has an augmentation team which performs staff assistance and compliance visits to MTFs. (Refer to the HSC Staff Assistance and Compliance Visit Write-Up)

G. There appears to be duplication of some work e.g., CA functions at the Office of the Surgeon General (OTSG), DHCMMS, MTFs; standards development and application at Joint Health Care Management Engineering Team (JHMET), DHCMMS, MTF; manpower functions at OTSG and DHCMMS.

H. MTF Commanders nominate recommendations for CA reviews at their MTF. These nominations are forwarded to the MACOM and then on to DA and Congress for announcement.

I. There is currently a moratorium on all CA reviews.

J. The directorate has a Systems Support Division, staffed primarily with management analysts who manage data bases and provide automation support to DHCMMS and HSC DCSRM personnel. This

office duplicates Health Care Systems Support Activity (HCSSA) functions but was created because of the lack of support received from HCSSA.

K. The current Joint and Army Manpower Staffing Standard System (MS3) represents an outmoded process and is of low value-add to the AMEDD. (Refer to HSC Manpower Write-Up)

L. The newly developed demographic model, developed by the Consultant Services Division, which utilizes benchmarking data tracks well with the capitated budget process and provides "value-added" information to Medical Activity and Medical Center commanders.

M. DHCMMS has recently reorganized and consolidated the Army Standards Division and Joint Standards Divisions.

N. There are currently five DHCMMS personnel assigned to the JHMET. The JHMET, a Tri-Service activity (located at Randolph Air Force Base) for which the U.S. Air Force is the executive agent, develops joint health care manpower staffing standards. These standards are then applied to the HSC MTFs by DHCMMS Standards Division and the results documented on MTF TDAs by the DHCMMS Manpower and Equipment Operations Division.

O. Capitation budgeting is believed to be contradictory to the "standards" development process.

III. ISSUES:

A. Is this Directorate properly aligned under the AMEDDC&S or are the functions it performs Major Army Command headquarters' (Medical Command) functions?

B. Can the AMEDD afford to continue to perform all of the functions currently performed by DHCMMS? If not, which functions should be discontinued?

IV. DISCUSSION:

This activity is performing functions which are MACOM HQ functions. The organization was realigned from a HQ FOA to the AMEDDC&S as a directorate to avoid scrutiny by higher HQ for potential manpower cuts. None of the functions are appropriate to the AMEDDC&S and therefore the analysis will be based on these functions as they relate to a MACOM rather than to the AMEDDC&S to which they are extantly organizationally documented.

This directorate is currently performing the following functions: manpower requirements determination using Joint and Army Manpower Standards as well as by utilizing a newly developed demographic model; HSC command program management for the Commercial Activities Program; HSC command program management for the Defense Region Interservice Support; HSC command manpower and equipment documentation; and manpower programming and allocation.

Requirements determination for subordinate activities is clearly a MACOM function. The methodology for how those requirements are determined is currently being questioned. (Refer to HSC DCSRM Manpower write-up.) DHCMMS is currently performing an

initial application of the Joint Health Care standards to determine whether the standard is applicable to the Army and to identify exceptions or additives that are unique to Army MTFs. DHCMMS also performs application of approved standards annually. It was initially recommended that the Army no longer continue participating in the standards arena. If the decision is to continue to participate then it is recommended that the application of any standards be downloaded to the activity level with only the documentation function continuing at the HQ.

The DHCMMS Commercial Activities (CA) Division has a MACOM function to provide "oversight" for the command CA program. These command functions include providing MACOM policy, review, and forward of proposed MTF CA reviews to Department of the Army. Generally, Commercial Activities is considered a productivity program and is located in the Management Division.

In addition this division also has an augmentation team which provides on-site assistance for the MTFs. One to three team members go on-site and conduct CA operational functions normally properly performed by the installation or activity (e.g., conducting management studies and cost comparisons, writing performance work statements). These visits can take anywhere from a few days to weeks in duration. The temporary duty cost for these visits are born solely by DHCMMS. The MACOM is responsible for policy and oversight only. This activity has taken it upon themselves to actually conduct studies for subordinate activities. This does not appear to be cost-effective or value added to the

mission of HQ, HSC or the AMEDDC&S. In light of the current moratorium on CA studies, the fact that DHCMMS continues to send analysts to subordinate activities for the purpose of conducting such studies appears to be inconsistent with current guidance.

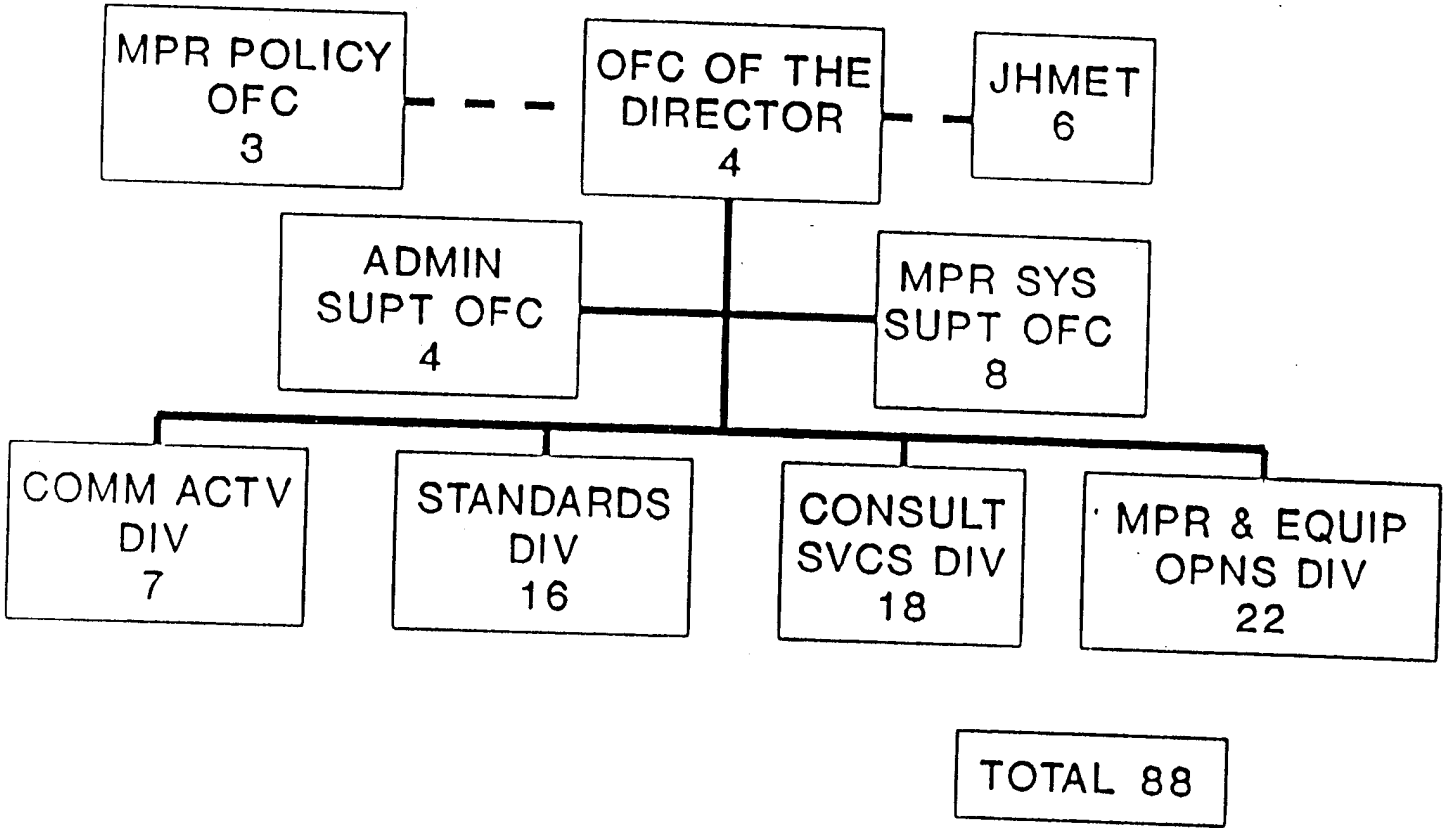
V. RECOMMENDATIONS:

A. Transfer the manpower allocations and requirements functions back to the HSC DCSRM to continue to provide valid MACOM functions.

B. Discontinue participation in the Army and Joint manpower standards process. If participation continues, application of standards should be downloaded to the activity (i.e., MTF). Transfer the function of documentation of standard applications to HSC DCSRM.

C. Discontinue all Commercial Activity compliance and staff assistance visits. MTF commanders should be held accountable for performing the operational work associated with CA reviews. Transfer the MACOM CA program oversight and policy functions to the HSC DCSRM Management Division.

DIRECTORATE OF HEALTH CARE MANPOWER MANAGEMENT SUPPORT



U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

INFORMATION MANAGEMENT OFFICE

BACKGROUND:

The Information Management Area (IMA) restructuring and realignment began in 1985 in accordance with guidance received from Health Services Command (HSC) and Information Services Command (ISC). This restructuring was completed in 1991. Today the Army Medical Department Center and School (AMEDDC&S) Information Management Office (IMO) consists of four Divisions: Administrative Services Division; Automation Management Division; Customer Support Division; and the Plans and Management Division.

The early 1990s witnessed heavy personnel turnovers within the IMO organization with all overstrength military personnel being reassigned to non-IMO activities. During this time frame a separate budget program (Program Objective Memorandum - POM) was developed identifying all IMO requirements within the AMEDDC&S. The desired end product of this requirements based analysis was an integrated, totally compatible communication system operating throughout the AMEDDC&S. The intent was to replace technologically obsolete workstations, multiuser systems and local unique software applications within the AMEDDC&S. This program budget effort was developed to ensure that the most effective and economical data automation tools were available to support both the current and future AMEDD mission.

I. THEMES:

A. IMO functions and roles are unclear, and widely misunderstood.

B. Personnel assigned to key IMO management positions do not have a strategic plan or programmed methods for achieving short or long-range goals.

II. FINDINGS:

A. The Administrative Services Division provides the following services to the students and faculty of the AMEDDC&S: postal, printing and ordering of publications, Temporary Duty (TDY) orders, distribution center support, records management, and electronic publishing.

B. The Automation Management Division provides computer operation support, telecommunications, and desktop publishing to the staff and faculty of the AMEDDC&S.

C. The Customer Support Division provides training to staff and faculty on standardized software, computer laboratory assistance to students, and runs the "Help Desk" for the AMEDDC&S.

D. The Plans and Management Division controls the requisition of hardware, software and supplies, discharges staff responsibility for the Capability Requests (CAPR) and Information Management Plan (IMP) tasks, manages the IMO budget and is the Contracting Officer Representative (COR) for ADPE maintenance contracts.

E. The newly assigned IMO has proposed reorganizing the IMO as follows: consolidation of the Automation Management Division

with the Customer Support Division and branch restructuring within the other divisions.

III. ISSUES:

A. How can IMO be organized so as to better utilize its capabilities in day-to-day operations as well as in the long-range planning process?

B. How will the proposed HSC IMO consolidation affect the AMEDDC&S IMO operations?

IV. DISCUSSION:

Interviews with the newly assigned IMO and his division personnel indicates that the current organization has little or no focus. The IMO indicated that while he has the full support of the Deputy Commandant, including all of the necessary resources to perform the assigned mission, nevertheless he has not been in place long enough to aggressively pursue all mission-related tasks.

The current IMO organization appears to suffer from a lack of continuity. Numerous comments were made by interviewees that personnel from various AMEDDC&S staff elements were funding and purchasing their own ADP equipment, including software. The data suggested that these offices were going outside normal IMO channels to fund and purchase the above items. Some organizational elements reportedly even established their own personal IMOs. These clandestine efforts and derogatory comments tend to reinforce the widely-held perception that the IMO function is "broken."

V. RECOMMENDATIONS:

A. The IMO organization should conduct a series of customer focus groups in order to better understand how the IMO can best support each element of the AMEDDC&S. These group workshops should be conducted prior to any reorganization of the IMO. Any reorganization, at this point in time, is likely to provide little or no value add if "customer" needs have not been identified.

B. The IMO should develop and implement a concise strategic plan in order to achieve both operational goals.

C. Realign various functions (i.e., Mailroom and distribution, printing and publications, and records management) to the Directorate of Support. This realignment will free up the IMO and staff from daily mundane operations. Also this reorganization will free up the IMO to deal with important issues in the Information Management Arena.

D. Organize remainder of IMO functions to support the customer database with standardized software and hardware.

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF LOGISTICS (DOL)

BACKGROUND: The DOL consists of three branches and is accountable for provisioning the Army Medical Department Center and School (AMEDDC&S) with all required supplies. Since the AMEDDC&S encompasses the largest allied health care training system in the free world, the support activity plays a central role in achieving the AMEDDC&S goal.

I. THEMES:

A. There was a genuine feeling that the organization was running well, and that while there were problems in the past, they were the result of the previous administration, and had since been corrected.

B. Considerable concern was expressed regarding the proposed consolidation with the Directorate of Operations to form a Support Battalion.

II. FINDING: All three of the individuals interviewed from DOL mentioned the proposed Support Battalion concept as a planned major mission change for their area. All three were also strongly opposed to the idea.

III. ISSUE: What is the most appropriate organizational alignment for DOL (Refer to Directorate of Support write-up)?

IV. DISCUSSION:

The consensus opinion from the interviewees was that if DOL was realigned to form a Support Battalion they would no longer be able to provide the high quality support they currently were doing. The problems they foresee were twofold. First, such a move would add another unneeded management layer (Brigade Commander), and secondly it would apply a Table of Organization and Equipment (TO&E) model to a Table of Distribution and Allowances (TDA) organization. The Director of DOL did feel however that if Fort Sam Houston became an AMEDD installation, then it would be logical to combine AMEDDC&S functions with those of the Garrison DOL. Such a merger would then effectively eliminate any duplication of effort, while simultaneously providing consistency of support.

V. RECOMMENDATION: That the AMEDDC&S DOL be realigned into a stand alone support activity and not become a Support Battalion within the Brigade.

ENCLOSURE 14

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TAB A

ENCLOSURE 14

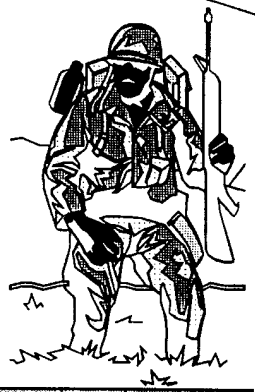
FORCE XXI VISION

"To fight and win the Nation's wars"

Yesterday

An Historical Viewpoint

Where We've Been



A Traditional Viewpoint

Today

Objective: Force XXI

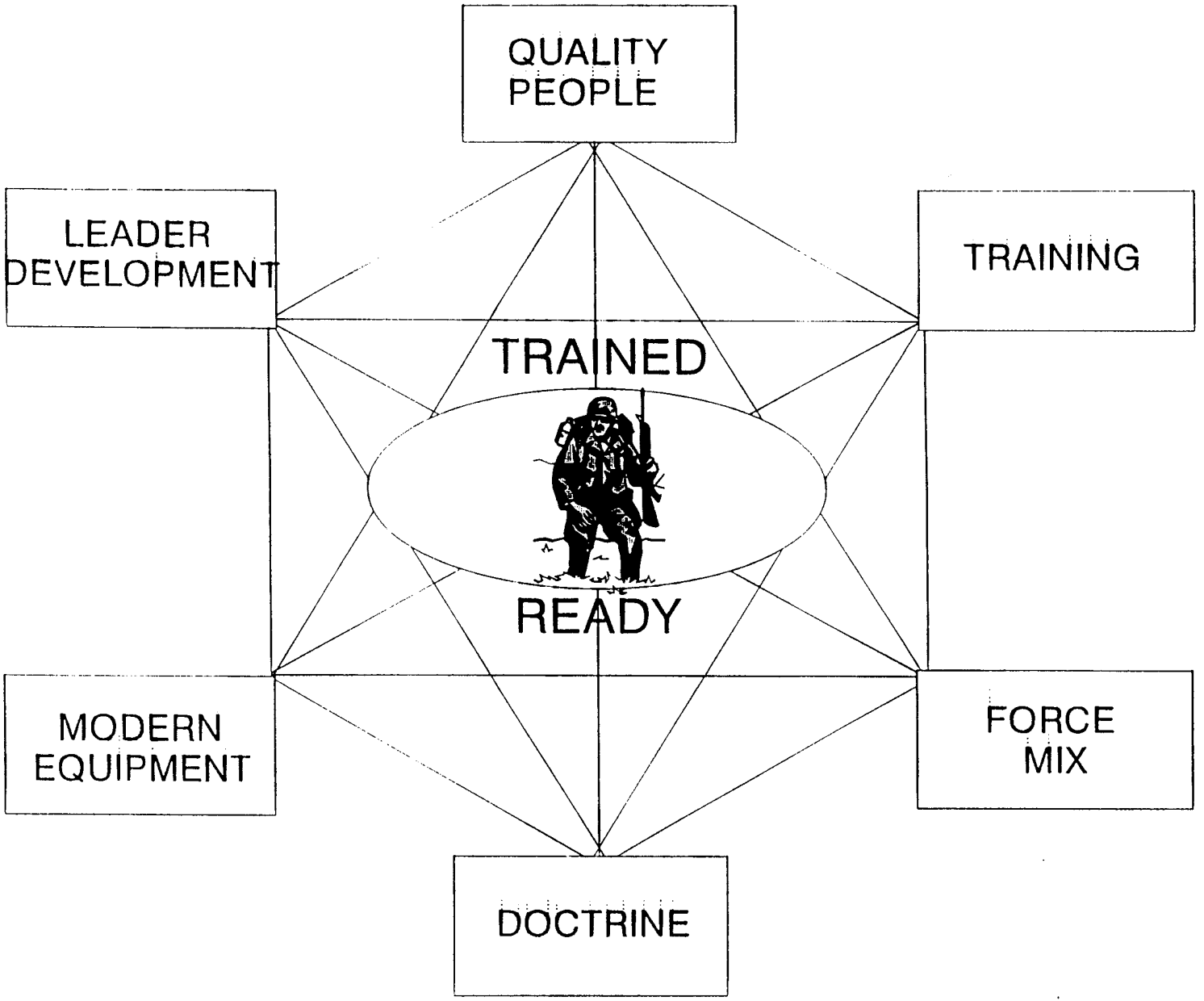
Tomorrow

2010

The Army Vision

A Visionary Viewpoint

THE ARMY IMPERATIVES



TRAINED AND READY....

TO I GHT AND WIN OUR NATIC 'S WARS!

THE TRAIN IS MOVING

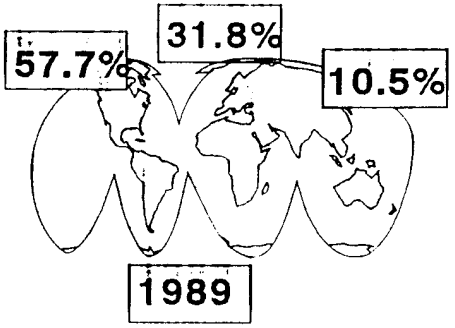
DIMINISHING RESOURCES

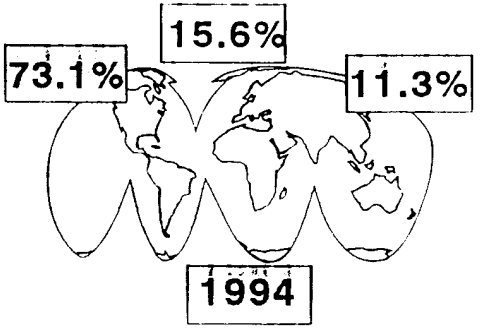
- 450,000 DECREASE IN PERSONNEL
- 40% DECREASE IN BUDGET
- 35% DECREASE IN MATERIEL BASE
- 650 INSTALLATIONS CLOSED (WORLD-WIDE)

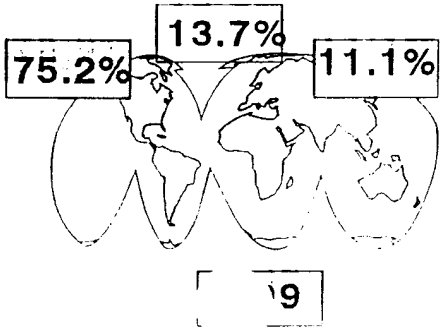
EXPANDING MISSIONS

- 125,000 SOLDIERS STATIONED OVERSEAS
- DAILY AVERAGE OF 14,000 SOLDIERS DEPLOYED IN 70 COUNTRIES
- 300% INCREASE IN OPERATIONAL DEPLOYMENTS SINCE 1990

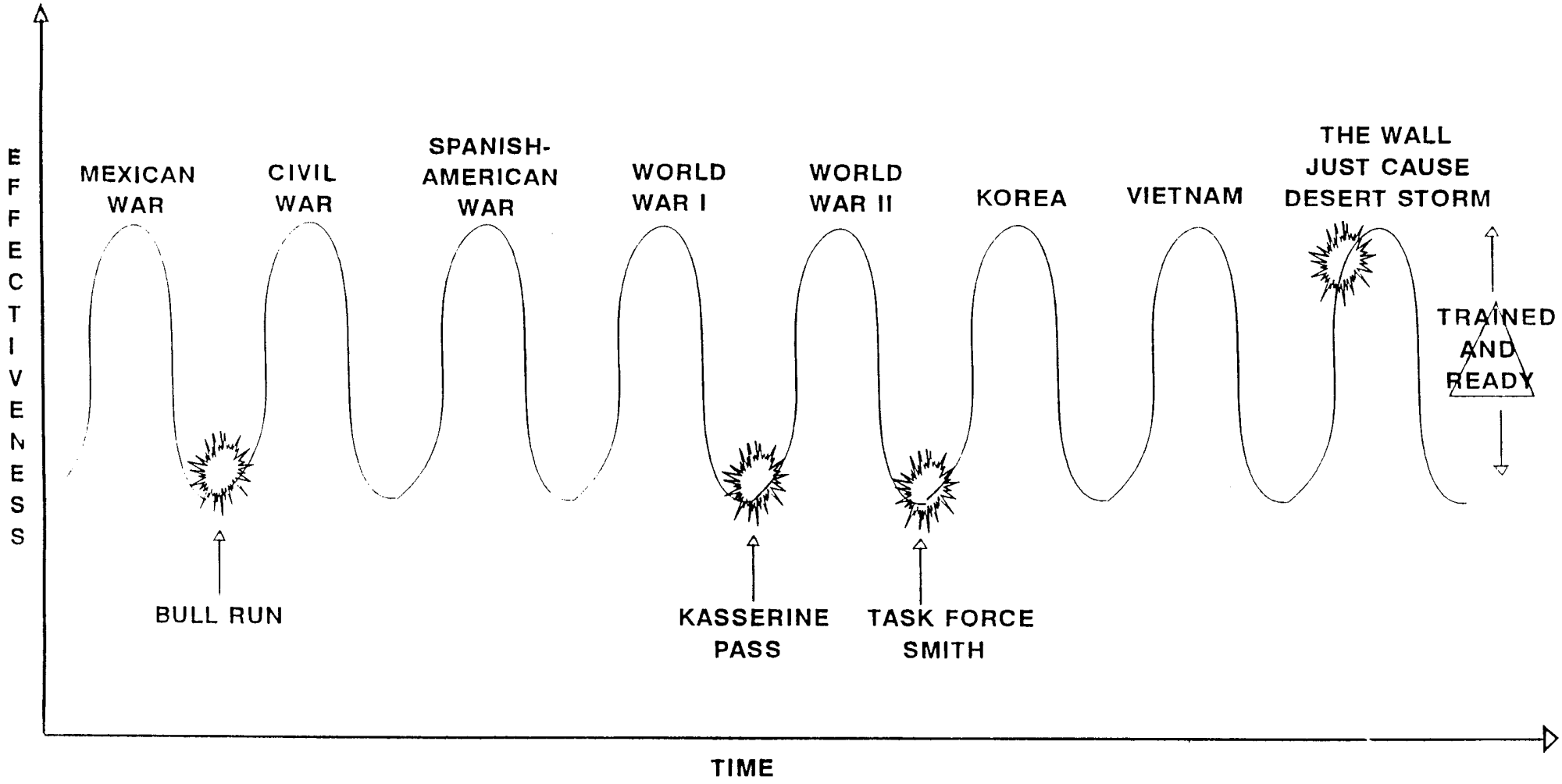
REPOSITIONING FORCES







BREAK THE MOLD



ARMY TRAINING GOALS
FOSTER INNOVATION AND GROWTH

- TRAINED AND READY
- LEVERAGE NEW TECHNOLOGY AND TRAINING
- CHANGE THE WAY WE CHANGE
  - LOUISIANA MANEUVERS
- BREAK DOWN WALLS
  - LIVE SIMULATION
  - CONSTRUCTIVE SIMULATION
  - VIRTUAL SIMULATION
- ENABLE PEOPLE TO SEE WHAT CAN BE

BE IMAGINATIVE; BE INNOVATIVE!

GEN GORDON R. SULLIVAN

CRITICAL ENVIRONMENTAL FACTORS

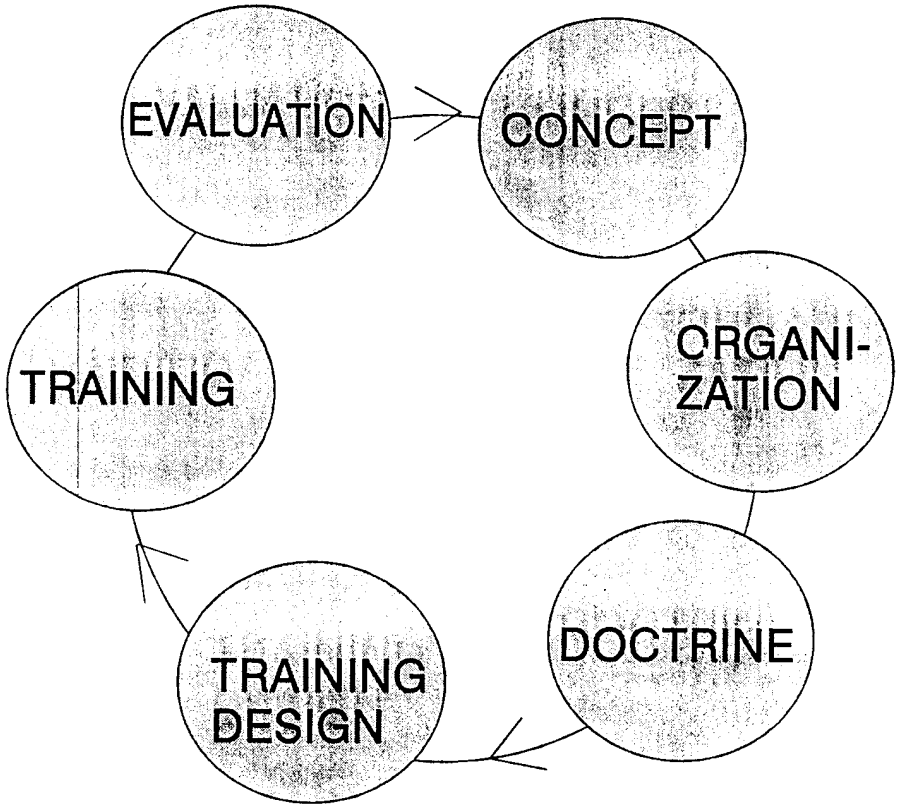
- FORCE PROJECTION PLATFORM

ORGANIC HEALTH CARE UNIT	AUGMENTATION UNIT/TEAM

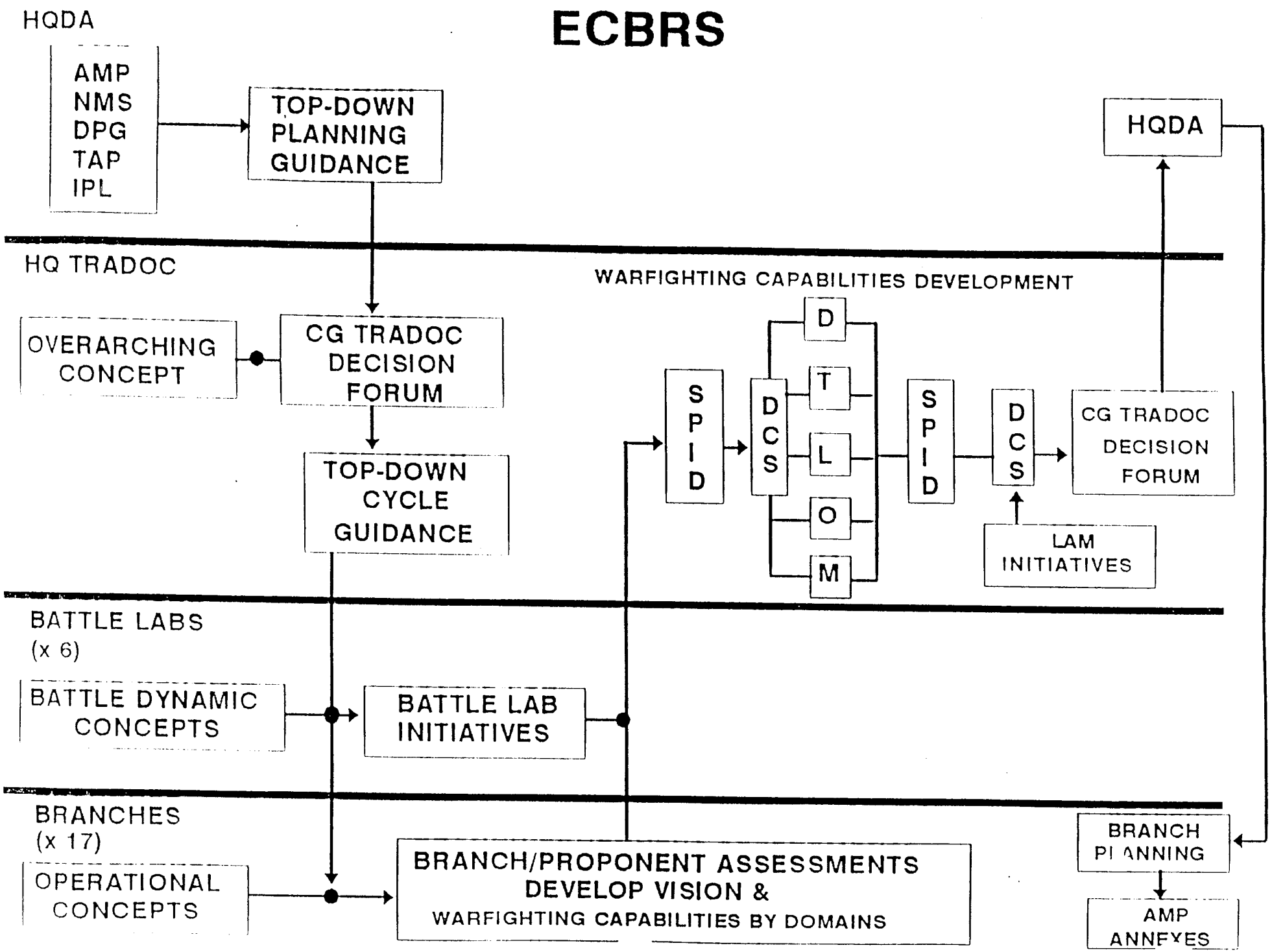
- TOE/TDA INTEGRATION
- BRANCH PROPONENCY INITIATIVES
- DOWNSIZING PRESSURE

KEY AMEDD PROCESSES

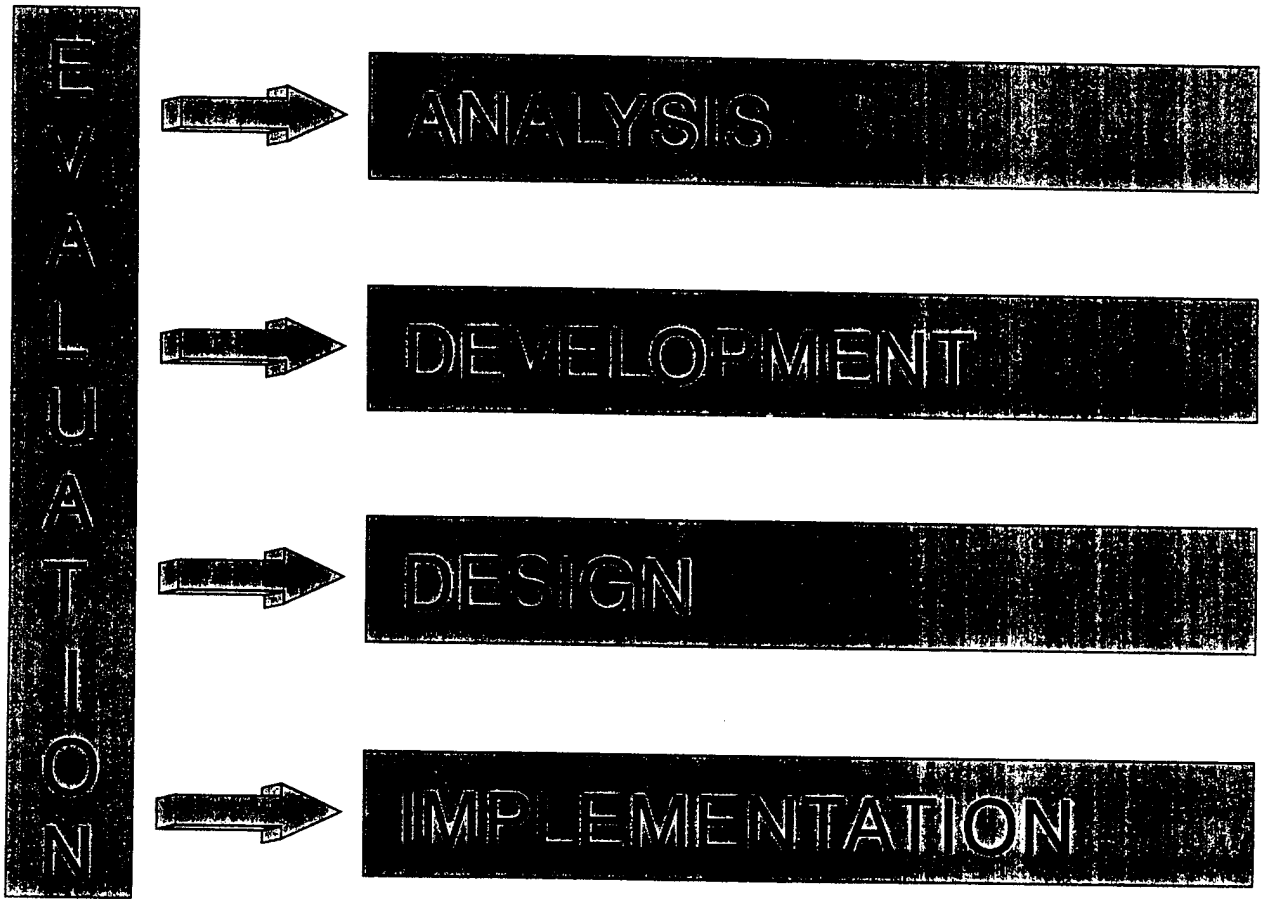
ECBRS PROCESS



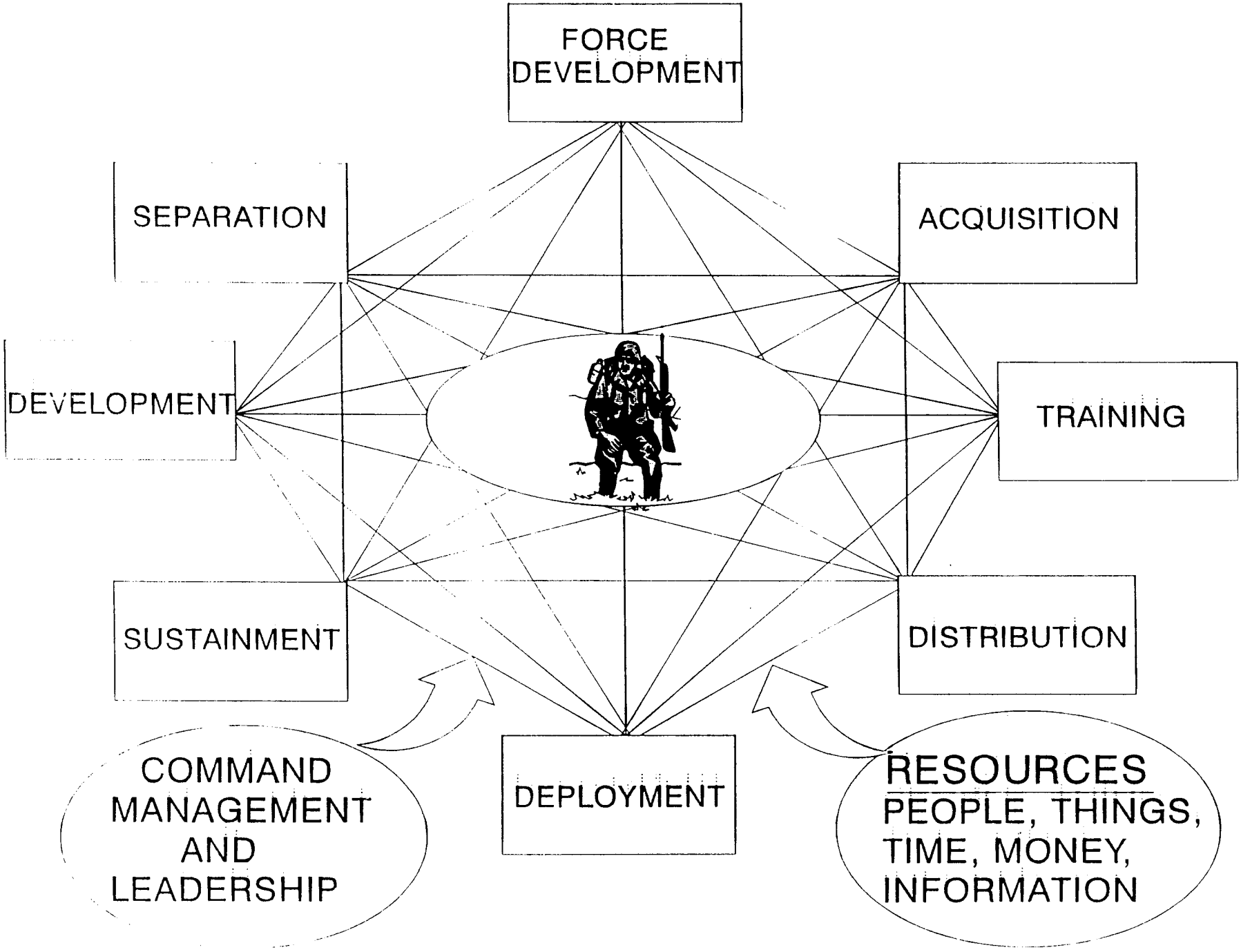
ECBRS


HQDA
AMP
NMS
DPG
TAP
IPL
TOP-DOWN PLANNING GUIDANCE
HQDA
HQ TRADOC
WARFIGHTING CAPABILITIES DEVELOPMENT
OVERARCHING CONCEPT
CG TRADOC DECISION FORUM
D
T
L
O
M
SPID
DCS
SPID
DCS
CG TRADOC DECISION FORUM
TOP-DOWN CYCLE GUIDANCE
LAM INITIATIVES
BATTLE LABS
(x 6)
BATTLE DYNAMIC CONCEPTS
BATTLE LAB INITIATIVES
BRANCHES
(x 17)
BRANCH PLANNING
OPERATIONAL CONCEPTS
BRANCH/PROPONENT ASSESSMENTS
DEVELOP VISION &
WARFIGHTING CAPABILITIES BY DOMAINS
AMP ANNEXES

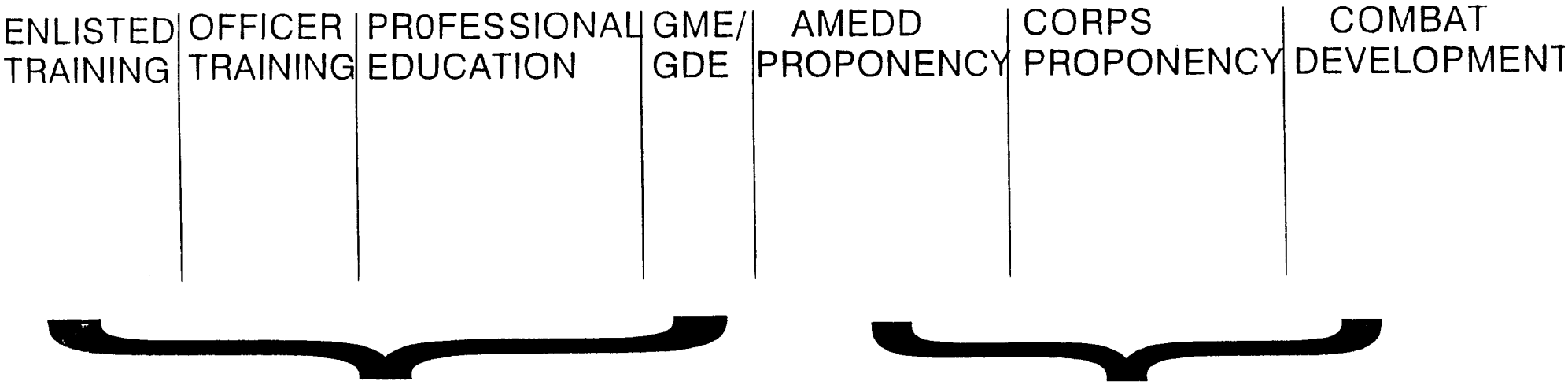
SAT PROCESS

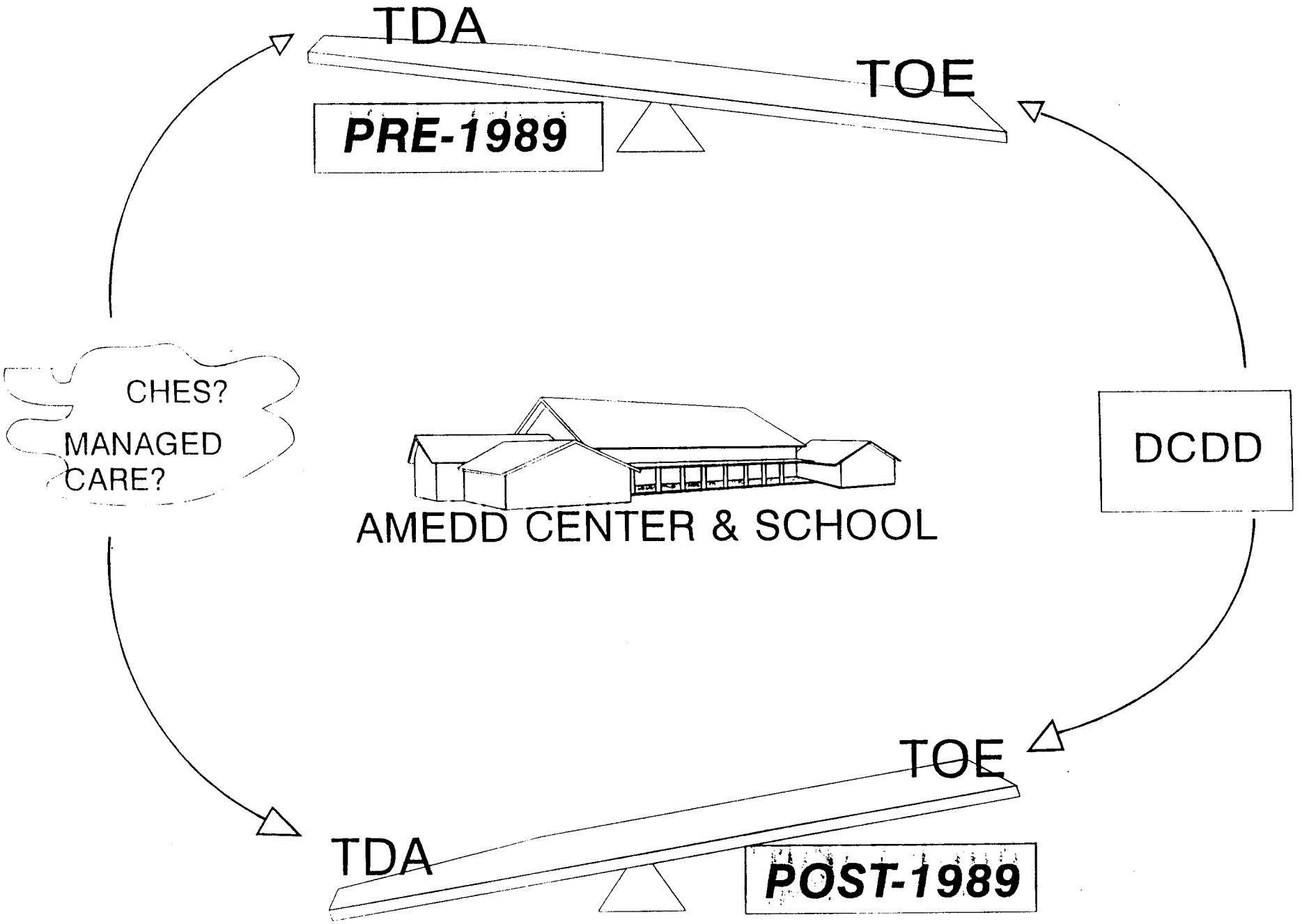


FUNCTIONAL LIFE CYCLE MODEL OF THE ARMY



AMEDD CENTER & SCHOOL
FUNCTIONAL WORK AREAS




TDA
TOE
PRE-1989
CHES?
MANAGED CARE?
AMEDD CENTER & SCHOOL
DCDD
TOE
TDA
POST-1989

TRADOC DOWNSIZING PRESSURES

- ELIMINATE 25% FUNCTIONAL COURSES
- REDUCE AIT LENGTH BY 10%
- REDUCE TRADOC HQ & FOAs BY 20%

COMMANDER'S GUIDANCE

- PROTECT THOSE WHO TEACH, TRAIN, AND WRITE DOCTRINE
- MAINTAIN AN ACCEPTABLE QUALITY OF LIFE

- COMPLETE ZERO-BASED STUDY WITHIN 60-90 DAYS
- PROVIDE PRIORITIZED DECREMENTS TO 02-95 TDA OF
  MILITARY STRENGTH: 5-10-15%
  CIVILIAN STRENGTH: 15-20-25%

TAB B

ENCLOSURE 14

AMEDD CENTER & SCHOOL CLIMATE

I. Background:

An organization's climate either reinforces desired behavior or it undermines it. The climate variable cannot be neutral. Leaders can get their people to operate enthusiastically and willingly and at their full individual capacity by creating a climate that provides the necessary underlying motivational conditions. Such conditions include challenging and meaningful work, openness and candor; fairness and justice; respecting the dignity of individuals; opportunities to participate in the work process; and competent leadership. These same conditions apply within the training environment with some obvious modifications. For example, students want to be able to devote sufficient time to their training tasks in order to master them; they want to be treated with respect and dignity in the unit environment; they want to be able to provide candid feedback without fear of reprisal; and they want a system which is both fair and just. Students do not necessarily want an easy environment, rather one that simply offers them a reasonable chance for success.

