



PERSONNEL AND  
READINESS

**UNDER SECRETARY OF DEFENSE**  
4000 DEFENSE PENTAGON  
WASHINGTON, D.C. 20301-4000

**MAR 10 2023**

The Honorable Jack Reed  
Chairman  
Committee on Armed Services  
United States Senate  
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to section 731 of the William M. (Mac) Thornberry National Defense Authorization Action Act for Fiscal Year 2021 (Public Law 116-283), "COVID-19 Military Health System Review Panel." Section 731 requires the Military Health System (MHS) to conduct a review of the response of the MHS to coronavirus disease 2019 (COVID-19), including strengths and weaknesses and to make appropriate recommendations in six "domains" relating to the MHS.

The complex course of the pandemic continues to require the Department of Defense to aggressively gather, analyze, and integrate new information and make new findings. Given that reality, the Department submitted a substantive interim report on April 21, 2022. This final report contains modifications resulting from our ongoing reviews. Overall, the Panel determined that the MHS responded to the COVID-19 pandemic with skill, agility, and imagination, providing essential and timely support to civil authorities as part of the "whole of Government" preventive health strategy and careful implementation of appropriate measures against the virus. Within that general finding, the Panel further discerned some 101 specific findings that will help sustain strengths and address weaknesses within the MHS.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and their families. I am sending similar letters to the other congressional defense committees.

Sincerely,

A handwritten signature in black ink, appearing to read "Gilbert R. Cisneros, Jr.", written in a cursive style.

Gilbert R. Cisneros, Jr.

Enclosure:  
As stated

cc:  
The Honorable Roger Wicker  
Ranking Member



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WASHINGTON, D.C. 20301-4000

**MAR 10 2023**

The Honorable Patty Murray  
Chair  
Committee on Appropriations  
United States Senate  
Washington, DC 20510

Dear Madam Chair:

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cc:  
The Honorable Susan Collins  
Vice Chair



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**MAR 10 2023**

The Honorable Mike D. Rogers  
Chairman  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Chairman:

The Department's response to section 731 of the William M. (Mac) Thornberry National Defense Authorization Action Act for Fiscal Year 2021 (Public Law 116-283), "COVID-19 Military Health System Review Panel." Section 731 requires the Military Health System (MHS) to conduct a review of the response of the MHS to coronavirus disease 2019 (COVID-19), including strengths and weaknesses and to make appropriate recommendations in six "domains" relating to the MHS.

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As stated

cc:  
The Honorable Adam Smith  
Ranking Member



PERSONNEL AND  
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**UNDER SECRETARY OF DEFENSE**  
4000 DEFENSE PENTAGON  
WASHINGTON, D.C. 20301-4000

**MAR 10 2023**

The Honorable Kay Granger  
Chairwoman  
Committee on Appropriations  
U.S. House of Representatives  
Washington, DC 20515

Dear Madam Chairwoman:

The Department's response to section 731 of the William M. (Mac) Thornberry National Defense Authorization Action Act for Fiscal Year 2021 (Public Law 116-283), "COVID-19 Military Health System Review Panel." Section 731 requires the Military Health System (MHS) to conduct a review of the response of the MHS to coronavirus disease 2019 (COVID-19), including strengths and weaknesses and to make appropriate recommendations in six "domains" relating to the MHS.

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Gilbert R. Cisneros, Jr.

Enclosure:  
As stated

cc:  
The Honorable Rosa L. DeLauro  
Ranking Member

# Report to the Congressional Defense Committees



## COVID-19 Military Health System Review Panel

**March 2023**

The estimated cost of this report or study for the Department of Defense (DoD) is approximately \$772,000 for the 2021 Fiscal Year and \$551,000 for the 2022 Fiscal Year for a total of \$1,323,000. This total estimate includes \$991,000 in expenses and \$332,000 in DoD labor.

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## **Introduction**

This report is submitted in response to section 731 of the William M. (Mac) Thornberry National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2021 (Public Law 116–283) (“section 731”), which requests that the Secretary of Defense shall establish a panel to review the response of the Military Health System (MHS) to coronavirus disease 2019 (COVID-19) and the effects of COVID-19 on such system, including by analyzing any strengths/weaknesses of such system as a result of COVID-19, and make recommendations as the panel considers appropriate.

## **Executive Summary**

Section 731 requests that the Secretary of Defense provide to the congressional defense committees a report on the response of the MHS to COVID-19 and the impact of COVID-19 on the MHS and recommendations for improvements in anticipation of future public health emergencies (PHEs).

In accordance with the process and structure prescribed in section 731, the Secretary of Defense established a Panel consisting of:

- The President, Uniformed Services University (USU) (Chair);
- The Surgeons General of the Military Departments (MILDEPs);
- The Joint Staff Surgeon (JSS);
- The Director, Defense Health Agency (DHA);
- The Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight (DASD(HRP&O)); and
- The Deputy Assistant Secretary of Defense for Health Resources Management and Policy (DASD(HRM&P)).

Building on the internal MHS After-Action Review (AAR) conducted from May through December 2020, the Panel established working groups to review the 11 elements required by section 731, then integrated the findings and recommendations into the six domains identified in section 731: policy, practice, organization, manning level, funding level, and legislative authority.

