



GENERATING READINESS

A Call for Transforming Medical Simulation Training Centers

By: COL Charles “Chip” O’Neal

“The most important 6 inches on the battlefield is between your ears.” - GEN Jim Mattis

In large-scale combat operations (LSCO), the role of a combat medic is pivotal. As the only medical provider at the injury site, the combat medic is the expert who must make life-saving decisions under extreme pressure. Ideally supported by combat lifesavers and buddy aid, these medics are tasked with the highest stakes—saving the lives of their fellow Soldiers. Just as an intelligence specialist redirects a reconnaissance drone or a tank crew member loads a specific round into the cannon, combat medics must rely on the best possible support to fulfill their mission effectively.

Although combat medics work closely with the battalion’s medical platoon sergeant, they fall under the command of the infantry platoon sergeant. This unique positioning reflects a dual accountability that is critical during combat situations. In the chaos and ambiguity of the battlefield, medics make immediate, life-saving decisions that can mean the difference between life and death.



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Recognizing the increasing complexity of their role, the Army has transitioned combat medics to Emergency Medical Technicians (EMTs) and established the Medical

Simulation Training Center (MSTC) program to support their training and skill development. MSTCs provide a vital home station training capability that mimics the unpredictable nature of war. These centers not only enhance the readiness of combat medics but also prepare all Soldiers to make split-second decisions in emergencies.

Despite their importance, MSTCs face considerable logistical, managerial, and training challenges. The current framework considers them a program rather than a fully resourced unit within the Army’s structure. To ensure the long-term viability and effectiveness of these training centers, the Army must establish a dedicated force structure that can effectively manage MSTCs.

Many Sergeant Majors will attest: “If you’ve seen one MSTC, you’ve only seen one MSTC.” The typicality of this sentiment underscores the need for standardized operations and resources across all MSTCs, enabling a more uniform and practical approach to training medical personnel in the Army.

As the Army ensures readiness for LSCO, carefully considering the combat medic’s role, the challenges MSTCs face, and the necessity for enhanced support structures will be crucial for improving medical capabilities in LSCO scenarios.

KEY ORGANIZATIONS AND THEIR ROLES

Three organizations are most directly responsible for MSTCs, but they did not exist when these centers were initially established, leading to competing priorities and budget concerns:

1. **Installation Management Command (IMCOM):** IMCOM oversees the infrastructure and support services

at installations hosting MSTCs, ensuring their efficient operation. Their Garrison Command teams manage MSTC facilities, utilities, communications infrastructure, and security to maintain functional and conducive training environments.

2. Medical Center of Excellence (MEDCoE): MEDCoE is an integral part of the Combined Arms Command (CAC) and the Training and Doctrine Command (TRADOC). It is responsible for establishing training objectives and standards for MSTCs. Through its Department of Simulations (DoS), MEDCoE creates curriculum, doctrine, and standards specifically for medical simulation training. This work is vital for ensuring that the training aligns with Tactical Combat Casualty Care (TCCC) principles and meets the Army's readiness goals. Additionally, the DoS ensures that MSTCs fully comply with Army-wide training standards, which helps maintain uniformity in Soldiers' medical skills and overall readiness. MEDCoE also provides training for instructors and develops leadership skills for MSTC staff, further enhancing the effectiveness of medical training in the Army.

3. Program Executive Office for Simulation, Training, and Instrumentation (PEO-STRI): PEO-STRI supports MSTCs by supplying advanced simulation technologies and tools used in medical training and managing overarching contracts for MSTC cadre. Partnering with MEDCoE's DoS, PEO-STRI helps incorporate the latest medical training technologies to ensure MSTCs deliver cutting-edge simulations.

The requirement to submit reports to multiple organizations has resulted in inefficiencies and reduced accountability. Consequently, this often leads to makeshift local solutions, such as assigning civilians as managers or depending on Senior Mission Commanders for oversight.

The original MSTC concept called for five contractors to staff each location. However, this model cannot adequately fulfill all necessary responsibilities, such as signing for equipment or facilities. Moreover, five contractors are insufficient to meet operational demands. Most installations address this shortcoming by tasking Soldiers as cadre for 90 to 180 days, creating a revolving door of instructors that disrupts training continuity and quality. This approach leads to inconsistencies; some installations have personnel on assignment for a year, while others rotate cadre every few months, undermining the stability and quality of training.

Some installations have designated government civilians as MSTC Managers without establishing clear chains of command or accountability, thus compounding the issue. Local stakeholders, including Senior Mission Commanders, division surgeon cells, and installation commanders, have stepped in to support MSTCs, but this localized assistance varies widely and lacks standardization.

A notable successful model exists at Fort Cavazos, where the III Corps Surgeon Cell serves as a de facto MSTC Manager, coordinating various stakeholders to meet the center's needs. They maintain communication with PEO-STRI to ensure accountability, and the installation commander oversees the buildings and training areas. IMCOM also collaborates to resolve facility needs, receiving training devices issued by PEO-STRI at their Training Support Center. MSTC cadre (excluding contracted personnel) sign out equipment from this center. The Fort Cavazos model can serve as a blueprint for other installations seeking to improve their MSTC operations.

