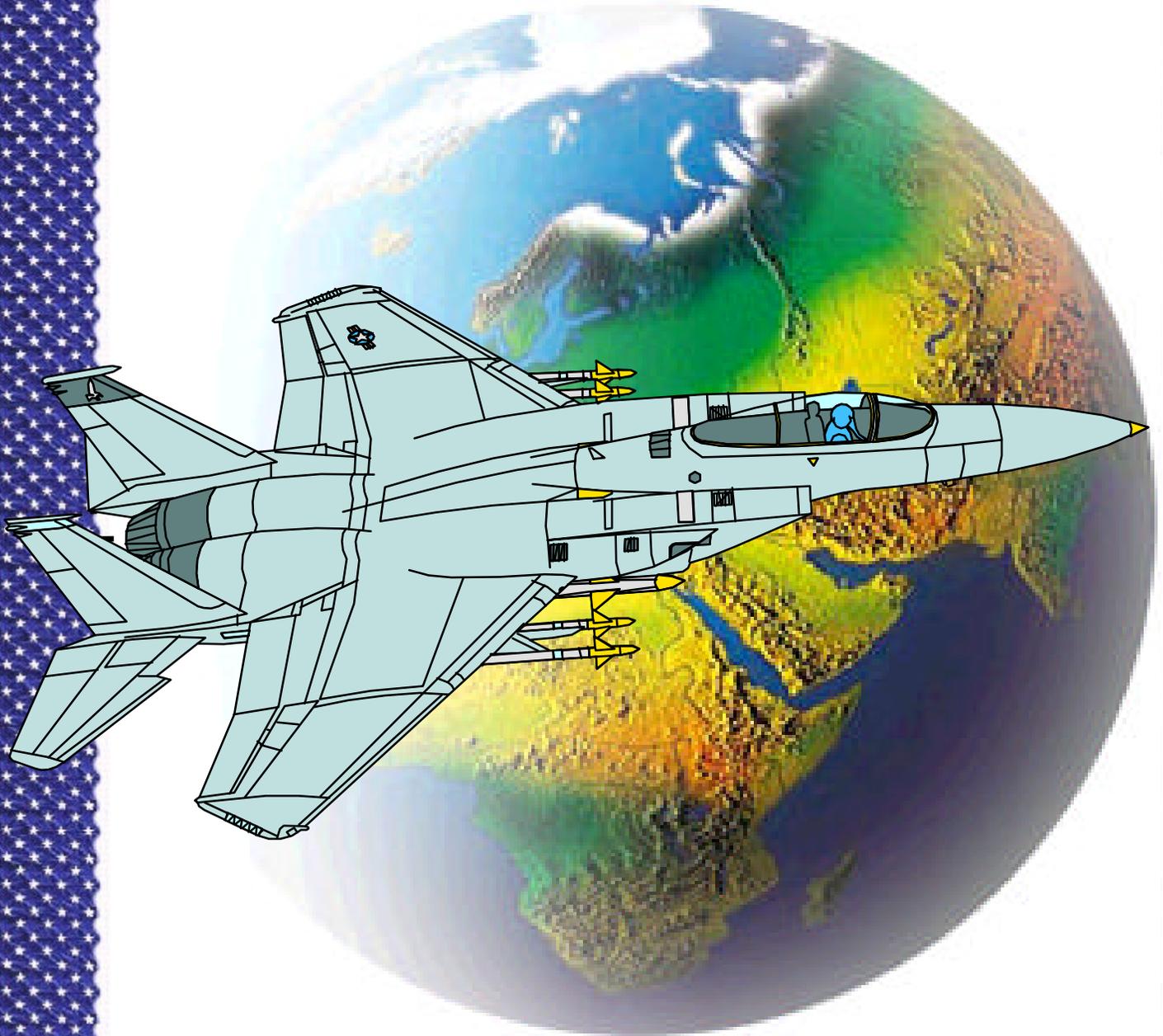


# **Air Combat Command Command Surgeon Mission Support Plan**



**Brigadier General Klaus O. Schafer  
Air Combat Command Surgeon  
May 1999**

## **From the Air Combat Command Surgeon**

The Air Combat Command Mission Support Plan is our roadmap for moving into the next millenium. Our mission is two-fold; to provide operational health care support and community-based health care for the men and women of Air Combat Command. Recognizing this competition for resources, it is an on-going task to maximize the efficiencies of our people and scarce funding. This is but another challenge to embrace and overcome through prudent planning and execution of strategies.

We stand positioned on the cutting edge of today's technology to provide our fighting forces the health care support they require to meet the mission. With an eye to the future, we place a strong emphasis on technology and solutions for the rapidly changing environment in which we serve.

The challenges are many, but the climate is ripe with opportunities for exploitation. Our plan illustrates our focus and strategies with an emphasis on the support we require. This plan while months in the making is not finished. Our MSP is a living document with many opportunities for continued development in the coming years. It is our source document for the direction and focus of ACC health support endeavors.

Agile Combat Support  
Force Protection

//Original Signed//  
KLAUS O. SCHAFER  
Brigadier General, USAF, MC, CFS  
Command Surgeon

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## Chapter 1: Executive Summary

### 1.1. Introduction and Strategic Management Connection

The Air Combat Command Surgeon (ACC/SG) Mission Support Plan (MSP) articulates and illustrates a Command focused on the future, building from the past, while sustaining in the present. We present our plan for a two-fold future: *operational health support* and *community-based health care*. Within these chapters, we have prepared our strategy for health care in the beginning of the next millenium.

**ACC MISSION:** “Air Combat Command Professionals providing the world’s best combat air forces, delivering rapid, decisive, and sustainable airpower, anytime, anywhere”

**ACC GOALS:**

- Take care of ACC *people*
- Provide a *trained* and sustainable aerospace combat force that meets the needs of the theater Commander in Chiefs (CINCs)
- Continually reduce the *cost* of operating ACC without adversely affecting our people or our mission

**ACC SG MISSION:** “Supporting the health of Air Combat Command’s global power Team through worldwide contingency operations and a comprehensive, community-based health care system”

### ACC/SG Roles and Missions

#### Operational Health Support

As the Air Component Surgeon to U. S. Atlantic Command (USACOM), ACC/SG is the medical Agile Combat Support (ACS) Force Provider for all Combatant Commands. Additionally, ACC/SG as the Air Component Surgeon to U. S. Central Command (USCENTCOM) and U. S. South Command (USSOUTHCOM) provides the deliberate and crisis action planning for medical ACS. ACC/SG functions as the Air Force Forces (AFFOR) SG for both Combatant Commands. In the AFFOR role, ACC/SG assumes the additional responsibility for operational execution in both deployed and reach-back roles to the Rear Operation Support Cell. As the staff deploys forward with the theater forces, a forward AFFOR surgeon component is established. This AFFOR role is unique to Air Combat Command.

The Air Force Medical Service (AFMS) organizes, trains, and equips two primary “weapons” systems: Aeromedical Evacuation and Ground-Based Medical Assemblages. In the role as the Combat Air Force (CAF) SG, ACC/SG possesses the unique responsibility to assure all deployable ground-based medical assemblages conform to and support ACS doctrine. Assemblages are developed, fielded and registered in the Joint Operations Planning and Execution System (JOPES) by the CAF SG.

ACC/SG is the Manpower Equipment Force Packaging (MEFPAK) command for the majority of deployable medical Agile Combat Support capability. As such, the focus is on delivering maximum medical capability to the theater while minimizing lift requirements. Deployable medical capability is tailored to meet the needs of the CINCs.

### **Community-Based Health Care**

Challenges such as TRICARE and rightsizing have moved us to foster the shift from episodic acute health care to preventive health care. All business decisions consider the impact on our medical readiness capability and the effective use of limited resources, but *support to the Line remains our number one priority*. The evolution to take on the challenges of community health care motivates ACC/SG to competitively provide health care while preparing for, and when necessary, deploying to contingency operations worldwide. Our approach is to put prevention programs in place while maximizing the use of technology to “force multiply” our limited resources. ACC/SG energies are focused on cost-effectively preserving and enhancing the health of our warfighters and their families for optimal mission performance.

## **1.2. Competitors, Partners and Strategy**

### **Competitors and Partners**

We operate in a competitive environment, yet rich with partners who contribute to both our successes and challenges in ACC. With shrinking medical budgets, we are forced both to compete and partner with our Line counterparts simultaneously to achieve our medical mission. Increased involvement with Line processes like the Mission Area Plans (MAPs) increases our awareness and sensitivities to the struggles our Line counterparts face to achieve their missions. Equally important though is the visibility this partnership brings to the Line of our unique medical mission. *Cooperative advocacy is a primary ACC strategy*.

TRICARE also presents us with unique competing and partnering relationships. With managed care support contracts established for all ACC Medical Treatment Facilities (MTFs), the result in some locations is increased capability enhancing the satisfaction of our beneficiaries. However, in some locations, this enhanced benefit also gives our beneficiaries the opportunity to “vote with their feet,” potentially opting to enroll with local providers. The message is clear; our beneficiaries have more choices and to keep them as customers in our community-based health care operation, *we must provide superior service*.

### **Strategy**

The clear strategy for the future of both deployable and community-based health care is *partnering*. We cannot achieve this mission alone but must establish partnerships with our beneficiaries, contractors, the AFMS, Mirror Forces, the Line of the Air Force and our sister services.

## **1.3. Provide Support to Employed Forces and Returning Casualties While Minimizing the Impact on the Medical Benefit-OT 1**

With the development of the Aerospace Expeditionary Force (AEF), we are engaged in the unique role of developing, testing, and (soon to be) deploying, new medical capability to theater

CINCs. The Expeditionary Medical Support (EMEDS) capability currently under development is a cooperative effort across the AFMS led by the CAF/SG. EMEDs will give deployed forces increased capability through a decreased medical footprint. With a core focus on aeromedical evacuation, patients will be stabilized and evacuated from the field, maintaining a mission ready force for the theater commanders. Optimally sized operational health support is appropriate medical capability from insertion of early AEF forces through the continuum to a large force beddown.

### **Force Protection**

Since the Khobar Towers bombing and resulting Downing Commission recommendations in 1996, Force Protection has received significant emphasis. As outlined in Joint Vision 2010, effective Force Protection is essential for freedom of action for friendly forces. Medical contributions to Force Protection are vital. HQ ACC has developed an Integrated Product Team (IPT) to study Force Protection issues and solutions. Additionally, HQ ACC sponsored the CAF Mission Needs Statement (MNS) for Enhanced Force Protection Capabilities (CAF 314-97).

Analysts agree that the superior forces of U.S. military may drive future enemies to select unconventional, asymmetric attacks as the best course of action to dislodge our centers of gravity. The use of chemical or biological agents is emerging as the most alarming transnational threat we might face.

In the U.S. Air Force Counterproliferation Master Plan quotes Secretary of Defense William Cohen states, "I believe the proliferation of weapons of mass destruction presents the greatest threat that the world has ever known." This plan and the corresponding ACC Counterproliferation Implementation Plan (Draft) include an outline of issues and responsibilities affecting the medical community. Among the requirements listed are: better detection, decontamination, and treatment capability vital to maximizing readiness while minimizing the impact of disease and non-battle injuries. Additionally, Joint Staff Communications Center message 112053Z Feb 97 states that a comprehensive medical surveillance program is a critical element of force protection, and that commanders at all levels are responsible for planning, preparing, and executing the medical surveillance program.

ACC/SG is actively pursuing force protection solutions. Technology such as the Ruggedized Advanced Pathogen Identification System (RAPIDS) currently in development and early testing will contribute to early warning, identification, and input into surveillance databases and intelligence systems. ACC/SG is also reviewing a medical decontamination system and a skin decontamination lotion. Both of these capabilities exemplify technological improvements over current decontamination techniques and products that are needed to improve effectiveness for the safety of our personnel.

### **AEF Infrastructure, Technology, and CONOPS Development**

The Chief of Staff Air Force directed the evolution to an Expeditionary Air Force (EAF). The EAF concept is a doctrinal shift that requires Air Forces to be rapidly deployable, highly mobile, and lightweight, while improving functional capabilities. The AFMS must support the AEF with the development of viable expeditionary medical combat assemblages. Directly supporting the doctrinal mandate of the EAF is the realization of EMEDS in conjunction with critical

infrastructure improvements such as the Air Transportable Hospital (ATH) Local Area Network (LAN), new technology such as telemedicine and digital radiology, and Mirror Force integration.

Real-time as well as “store-forward” communication capabilities are critical to medical EAF support. We are actively pursuing initiatives providing greater emphasis on worldwide medical command, control, communications, computers, and intelligence (C4I) capability. A prime example of C4I partnering is our relationship with the Air and Space Command and Control, Intelligence, Surveillance, and Reconnaissance Center (ASC2ISRC) located on Langley Air Force Base (AFB).

The ASC2ISRC is approaching its contributions for Health Services Support (HSS) C4I through the maturation and integration of the medical aspects of Command & Control (C2) within three key fields of endeavor. These include the Air Force Core Competencies of ACS and Global Mobility; as well as the integration of medical surveillance modalities, processes and systems within the Intelligence, Surveillance and Reconnaissance disciplines.

ACS integration includes the analysis and incorporation of medical unique C2 within the Global, Theater, and Installation C2 realms. They expand these through the expression of well-defined and supportable command relationships documented within Air Force Doctrine and Joint Doctrine; organizations expressed in Dynamic Aerospace Centers; and systems offered as modalities for the sensing, deciding, and executing of medical C2 processes. These include those processes, organizations, and systems located at the Commander Air Force Forces/Aerospace Expeditionary Task Force (COMAFFOR/ASETF) Headquarters Surgeon level, Expeditionary Operations Center (EOC), as well as those accomplished at the unit control center and field/team delivery levels. They embody the integration of HSS and other Combat Service Support functions along with Combat Support functions.

Global Mobility, albeit an Air Mobility Command effort, includes those C2 functions, processes, nodes, and supporting systems (like TRAC2ES) which allow for the integration of aeromedical evacuation C2 nodes, systems, and processes into the overall global and theater levels of airlift and air campaign execution within the Joint Forces Air Component Commander's Joint Air Operations Center.

The Intelligence, Surveillance & Reconnaissance (ISR) integration includes the maturation and evolution of Environmental Intelligence and its coupling of ISR (EVINT/ISR) platforms and sensors (both ground and aerospace) with human sensors (realized as patients). These medical surveillance ISR capabilities offer the Commander Air Force Forces /Joint Forces Air Component Command (COMAFFOR/JFACC) and his Surgeon the necessary decision support tools to mitigate against, and respond to, the insidious affects of the environment, endemic disease, and man-made and weaponized biological/chemical agents.

The AC2ISRC Medical Triad of ACS, Aeromedical Global Mobility, and EVINT/ISR counterparts constitute a full-spectrum of HHS involvement in the development, programming, testing, experimentation, and fielding of C2 systems and processes to support current and future AFMS operations.

### **Medical Training**

With a focus on forward medical support, medical training is required to assure force protection and forward-deployed medical capability for expeditionary air forces. Training requirements include initial and sustainment training. Training to enhance surgical trauma skills is difficult to ensure as our medical facilities rightsize to clinical capabilities. In order to ensure maintenance of these skills, we must find and fund new training opportunities. Medical training exercises are also required to test new Unit Type Code (UTC) capabilities for functionality and limitations. With centralized storage of many of our medical assets, Mobile Red Flag training must expand to include critical hands-on training with deployable assets. Pararescue airmen require emergency medical training certification every two years. We are working closely with U.S. Air Force School of Aerospace Medicine (USAFSAM) and HQ AETC/SG to improve existing training and development of new training capabilities.

Operational Task (OT) 1 solutions are linked and integrated. Without investment in the total mission capability required, the end states will not be equitably achieved. Total proportional capability is achieved through resourcing equity across the entire operational task.

### **1.4. Build a Managed Care System that Integrates Quality, Cost and Access-OT 2**

#### **Marketing**

The primary populations served by our MTFs are TRICARE Prime enrollees. TRICARE non-Prime, Space-Available, and enrollees to Network Primary Care Managers are additional populations targeted. The Managed Care Forecasting and Analysis System (MCFAS) is the primary tool used to identify our target population. A degree of our enrollment efforts will be directed towards the age 65 and over beneficiary population.

In order to achieve the goal of a seamless health care system for our beneficiaries, we must develop and implement strategies and tools to overcome existing deficiencies in our system. First and foremost, we must ensure the quality of the health care we provide. High quality health care is the best marketing tool we have. We know nothing travels like “word-of-mouth” news, we also know our beneficiaries are our eyes and ears to the services we provide and with our successes, can be our most vocal advocates.

#### **Computerized Patient Encounter Record**

Quality care is also seamless care and to further aid in our delivery of seamless health care, we are continuing to develop a computerized patient encounter record. We’re capturing and utilizing comprehensive health care information about our beneficiaries previously unavailable. One of the most important information systems in our “arsenal,” but most difficult to tap for data, is the Composite Health Care System (CHCS). We have embarked on a new methodology allowing ACC/SG to pull information from CHCS. This information is then linked to medical data available from the Ambulatory Data System (ADS), Defense Enrollment Eligibility Reporting System (DEERS), and financial rates to form a precise composite snapshot of our beneficiaries, their needs, and their utilization patterns. While an obviously critical tool in our community-based health care operations, this tool also gives us the ability to capture health care data about our deployed population at the site of health care and health related events. Information from the Desert Care II database deployed in the deserts of Southwest Asia (SWA)

is replicated to ACC/SG. Additionally, we're now able to analyze the Disease Non-Battle Injury (DNBI) information in real-time, as it occurs. Never before have our forces received the benefits of such comprehensive quality data. These tools enhance the quality of care we provide by aiding the provider and the beneficiary in determining the right level, amount, and the timing of care given.

### **Maximum Achievable Enrollment (MAE) Capitation/Revised Financing**

As we attract additional MTF enrollees, additional Operations & Maintenance (O&M) and revised financing funds will be needed to provide the required care for our enrolled population. We developed a methodology to project the O&M and revised financing requirements based on current variable costs applied against the projected demand, derived from the increase in enrollment reflected in our business plans' MAE. Enrollment Based Capitation (EBC) is not expected to be in place until FY02. In the interim we expect to use this enrollment/demand based model in tandem with the accepted Capitation Based Resource Allocation Model (CBRA) to project (O&M) funds and revised financing requirements. This methodology is explained in detail in Chapter 4. The ACC/SG enrollment/demand based model generated the O&M and revised financing requirements addressed in section 1.9.

Our focus however is not just on the beneficiary, but also our own staffs. As we work to achieve the 1500:1 patient to provider ratio, our utilization of space and support staff is increasingly critical. Additionally, effective demand management and preventive health strategies are key components to utilization management of scarce and eroding resources.

It is our goal to have our beneficiaries see their best option for comprehensive, customer focused, quality health care, exists within the walls of their local MTFs. We are confident our beneficiaries will continue to select the MTF as their choice for health care.

## **1.5. Be the Leader of Comprehensive and Integrated Programs of Disease Prevention, Health Promotion and Fitness-OT 3**

### **Population-based Health Plan**

The ACC/SG staff is excited to launch population-based health care initiatives throughout the command in accordance with AFMS Population-Based Health Plan guidance. Tools that will be used in implementing population-based health care include epidemiological assessments, demand management, putting prevention into practice, implementation of preventive health care applications, immunization tracking software, and preventive health assessments.

### **Health Promotion/HAWC Program**

Health Promotion along with proactive Health and Wellness Centers (HAWCs) are key components to realize a fit and healthy force. With an increasing number of deployments, ACC/SG has made a firm commitment to test a deployed health promotion and fitness program to keep our deployed forces at peak "performance." An in-depth business case analysis must be performed at each HAWC to facilitate program upgrades and reliability. ACC/SG works closely with the Line to ensure continued HAWC (Line) funding.

## **1.6. Promote a Safe and Healthy Environment-OT 4**

### **Industrial Hygiene Contract Support**

Industrial hygiene surveillance is a cornerstone of our community health care systems prevention program. Our smaller, trimmer workforce enforces increasing Occupational Safety and Health Agency (OSHA) requirements. These requirements include significantly more stringent chemical standards and an increased frequency (now annual) of quantitative fit-testing of industrial respirators. Simultaneously, we have implemented a program of quantitative fit-testing of gas masks for our warfighters. We are also taking a significant step towards privatization of many of our industrial hygiene surveillance activities.

### **Command Core System**

The Command Core System (CCS) integrates all occupational health management activities from industrial hygiene surveillance to conducting occupational health examinations to providing health trends analyses. Recently upgraded to version 4.0, CCS now provides increased environmental surveillance capability and mobility. Interfaces with numerous medical, safety, and environmental information management systems are in various stages of development. Ongoing sustainment and advanced training of this critical health care management system are mandatory. We propose to build a model for usage at remote sites AF-wide (refer to OT4 priority 6).

## **1.7. Provide a Responsive and Sensitive Health Care Atmosphere-OT 5**

### **Information Management/Information Technology (IM/IT) Support**

The Medical Systems Infrastructure Modernization (MSIM) project is targeted to design, engineer, and install new medical treatment facility cable plants and infrastructures to replace outdated cable plants and communications infrastructure. Each facility is surveyed and an infrastructure topology is designed in accordance with established standards for the specific facility. MSIM implementation will include facility backbone infrastructure as well as necessary vertical and horizontal wiring down to the desktop level. The MSIM project provides up-to-date communications infrastructure that facilitates the use of currently available technologies. Disruption to the facility is minimized through the MSIM installation project by installation of the total system versus the current practice of “piece-meal” installation of each new system.

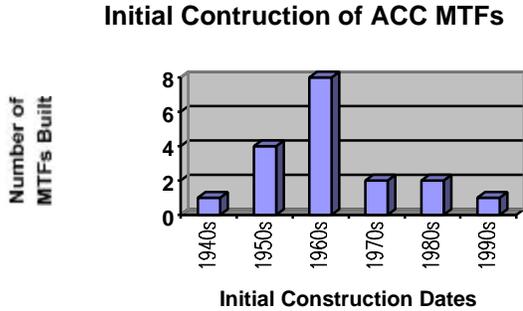
### **Real Property Maintenance Activity (RPMA)**

ACC’s medical treatment facilities encompass 3,196,855 square feet valued at \$777,000,000. The average MFT age is over 30 years. The continuous challenge is to keep the physical plants operating efficiently, despite austere funding. The goals are to ensure all medical facilities meet regulatory requirements, utilize standardized designs for Military Construction (MILCON) or renovation/repair projects, and increase readiness support by providing adequate storage facilities for War Reserve Materiel (WRM).

ACC is pursuing an aggressive program to upgrade and maintain our medical treatment facilities. Under the “cost-of-ownership” concept, we strive to maintain the real property maintenance funding level at 3% of the plant replacement value (PRV) of our MTFs (\$19.9M). However, since FY94, real property maintenance activity funding has slowly eroded to only 1% of PRV, and unfortunately we have fallen short of the 3% PRV target for the last four years. It is

important to strive to adhere to the cost-of-ownership concept if we expect to provide attractive, comfortable, and safe facilities for our beneficiaries.

There is great diversity among ACC bases in the size, age and condition of the hospitals and other medical facilities. Many of the facilities were built more than 30 years ago. All have received upgrades and enhancements, and most have received major additions and renovations. At a few bases, the medical activities are consolidated into one central facility, but most bases have a number of medical buildings constructed at different times scattered around the base. The size of the facilities vary from a 61,400 square foot facility at Moody to a 374,000 square foot hospital at Nellis AFB.



Some of the bases have inadequate floor space for two-exam rooms per Primary Care Manager (PCM). Rightsizing projects have been identified and design has started on most. All of the bases have developed plans for continuous facility improvements, upgrades, and enhancements. Table 1-1 displays the age of ACC MTFs based on their initial construction dates. The AFMS strives for MILCON funding to ensure 50-year replacement cycles. The majority of ACC MTFs are currently within this metric.

**Medical Facility Contract Maintenance:** In early FY96, COMACC asked for potential outsourcing/privatization candidates from the directorates. ACC Civil Engineers (CE) offered medical facility maintenance as a candidate. ACC/CE’s got out of the medical facilities maintenance business at end of FY98. The transition from reliance on CE support to contract facility maintenance continues with the most recent contract awarded through the Operations and Maintenance Engineering Enhancement (OMEE) program (sponsored by the U.S. Army Corps of Engineers, Huntsville, Alabama). Benchmarking estimates of the OMEE program from Nellis and Langley AFBs have proven to be reliable. Benchmark studies project that contracting maintenance services will cost more than we’ve traditionally paid in CE reimbursables.

Contract medical facility maintenance costs more for several reasons: 1) More maintenance work actually being accomplished in the medical facility due to proactive maintenance programs instead of the traditional reactive maintenance support our facilities received in the past 2) dedicated in house maintenance staff, and 3) administrative and contract management fees that must be paid to provide contract oversight.

On 1 July 1998, maintenance contracts were awarded for thirteen (13) ACC facilities. With this award, maintenance contracts are now in place at all ACC medical treatment facilities. These contracts provide the level of services required by a medical clinic, ambulatory surgery clinic, or hospital. Past practices have resulted in the accelerated deterioration of both real property and

the physical plant of our medical facilities. We are addressing this issue to prolong the life of our MTFs to reduce the need for real-property maintenance projects and major MILCONs.

Base	Bldgs	Square Footage	Facilities Replacement Value**	Equipment*	WRM***	Total Assets
Barksdale	15	193,578	\$ 32,680,593	\$ 7,795,798	\$ 1,288,983	\$ 41,765,374
Beale	12	104,183	\$ 22,916,519	\$ 3,249,802	\$ 1,966,658	\$ 28,132,979
Cannon	5	155,552	\$ 35,072,691	\$ 4,642,217	\$ 396,387	\$ 40,111,295
Davis-Monthan	15	205,389	\$ 33,356,009	\$ 8,227,600	\$ 2,075,085	\$ 43,658,695
Dyess	4	167,934	\$ 32,988,742	\$ 4,789,722	\$ 202,769	\$ 37,981,233
Ellsworth	4	176,158	\$ 41,315,735	\$ 4,099,178	\$ 242,497	\$ 45,657,410
Holloman	14	126,515	\$ 23,754,729	\$ 3,540,706	\$ 2,327,602	\$ 29,623,037
Howard	6	68,910	\$ 10,517,952	\$ 4,165,691	\$ 239,129	\$ 14,922,772
Lajes	10	128,730	\$ 23,824,087	\$ 1,118,883	\$ -	\$ 25,182,099
Langley	17	228,855	\$ 39,319,076	\$ 10,410,109	\$ 2,535,878	\$ 52,265,063
Minot	3	199,748	\$ 44,875,689	\$ 7,418,669	\$ 2,204,051	\$ 54,498,409
Moody	12	89,029	\$ 14,615,069	\$ 3,169,310	\$ 1,959,537	\$ 19,743,916
Mountain Home	5	174,639	\$ 41,100,667	\$ 6,033,599	\$ 2,238,014	\$ 49,372,279
Nellis	8	412,980	\$ 95,838,341	\$ 15,166,352	\$ 2,204,494	\$113,209,187
Offutt	12	296,580	\$ 59,818,478	\$ 13,811,704	\$ 2,465,892	\$ 76,096,074
Seymour Johnson	9	139,113	\$ 24,545,901	\$ 4,115,515	\$ 1,953,997	\$ 30,615,413
Shaw	11	164,168	\$ 25,570,108	\$ 6,610,153	\$ 3,613,750	\$ 35,794,011
Whiteman	5	164,794	\$ 32,951,579	\$ 2,995,822	\$ 2,043,475	\$ 37,990,876
ACC Total	167	3,196,855	\$635,061,965	\$111,360,832	\$29,958,198	\$776,620,123

\*Equipment valued at acquisition cost before depreciation.

\*\*Plant replacement value as of 30 Sep 98.

\*\*\*WRM value as of 30 Aug 98.

Table 1-1 ACC/SG Assets (Plant and Equipment)

### Digital Radiology/Dental/Telehealth

ACC has completed a command-wide telehealth study assessing the current needs and the present capabilities within the industry. The proposed plan will implement digital radiology, store and forward telehealth applications and digital dental capabilities. The estimated timeline for program implementation will be phased-in over a three-year period. Out-year funding is in support of required maintenance and technology refreshing.

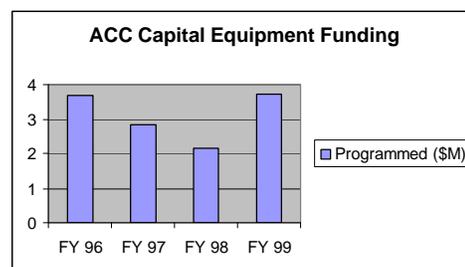
Through the use of telehealth technologies, capabilities will be enhanced while at the same time realizing substantial cost savings through the elimination of obsolete technologies. With many of our ACC MTFs geographically separated from large military medical centers and hospitals with many health care services available, telehealth technologies will facilitate electronic referrals without the cost of physically sending the patient to see a remote provider. Digital

storage and processing of images will generate cost savings through the elimination of most processing chemicals and imaging films.

### Capital Equipment

Capital Equipment (2F/0130) funding is essential to obtain and maintain the latest technology in our MTF's. This funding provides resources necessary to procure equipment and systems with a unit cost greater than \$100K. Each year this funding is used to acquire new equipment to provide capability not previously available or to replace/upgrade obsolete medical equipment and systems. In FY99 this funding level was restored to \$3.693M.

Without adequate funding, high dollar value equipment and systems can't be replaced. Each MTF endeavors to provide a level of care comparable to that in civilian facilities. However, without these funds, critical equipment will degrade, become obsolete, and have a negative impact on the delivery of quality health care. In addition, the impact may result in a negative impact on Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation ratings.



### Customer Service

Customer satisfaction is the capstone of the Air Force Medical Service strategic initiatives. In CYs98-99, the AFMS customer satisfaction task force provided customer service workshops for executives representing all ACC medical treatment facilities and sponsored the *Leadership Training for the Customer Service Revolution* course for over 900 ACC medical personnel. Follow-up workshops for MTF leaders are scheduled for May–Aug 99. Creating and sustaining a culture and climate of customer satisfaction is considered by senior leadership to be one of the most important elements in ensuring the survivability of the peacetime health care system.

Future efforts will emphasize operationalizing customer service until it becomes an integral part of the AFMS culture. The AFMS Customer Service Basics and AFMS Customer Satisfaction Priorities are the key components of the overall customer satisfaction strategy. The AFMS customer satisfaction priorities are:

- Put the Customer First
- Empower the Staff
- Eliminate Barriers/"Crazymakers"
- Reinforce the Basics

HQ USAF/SG directed AFMS Customer Service Basics be fully integrated in each AFMS organization by 1 Jul 99. A four-hour customer service training course for all newcomers is provided at each MTF in concert with the ACC Customer Care University (CCU). In many cases, the MTF has customized the CCU course to make it more meaningful to medical personnel and provides the training within the MTF. Medical personnel provide other customer service training in a wide variety of settings that require funds for materials and occasional travel. The MTF Skunkworks programs have developed many customer service initiatives based

upon local ideas, but have been hindered for further development by the lack of funds. Additional funding would provide excellent support for local recognition programs, marketing, and incidental expenditures incurred by each of these working groups.

### 1.8. MAJCOM Prioritized Deficiency List

Table 1-2 provides an overview and comprehensive listing of ACC/SG prioritized deficiencies. The list was built from our previous MSP deficiency list with updates provided from each OT Goal Champion. ACC/SG designed a scoring tool based upon the format in the Agile Combat Support Mission Area Plan guidance. The resulting ordinal ranking is listed below:

ACC/SG Needs by Priority	OT	Needs Statement
1	OT1	Existing training programs are inadequate to meet the demands of new equipment and strategies in ground-based operations.
2	OT1	Need improved concepts of operations and equipment to respond to current and future Weapons of Mass Destruction (WMD) threats.
3	OT1	Current concepts of operations and deployable assemblages are out-dated, manpower intensive, and cost ineffective to meet new EAF requirements.
4	OT1	Current communications capability does not support inter and intra-service required command, control and information superiority requirements (telehealth, medical informatics).
5	OT4	Selection, retention, training, and sustainment of flight surgeons, aeromedical technicians, pararescuemen and aerospace physiologists are inadequate to support complex AEF missions.
6	OT1	Current directed energy defensive countermeasures do not adequately meet the threat posed by known/future weapons capability.
7	OT5	Inability to capture, store, transmit, update, retrieve, and access information impedes clinical and command decision-making.
8	OT3	Lack of access to data to enable intelligent clinical, Utilization Management (UM), Health Plan Employer Data and Information Set (HEDIS), make-buy, provider profiling, and health risk assessment decisions.
9	OT1	Modern medical informatics are absent in current assemblages, and are required to meet the new AFMS strategies.
10	OT3	Need comprehensive clinical information systems to provide on-line data at point of care to include: scheduling, ancillary tests and reports, and diagnosis.
11	OT3	Total force preventive medicine support for pre-, during and post-deployment operations is inadequate.
12	OT4	Inadequate protection from directed energy weapons.
13	OT4	Human factors inadequately considered in operational planning, development & acquisition, and mission execution.
14	OT4	Determine Team Aerospace Medicine support to the AEF.
15	OT3	The Air Force/ACC needs to adequately value and practice prevention. Individual and population-based prevention is not integrated into AF managed care and operational medicine.
16	OT1	Impact of medical readiness or operational tasking requirements on capability to provide the medical benefit is not quantified.
17	OT4	Need to improve respiratory protection and personnel protective equipment (PPE)

<b>ACC/SG Needs by Priority</b>	<b>OT</b>	<b>Needs Statement</b>
		programs.
<b>18</b>	OT1	Inadequate development process for medical planners. Career pathways to maintain technical competency and institutional knowledge of medical planning require improvement.
<b>19</b>	OT5	Current Department of Defense (DoD) acquisition mechanisms and processes for health care services, supplies, equipment, and facilities are restrictive, time-consuming, and deters competitive performance.
<b>20</b>	OT4	Aircrew tolerance to agile flight extremes (high Gx and Gy, prolonged mission duration, high altitude, temperature, circadian desynchronization) is unknown or poorly understood.
<b>21</b>	OT3	Inappropriate utilization of MTF resources and lack of disease/demand management opportunities in direct care system.
<b>22</b>	OT5	Inadequate strategic resourcing for facilities.
<b>23</b>	OT3	AFMS personnel lack the skills, knowledge and tools to deliver optimal primary secondary, and tertiary prevention for individuals and populations.
<b>24</b>	OT4	Egress system seat design does not consider the performance effects of smaller, lighter weight aircrew. Aircraft performance envelope exceeds the performance envelope of egress systems.
<b>25</b>	OT4	Strategy for aircrew human performance enhancement training not fully operational.
<b>26</b>	OT2	Need to monitor TRICARE irritants.
<b>27</b>	OT5	Need to improve customer service. Staff not empowered or held accountable; practices are staff focused rather than customer focused; we fail to use information provided by customers to improve service.
<b>28</b>	OT2	Disconnect between Health Affairs, individual services, Lead Agents, Commands, and bases pertaining to authority, responsibility and coordination of projected and completed actions.
<b>29</b>	OT4	No field hyperbarics capability exists.
<b>30</b>	OT4	Information management and decision support system for the aircrew is inadequate. Cockpit and helmet mounted display information is not intuitive to the pilot and detracts from optimum mission effectiveness and situational awareness.
<b>31</b>	OT4	There is no single automated information system for the occupational health program.
<b>32</b>	OT4	Lack of female fighter aircrew urinary collection capability.
<b>33</b>	OT5	Lack of an effective cross-directional communications network.
<b>34</b>	OT5	Patient experience not managed as a system.
<b>35</b>	OT4	Need to conduct risk-based, process-oriented workplace surveillance surveys.
<b>36</b>	OT1	Earned manpower for support and maintenance of WRM assemblages is neither funded nor assigned at 100% thereby seriously degrading medical readiness capability at the outset.
<b>37</b>	OT2	Inadequate method of educating MTF personnel in managed care principles to meet near term and long term goals.
<b>38</b>	OT5	No rewards or incentives to ensure positive patient experience.
<b>39</b>	OT5	Demand for ambulatory care exceeds capacity (appointment availability) at most MTFs
<b>40</b>	OT5	Inefficient methods to share best practices.
<b>41</b>	OT5	Personnel are not effectively/properly utilized regarding training, education, and

ACC/SG Needs by Priority	OT	Needs Statement
		duties related to assigned responsibilities.
42	OT4	Need Line support to pursue life-support /aircrew performance enhancement systems development and sustainment.
43	OT2	Lack of trained cadre of personnel who understand managed care principles in order to proliferate managed care implementation.
44	OT2	Need incentives to support managed care principles.
45	OT2	No accurate standard cost system that leads to poor make vs. buy decisions.
46	OT4	Need to quantify risk due to poor ventilation in confined spaces and areas.
47	OT4	Guidance is needed on best practices to comply with the new chromate standard.
47	OT4	Guidance is needed on best practices to comply with standard for lead exposures at firing range.
47	OT4	Guidance is needed on best practices to comply with standard for isocyanate-containing paints.
50	OT4	Need to protect personnel In Accordance With (IAW) new restrictive OSHA chemical-specific standards.
51	OT4	Pneumatic tools presently used for sanding/grinding do not effectively capture emissions.
52	OT5	Personnel system is not flexible or responsive enough to MTF needs.
53	OT5	Inadequate, inefficient, and noncompetitive facilities.

Table 1-2 MAJCOM Prioritized Deficiency List

## 1.9. Resources

### 1.9.1. ACC/SG Solution Priorities

ACC/SG Solution Priorities are listed below in Table 1-3. Funding required to support these solutions totals \$110M for FY01 (**NOTE: FYs02-08 requirements are documented separately at Appendix A**). These priorities focus on force protection and AEF infrastructure at the high end and transition to customer service and distance learning at the lower end of our priorities. This is consistent with our primary focus: supporting the warfighter. The associated funding streams include the Defense Health Program (DHP) at \$77M or 70%; WRM at \$20.8M or 19%; Other Procurement (OP) at \$8.8M or 8%; Biological Warfare/Chemical Warfare (BW/CW) at \$2.2M or 2% and Line funding for \$1.6M or 1%.

Potential offsets total \$50.5M with the majority from personnel reductions (Table 1-5) of \$44.6M or 88%; and a small piece from WRM reallocation of \$6M or 12%. Achieving all our solution priorities is not possible in light of the amount of resources needed. However, we will carefully apply those funds made available to achieve a balanced approach in addressing the solutions defined.

\*Note: Solution priorities listed in Table 1-3 are a consolidated listing (by solution set) of the over 50 HQ ACC/SG individual solution quad charts detailed separately in chapter 3.