Overall, the Panel determined that the MHS responded to the COVID-19 pandemic with skill, agility, and imagination, providing essential and timely support to civil authorities as part of the “whole of Government” preventive health strategy and careful implementation of appropriate measures against the virus. Within that general finding, the Panel further identified some 101 specific findings and associated recommendations, all of which are designed to sustain strengths and address weaknesses within the MHS.

The Department of Defense (DoD), including the MHS, should take enormous pride in what we have accomplished thus far in the face of an unprecedented PHE, learning invaluable lessons as we have progressed through the pandemic. The challenge now is to continuously apply these identified lessons learned, take appropriate, rapid, and decisive action to continue protecting

DoD for the duration of the COVID-19 pandemic, and then refine plans based on additional epidemiological and virological data to minimize impacts of future SARS-CoV-2 outbreaks.

This report contains the findings that were developed through April 2021 and then “refreshed” through September 2022.

## **Background**

The COVID-19 pandemic has had a major impact on the DoD and its MHS, including the management of the pandemic within the DoD and the MHS’s larger role in supporting the “whole of Government” response to the virus. Under conditions of extreme institutional stress, the DoD, including the MHS, has performed admirably, maintaining a laser focus on the warfighter missions and readiness along with supporting the needs of the American people. As a resilient, highly reliable organization, the DoD has aggressively captured the lessons learned from the response to the pandemic and has made immediate process improvements. The following summarizes the Panel’s findings through September 2022. Key components of the AAR process include the following:

**a. The MHS AAR.** In April 2020, the Assistant Secretary of Defense for Health Affairs directed an MHS AAR under the coordination and leadership of the President of the USU. This process included full participation of all the principal organizations within the MHS. As outlined in the Letter of Instruction from the Assistant Secretary of Defense for Health Affairs, this AAR was designed “to capture MHS actions, discern lessons learned, and prepare the MHS to enhance the support for future public health crises as part of the DoD COVID-19 Lessons Learned LOE [Line of Effort].” The Letter of Instruction directed that the AAR focus on sustaining strengths and overcoming weaknesses that were highlighted and exposed during the response to the pandemic.

Most of the lessons learned and associated recommendations concerned internal DoD/MHS processes and improvements.

**b. The 731 Report.** Section 731 provides that the panel shall:

“(A) Review the response of the military health system to the coronavirus disease 2019 (COVID-19) and the effects of COVID-19 on such system, including by analyzing any strengths or weaknesses of such system identified as a result [of] COVID-19; and

(B) Using information from the review, make such recommendations as the panel considers appropriate with respect to any policy, practice, organization, manning level, funding level, or legislative authority relating to the military health system.” (Note: For the purposes of this report, we identify these six areas as “domains”).

**c. The COVID-19 Dynamics.** This section 731 report contains extensive findings based on the lessons learned from the pandemic through September 2022. The associated recommendations have been integrated into the Department’s comprehensive Biodefense Posture Review. The U.S. Government (USG) and DoD continue to respond to the COVID-19 pandemic, and the

DoD, including the MHS, are continuing beyond the end date of this report to learn new lessons with each passing day.

### **Section 731 Process**

**a. The Panel.** In accordance with section 731, the membership of the Panel consists of:

- The President, USU;
- The Surgeons General of the MILDEPs;
- The JSS;
- The Director, DHA;
- The DASD(HRP&O); and
- The DASD(HRM&P).

To this statutory membership, the chair of the panel, the President of USU, added the following advisory non-voting members:

- The Medical Officer, U.S. Marine Corps;
- The Joint Surgeon, National Guard Bureau;
- The Command Surgeon, Space Force; and
- The Deputy Assistant Secretary of Defense for Health Services Policy and Oversight.

**b. The Executive Committee (ExCom).** To effect detailed coordination, an ExCom was formed consisting of senior representatives from each panel member organization. The ExCom met regularly to assess progress on the element reviews required by section 731, addressing gaps and seams in efforts, and identifying issues that required resolution.

**c. Element Review Working Groups (ERWGs).** As specified in section 731, the Panel was organized in the identified 11 Element Review categories. Each organization represented on the Panel chaired at least one of the working groups, as noted in Figure 1. The ERWGs consisted of representatives from the identified organizations, who conducted a detailed analysis of their assigned elements and developed recommendations for potential MHS process improvements. Their findings and recommendations were aligned under the six “domains” (policy, practice, organization, manning level, funding level, and legislative authority) specified in section 731. The 11 Element Reviews were:

- Policy, including force health protection and medical standards for appointing, enlisting, and inducting individuals into the Armed Forces;
- Public health activities, including risk communication, surveillance, and contact tracing;
- Research, diagnostics, and therapeutics;
- Logistics and technology (including vaccinations);
- Force structure and manning;
- Governance and organization;
- Operational capabilities and operational support;
- Education and training;



- Health benefits under the TRICARE program;
- Engagement and security activities relating to global health; and
- The financial impact of COVID-19 on the MHS.

