Headquarters, U.S. Army Training Center
and Fort Jackson 2400 Jackson Boulevard
Fort Jackson, SC 29207

Fort Jackson Regulation 40-1

10 March 2026

(Expires 03 October 2027)
Medical Services

U.S. Army Training Center and Fort Jackson T2COM Organic Medical Structure

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OFFICIAL:

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History. This publication is a new U.S. Army Training Center and Fort Jackson Regulation.

Summary. This circular prescribes the mission, organization, and functions of the U.S. Army Training Center and Fort Jackson T2COM Organic Medical Structure.

Applicability. This circular applies to all U.S. Army Training Center and Fort Jackson organizations that provide staff support to, or control of elements of the U.S. Army Training Center and Fort Jackson T2COM Organic Medical Structure.

Proponent and exception authority. The USATC Surgeon Cell is the proponent of this regulation. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. Proponent may delegate authority, in writing, to a division chief in the grade of Major or the civilian equivalent within the proponent agency, its direct reporting unit or field operating activity. The commander or senior leader will endorse waiver requests and forward them through higher headquarters to the policy proponent.

Army management control process. This circular does not contain management control provisions.

Supplementation. Supplementation of this document and establishment of command and local forms is prohibited without prior approval from the Command Surgeon's Office, 2400 Jackson Boulevard., Fort Jackson, SC 29207.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Command Surgeon's Office, 2400 Jackson Boulevard., Fort Jackson, SC 29207.

Distribution. Publication is available in electronic media only and is published at https://home.army.mil/jackson/about/jackson-publications/fort-jackson-regs

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Introduction

1-1. Purpose
This United States (U.S.) Army Training Center and Fort Jackson regulation provides guidance that defines and delineates organizations, functions, and responsibilities for the T2COM Organic Medical Structure (TOMS).

1-2. References
See appendix A.

1-3. Explanation of abbreviations and terms
See the glossary.

1-4. Responsibilities
See chapter 2 for responsibilities.

1-5. Records management (recordkeeping) requirements
The records management requirement for all record numbers, associated forms, and reports required by this publication are addressed in the Records Retention Schedule–Army (RRS-A). The RRS-A is accessible via the Army Records Management Division SharePoint site at https://armyeitaas.sharepoint-mil.us/sites/HQDA-CIO-ISES-RMR/SitePages/Records-Management-Division.aspx. If any record numbers, forms, and reports are not current, addressed, and/or published correctly in the RRS-A, see DA Pamphlet 25-403 for guidance.

1-6. Scope
This regulation focuses on the organizational structure, core functions, and major responsibilities associated with TOMS; to include selected T2COM staff, U.S. Army Center for Initial Military Training (CIMT), U.S. Army Combined Arms Center (CAC), Centers of Excellence (CoEs), and the U.S. Army Training Center (ATC). It describes the supporting, supported, and operating relationships that create conditions necessary to accomplish the assigned TOMS mission.

1-7. Policy

a. A strong, healthy, resilient, and trained force is the most important indicator of the Army's readiness. For USATC&FJ, maintaining strength, health, and resilience, and maximizing the time available for training, is critical to delivering a ready and fit Soldier to the operational force. The addition of organic medical personnel in IET formations provides ready access to primary care, augments military medical treatment facilities (MTFs), and accesses systems that allow unit leadership to see and track their Soldier's medical readiness.

b. The TOMS resources upkeep of medical readiness, supports performance readiness, reduces attrition, reduces injuries, and mitigates risk to the training mission. The presence of organic medical personnel in IET formations, combined with direct support by MTFs,

results in recovery of otherwise-lost training hours due to delayed treatment of Soldiers, as well as battle buddy, cadre, and transportation costs.

1-8. General organizational requirements
In developing TOMS, medical support to the trainee and student population across lines of effort has been formally analyzed, planned, budgeted, and assessed for outcomes. The TOMS applies mechanisms to identify best practices at installations, with a view to standardizing them across the command. The key essential for unit commanders, namely time within the program of instruction (POI) for the trainee and student, was the primary consideration in developing TOMS.

1-9. Mission

a. Improve direct medical support to the trainee population to enhance efficiency and reduce lost training time.

b. Generate a force that is physically, mentally, and medically ready to enter the operational Army and contribute to the mission.

1-10. Organization
TOMS postures USATC&FJ to deliver appropriate, competent, and timely medical care to effectively and efficiently train and lead Soldiers to enter the operational force and maximize Army mission readiness. TOMS will maintain medical readiness, support performance readiness, reduce injury and subsequent attrition, reduce time away from POI for medically related concerns, and mitigate risk to the training mission in its training enterprise. TOMS was initially fielded in select initial entry training (IET) brigades (BDEs), and CAC.

Chapter 2
Responsibilities

2-1. Headquarters, U.S. Army Training Center and Fort Jackson

a. Chief of Staff (CoS).

(1) Support military and civilian personnel requirements for TOMS.

(2) Support facilities-related requirements for TOMS.

(3) Support logistics-related requirements for TOMS.

b. G-8. Manage manpower and acquisition-related resources pertaining to TOMS.

c. USATC&FJ Surgeon.

(1) Serve as the overall lead for the TOMS program.

(2) Coordinate TOMS with T2COM, the U.S. Army Medical Command (MEDCOM) and the DHA.

(3) Conduct in-progress reviews (IPRs) with organizations that have TOMS elements to ensure the program continues to meet objectives.

2-3. Commanding Generals or Senior Mission Commander, U.S. Army Combined Arms Center, Centers of Excellence, and the Army Training Center

a. Guide relationships between the TOMS personnel and supporting MTFs, existing T2COM healthcare personnel, and Holistic Health and Fitness (H2F) personnel (see para 2-5).

b. Provide representation from the command and staff, and from the supporting MTF, to IPRs conducted by the T2COM Surgeon (see para 2-2c).

c. Submit RFIs and RFAs to T2COM Surgeon's office as needed.

d. The CoE command surgeons whose positions existed prior to implementation of the TOMS (U.S. Army Aviation Center of Excellence) or who are performing the role of command surgeon from an existing duty description, will provide professional oversight to TOMS personnel assigned to their organizations.

2-4. U.S. Army Training Center and Fort Jackson Organic Medical Structure

a. The ATC, CAC, and CoE Surgeon or Equivalent.

(1) FM 4.02 describes the role of the command surgeon, and their relationship with the line commander. This Army medicine officer is a member of the commander's personal and special staff charged with planning, coordinating, and ensuring the mission is executed. The command surgeon should have a small staff section to assist in planning, coordinating, and synchronizing the appropriate medical support within the operational area. Not all CoEs are resourced for the CoE Surgeon or equivalent position. The CoE Surgeon responsibilities may be delegated (see para 2-4.a(4)) or may not be able to be fully executed.

(2) The command surgeon is responsible for ensuring that all Army medicine functions are considered and included in running estimates, planning, and operation orders. The command surgeon retains technical supervision of all healthcare operations. At the higher levels of command, the scope of duties and responsibilities expand to include all subordinate levels of command.

(3) Through mission command, the command surgeon may be empowered to act somewhat independently; however, the non-medical commander can retain the authority to make the decisions they feel are critical. Mission command, to be successful, requires an environment of trust and mutual understanding which may be challenging to establish for newly assigned staff members who have not had a previous supporting relationship with the command. For detailed information regarding the surgeon and surgeon section at echelon, refer to appendix B.

(4) The ATC and CoEs across T2COM do not include standardized command surgeon cell authorizations on their respective tables of distribution and allowances (TDAs). To meet the military medical readiness requirements of the senior supported military operational commander,

it is highly recommended to establish TDA authorizations, use augmented reserve personnel, borrowed manpower, senior BDE surgeons, or MTF-designated personnel.

(5) The commander of the MTF serves as the MTF director and responsibilities are authorized in DoDD 5136.13, September 30, 2013, as amended; Section 1073c, Title 10, United States Code (10 USC 1073c); and Defense Health Agency Administrative Instruction (DHA-AI) 5136.03, November 3, 2022. The MTF director may assign a member of the MTF to fill the CoE surgeon role as borrowed manpower, aligning T2COM medical assets with MTF responsibilities to meet the senior commander's mission requirements.

(6) As an alternative to an assigned, borrowed, or use of the MTF director, the senior commander may designate the senior BDE surgeon assigned to function as the CoE surgeon.

b. Brigade (BDE). The BDE surgeon is a member of the commander's personal and special staff. The BDE surgeon plans and coordinates the BDE medical support activities with the BDE's personal, special, and coordinating staff. The BDE surgeon is responsible for the technical control of all medical activities in the command. The BDE surgeon oversees and coordinates medical support activities through the BDE surgeon section and the BDE S-3. The BDE surgeon keeps the brigade commander informed on the status of medical support for BDE operations and the health of the command. The BDE surgeon provides input and obtains information to facilitate medical planning. For detailed information regarding the surgeon and surgeon section at echelon, refer to the following appendices:

(1) Appendix C, Surgeon's Cell, Combined Arms Center.

(2) Appendix D, Surgeon's Cell, Centers of Excellence and Army Training Center Brigades.

(3) Appendix F, Brigade Mental Health Officer and Mental Health Non-Commissioned Officer (MOS 68X) Standard Operating Procedures.

c. Battalion (BN).

(1) The BN surgeon (TOMS provider) is either a physician or physician assistant (PA) or nurse practitioner (NP) who provides sick call for IET Soldiers assigned to their respective units using either their forward care stations, Troop Medical Clinic (TMC), or MTF. The providers may conduct examinations within the scope of their approved credentials, limitations of the facility, and considerations of privacy as guided by the MTF. Enlisted healthcare personnel utilize Algorithm Directed Troop Medical Care (ADTMC) (see MEDCOM Pamphlet 40-7-21). Mental Health (MH) providers practice under their approved credentials and MEDCOM Pamphlet 40-19.

(2) Treatment is limited to minor care of wounds, sprains, strains, and medical conditions as the provider is credentialed. Medication will be dispensed only within healthcare personnel's credentials and approval by the MTF. Healthcare personnel will abide by applicable policies governing TMC and/or MTF operations in the care of patients.

(3) Based on the Soldier's presentation and the provider's clinical judgement, TOMS providers will promptly refer a Soldier to the appropriate level of care for further evaluation and

treatment in cases that are complex or require higher-level resources, in accordance with local MTF policy on consultations and referrals.

(4) The BN surgeon also serves as the medical advisor to the BN commander and his or her staff, company commanders, and may have additional responsibilities found in appendix E.

2-5. Existing Healthcare Personnel

a. T2COM's TDA contains authorizations for personnel in healthcare roles that existed prior to implementation of the TOMS. These positions are comprised of command surgeons, flight surgeons, clinical psychologists, nurse case managers, unit PAs, and medics for medical support to high-risk training, instructor cadre, and aviation support. See T2COM Circular 350-70-1 for guidance on medical support to high-risk training.

b. The Army established the H2F system in 2019 via Headquarters Department of the Army (HQDA) Execution Order (EXORD) 149-19 to create a comprehensive, integrated, and immersive health and fitness system that optimizes Soldiers' physical and non-physical readiness and enables Soldiers to engage with and overmatch the enemy in multi-domain operations across the spectrum of conflict. The H2F system authorizes assignment of licensed and credentialed health and fitness professionals to BDEs in U.S. Army Forces Command (FORSCOM), T2COM, Army National Guard (ARNG), and the U.S. Army Reserve (USAR) Command to incorporate H2F concepts in training. The TOMS healthcare personnel interact and coordinate with H2F personnel to ensure early access to care, continuity of medical care, and accomplishment of the commander's intent.

Chapter 3
T2COM Organic Medical Structure Operations

3-1. Scope of Care

a. The MTF will ensure TOMS providers are informed of, and comply with, all clinical guidelines, policies, and regulations mandated by the DHA and other official supervisory organizations.

b. The TOMS provider's focus is the trainee population, primarily in the forward care setting. As time permits, TOMS providers may provide care to cadre on an acute basis, but TOMS providers will not serve as the assigned PCM for permanent party personnel.

3-2. Forward Care

TOMS forward care is the delivery of quality, routine care to determine which Soldier can be returned to training, which Soldier requires a same-day appointment in the MTF or requires a higher level of care. This includes any encounter which occurs outside of a MTF setting. The intent of forward care is to minimize time away from training and maximize opportunities to identify and treat medical and MH issues within the operational footprint, while maintaining a consistent standard of care.

a. Location. The forward care station should be located within the BN area. See paragraphs 3-3c, 3-5, and appendix G for guidance on the setup of forward care stations.

b. Screen. The TOMS providers may conduct examinations within the scope of their approved credentials, limitations of the facility, and considerations of privacy as guided by the MTF. Enlisted healthcare personnel utilize ADTMC (see MEDCOM Pamphlet 40-7-21) with appropriate privileged provider oversight. The MH providers practice under their approved credentials and in accordance with DHA-AI 6490.01 and DHA-PM 6025.13.

c. Treatment. Medical treatment is limited to the care of minor wounds, sprains, strains, and medical conditions. Treatment for MH is limited to MH screening, psychoeducation, activities that promote psychological health and resiliency, and non-clinical counseling that is supportive in nature and addresses general conditions of living, life skills, improving relationships at home and at work, stress management, adjustment issues, marital problems, parenting, and grief and loss. Medication will be dispensed only within healthcare personnel's credentials and in accordance with local policies coordinated with the local MTF. Healthcare personnel will abide by all policies governing TMC/MTF operations in the care of patients.

d. Based on the Soldier's presentation and the provider's clinical judgement, TOMS providers will promptly refer a Soldier to the appropriate level of care for further evaluation and treatment in cases that are complex or require higher-level resources, in accordance with local MTF policy on consultations and referrals.

e. Documentation. All patient encounters will be documented in the EHR. If encounters occur in the field environment, the provider will complete a handwritten Standard Form 600

(Chronological Record of Medical Care) and upload into the patients EHR within 24 hours or document using the operational medicine version access of EHR.

f. Locally developed standard operating procedures should incorporate guidance from this regulation and should use the best practices of other healthcare operations and other healthcare guidance that promote the provision of safe, quality healthcare in the TOMS environment.

3-3. Resourcing U.S. Army Training Center and Fort Jackson Organic Medical Structure Operations

To be effective in its mission, TOMS must be adequately resourced at all levels.

a. Personnel. The U.S. Army distributes personnel across the Active Component (AC) based on Army priorities to build and preserve the highest level possible of unit and service-level readiness. The TOMS personnel assignments are managed by U.S. Army Human Resources Command in coordination with CoEs' G-1s and local commanders. Assignments and manning level are further guided by HQDA ACMG. The TOMS authorizations are manned at 70 percent across BDEs. Mission commanders should plan for manpower shortages. Possible courses of action include, but are not limited to, sharing TOMS resources across units, consolidating limited TOMS resources to support multiple units and operations, or relying on local MTF and TMC sick call procedures.