<b>ACC/SG Solution Priorities</b>			
<b>ACC/SG Priority</b>	<b>OT</b>	<b>Solution Set</b>	<b>Funding Requirements FY01 (\$000)*</b>
1	1	<b>Force Protection, Deployed &amp; In-Garrison</b>	\$ 4,085
2	1	<b>AEF Infrastructure &amp; CONOPS Development</b>	\$ 16,874
3	5	<b>IM/IT Support</b>	\$ 10,310
4	3	<b>Implement Population-Based Health Plan</b>	\$ 16,555
5	1	<b>Medical Training</b>	\$ 2,033
6	3	<b>Health Promotion/HAWC Program</b>	\$ 2,577
7	5	<b>RPMA at 3%</b>	\$ 21,273
8	4	<b>Aircrew Sustainment</b>	\$ 625
9	5	<b>Digital Radiology/Dental/Telemedicine</b>	\$ 3,124
10	4	<b>Industrial Hygiene Contractor Support</b>	\$ 1,067
11	2	<b>Marketing</b>	\$ 1,582
12	2	<b>MAE Capitation/Revised Financing</b>	\$ 13,679
13	5	<b>Capital Equipment</b>	\$ 3,805
14	5	<b>Create a Customer Service Culture</b>	\$ 118
15	4	<b>Command Core System</b>	\$ 365
16	2	<b>Computerized Patient Encounter System</b>	\$ 5,176
17	5	<b>Distance Learning</b>	\$ 260
<b>*FY02-08 See Appendix A</b>			
<b>Total</b>			<b>\$103,508</b>

Table 1-3 ACC/SG Solution Priorities

**1.9.2. Funding Stream FY01**

<b>Funding Stream</b>	<b>FY01 (\$000)</b>
2X = DHP	\$ 72,036
WRM	\$ 18,850
2F = OP>100K	\$ 8,805
BW/CW	\$ 2,228
Line	\$ 1,589
<b>Total</b>	<b>\$103,508</b>

Table 1-4 Funding Stream FY01

### 1.9.3. Offsets

<b>Offsets for FY01</b>		
<b>Enrollment Based Resourcing Model (EBRM) Reductions</b>		
Officer Reductions FY00-FY01 (\$87,607 X 1.03) X 201 Requirements	MILPERS*	\$ 18,137
Enlisted Reductions FY00-01 (\$39,040 X 1.03) X 69 Requirements	MILPERS	\$ 2,774
Civilian Reductions FY00-01 (\$35,000 X 1.03) X 69 Requirements	MILPERS	\$ 2,487
Reducing Administration Costs to 22% (See Chapter 4 Business Plan for details)	MILPERS/O&M	\$ 21,150
WRM Reallocation	WRM	\$ 6,000
<b>Total Potential Offsets</b>		<b>\$50,548</b>

\* Military Personnel (MILPERS)

Table 1-5 Offsets

### 1.10. Results and Performance Measurements

#### Performance Measurement Tool (PMT)

While PMT enhancements in the last year are to be commended, and accessibility has improved, ACC command-wide utilization is well below what would be required to make this an effectual resource. A summary of ACC concerns are:

- Concern with reliability of data-especially with CHCS and ADS
- Timeliness/Value of Data -- Need for real-time data, often data is too old to be of significant value
- Access/automatic pull of raw data
- Multiple management tools measuring identical metrics

#### ACC Mission Essential Task List (METL)/ACC/SG Performance Measure Connection

ACC/SG has eight strategic objectives that support COMACC's Mission Essential Tasks and strategic plan. ACC/CC monitors the progress of his objectives through the Planning Program System (PPS). Each directorate inputs supporting action items and reviews and updates data sets monthly. The action items support the strategic objectives listed below:

- Force Protection
- Implement Agile Combat Support
- Deploy a command-wide information network
- Build training programs
- Provide uniform, high quality health care benefits
- Customer service
- Employ metrics

### **ACC/SG Staff Performance Measures**

The ACC/SG staff has developed a wide range of performance measures used to provide COMMAC and Air Staff timely and accurate decision making information. The performance measures listed in Chapter 5 represents some of the performance measurements used in ACC/SG decision-making and the monitoring of our progress.

### **1.11. Critical Concerns for the AFMS**

#### **ACC Flight Surgeon Shortage**

Flight surgeon staffing is an Air Force-wide problem for summer FY99 replacement-cycle with a current projected shortfall of 73 positions. Some ACC bases remain below 50% with no short-term prospect of fills for these vacancies. Attempts to move individuals qualified as flight surgeons (but presently employed outside that discipline) into the flight surgeon role have been unsuccessful due to competing demands. ACC/SG is exploring the impact of these flight surgeon deficiencies upon operational readiness requirements. ACC/SG is proposing initiatives to Air Staff for developing short and long-term strategies to address experience and manning levels. AF/SG has initiated an IPT to work on potential solutions. The near term fix (through CY00) is to move specialty trained physicians (in overage positions) into flight medicine.

#### **Meeting the 1500:1 Ratio**

The challenge of reaching the 1500:1 enrollment ratio requires aggressive enrollment goals. With the reductions in personnel and current enrollment efforts, the Command is projecting a 1369:1 ratio. However, ACC/SG continues to investigate initiatives for employment to move our ratios closer to the 1500:1 target.

#### **Population Health**

It is imperative that as an enterprise when we speak of prevention we put “our money where our mouth is.” Policies and program mandates are issued to help steer the enterprise to fulfill the strategic vision of building healthy communities. Resources (manpower, money and time) are diminishing as AFMS MTFs execute right sizing completion. Prevention efforts and initiatives can be considered “soft” targets for cuts since “instant” results are not available. The AFMS must not lose focus that prevention results are paid out in the long-term. Programs such as Preventive Health Assessments and Preventive Health Care Application are tools in various implementation stages throughout the enterprise. The needed cultural shift to become prevention focused is still in its infancy. Components needed to build a strong prevention foundation include: prevention focused education and training; tools to facilitate identification of clinical preventive services for providers; money to fund prevention efforts targeted at tobacco cessation, weight management, stress reduction and cardiovascular disease; and programs such as disease management, population-based health and health promotion.

#### **Recompetition TRICARE Regions 2 and 5 Contracts**

Regions 2 and 5 TRICARE contracts will be recompeted as a result of the protest that was recently upheld by the General Accounting Office (GAO). Anthem Alliance will continue to operate the TRICARE health program until a new contractor is selected in late FY99 or FY00.

### **Anthrax Immunization Program**

As of Apr 99 there have been 70,000 anthrax immunizations given AFMS wide. Fewer than 15 minor adverse reactions have been documented in the ACC/SGOP database. While Command-wide we have not experienced problems with immunization requirements compliance, in light of the recent GAO report, and heightened safety issues brought about by media coverage, we are concerned about the possibility of future noncompliance.

## **1.12. Key Innovations, Accomplishments and Successes for the Enterprise and Command**

### **Form, Fit, And Function Follow-On (F4)**

Superb planning and preparation for the F4 exercise at Nellis AFB paid huge dividends. HQ USAF/SG requested HQ ACC/SG assess functional capabilities and limitations of new medical specialty sets and determine how each set can be optimally and efficiently integrated into ATH agile combat support operations. F4 consisted of an incremental build, starting with EMEDS (approximately 24 people), systematically incorporating 27 new medical specialty sets, building to a 114-bed AF theater hospital (over 400 people), and culminating with reconstitution of WRM assets in the final phase. This AFMS initiative culminates a 3-year effort to reengineer AFMS deployable assets. The validation at F4 demonstrated modularized medical capability can be provided to the warfighter to meet current and future operations.

### **Expeditionary Medical Support System (EMEDS)**

ACC/SG was charged by USAF/SG to build and lead a multi-disciplinary team to develop the next generation of deployable medical assets. Given guidance that it must fit on no more than 3 pallets and contain approximately 24 people, the team forged ahead to develop the Concept of Operations (CONOPS), Allowance Standards (ASs), staffing models, UTCs/Mission Capability Statements (MISCAPS) and training requirements. Block One is on track to conclude with a briefing to the AF Surgeon General 15 Sep 99.

### **Desert Care II (DC II) Deployment**

DC II was successfully fielded on schedule, end of month Apr 98. DC II represents a significant advancement in Medical Force Protection and Theater Medical Surveillance and one of our most successful and critically important initiatives. The information flow from theater to ACC and back to providers provides essential decision making data. The captured data also allows us to look at trends and illnesses. For example, through the data DC II captured on gastrointestinal related events, we are able to provide pre-deployment information to our forces addressing nutritional strategies to minimize and in some cases alleviate these events. DC II also gained Department of Defense (DoD) and National recognition when the program was briefed at the National Academy of Science Meeting on Medical Surveillance in Washington DC, 16 Apr 98. This Microsoft Windows-based technology is also documented in Bill Gates latest book *Technology at the Speed of Change*.

### **Centralized Industrial Operations (CIO)**

Ensuring WRM assets are maintained in a constant state of readiness to support the warfighter is a critical mission for the AFMS. Faced with the task of rightsizing our MTFs, ACC/SG wanted to limit the medical WRM assets maintained by personnel at operational bases to only that medical support capability needed in the very earliest stages of employment. The vision was to centrally

store and manage the heavier, more-intense medical assets at a CIO to be called upon when needed. The idea crossed Major Command (MAJCOM) lines and is being implemented on an enterprise-wide scale by the entire AFMS. This initiative, combined with the realignment of deployable medical capability (in many cases without the associated force package equipment) to AFMS medical centers, drives the requirement for an assessment of the training requirements for personnel physically separated from their WRM. Enterprise-wide solution and resourcing is required to alleviate this deficiency.

### **Panama Treaty Implementation**

HQ USSOUTHCOM/SG, in coordination with HQ U.S. South Air Force/SGX, HQ ACC/SGX and ACC/SGR coordinated on comprehensive tasks disengagement of the 24th Medical Group (MDG). The tasks included a Memorandum of Agreements (MOA) between U.S. Army Medical Command and HQ ACC/SG to transfer medical supply and maintenance Single Integrated Medical Logistics Manager (SIMLM) to the Army. A Memorandum of Understanding (MOU) signed by the Assistant Secretary of Defense, Health Affairs, transferred executive agent responsibility for health care in the Area of Responsibility to the TRICARE Region 3 Lead Agent (Army) from the Air Force. Another task included revising Annex Q, Health Service Support of U. S. Southern Command (USSOUTHCOM) Contingency Plan. Through the re-write of this Annex, the 24<sup>th</sup> MDG was relieved of their responsibility for healthcare in South and Central Latin America. For example, the Mobile Field Surgical Team (MFST) at Howard, previously used to deploy anywhere in South and Central Latin American (LATAM), is now relieved of that responsibility. The departure of all U.S. military forces from Panama remains on schedule.

### **First Latin American (LATAM) Medical Sourcing Conference**

Seventy-one missions were dispersed among the MAJCOMs and Mirror Forces. These medical deployments to Latin America provide the opportunity to employ emerging field medical technology. ACC signed up for three missions: Joint Chiefs of Staff Exercise (JCS-EX) Bolivia, General Medicine Team to El Salvador, and General Medicine Team to Peru. The conference established the LATAM Working Group and standard Air Force Specialty Code (AFSC) packages for LATAM Missions. The two-day conference was considered highly successful by all attendees, significantly improving communication and enhancing our support to U. S. Air Forces, U. S. Southern Command (USSOUTHAF).

### **Deployments To Latin America 1999**

USSOUTHAF, through ACC/SG support, executed the following missions: 10 Humanitarian and Civic Action (HCA) missions with an estimated 50,000 patients treated; two humanitarian assistance/peace keeping support missions to Haiti (Operation UPHOLD DEMOCRACY); four medical support packages for counter drug missions, Joint Inter-Agency Task Force South and MFST support, and; two Disaster Relief missions in support of Hurricane Mitch. Forty-three HCA missions remain to be executed this fiscal year. In summary, we are projecting 61 medical missions, supported by the AFMS, conducted throughout the Caribbean, Central and South America, deploying an estimated 1,000 medical personnel through the deployment cycle.

### **Ruggedized Advanced Pathogen Identification System (RAPIDS)**

Responding to an urgent national need the RAPIDS delivers capability for timely, accurate

identification of disease causing substances which can be found in human samples, food, and water. RAPIDS defines laboratory-based medical surveillance adding critical information to an epidemiological database having the potential to provide predictive and alert information. System deployment heightens medical readiness capabilities by early warning of potential epidemics that are either man-made or endemic. Pathogen identification is now achieved in 30 minutes or less using the RAPIDS.

### **Chemical Biological Warfare Defense Training Plan**

Current geopolitical climate dictates that ACC medical personnel be proficient in the management of chemical and biological warfare casualties. To meet this need, ACC/SG implemented a three-phased plan for ATH providers (physicians, nurses, and physician assistants). The plan is as follows:

- Phase I (completed): All ATHs were supplied with 10 sets of Medical Management of Biological and Chemical Casualty Handbooks and several CD-ROMs. These materials are reference for deploying personnel quarterly, and annual training.
- Phase II (Ongoing): Develop ATH training cadres to train ATH providers and all MTF personnel within one year. Each MTF with an ATH will have a cadre of 3-5 personnel trained at the US Army Research Institute of Chemical/Biological Defense "Medical Management of Chemical and Biological Casualties Care Course." The same staff will receive "Train the Trainer" certification and instruction materials. Twenty-six ACC providers have been trained. Phase II will be completed in October 1999.
- Phase III (Awaiting Funding): Initial and re-fresher training for all other MTF personnel. Medical Mobile Instruction Team will deploy to each MTF with an ATH to conduct the "Medical Management of Chemical and Biological Casualties Care Course."

### **Chemically Hardened Air Transportable Hospital (CHATH)**

The first 50-bed CHATH was evaluated at Langley AFB and rendered operationally functional by the 1<sup>st</sup> MDG. In compliance with AFI 10-106, Mission Needs and Operational Requirements Guidance and Procedures, the 1<sup>st</sup> MDG and the 1<sup>st</sup> Fighter Wing recommended declaration of Initial Operational Capability (IOC) by Commander Air Combat Command (COMACC). Twenty-one ATHs are projected to receive the CHATH components over the next two years.

### **Gerald Champion Memorial Hospital (GCMH)**

On 30 Sep 98, the USAF and GCMH signed a contract that allows the AF to provide and receive services at the new GCMH located near Holloman, AFB, New Mexico. The facility will be equipped, in part, using \$7M in funds provided by the AF. The entire \$7M was funded from AF O&M. In exchange for the AF contribution, GCMH will provide health care services to eligible beneficiaries at a discounted rate of 37% off billed charges. This example is the first of its kind for future civilian and military partnering initiatives.

### **Desktop Computer Status**

This year, ACC/SGMI completed the installation of 1200 Compaq Desktop computers in 17 ACC MTFs. These systems include the Windows-NT desktop operating system with Office 97 office automation software. Each system meets the Military Health System (MHS)

recommended minimum configurations and supports the implementation of the Defense Messaging System. DoD MHS policy is to lease all microcomputers in use in our MTFs.

### **Operations & Maintenance Engineering Enhancement (OMEE) Contracts**

ACC is the first command to have medical facility maintenance contracts in place at every medical treatment facility. Task orders issued through the U.S. Army Corps of Engineers provide scheduled and unscheduled maintenance along with other than duty-hour on-call emergency response. These task orders are part of the U.S. Army Corps of Engineers, OMEE Program. This effort is centrally funded through ACC/SGXL and in the first year alone, one MTF completed a single project that recovered the cost of their maintenance contract by providing a cost avoidance of \$547,500.

### **AFMS Customer Service Revolution**

A year ago the AF Surgeon General initiated a formal effort to improve customer service throughout the AFMS. Two of our MTFs, Langley and Mountain Home, were chosen as model sites before the worldwide deployment, currently underway. A customer satisfaction task force of approximately 15 officers and airmen presented regional rollout workshops to representatives from each MTF to aid in the establishment of local customer service working groups (also known as "Skunkworks"). Customer Service Revolutions started March 99. The AFMS customer service priorities are: a) put the customer first, b) empower the staff, c) eliminate barriers, and d) reinforce AFMS customer focus basics. We are excited about this initiative and note numerous improvements at MTFs which have enthusiastically embraced this cultural revolution.

### **Satellite Distance Learning Pilot Study**

In FY99, ACC/SG embarked on a pilot study for distance learning utilizing satellite technology. Partnering with Texas Tech University (known as HealthNet) and Swank Healthcare, the Command funded and installed satellite education programs in 6 ACC MTFs. By next year all 17 ACC MTFs will be linked to this program. With a goal to reduce Temporary Duty (TDY) costs and increase Continuing Medical Education (CME) and other training hours, ACC realized positive results. Initial data from the study shows that to date, 845 medical personnel have registered to participate in our program with HealthNet. In addition, 435 post tests have been taken, resulting in an average of 1.2 contact hours per program for over 520 CME's (120 failed tests to date, which when retaken and passed will push the CME rate to over 640 hours). We estimated cost savings of \$42K in the first half of program implementation through saved TDY costs.

**Chapter 2: Strategic Connections/Competitive Assessment**

**2.1. Strategic Connections**

The ACC/SG strategic management connection is derived from a combination of the national military strategy, CINC’s warfighting missions, and AFMS mission and vision. This chapter reviews medical and Line strategies and illustrates enterprise strategies from DoD, USAF, and ACC perspectives. Line of the Air Force strategic planning is directly integrated at the MAJCOM level. Based on national, DoD, and Air Force guidance, the ACC Commander develops a strategy, vision, and mission essential tasks. The ACC strategy, vision, and Mission Essential Tasks (METs) form the basis for the ACC/SG objectives and consequently, incorporate the national, DoD and Air Force strategies. ACC/SG is a partner with the AFMS and incorporates DoD and AFMS strategies using a strategy-to-task modernization tool modeled after the ACC modernization investment planning process. This tool compares and weighs missions-to-strategies, strategies-to-functions, functions-to-needs and needs-to-solutions. The result is an objective modernization requirements ranking (based on a weighted score) for executive review, approval, and corporate implementation.



Figure 2-1 Strategic Organization

**2.1.1. National and Line Strategy**

### **2.1.1.1. National Military Strategy**

The national military strategy is developed using a theater engagement planning process. The essential planning document for national military strategy is:

- Joint Vision 2010-Chairman, JCS Vision and Operational Concepts

Joint Vision 2010 describes how America's military will prepare for the future and encompasses four operational concepts that frame the ACC global power strategy in supporting the National Military Strategy, "Forward Presence/Rapid Force Projection." These operational concepts are as follows:

- Dominant Maneuver
- Precision Engagement
- Full Dimension Protection
- Focused Logistics

### **2.1.1.2. Air Force Strategy**

Air Force strategic planning is accomplished through the following documents:

- Global Engagement: A Vision for the 21<sup>st</sup> Century Air Force
- The Air Force Long Range Plan
- Annual Planning and Programming Guidance

Air Force strategic doctrine revolves around the ability to engage in defense of the United States and protection of its vital national interests through Air Power. This ability is defined in Air Force core competencies. Core competencies represent the combination of professional knowledge, airpower expertise, and technological know-how, when applied, produces superior military capabilities. There are six Air Force core competencies:

- Air and Space Superiority
- Global Attack
- Rapid Global Mobility
- Precision Engagement
- Information Superiority
- Agile Combat Support

### **2.1.1.3. Military Medical Strategy**

Military medical strategy was developed using the following key documents:

- The MHS Strategic Plan.
- DoD/HA End State Vision from the MHS Optimization Plan

**The MHS Strategy** stresses responsiveness and accountability to DoD, Line leadership, and to its beneficiaries.

**The MHS Mission:** The MHS is responsive and accountable to DoD, Line leadership, and its beneficiaries to ensure force health protection and to optimize the health of MHS beneficiaries by providing best value health services using best clinical and business practices. The following are selected system attributes of the MHS:

- **Military Mission:** The MHS must be responsive to readiness missions, meet Service readiness requirements, and support Service personnel readiness requirements.
- **The Customer:** Customer service will be paramount. Our beneficiaries must have easy access to services, information, and assistance.
- **Quality:** Our health services delivery system will receive JCAHO and National Committee for Quality Assurance accreditations. We will use an effective Utilization Management program.
- **Health Care Administration:** Our system will be optimized to gain maximal efficiency and cost effectiveness. Costs of goods and services will be readily ascertainable. Costs of our readiness mission will be separable.
- **Information Management:** A coordinated information management system will allow robust and responsive data analysis and tracking functions.
- **Population Health Focus:** The health of the population will be paramount – we will move from focusing primarily on intervention to prevention.
- **Performance Incentives for MTF Commanders and Providers** Incentives and feedback will be provided to our staff, based on well-established performance metrics, directly linked to the MHS mission.

#### 2.1.1.4. AFMS Strategy

The AFMS mission is to ensure healthy people to support the Air Force mission. The strategy for achieving this mission is based on assuring medical readiness and building healthy communities. The Air Force Surgeon General has developed four interlocking strategic initiatives representing the four pillars of the AFMS strategy. Together these result in a “customer satisfaction” capstone. The AFMS pillars are:

- **Pillar I:** Medical Readiness
- **Pillar II:** Employ TRICARE
- **Pillar III:** Tailored Force
- **Pillar IV:** Building Healthy Communities

The Air Force Surgeon General’s “Parthenon” is the modernization platform for development of strategic initiatives across five Operational Tasks (OTs). The five AFMS operational tasks are:

- **OT 1:** Provide Support to Employed Forces and Returning Casualties while Minimizing the Impact on the Medical Benefit
- **OT 2:** Build a Managed Care System That Integrates Quality, Cost and Access
- **OT 3:** Be the Leader of Comprehensive and Integrated Programs of Disease Prevention, Health Promotion and Fitness
- **OT 4:** Promote a Safe and Healthy Environment
- **OT 5:** Provide a Responsive and Sensitive Health Care Atmosphere

#### **2.1.1.5. ACC Strategies**

The ACC Mission Statement reads... “Air Combat Professionals providing the world’s best combat air forces, delivering rapid, decisive, and sustainable airpower, anytime, anywhere.”

ACC has seven Mission Essential Tasks (METs) which support its mission and related strategy. The seven ACC METs are provided under any physical, military, and civil conditions by meeting all supported unit requirements:

- **ACC MET 1:** Provide **Air Superiority**
- **ACC MET 2:** Provide **Precision Engagement**
- **ACC MET 3:** Provide **Information Superiority**
- **ACC MET 4:** Provide **Global Attack**
- **ACC MET 5:** Provide **Rapid Global Mobility**
- **ACC MET 6:** Provide **Agile Combat Support**
- **ACC MET 7:** Provide **Command and Control**

The Agile Combat Support MET is by far the most critical to the success of the ACC/SG health care mission. ACC/SG is responsible for medical support needs integration into the Agile Combat Support Mission Area Plan. ACC/SG is also directly involved in the Information Superiority, Rapid Global Mobility, and Command and Control METs.

**2.1.1.6. ACC/SG Strategy**

The ACC Command Surgeon Mission Statement reads...“Supporting the health of Air Combat Command’s Global Team through worldwide contingency operations and a comprehensive, community-based health care system.” In support of this mission, ACC/SG strategic objectives are developed to complement ACC METLs and the AFMS strategic pillars. They are:

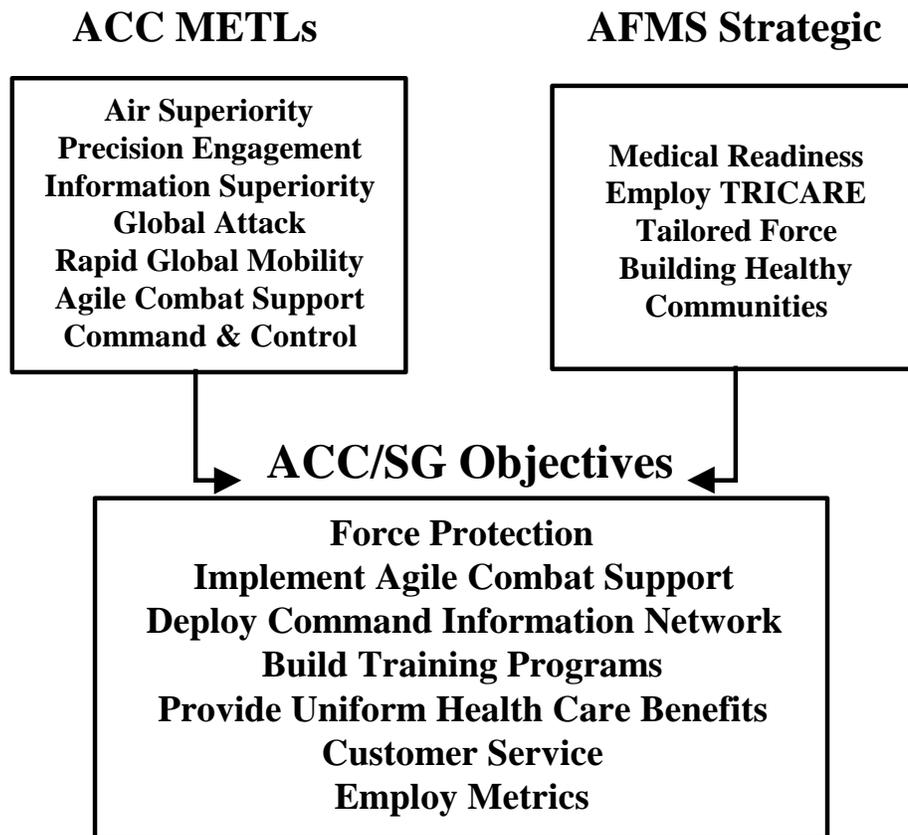


Figure 2-2 ACC/SG Objectives

ACC/SG’s seven strategic objectives that support COMACC’s mission and related strategic plan are expanded as follows:

- **Objective 1:** Make **Force Protection** training and planning a priority in every organization, both while deployed and at home.
- **Objective 2:** **Implement Agile Combat Support** concepts. Reduce airlift required to deploy an expeditionary Aerospace Force.

- **Objective 3:** Continue to **Deploy A Command-Wide Information Network** that improves the operational availability of data and information, guarantees information assurance across the spectrum of conflict, and facilitates process re-engineering to reduce cost of ownership.
- **Objective 4: Build Training Programs** that maximize balanced mission capabilities within available resources, to include Force Protection and the Ability to Survive and Operate.
- **Objective 5:** Provide **Uniform, High Quality Health Care Benefits**; promote prevention and improved health and wellness.
- **Objective 6:** Schedule all **Customer Service** providers and their supervisors for Customer Care University and develop follow-on customer care training.
- **Objective 7: Employ Metrics** that give key decision-makers visibility into the costs associated with every aspect of their operation.

#### **2.1.1.6.1. Medical and Line Integration Strategy**

ACC/SG is fully integrated with the ACC modernization and planning processes. Our involvement, primarily in the Agile Combat Support Mission Area Plan (ACS MAP), allows us to gain a cooperative exchange of advocacy and knowledge of medical programs with traditional Line programs. We have developed a close relationship with ACC Directorate of Requirements, resulting in increased medical review and input into Line products. This interactive relationship is evident particularly in areas with human systems concerns; a consideration often overlooked in the past that resulted in systems lacking appropriate human systems health and welfare provisions. Additionally through our cooperative advocacy efforts, ACC/SG has become a voice for the AFMS in multiple Joint forums. We are recognized as the AFMS expert and authority on medical chemical and biological warfare issues and work closely with our sister service counterparts. We embrace this role and work diligently to enhance our voice and capability as the AFMS leader for medical agile combat support.

#### **2.1.1.6.2. ACC Strategy-To-Task Modernization Investment Planning Tool**

ACC/SG designed a Strategy-To-Task tool to identify and prioritize strategic solutions. The combinations of the various missions and strategies are incorporated in the Strategy-To-Task tool through a series of spreadsheets that compare and relate strategies-to-objectives, objectives-to-functions, functions-to-needs, and finally needs-to-solutions. Each step in the process requires evaluations such as “What is the contribution of this ACC Operational Objective to the accomplishment of the AFMS Operational Task?” or “How relevant is this need to my function” and “what is the magnitude of the need to accomplish my functional task?” The result is an ordinal ranking of needs and solutions. The executive staff and Goal Champions validate the ACC/SG prioritized solution list. From this list, solutions that may compete for Line or WRM funding are further prepared for inclusion in the ACS MAP and the ACS Development Plan. The strategy-to-task tool and the associated scoring is attached in Appendix B.

**2.2. Competitor/Partner Analysis**

ACC/SG’s two core missions are distinct in their competitive situation. The mission to *provide deployable ground medical systems* is a unique military medical mission with no public competitors. Competition is internal to the Air Force to provide optimal performance in achieving medical service goals despite rapidly changing medical service requirements. The mission to *provide community-based health care* involves direct competition with public health care providers and competing federal provider programs. Following are the unique attributes of our two core missions:

	<b>Provide Deployable Ground Medical Systems</b>	<b>Community-Based Health Care</b>
<b>Strategy</b>	Organize, Train, and Equip	Improved Population Health
	Contingency Support	Enrollment Optimization
	Modernization	Best Clinical Practices
		Accurate Reports and Metrics
<b>Partners</b>	Beneficiaries	Beneficiaries
	Supported CINCs	Lead Agents
	Guard & Reserve	Federal & DoD Organizations
	AFMS Staff & AFMS Staff Organizations	Managed Care Support Contractors
	Joint Services	Other Insurance, Private Sector
		Joint Services
<b>Competitors</b>	The Line & Their Program Funding	Managed Care Support Contractors
	Changing needs of the AFMS	Other Insurance
	AFMS Staff & other MAJCOMS	Private Sector
	Joint Services	

Table 2-1 Competitor/Partner Analysis

**2.2.1. Competitor Analysis**

**2.2.1.1. Deployable Ground Medical Systems Competitors**

**Line of the AF Programs and Funding**

ACC/SG is the only MAJCOM SG that competes for modernization initiatives within the Combat Air Force for Air Force Line funds. Because ACC is the author of the Air Force’s ACS MAP, ACC/SG has the unique responsibility to articulate deployable ground medical systems requirements to the Line of the Air Force. The ACC operational readiness and development team is the only trained, equipped, and ready source for deployable ground medical systems modernization and sourcing. There are no other competitors uniquely positioned or ready.

**Changing AFMS Needs**

From South West Asia to South America and around the globe, the core mission to provide deployable ground medical systems is best articulated by the medical representatives of the Combat Air Forces. Changes in medical resourcing that resulted in the realignment of deployable personnel creates an organizational challenge in meeting ever changing go-to-war and contingency requirements. The ACC Health Care Operations Division under the guidance of the CAF/SG, is in a central position to provide the best service in supporting the CINCs needs. The ongoing peacetime operations provide critical training in the wartime skills necessary to meet the demands of a major theater war or small scale contingency operation.

### **Other AFMS MAJCOMS**

Funding within the AFMS remains a challenge with the decision and implementation authority centrally managed. The challenge for ACC/SG ground systems lies in our competition for advocacy and funding with the Line of the Air Force, within the AFMS, and other MAJCOMS. We are meeting that challenge locally through the ACS MAP as well as through a continued vocal advocacy for ACC and CAF needs to the AFMS corporate structure.

### **Joint Services**

Lastly, we face challenges in competing for funding in Joint Service programs. One example is Nuclear, Biological, and Chemical (NBC) defense programs that by law must compete for Joint funding. In the Joint environment the Army is all too frequently designated as the *Lead Command* for specific requirements. Experience has taught us to be strong, vocal, and well-prepared advocates for Air Force specific programs and for those Joint programs with a strong Air Force interest. Through strong partnerships with our sister services and the ACC Directorate of Requirements we are increasing our influence in the Joint Service programs.

#### **2.2.1.2. Competitors to Providing Community-Based Health Care**

##### **Managed Care Support Contractors (MCSC), Other Health Insurance (OHI), and Private Sector**

In an environment that allows our beneficiaries to “vote with their feet,” local managed care support contractors, as well as other civilian-based benefits programs will gain an advantage with beneficiary base if we don’t capitalize on our MTF strengths and recognize our weaknesses. Our customers prefer MTF services in comparison to our civilian competitors. However, dissatisfaction with aging medical facilities and a lack of comprehensive services available in the MTF is a weakness. Continued right-sizing resulting in a majority of MTFs having reduced clinical capabilities enhances the advantage our beneficiaries will find in the local community or through competing health plans. We are confident however, that with a strong, sustained customer service focus in our MTFs, we will retain a steady beneficiary base that prefers our “in-house” products and services.

#### **2.2.2. Partner Analysis**

##### **2.2.2.1. Partners to Providing Deployable Ground Medical Systems**

ACC medical personnel are situated throughout the Continental United States, the Azores, and Panama. Regional diversity reflects a broad spectrum of partners.

### **Beneficiaries**

First and foremost our military customers are the partners that will ensure our success. A healthy population who are provided the best quality service will ensure our continued success by assuring a healthy and fit fighting force prepared to deploy anytime, anywhere. Second, the care delivered to these customers and their families provides our health care providers the regular practice needed to maintain their clinical skills essential to their wartime role.

### **Supported CINCs**

As the Air Component Surgeon for the AFFOR assigned to USCENTCOM, USSOUTHCOM, and USACOM, the ACC/SG does the planning and employment for the execution of theater operations. This planning role continues during execution of contingency operations as the staff deploys forward with the theater forces and establishes a forward AFFOR surgeon staff. This unique mobility mission is tasked to meet the needs of the Theater CINCs with highly trained personnel. ACC/SG is also the Manpower Equipment Force Packaging Agent for numerous deployable assemblages and personnel packages with a focus on development of capability that is tailored to meet CINCs by providing maximum capability in minimal weight and cube.

### **Guard and Reserve**

Guard and Reserve medical assets are full-up partners in ACC/SG readiness planning initiatives as well as active partners in the ACC Surgeon's organizing, training, and equipping forces activities.

### **AFMS and MAJCOMS Staffs**

The ACC/SG staff members work closely with their Air Staff and MAJCOM counterparts in planning and developing deployable ground medical systems. A good example of AFMS partnering is the EMEDS assemblages currently under development. Though led by ACC/SG, the development team includes key representatives from across the entire AFMS representing nearly every discipline. This type of partnership is sure to produce a deployable medical system optimal to meeting CINC contingency needs from wartime to humanitarian operations.

### **Joint Services**

Multiple forums exist with Joint Service representation to address the requirements for deployable ground medical systems. For example one such group is the Joint Service Integration Group Medical Program Subpanel Working Group (JSIG MPSP WG) that addresses medical CW/BW requirements. ACC/SG as the Lead Command for medical CW/BW requirements, regularly represents the AFMS in this forum. ACC/SG also represents the AFMS shelter requirements to the Joint Committee on Tactical Shelters.

#### **2.2.2.2. Partners to Providing Community-Based Health Care**

ACC business partners include DoD, Lead Agents, TRICARE Managed Care Support Contractor, sister services and the Department of Veteran Affairs (VA). Each represent critical components of our efforts to provide our beneficiaries access to the highest quality of care,

delivered in comfortable surroundings; while maintaining best business practices. The challenges and contributions of each component are varied.

### **Beneficiaries**

ACC MTFs will be provided with beneficiary data that allows the facility to target potential enrollees who have visited the facility within the past year but are not enrolled. With this data and the appropriate funding from the Air Staff for marketing efforts MTFs will be able to achieve the goal of providing quality care to an optimal enrollment level.

### **Lead Agents**

ACC works closely with the various lead agents through Video Tele-conferences and face-to-face conferences, and endorses their lead with respect to managed care support contract implementation.

### **Other Federal and DoD Organizations**

Several VA/DoD Sharing Agreements have been initiated throughout ACC that greatly augments services to our beneficiaries as well as enhances skills of our providers. One example of successful partnering is the VA and DoD joint venture. The Michael O'Callaghan Federal Hospital allows the hospital at Nellis AFB, Nevada, to provide service more cost-effectively through sharing of operating expenses.

### **Managed Care Support Contractors**

The short term survivability of TRICARE requires our staff and the staffs of the MTFs to work cooperatively with the managed care support contractors in a coordinated and supportive manner to resolve major TRICARE irritants such as claims processing, network development, and access issues; among others.

### **Joint Services**

ACC also has extensive partner and service relationships with our sister services. The hospital at Langley AFB, Virginia regularly refers to the Portsmouth Naval Medical Center and the facility at Shaw AFB, North Carolina regularly refers to Eisenhower Army Medical Center Augusta, Georgia.

As the military health system moves forward focusing on population health and greater efficiency, current partners must be examined for partner renewal or decline. Lastly, we must continue to research and pursue new opportunities for partnership arrangements.

## **2.3. Competitive Strategy**

The ACC/SG competitive strategy is to develop optimal support to Line leadership and our beneficiaries. In this regard, the ACC medical community has a unique role in preparing for the future while taking care of people, training, and force sustainment. This strategy is achieved by providing high quality, cost effective health care services today. In addition, as the CAF medical support focal point for future medical needs, the ACC Surgeon's staff matrixes the needs and

requirements of the unified commanders to effectively manage training platforms, equipment and resources for the future. Contingency and operational medicine are at the center of this unique role supporting all theater unified commanders while promoting the health of the ACC global power team every day in every ACC community and deployed location.

The ACC competitive strategy focuses on core MAJCOM functions; organize, train, and equip. This focus allows us to achieve the ACC/SG Mission. ACC is operationally and requirements focused; from providing operational health support for global as well as local requirements to building requirements for future generations of ACC medical personnel. We are responsive not only to the present, but also to the future.

### **2.3.1. Provide Ground Medical Systems Strategy**

- **Organize, Train, and Equip**
- **Provide Contingency Support**
- **Modernize Resources**

Competent and effective deployable ground medical systems are the result of commitment and investment in initiatives to organize, train and equip ACC medical personnel. Building from this premise we can support rapid development of modernized ground medical systems that provide critical agile combat support to Line and CINC missions.

### **2.3.2. Providing Community-Based Health Care Strategy**

- **Improved Population Health**
- **Enrollment Optimization**
- **Best Clinical Practices**
- **Accurate Reports, Metrics, Data Analysis**

To optimize the health of the ACC beneficiaries, we must partner with the customer to provide high quality health services. Programs such as Put Prevention Into Practice (PPIP), Health Evaluation and Assessment Review (HEAR), and Preventive Health Care Assessment (PHCA) aide in the identification, early prevention and intervention of health events affecting our beneficiary population. Enrollment optimization ensures not only optimal use of our facilities, but optimal opportunities for our providers to develop and enhance their clinical capabilities. Best clinical practices, accurate reporting data, and metrics further serve to enhance our knowledge not only of our beneficiaries, but also of ourselves and the services we provide. Key to improved population health is coordinated information management with robust and responsive data analysis and tracking functions. Employing resultant data ensures we are providing what our beneficiaries need and analysis of the quality and cost effectiveness of those services.

## Chapter 3: OT Needs Analysis and Solution Concepts

### 3.1 Enterprise Issues

The following chapter covers issues, needs and solution concepts we advocate for implementation in the next seven years and beyond. Both material and non-material solutions are included in the MSP. Some material solutions have also been included in the ACS MAP for consideration for development, support, and funding through the Line. Through ACC/SG partnering with the ACC Line, we have adopted the Mission Area Planning (MAP) processes for SG solutions. The Line strategy entails cooperative planning for resources across all Directorates that results in cooperative advocacy. Through ACC/SG participation and partnering with the ACC Line, we learned to successfully defend our needs, we had to be able to by documenting clear and concise descriptions and justifications for each of our solutions. These solutions show linkages to COMACC goals as well as CINC Integrated Priority Lists (CINC IPLs). We also learned material solutions must be supported by Mission Needs Statements (MNS) and Operational Requirements Documents (ORDs) in accordance with AFI 10-601.