Climate is made up of many individual parts which aggregate to represent the whole. Specific variables that coalesce to form a unit climate include the policies and procedures which govern how work gets done; the manner in which soldiers are treated; the degree of congruence between the stated value system and the actual operating values (operating values are reflected in the way work is actually carried out, not how it is supposed to be done); the quality of life; the singleness of purpose within which the unit actually carries out it's primary mission.

At the AMEDD Center and School, these variables are personified in the way the training and teaching mission is actually carried out. For example, is the primary focus on developing technical competence or are other concerns allowed to override this objective? When conflicts arise between competing objectives what seem to be the overriding factors which determine a given set of priorities?

There also exists within the AMEDD Center and School a unique academic climate that is a reflection of the collective academic policies and procedures and instructor expectations regarding acceptable student behavior and corresponding performance levels. For example, sometimes instructors expect students to be far more knowledgeable than their background or work situation requires. In other words, expectations are sometimes unreasonably high. The quality and depth of training is also a contributing factor to inappropriate expectations. Sometimes training is delivered by subject matter experts or specialists in a given functional area and not the natural supervisor. The net effect of such a policy is that students often are exposed to more complex material than is necessary. In certain situations the student is actually required to know far more than is normally required of an individual at a given grade and experience level. Accreditation requirements also cause some students to be exposed to more material than the readiness requirement dictates.

II. Theme:

1. The organizational climate at the AMEDD Center and School does not routinely reinforce desired behavior and in some instances actually

undermines such behavior. Currently, there exists a basic incongruence between the command's stated values and it's operating values.

2. There appears to be some confusion regarding the true nature of the Brigade's mission; is it to support training or to focus on the soldierization process?

3. Soldiers are often caught between two conflicting sets of objectives; mastery of the knowledge and skills in their respective MOS training programs and mastery of soldierization tasks e.g., common skills training.

III. Findings:

1. Some soldiers stated that if they raised climate / environment problems with instructor personnel their drill sergeants "would come down hard on them".

2. Company commanders reported that they were glorified admin officers (e.g. PAC's).

3. Other service student personnel are not required to participate in early reveille and PT (e.g. 0430 hours) nor do they participate in weekend "extra" details.

4. The drill sergeant role is reportedly valuable in the 232d Battalion but questionable in other Brigade units.

5. Some drill sergeants reportedly spend a great deal of time in the gym once the troops have been dropped off.

6. It appears that attrition rates for some courses have risen sharply since the arrival of the drill sergeants.

7. The general consensus was that the merger between the 232d Bn and the CMSD division was working well.

8. Accountability for student training performance is diffused between the unit commander, the course director and the individual instructor.

9. Many interviewees felt that there was unnecessary duplication between the Brigade staff and the AHS support elements.

10. Several interviewees reported that they felt many instructors overteach students e.g they require higher performance levels than is absolutely necessary.

11. Accreditation requirements often contribute to a significant lengthening of courses.

12. Much instruction is taught by higher level supervisors or specialists.

13. Student survey cite a lack of sleep and an inappropriate emphasis on issues other than academics as significant training detractors:

- Inadequate study time - 43%

- Time on other issues - 34%
- Lack of sleep - 100%

IV. ISSUES:

1. Can the teaching departments and the Brigade structure be integrated in order to eliminate/reduce conflicting missions which undermine existing leadership efforts in both organizations aimed at creating an overall positive unit climate?

2. Are drill sergeants needed in the AIT portion of the AMEDD schoolhouse? If so, can their role be modified so as to put them on the platform for instruction other than CTT?

3. Can the three Surgeon's General reach agreement so that all service personnel at a given installation will adhere to that institutions command and control structure and overall work environment?

V. Discussion:

Accountability for student performance is diffused between the Brigade staff and the teaching departments. No single individual can be identified as fully accountable for all aspects of the soldiers life. As a result, no one is accountable for the final output. Such a situation confuses the soldier and often places undue hardship on him or her. For example, in many enlisted courses instructors often report that students fall asleep in class. Many students also forego lunch to sleep in the library. When confronted with this behavior, these students report that they routinely get up at 0430

hours to prepare for the training day. Surveys of students routinely identify the lack of study time as a contributing factor in their inability to master required training material. Some students reported that when they spoke to their instructors about problems occurring within the unit they were later severely chastised by their cadre for going outside the "chain of command". According to these same students, the problems were not corrected and cadre staff made it clear that future "complaints" would be dealt with harshly. On future occasions the students reported that they would live with recurring problems since the penalty for reporting them was simply too high.

Similar climate problems also exist within the academic area. For example, one course manager stated that it takes approximately three years to train a new instructor. Since that instructor (an NCO) was teaching into an AIT course, it would appear that the course director in reality required a college graduate to teach the course content. It appears that this may well be representative of a situation where overteaching is occurring. Additionally, in the officer basic course the question was posed to numerous subject matter experts on whether an ordinary Captain (Corps immaterial) could be expected to teach any or all of the subjects contained in the POI. Most lower ranking functional area specialists responded negatively to the question whereas most senior officers tended to answer in the affirmative. Again this may be another case of overteaching. Does the second lieutenant really need a PAD officer or a logistics officer to teach entry level PAD and logistics topics. While specialists may in fact be more knowledgeable, they are also prone to overteach.

As discussed previously, the current structure within the AMEDD Center and School appears to diffuse true accountability for student performance to several different individuals. The unit commander and staff are accountable for barracks life; soldierization of the student; PT; discipline and meeting a multitude of other care and feeding requirements. The teaching department chief is accountable for the academic and training performance of the student which in effect represents the primary reason why that soldier comes to the Center and School in the first place. The Dean's side of the institution approves all academic failures and recycles. When attrition rates get too high the course director is called upon to provide an explanation, not the company commander. An interesting statistic to note is the attrition rates for comparable courses pre and post the arrival of drill sergeants. For example in the lab 91 k course the attrition rate for personnel from all services was approximately the same (8%). However, after the arrival of the drill sergeants the attrition rate for Army students in this same MOS went up to nearly 20% (Navy personnel attrition rates remained at the 8% level throughout this period). While it may be difficult to draw a clear cause and effect relationship between these two events (the arrival of drill sergeants and higher attrition rates) the data would seem to suggest a relationship exists. Further, student surveys routinely identify drill sergeants as not adding value. Perhaps it is time to reexamine the necessity to use drill sergeants in AIT courses.

Finally, there appears to be a fundamental incongruence between the stated and operating values within the overall institution. The stated values are:

- respect the dignity of the individual

- provide a climate of trust and openness
- encourage success
- provide meaning and sense of purpose

In addition, the work environment is intended to build a sense of respect, loyalty and integrity within the individual soldier.

The stated values represent key design parameters intended to guide staff and faculty behavior. Loyalty, respect and integrity represent desired outcomes expected of individual soldiers. While both of these objectives are laudable; neither are supported by the existing climate within the Command. For example, when one attempts to ferret out the operationalization of the stated values a different conclusion is reached. In a survey of over 200 students the following data was obtained:

Openness and trust	- "we'll get hammored if we complain to the instructor"
Success	- 43% listed a lack of adequate study time - 34% listed time on other then academics - 100% reported a lack of sleep
Meaning and purpose	- 30% reported lack of cadre concern for soldier welfare - 30% reported lack of cadre concern for academics
Respect / dignity	- Cadre reportedly cursed soldiers - Bunks were frequently torn up

- People were intimidated and coerced -"If you don't volunteer --- I might not be there when you need it"

As is evident from the above comparison, there are some fundamental differences (either perceived or real) between the stated value system and the corresponding operating system. When these two systems get "out of synch" soldiers tend to give more credence to the operating system. Eventually, this bifurcation tends to erode the quality and health of the overall command climate. Such a phenomenon appears to be prevalent in the AMEDDC&S.

If a command wants soldiers who are committed, loyal, trustworthy, creative and innovative and operate to their full individual capacity, then that command has to provide an environment where those same soldiers are routinely treated with respect and dignity, fairness and justice, provided challenging work, given opportunities to work to their full individual capabilities, competent leadership, and opportunities to provide candid and open feedback (freedom from fear of reprisals). This is an exchange relationship. Soldiers will respond in the desired manner if they are first provided a supportive work environment. It is up to the leader at any given level to take the first step in this exchange process.

VI. Recommendations:

1. Integrate the Brigade with the teaching departments in order to clarify accountability and reduce a primary source of potential conflict.

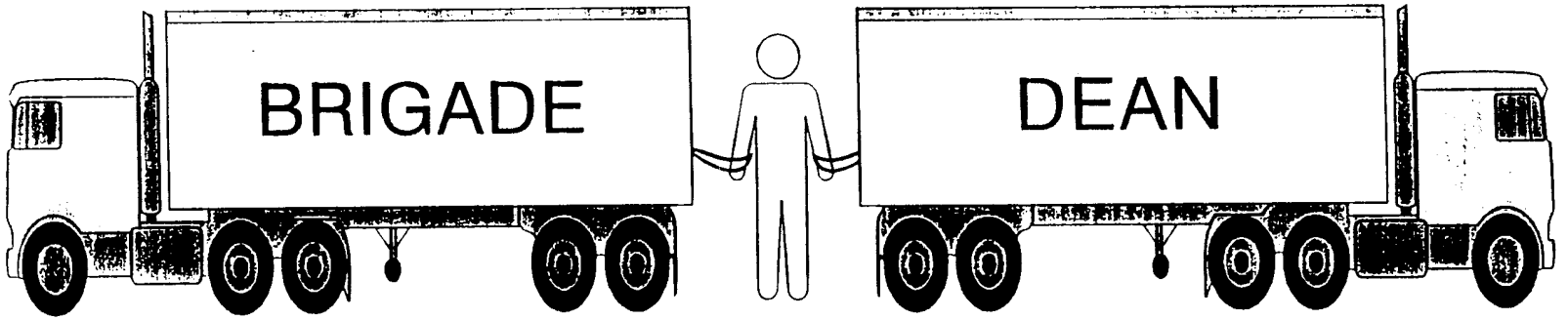
2. Dual hat the Dean/Commandant and the Brigade Commander.

3. Create a series of "new" battalions organized around the student and staffed by personnel regularly encountered in the natural work setting. Hold the battalion commander accountable for all aspects of student life including all soldierization tasks, care and feeding and academic performance.

4. Evaluate the educational requirements for each course of instruction and modify them as required.

THE STUDENT'S DILEMMA

SOLDIER SKILLS



MOS SKILLS

VALUE INCONGRUENCE

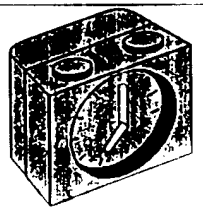
MEANING & PURPOSE

DIGNITY OF INDIVIDUAL

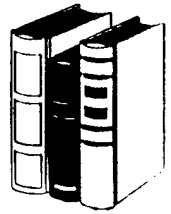
OPENNESS & CANDOR

SUCCESS

STATED VALUES



LACK OF STUDY TIME



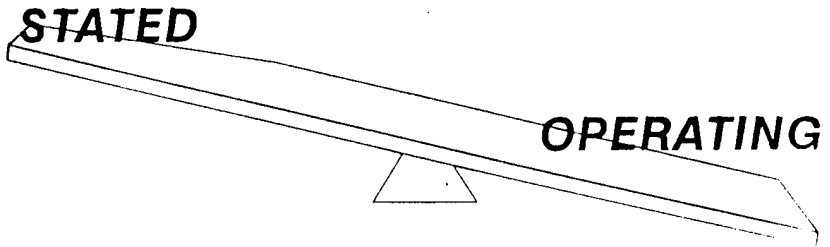
POLICIES & PROCEDURES

DEMEANING STYLE

OPERATING VALUES

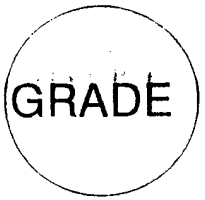
DESIRED

ACTUAL

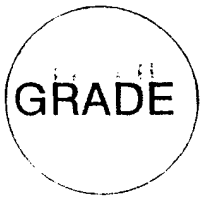


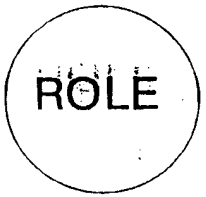
CIVILIAN PERSONNEL GRADE STRUCTURE

IV



III

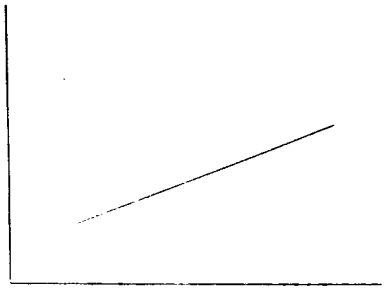




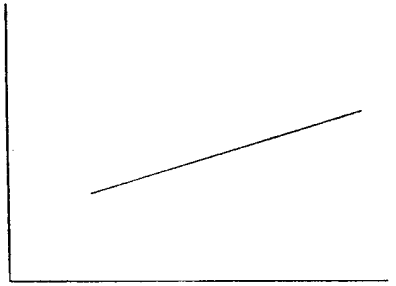
- UNDERPAID
- OVERWORKED

- OVERPAID
- UNDERWORKED

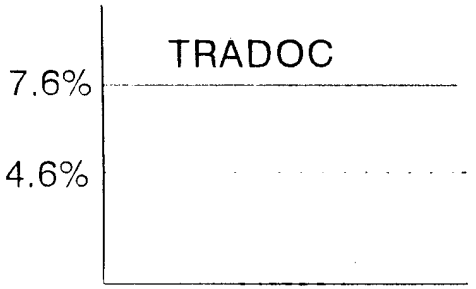
BRIGADE ACHIEVEMENTS



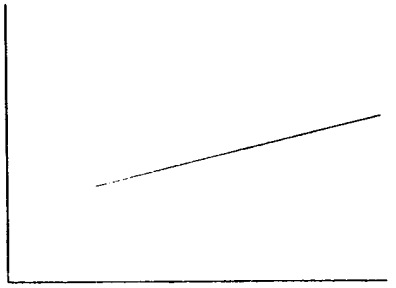
FTX COORD
& SUPPORT



PT



UCMJ



ACOE

TAB C

ENCLOSURE 14

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

COMPANY COMMANDERS

I. BACKGROUND:

Historically, Company Commanders represent a cornerstone of the Army's basic organizational structure and collectively they have been held responsible for accomplishing the institutions fundamental mission. This responsibility typically included developing training priorities, ensuring unit readiness, the care and feeding of soldiers and a host of other specified tasks. In general, the Company Commander, like leaders at all echelons, is accountable for everything the company accomplishes or fails to accomplish. Currently, Company Commanders assigned to the U. S. Army Medical Department Center and School (AMEDDC&S) appear to own only some of the above accountabilities while they share others with the instructional departments. This bifurcated responsibility has created some negative side-effects with respect to the overall quality of the unit climate within which the soldier currently functions.

II. THEME: A genuine perception exists within AHS staff and faculty that the company's focus is on soldierization, common task reinforcement, and "care and feeding", at the expense of academics.

III. FINDINGS:

A. It was reported by most respondents that all company commanders except Echo, Academy Battalion, are essentially Administrative Officers with Uniform Code of Military Justice (UCMJ)

authority.

B. Most Company Commanders within the 187th and 232nd Medical Battalions have no responsibility for course content, quality of education, or the graduation of students: their focus is on soldierization, common task reinforcement, and "The care and feeding" of soldiers.

C. Many Company Commanders reported that they spent the bulk of time performing routine administrative duties.

D. Some Commanders described their role as a "glorified house keepers, at best".

E. It was reported that commanding a company at the AMEDDC&S was not as difficult as command a "real" TOE company. In fact some comments were made that this was a good opportunity to complete advanced schooling at night because of the limited time demands.

F. Some Commanders were frustrated in their inability to focus more directly on soldiers academics.

G. Many respondents felt that the Brigade had lost sight of the real mission of the AMEDDC&S to produce fully trained medical specialists.

IV. ISSUE: What should be the role of a company commander assigned to the AMEDDC&S?

V. DISCUSSION:

The consensus opinion from the interviewees is that the current commanders are no more than personnel officers with UCMJ authority. The main training focus of all commanders within the AMEDDC&S is on soldierization, common task reinforcement, and other unspecified duties. Battalion commanders have even gone so far as to assign special projects in order to simulate

coordination efforts lost from the lack of Field Training Exercise (FTX) and Army Training Evaluation Programs (ARTEP). It has even been alledged that Officer Advance Course Students are fighting to obtain the "easy" command jobs for the opportunity to concurrently continue their educational goals.

Historically, commanders have always been responsible for everything their company did or failed to do. In accordance with TRADOC Regulation 350-6, commanders are required to find innovative ways to merge their responsibilities for training to achieve better unity of effort for training. Commanders must provide input to training developers and ensure that Advance Individual Training (AIT) graduates are proficient in their technical and common skills, as well as being responsible for soldiers welfare, discipline, physical training, and other related areas. The current structure lacks total soldier accountability for both soldierization and academics, hence the existing focus is quite understandably on what commanders are held accountable for.

VI. RECOMMENDATIONS: There is a strong need for company commanders to be subject matter experts with close professional ties to the discipline being instructed to the soldiers entrusted to their care . Two options appear possible:

A. Option 1: Redefine the role of the company commander to include the responsibility for the entire training product including both soldierization and academics. Disciplines more clinical in nature will have at a minimum a medical service officer, as the executive officer, to assist in the day to day operations of the company. Care must be taken during transition to ensure that speciality oriented officers are not set up for failure.

B. Option 2: If commanders roles are to remain in a status quo, then civilianization of the positions remains a feasible alternative, with court martial authority retained at the battalion level. Recommend that option 1 be adopted.

TAB D

ENCLOSURE 14

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL
CORPS CHIEF FUNCTIONS

I. BACKGROUND

Confusion and frustration continue to abound over the role of the Corps Chiefs in the AMEDD Center and School. Through the years, a number of plans for integration of proponency and corps chief functions in the Center and School have evolved. None of these plans have ever been fully implemented.

Today there are at least four separate "pockets" of corps chief representatives working in different areas of the Center and School. The overlap and misinterpretation of the purposes of these representatives lead to frequent disagreements within the AMEDD.

Over the years the role of the corps chief has evolved into a prestigious and powerful position, yet one that continues to be widely misunderstood. Much of the misunderstanding can be traced to a lack of clarity regarding the basic accountabilities associated with the role. Additionally, the nature of the working relationships among the corps chief role and a host of external roles has also been poorly defined, thereby adding to the confusion.

The misunderstanding over corps chief roles and responsibilities centers around the categories of proponency as outlined in AR 5-22. Most of the Army uses the four types of proponency

(branch, functional, specified, and personnel) as outlined in this regulation to perform their proponency functions. For example, the artillery school is commanded by a major general who has responsibility for all artillery corps functions. However, a colonel is responsible for branch proponent functions as they apply to day to day activities of the artillery. Other proponent functions are shared by various players. A visit to several corps chief offices in the combat service support area by COL Jackman et al found slight variances among all of them. A common thread that was found among all of them, however, was that the corps chief office acted as the integrator of branch, functional, and personnel proponency responsibilities. This integration was performed by a colonel on behalf of the senior officer in the branch.

All the AMEDD corps chiefs do not do the same work. In fact, they are very dissimilar once you consider their roles and responsibilities beyond those formally assigned in regulations and policies pertaining to branch and personnel proponency.

The AMEDD is unique in that most of the AMEDD Corps are linked to health care professions, separate from the military profession. These corps chiefs have links to the professional civilian organizations and other external forces as they affect their separate health care professions. Cultural expectations within the professional organizations, academia, private sector, and

government agencies exist that mandate a senior officer of corps specific origin be represented at the highest levels of executive management in the AMEDD.

Any changes in the way in which the AMEDD corps are managed must be structured such that the explicit and implicit responsibilities and authorities are not changed, but rather the manner in which they are executed is modified. The responsibility and authority must remain with the corps chief.

EXTANT ORGANIZATION OF CORPS CHIEFS IN THE AMEDD C&S:

As stated earlier, four "pockets" of AMEDD corps chief representatives exist within the AMEDD C&S. These groups are: the Assistant to the Corps Chiefs for Branch Proponency, the Personnel Proponent Officers in the AMEDD Personnel Proponency Directorate, the Clinical Consultants Office in the Directorate of Combat and Doctrine Development, and the corps chief representatives in the Clinical Administration Branch of the Center for Healthcare Education and Studies.

Most of the Assistants to the Corps Chiefs (ACC) for Branch Proponency are dual-hatted as teaching chiefs within the Academy of Health Sciences. AR 5-22 describes branch proponents as "the commandant or director of the respective school or institution that develops concepts, doctrine, tactics, techniques,

procedures, organization designs, materiel requirements, training programs, training support requirements, manpower requirements (except as provided in AR 600-3), education requirements, and related matters for a branch in the Army."

Although each of the ACC in the AMEDD C&S fulfill some of these roles, none described their work as outlined above. Most saw their duties as ACC as an additional responsibility related to their teaching position. The MS ACC came the closest to fulfilling the branch proponency position; however, this officer is not dual-hatted with other teaching responsibilities.

The Personnel Proponent Officers in the AMEDD Personnel Proponency Directorate represent their respective AMEDD Corps. The personnel proponent is responsible for the life cycle management of their respective corps. The personnel life cycle model consists of: structure, acquisition, individual training, distribution, unit deployment, sustainment, professional development, and separation. According to AR 5-22, the personnel proponent is the commander or chief of an organization assigned primary responsibility for providing recommendations to the Office of the DCSPER for career fields per AR 600-3. Personnel proponency has been a TSG responsibility. An initiative to change personnel proponency to the Commander, AMEDD C&S, faltered recently due to disagreement among the corps chiefs.

Because of the confusion surrounding the proponency issue (e.g., who is accountable for what component of proponency) and because TSG retains overall regulatory accountability for AMEDD functional proponency, APPD has had to develop a complicated working relationship with the corps chiefs and the AMEDD C&S. As a result, APPD often becomes involved in other areas of proponency beside personnel proponency.

The Clinical Consultants Office in the Directorate of Combat and Doctrine Development represents each of the AMEDD corps except AN, which is represented in Concepts Branch and Manpower Requirements Criteria Branch. These individuals represent corps specific interests on all matters in the combat developments arena. These officers primarily integrate actions within the TOE side of the force, however, they also report varying degrees of integration with action officers in APPD.

The corps chief representatives in the Clinical Administration Branch of the Center for Healthcare Excellence and Studies perform studies that are currently assigned directly from their respective corps chiefs. This branch presently has only two officers--one DC and AN officer.

II. THEMES:

A. There is no single integrator for all proponent functions for

the AMEDD corps.

B. The AMEDD Proponency Committee is a likely solution to many corps specific issues.

III. FINDINGS:

A. No single integrator for the various proponent functions exists within the AMEDD. Several initiatives to integrate proponency in the past have failed. Because of the uniqueness of the AMEDD, and because all AMEDD corps are different, there is understandable overlap and confusion concerning roles and responsibilities of the various proponency players.

Variation exists among the corps in the understanding of the individuals assigned to particular roles. Differences ranged from a deep and full appreciation for the role of branch proponent to having just received the job as an additional duty with virtually no understanding of the magnitude of responsibility.

B. The AMEDD Proponency Committee was approved earlier this year by TSG/CDR, MEDCOM. This committee is composed of: Commander, AMEDD C&S (chairman); the ACFI; Chief, APPD; the functional proponent from MEDCOM; the six AMEDD Corps Chiefs; a USAMRDALC representative; and representatives of the enlisted and civilian

corps. To date this committee has not met for lack of an executive coordinator or some other type of administrative structure to act as honest broker.

C. Continuing pressure to downsize the OTSG staff has resulted in the issue of the Assistant Corps Chief representatives assigned to the ARSTAF to be revisited. The consensus opinion (5 out of 6 Corps) is to assign the ACCs to the AMEDD C&S and let the respective Corps Chiefs determine staffing levels and duty location.

IV. ISSUES:

A. How can the AMEDD C&S become the center of gravity for AMEDD proponency issues?

B. How can each of the AMEDD Corps integrate all corps related proponency issues within the AMEDD C&S?

C. How can the AMEDD Proponency Committee be made a workable concept and become fully operational?

V. DISCUSSION:

A. As the center of gravity for the AMEDD has migrated to Fort Sam Houston, the logical location for AMEDD proponency

integration is the AMEDD C&S. This allows the AMEDD to function more like the rest of the Army and function more IAW AR 5-22. The intent is not to undermine the authority of the corps chiefs but rather to manage the day to day corps chief functions at the AMEDD center of gravity.

B. The ACC for Branch Proponency should be the integrators for proponency functions for their respective AMEDD Corps. These individuals are best postured to perform the true branch proponent functions as outlined in regulatory guidance. They also can best integrate the other proponency functions for their respective corps chiefs.

As the hub of corps chief activity, the ACC should assist the corps chief in the fulfillment of their responsibilities, manage the day to day and mid-term planning for the corps chiefs, and prepare the corps chiefs for policy decision making and long term corps planning and leadership functions. This concept represents an extreme paradigm shift for much of the AMEDD.

To implement this radical shift in responsibilities, the positions of ACC would necessarily become full time positions and not additional duties. This concept also allows for officers in APPD to perform the personnel proponency functions without much of the overlap currently experienced.

C. Recognizing that corps chief issues had to be better integrated, TSG approved the AMEDD Proponency Committee earlier this year. To date this committee has not met, reportedly because the committee lacked the administrative structure to facilitate meetings. Specifically, the committee reportedly lacks an executive coordinator who could act as honest broker.

The value-added of this committee is two-fold. First, corps chief and proponency issues facing the AMEDD could be dealt with from a corporate perspective. Secondly, this committee and the ACC can act as a system of checks and balances to each other.

VI. RECOMMENDATIONS:

A. Move the center of gravity for AMEDD proponency to the AMEDD C&S.

B. Empower the Assistant to the Corps Chiefs as true branch proponents, acting as integrator of all proponent functions within the AMEDD.

C. Fully implement the AMEDD Proponency Committee as approved by TSG.

AMEDD CENTER OF GRAVITY

CORPS CHIEF'S REPRESENTATIVES

CORPS CHIEF'S OFFICE

??????

APPD

COMBAT DEVELOPMENT

AHS TEACHING DEPARTMENTS

TAB E

ENCLOSURE 14

U.S. MEDICAL DEPARTMENT CENTER & SCHOOL

LOCATIONS FOR GME, GDE & CHE

I. BACKGROUND

The GME and GDE processes constitute the final phase in schooling for the Medical Corps (MC) and Dental Corps (DC) professional training experience. The centralized GME and GDE activities, presently operating at OTSG, provide oversight for existing internship, residency, and fellowship programs required for completion of basic qualification standards or advancement to specialist status. The actual GME and GDE programs are executed in the field at medical or dental treatment facilities.

The AMEDD has a long and proud history of accomplishment in GME and GDE that compares very favorably with any other Service or civilian program. AMEDD GME and GDE programs are accorded much credit for the recruitment and retention of high quality providers. Many MC and DC officers join the AMEDD because they seek additional training and higher level credentials. Retention statistics show that the AMEDD retains those individuals "grown" better than those who come in already qualified. The GME and GDE administrative staffs at OTSG manage the complex correspondence with a myriad of state and national accrediting bodies required to ensure that the AMEDD meets or exceeds stringent accrediting requirements deemed essential for preparing and maintaining high quality providers. Continuing Health Education (CHE) can be considered both as an

extension of, and as separate from, GME & GDE. CHE refers to a variety of health care focused educational programs offered to several categories of health care professionals for the purpose of assisting them in maintaining licensure. While GME and GDE pertain to physicians and dentists specifically, CHE programs also include nurses, physical and occupational therapists, dietitians, physicians assistants, other ancillary professionals, and some paraprofessionals. All clinical AMEDD officers are required by their respective corps to participate in CHE to ensure current professional proficiency. Each of the AMEDD Corps' requirements generally exceed civilian accrediting/licensure requirements.

II. THEME

GME, GDE, and CHE all need to be integrated into a comprehensive and progressive, long range strategy to support all clinically focused health care professionals in each of the AMEDD Corps. This integration should occur under the auspices of the branch proponent strategy office contained within the AMEDDC&S.

III. FINDINGS

1. The offices that manage the AMEDD's GME and GDE programs are expected to move during FY95 to San Antonio from the Health Professional Support Activity in Washington, DC.

2. There is some support within the AMEDD to position GME and GDE in the MEDCOM Clinical Operations Directorate because of the strategic and political visibility of these programs.

3. CHE is a function that is widely distributed between AMEDDC&S, each corps' continuing education cells at OTSG, and at the medical and dental treatment facilities.

4. The CHE coordinating cell at OTSG is scheduled to move to San Antonio during FY95.

5. The offices of the AMEDD Corps Chiefs are relocating to the AMEDDC&S where they will consolidate with branch proponency offices. GME and GDE are premier issues for MC and DC branch proponency. CHE is a proponency issue for all clinical providers of all corps.

IV. ISSUE

Where is the optimal site for GME, GDE and CHE as part of the ongoing reorganization of OTSG, the MEDCOM headquarters, and the AMEDDC&S in order to best serve the entire AMEDD?

V. DISCUSSION

A primary goal of the reorganizational effort at the AMEDDC&S is to legitimize the institution as the AMEDD's operational center of health care education and training. An underlying objective inherent in this mission is to encourage the staff and faculty to apply a complete range of advanced technology initiatives in order to constantly push the education and training envelope. Only through the application of advanced training technologies will the AMEDD be able to meet the vast array of training missions and

challenges in an environment of rapidly dwindling resources. For example, it is anticipated that the AMEDDC&S will function as a projection platform from which all manner of education and training programs, including GME, GDE and CHE are distributed throughout the AMEDD.

It is clearly recognized that GME and GDE represent seminal programs within the AMEDD, each of which has a profound impact on the day-to-day delivery of health and dental care throughout the command. Aligning these programs with the AMEDDC&S is not intended to denigrate their importance. Rather, this alignment has been proposed to complement and undergird the role of the Corps proponent. In a separate recommendation, it has been proposed that a key accountability of the corps proponent is that they develop long-range strategy for each of their corps. This strategy should be congruent with future warfighting concepts and doctrine and reflected in the training base in a timely manner. The approval authority for the corp strategy is the respective Corps Chief irrespective of where the Chief happens to be assigned.

GME and GDE are critical elements to any MC/DC Corps strategy. The impact of these crucial programs must be integrated into the very essence of the corps. They must be reflected in the life cycle personnel model and be updated and modified as warfighting requirements change. Since the proponent for each of the these elements is to be realigned under the AMEDDC&C (e.g., Personnel Proponent-APPD ; Branch proponent-Corps Chief Representative;

Functional Proponency-AMEDDC&S Commandant on behalf of the MEDCOM Commander/TSG, it also makes sense to align the GME/GDE programs under the same institution.

The likely basis of the argument mitigating such an alignment is threefold. First, since the GME/GDE programs apply across the AMEDD, they are strategic in nature and hence should belong to the MEDCOM headquarters. The programs themselves, however, are operational in nature and apply across the spectrum of the MEDCOM's major subordinate commands. This operational span is similar to a number of other programs for which the AMEDDC&S is accountable, e.g., all MOS training programs, officer training courses, the combat development process, APPD's life cycle management, CHES' research, etc.

The second argument is that because GME and GDE are so important, they need the visibility of the MEDCOM headquarters and should not be perceived as buried under a subordinate command. Again, it is felt that this is a spurious argument. GME/GDE will work directly with the Corps Proponent who is directly under the watchful eye of the Corps Chief. Additionally, the AMEDDC&S is collocated with the MEDCOM and a customer of the HSSA/DSSA commander under whose auspices the programs are carried out.

Finally, the argument will be offered that GME/GDE programs involve serious policy decisions. Again, one of the fundamental design premises of the new, requisite AMEDD is that policy input will be

obtained in a seamless manner from a unified but distributed staff. For all of these reasons, it is proposed that GME/GDE be aligned under the AMEDDC&S.

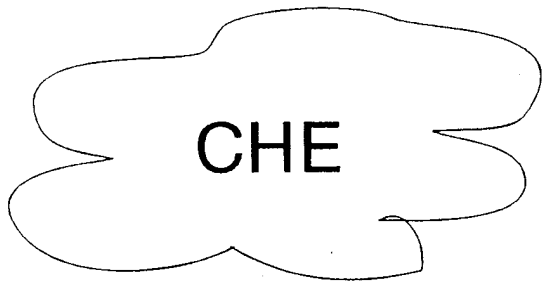
VI. RECOMMENDATIONS

1. Locate GME, GDE and CHE at the AMEDDC&S. The near simultaneous migration of GME, GDE and CHE to San Antonio provides a timely opportunity for consolidating in the AMEDDC&S. These activities are collectively responsible for ensuring AMEDD clinical providers continue to advance their credentials.

2. Exploit synergies between GME, GDE, CHE and branch proponency. There will be consider benefit from consolidating GME, GDE, and CHE with branch proponent personnel. This alignment would enhance each corps' life cycle modeling functions. Collocation with APPD would likewise produce synergies with the force planning requirements of each corps.

3. Explore projection capabilities of CHE from the AMEDDC&S. The AMEDDC&S could serve as a clearinghouse for courses developed and delivered anywhere throughout the MEDCOM. Teleconferencing and teleteaching promises better exportability from or to all of our MTFs. The CHE education and training cell, relocated to AMEDDC&S, is involved in command-wide coordination of all CHE.


GME/GDE


CHE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TAB F

ENCLOSURE 14

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DEPARTMENT OF TRAINING DEVELOPMENT

I. BACKGROUND:

Directorates of Training Development were organized in the Training and Doctrine Command (TRADOC) in the mid-1970s in response to a demand for greater rigor and organization in approaches to training and training development. In 1980, LieutenantGeneral Pixley, the Surgeon General, mandated the Army Medical Department (AMEDD) to implement a Directorate of Training Development (DOTD) similar to those in TRADOC. To staff DOTD, positions were initially taken from various resources including the Medical Field Service School (MFSS), reduction in force (RIF) personnel from local San Antonio Air Force bases, and from excess personnel made available by the partial closure of Gorgas Army Hospital.

Prior to the formation of DOTD, individual training was designed throughout the TRADOC community by instructors and course directors who often interposed their own personal agendas into existing training programs. No systematic approach to training design existed and the concept of designing training around job related critical tasks was an unknown concept throughout the training community. Documentation on training content was sketchy with most documentation maintained solely by the individual instructor teaching a given course.

To further fix accountability and systemize training development throughout the Department of Defense (DoD), Congress mandated an organized approach to training be

developed. The Instructional Systems Design (ISD), the precursor to the current Systems Approach to Training (SAT), was developed by TRADOC with experts from Florida State University. The ISD process evolved into the SAT process which was a more streamlined and understandable method of training development but was resource intensive and time consuming.

The analysis, design, and development phases of the SAT process are used by ITD to develop/ format POIs and ITPs. The SAT process characterized as supporting uniformity of military training needs, allowing for efficient revisions and improvements of both existing training and new courses, and ensuring that training programs and support materials are developed to match the doctrine, equipment, and organizational needs. SAT processes include analysis (to include Job Task Analysis Worksheets (JTAWS)), design, development, implementation and evaluation. The SAT process is very time intensive and TRADOC has recommended a more efficient process (Encl 1).

Previously, the Directorate of Training Development at the AMEDDC&S was organized into three divisions: Individual Training Division (ITD), Training Literature Division (TLD), and Unit Training Division. The ITD included the Enlisted Training Development Branch, Officer Training Development Branch, Training Operations Branch (to include functional course development and design), Distributed Training Branch and Training Technologies Branch. The Training Literature Division was comprised of the Training Literature Branch and Performance Measurement Branch. The Unit Training Division included the Army Training and Evaluation Program (ARTEP) Branch, Force Modernization Training (FMT) Branch, Exercise Branch, New Organization Training

(NOT) Branch, and Deployable Medical Systems and Equipment Training (DMSET) Branch.

Based upon the findings and recommendations of the 1993 TFA Study, coupled with the AMEDDC&S command group's own internal analysis, DOTD was moved from the ACFI to the Academy of Health Sciences (AHS) in FY94. Subsequent to that organizational realignment, two process action teams (PATs) were created to study how best to integrate DOTD assets into the existing teaching departmental organizational structure. As result of those two process action teams (PATs), DOTD functions were merged into the AHS training departments, Department of Academic Support, IMD, and the 232d Medical Battalion (Encl 2). Presently, the only functions remaining in DOTD are management and administration, Unit Training Branch, Distributive Training Section and Soldier Manuals/ STD writers/ ISSs.

II. THEMES:

A. Some of the remaining work related activities of DTD are perceived to be "non-value added" or need to be further consolidated into AHS and DCDD. It is perceived that consolidation could result in a more efficient process that will save additional manpower and eliminate duplication of efforts.

B. A common perception is that personnel remaining in DOTD focus more on unit training and RC functions, than on institutional training and individual functions.

III. FINDINGS:

A. AHS staff feel that bringing individual training development into the teaching divisions has yielded savings and gives synergy to the efforts of training students (RC/AC).

B. The initial realignment of instructional systems specialists (ISSs) into teaching departments is transitioning rather smoothly and is eliminating previously existing communication problems.

C. It is perceived that Division Chiefs are now becoming more involved in the development of training and equipment needs to include involvement in the Enhanced Concept Based Requirements System (ECBRS), RC and skill sustainment training.

D. Teaching staff uniformly feel that they know the needs of their students and are in a better position to develop training materials (lesson plans, POIs, correspondence courses, distributed training packages and soldier manuals) based on these student needs. The assignment of ISSs and other DOTD resources to teaching departments has provided "value-added" support to the AMEDD soldier and the AMEDD field mission.

E. The mission of the Distributive Training Section is not clearly understood by everyone outside of DTD. It is perceived that much of the work in DTS is " non-value added" and consists of xeroxing mimeos, lesson plans and formatting these as exportable training packages to AC and RC soldiers.

F. The new training integration support cell within AHS has the opportunity to facilitate the standardization of vertical and horizontal integration of training development inside and outside the Academy of Health Sciences, i.e., with DCDD, APPD and any

other Army agencies, such as, CASCOM, TRADOC, ATSC.

G. Personnel from teaching departments and DTD acknowledged that the process for approval of training materials and course changes are time consuming due to continued layers of bureaucracy at the AMEDDC&S. Most people interviewed feel that the course directors and/or the program directors should have more authority to make decisions with regard to students and academic areas. Presently, directors have to get the Commandant's or CG signature to get matters finalized.

H. There are individuals within the Department of Training Development who feel that the functions of Unit Training Branch would be more efficiently aligned under DCDD because their daily and critical mission interface is with other branches already aligned under DCDD.

I. The coordination and linkage of the FAST 21 initiative, now managed by DTD, should be more closely linked with the Office of the Commandant and RC Advisors Office. The accreditation of all Reserve Component institutional training is the responsibility of the Evaluation and Standardization Branch, ASD, AHS.

J. Mission Training Plans (MTPs) developed by the ARTEP Section are dependent upon an approved operational concept, an approved TOE, and doctrinal literature published by DCDD. Presently, the MTP is developed in a parallel process with the doctrinal manual within the Doctrine Literature Division, DCDD. This parallel processing allows for MTPs to get to TOE units in conjunction with or before the AMEDD doctrinal manual for that specific type unit. This is a time savings of 18-24 months.

IV. ISSUES:

A. Can the AHS maintain high quality training and training development and move the AMEDDC&S toward a world class center of training excellence if remaining DTD assets and responsibilities are consolidated with AHS, and DCDD?