Review Element	Lead
Policy	DASD(HRP&O)
Public Health	DHA
Research, Diagnostics and Therapeutics	DHA
Logistics and Technology	Air Force
Force Structure and Manning	Army
Governance and Organization	Army
Operational Capabilities and Support	Office of the JSS
Education and Training	Navy
TRICARE	DHA
Global Health	USU
Financial Impact	DASD(HRM&P)

**Table 1. Section 731 Review Elements**

**d. Integration with the MHS AAR Final Report.** Each of the 11 ERWGs used the findings and recommendations contained in the MHS AAR Final Interim Report as a foundation for its work. The ERWGs added input based on further analysis and ongoing lessons learned from each of the MHS components to generate a comprehensive set of findings. The source materials used for the Element Reviews were all unclassified.

**e. Fusion of the Element Reviews.** Using the 11 Element Reviews, the Panel staff integrated the findings to align them under the six domains specified in section 731. The process is depicted in Figure 2.

**f. Final Review.** After compiling the integrated report, the Panel reviewed, modified, and prepared a report for submission to the congressional defense committees.

**g. Substantive Interim Report.** Because of the dynamics of the pandemic, the Department submitted a substantive interim report to the congressional defense committees on April 21, 2022, with the expectation that a final Report to Congress would be completed no later than December 31, 2022.

**h. Final Report.** This final report focuses on the findings that the panel determined. The associated recommendations are being considered as part of an overall DoD implementation plan that is under development.

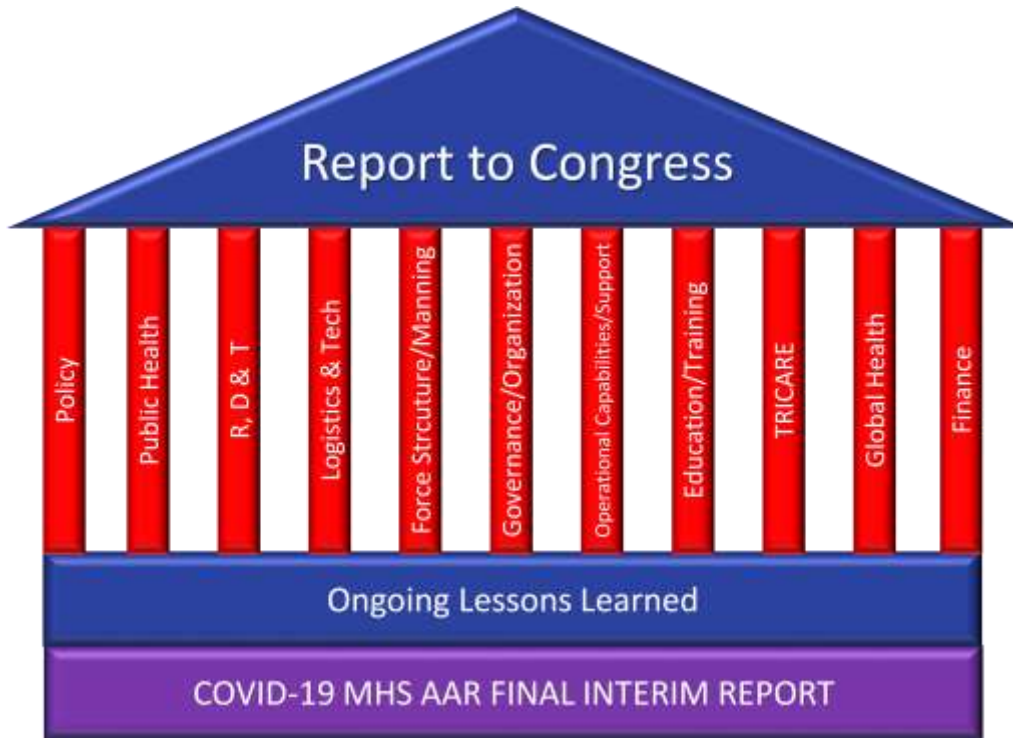


Figure 1: Report Foundations

## Findings

Overall, the MHS effectively responded to the pandemic—assessing, implementing, monitoring, and executing with skill, agility, and imagination. The MHS COVID-19 response highlighted both weaknesses and strengths in the MHS. The MHS and DoD are taking action to implement new or improved processes where needed, enhance our uniformity of efforts, and optimize our solutions to current problems. This approach will allow for a more robust response to current and future pandemics and PHEs.

Using the methodology previously outlined, the 11 ERWGs generated a series of findings. They are organized by topic under the six domains (policy, practice, organization, manning level, funding level and other findings).

### a. Policy

#### 1. Force Health Protection (FHP) Guidance

##### Findings:

- i. Timely FHP and travel/restriction of movement (ROM) guidance mitigated the spread of COVID-19 within the DoD. To address the rapidly expanding impact of the pandemic, 24 FHP guidance supplements were issued, covering a wide range of mitigation strategies (e.g., ROM, the wearing of masks, physical distancing) that closely mirrored the recommendations from the Centers for

Disease Control and Prevention (CDC). Notably, difficulties were experienced in developing and operationalizing FHP measures that reversed longstanding guidance regarding local-level risk assessment and decision making. Additionally, there were uneven applications of FHP guidance at the installation level, which generated some confusion. During the later stages of the pandemic, these issues were more successfully addressed.

