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IN REPLY REFER TO  
BUMEDNOTE 6440  
BUMED-M3F3  
30 Sep 2002

BUMED NOTICE 6440

From: Chief, Bureau of Medicine and Surgery  
To: Ships and Stations Having Medical Department Personnel

Subj: TIERED READINESS CONCEPT OF OPERATIONS

Ref: (a) NWP 1-03.3A (Rev. A) (Status of Resources and Training Status (SORTS))  
(b) BUMEDINST 6440.5B

Encl: (1) Casualty Receiving and Treatment Ship (CRTS) Tiered Readiness Concept of Operations (CONOPS)  
(2) Active Duty Fleet Hospital Unit Augmentation Rotation Schedule

1. Purpose. To provide a clear explanation of Tiered Readiness CONOPS, its impact on the Medical Augmentation Program (MAP), and to explain the difference between Tiered Readiness and the Readiness Reporting Measures used to represent individual unit readiness.

2. Background. To appropriately discuss Tiered Readiness, as it applies to the Medical Augmentation Program, it is essential to clearly understand the concepts of Readiness, Tiered Readiness, and Readiness Reporting as they apply to Naval forces (Navy and Marine Corps).

a. Readiness. The ability of the U.S. military to respond with the appropriate forces, with little or no warning, the cornerstone of the national military strategy. Integral to this concept of general readiness is the assumption that the individual units provided in response to the needs of the combatant commander have the ability to perform their assigned wartime roles in the manner for which they were designed. This unit readiness is essential for all assigned forces, whether combat or combat service support, and in a world of unconstrained resources every unit would be kept in the highest state of readiness at all times. Regrettably, fiscal and personnel constraints prevent the maintenance of all units in the highest level of readiness and a tiered approach to unit readiness was developed to meet the warfighting requirements of the combatant commander in the most cost effective manner while assuming minimal risk.

b. Tiered Readiness. The intent to have forces ready to deploy, or flow, into a theater of operations on a schedule that is established by the combatant commander. In other words, combat and combat service support units are scheduled to move into the theater of operations based on their capabilities and the needs of the operational environment. As would be expected, combat units are routinely the first to arrive with the combat service support elements (including medical) that are integral to their units. Follow-on combat units and increasingly capable logistics support (to include medical augmentation units) would then flow into the theater as operational or contingency plans mandate. Inherent to Tiered Readiness is a system to define

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which forces are designated to flow into theater first and which are designated as follow-on forces. These tiers, as they apply to Navy Medicine, are:

Tier I. Forward deployed and crisis response forces that are mission capable and ready to deploy within 10 days.

Tier II. Forces designated for the force build-up stage who are ready and capable of mobilizing and deploying within 60 days.

Tier III. Additional forces designated for further follow-on stages that are ready and capable of deploying within 180 days.

(1) While each tier provides a maximum number of days allowed for a unit to be considered as part of that specific tier, the numbers indicated should not be considered as time a unit would be allowed to plan for deployment in the event of a contingency.

(2) The geographic commander with cognizance over the theater of operations controls the required deployment date and time of arrival in theater for a specific unit. For example, if the Combatant Commander, Pacific Command (PACOM) requires and schedules a capability (e.g., Fleet Hospital (FH)) to deploy on day 11, this unit is still considered to be a Tier II unit. Had it been scheduled to deploy 2 days earlier on day 9 it would have then been considered a Tier I unit. As such, the Tier status of a unit should be considered a conceptual framework that gives a rough estimate of when a unit might be required in theater, based on the timelines associated with each tier. Actual deployment dates will be established based on the requirements outlined by the geographic commander and a Tier II unit may be required to deploy within the timeframe normally associated with a Tier I unit.

c. Readiness Reporting. While the tier status of operational forces represents the timeframe within which they are required to be in theater, a second factor is the process by which a unit's operational readiness is measured relative to similar units. In other words, how the deployable units report their readiness to meet their assigned mission in a consistent and measurable manner. The SORTS Joint Reporting – Navy (reference (a)), provides the baseline for operational readiness reporting and establishes the guidelines for the readiness reporting of personnel, training, and equipment. Based on metrics established to measure these three elements, SORTS provides five measures of unit readiness indicating the individual unit's self-reported ability to meet its mission:

C1. The unit is capable of undertaking the full wartime mission it was organized and designed for. It is considered fully combat ready.