B. Can the remainder of DTD training functions be realigned to AHS without compromising the integrity of training products?

C. Will the alignment of unit training functions with DCDD be a more effective process without compromising training development and result in better quality products?

D. Can the RC Liaison Advisors' authorizations in DTD be realigned to the RC Advisors Office of the Special Staff, so the RC Advisors Office can become the focal point for RC training integration?

E. Can the Reserve Component training development requirement be effectively conducted by training departments and the accreditation of RCTIs/ FAST 21 be accomplished by Evaluation and Standardization Branch (ESB), DAS with existing resources?

F. Is the SAT process the most effective and efficient way to develop training, and can we afford the resource requirements?

V. DISCUSSION:

As the AMEDDC&S continues to adapt to shrinking resources and growing demands, the effective provisioning of quality training programs and supporting training development efforts becomes paramount. The current structure and processes of DTD and the ongoing

interface which DTD has with the teaching divisions is not perceived by AHS teaching staff as meeting the needs of the teaching departments.

The remaining individual training functions of DTD appear to "fit" more effectively into the existing teaching divisions of AHS, while the unit training functions realign well into the DCDD. If such a realignment were to occur, Department Chiefs would be required to become more involved with their respective subject matter material and each department staff would benefit from having training developers/ information systems specialists (ISSs) within each department and/or teaching branch. It can be argued, however, that there are not enough existing ISSs to properly service the 30 Military Occupational Specialty (MOS) courses currently being supported. Many MOS producing courses are being incorporated into the Combat Medical Specialist (91B) course for initial entry training and the old MOSs are becoming additional skill identifiers (ASIs) to MOS 91B for these special skills' requirements. However, there will still be a requirement to develop and maintain POIs for these ASI producing courses.

To ensure that the integrity of training and training development is not compromised by teaching departments, a training integration office has been established under the Commandant's purview to oversee the integration of training and training development products within AHS and provide the necessary vertical and horizontal integration linkage with outside agencies, such as, CASCOM, TRADOC, CAC and ATSC.

VI. RECOMMENDATIONS:

A. Move the remaining Project Management Office (PMO) functions and personnel to

DCDD Lessons Learned to coordinate horizontal training development integration missions with AHS and DCDD, or consider for savings.

B. Place any remaining ISSs from DTS into MOS/ AOC producing courses to enhance training development within the teaching departments, or consider for savings.

C. Move the remaining ISSs responsible for Self- Development, Soldiers Manual and training literature format functions into a format/ product standardization section within the AHS. This element could ensure oversight of programs within teaching departments for vertical integration with TRADOC.

D. Continue to use the Evaluation and Standardiation Branch, DAS as TRADOC certified evaluator to conduct RCTI and FAST 21 accreditation mission and distribute DTD FAST resources to training departments, or consider as savings .

E. Office of the Commandant should be the central point of contact for FAST 21/ Total Army Schools initiatives.

F. Move the ARTEP Section to Doctrine Literature Division,DCDD. This will allow maximum utilization of resources to task organize and streamline the development of MTPs and doctrinal literature, and look at some savings due to alignment under Doctrine Literature Division.

G. Move the FMT Section to Materiel and Logistical Systems Division, DCDD, and look at some cost savings.

H. Move the NOT Section to Organization and Personnel Systems Division, DCDD.

I. Streamline the process of developing courses and revising curriculums to meet the needs of changes in specialties (MOSs) in a more timely manner than occurs

now (Encl 1).

J. Review the training materials approval process and if feasible, delegate the approval authority to the course and/or program directors, with DAS as an oversight agency/ monitor for the Commandant, AHS.

K. Eliminate all remaining department and branch headquarters functions for savings.

L. Move all DTD functions and personnel out of Building 4011 to recommended alignments within the ACFI and AHS, or consider for savings.

I-1-4. Guidelines: TD Efficiencies

Efficiencies

TD should be efficient. Some phases and functions can be performed simultaneously; and a few well-trained TDers and SME can execute an efficient, effective, and timely process. See options in the following table:

Phases	Efficiencies
Entire TD Process	• Develop training *only* when identified by needs analysis or training design as a valid requirement. • Redesign/revise existing products when possible. • Set up a ***dedicated team***: -- Compose team of appropriate AC and RC SME(s) and at least one Instructional System Specialist. Bring in safety, visual info specialist, and evaluation personnel as necessary -- Train team members in the TD process. -- Keep the **same** team throughout the development process. *Note:* A dedicated team that is in a "closed room" working without interruptions can design/redesign/revise/develop an entire course from analysis to implementation much more efficiently than TDers working in various divisions doing various jobs. • Revise/Update analysis, design, and development data when possible instead of going through the complete analysis, design, and development processes. • Give TD Model overview training to all TD proponent manage-ment, from the commandant / assistant commandant down. • Give all individuals doing TD work TD Model overview training and indepth process/product training as needed in job. • Use the workload management database (currently TD Workload Planner [TDWP]) to plan and prioritize workload and assist in personnel mgt.
Analysis	• Use team input instead of developing intensive field or AOSP surveys for job analysis and critical task selection. *Note:* Need adequate number and appropriate skill level of SME to ensure valid critical task selection and training content. • Automate: Develop task analysis database that can be printed in report formats, such as STP, and be accessed for design and dev. • MOS consolidation or equipment updates: use existing analysis data and crosswalk tasks to determine critical task additions, deletions, and modifications.
Design	• Redesign existing training products when possible. • Perform concurrently with course development when possible. • Common AC/RC Courses: Revisit long and short-range training strategie for each MOS/AOC/etc. skill level. If needed, develop a Career Development Model which shows where and how each task is trained: -- Eliminate duplicative training. -- Perform another media/method/site selection on selected tasks to determine effective and cost efficient media. -- Use the same media for both AC and RC if possible.
Develop-ment	• Develop related products simultaneously, sharing information from analysis and design databases or word processing program files
Evalua-tion	• Lend assistance to / participate with the team or individuals performing to ensure quality product development. *Note:* This approach should reduce [illegible]

HSMC-ZD-S (25) 6 July 1994

MEMORANDUM FOR HSMC-ZS

SUBJECT: After Action Report for Instructional Systems Specialist Process Action Team (PAT)

1. PURPOSE. The PAT convened 20 June 1994 through 1 July 1994 to examine the support that instructional systems specialists (ISS) provide to the individual training development process and their responsibilities for integrating doctrinal concepts into individual training. The team was tasked to make recommendations to improve the quality of the AMEDD individual training development process.

2. CONCEPTUAL FRAMEWORK. Success of the PAT required that the process be examined from three perspectives. First, the team examined the process to determine how individual training development is conducted. Second, they examined the culture in which the processes are performed. Finally, they examined the strategic alignment of the processes with the mission of the organization. Only by understanding each of these three perspectives could the team make sound recommendations (TAB A).

3. TEAM MEMBERS. The team members represented all aspects of the training development process to include training developers, program directors and evaluators within the Academy of Health Sciences (TAB B).

4. CHARTER.

a. Define the current role of the ISS.

b. Describe how the current system works.

c. Describe benefits and problems with the current process.

d. Propose a system which would improve the quality of our individual training development effort.

e. Identify the criteria for evaluating alternatives.

f. Identify specific actions.

Encl 2

5. METHODOLOGY.

a. Reviewed the Systems Approach to Training process to ensure a common level of understanding among team members.

b. Discussed the flow of the current training development and staffing processes.

c. Defined the current role of the ISS in the individual training development process (TAB C).

d. Interviewed key personnel internal and external to the Directorate of Training Development (DTD) to gain an overall perspective of the issues involved.

e. Discussed and analyzed interview responses to identify common themes.

f. Developed alternatives and recommended preferred option.

g. Identified specific actions to implement the recommended alternative.

6. FINDINGS.

a. Role of the ISS is not clearly communicated to all users of the training development process.

b. Document development and staffing is hindered by multiple layers of supervision (TAB D).

c. No formal mechanism exists to ensure that training products are integrated and synchronized for resident, non-resident and unit training. An example of the integrated process is provided at TAB E. However, since the process flow is sometimes out of sync, training products do not always align.

d. Benefits of the existing system are at TAB F.

e. The training development process, employee morale and DTD leadership were identified as problems within the current system (TAB G).

7. ALTERNATIVES. In-depth discussion of the findings led to three alternatives (TAB H):

a. Alternative 1: Status Quo - does not solve any of the problems associated with the current system.

b. Alternative 2: Reorganize System from within DTD - has merit but does not adequately address the process, cultural and alignment issues.

c. Alternative 3: Paradigm Shift: Realign assets and consolidate proponent responsibilities - this alternative addresses process, culture and alignment issues. It clearly delineates command and control of and responsibility and accountability for the training development process.

(1) The proposed organizational diagram with reporting relationships is at TAB I.

(2) The proposed functions of the ISS within the Office of the Dean are at TAB J.

8. RECOMMENDATION. Adopt Alternative 3.

a. Place command and control for training development at the Office of the Dean.

b. Assign course director as proponent for all resident and non-resident training and training development for all components.

c. The value added of this option is provided at TAB K.

9. RECOMMENDATIONS FOR IMPLEMENTATION.

a. Establish and maintain workable processes which would allow for integration of the training development process into the total AMEDD mission.

b. Establish an implementation team that includes adequate representation from DTD, Office of the Dean, Course Directors, union and civilian personnel offices. Include members from the process action team on the implementation team to ensure continuity of process and to provide rationale for recommendations.

c. Develop a marketing strategy for the training development process.

d. Develop a staff and faculty training program to orient and sustain skills and knowledges required by department chiefs, course and program directors, ISSs, and other personnel involved with the training development process. Senior ISSs and Chief, Staff and Faculty Development Branch should coordinate and oversee the development.

e. Develop a monitoring program to ensure this new program is nurtured and progressing as it should be.

f. Link quality outcomes to performance appraisals at all levels.

g. Ensure the principles of TQM are an integral part of the implementation plan.

h. Forward recommendations to the Clement team.

i. Establish a support system to assist personnel during the transition period.

j. Evaluate the efficiency/effectiveness of the revised structure a year after implementation.

10. RECOMMENDATIONS FOR FURTHER STUDY.

a. Examine the remaining DTD structure to determine how individual elements can be integrated to maximize AMEDD mission accomplishment.

b. Incorporate ISS support for organizations like USAMEOS, USASAM and JMRTC with related teaching departments.

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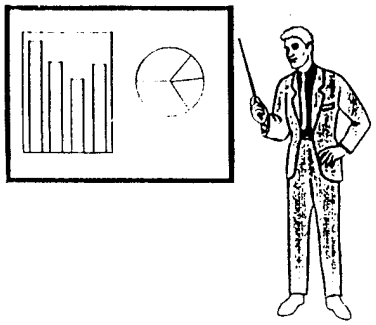
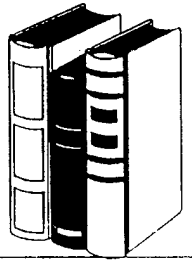
JAMES DEAN FAIRLESS
LTC, MS
Chairperson

TRAINING DEVELOPMENT



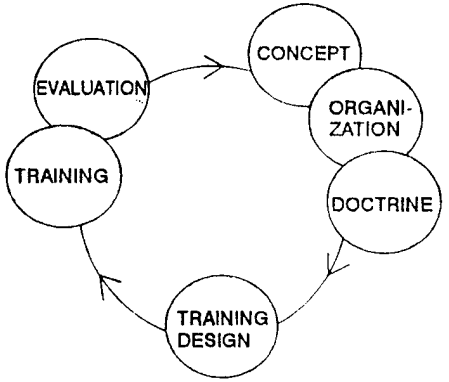
1960's

INSTRUCTOR DRIVEN



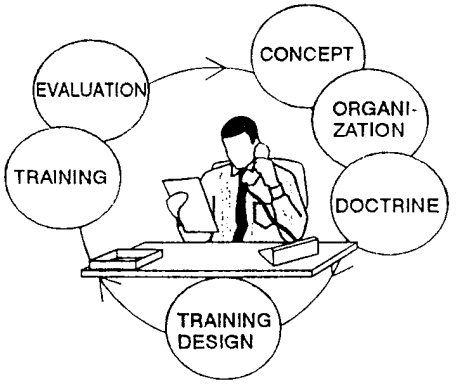
1970's

TASK DRIVEN



1980-1994

SYSTEMS DRIVEN

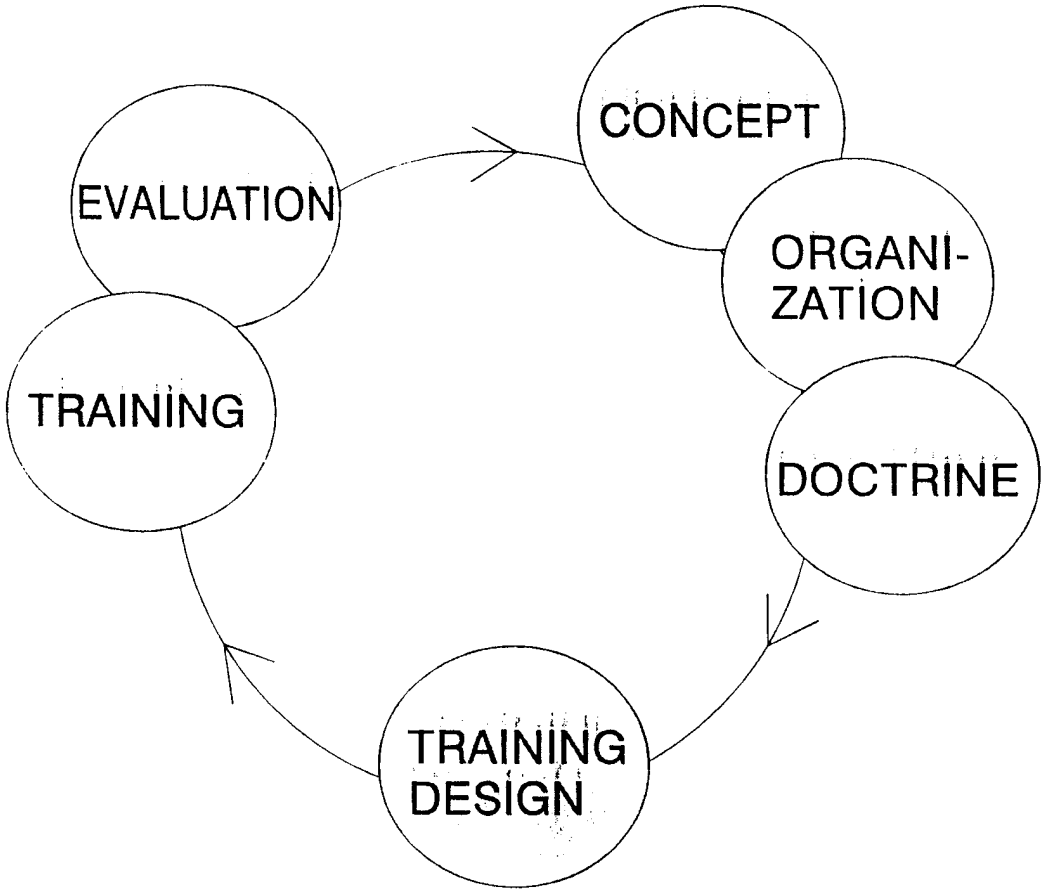


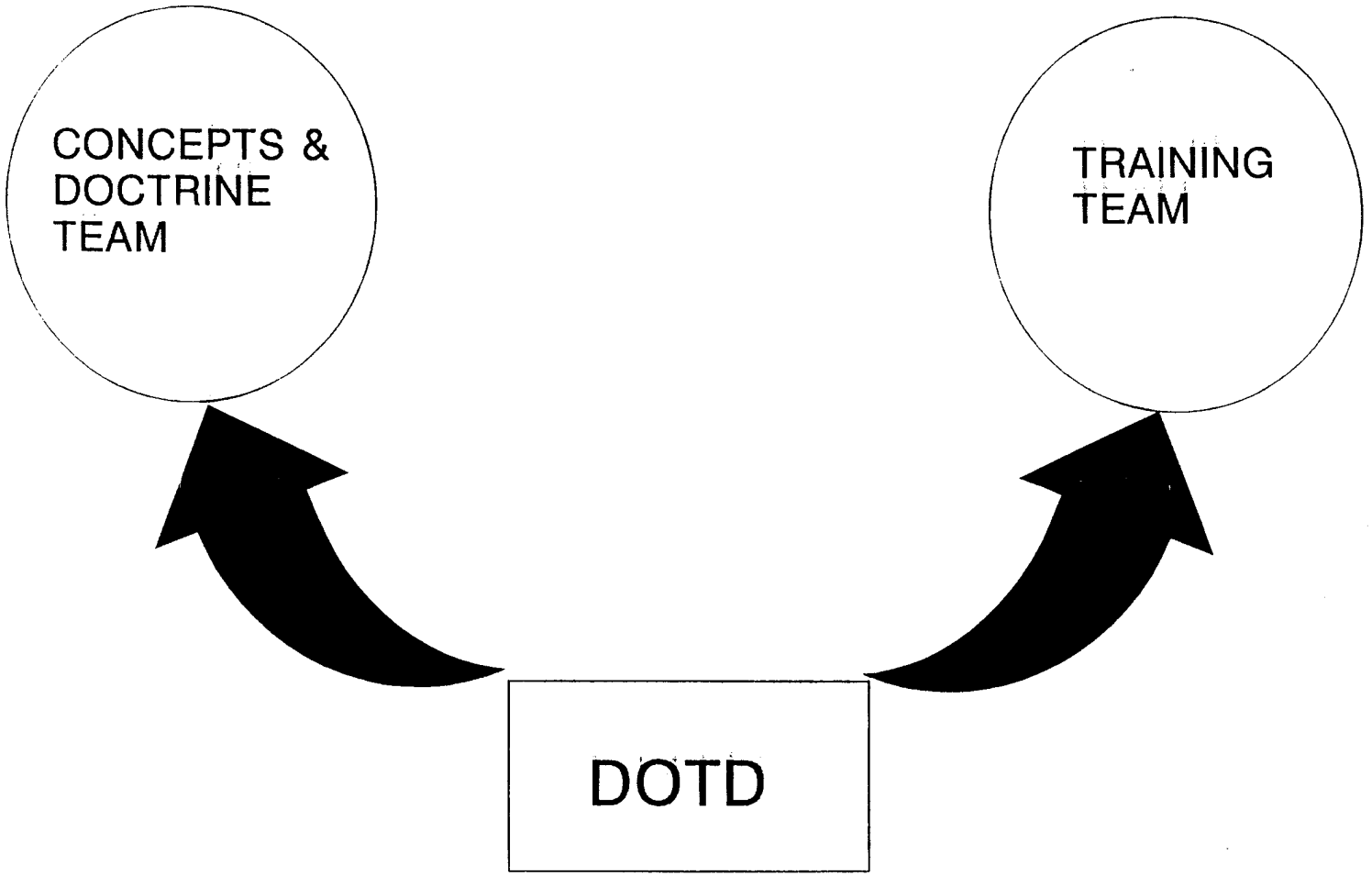
1994-

INTEGRATION

KEY AMEDD PROCESSES

EXTANT ECBRS PROCESS




CONCEPTS &
DOCTRINE
TEAM
TRAINING
TEAM
DOTD

TAB G

ENCLOSURE 14

U.S. ARMY MEDICAL DEPARTMENT CENTER & SCHOOL

ANALYTIC SUPPORT FOR PROPONENCY AND DOCTRINE DEVELOPMENT

I. BACKGROUND

There are two critical analytic cells within the AMEDDC&S, Concepts and Analysis Division (CAD) in APPD and Concepts and Analysis Division in DCDD. The APPD cell is involved in force modeling and long-range force projection issues. The DCDD cell is involved in workload data generation, focused specifically on the TOE environment. Both appear to have been dangerously under-resourced, e.g. their statistical and ORSA capability.

APPD conducts modeling studies that project AMEDD force structure requirements by corps, grade, and AOC and are actively involved in answering "what-if" inquiries about accessions, promotions, retirements, etc. Two recent APPD projects that have highlighted their critical role in shaping the AMEDD's future were the Total AMEDD Personnel Structure Study (TAPSS) and the AMEDD's Leader Development Workshops. These projects are designed to strongly influence both the skill mix of AMEDD personnel in the future and to simultaneously guide those personnel through a more evenly competitive leader development pathway.

APPD is responsible for integrating the eight life cycle functions of acquisition, distribution, deployment, professional development, structure, individual education and training,

sustainment, and separation for all six AMEDD officer corps plus the enlisted and civilian corps. One factor that makes AMEDD proponency unique, when compared with proponency in the mainstream Army, is that the AMEDDC&S manages six branch proponencies (plus enlisted and civilian) while the Infantry Center & School, as one mainstream example, manages only one. The potential for inter-Corps conflict is considerable.

The AMEDDC&S requires a complex, operations research/systems analysis (ORSA) approach to generate meaningful data. Such data can then be used to direct the TOE and TDA parallel pathways of the force structure. The AMEDDC&S operations research and systems analysis (ORSA) cell is located under the Concepts and Analysis Division (CAD) in the Directorate of Combat Development and Doctrine (DCDD). The ORSA cell in CAD provides the TOE patient population data for all TAA analyses. The TOE data eventually drives the AMEDD TOE force structure. CAD represents the upstream data generation effort which significantly influences the future look of the AMEDD. The CAD cell does not generate the peacetime patient population workload data necessary for constructin the required TDA structure.

Last year's TFA analysis of AMEDDC&S summarized that the roles and the accountabilities of APPD were unclear. That analysis described prospects for improved role clarity through the anticipated integration of APPD's efforts with branch proponency

(as conducted by the Corps Chiefs' offices all under the auspices of the ACFI). At this time only one of the six corps chiefs offices has relocated to the AMEDDC&S so that integration has not yet been achieved.

The ORSA personnel in DCDD's CAD coordinate with activities at DoD and DA to create total casualty figures and bed requirements for AMEDD support in Moderate Regional Conflicts (MRCs). This data is eventually translated into personnel statistics directing the AMEDD personnel skill mix, by corps and by AOC, for TOEs. ORSA's input to building the AMEDD force structure for the TOE environment is especially critical now, given the sensitive nature of the 733 and TAPSS studies. If the AMEDDC&S cannot ensure accurate and rigorous data "upstream", the result will be flawed derivative data, unreliable calculations, and errant decisions about AMEDD TOE force structure requirements.

Similarly, the APPD CAD cell is actively involved in determining the number and grade structure of each corps' MOSs and AOCs. Recommendations made by APPD can have a pronounced effect on the long-term morale of individuals assigned to a given specialty area.

II. THEME

The AMEDD requires robust ORSA and other analytical capability. Such systems must be flexible and responsible to provide

accurate, forward looking decision support for both TOE and TDA environments.

III. FINDINGS

1. APPD's chief in the Objective Force Modeling Division recently retired but has returned in a consulting capacity to continue his uniquely specialized work. The supporting staff consists of retired NCOs without analytical background.

2. The Concepts and Analysis Division in DCDD has only four staff assigned now and the only officer formally trained in ORSA is due to retire in FY95. The ORSA position is not authorized.

3. There is no standardized, concept based requirement system (CBRS) to guide the AMEDD's future TDA doctrine development as there is for TOE doctrine.

4. The Center for Healthcare Education Studies (CHES), established in 1994 was described by several interviewees as the answer to how the AMEDDC&S would pursue formalized TDA doctrine development.

5. The observation from the 1993 study that APPD's charter and accountability were unclear is persistent and pervasive among AMEDDC&S staff, including APPD personnel.

6. APPD has changed the civilian personnel requirement to eliminate the ORSA related civilian series. The remaining civilian series are 301 and 205 which do not require the same stringent analytical background.

IV. ISSUES

1. Can the AMEDDC&S afford not to simultaneously expand the ORSA capability in both APPD's Objective Force Modelling Division and DCDD's Concepts and Analysis Division?

2. What is the optimal alignment of APPD, vis a vis the incoming Corps Chiefs' offices, to improve synergies between their respective proponency activities within AMEDDC&S?

3. What is the optimal alignment for CHES in order to potentiate its role as the AMEDDC&S' center for future TDA doctrine development?

V. DISCUSSION

The ability to generate credible analytical data pertaining to numerous force structure issues is essential in this era of continual staffing pressure. In the past, the AMEDD wartime requirements (TOE) far exceeded the peacetime (TDA) health care staffing requirements. Today the larger requirement exists in the TDA sector. At the same time, the TDA structure is under heavy downsizing pressure. To preclude unacceptable staffing

reductions, the AMEDD must be able to conduct thorough analytical examination of force structure options. For example, the DoD 733 study generated a set of casualty data based on a suspicious DNBI algorithm. Similarly, the Concepts Analysis Branch generates a single wartime casualty figure when, in fact, they should generate a band of potential casualties based on various combinations of independent variables. To deal effectively with such issues, the AMEDD must retain a strong internal analytical capability.

Along the same line, because of the rising cost of health care, the AMEDD must be able to analytically demonstrate the utility of retaining a larger MC force structure than wartime models might call for. Answering this and similar questions is the rationale behind the current Vector, Inc. contract. An important deliverable from that contract is an analytical model that permits the AMEDD to regularly calculate staffing options.

Current active duty AMEDD personnel with an ORSA background are classified as 67D, Information Management Specialists. Further, there is no ASI that permits the ready identification of such personnel. Aligning this academic specialty with the IM AOC does not seem to make good sense. One could argue that ORSA trained individuals would be better aligned with 67A or 67H specialties. At a minimum, they should be identified by an ASI. Certainly the ability to manage a modern health care facility is heavily

dependent on keen analytical skills. The ORSA specialty in the rest of the Army is not managed in the same way as it is in the AMEDD.

It should be noted that APPD's TDA does not contain any ORSA specialty positions. All of the analytical personnel are either in the 0301 series, Various Administrative, or the 0225 series,

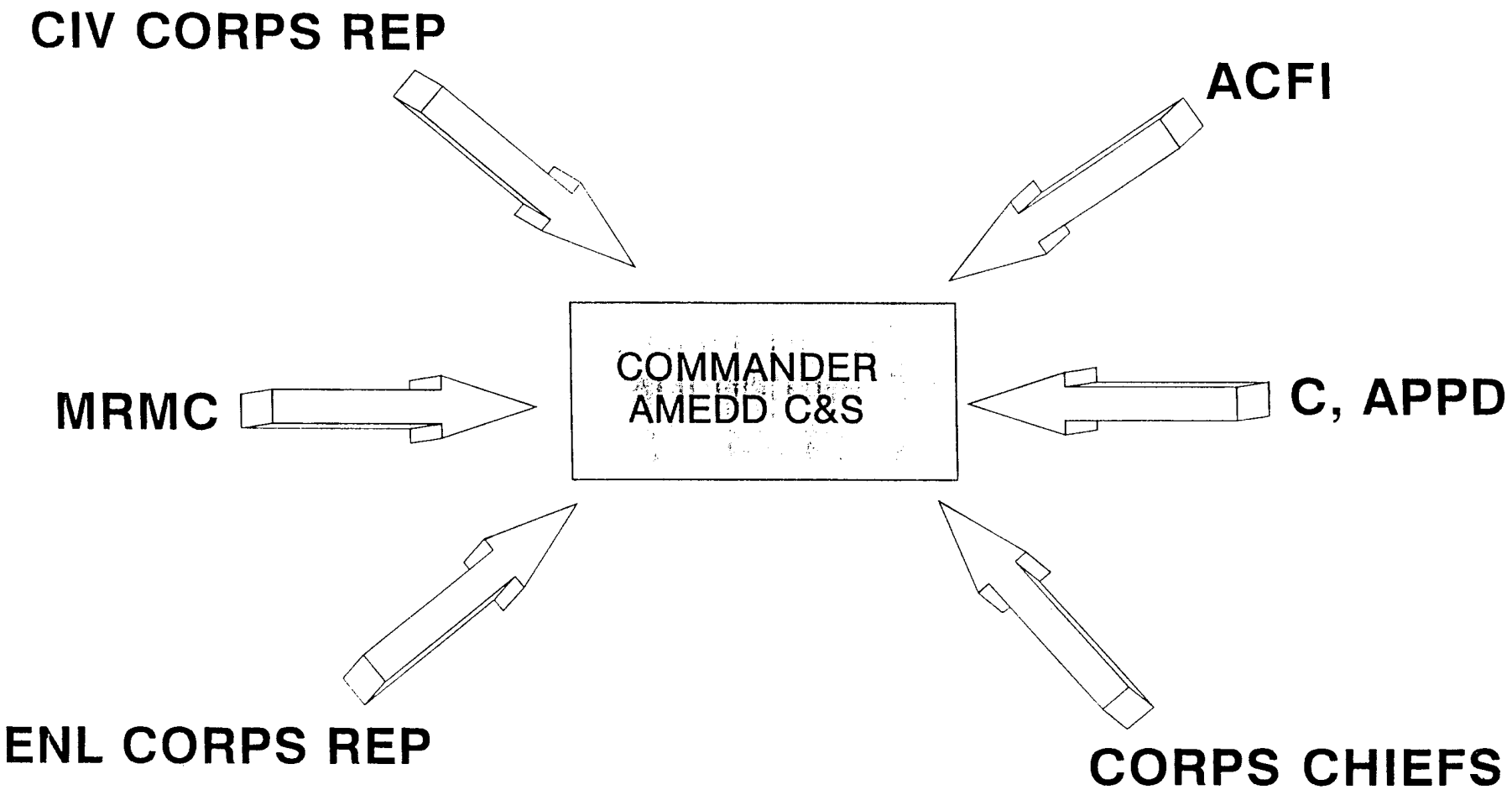
neither of which require the rigid academic background normally associated with the ORSA discipline.

VI. RECOMMENDATION

1. The analytical personnel assets at both APPD and DCDD should be augmented with fully trained ORSA individuals.

2. APPD should be aligned under the ACFI along with the six branch proponents. This would permit both elements to function collegially as they work long-range personnel issues.

AMEDD PROPONENCY COMMITTEE



TAB H

ENCLOSURE 14

AMEDD BOARD

I. BACKGROUND:

The US Army created the Test and Evaluation Command to carry out systematic evaluations of new equipment. The AMEDD was never a participating member of this command and instead, always maintained its own U.S. Army Medical Department Board (USAMEDDBD). The mission of the USAMEDDBD is to manage user tests and materiel evaluations of medical and designated nonmedical equipment having application to the AMEDD health care delivery systems. In July 1991, the Evaluation Division, Directorate of Combat and Doctrine Development, was transferred to the USAMEDDBD. This action expanded the USAMEDDBD mission to include functioning as the independent operational evaluator for the AMEDD. In this role, the USAMEDDBD provides analysis and proponent evaluation for the Force Development Test and Experimentation activity, and the Concept Evaluation Program Data Collection Effort. This analysis and evaluation role consists of the assessment of the interdependence between doctrine, tactics,

organizations, and materiel, with emphasis placed on the ability of medical TOE units to perform their assigned missions. The USAMEDDBD plays an integral part of the Army medical materiel acquisition process.

II. THEME:

There appears to be some duplication between the AMEDDBD and TEXCOM.

III. FINDINGS:

Some respondents reported a need for a separate Test Command. If placed under TEXCOM which is located in the Operational Test and Evaluation Command (OPTEC), AMEDDBD personnel believe AMEDD priorities would be lost and AMEDD needs would be left unfinanced. In addition to assuring AMEDD priorities are met, the current organizational placement of the AMEDDBD is identified as value added because of the easy accessibility of Subject Matter Experts (SMEs) and because AMEDDBD members are not viewed

as "outsiders". AMEDDBD personnel evaluate that placement of the AMEDDBD in the AMEDDC&S does provide autonomy and resources without bias and that this placement allows for independent functioning without outside influence.

IV. ISSUE:

What is the best alignment strategy for the Test function within the AMEDD?

V. DISCUSSION:

It is argued that current placement of the AMEDDBD as an independent test board provides the AMEDD with better service at less expense than if AMEDD test board functions were included in TEXCOM. While there may be some "truth" to the above proposition, the fact remains that this is another functional area within the AMEDD where we continue to do someone else's work because we can either do it better or more cheaply or both. At some point, however, the command needs to decide how important is

it to continue to do someone else's work, especially in lieu of rapidly dwindling personnel resources. The point is raised that if the AMEDDBD mission were transferred to TEXCOM, costs would go up and service quality would suffer. Let us explore the efficacy of such a position. First, testing expenses are currently built into the overall acquisition costs. These costs are normally down-loaded to the material developer (contractor). Second, the work load of TEXCOM is undergoing a dramatic change like the change affecting the rest of the Army. The overall availability of material resources has decreased by 40% over the past five years. This is bound to have had an impact on the TEXCOM workload. Finally, everyone in the Army is getting customer focused; this is a natural by-product of the Army's involvement in the TQM program. It is likely that TEXCOM has also improved it's focus on customers.

Finally, at some point the AMEDD needs to decide that it no longer can afford to do other people's work even if it means that

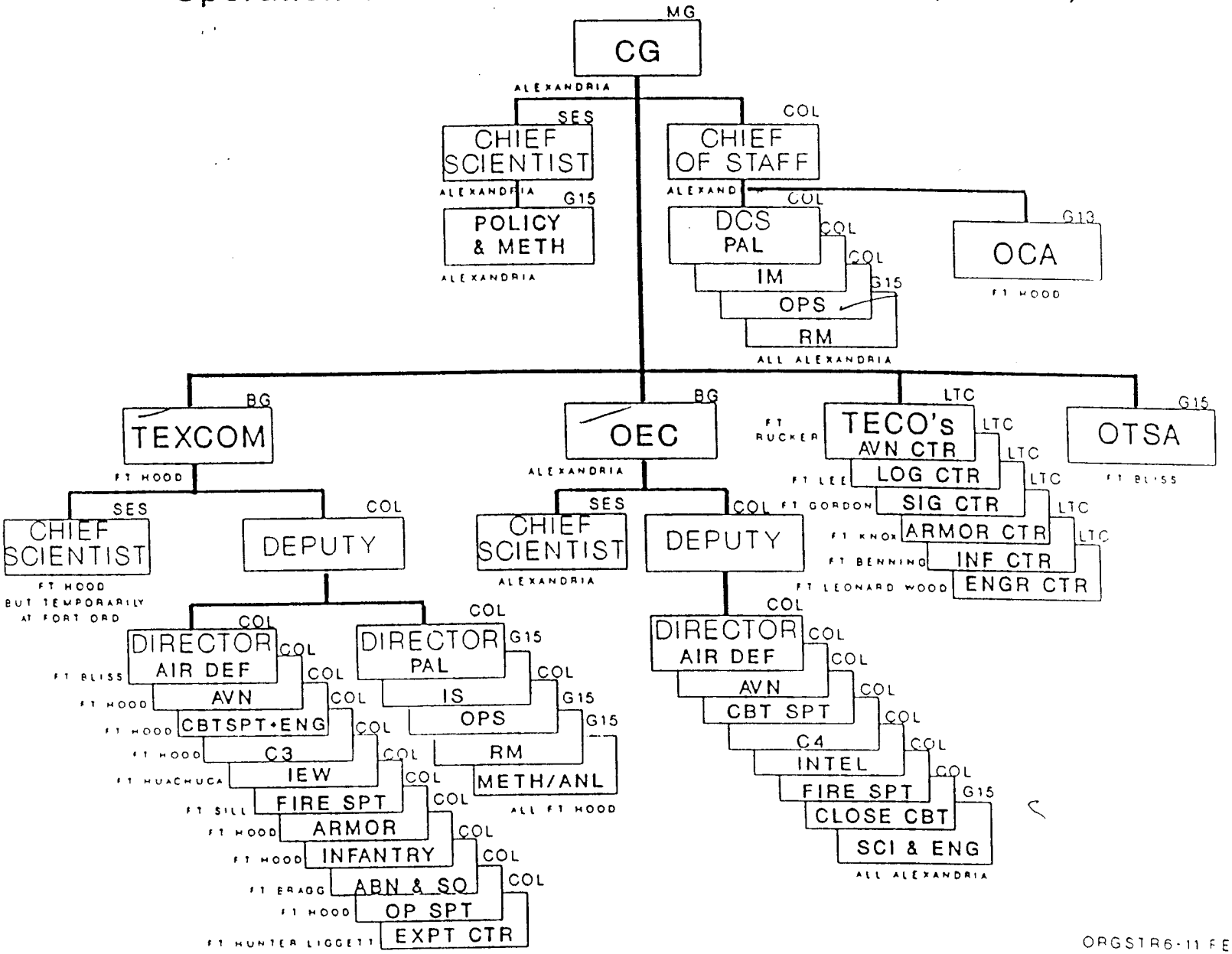
quality may suffer. The cost of doing so, in overhead and other opportunity costs may not be worth the outcome. Therefore, it is suggested that the USAMEDDBD be downsized dramatically with a small residul cell left to oversee special contracting efforts and to provide necessary liason with with TEXCOM.

VI. RECOMMENDATIONS:

a. Give the mission of the AMEDDBD to TEXCOM.

b. Downsize the AMEDDBD to a small residual cell of 3-4 people; this activity should continue to report to the ACFI.

Operational Test and Evaluation Command (OPTEC)



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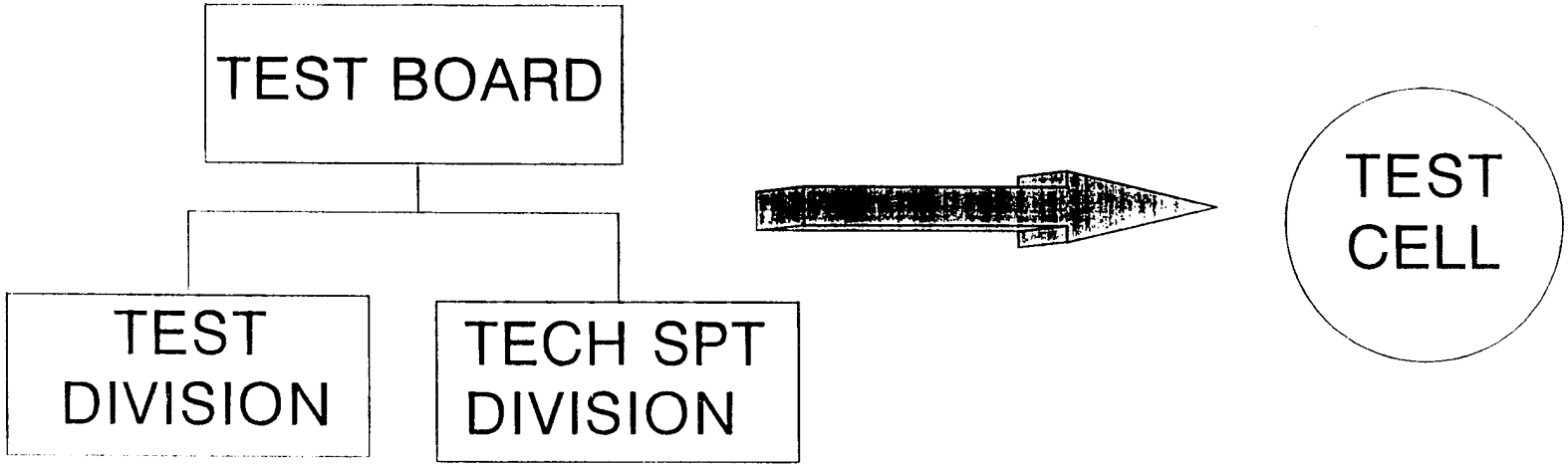
TEST BOARD



TAB I

ENCLOSURE 14

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF COMBAT AND DOCTRINE DEVELOPMENT

I. BACKGROUND

The mission of the Directorate of Combat and Doctrine Developments (DCDD) is to define future warfighting requirements facing the AMEDD. As the change agent for the AMEDD, DCDD is responsible for five basic combat domains: doctrine, training, leader development, organization and materiel (DTLOM). Among the current initiatives DCDD is deeply involved with is the Medical Reengineering Initiative (MRI) which is reevaluating the AMEDD's ability to support the force projection defense strategy of the 21st century.

The directorate is by far the largest part of the Assistant Commander for Force Integration (ACFI) office. DCDD is organized into five operational activities: clinical consultants office, concepts and analysis division, materiel and logistics system division, organization and personnel systems division, and doctrine literature division.

II. THEMES

A. The ACFI often performs DCDD functions. He often acts as Director, DCDD.

B. The layer of division chiefs in DCDD is of questionable

value.

C. No apparent progress has been made to develop a career track for combat development officers and civilians. (previous recommendation)

D. The position of E-CBRS consultant is too far down in the organization.

E. Most of the Clinical Consultants Office could be better utilized in Concepts and Analysis Division.

F. The threat cell needs greater emphasis.

G. The Operations Analysis Branch is understaffed.

H. The Medical Assemblage Design and Development (MADD) Branch should be considered for movement to U.S. Army Medical Materiel Agency (USAMMA).

III. FINDINGS:

A. The ACFI often performs DCDD functions. Overlap in work is inherent in the position of ACFI.

B. Virtually all division chiefs in DCDD described their work in

terms of their subordinate branch chiefs. No true division chief work was apparent.

C. No progress was noted in developing a combat developments career development track for either military or civilian personnel. However, more individuals have been offered the combat developments course leading to the 7Y ASI.

D. Dr. Navo, in his role as E-CBRS consultant, is often tasked directly by the ACFI. He also performs work consistently at a higher level than in the Materiel and Logistics System Division.

E. Most of the consultants are in effect action officers and could appropriately work in the concepts branch, as does the nursing consultant. The integrating role required of these individuals lends itself well to work in the concepts branch.

F. The threat cell has suffered due to lack of emphasis. The Army has chosen not to train military officers in this specialty. Although the requirement to define the threat continues, little concern exists to fill this position.

G. The Operations Analysis Branch cannot adequately perform its mission with available resources.

H. The MADD Branch was formerly with Basis of Issue Plan (BOIP)

Branch as part of the Organization and Personnel Systems Division. Some feel they should be reunited in the Materiel and Logistics System Division. Others feel the work of the MADD Branch can best be executed as part of USAMMA.

IV. ISSUES:

A. Should the ACFI be dual-hatted as the Deputy Commander? Should the Director, DCDD, be dual-hatted as the ACFI? What is the role of the ACFI?

B. What is the value-added work of the division chief level? Can DCDD operate without division chiefs? Can branch chiefs be dual-hatted as division chiefs? Do these positions remain as colonels to perpetuate a leader development position for colonels?

C. Is there a need for a career development track for combat developments?

D. Dr. Navo is often tasked directly from the ACFI. Is he positioned too far down in the organization to operate effectively? Should Dr. Navo be Deputy Director of DCDD? Should he work directly for ACFI? Should he be part of the Consultants Office?

E. Can most members of the Clinical Consultants Office perform more effectively in Concepts Branch?

F. The Threat Branch has been downsized to a single officer. The AMEDD has not trained enough officers in medical intelligence. There is no clear career track for medical intelligence. Can this function be civilianized? Can this function be moved to ACFI or combined with the Security and Intelligence Office at AMEDD C&S Headquarters?

G. Is the current OA structure able to meet the analytical needs of DCDD and the increased demands of the AMEDD? Where within the current organizational design should this analytical cell be located?

H. Can MADD Branch be moved to USAMMA? Should BOIP and MADD Branches be co-located? If so, where is the appropriate location?