- ii. The variance in response and decision making were a result of local installation commanders having the latitude and authority to modify or override FHP guidance, based on their local assessment and perceived risk to mission.
- iii. FHP was generally focused on continental United States (CONUS) installations, creating issues for installations outside the continental United States (OCONUS), based on different cultural environments and the availability of services and capabilities.

## **2. Case Tracking and Reporting**

Finding: Case tracking and reporting did not have a single, uniform, and rapidly adaptable department-wide repository to accommodate emerging information requirements. Additionally, this repository was unable to rapidly generate meaningful data analysis and modeling at the departmental level, leading to stove-piped and disparate findings, resulting in an inability for many months to evaluate the effectiveness of evolving policies in a timely or holistic manner.

## **3. Public Health Surveillance Policy**

Finding: Roles and responsibilities identified in Department of Defense Directive 6420.02, “DoD Biosurveillance,” and related to biosurveillance for MHS organizations were not clearly defined, leading to suboptimal coordination within the MHS and with other Federal agencies.

## **4. Public Health Emergency Management (PHEM) Policy**

Findings:

- i. Key personnel did not consistently have defined roles and responsibilities across the enterprise, and where there were roles and authorities, execution of those authorities was sometimes precluded or obscured by departmental and administration guidance. This inconsistency underscored the need for an adaptable and scalable PHEM policy that factors both internal and external influencers. Decision authorities need to be clearly defined, with a decision framework for delegation of authority related to risk mitigation activities. Such activities include health protection conditions and ROM.

- ii. To address this issue, the Department of the Air Force updated the Air Force Incident Management System to include a PHEM Incident Lead role for Public Health Emergency Officers (PHEOs) and Medical Emergency Managers (MEMs).
- iii. There was a gap identified in Department of Defense Instruction (DoDI) 6200.03, “Surge Capabilities and Procedures for Health Care in DoD Public Health Emergencies,” regarding coordination of PHEM responses at the theater, command center, Combatant Command (CCMD), and global levels. Roles and responsibilities, regarding declaring DoD PHEs and exercising blanket emergency health powers for installations in the respective area of responsibility (AOR), need clarification.

## **5. Contact Tracing Policy**

Finding: DoD lacks a clearly defined policy and associated plan to provide guidance for contact tracing during a personnel surge within a pandemic and how to quickly provide training for these personnel.

## **6. Research Priorities Policy**

Finding: Early in the pandemic, the MHS research enterprise rapidly pivoted to intense COVID-19-focused research. This shift of research priorities left other established research priorities and activities in abeyance, affecting long-range MHS research activities. Some research funding expired at the end of FYs 2020 and 2021. In other cases, the windows for data collection or monitoring passed, limiting the accuracy of the final research conclusions.

## **b. Practice**

### **1. Preparedness**

Finding: The MHS as an integrated enterprise was not fully prepared to provide an immediate and robust response to the pandemic as it emerged in January 2020 and throughout the first wave in 2020. The military component of medical care is structured for wartime. Service medical capability is aligned to support military operations, not pandemic response or Defense Support of Civil Authorities (DSCA).

### **2. Vaccination Development and Implementation**

Findings:

- i. A variety of inputs and guidance regarding vaccination policies, distribution, and administration procedures presented challenges to timely implementation and execution across the MHS.

- ii. Multiple challenges exist in navigating the privacy/Health Insurance Portability and Accountability Act and legal issues surrounding COVID-19 vaccinations.
- iii. Challenges were encountered with consistent vaccine documentation and integrity in the various MHS information technology systems.
- iv. Delays in shipping vaccine ancillary supplies caused discontinuities in vaccine administration.
- v. Vaccine distribution was misaligned with demand signal.
- vi. Vaccine administration in military medical treatment facilities (MTFs) was disjointed, with no master process template. MTF issues included:
  - a) Applying the current DoD schema to a diverse catchment population;
  - b) Advertising vaccine for the unconnected geriatric population, including those without internet access;
  - c) Processing geriatric patients through a high-volume shot line;
  - d) Getting vaccines to geographically separated units;
  - e) Charging fees for providing vaccinations to host nation employees in OCONUS installations; and
  - f) Accounting for beneficiaries who opt to be vaccinated at commercial sites.
- vii. There were initial shortages in key personnel trained in vaccine administration, particularly in documentation.
- viii. A percentage of the eligible beneficiary and employee populations, including military personnel, opted not to receive the vaccination.

### **3. Controlling COVID-19 within DoD**

#### Findings:

- i. Physical distancing, quarantine, isolation, and other FHP measures helped mitigate the spread of COVID-19 and other communicable diseases, keeping the pandemic from affecting operational readiness, as measured by low rates of morbidity and mortality in the DoD community. Rapid development, deployment, and use of innovative measures (e.g., COVID-19 anesthesia hoods) aided in mitigating the spread of the pandemic in controlled military environments.