C2. The unit is capable of undertaking the bulk of its wartime mission. It is considered substantially combat ready with only minor deficiencies reported.

C3. The unit is capable of undertaking a major portion of its wartime mission. While it has major deficiencies, it can still perform its assigned mission.

C4. The unit is unable to perform its wartime mission unless it is provided additional resources or training. However, if the situation warrants, the unit may still be required to perform portions of its mission using its existing resources.

C5. The unit is not able to perform its wartime mission and is not combat ready. Routinely this status is assigned to ships in major overhauls, which cannot be deployed because of the need for substantial maintenance.

(1) SORTS reporting is directly tied to operational commands and their ability to perform their wartime mission. As a result, the C-Status reported on these operational units is classified. However, Navy Medicine's readiness reporting requirements for the MAP units are unique and, with the exception of the four Reserve FHs, do not represent operational commands that are required to report their readiness via the SORTS system. Rather, MAP units represent personnel augmentation packages providing trained medical personnel to CRTSs, the Fleet Marine Force (FMF), Hospital Ships (T-AHs), and active duty FHs.

(2) With these augmentation packages representing only two portions of the normal SORTS reporting requirements, personnel and training, Navy Medicine found it necessary to develop a system of readiness measurement that would provide a systematic approach to the measurement process and closely parallel the reporting requirements of SORTS without mandating a classified reporting system. Readiness metrics reported by Navy Medicine MAP platforms are as follow:

(a) Personnel Status. Represented by the billet fill rate for a MAP platform calculated by dividing the total number of billets filled by the total number of platform billets.  $\text{Fill Rate} = [\text{sum}(\text{filled platform billets})]/[\text{sum}(\text{platform billets})]$ . Personnel readiness represented as a fill rate is measured as follows:

<b>Personnel Status</b>	<b>% Fill Rate</b>
P-1	85-100
P-2	75-84
P-3	65-74
P-4	< 65

(b) Training Status. Represented as a percent of personnel trained calculated by dividing the total number of personnel fully trained by the total number of personnel currently assigned to the platform.  $\text{Personnel Trained (as a \% trained)} = [\text{sum}(\text{personnel fully trained})]/[\text{sum}(\text{platform personnel})]$ . Training status represented as a percent of personnel fully trained is measured as follows:

<b>Training Status</b>	<b>% Personnel Trained</b>
T-1	85-100
T-2	70-84
T-3	55-69
T-4	< 55

(c) The MAP platform's overall Readiness Status (R-Status) is measured similarly to the C-Status noted previously. However, unlike C-Status the medical Readiness Status is limited to the first four definitions associated with C-Status (see paragraph 2c) and is based on the combination of the Personnel Status and the Training Status without reference to equipment status. The following provides a graphic demonstration of the R-Status:

<b>Medical Augmentation Program Readiness Status</b>		
<b>R-Status</b>	<b>% P-Status</b>	<b>% T-Status</b>
R-1	85-100	85-100
R-2	75-84	70-84
R-3	65-74	55-69
R-4	< 65	< 55

1. While R-1 Status is achieved by the P-Status and T-Status scores being in the ranges indicated, the overall R-Status cannot be higher than the P-Status regardless of the T-Status score achieved. As an example, while a MAP platform with an 82 percent fill rate may have been able to train 100 percent of the personnel assigned they can only be rated as R-2.

2. It is important to note that the C-Status, which takes into account equipment status, for MAP platforms remains a classified report that is maintained and tracked by BUMED M3F3.

(3) It is important to clearly understand that a unit's overall Readiness Status indicates the unit's self-reported ability to meet its full mission based on clearly established metrics. This information provides the parent activity commander and higher authority with a snapshot of the units capabilities during a given period in time and assists in identifying additional resources and training that are required to ensure the unit is fully mission capable in the event of deployment. The unit's Readiness Status has absolutely no impact on the tiered status of the unit and should not be presumed to be a barrier to deployment.

3. Applicability. This BUMED Notice applies to all Claimancy 18 commands with personnel assigned to the MAP.

#### 4. Tiered Readiness for Operational Platforms

##### a. CRTS Augmentation Teams

(1) Tier Status. There are currently eleven augmentation teams identified for the large deck amphibious ships (LHA/LHD) of the fleet. Four teams are maintained in a Tier I status for immediate deployment. CRTS augmentation teams are not maintained in a Tiered Readiness status lower than Tier II. The Tiered Readiness status for the individual teams is illustrated in enclosure (1).