(1) Requirements determination. Manpower requirements are based on the most effective and efficient organization and, therefore, represent the minimum essential numbers of civilian and military positions needed to accomplish valid mission responsibilities for both TDA and table of organization and equipment (TOE) organizations. Methodologies to determine manpower requirements include manpower surveys and studies; the Manpower Staffing Standards System; staffing guides; manpower requirements criteria; doctrinal basis determinations for TOE organizations; and other TOE development programs such as Force Design Update. Other methodologies include computer modeling, comparative analysis, and other statistical analyses as well as local appraisals when workload is not quantifiable and measurable.

(2) Planning, programming, and budgeting. These three functions are components of the DoD PPBE System. Planning includes the structuring of Army forces within established manpower constraints to accomplish national strategic goals. This includes not only peacetime maintenance but also contingency and mobilization capabilities. Programming involves the allocation of manpower throughout the years of the Future Years Defense Program to support a given force structure. Due to the extended period of time over which manpower is programmed, revisions to the program are made and justified as needed to meet the guidance and evolving decisions of the Army and the Defense leadership. Budgeting is the request, appropriation, allocation, and management of resources expressed in quantities, rates, and dollars.

(3) Total Army requirements will often exceed current available manpower. Each new mission and each new manpower requirement must be carefully evaluated and justified. Leaders must establish priorities, eliminate unnecessary tasks or procedures, and actively seek to

eliminate nonessential missions and identify areas of decreasing workload from which to transfer manpower to satisfy new or changing requirements.

(4) The TOMS providers' responsibilities include both clinical and non-clinical tasks. Each provider should allocate specific time for clinical duties to meet individual readiness and professional clinical requirements. Clinical duties may be performed either in TOMS specific locations as part of TOMS operations or at local TMC and MTF. The DHA-PI 6025.11 and Army AC health professions (HP) officer specialty and incentive pay documents should be used to develop specific local requirements and schedules.

(5) Recommended minimum time for clinical duties to maintain clinical readiness and currency that can be performed either in TOMS specific locations or at local TMC/MTF:

(a) BDE Surgeon – 0.3 FTE minimum

(b) BDE Mental Health Officer (MHO) – 0.3 FTE minimum

(c) BN PA and NP – 0.5 FTE minimum

(d) Health profession officer incentive pay (IP) and retention bonus (RB). All HP officers must be currently credentialed, privileged, and practicing a minimum of 40-hours per year at a facility designated by the Army, in the specialty for which the IP and RB is being paid

Note. This recommendation does not constitute a T2COM endorsement of the requirement that providers spend a minimum amount of time working inside an MTF and/or TMC.

(6) Local commands are encouraged to cross-level TOMS resources as local conditions change.

b. Funding. There will be a cost to units providing forward care for class VIII (medical) supplies and equipment, furniture, and computer equipment, and engagement of unit personnel. Each TOMS BN is provided with funding in the program objective memorandum (POM) under operations and maintenance.

c. Facilities. Space recommendations for existing re-purposed TOMS facilities are based on the DoD Medical Space Planning Criteria found in Appendix I. Although not directly subject to JC inspection and review, JC Environment of Care (EOC) and Life Safety (LS) checklist may be used for self-inspection (appendix J). Operational healthcare units, not a component of an accredited MTF, are exempt from the accreditation requirement (see DoDI 6025.13, 26 July 2023).

d. Information Technology (IT). All requirements for IT support will be coordinated through S-6/G-6 channels. The S-6/G-6 will coordinate with the supporting MTF for connectivity to the EHR (MHS GENESIS), medical logistics support systems, and any other equivalent medical database systems. All care provided by TOMS must be entered into the EHR in accordance with AR 40-68, and in accordance with DHA and local MTF policy, and therefore, TOMS must be

adequately resourced for IT requirements at all levels including local sources of IT requirements. For EHR and MHS GENESIS access, hardware and training is required. TOMS personnel will also need to access healthcare related databases and electronic domains for safe and efficient delivery of healthcare. Execution remains a local responsibility.

e. Class VIII, Durable and Non-Expendable and Expendable. Each unit gaining TOMS forward care capabilities will be required to develop their own MEDLOG policies based upon the requirements at their specific location. Specific guidance is in appendix G.

3-4. Local Memorandum of Understanding - U.S. Army Training Center and Fort Jackson Organic Medical Structure Operations

a. The TOMS is part of the continuum of healthcare operations supporting operations at training installations that include DHA and MTF activities. A memorandum of understanding (MOU) should be developed between units with TOMS capabilities and the local MTF that establishes a basic agreement, defining relationships, outlining common intentions, and providing a framework for future actions. The MOU should also communicate mutually accepted expectations of all parties which will help reduce the risk of uncertainty.

b. The Installation Health Services Support Plan (IHSSP) is developed by the local MTF in conjunction with the installation senior commander and staff. See appendix H for IHSSP/MOU considerations between the local MTF and T2COM. The TOMS capabilities and their roles should be addressed in the local IHSSP.

3-5. Use of Facilities for Healthcare and Use of Non-Category 500 Facilities for Healthcare

a. Per DoDI 6010.13-M, military MTFs utilize a standardized costing system for all DHP fixed facilities. DA Pamphlet 415-28 lists the category 500 facilities in which the MEDCOM operates, sustains, and programs for replacement through the military construction program defined in AR 420-1. In today's environment, direct healthcare has been extended to non-category 500 facilities, including gymnasiums, schools, barracks, and aid stations in order to meet clinical and operational requirements. Healthcare providers treat patients for a variety of conditions, including MH, physical therapy, and primary care visits within non-category 500 facilities and are capturing the workload data in the Medical Expense and Performance Reporting System (MEPRS). The local MOU or memorandum of agreement (MOA) should provide organizational responsibilities of both non-category 500 and MTFs.

b. The DHA receives DHP funding to operate MTFs including staffing, supplies, and facility operations. DHA utilizes the JC to accredit its MTFs. As part of the JC accreditation, the EOC and LS codes apply to the MTFs and ancillary facilities. Although the JC does not accredit business occupancies, JC Tracer Methodology does allow a JC surveyor to visit any location where a patient may have received treatment.

c. The non-category 500 facilities are not funded or operated by the MTF and validation of compliance with the EOC and LS standards of the JC can be problematic. The EOC and LS standards do require the non-category 500 facilities to meet the LS Code (National Fire

Prevention Association 101) for their designated facility classifications. Typical EOC and LS items are listed in appendix J.

d. The MTF quality manager must determine if TOMS facilities will be on the JC survey application. If the MTF quality manager determines TOMS facilities will be added to a JC survey, the MTF must ensure they meet appropriate EOC and LS standards. Since these non-category 500 facilities are not funded with DHP funding, the MTF commander shall coordinate with the facility proponents to ensure the buildings are meeting the EOC and LS standards and have a MOU in place to cover any JC standard requirement.

e. Operational healthcare units, not a component of an accredited MTF, are exempt from the accreditation requirement (see DoDI 6025.13).

f. The MTF staff may survey the non-category 500 facilities for compliance with JC standards. The MTF will provide written documentation of findings to the facility proponent. Any unresolved findings will be noted in the MOU with resolution timelines. The MTF's MOU will include requirements to keep records of all maintenance of any LS system. See appendix I for a complete listing of applicable systems.

g. Accreditation and Certification. Operational healthcare units are under separate rules with respect to accreditation.

(1) On a military installation in or outside the U.S., unless under the operational control of Combatant Commands, if the unit provides healthcare services in a fixed facility, the facility is subject to accreditation. Although not under the control of an MTF on the installation, the facility may, for accreditation purposes, be affiliated with the MTF, such as by a MOA, to be covered by the MTF's accreditation. For purposes of command and control, this may affiliate with the commander responsibilities of the dual-hatted MTF director and commander. Alternatively, the separate facility may obtain accreditation in its own right.

(2) As an alternative to satisfying the accreditation requirement in paragraph 3-5g(1), the facility involved may obtain from the Assistant Secretary of Defense for Health Affairs, upon a request from the OTSG, an exemption from accreditation based on documentation that it operates under comparable clinical quality management (CQM) compliance mechanisms established and implemented by the military department. At a minimum, the functions of patient safety, healthcare risk management, credentialing and privileging, clinical measurement, and clinical quality improvement programs must be included in the CQM compliance mechanisms, and assessments done by the military departments no less than every 3 years shall be sent to the DHA HQ Accreditation and Compliance Program.

h. Medical Specific. Although not subject to the JC inspection and accreditation, the JC EOC and LS checklist can be used as an internal checklist by TOMS personnel for self-inspection and planning. The JC guidelines are considered the best practice for high reliability organizations.

i. Mental Healthcare Specific Delivery of Service. Mental Healthcare may be provided in non-category 500 facilities in accordance with MEDCOM facility regulations and

policy. Facilities used to deliver MH care should meet the JC standards and may be listed by the MTF on a JC application as determined by the MTF Quality Manager.

j. Facilities. Space recommendation for existing re-purposed facilities for TOMS may be found in appendix I. Although not directly subject to JC inspection and review, JC EOC and LS checklist may be used for self-inspection (appendix J).

Chapter 4
Workload Measurement

4-1. Defense Medical Information System Identifier

a. The TOMS initiative provides medical personnel forward to a variety of T2COM units who are otherwise reliant on MTFs and TMCs for healthcare, with the expectation that closer proximity to primary healthcare will result in increased access to care for trainees. Costs, workload, and EHR must be easily accessible to these new forward care stations. Creating a unique identification for a TOMS forward care station is critical to accurately capturing data and workload/ costs. Using a web-based platform to access EHRs and appointing systems allows flexibility outside of the MEDCOM infrastructure.

b. The DHA MEPRS office can provide the Defense Medical Information System (DMIS) and Functional Cost Code (FCC) request forms. The Defense Medical Information System Identifier (DMIS ID) request must be completed and submitted for approval to your MTF's DHA MEPRS analyst. Once the DMIS ID is approved and returned to the MTF, they can then complete and submit the request for a forward care station to your MTF's DHA MEPRS analyst. Once the FCC is approved and sent back to the MTF, then the MTF Information Management Directorate/Division (IMD) can build the forward care station into the MHS GENESIS system. Once the forward care stations are built into the MHS GENESIS system, it can take up to 20-30 days to be visible in the MHS GENESIS system at the user station. The MHS GENESIS system updates once per month and may not be seen at the user station until the monthly update is complete.

4-2. Workload Utilization Defense Medical Human Resource System-Internet

a. Defense Medical Human Resource System-Internet (DMHRSi) is a human resources (HR) management application and is designed to manage essential HR information affecting MHS activities. The DMHRSi is a joint-service web-based information system for use in military MTFs. The DMHRSi assists in managing HR for DHA. It supports time-sensitive decisions regarding medical personnel readiness, training, financial reporting and other HR requirements for efficient contingency planning. The DMHRSi is hosted behind the Defense Information Systems Agency (DISA) firewall at centralized DISA facilities.

b. The TOMS personnel are not required to complete DMHRSi while engaged in TOMS forward care or other TOMS activities. The TOMS personnel should use DMHRSi when working inside a local MTF and TMC if required by the MTF command.

4-3. Metrics

a. The objective of the TOMS metric initiative is to evaluate the effect of TOMS on Soldier readiness with the use of medical and administrative data by conducting healthcare metrics collection, analysis, and reporting. The parameters on TOMS metrics to be collected and analyzed will focus on conserved POI training hours, training related injuries, attrition, and medical readiness. The TOMS will work in concert with CIMT's H2F to ensure maximum transparency when collecting, analyzing, storing, and reporting return on investment metrics.

b. The TOMS data collection and reporting will take advantage of automated workload collection systems and other data collection systems as those systems become operational and available. The TOMS will augment automated data collection with manual systems when automated systems are not available or do not meet information requirements.

Appendix A
References

Section I
Required Publications
Unless otherwise indicated, T2COM publications and forms are available on the T2COM administrative publications website at https://adminpubs.T2COM.army.mil/. MEDCOM publications are available at https://amp.health.mil/sites/DC/Pages/DocumentDashboard.aspx. Army publications are available on the Army Publishing Directorate website at https://armypubs.army.mil/. DHA publications are available at https://health.mil/Reference-Center; external users may contact dha.ncr.j-6.mbx.publications-office@health.mil. DOD issuances are available on the Executive Services Division website at https://www.esd.whs.mil/DD/.

AR 40-61
Medical Logistics Policies

AR 40-66
Medical Records Administration and Health Care Documentation

AR 40-68
Clinical Quality Management.

STP 8-68X14-SM-TG
Soldier's Manual and Trainer's Guide MOS 68X MH Specialist

T2COM Circular 350-70-1
Medical Support to Training

T2COM Regulation 350-6
Enlisted Initial Entry Training (IET) Policies and Administration

Section II
Related Publications
A related publication is a source of additional information. The user does not have to read a related reference to understand this publication.

AR 5-9
Installation Agreements

AR 40-501
Standards of Medical Fitness

AR 40-502
Medical Readiness

AR 351-3
Professional Education and Training Programs of the Army Medical Department

AR 420-1
Army Facilities Management

AR 612–201
Initial Entry/Prior Service Trainee Support

AR 623-3
Evaluation Reporting System

AR 635-200
Active Duty Enlisted Administrative Separations

DA Pam 25–403
Army Guide to Recordkeeping

DA Pam 415-28
Guide to Army Real Property Category Codes

DoDD 5101.09E
Class VIIIA Medical Materiel Supply Management

DoDD 5136.13
Defense Health Agency

DoDI 3020.41
Operational Contract Support outside the United States

DoDI 5000.64
Accountability and Management of DOD Equipment and Other Accountable Property

DoDI 6025.19
Individual Medical Readiness Program

DoDI 6430.02
Defense Medical Logistics Program

DoDM 4147.27 Vol. 1
DOD Shelf-Life Management Program: Program Administration

DoDM 4147.27 Vol. 2
DOD Shelf-Life Management Program: Material Quality Control Standards

DoDM 6025.18
Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs

DHA-AI 5136.03
Delegation of Authority and Assignment of Responsibility for Administration and Management of Direct Care

DHA-AI 6490.01
Mental Health System of Care

DHA-PI 6200.06
Periodic Health Assessment (PHA) Program

DHA-PI 6430.02
Defense Medical Logistics (MEDLOG) Enterprise Activity (EA)

DHA-PM 6010.13 Volume 1
Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment Facilities (DTFs): Business Rules

DHA-PM 6025.13
Clinical Quality Management in the Military Health System

DHA-PM 6050.01
MEDLOG Regulated Medical Waste

DLAR 4155.24
Product Quality Deficiency Report Program
https://issuances.dla.mil/Pages/ViewAllIssuances.aspx

DLAR 4155.37
Department of Defense (DoD) Shelf-Life Materiel Quality Control Storage Standards
https://issuances.dla.mil/Pages/ViewAllIssuances.aspx

FM 4.02
Army Health System
https://armypubs.army.mil/epubs/DR_pubs/DR_a/ARN35791-FM_4-02-001-WEB-3.pdf

Health Affairs Policy 11-005
TRICARE Policy for Access to Care

HQDA EXORD 149-19
Establish the Army Holistic Health and Fitness (H2F) System, DTG: 131759Z MAY 19 (https://armyeitaas.sharepoint-mil.us/sites/HQDA-G357-DAMO-OD/HQDA%20EXORDS/Forms/AllItems.aspx).