V. DISCUSSION

A. The last analysis of AMEDD C&S recommended the Deputy Commander be dual-hatted as the ACFI. The work of Director, DCDD, and the current ACFI overlaps to a great extent. The ACFI organization is considered in another paper; however, the potential for combining the ACFI with the Director, DCDD, is

readily apparent to the study group. As the ACFI often directly tasks members of DCDD to perform work, he in effect is acting as the Director, DCDD. Part of this phenomenon may be because the current ACFI was previously Director, DCDD.

B. The division chief level of DCDD is of questionable value. Most division chiefs described their work in the context of their subordinate branch chiefs and were unable to articulate a separate stratum of work.

One interviewee indicated that these positions were civilianized but remain military, as the GS-14 positions to fill division chief roles were unavailable. Therefore, colonels were again placed into these positions. Recognizing that positions for colonels are necessary, speculation exists as to whether this layer of the organization was added to create leader development positions.

C. The need for a career development track for combat developments was identified in the previous study. This deficiency is systemic throughout the Army. Although no progress was noted in developing a career track for combat developments, more individuals were provided the combat developments course leading to the 7Y Skill Identifier as combat developer.

Both military and civilians interviewed indicated a need for a

proper mix of civilians and military in combat developments. The civilian population provides the continued historical perspective and the military population the new ideas necessary to stimulate the processes.

D. The importance of the E-CBRS process cannot be understated. This highly complex methodology centers on refinement of concepts and identification and prioritization of capabilities within the five domains of DTLOM. Although materiel related issues are the most complicated and resource intensive, all domains of the E-CBRS are equally important. This is evidenced by the ACFI often directly tasking Dr. Navo to work issues.

The position of E-CBRS action officer is too critical to be layered under the Materiel and Logistics System Division. Dr. Navo's position can be compared to that of Dr. Mosebar--a clearinghouse for all pertinent actions. This position should be elevated to an independent contributor working directly for ACFI or Director, DCDD. Consideration should also be give to making the E-CBRS independent contributor as Deputy Director, DCDD. This combines the civilian continuity with the military hierarchy in an appropriate position of leadership.

E. Several years ago the office of the Clinical Consultants was created to work directly for the Director as an integrating activity for the entire DCDD. Historically most clinical

consultants have worked in Concepts Branch. Currently only the nursing clinical consultant works in that branch.

The work of most clinical consultants falls logically into the purview of the Concepts Branch. Since they are accountable for the integrating function, the clinical consultants can most adequately perform from within this branch. At the same time clinical consultants can be exposed to other functional areas of the AMEDD and the Army. This prevents the isolation inherent in working in a separate office.

The only individual working truly as a consultant is Dr. Mosebar. The work of the other clinical consultants can best be described as action officer work concentrating on specific clinical areas.

F. Although the historical Soviet threat has diminished, the medical threat and other threats continue. For a number of reasons, the threat cell at AMEDD C&S has been downsized to one officer. Although this individual is due for reassignment, no medical intelligence trained officers are available to fill this position. In fact, the AMEDD has chosen not to identify any military officers for medical intelligence training, even though the training is available from the Defense Intelligence Agency.

The threat function must continue. As the AMEDD has apparently chosen not to continue a career track for these individuals, this

position seems a likely candidate to civilianize. Another suggestion is to combine the threat cell with the Security and Intelligence Office at AMEDD C&S Headquarters.

G. The current Operational Analysis structure is unable to meet the analytical needs of DCDD and the AMEDD. This was reported in the last analysis of the AMEDD C&S. Most interviewees felt that the OA function should remain in DCDD with adequate personnel to meet the increased needs of the AMEDD.

H. The mission of the MADD Branch has overlap with functions of USAMMA. Consideration should be given to co-locating the MADD Branch with USAMMA. In addition, coordination with Defense Standardization Medical Board can be better effected at Fort Detrick.

Others feel that the MADD Branch should be co-located with the BOIP Branch, as it was previously. The co-location of the two branches remains subject for debate.

VI. RECOMMENDATIONS

A. Reconsider dual-hatting the Deputy Commander as the ACFI. Combine the ACFI and Director, DCDD.

B. Eliminate the division chief layer of DCDD.

C. Continue work to develop a career track for combat developments. Establish a proper mix of civilians to military in DCDD.

D. Elevate the position of E-CBRS consultant to Deputy Director, DCDD. At the very least elevate to Consultants Office.

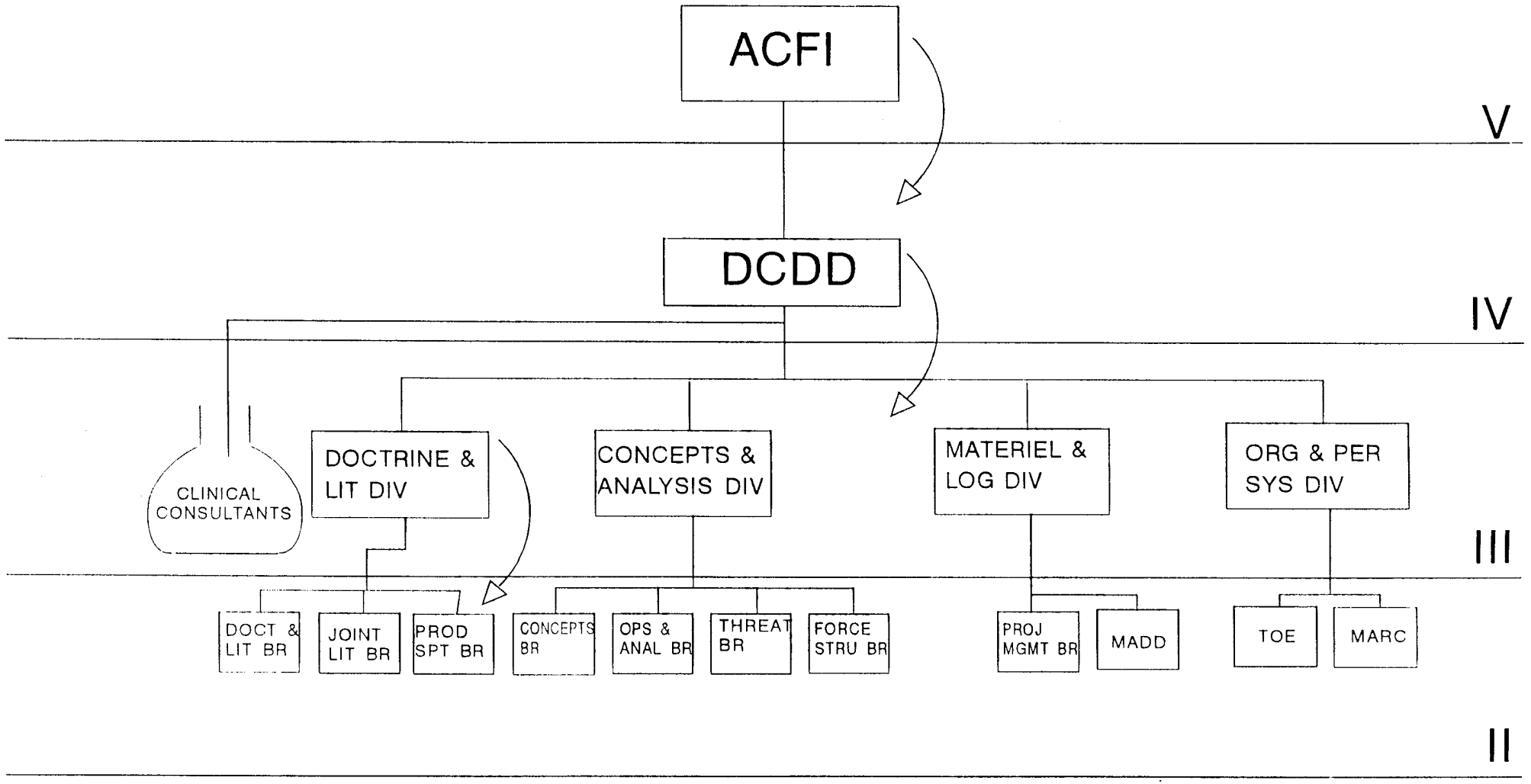
E. Place most of Clinical Consultants Office into Concepts Branch.

F. Civilianize the threat cell or place emphasis on a military career track for medical intelligence. Consider placing in ACFI or HQ.

G. Enhance the capabilities of the OA Branch.

H. Move MADD Branch to USAMMA.

DCDD EXTANT ORGANIZATION



TAB J

ENCLOSURE 14

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DOCTRINE LITERATURE DIVISION

DIRECTORATE OF COMBAT AND DOCTRINE DEVELOPMENT

I. BACKGROUND:

The overall mission of the Directorate of Combat and Doctrine Development (DCDD) is to define the future warfighting requirements facing the Army Medical Department (AMEDD). DCDD is the manager of change for the Army Medical Department (AMEDD) in five basic combat domains: Doctrine, Training, Leader Development, Organizations, and Materiel (DTLOM). The directorate is organized into five operational activities: Clinical Consultants Office, Concepts and Analysis Division, Material and Logistics Systems Division, Organization and Personnel Systems Division, and Doctrine Literature Division. The central challenge facing DCDD is to define and forecast the AMEDD's role in support of a national defense strategy which has shifted from a forward- based force structure to a force projection platform operating out of CONUS. In addition to this mission shift is a corresponding requirement to accomplish the above amidst significant and continuing budget reductions.

The Doctrine Literature Division's (DLD) mission is to formulate, coordinate, and develop AMEDD doctrinal manuals and provide AMEDD input to combat arms, combat support, and combat service support proponency doctrinal manuals. Also the DLD reviews and provides input to joint services doctrinal manuals.

The Doctrine Literature Division is organized into three branches: Doctrine Literature

Branch, Joint Literature Branch, and Production Support Branch.

II. THEMES:

A. Some of the work related activities within Doctrine Literature Division are perceived to be "non-value added" and duplicative of on-going efforts within IMD. Consolidation would result in a more efficient process and save manpower and eliminate duplication of effort.

B. There is a belief that the doctrinal development linkage between Doctrine Literature Division and Department of Training Development, AHS could be streamlined better if the ARTEP Section was merged with DLD.

C. There is a perception that the Joint Literature Branch is inadequately staffed and lacks the tri-service participation and joint background necessary for the development of joint doctrine.

III. FINDINGS:

A. Doctrine Literature Branch is actively involved in the development, review and revision of AMEDD doctrinal publications, as well as, the review of other Army doctrinal publications to insure the health service support portion is correct. Individual writers are assigned specific manuals and they prepare initial, coordinating, and final draft copies for staffing before a manual is approved and sent to TRADOC as a camera-ready copy for publication.

B. PROJECT WARRIOR (PW) is designed to use observer/ controller (OC) experience

by assigning former OCs from the National Training Center (NTC) and the Joint Readiness Training Center (JRTC) to TRADOC schools as instructors and doctrine writers (Encl 1). The program has been operational since 1989. AMEDD observer/ controllers (OCs) departing from the combat training centers (CTCs) are not identified nor managed by the personnel system to be given priority for assignment to doctrine development, leader development (AHS instructor duties), training development, or to the Lessons Learned cell of ACFI.

C. The Production Support Branch receives the written doctrinal publications from the doctrine writers on floppy disks and conducts desk top publishing, on-line editing, and produces camera ready copies (CRC) of these doctrinal publications for printing by TRADOC and OTSG.

D. It was reported by some interviewees that the Production Support Branch functions and personnel could be utilized more efficiently in the Information Processing Branch, Information Management Directorate (IMD) to facilitate the production support of all AMEDDC&S publications, instead of one specific type of publication.

E. The Joint Literature Branch is authorized three personnel, with only two positions filled. There is no requirement for individuals to have had a joint duty assignment before being assigned to the Joint Literature Branch. In most cases, joint- duty assignments are at the colonel-level for AMEDD officers.

F. Joint manuals can take up to five years to reach final draft stage for publication.

G. Some respondents stated that there is not enough direct contact with the other services to coordinate joint doctrine. Reportedly, services cut and paste their individual

service specific doctrine into joint manuals, creating a final product of three manuals jammed into a single document. There is no designated POC at OTSG/ MEDCOM to coordinate with other services.

H. Instructors throughout the schoolhouse routinely develop lesson plans and teach students based on an outdated doctrinal base.

I. Many teaching departments report that they provide subject matter experts (SMEs) to actually develop future doctrine, and the Doctrine Literature Branch simply formats the information correctly to fit the TRADOC/ Army model.

J. Doctrine development is often delegated down to the lowest ranking individual within a staff section (teaching department or DCDD). No clear set of operating design principles regarding doctrine development appear to be routinely applied.

K. Rapid prototyping and aspects of the ECBRS process appear to change more rapidly than the doctrine development process resulting in a situation where doctrine is way behind, i.e. Tele-medicine doctrine.

L. No evidence was found that multiple versions of doctrinal manuals were concurrently underway, i.e. Force 21 White Paper, FM 8-10 (current), FM 8-X (future), etc.

IV. ISSUES:

A. Can the Doctrine Literature Division continue to maintain high quality literature development if the Production Support Branch is moved to the IMD?

B. Can the Joint Literature Branch in its current organizational alignment status continue to function and support the AMEDD requirements for joint doctrine during a

force projection/ contingency operations era?

C. Can The ARTEP Branch in DTD be aligned under the Doctrine Literature Division for greater efficiencies and more effective development of doctrinal manuals?

D. Should there be more emphasis placed on the requisite assignment criteria for the Chief, Joint Literature Branch and supporting staff?

E. Should efforts be made to more efficiently manage the assignment of AMEDD CTC OCs to the AMEDDC&S, thus placing them in positions where they can provide valuable feedback to doctrine development, leader development, training development and lessons learned?

V. DISCUSSION:

Doctrine reflects how the Army expects to carry out its business. Thus, it flows logically from a continually changing stream of operational concepts which themselves reflect the changing nature of the larger environment, i.e. the political, social, technical and economic developments. Force 21 is a prime example of how fast changing world events have resulted in the Army revolutionizing its existing doctrinal base, i.e. shifting from a forward- based deployed fighting organization to a force projection CONUS- based structure. Army Doctrine must now catch up with this changing operational concept. Since doctrine reflects how the Army intends to carry out its warfighting mission (including operations other than war- OOTW and humanitarian missions), doctrine development should logically be conducted by individuals who are best prepared to codify the operational requirements. In other words, doctrinal writers should be individuals who

possess the depth of experience and wisdom necessary to describe and integrate all of the actions likely to occur at a given organizational level.

To date, there is no uniform set of design principles applied to the doctrinal development process. Instead, doctrinal writing is often delegated down to individuals assigned to the lowest level of the organization responsible. While these individuals are well intentioned to codify effective doctrine, they often lack the experience and cognitive ability to effectively process the information required to do so. Our recent history has been replete with examples where doctrine was assigned to the wrong level which resulted in a situation where draft after draft was rejected because it was not all encompassing enough to capture the essence of operations at a given level. For example, the original FM 100-5 was not acceptable until the TRADOC commander (General Depuy) locked away the various school commandants at Camp A. P. Hill until they had produced an acceptable draft. FM 100-5 is a CAPSTONE manual, it is general officer work. Similarily, the Joint manuals describing CINC operations were not acceptable until the TRADOC commander (General Thurman) contracted with a number of retired CINCs to produce an acceptable working draft. At the other extreme, doctrinal writing is often reviewed by individual staff officers who are not qualified to carry out such reviews. For example, if a doctrinal manual is produced by one school, signed- off by a two-star commandant as appropriate, it then should not be reviewed by a CAC/ CASCOM staff officer (major- lieutenant colonel) unless it has a specific integrative impact on other doctrinal manuals. Rules such as these do not exist within the doctrinal development community. And while the AMEDDC&S cannot fix the entire TRADOC system, it can

fix its own internal development process.

The Doctrine Literature Division currently develops, reviews, revises and produces all AMEDD doctrinal literature. Presently the division has the capability to write, edit, and produce desktop published products as camera- ready copies, which are submitted to the Army Training Support Center (ATSC) for printing and distribution to AMEDD units throughout the Army. Although the DLD is very efficient and effective, emphasis should be placed on assigning CTC seasoned OCs to doctrine development so their valuable experiencies from the CTCs can properly influence the way we develop health service support for the warfight.

The Production Support Branch provides the desktop publishing capability to both the Doctrine Literature Branch and the Joint Literature Branch, while providing minimal support to other activities within DCDD. Presently, there is no production support back-log in the Doctrine Literature Division, however there is currently a three month back-log in IMD for production support of priority 1 documents. As the AMEDDC&S continues to adapt to shrinking resources and growing demands, the effective provisioning of quality production support efforts become critical in meeting many of the administrative support missions of the AMEDDC&S.

There is a close technical linkage of the Doctrine Literature Branch and the ARTEP Section within the Department of Training Development (DTD) in the development and production of doctrinal manuals and supporting literature. Primarily, these manuals consist of Field Manuals (FMs) and Mission Training Plans (MTPs). Normally, MTPs are developed for units after the corresponding FM is completed. This process, however,

often leads to a 18-24 month delay in the distribution of the much needed MTP to a unit. Presently, approval has been granted to develop MTPs while the corresponding FM is being developed. This allows MTPs to be distributed to units simultaneously with FMs. Due to their close affiliation with one another, it would seem appropriate to merge these two branches' talent pool of writers to more efficiently manage the developmental process of doctrinal literature, thus creating a savings in manpower utilization. Managing parallel processes is colonel's work!

The Joint Literature Branch was established to provide the necessary AMEDD health service support input to joint health service support manuals. These efforts require interaction and coordination with the other DoD military services. Routinely, this necessary interaction with other sister services does not occur. Most product suspenses/ requirements come from the J7 office of the JCS. Presently, most health service support input for joint manuals consists of each services medical doctrine being integrated into one manual, without standardization of similar processes. Following this process, it can take up to five years to publish a joint manual. Also, there is no requisite criteria placed on the assignment of military or civilians to the Joint Literature Branch. More emphasis must be placed on the appropriate mix of talent in the joint arena to ensure effective doctrine is developed to support a contingency force operation throughout the world.

VI. RECOMMENDATIONS:

A. Move the Production Support Branch to IMD to consolidate and maximize the usage of publication support capabilities for the entire AMEDDC&S.

B. Move the ARTEP Branch from DTD to the Doctrine Literature Division to consolidate efforts in the production of linked manuals. This merger will allow maximum utilization of resources to task organize and streamline the development of doctrinal literature and Mission Training Plans (MTPs) in the ARTEP.

C. Establish requisite assignment criteria for the Chief, Joint Literature Branch and establish the necessary staffing requirements to ensure the required skills and technical expertise are assigned to perform joint-level doctrinal literature development.

D. Assign AMEDD CTC OCs to Doctrine Literature Division to provide valuable CTC knowledge and experiences in the development of doctrinal manuals.

E. The following design principles should apply to all doctrine development efforts:

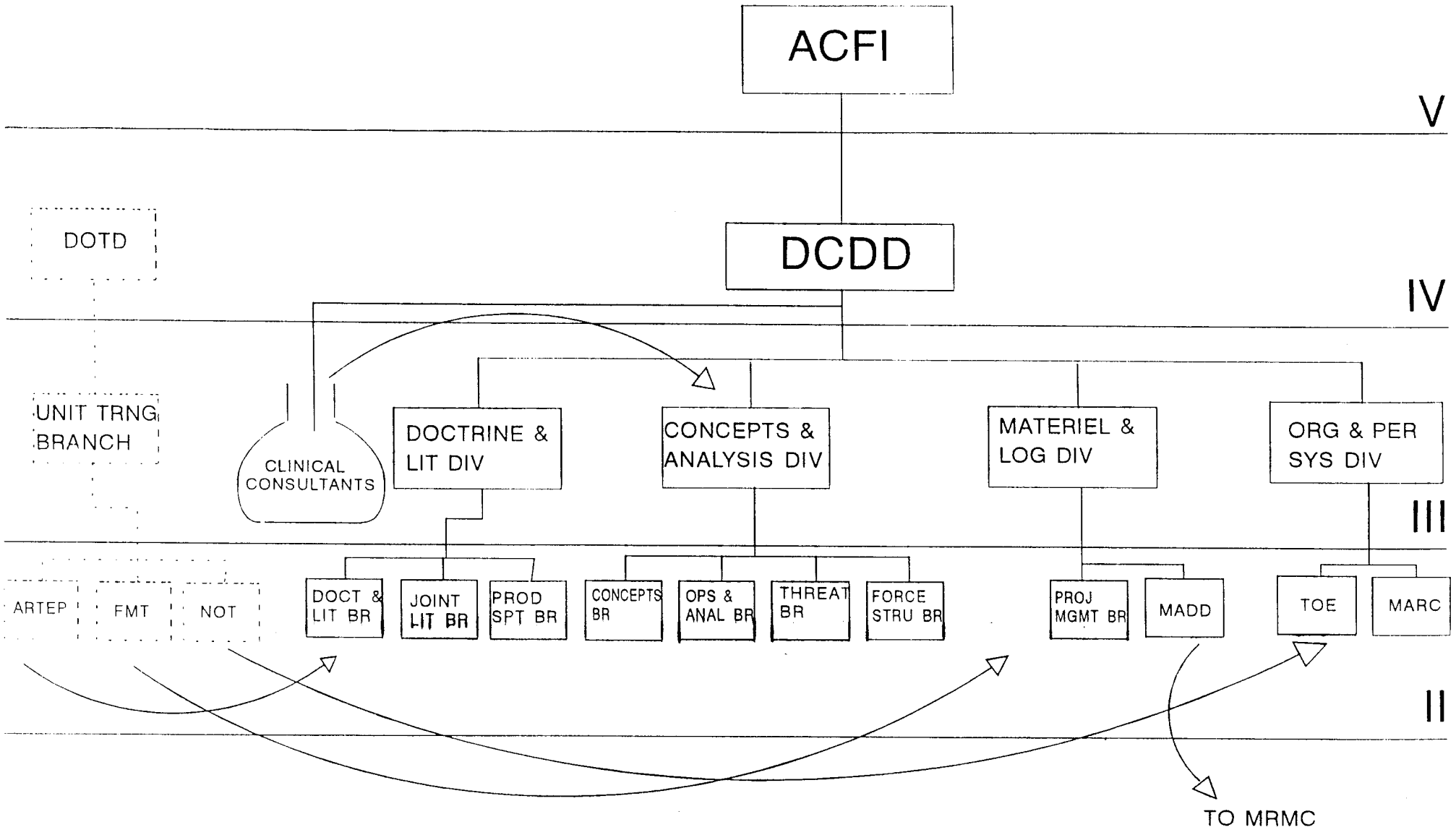
1. To develop and write doctrine, the writer must have had operational experience at the targeted level of the doctrinal publication, i.e. battalion aid station- battalion surgeon, Group level- Group commander.

2. To review doctrine and to integrate into more complex doctrinal publications, the reviewer/ integrater should be one level higher (or have operated at one level higher) than the draft publication level.

3. To sign-off on doctrinal publications, the sign-off authority should be two levels higher than the targeted publication.

4. Joint doctrine development requires joint experience at the appropriate organizational level.

DCDD RECOMMENDED ORGANIZATION



TAB K

ENCLOSURE 14

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

LESSONS LEARNED/HISTORIAN

I. BACKGROUND:

From 1988 to 1993 the Lessons Learned cell was under the Directorate of Standardization and Evaluation, which followed the guidance of TRADOC Regulation 350-15. After the 1993 TFA Study, the AMEDDC&S leadership concluded that the Lessons Learned cell's requisite location should be in the Assistant Commander for Force Integration (ACFI) to enhance the interface with the combat training centers (CTCs), as well as, managing the lessons learned data base.

The AMEDDC&S history cell consists of the MEDCOM historian and the AMEDDC&S historian. Previously, only one historian billet existed at the former Health Services Command (HSC). Since the movement of the HSC historian position to the AMEDDC&S staff, the history staff has increased two-fold.

II. THEME:

The Lessons Learned and History cells are valuable assets if their functions are managed efficiently and effectively in support of the AMEDD and the mission of the AMEDDC&S.

III. FINDINGS:

A. One NCO is managing lessons learned in the ACFI, while five authorizations were

transferred from DOES. One of the five authoriations is a key civilian position that has not been filled.

B. The lessons learned interface with the combat training centers (CTCs) and CASCOM has been enhanced under ACFI management.

C. The staffing of lessons learned issues and the management of the lessons learned data base is on hold pending the civilian position hiring action. Also, there is a need for automation to manage these areas. A file server has been requested that will allow the overall mission of the lessons learned cell to be efficiently accomplished.

D. Integration between the ACFI Lessons Learned cell and the doctrinal manual publishers in Doctrine Literature Division,DCDD is minimal.

E. Since the relocation of the MEDCOM Historian to the AMEDDC&S, the history cell in the AMEDDC&S grew by two-fold.

F. The MEDCOM and the AMEDDC&S Historians are rated by the SGS and are co-located at the AMEDDC&S in the Strategic Planning Office, basically for the purpose of sharing office necessities.

G. The MEDCOM Historian exclusively manages the MEDCOM history requirements and does not collaborate with the AMEDDC&S Historian on any other history requirements.

H. The history cell has no office automation or administrative support to prepare or publish history articles. The historians do not have the requisite automation skills or training to effectively accomplish these administrative requirements.

I. The AMEDDC&S Historian plans, organizes, and directs the command historical

program and manages the publication of the annual AMEDDC&S historical report. Presently, the annual report has not been published, due to administrative support needs.

J. There is a perception that organizational history requirements are not given a high priority for accomplishment and a one person office is lost in the command structure.

K. The AMEDDC&S historian's job description lists substitute history instructor for The AHS, however he is never utilized. He does participate in the grading of required history papers from the officer courses with the Deartment of Healthcare Operations, AHS and assists in the staff ride training requirements of the OAC course.

L. The history cell and the lessons learned cell do not interact or integrate information.

IV. ISSUES:

A. Can the functions of the Lessons Learned and history cells be consolidated to gain efficiencies in the capturing of historical issues and data which affect current and future training at the AMEDDC&S?

B. Can the lessons learned and history cells be aligned with the doctrinal writers in DCDD?

V. DISCUSSION:

Presently, the lessons learned and history cell are minimally staffed, resulting in some requirements not being conducted. There seems to be a perception that these functions are not as important as they should be and emphasis has not been placed on the importance of their functions. Presently, there is no collaboration in the history area.

Historians assigned to DHO do not work with the AMEDDC&S historian except in the conduct of staff rides and the grading of OAC history papers. Although the MEDCOM Historian is located with the AMEDDC&S historian there is no shared responsibilities to maximize efficiencies, since neither has any administrative staff. The location of the historians with the Strategic Planning Office further adds to the dysfunctional relationship and recognized significance of the history requirements of the AMEDDC&S, as well as, the MEDCOM requirements. Presently, the Lessons Learned cell in ACFI is efficient in the areas of performed, however the civilian position must be filled and the necessary automation support (i.e. a file server) must provided. Also, the interface with the doctrinal writers should be established to more efficiently utilize assets and integrate the lessons learned into AMEDD doctrine.

VI. RECOMMENDATIONS:

A. Assign the Lessons Learned cell in ACFI to the Doctrine Literature Division, DCDD to enhance the integration of lessons learned into the doctrinal manuals (i.e. FMs and MTPs) and fill the civilian position with personnel transferred from PMO, DTD.

B. Place a high priority on the procurement of file server to manage both lessons learned issues and data base, as well as for the utilization in the writing of doctrinal manuals (FMs and MTPs).

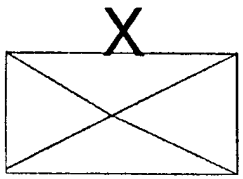
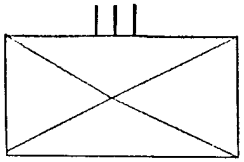
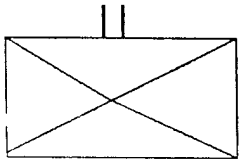
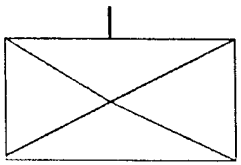
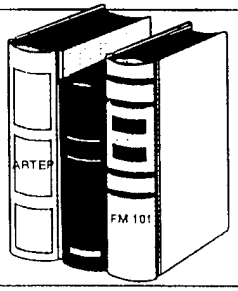
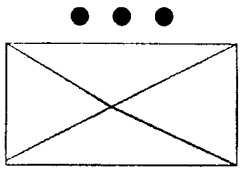
C. Assign and integrate the AMEDDC&S Historian to the Department of Healthcare Operations (history cell), AHS for the accomplishment of all instructional history requirements, as well as, continue to require AMEDDC&S historian to accomplish those

assigned job elements of the duty description.

D. Relocate the MEDCOM Historian to MEDCOM to perform command history requirements.

E. Ensure necessary administrative staff is assigned to each cell to support requirements.

DOCTRINE DEVELOPMENT DESIGN RULES

V		SIGN-OFF
IV		APPROVAL
III		WRITER
II		
		

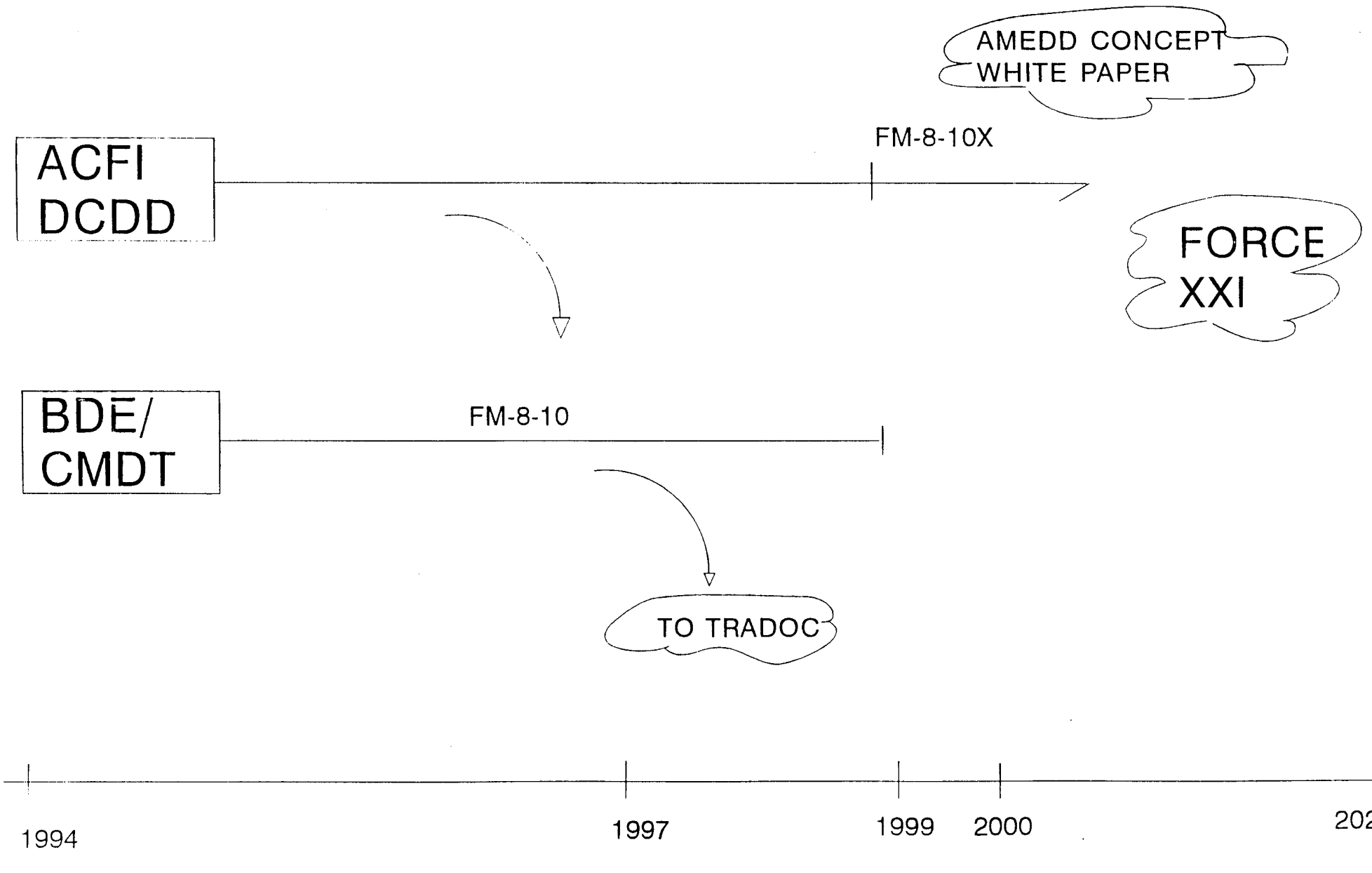
DOCTRINE FOCUS

3 LEVELS HIGHER

2 LEVELS HIGHER

1 LEVEL HIGHER

DOCTRINE DEVELOPMENT



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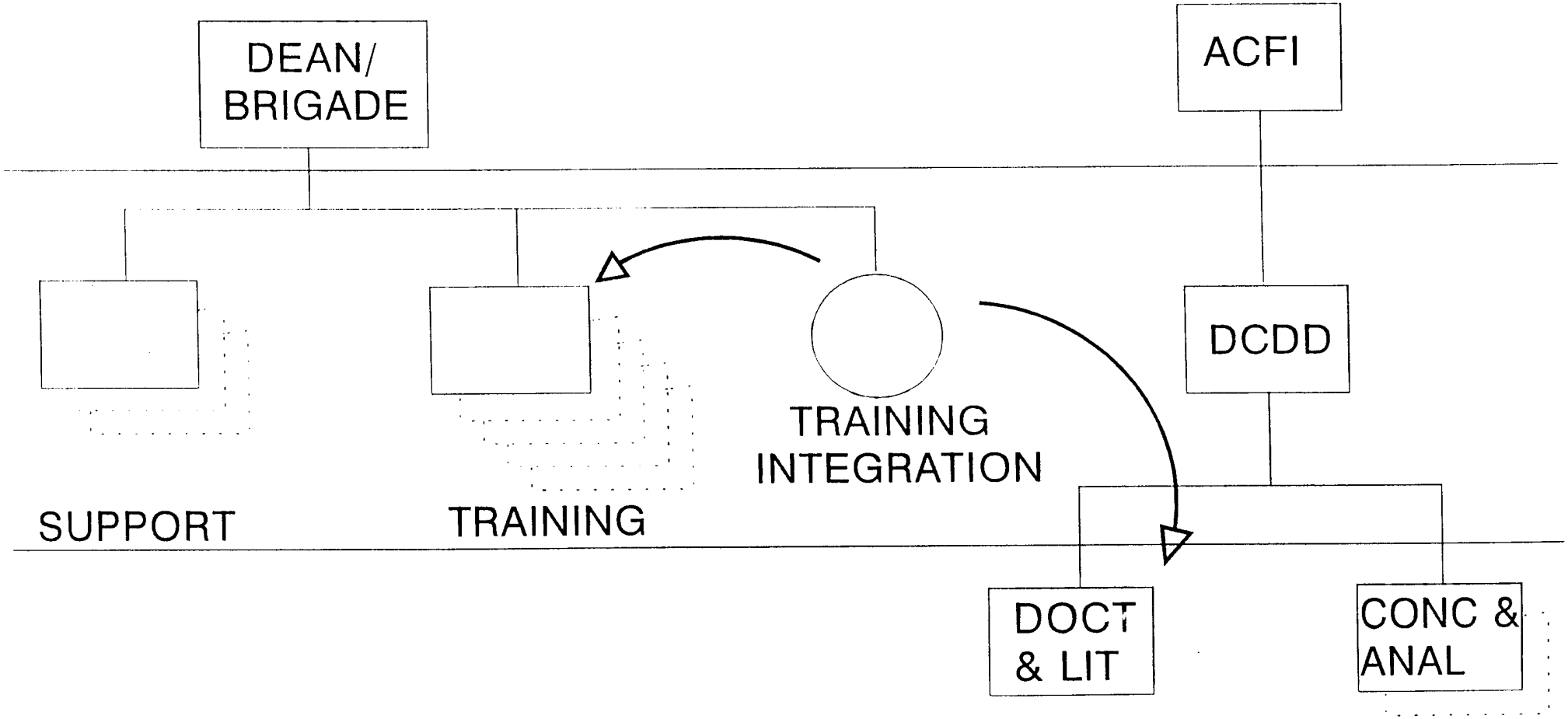

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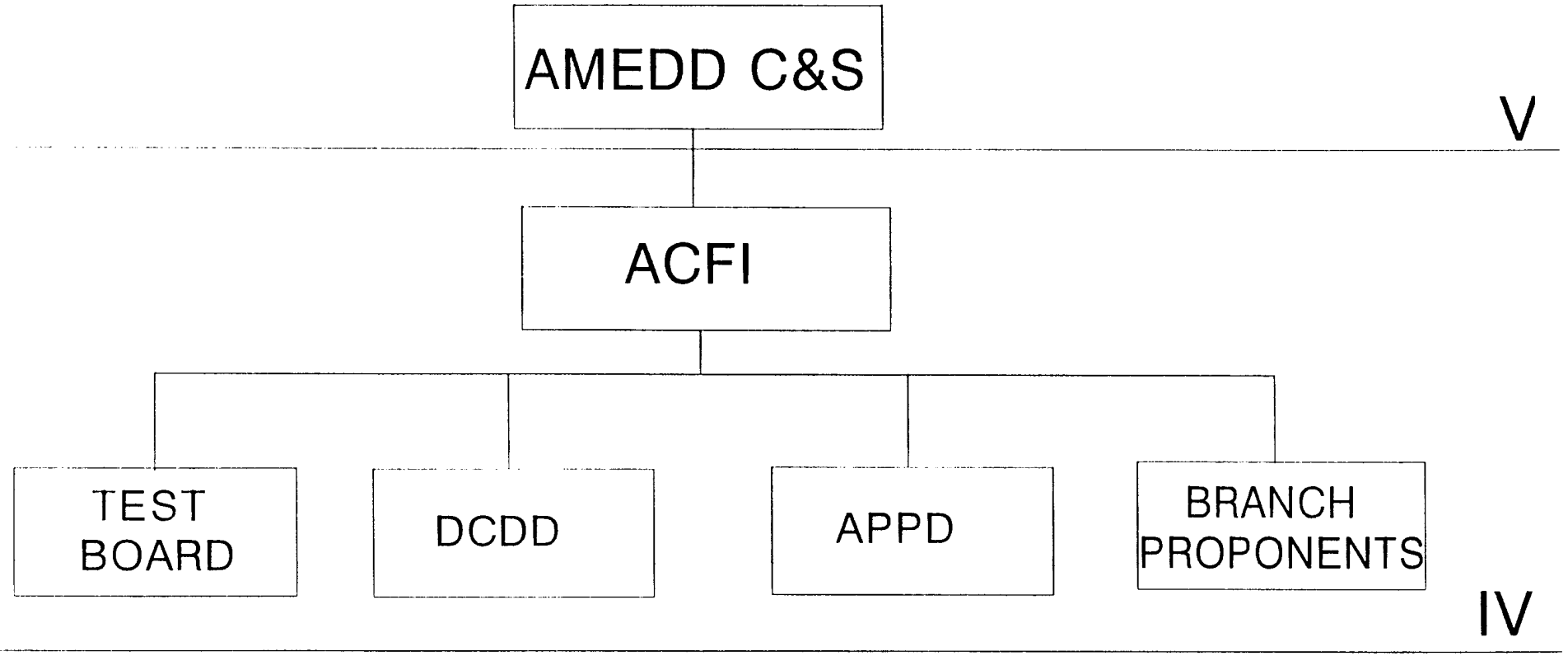
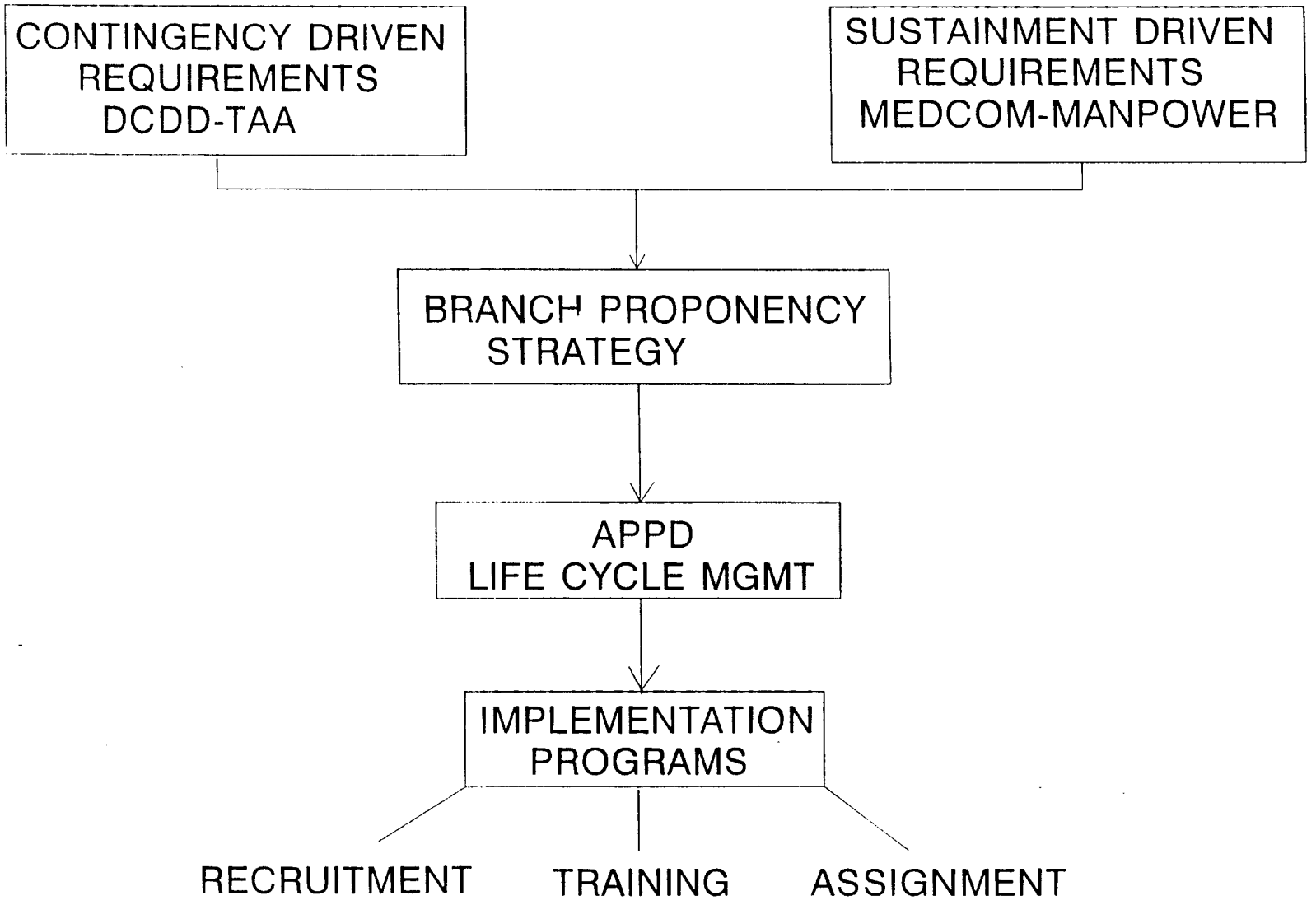


"IF APPD/BR PROPONENTS NOT INTEGRATED INTO ACFI, NO NEED FOR ACFI."