(2) MAP Training Cycles. While the teams were originally assigned to individual ships, the Commander in Chief, Atlantic Fleet (CINCLANTFLT) and the Commander in Chief, Pacific

Fleet (CINCPACFLT) endorsed a BUMED proposed team rotation plan in December 2001 which rotates augmentation teams on a 2-year cycle without assignment to a specific ship. This 2-year plan allows both Fleets and medical treatment facilities (MTFs) to strategically plan for training requirements and clearly identify recently trained teams for operational requirements. Enclosure (1) also provides the current training plan and MTF team rotation.

b. FMF Augmentation Personnel

(1) Tier Status. The Tiered Readiness CONOPS for the provision of health service support to the FMFs consists of the following:

(a) Tier I. Capability to provide health service support to a full Marine Expeditionary Brigade (MEB). This consists of augmentation forces for one full Surgical Company, two Shock Trauma Platoons, and regimental augmentations for both Division and Wing assets, for each of the three Marine Expeditionary Forces (MEFs) I, II, and III.

(b) Tier II. The remaining active duty Force Service Support Group, Marine Air Wing, and Division augmentation units will be maintained in a Tier II status.

(2) Component UICs for Marine Corps. Because of delays in the implementation of Component UICs for Marine Corps augmentation platforms, the tiered readiness rotation cycle and MAP training cycles are currently being developed. These will be published to all concerned by separate correspondence.

c. Hospital Ships (T-AH)

(1) Tier Status. The two hospital ships, USNS COMFORT and USNS MERCY, are maintained in a Tier I status at the 250 bed level.

(2) Map Training Cycles. Required training is provided for augmentation personnel through quarterly training evolutions.

d. Fleet Hospitals (FHs)

(1) Tier Status. The Fleet Hospital Program consists of six FHs assigned to active duty augmentation teams and four assigned to Reserve augmentation teams.

(a) Active Duty

1. Tier I. Two FHs will be maintained in a Tier I status at all times. The Tier I platforms will assume the Tier I status in a staggered interval with a new Tier I platform assuming their 1-year rotation every 6 months. At the end of the 1 year in a Tier I status the FH will roll to a Tier III status for a period of 6 months prior to reentering the training and operational readiness cycle. Enclosure (2) provides a graphic representation of this process. Tier I FHs are required to maintain a Readiness Status for Core Personnel of R-1 for the duration of their Tier I period.

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2. Tier II. Three active duty FHs will be maintained in a Tier II status at all times and maintain at least a Readiness Status of R-2 for Core Personnel for the period they are in Tier II.

3. Tier III. The FH most recently released from a Tier I status will be held in a Tier III status for 6 months prior to reentering the training and operational readiness cycle. During this period the Readiness Status will be maintained at a level no lower than R-3 for Core Personnel.

(2) Map Training Cycles. Maintenance of the platform's readiness status is measured on the Core Personnel group assigned to individual FHs. The Core consists of personnel identified as essential for the initial deployment and establishment of the FH and the base operating support. This group consists of 282 personnel from the full contingent of 978 normally assigned to the FH. The Fleet Hospital Operations and Training Center (FLEHOSPOTC) maintains a Web site at: <https://fhotc.med.navy.mil>, which posts the training schedule for FHs 1 year in advance.

(a) Reserve

1. The Reserve FHs will be considered to be in a Tier III status for deployment planning. However, to husband scarce medical resources currently held in the Reserves, a training cycle was developed to maintain the readiness levels of the Reserve platforms. On a rotational basis, one Reserve FH, consisting of the core personnel, will be designated to do a Fleet Hospital Field Training (FHFT) each fiscal year. After completion of the FHFT, the FH will be assigned to participate in the fiscal year Medical Readiness Training Exercise and other exercises and contingency operations as deemed necessary. The other Reserve FHs will have the option of acquiring alternative training elsewhere until such time as they become the designated Reserve FH. This will provide the personnel associated with the Reserve FHs with increased flexibility to respond to missions appropriate to the Reserve Components and also provide a cadre of personnel with the training appropriate for other support roles in Navy Medicine.

2. Reserve FHs will no longer participate in a scheduled Operational Readiness Evaluation (ORE) during their normal training cycle. If a Tier III Reserve FH is required to deploy in support of operational forces, an ORE will be provided on a "just-in-time" basis.