Individual Critical Task Lists (ICTLs)
https://rdl.train.army.mil/catalog/dashboard.

MEDCOM Pamphlet 40-7-21
Algorithm Directed Troop Medical Care (ADTMC), A Guide for Patient Screening

MEDCOM Pamphlet 40-19
U.S. Army Medical Command Embedded Mental Health Guide,

MEDCOM Regulation 10-1
U.S. Army Medical Command (MEDCOM) Organization and Functions

MEDCOM Regulation 40-50, Career Management Field (CMF) 68 Clinical Baseline Competencies for Enlisted Medical Personnel Performing Direct Patient Care at the Military Treatment Facility

MEDCOM Regulation 600-3
Off-Duty Employment

National Defense Authorization Act for Fiscal Year 2017/Public Law 114-378
https://www.congress.gov/bill

National Defense Authorization Act for Fiscal Year 2019, Public Law 115-232
https://www.congress.gov/bill

OTSG MEDCOM Policy Memorandum 22-108
Transferring Mental Health, Substance Use Disorder, and Family Advocacy Program Care for Transitioning Soldiers

Training Circular 8-800
Medical Education and Demonstration of Individual Competence

Table of Distribution and Allowances (TDA) for T2COM https://fmsweb.fms.army.mil/

Section III
Prescribed Forms
No Entries for this section

Section IV
Referenced Forms

DA Form 2028
Recommended Changes to Publications and Blank Forms

Standard Form 600
Chronological Record of Medical Care (available at https://www.gsa.gov/forms)

Appendix B
Surgeon's Cell, Centers of Excellence, and Army Training Centers
Not all CoEs are resourced for a Surgeon's Cell. The CoE Surgeon responsibilities may be delegated (para 2-4(a)(1)) or may not be able to be fully executed to perform the mission.

B-1. CoE and ATC Surgeon's Cell Recommended Personnel:

(1) Surgeon (field surgeon, Area of Concentration (AOC) 62B, is recommended)

(2) Senior Non-commissioned officer (NCO) (68 Series is recommended)

(3) Deputy Surgeon and/or Operations officer

(4) Medical Logistics NCO (68 Series is recommended)

B-2. Surgeon's Cell, CoEs, and ATC Duties:

(1) Serves as the medical services advisor to T2COM senior commander.

(2) Provides oversight on clinical quality management/assurance by coordinating with the MTF director. These efforts ensure the provision of safe, quality healthcare.

(3) Ensures health services and force health protection operations sustain collaborative planning between CoE staff, T2COM Surgeon's office, and the DHA MTF director.

(4) Provides medical planning and course of action analysis.

(5) Assists commanders in building and maintaining a fit and healthy force. Focuses on prevention of musculoskeletal (MSK) injuries and effective and efficient, responsive health support for trainees and cadre.

(6) Communicates risks on health and safety including protective countermeasures and other topics such as use of chemoprophylaxis, immunizations, pretreatments, insect repellants, sanitation, and first aid to personnel at the CoE.

(7) Recommends prioritization and organization of medical units to satisfy CoE mission requirements and monitors the availability of and recommends the reassignment or reallocation and utilization of medical assets at the CoE.

(8) Senior T2COM assigned physician will provide professional medical oversight for TOMS, H2F, high risk training 68W (medics), and 68W instructors under T2COM umbrella.

(9) Educates leadership on TOMS capabilities as part of the continuum of care associated with MTF responsibilities of enrolled beneficiary (cadre care).

Appendix C
Surgeon's Cell, Centers of Excellence, and Army Training Center Brigades
The Surgeon's cell for CoE and ATC BDEs is comprised of the following personnel, with duties as described:

C-1. Surgeon
The CoE or ATC BDE surgeon is a physician associate, AOC 65D, with the following duties:

a. Supervises the monitoring of readiness within the command; be prepared to advise the commander on trends, including measures necessary to maintain positive trends and correct negative trends.

b. Advises the leadership team on trends in health and fitness in the command, and measures to maintain or improve health and fitness.

c. Maintains user accounts in MODS, MEDPROS Medical Readiness and MHA Portals, and MHS GENESIS.

d. Maintains data on health and fitness status; support studies and research as required (via appropriate tasking).

e. Maintains professional relationships with equivalent-level staff in the MTF and the Safety Office.

f. Oversees the quality of healthcare delivery within the command.

g. Maintains credentialing and privileges with the servicing MTF.

h. Maintains visibility on credentialing and upkeep of MOS qualifications of PAs and NPs and 68Ws in the command.

i. Provides healthcare directly as needed to the unit of assignment, and other related non-IET training units as determined by the senior commander.

C-2. Mental Health Nurse Practitioner
The MH NP's (AOC 66R) duties are as follows:

a. Maintains user accounts in the MODS, MEDPROS, and MHS GENESIS.

b. Conducts psychological evaluations of students and faculty utilizing information from clinical interviews, psychological testing, and collateral sources, as appropriate.

(1) Establishes psychiatric diagnoses according to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(2) Provides individual and group MH treatments for which the provider holds privileges.

(3) Independently and collaboratively manages the MH care of patients and refers patients to appropriate providers for healthcare which falls outside their scope of practice.

c. Serves as expert consultant in human behavior to community agencies, health- care providers, and organizational leaders.

d. Provides operational psychological services to include operational stress control.

e. Conducts behavioral research in diverse settings to address the full range of psychological issues that impact individuals, groups, and military organizations.

f. Conducts personnel assessment and selection for specialized military occupations.

g. Authorized to independently and collaboratively treat and collaborate on the discharge of patients from inpatient care to include psychiatric units staffed by psychiatrists.

C-3. Healthcare Non-Commissioned Officer
The healthcare NCO's (military occupation specialty (MOS) 68W4) duties are as follows:

a. Maintains user accounts in MODS, MEDPROS, and MHS GENESIS.

b. Monitors readiness within the command; be prepared to advise senior NCO leadership on trends.

c. Advises senior NCO leadership on trends in health and fitness in the organization, and measures to maintain or improve health and fitness.

d. Supports the maintenance of data on health and fitness status; support studies and research as required.

e. Maintains professional relationships with equivalent-level staff in the MTF and the Safety Office.

f. Supports the monitoring of the condition of field and indoor environments for sanitation, climate, and hazards.

g. Maintains own MOS qualifications.

h. Under the supervision of a physician, NP, or PA, healthcare directly as needed to CAC personnel, and other related non-CAC personnel as determined by the senior commander.

C-4. Mental Health Non-Commissioned Officer (MOS 68X)
Under the supervision of a MHO, the MH NCO:

a. Maintains user accounts in MODS, MEDPROS, and MHS GENESIS.

b. Assists with the management and treatment of outpatient mental health activities.

c. Collects and records psychosocial and physical data and assists with care and treatment of psychiatric and drug and alcohol patients.

d. Counsels and treats patients with personal, behavioral, or mental health problems.

Appendix D
Medical Section, Centers of Excellence, and Army Training Center Battalions
The medical section for CoE and ATC BNs is comprised of the following personnel, with duties as described:

D-1. Physician Assistant (AOC 65D) or Family Nurse Practitioner (AOC 66P)

a. Supervises the monitoring of readiness within the command; is prepared to advise the commander on trends, including measures necessary to maintain positive trends and correct negative trends.

b. Advises the leadership team on trends in health and fitness in the command, and measures to maintain or improve health and fitness.

c. Maintains user accounts in MODS, MEDPROS Medical Readiness and MHA Portals, and MHS GENESIS.

d. Maintains data on health and fitness status; support studies and research as required (via appropriate tasking).

e. Maintains professional relationships with equivalent-level staff in the MTF and the Safety Office.

f. Oversees the quality of healthcare delivery within the command.

g. Maintains credentialing and privileges with the servicing MTF.

h. Maintains visibility on credentialing and upkeep of MOS qualifications of 68Ws in the command.

i. Provides healthcare directly as needed to the unit of assignment, and other related non-IET units as determined by the senior commander.

D-2. Healthcare Sergeant (MOS 68W2)

a. Maintains user accounts in MODS, MEDPROS Medical Readiness and MHA Portals, and MHS GENESIS.

b. Monitors readiness within the command; is prepared to advise NCO leaders on trends, including measures necessary to maintain positive trends and correct negative trends.

c. Advises senior NCO leaders on trends in health and fitness in the command, and measures to maintain or improve health and fitness.

d. Supports the maintenance of data on health and fitness status; support studies and research as required.

e. Maintains professional relationships with equivalent-level staff in the MTF.

f. Oversees the quality of healthcare delivery provided by junior 68Ws and nursing assistant.

g. Monitors the condition of field and indoor environments for sanitation, climate, and hazards.

h. Maintains own MOS qualifications.

i. Provides CLS training and refresher training as required; provide hot and cold weather training as required.

j. Under the supervision of a physician, nurse, PA, or a combat medic NCO, provides healthcare directly as needed to the unit of assignment, and other related non-IET training units as determined by the senior commander.

k. Participates in medical proficiency training with the MTF, as available.

D-3. Healthcare Specialist (MOS 68W1)

a. Accesses patients' EHRs, screens patients and measures vital signs and height and weight. Documents screening notes, vital sign measurements, and other patient data in the EHR, or on hardcopy forms in case of electronic system failure. Supports the monitoring of readiness within the command.

b. Advises the healthcare sergeant on trends in health and fitness in the command.

c. Supports the maintenance of data on health and fitness status.

d. Maintains professional relationships with cadre in supported companies.

e. Supports the monitoring of the condition of field and indoor environments for sanitation, climate, and hazards.

f. Maintains own MOS qualifications.

g. Instructs CLS training and refresher training as required; instruct hot and cold weather training as required.

h. Maintains user accounts in MODS, MEDPROS Medical Readiness Portal, and MHS GENESIS. Provides healthcare as per MOS training, and ADTMC procedures.

i. Under the supervision of a physician, NP, PA, or a combat medic NCO, provides healthcare directly as needed to the unit of assignment, and other related non-IET training units as determined by the senior commander.

j. Augments first aid instructors and medical support to high-risk training, as needed to perform the mission

k. Participates in medical proficiency training with the MTF, as available.

D-4. Nursing Assistant (Civilian Occupational Code 0621)
Under general supervision of the healthcare sergeant, the nursing assistant:

a. Accesses patients' EHRs, screens patients and measures vital signs (blood pressure, pulse, respiration, temperature) and height and weight. Documents screening notes, vital sign measurements, and other patient data in the EHR, or on hardcopy forms in case of electronic system failure.

b. Retrieves laboratory and x-ray reports from the EHR.

c. Assists PAs and NPs during examination and treatment of patients. Sets up for examinations, to include equipment and supplies needed, and positioning and draping of patients, and assists with exams.

d. Applies binders, bandages, simple dressings, and heat and cold as directed.

e. Assists with patient flow, maintains workload data, answers telephone and takes messages as needed.

f. Assists in the dissemination of patient education literature. Selects medical pamphlets, instructional or information sheets and gives materials to patients to reinforce and support teaching of medical processes and healthcare.

g. Arranges supply cupboards; cleaning and sorting supplies, instruments, and equipment; calls attention to deficiencies in supplies and equipment; cleans utility room; handles linens according to unit policies; and cleans exam areas as needed. Maintains clean, safe, orderly environment. Applies knowledge of infection control measures and aseptic techniques.

Appendix E
Brigade Mental Health Officer/Mental Health Non-Commissioned Officer (MOS 68X) Standard Operating Procedures

E-1. Introduction

a. The objective of the TOMS is to posture T2COM to deliver appropriate, competent, and timely medical care to effectively and efficiently train and lead Soldiers to enter the operational force and maximize Army mission readiness with the enduring capability to plan, govern, oversee, and manage a healthcare system that generates a physically, mentally, and medically-ready Soldier to join the operational force and contribute to mission success.

b. The TOMS BDE MHO and MH NCO (68X) roles are distinguished from other positions in Army MH because of their embedded nature in CIMT units to include all IET: basic combat training (BCT), one station unit training (OSUT), and advanced individual training (AIT). The MHO and 68X provide MH support, in varied forms, to IET units who train and develop new Soldier baseline proficiencies on warrior tasks and battle drills and critical skills associated with their MOS. The TOMS is considered part of the continuum already existing MH care provided by DHA/OTSG MEDCOM and the local MTF.

