SECRETARY OF THE ARMY
WASHINGTON

19 MAR 2021

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Army Directive 2021-08 (Implementation and Sustainment of Army Medical Department Individual Critical Task Lists)

1. References.

a. National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017, Public Law 114-328, sections 708(c) and 725 (2016)

b. NDAA for FY 2019, Public Law 115-232, section 712 (2018)

c. Department of Defense Instruction 6000.19 (Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers), 7 February 2020

d. Army Regulation (AR) 5–22 (The Army Force Modernization Proponent System), 28 October 2015

e. AR 40–68 (Clinical Quality Management), 26 February 2004, including Rapid Action Revision of 22 May 2009

f. AR 350–1 (Army Training and Leader Development), 10 December 2017

g. Army Doctrine Publication 7–0 (Training), 31 July 2019

h. Training and Doctrine Command (TRADOC) Pamphlet 350-70-1 (Training Development in Support of Operational Training Domain), 12 February 2019

2. Purpose. This directive establishes responsibilities for implementing medical individual critical task lists (ICTLs) in support of the Ready Medical Force capability. Section 725 of the FY 2017 NDAA mandates reforms to the Department of Defense Military Health System to improve readiness, requiring implementation of measures to maintain the critical wartime medical skills and core competencies of healthcare providers. Pursuant to Title 10, United States Code, section 7013, the Secretary of the Army retains statutory responsibility and authority to, among other functions, recruit, train, equip, organize, and administer the Department of the Army to provide ready medical forces and medically ready forces. Individual critical tasks (ICTs) specify the knowledge, skills, and abilities for each Army Medical Department (AMEDD) Area of Concentration (AOC) and military occupational specialty (MOS), and serve as the

foundation for maintaining a trained, ready, and deployable medical force in support of the full range of military operations.

3. Applicability. The provisions of this directive apply to the Regular Army, Army National Guard/Army National Guard of the United States, and U.S. Army Reserve.

4. Policy. The Assistant Secretary of the Army for Manpower and Reserve Affairs is responsible for strategic guidance, policy, and oversight for AMEDD ICTL implementation requirements. The Office of The Surgeon General (OTSG) is the Army proponent responsible for coordinating AMEDD ICTL implementation. For the terms and definitions applicable to this policy, see the enclosure.

a. OTSG will—

(1) Ensure that medical and dental ICTL implementation supports tiered clinical readiness standards and requirements.

(2) Coordinate with the Defense Health Agency (DHA) to ensure that AMEDD personnel, resources, and medical training within military treatment facilities support ICTL implementation and sustainment requirements pursuant to reference 1b.

(3) Leverage partnerships and clinical simulation training opportunities with other military services, the Veterans Administration, civilian medical centers, universities, and institutional training centers to augment AMEDD ICT sustainment when practical or efficient.

(4) In coordination with the U.S. Army Medical Center of Excellence, ensure that all AMEDD ICTLs are included in the Central Army Repository for use Armywide to monitor and report ICTL training and proficiency of AMEDD Soldiers.

b. No later than 30 September 2021, the Commanding General, TRADOC, in coordination with the Commanding General, U.S. Army Medical Command, will issue procedural guidance for implementing and evaluating AMEDD ICTL training programs across the Army. TRADOC will also take the following action:

(1) In coordination with Army commands (ACOMs) and Army service component commands (ASCCs), consolidate and integrate expeditionary AMEDD skills readiness training and validation requirements across the enterprise.

(2) No later than 30 September 2022, update applicable regulations and pamphlets with standards for AMEDD ICTL proficiency and sustainment training requirements.

c. U.S. Army Forces Command (FORSCOM) is responsible for all readiness and reporting of expeditionary AMEDD specialties for assigned forces and will—

(1) Ensure that AMEDD ICTL training supports tiered clinical readiness requirements and operational priorities for all FORSCOM units.

(2) In coordination with OTSG and DHA, ensure that AMEDD ICTL training of assigned AMEDD AOC/MOS personnel is monitored and reported as required.

d. ACOMs and ASCCs are responsible for all readiness and reporting of AMEDD specialties for assigned forces and will—

(1) Ensure that AMEDD ICTL training supports tiered clinical readiness requirements and operational priorities for assigned units.