Furthermore, MSTCs can operate as detachments under Garrison Headquarters. A successful example is from 2010 when Vilseck, Germany, created a Table of Distribution and Allowances (TDA) for their MSTC under the Seventh Army Training Command, becoming the only installation to do so.

“Life is really simple, but we insist on making it complicated.” - Confucius

STRENGTHENING MSTC OPERATIONS

When military medical personnel are asked to identify the organization responsible for MSTCs in the Army, the typical response is, “It depends.” Unfortunately, this answer reflects the confusion within the current environment.

The Army has designed each of its 25 MSTCs to train approximately 2,500 medical and non-medical Soldiers through direct instruction on the latest battlefield trauma and critical care techniques. While the original staffing and support concept was feasible on paper and effectively supported operations during the Global War on Terror (GWOT), conditions have drastically changed over the past two decades. Varied standards, challenges with instructors, and shortages of training resources indicate that MSTCs urgently need an upgrade to address the medical challenges of LSCO.

This MSTC has its own Unit Identification Code (UIC) and Department of Defense Activity Address Code (DODAAC), benefiting from stability and expert staffing, which includes one GS-11 MSTC Manager, five 68W medical non-commissioned officers (68W NCOs), and five contractors.

While decentralization provides flexibility for MSTCs, it also leads to significant staffing, accountability, and resource management challenges. By implementing successful centralized models, the Army can greatly enhance the effectiveness of MSTCs across its installations.

LOG TRAINS, PAINS, AND SURGEON'S OFFICES

One of the most pressing issues facing MSTCs is the acquisition of Class VIII medical supplies, which are essential for TCCC training. In 2018, the decision to

shift the responsibility for Class VIII funding to local unit commanders has proven problematic. This change created a pay-to-play scenario where commanders must allocate resources to order necessary expendable materials for the MSTCs training their Soldiers. As a result, many units now rely on division or corps surgeon offices to fulfill supply orders.

“The line between order and disorder lies in logistics.” - Sun Tzu

The introduction of TCCC in 2021 significantly changed training requirements, replacing earlier training tables with more demanding standards. Because TCCC requires substantially more Class VIII supplies than previous training protocols, acquiring these materials for Soldiers at the MSTCs has become increasingly costly and challenging. According to the Medical Center of Excellence’s Directorate of Simulations (MEDCoE DoS), each MSTC requires approximately \$250,000 annually in Class VIII supplies to meet training demands.

To address these challenges, MSTCs often turn to donated Class VIII supplies to support as much training as possible. Typically, they request these supplies through Division or Corps Surgeon offices, with the associated expenses covered by the Senior Mission Commander’s budget. This reliance on donations underscores the urgent need for a more sustainable and reliable funding mechanism for acquiring essential medical training supplies.

RED TEAM INSIGHTS: THE CASE FOR MSTC STRUCTURE

NAVIGATING PERSONNEL CHANGES

Creating a force structure dedicated to MSTCs is not as simple as shuffling deck chairs.

Forming a new unit, even a detachment, requires careful planning to ensure that the latest TDA does not disrupt existing operations within the parent organization. MEDCoE’s DoS is investigating the potential of establishing a Derivative Unit Identification Code (DUIC) from III Corps to support the Fort Cavazos MSTC. However, this initiative faces hurdles: numerous high-priority units within III Corps need 68W NCO positions, critical in personnel evaluations on Unit Status Reports.

Given the designation of the 68W Medic position as a pacing Military Occupational Specialty (MOS), reallocating these positions is a challenge. This situation raises a crucial question: What will the impact on existing units be if we create a DUIC?

“You need the naysayers and the nonbelievers to add fuel to your creative fire.” - Ice T

STRATEGIC ASSIGNMENTS AND CHALLENGES

One potential strategy is to incorporate MSTCs as permanent components of installation Training Support Centers (TSCs). Acquiring an additional 68W authorizations seems unlikely. Under Title X, the Surgeon General (TSG) is responsible for all Army medical training; thus,

reassigning 68W NCOs from clinics and hospitals to MSTCs appears logical. However, this path is complicated because all clinical authorizations have now transitioned to the Defense Health Agency (DHA), detaching them from TSG’s oversight.

While it may be possible to negotiate a reassignment with DHA, MEDCOM must then find backfill personnel for any NCOs moved from DHA clinical posts to MSTCs, bringing us back to the same persistent dilemma of personnel allocation.



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One more viable solution is for FORSCOM to reassign their MTOE-Assigned Personnel (MAP; formerly PROFIS) 68W NCOs directly to the MSTCs, ensuring they are officially attached to FORSCOM but fulfill their duties at the MSTCs. This reallocation will stabilize the staffing of MSTCs in line with the Army’s assignment cycles, providing immediate readiness benefits.