The results of our efforts are documented in the solution description quad charts located after each OT priority list. The quad chart format includes a solution description, justification for the solution and funding schedule (roadmap). Solution linkages show how our priorities support AF/SG goals, ACC/SG priorities, and needs addressed in the ACS MAP. Solutions with Joint applicability are also identified for consideration for Joint funding and development opportunities.

This is our first attempt at incorporating a Line process for identifying and documenting ACC/SG needs. We've learned a lot from the process and we recognize we have a lot more work ahead of us. While not all of the quad charts are fully developed, we include them in the MSP for consideration for funding, to gain advocacy across the AFMS enterprise, and to educate and inform the rest of the AFMS of the desired end states for ACC operational tasks. We also are eager to aid others who may want to incorporate the ACC/SG strategic process into their Commands.

Key to this process is a trained and proactive staff to work with local requirements personnel. A commitment of personnel, expertise and resources is critical to success. Consideration should be given to training and certifying medical personnel in Acquisitions. Additionally, partnering with Human Systems Wing (HSW), Air Force Research Labs (AFRLs), and Technical Planning Integrate Product Teams (TPIPTs) personnel is required.

#### 3.1.1. Information Systems

##### **Year 2000 (Y2K) Preparation**

One of the most important issues ACC/SG addressed during FY99 was our Information Systems (IS) assessment of Y2K preparedness. All desktop and mission critical systems are certified as Y2K compliant. We continue to monitor these and other critical devices for additional date sensitivities that could threaten operations and security.

### **Infrastructure Upgrade**

Our reliance on information systems to provide medical informatics and connectivity are critical success factors for the AFMS. Overall, enterprise-wide improvements are being made in our infrastructure. We fully expect to bring all of our medical treatment facilities up to the MSIM standard by the end of FY01. During this upgrade, we will install a network cable plant capable of handling 100 Mega Byte (Mb) to the desktop.

### **Command Leasing Strategy**

In addition to having a solid network layer, ACC/SG has strategically executed a command-wide desktop leasing contract that will ensure a technical refresh rate of every three years. A solid network, coupled with state-of-the-art devices will give our medical staff the edge in improving the health care delivery system. As the TRICARE Management Activity (TMA) deploys leading edge technology that leverages advances in multimedia applications, ACC medical personal will be ready. The command-wide lease also provides us enterprise-wide asset management. We will be able to provide an accurate inventory of all desktops within the command from a consolidated web page.

### **Deployable Technology**

Providing our warfighters and medical personnel with leading edge technology while deployed is a critical requirement of the ACC/SG. We are building upon our success with the Desert Care I and II clinical encounter application in Southwest Asia and adding functionality. We will deploy a next generation application that will improve upon Desert Care II, interface with our peacetime database, and provide for a lateral patient record as we deploy throughout the world. We will also add early BW/CW detection and notification.

As the Lead Command, ACC/SG is also aggressively working the infrastructure technical solution with Air Force Theater Medical Information Program (TMIP). The technical solution will support the aforementioned application as well as integration with other standard systems (e.g., logistics, blood bank). We will utilize the best technology possible for our deployed troops and provide a reliable network. Wireless and satellite communication will support our EMEDS information and communications systems.

### **Staffing Requirements**

Information Dominance is a critical goal of the ACC/SG and adequate staffing is paramount to our success, however, there is a mismatch in manning to support the IM/IT initiatives currently underway. The goal of ACC is to work the Human Resource Management issues pertaining to this command. Also, it is the responsibility of HQ AF/SG to identify the Human Resource Management requirements as new systems are installed and more importantly fund all requirements associated with these systems for the life cycle. As we right size our facilities, we are paying close attention to ensure that our MTFs are staffed to support application systems and infrastructure. Additionally, we need to ensure that there are skilled information managers attached to each unit to satisfy local and command information management requirements.

### **Training and Support**

In addition to ensuring our MTFs have adequate staffing, we need to ensure that our technicians are technically competent in performing their peacetime mission. It is critical that we invest in

developing the skill set of our medical workforce to keep our peacetime health care system running. They also will be called upon to sustain a deployed expeditionary medical team. ACC/SG strongly believes in getting our medical technicians certified in the latest technologies (Microsoft NT, Office Suite, and Databases), because we will rely on this capability. In addition to instructor led courses, computer-based training modules are available to all AFMS members via the ACC or Air Force Medical Support Activity computer based training web sites (<http://cbt.langley.af.mil/cbtweb/> or <http://sg-www.satx.disa.mil/cbt/cbtweb/afmsacbt.htm>).

### **Data Mining and Information Dominance**

Information Dominance is one of ACC/SG's top priorities. To execute this vision, we must get our arms around all of the critical medical databases. In support of this vision, ACC/SG has put in place a systems architecture that allows us to pull health care information from CHCS, ADS, and Desert Care and perform population health analysis. Within this architecture, we can perform medical surveillance across the nation and at our deployed locations. The data repository must be current to allow for the application of algorithms against the data sets that will assist us in detecting covert BW/CW attacks as well as disease breakouts.

### **Telehealth Initiative**

The last area, but definitely not the least important initiative for ACC/SG, is to develop and deploy a command-wide store and forward telehealth program. As we execute our right-sizing plans, we have learned that "gaps" can occur between the MTF staffing and the TRICARE managed care network. Rather than allow this gap to impact our beneficiaries, we will try to establish a telemedicine referral network that covers the services needed by our beneficiaries. As the clinical business area deploys its next generation health care system, capable of leveraging state-of-the-art technology, ACC/SG will press to get lightweight mobile technology inserted into the homes of our patients. Remote monitoring and information transfer will assist our medical staff in caring for our population.

### **Investment Strategy**

We have secured funding to upgrade our infrastructures, sustain our command lease, and procure components of our next generation deployable system. However, we currently do not have a funding line to take care of two critical initiatives that would benefit our staff and our patients; training and telehealth. If funded, these two unfunded initiatives would begin to show a return on investment for the command within one year. These investment opportunities represent an investment in our future -- critical to us remaining competitive. Our facilities are relatively small compared to other Commands, we have less concentration of specialties, a higher referral trend, higher bid price adjustment for facilities under contract, and a need to become more virtually integrated through technology.

#### **3.1.2. Education and Training**

With a focus on forward medical support, medical training is required to assure force protection and forward-deployed medial capability for expeditionary air forces. Training requirements include initial and sustainment training. Training to enhance war ready surgical trauma skills is difficult to obtain and maintain in peacetime settings. Medical training exercises are also required to test new Unit Type Code (UTC) capabilities for functionality and limitations. With

centralized storage of many of our medical assets, Mobile Red Flag training must expand to include critical hands-on training with deployable assets. Pararescue airmen require Emergency Medical Training (EMT) certification every two years. We are working closely with USAFSAM and HQ AETC/SG in improving existing training and development of new training capabilities.

### **Distance Learning Background**

Traditionally we have spent countless staff hours and millions of dollars to send our staff members to conferences to receive CME hours. Today, there are fewer dollars available to fund these TDY's. At the same time, we are less able to afford the opportunity cost of our providers leaving the MTF to obtain CME. As Air Force health care professionals, we must abide by the many mandates of state, federal, and professional organizations to maintain competency and certification. A wide variety of educational opportunities are available to us—though many are not convenient. We recognize that while the base of knowledge seems to be expanding exponentially, our ability to access the many opportunities is not without barriers.

There are multiple technologies available for distance education. ACC/SG has taken the initiative to pursue the use of a few of these recognizing that remaining occupationally competent in today's knowledge economy necessitates continual learning. Along the way to developing a distance learning ethos, we identified a great need for continuing education (both credit and non-credit) for non-physicians such as nurses, allied health professionals, dentists, pharmacists, administrators, and the entire spectrum of medical technicians. These groups also have requirements to maintain advanced skills, licensure and certification requirements. We also recognized that there are barriers to providing the required training including time away from work, expense, deployments, and other Air Force related priorities which might preclude many of our professionals from obtaining necessary training. Our distance learning initiative seeks to address the unmet need for convenient, effective and affordable high quality health care education.

### **Distance Learning Goal**

The goal of our efforts is simply to “connect learners with distributed learning resources.” It's our belief that by providing at least one avenue to obtain high quality CME, we will spark people to seek out and utilize the universe of distributed learning resources available—be it satellite, inter- and intra-net, CD-rom, video teleconference, or computer-based training.

### **Desired Benefits**

The desired benefits are many and include: ability to remain competitive, ensuring our health care professionals stay current in a rapidly changing world, cost-effective (decreased TDY and training budgets), and quality programming. For these benefits to be realized, MTF leadership must emphasize the value of this type of training. In the end, we seek to produce an educated health care team better able to cope with a world which is changing with startling speed.

### **Pilot Study Initiation**

In FY99 ACC/SG initiated an ambitious pilot study to fund the use of satellite-centered distance learning technology at 8 ACC MTFs (though installation difficulties hampered 2 MTFs from coming on-line). The ACC/SG chartered the pilot study with two metrics: first, increase the number of CME and other training hours our personnel obtain and second, reduce overall CME

TDY costs. Contracting with HealthNet, a division of Texas Tech University Health Sciences Center--programming--(and partnered with Swank Healthcare Services in St. Louis, Missouri—Customer Service) the MTFs receive over 180 Category 1 accredited CME programming yearly.

The HealthNet offers our MTF service in the following two primary areas:

- **Staff Continuing Education** The heart of our distance learning effort; programs are received via digital satellite technology and viewed live or captured on video tape by the MTF Education and Training staff for use by staff members. CEUs are generated when staff members pass a test. Both testing and proof of completion are now provided via the Internet directly from Swank Healthcare Services. CME hours are accredited from a wide variety of bodies—and HealthNet is in negotiations to add more based on our input.
- **Patient Education** Programming oriented towards patients assists with patient education of medical conditions as well as providing health and wellness information. This programming is either sent through out the MTFs via a centralized cable network or played in individual patient education settings. It satisfies a portion of Joint Commission on Accreditation of Healthcare Organization requirements.

### **Pilot Study Results**

A 1998 Army study, using data from MTFs in all 50 states found the average nursing CME unit cost was \$65.00 while the average cost for physician CME was \$200.00. Savings are achieved when CMEs are received using HealthNet and reducing the number of TDYs. Initial ACC/SG cost savings generated through distance learning based on the cost of nursing CME is \$42K in the first half of program implementation.

### **Future Plans**

Based on the positive pilot study results, ACC/SG has optioned to expand funding the initiative to include all 17 ACC MTFs in FY00. In addition, ACC/SG will continue to work with the contractor to develop military specific training with an eye on reducing readiness-training costs. Texas Tech University has enthusiastically partnered with us, and will continue to do so in the year to come. We are working on contracting vehicles that will make it easier for all DoD MTFs to buy this service. Additionally we are working with our Air Staff counterparts to develop satellite distance learning for use throughout the AFMS.

#### **3.1.3. Policy**

#### **3.1.4. Mirror Force Integration**

ACC/SG supports the mirror force goals. The ACC/SG is responsible for the management of medical readiness operations at 16 CONUS bases and one overseas base. In addition to these ACC bases, there are 43 Air National Guard (ANG) units and 18 USAF Reserve medical gained units to ACC bases. The key strategy of Mirror Forces is achieving a seamless, ready AFMS.

- **Goal 1 Statement** – The success of our medical readiness posture depends on how effectively the Active and Reserve Components integrate together as a team using all available resources. The net effect of this enterprise-wide strategy is a force multiplier.

- **Goal 2 Statement** – The capability of the AFMS is based on a well-trained, highly competent work force with skills that meet both peacetime and wartime missions best supported by Active and Reserve Components ensuring all members are trained to the highest standards.
- **Goal 3 Statement** – In order for the AFMS to become a true force multiplier it must ensure that both components are utilized wisely and to the fullest extent possible.

Initiatives are underway within ACC to promote integration of the Mirror Force strategies to meet mission requirements including many of the Readiness initiatives described at 3.2.1.3. These efforts include:

#### **Command Support**

HQ ACC/SG has four full time mirror force representatives to implement the Mirror Force Tactical Plan. ACC/SG has over 43 gained ANG units with over 53,300 airmen. Additionally, there are 10 medical reserve units with 1098 personnel gained to ACC. ACC actively supports the integration and combining of staff. ACC/SG has and continues to strongly support the placement of a Colonel (06) Title 10, Section 10211 officer at the command section of HQ ACC/SG. This position is the ACC/SG's and staff's primary senior interface with the ANG. This position is also one of the senior ANG officers on base and functions as a full team member with the other directorates senior ANG positions.

#### **Mirror Force Operational Support**

The command is actively involved with sourcing mirror force units for operational medical support. Southwest Asia and South AF deployments have furthered Mirror Force integration by providing deployed personnel opportunities to work in a Total Force environment. ACC/SG has and will continue to support and work toward further operational integration. We hope to fill one validated ANG Medical Readiness action officer position and work with the Air Force Reserve to fund a similar position. This would enable Active, Guard, and Reserve Forces to work side by side in support of deployments, exercises, training, plans, and inspections. We feel this would give the Reserve Components the opportunity to be on the front end of and have more seamless involvement related to our primary mission. It will also provide the opportunity to review requirements on a real-time basis. These efforts will also insure we task supportable requirements to the Reserve Components.

#### **Individual Mobilization Augmentees (IMA)**

We are currently participating with the Air Staff in an effort to develop a system designed to evaluate the IMA program. We have data on the number of IMAs attached to our facilities and are developing a method of evaluating the impact of the IMA program on our mission. We must use the IMA program wisely. In this time of lean resources, we need to ensure we have the IMA's in the correct locations and positions that are needed and that they are trained in the skills required.

### **3.1.5. Other MAJCOM Enterprise Issues**

#### **Lead MAJCOM**

ACC/SG focus is on our ability to provide operational and community-based health care. Current ACC/SG endeavors are highly successful but could be improved through an enhanced decision-making strategy. ACC/SG is recognized as the “lead command” for medical BW/CW issues, by virtue of its unofficial lead role advocating, planning and resourcing for ground medical weapons systems. However, our ability to fulfill lead MAJCOM responsibilities is hindered by a lack of official designation as “Lead Command.”

Lead MAJCOM authority is required to properly mesh lines of authority, resourcing, and integration of processes. This authority would allow the CAF/SG to be strategically and operationally aligned and tactically agile in order to respond to the broad range of worldwide requirements. Lead MAJCOM authority would provide the resources required to support the entire continuum of warfighting concepts to include force protection, peace keeping operations, and humanitarian assistance. It will allow CAF/SG to continue its work “legitimately” and become the recognized test-bed for ground assemblage weapons systems. In the end, Lead MAJCOM authority will allow the command to smoothly join, under a single “roof” all aspects of medical weapon systems development.

ACC/SG, as the CAF Surgeon, sees a real and compelling need to establish a medical ACS development center. This operation would serve as the single point of contact for oversight of theater medical technology development, integration, test and evaluation, modeling, rapid prototyping, and program planning. This need is precipitated by the speed with which the Line of the Air Force is pursuing the development of the Expeditionary Air Force and its associated force employment concept, the Air Expeditionary Force.

In parallel with the current COMACC reengineering efforts, the time is ripe to position the CAF to better use all available resources in supporting the USACOM. In this role, ACC/SG is in a strong position to advocate for, and align its efforts with, the warfighting CINC needs. Current command structure, brought about in a large part through the passage of the Goldwater-Nichols Act, increases the role of the warfighting CINC and decreases the role of the service chiefs. Now, the role of the CINC eclipses the service chiefs while allowing the directorates to advocate for the CINC needs from the user level. Under the current Unified Command Plan, the stand-up for the AF Joint Experimentation Office at Langley AFB, and the close proximity to U. S. Army Training and Doctrine Command, ACC/SG is well positioned to represent the AFMS to one of its major customers, USACOM.

We must continue to push the limits of the ACC mission to “Organize, Train, and Equip” our warfighters. The establishment of a medical ACS development center within ACC/SG will allow the staff to drive toward developing capabilities in support of current and future needs—both within the Air Force as well as in the joint-world. When reengineered properly, the AFMS will have developed new processes where the right resources are located in close proximity between the developers and the operators.

In summary, HQ ACC/SG advocates for the establishment of Lead MAJCOM authority for all ground assemblages. Further, it seeks the same authority to establish a medical ACS development center under its auspices. It's the right time to place the right resources, in the right command—and migrate the authority commensurate with the responsibility to support today and tomorrow's warfighter.

### **HQ ACC/SG Managed Care Activities**

While the MFTs have ongoing managed care missions, HQ ACC/SG is focusing on organizing, training, and equipping the warfighting force. ACC/SG responds to and advocates for TRICARE managed care issues and oversees the implementation of DoD Health Affairs and AFMS policies throughout the Command. AFMS enterprise savings would result if MAJCOMs divested the managed care function to a centralized Field Operating Agency aligning organizationally with Health Affairs.

## **3.2. Operational Tasks**

### **3.2.1. OT-1 Needs Analysis and Solution Concepts**

**Operational Task 1 (OT-1). Provide Support to Employed Forces and Returning Casualties While Minimizing Impact on Medical Benefits. Goal Champion: Col Vivian, e-mail: [talbot.vivian@langley.af.mil](mailto:talbot.vivian@langley.af.mil)**

#### **3.2.1.1. OT-1 End States**

**OT-1 End State 1:** In the near term (NLT CY02), develop, test, and field modularized deployable medical support systems that meet AEF and ACS operational requirements within existing DoD assets.

**OT-1 End State 2:** In the mid term (NLT CY07), develop deployable medical support systems with improved capabilities and reduce lift requirements meeting AEF and ACS operational requirements.

**OT-1 End State 3:** In the mid-term (NLT CY05), develop interim solutions to enhance integrated, worldwide medical command, control, communications, computers, and intelligence (C<sup>4</sup>I) capability. Migrate medical support systems like MRDSS, DCII and others into the Global Command and Control System (GCCS) and the Global Command Support System (GCSS).

**OT-1 End State 4:** In the near term (NLT CY03), field an integrated medical logistics system, based upon tenets of the Focused Logistics Roadmap, which is capable of supporting Joint Service requirements and providing full-spectrum supportability.

**OT-1 End State 5:** In the near term (NLT CY03), field an improved capability to respond to weapons of mass destruction and directed energy threats, including links with Line Intelligence Surveillance Reconnaissance (ISR) programs, standardized medical countermeasures, and enhanced partnerships with national and state emergency response agencies.

**OT-1 End State 6:** Prepare to field an Combat Development Center to meet field CONOPs, develop capabilities using COTs/GOTs technologies and rapid prototyping, conduct field testing, and make recommendations to the Air Staff for fielding in deployable assets.

**OT-1 End State 7:** In the near term (CY02) integrate Mirror Force personnel into ACC/SG operations.

**OT-1 End State 8:** In the near term (CY01) develop training programs to meet the demands of new equipment and strategies in ground based operations.

**3.2.1.2. Operational Task Deficiencies**

**OT-1 Needs:** The following ACC needs and associated end states are derived from the preceding discussions.

<b>OT-1 Need Priority</b>		
<b>ACC/SG Priority</b>	<b>Need</b>	<b>Need to End State</b>
1	Existing training programs are inadequate to meet the demands of new equipment and strategies in ground-based operations.	1, 5
2	Need improved concepts of operations and equipment to respond to current and future WMD threats.	1, 2, 5
3	Current concepts of operations and deployable assemblages are out-dated, manpower intensive, and cost ineffective to meet new EAF requirements.	1, 2, 5, 6
4	Current communications capability does not support inter and intra service required command, control and information superiority requirements (telehealth, medical informatics).	1, 2, 3
6	Current directed energy defensive countermeasures do not adequately meet the threat posed by known/future weapons capability.	5
9	Modern Medical informatics are absent in current assemblages, and are required to meet the new AFMS strategies.	3
16	Impact of medical readiness or operational tasking requirements on capability to provide the Medical Benefit is not quantified.	1,7
18	Inadequate development process for medical planners. Career pathways to maintain technical competency and institutional knowledge of medical planning require improvement.	1, 3
36	Earned manpower for support and maintenance of WRM assemblages is neither funded nor assigned at 100% thereby seriously degrading medical readiness capability at the outset.	4

Table 3-1 OT-1 Need Priority

3.2.1.3. New Initiatives and Solutions

Solution Priorities:

<b>OT-1 Solutions Priorities</b>			
<b>OT-1 Priority</b>	<b>ACC/SG Priority</b>	<b>Solution Set</b>	<b>*Funding Requirements FY01 (\$000)</b>
	1	<b>Force Protection, Deployed &amp; In-Garrison</b>	\$ 4,085
1		RAPIDS	
2		BW/CW Training	
3		Medical Decontamination System	
4		RSDL	
	2	<b>AEF Infrastructure &amp; CONOPS Development</b>	\$ 16,874
5		EMEDS	
6		Mobile Tentage	
7		ATH LAN	
8		Telemedicine	
9		Digital X-Ray Modernization	
10		Microlab System	
11		Alternative Medical Oxygen Supply System	
12		ATC/ATH WRM	
13		Casualty Evacuation/Ambulance Platform	
14		Latrine System for the CHATH	
15		Mirror Force Integration	
	5	<b>Medical Training</b>	\$ 2,033
16		Trauma Skills Maintenance	
17		Training Exercises	
18		Mobile Red Flag Course	
19		PJ Medical Training	
		<b>TOTAL</b>	\$ 21,992

\*FY02-08 See Appendix A

Table 3-2 OT-1 Solutions Priority

<b>Force Protection, Deployed &amp; In-Garrison (Ruggedized Advanced Pathogen Identification System/Joint Biological Agent Identification and Detection System (JBAID))</b>								
<p><b><u>Solution Description:</u></b> Provides the means to rapidly identify biological agents and other disease causing organisms in field conditions. Results used to prevent disease, optimally treat, and manage infected personnel. Information will also be used to document patient encounter, update medical intelligence and advise command and control of significant events.</p> <p><b><u>Justification:</u></b> Pervasive threat to troops from BW agents and endemic disease. Current systems provide limited ability to identify disease-causing organisms. This system will provide genus-species level data at high sensitivity within one hour. Current systems take days and may not identify an organism. Provides breakthrough disease prevention and treatment capability.</p> <p><b><u>Enabling Technologies:</u></b> COTS DNA identification technologies available</p> <p><b><u>Related ATDs/ACTDs/Battlelab Initiatives:</u></b> Force Protection Battlelab has initiative drafted to cover rapid pathogen identification.</p>					<p><b><u>Solution Linkages:</u></b></p> <p><b>OT Platform:</b> OT1</p> <p><b>End State Addressed:</b> 2, 5, 6</p> <p><b>Need(s) Addressed:</b> 2, 3, 7, ACS MAP</p> <p><b>ACC/SG OT Priority:</b> 1 of 17</p> <p><b>OT Priority:</b> 1</p> <p><b>Requirements Documentation:</b> CAF 314-97, MNS for Enhanced Force Protection; MNS 002-96, Rapidly Deploying Medical Capability; Army MNS for Field Medical Equipment; Navy MNS for Biological Warfare Defense; CAF 316-92, Air Force Bare Base Systems.</p>			
<b><u>Funding Schedule (\$000):</u></b>								
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	-	200	208	216	-	-	-	-
Contractor	573	606	641	676	699	735	771	808
Equipment	427	452	478	504	530	557	584	612
Supplies	406	425	445	466	485	505	526	546
Training	155	157	181	196	211	227	243	260
RPMA	77	105	53	65	78	91	104	118
TDY	52	58	65	72	79	86	93	101
<p><b><u>Scope Statement:</u></b> Funding includes RAPIDS total requirements. Total systems required pending.</p>					<p><b><u>Major Advantages/Payoff:</u></b></p> <ol style="list-style-type: none"> <li>1. Preserves mission capability. Major force protection initiative and capability.</li> <li>2. Unprecedented ability to prevent spread of disease through early detection.</li> <li>3. Treatment tailored to specific disease.</li> </ol> <p><b><u>Joint Service Applicability:</u></b> Yes. Similar system capabilities are also under development through the JSIG MPSP JBAID ORD.</p> <p><b><u>POC for Solution:</u></b> Capt Todd Ritter; HQACC/SGR; email: <a href="mailto:todd.ritter@langley.af.mil">todd.ritter@langley.af.mil</a> ; DSN 574-1256. Or, Major C. Bell; HQACC/SGR; email: <a href="mailto:carolyn.bell@langley.af.mil">carolyn.bell@langley.af.mil</a> ; DSN 574-1282.</p>			

**Force Protection, Deployed & In-Garrison  
(BW/CW Training)**

**Solution Description:** Develop BW/CW Training Cadres for all 32 AFMS EMEDS (does not include 5 prepositioned EMEDS). Each cadre consists of 5 providers. They must take the six day resident course at the Army's Aberdeen Proving Grounds and then accomplish a five day Train-The-Trainer's (TTT) Course at same location. The TTT course is every other month. We plan to send 5 providers to resident course from each MTF with an EMEDS mission. The same 5 members will then be scheduled for the TTT course. Finally, we would like to send the Army's Mobile Team to all 32 AFMS EMEDS locations for on site three day training: estimated cost for each local training by a three-member mobile team is \$4K.

**Justification**  
To provide critical BW/CW training to at-risk forces both deployed and in-garrison. Currently a critically deficient training requirement.

**Solution Linkages:**  
**OT Platform:** OT1  
**End State Addressed:** 5, 8  
**Need(s) Addressed:** 1, 2, 39  
**ACC/SG OT Priority:** 1 of 17  
**OT Priority:** 2  
**Requirements Documentation:** NA

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training	147.36	149.72	152.12					
RPA								
TDY								

**Major Advantages/Payoff:**  
Improved critical force protection skills.

**Joint Service Applicability:** No

**POC for Solution:** Major Andy Jorgensen, HQ ACC/SGXO; DSN 574-1283, email: [andrew.jorgensen@langley.af.mil](mailto:andrew.jorgensen@langley.af.mil), or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement: BW/CW Resident Course:** Estimated total for 32 EMEDS X \$7118 = \$228K/3 yr = \$75.9K/YR  
**Train the Trainer (TTT) Course:** Estimated total 32 EMEDS X \$6250 = \$200K/3 yr Total \$66.6K/YR. Cost to send a Mobile Team to the eleven ACC EMEDS locations for on site three-day training is \$4K. Total for mobile team training 32 EMEDS X \$4K = \$1.28K, Total = \$.43K

## Force Protection, Deployed & In-Garrison (Medical Decontamination System)

### **Solution Description:**

**Overview:** A complete system that will provide for casualty, equipment, facility, vehicle, personnel, food and water decontamination and a tent system.

**Description:** A broad-spectrum aqueous or non aqueous rapid acting (15 min or less for vehicles, facilities, equipment, food and water and 2 min or less for personnel and casualties) decontaminant or family of decontaminants that is effective against CB agents, is non or less corrosive than current systems, is reasonably stable after preparation (12 hours) is less destructive to military materials when applied, is safe for use on food and water, is safe for usage in wounds, eyes and mucous membranes, does not cause further injury or discomfort to the casualty, is compatible with other personal protective items i.e. DEET, lip balm, permethrin, etc, is environmentally friendly biodegradable, and produces no off gassing when used in a closed environment. A rapidly setup (1 hour by 5 people) transportable collective protection system that will provide for the safety, protection and rapid decontamination of casualties, decontamination personnel and medical personnel operating outside the MTF in a contaminated environment. This collective protection system will require filtration, over pressure, latrine(s), storage, heating, air conditioning, CB, UltraViolet (UV), and fire retardant protective cover, a fragmentation cover, lights, water, sewage, shower(s), Contamination Control Area (CCA), Toxic Free Area (TFA), easy ingress and egress for personnel and litters, a roller type system and compatible to other MTF facilities, i.e. CHATH, ATH, Alaska, etc. Other operational considerations may be required.  
(One complete system should be sent to all 15 bases).

**Justification:** To operate effectively in chemical-biological warfare environments, forces need: 1) a rapid-acting decontaminant for CB agents deposited on the surfaces of vehicles, facilities, personal equipment, and medical equipment, 2) a rapid acting decontaminant for personnel and casualties (to include decontaminating of wounds/injuries, eyes, and mucous membranes), 3) a rapidly setup collective protection system to perform the decontamination operation in, 4) a decontaminant for food and water.

**Enabling Technologies:** May need a retrofit for CHATH if we buy new decontamination tentage. If filtration system is purchased – filters will need to be purchased separately, and fuel for the generator.

### **Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 2, 5, 6

**Need(s) Addressed:** 1, 2, 3, ACS MAP

**ACC/SG OT Priority:** 1 of 17

**OT Priority:** 3

### **Requirements Documentation:**

CAF 316-92, Air Force Bare Base Systems; CAF 314-97, MNS for Enhanced Force Protection; MNS 002-96, Rapidly Deploying Medical Capability; Army MNS for Field Medical Equipment; Navy MNS for Biological Warfare Defense; Marine Corp MNS NBC 217 for a Family of Biological and Chemical Decontaminants; MNS 215.2.2 for a Family of Lightweight Decontamination Systems; Marine Corps Master Plan and Mission Area 21, Direct Fire and Maneuver; USAF SON 004-85, Sustained Operations in a Chemical/Biological Environment (SECRET); OPNAVINST S3400.10E, Chemical Warfare, Chemical, Biological, and Radiological Defense; Navy MNS M071-88-96, Naval Aviation Chemical and Biological Survivability; Army MNS for Advanced Deployable Collective Protection Equipment; Marine Corp Required Operational Capability, #215.2.4, for Portable Collective Protection; AF ORD (in coordination) for Ruggedized Advanced Pathogen Identification System (RAPIDS); JORD (in coordination) Joint Service Fixed-Site Decontamination System (JSFXDS); JORD (in coordination) Joint Transportable Collective Protection System (JTCOPS).

**Related ATDs/ACTDs/Battlelab Initiatives:** The Canadians have developed a Canadian decontamination system consisting of three parts: 1) Reactive Skin Decontamination Lotion (RSDL) which can be used on personnel, personal equipment, medical equipment, casualties (including wounds, eyes, mucous membranes), and spot decontamination of vehicles for CB warfare agents with out detriment to the individual, equipment or vehicle. RSDL is biodegradable and environmentally friendly. RSDL works within minutes and destroys CB agents. The Dutch government has purchased RSDL for the Dutch military and the Canadian Forces have purchased it. 2) Canadian Aqueous System for Chemical-Biological Agent Decontamination (CASCAD) which is used on large equipment, tents, terrain, vehicles, aircraft, and buildings. CASCAD is a foam based decontaminate that destroys the agent in 20 minutes or less, is biodegradable and environmentally friendly. CASCAD has very low corrosiveness. CASCAD comes in a complete self supporting system only requiring a water source, (works with gray water, regular water and salt water) and fuel for the generator. 3) Collective Protection (COLPRO) is a tent system which consists of a Contamination Control Area (CCA), Liquid and Vapor Hazard Area (LHA/VHA), and a Toxic Free Area (TFA). It has a latrine, storage, and shower capability. The COLPRO is an over pressure filtrated system (can operate and have the filters changed out without shutting down). Is presently being modified to have a roller system for casualty decontamination. The system can be setup by four people in 1 to 2 hours. It has a fragmentation cover and a cover, which is chemical, biological, and UV, protected. It is also is fire retardant. The COLPRO tentage can be modified to fit any existing frame currently in use.

**Major Advantages/Payoff:**

1. The Medical Decontamination System will save lives, resources, and extend our operations. The current system does not allow for vehicle, equipment, and facility decontamination, nor is it adequate for casualty decontamination. The current system also does not provide for decontamination of casualties during or after a CB attack. The new system will be capable of this and more.
2. The number of contaminated casualties, which the new system will allow us to decontaminate, will increase 3X or more than the current system (10-12 contaminated casualties).
3. The current system is not completely compatible with the CHATH or ATH.

**Joint Service Applicability:** Yes

**POC for Solution:** MSgt Paul Clark, HQACC/SGR; email: [paul.clark@langley.af.mil](mailto:paul.clark@langley.af.mil), DSN 574-1253. Or, Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

<b>Funding Schedule (\$000):</b>	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor	1,164.3	1,188.8	1,213.8	1,239.2	1,261.1			
Equipment	562.4	574.2	586.3	598.5	609.1			
Supplies								
Training								
RPMA								

**Scope Statement:**  
 Collective Protection \$220K unit X 27 (2 WMD teams) = \$5,940K over 5 years  
 CASCAD (\$80K unit + \$20K supplies) X 27 Units = 2,700K over 5 years

**Force Protection, Deployed & In-Garrison  
(Reactive Skin Decontamination Lotion (RSDL))**

**Solution Description:**

The Reactive Skin Decontamination Lotion is a possible Bare Base Enhancement Proposal as well as a possible Medical Service Proposal. Proposes using RSDL, a product developed by the Canadians for use by the Canadian Forces, as the decontaminate of choice for USAF bare base forces. This decontaminate would be used in place of M291/M258A1, hypochlorite, DS2, diatomaceous earth, etc.

**Justification:**

RSDL can be used to decontaminate many different surfaces, such as human skin or weapons and has no degrading effects. RSDL is also environmentally friendly and biodegradable. Use of RSDL destroys all known chemical agents in less than 90 seconds and has application for biological agents. It is easy to apply, easy to remove, and nonhazardous. It is safe to use around the mouth and eyes and may have potential usage in wounds. RSDL comes in 45 gram pouches or 500 ml bottles that make for easy transport. Training on RSDL is elementary – open pouch, spread on, leave two minutes, wash off at leisure. No special disposal requirements.

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 2, 5, 6

**Need(s) Addressed:** 2, 3, ACS MAP, ACC Counterproliferation Plan

**ACC/SG OT Priority:** 1 of 17

**OT Priority:** 4

**Requirements Documentation:** CAF 314-97, MNS for Enhanced Force Protection; MNS 002-96, Rapidly Deploying Medical Capability; Army MNS for Field Medical Equipment; Navy MNS for Biological Warfare Defense; CAF 316-92, Air Force Bare Base Systems.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies	520.70	531.65	542.85	554.20	564.00			
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Decontaminates many surfaces such as human skin or weapons immediately.
2. Environmentally friendly and biodegradable.

**Joint Service Applicability:** Yes

**POC for Solution:** MSgt Paul Clark, HQ ACC/SG, Langley AFB, VA Email address: [paul.clark@langley.af.mil](mailto:paul.clark@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

\$200/unit container X 500 people X 25 teams = \$2,500K over a 5 year period

**AEF Infrastructure & CONOPS Development  
(Medical Planning Support for Air Expeditionary Forces)**

<p><b><u>Solution Description:</u></b></p> <p>AF/SG tasked ACC/SG to lead in the development of the next generation AEF medical support team and the ATH. Key elements of the project are the development of the expeditionary medical support (EMEDS) and Air Force Theater Hospitalization (AFTH) concept of operations (CONOPS), allowance standards (AS), UTC MISCAPS, UTC manpower detail, and transition plan. The EMEDS/AFTH mission is to deploy and provide forward stabilization, primary care, force medical protection and preparation for aeromedical evacuation for deployed EAF. AFTH will optimize warfighter performance by delivering essential care targeted to maximize unit effectiveness, readiness, and morale.</p> <p><b><u>Justification:</u></b> EMEDS and the AFTH support the National Military Strategy and is the cornerstone of medical support to EAF deployed in any contingency worldwide.</p>									<p><b><u>Solution Linkages:</u></b></p> <p><b>OT Platform:</b> OT1</p> <p><b>End State Addressed:</b> 1, 2, 4, 5, 7</p> <p><b>Need(s) Addressed:</b> 1, 2, 3, 4, 9, 18</p> <p><b>ACC/SG OT Priority:</b> 2 of 17</p> <p><b>OT Priority:</b> 5</p> <p><b>Requirements Documentation:</b> CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment.</p>																																																																																
<p><b><u>Funding Schedule (\$000):</u></b></p> <table border="1"> <thead> <tr> <th></th> <th>FY01</th> <th>FY02</th> <th>FY03</th> <th>FY04</th> <th>FY05</th> <th>FY06</th> <th>FY07</th> <th>FY08+</th> </tr> </thead> <tbody> <tr> <td>MILPER</td> <td>189.72</td> <td>197.03</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Contractor</td> <td>124.97</td> <td>127.60</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Equipment</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Supplies</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Training</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>RPMA</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>TDY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>										FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+	MILPER	189.72	197.03							Contractor	124.97	127.60							Equipment									Supplies									Training									RPMA									TDY									<p><b><u>Major Advantages/Payoff:</u></b></p> <ol style="list-style-type: none"> <li>1. This is a modularized medical system better able to support AEF deployments.</li> <li>2. Medical systems that reduce lift requirements and theater footprint.</li> </ol> <p><b><u>Joint Service Applicability:</u></b> No</p> <p><b><u>POC for Solution:</u></b> Captain John Neuser, DSN 574-1264, email: <a href="mailto:john.neuser@langley.af.mil">john.neuser@langley.af.mil</a> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: <a href="mailto:carolyn.bell@langley.af.mil">carolyn.bell@langley.af.mil</a></p>								
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<p><b><u>Scope Statement:</u></b></p> <p>The funding provides for contract and Air Force support for the planning, purchasing, fielding, maintenance, and training for 37 EMEDS systems.</p>																																																																																									

**AEF Infrastructure & CONOPS Development  
(Mobile Tentage/ECU)**

**Solution Description:**

Portable light-weight, quick-erect tentage with the capability to resist chemical/biological (CB) agent penetration and compatible with supporting environmental control and generator capability. Field ruggedized, able to accommodate litter/ambulatory flow, frequent set-up and teardown, insulated, lightweight (weight and cube critical), and designed to operate in worldwide environments/temperatures.

**Justification:**

Current equipment for deployable systems is heavy, inefficient, and lacks flexibility to reconfigure and respond to contingencies. This is a need of the medical community addressed in CBOCE44-46, Commercial Shelters/ECU. New system will replace current TEMPER systems for utilization in MTWs as well as global contingency operations.

**Issues/Impacts:** ACS principles drive the requirement for lighter, more mobile, efficient capabilities for field medical services. Existing tentage is weight and cube demanding without the ability to tailor to new expectations of Air Expeditionary Force concepts. If not funded, reductions in airlift requirements will be limited. This is a commercial-off-the-shelf (COTS).

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 1, 2

**Need(s) Addressed:** 3, ACS MAP

**ACC/SG OT Priority:** 2 of 17

**OT Priority:** 6

**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment. ACS MAP, FY98.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	8,832	9,018	9,208	9,400	9,567			
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Reduce airlift requirements.
2. Reduction in personnel workload.
3. Chemical/biological protection.

**Joint Service Applicability:** Yes

**POC for Solution:** Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** \$26K X 1,631 = \$42,406K. Acquisition strategy pending .