FORCE MANAGEMENT PROCESS



TAB L

ENCLOSURE 14

THE ACADEMY OF HEALTH SCIENCES (AHS)

I. BACKGROUND:

The Academy of Health Sciences (AHS) (formerly MFSS) has undergone a number of significant organizational changes over the past several decades. The school was originally founded in 1920 at Carlisle Barracks and was initially organized as a training school for Army Medical Department personnel. Over the years the original structure underwent a number of modifications in response to a series of significant changes in the external environment. For example, in the late 1970s the school emulated the massive changes that were occurring in Training and Doctrine Command (TRADOC) at the time. During this period, an entire new focus on training design was introduced as the Army implemented the task based Instructional System Design/Systems Approach to Training (ISD/SAT) process. These changes led to the creation of two new directorates within the AHS: the Directorate of Training Development and the Directorate of Training Evaluation. Throughout this same period the entire combat development process also underwent considerable change as the Army implemented the Concept Based Requirements System (CBRS)/Enhanced CBRS (ECBRS).

As a result of the impact of these changes, the AHS was established and the school organized around 12 teaching divisions under the command and control of a Dean, a Brigade, and other support directorates. In October 1992, the AHS became a

subordinate element under the Army Medical Department Center and School (AMEDDC&S) and, shortly thereafter, the position of Assistant Commandant, AHS was established to integrate the function of subordinate schools: MFSS, USAMEOS, USASAM, JMRTC, and the NCO Academy.

A Task Force Aesculapius (TFA) study was conducted in 1993. Based upon the results of that study, the work of the Assistant Commandant was combined with the work of the Dean, MFSS. A process action team (PAT) was formed and the combined office became the Academy of Health Sciences with subordinate departments (See Encl 1). The reorganization eliminated layering and resulted in efficiencies and some savings. The Department of Training Development (DTD), Individual Training Division (ITD) assets have recently merged with existing training departments, resulting in further efficiencies and eliminating duplication of effort. The system approach to training (SAT) process is being reviewed, streamlined, and modified. The role of the Department Chief and course directors and/or program directors has been expanded to include responsibility for all AC & RC individual training development, training, and training products.

IIa. THEME:

A perception exists within the AHS staff and faculty that the Brigade's emphasis on soldierization, common task reinforcement, and other duties prevents students from adequately studying

and preparing for classes.

IIIa. FINDINGS:

a. Brigade personnel interpret their current mission IAW TRADOC Regulation 350-6, which charges them with assuring that soldiers receive reinforcement training in common task, physical fitness, and other soldierization skills. Therefore, many students face a day with competing demands (i.e., academic vs soldierization). The net effect of the above incongruence is that the student often suffers from an inadequate amount of sleep, lack of study time and confusion regarding priorities, i.e., to study MOS specific material or focus on soldierization tasks. (Typical student hours are from 0430-2200.)

b. The distinction between the responsibilities and roles of the instructors, cadre sergeants, and the Drill Sergeant appears to contribute to the above competing demands. Many departments and branch chiefs feel Drill Sergeants should only be required for the 91B10 course and that cadre sergeants or instructors should be used for other AIT training. Many chiefs feel that having instructors involved in soldierization, housing, and care of students would result in a training environment that would include the required soldierization and at the same time facilitate learning.

c. There are also concerns about the difference between the environments of the Army, Navy, and Air Force students. Navy and Air Force students do not have drill sergeants. Navy Petty

Officers are assigned to courses as instructors and as first level managers to assure that Navy students meet military standards and that all Navy students' administrative issues are directed through the appropriate chain of command. Their service specific requirements involve much less time. The US Navy military training is a component of entry-level courses (Basic Training & A School, for example). Advanced courses concentrate on MOS-specific training.

d. Soldiers/students are required to conduct common task and soldierization training after a nine period academic day and on weekends. There is no similar training requirement for Navy students. At the same time students must prepare/study for academic subjects after the nine period academic day ends. Remedial instruction (reteach/retest) must also be conducted outside of the academic day.

e. The typical AIT student/soldier's day consists of a 42/47 period week of MOS technical training plus a minimum of three periods of PT per week. Periods of reteach, retest, and mandatory study halls are also conducted outside of the already crammed 42-47 period week (See AHS Reg 351-1). Students are subject to constant inspections, long formations, fire guard, charge-of-quarters, march-bys and numerous parades. All lights must be out by 2200, therefore students study in the bathroom or with flashlights in bed.

f. Limited training time and lack of time to study may be a contributing factor to the high academic relief/recycle/attrition

rates in some courses. Courses with students from other services often report higher attrition rates for Army students than for Navy or Air Force students.

g. Most drill sergeants do not serve as instructors and many AMEDDC&S instructors do not assist with soldierization efforts.

h. Mandated and required military training is not documented in most AMEDDC&S Program of Instructions (POIs).

i. The 232d Med Bn and the Combat Medical Specialist Division (CMSD, 91B MOS) were consolidated in 1993 and the student environment has improved. The Dean, AHS, is the intermediate rater for the Battalion Commander, 232d Med Bn, who in turn is accountable for 91B training, common task reinforcement, and soldierization tasks. Drill sergeants also serve as instructors for CTT and FTX but most do not teach academic material. AN officers are assigned as training officers from the Academy Battalion and 91B/Cs are assigned as instructors from the Academy Battalion. The Commander, 232d Med Bn, works for the Brigade Commander and is caught in the middle between the Brigade Commander and the Commandant/Dean. There is a strong belief within the 232d Med Bn that the 232d Med Bn should be under the AHS.

IVa. ISSUES:

a. How can the AMEDD develop and maintain an environment that allows for achieving a proper balance between academic training and soldierization/task objectives?

b. What is the best environment for cost effective training that allows for maximum transfer of learning?

c. What is the AMEDD primary training priority at the AHS - soldierization or technical proficiency? Does the Brigade exist to support the teaching mission or does the school exist to support the Academy Brigade?

d. What is the most effective organizational structure to maintain and provide a balance between technical training and soldierization during a time of constrained resources?

e. Many Departments have courses that are presently being considered for ITRO. They are concerned that the Army student environment and facilities will prevent AHS from being selected as a training site. Most Department Chiefs feel some savings and efficiencies will be realized from ITRO and strongly support ITRO initiatives. Does the AHS lose ITRO proponency because of the status of the existing student environment?

Va. DISCUSSION:

The AHS has successfully conducted business for many years under its present configuration of teaching divisions/ departments and subordinate functional branches. In fact, the present organization has produced many outstanding products which are nationally recognized for excellence. However, the current fiscally constrained operating environment dictates that the command explore alternate organizational designs that not only save resources but also maintain the quality of the AMEDDC&S

various products.

There are several possible design alternatives that offer potential savings. One option is to organize by process instead of function. Organizing by process is a popular design strategy in industry today. This organizational design strategy is a marked departure from how the AHS currently operates and is focused on streamlining the organization, reducing non-value added activities, and focusing on the Military Occupation Specialty (MOS)/AOC producing process instead of functions.

The process option implies reorienting the entire training function around the natural environment a student would face in the field (i.e., under the direct supervision of his/her normal supervisor. This approach would not organize the schoolhouse around an academic discipline [e.g., Behavioral Science], a medical area [e.g., Laboratory Science], or a Corps [e.g., Dental Science]). A process reorientation would have the supervisor responsible for not only teaching the skills and knowledge required on the job, but also for providing soldier care and feeding throughout the training cycle. In other words, a 91B soldier would have a Noncommissioned Officer (NCO) primary instructor who would teach all of the required skills and tasks while simultaneously leading the student in a non-MOS related tasks (i.e., Physical Training, study halls, etc.). The supervisors of the NCOs would be the normal supervisor in a

field/work setting, in this example, a physician assistant (PA) or a nurse.

This approach would in turn mean that the PA/nurse (in the example of 91B10 training) would also command the unit to which the soldiers are assigned. The argument that the PA/nurse has insufficient expertise to command is spurious, especially in view of the increasing number of nurses who are assessed from ROTC programs where they receive the same leadership experiences and training as their combat arms counterparts.

The biggest problem with organizing the school in the above fashion is that it requires a completely new mind set and a totally different organizational structure. The process option is similar to the merger of the 232d Medical Battalion and the Combat Medical Specialist Division (CMSD) that was made effective on 12 April 1993. Given that a reorganization along process lines for the entire school is somewhat radical, it might be wise to implement three or four pilot programs. Also see enclosure 2, Armor School.

VIa. RECOMMENDATIONS:

a. Drill Sergeants should only be required for 91B10 training. Cadre sergeants/instructors should replace drill sergeants for other courses.

b. The philosophy on parades should be re-evaluated and

limited to fewer parades per quarter (perhaps only one). Recommend considering having smaller retirement ceremonies at the 5th Army quadrangle.

c. March-bys should be discontinued and fire guard detail consolidated with charge-of-quarters (CQ) responsibilities.

d. The soldier's environment needs to be improved and excessive inspections and soldierization should stop immediately.

e. Open barracks should be renovated ASAP to provide smaller rooms and student study areas in the rooms.

f. Complete the reorganization of the 232d by reassigning to the 232d, Training Officers (ANs) and 91B/C instructors currently assigned to the Academy Battalion, but attached and teaching in the 232d Med Bn. Ensure that Drill Sergeants also serve as 91B10 instructors IAW TRADOC 350-6. Consider PAs & ANs for positions of company commander and executive officer and battalion commander and executive officer.

g. Courses such as those currently in Dental, Nursing, Preventive Health Services, and Medical Science departments should organize similar to the 232d or 18D model. These model battalions/companies would serve as a pilot program to test the process model (see Encl 2). If the pilot program proves effective, complete the reorganization from teaching departments to training companies and training battalions. "Dual hat" - the Dean/Commandant and Brigade Commander. (This may involve the eventual creation of more battalions than the current three).

IIb. THEME:

Even though the role of the Department Chief has been expanded, Department Chiefs generally do not concern themselves with long range planning for the future and the development and integration of new operational concepts and doctrine into the area of interest. Most Department Chiefs spend the majority of their time involved in the daily operations of their departments.

IIIb. FINDINGS:

Little evidence was found that Department Chiefs incorporate and integrate outcomes and products generated by ECBRS into their respective products and training materials. There is limited interface between teaching departments and the Directorate of Combat and Doctrine Development (DCDD). Personnel interviewed stressed that this had been a problem for years due to lack of time. Some of the DCDD clinical consultants provide instruction into their respective AHS areas but this is not the norm. Many lesson plans contain outdated doctrine. Programs of instruction (POIs) can't seem to keep up with doctrine changes. Many training developers, including ISSs and the teaching staff, do not research the latest doctrine.

IVb. ISSUES:

a. How can state-of-the-art doctrine be incorporated into the training base in a timely manner?

b. Should doctrine developers and writers also be

instructors?

c. Are teaching staff adequately oriented to the role and contributions of DCDD?

d. Faced with the demands of teaching, academic counseling and current staffing, is it realistic to expect the teaching staff to maintain a close relationship with DCDD?

Vb. DISCUSSION:

Department Chiefs currently provide subject matter experts (SMEs) to develop preliminary drafts that are used to revise existing doctrinal publications.

New doctrine. The doctrine developers then integrate recommended changes into the doctrinal manuals and ensure that these manuals are in the proper TRADOC and Army format. Despite participating in the development process, SMEs rarely incorporate proposed changes into their respective training courses. Generally, the departments wait until the new doctrine is officially published before they alter their respective curriculum POIs. Hence, there is always a lag between doctrine input and training design. In an era when change was not rampant this may have been an acceptable outcome. Today, however, with the pace of technological innovation and the emergence of the rapid prototyping process to speed up the acquisition and fielding process, such a lag cannot be tolerated. Somehow the training developer and the trainer must be more effectively tied to the doctrine and concept developer.

Department Chiefs must become more involved in the concept and doctrine development process to ensure that the latest doctrine is taught. One alternative would be to make the training department/MOS proponent responsible for development of all phases of training material to include doctrine manuals. Instructors that are involved in the writing of doctrine will be more likely to update lesson plans based upon doctrine if they are involved in the doctrine process. Another alternative is to assign a liaison to DCDD that has knowledge of ECBRS and the training process. Liaisons would coordinate and integrate doctrine into the training base.

The DCDD consultants and representatives of the AMEDD Corps must increase their visibility with the teaching departments. The Faculty Development course must orient all new instructors to the role of DCDD and the importance of incorporating the latest doctrine into training.

VIb. RECOMMENDATIONS:

Accountability for doctrine development or doctrinal input should be clarified between the department chief and the Doctrine Literature Division. Development of new doctrine should belong to the doctrine development section. If a given effort involves a comprehensive overhaul as for example in responding to the Force XXI concept, then an SME should be attached to the Project Chief as required. This doctrinal effort should be focused on

producing the next generation of doctrinal material. If the doctrinal effort involves the rewrite or editing of existing doctrine that should be the responsibility of the teaching department chief. Again, if the effort involves a number of AOCs, then a project team may be called for. Both of these doctrinal efforts should be ongoing simultaneously.

IIc. THEME:

The number of staff and faculty has been significantly reduced but the number of students and courses have remained the same and accreditation requirements have increased.

IIIc. FINDINGS:

a. The number of AHS numbered MOS/ASI courses have increased over the years. Numerous functional courses have been added; some courses have been lengthened; but very few courses have ever been deleted.

b. A DOES study in 1992 revealed that many of the functional courses were not linked to an MOS/area of concentration (AOC) or have ITPs/POIs dated prior to 1989. AOC or warrant officer specialty Individual Training Plans (ITPs) are contained at enclosure 3.

c. Accreditation requirements have caused some courses to double in length and to train tasks that are not directly related to readiness. For example, the X-ray Specialist, 91P10, course length more than doubled to met program accreditation standards.

Alternatively, the Dental Corps elected not to lengthen their courses simply to meet accreditation standards because to do so (or to adopt a civilian equivalent program standard) would require the existing dental program to double or triple in length. Yet, their programs continue to be of high quality, support readiness, and provide excellent dental support to our soldiers. Other courses such as the Laboratory Specialist 92B30/91K10 course lengthened by seventeen weeks in order to meet hospital requirements (CLIA88).

IVc. ISSUES:

a. Can the AMEDD afford to train students to meet accreditation and licensure standards?

b. Should the Department of Dental Science be rewarded for effective management or encouraged to seek program accreditation like other MOSs have? What is the standard medical readiness or accreditation/licensure?

c. Can the AMEDD afford to provide functional courses that are not even mentioned in a parent ITP or that haven't been updated in over 5 years?

d. Do we adequately resource and train priority MOS courses to meet readiness requirements or do we continue to marginally resource numerous functional courses and low density MOS courses that could be trained by contract instructors or a civilian institution?

Vc. **DISCUSSION:**

While licensure and accreditation standards are reflective of high quality, they are not achievable without incurring considerable costs. In a different era, it may have been desirable to strive for the highest possible standards but in a case of dwindling resources the trade-offs for seeking accreditation may need to be re-evaluated. Each course that is currently accredited should be carefully analyzed to determine if that accreditation standard is absolutely required and affordable. Relevant benchmarking data from the other services should be considered in any re-evaluation. Further, the accrediting agency should also be evaluated. Is such a body the best possible candidate or are other possibilities viable? When was the accrediting contract last opened for external competition?

A second major academic area that needs to be re-analyzed is the graduate program. Historically, it has been argued that a minimum of personnel (4) are involved in the Baylor Health Care Admin Course. Recently, however, the course has expanded to include additional tri-service personnel as well as civilians. Given that the AMEDDC&S is likely to revise both the Officer Basic Course as well as the Officer Advanced Course, perhaps it is time to re-evaluate the cost effectiveness of the Health Care Course. At the very least, the policies regarding who can attend and the pay-back period ought to be revisited. It seems to make

no sense to assign senior level officers to the course, (e.g., colonels, senior lieutenant colonels). Nor does it seem to make sense to limit the pay-back period to 3 years, a period which runs concurrent. Normally, the pay-back period for graduate level is 3 for 1, starting upon graduation. If this policy were applied to the Baylor course availability would improve. Certainly, any excess capacity could be wisely assigned to the HSSAs which are all heavily involved in lead agency and contracting issues. Additionally, officers other than MSC could also be utilized at the HSSA.

Finally, it is suggested that wherever possible recruitment qualifications or hiring credentials should be re-looked with respect to eliminating the need for some low density courses or outdated functional courses, e.g., drug and alcohol courses.

VIc. RECOMMENDATIONS:

a. Consider the list of courses for deletion, civilian contract or transfer to other AMEDD locations (Encl 4). Have AHS departments determine priority courses and require deletion of lower priority courses.

b. Review accreditation requirements and delete material taught that supports only accreditation unless required by law. Courses must focus on readiness.

c. Train priority AOCs, MOS, leadership, and mandated functional courses only. Determine most effective way to train

or contract instruction for low density specialist courses.

d. Consider deleting graduate courses and using long term civilian training.

e. Consider recruiting fully credentialed PAs instead of institutional training through our current OCS training program.

IId. THEME:

The mission of the Faculty Development Course is to prepare quality instructors and orient new faculty to instructional design and development. However, it is the perception of many teaching departments that the process of credentialing faculty does not adequately meet teaching department needs.

IIId. FINDINGS:

a. Teaching departments reported that it can take up to 6 months before a new instructor can attend the 2 1/2 week Faculty Development Course (FDC) due to a lengthy waiting list.

b. Teaching departments reported that newly assigned faculty cannot be utilized as instructors even if the new faculty hold graduate degrees and/or have years of teaching experience elsewhere. Newly assigned instructors who provide proof of successful completion of FDC are still required to have "credentials" reviewed by FDC personnel, attend selected FDC presentations and present a class in their teaching department (FDC-Phase 2) prior to being issued an AMEDDC&S Instructor Badge.

c. Some Teaching Departments allow individuals such as IMA Reservists to teach as "guest speakers" so they do not have to

attend a 2 1/2 week FDC.

d. Some Teaching Departments have newly assigned personnel who are awaiting FDC (and who are SMEs in their specialty) teach while a credentialed instructor sits in the back of the classroom.

e. The FDC does provide thorough instruction in lecture and demonstration format presentations using a "say-show-tell" method which is helpful for inexperienced, newly assigned instructors. However, many Teaching Departments stated that students find the "say-show-tell" teaching style boring and dislike "fill in the blank" mimeos. Several instructors reported that they disliked this teaching style but use it to satisfy what they believe is and AMEDDC&S requirement.

f. The FDC provides an overview of the SAT process, computer software (WordPerfect and Harvard Graphics), AMEDDC&S guidelines for LPs, mimeos, test item development and use of media services.

IVd. ISSUES:

a. Can the AMEDDC&S afford to have newly assigned personnel unable to instruct for months because of limited FDC seats/long waiting lists for FDC?

b. What is the most efficient and cost effective training and orientation for newly assigned instructors?

c. Should teaching departments/branch chiefs who are qualified to instruct determine what type of training is required

for their faculty? Can the responsibility for training instructors be given to branch/department chiefs?

d. Do faculty with teaching experience and/or graduate degrees need to be in the same FDC as inexperienced faculty? Do department chiefs with minimal teaching responsibilities need to complete FDC? Do subject matter experts (SMEs) who are USAR members require FDC prior to teaching at the AMEDDC&S during ADT?

e. Are the "say-show-tell" method of instruction and mimeos the best and only way to provide large group instruction?

Vd. DISCUSSION:

The AHS Staff and Faculty Development Branch is the primary agency for delivering and coordinating staff and faculty training. TRADOC Reg 350-7 states that TRADOC schools and Army training centers will implement TRADOC's Train the Trainer Program by training core objectives to the established standard using either the TRADOC-developed materials or school-developed and validated materials. School commandants or their designated representatives approve all locally developed programs of instruction before Staff and Faculty Development Branch conducts the course. TRADOC Common Core Curriculum covers 13 different areas with 25 hours recommended to cover the material (see enclosure 5). The current FDC at AHS consists of 13 days of core curriculum/classroom training followed by a Phase II where Department/Branch Chiefs evaluate a presentation by the instructor candidate. The Staff and Faculty Development Branch

Chief stated that the AHS FDC complies with TRADOC regulatory requirements and in addition, develops an AHS-specific agenda and curriculum. The AHS FDC is taught by ISSs who are graduates of the FDC.

VId. RECOMMENDATIONS:

a. Consider applying the Army model of "Train the Trainers" to the training of newly assigned instructors. Empower Department/Branch chiefs to conduct training of their new instructors through ISSs assigned to the teaching department. Branch Chiefs would determine the appropriate training required for each newly assigned instructor based on individual and Branch needs. In addition, each instructor candidate would complete a FDC correspondence course for TRADOC core curriculum material that includes standardized materials such as LP format, test items, etc. The correspondence course should be developed by FDC with assistance from distributed training developers.

b. Formalize a mentoring program of experienced instructors with new instructors.

c. Develop a modified FDC for Department Chiefs and Branch Chiefs as already recommended by the Dean. Staff and Faculty Development Branch must develop this course with feedback from Department Chiefs and Branch Chiefs. This modified course must meet the needs of senior level staff (to include content and course length) and focus on integration of issues to include doctrine development and proponency as well as the SAT process.

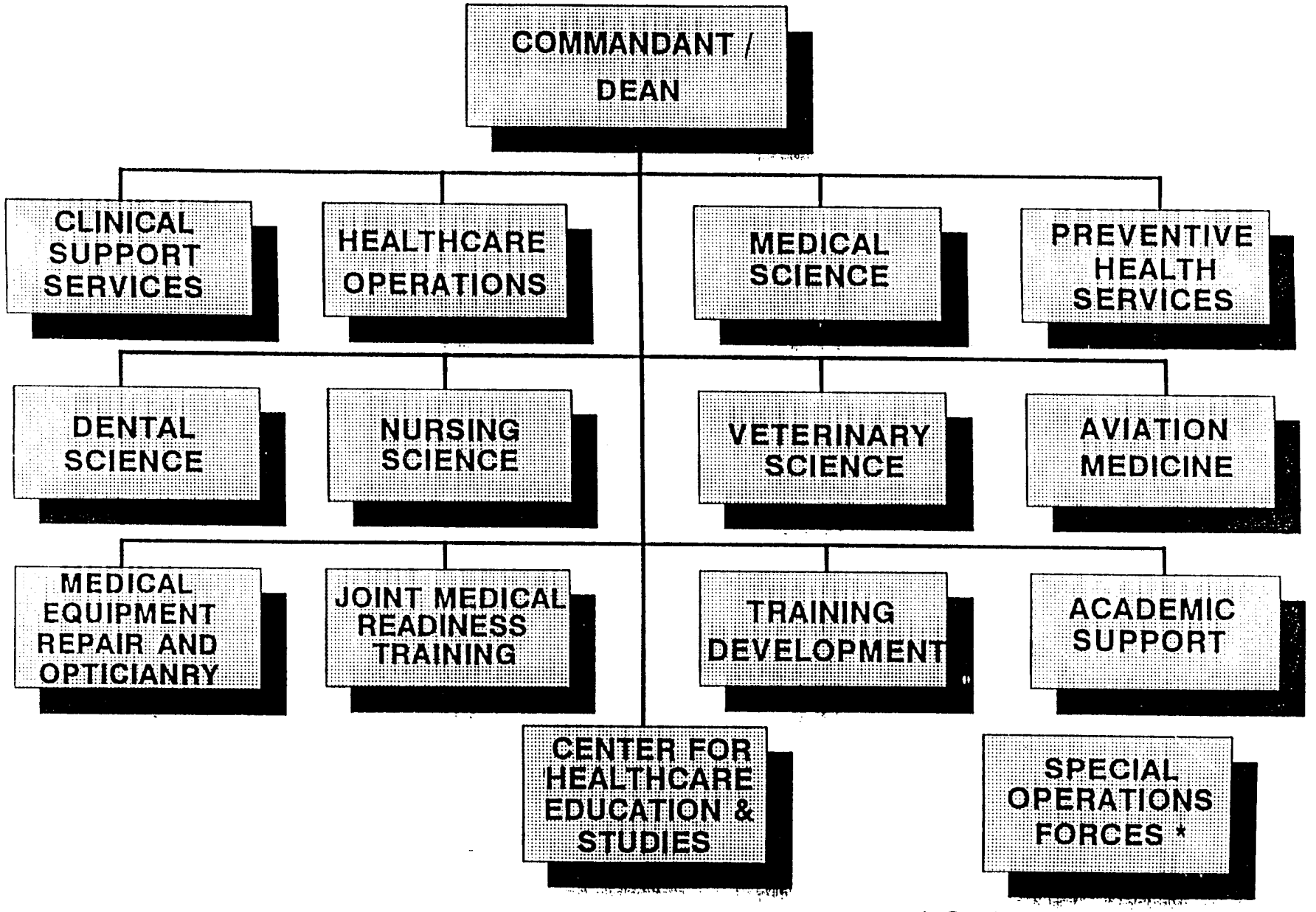
d. Develop a FDC for ISSs assigned to Teaching Departments that would prepare them to train and evaluate personnel assigned to instructor positions in Teaching Departments.

e. Provide a centralized orientation program (not to exceed 8 hours) for all newly assigned personnel. The program should consist of an overview of the organizational and support elements and services within the AMEDDC&S, essential regulations and a brief overview of the SAT process. An overview of DCDD and APPD functions in relationship to teaching departments is essential.

f. Encourage instructors to use teaching styles that fit the student population, subject material and their own preference.

g. Branch chiefs must monitor instruction on a regular basis as well as encourage feedback from students and monitor course success/attrition rates.

New Structure of the Academy of Health Sciences (AHS), USAMEDDC&S



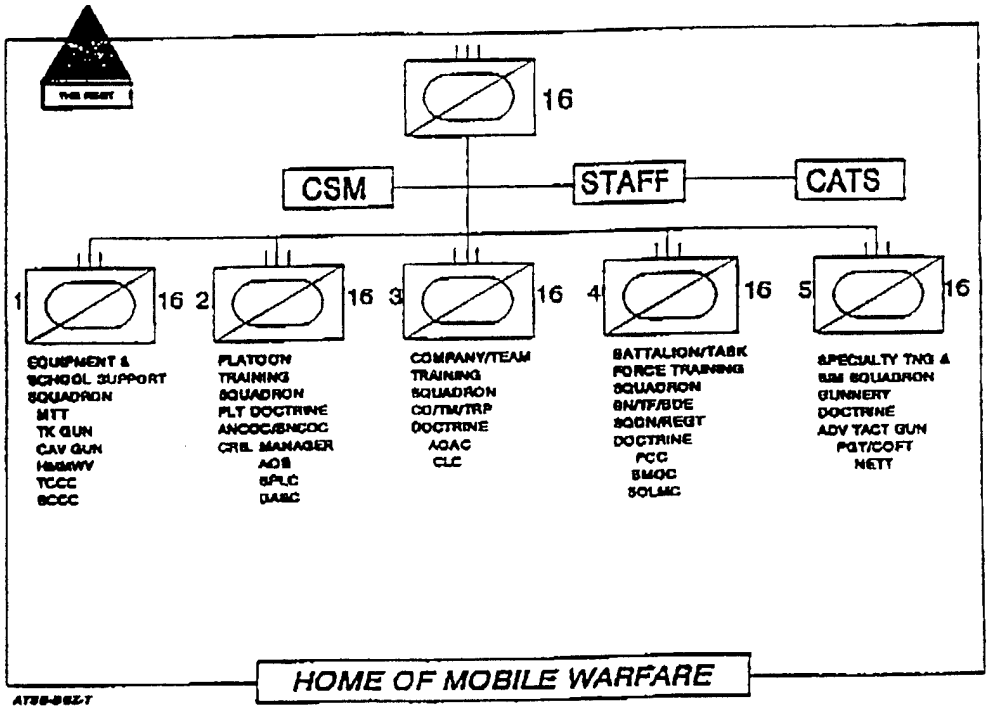
* Co F, Acad Bn, Transfer to Ft Bragg, NC in FY

REGIMENT HEADQUARTERS

16th Cavalry Regiment headquarters is located in Building 1468A at 3rd and Old Ironsides Avenues.

REGIMENTAL SQUADRONS

The 16th Cavalry Regiment is comprised of six subordinate units designated as the 1st, 2d, 3d, 4th, 5th Squadrons of the 16th Cavalry and the Combined Arms Training Strategies Division (CATS). Each squadron is designed and responsible for training a specific group of mounted warfighting leaders or supporting their training with equipment and simulators (Figure 3).



16TH CAVALRY REGIMENT ORGANIZATION

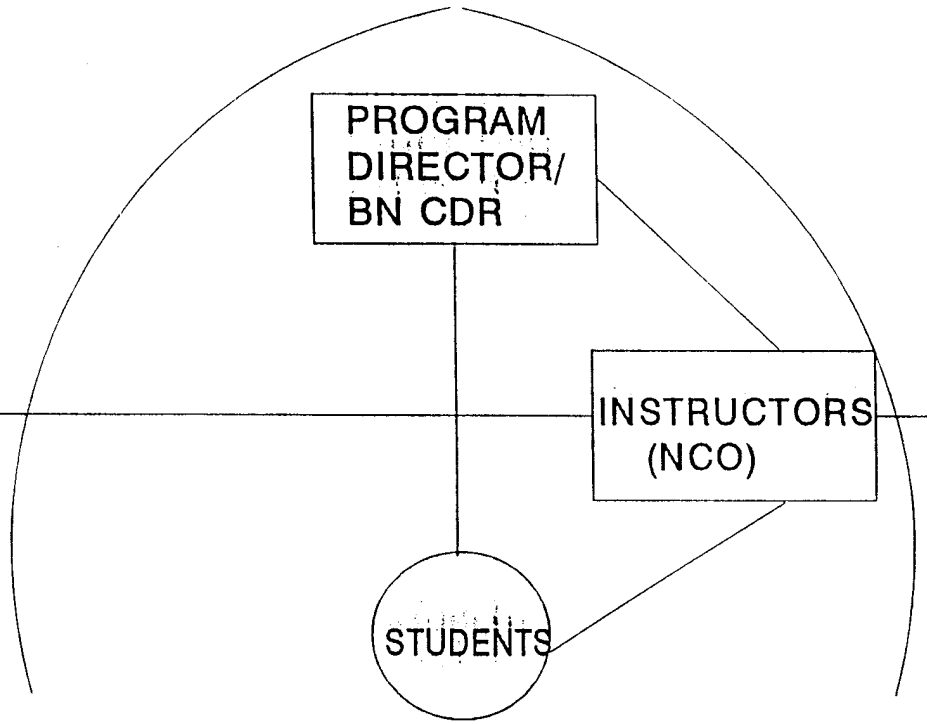
enc 2

BASIC BUILDING BLOCK

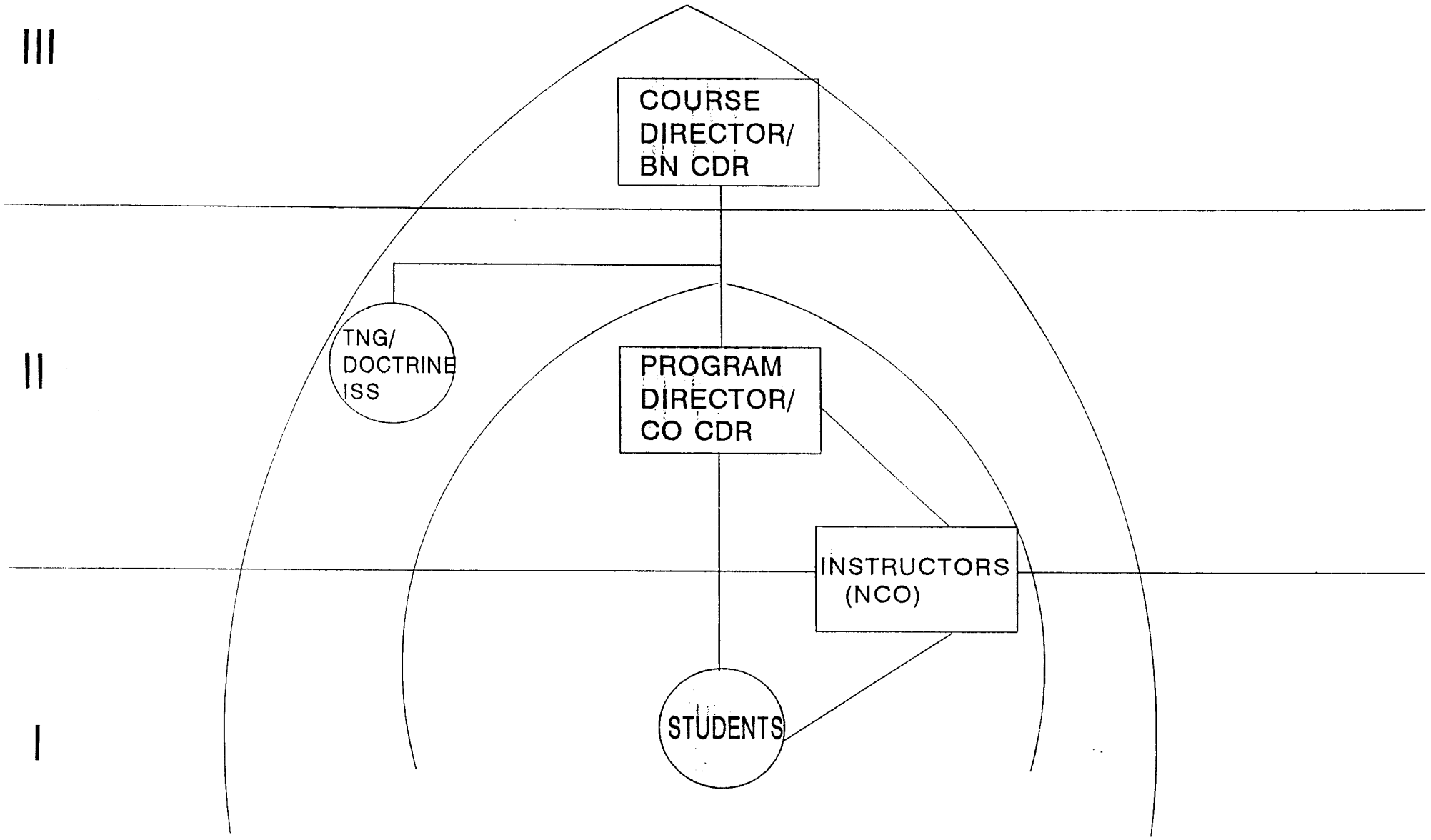
III

II

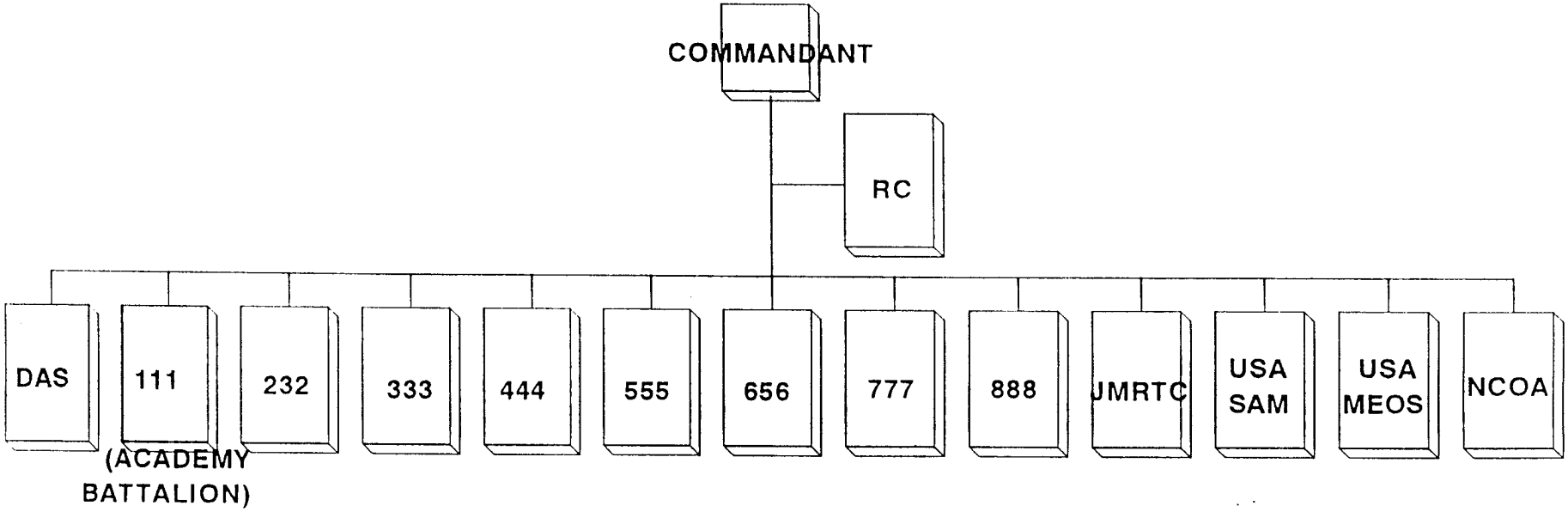
I



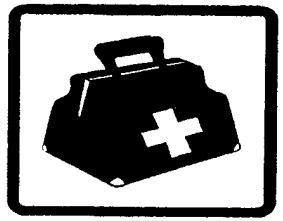
BATTALION BUILDING BLOCK

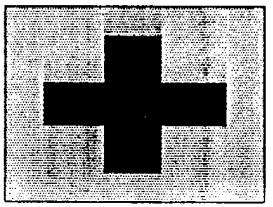


DEAN/BRIGADE CONCEPT



333D MEDICAL BN





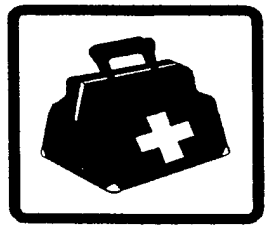
LTC
MAJ
E-9

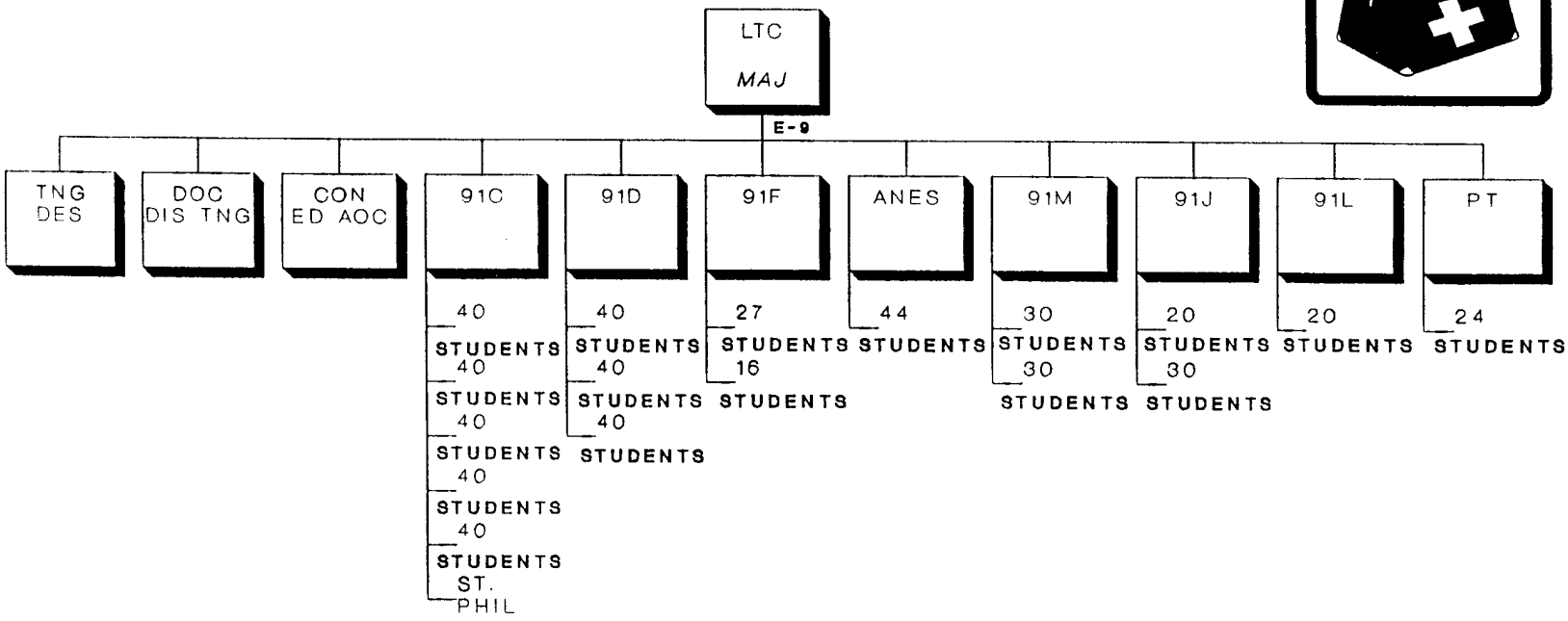
- TNG DES
- DOC DIS TNG
- CON ED AOC
- 91H
  - 20 STUDENTS
- 91V
  - 25 STUDENTS
  - 25 STUDENTS
  - 25 STUDENTS
- 91U
  - 15 STUDENTS
- 91Y
  - 15 STUDENTS
- PA
  - 25 STUDENTS
  - 25 STUDENTS
- F4
- CLIN SUPT SUBJ
  - SHORT COURSES
  - A&P

+ 5 CADRE SGTS
+ 1 OPS NCO

ENR 7

444TH MEDICAL BN





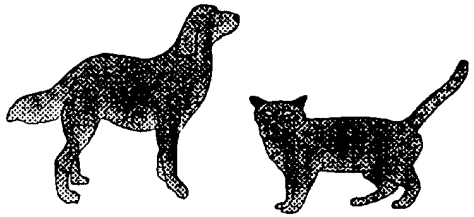
+ 7 CADRE

+ 1 OPS NCO

555TH MEDICAL BN

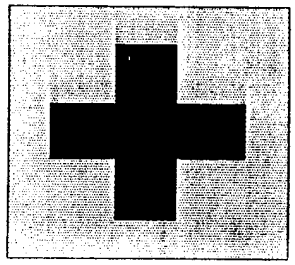
LTC
MAJ
E-9

TNG DES	DOC DIS TNG	CON ED AOC	91T	91R	91S	91SN4	91G	GAF5	WO
			20 STUDENTS	20 STUDENTS	35 STUDENTS 35 STUDENTS	30 STUDENTS	30 STUDENTS 30 STUDENTS	28 STUDENTS 28 STUDENTS	