Despite these potential solutions, some critics argue that MSTCs are in decline, mainly due to the high costs of maintaining state-of-the-art medical simulation equipment across 25 locations. Detractors question the value of sustaining Combat Lifesaver and Tactical Combat Casualty Care (TC3) programs through MSTCs.

ALIGNING OPTICS WITH REALITY

These concerns often stem from misinterpretations within the Army’s training device reporting systems, specifically the Training Support Management Army Training Systems (TS-MATS). Viewing MSTCs simply as training devices leads to misleading figures, showing them as available 8

hours a day for 24 students, neglecting the actual course lengths and resulting in perceptions of underutilization.

In actuality, MSTCs provide a wide range of training options, including TC3, Paramedic Refresher, Combat Life Saver, Basic Life Support (BLS), Advanced Life Support, National Registry of Emergency Medical Personnel Technicians-Paramedic (NREMT-P), Pediatrics Advanced Life Support (PALS), and Delayed Evacuation Casualty Management (DECM).

This situation highlights the urgent need to update MSTCs' status from mere training devices to comprehensive training platforms or ranges. Implementing systems like ATRRS and RFMSS will facilitate better tracking and data-driven decision-making, ultimately enhancing the effectiveness and perception of MSTCs as critical components of medical training in the Army.

ENHANCING MSTC INTEGRATION AND MANAGEMENT: SO, WHAT'S OUR PLAY?

Treating MSTCs as standalone facilities ensures they receive dedicated funding streams necessary for effective operation. By formalizing MSTCs within the Army's structure, the organization can provide the oversight, accountability, and resources required for their success.

“Simplicity is the ultimate sophistication.” - Leonardo da Vinci

By centralizing oversight and standardization, MSTCs can integrate into the Army's hierarchy as a key component of the installation's TSCs, creating a transparent chain of command that enhances accountability. However, since TSCs currently lack 68W positions, a collaborative effort between FORSCOM and MEDCOM is essential for allocating the necessary cadre. Establishing a dedicated MSTC TDA will foster a stable training environment and enable the cadre to develop into Master Medical Trainers, who can reintegrate into operational units to enhance overall readiness.

Currently, most MSTCs currently rely on Excel spreadsheets and locally developed, underpromoted websites for registration, accountability, and data management. Formally registering MSTCs as Troop Schools in the Army Training Requirements and Resources System (ATRRS) will optimize training efforts, standardize processes, harmonize training schedules, and prevent arbitrary class cancellations.

Additionally, implementing the Range Facility Management Support System (RFMSS) can significantly improve accountability and resource management by tracking training data and student progress. For instance, Fort Carson utilizes RFMSS for student registration within their MSTC, following a directive from the Fourth Infantry Division Commanding General/Senior Mission Commander. The Fort Carson TSC facilitates and oversees the MSTC operations.

Lastly, a centralized funding model for Class VIII medical supplies will stabilize resourcing for MSTCs. Reallocating funds from TRADOC, the Defense Health Agency (DHA), and alternative sources ensures that MSTCs can access the medical supplies necessary for training. Although MEDCOM initially managed Defense Health Program funds in establishing MSTCs, this responsibility has since shifted to DHA, necessitating a reevaluation of funding strategies.

MIC DROP: MORAL OF THE STORY

The MSTC Program of Record will transition into Sustainment mode in FY2025, paving the way for the next transformative step: MSTC-Next Generation (MSTC-NG). However, immediate improvements can be secured through personnel enhancements, improved logistics, and automated administrative solutions.

Transforming MSTCs is not merely about upgrading training. Fundamentally, it is about saving lives.

Well-trained medics lead to higher survival rates on the battlefield, improved mission outcomes, and greater confidence among Soldiers and their leaders. By employing standardized methods and advanced tools, we can enhance training effectiveness and better prepare medics for the demands of modern warfare. Adequate funding and

centralized oversight will increase operational efficiency, minimizing waste and eliminating delays. MSTCs have the potential to bolster readiness by ensuring a consistent flow of skilled medical personnel ready for deployment. The time to act is now. MSTCs serve as readiness multipliers, crucial in the Army's capacity to fight and win in Large-Scale Combat Operations. By establishing MSTCs as dedicated units with tailored TDAs, centralizing oversight, and investing in cutting-edge technologies, the Army can guarantee that these centers continue to advance combat medics' expertise and enhance our warriors' survivability.

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COL Charles “Chip” O’Neal is a seasoned Strategist and Medical Service Corps Officer with 30 years of distinguished service, including leadership roles in OIF 1, coordinating the Army's medical response to Hurricane Katrina, authoring the Army Medical Action Plan following the Walter Reed scandal, and expanding Joint Force testing capabilities during the COVID-19 pandemic. Throughout his career, he has worked alongside numerous distinguished professionals and contributed to significant advancements in military medical operations.

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