- ii. Rapidly deploying forces across the U.S. Indo-Pacific Command\_AOR did not have adequate pre-deployment protocols, which impacted on critical services such as mess halls and general facilities, along with unit movements.
- iii. While stocks of Personal Protective Equipment (PPE) and other pandemic-associated equipment were adequate for MHS requirements, there were demands placed on MHS stockages by activities, entities, and installations outside of the MHS as well as outside of DoD, as part of the “whole of Government” response.
- iv. The U.S. industrial base heavily relies on China for its medical material. Raw materials or medical devices components sourced from China could be compromised in the U.S. military medical supply chain.
- v. There were challenges related to physical space and design of DoD and Veterans Health Administration healthcare facilities for controlling the spread of an infectious agent. The small number of rooms with negative-pressure capabilities made it difficult to isolate patients with known or suspected COVID-19 infections. Small waiting rooms also made social distancing a challenge. Negative-pressure rooms are essential for preventing the spread of respiratory pathogens when patients undergo invasive procedures such as intubation.

#### **4. Common Operating Picture (COP)**

Finding: DoD, and particularly the COVID-19 Task Force managed by the Office of the Under Secretary of Defense for Policy, created a COP that included pandemic-related information (e.g., the number of COVID-19 cases, hospitalizations, and deaths across DoD). Within the MHS, maintaining a COP was challenging, with multiple commands and agencies issuing sometimes conflicting perspectives on day-to-day operations, requirements, and actions.

#### **5. Telehealth**

Findings:

- i. The MHS rapidly shifted care delivery to telemedicine but has not implemented a unified virtual/telehealth strategy. The need to increase physical distancing and decrease the quantity of patients engaging directly with the MHS resulted in an increased need for telemedicine support.
- ii. This increased need for telemedicine support was manifest throughout the MHS, including for personnel located OCONUS. The MHS was required to expand and encourage the use of telemedicine, and the response from providers and patients was positive.
- iii. The overall MHS strategy for the use of virtual health solutions across the MHS has yet to be fully implemented.

## **6. Clinical Practice Guidelines (CPGs)**

Finding: The MHS rapidly produced more than six sets of comprehensive CPGs in coordination with MILDEP subject matter experts, but communication and implementation were not consistent across the MHS. CONUS and OCONUS MTFs lacked timely updates to the CPGs.

## **7. Testing Operations and Capabilities**

### Findings:

- i. The MHS demonstrated that it was able to develop near immediate testing capability and initial testing capacity using legacy instruments that were compatible with the CDC's National Laboratory Response Network (LRN). Diagnostic capability positioned DoD ahead of the private sector, but the LRN will be phased out of use by CDC in the near term. This may impact on MHS testing capabilities.
- ii. In certain OCONUS areas, MTFs were the sole authorized site for testing of Status of Forces Agreement (SOFA)-covered personnel; individual SOFA-covered members were not authorized to use private host national testing facilities. Moreover, local contracts and procurement of testing supplies varied throughout the pandemic.

## **8. DoD Research Capabilities**

Finding: DoD's in-house scientific expertise was instrumental in addressing research on high-containment pathogens, coronavirus research, and vaccine development, with therapeutics clinical trials beginning as early as February 2020. DoD's experience with high-containment infectious disease research provided the groundwork to enable the rapid generation of effective FHP guidance documents early in the pandemic response.

## **9. Field Testing and Research**

### Findings:

- i. The DoD labs were able to provide support to operational forces for testing and research (epidemiology). However, there is a gap in organic capability to do field tests and research, including comprehensive evaluations within the medical force.
- ii. Clinical laboratories located within the MTFs and supporting research reference laboratories lacked the infrastructure, capabilities, and materials to rapidly respond to the magnitude of testing required for DoD's testing needs during the pandemic.

## 10. MHS Support to Civil Authorities

### Findings:

- i. The MHS provided a range of support to civil authorities that proved to be invaluable in response to COVID-19.
- ii. DoD deployed multiple assets, including: two Navy hospital ships, several Navy Expeditionary Medical Facilities, Army Combat Hospital Centers, Army Reserve Urban Augmentation Medical Task Forces, and Air Force Expeditionary Medical Support units. These assets provided surge medical support on ships, at alternate-care facilities, and in civilian hospitals and nursing homes.
- iii. The MHS deployed personnel to support civil authorities in administering vaccinations throughout the United States.
- iv. DoD's capacity for medical aid to civilian authorities is limited due to increased internal requirements for medical care for DoD personnel and beneficiaries.
- v. Some of these deployed medical capabilities saw minimal or no utilization by civil authorities, resulting in depleted medical capability available for other requests from civil partners.
- vi. Medical capacity of the DoD to support civil authorities was greatly augmented by National Guard (NG) personnel. Civil authorities identified gaps in response capabilities, which triggered requests for NG assistance. NG medical personnel administered more than 15 million COVID-19 vaccinations to civilians, provided medical services in hospitals and nursing homes, and manned vast numbers of community COVID-19 testing sites.

## 11. Health Intelligence

Finding: Investments in medical intelligence capabilities and infectious disease made by DoD, including the MHS enterprise, were not adequate to meet the demands of this fast-moving event.

## 12. Information Technology (IT) Resources at MTFs

Finding: MTFs experienced issues with IT resources, including:

- i. Preexisting shortages of IT equipment, such as webcams, common access card readers, and laptops, due to budget cuts left the enterprise underequipped to transition to a virtual environment.