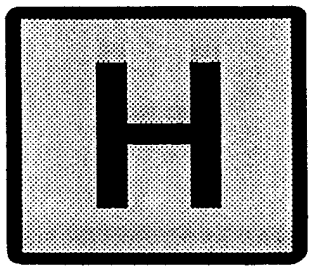


+4 CADRE
+1 OPS NCO

656TH MEDICAL BN



777TH MEDICAL BN



LTC

MAJ

E-9

TNG DES

DOC DIS TNG

CON ED AOC

91P

91Q

91K

20 20 20 20

25 25 25 25

30 30 30 30 30

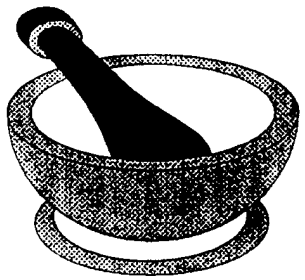
STUDENTS

STUDENTS

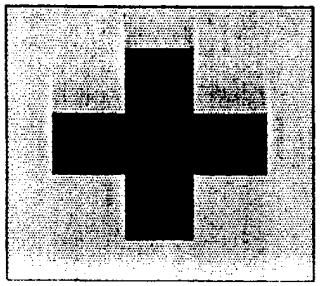
30 30 30 30 30

STUDENTS

+4 CADRE
+1 OPS NCO



888TH MEDICAL BN



COL

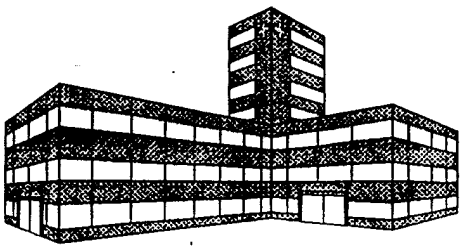
LTC

E-9

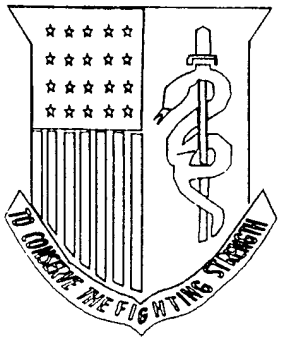
TNG DES	DOC DIS TNG	CON ED AOC	CBC	OAC	76J	71G	8BFSO
			40 STUDENTS	40 STUDENTS	20 STUDENTS	25 STUDENTS	
			40 STUDENTS	40 STUDENTS		25 STUDENTS	
			40 STUDENTS	40 STUDENTS			
			40	40 STUDENTS			

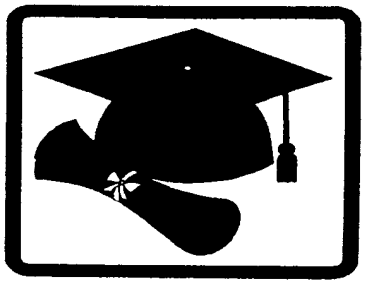
+2 CADRE

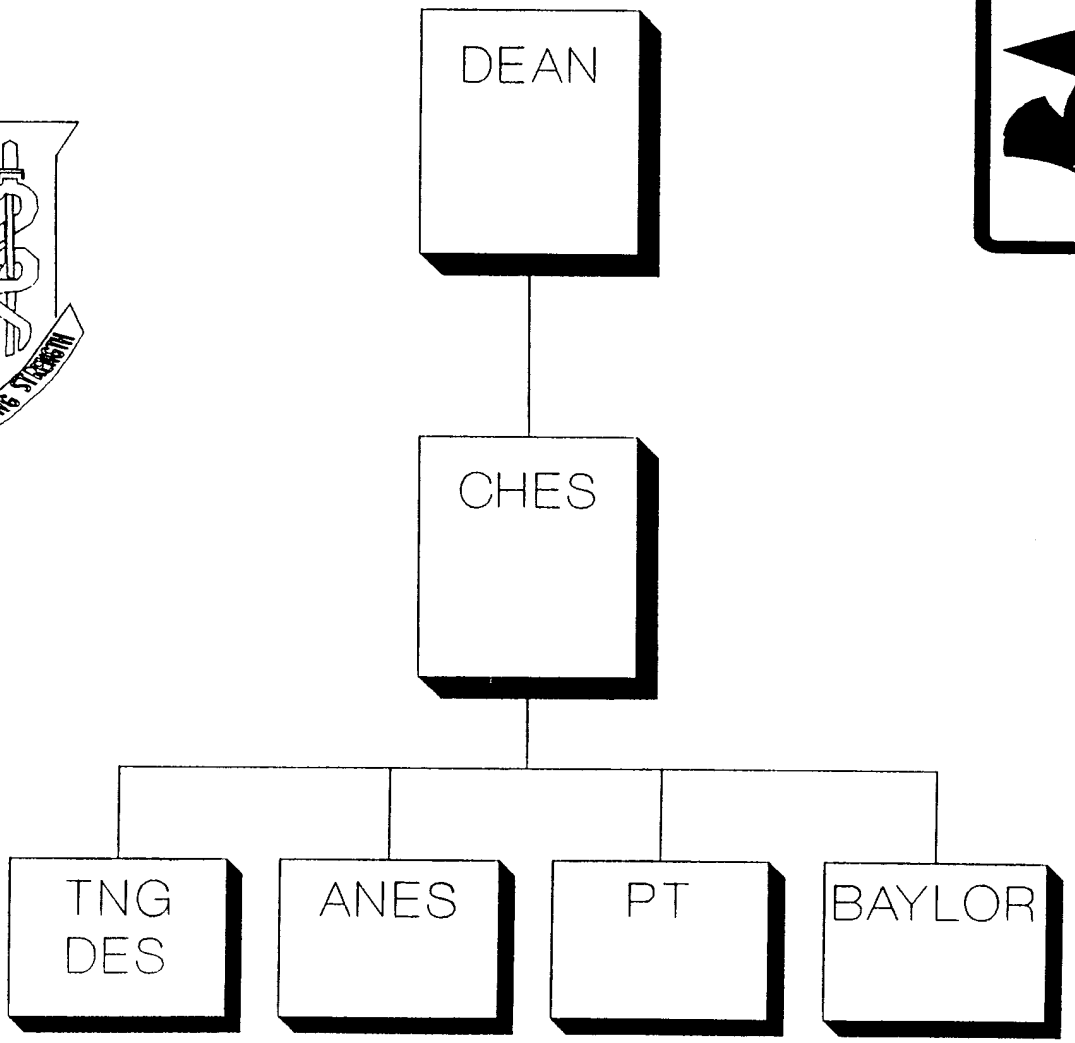
+ 1 OPS NCO



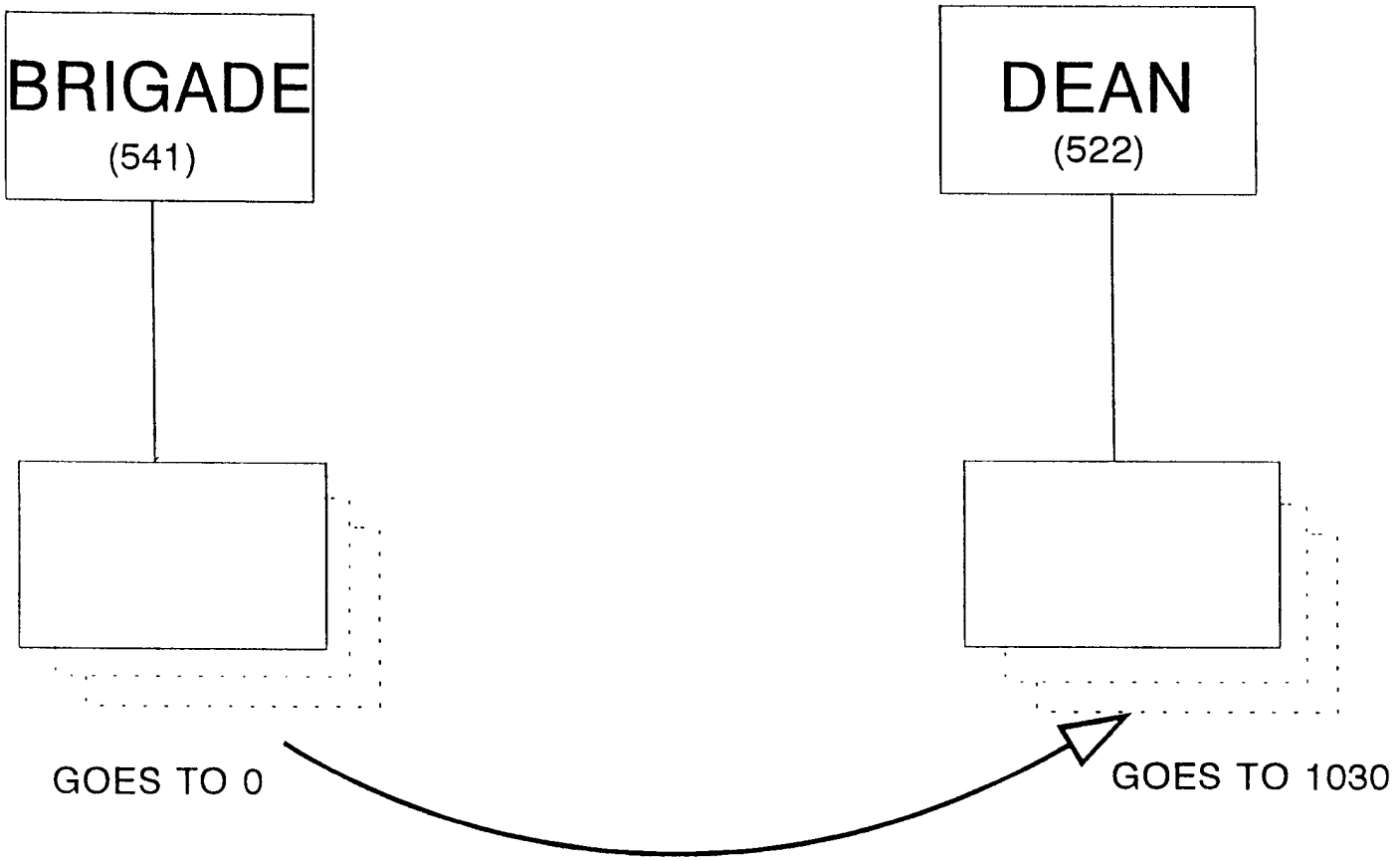
GRADUATE EDUCATION BN







BRIGADE-COMMANDANT INTEGRATION



SAVINGS

- 33
- 232d POSSIBLE +16 TBD
  (IF EMT ELIMINATED)
- DELETE) ; IN 187th +5

HSHA-EE (351f)

2 November 1992

MEMORANDUM FOR Assistant Commandant

SUBJECT: Review of Functional Course Documentation in TRAS Repository

1. The Directorate of Evaluation and Standardization (DOES) has reviewed the Individual Training Plans (ITP), Course Administrative Data, and Programs of Instruction for the Functional Courses in the TRAS repository. For this review, functional courses were considered IAW AR 350-10 which states that functional courses: "enhance the effectiveness of military personnel in specific skill areas that are needed to fill immediate training requirements that cannot be met effectively by other means. These courses do not award an AOC, MOS, SQI, ASI." Career development courses were also considered as functional due to the ambiguity of what constitutes a career development course.

2. Quality TRAS documents are critical for effective resource estimates and course management. The TRAS identifies training and resource requirements in a timely manner to integrate the training development and implementation process with external resources acquisition systems which provide the support for training development.

3. The ITPs are key resource and planning documents. Both TRADOC Reg 351-1 and AHS Reg 351-1 state that an ITP is prepared for each enlisted MOS, warrant officer MOS, and separate functional training programs. AHS Reg 351-1 requires an ITP for each commissioned officer course. Baseline costs need to be analyzed, identified, and included in all ITPs for all courses at each skill level to validate course resource requirements.

4. Currently 68% of the functional courses either have no course documentation in the DOES repository or have documentation which is older than five years. In the majority of instances, functional courses should be included in the parent ITP (e.g. the 35G/35U ITP should contain the baseline cost for the Advanced Digital Theory and Microprocessor functional courses). Functional courses which are open to a cross section of personnel (e.g., officer, enlisted, civilian and other branches of the Armed Services) may require individual ITPs.

5. The DOES recommends that maximum emphasis be placed on the development and/or update of TRAS documents that include baseline resource estimates. Enclosures 1 and 2 provide specific information on the documents presently on file in the repository. This information has been verified by the Deans and DOTD.

enc 3

HSHA-EE (351f)
SUBJECT: Review of Functional Course Documentation in TRAS Repository

6. Point of contact is Ms. Southern, X18554/16001.

2 Encls

MARC G. CLOUTIER
Lieutenant Colonel, MS
Director of Evaluation
and Standardization

28 October 1992

REVIEW OF FUNCTIONAL COURSES

A review of forty-nine (49) AMEDDC&S functional courses in the Training Requirements Analysis System (TRAS) repository reveals that:

16	(33%) have ITPs (approved and non-approved)
13	(27%) have ITPs approved by the OTSG
7	(14%) have baseline costs identified
5	(10%) have incremental/decremental cost data
17	(35%) have no course documentation in DOES
16	(33%) have course documentation which is older than 5 years

Encl 1

FUNCTIONAL COURSES

SITE/NO	TITLE	ITP	BS$	INC/DC	POI	WKS	PROP	TYPE *
WRAMC:								
6F-F8	RENAL DIALYSIS NURSE EDUC.	86 (CCL)	NO	NO	87	6	NS	OFF SP
6H-F21	HEMATOLOGY/ ONCOLOGY PHAR SERVICES	NA	NO	NO	87	2	MED&SU	OFF FU
WRAIR:								
6H-F23	TROPICAL MEDICINE	90(SG)	NO	YS	83	6	PMD	OFF FU
EHA:								
6H-F10	ADV INDUST HYGIENE	NA	NO	NO	88	2	PMD	OFF/ENL FU
6H-F17	LASER & RADIO FREQ RAD HAZARDS	NA	NO	NO	91	1	PMD	" "
6H-F20	OCCUP. HLTH	NA	NO	NO	83	1	PMD	OFF SP
BAMC:								
6F-F5	CRITICAL CARE NURSING	91(SG)	NO	NO	90	16	NS	OFF SP
FAMC:								
6H-F19	NUCLEAR PHAR ORIENTATION	90(?)	NO	NO	83	2	MED&SU	OFF FU

BS$: Baseline Cost
INC/DC: Incremental/Decremental
ITP: Individual Training Plan
POI: Program of Instruction
PROP: Proponent
WKS: Weeks

SITE/NO	TITLE	ITP	BSS	INC/DC	POI	WKS	PROP	TYPE
USAMRIID:								
6H-F24	MED DEFENSE AGAINST BIO WARFARE & INF DISEASE	89(SG)	YS	NO	85	3DAY	PMD	OFF/ENL FUNC
USARICD:								
6H-F25	MEDICAL MGMT OF CHEM CAS	90 NOT APPR	YS	NO	91	1	PMD	OFF FU
USASAM:								
2C-F7	AERO MED EVAC OFFICER	89(SG)	YS	YS	90	2	SAM	OFF FU
300-F6	FLIGHT MED AIDMAN CRS	88(SG)	NO	NO	89	2	SAM	OFF SP
6A-61N9D	ARMY FLIGHT SURGEON	90(SG)	NO	YS	91	6	SAM	OFF SP
6A-6AN9D (RC)	ARMY FLIGHT SURG (PH 2)	PARENT	NO	NO	NA	3	SAM	OFF SP
USAMEOS:								
4B-F4	ADV DIGITAL THEORY	87(SG)	NO	NO	88	1	MEO	ENL FU
4B-F7	MICROPROCESS	87(SG)	NO	NO	88	3	MEO	ENL FU
MFSS:								
300-F10	GENERAL MED ORIENTATION	84 NOT APPR	NO	NO	90	4	CMSD	ENL
313-F1	RADIOLOGY NCO MGMT	1 line in 91P	YS	NO	87	1	MED&SU	ENL FU
5H-F01	USAADAPCP EDUC COORD	NA	NA	NO	91	1	BEH SC	OFF & DAC FU

SITE/NO	TITLE	ITP	BS$	INC/DC	POI	WKS	PROP	TYPE
5H-F03	USAADAPCP CIV PROG COORD	NA	NO	NO	91	1	BEH SC	OFF & DAC FU
5H-F04	USADART IND DRUG & ALCOHOL REHAB TRNG	76(CCL)	NO	NO	89	2	BEH SC	ENLSSI DAC FU
5H-F05	USADART GROUP DRUG & ALCOHOL REHAB TRNG	NA	NO	NO	89	2	BEH SC	ENLSSI DAC FU
5H-F06	USAADAPCP ALCOHOL & DRUG CONTROL OFFICER	83(RA)	NO	NO	91	1	BEH SC	OFF & DAC FU
5H-F07	USAADAPCP FAMILY SVC	84(RA)	NO	NO	91	2	BEH SC	ENL & DAC FU
FH-F08	USAADAPCP FAMILY COUNSELING	83(RA)	NO	NO	91	2	BEH SC	ENL & DAC FU
5H-F09	USAADAPCP CLINICAL DIRECTOR	NA	NO	NO	91	2	BEH SC	O,E,C FU
5H-F10	USAADAPCP ADV COUN	NA	NO	NO	89	1	BEH SC	ENL & DAC FU
5H-F20	FAMILY ADVOCACY STAFF TRNG	84(RA)	NO	NO	90	2	BEH SC	OPEN ENROL
5H-F21	FAMILY ADVOCACY STAFF TRNG ADV	88(SG)	NO	NO	90	1	BEH SC	OPEN ENROL
6-8-C8	VET CORPS PLANS & OPS	79(RA)	NO	NO	90	2	VET SC	OFF FU

SITE/NO	TITLE	ITP	BS$	INC/DC	POI	WKS	PROP	TYPE
6A-DCCS	DEPUTY CMDR CLIN SVC	91(SG)	YS	--	91	2	HCA	OFF FU
6A-F6	PREV MED PROG MGMT	92(SG	NO	YS	90	2	PMD	OFF FU
6F-F2	PRINC OF ADV NURS ADMIN	NA	NO	NO	90	2	NS	OFF FU
6F-F3	AMEDD OFF CLINICAL HEAD NURSE	NA	NO	NO	90	2	NS	OFF FU
6G-F2	VET SVC IN THR OF OPS	78RA	NO	NO	89	3	VET SC	OFF FU
6G-F3	INSTALLATION VET SVC	77RA	NO	NO	89	2	VET SC	OFF FU
6G-F4	SUPPLY POINT VET SVC	?CCL	NO	NO	89	1	VET SC	OFF FU
6G-F5	QUALITY AUDIT SUBSIST ANCE	77RA	NO	NO	89	2	VET SC	OFF FU
6G-F6	DEPOT VET SVC	NA	NO	NO	NA	1	VET SC	OFF FU
6H-F9	SEX TRANS DISEASE INTERVIEW	88(SG)	YS	NO	88	2	PMD	O,E,C FU
6H-F11	BASIC IND HYGIENE	NA	NO	NO	88	2	PMD	O,E,C FU
6H-F12	DOD PEST MGMT	78RA	NO	NO	89	3	PMD	O,E,C FU
6H-F13	DOD PEST RECERT	NA	NO	NO	88	4DAY	PMD	O,E,C FU
6H-F15	ENVIR SC & ENGIN PRAC	NA	NO	NO	88	1	PMD	OFF FU
6H-F18	MED X-RAY SURVEY TECH	NA	NO	NO	90	2	PMD	O,E,C FU
6H-F22	PREV & CONTROL OF HOSP ASSOC INFECTION	NA (held biennially)	NO	NO	Excep to pol	1	NS	OFF & DAC FU

SITE/NO	TITLE	ITP	BS$	INC/ DC	POI	WKS	PROP	TYPE
7M-F2	AMEDD BN/BRG PRE-COMMAND	85CCL	NO	NO	87	2	MIL SC	OFF FU
7M-F9	AMEDD TDA PRE-CMD	92(SG)	YS	YS	89	2	HCA	OFF FU
8B-F22	AUTOMATED INV MGMT	79RA	NO	NO	89	2	HCA	O,E,C FU

ABREVIATIONS

ASI:	Advance Skill Identifier
BAMC:	Brook Army Medical Center
BEH SC:	Behavioral Science
CCL:	Course Concept Letter
CMSD:	Combat Medical Specialist
DAC:	Department of the Army Civilian
DDEAMC:	Dwight D. Eisenhower Army Medical Center
EHA:	Environmental Hygiene Agency
ENL:	Enlisted
FAMC:	Fitzsimmons Army Medical Center
FU:	Functional
HCA:	Health Care Administration
LAB SC:	Laboratory Science
MAMC:	Madigan Army Medical Center
MED&SU:	Medicine and Surgery
MEO:	USAMEOS
MFSS:	Medical Field Service School
MIL SC:	Military Science
NA:	Not Available in Repository
NOT APPR:	Not Approved
NS:	Nursing Service
O,E,C:	Officer, Enlisted, Civilian
OFF FU:	Officer Functional
OFF SP:	Officer Specialty
PMD:	Preventive Medicine Division
RA:	Request for Approval
SAM:	USASAM
SG:	Approved by The Surgeon General
TAMC:	Tripler Army Medical Center
USAMEOS:	USA Medical Equipment and Optical School
USAMRIID:	USA Medical Research Institute of Infectious Diseases
USARICD:	USA Medical Research Institute for Chemical Defense
USASAM:	USA School of Aviation Medicine
VET SC:	Veterinary Science
WBAMC:	William Beaumont Army Medical Center
WRAIR:	Walter Reed Army Institute of Research
WRAMC:	Walter Reed Army Medical Center

CANDIDATE COURSES FOR DELETION

NUMBER	TITLE	DEPARTMENT
5H-F02/302-F2	USAADATT	DPHS
5H-F04/302-F4	USADART (INDIV) Phase out by 96	DPHS
5H-F05/302-F5	USADART (GROUP) Phase out by 96	DPHS
5H-F07/302-F7	USAADAPSP (FAMILY) Phase out by 96	DPHS
5H-F10/302-F10	USAADAPCP (ADVANCED COUNSELING) Phase out by 96	DPHS

CANDIDATE COURSES THAT CAN BE TAUGHT BY CONTRACT INSTRUCTORS

NUMBER	TITLE	DEPARTMENT
5K-F3/520-F3	FACULTY DEVELOPMENT	DAS
5K-F4/520-F4	ORIENTATION TO SYSTEMS APPROACH TO TRAINING	DAS
5K-F5/520-F2	SYSTEMS APPROACH TO TRAINING FOR MANAGERS	DAS
311-42E10	OPTICAL LABORATORY SPECIALIST	USASAM
4B-470A/ 198-35U10	MED EQUIP REPAIRERS (ADV)	USASAM
4B-F2/ 198-35G10	MEDICAL EQUIPMENT REPAIRER (UNIT LEVEL)	USASAM
300-91V10	RESPIRATORY SPECIALIST	DMS
300-91Y10	EYE SPECIALIST	DMS
300-F4	ALLERGY/CLINICAL IMMUNOLOGY SPECIALIST	DMS
300-P2 (91U10)	EAR, NOSE, THROAT (ENT) SPECIALIST	DMS
300-Y6	CARDIOVASCULAR TECHNICIAN	DMS

enc 4

322-91X20	HEALTH PHYSICS SPECIALIST	DPHS
5A-F5	PRINCIPLES OF MILITARY PREVENTIVE MEDICINE	DPHS
6A-F6	PREVENTIVE MEDICINE PROGRAM MANAGEMENT	DPHS
6H-F09/322-F9	SEXUALLY TRANS DISEASES (STD) INTERVENTION	DPHS
6H-F10/322-F10	INTERMEDIATE INDUSTRIAL HYGIENE TOPICS	DPHS
6H-F11/322-F11	BASIC INDUSTRIAL HYGIENE TECHNICIAN	DPHS
5H-F20/302-F20	FAMILY ADVOCACY STAFF TNG (FAST)	DPHS
5H-F21/302-F21	FAMILY ADVOCACY STAFF TNG (ADV) (FASTA)	DPHS
6H-F15	ENVIRONMENTAL SCIENCES & ENGINEERING PRACTICES	DPHS
6H-F17/322-F17	LASER AND RADIO FREQ RADIATION HAZARDS	DPHS
6H-F18/322-F18	MEDICAL X-RAY SURVEY TECHNIQUES	DPHS
321-91T10	ANIMAL CARE SPECIALIST	DVS
6G-F2/321-F2	VETERINARY SERVICE IN THEATER OF OPERATIONS (94 CLASS CANCELED)	DVS
6G-F3/321-F3	INSTALLATION VETERINARY ACTIVITIES	DVS
6G-F4/321-F4	SUPPLY POINT VETERINARY SVCS	DVS
6G-F5-321/F5	QUALITY AUDIT OF SUBSISTENCE	DVS
6G-F6-321-F6	DEPOT VETERINARY SERVICES	DVS
2C-F7(MS/WO/RC)	AERO MEDICAL EVAC OFF	USASAM
300-F6	FLIGHT MEDICAL AIDMAN	USASAM
6A-61N9D	ARMY FLIGHT SURGEON	USASAM
6A-61N9D(RC) (PH1)	ARMY FLIGHT SURGEON (RC) (PH1)	USASAM
6A-61N9D(RC) (PH2)	ARMY FLIGHT SURGEON (RC) (PH2)	USASAM

6A-F1	ARMY AVIATION MEDICINE ORIENTATION	USASAM
301-91D10	OPERATING ROOM SPECIALIST	DNS

CANDIDATE COURSES FOR LONG TERM CIVILIAN TRAINING

NUMBER	TITLE	DEPARTMENT
6H-70A67	USA/BAYLOR UNIVERSITY PROGRAM IN HCA	CHES
6H-65B	USA/BAYLOR UNIVERSITY PROGRAM IN PHYSICAL THERAPY	DMS
6H-65D	MILITARY PHYSICIAN ASSISTANT	DMS
6F-66F	USA UTHSC HOUSTON PROGRAM IN ANESTHESIA NURSING	DNS

CANDIDATE COURSES THAT CAN BE PRESENTED BY CONTRACTING WITH COLLEGE/UNIVERSITY

NUMBER	TITLE	DEPARTMENT
311-91K20(MLT)(T)	MEDICAL LABORATORY SPECIALIST TRANSITION	DCSS
300-91C20 6-8-C42(91C)	PRACTICAL NURSE (PHASE I & II)	DNS
312-91Q10	PHARMACY SPECIALIST	DCSS
313-91P10	RADIOLOGY SPECIALIST	DCSS

TRADOC COMMON CORE

Training Support Package (TSP)	Recommended Hrs
1. ITCC Introduction	1
2. Instructor's Role in SAT	1
3. Counseling Duties	1
4. Principles of Learning	1
5. Basic Methods of Training	1
6. Training Aids/Instructional Media	2
7. Communication Techniques	2
8. Classroom Management/Administrative Duties	2
9. Learning Objectives	1
10. Evaluation of Learning/After Action Review	2
11. Lesson Planning	2
12. Hands-on Training Methods	1
13. Lecture/Conference Training Methods	1
---- GRADED 30 MINUTE PRESENTATION ---- (HANDS-ON OR LECTURE/CONFERENCE)	6
15. ITCC After Action Review *	1
	25

* All students must receive training covered in TSPs 01-13, and 15 plus conduct a 30 minute graded presentation using hands-on or lecture/conference method.

TRACKS *	
Hands-on/Lecture Track	14. Small Group Instruction Track
Graded 50 min presentation (different than 30 min pres)	Graded SGI 50 min presentation
10 hrs	14 hrs

* (Students must track depending upon type of instruction they will be utilizing)

TOTAL 35 hrs 39 hrs

End 14

TAB M

ENCLOSURE 14

U.S. ARMY MEDICAL EQUIPMENT AND OPTICAL SCHOOL

I. BACKGROUND

The primary mission of the U.S. Army Medical Equipment and Optical School (USAMEOS) is to conduct courses of instruction for:

(a) maintenance and repair of medical equipment for enlisted personnel and warrant officers of the US Army, US Navy, US Coast Guard, selected US Government employees, and designated personnel of other countries.

(b) optical laboratory technology for enlisted personnel of the US Army, US Air Force and designated personnel of other countries.

The two training programs have been co-located on the grounds of Fitzsimons Army Medical Center (FAMC) since 1956. In 1973, they became part of the Academy of Health Sciences. The USAMEOS Student Company stood up separate from the FAMC brigade in 1992. As part of the AMEDD Center and School reorganization, USAMEOS became a teaching department under the Dean earlier this year.

The Army students are under the command and control of the student company. The Navy and Coast Guard students are under the command and control of the Naval School of Health Sciences (NSHS)

Bethesda, Detachment, Aurora, Colorado. This detachment reports directly to the Commanding Officer of the NSHS, Bethesda, Maryland.

The academic side of USAMEOS is divided into three branches: Medical Equipment Repair Branch, Optical Branch and Academic Support Branch. The Academic Support Branch is responsible for janitorial services, data processing and engineering/drafting. The engineering/drafting function produces training aids for the medical equipment repair students that are not commercially available.

The Optical Branch provides optical laboratory technology training for enlisted personnel (MOS 42E) of the US Army, USAR, ARNG, USAF and Allied students. Length of training is 21 weeks. Training is provided in the same building as the optical fabrication laboratory at FAMC. The Branch mission also includes evaluating optical surface and fabrication equipment, procedures and eyewear components for TDA and TOE optical laboratories used by all Services.

The Medical Equipment Repair Branch is subdivided into three sections: Development Section, Technician Training Section and Specialty Training Section. The Development Section is composed of an equipment development team, an education and safety manager, and a NCOIC/facility manager.

The Technician Training Section conducts training to provide maintenance and repair of medical equipment in a TOE environment. Successful completion of the course (38 weeks) results in awarding of the MOS 35G10 (Medical Equipment Repairer [Unit Level]). The Specialty Training Section provides more advanced training in medical equipment repair and leads to the MOS 35U30 (Medical Equipment Repairer [Advanced]). Length of this course is 30 weeks.

Student load at USAMEOS for the last 3 years has averaged 478 starts per year. The FY 94 training starts were 410. The 35G course has 12 iterations per year. The 35U course has 8 iterations per year. The 42E course has 4 iterations per year.

II. THEMES

A. USAMEOS faces continual challenges to its existence from a variety of threats. Whether USAMEOS will re-locate or be part of the Inter-Service Training Review Organization (ITRO) initiative are most notable.

B. A distinct "we--they" attitude exists between the company and academic side of USAMEOS.

C. The optical training branch will most likely be incorporated into the Navy facility in Yorktown, Virginia, as part of the ITRO

process.

D. The distance between USAMEOS and the parent organization at Fort Sam Houston can work to both an advantage and a disadvantage.

III. FINDINGS

A. USAMEOS may partly or fully be involved in the ITRO or BRAC processes.

B. The current facility for Medical Equipment Repair Training is antiquated and in disrepair.

C. Consistent with the findings at the parent AMEDD C&S, a distinct "we--they" attitude exists between the company and the academic branches.

D. The work of three senior NCOs in USAMEOS is redundant and contains significant overlap.

E. Although the drill sergeants are platform qualified in the medical equipment repair MOS 35G, only one routinely teaches.

F. The Optical Training Branch will most likely re-locate to the Navy Optical Training Facility at Yorktown, VA, as part of the

ITRO process.

G. The distance between FAMC and Fort Sam Houston works as both an advantage and a disadvantage to USAMEOS.

IV. ISSUES

A. Assuming the Optical Branch will move to the Navy facility at Yorktown, VA, what support will the Army need to provide?

B. Should the remaining portion of USAMEOS re-locate?

C. As the optical training moves away from FAMC, can the optical fabrication laboratory be contracted?

D. Can the ill feelings between the company staff and academic staffs be mended by better integration of the two staffs.

E. Can savings be realized by integrating the functions of the three senior NCOs within USAMEOS?

V. DISCUSSION

Over the last few years, USAMEOS has faced a number of challenges concerning its location, deteriorating facilities, and the likelihood of combining with other Services' facilities.

Although these challenges have come from a variety of sources, few definitive decisions have been made. Several interviewees indicated the high likelihood that the USAMEOS Optical Training Branch will be co-located with the Navy's optical training facility at Yorktown, Virginia, as part of the ITRO process. This integration with the Navy facility will have several effects on USAMEOS.

Although the training will move, the Navy will most likely require some teaching support from the Army. Most of the administrative support may come from nearby Fort Eustis; however, the end result will be fewer individuals required to train Army optical technicians. Less support will be required from USAMEOS, particularly from the student company; i.e., drill sergeant(s). In addition, there remains little logic for the USAMEOS Commander to be an optometrist.

Although some discussion presented the possibility of moving the optical training and laboratory to Fort Sam Houston, the impending ITRO decision for the training has lessened this likelihood. With the already discussed ITRO decision, the optical laboratory will remain alone at FAMC. As the approximately 75 laboratory personnel are on the FAMC TDA, the probability of contracting this facility should be explored.

The Medical Equipment Repair Branch is located in an antiquated

facility with renovation or a new facility at FAMC a very low priority. The classrooms are small and many have posts obstructing clear vision to instructors who must often demonstrate hands-on procedures. Some instruction is placed on closed circuit television to improve vision; however, the facility is admittedly in need of replacement or extensive renovation.

Although opinions differed, the majority of interviewees agreed that relations between the student company cadre and academic staff were strained if not openly hostile. This is consistent with findings at the AMEDD C&S at Fort Sam Houston. Both the company and the academic staffs were keenly attuned to the needs of the student; however, each had their own priorities. The conflict between soldiering skills taught by the company and academic skills and knowledge taught by the academic staff was well recognized.

USAMEOS was criticized in the past for poor discipline of its students. Feedback from the field indicated they were producing good technicians but poor soldiers. At times it was openly referred to as "Club Fitz". As a result, approval was gained to form the student company under USAMEOS control, separate from the FAMC brigade. Although discipline is now stressed, the rate of UCMJ action in the company is much higher than the TRADOC average and the AMEDD C&S brigade. USAMEOS reported nearly as many

Article 15s as the entire AMEDD C&S for FY 94. The TRADOC average is 76/1000 students and the AMEDD C&S less USAMEOS is 46/1000. Recognizing the importance of discipline, particularly in young soldiers, one must conclude that the pendulum has perhaps swung too far.

The logical approach to improving relations between the two staffs is to involve the other in an integrated approach to training students to be soldiers and technicians. As most of the drill sergeants were selected from the USAMEOS Medical Equipment Repair teaching platform, conventional wisdom would be to integrate the two staffs to a greater degree. With fewer numbers of students estimated, savings in personnel could also be realized by integrating the two staffs. Involving drill sergeants in classroom instruction to a greater degree would also comply with TRADOC regulatory guidance requiring drill sergeants to platform teach. Although four drill sergeants are 35Gs with platform teaching experience, reports varied on their classroom involvement. Other savings could be realized by involving senior instructors in platform teaching to a greater degree.

USAMEOS has two SGMs and one MSG company first sergeant. The two SGMs fulfill niches within the organization and complement each other well; however, the work of separate SGMs for the command and as a separate senior instructor is not clearly delineated. In this era of constrained resources, we can ill afford two

separate SGMs doing redundant work. In addition, savings could be gained by combining the company first sergeant position with the SGM position, thereby integrating the company side with the academic staff which should improve conditions between the two factions.

VI. RECOMMENDATIONS

A. Plan to integrate the Optical Training Branch with the Navy. Plan to support the Navy with reduced numbers of instructors.

B. Plan to support the reduced mission of USAMEOS with the loss of the optical training.

C. Explore the possibility of contracting the optical laboratory facility remaining at FAMC.

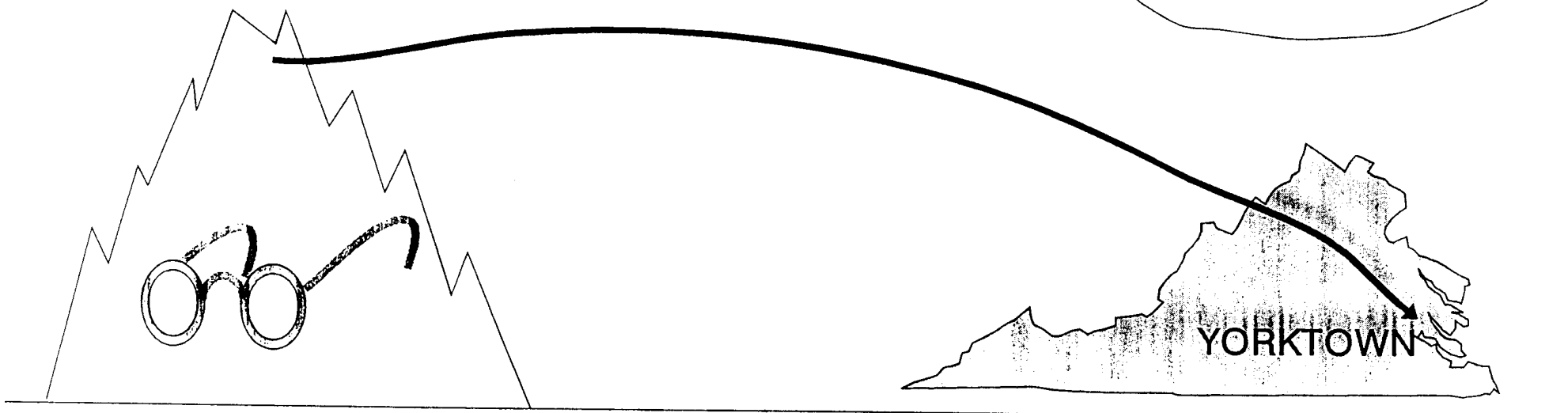
D. Improve relations between the company and the academic staffs. Involve drill sergeants more in platform teaching.

E. Combine the positions of USAMEOS SGM, Chief Instructor of the Medical Equipment Repair Branch and Company First Sergeant.

F. Continue efforts to replace or renovate existing facilities for the Medical Equipment Repair Branch.

USAMEOS

CONTRACT OPTICAL LABORATORY

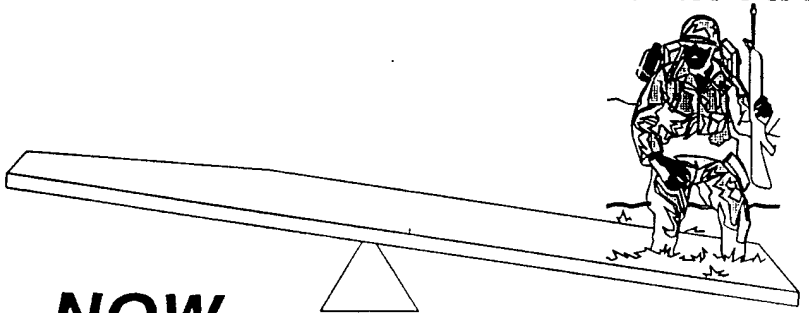


SOLUTION

ACADEMIA

EARLIER
"CLUB FITZ"

COMPANY



NOW

TAB N

ENCLOSURE 14

ALCOHOL AND DRUG TRAINING BRANCH

I. Background:

The Alcohol and Drug Training Branch (ADTB) was created in the mid-1970's to provide needed training to the newly established Alcohol and Drug Abuse Prevention and Control Program (ADAPCP). There was no civilian equivalent training available at the time and over a period of years (1975-1984) courses were developed in two main areas, 1) Prevention and Education and 2) Clinical Training.

Under the Prevention and Education umbrella the following courses were created:

5H-F1/302-F1 Education Coordinator Course

5H-F2/302-F2 US Army Alcohol and Drug Abuse Team Training (USAADATT)

5H-F3/302-F3 Civilian Program Coordinator Course

5H-F6/302-F6 Alcohol and Drug Control Officer Course

The purpose of these 1 week functional courses was to familiarize newly employed and predominately civilian staff with their roles and responsibilities within the ADAPCP. These courses were intended to train personnel within their first year to 3 years of

employment. The purpose of the USAADATT course was to provide leaders and supervisors, military and civilian, with a working knowledge of the ADAPCP with emphasis on their managerial and administrative duties.

Under the Clinical umbrella the following courses were created:

5H-F4/302-F4 United States Army Drug and Alcohol Rehabilitation Training (USADART) Individual Course

5H-F5/302-F5 USADART Group Course

5H-F7/302-F7 Family Services Course

5H-F8/302-F8 Family Counseling Course

5H-F9/302-F9 Clinical Consultant/Medical Review Officers Course

5H-F10/302-F10 Advanced Counseling Course

These courses served a vital role in teaching military and civilian personnel the basic skills needed to provide counseling related to substance abuse. At the time of inception there was only limited civilian training available and there were no civilian certification programs.

An Army certification program was established for Drug and

Alcohol counselors which consisted of successful completion of the Individual and Group courses, and successful completion of the exam. Certification within 2 years of employment was made a condition of employment.

In 1993 a decision paper was staffed within the Academy of Health Sciences reviewing ADTB courses and leading to the elimination of 2 courses (Education Coordinator and Civilian Program Coordinator), consolidation of 2 courses into 1 (Family service and Family Counseling), and the redesigning of 1 course (ADCO to Management). It was decided that the courses eliminated had accomplished their goals and were not needed, and the others needed revamping to be more cost efficient and effective.

In April 1994 the DCSPER directed a modernization plan for the ADAPCP in an effort to meet changing requirements. The most significant change is that oversight of the clinical segment is the responsibility of the MEDCOM and all other aspects are the responsibility of USADOA. There is a requirement for a complete rewrite of AR 600-85. These changes have created a window of opportunity to review employment requirements, the certification program, and future training needs.

II. THEME: Given the current availability of civilian training and licensing, as well as a 91G Training Branch, the Alcohol and Drug Training Branch is obsolete.

III. FINDINGS:

A. IAW the DCSPER message in Apr 94, Prevention and Education is no longer a responsibility of the ADTB. The USAADATT can and should be eliminated.

B. State licensing and/or National Certification is now available for ADAPCP personnel making the Army Certification Program unnecessary and not cost effective.

C. Local, State, and National training opportunities are available for ADAPCP staff to maintain their skill levels.

D. Making state licensure a requirement for employment will eliminate the need for the Army Certification Program and for 4 of the courses (Individual, Group, Family, and Advanced) currently taught.

E. Justification for current requirements to receive the M8 Alcohol and Drug Counselor ASI for 91G's is unclear.

F. Current ADTB courses are outdated.

G. 91G's do not require certification.

IV. ISSUES:

A. Is the Army's Certification Program needed?

B. Should civilian employees be required to have State licensure or National certification as a condition of employment?

C. Is the ADTB needed or can the requirements and needs be redistributed to other branches within the Department of Preventive Health Services?

D. What training do 91G's require to function as Alcohol and Drug counselors and to receive the M8 ASI.

V. DISCUSSION:

The Army's Alcohol and Drug Certification Program and current ADTB courses are outdated. Civilian equivalent licensing and continuing education training are available. The AHS programs were created when no civilian training or licensing were available but they have not been updated nor kept pace with the civilian sector. In addition, the training is civilian or garrison focused with no training for mobilization or for a field environment.

If counselors are hired with a license, there would be no need for the clinical courses. The training for 91G's can be accomplished through the 91G Branch which can review and update the M8 (Alcohol and Drug Counselor) requirements. Sustainment

and mobilization training can occur through the Annual Behavioral Science NCO course, BNCOC, and ANCOC. Training for the Clinical Director's (Management Course), Clinical Consultant's, or other AMEDD personnel (OBC, OAC, etc..) can be accomplished by augmenting the Soldier and Family Support Branch.

VI. RECOMMENDATIONS:

A. Require all civilian ADAPCP clinical staff to have a State License or National Certification as a condition of employment.

B. Eliminate the USAADATT course.

C. Phase out the Individual, Group, Family, and Advanced courses over the next FY.

D. Initiate a Process Action Team to establish or update the tasks, standards, and requirements for the M8 ASI.

E. Eliminate the ADTB, redistributing it's training requirements to the Soldier and Family Support Branch and the 91G Branch.

1. The Soldier and Family Support Branch would teach:

a. Clinical Consultant's Course.

b. Management Course.

c. Any orientation course directed by MEDCOM.

d. All substance abuse classes taught into other AHS courses.