E-2. Mental Health Officer

a. The MHO's primary focus is the trainee population, though as time permits, MH care may be provided to cadre.

b. The TOMS MHO role is occupied by a MH NP (AOC 66R) from the AC, and in certain circumstances and dependent upon the needs of T2COM and provider availability, could also be filled by a psychologist (AOC 73B) or social worker (AOC 73A). The MHO is housed at the BDE level and reports directly to the BDE surgeon or the BDE commander, depending upon what makes the most sense for the unit and MHO.

c. The TOMS MHO helps the overall mission by generating Soldiers who are mentally ready to enter the operational force and contribute to mission readiness. This is bridged by the presence and influence of the BDE MHO. Through the use of clinical expertise, knowledge of regulations and policy, and relationship building through command consultation, the MHO assists in maintaining a ready fighting force and promoting overall mental health and well-being in the training unit.

d. The MHO effectively becomes the leader of all MH matters for the unit. The relationship between the MHO to CIMT units and cadre may be the most important aspect of being an agent of change in the organization, and it starts with a clear understanding of the role and identity of the MHO. To be embedded means the presence of MH is interwoven within all layers of the organization emphasizing a promotion of change from within. The impact of a well-embedded and integrated MHO can be seen through individuals receiving direct clinical care, the maintenance of a healthy fighting force throughout the organization, the professional development of leaders at all levels, the implementation of health promotion and prevention

strategies, strong morale within the unit, the reduction of stigma associated with MH care among leaders and Soldiers, and decreased attrition rates.

e. Day-to-day duties of the MHO vary depending on the unit; however, the professional identity of the MHO remains consistent. The MHO's professional responsibilities of readiness, prevention, health promotion, morale, professional development, and stigma reduction are moving targets that require dynamic and creative approaches all while maintaining consistent movement towards progress. The challenge of successfully meeting those moving targets requires a balancing of responsibilities and leveraging resources in the community in such a way that allows for a tailored systemic approach dependent upon the specific needs of the unit.

f. Understanding the role of the MHO can aid in practical problem-solving strategies at all levels within the unit. The MHO is often referred to as the subject matter expert for all things MH. Once established as a trusted agent within the unit, the MHO may more effectively lend subject matter expertise to a variety of issues, from individual clinical treatment to systemic prevention initiatives, and make recommendations related to dispositioning Soldiers. As such, gaining the trust of the unit is a MHO's key to success. In this sense, the MHO leverages their embedded identity to align with Soldiers and cadre to achieve mission success.

g. It's important for the MHO to demonstrate objectivity and impartiality as they work to balance the needs of the unit with the needs of the Soldier. This can be a fine balancing act when the unit desires a specific outcome that may be inconsistent with medical or administrative dispositioning. It's necessary for the MHO to educate all parties involved and provide a transparent and comprehensive rational for MH recommendations and decision-making so both unit and Soldier understand the bigger picture. A MHO commands the respect of trainees, cadre and on-post agencies through demonstrated expertise, professionalism, timeliness, transparency, trust, usefulness, open-mindedness, and a strong moral code.

h. A MHO will work to leverage resources across the enterprise. Building relationships not only with trainees and cadre, but with Army Community Service (ACS), the ready and resilience integrator, the suicide prevention program manager, the military family life consultant, the Army substance abuse program, the Installation Director of Psychological Health (IDPH), and the H2F program coordinator, will prove invaluable in the MHO's ability to accomplish the mission.

i. In this TOMS role, the MHO will work to:

(1) Decrease attrition rates of IET trainees through MH prevention, education, non-clinical counseling, and direct patient care.

(2) Decrease lost POI hours.

(3) Increase mission readiness of IET Soldiers and operational units.

(4) Identify Soldiers with MH challenges early and disposition trainees in a timely manner when appropriate.

(5) Act as a liaison between commanders and the MH MTF and other installation entities.

(6) Consult with TOMS BDE and BN medical assets, as necessary, regarding Soldier's MH issues and problems identified at the TOMS location and assist with care coordination.

(7) Assist in the transition of trainee and cadre MH care.

(8) Coordinate MH care with the MTF and community hospitals.

(9) Track trends in the unit and work to reduce harmful behaviors.

(10) Improve access to care.

(11) Work to improve the overall health of the force through use of the unit risk inventory, commander’s risk reduction tool, the MH Pulse, and other standardized tools and methods as applicable.

(12) Reduce stigma through normalization, education, creating safe spaces, responding to misperceptions, and empowering others to seek help.

E-3. Mental Health Specialist (68X)

a. The 68X serves an important role at the BDE level and acts as an extension to the MHO. The 68X works alongside the MHO to provide non-clinical forward care in the form of supportive counseling to address general living conditions, life skills, improving relationships at home and at work, stress management, adjustment issues marital problems, parenting, and grief and loss. The 68X also conducts MH screening, prevention, and outreach to unit Soldiers and may also work in conjunction with the MHO at the MTF. The 68X and the MHO are a team and provide a unified voice to the unit regarding all things MH. The 68X is an invaluable asset as a senior enlisted Soldier, with the ability to connect with and relate to trainees. The 68X can often be seen as a coach and mentor to new trainees struggling to adjust to a new way of life. The 68X’s visibility and daily interactions with trainees, in and of itself, acts as a preventative measure. These positive interactions throughout the days and weeks of training can help prevent life stressors from becoming overwhelming and requiring clinical intervention.

b. The 68X is out and about in the unit acting as the face of MH. The 68X is introduced to the unit early in the training cycle and attends physical training and other unit training to lend a helping hand and provide supportive “on-the-spot" non-clinical counseling.

c. The 68X acts under the guidance, direction, and licensure of the MHO or other MTF credentialed provider and is supervised by the BDE MHO. In the absence of a MHO, the 68X will be supervised by the BDE surgeon with clinical oversight and support by the MTF IDPH or representative thereof. The 68X builds collaborative relationships with command teams, provides MH consultation under the supervision of the MHO, facilitates Soldier MH care, provides prevention and outreach interventions, provides MH resourcing, coordinates care, and provides psychoeducation.

E-4. Mental Health Officer Responsibilities

a. Ensures all onboarding and credentialing requirements are met through the local MTF in accordance with DHA-PM 6025.13, Vol 4, before engaging in patient care.

b. Attends the U.S. Army Medical Center of Excellence (MEDCoE) Traumatic Event Management (TEM) course either prior, or enroute to, TOMS MHO assignment. Registers through the Army Training Requirements and Resources System (ATRRS) at https://www.atrrs.army.mil. The TEM Facilitator Course is designed to train TEM facilitators, primarily targeting MH providers and unit ministry teams, on providing traumatic event management to units that are exposed to potentially traumatic events. The course will cover supporting individuals, supporting groups, making referrals, applying prevention measures, and conducting needs assessments after a potentially traumatic event. This course will allow ample opportunities for students to practice the new skills learned during the course.

c. Attends MEDCoE Master Resilience Training Course (MRTC) either prior, or enroute to, the TOMS MHO assignment. Registers through the ATRRS at https://www.atrrs.army.mil. The MEDCoE MRTC is a 2-week course that will produce leaders with the capability to teach proven resilience skills to the Soldiers in their teams, squads, platoons, and companies in order to enhance their performance and increase their resilience, both individually and collectively. The MRTC is an established training program that has demonstrated efficacy in reducing MH problems. The MHOs will review the myths about resilience and why resilience is critical for success and well-being and will learn about the scientific literature of the core factors that predict resilience, with a specific focus on the factors that are amenable to change. The MHOs will learn resilience and performance enhancing skills and how to effectively introduce and apply these skills in their daily activities and operations. These skills have proven efficacy in contributing to the success of teams, leaders, families, students, executives, and military personnel. Skills learned include emotion awareness and regulation, impulse control, countering catastrophic thinking, gaining perspective, effective communication, challenging negative beliefs, problem-solving, and real-time-resilience. Additionally, several techniques proven successful by elite sports figures and athletes will be introduced, such as imagining success, goal setting, and energy management. Attendees should have interest in, and an ability to teach and moderate small groups.

d. Provides TOMS non-clinical forward MH care in the BDE footprint, where EOC and LS standards are met in accordance with current DHA policy. Ensures a MOU or SLA is in place between the DHA, OTSG/MEDCOM, the local MTF, and the T2COM unit prior to providing non-clinical forward MH care. Mental Healthcare may be provided in non-category 500 facilities in accordance with DHA, OTSG/MEDCOM facility regulations, and policy.

(1) Non-clinical forward MH care is defined as supportive counseling to address general conditions of living, life skills, improving relationships at home and at work, stress management, adjustment issues, marital problems, parenting, and grief and loss. The MHO also conducts MH screening, prevention, and outreach to unit Soldiers and provides formal clinical care inside the MTF footprint.

(2) It is highly encouraged that TOMS non-clinical forward MH care be co-located with other TOMS medical assets in the TOMS footprint or at the BDE TMC, to minimize the inherent risk associated with providing MH care outside the MTF. A comprehensive Emergency Management Plan (EMP) must be in place to respond to the effects of a potential emergency. The EMP must include mitigation, preparedness, response, and recovery. The practice of MH care will not, under any circumstances, be rendered by the MHO alone, in the absence of other personnel in close proximity, who can respond appropriately in the event of an emergency. This practice mitigates inherent risks associated with providing care outside a staffed medical facility.

(3) Before non-clinical forward MH care is administered, the Soldier must complete all necessary paperwork as identified by the MTF that will, at a minimum, consist of patient rights to include: Limits of Confidentiality, Privacy Act, and Consent to Treatment, and ensure documents are properly uploaded and stored in the EHR per DHA, OTSG/MTF policy.

(4) When the MHO is providing TOMS non-clinical forward MH care, at a minimum, trainees will be screened for the risk of suicide using the most recent paper-pencil version of the Columbia Suicide Severity Rating Scale (C-SSRS). Additional screening instruments to include the Patient Health Questionnaire (PHQ-2), Patient Health Questionnaire – 9 (PHQ-9), Primary Care Post-Traumatic Stress Disorder Screen (PC-PTSD-5), Generalized Anxiety Disorder –2 (GAD 2), Generalized Anxiety Disorder – 7 (GAD-7), or other screening measures deemed appropriate by the MHO may be utilized. Paper-pencil screening instruments are used in the absence of the MH Data Portal (MHDP) in the BDE footprint. Results from screening instruments must be documented in the EHR. Screening instruments themselves do not need to be scanned into the medical record. Screening instruments are not required for prevention activities.

(5) In situations where the trainee is identified as at-risk for suicide or homicide at the TOMS forward location, based upon results of the C-SSRS or clinical evaluation, the Soldier will be escorted to the installation MH Clinic (MHC) or nearest Emergency Department for further evaluation and dispositioning. The Soldier's commander will be contacted to provide the appropriate escort(s). The TOMS provider will follow current DHA 6025.06, OTSG/MEDCOM Policy Memorandum 21-001, Mental Health At-Risk Management Policy, and T2COM Regulation 350-6, Enlisted Initial Entry Training Policies and Administration. The MHO will coordinate with the IDPH or clinic Nurse Care Manager when the Soldier is escorted to the installation MHC for further evaluation and dispositioning to ensure a warm handoff.

e. Provides formal MH care in the form of intake evaluations, individual or group psychotherapy, medication evaluation and management, administrative evaluations (chapters, schools, sexual harassment and response prevention program, or other positions of significant trust), command-directed Mental Health evaluations (CDMHEs), and other formalized care or assessment to Soldiers inside the MTF, at agreed upon day(s) and time(s), and in coordination with the IDPH, where the appropriate infrastructure is provided to ensure a safe and secure environment for the Soldier and the MHO.

(1) Trainees requiring formal clinical MH care beyond non-clinical forward MH care identified in F-4.d.(1), involving intake evaluations; ongoing or routine MH care; or medication evaluation and management should be seen at the MTF by the MHO credentialed MH provider, or psychology technician, where the infrastructure exists to manage such care. If follow-on MH care, limited to routine follow-up appointments only, cannot be rendered inside the MTF, in very extenuating circumstances, the MHO may provide routine MH follow-on care in a non-category 500 building so long as the MHO ensures the infrastructure exists where all DHA, OTSG/MEDCOM, and local MTF policies are followed and an MOU or SLA, and an EMP exists. This ensures the MTF commander concurs with the scope of MH care rendered outside the MTF and risk is managed accordingly.

(2) The CDMHEs, administrative evaluations, psychological testing, and the like must be performed inside the MTF given the nature of the evaluation or assessment.

(3) The T2COM Surgeon's Office has prescribed a required minimum FTE of point one (.1) clinical for the TOMS MHO due to heavy involvement in prevention activities, screening, and command consultation. The DHA is in agreement with the recommended TOMS MHO FTE, understanding this figure differs from DHA-AI 6490.01, whereby 0.5 FTE is recommended for FORSCOM MHOs. The MHOs supporting BCT and OSUT units may find it makes more sense to increase prevention and outreach efforts due to sheer volume, while AIT locations may find more time to allocate to care inside the MTF. It is recommended the MHO facilitate discussions with the BDE commander and IDPH early on to set expectations.

f. Documents all MH care, to include both TOMS non-clinical forward MH care encounters, care at the MTF, and care coordination, in the EHR in accordance with AR 40-68, and in accordance with DHA/local MTF policy. The MHO is required to follow all DHA/OTSG MEDCOM policy pertaining to documentation of clinical encounters.

g. Provides prevention activities in the form of, but not limited to:

(1) In-processing briefs, ideally within the first 72 hours, and in coordination with MTF at the RECBN, where trainees are provided with MH resourcing and contact information.

(2) Preventative psychoeducation to include life skills, coping strategies, resilience, sleep hygiene, managing emotions, anger management, management of anxiety and depression, effective communication, and managing life transitions.

(3) Prevention activities are not required to be documented in the EHR but will be captured using the T2COM TOMS MHO monthly metric spreadsheet (see paragraph 4-4) or other method of data collection specified by T2COM.

h. Leverages installation resources and coordinates with the following to shape the overall mental wellness of the force:

(1) Unit Chaplain

(2) Military Family Life Consultant

(3) Community Ready and Resilient Integrator

(4) Suicide Prevention Program Manager

(5) H2F Coordinator

(6) IDPH and MHC staff

(7) Army Substance Abuse Program Manager

(8) ACS

i. Facilitates coordination of care for BDE Soldiers involving MTF MHC, Substance Use Disorder, Family Advocacy Program, and other installation entities as needed.

(1) Attends MTF MHC At-Risk Case Tracking (ARCT) meeting to maintain a pulse on BDE MH "at-risk" cases and facilitate dispositioning when necessary.

(2) Assists BDE commander in preparation for the Commander's Ready and Resilient Council.

(3) Ensures processes-in place for referrals at all levels between TOMS and BDE and installation resources to include Chaplain, Military Family Life Consultant, MHC, ACS, etc.

(4) Facilitates and coordinates with MTF MHC to ensure Soldiers involved in MH care, and in transition from OSUT/AIT to first duty station of assignment, are following OTSG MEDCOM Policy Memorandum 22-108.

j. Provides operational psychology services in the form of, but not limited to:

(1) Critical incident stress debriefing.

(2) Attendance during training exercises.

(3) Performance enhancement education and training activities.

k. Engages in BDE MH research and process improvement projects when and where applicable.

(1) Institutional Review Board approved activities.

(2) Standard Operating Procedures.

l. Attend monthly T2COM MHO meetings and provide data metrics to identify T2COM personnel by the 15th of the month for the preceding month.

m. The TOMS MHO will ensure the following:

(1) Adherence to current DHA Procedures Manual, Clinical Quality Management in the Military Health System Manual 6025.13, volumes 1-7.

(2) Limits of Confidentiality, Consent to Treatment, Health Insurance Portability and Accountability Act (HIPAA) Privacy Act and Personally Identifiable Information policy are completed prior to performing any screening, evaluation, or care. Documentation will be scanned into the medical record. Confidentiality and privacy will be respected and maintained at all times.

(3) Adherence to OTSG/MEDCOM Mental Health At-Risk Management Policy 21-011 (or most recent version).

(4) Adherence to T2COM Regulation 350-6 in regard to suicide prevention.

