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The term “Transformation” has been used so much lately it is almost a cliché. The entire Navy is undergoing deep, important changes that will lead to a smaller, but more capable, future force. Neither Navy Medicine nor the Naval Reserve Force is exempt from participation in these changes.

In July 2003, VADM Cowan asked me to lead an integrated process team (IPT) to address the transformation of the Naval Reserve Medical Force. In this effort, I was ably assisted by CAPT Stephen Frost, a recalled Reserve medical officer at BUMED, and a team of participants that included Selected Reservists and Active Component personnel, officers of all four designators, and members from both our enlisted ratings. Our task was to create a more agile, effective Reserve medical force that could better meet the clinical and operational requirements of Navy Medicine. The IPT met bimonthly in person and by telephone conference calls and reported out in April 2004.

Concurrently, Navy Medicine was integrating its active duty medical and dental commands to reduce the number of command “flagpoles” in the interest of administrative efficiency and improved health service delivery to our beneficiary populations. Likewise, substantial redefinition of operational capabilities was underway. Noteworthy was the need for smaller, lighter expeditionary medical facilities to replace the larger, static 250-500 bed fleet hospitals that have been a centerpiece of our operational medical armamentarium. Additionally, new capabilities such as forward-deployed preventive medicine units and the forward resuscitative surgical system are being

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tested and used in the updated operational scenarios that confront Navy Medicine.

As a result of mobilizations during the past two years, it is clear that the prior model of Reservists serving simply as a “backfill” capability in support of medical treatment facilities (MTFs) was not a model designed either to ensure a robust Reserve medical force or to provide optimal support for active duty Navy Medicine. The civilian leadership of DoD had permitted only a 47 percent mobilization to our MTFs (i.e., about one Reservist mobilized for every two Active Component personnel deployed forward). Further, the use of Reserve medical assets only in a backfill role clearly suboptimized the impressive capabilities that Reserve medical personnel brought to the fight when used in more creative, forward-deployed roles during recent engagements in the War on Terrorism.

Initially, the IPT investigated various models of Reserve employment as practiced by the Army and Air Force Reserve, as well as other components of the Naval Reserve, such as the Merchant Marine program. Vigorous debate ensued among IPT members as to the variety of innovative opportunities for employment of Reserve health service personnel that were available to us. Eventually, the model that was struck upon was the creation of operational health support units (OHSUs).

These OHSUs would be centered on the current eight active duty MTFs as well as the current Reserve Fleet Hospitals (FH) headquartered at Great Lakes and Dallas. As the active Naval Dental Clinics integrate with their corresponding MTFs, so to the Reserve Naval Dental Clinic units will integrate with the corresponding reserve MTF or FH unit. Each Reserve member will be tasked for potential employment at the parent stateside treatment facility or for deployment forward to an operational capability (e.g., hospital ship, forward-deployed preventive medicine unit, expeditionary medical facility, etc). Thus, Reservists become doubly valuable

both for the clinical capability they offer in CONUS and, also, for their operational capability in a forward-deployed setting. This contributes greatly to the overall capability of the Naval Reserve Medical Force’s ability to integrate, augment, and sustain the active duty Navy medical department.

As with the current structure of Programs 32 and 46, each OHSU has a headquarters unit collocated with the active duty command that it supports and housing all of the unit’s billets. The detachments of a particular OHSU are geographically arrayed around its headquarters and house the personnel of the OHSU drilling at their local Reserve centers where they provide medical/dental readiness support to their shipmates in the Naval Reserve Force. They also train for their individual defined operational platform/capability and provide clinical service (where feasible) for the active duty medical treatment facility. The vast majority of Reserve centers will house only one OHSU detachment, thereby supporting improved command and control of the unit and its personnel in mission accomplishment. Only in fleet concentration areas, where there are unusually large numbers of medical department Reservists, will there be more than one OHSU detachment assigned to a given center. Leadership opportunities will be available on a best-qualified, designator-neutral basis.

While the organizational structure of medical department personnel and units drilling in the operational units (Programs 5-Air, 7-Seabees, and 9-USMC) will remain unchanged, it is envisioned that enhanced coordination and cooperation among the OHSUs and their Naval Reserve Medical Force shipmates in these units will be emphasized to ensure full active/reserve integration and optimize health service support to all parts of the Navy-Marine Corps team. We will have more to say on the OHSUs and rightsizing of the Naval Reserve Medical Force in subsequent columns. ⚓