**AEF Infrastructure & CONOPS Development  
(LAN System for ATHs/EMEDS)**

**Solution Description:** This is a requirement for an internal foundation system (LAN) to link all areas of informatics within the EMEDS and to provide a linkage to all DoD Theater Medical Information Systems. The LAN system will not be a stand-alone network, but will integrate with operating location communications systems. **Justification:** The LAN is required to provide a linkage from different clinical and administrative areas within the EMEDS to each other as well as to other base, DoD, Theater, and CONUS information systems. Deployable hospitals lack the sophisticated information control systems to deal with the rapidly changing medical environment at contingency locations. Computer systems are required to enhance communication of critical medical/patient information. LAN linkage can also be used for treatment data retrieval, resource references, and as a source of medical forms. This system will provide a critical linkage for the Clinical Data Management System as described in the ACS MAP. **Issues/Impacts:** Theater medical surveillance is a priority force protection measure and theater command responsibility. (Note: EMEDS LAN system must be interoperable with base information systems infrastructure.) Availability is COTS

**Solution Linkages:**  
**OT Platform:** OT1  
**End State Addressed:** 2, 3, 5  
**Need(s) Addressed:** 1, 3, 4, 7, 33, ACS MAP  
**ACC/SG OT Priority:** 2 of 17  
**OT Priority:** 7  
**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment. ACS MAP, FY98.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	260	1,063	1,221	1,386	1,128			
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Meet Congressionally mandated medical data collection requirements resulting from Gulf War Syndrome findings.
2. Reduction in personnel workload.
3. Meet patient medical records legal standards.

**Joint Service Applicability:** Yes

**POC for Solution:** Maj Randy Carpenter, ACC/SGMI, email: [randy.carpenter@langley.af.mil](mailto:randy.carpenter@langley.af.mil); DSN: 574-1333 or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** The HSW configuration design is not available yet so the following estimates are based upon a planning factor of \$125K per EMEDS fielded IAW the current estimate by Fiscal Year of EMEDS stand-ups:

	<b>FY99</b>	<b>FY00</b>	<b>FY01</b>	<b>FY02</b>	<b>FY03</b>
Number Per FY	2	8	9	10	8

**AEF Infrastructure & CONOPS Development  
(Clinical Data Management Application/Telehealth)**

**Solution Description:** Initiative is to pursue capability to utilize specialty resources at remote locations through electronic networks. The Clinical Data Management Application is a system that automatically updates patient status and location throughout the treatment process to include patient symptoms, treatments, and location of patient encounter (i.e., PSAB vs. Daharan). This system will be a component of DOD-wide Theater Information Systems.

**Justification:** Public law and operational needs mandate the electronic capture of medical encounter data in theater. The first requires the ability to perform a retrospective analysis of health problems experienced in theater by deployed personnel. The latter drives a timely capture and analysis of the data for evidence of biological and/or chemical exposure in an ongoing effort to preserve and protect the deployed force.

The first iteration of Clinical Data Management Application (a.k.a. Desert Care I) addressed the first concern by giving medical providers the tool to electronically capture their diagnoses and procedures. The second iteration of Clinical Data Management Application (a.k.a. Desert Care II) achieved the next step with the addition of symptom level information and info flow engineered to replicate that info back for analysis to HQ ACC SG within minutes of the medical encounter. This info flow drives the need for a network infrastructure that includes robust communication rates between providers' workstations and the database in theater and between the interim theater database and CONUS.

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 2, 3

**Need(s) Addressed:** 3, 4, 7, 9, 33, ACS MAP

**ACC/SG OT Priority:** 2 of 17

**OT Priority:** 8

**Requirements Documentation:** Theater Medical Information Program Capstone Document. CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment. ACS MAP, FY98

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	547.8	559.3	571.1	583.0	593.3	603.8	614.4	624.9
Supplies								
Training								
RPMA								
TDY								

**Scope Statement:** For EMEDS support

**Major Advantages/Payoff:**

1. Immediate electronic capture of patient diagnosis and procedures.
2. Immediate electronic capture of BW/CW exposure in deployed locations.
3. Prevents unnecessary patient aeromedical evacuation.

**Joint Service Applicability:** Yes

**POC for Solution:** Lt Col Ed Kline; ACC/SGR, DSN 574-1258, email: [edward.kline@langley.af.mil](mailto:edward.kline@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**AEF Infrastructure & CONOPS Development  
(Digital X-Ray Modernization (Digital X-Ray (Retrofit)))**

**Solution Description:**

Provide digital processors and monitors, replacing the conventional x-ray processors in deployable medical systems.

**Justification:**

Digital imagery technology improves diagnostic capability, minimizes patient exposure, eliminates hazardous material waste streams, reduces weight, and eliminates resupply requirements. Commercial modernization will make procurement of conventional processing chemicals expensive or unattainable.

(Availability is Commercial Off the Shelf)

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 2

**Need(s) Addressed:** 3, 4, 7, 9, ACS MAP

**ACC/SG OT Priority:** 2 of 17

**OT Priority:** 9

**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment		400	300	300				
Supplies				900				
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Medical treatment in the field setting will more closely approach standards.
2. Elimination of HAZMAT requirements.
3. Required for telemedicine application.

**Joint Service Applicability:** Yes

**Scope Statement:** Development (2Yrs): Studies (1Yr), Qualification Testing (1Yr). Production - Single Lot Buy (58 Units), FY04 (1Yr). Diagnostics Testing, Shock & Airworthiness Testing, FDM Approval Study Prototypes @ \$20K/unit 1.5 man-years (3Yrs). Development (3600) Dollars(\$1.0M): Contractor/government \$.9M, Prototypes \$.1M. Production (3080) Dollars (\$.9M): Contractor/govt. \$.2M, Production Units \$.7M

**POC for Solution:** Major Tom Langston, ACC/SGXL; email: [thomas.langston@langley.af.mil](mailto:thomas.langston@langley.af.mil); DSN 574-1284 or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**AEF Infrastructure & CONOPS Development  
(Digital X-Ray Modernization (Hand Held X-Ray System))**

**Solution Description:**  
(also known as Portable Digital Imaging).  
Provide man-portable digital imaging system for use by the independent duty and radiology technicians. Image quality must allow for a broad range of diagnosis.

**Justification:**  
This next generation system eliminates current heavy equipment and DEPMEDS ISO shelter. Digital imagery technology improves diagnostic capability, minimizes patient exposure, eliminates hazardous material waste streams, reduces weight, and eliminates resupply requirements. Commercial modernization will make procurement of conventional processing chemicals expensive or unattainable.

**Issues/Impacts:**  
Digital imaging technologies is a facet of telemedicine, which allows for a reduced forward deployment of personnel and equipment.  
(Availability is Commercial Off the Shelf)

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 2

**Need(s) Addressed:** 3, 4, ACS MAP

**ACC/SG OT Priority:** 2 of 17

**OT Priority:** 9

**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment			54.29	83.13	112.80	114.80		
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Enhances diagnosis and treatment.
2. Very significant weight and cube reductions.
3. Allows telemedicine and electronic information storage.

**Joint Service Applicability:** Yes

**POC for Solution:** Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** Procurement: FY04, Quantity: 5 Prototypes, 58 Units, One Time Procurement: Interfaces With X-ray System, “Palm Pilot” Analogy (Plug-in), Contractor/govt. Labor Captured In Overall System Effort, \$3K/unit, Development (3600) Dollars Prototypes \$25K, Production (3080) Dollars Production Units \$200K

**AEF Infrastructure & CONOPS Development  
(Microlab System (old Therapeutic Lab Equipment))**

**Solution Description:**  
Previously known as Therapeutic Lab Equipment. This initiative involves the miniaturization of all medical laboratory capabilities using emerging technologies such as microfluidics and fiberoptic spectroscopy.

**Justification:**  
Eliminates the need for climactic controlled reagents and reduces weight and cube.

**Solution Linkages:**  
**OT Platform:** OT1  
**End State Addressed:** 2  
**Need(s) Addressed:** 2, 3, 4, 9, 11, 23, 27 ACS MAP  
**ACC/SG OT Priority:** 2 of 17  
**OT Priority:** 10  
**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Smaller, lighter lab.
2. Provides additional critical lab capability.

**Joint Service Applicability:** Yes  
**POC for Solution:** Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**  
Critical lighter leaner required for EMEDS support.  
HSW to provide costing data.

**AEF Infrastructure & CONOPS Development  
(Alternative Medical Oxygen Supply System)**

**Solution Description:** Therapeutic grade oxygen generation for aeromedical evacuation and ground medical operations with increased oxygen delivery and storage capacity, improved reliability, maintainability and decreased cube/weight from current systems. Current systems must carry a large quantity of liquid oxygen on board the aircraft. Liquid oxygen containers are constantly offloaded, serviced, and then re-loaded.

**Justification:** System reduces cost and logistical/maintenance footprint associated with providing medical grade oxygen in worldwide operations. HQ AMC/SG is to replace the approximately 1000 patient therapeutic liquid oxygen systems (PT LOXs), that currently serve the AFMS. The draft CONOPS identifies the PT LOX systems as “labor intensive, logistically difficult to maintain and not user-friendly in deployed settings.” There are no formal agreements or inter-organizational procedures for performing the maintenance on PT LOX systems. In many cases periodic maintenance is not performed, resulting in failure of the units. Additionally, the deployed PT LOX systems must compete for priority with aircraft for LOX servicing if near a flight line, or the systems must be airlifted to a location where such facilities exist. With aircraft going to On-Board Oxygen Generating Systems (OBOGS), there will be no liquid oxygen available at a deployed or home base. These unique, costly maintenance and support problems would be eliminated with the new system.

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 2

**Need(s) Addressed:** 3, ACS MAP

**ACC/SG OT Priority:** 2 of 17

**OT Priority:** 11

**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor		1,063	1,086	1,108	1,015			
Equipment		-	-	222	135,360			
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Lower overall cost.
2. Reduced supply-line difficulties and reduced aircraft turnaround time.
3. Reduced footprint.

**Joint Service Applicability:** Yes

**POC for Solution:** Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

Technology Assessment In EMD: Next Generation Ceramics, Turbomachine & Microsensors Down-select Concept, 2.0 Man-years For 6years, Projected Production Article Cost \$100k/unit  
 Development: Studies (2yrs), Design & Testing (1yr), Procurement (3yrs), Production Buys @ 40 Per Year  
 Development (3600) Dollars (\$3.2m): Contractor/govt. \$3m, Prototypes \$.2m,  
 Production (3080) Dollars (\$120.9m): Contractor/govt. \$9m, Production Units \$120m

**AEF Infrastructure & CONOPS Development  
(Current ATH/ATC WRM Initiatives)**

**Solution Description:**

ACC/SG to lead in development of the next generation (AEF) medical support team and ATH. Key elements of the project are the development of the EMEDS and AFTH CONOPS, AS's, UTC MISCAPS, UTC manpower detail, and transition plan. The EMEDS/AFTH mission is to deploy and provide forward stabilization, primary care, medical force protection, and preparation for aeromedical evacuation for deployed EAFs. AFTH will optimize warfighter performance by delivering essential care targeted to maximize unit effectiveness, readiness, and morale.

**Justification:**

EMEDS and AFTH support the National Military Strategy and are the cornerstones of medical support to expeditionary air forces deployed in any contingency, worldwide.

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 1, 2, 7

**Need(s) Addressed:** 1, 2, 3, 4, 9, 18

**ACC/SG OT Priority:** 2 of 17

**OT Priority:** 12

**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	6,248	6,380	6,514	6,650	6,768	6,888		
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. This is a modularized medical system better able to support AEF deployments.
2. Medical systems that reduce lift requirements.

**Joint Service Applicability:** No

**Scope Statement:** The funding above in the schedule above provides for planning, purchasing, fielding, maintenance, and training for existing ATCs and remaining ATHs.

**POC for Solution:** Capt John Neuser, DSN 574-1264, <mailto:john.neuser@langley.af.mil> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**AEF Infrastructure & CONOPS Development  
(Casualty Evacuation/Ambulance Platforms)**

**Solution Description:**

To manufacture a fleet of ruggedized field ambulances to include increased and enhanced patient treatment capabilities to include creating a chemical/biological free environment allowing for the continued treatment of casualties.

**Justification:**

Current fleet of ambulances is aging with decreased repair/replacement opportunities. New systems will decrease operating and maintenance costs with significantly improved technological capabilities.

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 2, 5

**Need(s) Addressed:** 2, 3, ACS MAP

**ACC/SG OT Priority:** 2 of 17

**OT Priority:** 13

**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability Army MNS for Field Medical Equipment.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment		577.4	589.5	601.9	612.5	623.4		
Supplies		-	-	-	-	-		
Training		-	21.3	21.7	22.2	22.7		
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Increased patient treatment capabilities.
2. Decreased operating costs.
3. Improved technical capabilities.

**Joint Service Applicability:** NA

**POC for Solution:** MSgt Robyn Gamble, ACC/SGXP; email: [robyn.gamble@langley.af.mil](mailto:robyn.gamble@langley.af.mil), DSN 574-1215 or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

Funding is for the manufacture and fielding of HMMVW ambulances to replace the existing aged AFMS deployable ambulance fleet. Cost \$49,350 EA plus 10% (\$4,900) for associated support items total HMMVW Cost \$54,250. 10 Units per year.

**AEF Infrastructure & CONOPS Development  
(Latrine System for CHATH)**

<p><b><u>Solution Description:</u></b> CHATH inventory requires latrine system. Quantity: 2 Prototypes, 21 Production Units</p> <p>*Only System In AF To Provide Capability</p> <p><b><u>Justification:</u></b> System improvement will allow 72 hour continuous operations without interruption to the integrity of the CHATH.</p>									<p><b><u>Solution Linkages:</u></b> <b>OT Platform:</b> OT1 <b>End State Addressed:</b> 2, 5 <b>Need(s) Addressed:</b> 2, 3 ACS MAP</p> <p><b>ACC/SG OT Priority:</b> 2 of 17 <b>OT Priority:</b> 14 <b>Requirements Documentation:</b> CAF 314-97, MNS for Enhanced Force Protection; MNS 002-96, Rapidly Deploying Medical Capability; Army MNS for Field Medical Equipment; Navy MNS for Biological Warfare Defense; CAF 316-92, Air Force Bare Base Systems.</p>																																																																																
<p><b><u>Funding Schedule (\$000):</u></b></p> <table border="1"> <thead> <tr> <th></th> <th>FY01</th> <th>FY02</th> <th>FY03</th> <th>FY04</th> <th>FY05</th> <th>FY06</th> <th>FY07</th> <th>FY08+</th> </tr> </thead> <tbody> <tr> <td>MILPER</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Contractor</td> <td>573</td> <td>585</td> <td>597</td> <td>610</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Equipment</td> <td>-</td> <td>213</td> <td>217</td> <td>5,099</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Supplies</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Training</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>RPMA</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>TDY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>										FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+	MILPER									Contractor	573	585	597	610					Equipment	-	213	217	5,099					Supplies									Training									RPMA									TDY									<p><b><u>Major Advantages/Payoff:</u></b> Provide additional treatment and sustainment capabilities.</p> <p><b><u>Joint Service Applicability:</u></b> Yes</p> <p><b><u>POC for Solution:</u></b> Major Tom Langston, ACC/SGXL; email: <a href="mailto:thomas.langston@langley.af.mil">thomas.langston@langley.af.mil</a>; DSN 574-1284 or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: <a href="mailto:carolyn.bell@langley.af.mil">carolyn.bell@langley.af.mil</a></p>								
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+																																																																																	
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<p><b><u>Scope Statement:</u></b> Development: Studies (2yrs), Testing (1yr), 2 Prototypes. Production: Single Lot Buy (21 Units), FY04 (1yr). Procurement of latrine Modules: \$200K/module. 1.5 Man-years for 4yrs: Testing, engineering, configuring, logistician. Development (3600) Dollars(\$2.4M): Contractor, govt.\$2.2M. Prototypes \$.2M. Production (3080) Dollars(\$4.6M)</p>																																																																																									

**AEF Infrastructure & CONOPS Development  
(Mirror Force Operational Integration)**

**Solution Description:**

HQ ACC/SG requires staffing to integrate Reserve Forces into contingency, training, and operational deployments. As ACC/SG meets the goal of integrating reserve forces a complex and detailed tracking system is required to ensure the missions are accomplished.

**Justification:**

Without the additional manpower position Mirror Force integration is limited and below optimal levels.

**Solution Linkages:**

**OT Platform:** OT1  
**End State Addressed:** 2, 7, 8  
**Need(s) Addressed:** 1, 16 ACS MAP  
**ACC/SG OT Priority:** 2 of 17  
**OT Priority:** 15  
**Requirements Documentation:** Mirror Force Tactical Plan

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	87.6	87.6	87.6	87.6	87.6	87.6	87.6	87.6
Contractor								
Equipment								
Supplies								
Training								
RPMA								
TDY	3	3	4	4	4	4	4	4

**Major Advantages/Payoff:**

1. Augments tasked Active Duty forces.
2. Significantly enhance Mirror Force training opportunities.

**Joint Service Applicability:** No

**Scope Statement:**

Funds one officer position at HC ACC/SG.

**POC for Solution:** Maj Andrew Jorgensen, HQ ACC/SGXL, <mailto:Andrew.Jorgensen@langley.af.mil> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Medical Training  
(Trauma Skills Maintenance)**

**Solution Description:**

Funding to provide surgeons the opportunity to attend trauma skill/maintenance courses that are required to maintain required readiness skills. As our facilities rightsize, we see increasing difficulty with clinicians maintaining trauma skills.

**Justification:**

Without this training our deployable surgeons lack the opportunity to maintain and improve readiness required trauma skills.

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 2, 8

**Need(s) Addressed:** 1, 5

**ACC/SG OT Priority:** 5 of 17

**OT Priority:** 16

**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	24	24	24	24	24	24	24	24
Contractor								
Equipment								
Supplies								
Training	353	353	353	353	353	353	353	353
RPA								
TDY	15	15	15	15	15	15	15	15

**Major Advantages/Payoff:**

1. Increased Readiness.
2. Develop and maintain critical skills.

**Joint Service Applicability:** No

**POC for Solution:** Major Andrew Jorgensen, DSN 574-1283, <mailto:andrew.jorgensen@langley.af.mil> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

**ACTIVE DUTY GK6/7's:** 46 (27 + 19) (GK6/7) Teams (active) X 11 people each X 12 (10+2) days = 506 TDY's travel + per diem + lodging = \$500 + \$345 + \$550 = \$1395, Active Duty will train bi-annually 506 X \$1395 = \$705,870 / 2 (bi-annually) = TOTAL = \$352,935 per year

**ARC GK6/7's:** 4 (3 + 1) (GK6/7) Teams (ARC) X 11 people each X 12 (10+2) days = 44 TDY's travel + per diem + lodging = \$500 + \$345 + \$550 = \$1395, ARC will train once every four years 44 X \$1395 = \$61,380 / 4 (every four yrs) = TOTAL = \$15,345 per year for travel and per diem

**MANDAYS**

7off X 12 days TDY = 84 officer mandays, 84 days X \$228.11 per day = \$19,161, 4 enenlisted X 12 days TDY = 48 enlisted mandays, 48 days X \$100.84 per day = \$4,841  
TOTAL = \$24,001

**Medical Training  
(Training Exercises)**

**Solution Description:** ACC directed exercise is designed to comply with HQ USAF/SGX objective to evaluate/conduct integrated medical specialty sets training. Exercise will test/assess the employment capabilities/limitations of each set and how each can be optimally and efficiently integrated into the appropriate increment(s) of an ATH and hospital surgical expansion package.

- Test functional capability of technology inserted in ATH and specialty sets.
- Assure all specialty sets are functionally integrated into appropriate increments of the ATH. Include a scenario that tests the functional capability proposed for the future Air Force Theater Hospital.
- Evaluate MISCAPS, CONOPS, AS for appropriateness and fulfill the requirement for annual testing and evaluation of UTCs.
- Maximize training for exercise participants to include providing familiarity with doctrinal changes, new UTCs, and CONOPS. Assure total force participation in this exercise to the maximum extent possible.
- Conduct interoperability exercises with the AE system to extent possible.
- Conduct this test utilizing the following scenarios: AEF support, support beddown of personnel, support a small-scale contingency operation involving humanitarian care.

**Solution Linkages:**

**OT Platform:** OT1

**End State Addressed:** 1, 2, 4, 6, 7, 8

**Need(s) Addressed:** 1, 2, 3, 4, 5, 18

**ACC/SG OT Priority:** 5 of 17

**OT Priority:** 17

**Requirements Documentation:** USAF/SG and ACC/SG directed

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	100	100	100	100	100	100	100	100
Supplies	75	75	75	75	75	75	75	75
Training	250	250	250	250	250	250	250	250
RPA								
TDY	75	75	75	75	75	75	75	75

**Major Advantages/Payoff:**

Test, Evaluate and Train on Sets not normally brought to excersises requiring medical support.

**Joint Service Applicability:** Yes

**POC for Solution:** Major Andrew Jorgensen, DSN 574-1283, <mailto:andrew.jorgensen@langley.af.mil> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

<b>Medical Training (Mobile Red Flag Course)</b>								
<p><b>Solution Description:</b> Expand/Create Centralized Site/Mobile Red Flag Team. Transitioning to centralized storage of the 2<sup>nd</sup> and 3<sup>rd</sup> ATH-X increments will prevent annual training with WRM assets. Expanded central training site or a mobile training team concept with 2<sup>nd</sup> increment capability can ensure units are properly trained. Plan to purchase three ATH-X 2<sup>nd</sup> increments for expansion of the mobile Red Flag Course. Fund 15 FTE's for 29 TDY's of 10 days each to conduct the course.</p> <p><b>Justification:</b> Training is required to allow hands-on training of 2<sup>nd</sup> and 3<sup>rd</sup> equipment sets. Training team option is significantly cheaper than the enhanced single training site concept.</p>					<p><b>Solution Linkages:</b>  <b>OT Platform:</b> OT1  <b>End State Addressed:</b> 2, 7, 8  <b>Need(s) Addressed:</b> 3, 1  <b>ACC/SG OT Priority:</b> 5 of 17  <b>OT Priority:</b> 18  <b>Requirements Documentation:</b> USAF/SG and ACC/SG directed</p>			
<b>Funding Schedule (\$000):</b>					<b>Major Advantages/Payoff:</b>			
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER		1,559.7	1,559.7	1,559.7	1,559.7	1,559.7	1,559.7	1,559.7
Contractor								
Equipment	1,439	2,074.7						
Supplies								
Training		407.6	407.6	407.6	407.6	407.6	407.6	407.6
RPA								
TDY		26.1	26.1	26.1	26.1	26.1	26.1	26.1
<p><b>Scope Statement:</b>  <b>EQUIPMENT COST:</b> Equip = 1<sup>st</sup> increment; \$1,439,000 X 1 Each = \$1,439,000                      Equip = 2<sup>nd</sup> increment; \$1,037,332 X 2 Each = \$2,074,664, <b>TOTAL= \$3,513,664</b>  <b>TRAINING COST:</b> Travel: Per Diem (training) = 15 people X 22 trips (10 Days each) = 330 trips, travel + per diem + lodging = \$500 + \$285 + \$450 = \$1235/tdy, <b>TOTAL = (330 X \$1235) = \$407,550</b>  <b>SITE SURVEY COST:</b> Travel/Per Diem (site survey) = 2 people X 22 trips (2 Days each) = 44, Site Survey/ travel + per diem + lodging = \$500 + \$45 + \$50 = \$595, <b>TOTAL = (44 X \$595) = \$26,180</b>                      FTE = 30 people (2 teams of 15 people (4 off, 11 enl) each team <b>TOTAL = 30 FTE's = (((\$87,600 X 4 = \$350,400) + ( 11 X \$39,040 = 429,440) = \$779,840 per team</b></p>					<p>Allows adequate hands-on training of the 2<sup>nd</sup> and 3<sup>rd</sup> ATH-X equipment sets.</p> <p><b>Joint Service Applicability:</b> No</p> <p><b>POC for Solution:</b> Major Andrew Jorgensen, DSN 574-1283, <a href="mailto:andrew.jorgensen@langley.af.mil">mailto:andrew.jorgensen@langley.af.mil</a> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: <a href="mailto:carolyn.bell@langley.af.mil">carolyn.bell@langley.af.mil</a></p>			

**Medical Training  
(PJ Medical Training)**

**Solution Description:**  
Each PJ in ACC must attend a 40-hour clinical rotation and medical seminar every two years for EMT rectification. EMT-paramedic upgrade/transition course can be attended for the same cost.

**Justification:**  
AFSOC/MARC 160-34, ACC/SG PJ Medical Training Letter

**Solution Linkages:**  
**OT Platform:** OT1  
**End State Addressed:** 8  
**Need(s) Addressed:** 1, 3, 5, 41  
**ACC/SG OT Priority:** 5 of 17  
**OT Priority:** 19  
**Requirements Documentation:** AFSOC/MARC 160-34, ACC/SG PJ Medical Training Letter

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training	125	125	125	125	125			
RPA								
TDY								

**Major Advantages/Payoff:**

1. Increased emergency medical capability of PJs.
2. Increased joint interoperability of all SOF medical personnel.
3. Increased accessibility to civilian trauma centers for PJ training.

**Joint Service Applicability:**

**Scope Statement:**  
125K/year provide funding for approximately 60 PJs per year @ 2.1K per training session.

**POC for Solution:** MSgt Monty Fleck, HQ ACC/SGOp DSN 574-1275, email: [fleck.ml@langley.af.mil](mailto:fleck.ml@langley.af.mil), or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

#### 3.2.1.4. OT-1 Assessment

Cold War “heavy” medical capability must evolve to the lighter, leaner, precepts of the new expeditionary Air Force doctrine now. There are many moving parts/conflicting initiatives. OT-1 focus is to meet our statutory Title 10 mandates to organize, train, and equip:

- Right sizing
- Force reductions
- Reengineering

Modularization of our deployable force packages (UTCs) requires concomitant advances in technology insertion and institutionalization of the processes that promulgate our ability to “skate to where the puck will be.” We have been chipping away at the technology piece here at ACC/SG with “out of hide” resourcing. To achieve maximum efficiency and capability in the maintenance and sustainment of state of the art medical expeditionary combat support forces with state of the art equipment, a medical ACS development center must be formally established and institutionalized at ACC. The rationale for siting the ACS development center at ACC is resident in the spirit and intent of the Goldwater-Nichols Act and current AFMS structural alignment under the Line of the Air Force. In short, our focus must be on recognizing and reacting to our statutory obligations, focus on enterprise deficiencies and solutions, maximize the lighter, leaner advantages that accrue from modernization/technology insertion, institutionalize a medical ACS development center, and stop treating the symptoms and cure the disease.

#### 3.2.1.5. Master Plan (Roadmaps)

See Appendix C

### 3.2.2. OT-2 Needs Analysis and Solution Concepts

**OT-2 Build a Managed Health Care System that Integrates Quality, Cost and Access. Goal Champion: Lt Col Quinnelly, e-mail: [mike.quinnelly@langley.af.mil](mailto:mike.quinnelly@langley.af.mil)**

#### 3.2.2.1. OT-2 End States

**OT-2 End State 1:** Seamless health care system that provides a uniform benefit by FY04.

**OT-2 End State 2:** Employ a managed care system in which delivery of care meets or exceeds national standards (Quality Management – QM) delivered at least cost (Utilization Management – UM), and has the capability to measure and compare productivity and effectiveness of care across the AFMS by FY04.

**OT-2 End State 3:** In the near term (NLT CY01) achieve Maximum Achievable Enrollment.

**3.2.2.2. Operational Tasks Deficiencies**

<b>OT-2 Need Priority</b>		
<b>ACC/SG Priority</b>	<b>Need</b>	<b>Need to End State</b>
26	Need to monitor TRICARE Irritants.	1, 2
28	Disconnect between Health Affairs, individual services, Lead Agents, Commands, and bases pertaining to authority, responsibility and coordination of projected and completed actions.	1, 2
37	Inadequate method of educating MTF personnel in managed care principles to meet near term and long term goals.	1, 2
43	Lack of trained cadre of personnel who understand managed care principles in order to proliferate managed care implementation.	1,2
44	Need incentives to support managed care principles.	1,2
45	No accurate standard cost system which leads to poor make vs. buy decisions.	2

Table 3-3 OT-2 Need Priority

**3.2.2.3. New Initiatives and Solutions**

**Solution Priorities:**

<b>OT-2 Solutions Priorities</b>			
<b>OT-2 Priority</b>	<b>ACC/SG Priority</b>	<b>Solution Set</b>	<b>*Funding Requirements FY01 (\$000)</b>
1	11	<b>Marketing</b>	\$ 1,582
2	12	<b>MAE Capitation/Revised Financing</b>	\$ 13,679
3	16	<b>Computerized Patient Encounter System</b>	\$ 5,176
4		EMPI	
5		CIW	
		<b>TOTAL</b>	\$ 20,437

\*FY02-08 See Appendix A

Table 3-4 OT-2 Solutions Priority

**Marketing**

**Solution Description:**

Marketing funds for current and potential enrollees. The target population is TRICARE non-Prime, Space-Available, and enrollees to network PCMs. The ACC marketing plan is based upon the goal of realizing our Maximum Achievable Enrollment (MAE) of 349,000. To do this, we plan to target market to specific beneficiary categories such as retirees and active duty dependents and to those who live in geographical areas currently are using MTF services. Our target for enrolling Medicare-eligibles will be based upon the user population identified in MCFAS, and will be capped. Implementation of the ACC marketing plan requires specific population data and the resources to inform and persuade targeted populations.

**Justification:**

ACC/SG and AFMS funding and Manpower projections are based on meeting the targeted MAE. Resources are required to sustain and increase enrollment.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Equipment								
Supplies	519	519	519	519	519	519	519	519
Training								
RPMA								
TDY								

**Scope Statement:** \$3.00 of marketing funds are projected for sustainment (231,000 X \$3 = \$693,000). Funding of \$7.00 per person in the target market (118,000 X \$7.00 = \$826,000) so that MTFs can achieve MAE addressed in individual business plans. The average marketing cost is \$94,938 per facility (((\$693,000 + \$826,000) / 16 = \$94,938).

**Solution Linkages:**

**OT Platform:** OT2

**End State Addressed:** 1, 2

**Need(s) Addressed:** 22, 27, 28, 37, 40, 41, 43

**ACC/SG OT Priority:** 11 of 17

**OT Priority:** 1

**Requirements Documentation:**

**Major Advantages/Payoff:**

Targeted Marketing brings in current users as Prime Enrollees.

**Joint Service Applicability:** No

**POC for Solution:** Maj Jeffery Kidd, HQ ACC/SGM, DSN 574-0169, <mailto:Jeffery.Kidd@langley.af.mil> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**MAE Capitation/Revised Financing**

**Solution Description:**

Increase funding to achieve MAE. This solution addresses associated costs for increased enrollment.

**Justification:**

MAE requires the enrollment of and additional 118,000 enrollees.

**Solution Linkages:**

**OT Platform:** OT2

**Need(s) Addressed:** 22, 27, 41

**ACC/SG OT Priority:** 12 of 17

**OT Priority:** 2

**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	13,135	13,135	13,135	13,135	13,135	13,135	13,135	13,135
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

Covers a must pay for increased enrollment.

**Joint Service Applicability:** No

**POC for Solution:** Major Mark Lewandowski, HQ ACC/SGMC, DSN 574-1344, <mailto:Mark.Lewandowski@langley.af.mil> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

The overall capitated rate of \$216 per enrollee is based on the use of an annualized EBC variable PM/PM Cap Rate in CEIS Dec 98 applied to equivalent lives delta (projected enrollment in equivalent lives FY01 less Current enrollment equivalent lives). This average capitated cost reflects cost of care for an MTFs own enrollees calculated by using the EBC methodology for care provided at the enrollment MTFs in ACC which also reflects cost of care purchased from other MTFs and the amount the government paid for CHAMPUS claims. This rate was further refined by determining the O&M portion of the \$216 rate. The ACC overall variable O&M cost per enrollee is \$99 per equivalent enrolled life delta which is reflected within the \$216 overall annualized EBC PMPM Cap rate. These rates are in FY99 dollars. If MAE is achieved by FY01 the total additional O&M requirement needed to care for the additional enrollees is \$13,135, 704. FY02+ figure's are not adjusted for inflation

**Computerized Patient Encounter System  
(Electronic Master Patient Index)**

**Solution Description:**

Provides the establishment of a Master Patient Index which will track all patients who encounter our health care system with one unique identifier.

**Justification:**

The establishment of a MPI will allow all patient information to be linked longitudinal.

**Solution Linkages:**

**OT Platform:** OT2

**Need(s) Addressed:** 4, 5, 7, 8, 9, 10, 11, 15, 21, 23, 26, 28, 33, 37, 45

**ACC/SG OT Priority:** 16 of 17

**OT Priority:** 3

**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	2250	2250	450	450	450	450	450	450
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Provides methodology for longitudinal tracking of patient information.
2. Links all patient information currently dispersed in several different MHS information systems.

**Joint Service Applicability:** No

**Scope Statement:**

Initial costs of \$250k to implement at one test base with continued proliferation over a 2 year period to the remaining 17 ACC facilities. Sustainment tail is estimated to be 10% of total implementation costs with is \$450k per year.

**POC for Solution:** Major Randy Carpenter, HQ ACC/SGMI, DSN 574-3295, [Randy.Carpenter@Langley.af.mil](mailto:Randy.Carpenter@Langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Computerized Patient Encounter System  
(Clinical Integrated Workstation – Lite)**

**Solution Description:**

Provides a platform for the establishment and implementation of the computerized patient record (CPR). System will interface with current core Hospital Information System (HIS) the Composite Health Care System (CHCS). System will also replace the Ambulatory Data System (ADS).

**Justification:**

Computerized Patient Records are desperately needed for use in our MTFs. Use of such a CPR will facilitate the flow of patient information to better serve both the patient and the health care provider. Additional capabilities that this system will provide enhance the available information for analysis and provide easily accessible historical information.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor	1,020	1,020	1,020	1,020	1,020	1,020	1,020	1,020
Equipment	1,700	1,450	1,050					
Supplies								
Training								
RPA								
TDY								

**Scope Statement:**

Equipment: Costs estimates based on costing criteria provided by the Advanced Technology Integration Center – West and past implementation of CIW-Lite at Mt. Home AFB. 5 facilities in FY01, 6 facilities in FY02, and 5 facilities in FY03. Contractor costs estimates based on 60k per year /per facility for annual maintenance support contract.

**Solution Linkages:**

**OT Platform:** OT5

**Need(s) Addressed:** 3, 7, 9, 10, 11, 15, 21, 23, 26, 28, 33, 37, 45

**ACC/SG OT Priority:** 16 of 17

**OT Priority:** 3

**Requirements Documentation:**

**Major Advantages/Payoff:**

1. Eliminates paper bubble sheets used by providers, decommissions ADS.
2. Enhances information availability throughout our MTFs.
3. Provides platform for establishment of longitudinal electronic patient record.

**Joint Service Applicability:** Yes:

**POC for Solution:** Major Randy Carpenter, HQ ACC/SGMI, DSN 574-3295, [Randy.Carpenter@Langley.af.mil](mailto:Randy.Carpenter@Langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

#### **3.2.2.4. OT-2 Assessment**

The mission of HQ ACC/SG is to support the health of the ACC global power team through worldwide medical contingency operations and to execute a comprehensive, effective, community-based health care system.

- ACC/SG is one of the many partners associated with operating the MHS, TRICARE managed health care system.
- ACC is characterized by numerous small MTFs located primarily in rural health care environments. The primary influences on the implementation of managed care in ACC are variable in complexity and influence due to having MTFs in five different TRICARE regions, TRICARE Latin America, and TRICARE Europe.

The FY99-00 AFMS MSP provides FY04 End State specific guidance, assumptions, constraints, and strategic initiative (pillar) guidance, which forms the framework for the solution set development and the efforts associated with this operational task.

TRICARE and the level of effort that the MAJCOM spends on the issue of TRICARE irritants require that our solutions meet the needs of this deficiency and are acted upon immediately. There are frequent disconnects among Health Affairs, Lead Agents, individual Services, Commands, and bases pertaining to authority, responsibility and coordination of projected and completed action. ACC sees these as major challenges.

Additionally, the inability to get standardization on policy and execution issues will yield lots of inconsistent data and costly errors in decision making. The impact of this deficiency is of major importance to ACC due to the type and location of facilities in this command. ACC/SG is working closely with the various lead agents and endorses their lead with respect to TRICARE implementation and its managed care process.

Additionally, ACC/SG is a strong advocate for prompt Air Staff funding of disease management initiatives. Disease management will set the tone for long overdue and fundamentally different proactive patient care. Approved initiatives like Health Evaluation and Assessment Review (HEAR), Preventive Health Assessment (PHA) and Put Prevention Into Practice (PPIP) provide the foundation data upon which to build a disease management system. Cost controls and increased efficiencies will follow the rational, continuous treatment pathways a disease management approach opens up.

Lastly, ACC/SG promotes Air Staff funding for the various initiatives mentioned above which ultimately will help establish a model site. This concept would create a best practice facility with optimal manpower, office space, etc. to ensure the 1500:1 patient to PCM ratio.

#### **3.2.2.5. OT-2 Master Plan ( Roadmaps)**

See Appendix C

#### **3.2.3. OT-3 Needs Analysis and Solution Concepts**

**ACC MSP OT-3: Be the Leader of Comprehensive and Integrated Programs of Disease Prevention, Health Promotion, and Fitness. Goal Champion: Col Williams, email: [robert.williams@langley.af.mil](mailto:robert.williams@langley.af.mil)**

**3.2.3.1. OT-3 End States**

**OT-3 End State 1:** In the near term (CY02) wellness is intrinsically valued by the AFMS at all levels. Appropriate resources are available to support wellness/prevention efforts, including facilities (such as HAWCs), personnel, and funding.

**OT-3 End State 2:** In the near term (CY02) primary, secondary, and tertiary preventive services are integrated community-wide and are an essential part of the daily activities of all medical staff.

**OT-3 End State 3:** In the near term (CY02), wellness of all troops (including medical) is optimized and personnel are ready for immediate deployment.

**OT-3 End State 4:** In the near term (CY02) customers are invested in prevention. There is a self directed and self-motivated focus on wellness/prevention supported by the executive management of the Line and medical community.

**3.2.3.2. Operational Tasks Deficiencies**

**Operational Task Needs.** HQ ACC/SG has identified the top needs to integrated programs for disease prevention, health promotion, and fitness. These needs are summarized in Table 7-1.