(5) Reference T2COM Pamphlet 600-22, Leader's Guide for Risk Reduction and Suicide Prevention.

n. Provides supervision and clinical oversight to TOMS 68X MH Specialist. Refers to DHA Healthcare Provider's Practice Guide for Utilization of MH Technicians.

(1) The TOMS MHO oversees 68X clinical care and documentation and is responsible for providing higher level review and signature for MH clinical encounters of the 68X at the TOMS location. The MHO assumes clinical responsibility for all prevention and outreach activities of 68X working under the license of the MHO.

(2) The MHO ensures the 68X is working within his/her scope of practice.

E-5. Mental Health Non-Commissioned Officer (MOS 68X) Responsibilities

a. Reviews DHA Healthcare Provider's Practice Guide for utilization of MH technicians.

b. Reviews and references Soldier Training Publication 8-68X14-SM-TG - Soldier Manual and Trainer's Guide, MOS 68X MH Specialist.

c. Provides TOMS non-clinical forward MH care in the BDE footprint, where EOC and LS standards are met in accordance with current DHA policy. A MOU or SLA must be in place between the DHA, OTSG/MEDCOM, local MTF, and the T2COM unit prior to providing forward care.

(1) MH care provided by the 68X is under the direction and supervision of the MHO, or other designated credentialed MH provider, at the identified TOMS or MTF location.

(2) Non-clinical forward MH care is defined as supportive counseling to address general conditions of living, life skills, improving relationships at home and at work, stress management, adjustment issues, such as those related to returning from a deployment, marital problems, parenting, and grief and loss. The 68X also conducts MH screening, prevention, and outreach to unit Soldiers.

(3) Before non-clinical forward MH care is administered in the BDE footprint, the 68X will ensure the Soldier completes all necessary administrative paperwork as identified by the MTF that will, at a minimum, consist of patient rights to include Limits of Confidentiality, Privacy Act, and Consent to Treatment. The 68X will ensure documents are properly uploaded and stored in the EHR per MTF policy. Soldiers will be screened for the risk of suicide using the paper-pencil version of the C-SSRS. Additional screening instruments to include the PHQ-2, PHQ-9, PC-PTSD-5, GAD 2, or the GAD-7, or other screening measures deemed appropriate and under the direction of the MHO. Paper-pencil screening instruments are used in the absence of the MHDP in the BDE footprint. Results from screening instruments must be documented in the EHR. Screening instruments themselves do not need to be scanned into the medical record. Screening instruments are not required for prevention activities.

(4) In situations where the Soldier is identified as "at risk" for suicide or homicide at the TOMS forward location, based upon results of the C-SSRS or clinical evaluation, the Soldier will be escorted to the installation MHC for further evaluation and dispositioning. The Soldier's commander will be contacted to provide the appropriate escort(s). The TOMS provider will follow current DHA 6025.06, OTSG/MEDCOM Policy Memorandum 21-001, and T2COM Reg 350-6. The 68X will coordinate with the MHO, IDPH (or representative thereof), or clinic Nurse Care Manager, when the Soldier is escorted to the installation MHC for further evaluation and dispositioning to ensure a warm handoff.

d. Provides follow-up care within 68X scope of practice and under the supervision and direction of the MHO or credentialed MH provider.

(1) Soldiers requiring formal clinical MH care beyond non-clinical forward MH care identified in F-4d(1), involving intake evaluations, ongoing, routine MH care, or medication evaluation and management, should be seen at the MTF by the 68X, MHO, credentialed MH provider, or psychology technician, where the infrastructure exists to manage such care. If follow-on MH care, limited to routine follow-up appointments only, cannot be rendered inside the MTF, in very extenuating circumstances, the 68X may provide routine MH follow-on care in a non-category 500 building so long as the 68X/MHO ensures the infrastructure exists where all DHA, OTSG/MEDCOM, and local MTF policies are followed and an MOU or SLA, and an EMP exists. This ensures the MTF commander concurs with the scope of MH care rendered outside the MTF and risk is managed accordingly.

(2) All MH practices and procedures regarding administrative paperwork and MHDP administration will be followed per local MTF policy.

(3) In instances where the 68X may see a Soldier, at the request of the MHO, in relation to circumstances involving administrative evaluations, CDMHEs, or psychological testing, the encounter must be performed inside the MTF given the nature of the evaluation or assessment.

e. Provides prevention efforts, under the direction and supervision of the MHO, in the form of in-processing briefs and preventative psychoeducation to include, but not limited to life skills, coping strategies, resilience, sleep hygiene, managing emotions, anger management, management of anxiety and depression, effective communication, and managing life transitions.

f. Coordinates MH care, resourcing, and referrals for unit Soldiers under the direction and supervision of the MHO.

g. Provides consultation to unit leadership, under the direction and supervision of the MHO.

h. Provides MH support during training events to include “on-the-spot" non-clinical counseling as needed.

i. Establishes and maintains positive relationships inside and outside the MTF with unit commanders, medical personnel, and installation assets.

j. Assists the MHO with reports, trends, research, and process improvement activities.

Appendix F
Logistics

F-1. Purpose
To implement standardized medical logistics policies and procedures in support of TOMS.

F-2. Medical Logistics Policies and Procedures
Each unit gaining TOMS forward care capabilities will be required to develop their own MEDLOG policies based upon the requirements at their specific location. To assist commanders in their policy development, this appendix outlines the policies and regulations that summarize Army MEDLOG.

F-3. Responsibilities
The commanding officer is responsible for assuring TOMS MEDLOG operations meet the requirements of current regulations. The following personnel are responsible as indicated:

a. CoE and ATC G-4s:

(1) Coordinates Defense Medical Logistics Standard Support (DMLSS) access and ordering catalogue in coordination with the installation hospital commander (or authorized representative), IMSA, and CoE G-6.

(2) Establishes and maintains CoE MEDLOG policies and procedures in support of TOMS.

(3) Establishes installation MEDLOG support agreements with supporting MTF and IMSA in accordance with applicable Army, MEDCOM/OTSG, and DHA policies.

(4) Ensures all class VIII non-expendables are accounted for by the unit property book officer.

(5) Ensures MEDLOG is a part of the Command Supply Discipline Program (CSDP).

(6) Reports discrepancies and/or issues through command channels to HQ T2COM.

(7) Ensures TOMS/MEDLOG supports logistics requirements as needed, i.e., General Equipment Audits.

b. BDE S-4s:

(1) Ensures BDE MEDLOG procurement systems in place and operational.

(2) Communicates issues associated with TOMS MEDLOG through the chain of command for situational awareness and appropriate action.

(3) Conducts CSDP inspection of TOMS/MEDLOG unit.

(4) Assigns primary and a secondary class VIII procurement responsibilities.

(5) Coordinates MEDLOG support from the MTF and IMSA through CoE leadership.

(6) Coordinates life cycle management of non-expendable class VIII through the supporting MTF.

(7) Ensures hand receipt holder is appointed by the commander and that required inventories are conducted in accordance with regulatory guidance.

F-4. Class VIII Procurement

a. Class VIII Durables:

(1) Primarily sourced through Defense Logistics Agency Disposition Services (DLADS) DLADS information can be found at https://www.dla.mil/Disposition-Services/.

(2) Procurement coordinated through supporting acquisition support organization or property book office.

(3) Durables unable to be procured through DLADS must be procured through MTF, DCAM, or Global Combat Support System-Army.

(4) Units should not procure medical expendable supplies through U.S. Army Medical Materiel Development Activity to meet TOMS class VIII requirements.

(5) Recommended BN class VIII durables are listed in table G-1, Class VIII Durables/Non-Expendables.

(6) Medication cabinets must be capable of being locked in a manner that prevents non-TOMs personnel from accessing medications. The CoEs are recommended to coordinate appropriate medication cabinets with the supporting MTF and IMSA.

b. Class VIII Expendables:

(1) Class VIII expendables are to be procured through DMLSS.

(2) DMLSS access is to be coordinated by the CoE G-4 and G-6 through the supporting MTF.

(3) When creating CoE DMLSS accounts, procurement catalogues should contain the recommended items and units of issue listed in table G-2, Class VIII Expendables, and any locally approved items.

(4) The BDE personnel responsible for procuring class VIII should be trained in the use of DMLSS by MTF MEDLOG personnel.

(5) Issues with DMLSS access or procurement catalogues affecting TOMS MEDLOG operations should be communicated through the chain of command for awareness and appropriate action.

(6) The ordering and procurement of TOMS class VIII through DMLSS should be coordinated between TOMS personnel and the BDE S-4.

c. Medications:

(1) Medication procurement and stocking capability must be coordinated through the installation MTF commander or authorized representative.

(2) Medications are to be stored in medication cabinets, only accessible to TOMS providers or authorized representatives.

(3) Medications are to be inspected at least monthly to reduce spoilage and prevent medication expiration.

(4) Medication inspection checklists will be developed in accordance with local MTF policies and procedures. Inspection of medications will be conducted in coordination with supporting MTF commander or authorized representative, to ensure compliance with all applicable policies and procedures.

(5) The TOMS BNs should procure the recommended medications listed in table G-3, MTF Commander Recommended Medication List, at the discretion of the installation MTF commander, per their scope of practice.

(6) Expired, damaged, or otherwise indispensable medication should be discarded per applicable installation and MTF policies and procedures. The TOMS units are not to dispose of medications in waste containers/receptacles.

(7) Medications are to be dispensed by expiration date, with the earliest medication expiration dates being dispensed prior to the dispensing of medications with longer dates.

F-5. Class VIII Utilization

a. Class VIII expendable supply utilization should be monitored and reported over a period of at least 6 months to the next higher echelon to properly account for peak and down time usage.

b. Utilization rates are the primary means of determining long-term class VIII funding requirements for TOMS.

F-6. Shelf-Life Extension
Shelf-life extension programs should be established in accordance with DoD Manual 4147.27 and Defense Logistics Agency Regulation 4155.37

F-7. Recommended Class VIII Supplies and Equipment
Tables G-1 and G-2 provided a recommendation for Class VIII supplies and equipment that may be procured to support TOMS operations. This list is not all encompassing and supplies and equipment procured should be made in consideration of the location and scope of care rendered.

Table F-1
Recommended Class VIII Durables/Non-Expendables

NONMENCLATURE	UI	Qty.
CABLE LOCK	EA	1
HAMMER REFLEX TESTING	EA	1
SAW FINGER RING	EA	1
SPECULUM NASAL 5.75"L	EA	1
REMOVER SURG STAPLE	PG	1
STETHOSCOPE 28"LG	EA	4
OTOSCOPE & OPHTHALMOS	SE	2
SPHYGMOMANOMETER	EA	6
CUFF SET SPHYGMOMANOM	EA	1
THERMOMETER KIT CLIN	EA	2
MASK RESPIRATOR 20S	PG	1
TRAY COUNTING TABLET	EA	2
MARKER, TUBE TYPE	DZ	1
SENSOR OXYGEN OXIMETER	EA	1
PHILLIPS HEARTSTART ONSITE AED (M5066A)	EA	1
PHILLIPS HEARTSTARE AED (O2) CASE	EA	1
PHILLIPS ONSITE/FRX REPLACEMENT BATTERY	EA	1
PHILLIPS HEARTSTART ONSITE REPL PADS CARTRIDGE - ADULT	EA	1
WOODS LAMP		1
3 PANEL PRIVACY SCREEN		2
MEDICATION CABINET		1
DESK CHAIR		4
DESK		4
EXAM TABLE		2
CHAIRS FOR PATIENTS (reception/exam)		5
SUPPLY CABINET		1
5 DRAWER VERTICAL F CABINET		1
WASTE RECEPTICLES		3

Table F-2
Recommended Class VIII Expendables

NONMENCLATURE	UI	Qty.
BANDAGE 37X37X52"	EA	25
ADHE TAPE SUR 12"X5YD	RO	1
PAD ISOPROPYL ALCOHOL	PG	2
BAND ADH .75X3" 300S	BX	1
ADH TAPE 1"X360" 12S	PG	2
ADH TAPE 3"X10YD 4S	PG	4
BANDAGE ELAS 4.5YDX4"	PG	3
BANDAGE 6"X4.5YD 10S	PG	5
BANDAGE KIT 6"X4.5M	EA	60
BANDAGE 4.5"X4.1YD	RO	84
BANDAGE KIT ELAS ABDO	KT	5
BANDAGE GAUZE 3"X4YD	EA	40
BRACE, ANKLE	EA	10
CRUTCHES	PR	5
DRESS WOUND SEAL 6X8"	PG	1
DEPRESSOR TONGUE 100S	PG	1
SYRINGE, HYPODERMIC	PG	1
APPLICATOR DISP 200S	PG	1
COVER ELECTRONIC THER	PG	1
MASK ORONASAL ADL 50S	PG	1
CURETTE EAR 7" LG 50S	PG	1
SHIELD EYE SURG 12S	PG	2
GLOVESPAT MEDIUM 100S	PG	2
GLOVES PAT SMALL 100S	PG	1
GLOVESPATIENT XL 100S	PG	2
GLOVES PAT LARGE 100S	PG	2
SPLINT UNIVERSAL 12S	EA	40
BAG RECLOSABLE 1000S	PG	1
DISPOSAL CONTAIN 40S	PG	1
MASKS	BX	4
FLOURESCEIN STRIPS		
BATTERY NONRECHARGEAB	PG	2
BATTERY, NONRECHARGEAB	PG	2
PEN, BALL-POINT	DZ	2
PAD BED LINEN 23X36"	PG	1

F-8. Military Medical Treatment Facility Commander Recommended Medication List
While Table G-3 contains a recommended list of medications, the medications listed should only be procured as appropriate per the scope of practice.

Table F-3
Military Medical Treatment Facility Commander Recommended Medication List

ANALGESICS
ANTACIDS
ANTIBIOTICS (including topical)
ANTIDIARRHEALS
ANTIEMETICS
ANTIFUNGALS (including topical)
ANTIHISTAMINES
ANTI-INFLAMMATORIES
ANTIPYRETICS
BRONCHODILATORS
CORTICOSTERIODS (including topical)
COUGH SUPPRESANTS
DECONGESTANTS (including sprays)
EXPECTORANTS
VITAMINS/ELECTROLYTES
EPINEPHRIN (epi-pen)
ASTHMA/PULMONARY
DERMATOLOGIC
GASTROINTESTINAL
OPTHALMIC
DENTAL/ORAL CARE

Appendix G
Installation Health Service Support Plan Considerations

G-1. Introduction
Appendix H provides references and content considerations when contributing to or generating an Installation Health Service Support Plan (IHSSP) or Memorandum of Understanding (MOU) between supported CoE/Installation commands and supporting MTF. Inclusion of provided content is at the discretion of local MTF and CoE leadership.