- ii. IT infrastructure was in the middle of a transition to DHA responsibility under the consolidated Med-COI network. This situation complicated the transition to a virtual environment because not all IT infrastructure fell under the same authority.
- iii. There was inadequate capability to conduct virtual health care because remote health applications were not yet approved, there were challenges with bandwidth, and access to the virtual private network was lacking. The DoD responded to the Department of Health and Human Services Office for Civil Rights-issued Notification of Enforcement Discretion for Telehealth Remote Communications during the COVID-19 Nationwide Public Health Emergency, which allowed covered health providers that wanted to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide PHE to use any non-public facing remote communication product that was available to communicate with patients.

### **13. Blood Supply**

#### Findings:

- i. The Armed Services Blood Program (ASBP) quickly adapted to emerging needs early in the pandemic
- ii. However, both DoD blood collection facilities and civilian blood agencies experienced critical shortages of consumable supplies and donors as the pandemic progressed. Access to donors was restricted due to ROM requirements, shipping was delayed, and supply chain issues resulted in a slowdown in the ability to position materials needed for blood product manufacture.
- iii. As the pandemic evolved, the Food and Drug Administration (FDA) approved the use of convalescent plasma. The ASBP was well positioned to run a coordinated multi-Service collection operation to identify and safely collect plasma from recovered COVID-19 patients.

### **c. Organization**

#### **1. Command and Control (C2)**

#### Findings:

- i. The pandemic occurred in the middle of the transferring of authority, direction, and control of MTFs from MILDEP management to DHA. This timing resulted in significant issues in doctrine, guidance, authorities, and unity of command.
- ii. The doctrinal and operational roles for DHA in the Department's contingency response for COVID-19 were unclear, causing duplication, confusion, and friction among the various MHS components and field activities. The confusion was

brought on in part by the transition of health care delivery from the MILDEPs to DHA.

- iii. The nature of response to a viral pandemic required application of significant clinical capabilities integrated with MILDEP responsibilities to organize, train, equip, deploy, and exercise C2 over operational medical forces.
- iv. The pandemic impeded progress in implementing the public health transition required by section 711 of the NDAA for FY 2019. Establishment of the DHA Public Health organization will provide an opportunity to reduce duplication of effort and streamline response to future public health events, emergencies, and crises.
- v. Effective communication and collaboration among MHS component C2 elements were uneven and inadequate during the pandemic response.

## **2. Organizational Authorities**

Finding: The absence of an authoritative source for data, analysis, and modeling resulted in confusion. It was routine during the pandemic for CCMD, MILDEP-specific, and other DoD data and modeling reports to differ in findings and processes. Most discrepancies were resolved, but the lack of authoritative data sources and/or arbiters hindered efforts to reconcile divergent findings quickly.

## **3. DSCA**

### Findings:

- i. Federal partners, States, and regions imposed significant expectations and demands on DoD to provide critical operational capability in response to the COVID-19 pandemic.
- ii. The coordination of medical DSCA operations was less than optimal at multiple levels.
- iii. There was insufficient capacity within the health care system for a significant COVID-19 pandemic response. DoD can provide additional medical support to a community but will face challenges in balancing support to the DoD beneficiary population.
- iv. NG mobilizations successfully satisfied most assistance requests tendered by civil authorities. In many instances, however, NG medical assets were not mobilized so that those health care workers could remain in their critical civilian health care roles.

#### **4. Public Health Operations**

Finding: Effective communication among MHS component pandemic C2 elements was not adequate or consistent. DoD has no clear risk communication plan within the DoD or external to the (public-facing) audiences.

#### **5. Research Enterprise Emergency Management**

Findings:

- i. The rapid initiation of new research and development (R&D) projects in response to COVID-19 led to deviation from well-established requirements-based processes. The initiation of multiple projects across several technical areas and organizations before a comprehensive development strategy was clearly outlined produced suboptimal results.
- ii. The MHS was able to discern quickly that the threat was a novel coronavirus. Research on previously identified novel coronaviruses (e.g., severe acute respiratory syndrome and Middle East respiratory syndrome and other ribonucleic acid viruses) informed DoD's understanding of the threat and enabled DoD R&D stakeholders to swiftly initiate medical countermeasures development and treatment plans.

#### **6. Medical Materiel**

Findings:

- i. Policy for allocation of medical materiel had unclear lines of authority, dated policy guidance, and broad priorities from DoD, which led to inconsistent execution across the system.
- ii. At the inception of the USG's COVID-19 response, the MHS lacked a task force or designated lead to synchronize MHS-wide medical materiel management. That weakness was addressed in the first few months of the pandemic.
- iii. DoD public emergency policies were not clear on ownership and release authority for PPE, specifying only that pandemic stocks were assigned to the operational control of MTF commanders.

#### **7. Processing TRICARE Claims COVID-19 Related Services**

Findings:

- i. DHA proactively developed health benefit policy, reimbursement, and claims processing requirements to ensure access to care. Examples included adding provider licensing flexibility, removing copayments for telehealth services to

encourage their use, and eliminating copayments for diagnostic COVID-19 testing consistent with statutory requirements.