2. The 91G Branch would teach:

a. All training related to M8 ASI.

b. All 91G NCO training.

c. All ANCOC and BNCOC courses for 91G's.

F. Redistribute personnel within ADTB as follows:

1. To Soldier and Family Support Branch:

a. 1 officer - 73A - Social Worker.

b. 2 GS-12 instructors.

c. 1 Training Technician (converted to secretary).

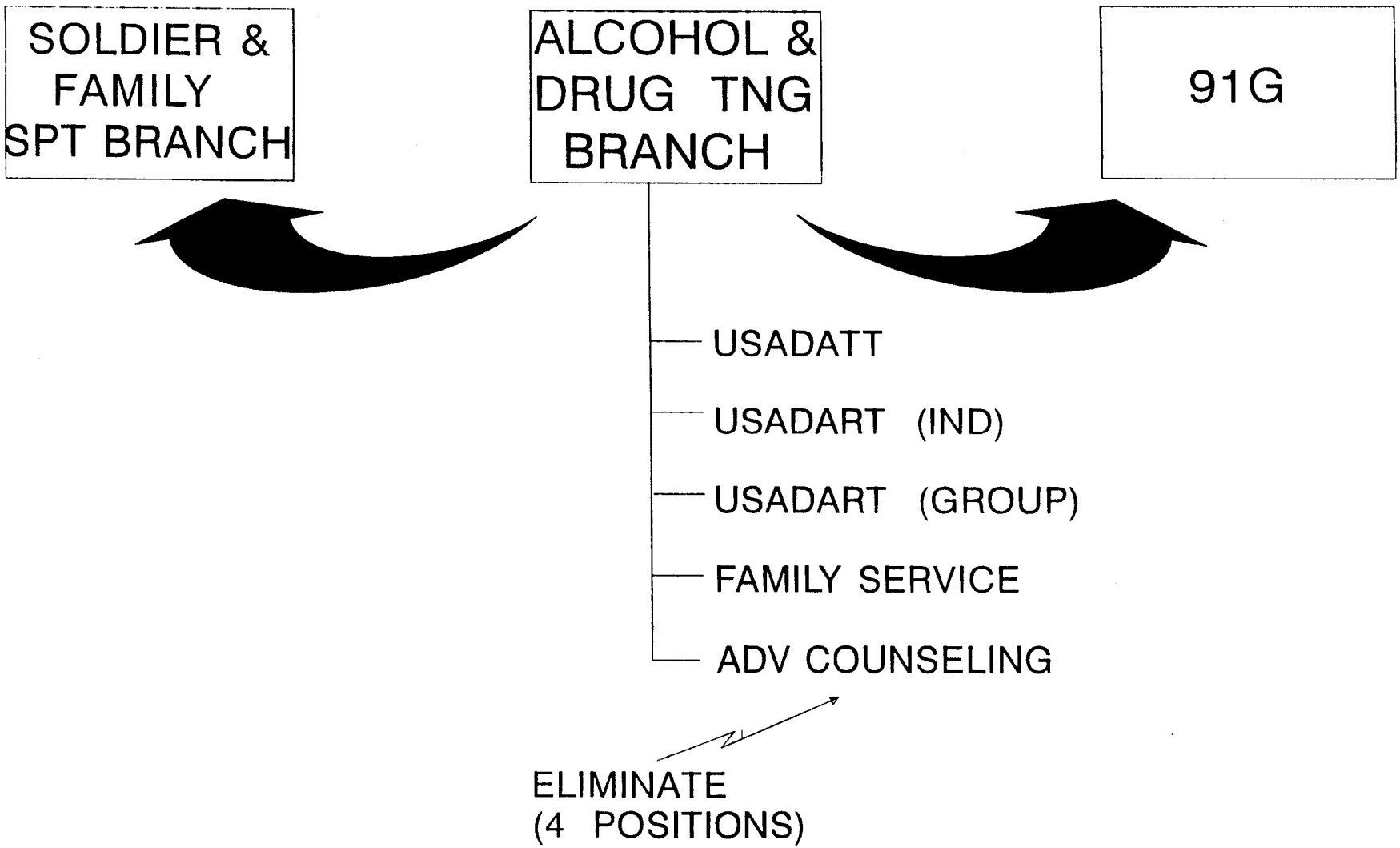
d. 1 ISS GS-11.

2. To 91G Branch - 3 91G NCO's.

3. Eliminate 2 GS-12 positions.

G. Eliminate the GS-11 and GS-4 positions in the Certification Program.

ALCOHOL & DRUG TRAINING FUNCTIONAL AREA



CANDIDATE COURSES FOR DELETION

NUMBER	TITLE	DEPARTMENT
5H-F02/302-F2	USAADATT	DPHS
5H-F04/302-F4	USADART (INDIV) Phase out by 96	DPHS
5H-F05/302-F5	USADART (GROUP) Phase out by 96	DPHS
5H-F07/302-F7	USAADAPSP (FAMILY) Phase out by 96	DPHS
5H-F10/302-F10	USAADAPCP (ADVANCED COUNSELING) Phase out by 96	DPHS

CANDIDATE COURSES THAT CAN BE TAUGHT BY CONTRACT INSTRUCTORS

NUMBER	TITLE	DEPARTMENT
5K-F3/520-F3	FACULTY DEVELOPMENT	DAS
5K-F4/520-F4	ORIENTATION TO SYSTEMS APPROACH TO TRAINING	DAS
5K-F5/520-F2	SYSTEMS APPROACH TO TRAINING FOR MANAGERS	DAS
311-42E10	OPTICAL LABORATORY SPECIALIST	USASAM
4B-470A/ 198-35U10	MED EQUIP REPAIRERS (ADV)	USASAM
4B-F2/ 198-35G10	MEDICAL EQUIPMENT REPAIRER (UNIT LEVEL)	USASAM
300-91V10	RESPIRATORY SPECIALIST	DMS
300-91Y10	EYE SPECIALIST	DMS
300-F4	ALLERGY/CLINICAL IMMUNOLOGY SPECIALIST	DMS
300-P2 (91U10)	EAR, NOSE, THROAT (ENT) SPECIALIST	DMS
300-Y6	CARDIOVASCULAR TECHNICIAN	DMS

322-91X20	HEALTH PHYSICS SPECIALIST	DPHS
5A-F5	PRINCIPLES OF MILITARY PREVENTIVE MEDICINE	DPHS
6A-F6	PREVENTIVE MEDICINE PROGRAM MANAGEMENT	DPHS
6H-F09/322-F9	SEXUALLY TRANS DISEASES (STD) INTERVENTION	DPHS
6H-F10/322-F10	INTERMEDIATE INDUSTRIAL HYGIENE TOPICS	DPHS
6H-F11/322-F11	BASIC INDUSTRIAL HYGIENE TECHNICIAN	DPHS
5H-F20/302-F20	FAMILY ADVOCACY STAFF TNG (FAST)	DPHS
5H-F21/302-F21	FAMILY ADVOCACY STAFF TNG (ADV) (FASTA)	DPHS
6H-F15	ENVIRONMENTAL SCIENCES & ENGINEERING PRACTICES	DPHS
6H-F17/322-F17	LASER AND RADIO FREQ RADIATION HAZARDS	DPHS
6H-F18/322-F18	MEDICAL X-RAY SURVEY TECHNIQUES	DPHS
321-91T10	ANIMAL CARE SPECIALIST	DVS
6G-F2/321-F2	VETERINARY SERVICE IN THEATER OF OPERATIONS (94 CLASS CANCELED)	DVS
6G-F3/321-F3	INSTALLATION VETERINARY ACTIVITIES	DVS
6G-F4/321-F4	SUPPLY POINT VETERINARY SVCS	DVS
6G-F5-321/F5	QUALITY AUDIT OF SUBSISTENCE	DVS
6G-F6-321-F6	DEPOT VETERINARY SERVICES	DVS
2C-F7(MS/WO/RC)	AERO MEDICAL EVAC OFF	USASAM
300-F6	FLIGHT MEDICAL AIDMAN	USASAM
6A-61N9D	ARMY FLIGHT SURGEON	USASAM
6A-61N9D(RC) (PH1)	ARMY FLIGHT SURGEON (RC) (PH1)	USASAM
6A-61N9D(RC) (PH2)	ARMY FLIGHT SURGEON (RC) (PH2)	USASAM

6A-F1	ARMY AVIATION MEDICINE ORIENTATION	USASAM
301-91D10	OPERATING ROOM SPECIALIST	DNS

CANDIDATE COURSES FOR LONG TERM CIVILIAN TRAINING

NUMBER	TITLE	DEPARTMENT
6H-70A67	USA/BAYLOR UNIVERSITY PROGRAM IN HCA	CHES
6H-65B	USA/BAYLOR UNIVERSITY PROGRAM IN PHYSICAL THERAPY	DMS
6H-65D	MILITARY PHYSICIAN ASSISTANT	DMS
6F-66F	USA UTHSC HOUSTON PROGRAM IN ANESTHESIA NURSING	DNS

CANDIDATE COURSES THAT CAN BE PRESENTED BY CONTRACTING WITH COLLEGE/UNIVERSITY

NUMBER	TITLE	DEPARTMENT
311-91K20(MLT)(T)	MEDICAL LABORATORY SPECIALIST TRANSITION	DCSS
300-91C20 6-8-C42(91C)	PRACTICAL NURSE (PHASE I & II)	DNS
312-91Q10	PHARMACY SPECIALIST	DCSS
313-91P10	RADIOLOGY SPECIALIST	DCSS

TAB O

ENCLOSURE 14

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DEPARTMENT OF JOINT MEDICAL READINESS TRAINING

I. BACKGROUND:

The Department of Joint Medical Readiness Training (DJMRT) originally was chartered as the Joint Medical Readiness Training Center (JMRTC) by the surgeon generals' of the component services during the late 70s. The Army Surgeon General accepted the responsibility as the lead agent for the JMRTC and located the organization at Camp Bullis, Texas for close proximity to the Academy of Health Sciences and Fort Sam Houston, home of Army medicine. The training center came under the control of the Uniformed Services University of Health Sciences (USUHS) and remained under this organization until the early 1990s, when the JMRTC was transferred to the AMEDDC&S.

The training conducted at JMRTC was oriented toward Medical Corps (MC) officers with emphasis on combat medical care. The resulting course came to be known as the Combat Casualty Care Course (C4), which in turn was tied to MC officer professional development (c.s. supplementing OBC/OAC). Over the years, the JMRTC evolved into an Advanced Trauma Life Support (ATLS) course and attendance was expanded to non-physicians. Currently, trauma physicians are assigned to Brooke Army Medical Center (BAMC), Wilford Hall Medical Center, and Ben Taub Trauma Center in Houston, Texas for advanced trauma training.

The present mission for the DJMRT is to design, implement, and execute joint medical

readiness training to help prepare medical department officers and selected enlisted medical personnel from all active and reserve components to function in a theater of war, primarily in the forward echelons of the combat health support system.

II. THEME:

The Department of Joint Medical Readiness Training is not a joint activity and does not have a formal chain of command authority for all assigned personnel. DJMRT is a tri-service training activity, with each service component representative stoved-piped to their respective service.

III. FINDINGS:

A. The DJMRT is not a joint organization. Chief, DJMRT is rotated among the three services (Air Force, Army, and Navy), however the rating schemes do not reflect this, i.e. the Chief does not rate other services personnel. The Chief's position is currently not recognized as a joint billet.

B. The three services' surgeon generals have agreed to fix common problems without Health Affairs input.

C. There is a uniform agreement that the training is worthwhile.

D. There is no established relationship between combat casualty care in DJMRT and the C3 Research Area Director or the Trauma Research Lab (Institute of Surgical Research) of USA Medical Research and Materiel Command (USAMERMAC).

E. DJMRT staff feel they would better serve the joint medical arena by becoming a

joint command. with command and control of all assigned personnel. and reporting to Health Affairs or a joint command.

F. Assignments of personnel to DJMRT are not high priority with the service components. There is no firm commitment to regularly assign quality personnel to the DJMRT. Individuals are assigned to DJMRT if it is convienent to the service member. Many positions have been vacant for more than a year.

G. Currently, joint medical options for joint warfighting is stoved-piped by each service, with concentration on their service specific piece of the medical options.

H. Staff feelings are that joint doctrine should be written by DJMRT.

I. Current alignment under AHS creates unnecessary layering for response to the Joint Readiness Executive Committee (JREC), i.e. DJMRT-- AHS-- AMEDDC&S-- MEDCOM-- JREC.

J. Since the DJMRT lost its affiliation with a joint activity (USUHS), the joint flavor has been lost. Due to this lose, DJMRT is only another teaching department for C-4 and C-4A courses.

K. If DJMRT was eliminated, the services would only lose free ATLS training for medical personnel. The reserve components would be the biggest losers if DJMRT were dissolved.

L. There is a perception that individuals attend the C4 course for a "ticket punch" or to fulfill the quotas given their branch/ component service.

M. Most lesson plans/training plans have not been updated in many years.

IV. ISSUES:

A. What is the best organizational alignment for DJMRT?

B. What is the requisite command and control structure for personnel assigned to DJMRT.

V. DISCUSSION:

There is a strong perception that the DJMRT is a tri-service activity attempting to function as a joint organization, without any joint authority. This situation has culminated into a "hit or miss" operation because no single specific person has overall command and control of the organization. Presently, each services' senior officer reports to and is rated by a different chain of command through their respective service component.

In the recent past, the DJMRT was the JMRTC and had a joint command relationship with USUHS. There was a commander of JMRTC and this position had complete control of the organization. When the JMRTC was aligned under the AMEDDC&S and was further arrayed under the Dean's control in the AHS, the perception was that the importance of the activity somehow became diminished.

Currently, DJMRT has become an ATLS training opportunity for all medical department officers, without regard to the trauma training needs of the service components. This has resulted in many medical corps officers attending C4 who have no medical readiness requirements to complete trauma training, but do it to fill a quota requirement for their corps or an individual preference for continuing education credit. Thus, corps have become managers of quotas instead of training needs of the AMEDD.

Also, because the AMEDD has no established requirement for joint assignments, there is no incentive for the AMEDD community to pursue joint assignments at the DJMRT or other joint activities.

VI. RECOMMENDATIONS:

A. Establish the Army as the DoD Executive Agent (not lead Agent) for joint medical readiness training.

B. Redesignate the DJMRT as the Joint Medical Readiness Training Center (JMRTC) and establish the chief's position of the readiness center as a colonel- equivalent, joint command billet, rotated between the three services.

C. Establish the DJMRT as a joint command reporting to the USUHS.

D. Give the DJMRT the mission to write doctrine, develop training and teach joint medical readiness requirements for contingency operations. Assign the necessary mix of tri-service personnel and equip the organization with the necessary operational assets to accomplish the mission.

E. If there are no organizational changes, eliminate the DJMRT for savings and incorporate the ATLS requirement under the CHE program to obtain training for necessary medical personnel.

TAB P

ENCLOSURE 14

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

NONCOMMISSIONED OFFICERS ACADEMY

I. BACKGROUND:

The AMEDD Noncommissioned Officers Academy (NCOA) conducts Noncommissioned Officer Education System (NCOES) training, exercises operational control and provides for the discipline, health, morale, welfare, administrative support and billeting of all assigned and attached personnel for the Basic Noncommissioned Officer Course (BNCOC) and the Advanced Noncommissioned Officer Course (ANCOC). The goal of the NCOES is to develop creative, logical, quick-thinking leaders who can apply Army training and fighting doctrine in their units. Performance-oriented training and small group instruction is the primary method of instruction for NCOES courses. The AMEDD NCO Academy accomplishes this through the utilization of technically and tactically competent AMEDD Noncommissioned Officers (NCOs) and use of the small group instruction (SGI) method to train, lead, and evaluate all NCOs attending BNCOC and ANCOC.

NCO Academy commandants are charged by TRADOC Regulation 351-17 to ensure that training is conducted IAW the principles of FM 25-100. These principles are: (1) Train as you fight, (2) Use appropriate doctrine, (3) Use performance-oriented training, (4) Train to challenge, (5) Train to sustain proficiency, (6) Train using multi-echelon techniques, (7) Train to maintain, and (8) Make commanders the primary trainers.

TRADOC Regulation 351-17 requires the NCO Academy to be organized under the installation/service school commandant. The NCO Academy commandant must be a CSM,

rated by the service school CSM and senior rated by the service school commandant. Prior to the merger of the Office of the Assistant Commandant with the Office of the Dean, the NCO Academy was located under the Assistant Commandant with the other technical training divisions (Encl 1). Following the merger, the NCO Academy was located under the AMEDDC&S CSM and senior rated by the Commander, AMEDDC&S (Encl 2).

II. THEMES:

A. There is a perception that the relationship between the AMEDD NCO Academy and the AHS training departments needs to be improved. Some leaders feel the NCO Academy's relocation has caused a lack of communication and coordination between the NCO Academy and the technical training departments.

B. The NCO Academy feels they have full control of the common leader training (CLT) and the career management field (CMF), but has limited influence on the technical tracks that exceed 21 hours.

III. FINDINGS:

A. It is perceived the AMEDDC&S CSM exerts significant control over all NCO Academy business.

B. The NCO Academy is looked upon as an independent and autonomus functioning organization, with no accountability to the AHS.

C. The NCO Academy is not a part of the AHS, therefore support from the AHS

training departments is not emphasized or seen as a priority.

D. Currently, the UCMJ authority for the NCO Academy rests with the Commander, Academy Battalion. Otherwise, the Academy Battalion is not involved with the NCO Academy. The NCO Academy CSM works for the AMEDDC&S CSM which violates normal command and control lines and adds an additional layer in the chain of command. This could cause a conflict of authority.

IV. ISSUES:

A. Since the Dean, AHS is now dual-hatted as the AHS Commandant, should the AMEDD NCO Academy be located under the Academy of Health Sciences, to better align NCOES training with the proponent school, as stated in TRADOC Regulation 351-17?

B. Would the location of the NCO Academy CSM under the AHS Commandant meet the intent of TRADOC Regulation 351-17?

C. Could the NCO Academy meet TRADOC Regulation 351-17 standards if the NCO Academy Commandant/CSM was not rated by a service school CSM?

V. DISCUSSION:

The NCO Academy CSM is responsible for the ANCOC and BNCOC courses but only directs the FTX phase and the common leader training in the NCO career management field (CMF) training. The technical phase of six BNCOC and four ANCOC linked courses (i.e., tracks longer than 21 hours) are under the direction of AHS course

directors. The fact that course directors work for the Dean and the NCO Academy works for the AMEDDC&S CSM appears to limit the working relationship, restrict communications, and decrease the emphasis on support. There is a perception that the process was more effective when the Commandant provided direction to all key players. The NCO Academy CSM feels that the support of the AHS Commandant/Dean would ensure maximum coordination and increase maximum integration between technical and leadership training.

Reportedly, the AMEDDC&S CSM is heavily involved in the management of the NCO Academy. Moving the NCO Academy under the Academy of Health Sciences would allow the AMEDDC&S CSM to concentrate on the quality of life issues for the entire AMEDDC&S and on the individual unit climates. The AMEDDC&S CSM would be able to get to influence soldiers, staff, and faculty at all levels of the organization and solicit their feedback on how well the institution is functioning. The AMEDDC&S CSM must be free to advise and guide the entire AMEDDC&S enlisted training effort and integrate that effort with other TRADOC schools.

VI. RECOMMENDATIONS:

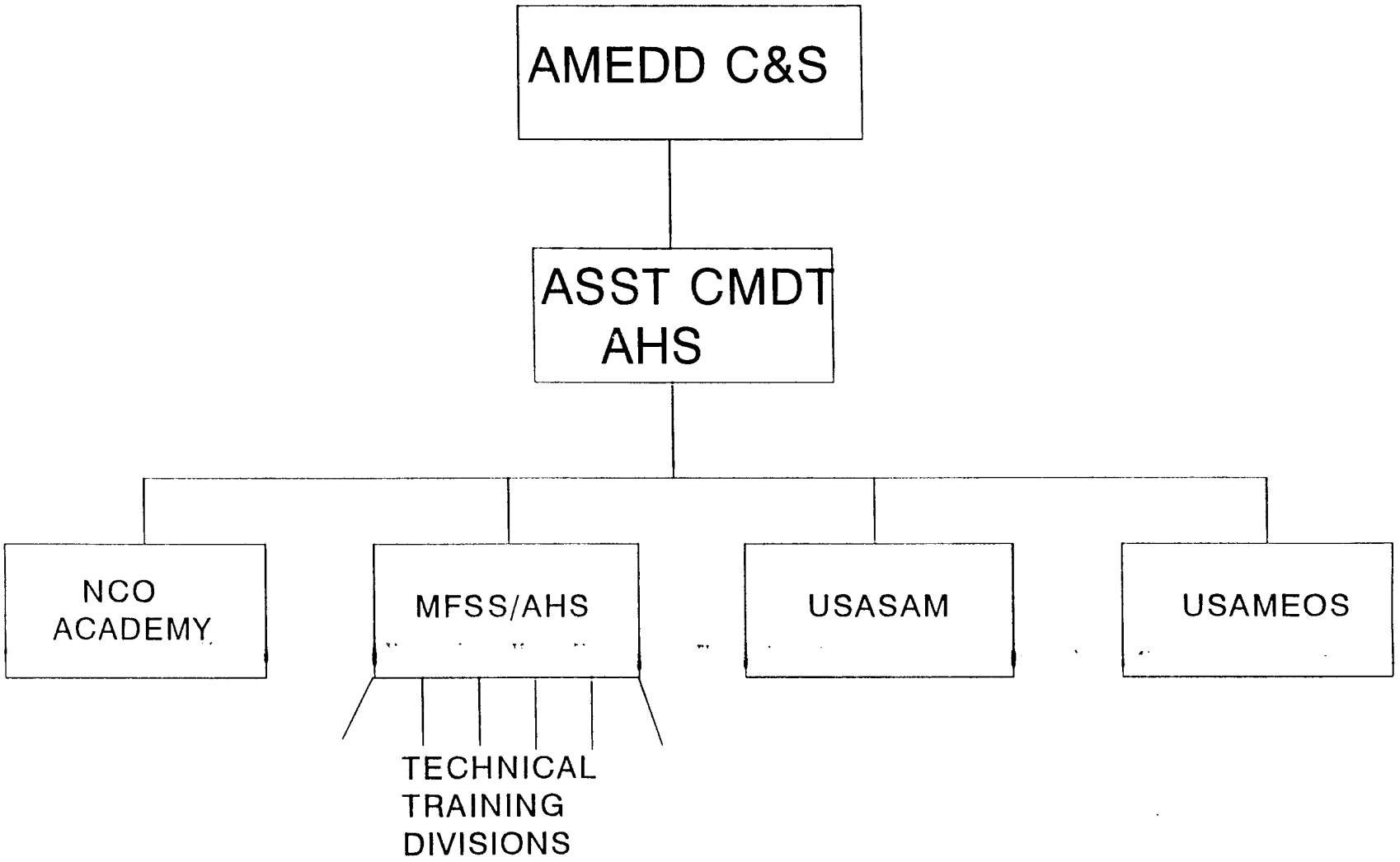
A. The NCO Academy should be aligned under the Academy of Health Sciences.

B. The NCO Academy CSM should be rated by the AHS Commandant. The Evaluation and Standardization Branch, DAS should coordinate with TRADOC and the U.S. Army Sergeants Major Academy (USASMA) to determine if this meets accreditation requirements.

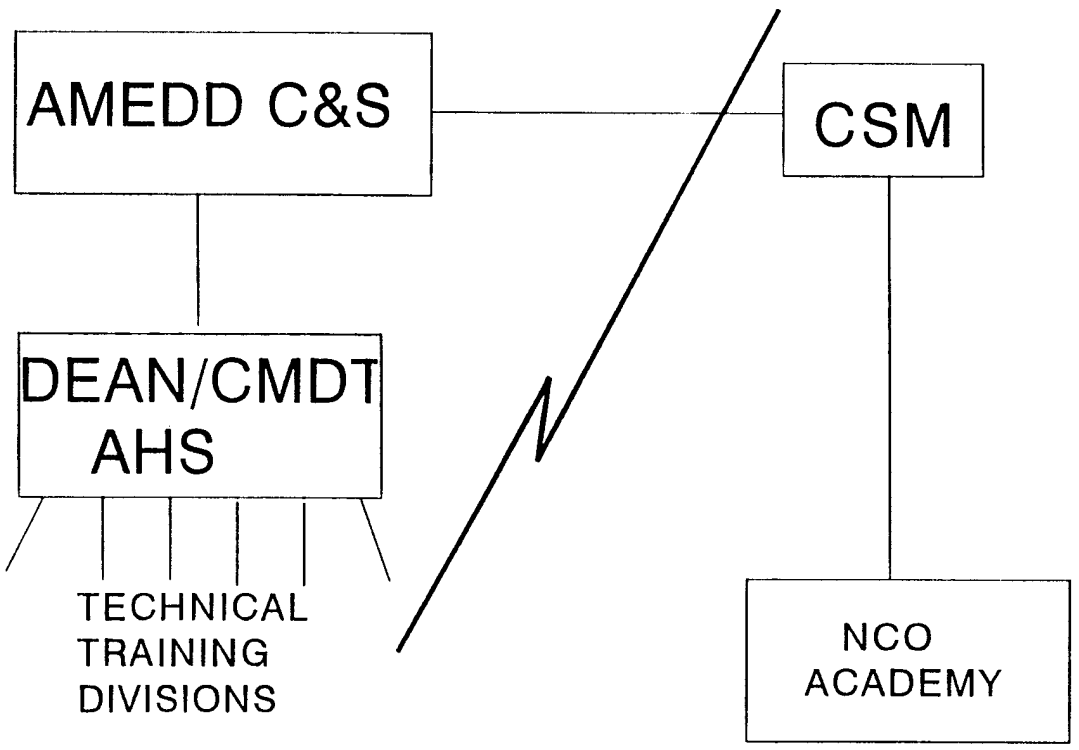
C. The role of the AMEDDC&S CSM should be better defined for the larger AMEDDC&S picture, to prevent the AMEDDC&S CSM from utilizing his talents at too low of a work level within the organizational structure. Work should evolve around the management of an equitable distribution of assets throughout the AMEDDC&S and provide recommendations to the CG AMEDDC&S, as appropriate.

D. The AHS SGM position should become a AHS CSM position, when the Center Brigade and AHS are merged, thus creating the requisite chain of command described in TRADOC Regulation 351-17 for the NCO Academy and service school relationship.

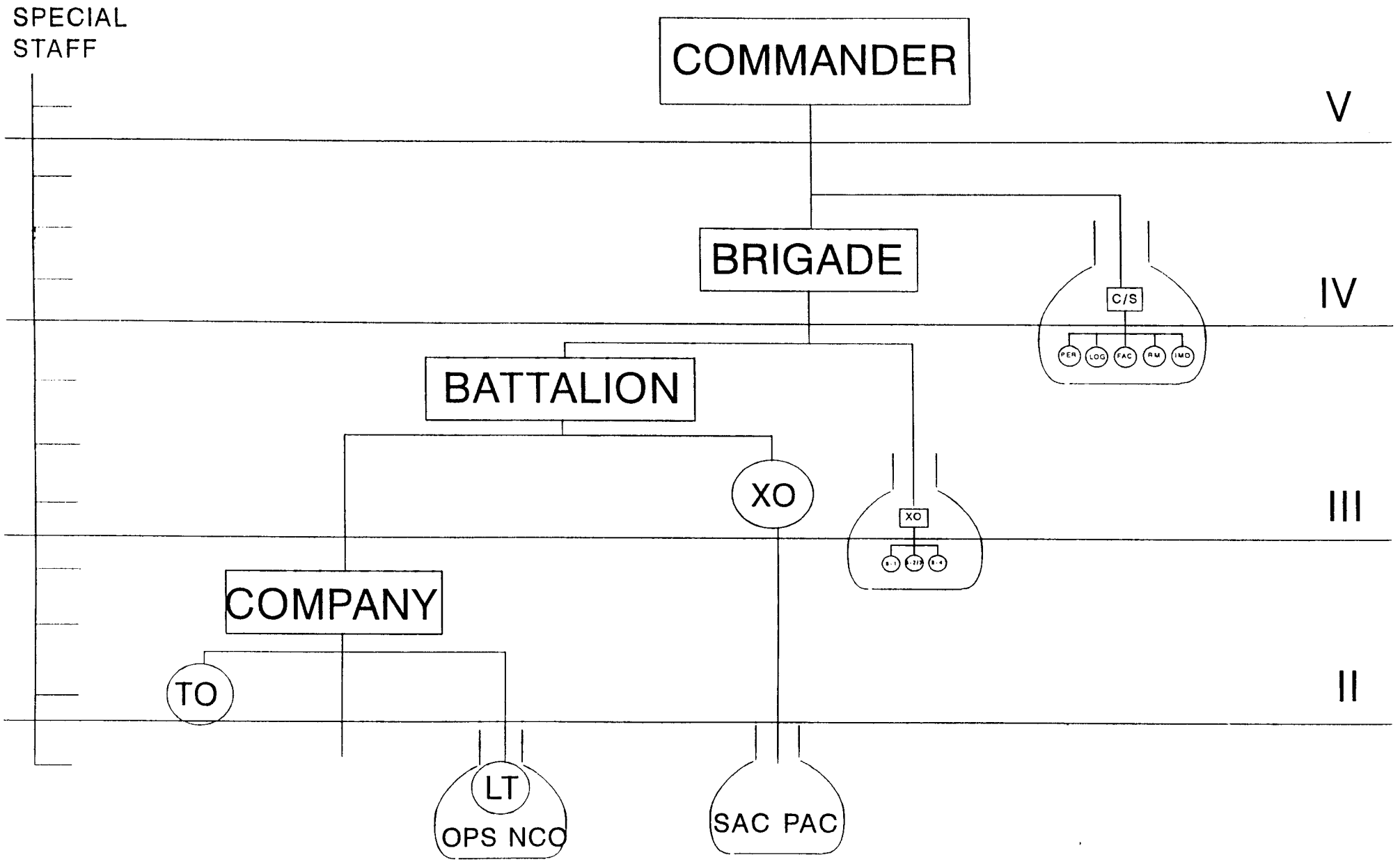
PREVIOUS ORGANIZATION



CURRENT ORGANIZATION



AMEDD C&S STAFFS



TAB Q

ENCLOSURE 14

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF LOGISTICS

I. BACKGROUND:

The Directorate of Logistics (DOL) consists of three branches and is accountable for provisioning the U. S. Army Medical Department Center and School (AMEDDC&S) with all required logistical sustenance. As an outgrowth of the previous reorganization study, the DOL and the Brigade S-4 were to be consolidate into a single activity. Considerable concern was expressed regarding this proposed consolidation especially with the on-going requirement to continue to support garrison missions. Since the AMEDDC&S encompasses the largest allied health care training system in the free world, the support operation plays a central role in accomplishing the AMEDDC&S primary teaching goal. Any disruption to the day-to-day support requirements could undermine the successful accomplishment of the training mission. Therefore, the consolidation has not come to fruition.

II. THEMES:

A. What is the best way to organizationally align the Directorate of Logistics to maintain continuity within the logistic arena?

B. What is the best way to realign the Supply Action Centers (SAC) in support of the AMEDDC&S?

III. FINDINGS:

A. . Most of interviewees reported that the proposed merger between the DOL and the Brigade S-4 would require a mission change for the logistic arena.

B. Some interviewees questioned the practicality of the proposed merger between the DOL and the Brigade S-4.

C. Many respondents felt that there was too much layering within the logistical community which ultimately increased the time lag between support request and subsequent completion.

D. The Battalion SAC supports all levels of supply within the AMEDDC&S with the Brigade S-4 functioning as a clearing house operation.

E. The DOL is responsible for the management of the Central Issue Facility for the AMEDDC&S by default; a traditional garrison mission the DOL has inherited over time

F. The support of the DOL has suffered recently due to the DOLs inability to hire eleven required and authorized personnel positions.

G. It was reported by DOL staff that there is an underlying problem within the AMEDDC&S on bypassing the DOL on logistically issues especially in the area of space management.

H. The Department of Public Works (DPW) is reportedly not providing adequate or timely support to it's customers (including the AMEDDC&S). DPW currently is managing an $82 million dollar back log in repairs.

IV. ISSUE: What is the most appropriate organizational alignment of the logistical community in order to maintain quality support without needless duplication of effort?

V. DISCUSSION:

The DOL has successfully conducted business for many years under its present configuration. However, the current fiscally constrained operational environment dictates that the command explore alternative organizational designs that offer the possibility of not only saving resources but also maintaining the quality of support that the staff and faculty have come to expect from all levels of the logistical community.

The consensus opinion from interviewees is that if DOL were realigned with the Brigade S-4 the combined activity would no longer be able to provide the same high quality support they currently are providing. The problems appear to be twofold. First, such a move would add another management layer (Brigade Commander), and secondly DOL would not be able to address garrison issues from the perspective of a Major General. Interestingly enough, Brigade and Battalion S-4s have operated this way functionally for years. As the senior logistical officer within the AMEDDC&S, the newly assigned Brigade S-4 would have full command authority to conduct logistical business day-to-day . The AMEDDC&S can no longer afford the luxury of multiple efforts not fully integrated throughout the command. Centralization of capabilities makes economic sense. Moreover, the Director of DOL did feel that if the Fort Sam Houston installation and the AMEDDC&S merged, it would be logical to combine the logistical functions with those of the Garrison DOL. Such a merger would then effectively eliminate any duplication of effort, while simultaneously providing consistency of support.

The SACS within the battalions generate a numerous of transactions per quarter contingent upon

the number of soldiers supported. However, with the 187th and the 232d Medical Battalions adjacent to one another and considering the proposed staffing cuts a synergy of effort makes operational sense. Role redefinment within the logistical community is needed in order to maintain support while reducing layering. Consolidation of roles will eliminate the overlaps and greatly increase the efficiency of the Battalion SACS, Brigade S-4, and DOL.

VI. RECOMMENDATIONS:

A. The AMEDDC&S DOL should be realigned into the Brigade S-4.

B. The Brigade S-4 position should be upgraded to a Lieutenant Colonel position.

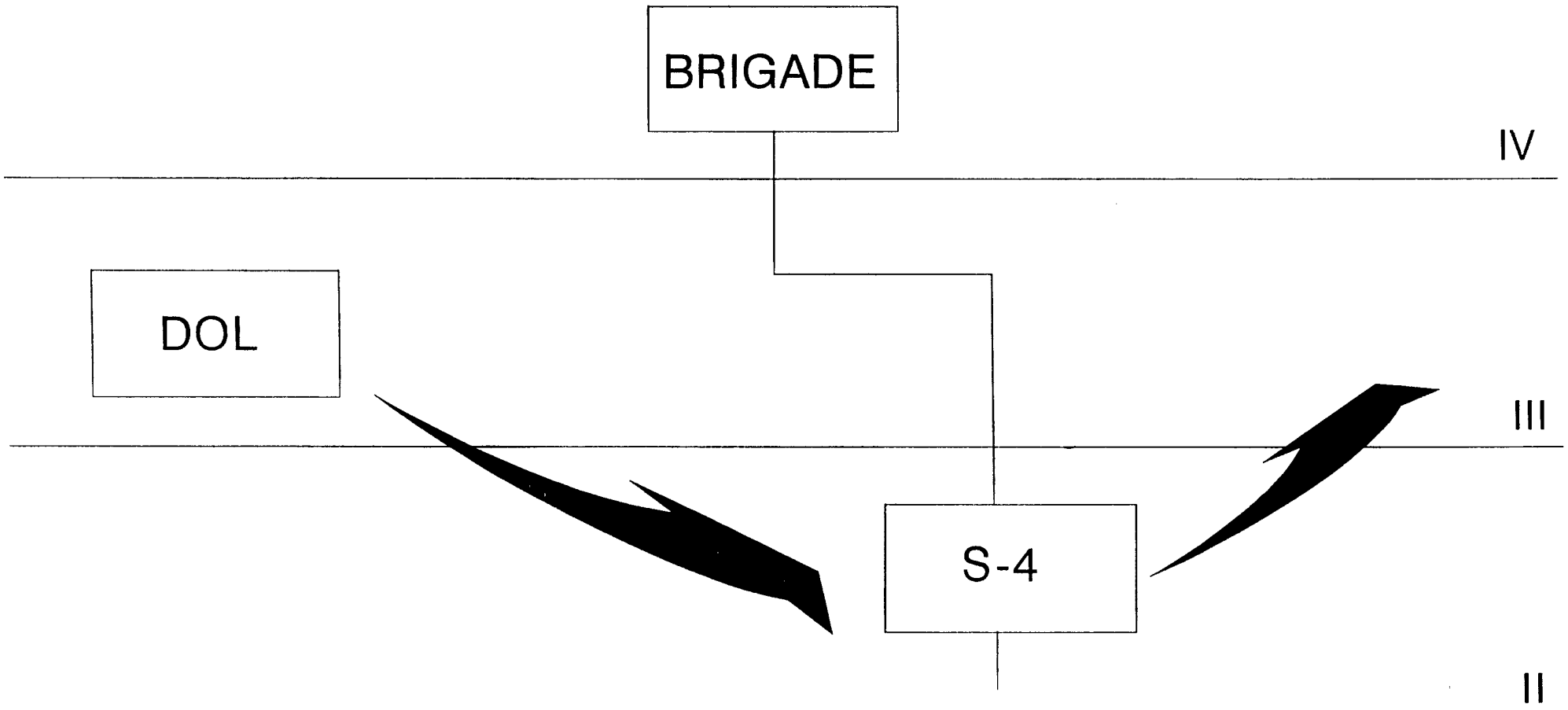
C. Realign the Academy Battalion SAC personnel into the Brigade S-4 to support its increased missions.

D. The Brigade S-4 should have oversight responsibility for the entire logistical disciplines within the AMEDDC&S.

E. Realign the 187th and the 232d Medical Battalion SACS centrally , with oversight responsibility coming from the brigade S-4.

F. Realign the Central Issue Facility, which is a garrison mission, back to garrison thus freeing up the Brigade S-4 to concentrate on logistical support of the AMEDDC&S.

LOGISTICS FUNCTIONAL AREA



TAB R

ENCLOSURE 14

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

INFORMATION MANAGEMENT DIRECTORATE

I. BACKGROUND:

The U. S. Army is undergoing a period of significant change brought about by fast moving world events and rapidly dwindling resources. Since 1989 the Army has experienced a 450,000 decrease in personnel, a 40% decrease in budget and a 35% decrease in material base. All of this has caused the institution to embrace a series of significant downsizing initiatives. The Information Management Area (IMA) restructuring and realignment effort began in 1985 in accordance with guidance received from U. S. Army Health Services Command and Information Services Command. The initial restructuring was completed in 1991. In 1993, the Office of The Surgeon General (OTSG) commissioned another study of the Information Management Discipline designed to further redefine roles and structures in order to better focus IMA assets in supporting strategic AMEDD needs. This study is currently on going.

Today the U. S. Army Medical Department Center and School (AMEDDC&S) Information Management Directorate (IMD) consists of four divisions: Administrative Services Division; Customer Support Division; Health Science Media Division (HSMD); and Plans and Management Division. The early 1990s witnessed heavy personnel turnovers within the IMD organization with all over strength military personnel being reassigned to non-IMD activities. During this same time frame a separate budget program (Program Objective Memorandum -

POM) was developed identifying all IMD requirements within the AMEDDC&S. The desired end product of this requirements based analysis was an integrated, totally compatible communication system operating existing workstations, multiuser systems and local unique software applications within AMEDDC&S. This program budget effort was developed to ensure that the most effective and economical data automation tools were available to support both the current and future AMEDD mission.

II. THEMES:

A. There is an apparent lack of understanding on the part of many AMEDDC&S personnel regarding the role of office automation and how to integrate network systems within the organization's everyday activities .

B. IMD functions and roles are unclear, and widely misunderstood by many non-IMD staff.

III. FINDINGS:

A. The Administrative Services Division provides the following services to the students and faculty of the AMEDDC&S: postal, printing and ordering of publications, Temporary Duty (TDY) orders, distribution center support, records management, forms management, editorial services, electronic publishing and desktop publishing.

B. The Customer Support Division provides training to staff and faculty on standardized software, computer laboratory assistance to students, computer operations support.

telecommunications, and operates the "Help Desk" for the AMEDDC&S.

C. The Health Science Media Division provides visual information support thru production, duplication, and distribution of television productions; closed circuit television; acquisition of commercially produced products, graphics and photographic support, and self-help media support.

D. The Plans and Management Division controls the requisition of hardware, software and supplies, discharges staff responsibility for capability requests (CAPR) and Information Management Plan (IMP) tasks, manages the IMD budget and is the Contracting Officer Representative for ADP maintenance contracts.

E. The Dean's office, Academy of Health Science, operates a duplicate distribution center for all subordinate activities.

F. Staff reported that as year-end money was made available, it was possible to order new furniture but not badly needed automation equipment.

G. The HSMD reportedly did not respond effectively to customer needs or provide timely service.

H. There is some potential duplication of effort in desktop publishing between elements of DCDD and DOTD and the Administrative Services Division.

I. It was reported by many staff members that historically the IMD activity did not provide adequate support to the customer base, hence each Department pursued their own independent solutions.

J. The IMA function at the MEDCOM is reportedly not providing adequate or timely support to it's customers (including the AMEDDC&S).

K. Some staff members felt that the library should be aligned with other IMA related support activities.

L. The current way of doing business with regards to paying for printing and office copiers from a centralized pool of money is "broken" and leads to escalating costs and reduced control.

IV. ISSUES:

A. How can IMD be organized so as to better utilize its capabilities in meeting day-to-day operational requirements as well as to be able to support the strategic objectives of the Command and Staff?

B. How will the Information Management Study affect the AMEDDC&S IMD Operations?

C. Training Technology Branch, DTD, resources have been transferred to IMD. How are these resources being utilized?

V. DISCUSSION:

The IMD currently is focused on upgrading the AMEDDC&S ADP product line into a state-of-the-art-network with world-class implications. The priority is on upgrading capabilities in video teleconferencing, communication, training, standardization, modernization, and moving toward a paperless office. A summary of interview findings to date shows that customers generally feel that automation has not occurred fast enough or aggressively enough to meet the bulk of their requirements. In some cases, the lack of standardized hardware within organizations has actually

increased workloads rather than reduced them.

In the past, previous manpower cuts have often been applied to support staff personnel. Thus, the ability of automation initiatives to keep abreast of such cuts has been further exacerbated on an already difficult situation. For example, classroom scheduling is still being performed as a manual procedure as are other similar administrative functions. As further downsizing pressures continue, it appears imperative that IMD continue with an aggressive modernization program focused on upgrading existing systems and implementing new and additional capabilities as rapidly as possible.

In addition to equipment problems, many respondents, also stated that there existed a general lack of knowledge of ADP operations throughout the command. No comprehensive training program was found to support current IMD products. Currently, the IMD is training approximately five percent of the content needed to fully utilize existing equipment with the rest coming from the external environment. There is a widely held belief that current users are only now beginning to tap into the full potential of available products.

The Training Technology Branch, DOTD (one GS-12 and four GS-11 instructional system specialist) has recently moved form DTD to IMD. AHS department chiefs question the value added of their contribution to training. Most departments feel they have the ability to determine their technology needs and that ISSs are not required to duplicate their mission.