5. Point of Contact. Additional information concerning the Navy Medicine's Tiered Readiness CONOPS can be obtained by contacting BUMED's Current Operations and Platform Readiness Division (M3F3) at (202) 762-3425 or DSN 762-3425.

6. Cancellation Contingency. Retain until incorporated into reference (b).



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Available at: <http://navymedicine.med.navy.mil/instructions/external/external.htm>

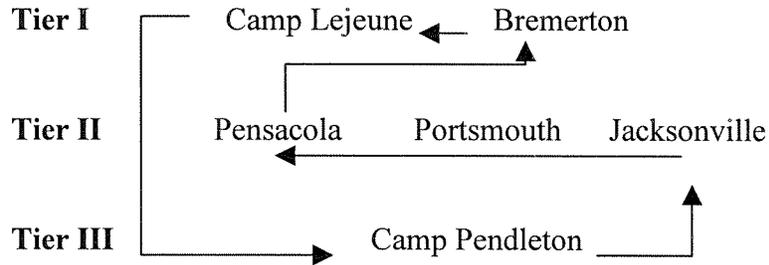
**CASUALTY RECEIVING AND TREATMENTS SHIPS (CRTS) TIERED READINESS  
CONCEPT OF OPERATIONS (CONOPS)**

Rotation Group	FY01	FY02	FY02	FY03	FY03	FY04	FY04	FY05	FY05	FY06	FY06
<b>Rotation Schedule A</b>	<i>Team 2</i> NMC PRTSVA	<i>Team 10</i> NNMC Bethesda	<i>Team 6</i> NMC PRTSVA	<i>Team 4</i> NMC PRTSVA	<i>Team 11</i> NNMC Bethesda	<i>Team 2</i> NMC PRTSVA	<i>Team 6</i> NMC PRTSVA	<i>Team 10</i> NNMC Bethesda	<i>Team 4</i> NMC PRTSVA	<i>Team 2</i> NMC PRTSVA	<i>Team 11</i> NNMC Bethesda
<b>Rotation Schedule B</b>	<i>Team 5</i> NMC SD	<i>Team 1</i> NMC SD	<i>Team 8</i> NH JAX	<i>Team 3</i> NMC SD	<i>Team 5</i> NMC SD	<i>Team 8</i> NH JAX	<i>Team 1</i> NMC SD	<i>Team 3</i> NMC SD	<i>Team 8</i> NMC JAX	<i>Team 5</i> NMC SD	<i>Team 1</i> NMC SD
				<i>Team 7</i> NH GLakes				<i>Team 9</i> NH GLakes			

**Notes**

1. Teams noted in the Fiscal Year columns are the teams scheduled for MAP training during that fiscal year. For example, Teams 6 and 8 completed MAP training during the second half of FY02. Teams, 4, 3, and 7 are scheduled for the first half of FY03, approximately 6 months after Teams 6 and 8 were trained in FY02. Teams 11 and 5 are then scheduled for training during the second half of FY03, again, approximately 6 months after Teams 4, 3, and 7 received their training. Note that the Great Lakes training cycle corresponds with the biannual Kernal Blitz Exercise.
2. As outlined in paragraph 4a(1) of this Notice, the eleven CRTS MAP augmentation teams are maintained in the following Tiered Readiness status:
  - Tier I: 4 Teams
  - Tier II: 7 Teams
  - a. To accomplish the rotation necessary to meet this requirement, each team, with the exception of Naval Hospital Great Lakes; Teams 7 and 9, will rotate into a Tier I status at the completion of their scheduled MAP training for a period of approximately 1 year. When the new team assumes the Tier I status, then the team in that rotation schedule having been in a Tier I status for approximately 1 year, will revert to a Tier II status. For example, in Rotation Schedule A, when Team 4 from Naval Medical Center Portsmouth VA moves to a Tier I status in FY03, then Team 10 from National Naval Medical Center Bethesda MD will move into a Tier II status.
  - b. Rotation Schedules are for Tier planning purposes and should not be viewed as constraining teams to one coast/fleet or the other. Teams will be deployed according to their Tier status and as the requirements of the operational commander indicate.

**ACTIVE DUTY FLEET HOSPITAL  
UNIT AUGMENTATION ROTATION SCHEDULE**



Note. Movement between tiers is staggered at 6-month intervals and is driven by displacement of the senior Tier I Fleet Hospital with the Fleet Hospital having most recently completed its ORE.