<b>OT-3 Need Priority</b>		
<b>ACC/SG Priority</b>	<b>Need</b>	<b>Need to End State</b>
8	Lack of access to data to enable intelligent clinical, UM, HEDIS, make-buy, provider profiling, and health risk assessment decisions.	1, 2,
10	There is a need for a comprehensive clinical information system to provide on-line data at point of care to include: scheduling, ancillary tests and reports, and diagnosis.	1, 2, 3, 4
11	Total force preventive medicine support for pre-, during and post-deployment operations is inadequate.	2,3,4
15	The Air Force/ACC needs to adequately value and practice prevention. Individual and population-based prevention is not integrated into AF managed care and operational medicine.	1, 2, 3,4
21	Inappropriate utilization of MTF resources and lack of disease/demand management opportunities in direct care system.	1,2,3,4
23	AFMS personnel lack the skills, knowledge, and tools to deliver optimal primary, secondary, and tertiary prevention for individuals and populations.	2,3,4

Table 3-5 OT-3 Need Priority

**3.2.3.3. New Initiatives and Solutions**

**Operational Task Solutions** The prioritized solutions for integrated programs for disease prevention, health promotion, and fitness are discussed in the quad chart section that follows.

**Solution Priorities:**

<b>OT-3 Solutions Priorities</b>			
<b>OT-1 Priority</b>	<b>ACC/SG Priority</b>	<b>Solution Set</b>	<b>*Funding Requirements FY01 (\$000)</b>
	4	<b>Implement Population-Based Health Plan</b>	\$ 16,555
1		Preventive Health Assessment (PHA)	
2		Implement Preventive Health Care Application (PHCA)	
4		Putting Prevention Into Practice (PIIP)	
6		Epidemiological Assessment and Demand Management	
7		Disease Management Implementation Initiatives	
11		Preventive Dentistry	
12		Breast Cancer Prevention	
	6	<b>Health Promotion/HAWC Program</b>	\$ 2,577
3		Deployed Health Promotion and Fitness	
5		Tobacco Cessation Programs	
8		HAWC Business Case Analysis	
9		Fitness Assessment Program Modernization	
10		Expand Fitness Program Assessment	
		<b>TOTAL</b>	\$ 19,132

\*FY02-08 See Appendix A

Table 3-6 OT-3 Solutions Priority

**Implementation of Population-Based Health Plan  
(Preventive Health Assessment (PHA))**

<p><b>Solution Description:</b> AFMS PMT (as of Jan 99) shows ACC’s PHA completion rate at 44.8% versus the Air Force’s rate of 47.8%. The PHA program is considered work intensive requiring additional resources. The PHA administrator position (either contracted or enlisted position) would be responsible to implement and track the PHA program and to assist the provider in identifying/screening individuals requiring medical profiles (especially prior to deployment processing).</p> <p><b>Justification:</b> USAF/SG mandates this program. Metrics are tracked and reported through the AFMS PMT on PHA completion rates for Air Force, Command and MTF. Resources should be dedicated to this program to ensure a ready fit force.</p> <p>Preventive Health Assessment Implementation Plan dated 29 July 1997</p>									<p><b>Solution Linkages:</b></p> <p><b>OT Platform:</b> 3</p> <p><b>End State Addressed:</b> 1, 2, 3</p> <p><b>Need(s) Addressed:</b> 8, 10, 11, 15, 21, 23, 27, 31, 37, 38, 39, 43, 44</p> <p><b>ACC/SG OT Priority:</b> 4 of 17</p> <p><b>OT Priority:</b> 1</p> <p><b>Requirements Documentation:</b></p>																																																																																
<p><b>Funding Schedule (\$000):</b></p> <table border="1"> <thead> <tr> <th></th> <th>FY01</th> <th>FY02</th> <th>FY03</th> <th>FY04</th> <th>FY05</th> <th>FY06</th> <th>FY07</th> <th>FY08+</th> </tr> </thead> <tbody> <tr> <td>MILPER</td> <td>663</td> <td>663</td> <td>663</td> <td>663</td> <td>663</td> <td>663</td> <td>663</td> <td>663</td> </tr> <tr> <td>Contractor</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Equipment</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Supplies</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Training</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>RPA</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>TDY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>										FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+	MILPER	663	663	663	663	663	663	663	663	Contractor									Equipment									Supplies									Training									RPA									TDY									<p><b>Major Advantages/Payoff:</b></p> <ol style="list-style-type: none"> <li>1. Focuses medical care towards keeping our active duty ready, for any mobility requirement or tasking.</li> <li>2. Early prevention and disease management interventions should reduce acute care demand and health care costs.</li> </ol> <p><b>Joint Service Applicability:</b> No</p> <p><b>POC for Solution:</b> Maj Carole Robbins, HQ ACC/SGOP, DSN 574-1277 email address: <a href="mailto:carole.robbs@langley.af.mil">carole.robbs@langley.af.mil</a> and Lt Col MaryAnn Solano, HQ ACC/SGO, DSN 574-3180 email address: <a href="mailto:maryann.solano@langley.af.mil">maryann.solano@langley.af.mil</a> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: <a href="mailto:carolyn.bell@langley.af.mil">carolyn.bell@langley.af.mil</a></p>								
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<p><b>Scope Statement:</b> One enlisted authorization or contracted position per base (17) for PHA program management.</p>																																																																																									

**Implementation of Population-Based Health Plan  
(Implementation of Preventive Health Care Application (PHCA))**

**Solution Description:** Five ACC bases will have PHCA software implemented (Beale, Langley, Offutt, Seymour Johnson, and Shaw) in FY99. Nellis implemented program in early FY99. The remaining ACC MTFs will be projected to implement the PHCA software as part of the CHCS II deployment in FY00/01. PPIP and PHA programs must be in place prior to implementing PHCA. PHCA pulls together HEAR (automated survey), CHCS, DEERS, immunization data and clinical preventive services with the capability of documenting interventions in the clinical setting. The MTF concerns raised about PHCA implementation concentrate in three areas: (1) Manpower, that is the HEAR proctor requirement, the concern is “another program mandated” with intense manpower requirements with no additional manning; (2) Lack of integration between PHA and PHCA systems, that is the issue of workload duplication with the two systems; and (3) Lack of a fully automated DD Form 2766, in particular all fields not being completed electronically on this form (unable to enter history, surgeries, profiles).  
**Justification:** This program is an initiative funded by Health Affairs as a DoD wide project. TMSSC is responsible for project oversight.

**Solution Linkages:**  
**OT Platform:** 3  
**End State Addressed:** 1, 2, 3  
**Need(s) Addressed:** 8, 10, 11, 15, 20, 23, 27, 31, 38, 39, 43, 44  
**ACC/SG OT Priority:** 4 of 17  
**OT Priority:** 2  
**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	663	663	663	663	663	663	663	663
Contractor								
Equipment								
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Gives the provider and support staff desktop capability to view and edit clinical preventive services needed.
2. Vital tool to assist facilities to shift to prevention thinking and to facilitate the culture shift.

**Joint Service Applicability:** Yes

**POC for Solution:** Maj Carole Robbins, HQ ACC/SGOP, DSN 574-1277, email address: [carole.robbins@langley.af.mil](mailto:carole.robbins@langley.af.mil) and Lt Col MaryAnn Solano DSN 574-3180, email address: [maryann.solano@langley.af.mil](mailto:maryann.solano@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** 1. May require one enlisted authorization (17) when fully implemented to perform the HEAR proctor function.  
 2. MTFs may require systems upgrade to support PHCA software application requirements.

**Implementation of Population-Based Health Plan  
(Putting Prevention Into Practice (PIIP))**

**Solution Description:** HQ ACC/SG will continue to explore marketing techniques, educational programs, and training opportunities to motivate ACC medical personnel to effectively implement PPIP. The AF is educating personnel on the importance of healthy lifestyles and prevention. Keeping people well must be stressed at each encounter. Demand management strategies should be incorporated into wellness briefings. All newcomers to each base should be given briefings on how to better take care of themselves as part of their in-processing checklist/briefings. The self-care manuals should be distributed at these briefings with education on how to use them. At each clinical visit, individuals should be questioned to see if they have and are using their self-care manuals. Nurse-managed clinics should be at each MTF. Nurse-managed clinics could be used to be a part of the PHA process, be a mechanism to review HEAR surveys for increased health-risks, identifying immediate and providing educational services and referrals when risks are identified. PPIP has not yet been fully integrated into everyday practice. HQ ACC/SG will encourage all MTFs to have full-time PPIP coordinators IAW AFPAM 44-155. Prevention committees with a provider goal champion should work on constantly improving processes and focus on available epidemiological data. Integration of services to provide continuity of care is essential. Quarterly PPIP VTC or teleconferences will be held for program updates, lessons learned, best practices and technical assistance. Refer to OT 3 priority 15 for dental prevention initiatives  
Refer to OT 3 priority 16 for breast cancer prevention initiatives

**Justification:**  
HQ ACC SG advocates for a “whole” person look at prevention focused care. Dental prevention programs may be overlooked. Dental exams are an excellent forum to assess tobacco product use and to provide education for active duty. In the past, Breast Cancer prevention funds were “fenced” and used to initiate prevention programs. Programs may now be in place (such as mobile mammography) which no longer have the necessary funding to continue. Strongly recommend the need to continue to “fence” prevention money including breast cancer prevention funds.

**Solution Linkages:**

**OT Platform:** 3

**End State Addressed:** 1, 2, 3, 4

**Need(s) Addressed:** 8, 11, 15, 23, 27, 39

**ACC/SG OT Priority:** 4 of 17

**OT Priority:** 4

**Requirements Documentation:** DoD Health Affairs Policy 9800027 and AFPAM 44-155 *Implementing Put Prevention Into Practice*

<b>Funding Schedule (\$000):</b>								
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	3026	3026	3026	3026	3026	3026	3026	3026
Contractor								
Equipment	3490	3490	3490	3490	3490	3490	3490	3490
Supplies								
Training								
RPA								
TDY								
<p><b>Scope Statement:</b></p> <ol style="list-style-type: none"> <li>1. One officer authorization per base (17) for full time PPIP coordinator per AFPAM 44-155 para 2.2.2.4 (\$89,000 x 17 bases = 1,513,000)</li> <li>2. One officer authorization per base (17) for full time health educator in the primary care clinics per AFPAM 44-155 para 2.2.9 (\$89,000 x 17 bases = 1,513,000)</li> <li>3. \$10 prevention funds/Active Duty and TRICARE Prime enrollees per MTF (349,000 beneficiaries) = \$3,490,000</li> <li>4. Funding for VTC quarterly meetings with PPIP Coordinators (4 Video Teleconferences for approx. 1 hour)</li> </ol>								
<p><b>Major Advantages/Payoff:</b></p> <ol style="list-style-type: none"> <li>1. Enhance/improve health and fitness of active duty members in support of mission readiness requirements.</li> <li>2. Enhance/improve health and fitness of all other eligible beneficiaries.</li> <li>3. Impact (by decreasing) direct and indirect health care costs.</li> <li>4. Decrease preventable diseases.</li> </ol> <p><b>Joint Service Applicability:</b> No</p> <p><b>POC for Solution:</b> Maj Carole Robbins, HQ ACC/SGOP, DSN 574-1277, email address: <a href="mailto:carole.robbins@langley.af.mil">carole.robbins@langley.af.mil</a> and Lt Col MaryAnn Solano DSN 574-3180, email address: <a href="mailto:maryann.solano@langley.af.mil">maryann.solano@langley.af.mil</a> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: <a href="mailto:carolyn.bell@langley.af.mil">carolyn.bell@langley.af.mil</a></p>								

**Implementation of Population-Based Health Plan  
(Epidemiological Assessment and Demand Management)**

**Solution Description:**

HQ ACC/SG will develop guidelines to assist MTFs in implementing the AFMS PBH Plan published Jan 99. Key components to successful implementation include epidemiological assessment, demand management, putting prevention into practice (see OT3 priority #5) and disease management implementation initiatives (see OT3 priority #9):

***Epidemiological Assessment:*** It is vital that all ACC MTFs are able to identify their catchment area demographics, needs and health status. ADS, CHCS, DEERS, HEAR, PHCA and PHA are tools currently available to assist in gathering this data. Demographic data (age, gender, income, and number of dependents) should be readily available. Needs and health status can be assessed using behavioral health surveys, HEAR or HRA surveys, locally developed need assessment tools, outpatient encounter data, PHA, PHCA, and MITS. Emphasis needs to be placed on each facility’s capability to collect, aggregate, and interpret data to drive clinical preventive services. The tools are there but are not integrated.

***Demand Management:*** Strong emphasis must be placed on patient education for self-care. Use of the Take Care of Yourself manuals (either provided by TRICARE Contractor or MTF) and a telephone triage program can be successful tools in demand management. Thirteen of seventeen ACC MTFs currently have a formal or informal telephone triage program in place. Staffing for this program is taken “out of hide” and is often linked with the appointment system. HQ ACC/SG will advocate for self-care classes to be incorporated into base orientation programs – a “medical right start” program. Line commitment/buy-in is imperative to get the additional time needed to present or add-on such a program. HQ ACC/SG will also advocate for UMD changes to establish authorized funded positions for telephone triage at each MTF. Manpower model recommends four FTEs per MTF.

**Justification:**

Systems must be integrated – focus must shift to integrating these systems.

**Solution Linkages:**

**OT Platform:** OT3

**Need(s) Addressed:** 8, 10, 11, 15, 21, 23, 37

**ACC/SG OT Priority:** 4 of 17

**OT Priority:** 6

**Requirements Documentation:** The AFMS Population-Based Plan, dated January 1999

MTFs need to be able to pull usable, accurate data in order to make a population-based health plan work. The harder it is to get this data the more likely their program will fail. Demand Management can be a valuable tool for MTFs to use in meeting access standards. The MTF manpower strain to provide telephone triage system pulls staff away from other primary duties. The opportunity exists to market, provide education and facilitate demand management initiatives with dedicated manpower. MTFs should be rewarded for decreased appointment utilization linked to better demand management initiatives and shifts to prevention-focused care.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	6052	6052	6052	6052	6052	6052	6052	6052
Contractor								
Equipment								
Supplies	273	273						
Training								
RPA								
TDY								

**Scope Statement:**

1. May require systems upgrade to support integration efforts.
2. Funds to cover Take Care of Yourself book for Active Duty when not provided by TRICARE contractor (approx. \$6.50 per book) Estimated need at 25% of AD force (approx. 42,000) for 2 years to all time for contract standardization to provide uniform benefit.
3. Four officer authorizations (17) for telephone triage program.

**Major Advantages/Payoff:**

1. The right thing to do – targets MTF initiatives towards catchment demographics.
2. Successful demand management initiatives will open up appointment availability – less patients using acute appointments for “self care” medical concerns. Appointment templates could be redesigned towards prevention efforts, i.e. “wellness” versus “sickness” appointment.

**Joint Service Applicability:** No

**POC for Solution:** Lt Col MaryAnn Solano DSN 574-3180, email address: [maryann.solano@langley.af.mil](mailto:maryann.solano@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Implementation of Population-Based Health Plan  
(Disease Management Implementation Initiatives)**

**Concept Description:**

HQ ACC/SG began developing a Disease Management Program based off of the Lovelace<sup>®</sup> Disease Management Program in late 1997. HQ ACC/SG developed a corporate disease management development and implementation strategy that was published in Oct 97. The disease management strategy program objectives are:

- Improve clinical practice for a disease across the continuum of care
- Organize quality management tools for systematic, effective management
- Focus on improving customer satisfaction
- Use disease management strategies as a measure to develop clinical indicators
- Develop patient education tools
- Nurse UM/Case Managers etc. become disease management strategy managers

MTFs agreed to develop and implement episodes of care for asthma, hypertension, and low back pain. Facility breakouts per disease were:

- Asthma: Beale, Cannon, Davis Monthan, Dyess, Holloman, and Nellis
- Hypertension: Howard, Lajes, Langley, Moody, Shaw, and Seymour Johnson
- Low Back Pain: Barksdale, Ellsworth, Minot, Mountain Home, Offutt, and Whiteman

Episodes of Care redesign the entire patient care process along the continuum for a given diagnosis using best practices, evidence-based medicine, data, and outcomes. In CY 99/00 HQ ACC/SG will focus on assisting MTFs in refining episodes of care, data extraction/analysis and provider/support staff disease management education. Quarterly Disease Management VTCs or teleconferences will be held for program updates, lessons learned and technical assistance. HQ ACC/SG will coordinate with MTFs to facilitate population based data extraction and to target new disease management initiatives based on each MTF population assessments.

Some progress has been made on completing disease management strategy program objectives. Data extraction and analysis is the major weak link for MTFs in the disease management program. HQ ACC/SG has made a strong

**Solution Linkages:**

**OT Platform:** OT3

**End State Addressed:** 1, 2, 3

**Need(s) Addressed:** 8, 10, 11, 15, 21, 23, 37

**ACC/SG OT Priority:** 4 of 17

**OT Priority:** 7

**Requirements Documentation:**

commitment to fund HQ ACC/SG contracted civilian position on ACC SG staff to assist in improving data access, extraction, and analysis. A provider report summary of patients will be created and field-tested at ACC MTFs for tool usefulness in assisting PCMs to “manage” their patient population.

**Justification:**

HQ ACC SG Disease Management Development and Implementation Strategy states: “We must be able to standardize, guide, improve, and measure our performance and outcomes. Monitoring our patient epidemiological pulse, and mapping this to our prevention treatment and/or referral activities is essential to gain control of our costs and achieve acceptable levels of access. Success depends on our ability to implement programs and services which proactively and prospectively partner patients, physicians and the health care delivery system. A fully successful disease management model will promote the management of disease processes rather than focusing simply on managing individual patients, providers, and episodic care indices.” The opportunity to create a useful patient information tool (provider support report) can give a provider or PCM team a look at patients who are out of variance with similar conditions. HQ ACC SG is targeting diabetes, asthma and hyperlipidemia for the first provider support report.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor	200	200	200	200	200	200	200	200
Equipment	50	50	50	50	50	50	50	50
Supplies	5	5	5	5	5	5	5	5
Training								
RPA								
TDY	20	20	20	20	20	20	20	20

**Scope Statement:**

1. One contracted FTE position at ACC/SG.
2. Cost of quarterly VTCs/distant learning.
3. Funds to cover Provider Support Report – systems interface.

**Major Advantages/Payoff:**

1. Redesigns patient care process across the continuum of care for a given diagnosis; evidence-based medical practice to target best outcomes (clinical, humanistic, and economic).
2. Strongly supports “Best Value Health Care” model (quality, cost, access).
3. Metrics will pull provider behavior via provider support report to eliminate/reduce variances of care.

**Joint Service Applicability:** No

**POC for Concept:** Lt Col MaryAnn Solano DSN 574-3180, email address: [maryann.solano@langley.af.mil](mailto:maryann.solano@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Implementation of Population-Based Health Plan  
(Preventive Dentistry)**

**Solution Description:**  
Prevent dental caries by expanding the use of pit and fissure sealants in young adults and providing fluoride varnishes, chlorhexidine rinses and salivary testing for caries active patients in accordance with recent changes in American Dental Association recommendations. The protocol will be customized for each patient depending upon his or her recent caries experience. The goal is to remineralize small carious lesions and reduce occurrence of new lesions in the population most susceptible to caries.

**Justification:**  
According to the 1194 Triservice dental needs study 25% of Active Duty personnel are at high risk for dental carries. This capability is projected to reduce the occurrence and recurrence of dental caries primarily in the active duty population. This will improve the health and readiness of AD population and reduce the number of dental restorations that will be required in the future. According to the USAF Consultant in Preventive Dentistry, Lt Col Gary C. Martin, this will become the recommended procedure for the USAF Dental Service within the next six months.

**Solution Linkages:**  
**OT Platform:** 3  
**End State Addressed:** 1, 3, 4  
**Need(s) Addressed:** 11, 15, 23  
**ACC/SG OT Priority:** 4 of 17  
**OT Priority:** 11  
**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies	308	308	308	308	308	308	308	308
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Improves dental health of AD members.
2. Reduces the number of dental restorations required in future.
3. Reduces time active duty members will spend at dental appointments.

**Joint Service Applicability:** No

**Scope Statement:**  
Cost of sealant material (fluoride varnish, chlorhexidine rinse, and saliva testing for 25% of the Active Duty force per year.

**POC for Solution:** Col John Watkins, HQ ACC/SGO DSN 574-1328, mail: [John.Watkins@langley.af.mil](mailto:John.Watkins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Implementation of Population-Based Health Plan  
(Breast Cancer Prevention)**

**Solution Description:**  
Breast Cancer Initiative: A program to improve early diagnosis, education and prevention of breast cancer for women beneficiaries of the Military Health System. The program focuses on beneficiary access, dedicated tumor boards, DoD Automated Central Tumor Registry (ACTUR) registrar training and data analysis, Primary care manager master faculty train-the-trainer program, clinical data managers, mammography tracking system, breast cancer care clinical practice guideline development, breast cancer interactive decision guide for patients, and mammography technician recertification training.

**Justification:**  
The capability is required because breast cancer has become a readiness issue since the lifetime risk has gone from 1 in 20 women two decades ago to 1 in 8 women today. Women represent 13% of the active forces.

The Breast Cancer Initiative is a congressionally mandated program established in 1996.

**Solution Linkages:**

**OT Platform:** OT3

**End State Addressed:** 1, 2, 3, 4

**Need(s) Addressed:** 11, 15, 23

**ACC/SG OT Priority:** 4 of 17

**OT Priority:** 12

**Requirements Documentation:** The Breast Cancer Initiative is a congressionally mandated program established in 1996.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	-	-	-	-	-	-	-	-
Contractor	-	-	-	-	-	-	-	-
Equipment	762.30	778.34	794.73	811.35	825.70	840.34	854.98	869.62
Supplies	-	-	-	-	-	-	-	-
Training	-	-	-	-	-	-	-	-
RPA	-	-	-	-	-	-	-	-
TDY	-	-	-	-	-	-	-	-

**Major Advantages/Payoff:**

1. Through education, improve early diagnosis.
2. Reduces the risk of death from Breast Cancer.
3. Aids in the maintenance of a healthy, ready, force.

**Joint Service Applicability:** Yes

**Scope Statement:** Funding to support program begin with fenced fund but fenced funding ends in FY00 leaving a funding shortfall for FY01 and beyond.

**POC for Solution:** Chief Master Sergeant Connie Nesbitt, HQ ACC/SGOC, DSN 574-2334, email: [Connie.Nesbitt@langley.af.mil](mailto:Connie.Nesbitt@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Health Promotions/HAWC Programs  
(Deployed Health Promotion and Fitness)**

**Solution Description:**

HQ ACC/SG is developing guidelines for deployed medical assets to implement fitness and wellness programs in the deployed environment. The intent is to initiate HAWC programs as soon as possible at deployed locations using off-the-shelf prepared programs, exercise motivation (Microfit), tobacco cessation programs, and nutritional classes. Anticipate test program deployment in CY00.

**Justification:**

Strategic goal of ACC/SG is to expand health promotion programs to deployed forces. The purpose of health promotion programs is to enhance readiness through optimal health and total force fitness to include all active duty members

**Solution Linkages:**

**OT Platform:** 3

**End State Addressed:** 1, 2, 3, 4

**Need(s) Addressed:** 8, 11, 15, 23, 27, 39

**ACC/SG OT Priority:** 6 of 17

**OT Priority:** 3

**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training								
RPA								
TDY	26.04							

**Major Advantages/Payoff:**

1. Reduced stress related incidences; increased moral.
2. Reduced field/sport injuries.
3. Overall increases readiness mission.

**Joint Service Applicability:** No

**POC for Solution:** Maj Carole Robbins, HQ ACC/SGOP, DSN 574-1277, email: [Carole.Robbins@langley.af.mil](mailto:Carole.Robbins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

TDY money for working group input for guideline development (4-5 individuals from ACC bases).

**Health Promotions/HAWC Programs  
(Tobacco Cessation Programs)**

**Concept Description:**  
 HQ ACC/SG will develop guidance to target tobacco usage assessment at the time of their annual fitness assessments, annual dental exams, PHA, from HEAR data, and/or during deployments. HQ ACC/SG will work in conjunction with MTF HAWCs to tailor tobacco cessation programs using this data. Objectives will be developed focusing on DoD "ALFIT" program goals to decrease tobacco use by five percent each year, decrease smokeless tobacco by 15 percent by 2001 and become tobacco free by 2010. HQ ACC/SG will ensure resources are made available for nicotine replacement therapy and behavior modification programs.

**Justification:**  
 AF/SG goals mirror DoD goals for tobacco reduction.

**Solution Linkages:**

**OT Platform:** 3

**End State Addressed:** 1, 2, 3, 4

**Need(s) Addressed:** 8, 10, 11, 15, 21, 23, 27, 39, 43, 44

**ACC/SG OT Priority:** 6 of 17

**OT Priority:** 5

**Requirements Documentation:** DoD "ALFIT" goals to include tobacco use reduction through CY 2010. AFD 40-1, *Health Promotion*, establishes procedures to control tobacco use in AF facilities. AFI 40-102, *Tobacco Use In The Air Force*, establishes guidance for usage assessments and cessation programs.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	-	-	-	-	-	-	-	-
Contractor	121.84	124.41	127.03	129.68	131.98	134.32	-	-
Equipment	-	-	-	-	-	-	-	-
Supplies	529.03	540.16	551.54	563.07	573.02	583.18	593.34	603.50
Training	-	-	-	-	-	-	-	-
RPA	-	-	-	-	-	-	-	-
TDY	-	-	-	-	-	-	-	-

**Major Advantages/Payoff:**

1. Decrease absenteeism relating to illness associated with tobacco use.
2. Enhance readiness through optimal health and total force fitness.
3. Cost reduction related to health risk reduction.

**Joint Service Applicability:** No

**POC for Concept:** Maj Carole Robbins, HQ ACC/SGOP, DSN 574-1277, email: [Carole.Robbins@langley.af.mil](mailto:Carole.Robbins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** Tobacco replacement costs: NRT (patch) is \$90/person; Zyban is \$127/person. Most HAWCs are seeing 130 individuals per year. \$507,780/year for 18 HAWCs - with 10% increase (\$50,778/year). Cost of behavior modification (\$50/person) (50 x 130 = 6500 x 18 bases = 117,000)

### Health Promotions/HAWC Programs (Business Case Analysis)

**Concept Description:** HQ ACC/SG will conduct a business case analysis of HAWC manpower, equipment, and facilities to upgrade program consistency and reliability. **Manpower:** HQ ACC/SG will review HAWC UMDs for present and future manpower requirements as identified in each MTF's 1999 Business Plans. The following are positions that need to be evaluated for insertion into MTF UMDs:

- (a) Credentialed dietician in each HAWC as nutritional program manager
- (b) Adding a health fitness instructor for bases with 6,000+ AD population
- (c) Adding a fitness program manager assistant to all bases to assist with new expanded fitness program and body fat tapings
- (d) Proposing a Special Experience Identifier (SEI) for Health Promotion NCOICs to HQ USAF/SG
- (e) HQ ACC/SG will review HAWC scope of practice, skills and manning

**Equipment:** Health and fitness are inextricably linked to operational readiness. It is imperative that our HAWC and fitness center staffs work together as one team to enhance individual fitness, meet the fitness needs of the Air Force community, and deliver a fit and healthy force. An Integrated Process Team (IPT) has developed an implementation plan including equipment transfer that is effective 1 May 99 to enhance the synergy between HAWCs and fitness centers to reduce redundancy. HAWC exercise equipment will be limited to one piece each of cardiovascular equipment and basic strength training equipment (when the HAWC is not collocated with the fitness center). HAWCs collocated with fitness centers should not have exercise equipment. They will use fitness center equipment for demonstration purposes. **Facilities:** As of March 1999, 15 of 18 ACC HAWCs meet PGL 94-8 criteria for six core facility areas. Cannon AFB has been approved for a FY99 Quality of Life Enhancement Program. Funding has not been determined for construction of a HAWC at Seymour-Johnson AFB. Davis-Monthan AFB is slated to move into a renovated existing Fitness Center in 2001. The Air Force received a Quality of Life Wedge funding (\$183 million over period FY00-FY05) for fitness center requirements. As part of this, each HAWC will be visited this FY99 as part of the Fitness Center's Master Plan to determine HAWC deficiencies and prepare cost estimates to bring facilities

#### Solution Linkages:

**OT Platform:** OT3

**End State Addressed:** 1, 2, 3

**Need(s) Addressed:** 8, 10, 11, 15, 21, 23, 27, 39, 43, 44

**ACC/SG OT Priority:** 6 of 17

**Priority:** 8

**Requirements Documentation:** HQ USAF Program Guidance Letter (PGL 94-8) Guidance for Health and Wellness Centers, AFI 40-101, *Health Promotion Program*, ACC/SG Programming Plan (PPlan) 96-18, AFI 40-502, *Weight Management Program*, 2 March 1999, HQ USAF/CV, *HAWC/Fitness Center Implementation Guide*

into standards. The goal is to have all HAWCs co-located with Fitness Centers in the future. The POC for this project is HQ AFSVA.  
**Justification:** HQ USAF Program Guidance Letter (PGL 94-8) established guidance for Health and Wellness Center’s core requirements for personnel and facilities- did not take into account additional requirements (WMP- taping, expanded fitness program, nutritional education requirement). ACC/SG Programming Plan (PPlan) 96-18 supports HQ USAF letter. AFI 40-101, *Health Promotion Program*, delegates responsibilities for ensuring adequate staff, trained staff and facility requirements are met. AFI 40-502, *Weight Management Program*, requires HAWC staff be responsible for all body fat circumference taping and nutritional counseling for WMP 2 March 1999, HQ USAF/CV, *HAWC/Fitness Center Implementation Guide*, requires Fitness Program Manager assume responsibility of training Services Fitness Specialist to assist with exercise prescriptions and programs, returns all unspecified fitness equipment to Fitness Centers, and incorporates HAWCs into the Fitness Center’s Master renovation plan.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	1,638	1,702	1,767	1,835	1,906	1,979	2,055	-
Contractor								
Equipment								
Supplies								
Training								
RPA								
TDY	26.04							

**Scope Statement:**

1. TDY costs to determine HAWC deficiencies and prepare cost estimates to bring HAWCs into standards.
2. Cost of adding credentialed dietician (one officer authorization) or certified nutritional technician (enlisted authorization) at each HAWC (17).
3. Cost of adding health fitness instructor for bases with 6,000+ AD population (Langley, Offutt, and Nellis).

**Major Advantages/Payoff:**

1. Enables HAWC to continue present programs and meet newly expanded program needs.
2. Decrease Fitness Center and HAWC program redundancies.
3. Meet the fitness needs of the Air Force community delivering a fit healthy deployable force.

**Joint Service Applicability:** No

**POC for Concept:** Major Carole Robbins, HQ ACC/SGOP, DSN 574-1277, email: [Carole.Robbins@langley.af.mil](mailto:Carole.Robbins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Health Promotions/HAWC Programs  
(Fitness Assessment Program Modernization)**

**Solution Description:**

The HAWC is an integrated Line (cycle ergometry) and medical program (Health Promotion). The HAWC facilities are wing buildings throughout ACC. Each HAWC requires an annual O&M budget to maintain facilities and run the fitness assessment and improvement program for the wing; \$30K per base for a total of \$540K annually. HQ ACC/SG will work with our Line counterparts to advocate for inclusion of this requirement in the 02-07 POM. HQ ACC/SG will provide guidance on marketing to Line the importance of total wellness to decrease preventable risks thus having a strong impact on readiness mission. In FY99, HAWC fitness programs have obtained heart sensors for each cycle station to have more consistency in heart rate entry and less tester error. Recommend obtaining Accurex Plus tracking system with interface to better

**Justification:**

AFI 40-501, *The Air Force Fitness Program*, states the wing will provide appropriate staff, facilities, equipment, resources and funds to establish and maintain fitness testing and conditioning programs.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	-	-	-	-	-	-	-	-
Contractor	-	-	-	-	-	-	-	-
Equipment	53.11	54.23	55.37	56.53	57.53	58.55	59.57	60.59
Supplies	-	-	-	-	-	-	-	-
Training	-	-	-	-	-	-	-	-
RPA	-	-	-	-	-	-	-	-
TDY	-	-	-	-	-	-	-	-

**Scope Statement:**

Cost of upgraded heart monitors (Accurex Plus Tracking System) \$300 X 10 EA X 17 Bases.

**Solution Linkages:**

**OT Platform:** OT3

**Need(s) Addressed:** 11, 15, 23

**ACC/SG OT Priority:** 6 of 17

**OT Priority:** 9

**Requirements Documentation:** AFI 40-501, *The Air Force Fitness Program*

**Major Advantages/Payoff:**

The Air Force Fitness Program will provide the best-monitored and scientifically based programs and assessments to members ensuring force readiness.

**Joint Service Applicability:** No

**POC for Solution:** Major Carole Robbins, HQ ACC/SGOP, DSN 574-1277, email: [Carole.Robbins@langley.af.mil](mailto:Carole.Robbins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Health Promotions/HAWC Programs  
(Expand Fitness Program Assessment)**

**Solution Description:** HQ ACC/SG is conducting beta testing at four ACC base sites in order to develop guidance describing how to implement the addition of strength, flexibility, and body composition analysis to the annual fitness test. Beta testing will be completed April 99. The Air Force standard will be set based on research findings. The expanded fitness program will begin CY00. A Fitness Program Manager Assistant will be needed to track fitness improvement programs. Facility requirements will be impacted with this expanded testing. Additional space for program will be required to assure a minimum of 6' x 10' free space per member assessment. Each assessment area will also require sit and reach boxes for flexibility testing.

**Justification:** A Muscular Fitness and Flexibility Assessment guide has been developed by the AF Fitness Program Office, Brooks AFB, in coordination with Department of Aerospace Physiology and Human Performance to look at the feasibility of an expanded fitness program and set the program standards based on beta testing. Manpower and facility expanded requirements are issues to address in test phase. AF/SG supports this initiative.

**Solution Linkages:**

**OT Platform:** 3

**End State Addressed:** 1, 3, 4

**Need(s) Addressed:** 11, 15, 23

**ACC/SG OT Priority:** 6 of 17

**OT Priority:** 10

**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor	104.14	106.33						
Equipment	78.11	79.75						
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

Deliver fit and healthy force via a program that is valid, reliable, legally defensible and practical to administer. Program will assess member's health, physical capacity, readiness and program compliance.

**Joint Service Applicability:** No

**Scope Statement:** A Fitness Program Manager Assistant for fitness improvement programs tracking. Additional space for the program is required to assure a minimum of 6' x 10' free space per member assessment.

**POC for Solution:** Major Carole Robbins, HQ ACC/SGOP, DSN 574-1277, email: [Carole.Robbins@langley.af.mil](mailto:Carole.Robbins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Implementation of Population-Based Health Plan  
(Immunization Tracking Software)**

**Solution Description:**  
 HQ ACC/SG developed the “Medical Immunizations Tracking System (MITS)” to upload data into DEERs. The intent now is to transfer MITS functionality into the Immunization Tracking Module (ITM) of the PHCA program. PHCA deployments to ACC MTFs are scheduled FY99 through FY01 with data conversion from MITS to ITM during each PCHA deployment. TMSCC will provide training to MTF immunization technicians on ITM as part of the PHCA training. HQ ACC/SG will provide resources for program continuity and advocate for program modifications/updates based upon users (MTFs) input.

**Justification:**  
 This program is an initiative funded by Health Affairs as part of the PHCA project. TMSSC is responsible for project oversight.

**Solution Linkages:**

**OT Platform:** 2 and 3

**Need(s) Addressed:**

**ACC/SG OT Priority:**

**OT Priority:**

**Requirements Documentation:** PHCA Requirement

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training								
RPA								

**Major Advantages/Payoff:**

1. Gives the provider and support staff desktop capability to view and edit immunization status.
2. Immunization data portability via DEERs bi-directional interface

**Joint Service Applicability:** Yes

**POC for Solution:** Col Robert Williams, HQ ACC/SGOP, DSN 574-1268, email: [Robert.Williams@langley.af.mil](mailto:Robert.Williams@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** Advocacy only. Non-material solution.

**Implementation of Population-Based Health Plan  
(Ambulatory Data System (ADS) Upgrade)**

**Solution Description:**

ADS currently does not allow data exchange with other medical information systems. HQ ACC/SG will advocate for this data exchange to be developed to eliminate manual entry of existing medical data. In addition, HQ ACC/SG will partner with OPHSA to seek ways to access ADS summary data to improve analysis of MTF outpatient encounters. ADS data accuracy is another major concern. Automating coding could decrease the time spent by support staff “looking up” codes. Emphasis must continue on the importance of accurate coding regardless whether the data is manually or electronically completed. Accurate outpatient encounter data can be a gold mine of information for facilities to use in identifying areas to target disease management and prevention opportunities.

**Justification:**

ADS is a DoD program mandated to capture outpatient encounters. Funding must continue to keep ADS program in place at each MTF.

**Solution Linkages:**

**OT Platform:** OT3

**Need(s) Addressed:**

**ACC/SG OT Priority:**

**OT Priority:**

**Requirements Documentation:** DoD mandated.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Improved data accuracy.
2. Decrease support staff ADS processing time.

**Joint Service Applicability:** Yes

**POC for Solution:** Dr James Gerald, HQ ACC/SGOP, DSN 574-1261, email: [James.Gerald@langley.af.mil](mailto:James.Gerald@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** Advocate only. Non Material solution.

**Implementation of Population-Based Health Plan  
(Occupational Health Training for Primary Care Managers)**

**Solution Description:**

PPIP will expose primary care managers (PCMs) to a broad spectrum of occupational health issues. HQ ACC/SG will explore distance learning, certification, and training programs to equip PCMs with the skills needed to handle these concerns. Flight surgeons are a potential asset to provide some of the training as well as “mentoring” the PCMs on occupational issues.

**Justification:**

The Preventive Health Assessment (PHA) exam is accomplished by PCMs using both PPIP and occupational work exposure determinations. Flight surgeons have the occupational expertise to train PCMs. Use of distance learning will facilitate training and improve overall health intervention by PCMs; decrease costs associated with TDYs of personnel, and provide training to a larger number of personnel.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training								
RPA								
TDY								

**Scope Statement:**

Advocacy only. Non-material solution.

**Solution Linkages:**

**OT Platform:** 3

**Need(s) Addressed:**

**ACC/SG OT Priority:**

**OT Priority:**

**Requirements Documentation:** PHA implementation guide

**Major Advantages/Payoff:**

1. Improve PCM determination of occupational health risks and preventive actions to reduce, eliminate continued risks.
2. Provide training to more personnel at decrease cost.

**Joint Service Applicability:** Yes

**POC for Solution:** CMSgt Michael Wade, HQ ACC/SGOP, DSN 574-1299, email: [michael.wade@langley.af.mil](mailto:michael.wade@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Health Promotions/HAWC Programs  
(Program Guidance)**

**Concept Description:** HQ ACC/SG developed an internal inspection checklist for ACC Health Promotion and Fitness Programs. An annual internal inspection should occur ensuring all criteria are met. ACC HAWCs will evaluate and implement practices identified in the Air Force Office for Prevention and Health Services Assessment “Best Practices in Health Promotion.” HAWCs will assume responsibility for doing all installation body fat taping and education of identified over fat individuals CY 99. This program will increase HAWC manning needs. AFI 40-502 states taping will be accomplished by same gender. Services have agreed to assist with measurements, but no more than 2 hours per week. A private room for taping will also be an issue/concern at space limited HAWC facilities. HQ ACC/SG will strongly advocate for additional manning and resources for facility expansion. Resource partnering with “Put Prevention into Practice” for Demand Reduction programs to include *Take Care of Yourself*, health education and nurse base clinic referrals.