G-2. References

a. Office of the Surgeon General (OTSG)/ U.S. Army Medical Command (MEDCOM) Policy Memorandum 17-069, MCHO-CL, subject: Physical Performance Service Line (PPSL) Data Quality, 27 Dec 17, para 5b.

b. Defense Health Agency (DHA) - Interim Procedures Memorandum (IPM) 18-001, Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Mental Health Care in Medical Treatment Facilities (MTFs), 4 Feb 20.

c. DHA - Procedural Instruction (PI) 6025.11, Standard Processes for PCM Empanelment, 9 Oct 18.

d. Memorandum of Agreement (MOA) between DHA, the Army (Manpower and Reserve Affairs (M&RA), the Navy (M&RA), and the Air Force (M&RA) for the Business Rules for Management of Military Personnel Working in Military Medical Treatment Facilities Administered by the DHA (DHA-2019-S-1284).

e. U.S. Army Training and Doctrine Command Circular (T2COM) 40-1, U.S. Army Training Center and Fort Jackson Organic Medical Structure (TOMS), 40-1.

f. Army Regulation (AR) 40-61, Medical Logistics Policies.

g. AR 40-68, Clinical Quality Management.

h. MEDCOM Regulation 40-50

i. Training Regulation 8-800, Medical Education and Demonstration of Individual competence.

j. AR 40-501.

k. AR 635-200.

l. MEDCOM Regulation 600-3.

G-3. MTF Roles and Responsibilities

a. Provide professional oversight.

b. Level of care/scope of practice/standard of care required: Includes healthcare providers and enlisted medical personnel (ADTMC). Level of access to systems. Documentation in Armed Forces Health Longitudinal Technology Application or Military Health System (MHS) GENESIS (hereinafter referred to as electronic health record (EHR)) and e-Profile.

c. If T2COM does not have an assigned physician at a given installation, the MTF will appoint a physician in writing for clinical oversight of T2COM medical personnel to ensure appropriate clinical practice standards.

d The T2COM healthcare personnel may perform duty within the Troop Medical Clinic (TMC)/MTF to sustain skills or proficiency, and will be under the authority, direction, and control of the MTF commander when performing credentialed duties in the MTF. These personnel may not be detailed to TMC/MTF or supervisory duty position unless authorized by a T2COM brigade (BDE) commander.

e. Provide clinical guidance to T2COM privileged providers in meeting standard of care to include direction for pre-hospital medical care and protocols.

f. Retain responsibility for processing special pay.

g. Support military occupational specialty and area of concentration specific training and education to T2COM assigned healthcare personnel required to maintain and enhance individual critical task lists, teaching of new clinical skills/tasks, and obtain continuing health education (CHE) necessary to maintain certifications. See AR 351-3 for guidance on CHE.

h. Provide T2COM assigned medical personnel required MTF-based in-processing to include orientation, training, and badging.

i. Provide space at TMCs or MTFs for TOMS medical staff follow-up care and/or care requiring medical facility standards.

j. Provide space at aligned Mental Health (MH) clinic for TOMS Mental Health officers (MHOs) to provide routine MH services to their assigned BDEs.

k. Include TOMS MHOs and/or MH technicians in the weekly At-Risk Case Tracking meeting with the aligned MTF MH clinics to provide continuity of care for Soldiers within their BDEs.

l. The MTFs will maintain responsibility for MH care plan and/or services, including

evaluations for separations in collaboration with the T2COM MHOs.

m. The MTFs will continue to maintain responsibility for the installation after-hours MH care plan and/or services, and to provide information on the after-hours care plan to TOMS MHOs. Senior command level headquarters will determine utilization of T2COM MHOs for after-hour duty requirements.

n. The MTFs will support requests for MH metrics submitted by TOMS MHOs to include: walk-ins, profiles, diagnosis, administrative separations, medical evaluation boards, number of office visits, etc.

o. Serve as the release authority for all medical information from health records for personnel in accordance with reference, which implements the Health Insurance Portability and Accountability Act (HIPAA) and Department of Defense Manual 6025.18.

p. Systems interfaces (Defense Medical Information System (DMIS); Medical Expense and Performance Reporting System (MEPRS); the EHR; and Defense Medical Logistics Standard Support (DMLSS).

(1) Install and configure networking equipment required to extend medical DHA network into service area used by T2COM personnel.

(2) Provide a MEPRS code or MHS GENESIS equivalent, with distinct Defense Medical Information System Identifier separate from the MTF, to ensure T2COM personnel workload outside of the MTF's certifying body accurately captures TOMS performance metrics and expense data. See references 1, 3, 4, and 5.

(3) Permit T2COM healthcare personnel use of end user devices (computers and printers) within associated MTFs.

(4) Provide information management (IM)/information technology (IT), video teleconference, telehealth, network sustainment and support for network outages, adds, moves, and changes within the service area.

(5) Support any required software updates to DHA imaged/network connected End User Devices (EUD).

(6) Provide EUD customer support to users utilizing the DHA network within the service area.

(7) Coordinate with local information management services to ensure T2COMhealthcare personnel have access to the EHR.

(8) Educate and train T2COM healthcare personnel to record medical encounters in the EHR using the required evaluation/management, procedure, and diagnosis codes.

q. Logistics and Real Property

(1) Supervise and manage medical logistics for T2COM units as the Installation Medical Supply Activity (IMSA) and Installation Medical Maintenance Activity (IMMA). The IMSA's mission is described in reference 6. The IMSA will support class VIII requisitions, receipts and turn-ins for medical surgical and pharmaceutical items, to include medical chemical defense materiel. Review all durable medical equipment requests from installation activities ordered from the IMSA. This will ensure maintenance support is available and standardized across the installation.

(2) Provide logistical oversight and training to T2COM personnel utilizing DMLSS software for class VIII supply procurement including receipt, movement, storage, reconciliation, maintenance, repair, and accountability of materiel and equipment.

(3) Integrate T2COM healthcare personnel into the IMSA/IMMA electronic ordering and maintenance processes. Establish a class VIII account and coordinate with local information management services to ensure T2COM healthcare personnel have remote connectivity to Defense Customer Assistance Module.

(4) Provide class VIII consumable supplies for care rendered in forward care to include during field training exercises for screening and ADTMC only.

(5) In accordance with reference 5, initial operating capability costs of medical supplies and expendables used during training events are a unit cost and thus will be paid for by T2COM.

(6) Provide T2COM healthcare personnel with an external customer handbook or access to online resources outlining the local IMSA and IMMA’s policies and procedures for ordering, receiving, and turn-in of class VIII materiel and receipt of biomedical calibration and maintenance support.

(7) Screen and forward expired class VIII appropriate for pre-hospital medical training to property book officer to consider property utilization for training purposes (see reference 6).

(8) Facilitate T2COM units’ turn-in of controlled substances with complete units of issue to the supporting IMSA and turn-in of controlled substances less than the unit of issue to supporting pharmacy for destruction.

(9) Provide biomedical maintenance assistance in calibrating and maintaining T2COM-

owned durable medical equipment.

(10) Periodically survey non-category 500 facilities that are not funded or operated by the MTF to validate compliance with the Environment of Care (EOC) and Life Safety (LS) standards of The Joint Commission (JC). The EOC and LS standards do require the non-category 500 facilities to meet the LS Code (National Fire Prevention Association 101) for their designated facility classifications. Other areas include egress passageways, regulated medical waste handling and storage, hand washing locations, trash storage, security and accountability of medical supplies, housekeeping of the treatment area, maintenance of any medical equipment, general security of treatment area/space, and patient privacy in the treatment area.

r. Operations.

(1) Provide specialty care services within the capability of the MTF using TRICARE beneficiary priorities of AD over other beneficiary categories which will decrease time away from training.

(2) Reception Battalion (RECBN). Dedicated medical personnel requirements will vary at each training location in support of surge and steady state student throughput.

(a) Establish individual medical requirement record in the Medical Protection System.

(b) Conduct Medical Moment of Truth Briefing.

(c) Obtain and test laboratory specimens.

(d) Administer immunizations.

(e) Conduct vision examinations and prescribe eyewear.

(f) Conduct hearing examinations and issue ear protection.

(g) Conduct sick call.

(h) Maintain professional credentials.

(i) Oversee accountability for medical equipment/supplies.

(3) Injury Surveillance.

(a) The Defense Center for Public Health – Aberdeen will provide injury surveillance for IET to monitor and report injury rates and trends for units.

(b) Provide consultation services to the T2COM Surgeon's Office and TOMS personnel to support and collaborate on injury mitigation efforts and programs during IET.

(c) When requested by T2COM, conduct injury surveys, investigations, and program evaluations to assess the impact of programmatic changes in training on injury risk factors, causes, and rates.

(4) Provide Substance Use Disorder Clinical Care (SUDCC) support to geographically separated T2COM personnel.

(a) Facilitate Enrollment in Drug and Alcohol Management Information System (DAMIS).

(b) Treatment of substance use disorder via telemedicine.

(c) Support chemical surety management at the Chemical Defense Training Facility.

G-4. T2COM Roles and Responsibilities

a. Exercise administrative and operational control of T2COM medical personnel. When T2COM medical personnel are performing duty within the TMC/MTF, they will be utilized in a manner that sustains readiness through maintaining skills or proficiency, and will be under the authority, direction, and control of the MTF commander when performing credentialed duties in the MTF. These personnel may not be detailed to a TMC/MTF or supervisory duty position unless authorized by T2COM BDE commander.

b. Ensure healthcare personnel maintain appropriate certifications, licensures, registries, and other requirements of the profession (references 7, 8, and 9).

c. The MTF will have the primary responsibility for privileging and credentialing. If there is a change or loss of credentials or privileges, the change will be communicated to the BDE commander for visibility, assistance, and resolution. The T2COM commanders will communicate personnel actions that could affect credentialing to the MTF commander (see reference 7).

d. Ensure healthcare personnel follow standards of fitness in evaluations for retention and separation (references 10 and 11) and with standards for readiness.

e. Off duty employment (ODE) will be at the discretion of the BDE commander. Healthcare practitioners (defined in MEDCOM Regulation 600-3) will submit their request through the MTF chain of command for review and endorsement to the BDE commander for decision. The MTF will continue to track monthly reporting hours for all ODE in accordance with MEDCOM Regulation 600-3 (reference 12) and local MTF policy as applicable. All ODE requests and approvals must meet all applicable Army regulations (reference 2.8) and follow the Joint Ethics Regulation.

f. Assign a local contracting officer representative (COR) and alternate COR for contract(s) as applicable.

g. Provide space and utilities for healthcare operations in their own unit areas, or space

designated by the MTF. The space will include secure storage for expendable medical supplies, physical training equipment, and room for small group instruction for classes, in addition to JC requirements.

h. Providers or medics may work at the MTF as well as for their units. Senior command level headquarters will determine utilization of T2COM personnel in MTFs. Full time equivalent (FTE) is suggested either in the TOMS setting or in the MTF for clinical readiness/currency:

(1) BDE Surgeon – 0.3 FTE maximum

(2) BDE MHO – 0.3 FTE maximum

(3) BN physician assistant (PA) / nurse practitioner – 0.5 FTE maximum

(3) Health profession (HP) officer incentive pay and retention bonus (RB): HP officers must be currently credentialed, privileged, and practicing a minimum of 40-hours/year at a facility designated by the Army, in the specialty for which the incentive pay and and RB is being paid

Note. This does not constitute a T2COM endorsement of requirement that providers spend a minimum amount of time working inside an MTF/TMC.

i. Commanders with MHO PAs and MHOs will ensure a physician and MH clinician, respectively, are included in their rating schemes.

j. Assigned T2COM PTs will serve as the liaisons between unit commanders and the MTF commander to ensure proper MSK care and coverage is provided at the designated locations. Locations resourced with holistic health and fitness assets will provide administrative and logistics support to the PTs in T2COM BDEs.

k. In accordance with T2COM Tasking Order IN 200561, initial operating capability costs of medical supplies and expendables used during training events are a unit cost and thus will be paid for by T2COM.

l. Fund the purchase of all required IM/IT network hardware in order to establish medical (DHA) network connectivity within the service area.

m. Provide inventory of T2COM-owned durable medical equipment requiring biomedical maintenance assistance in calibration and maintenance to MTF annually.

n. Coordinate with respective Information Management Directorates (IMD) for access to the DHA network and access to the EHR.

o. Ensure personnel utilizing the DHA network are in compliance with annual HIPAA training requirements and any additional requirement for maintaining active access to the DHA network.

p. Ensure personnel utilizing EHR complete any required clinical systems training with the respective IMD prior to gaining access to these systems.

q. Follow local policy for resolving any IM/IT issues by contacting the Global Service Center first prior to contacting the MTF IMD.

r. Be responsible for the replacement/addition of computers, printers and associated peripherals utilized within the service area connected to DHA network and any future expansion requiring additional networking equipment.

s. Operations will provide student quotas and reservations for RECBN planning purposes.

G-5. Shared Roles and Responsibilities

a. Immediately notify the other party of potential challenges to any part of the agreement.

b. Maintain open and responsive communication.

c. Accomplish agreed upon tasks with due expediency.

G-6. Personnel

a. Each Party is responsible for supervision, management, and costs of its own personnel. There will be no shared responsibility for management and supervision of personnel, unless detailed above or in the applicable MOA Annex.

Appendix H
U.S. Army Training Center and Fort Jackson Organic Medical Structure Facility Recommendations

H-1. TOMS Forward Care

a. The TOMS postures T2COM to deliver appropriate, competent, and timely medical care to effectively and efficiently train and lead Soldiers to enter the operational force and maximize Army mission readiness. The TOMS will maintain medical readiness, support performance readiness, reduce injury and subsequent attrition, reduce time away from POI for medically related concerns and mitigate risk to the training mission in its training enterprise, consisting of IET BDEs, and CAC.

b.. To appropriately meet the intent of TOMS, the following are facility recommendations taken from The DoD Medical Space Planning Criteria at https://www.wbdg.org/ffc/dha/mhs-space-planning-criteria-health-facilities.

c. The DoD Medical Space Planning Criteria lists specific requirements, which define and provide specialized working environments within medical facilities according to departments and function areas within the departments. The criteria provides current guidance for the most efficient utilization of space to meet medical requirements. Private sector standards of practice and unique military requirements have been taken into consideration during the development of these criteria.

d. In developing the appropriate space for TOMS, each location should review Chapter 301, Primary Care/Patient Centered Medical Home and Chapter 318, Mental Health Ambulatory Care Services, from The DoD Medical Space Planning Criteria, for space planning evaluation.

e. The space planning criteria in this chapter applies to all DHA MTFs and are based on current DHA policies and directives, established and/or anticipated best practices, industry guidelines and standards, and input from MHS subject matter experts and DHA directorates. The TOMS design ideally will be zoned for patients, visitors, support, and staff areas to improve efficiency. A separate flow will be created between patients and visitors and staff to optimize privacy, safety, and overall satisfaction. “On Stage” is defined as the public/reception zone, and the patient care/treatment zone. “Off Stage” is defined as the staff/administration zone, the clinic support zone, and staff/service corridors were possible.