(2) In coordination with OTSG and DHA, ensure that medical and dental ICTL training of assigned medical AOC/MOS personnel is monitored and reported.

5. Proponent. The Assistant Secretary of the Army for Manpower and Reserve Affairs is the proponent for this policy. Within 2 years of the date of this directive, OTSG will ensure that applicable provisions are incorporated in AR 40–68; and DCS, G-3/5/7 will incorporate applicable provisions into AR 5–22 and AR 350–1.

6. Duration. This directive is rescinded on publication of the revised regulations.

Encl

John E. Whitley
Acting

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DEFINITIONS

Unless otherwise noted, these terms and definitions apply for the purpose of this Army directive.

Clinical Proficiency: The ability of an individual or team to perform a clinical task to standard. Assessed clinical proficiency is based primarily on the evaluated task proficiency rating from the time the task was last trained and the providers' understanding of the clinical task, factoring task atrophy.

Health Readiness Platform (HRP): Military treatment facilities that enable Soldier medical readiness and ensure operational medical currency and competency in critical wartime medical readiness skills and core competencies of military healthcare personnel.

Individual Critical Task (ICT): A task individuals must perform to accomplish their mission and duties in a full range of Army operations. ICTs specify the knowledge, skills, and attributes for each AMEDD modification table of organization and equipment (MTOE) AOC or MOS. It must be specific; usually has a definite beginning and ending; may support or be supported by other tasks; has only one action and, therefore, is described using only one verb; generally is performed in a relatively short time (with or without a specified time limit); and must be observable and measurable.

Individual Critical Task List (ICTL): A list of tasks that individuals must perform to accomplish their mission and duties and to survive in the full range of Army operations.

Readiness: The ability to perform a capability at a given time.

Ready Medical Force: A force with the medical capability to support across the full spectrum of conflict as part of Joint Forces.

Task: A clearly defined and measurable activity accomplished by individuals and organizations. It is the lowest behavioral level in a job or unit that is performed for its own sake. It must be specific; usually has a definite beginning and ending; may support or be supported by other tasks; has only one action and, therefore, is described using only one verb; generally is performed in a relatively short time (with our without a specified time limit); and must be observable and measurable.

Tiers: A classification system used to prioritize training resources and opportunities for medical personnel aligned to operational requirements.

Tier 1 Clinical Readiness: Highest level of readiness. Validated medical and dental AOC/MOS personnel fully capable of performing, individually or as part of a team, critical wartime tasks in an operational environment. Each medical Soldier is fully deployable and meets all Tier 2 and Tier 3 clinical readiness requirements.

Tier 1 clinical readiness requirements apply to medical AOC/MOS Soldiers (all components) (a) assigned to support operational units with Global Force Management Allocation Plan requirements within 12 months (such as the Defense Support to Civil Authorities; U.S. Homeland Defense Command; and Joint Chemical, Biological, Radiological, and Nuclear Defense Capability Development Group) and (b) assigned to U.S. European Command and U.S. Indo-Pacific Command units.

Tier 2 Clinical Readiness: Medical and dental AOC/MOS personnel are deployable and meet Tier 3 requirements. Each medical Soldier can meet Tier 1 clinical readiness requirements within 180 days. Minimal requirements for just-in-time training and post-mobilization training.

Tier 2 clinical readiness requirements apply to medical and dental AOC/MOS personnel (all components) (a) assigned to operational units, (b) in low-density or high-demand AOC/MOSs assigned to table of distribution and allowances (TDA) units, and (c) MTOE Assigned Personnel (MAP) not deploying within 12 months.

Tier 3 Clinical Readiness: Each medical and dental AOC/MOS Soldier is deployable and can meet Tier 2 clinical readiness requirements within 365 days. Privileged and non-privileged medical personnel meet requirements in AR 40–68 (Clinical Quality Management) for licensure, credentials, privileges, and certification.

Tier 3 clinical readiness requirements apply to medical and dental AOC/MOS personnel (all components) assigned to TDA units and not otherwise designated as Tier 2.