- ii. DHA promulgated rulemaking to: 1) authorize coverage for treatment use of investigational drugs under FDA's expanded access program to treat COVID-19; and 2) authorize coverage of routine costs associated with National Institute of Allergy and Infectious Diseases-sponsored clinical trials for the treatment and prevention of COVID-19.
- iii. The managed care support contractors (MCSCs) deferred or manually paid claims and implemented initiatives to update pricing systems to ensure COVID-19 claims were tracked properly and to add parameters to the annual risk registry so that DHA could monitor and track potentially fraudulent COVID-19 claims.
- iv. TRICARE MCSCs paid TRICARE providers more than once for administering the first and second doses of COVID-19 vaccines. There were also instances where TRICARE MCSCs applied cost shares for the administration of COVID-19 vaccines, even though the DHA waived cost share requirements.
- v. TRICARE MCSCs paid providers to administer vaccines in a manner that did not meet CDC requirements.

#### **d. Manning Level**

##### **1. Force Structure**

###### Findings:

- i. Although the MILDEPS had adequate force structure at the beginning of the pandemic to support civil authorities, the deployment of uniformed personnel away from their MTFs created gaps in MTF coverage that resulted in the reduction of clinical and public health services, with associated impacts on the "Medically Ready Force."
- ii. OCONUS installations and units confronted challenges. COVID-19 stressed the entire medical system, limiting the ability for personnel to transfer, halting and delaying medical evacuation operations, and expanding gaps in hiring actions. Illnesses of one-of-one providers caused significant interruptions in specialty medical treatment. OCONUS MTFs that relied heavily on the local Private Sector Care (PSC) network could not provide medical services for dependent populations when the PSC network collapsed due to unprecedented demand.
- iii. The COVID-19 pandemic stressed the ability of the MHS to rapidly identify and mobilize medical professionals in support of an unplanned contingency, particularly in specific specialties (infectious disease providers, critical care nursing, and emergency medicine providers). Showing the dual demand created

from a need for an operational force to deploy providers while also demonstrating a continued or increased demand on U.S. MTF staff.

- iv. The pandemic highlighted risks associated with the differences in the way that MILDEPS report unit readiness for medical force elements. While Chairman of the Joint Chiefs of Staff Instruction 3401.02B, “Force Readiness Reporting,” requires units to report a C level based on Personnel/Supply/Equipment Readiness/Training metrics, the MILDEPS widely vary on how those data are reflected.
- v. Section 5 of DoDI 6200.03 tasks the MTFs with identifying resources to meet surge demands. This tasking includes special work schedules, increased use of Reserve Component members, intermittent employees, re-employed annuitants, contractor personnel, and volunteers. The tasking also requires coordination with the TRICARE MCSC.
- vi. The medical specialties in highest demand from the civilian sector for DoD to provide were many of the same the specialties required for warfighting and for which DoD has had chronic shortages.

## **2. Accessions**

### Findings:

- i. COVID-19 adversely affected recruiting, accession, and entry-level training activities. This issue was mitigated through ROM measures.
- ii. DoD successfully continued the accessions and initial training process but had to apply lessons learned in real time to decrease transmission rates and accomplish training.

## **3. Global Health Engagement (GHE) Operations**

### Findings:

- i. GHEs with partner nations were essential for providing actionable situational awareness and investigation of outbreaks. However, the global public health and biosurveillance communities were not well integrated and funded to address the threat posed by disease and biological agents.
- ii. Difficulties continue to exist in implementing multiyear GHE plans to cooperatively build essential capacities and capabilities to enhance partner nation resilience and interoperability.

#### **4. Concept of Operations (CONOPS)**

##### Findings:

- i. The domestic military response evolved to include four medical CONOPS: (1) deploying medical units; (2) establishing expeditionary medical facilities; (3) establishing operations in existing military medical facilities and/or operating in fully developed alternate care facilities; and (4) embedding medical personnel within existing local non-military facilities. Embedding was found to be the most effective use of military personnel and assets.
- ii. The CCMDs and MILDEPs were able to quickly adjust the way in which forces were organized and employed to meet the dynamic threat posed by COVID-19.
- iii. Extant CONOPS focused on CONUS installations and were sometimes unable to quickly adapt to OCONUS challenges.

#### **5. PHEM Personnel**

##### Findings:

- i. Across the DoD, there were insufficient numbers of qualified PHEM personnel and other resources at the outset of the COVID-19 pandemic, based on the requisite training requirements for PHEOs and MEMs published in DoDI 6200.03. Limitations on training throughput, faculty availability, support resources, and command buy-in all contributed to this shortfall.
- ii. Additionally, PHEOs were required to be clinicians to provide installation commanders with qualified medical advice about responding to public health emergencies. Not all DoD installations had intrinsic medical capabilities, and some PHEOs serve multiple installations. Further complicating this workload, the role of PHEO was a collateral duty on top of other responsibilities, including seeing patients. Often, PHEO duties for preparedness, planning, and networking with other civilian and military providers were secondary priorities.