There appears to be some duplication of effort between elements of the DCDD and the Administration Support Division of IMD regarding doctrinal publishing and on-line editing efforts. As resource constraints continue to mount and as DOTD and DCDD training design and doctrinal literature preparation are more fully integrated into the existing teaching departments, further centralization of production support capabilities needs to occur. The AMEDDC&S can no longer afford the layering of multiple efforts not fully integrated throughout the organization.

The HSMD encompasses a broad functional area with specific mission ties to the Army's Audio Visual Command. The division historically has implemented programs in accord with the Concepts Based Requirement System and the more recent Enhanced Concept Based Requirement System. Currently, however, HSMD has experienced considerable difficulty in trying to adjust to the latest change in the combat development process e.s. rapid prototyping. Several respondents indicated that they felt that the division no longer provided value-added service in a timely manner. In addition, it was also reported that the division appeared unable to respond to fast changing customer needs. Many of the interviewees questioned the overall value of maintaining the division in lieu of the costs associated with the quality of services provided. It was reported however, that the Medical Graphics branch and the Combat Camera section were providing timely products to the customer base.

V. RECOMMENDATIONS:

A. The IMD should continue to proceed in its efforts to publish the Information Management

Services and Procedural guide which the IMD believes will go a long way in informing the AMEDDC&S staff and faculty regarding available Information Management (IM) resources and procedures to obtain them.

B. A detailed analytical study should be conducted in order to better understand the current use of personnel with ADP products and how this use is likely to effect administrative support requirements.

C. The current way of doing business with regard to reproduction products needs to be relooked. A concise plan with centralized management and decentralized execution needs to be adopted to eliminate escalating costs in a time of reduced personnel. Therefore: Realign the Production Support Branch, Doctrine Literature Division, DCDD, and the auditorial assistant from Administrative Support Office, AHS, to Administrative Services Division IMD. This realignment will provide a centralized office automation, desktop publishing, and on line editing capability for the entire AMEDDC&S providing a greater range of products, increased turn around time, and improved efficiency.

D. The Health Science Media Division (with the exception of Medical Graphics Branch and Combat Camera) needs to adjust to the new requirements associated with rapid prototyping. Since to date, HSMD, has been unable to respond effectively to customer needs consideration should be given to out-sourcing required services with oversight responsibility given to the IMD. Medical Graphics and Combat Camera should be realigned into the customer support branch within the IMD.

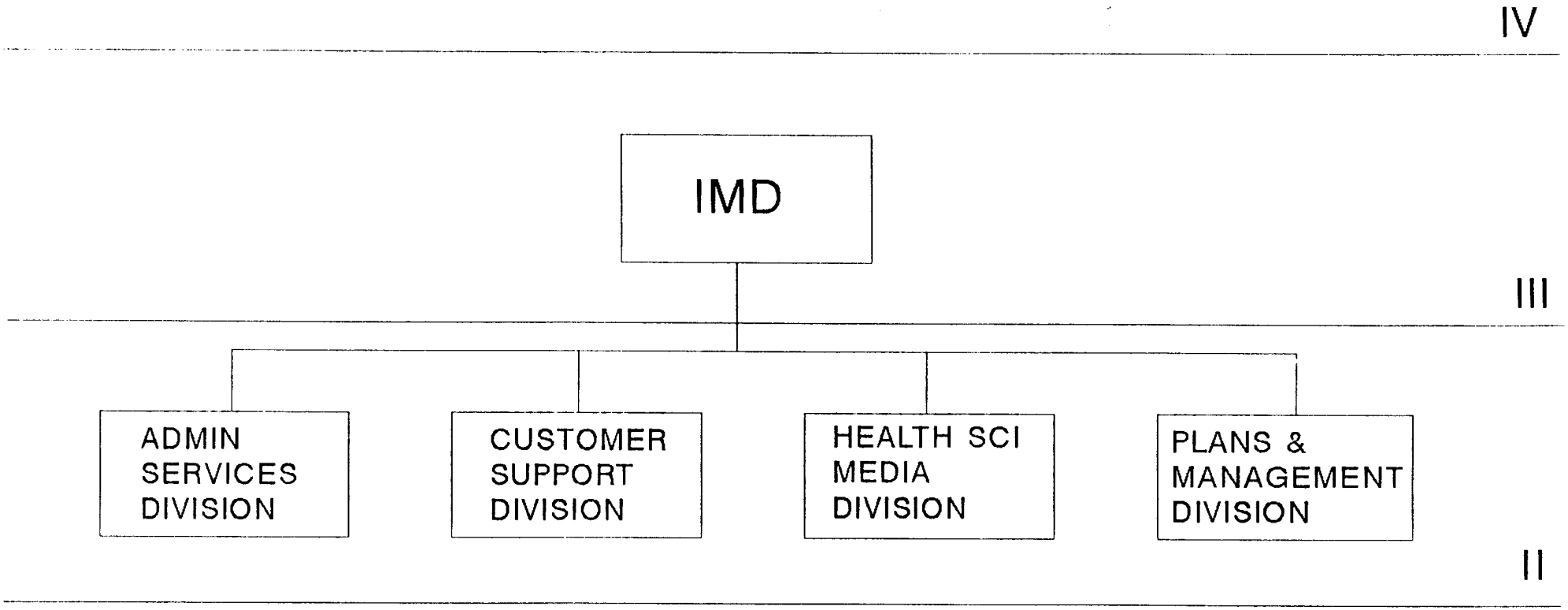
E. The IMD should develop and implement a concise training plan focusing on "customers" needs in order to achieve both organizational and operational goals.

F. A Coordination of efforts is needed in all directorates to ensure ADP standardization of products and training are maintained within the IMD.

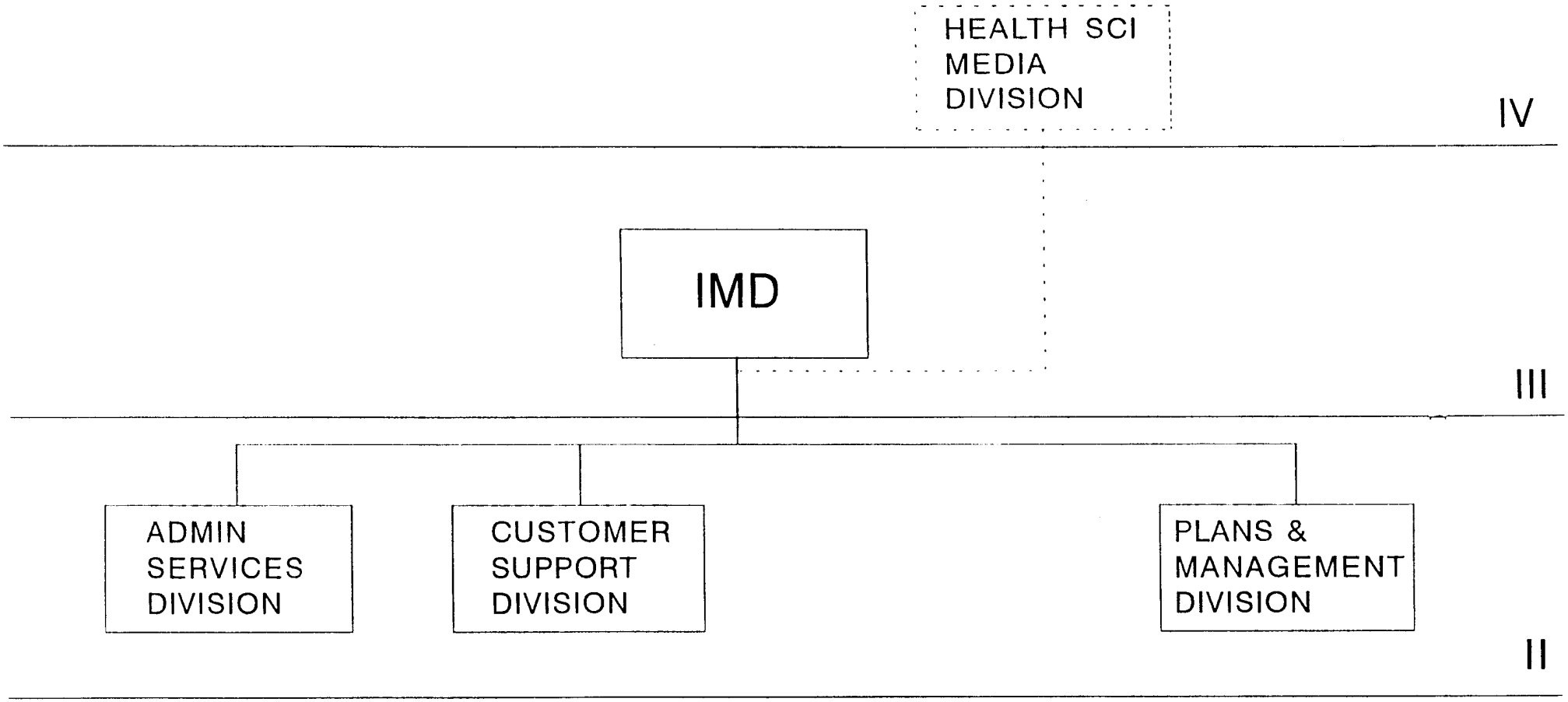
G. The IMD needs the ability to establish with internal IM staff or through contract sources, a substantial capability to develop and support database management system based applications and information systems.

H. Analyze the AHS training technology resource requirement to determine if a Training Technology Branch is needed. If needed, do ISSs have the expertise required to perform the mission? If the ISSs are indeed duplicating the training department effort the five resources should be considered as savings.

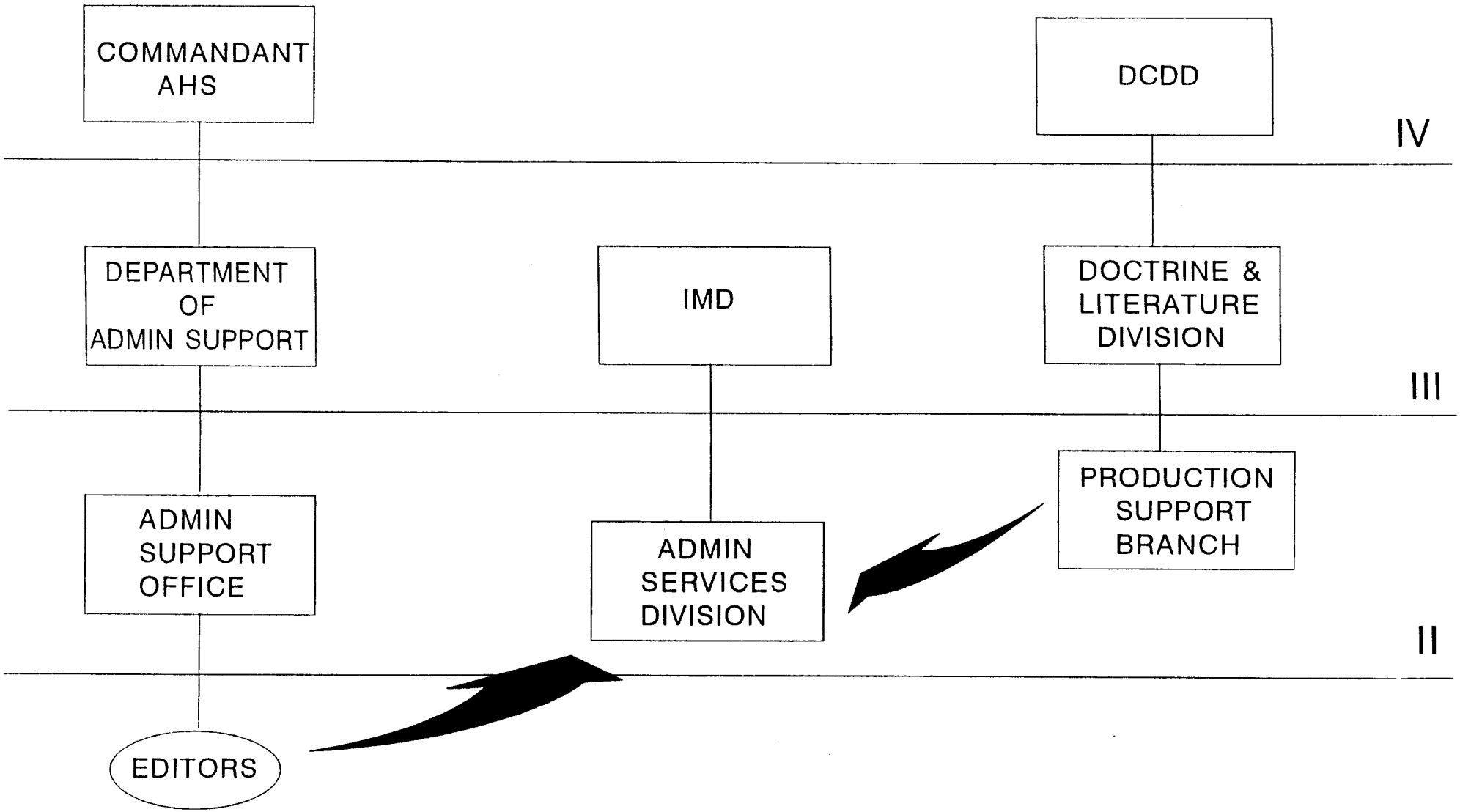
IMD MANIFEST ORGANIZATION



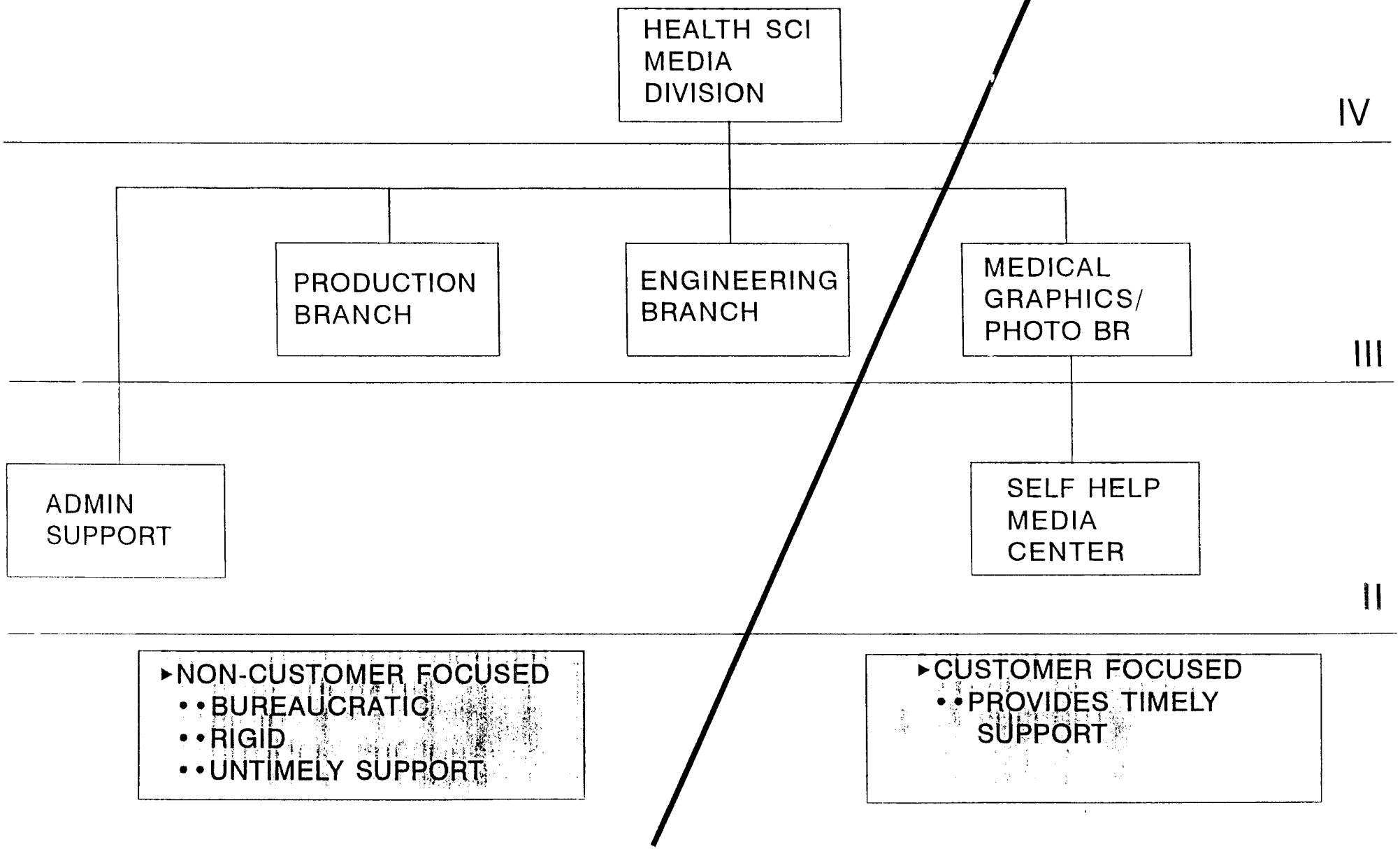
IMD EXTANT ORGANIZATION



PRODUCTION SUPPORT SERVICES



HEALTH SCIENCE MEDIA DIVISION



TAB S

ENCLOSURE 14

U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF PERSONNEL

I. BACKGROUND:

The Directorate of Personnel consists of three distinct areas of concentration: a student detachment; personnel security section; and student liaison function. It currently is accountable for numerous staff and faculty related personnel actions within the U. S. Army Medical Department Center and School (AMEDDC&S). The Student Detachment focuses on overseeing all long-term civil schooling. This mission is essentially a caretaker activity and duplicates the efforts of the Army Student Detachment, Fort Jackson, South Carolina, which monitors all other Army student personnel. The personnel security section is focused on monitoring and updating security clearances. Finally, the AMEDD Student Liaison is responsible for officer assignments, both permanent party and students, and officer and noncommissioned officer evaluations. The Directorate of Personnel has evolved over the years, each time gathering more and more missions, until the directorate is perceived as the defacto DCSPER for the AMEDDC&S. Interestingly, other TRADOC schools do not contain a Directorate of Personnel similar to the one described above. Instead these schools rely on the post DPCA, and the BN PACs to carry out many of their personnel functions.

II. THEMES:

A. What is the best way to organizationally align the Directorate of Personnel to maintain

continuity within the personnel arena?

B. What is the best way to realign the Personnel Administration Centers (PAC) in support of the AMEDDC&S?

III. FINDINGS:

A. The AMEDD C&S currently has three PACs, a Brigade S-1 office, a Directorate of Personnel, and the garrison has a milpo, all focused on selected personnel actions.

B. Some interviewees responded that there is too much layering within the personnel community which inherently adds to multiple responsibilities crossing command lines and ultimately increasing the time lag from a personnel action request to final completion.

C. PACS within the battalions generate 10,000 transactions a quarter with the Brigade S-1 providing a clearing house operation for issues which require the brigade commanders signature.

D. Currently the directorate is staffed by the Director, Deputy Director/Officer Student Liaison, Personnel Security, and the AMEDD Student Detachment. Responsible for officer assignments, both permanent party and student, officer schools, officer evaluations and noncommissioned officer evaluations, monitoring and updating security clearances, and a myriad of administrative functions.

VI. ISSUE: What is the most appropriate organizational alignment of the Personnel Disciplines?

V. DISCUSSION:

The Directorate of Personnel (DOP) has successfully conducted business for many years under its present configuration. In fact, the organizational support has been so successful that DOP has consistently been assigned greater and greater responsibilities including the recently added missions of monitoring noncommissioned officers evaluations and the processing of personnel security clearances. However, the current fiscally constrained operational environment dictates that the command explore alternative organizational designs that will not only save resources but also maintain the quality of support we have come to expect from all levels of the personnel disciplines.

The consensus opinion from the interviewees is that the DOP and the Brigade S-1 operational responsibilities represent a duplication of effort which results in added bureaucratic layers to the AMEDDC&S personnel actions. If a realignment of personnel processes and organizational entities were implemented, the net result would offer potential savings and would generally improve the support of the Personnel Disciplines within the AMEDDC&S by elimination of non-value added layers.

The PACS within the battalions generate 10,000 transactions per quarter each depending on the number of soldiers assigned. However, with the 187th and 232d Medical Battalions adjacent to each other and taking into account the present reduction of personnel, a synergy of effort would seem to make operational sense. Role redefinment within the personnel discipline is needed in

order to maintain support while reducing layering. Consolidation of roles should eliminate the overlaps and greatly increase the efficiency of the Battalion PACS, Brigade S-1, and the DOP.

The Personnel Security branch was recently realigned under the DOP reportedly due to a conflict between the personalities of two co-workers. While this technique for managing conflict has been acceptable in the past, fiscal and operational constrains dictate a new way of thinking today.

VI. RECOMMENDATIONS:

A. That the AMEDDC&S Directorate of Personnel be realigned into the Brigade S-1.

B. The Brigade S-1 position be upgraded to a Lieutenant Colonel position.

C. That the AMEDD Student Detachment be resubordinated to Alpha Company, 187th Medical Battalion for all levels of support.

D. Realign the Academy Battalion PAC personnel into the Brigade S-1 to support its increased missions.

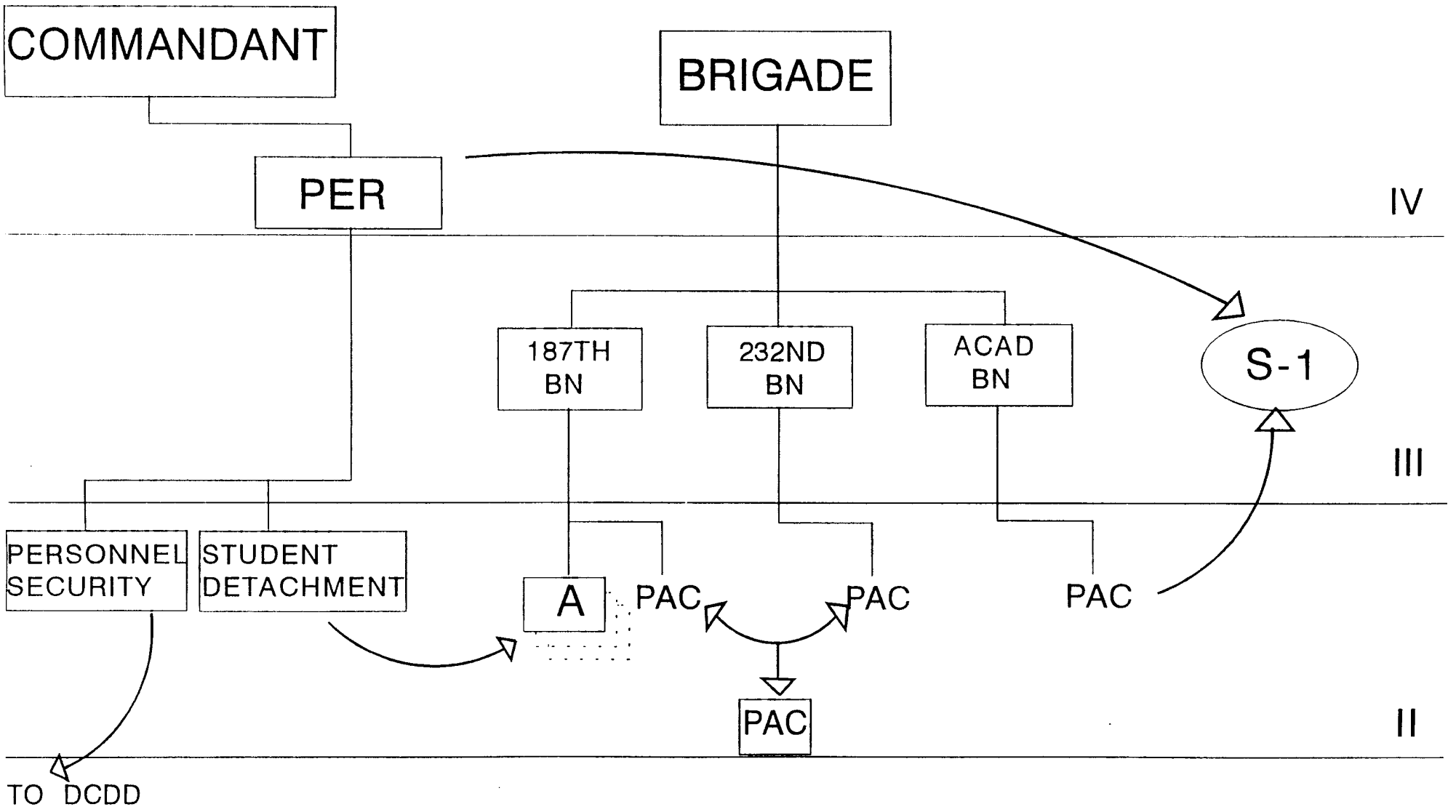
E. The Brigade S-1 will have oversight responsibility for the entire personnel functional disciplines within the AMEDDC&S.

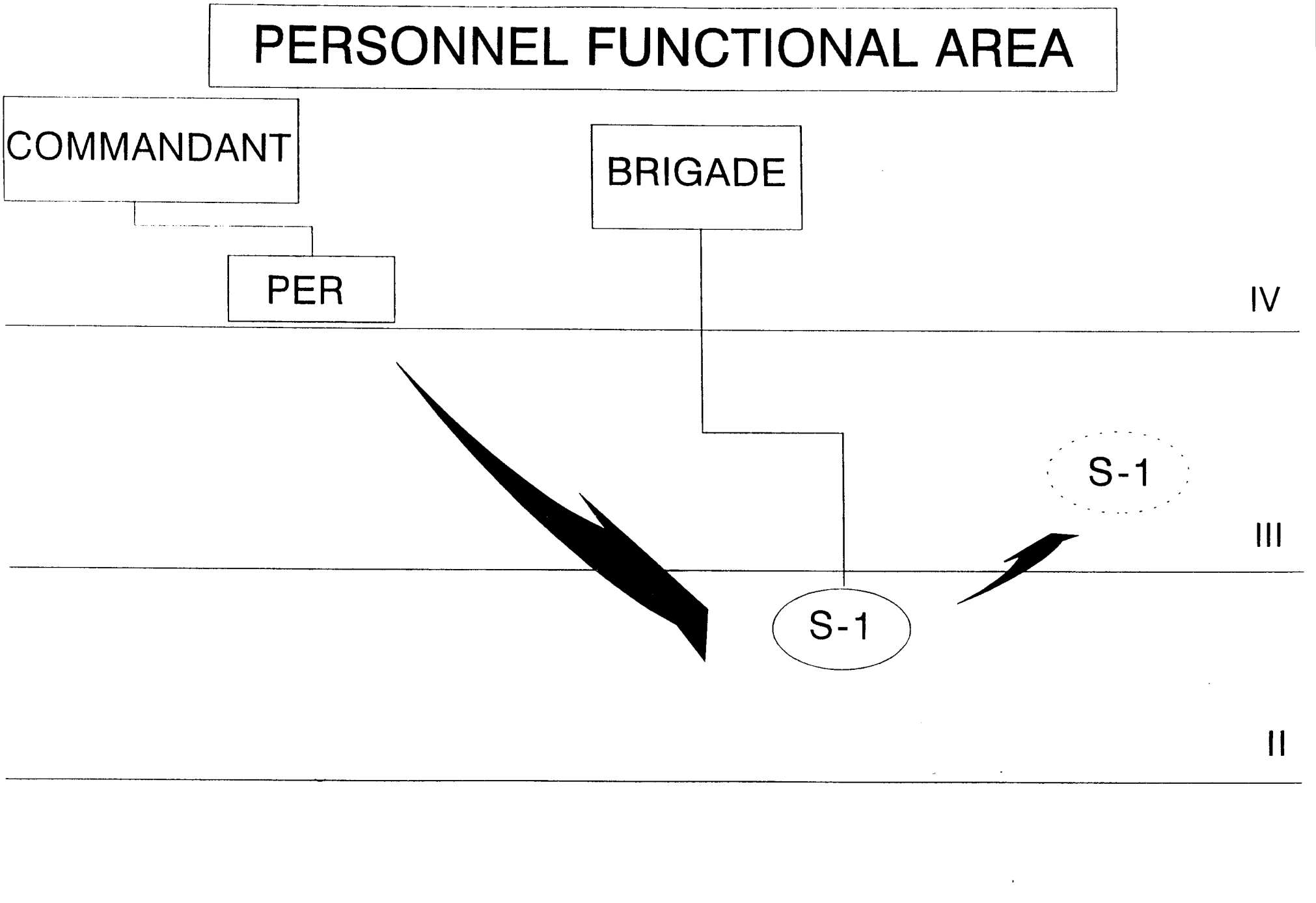
F. Realign the 187th and the 232d Medical Battalion PACS, with the exception of the mail room personnel, centrally located with oversight coming from the Brigade S-1.

G. Personnel Security should be realigned to the Threat Branch, Directorate of Combat & Doctrine Development.

my threat recommendation was different.

PERSONNEL FUNCTIONAL AREA




PERSONNEL FUNCTIONAL AREA
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TAB T

ENCLOSURE 14

U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

DIRECTORATE OF OPERATIONS

I. BACKGROUND:

In October 1992 the Directorate of Support was reorganized into two separate directorates: Directorate of Operations and Directorate of Logistics. Basically, the functions were distributed according to the implicit design principle that " if a function was not logistics, it belonged to operations.". Since the 1993 TFA Study, the functions of the Directorate of Operations (DOPS) have been significantly reduced. Many existing functions were realigned to other functional areas where the level and type of work appropriately fit.

Presently, DOPS still has the International Military Student Office, Security and Intelligence Branch, Mobilization Branch, classroom support, U. S. Army Medical Museum, and coordinates special taskings for the AMEDDC&S Chief of Staff. Some of these functions were also identified for realignment in the 1993 TFA Study, but were not moved to the recommended areas.

II. THEME:

The Directorate of Operations still performs a few essential support functions which should be realigned to other areas for better efficiency and savings.

III. FINDINGS:

A. Remaining pieces of DOPS are too small to form a nucleus for an operational staff organization appropriate to the two-star general officer level (i.e. TOE division command equivilant), thus creating a redundant relationship with other AMEDDC&S and Center Brigade staff elements.

B. The Mobilization Branch is perceived as a nuisance to AMEDDC&S staff members and the Center Brigade. Many of the functions managed by the branch are usually accomplished by tasking the work to the brigade or to other staff members within the AMEDDC&S. This branch is seen as a repository of information gathered or accomplished by the AMEDDC&S staff or the brigade.

C. The International Military Student Office is an extremely high visibility organization with international socio-political implications.

D. The Security and Intelligence Branch has personnel assigned to the Directorate of Personnel and the DOPS, because of past personality conflicts between assigned staff members.. Management of these security functions is split between the two organizations which results in a dysfunctional atmosphere regarding the accomplishment of security matters.

E. The Medical Museum is an important aspect to the history and lineage of the AMEDD and has an excellent reputation throughout the Army as a show place at the AMEDDC&S. Due to the strong influence and involvement of military (retired and active duty) and civilian dignitaries, this activity reportedly requires a general officer level executive management activity to coordinate the required affairs.

F. The classroom support personnel provide flag, VTC, and classroom support services.

IV. ISSUE:

Can the DOPS functions be realigned with other AMEDDC&S organizations to gain efficiencies and savings?

V. DISCUSSION:

Since the 1993 TFA Study, the Directorate of Operations has significantly changed. Almost all of the functions have been redistributed to other AMEDDC&S organizations in order to accomplish synergy and avoid duplication of efforts. With only a small remnant of functions remaining there seems to be some additional efficiencies which could be achieved with a further consolidation of functions within the AMEDDC&S. Such a consolidation would eliminate any remaining duplication and could create possible personnel savings.

VI. RECOMMENDATIONS:

A. Eliminate the DOPS and realign functions and personnel for best efficiency and savings.

B. Eliminate the Mobilization Branch and realign the functions with the Center Brigade S3. Also, move the AMEDDC&S PROFIS management functions to the Center Brigade S1 for personnel management efficiencies.

C. Realign the International Military Student Office functions and personnel with the Department of Academic Support, AHS. This will create better visibility and

accountability for international students with the school commandant.

D. Move the Security and Intelligence Branch functions and personnel (minus the Provost Marshal) to the Concepts and Analysis Division, DCDD to increase the capabilities of the Threat Analysis Cell.

E. Keep the Provost Marshal's position under the Chief of Staff as a special staff officer to provide law enforcement guidance to the command.

F. Align the U. S. Army Medical Museum with the Executive Operations Office to maintain the special staff affiliation and proponency visibility with the Commander, AMEDDC&S. Also, assign the personnel responsible for flag support to Executive Operations. The flag support activity supports many activities, social functions, and graduation exercises that Executive Operations presently assists with. Presently, the flag support requires civilian overtime to meet support requirements. Assignment of one or two junior enlisted personnel (E-3/E-4) would eliminate overtime and potentially increase the quality of support.

G. The personnel responsible for supporting the dedicated classrooms (e. g. set-up, cleaning, etc) should be assigned to the Directorate of Logistics/ S4.

H. The coordination and operation of the VTC conference room, as well as, any special tasking authority requirements should be the responsibility of the SGS office.

TAB U

ENCLOSURE 14

U.S. ARMY MEDICAL DEPARTMENT CENTER & SCHOOL

U.S. ARMY MEDICAL DEPARTMENT REGIMENT

I. BACKGROUND:

The AMEDD Regiment was activated 28 July 1986 and has been located in Aabel Hall, AMEDD Center and School since that date. The Regiment is governed by AR 600-82, U.S. Army Regimental. The Adjutant is an officer or SGM from one of the corps (rotated every two years). The Adjutant is rated by COL Stevens, executive officer, OTSG and senior rated by Gen Lanoue, but receives primary guidance from COL Stevens, XO, and OTSG on all Regimental matters, and additional guidance from the AMEDDC&S Chief of Staff and/or SGS on matters that pertain only to that activity. Mr. Still, a retired SGM now GS-9, has always run the Regiment office and performs all functions without administrative assistance. He ensures all operations to include budgeting and property book run smoothly.

II. THEMES:

a. The AMEDD Regiment is definitely a valued asset that markets the AMEDD at a low cost. The goal is to help soldiers identify with the Regiment by fostering a sense of belonging. The marketing program includes a traveling flag program, medal of honor posters program, certificates of

affiliation, and recognition of personnel program.

b. The AMEDD Regiment represents the entire AMEDD, but is located at the AMEDDC&S.

c. Mr. Still provides value added support as a history instructor for the NCO Academy.

d. The AMEDD Regiment coordinates the appointment of the Honorary Colonel and Sergeant Major and schedules their visits to medical activities and provides administrative support for the two positions.

e. Formal briefings are given at major medical conferences for the active and reserve component forces.

f. Speaking engagements are given to civilian personnel under the community relations program.

g. Mr. Still prepares monographs and documentary films on special subjects for the OTSG.

h. Additionally, he compiles the history of the AMEDD NCO and Enlisted soldier publication.

III. FINDING:

Mr. Still is the key person responsible for the oversight and value added operation of the Regiment. Corps representation (Adjutant) was required and essential when Corps Chiefs were at OTSG. However, with the MEDCOM located at Ft. Sam Houston, the representation is available and should eliminate the requirement of the Adjutant being

physically located in the Regimental Office. Mr. Still and a contract or temporary administrative assistant could effectively operate the Regiment.

IV. ISSUES:

a. What is the role of AMEDD Regiment?

b. Where is most effective location of the AMEDD Regiment?

V. DISCUSSION:

Mr. Still is considered the AMEDD's true historian and is highly respected by staff and faculty for his expertise, quick response to inquiries, historical displays, exhibits, marketing ability, and extensive knowledge. The last Adjutant stated, "Mr. Still runs the Regiment and makes the Adjutant look good." The AMEDD Regiment is operated IAW AR 600-82, U.S. Army Regimental. To change the operation would require an Army regulation change. The possibility of a regulation change should be explored to delete the requirement for an adjutant. If the regulation cannot be changed, consider using an adjutant that is not involved in full time daily operations.

VI. RECOMMENDATIONS:

a. The MEDCOM/Regimental Staff should review and determine if there is still a need for a military position to fill the

role of the adjutant or appoint Mr. Still or another member of the staff to fill the position as an additional duty.

b. The AMEDD Regiment should continue to be under the direct control of the MEDCOM/Regimental Staff to meet the requirements outlined in AR 600-82. The office is the direct link between the honorary positions, the corps chiefs and the Regimental Staff. The Regiment should remain in the AMEDDC&S where it is presently located to maintain the high level of effectiveness and visibility critical to its overall mission.

TAB V

ENCLOSURE 14

U.S. Army Medical Department Center and School

Student-Soldier Health Care

I. Background

The Troop Medical Clinic (TMC) was constructed in the 1970's. It was designed to provide access for primary patient care to active duty military personnel assigned to Fort Sam Houston and to remove the primary patient care workload from the Brooke Army Medical Center (BAMC) emergency room (ER). By most accounts, this TMC was too "small" when it opened and has never been appropriately or adequately staffed, both in numbers of clinicians and quality of providers.

The active duty permanent party population assigned to Fort Sam Houston is considered constant. The variable factor is the number of students assigned to the Center and School. This number is subject to seasonal variations, usually peaking in the summer. It is difficult to assign a dedicated, complete health care team to the TMC when there is decreased work-load. However, it is imperative that maximum providers be assigned in peak training periods. Additionally, regardless of "season", sick-call increases on physical training (PT) mornings. Perceptions exist--regardless of the time of year and the numbers of provider/clinician assigned to the TMC--that patients wait an

"inordinate" amount of time for treatment. Unfortunately, these perceptions are real; thus patients avoid the TMC for treatment because they "don't have the time."

Sick call is provided from 0630 to 0730, Monday through Friday. Appointments are available after 1000. The TMC conducts no post duty-day health care, either in the evenings or on weekends. Soldiers who require medical intervention must go to the BAMC emergency room. Once logged-in, the soldier is triaged to receive treatment in the emergency room or acute care clinic. This service is available 24 hours per day, seven days per week.

Permanent party who receive treatment at the ER equally find the wait exceedingly lengthy. Waits for definitive care can exceed two to three hours, longer if there is trauma on sight. Permanent party either try to avoid this portal or call a friend or colleague to assist them in being treated at another clinic. Should a student access this clinic, they can miss important class instruction, soldier specific training, study hall, details or to many, most importantly, sleep.

An additional health care portal for active duty personnel is the TMC at Camp Bullis. This TMC is operated and staffed by BAMC. For the past several years, two active duty medical personnel staff this clinic. They remain on-site or on-call 24 hours per day, seven days per week. This clinic provides care to permanent

party supporting staff and to students engaged in training at Camp Bullis. The Camp Bullis clinic is equiped with life support equipment and an ambulance.

Two central issues exist with this clinic. First, if a soldier has to be evacuated to BAMC, the clinic closes to support this evacuation. Subsequent patients, either seeking routine care or emergent care, are left with no provider available. Secondly, only 91B's staff this clinic. No physician, physician assistant or nurse practitioner work at this clinic. This results in the provision of screening care only, not definitive health care. The trip from Camp Bullis to BAMC takes approximately 30 minutes when not engaged in heavy traffic. If a permanent party or training soldier requires definitive care, they lose approximately one-half to two-thirds of the duty day going to BAMC to see the physician.

II. Theme:

1. The perceived quality and timeliness of medical treatment provided by the TMC does not meet student and permanent party soldier expectations.

2. Students often exploit, to their advantage, existing TMC operating procedures.

3. The staffing, operation and evacuation procedures at the Camp Bullis clinic represent significant patient safety and quality of care concerns to the Center Brigade and Academy staff.

III. Findings:

a. Waiting times for sick-call treatment are excessive, often causing the student to miss valuable class instruction.

b. Permanent party soldiers avoid morning sick-call at the TMC because of the lengthy wait.

c. TMC operating hours are not conducive to student schedules.

d. Sick-call rates rise dramatically on PT days.

e. BAMC TMC staff is marginally augmented by providers assigned to the AMEDD Center and School.

f. BAMC ER wait is excessive and is not the optimum location/clinic to treat students.

g. Camp Bullis clinic under-staffed.

h. Camp Bullis clinic closes when a patient is evacuated.

i. Camp Bullis clinic workload does not warrant assigning a full-time primary care provider.

IV. Issues:

a. What is the most efficient and effective way to provide quality health care to students and permanent party soldiers at the TMC?

b. How can waiting time to see a primary care provider be reduced, resulting in decreased lost classroom instruction for students, and less time away from the job for permanent party soldiers?

c. How can all providers assigned to the Center and School (credentialed by BAMC) become integrated into the TMC primary care network?

d. How can the Camp Bullis clinic staff be augmented to improve the perception of "professional and continuous care?"

e. How can the Camp Bullis clinic remain open during ambulance evacuations to BAMC?

V. Discussion:

a. Historically, Army MTF's primary responsibility is to provide a complete spectrum of health care to active duty soldiers focusing on primary care and wellness. Dependents of active duty and retirees and their dependents receive medical care on a "space available" basis. Many at Fort Sam Houston feel that soldiers are not the primary focus for health care delivered at BAMC, more specifically at the TMC. Specifically, the TMC is routinely under staffed, often times with marginal providers. Staffing is inconsistently augmented by credentialed providers engaged in full-time administrative/teaching work at BAMC, Center and School and MEDCOM.

BAMC and the TMC must develop a primary focus on the soldier, both student and permanent party. The TMC must look at the hours of operation and how to better augment staffing to decrease lost training/duty time. Additionally, the AMEDD Center and School must address the availability of assigned credentialed clinical providers that can augment the TMC on a regular basis. Additional options to improve turn-around is to hold afternoon sick-call at the TMC or at the Center and School. Further, each Battalion can establish a form of Battalion Aid Station to conduct "screening" sick-call each morning to include weekends.

The BAMC Deputy Commander supports changing the current structure

to better support the student-soldier population that uses the TMC. Options discussed included, but not limited to, opening a second TMC at the Center and School, establishing Center and School operated Battalion Aid Stations, expanding TMC hours of operations with split responsibility and opening the TMC on weekends. It is imperative that all credentialed clinicians assigned to the Center and School work as a primary care provider in any resolved solution. It is estimated that each provider will need to work four hours per week to support this change. The winner is the student and the permanent party soldier. The focus for primary care will once again be on the primary customer.

b. The Camp Bullis clinic workload does not justify a primary care provider. The workload does support the clinic remaining open during the duty day and maintaining acceptable call coverage in the evenings/weekends. The Deputy Commander at BAMC is willing to negotiate several options, especially during peak periods of Center and School training. Options include: Adding a third full-time corpsman to the clinic staff. This will ensure better access for screening procedures and for continuous coverage if the ambulance needs to evacuate a patient to BAMC; authorize the use of a nearby civilian ambulance service; and to explore the feasibility of creating a telemedicine link between BAMC and the Camp Bullis clinic.

VI. Recommendations:

a. Establish AMEDD Center and School Battalion Aid Station operation to pre-screen sick-call and provide appropriate care within the scope of operations.

b. Analyze students "lost" classroom instruction time and determine if evening TMC operations will reduce morning sick-call.

c. Mandate that each clinician on the Center and School staff who maintains credentials at BAMC work at the Battalion Aid Station, extended TMC, or the newly created second TMC.

d. Ensure BAMC adds a third corpsman to the Camp Bullis clinic.

e. Utilize the civilian ambulance service during peak training periods.

f. Establish a telemedicine link between BAMC and the Camp Bullis clinic.