**Justification:** AFI 40-502, *Weight Management Program*, requires HAWC staff be responsible for all body fat circumference taping and nutritional counseling for WMP.

**Solution Linkages:**

**OT Platform:** OT3

**Need(s) Addressed:**

**ACC/SG OT Priority:**

**ACC/SG OT Priority:**

**OT Priority:**

**Requirements Documentation:** AFI 40-502, *Weight Management Program*

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Technique standardization (taping and education).
2. Quicker intervention from trained professionals ( fitness and nutrition education) once individual has been identified as being over-fat.
3. Metrics tracked will show better progress to commanders.

**Joint Service Applicability:**

**POC for Concept:** Maj Carole Robbins, HQ ACC/SGOP, DSN 574-1277 email: [Carole.Robbins@langley.af.mil](mailto:Carole.Robbins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** Advocacy only. Non-material solution.

#### **3.2.3.4. OT-3 Assessment**

Disease prevention, health promotion, and fitness are three vital links needed as part of building a strong prevention foundation. HQ ACC/SG makes a strong commitment towards implementing and sustaining prevention programs in support of the AFMS Strategic Initiatives: building healthy communities, employ TRICARE, tailored force, and medical readiness. ACC leads the AFMS in fostering disease prevention, health promotion and fitness towards maximizing the human performance weapons system.

HQ ACC/SG will continue to emphasize the need to shift health care towards prevention and the increased importance on staff training to raise awareness and to ensure successful implementation. Improved health care informatics (ADS, CHCS, HEAR, PHCA), electronic medical record, population-base demographics, health risks identification, and facility access are priority programs.

#### **3.2.3.5. OT-3 Master Plan (Roadmaps)**

See Appendix C

#### **3.2.4. OT-4 Needs Analysis and Solution Concepts**

**OT-4 Promote a Safe and Healthy Environment. Goal Champion: Col Browne, Email: [michael.browne@langley.af.mil](mailto:michael.browne@langley.af.mil)**

##### **3.2.4.1. OT-4 End States**

**OT-4 End State 1:** Environmental and occupational health risk identification, measurement, and assessment techniques and decision tools (including risk communication processes) are developed and mature (NLT FY03).

**OT-4 End State 2:** Occupational support of aircrew includes fact-based determinations of fitness for flying duties and provisions for force protection and performance enhancement (NLT FY03).

**OT-4 End State 3:** The Air Force will use risk based decision making to eliminate or mitigate unacceptable risks to human health and enhance human performance in the conduct of AF operations and to assure full compliance with applicable environmental and occupational health laws and attendant regulations (NLT FY10).

**OT-4 End State 4:** Continue to develop and deploy Command Core, integrate the Aeromedical Services Information Management System (ASIMS) and ensure Preventive Health Assessment (PHA) information is integrally linked (NLT FY08).

## 3.2.4.2. Operational Tasks Deficiencies

<b>OT-4 Need Priority</b>		
<b>ACC/SG Priority</b>	<b>Need</b>	<b>Need to End State</b>
5	Selection, retention, training and sustainment of flight surgeons, aeromedical technicians, pararescue airmen and aerospace physiologists are inadequate to support complex AEF missions.	2, 3
12	Inadequate protection from directed energy weapons.	2, 3
13	Human factors inadequately considered in operational planning, development & acquisition, and mission execution.	2, 3
14	Determine Team Aerospace Medicine support to the AEF.	2, 3
17	Improve respiratory protection and personnel protective equipment (PPE) programs.	1
20	Aircrew tolerance to agile flight extremes (high Gx and Gy, prolonged mission duration, high altitude, temperature, circadian desynchronization) is unknown or poorly understood.	2, 3
24	Egress system seat design does not consider the performance effects of smaller, lighter weight aircrew. Aircraft performance envelope exceeds the performance envelope of egress systems.	2, 3
25	Strategy for aircrew human performance enhancement training not fully operational.	2, 3
29	No field hyperbarics capability.	2, 3
30	Information management and decision support system for the aircrew are inadequate. Cockpit and helmet mounted display information is not intuitive to the pilot and detracts from optimum mission effectiveness and situational awareness.	3
31	There is no single automated information system for the occupational health program.	1
32	Lack of female fighter aircrew urinary collection capability.	2, 3
35	Conduct risk-based, process-oriented workplace surveillance surveys.	1
42	Need Line support to pursue life-support/aircrew performance enhancement systems development and sustainment.	2, 3
46	Quantify risk due to poor ventilation in confined spaces and areas.	1
47	Guidance is needed on best practices to comply with the new chromate standard.	1
47	Guidance is needed on best practice to comply with standard for lead exposures at firing range.	1
47	Guidance is needed on best practice to comply with standard for isocyanate-containing paints.	1
50	Protect personnel IAW new restrictive OSHA chemical-specific standards.	1, 4
51	Pneumatic tools presently used for sanding/grinding do not effectively capture emissions.	1

Table 3-7 OT-4 Needs Priority

3.2.4.3. New Initiatives and Solutions

<b>OT-4 Solutions Priorities</b>			
<b>OT-1 Priority</b>	<b>ACC/SG Priority</b>	<b>Solution Set</b>	<b>*Funding Requirements FY01 (\$000)</b>
	8	<b>Aircrew Sustainment</b>	\$ 625
1		Hyperbaric Medicine	
2		Female Aircrew Member Bladder Relief Capability	
	10	<b>Industrial Hygiene Contractor Support</b>	\$ 1,067
3		Workplace Surveillance Surveys	
4		Respirator Fit-testing	
	15	<b>Command Core System</b>	\$ 365
5		Command Core System Support	
6		Command Core System Support at Lajes	
		<b>TOTAL</b>	\$ 2,057

\*FY02-08 See Appendix A

Table 3-8 OT-4 Solutions Priority

**Aircrew Sustainment  
(Hyperbaric Medicine)**

**Solution Description:** Highly portable, single place hyperbaric chambers to provide emergency treatment of decompression sickness (DCS) in aviators at forward operating locations where fixed hyperbaric chambers do not exist. This capability will provide a flexible decompression sickness treatment option for all aircrew members, and especially for those flying the U-2 and F-22s with their risk of DCS.

**Justification:** Hyperbaric chamber therapy is the primary method and treatment of choice for DCS. DCS is a serious risk to aircrew flying at cabin altitudes above 18,000 ft for prolonged periods. This technology will allow for portable hyperbaric treatment virtually anywhere, providing critical operational flexibility. Treatment capability and timelines for aircrew members will be substantially improved to include the capability of treatment while in transport. Portable hyperbaric chamber presents an extremely low cost, easily stored and transportable treatment capability with minimal to no ancillary support requirements.

**Issues/Impacts:** Failure of the AF to pursue acquisition of these chambers will limit capability to provide timely treatment to aircrew who experience DCS. Without these chambers the AF will have to continue to rely upon foreign hyperbaric treatment, where treatment regimes are not always as effective as those used in U.S. facilities.

**Solution linkages:**

**OT Platform:** OT4

**End State Addressed:** 2

**Need(s) Addressed:** 3, ACS MAP

**ACC/SG OT Priority:** 8 of 17

**OT Priority:** 1

**Requirements Documentation:** CAF 316-92, Air Force Bare Base Systems. MNS 002-96, Rapidly Deploying Medical Capability. Army MNS for Field Medical Equipment.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor	625	425	434	-	135	138	140	143
Equipment	-	-	-	443	-	-	-	-
Supplies	-	-	-	-	11	11	12	12
Training	-	-	-	-	22	23	23	24
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Low cost, transportable treatment capability worldwide.
2. Reduced recovery time of aircrew from DCS.

**Joint Service Applicability:** Yes

**POC for Solution:** Lt Col Charles Caulkins; ACC/SGOP; DSN 574-1276, email: [charles.caulkins@langley.af.mil](mailto:charles.caulkins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

Development Schedule (20 months): Studies (12 Months)/Testing (8 Months)  
 Production – Single Lot Buy (3 Units) FY04 (1yr)  
 Development: Hardening, Shock Testing, Safety Analysis, 1.5 man-years (3 yrs), engineering, logistician, contractor/govt. sustainment, 15 man-years for 6 years, \$150k/year

- Development (3600) Dollars (\$1.4M): Contractor/govt. \$1.2M, Prototypes \$.2M
- Production (3080) Dollars (\$.4M): Production Units \$.4M
- Sustainment (3400) Dollars (\$1M): Contractor/govt. \$1M

**Aircrew Sustainment  
(Female Aircrew Member Bladder Relief Capability (FMBRC))**

**Solution Description:**

The Female Aircrew Member Bladder Relief Capability (FAMBRC) will provide a system for bladder relief to female aircrew members who fly long-duration missions in aircraft, which do not have on-board toilets. The current aircrew bladder relief system for these aircraft are designed specifically for male gender anatomy and are difficult for female aviators to use. HSCJYAS is currently monitoring Armstrong Laboratory's evaluations of COTS devices to meet near-term female user requirements. They are also working with the US Navy to meet their near term requirements for female aviator bladder relief. There are no formal requirements documents in place for FMBRC and funding for this program has not been identified

**Solution linkages:**

**OT Platform:** OT4  
**End State Addressed:** 2  
**Need(s) Addressed:** 32  
**ACC/SG OT Priority:** 8 of 17  
**OT Priority:** 2  
**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Capability will greatly increase the relief and comfort for female aircrew members subjected to long-duration missions.
2. System will provide critical capability that does not currently exist.

**Joint Service Applicability:** Yes

**Scope Statement:**

Costing for system is pending.

**POC for Solution:** Major Joe Anderson, HQ ACC/SGOP, DSN 574-1325, [joseph.anderson@langley.af.mil](mailto:joseph.anderson@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Contractor Industrial Hygiene Support  
(Workplace Surveillance Surveys)**

**Solution Description:** Bioenvironmental Engineering (BEE) has inadequate staffing for conducting wall-to-wall workplace surveillance surveys. This funding provides resources for accomplishing this work incrementally. The specific tasks are:

- Evaluate adequacy of ventilation in permit-required confined spaces
- Evaluate AF compliance with new, restrictive chromate standards
- Evaluate lead exposure at remodeled firing ranges
- Evaluate the usage of isocyanate-containing paints
- Evaluate AF compliance with new, restrictive, chemical-specific OSHA standards once they are published in the near future
- Evaluate the usage of pneumatic tools used for sanding and grinding operations.

**Justification:**

The requirements for conducting an occupational health program are mandated by OSHA (Occupational Safety and Health Agency).

**Solution linkages:**

**OT Platform:** OT4

**End State Addressed:** 1

**Need(s) Addressed:** 35, 46, 51

**ACC/SG OT Priority:** 10 of 17

**OT Priority:** 3

**Requirements Documentation:** AFI 48-145 and OSHA standards

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	-	-	-	-	-	-	-	-
Contractor	546.74	558.23	569.99	581.91	592.20	602.70	613.20	623.70
Equipment	-	-	-	-	-	-	-	-
Supplies	-	-	-	-	-	-	-	-
Training	-	-	-	-	-	-	-	-
RPMA	-	-	-	-	-	-	-	-
TDY	-	-	-	-	-	-	-	-

**Major Advantages/Payoff:**

1. Ensures human health protection of all Air Force industrial workers.
2. Creates available time for BEE personnel to conduct quantitative fit-testing of gas masks for all Air Force personnel assigned to mobility positions.
3. Enables privatization of BEE peacetime duties.

**Joint Service Applicability:** No

**POC for Solution:** Lt Col Henry J. Thompson, Jr.,HQ ACC/SGOP, DSN 574-1273, email: [henry.thompson@langley.af.mil](mailto:henry.thompson@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** Procure contractor as Certified Industrial Hygienists (CIHs) to perform evaluations and recommend administrative controls, proper personal protective equipment, and necessary engineering controls.

**Contractor Industrial Hygiene Support  
(Respirator Fit-testing)**

**Solution Description:**

This funding provides resources for base Bioenvironmental Engineering (BEE) personnel to perform annual fit-testing and respirator training of all base personnel enrolled in the Respiratory Protection Program. The workload has increased dramatically:

1. All firefighters must now be trained and fit-tested annually.
2. Workplace supervisors can no longer provide this annual training.
3. Quantitative fit-testing must now be performed on each individual enrolled in the RPP. This increases the average test time from five minutes to 35 minutes. A typical ACC base has 300 people enrolled in the program.

**Justification:**

The requirements for conducting a respiratory protection program are mandated by OSHA.

**Solution linkages:**

**OT Platform:** OT4

**End State Addressed:** 3

**Need(s) Addressed:** 17

**ACC/SG OT Priority:** 10 of 17

**OT Priority:** 4

**Requirements Documentation:** AFOSH Standard 48-137

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	-	-	-	-	-	-	-	-
Contractor	520.70	318.99	325.71	277.10	282.00	287.00	292.00	297.00
Equipment	-	-	-	-	-	-	-	-
Supplies	-	-	-	-	-	-	-	-
Training	-	-	-	-	-	-	-	-
RPMA	-	-	-	-	-	-	-	-
TDY	-	-	-	-	-	-	-	-

**Major Advantages/Payoff:**

1. Ensures human health protection of all Air Force industrial workers.
2. Creates available time for BEE personnel to conduct quantitative fit-testing of gas masks for all Air Force personnel assigned to mobility positions.
3. Enables privatization of BEE peacetime duties.

**Joint Service Applicability:** No

**Scope Statement:**

Procure local contractor to develop tracking system and conduct annual training and fit-testing at 15 ACC bases.

**POC for Solution:** Lt Col Henry J. Thompson, Jr.,HQ ACC/SGOP, DSN 574-1273, email: [henry.thompson@langley.af.mil](mailto:henry.thompson@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

<b>Command Core System (Support)</b>								
<p><b><u>Solution Description:</u></b> The Command Core System (CCS) has been deployed throughout ACC. CCS provides an integrated information management system for conducting the Air Force's occupational health program. Funds are necessary to sustain this Oracle-based database system, implement changes, and provide advanced training to users in Aerospace Medicine (primarily) and throughout the MTF.</p> <p><b><u>Justification:</u></b> The requirements for conducting an occupational health program are mandated by OSHA</p>					<p><b><u>Solution linkages:</u></b></p> <p><b>OT Platform:</b> OT4</p> <p><b>End State Addressed:</b> 4</p> <p><b>Need(s) Addressed:</b> 31</p> <p><b>ACC/SG OT Priority:</b> 15 of 17</p> <p><b>OT Priority:</b> 5</p> <p><b>Requirements Documentation:</b> AFI 48-145.</p>			
<b>Funding Schedule (\$000):</b>								
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	-	-	-	-	-	-	-	-
Contractor	208.28	106.33	217.14	110.84	225.60	114.80	233.60	118.80
Equipment	-	-	-	-	-	-	-	-
Supplies	-	-	-	-	-	-	-	-
Training	-	-	-	-	-	-	-	-
RPMA	-	-	-	-	-	-	-	-
TDY	-	-	-	-	-	-	-	-
<p><b>Scope Statement:</b></p> <p>Procure contractor support to maintain computer systems and provide advanced training to medical personnel at 16 ACC bases.</p>					<p><b><u>Major Advantages/Payoff:</u></b></p> <p>Ensures human health protection of all Air Force personnel.</p> <p><b><u>Joint Service Applicability:</u></b> No</p> <p><b><u>POC for Solution:</u></b> Lt Col Henry J. Thompson, Jr.,HQ ACC/SGOP, DSN 574-1273, email: <a href="mailto:henry.thompson@langley.af.mil">henry.thompson@langley.af.mil</a> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: <a href="mailto:carolyn.bell@langley.af.mil">carolyn.bell@langley.af.mil</a></p>			

**Command Core System  
(Support @ Lajes)**

**Solution Description:**  
The Command Core System (CCS) has been deployed throughout ACC. CCS provides an integrated information management system for conducting the Air Force's occupational health program. The high turnover rate of BEE personnel at Lajes leads to inefficient operations. Funds are necessary to provide a full-time CCS manager for the MTF.

**Justification:**  
The requirements for conducting an occupational health program are mandated by OSHA.

**Solution linkages:**  
**OT Platform:** OT4  
**End State Addressed:** 4  
**Need(s) Addressed:** 31  
**ACC/SG OT Priority:** 15 of 17  
**OT Priority:** 6  
**Requirements Documentation:** AFI 48-145 and OSHA standards.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	-	-	-	-	-	-	-	-
Contractor	156.21	159.50	162.86	166.26	169.20	172.20	175.20	178.20
Equipment	-	-	-	-	-	-	-	-
Supplies	-	-	-	-	-	-	-	-
Training	-	-	-	-	-	-	-	-
RPMA	-	-	-	-	-	-	-	-
TDY	-	-	-	-	-	-	-	-

**Major Advantages/Payoff:**  
Increase efficiency of Air Force's occupational health program at Lajes.

**Joint Service Applicability:** No

**Scope Statement:**  
Procure contractor support to provide a full-time on-site CCS manager at the Lajes MTF. All costs for oversight, housing, travel, and benefits are incurred by the contractor.

**POC for Solution:** Lt Col Henry J. Thompson, Jr.,HQ ACC/SGOP, DSN 574-1273, email: [henry.thompson@langley.af.mil](mailto:henry.thompson@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Insertion of Air Force Biomedical Scientists in AF and DOD Counterproliferation Offices**  
(NEW SOLUTION)

**Solution Description:**  
Establish authorizations for mid to senior level biomedical scientists in key organizations responsible for managing counterproliferation programs. Specifically, create authorizations at the Joint Program Office for Biological Defense, the Defense Threat Reduction Agency, and the Air Force Counterproliferation Office (AF/XONP), at a minimum.

**Justification:**  
There is a deficiency in Air Force biomedical science representation and staffing in key DoD agencies charged with managing Counterproliferation Programs. Biomedical Scientists may be the best qualified yet least utilized AF assets to lead and manage CP Programs. Many AFMS biomedical scientists routinely manage large programs and perform workplace and environmental surveillance for chemicals, infectious agents, and radioactive materials. Many of the BSCs also hold advanced degrees in environmental engineering, toxicology, and even molecular biology. Air Force BSC involvement in CP programs is critical both in furthering DoD's programs and in supporting AF needs.

**Solution Linkages:**  
**OT Platform:** OT4  
**End State Addressed:** End State 3 and OT1 End State 5  
**Need(s) Addressed:**  
**ACC/SG OT Priority:** *This solution was not included in our earlier priority listing and will need to be scored at our next MSP update but it will be a high ACC/SG and CAF/SG priority*  
**OT Priority:** TBD  
**Requirements Documentation:**  
CAF 314-97, MNS for Enhanced Force Protection; MNS 002-96, Rapidly Deploying Medical Capability; Army MNS for Field Medical Equipment; Navy MNS for Biological Warfare Defense; Marine Corp MNS NBC 217 for a Family of Biological and Chemical Decontaminants; MNS 215.2.2 for a Family of Lightweight Decontamination Systems; Marine Corps Master Plan and Mission Area 21, Direct Fire and Maneuver; USAF SON 004-85, Sustained Operations in a Chemical/Biological Environment (SECRET). Draft ORD Joint Biological Agent Identification and Diagnosis System (JBAID).

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER	361	372	384	396	408	421	434	447
Contractor								
Equipment								
Supplies								
Training								
RPMA								

**Major Advantages/Payoff:**

1. Improved AF and DoD force protection by utilizing all appropriate DoD specialties in counterproliferation programs.
2. Increased depth of program manager expertise at DoD and AF levels -- system knowledge about risks from NBC agents, NBC agent collection and analysis devices/systems, data management and reporting, and health risk assessment.
3. Improved disease prevention -- biomedical scientists understand the medical system and will forge and maintain an interface between biomedical science, passive defense systems, and the medical system.

**Joint Service Applicability:** Yes. The Defense Threat Reduction Agency and the Joint Program Office for Biological Defense are both DoD organizations. The Chem/Bio program is a mandated *Joint* program.

**POC for Solution:** Maj Richard Matta, AC2ISRC; email: [richard.matta@langley.af.mil](mailto:richard.matta@langley.af.mil), DSN 574-0999. Or, Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**  
To create four authorizations and fill these funded positions with best qualified biomedical scientists to provide expertise and manage Counterproliferation Programs at the Joint Program Office for Biological Defense, Defense Threat Reduction Agency, and Air Force Counterproliferation Office (AF/XONP)

#### 3.2.4.4. OT-4 Assessment

Aircrew sustainment solutions constitute our highest priority within OT-4. Portable, worldwide-deployable hyperbaric medicine support for the U-2 and, eventually, the F-22 are critical to mission accomplishment. Development of a Female Aircrew Member Bladder Relief Capability is long overdue to fully support the unique requirements of this fast-growing sector of the aircrew population. Regular interface between HQ ACC/SG and the Research & Development community is essential to ensure the latter's ongoing efforts are focused on ACC's operational requirements.

Next in importance to OT-4 is contractor industrial hygiene support of our under-resourced base-level bioenvironmental engineering flights. Contractor supplied workplace surveillance surveys and industrial respirator fit-testing will permit base bioenvironmental engineers to focus their efforts on wartime-related tasks, including NBC surveillance and gas mask fit-testing.

Finally, the Air Force Surgeon General has designated the CCS as the single integrated information management system for Team Aerospace Medicine. We have fielded CCS at all ACC bases, but require sustainment of hardware and software, as well as technical support and training to maintain the systems. Additionally, because of the high turnover of personnel, we require a full-time, contract CCS manager at Lajes to ensure their system meets the needs of the local Team Aerospace Medicine.

#### 3.2.4.5. Master Plan (Roadmaps)

See Appendix C

#### 3.2.5. OT-5 Needs Analysis and Solution Concepts

**OT-5 Provide a Responsive and Sensitive Health Care Atmosphere. Goal Champion: Lt Col Quinnelly, e-mail: [mike.quinnelly@langley.af.mil](mailto:mike.quinnelly@langley.af.mil)**

##### 3.2.5.1. OT-5 End States

**OT-5 End State 1:** In the near term (CY02) develop, implement and sustain processes where we provide quality service, put customers first, empower staff, eliminate barriers and reinforce the customer service basics.

**OT-5 End State 2:** In the mid-term (CY08) plan, design, construct and maintain customer-focused facilities with flexibility to meet the current and future needs of the populations being served.

**OT-5 End State 3:** In the mid-term (CY08) provide timely delivery of services, equipment, supplies and systems (including automated information systems) that meet customer-identified requirements to support delivery of health care in contingency operations and community-based health care.

**3.2.5.2. Operational Tasks Deficiencies**

<b>OT-5 Need Priority</b>		
<b>ACC/SG Priority</b>	<b>Need</b>	<b>Need to End State</b>
7	Inability to capture, store, transmit, update, retrieve, and access information impedes clinical and command decision making.	1, 3
19	Current DoD acquisition mechanisms and processes for health care services, supplies, equipment, and facilities are restrictive, time-consuming, and deters competitive performance.	3
22	There is inadequate strategic resourcing for facilities.	2
27	Improved customer service. Staff not empowered or held accountable; practices are staff focused rather than customer focused; we fail to use information provided by customers to improve service.	1, 2
33	There is a lack of an effective cross-directional communications network.	1, 3
34	The patient experience not managed as a system.	1
38	There are no rewards or incentives to ensure positive patient experience.	1
39	The demand for ambulatory care exceeds capacity (appointment availability) at most MTFs.	1, 3
40	Inefficient methods to share best practices.	1,3
41	Personnel are not effectively/properly utilized regarding training, education, and duties related to assigned responsibilities.	1
52	Medical facilities are inadequate, inefficient, and noncompetitive.	26
52	The personnel system is not flexible or responsive enough to MTF needs.	1, 3

Table 3-9 OT-5 Needs Priority

**3.2.5.3. New Initiatives and Solutions**

<b>OT-5 Solutions Priorities</b>			
<b>OT-5 Priority</b>	<b>ACC/SG Priority</b>	<b>Solution Set</b>	<b>*Funding Requirements FY01 (\$000)</b>
	3	<b>IM/IT Support</b>	\$ 10,310
1		OA Platform Upgrade/PC Leasing	
2		IM/IT Co-Sourcing	
3		Medical Systems Infrastructure Modernization	
4	7	<b>RPMA @ 3%</b>	\$ 21,273
5	9	<b>Digital Radiology/Dental/Telemedicine</b>	\$ 3,124
6	13	<b>Capital Equipment</b>	\$ 3,805
7	14	<b>Create a Customer Service Culture</b>	\$ 118
8	17	<b>Distance Learning</b>	\$ 260
		<b>TOTAL</b>	\$ 38,890

\*FY02-08 See Appendix A

Table 3-10 OT-5 Solutions Priority

**IM/IT Support  
(OA Platform Upgrade/PC Leasing)**

**Solution Description:**

Provides standardized desktop computers with integrated office automation suite of software in each ACC MTFs. There are currently approximately 5200 desktops in use at 18 ACC/SG locations. Concept also provides for annual software upgrades as well as on-site maintenance of leased equipment.

**Justification:**

DoD HA issued a policy letter directing the lease of all Automated Data Processing Equipment (ADPE) resources. Due to quickly evolving technology lifecycle and increasing systems requirements of new applications being deployed it is imperative that we have the ability to update our desktop resources as needed.

**Solution linkages:**

**OT Platform:** OT5

**End State Addressed:** 3

**Need(s) Addressed:** 7, 8, 10, 26, 33

**ACC/SG OT Priority:** 3 of 17

**OT Priority:** 1

**Requirements Documentation:** DoD HA Policy Letter

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	4,686	4,785	4,886	4,988	5,076	5,166	5,256	5,346
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Provides standardized desktop equipment platform for each of our MTFs.
2. Provides tool for technology refreshment on an annual basis.
3. Provides methodology for effective asset management.

**Joint Service Applicability:** No

**Scope Statement:** Provides annual lease (renewable for up to 3 years total) of 5200 desktop computers deployed at 17 ACC MTFs and HQ ACC/SG. Included in annual costs are software upgrades, equipment maintenance, and asset management capability.

**POC for Solution:** Major Randy Carpenter, HQ ACC/SGMI, DSN 574-3295, email: [Randy.Carpenter@Langley.af.mil](mailto:Randy.Carpenter@Langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

<b>IM/IT Support (IM/IT Co-Sourcing)</b>																																																																																
<p><b><u>Concept Description:</u></b></p> <p>Provide two information management/information technology contract employees for each ACC MTF.</p> <p><b><u>Justification:</u></b></p> <p>With the continual influx of MHS downward directed information systems and the evolving requirements for the use of electronic information within our medical enterprise IM/IT staffs are struggling to meet the basic information requirements. As the technology continually changes our IM/IT staffs also struggle to maintain core competencies in the many technologies that evolve. Co-sourcing a part of the IM/IT staffs will ensure current knowledge and experience levels of the IM/IT staffs will meet the information needs of the facilities.</p>					<p><b><u>Solution linkages:</u></b></p> <p><b>OT Platform:</b> OT5</p> <p><b>End State Addressed:</b> 3</p> <p><b>Need(s) Addressed:</b> 1, 7, 8, 10, 21, 26, 33, 41</p> <p><b>ACC/SG OT Priority:</b> 3 of 17</p> <p><b>OT Priority:</b> 2</p> <p><b>Requirements Documentation:</b></p>																																																																											
<p><b><u>Funding Schedule (\$000):</u></b></p> <table border="1"> <thead> <tr> <th></th> <th>FY01</th> <th>FY02</th> <th>FY03</th> <th>FY04</th> <th>FY05</th> <th>FY06</th> <th>FY07</th> <th>FY08+</th> </tr> </thead> <tbody> <tr> <td>MILPER</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Contractor</td> <td>3,541</td> <td>3,796</td> <td>4,069</td> <td>4,362</td> <td>4,661</td> <td>4,980</td> <td>5,320</td> <td>5,682</td> </tr> <tr> <td>Equipment</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Supplies</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Training</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>RPA</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>TDY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+	MILPER									Contractor	3,541	3,796	4,069	4,362	4,661	4,980	5,320	5,682	Equipment									Supplies									Training									RPA									TDY									<p><b><u>Major Advantages/Payoff:</u></b></p> <ol style="list-style-type: none"> <li>Supplements overburdened IM/IT staffs.</li> <li>Enhances ability of IM/IT staffs to meet information needs of the MTFs.</li> </ol> <p><b><u>Joint Service Applicability:</u></b> No.</p> <p><b><u>POC for Solution:</u></b> Major Randy Carpenter, HQ ACC/SGMI, DSN 574-3295, email: <a href="mailto:Randy.Carpenter@Langley.af.mil">Randy.Carpenter@Langley.af.mil</a> or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: <a href="mailto:carolyn.bell@langley.af.mil">carolyn.bell@langley.af.mil</a></p>			
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TDY																																																																																
<p><b><u>Scope Statement:</u></b></p> <p>Contractor: Cost estimates are for 2 FTEs at each ACC MTF. Annual cost is estimated to be \$100k per contractor with a 5% annual escalation.</p>																																																																																

**IM/IT Support  
(Medical Systems Infrastructure Modernization)**

**Concept Description:**  
 The Medical Systems Infrastructure Modernization (MSIM) project is targeted to design, engineer and install new MTF cable plant and infrastructures. Each facility is surveyed and an infrastructure topology is designed in accordance with established standards for the specific facility. MSIM implementation will include facility backbone infrastructure as well as necessary vertical and horizontal wiring down to the desktop level.

**Justification:** Many of our facilities have outdated cable plants and communications infrastructure. Implementation of the MSIM project will provide up to date communications infrastructure that facilitates the use of currently available technologies. In addition with the implementation of MSIM the facility is disrupted only once for installation of cabling, etc. and therefore eliminated the current practice of having to install small amounts of infrastructure with each new system that is implemented.

**Solution linkages:**

**OT Platform:** OT5

**End State Addressed:** 3

**Need(s) Addressed:** 1, 7, 8, 10, 21, 26, 33, 41

**ACC/SG OT Priority:** 3 of 17

**OT Priority:** 3

**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	2,083	3,190	3,257	443	451	459	467	475
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Provides standardized cable plant and communications infrastructure for our medical treatment facilities.
2. Provides platform for acceptance and implementation of new technologies as they become available.
3. Limits disruption to MTF business by implementing all necessary infrastructure during one installation.

**Joint Service Applicability:** No

**Scope Statement:**

Equipment and services cost based on completion costs of like size facilities. More facilities can be implemented earlier if capital becomes available. Cost provided by Air Force Medical Support Agency. Funds are 3080.

**POC for Concept:** Major Randy Carpenter, HQ ACC/SGMI, DSN 574-3295, email: [Randy.Carpenter@Langley.af.mil](mailto:Randy.Carpenter@Langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Real Property Maintenance Activity (RPMA)**

**Solution Description:**

Real Property Maintenance Activity (RPMA) funds are essential to the successful operation of each MTF. These funds cover the costs of contract maintenance, repair/maintenance projects, and RPIE equipment replacement. These funds are projects and programmed at a level of 3% of plant replacement value (PRV).

**Justification:**

If these funds are not provided, the physical plant of ACC MTF's will degrade. Significant effort and resources have been spent to bring each facility to a level of maintenance comparable to that in civilian facilities. Without these funds, critical facility infrastructure will degrade at an accelerated rate requiring the premature replacement of high dollar value systems. In addition, a degraded infrastructure may result in significant negative impact on JCAHO accreditation.

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies								
Training								
RPMA *	21,273	21,938	22,623	23,445	24,296	25,178	26,093	27,041
TDY								

**Scope Statement:** The average age of an ACC MTF is 30.2 years. This requirement provides funding for maintenance contracts at all 17 ACC MTF's. In addition, these funds will allow for the completion of projects that support right sizing initiatives and will be used to repair, replace and/or upgrade facility systems. \* Inflation adjusted figures of a 1.5% rate per year.

**Solution linkages:**

**OT Platform:** OT5

**End State Addressed:** 2

**Need(s) Addressed:** 22, 23, 27, 34, 39, 52

**ACC/SG OT Priority:** 7 of 17

**OT Priority:** 4

**Requirements Documentation:**

**Major Advantages/Payoff:**

1. Sustains the MTF physical plant to extend the useful life of critical systems.
2. Ensures health care physical environment is sufficient to allow MTF to pass JCAHO accreditation.
3. Provides funding for MTF projects that support right sizing initiatives.
4. Provides for the replacement of facility systems at the end of their useful life.

**Joint Service Applicability:** No

**POC for Solution:** Mr. E. Ray Nickell, HQ ACC/SGXL, DSN 574-0162, email: [ray.nickell@langley.af.mil](mailto:ray.nickell@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Digital Radiology/Dental/Telemedicine**

**Concept Description:**

ACC has completed a command-wide study assessing current needs and present capabilities. Proposed plan will implement digital radiology, store and forward telemedicine applications and digital dental capabilities. Estimated timeline for implementation will be program dependent and is expected to be phased in over a 3-year period. Out year funding is in support of required maintenance and technology refresh.

**Justification:** Current practice in this area requires that we investigate heavily in the newly available technologies to enhance our capabilities. Substantial cost savings may be able to be realized with the use of currently available technologies in this arena. With many of our ACC MTFs located great distances from large military medical centers and hospitals with a large scope of services available, this technology will facilitate electronic referrals without the cost of sending the patient to see the remote provider in person. Digital storage and processing of images will also provide a better quality of images for diagnosis by the provider and eliminate the majority of any storage requirements of processing chemicals and image films, which we now have in our facilities.

**Solution linkages:**

**OT Platform:** OT5

**End State Addressed:** 3

**Need(s) Addressed:** 1, 7, 8, 10, 21, 26, 33, 41

**ACC/SG OT Priority:** 3 of 17

**OT Priority:** 5

**Requirements Documentation:** Marine Corps ORD for Digital Radiology

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment	3,124	4,993	5,331	1,785	1,816	1,848	1,880	1,913
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Enhanced imaging capability for provider diagnosis
2. Reduce amount of in-person patient referrals
3. Eliminate storage requirements for processing chemicals and image films.

**Joint Service Applicability:** Yes

**POC for Concept:** Major Randy Carpenter, HQ ACC/SGMI, DSN 574-3295, email: [Randy.Carpenter@Langley.af.mil](mailto:Randy.Carpenter@Langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:**

**Capital Equipment Funding (2F)**

**Solution Description:**  
 Capital Equipment funding is essential to maintain the latest technology in ACC MTF's. These funds cover the costs of replacing outdated capital medical equipment.

**Justification:**  
 If these funds are not provided, resources will not be available to replace high dollar value equipment and systems. Significant effort and resources are spent each year to enable each MTF to provide a level of care comparable to that in civilian facilities. Without these funds, critical equipment will degrade, become obsolete, and have a negative impact on the delivery of quality health care. An increased number of patients will be sent to civilian facilities due to unavailability of required equipment. In addition, the impact may result in significant negative impact on JCAHO accreditation.

**Solution linkages:**  
**OT Platform:** OT5  
**End State Addressed:** 3  
**Need(s) Addressed:** 27, 54, 52  
**ACC/SG OT Priority:** 13 of 17  
**OT Priority:** 6  
**Requirements Documentation:**

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment *	3,805	3,862	3,920	3,978	4,038	4,098	4,160	4,223
Supplies								
Training								
RPMA								
TDY								

**Major Advantages/Payoff:**

1. Allows funding to provide the latest equipment technology to MTF's.
2. Ensures equipment is available to support the health care mission of each MTF.
3. Provides for the replacement of obsolete and unservicable equipment with a unit cost greater than \$100K.

**Scope Statement:**  
 Each year funding is required to replace medical equipment and systems with a unit cost greater than \$100K. This requirement provides funding for replacement of obsolete and unservicable equipment at all 17 ACC MTF's.  
 \*Figures shown above are adjusted for inflation at a rate of 1.5% per year.

**Joint Service Applicability:** No  
**POC for Solution:** Mr. E. Ray Nickell, HQ ACC/SGXL, DSN 574-0162, email: [ray.nickell@langley.af.mil](mailto:ray.nickell@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Create A Customer Service Culture**

**Solution Description:**

Customer satisfaction is the capstone of the AFMS Strategic Initiatives. Creating and sustaining a culture and climate of customer satisfaction is considered by senior leadership to be one of the most important elements in ensuring the survivability of the peacetime health care system. Future efforts will emphasize operationalizing customer service until it becomes an integral part of the AFMS culture. The AFMS Customer Service Basics and AFMS Customer Satisfaction Priorities are the key components of the overall customer satisfaction strategy.

**Justification:**

HQ USAF/SG has directed that the AFMS Customer Service Basics be fully integrated in each AFMS organization by 1 Jul 99.

**Solution linkages:**

**OT Platform:** OT5

**End State Addressed:** 1, 2

**Need(s) Addressed:** 27, 34, 38

**ACC/SG OT Priority:** 14 of 17

**OT Priority:** 7

**Requirements Documentation:** HQ USAF/SG directed

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor								
Equipment								
Supplies	83.31	85.06	86.86	88.67	90.24	91.84	93.44	95.04
Training	35.06	35.62	36.19	36.95	37.73	38.52	39.33	40.16
RPMA								
TDY								

**Major Advantages/Payoff:**

Sustain the activities of MTF customer service working groups (Skunkworks) established at each ACC MTF.

**Joint Service Applicability:** NA

**POC for Solution:** Col John F. Watkins, HQ ACC/SGO, DSN 574-1328, email: [john.watkins@langley.af.mil](mailto:john.watkins@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

**Scope Statement:** Medical personnel provide other customer service training in a wide variety of settings and require funds for materials and occasional travel (\$2K/MTF/Yr). An ACC Grant program providing funds for customer service initiatives i.e. Local recognition programs, marketing, and incidental expenditures (\$100K).

**Distance Learning**

**Solution Description:**

This funding provides a comprehensive satellite service to all ACC MTFs. The program of physician and staff training courses, as well as patient education and wellness programs allows the enrollees and the entire medical team to keep pace with changing health care technology. The hospital records the programs from the satellite feed for its library so staff members can view the training at convenient times.

**Justification:**

This satellite-based distance learning pilot project reduces CME TDY costs while increasing the number of CME and other training hour obtained by the entire staff. We are testing the Returns in cost savings and increased CME. Without this funding costs shift to TDY requirements.

**Solution linkages:**

**OT Platform:** OT5

**End State Addressed:** 1, 2, 3

**Need(s) Addressed:** 1, 5, 22

**ACC/SG OT Priority:** 17 of 17

**OT Priority:** 7

**Requirements Documentation:** ACC/SG Initiative

**Funding Schedule (\$000):**

	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08+
MILPER								
Contractor	250	250	250	250	250	250	250	250
Equipment								
Supplies								
Training								
RPA								
TDY								

**Major Advantages/Payoff:**

1. Reduces Travel Costs For CME credits.
2. Provides opportunities for CME credit currently not available due to funding limits.