#### **6. Personnel Burnout**

Finding: Within the MTFs (as well as across the entire U.S. health enterprise), there were serious personnel challenges stemming from personnel burnout. These challenges included increased exhaustion, depression, sleep disorders, and other mental health/substance abuse issues among the personnel suffering burnout. In some instances, this burnout resulted in lower quality of care, absenteeism, high turnover rates, staffing shortages, and more. The problem was greatest in emergency departments and urgent care clinics, who were the frontline care providers for COVID-19 patients.

## **e. Finance Level**

### **1. Rapid Funding Processes**

Finding: DoD moved emergency funding early to DoD commands for execution. However, the rate of obligation and contracting/execution was too slow. The complexity of the R&D contracts for an emergency response effort requires greater flexibility on Office of the Secretary of Defense obligation and execution parameters.

### **2. COVID-19 Countermeasures Investments**

Finding: Previous DoD investments in platform technologies to test and evaluate medical countermeasures were invaluable in accelerating therapeutic discovery to inform CPGs.

## **f. Other**

### **1. TRICARE Performance**

Findings:

- i. Policy decisions that restricted access to MTFs for certain diagnostics and elective procedures drove beneficiaries to the PSC network and TRICARE in unexpected numbers.
- ii. TRICARE, as a program under the direction of DHA, was slow to approve certain telehealth (e.g., audio-only, telephonic office visits) and other treatment options and did not clearly communicate new service options and cost shares to beneficiaries. This situation resulted in numerous challenges, including hundreds of beneficiaries being denied access to Intensive Outpatient Programs and Partial Hospital Programs via telehealth. To address some of these issues, DHA TRICARE published an interim final rule to provide additional telehealth flexibilities. DHA did not have the necessary authorities like those available to the Centers for Medicare and Medicaid services to waive statutory constraints on telehealth services without rulemaking.
- iii. As the pandemic developed, DHA responded by creating information “toolkits” that facilitated consistent and authoritative messaging to the PSC network.
- iv. DHA/TRICARE had issues with requests for exceptions to policy and clarifications’ being handled through unofficial channels. These issues included Requests for Information that were sent directly to points of contact via telephone, email, or face-to-face meetings.

## **2. Vaccinations and Testing for Non-Eligible Personnel During a Pandemic**

Finding: To protect the Armed Forces during COVID-19 and ensure operational readiness, consideration must be given to those individuals with whom Service members regularly come into contact in a work environment, including DoD contractor personnel, DoD civilian employees, volunteers, students, visitors, third-country nationals, refugees, foreign nationals employed by DoD, and non-appropriated fund employees. Although these individuals are not eligible beneficiaries of the MHS, they are essential to the effective management of a pandemic, both within DoD and in supporting civilian authorities.

## **3. “No-Year” Funding**

Finding: The limited period of availability for pandemic response funding adversely affected the efficient use of resources. Disaster response and recovery (to include pandemics) are rarely aligned to fiscal years.

## **4. Economy Act Application**

Finding: The use of the provisions of the Economy Act, 31 U.S.C. § 1535, facilitated the rapid exchange of funding, goods, and services between the National Institutes of Health and elements of the MHS research enterprise through cooperative agreements.

## **Conclusion**

The DoD, including the MHS, should take enormous pride in what it has accomplished in the face of an unprecedented PHE, learning invaluable lessons as the MHS progressed through the pandemic. Even as the DoD continues to manage the COVID-19 pandemic, the MHS must assess and address the important findings in this Report and develop an effective action plan to take rapid and decisive action so that the MHS and its components are better prepared for any future public health uncertainties while continuing to execute their vital missions in support of the American warfighter.



## Acronyms, Terms, and References

Acronym	Term
AAR	After-Action Review
AOR	area of responsibility
ASBP	Armed Services Blood Program
C2	Command and Control
CCMD	Combatant Command
CDC	Centers for Disease Control and Prevention
CONOPS	Concept of Operations
CONUS	continental United States
COP	Common Operating Picture
COVID-19	coronavirus disease 2019
CPG	Clinical Practice Guideline
DASD(HRM&P)	Deputy Assistant Secretary of Defense for Health Resources Management and Policy
DASD(HRP&O)	Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight
DHA	Defense Health Agency
DoD	Department of Defense
DoDI	Department of Defense Instruction
DSCA	Defense Support of Civil Authorities
ERWG	Element Review Working Group
ExCom	Executive Committee
FDA	Food and Drug Administration
FHP	Force Health Protection
FY	Fiscal Year
GHE	Global Health Engagement
IT	information technology
JSS	Joint Staff Surgeon
LRN	Laboratory Response Network
MCSC	managed care support contractor
MEM	Medical Emergency Manager
MHS	Military Health System
MILDEP	Military Department
MTF	military medical treatment facility
NDAA	National Defense Authorization Act
NG	National Guard
OCONUS	outside the continental United States

PHE	public health emergency
PHEM	Public Health Emergency Management
PHEO	Public Health Emergency Officer
PPE	Personal Protective Equipment
PSC	Private Sector Care
R&D	research and development
ROM	restriction of movement
SOFA	Status of Forces Agreement
USG	U.S. Government
USU	Uniformed Services University