H-2. TOMS Area

a. Seating in the waiting area should be comfortable with adequate space. Consider arranging seats into separate, small clusters to accommodate social distancing and enhance physical separation of well and sick patients.

b. To maximize speech privacy for patients at reception area, provide open, clear floor area between the waiting seats and reception area.

c. Consider flexible seating options that can accommodate greater demands during peak primary care hours.

d. Locate the patient education room near the front of the exam patient care area for patient convenience and to reduce unnecessary traffic through the clinic.

e. Locate the immunization/observation waiting area in line of sight to the immunization treatment area or to another staff occupied area.

f. Exam rooms and office space will support a TOMS BN Surgeon who is a provider and assigned medics. Additionally listed is BDE MHO space requirements when co-located.

H-3. Space Planning Criteria

a. Waiting Area (WRC01) 360 Net Square Feet (NSF): the 360 NSF accommodates 21 chairs at 16 NSF each and 1 handicapped chair at 25 NSF.

b. Reception (RECP1) 100 NSF

c. Patient Education (CLSC3)

d. Medical Patient Exam Area:

(1) Alcove (EXR11) 15 NSF. The alcove supports height and weight measurements before moving the patient to the exam room for obtaining vital signs and other health information.

(2) Exam room, general (EXRG1) 120 NSF, provide two.

(3) Team workroom (OFA04) 120 NSF; provide one. Team shall be co-located in a team workroom rather than in individual offices. This promotes improved collaboration and coordination of care through increased communication and staff efficiency. Team workrooms and staff areas should be located so staff members may have private conversations regarding patients and clinical matters without being heard by patients or visitors.

e. MH Area:

(1) Office, MH provider (OFDC1) 120 NSF, provide one.

(2) Office, MH technician (OFDC1) 120 NSF, provide one.

(3) Room, MH consult (EXR10) 120 NSF, provide one, which is not part of the total exam room count.

f. Other Considerations:

(1) The location and number of recessed or semi-recessed Automatic External Defibrillator cabinets will be determined during project design. The Designer of Record (DOR) is responsible to ensure quantity, placement and all appropriate markings are shown in the final design solution. The DOR will coordinate with the design and construction agent and clinical representative to ensure adequate placement and facility coverage.

(2) Chapter 318 MH Ambulatory Care Services: https://www.wbdg.org/ffc/dha/mhs-space- planning-criteria-health-facilities/318. Safety features for MH care are not addressed in chapter 318.

Appendix I
The Joint Commission Checklists

I-1. The Joint Commission Environment of Care and Life Safety Items for Compliance Review

a. Egress passage ways including egress lighting, emergency lighting, egress signage, exits signs fire barrier doors, unobstructed corridors, and stairways, including all required maintenance records for egress lighting, exits signs, and doors.

b. Fire protection system, including fire alarm system and smoke detection systems. This includes maintenance recordkeeping.

c. Written fire response plan describing the specific roles of staff and licensed independent practitioners at and away from the fire's point of origin, including when and how to sound the fire alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate to areas of refuge. This includes documented fire drills.

d. Fire suppression systems include fire sprinklers, fire pumps, flow and tamper valves, and fire sprinkler controls. This includes maintenance recordkeeping.

e. Regulated medical waste handling and storage

f. Hand washing locations in or near treatment area

g. Security and accountability of medical supplies

h. Housekeeping of the treatment area

i. Maintenance of any medical equipment

j. General security of treatment area/space

k. Patient privacy in treatment area including protected information

l. Portable fire extinguishers, including monthly and annual testing

m. Hazardous waste/regulated medical waste management and handling

I-2. Environment of Care Safety and Infection Control Checklists
Contact your local MTF for copies.

Appendix J
Other Organizations

J-1. Defense Health Agency
Historically, MEDCOM executed healthcare delivery, public health service delivery, and medical readiness requirements within the MTFs and dental treatment facilities (DTFs) using the resources that have transferred to DHA under the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019, Section 711(b)(1). The MTF and DTF support for medical readiness is categorized in three major areas: (1) Active Duty (AD) and Reserve Component (RC) Medical Readiness Support Requirements, (2) Installation Medical Readiness Support Requirements including Army's Organic Industrial Base, Industrial Hygiene (IH), Occupational Health (OH), Environmental Health (EH) activities, and (3) Medical and IH and OH and EH related training support requirements. Support also includes administrative and logistical support provided by some larger MTFs to other Army medical organizations on an installation and assigned remote facilities as defined in the tenant Installation Health Services Support Agreements. In accordance with NDAA FY 2019, Section 711(b)(1), the DHA:

a. Provides MTF-rendered clinical services, coordinates purchased-care network access, and coordinates enterprise healthcare delivery and installation level public health and medical readiness support services to Army installations with resources determined by the DHA planning, programming, budgeting, and execution (PPBE) processes, and is sufficient to meet the demand of the eligible and supported population including RC medical readiness requirements. Consistent with Department of Defense (DoD) safety and occupational health programs and deployment health policy, provides appropriate occupational health and deployment health services to Department of the Army (DA) AD Soldiers, USAR and ARNG Soldiers, and DA Civilians as applicable. When applicable, provides specified services to contractor employees, as defined by requirements of the applicable contract and to the extent provided in the applicable contracts, and consistent with Subparts 207.503 and 252.225-7040 of the Defense Federal Acquisition Regulation Supplement, pursuant to DoD Instruction (DoDI) 3020.41.

b. Ensures support to Army operational medical requirements by integrating activities to enable the current and future suite of operational healthcare applications' ability to move medical readiness data from point of care to the EHR.

c. Provides MTF and DTF healthcare delivery and specified administrative, logistical, and installation medical readiness support as defined in the Service Level Agreement between DHA and U.S. Army and resources determined by the DHA PPBE processes.

d. Supports the medical requirements of the Army's installation safety and occupational health program requirements related to OH, and IH, and EH services.

e. Ensures that Army medical personnel, resources, and medical and dental training within MTFs and DTFs support Graduate Medical Education (GME), Graduate Dental Education, Phase II Hospital Training, and DA defined Individual Critical Task Lists (ICTLs) implementation and sustainment requirements, pursuant to NDAA for FY 2019, Public Law 115-232, section 712 (2018). Optimize the MTFs and DTFs to maximize medical and dental training

supporting ICTLs to enable Ready Medical Force capability. Section 725 of FY 2017 NDAA mandates reforms to the DoD Military Health System to improve readiness, requiring implementation of measures to maintain critical wartime medical skills and core competencies of healthcare providers.

f. Ensures Army commanders, managers, and supervisors are informed of the execution and performance of OH and IH and EH services.

g. Supports the MTFs in executing administrative and logistical support functions to T2COM (i.e., Reception Battalions (RECBNs).

h. Supports Initial Entry Training (IET) and RECBNs. Initial medical and dental in-processing at RECBNs is staffed by the respective local MTF personnel.

(1) Provides medical screening associated with the initial military training centers at Forts Jackson, Benning, Leonard Wood, and Sill in support of Soldiers in-processing.

(2) Military, Army civilian professionals, and contractors are assigned to the reception processing center and are regularly augmented by MTF optometry, audiology, MH, and other personnel when RECBN requirements exceed assigned staff capacity and capability.

i. Provides medical, dental, or veterinary facility clinical medicine and operations support, quality, and safety.

(1) Credentialing and privileging of providers as necessary.

(2) Medical records management and systems access.

(3) Medical gases (i.e., oxygen) tank handling and replacement.

(4) Ancillary diagnostic and treatment support services for DoD-owned animals, including, but not limited to, radiology diagnostic services, advanced imaging (computed tomography, magnetic resonance imaging, etc.); emergent laboratory diagnostic services (clinical and pathology).

(5) Non-routine sterile processing.

(6) IH, OH, and EH services.

(7) Pharmacy support, including dispensing; disinterested officer-controlled drug and substance inventory; and diversion prevention management.

(8) Cold chain support for medicines and vaccines in the event of a power outage or disaster; remote cold chain temperature monitoring.

(9) Integration between emergency services, veterinary services, and preventive medicine.

(10) Facility and space support for military working dog postmortem examinations and cold storage.

(11) Commercial shipping for clinical and food protection samples for the appropriated fund mission.

j. Provides public health and installation medical readiness support health (installation preventive medicine and occupational health and community public health). Public health's vital programs are health surveillance and epidemiology, occupational health (occupational and environmental medicine clinics), environmental health, community-based prevention and health promotion (Armed Forces wellness centers, public health nursing), and clinical public health (immunization clinic, Army hearing program, vision conservation, and clinical prevention).

k. Provides traumatic brain injury screening including automated neurocognitive assessment model.

l. Provides optometry, ophthalmology and warfighter refractive eye surgery program.

m. Provides flight and aviation medicine.

n. Provides medical logistics (MEDLOG), medical supply, and medical maintenance, including:

(1) Capital expense equipment program procurement property management.

(2) Equipment lifecycle and property book management.

(3) General Service Administration vehicles and fleet management.

(4) Physical security and key control.

(5) Pest control and grounds keeping that affect health and medical functions.

(6) Safety inspections to include radiological safety.

(7) Regulated medical waste management and disposal.

(8) National Institute for Occupational Safety and Health-designated hazardous drugs.

(9) Controlled substances and hazardous waste management support.

(10) Biomedical materiel packaging and shipment (i.e., lab sample, biomedical waste, specimens).

(11) Healthcare environmental cleaning (e.g., housekeeping).

(12) Healthcare linen and laundry management.

(13) Property book management.

o. Provides installation medical logistics support and maintenance support to operational units.

(1) Serves as the primary class VIIIA (medical material less blood and blood products) source of supply and provides reinforcing medical equipment maintenance on an area support basis to continental U.S. (CONUS), Alaska, and Hawaii based Army units through the MTF Installation Medical Supply Activity (IMSA); providing the same level of support as prior to 1 October 2021.

(2) As necessary, establishes policies, procedures, and standard operating procedures for MEDLOG support to CONUS based Army units.

(3) Ensures sufficient Defense Health Program (DHP) funding is allocated to MTFs to provide IMSA support for CONUS based Army units at the same level as prior to 1 October 2021.

(4) Executes specific MEDLOG support roles and responsibilities in support of Army units pursuant to Table K-1.

Table J-1.
Defense Health Agency Military Medical Treatment Facility Installation Medical Supply Activity Support to Army Units

MEDLOG Support Home Station Training Operations	AMC3	OTSG	DHA	Army Units[4]
MEDICAL MATERIEL (CL VIIIA)[2]	o Provide and/ or synchronize enterprise-wide, end-to-end (E2E) DS CL VIIIA sustainment execution in support of Army operational requirements APS and Contingency program support to Army units & Joint forces ISO Large Scale Combat Operations (LSCO) the Range of Military Operations (ROMO). o Execute Programming (POM) actions in coordination with (ICW) HQDA staff and in support of (ISO) the CG, AMC SS PEG Co-Chair role o Establish, maintain, and monitor Army operational / deployable units and installation support units MEDLOG readiness and support (e.g., IMCOM/ DES capabilities) MEDLOG Readiness Supply COP	o Provide HQDA Level Policy & Staff Oversight of MEDLOG Support and Readiness	o Serve as the CL VIIIA Source of Supply (SoS) in support of Army units through the Medical Treatment Facility (MTF) Installation Medical Supply Activity (IMSA) on an installation direct support (DS) and area support (AS) basis o As necessary, establish: policies, procedures, and SOPs at the Enterprise, Regional, and MTF/ IMSA- levels for CL VIIIA support to Army units	o Provide funded requisitions for all CL VIIIA materiel procured through an MTF IMSA o Monitor, report & maintain Army operational and installation tenant units Medical Equipment and Medical Sets, Kits, and Outfits (SKO) supply and maintenance readiness IAW applicable Policy and Regulations

Table J-1.
Defense Health Agency Military Medical Treatment Facility Installation Medical Supply Activity Support to Army Units Continued

MEDLOG Support Home Station Training Operations	AMC3	OTSG	DHA	Army Units4
MEDICAL EQUIPMENT MAINTENANCE & REPAIR	o Provide Strategic Support Area, depot and industrial base reach-back support to Army units through AMLC Medical Logistics Readiness Support Team (LRST) pax co-located with CONUS and OCONUS Army Support Command (ASC) Army Field Support Brigade (AFSB) Headquarters o Provide MMOD (Depot-level) Field and Sustainment level support to Army units o Establish, maintain, and monitor Army deployable units and installation support units (e.g. IMCOM DES) MEDLOG Readiness Equip Maint COP o Execute Programming (POM) actions in coordination with (ICW) HQDA staff and in support of (ISO) the CG, AMC SS PEG Co-Chair role	o Provide HQDA Level Policy & Staff Oversight of MEDLOG Support and Readiness	o Provide DS primary and/ or reinforcing maintenance and parts support through the MTF IMMA to Army Units on an installation DS and AS basis o As necessary, establish: policies, procedures, and SOPs at the Enterprise, Regional, and MTF/ IMMA - levels for CL VIIIA support to Army units o Parts, supplies and labor may be provided on a reimbursable basis per DHA Policy or IMSA. o The provider has determined that the capabilities exist to render the requested support without jeopardizing its assigned missions	o Monitor, report, and execute field level maintenance and repair of MTOE/ TDA authorized bio-medical equipment IAW capability & capacity; and applicable policy and regulations o Synchronize AMLC MMOD Field & Sustainment Level Depot Support as required o Synchronize MTF IMSA maintenance and parts support as required in support of medical equipment/ device readiness
REGULATED MEDICAL WASTE	o NA	o Provide HQDA Level Policy & Staff Oversight of MEDLOG Readiness, Systems and Programming	o Provide Regulated Medical Waste Disposal support and services through the MTF IMSA to Army units on an installation DS and AS basis. Reimbursement will be negotiated between Non-medical Army units and the DHA MEDLOG for RMW costs associated with disposal of items that do not comply with DHA RMW Groups defined in MEDLOG Regulated Medical Waste RMW) Management, DHA-PM 6050.01 July 22, 2021. Trauma scene wastes originating outside of MTFs are excluded from DHA RMW management.	o Dispose of regulated medical waste through the MTF/ IMSA IAW installation and supporting MTF/ IMSA requirements
COMBAT TRAINING CENTER (CTC) MEDLOG SUPPORT (Army Rotational Units)	o Establish, maintain, and monitor Army deployable units and installation support units (e.g., IMCOM DES) MEDLOG Readiness Supply & Equip Maint COP o Capture lessons learned ICW FC, CTC, DHA, & MEDCOM/ ASG for application in AMC MEDLOG execution mission	o Provide HQDA Level Policy & Staff Oversight of MEDLOG Support and Readiness	o Serve as the CL VIIIA Source of Supply (SoS) in support of Army units executing CTC rotations through the CONUS-based CTC installation MTF IMSA at the National Training Center (NTC) & Joint Readiness Training Center (JRTC)	o Project requirements and provide a funded requisitions for all CL VIIIA materiel procured through a CTC installation MTF IMSA ISO rotational unit training requirements
Medical Gases			o Render services for re-filling and disposing (if applicable) medical gas cylinders.	o Provide serviceable medical gas cylinders to be refilled and/or replaced

p. Provides information management and information technology support and maintenance as it applies to health service support.