**Joint Service Applicability:** No

**Scope Statement:**

System setup and full operation for 17 ACC Medical Facilities.

**POC for Solution:** Lt Col John Binder, HQ ACC/SGR, DSN 574-1256, email: [john.binder@langley.af.mil](mailto:john.binder@langley.af.mil) or Major C. Bell, HQ ACC/SGR; DSN 574-1282; email: [carolyn.bell@langley.af.mil](mailto:carolyn.bell@langley.af.mil)

#### **3.2.5.4. OT-5 Assessment**

The goal of OT 5 is to provide the information management, medical technology, facility improvements, maintenance, and medical equipment support needed to enhance customer satisfaction and operate state-of-the-art facilities in a peacetime healthcare system. To realize this goal, ACC is pursuing an aggressive program which encompasses: (1) A MSIM project to design, engineer and install new medical treatment facility information systems' infrastructures, (2) A RPMA program to upgrade and modernize our medical treatment facilities, (3) Increased reliance on contract facility maintenance rather than military civil engineering support, (4) Implementation of digital radiology and telehealth applications, (5) Enhanced procurement of capital equipment, and (6) Continued training and marketing of customer service principles. Funding of these programs over the near- and mid-term are essential in order for ACC to meet the healthcare delivery requirements of its beneficiaries.

#### **3.2.5.5. Master Plan (Roadmaps)**

See Appendix C

## Chapter 4: Business Plans

### 4.1. Business Plan Development

This chapter is a review and update of our MAJCOM Business Plan submitted to the Air Staff in Jan 99. MTF business planning process supports MAJCOM business planning which, in turn, supports the Air Staff business strategy. Base-level programming information is essential as each MAJCOM builds its MSP. The integration between planning and programming, including corporate review of enterprise initiatives, is essential to achieving our long-range goals. The business plan is the “link” between long-range planning and resource allocation. Additionally, MAJCOM programming information is essential for Air Staff programmers to ensure necessary resources are in place--both when and where required. MAJCOM involvement is critical for the enterprise-wide prioritization of requirements and allocation of resources. The ACC/SG Business Plan Guidance, Appendix D was the primary tool provided to our MTFs to guide their planning for manpower and resource initiatives. We have included our guidance for your review to assist you in understanding how our Business Plan was achieved. The MTF business plans focus included:

- **Tailored Force**
- **Enrollment Based Resourcing Model (EBRM)**
- **O&M Resourcing and Offsets**

### 4.2. Tailored Force

ACC completes all programmed tailored force initiatives by the end of FY00. The tailored force is primarily the result of congressionally mandated rightsizing, 1500:1 patient to primary care provider ratio and EBRM, and changes in the MRL.

#### **Medical Resource Letter (MRL)**

Adjustments to the MRL (i.e., transfer of many surgical taskings from ACC units) have removed the readiness mandate to maintain surgical services at several ACC medical facilities. All facilities programmed to be ambulatory surgical clinics are now performing Business Case Analyses on their surgical services.

The current timeline for ACC’s tailored force initiative is displayed below. By 4<sup>th</sup> quarter FY00 ACC will be comprised of 4 hospitals, 5 ambulatory surgery clinics (ASC), and 8 clinics.

<b>Base</b>	<b>FY97</b>	<b>FY98</b>	<b>FY99</b>	<b>FY00</b>
Barksdale	Hospital	Hospital	ASC	ASC
Beale	Hospital	Clinic	Clinic	Clinic
Cannon	Hospital	ASC	ASC	Clinic
Davis-Monthan	Hospital	Hospital	ASC	ASC
Dyess	Hospital	Hospital	Hospital	Clinic

Ellsworth	Hospital	Hospital	Hospital	Clinic
Holloman	Hospital	Hospital	Hospital	Clinic
Howard	Hospital	Hospital	Hospital	
Lajes	Hospital	Clinic	Clinic	Clinic
Langley	Hospital	Hospital	Hospital	Hospital
Minot	Hospital	Hospital	Hospital	ASC
Moody	Hospital	Clinic	Clinic	Clinic
Mt Home	Hospital	Hospital	Hospital	Hospital
Nellis	Hospital	Hospital	Hospital	Hospital
Offutt	Hospital	Hospital	Hospital	Hospital
Seymour-J	Hospital	Hospital	ASC	ASC
Shaw	Hospital	Hospital	Hospital	ASC
Whiteman	Hospital	Clinic	Clinic	Clinic

Table 4-1 ACC's Tailored Force Timeline

**Total Manpower Requirements**

The Tailored Force initiatives discussed above will result in a reduction of over 550 manpower requirements from FY99 to FY00 alone. At end-state and after fully implementing the EBRM (Table 4-2 below) ACC will reduce its medical manpower requirements by a total of 1718 (19.4%) since FY96.

	<b>FY96</b>	<b>FY97</b>	<b>FY98</b>	<b>FY99</b>	<b>FY00</b>	<b>FY01</b>
<b>Officer</b>	2446	2269	2274	2118	1974	1773
<b>Enlisted</b>	5141	5192	5098	4877	4590	4531
<b>Civilian</b>	1251	1326	1128	1018	910	816
<b>Total</b>	8838	8787	8500	8013	7474	7120

Table 4-2 Total Manpower Requirements

**Individual Mobilization Augmentee (IMA)**

Readiness taskings are the first and foremost consideration in determining all manpower requirements. As mentioned previously, any service closures or reductions were considered against the backdrop of anticipated readiness taskings traceable to the MRL. IMA requirements were reviewed and established as follows:

	<b>FY99</b>	<b>FY00</b>	<b>FY01</b>
<b>Officer</b>	125	125	116
<b>Enlisted</b>	217	217	210
<b>Total</b>	<b>342</b>	<b>342</b>	<b>326</b>

Table 4-3 Individual Mobilization Augmentee

**4.3. Enrollment Based Resourcing Model (EBRM)**

In developing manpower requirements for FY01, all ACC medical facilities were instructed to use the EBRM. The challenge of reaching the 1500 enrolled beneficiaries per PCM was considered and aggressive enrollment goals were set for each base. To reach these goals, aggressive marketing plans are being developed.

The total ACC Maximum Achievable Enrollment (MAE) is 349,087 with the following breakout by beneficiary category:

<b>Beneficiary Category</b>	<b>Enrollment</b>
Active Duty	83,230
Active Duty Family Member	143,853
Retired & Family Member (under 65)	86,101
Retired & Family Member (65 and over)	32,572
Other	3,331

Table 4-4 MAE by Beneficiary Category

This enrollment goal drives a requirement for 255 PCMs. This accounts for the more liberal aerospace medicine enrollment ratio as directed by Air Force Medical Operations Agency (AFMOA)/SGOP. The following table breaks out those requirements by AFSC.

<b>AFSC</b>	<b>PCM</b>	
042G3	Physician Assistant	42
044F3	Family Practice Physician	75
044G3	General Practice Physician	0
044K3	Pediatrician	48
044M3	Internist	41
046N3B	Pediatric NP	10
046N3H	Family NP	7
048*	Aerospace Medicine	32
	Total	255

Table 4-5 PCM by AFSC

Overall, the command’s enrollment ratio is projected to be 1369:1. Upon determining the number of PCMs, more robust support staff ratios were applied across the command. Using the 255 PCMs as the basis, the following total numbers of support staff are required:

Support Staff		Support Staff to PCM Ratio
Nurse	138	(.54 / PCM)
Technician	507	(1.99 / PCM)
Administrative	208	(.82 / PCM)
Total	853	(3.35 / PCM)

Table 4-6 Staff Support Ratios

In addition to a more robust support staff, there are several other infrastructure and system constraints that must be addressed if the 1500:1 enrollment ratio is to be achieved. Several of these constraints are listed below and are addressed in more detail in other sections of this MSP. In summary, a 1500:1 enrollment ratio is achievable, but many actions requiring resources must be taken to reach this goal. Examples are:

- **Facilities.** Facilities must be modified to provide an efficient ambulatory-focused setting. Providers with only one exam room are not optimally resourced to manage 1500:1 (or greater for some primary care specialties) enrollment ratio.
- **Information Management/Information Technology (IM/IT).** Providers must have efficient and appropriate IM/IT support. Not necessarily more IM/IT, but value-added IM/IT support (e.g. computerized patient encounter system).
- **Population Health.** Programs must be implemented to reduce the number of visits. Excellent programs such as PPIP and the PHA are in development, but they are in their infancy and will take years to mature. In order to make 1500:1 work, these programs must be appropriately and consistently resourced and given time to mature.

**4.4. O&M Resourcing and Offsets**

As we increase enrollment, additional O&M funding is required to provide resources for the increased care provided. To support this requirement, we developed a methodology to project the additional O&M requirements based on current O&M variable costs applied against projected demand. Projected O&M requirements are based on the following:

$$\begin{array}{rclclcl}
 \text{Projected} & & \text{Variable} & & \text{Projected outpatient} & & \text{FY01} & & \text{Space A Care in} \\
 \text{annual} & & \text{cost per} & & \text{visits/enrollee} & & \text{MAE in} & & \text{equivalent lives} \\
 \text{O\&M} & = & \text{visit} & \times & \text{reflecting DM/UM} & \times & \text{equivalent} & - & \text{assumed to} \\
 \text{increase} & & & & \text{decrement} & & \text{lives delta} & & \text{enroll}
 \end{array}$$

Based on the model above, achieving MAE in FY01 generates an additional O&M requirement of \$13,666,386 adjusted for inflation. The ACC overall variable O&M cost per enrollee is \$99 per equivalent enrolled life. The overall capitated rate of \$216 per enrollee is an annualized variable per member per month capitation rate, which is based on the Dec 98 CEIS Enrollment Based Capitation Report. The capitated cost of \$216 per enrollee reflects: cost of care provided at the enrollment MTF, care from other MTFs, and the civilian medical care the government paid for under TRICARE. The \$99 per additional equivalent enrollee represents a portion of the \$216 annualized rate.

### **Revised Financing Resourcing Requirements for MAE**

Signing more enrollees to the “revised financing” MTFs drives a requirement for additional funds to pay claims for TRICARE PRIME MTF enrollees.

- **Langley**

Based on projected requirements vs. current funding level which is inadequate, we project Langley’s additional requirement is:

- \$2,500,000 divided by 12,257 (the current enrollment in equivalent lives) = \$204.0 (per enrollee)
- Revised financing FY01 funding requirement based on projected MAE delta is (35,005-12,257) = 22,748 times \$212 (inflated cap rate) = \$4,823,849

- **Seymour-Johnson**

Based on current funding level we project Seymour-Johnson’s additional requirement is:

- \$4,000,000 divided by 10,800 (current enrollment in equivalent lives) = \$370.4 (per enrollee)
- Revised financing FY01 Funding requirement based on projected MAE delta (17,832-10,800) = 7,032, times \$385.18 (inflated cap rate) = \$ 2,708,585

The total revised incremental financing funding requirement for Langley and Seymour-Johnson is \$7,532,434.

### **Telehealth Economic Analysis**

This telehealth analysis was a recent financial justification of an unfunded requirement. The analysis determines the most cost-effective solution when there are several options available. The analysis takes into account equipment cost and installation, equipment maintenance, training, the estimated use full equipment life, depreciation, and inflation. The result of the analysis is a total cost of \$1.46M in FY99, which is comprised of \$1.1M for equipment, \$250K for training, and \$110K for maintenance. This analysis clearly demonstrates, based on cost, that the telehealth is a viable option.

<b>Telehealth Option</b>			
<b>Year</b>	<b>Initial Investment and Training Costs</b>	<b>Recurring Maintenance Costs</b>	<b>Total Costs</b>
1	\$1,350,000	\$110,000	\$1,460,000.0
2		\$112,310.0	\$112,310.0
3		\$114,826.0	\$114,826.0
4		\$117,467.0	\$117,467.0
5		\$120,227.0	\$120,227.0
		<b>Total</b>	<b>\$1,924,830.0</b>
		<b>NPV</b>	<b>\$1,764,253.3</b>
		<b>Uniform Annual Cost</b>	<b>\$415,418.50</b>

Table 4-7 Telehealth Uniform Annual Costs

### Reductions in Overhead

We have reviewed the MTFs' administrative support cost as a percent of total cost against the managed care benchmark of 15%. Only two of our larger MTFs are close to meeting this benchmark. This points to the fact that our "opening the door costs" at our smaller MTFs need to be reviewed. One conclusion to be drawn is that our administrative support function has not been properly sized to the MTF. During the Feb 99 General Officer Roundtable, an IPT was established to analyze and recommend solutions. Several solutions exist, one is using the "Navy Model," a hub and spoke design, where a larger MTF is given administrative functional responsibility for smaller MTF clinics within a certain geographical area.

Using Cannon MTF as an example of the administrative savings potential, the reduction of Administrative Cost Ratio from the current 37% to a benchmark of 22% would yield potential savings of over \$3.5M. The cost saving is primarily in military personnel compensation. The following is a listing of MTF current administrative cost ratios and potential savings if overhead is reduced.

<b>Medical Admin/Support Cost as a % of Total Cost by MTF</b>			
<b>MTF</b>	<b>Current Ratio</b>	<b>Ratio After Reengineering</b>	<b>Savings (\$000)</b>
<b>Nellis *</b>			
<b>Offutt *</b>	18%		
<b>Langley*</b>	18%		
<b>Barksdale</b>	29%	22%	\$ 3,000
<b>Davis Monthan</b>	32%	25%	\$ 4,000
<b>Shaw</b>			
<b>Cannon</b>	37%	22%	\$ 3,500
<b>Dyess</b>	33%	26%	\$ 2,000
<b>Ellsworth</b>	22%	20%	\$ 1,000
<b>Minot</b>	30%	21%	\$ 3,000
<b>Mt Home**</b>	29%		

<b>Medical Admin/Support Cost as a % of Total Cost by MTF</b>			
<b>MTF</b>	<b>Current Ratio</b>	<b>Ratio After Reengineering</b>	<b>Savings (\$000)</b>
<b>Seymour</b>	21%		
<b>Beale</b>	22%	19%	\$ 1,000
<b>Holloman</b>	23%	20%	\$ 1,000
<b>Moody</b>	25%	22%	\$ 1,000
<b>Whiteman</b>	28%	23%	\$ 2,000
<b>Lajes ***</b>	39%		
<b>Command Wide</b>	27%	Total	\$ 21,500

\* Larger hospital, overhead to remain the same, \*\* Isolated CONUS Hospital, \*\*\* Isolated CONUS Hospital

Table 4-8 Medical Admin/Support Cost as a % of Total Cost by MTF

**4.5. Summary**

ACC is nearing completion of a noteworthy effort to identify inefficiencies, rightsizing and closing inefficient services. Our next challenge is to meet enrollment goals and reengineer our primary care services to allow for the success of EBRM-produced manpower requirements. The reduced manpower requirements established through our efforts are the minimum required to meet the operational medical support expected by our Line leadership, while providing a uniform health care benefit for our enrolled beneficiaries.

**Chapter 5: Results and Performance Measures**

**5.1. Performance Measurement Tool (PMT)**

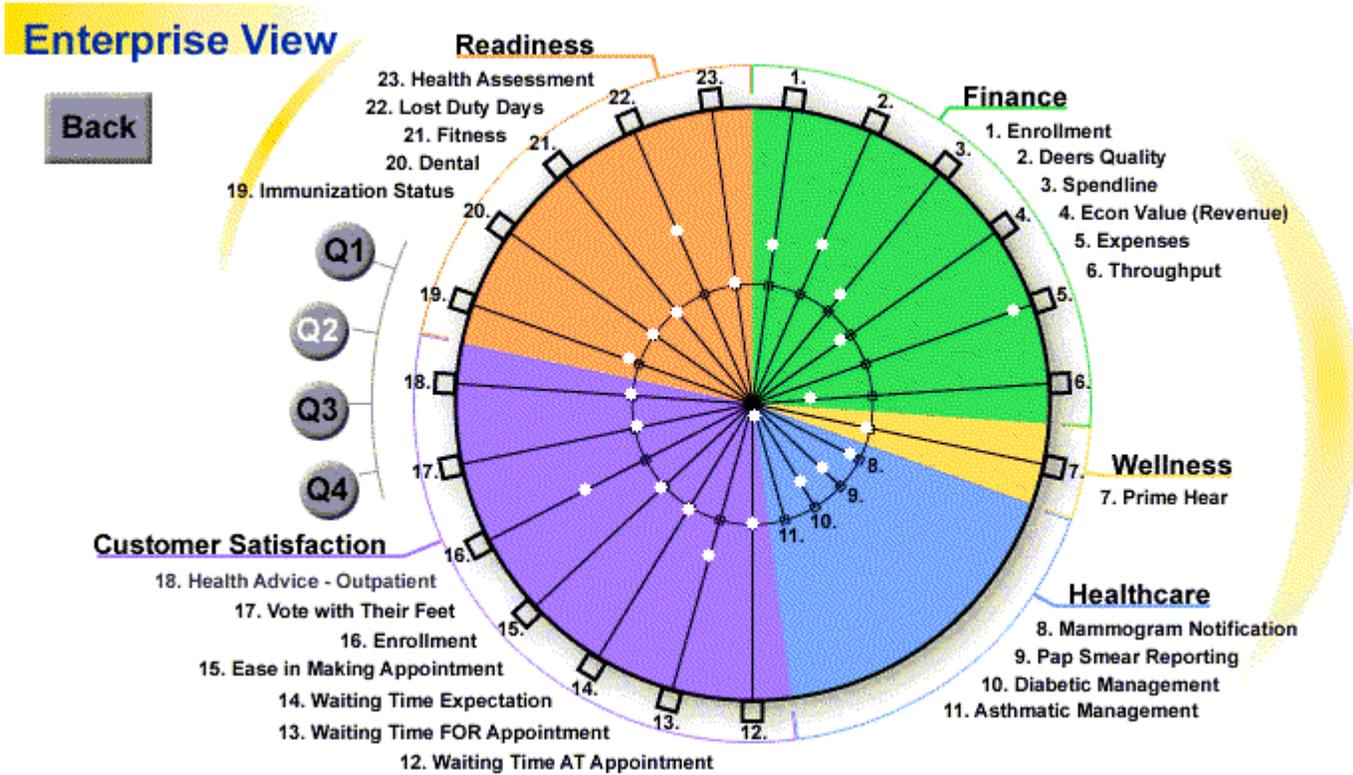


Figure 5-1 PMT Attributes

**5.1.1. Discussion of the PMT**

The PMT enhancements in the last year have improved accessibility and the new screen format is aesthetically pleasing and easier to navigate. However, at this time, the PMT as a management tool has limited effectiveness. We expect with further program advancements ACC command-wide utilization will improve. In an effort to maximize ACC utilization and aid in the improvement/enhancement of the tool, ACC MTF and Headquarters users were queried for feedback on the PMT. A summary of ACC concerns follows:

**Data Integrity**

Concern with reliability of data-especially with CHCS and ADS. Historically, the data sets while interrelated, have not produced "like numbers" when compared. The data from both ADS and CHCS must reflect the accurate workload that is being accomplished by the clinic or this entire process will provide no meaningful feedback for reviewing either processes or outcomes.

**Timeliness/Value of Data**

Need for real-time data. Some data graphs/charts have lengthy time gaps between data submission and graph displays. Users feel they can find more current data elsewhere. Most current month on HEAR is more than six-months old. The Customer Satisfaction annual graphs display 1997 data. Customer Satisfaction quarterly data has a lag time of six months.

**Raw Data**

There is a desire to have access to raw data for a couple of reasons: (1) Validation of data at the PMT site and (2) MTFs would like to use the data to build their own slides, e.g., comparing their MTF with AF and their MAJCOM average.

**Spendline**

Automatic pull of data from the financial system would result in saved man-hours in monthly reporting from MAJCOM to Air Staff.

**Duplication of Effort**

Too many management tools trying to do the same thing (PMT, CEIS, MTF-level metrics). Redundant data being reported to multiple places. A 23 Sep 97 letter from OPHSA identified the AFMS PMT as a transitional step to a comprehensive CEIS.

**5.2. PMT Results**

**5.2.1. Readiness PMT**

	<b>ACC</b>	<b>Air Force</b>	<b>Date of Data</b>
Dental (Class 1 & 2)	92.4%	87.6%	Dec 98
Meeting Fitness Standards	75.8%	74.0%	1999
Immunization Status	76.3%	77.4%	Feb 99
Health Assessments Complete	42.9%	48.35	Feb 99
Lost Duty Days per 1,000	85.6/1000	95.8/1000	Jan 99

Table 5-1 Readiness PMT

**5.2.2. Health Care PMT**

	<b>ACC</b>	<b>Air Force</b>	<b>Date of Data</b>
Asthma Management	NA	NA	NA
Diabetic Management	81.4%	76.7.0%	Feb 99
Mammogram (% notified within 14 days)	97.6%	98.6%	Feb 99
Pap Smear	89.3%	98.6%	Feb 99

Table 5-2 Health Care PMT

**5.2.3. Wellness PMT**

	<b>ACC</b>	<b>Air Force</b>	<b>Date of Data</b>
PRIME HEAR Compliance	.5%	1.3%	Apr 98

Table 5-3 Wellness PMT

**5.2.4. Finance PMT**

	<b>ACC</b>	<b>Air Force</b>	<b>Date of Data</b>
DEERS/Alpha Roster Match	76.2%	70.9	Jan 99
DEERS Data Quality	82.3%	85%	Feb 99
Spend Line	Normal		Feb 99
Total Revenue (% + or – 12 month moving average)	-35%	-36%	Feb 99
Total Expense (% + or – 12 month moving average)	-87%	-92%	Feb 99

Table 5-4 Finance PMT

### 5.2.5. Customer Satisfaction PMT

	ACC	Air Force	Date of Data
Waiting Time At Appointment (30 Minutes)	73.6%	73.1%	Sep 98
Waiting Time For Appointment (routine)	64.5%	60.0%	Sep 98
Waiting Time Expectation (routine, good-excellent)	93.8%	90.7%	Sep 98
Ease in Making Appointment (good-excellent)	84.4%	84.6%	Sep 98
Enrollment in TRICARE Prime (user)	57.4%	54.0%	Sep 98
Vote With Their Feet (enroll or reenroll)	87.2%	86.4%	Sep 98
Health Advice/Outpatient (good-excellent)	90.5%	91.1%	Sep 98

Table 5-5 Customer Satisfaction PMT

### 5.3. Performance Measures ACC Connection

ACC/SG has seven strategic objectives that support COMACC's mission and related strategic plan. The Strategic objectives listed below directly reflect the ACC METL.

- Objective 1: Make *force protection* training and planning a priority in every organization, both while deployed and at home.
- Objective 2: *Implement Agile Combat Support* concepts. Reduce airlift required to deploy an expeditionary Aerospace Force.
- Objective 3: Continue to *deploy a command-wide information network* that improves the operational availability of data and information, guarantees information assurance across the spectrum of conflict, and facilitates process re-engineering to reduce cost of ownership.
- Objective 4: *Build training programs* that maximize balanced mission capabilities within available resources, to include Force Protection and the Ability to Survive and Operate.
- Objective 5: Provide *uniform, high quality health care benefits*; promote prevention and improved health and wellness.
- Objective 6: Schedule all *customer service* providers and their supervisors for Customer Care University and develop follow-on customer care training.
- Objective 7: *Employ metrics* that provide key decision-makers visibility into the costs associated with every aspect of their operation

**5.3.1. HQ ACC/SG Performance Measures**

The ACC/SG staff has developed a wide range of performance measures to provide the Command and Air Staff with timely, accurate decision making information. The list below represents some of the performance measurements used in ACC/SG decision-making and progress monitoring.

**Information Systems**

- Y2K Compliance Reporting
- MISM Standards Report
- Project Progress Reports

**Readiness**

- World Threat Status
- UTC Readiness Status
  - Training Status
  - Training Exercise Status
  - Deployment Status
  - Facilities Management Status
- Training Status
  - NBC
  - UTC
  - Skills
- Reserve and National Guard Utilization

**Managed Care**

- Network Adequacy
- Enrollment
- Access and Drive Time
- Claims Processing
- Active Duty Enrollment/DEERs quality

**Community Health Care**

- Immunization Status i.e. Anthrax
- Suicide Rates/Substance Abuse
- Clinical Issues: Women’s Health, Credentials, QA/JACHO/HSI
- Population Health: PHA Completion, Cycle Ergometry Metrics
- Dental Status
- Customer Satisfaction
- Demand Management
- DNA Testing Statistics
- Profiles

**Resource Management**

- Third Party Collections
- Reserve and National Guard Mandays
- Medical Expense and Performance Reporting System Transactions
- Budget

**Manpower**

- Tailored Force
- Personnel Fill Status by AFSC
- Personnel Fill Status by Product Line

Figure 5-2 Competitor/Partner Analysis

**Demand Management Metrics**

**HQ ACC Short Term Deliverable Metrics:**

<b>Asthma</b>	<b>Definition</b>
Asthma Cohort	All patients in ADS data, beginning June 97 with any of the following ICD-9 codes: 493, 493.0, 493.01, 493.1, 493.10, 493.11, 493.2, 493.20, 493.21, 493.9, 493.90, 493.91
Ambulatory Urgent Care Rate	The rate per thousand at which cohort members present at a clinic for urgent asthma care during a three month period.
Patient Education Status	The status of asthma counseling for each member of the asthma cohort.
Percentage Educated	The percentage of patients diagnosed with asthma who have

	received education within the last quarter, the last six months, the last nine months, and the last year.
<b>Hypertension</b>	<b>Definition</b>
Hypertension Cohort	All patients in ADS data, beginning June 97 with any of the following ICD-9 codes: 401, 401.0, 401.1, and 401.9.
Ambulatory Visit Rate	The rate per thousand at which cohort members present with a primary ICD-9 code corresponding to one of those above.
Active Duty Attack Rates	The rate per thousand at which active duty personnel are diagnosed with hypertension.
Patient Educational Status	The status of hypertension counseling for each member of the hypertension cohort.
Percentage Educated	The percentage of patients diagnosed with hypertension who have received education within the last quarter, the last six months, the last nine months, and the last year.
<b>Low Back Pain</b>	<b>Definition</b>
Low Back Pain Cohort	All patients in ADS data, beginning June 97 with any of the following ICD-9 codes: 724,724.2, 724.3, 724.4, 724.5, 724.8, and 724.9.
Ambulatory Visit Rate	The rate per thousand at which cohort members present at a clinic with a primary ICD-9 code corresponding to one of those above.
Active Duty Attack Rates	The rate per thousand at which active duty personnel are diagnosed with low back pain.

**HQ ACC Long Term Deliverable Metrics**

<b>Asthma</b>	<b>Definition</b>
Hospitalization Rate	The rate per thousand at which cohort members are admitted with a primary diagnosis of asthma during a three month period.
Preventive Medicine Rate	The percentage of asthmatic patients age 39 or less who are on preventive medications.
Beta Agonist Rate	The percentage of asthmatic patients age 39 or less who are using more than 3 beta agonist scripts per year.
Severent Rate	The percentage of asthmatic patients age 39 or less who are using Severent alone.
Systemic Steroid Rate	The percentage of asthmatic patients age 39 or less who are given systemic steroids x 2 and more and are not on any anti-inflammatory agent.
<b>Hypertension</b>	<b>Definition</b>
Prescribed Medication Compliance	The percentage of hypertension patients compliant with their prescribed medication.
<b>Low Back Pain (LBP)</b>	<b>Definition</b>
Drug Guidance Compliance	The percentage of cohort members who receive narcotics.
Lumbar Sacral Magnetic Resonance Imaging (MRI)	The percentage of cohort members who receive lumbar sacral MRI.

Table 5-6 Short and Long Term Demand Management Metrics

## Chapter 6: Glossary of Terms and Acronyms

Acronym	Definition
ACC	Air Combat Command
ACC/SG	Air Combat Command/Command Surgeon
ACCMET	Air Combat Command Mission Essential Task
ACS	Agile Combat Support
ACTD	Advanced Concept Technology Demonstration
ADS	Ambulatory Data System
AEF	Air Expeditionary Force
AETC	Air Education and Training Command
AF	Air Force
AFB	Air Force Base
AFCS	Air Force Corporate Structure
AFDD	Air Force Doctrine Document
AFFOR	Air Force Forces
AFI	Air Force Instruction
AFMAM	Air Force Medical Applications Model
AFMC	Air Force Materiel Command
AFMOA	Air Force Medical Operations Agency
AFMS	Air Force Medical Service
AFMSA	Air Force Medical Support Agency
AFPMT	Air Force Performance Measurement Tool
AFRC	Air Force Reserve Component
AFRL	Air Force Research Lab
AFSC	Air Force Specialty Code
AFSOC	Air Force Special Operations Command
AFTL	Air Force Task List
ALFIT	Alcohol Abuse Control, Life Skills Enhancement, Injury Prevention, and Tobacco Control
AMC	Air Mobility Command
ANG	Air National Guard
APES	Automated Patient Evacuation System
ARC	Air Reserve Component
AS	Allowance Standards
ASC	Ambulatory Surgery Clinics
ASC2ISRC	Air & Space, Command & Control, Intelligence, Surveillance & Reconnaissance Center
ASIMS	Aeromedical Services Information Management System
ATD	Advanced Technology Demonstration
ATH	Air Transportable Hospitals
BPA	Bid Price Adjustment
BW/CW	Biological Warfare/Chemical Warfare
C2	Command and Control
C4I	Command, Control, Communications, Computers, and Intelligence

<b>Acronym</b>	<b>Definition</b>
CAF	Combat Air Forces
CBRA	Capitation Based Resource Allocation Model
CCQAS	Centralized Credentials and Quality Assurance System
CCS	Command Core System
CCU	Customer Care University
CE	Civil Engineers
CEIS	Corporate Executive Information System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHATH	Chemically Hardened Air Transportable Hospital
CHCS	Composite Health Care System
CIO	Centralized Industrial Operations
CINC	Commander in Chief
CME	Continuing Medical Education
COMACC	Commander Air Combat Command
COMAFFOR/ASETF	Commander Air Force Forces/Aerospace Expeditionary Task Force
COMAFFOR/JFACC	Commander Air Force Forces /Joint Forces Air Component Command
CONOPS	Concept of Operations
COTS	Commercial Off-The-Shelf
CPD	Central Processing and Distribution
CY	Calendar Year
DC II	Desert Care II
DE	Directed Energy
DEERS	Defense Enrollment Eligibility Reporting System
DHP	Defense Health Program
DL	Distance Learning/Distributed Learning
DOC	Desired Operational Capability
DoD(HA)	Department of Defense Health Affairs
DNBI	Disease and Non Battle Injury
EAF	Expeditionary Aerospace Force
EAS III	Expense Assignment System Version III
EBC	Enrollment Based Capitation
EBRM	Enrollment Based Resourcing Model
ECU	Environmental Control Unit
EEIC	Element of Expense/Investment Code
EMEDS	Expeditionary Medical Support
EMT	Emergency Medical Treatment
EOC	Expeditionary Operations Center
ESOH	Environmental Safety, Occupational Health
EVINT/ISR	Environmental Intelligence/Intelligence, Surveillance, & Reconnaissance
F4	Form, Fit, Function, & Follow-on
FEHBP	Federal Employee Health Benefits Program
FHP	Force Health Protection
FTE	Full Time Equivalent
FY	Fiscal Year
GAO	General Accounting Office
GCCS	Command and Control System

<b>Acronym</b>	<b>Definition</b>
GCMH	Gerald Champion Memorial Hospital
GCSS	Global Command Support System
GMO	General Medical Officer
GO	General Officer
GOTS	Government Off-The-Shelf
HAWC	Health and Wellness Center
HCA	Humanitarian and Civic Action
HEAR	Health Evaluation and Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HQ	Headquarters
HSS	Health Services Support
HSW	Human Systems Wing
IAW	In Accordance With
IM/IT	Information Management/Information Technology
IMA	Individual Mobilization Augmentee
IOC	Initial Operational Capability
IPL	Integrated Priority List
IPT	Integrated Product Team
IS	Information Systems
ISR	Intelligence, Surveillance & Reconnaissance
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
JCS-EX	Joint Chiefs of Staff Exercise
JMETL	Joint Mission Essential Task List
JOPEs	Joint Operations and Planning Execution system
JSIG MPSP WG	Joint Service Integration Group Medical Program Sub-panel Working Group
LAN	Local Area Network
LATAM	Latin American
MAE	Maximum Achievable Enrollment
MAJCOM	Major Command
MAP	Mission Area Plan
MAPPG	Medical Annual Planning and Programming Guidance
MCFAS	Managed Care Forecasting and Analysis System
MCSC	Managed Care Support Contract
MDG	Medical Group
MEFPAK	Manpower Equipment Force Packaging
MEPRS	Medical Expense Performance Reporting System
MEQS	MEPRS Executive Query System
MET	Mission Essential Tasks
METL	Mission Essential Task List
MFST	Mobile Field Surgical Team
MHS	Military Health System
MHSS	Military Health Services System
MILCON	Military Construction
MILPERS	Military Personnel
MISCAPS	Mission Capability Statements
MNS	Mission Need Statement

<b>Acronym</b>	<b>Definition</b>
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRDSS	Medical Readiness Decision Support System
MRL	Medical Resourcing Letter
MSIM	Medical Systems Infrastructure Modernization
MSP	Mission Support Plan
MTF	Medical Treatment Facility
NBC	Nuclear, Biological, and Chemical
NLT	Not Later Than
OCR	Office of Collateral Responsibility
OHI	Other Health Insurance
O&M	Operations and Maintenance
OMEE	Operations and Maintenance Engineering Enhancement
OP	Other Procurement
ORD	Operational Requirements Documents
OSHA	Occupational Safety and Health Agency
OT	Operational Task
PAM	Preventive Aerospace Medicine
PCM	Primary Care Manager
PEC	Program Element Code
PHA	Preventive Health Assessment
PHCA	Preventive Health Care Assessment
PMT	Performance Measurement Tool
POM	Program Objective Memorandum
PPBS	Planning, Programming, and Budgeting System
PPE	Personnel Protective Equipment
PPIP	Putting Prevention Into Practice
PPS	Planning Program System
PRV	Plant Replacement Value
QM	Quality Management
RAPIDS	Ruggedized Advanced Pathogen Identification System
RAPS	Resource Analysis and Planning System
RFP	Request for Proposal
RPMA	Real Property and Maintenance
RSDL	Reactive Skin Decontamination Lotion
SGMI	Information Systems/Information Technology Branch
SGR	Combat Development Center (Medical)
SGX	Readiness Division
SGXL	Logistic and Deployable Systems Branch
SIMLM	Single Integrated Medical Logistics Manager
S&T	Science and Technology
SRP	Strategic Resourcing Portfolio
SWA	Southwest Asia
TDY	Temporary Duty
TMA	TRICARE Management Activity

<b>Acronym</b>	<b>Definition</b>
TMIP	Theater Medical Information Program
TMSSC	Tri-Service Medical Systems Support Center
TPIPT	Technical Planning Integrated Product Team
TRAC2ES	TRANSCOM Regulating And Command & Control Evacuation System
UM/QM	Utilization Management/Quality Management
USACOM	U. S. Atlantic Command
USAF	U. S. Air Force
USAFSAM	U. S. Air Force School of Aerospace Medicine
USCENTCOM	U. S. Central Command
USSOCOM	U. S. Special Operations Command
USSOUTHCOM	U. S. Southern Command
USSOUTHAF	U. S. Air Forces, U. S. Southern Command
USTRANSCOM	U.S. Transportation Command
UTC	Unit Type Code
UTL	Universal Task List
WMD	Weapons of Mass Destruction
WRM	War Reserve Materiel
Y2K	Year 2000

	2001	2002	2003	2004	2005	2006	2007	2008	
<b>OT1</b>									
<b>Force Protection, Deployed &amp; In-Garrison</b>									
<b>(Ruggedized Advanced Pathogen Identification System/Joint Biological Agent Identification and Detection System (JBAID))</b>									
MILPERS	\$ -	\$ 200.18	\$ 207.89	\$ 215.89	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 572.77	\$ 606.08	\$ 640.56	\$ 676.12	\$ 699.36	\$ 734.72	\$ 770.88	\$ 807.84	
Equipment	\$ 426.97	\$ 451.90	\$ 477.71	\$ 504.32	\$ 530.16	\$ 556.78	\$ 584.00	\$ 611.82	
Supplies	\$ 406.15	\$ 425.32	\$ 445.14	\$ 465.53	\$ 485.04	\$ 505.12	\$ 525.60	\$ 546.48	
Training	\$ 154.69	\$ 157.16	\$ 180.97	\$ 195.63	\$ 210.84	\$ 226.60	\$ 242.92	\$ 259.84	
RPMA	\$ 77.34	\$ 104.77	\$ 53.23	\$ 65.21	\$ 77.68	\$ 90.64	\$ 104.11	\$ 118.11	
TDY	\$ 52.07	\$ 58.48	\$ 65.14	\$ 72.05	\$ 78.96	\$ 86.10	\$ 93.44	\$ 100.98	
<b>Total</b>	<b>\$ 1,689.99</b>	<b>\$ 2,003.90</b>	<b>\$ 2,070.63</b>	<b>\$ 2,194.76</b>	<b>\$ 2,082.04</b>	<b>\$ 2,199.96</b>	<b>\$ 2,320.95</b>	<b>\$ 2,445.06</b>	<b>\$ 17,007.28</b>
<b>Force Protection, Deployed &amp; In-Garrison</b>									
<b>(BW/CW Training)</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ 147.36	\$ 149.72	\$ 152.12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 147.36</b>	<b>\$ 149.72</b>	<b>\$ 152.12</b>	<b>\$ -</b>	<b>\$ 449.20</b>				
<b>Force Protection, Deployed &amp; In-Garrison</b>									
<b>(Medical Decontamination System)</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 1,164.29	\$ 1,188.77	\$ 1,213.81	\$ 1,239.19	\$ 1,261.10	\$ -	\$ -	\$ -	\$ -
Supplies	\$ 562.36	\$ 574.18	\$ 586.28	\$ 598.54	\$ 609.12	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

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	2001	2002	2003	2004	2005	2006	2007	2008	
Total	\$ 1,726.64	\$ 1,762.95	\$ 1,800.09	\$ 1,837.73	\$ 1,870.22	\$ -	\$ -	\$ -	\$ 8,997.63
<b>Force Protection, Deployed &amp; In-Garrison</b>									
<b>RSDL</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ 520.70	\$ 531.65	\$ 542.85	\$ 554.20	\$ 564.00	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 520.70	\$ 531.65	\$ 542.85	\$ 554.20	\$ 564.00	\$ -	\$ -	\$ -	\$ 2,713.40
	\$ 4,084.69								\$ 29,167.52
<b>Force Protection, Deployed &amp; In-Garrison Total</b>									

<b>AEF Infrastructure &amp; CONOPS</b>									
<b>Development</b>									
<b>EMEDS</b>									
MILPERS	\$ 189.72	\$ 197.03	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 124.97	\$ 127.60	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 314.69	\$ 324.62	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 639.32