(1) Provision of computers.

(2) Lifecycle management, hardware and software updates, peripheral devices.

(3) Risk management framework for information technology (IT) systems on DoD networks.

(4) Local area network system connectivity and accreditation, system design, desktop support, Enterprise Service Desk tier-1 support, and on-call technical assistance and maintenance.

(5) Telephone, phone line connectivity for credit card machines, cellular network, and wireless hotspot service and support.

(6) Printer, copier, and fax machine service contracts.

J-2. Office of the Surgeon General and U.S. Army Medical Command

a. In accordance with 10 USC 1073c, the Office of the Surgeon General (OTSG) serves as the chief medical advisor of the Army to the Director of the DHA on matters pertaining to military health readiness requirements and safety of members of the Army; and executes the development, policy direction, organization, and overall management of an integrated Army-wide system of health in a manner consistent with the implementation of DHA's responsibility for administering each military MTF.

b. The MEDCOM's mission includes promoting, sustaining, and enhancing Soldier health; and monitoring and reporting medical readiness and deployability data for individuals, units, and task forces.

J-3. Military Medical Treatment Facility

a. The commander of the MTF serves as the MTF Director and responsibilities are assigned and authorized in DoDD 5136.13, as amended; 10 USC 1073c; and Defense Health Agency Administrative Instruction 5136.03. In accordance with the cited references, the MTF director is responsible for:

(1) Ensuring the MTF is ready to support all mission requirements.

(2) Furnishing the healthcare and medical treatment provided within the MTF.

(3) Executing clinical quality and patient safety programs in accordance with DHA Procedures Manual (DHA-PM) 6025.13, Clinical Quality Management in the Military Health System, August 29, 2019, Volumes 1 through 7, including implementation guidance. The MTF Director is the privileging authority.

(4) Meeting the military medical readiness requirements of the senior supported military operational commander(s).

(5) Exercising operational control over uniformed medical and dental personnel assigned, allocated, detailed to, or otherwise used to perform duties and functions associated with MTF

operations, including delivery of clinical and healthcare services and MTF business operations.

(6) Facilitating actions by the Army Surgeon General to ensure that the operational medical force readiness organizations of the Military Departments support the medical and dental readiness responsibilities of the Director, DHA.

(7) Exercising authority, direction, and control of all MTF operations and operational control of all personnel assigned, allocated, detailed to, or otherwise used to perform duties and functions associated with MTF operations, including the delivery of clinical and healthcare and MTF business operations. These MTF operations include the operations for any MTF clinics defined as a "child clinic" in DMIS-ID relationships.

(8) Executing and approving support agreements, memoranda of understanding, memoranda of agreement, training agreements, and any other such agreements necessary to fulfill the responsibilities of the MTF in coordination with their immediate higher headquarters and the DHA Agreements and Partnerships Management Office.

(9) Credentialing and Privileging. DHA-PM 6025.13, Volume 4, August 29, 2019, describes the credentialing and privileging process to provide medical and other patient care services. Clinical privileges are based on the capability of the healthcare facility, licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations.

(10) Empanelment. Beneficiaries enrolled in TRICARE Prime or Plus in the direct care system are empaneled to a specific MTF primary care manager (PCM) by name in accordance with Health Affairs Policy 11-005.

(a) The PCMs are those providers with a panel of assigned beneficiaries (i.e., permanent party T2COM cadre) who are assigned to a clinic which is DHA funded and to a MEPRS code whose third level identifier indicates a primary care product line (Family Medicine, Internal Medicine, Pediatrics, Adolescent Medicine, Primary Care GME, Flight Clinics, Aviation Clinics, Undersea Clinics, Personnel Reliability Clinics, and Operational Medicine).

(b) Borrowed labor will not be included in the total count of MTF PCMs, even if they are empaneled. Part-time labor will be included. Part-time labor is defined as providers who are hired to work less than full-time.

(c) Line-funded PCMs will not be included in the MTF average empanelment calculation. Beneficiaries empaneled to line-funded PCMs also will not be included in the MTF average empanelment calculation to ensure accurate accounting and parity between the calculated numerator and denominator.

(d) "Must Sees." Active duty Service members (ADSMs) and other "must sees" are classified as "pseudo enrollees." The ADSMs include personnel from both the active and reserve components who are on AD. The ADSMs have the highest priority for care in MTFs in accordance with Health Affairs Policy 11-005 including ADSMs who are not empaneled to the MTF. The ADSMs who are not empaneled to the MTF (i.e., trainees) may receive acute primary

care in MTF emergency rooms and urgent care clinics, acute and routine primary care in patient centered medical home (PCMH), and for military-specific requirements including, but not limited to, periodic health assessments, line of duty determinations, and profile updates.

(e) The ADSMs in training status fall under "Must Sees."

(f) "Must See" Empanelment Adjustments. Visits by "must see" non-empaneled patients will translate to a full time equivalent (FTE) adjustment for each MTF by dividing the number of non-empaneled visits to primary care in the last rolling 12 months by the Military Health System (MHS) average utilization rate to be provided annually by DHA. This process will generate a number of "pseudo enrollees"; the number of pseudo enrollees will be converted to a FTE, divided by minimum empanelment of 1,100 or the average MTF empanelment if higher and then deducted from the MTF's FTE denominator. The PCM adjustment for "must sees" will be calculated annually.

b. The director will make recommendations to the Market or Defense Health Region commander or director on additional manpower required if additional beneficiary empanelment demand exists in the market and the MTF has met all objective criteria, but the MTF cannot increase empanelment with current resources.

c. Standard Objective Criteria. The MTFs' capacity will be assessed based on the standards identified in DHA-PI 6025.11.

d. The Director of Health Services (DHS) ensures adherence to DoD healthcare regulations and policies. The DHS provides oversight for quality, safety, and Joint Commission compliance of the healthcare delivered by TOMS providers.

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Glossary

Section I
Abbreviations

AC	Active Component
ACMG	Active Component Manning Guidance
ACS	Army Community Services
AD	Active Duty
ADSM	Active Duty Service Member
ADTMC	Algorithm Directed Troop Medical Care
AIT	Advanced Initial Training
AOC	Area of Consideration
AR	Army Regulation
ARCT	At-Risk Case Tracking
ARNG	U.S. Army National Guard
AT	Athletic Trainer
ATC	Army Training Center
ATRRS	Army Training Requirements and Resources System
BCT	Basic Combat Training
BDEs	Brigades
MH	Mental Health
MHC	Mental Health Center
MHDP	Mental Health Data Portal
MHO	Mental Health Officer
BN	Battalion
CAC	U.S. Army Combined Arms Command
CDMHEs	Command-Directed Mental Health Evaluations
CGSC	U.S. Army Command and general Staff College
CHE	Continuing Health Education
CIMT	Center for Initial Military Training
CLS	Combat Life Saver
CMF	Career Management Field
CoEs	Centers of Excellence
CONUS	Continental United States
COR	Contracting Officer Representative
CQM	Clinical Quality Management
CSDP	Command Supply Discipline Program
C-SSRS	Columbia Suicide Severity Rating Scale
DA	Department of the Army
DAMIS	Drug and Alcohol Management Information System
DCAM	Defense Customer Assistance Module

DCS	Deputy Chief of Staff
DHA	Defense Health Agency
DHA-AI	Defense Health Agency - Administrative Instruction
DHA-PI	Defense Health Agency Procedural Instruction
DHA-PM	Defense Health Agency Procedures Manual
DHP	Defense Health Program
DHS	Director of Health Services
DISA	Defense Information Systems Agency
DLADS	Defense Logistics Agency Disposition Services
DMHRSi	Defense Medical Human Resource System-internet
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System - Identification
DMLSS	Defense Medical Logistics Standard Support
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDi	Department of Defense Instruction
DOR	Designer of Record
DTF	Dental Treatment Facility
EH	Environmental Health
EHR	Electronic Health Record
EMP	Emergency Management Plan
EOC	Environment of Care
EUD	End User Device
EXORD	Execute Order
FCC	Functional Cost Code
FM	Field Manual
FORSCOM	U.S. Army Forces Command
FTE	Full-Time Equivalent
FY	Fiscal Year
GAD-2	Generalized Anxiety Disorder
GAD-7	Generalized Anxiety Disorder
GME	Graduate Medical Education
H2F	Holistic Health and Fitness
HA	Health Affairs
HIPAA	Health Insurance Portability and Accountability Act
HP	Health Professions
HQ	Headquarters
HQDA	Headquarters Department of the Army
HR	Human Resources
ICTL	Individual Critical Task List
IDPH	Installation Director of Psychological Health

IET	Initial Entry Training
IH	Industrial Hygiene
IHSP	Installation Health Service Plan
IM	Information Management
IMAs	Individual Mobilization Augmentees
IMD	Information Management Division
IMMA	Installation Medical Maintenance Activity
IMSA	Installation Medical Supply Activity
IP	Incentive Pay
IPM	Interim Procedures Memorandum
IPR	In-Progress Review
IT	Information Technology
JC	The Joint Commission
LS	Life Safety
M&RA	Manpower and Reserve Affairs
MEDCoE	U.S. Army Medical Center of Excellence
MEDCOM	U.S. Army Medical Command
MEDLOG	Medical Logistics
MEDPROS	Medical Protection System
MEPRS	Medical Expense and Performance Reporting System
MHA	Medical Health Assessment
MHS	Military Health System
MOA	Memorandum of Agreement
MODS	Medical Operational Data System
MOS	Military Occupational Specialty
MOU	Memorandum of Understanding
MRTC	Master Resilience Training Course
MSK	Musculoskeletal
MTF	Medical Treatment Facility
NCO	Non-Commissioned Officer
NDAA	National Defense Authorization Act
NP	Nurse Practitioner
NSF	Net Square Feet
ODE	Off Duty Employment
OH	Occupational Health
OSUT	One-Station Unit Training
OTSG	Office of the Surgeon General
PA	Physician Associate
PAM	Pamphlet
PCM	Primary Care Manager
PCMH	Patient Centered Medical Home

PC-PTSD-5	Primary Care Post-Traumatic Stress Disorder Screen
PHQ-2	Patient Health Questionnaire - 2
PHQ-9	Patient Health Questionnaire - 9
PI	Procedural Instruction
POI	Program of Instruction
POM	Program Objective Memorandum
PPBE	Planning, Programming, Budgeting, and Execution
PPSL	Physical Performance Service Line
PT	Physical Therapist
RAR	Rapid Action Revision
RB	Retention Bonus
RC	Reserve Component
RECBNs	Reception Battalion
RFA	Request for Action
RFI	Request for Information
SLA	Senior Leader Agreement
SUDCC	Substance Use Disorder Clinical Care
TDA	Table of Distribution and Allowances
TEM	Traumatic Event Management
TMC	Troop Medical Clinic
TOE	Table of Organization and Equipment
T2COM	Training and Transformation Command
TOMS	T2COM Organic Medical Structure
USAR	U.S. Army Reserve

Section II
Terms

Active duty Service members. Members of both the active and reserve components who are on active duty.

Borrowed labor. When a primary care provider is assigned to a full-time job outside the MTF but who provides care on an ad hoc basis to beneficiaries empaneled to an MTF. It includes but it not limited to non-empaneled medical officers and individual mobilization augmentees (IMAs). Borrowed labor, in some instances, can be classified as PCMs; however, PCMs who are borrowed labor will not be included in the MTF average empanelment calculation. This includes operational providers regardless of funding who provide care to their empaneled beneficiaries within the MTF purview.

Direct care. Direct care refers to healthcare delivered in MTFs.

Empanelment. TRICARE Prime or Plus beneficiaries are empaneled to a MTF PCM.

Empanelment capacity. Empanelment capacity is the total MTF capacity to empanel TRICARE beneficiaries to MTF PCMs.

Enrollment. Enrollment is the term the MHS uses to describe the TRICARE Plan (Prime or Select) to which a TRICARE beneficiary is enrolled.

MHS GENESIS. The MHS's new EHR, operated by the DHA, intended to provide a single health record for Service members, veterans, and their families.

Medical Occupational Data System (MODS). An electronic system operated by the Army Medical Department that contains applications for MH data, medical readiness (including the e-Profile), the MEDPROS, and the Medical Health Assessment (including Periodic Health Assessment).

Medical Protection System (MEDPROS). The Army's medical readiness system of record for all medical readiness data elements. It is a software application in MODS that interfaces with systems across the Army that support personnel actions, readiness reporting, assignments, logistics, and senior leader decisions. This information informs leaders, commanders, and healthcare providers guiding the policies and procedures, resource management, and medical support planning to achieve and maintain a medically ready and deployable force.

Military Medical Treatment Facility (MTF). Any fixed facility of the DoD that is outside of a deployed environment and used primarily for healthcare; and any other location used for purposes of providing healthcare services as designated by the Secretary of Defense.

Non-empaneled medical officer. A primary care clinician who is not empaneled but who sees patients in an MTF. They may be permanently assigned to the MTF or to another organization.

Non-enrolled beneficiaries. Non-enrolled TRICARE beneficiaries have not elected to enroll in either PRIME or Select. They may receive care in the direct care system on a space-available basis only.

Primary care manager. The MHS term for physicians, NPs, and PAs trained in primary care specialties and to whom TRICARE Prime beneficiaries are empaneled.

Patient centered medical home. The MHS's model of primary care, which includes family medicine, pediatrics, internal medicine, operational medicine, and multi-disciplinary primary care clinics. The PCMHs' operations are guided by Tri-Service standard processes and procedures with warranted variance in the type of additional care available based on the needs of the patient population.

Private sector care. Healthcare delivered in the civilian private sector care system through TRICARE contracts.