<b>AEF Infrastructure &amp; CONOPS</b>									
<b>Development</b>									
<b>Mobile Tentage</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 8,832.11	\$ 9,017.85	\$ 9,207.82	\$ 9,400.34	\$ 9,566.57	\$ -	\$ -	\$ -	\$ -

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	2001	2002	2003	2004	2005	2006	2007	2008
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 8,832.11</b>	<b>\$ 9,017.85</b>	<b>\$ 9,207.82</b>	<b>\$ 9,400.34</b>	<b>\$ 9,566.57</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

\$ 46,024.69

**AEF Infrastructure & CONOPS  
Development  
EMEDS LAN**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 260.35	\$ 1,063.30	\$ 1,221.41	\$ 1,385.50	\$ 1,128.00	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 260.35</b>	<b>\$ 1,063.30</b>	<b>\$ 1,221.41</b>	<b>\$ 1,385.50</b>	<b>\$ 1,128.00</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

\$ 5,058.56

**AEF Infrastructure & CONOPS  
Development  
Telemedicine**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 547.78	\$ 559.30	\$ 571.08	\$ 583.02	\$ 593.33	\$ 603.85	\$ 614.37	\$ 624.89
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 547.78</b>	<b>\$ 559.30</b>	<b>\$ 571.08</b>	<b>\$ 583.02</b>	<b>\$ 593.33</b>	<b>\$ 603.85</b>	<b>\$ 614.37</b>	<b>\$ 624.89</b>

\$ 4,697.60

**AEF Infrastructure & CONOPS  
Development  
Digital x-ray  
Retrofit**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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	2001	2002	2003	2004	2005	2006	2007	2008
Contractor	\$ -	\$ -	\$ -	\$ 110.84	\$ 112.80	\$ -	\$ -	\$ -
Equipment	\$ -	\$ 531.65	\$ 542.85	\$ 387.94	\$ 394.80	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ -</b>	<b>\$ 531.65</b>	<b>\$ 542.85</b>	<b>\$ 498.78</b>	<b>\$ 507.60</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

\$ 2,080.88

**AEF Infrastructure & CONOPS**

**Development**

**Digital x-ray**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ 54.29	\$ 83.13	\$ 112.80	\$ 114.80	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 54.29</b>	<b>\$ 83.13</b>	<b>\$ 112.80</b>	<b>\$ 114.80</b>	<b>\$ -</b>	<b>\$ -</b>

\$ 365.02

**AEF Infrastructure & CONOPS**

**Development**

**Micro Lab**

**AEF Infrastructure & CONOPS**

**Development**

**AMOSS**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ 1,063.30	\$ 1,085.70	\$ 1,108.40	\$ 1,015.20	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ 221.68	\$ 135,360.00	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ -</b>	<b>\$ 1,063.30</b>	<b>\$ 1,085.70</b>	<b>\$ 1,330.08</b>	<b>\$ 136,375.20</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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	2001	2002	2003	2004	2005	2006	2007	2008	
									\$ 139,854.28
<b>AEF Infrastructure &amp; CONOPS</b>									
<b>Development</b>									
<b>ATC/ATH WRM</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 6,248.40	\$ 6,379.80	\$ 6,514.20	\$ 6,650.40	\$ 6,768.00	\$ 6,888.00	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 6,248.40	\$ 6,379.80	\$ 6,514.20	\$ 6,650.40	\$ 6,768.00	\$ 6,888.00	\$ -	\$ -	\$ 39,448.80
<b>AEF Infrastructure &amp; CONOPS</b>									
<b>Development</b>									
<b>Casualty Evacuation System</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ 577.37	\$ 589.54	\$ 601.86	\$ 612.50	\$ 623.36	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ 21.29	\$ 21.74	\$ 22.19	\$ 22.66	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ -	\$ 577.37	\$ 610.83	\$ 623.60	\$ 634.70	\$ 646.02	\$ -	\$ -	\$ 3,092.52
<b>AEF Infrastructure &amp; CONOPS</b>									
<b>Development</b>									
<b>CHATH Latrine</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 572.77	\$ 584.82	\$ 597.14	\$ 609.62	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ 212.66	\$ 217.14	\$ 5,098.64	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

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	2001	2002	2003	2004	2005	2006	2007	2008	
Total	\$ 572.77	\$ 797.48	\$ 814.28	\$ 5,708.26	\$ -	\$ -	\$ -	\$ -	\$ 7,892.78
<b>AEF Infrastructure &amp; CONOPS</b>									
<b>Development</b>									
<b>Mirror Force</b>									
MILPERS	\$ 94.86	\$ 98.51	\$ 102.31	\$ 106.25	\$ 110.34	\$ 114.59	\$ 119.00	\$ -	
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
TDY	\$ 3.12	\$ 3.19	\$ 4.34	\$ 4.43	\$ 4.51	\$ 4.59	\$ 4.67	\$ 4.75	
Total	\$ 97.99	\$ 101.70	\$ 106.65	\$ 110.68	\$ 114.85	\$ 119.18	\$ 123.67	\$ 4.75	\$ 779.48
	\$ 16,874.09								\$ 249,933.92
<b>AEF Infrastructure &amp; CONOPS</b>									
<b>Development Total</b>									
<b>Medical</b>									
<b>Training</b>									
<b>Trauma Skills Maintenance</b>									
MILPERS	\$ 25.99	\$ 26.99	\$ 28.03	\$ 29.11	\$ 30.23	\$ 31.39	\$ 32.60	\$ -	
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Training	\$ 364.03	\$ 369.85	\$ 375.77	\$ 383.66	\$ 391.72	\$ 399.94	\$ 408.34	\$ 416.92	
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
TDY	\$ 15.62	\$ 15.95	\$ 16.29	\$ 16.63	\$ 16.92	\$ 17.22	\$ 17.52	\$ 17.82	
Total	\$ 405.64	\$ 412.79	\$ 420.08	\$ 429.40	\$ 438.87	\$ 448.56	\$ 458.47	\$ 434.74	\$ 3,448.54
<b>Medical</b>									
<b>Training</b>									
<b>Training</b>									
<b>Exercises</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	

Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008
Equipment	\$ 104.14	\$ 106.33	\$ 108.57	\$ 110.84	\$ 112.80	\$ 114.80	\$ 116.80	\$ 118.80
Supplies	\$ 78.11	\$ 79.75	\$ 81.43	\$ 83.13	\$ 84.60	\$ 86.10	\$ 87.60	\$ 89.10
Training	\$ 257.81	\$ 261.93	\$ 266.13	\$ 271.71	\$ 277.42	\$ 283.25	\$ 289.19	\$ 295.27
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ 78.11	\$ 79.75	\$ 81.43	\$ 83.13	\$ 84.60	\$ 86.10	\$ 87.60	\$ 89.10
<b>Total</b>	<b>\$ 518.16</b>	<b>\$ 527.76</b>	<b>\$ 537.55</b>	<b>\$ 548.81</b>	<b>\$ 559.42</b>	<b>\$ 570.25</b>	<b>\$ 581.19</b>	<b>\$ 592.27</b>

\$ 4,435.41

**Medical Training Mobile Red Flag**

MILPERS	\$ -	\$ 1,754.02	\$ 1,821.57	\$ 1,891.72	\$ 1,964.57	\$ 2,040.23	\$ 2,118.80	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 1,498.57	\$ 2,206.03	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ 433.89	\$ 443.00	\$ 452.31	\$ 461.80	\$ 471.50	\$ 481.40
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ 27.75	\$ 28.34	\$ 28.93	\$ 29.44	\$ 29.96	\$ 30.48	\$ 31.01
<b>Total</b>	<b>\$ 1,498.57</b>	<b>\$ 3,987.81</b>	<b>\$ 2,283.80</b>	<b>\$ 2,363.65</b>	<b>\$ 2,446.32</b>	<b>\$ 2,531.99</b>	<b>\$ 2,620.78</b>	<b>\$ 512.41</b>

\$ 18,245.34

**Medical Training PJ Training**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ 128.91	\$ 130.97	\$ 133.06	\$ 135.86	\$ 138.71	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 128.91</b>	<b>\$ 130.97</b>	<b>\$ 133.06</b>	<b>\$ 135.86</b>	<b>\$ 138.71</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

\$ 2,033.12

\$ 667.50

**Medical Training Total**

\$ 26,796.80

Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008	
<b>OT2</b>									
<b>Marketing</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 1,041.40	\$ 1,063.30	\$ 1,085.70	\$ 1,108.40	\$ 1,128.00	\$ 1,148.00	\$ 1,168.00	\$ 1,188.00	
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Supplies	\$ 540.49	\$ 551.85	\$ 563.48	\$ 575.26	\$ 585.43	\$ 595.81	\$ 606.19	\$ 616.57	
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Total	\$ 1,581.89	\$ 1,615.15	\$ 1,649.18	\$ 1,683.66	\$ 1,713.43	\$ 1,743.81	\$ 1,774.19	\$ 1,804.57	\$ 13,565.89
<b>MAE</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Equipment	\$ 13,678.79	\$ 13,966.45	\$ 14,260.67	\$ 14,558.83	\$ 14,816.28	\$ 15,078.98	\$ 15,341.68	\$ 15,604.38	
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Total	\$ 13,678.79	\$ 13,966.45	\$ 14,260.67	\$ 14,558.83	\$ 14,816.28	\$ 15,078.98	\$ 15,341.68	\$ 15,604.38	\$ 117,306.06
<b>Computerized Patient Record EMPI</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Equipment	\$ 2,343.15	\$ 2,392.43	\$ 488.57	\$ 498.78	\$ 507.60	\$ 516.60	\$ 525.60	\$ 534.60	
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Total	\$ 2,343.15	\$ 2,392.43	\$ 488.57	\$ 498.78	\$ 507.60	\$ 516.60	\$ 525.60	\$ 534.60	\$ 7,807.32

	2001	2002	2003	2004	2005	2006	2007	2008
<b>Record</b>								
<b>CIW</b>								
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 1,062.23	\$ 1,084.57	\$ 1,107.41	\$ 1,130.57	\$ 1,150.56	\$ 1,170.96	\$ 1,191.36	\$ 1,211.76
Equipment	\$ 1,770.38	\$ 1,541.79	\$ 1,139.99	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 2,832.61</b>	<b>\$ 2,626.35</b>	<b>\$ 2,247.40</b>	<b>\$ 1,130.57</b>	<b>\$ 1,150.56</b>	<b>\$ 1,170.96</b>	<b>\$ 1,191.36</b>	<b>\$ 1,211.76</b>
	\$ 5,175.76							\$ 13,561.57

**Computerized Patient Record Total** \$ 21,368.89

**OT3**

**Implement Population-Based Health Plan**

	2001	2002	2003	2004	2005	2006	2007	2008
<b>PHA</b>								
MILPERS	\$ 717.96	\$ 745.60	\$ 774.32	\$ 804.14	\$ 835.10	\$ 867.26	\$ 900.66	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 717.96</b>	<b>\$ 745.60</b>	<b>\$ 774.32</b>	<b>\$ 804.14</b>	<b>\$ 835.10</b>	<b>\$ 867.26</b>	<b>\$ 900.66</b>	<b>\$ -</b>
								\$ 5,645.05

**Implement Population-Based Health Plan**

	2001	2002	2003	2004	2005	2006	2007	2008
<b>PHCA</b>								
MILPERS	\$ 717.96	\$ 745.60	\$ 774.32	\$ 804.14	\$ 835.10	\$ 867.26	\$ 900.66	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

	2001	2002	2003	2004	2005	2006	2007	2008	
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 717.96	\$ 745.60	\$ 774.32	\$ 804.14	\$ 835.10	\$ 867.26	\$ 900.66	\$ -	\$ 5,645.05

**Implement Population-Based Health Plan**

<b>PPIP</b>									
MILPERS	\$ 3,276.85	\$ 3,403.01	\$ 3,534.06	\$ 3,670.16	\$ 3,811.50	\$ 3,958.28	\$ 4,110.71	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 3,634.49	\$ 3,710.92	\$ 3,789.09	\$ 3,868.32	\$ 3,936.72	\$ 4,006.52	\$ 4,076.32	\$ 4,146.12	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 6,911.34	\$ 7,113.93	\$ 7,323.16	\$ 7,538.48	\$ 7,748.22	\$ 7,964.80	\$ 8,187.03	\$ 4,146.12	\$ 56,933.07

**Implement Population-Based Health Plan  
Epidemiological Assessment and Demand Management**

MILPERS	\$ 6,553.71	\$ 6,806.03	\$ 7,068.13	\$ 7,340.32	\$ 7,622.99	\$ 7,916.56	\$ 8,221.42	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ 284.30	\$ 290.28	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 6,838.01	\$ 7,096.31	\$ 7,068.13	\$ 7,340.32	\$ 7,622.99	\$ 7,916.56	\$ 8,221.42	\$ -	\$ 52,103.73

**Implement Population-Based Health Plan  
Disease Management Implementation**

<b>Initiatives</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 208.28	\$ 212.66	\$ 217.14	\$ 221.68	\$ 225.60	\$ 229.60	\$ 233.60	\$ 237.60	\$ -
Equipment	\$ 52.07	\$ 53.17	\$ 54.29	\$ 55.42	\$ 56.40	\$ 57.40	\$ 58.40	\$ 59.40	\$ -
Supplies	\$ 5.21	\$ 5.32	\$ 5.43	\$ 5.54	\$ 5.64	\$ 5.74	\$ 5.84	\$ 5.94	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008
TDY	\$ 20.83	\$ 21.27	\$ 21.71	\$ 22.17	\$ 22.56	\$ 22.96	\$ 23.36	\$ 23.76
Total	\$ 286.39	\$ 292.41	\$ 298.57	\$ 304.81	\$ 310.20	\$ 315.70	\$ 321.20	\$ 326.70

\$ 2,455.97

**Implement Population-Based Health Plan**

**Preventive Dentistry**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ 320.75	\$ 327.50	\$ 334.40	\$ 341.39	\$ 347.42	\$ 353.58	\$ 359.74	\$ 365.90
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 320.75	\$ 327.50	\$ 334.40	\$ 341.39	\$ 347.42	\$ 353.58	\$ 359.74	\$ 365.90

\$ 2,750.69

**Implement Population-Based Health Plan**

**Breast Cancer Prevention**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 762.30	\$ 778.34	\$ 794.73	\$ 811.35	\$ 825.70	\$ 840.34	\$ 854.98	\$ 869.62
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 762.30	\$ 778.34	\$ 794.73	\$ 811.35	\$ 825.70	\$ 840.34	\$ 854.98	\$ 869.62

\$ 16,554.71

\$ 6,537.35

**Implement Population-Based Health Plan**

**Total**

\$ 132,070.89

**Health Promotions/HAWC**

**Programs**

**Deploy Health Promotion and Fitness**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ 26.04	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 26.04</b>	<b>\$ -</b>						

\$ 26.04

**Health Promotions/HAWC Programs**

**Tobacco Cessation Programs**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 121.84	\$ 124.41	\$ 127.03	\$ 129.68	\$ 131.98	\$ 134.32	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ 529.03	\$ 540.16	\$ 551.54	\$ 563.07	\$ 573.02	\$ 583.18	\$ 593.34	\$ 603.50
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 650.88</b>	<b>\$ 664.56</b>	<b>\$ 678.56</b>	<b>\$ 692.75</b>	<b>\$ 705.00</b>	<b>\$ 717.50</b>	<b>\$ 593.34</b>	<b>\$ 603.50</b>

\$ 5,306.10

**Health Promotions/HAWC Programs**

**HAWC BCA**

MILPERS	\$ 1,638.43	\$ 1,701.51	\$ 1,767.03	\$ 1,835.08	\$ 1,905.75	\$ 1,979.14	\$ 2,055.36	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ 26.04	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 1,664.46</b>	<b>\$ 1,701.51</b>	<b>\$ 1,767.03</b>	<b>\$ 1,835.08</b>	<b>\$ 1,905.75</b>	<b>\$ 1,979.14</b>	<b>\$ 2,055.36</b>	<b>\$ -</b>

\$ 12,908.32

**Health Promotions/HAWC Programs**  
**Fitness Assessment Program**

	2001	2002	2003	2004	2005	2006	2007	2008
<b>Mocernization</b>								
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 53.11	\$ 54.23	\$ 55.37	\$ 56.53	\$ 57.53	\$ 58.55	\$ 59.57	\$ 60.59
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 53.11</b>	<b>\$ 54.23</b>	<b>\$ 55.37</b>	<b>\$ 56.53</b>	<b>\$ 57.53</b>	<b>\$ 58.55</b>	<b>\$ 59.57</b>	<b>\$ 60.59</b>
								\$ 455.47

<b>Health Promotions/HAWC Programs</b>								
<b>Expand Fitness Program</b>								
<b>Assessment</b>								
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 104.14	\$ 106.33	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 78.11	\$ 79.75	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 182.25</b>	<b>\$ 186.08</b>	<b>\$ -</b>					
	\$ 2,576.73							\$ 368.32

**Health Promotions/HAWC Programs Total** \$ 19,064.25

**OT4**

<b>Aircrew Sustainment</b>								
<b>Hyperbaric Medicine</b>								
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 624.84	\$ 425.32	\$ 434.28	\$ -	\$ 135.36	\$ 137.76	\$ 140.16	\$ 142.56
Equipment	\$ -	\$ -	\$ -	\$ 443.36	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ 11.28	\$ 11.48	\$ 11.68	\$ 11.88
Training	\$ -	\$ -	\$ -	\$ -	\$ 22.19	\$ 22.66	\$ 23.14	\$ 23.62

Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 624.84	\$ 425.32	\$ 434.28	\$ 443.36	\$ 168.83	\$ 171.90	\$ 174.98	\$ 178.06
								\$ 2,621.57

**Industrial Hygiene Contract Support Workplace Surveillance Surveys**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 546.74	\$ 558.23	\$ 569.99	\$ 581.91	\$ 592.20	\$ 602.70	\$ 613.20	\$ 623.70
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 546.74	\$ 558.23	\$ 569.99	\$ 581.91	\$ 592.20	\$ 602.70	\$ 613.20	\$ 623.70
								\$ 4,688.67

**Industrial Hygiene Contract Support Respirator Fit-Testing**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 520.70	\$ 318.99	\$ 325.71	\$ 277.10	\$ 282.00	\$ 287.00	\$ 292.00	\$ 297.00
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 520.70	\$ 318.99	\$ 325.71	\$ 277.10	\$ 282.00	\$ 287.00	\$ 292.00	\$ 297.00
	\$ 1,067.44							\$ 2,600.50

**Industrial Hygiene Contract Support Total**

\$ 7,289.17

**Command Core Support**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008
Contractor	\$ 208.28	\$ 106.33	\$ 217.14	\$ 110.84	\$ 225.60	\$ 114.80	\$ 233.60	\$ 118.80
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 208.28</b>	<b>\$ 106.33</b>	<b>\$ 217.14</b>	<b>\$ 110.84</b>	<b>\$ 225.60</b>	<b>\$ 114.80</b>	<b>\$ 233.60</b>	<b>\$ 118.80</b>

\$ 1,335.39

**Command Core**

**Lajes**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 156.21	\$ 159.50	\$ 162.86	\$ 166.26	\$ 169.20	\$ 172.20	\$ 175.20	\$ 178.20
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 156.21</b>	<b>\$ 159.50</b>	<b>\$ 162.86</b>	<b>\$ 166.26</b>	<b>\$ 169.20</b>	<b>\$ 172.20</b>	<b>\$ 175.20</b>	<b>\$ 178.20</b>

\$ 364.49

\$ 1,339.62

**Command Core**

**Total**

\$ 2,675.01

**OT5**

**IM/IT Support**

**AO Platform Upgrade/PC**

**Lease**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 4,686.30	\$ 4,784.85	\$ 4,885.65	\$ 4,987.80	\$ 5,076.00	\$ 5,166.00	\$ 5,256.00	\$ 5,346.00
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 4,686.30</b>	<b>\$ 4,784.85</b>	<b>\$ 4,885.65</b>	<b>\$ 4,987.80</b>	<b>\$ 5,076.00</b>	<b>\$ 5,166.00</b>	<b>\$ 5,256.00</b>	<b>\$ 5,346.00</b>

Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008	
									\$ 40,188.60
<b>IM/IT Support</b>									
<b>IM/IT Co-Sourcing</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Contractor	\$ 3,540.76	\$ 3,795.98	\$ 4,069.20	\$ 4,361.55	\$ 4,660.90	\$ 4,980.02	\$ 5,320.24	\$ 5,682.20	
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
<b>Total</b>	<b>\$ 3,540.76</b>	<b>\$ 3,795.98</b>	<b>\$ 4,069.20</b>	<b>\$ 4,361.55</b>	<b>\$ 4,660.90</b>	<b>\$ 4,980.02</b>	<b>\$ 5,320.24</b>	<b>\$ 5,682.20</b>	<b>\$ 36,410.86</b>
<b>IM/IT Support MSIM</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Contractor	\$ 2,082.80	\$ 3,189.90	\$ 3,257.10	\$ 443.36	\$ 451.20	\$ 459.20	\$ 467.20	\$ 475.20	
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
<b>Total</b>	<b>\$ 2,082.80</b>	<b>\$ 3,189.90</b>	<b>\$ 3,257.10</b>	<b>\$ 443.36</b>	<b>\$ 451.20</b>	<b>\$ 459.20</b>	<b>\$ 467.20</b>	<b>\$ 475.20</b>	<b>\$ 10,825.96</b>
	\$ 10,309.86								\$ 87,425.42
<b>IM/IT Support Total</b>									
<b>RPMA</b>									
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
RPMA	\$ 21,273.45	\$ 21,937.58	\$ 22,622.83	\$ 23,444.62	\$ 24,296.49	\$ 25,178.34	\$ 26,093.45	\$ 27,040.61	

Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 21,273.45	\$ 21,937.58	\$ 22,622.83	\$ 23,444.62	\$ 24,296.49	\$ 25,178.34	\$ 26,093.45	\$ 27,040.61

\$ 191,887.37

**Digital Radiology/Dental/Telemedicine**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 3,124.20	\$ 4,993.26	\$ 5,330.79	\$ 1,784.52	\$ 1,816.08	\$ 1,848.28	\$ 1,880.48	\$ 1,912.68
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 3,124.20	\$ 4,993.26	\$ 5,330.79	\$ 1,784.52	\$ 1,816.08	\$ 1,848.28	\$ 1,880.48	\$ 1,912.68

\$ 22,690.29

**Capital Equipment**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ 3,805.00	\$ 3,862.00	\$ 3,920.00	\$ 3,978.00	\$ 4,038.00	\$ 4,098.00	\$ 4,160.00	\$ 4,223.00
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 3,805.00	\$ 3,862.00	\$ 3,920.00	\$ 3,978.00	\$ 4,038.00	\$ 4,098.00	\$ 4,160.00	\$ 4,223.00

\$ 32,084.00

**Customer Service**

MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ 83.31	\$ 85.06	\$ 86.86	\$ 88.67	\$ 90.24	\$ 91.84	\$ 93.44	\$ 95.04
Training	\$ 35.06	\$ 35.62	\$ 36.19	\$ 36.95	\$ 37.73	\$ 38.52	\$ 39.33	\$ 40.16
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Appendix A FY01-08 Funding Sheets

	2001	2002	2003	2004	2005	2006	2007	2008
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 118.37	\$ 120.69	\$ 123.05	\$ 125.63	\$ 127.97	\$ 130.36	\$ 132.77	\$ 135.20
								<u>\$ 1,014.03</u>
<b>Distant Learning</b>								
MILPERS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contractor	\$ 260.35	\$ 265.83	\$ 271.43	\$ 277.10	\$ 282.00	\$ 287.00	\$ 292.00	\$ 297.00
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RPMA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TDY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ 260.35	\$ 265.83	\$ 271.43	\$ 277.10	\$ 282.00	\$ 287.00	\$ 292.00	\$ 297.00
								<u>\$ 2,232.70</u>

# Strategy-To-Task Tool

1. **General Scoring Guidance:** Review, suggest changes, and provide a note or comment to the STT by:

- Making a change in the cell in question:
- For each desired score change, assign either a '9' '3' '1', or '0' (blank). **DO NOT USE THE SPACEBAR TO CLEAR A CELL.**
- If a cell receives a '9', there is a direct, strong, and highly relevant relationship between the objectives or tasks. If a cell receives a '3', there is a direct, but moderate contribution or relevance and if a cell receives a '1', there is a weak direct or low relevant relationship. If a cell receives a "0" (blank), there is very little to no contribution or relevance between the objectives.
- All strong '9' relationships should be approximately equal in scope or fidelity. The same can be said for other relationships ('3', '1', or '0').
- Justify the change in each cell with a Cell note/comment

2. **Sheet Scoring Guidance** -- you are answering the following questions:

- **AFMS OT vs. ACC Objective:** "What is the contribution of this ACC operational objective to the accomplishment of the AFMS Operational Task?"
- **ACC Objective vs. ACC Medical Functions:** "What is the contribution of this medical function to the accomplishment of the ACC medical objectives?" This scoring is done for the Major Regional War (MRW) scenario.
- **Functions Scorecard:** "How relevant is this deficiency to my function and what is the magnitude of the deficiency to accomplish my functional tasks?"

**Functions Scorecard:** Review, suggest changes, and provide a note or comment justifying the change in the cell. In this step, assess the relationships using one of three scores for each cell in the matrix. Start at the top of a column and continue down to the bottom.

In each cell, assign either a 'Blank', '1', '3' or '9'. If a cell receives a:

- "Blank" the deficiency is not applicable to the function
- '1' the ACC/SG deficiency is important to the function
- '3' the ACC/SG deficiency is moderately critical to the function.
- '9' the ACC/SG deficiency is critical to the function.

AFMS Operational Tasks to ACC Strategic Objectives		Rank	ACC Strategic Objectives											
		Initial Weight	1	2	3	4	5	6	7	8				
			Improve Force Protection Training &											
			Provide Health Care Benefits and Improve											
			Schedule Customer Service Training											
			Implement Balanced Training Programs --											
			Implement Agile Support Concepts											
			Deploy Command Wide Informatior											
			Deploy Decision Making Network											
			Implement Competitive Sourcing &											
			ACC Strategic Objectives											
<b>AFMS Operational Tasks</b>				<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>			
Provide Support to Deploying & Returning Forces	4.0	0.27		9			3	9	3	3				
Develop a Managed Care System -- Quality, Cost, & Access	3.5	0.23			3	3			3	3	3			
Promote Disease Prevention & Health Promotion	3.0	0.20		3	3		3	1	1	1	1			
Promote a Safe and Healthful Environment	2.0	0.13		1				1	1				1	
Promote a Responsive & Healthful Environment	2.5	0.17			3	3	1							
			15	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>			
<b>ACC OT Total</b>				3.13	1.80	1.20	1.57	2.73	1.83	1.70	1.03			
<b>OT Rank</b>				1	4	7	6	2	3	5	8			

<h1 style="text-align: center;">Major Regional War ACC Strategic Objectives to ACC Medical Functions</h1>		Rank	Initial Weight	ACC/SG Medical Functions												
				Educate and Train Personnel Medical C4IM	Manpower & Personnel NBC Defense/Counterproliferator Research & Managed Care	Medical Logistics/Facilities Sustain Human Performance Medical Planning/Mission Support Mirror Force	1	2	3	4	5	6	7	10	11	12
<b>ACC Strategic Objectives</b>																
Improve Force Protection Training & Planning	<b>1.0</b>	<b>3.13</b>		9	3	3	9	3		1	3	9	3			
Provide Health Care Benefits and Improve Wellness	<b>4.0</b>	<b>1.80</b>		3	3	1		1	9	1	1					1
Schedule Customer Service Training	<b>7.0</b>	<b>1.20</b>		3		1			1							1
Implement Balanced Training Programs -- Survive & Operate	<b>6.0</b>	<b>1.57</b>		3		1	3		1		1	3	3			
Implement Agile Combat Support Concepts	<b>2.0</b>	<b>2.73</b>		1	1	1	1	3		3	1	1	3			
Deploy Command Wide Information Network	<b>3.0</b>	<b>1.83</b>			9		1	3	1		1					
Deploy Decision Making Network	<b>5.0</b>	<b>1.70</b>		1	3		1	1	1	1			3			
Implement Competitive Sourcing & Privatization	<b>8.0</b>	<b>1.03</b>		1	3	3			3	3						
	<b>36</b>			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>10</b>	<b>11</b>	<b>12</b>			
<b>ACC Medical Function Total</b>					47.37	42.23	19.80	39.17	26.60	25.60	17.93	17.33	40.73	25.30		
<b>ACC Medical Function Need Rank</b>					1	2	8	4	5	6	9	10	3	7		

<h1 style="text-align: center;">Major Regional War ACC Medical Functions to MSP Needs</h1>		Operational Task	ACC/SG Medical Functions												Rank	Weighted Score
			Educate and Train Personnel Medical C4IM Manpower & Personnel NBC Defense/Counterproliferator Research & Development/Modernization Managed Care Medical Logistics/Facilities Sustain Human Performance Medical Planning/Mission Support Mirror Force													
ACC MSP Needs			1	2	3	4	5	6	7	10	11	12				
Current concepts of operations and deployable assemblages are out-dated, manpower intensive, and cost ineffective to meet new EAF requirements.	OT1		3	3	3	3	3		9	1	9	3	3	1146.73		
Existing Training programs are inadequate to meet the demands of new equipment and strategies in Ground-based operations.	OT1		9	3	1	3	1	3	3	1	9	3	1	1307.33		
Current communications capability does not support inter and intra service required command, control and information superiority requirements (telehealth, medical informatics).	OT1		3	9		3	3	1	3	3	3	1	4	998.40		
Require improved concepts of operations and equipment to respond to current and future WMD threats.	OT1		9	1	1	9	9		1	3	1	1	2	1216.20		
Current directed energy defensive countermeasures do not adequately meet the threat posed by known/future weapons capability.	OT1		3	1		9	9			1	1	1	6	859.60		
Inadequate development process for medical planners. Career pathways to maintain technical competency and institutional knowledge of medical planning require improvement.	OT1		3	1	1	1	1	1	3		3	1	18	496.80		
Modern Medical informatics are absent in current assemblages, and are required to meet the new AFMS strategies.	OT1		1	3		3	9		3		3		9	706.97		
Earned manpower for support and maintenance of WRM assemblages is neither funded nor assigned at 100% thereby seriously degrading Medical Readiness capability at the outset.	OT1	X							9		3		36	283.60		
Impact of Medical Readiness or Operational Tasking requirements on capability to provide the Medical Benefit is not quantified.	OT1	X	3		1	3		1		1	3	3	16	520.43		
Monitor TRICARE Irritants	OT2		3				1	9					26	399.10		
Disconnect between Health Affairs, individual services, Lead Agents, Commands, and bases pertaining to authority, responsibility and coordination of projected and completed actions.	OT2		1	1	3			9					28	379.40		

<h1 style="text-align: center;">Major Regional War ACC Medical Functions to MSP Needs</h1>		Operational Task	ACC/SG Medical Functions												Rank	Weighted Score		
			Educate and Train Personnel	Medical C4IM	Manpower & Personnel	NBC Defense/Counterproliferator Research & Development/Minimization	Managed Care	Medical Logistics/Facilities	Sustain Human Performance	Medical Planning/Mission Support	Mirror Force	1	2	3			4	5
<b>ACC MSP Needs</b>			1	2	3	4	5	6	7	10	11	12						
Inadequate method of educating MTF personnel in managed care principles to meet near term and long term goals.	OT2	3	1	1			3						<b>37</b>	<b>280.93</b>				
Lack of access to data to enable intelligent clinical, UM, HEDIS, make-buy, provider profiling, and health risk assessment decisions.	OT3	3	9	3		1	3		3		1		<b>8</b>	<b>762.30</b>				
Need a comprehensive clinical information system to provide on-line data at point of care to include: scheduling, ancillary tests and reports, and diagnosis.	OT3	3	9	1		3	3						<b>10</b>	<b>698.60</b>				
Inappropriate utilization of MTF resources and lack of disease/demand management opportunities in direct care system.	OT3	3	3	3		1	3		1				<b>21</b>	<b>448.93</b>				
Lack of trained cadre of personnel who understand managed care principles in order to proliferate managed care implementation.	OT2	3					3				1		<b>43</b>	<b>244.20</b>				
Need incentives to support managed care principles.	OT2	3		1			3						<b>44</b>	<b>238.70</b>				
No accurate standard cost system which leads to poor make vs. buy decisions.	OT2	1	1	1		1	3	1					<b>45</b>	<b>230.73</b>				
The Air Force/ACC needs to adequately value and practice prevention. Individual and population-based prevention is not integrated into AF managed care and operational medicine.	OT3	9		3			1		1		1		<b>15</b>	<b>553.93</b>				
Total force preventive medicine support for pre-, during and post-deployment operations is inadequate.	OT3	3	3	1	1	1	1	1	3	3	3		<b>11</b>	<b>648.00</b>				
AFMS personnel lack the skills, knowledge and tools to deliver optimal primary secondary, and tertiary prevention for individuals and populations.	OT3	3	1	1	1	1	1		3		3		<b>23</b>	<b>423.40</b>				
Selection, retention, training and sustainment of flight surgeons, aeromedical technicians, pararescuemen and aerospace physiologists are inadequate to support complex AEF missions.	OT4	9	1	9			1		3	3	1		<b>5</b>	<b>871.83</b>				
Human factors inadequately considered in operational planning, development & acquisition, and mission execution.	OT4	3		1	1	3			9	3	1		<b>13</b>	<b>584.37</b>				
Aircrew tolerance to agile flight extremes (high Gx and Gy, prolonged mission duration, high altitude, temperature, circadian desynchronization) is unknown or poorly understood.	OT4			1		9			3	3	1		<b>20</b>	<b>458.70</b>				

<h1 style="text-align: center;">Major Regional War ACC Medical Functions to MSP Needs</h1>		Operational Task												Rank	Weighted Score
		<b>ACC/SG Medical Functions</b> Educate and Train Personnel Medical C4IM Manpower & Personnel NBC Defense/Counterproliferator Research & Development/Minimization Managed Care Medical Logistics/Facilities Sustain Human Performance Medical Planning/Mission Support Mirror Force													
ACC MSP Needs		1	2	3	4	5	6	7	10	11	12				
Strategy for aircrew human performance enhancement training not fully operational.	OT4	3		9						3	1		<b>25</b>	<b>413.03</b>	
No field hyperbarics capability.	OT4	1		1		3		1	3	3			<b>29</b>	<b>339.10</b>	
Information management and decision support systems for the aircrew are inadequate. Cockpit and helmet mounted display information is not intuitive to the pilot and detracts from optimum mission effectiveness and situational awareness.	OT4	1				9				3			<b>30</b>	<b>338.77</b>	
Egress system seat design does not consider the performance effects of smaller, lighter weight aircrew. Aircraft performance envelope exceeds the performance envelope of egress systems.	OT4					9				3	3		<b>24</b>	<b>413.60</b>	
Determine Team Aerospace Medicine support to the AEF.	OT4	3	1	3	3	1		3		3			<b>14</b>	<b>563.83</b>	
Lack of female fighter aircrew urinary collection capability.	OT4					9			3	1			<b>32</b>	<b>332.13</b>	
Need line support to pursue life-support /aircrew performance enhancement systems development & sustainment.	OT4					3			3	3			<b>42</b>	<b>254.00</b>	
Inadequate protection from directed energy weapons.	OT4	3	1			9			3	3			<b>12</b>	<b>597.93</b>	
Improve respiratory protection and personnel protective equipment (PPE) programs.	OT4	9		3					1				<b>17</b>	<b>503.03</b>	
Protect personnel IAW new restrictive OSHA chemical-specific standards.	OT4	3		1					1				<b>50</b>	<b>179.23</b>	
There is no single automated information system for the occupational health program	OT4	3	3	1		1			1				<b>31</b>	<b>332.53</b>	
Conduct risk-based, process-oriented workplace surveillance surveys	OT4	1	1	9					3				<b>35</b>	<b>319.80</b>	
Quantify risk due to poor ventilation in confined spaces and areas.	OT4			9					3				<b>46</b>	<b>230.20</b>	
Pneumatic tools presently used for sanding/grinding do not effectively capture emissions	OT4	1				3			1				<b>51</b>	<b>144.50</b>	
Guidance is needed on best practices to comply with the new chromate standard.	OT4	3		1					3				<b>47</b>	<b>213.90</b>	
Guidance is needed on best practice to comply with standard for lead exposures at firing range.	OT4	3		1					3				<b>47</b>	<b>213.90</b>	



## **ACC Medical Solutions to ACC/SG Needs**

**Matrix not included because of its size**

<b>Medical Solutions ACC/SG Priority</b>		<b>Rank</b>	<b>Funding (\$000)</b>
<b>Medical Solutions</b>			
BW/CW Training	OT1	1	\$ 140
Enterprise Master Patient Index (EMPI)	OT5	2	\$ 2,250
Medical Support for Air Expeditionary Forces	OT1	3	\$ 295
Medical Decontamination System	OT1	4	
LAN System for ATHs	OT1	5	
Rapid Pathogen Detection System/ JBAID	OT1	6	\$ 1,625
Implementation of Preventive Health Care Application (PHCA)	OT3	7	\$ 663
WRM-ATC	OT1	8	\$ 6,800
Preventive Health Assessment (PHA)	OT3	9	\$ 663
Digital Radiology/Dental/Telemedicine	OT5	10	\$ 3,000
Disease Management Implementation Initiatives	OT3	11	\$ 275
Reactive Skin Decontamination Lotion (RSDL)	OT1	12	
OA Platform Upgrade/PC Leasing	OT5	13	\$ 4,500
Population-Based Health (PBH) Plan Implementation	OT3	14	\$ 273
Microlab System	OT1	15	
Deployed Health Promotion and Fitness	OT3	16	\$ 25
Training Exercises	OT1	17	\$ 500
Telemedicine	OT1	18	\$ 526
IM/IT Co-Sourcing	OT5	19	\$ 3,400
Tobacco Cessation Programs	OT3	20	\$ 508
Preventive Dentistry	OT3	21	
HAWC Business Case Analysis	OT3	22	\$ 1,538
Fitness Assessment Program Modernization	OT3	23	
Medical Systems Infrastructure Modernization	OT5	24	\$ 2,000
Marketing	OT2	25	\$ 1,519
Real Property Maintenance Activity (RPMA)	OT5	26	\$ 20,629
Clinical Integrated Workstation - Lite	OT5	27	\$ 2,720
Latrine System for CHATH	OT1	28	\$ 550
Create A Customer Service Culture	OT5	29	\$ 134
PJ Training	OT4	30	\$ 125
Digital X-Ray (Retrofit)	OT1	31	\$ 500
Distance Learning	OT5	32	\$ 250
Breast Cancer Prevention	OT3	33	
Mobile Red Flag Course	OT1	34	\$ 1,439
Expand Fitness Program Assessment	OT3	35	
Trauma Skills Maintenance	OT1	36	\$ 392
Causality Evacuation/Ambulance Platforms	OT1	37	\$ 563
Hand Held X-Ray system	OT1	38	\$ 50

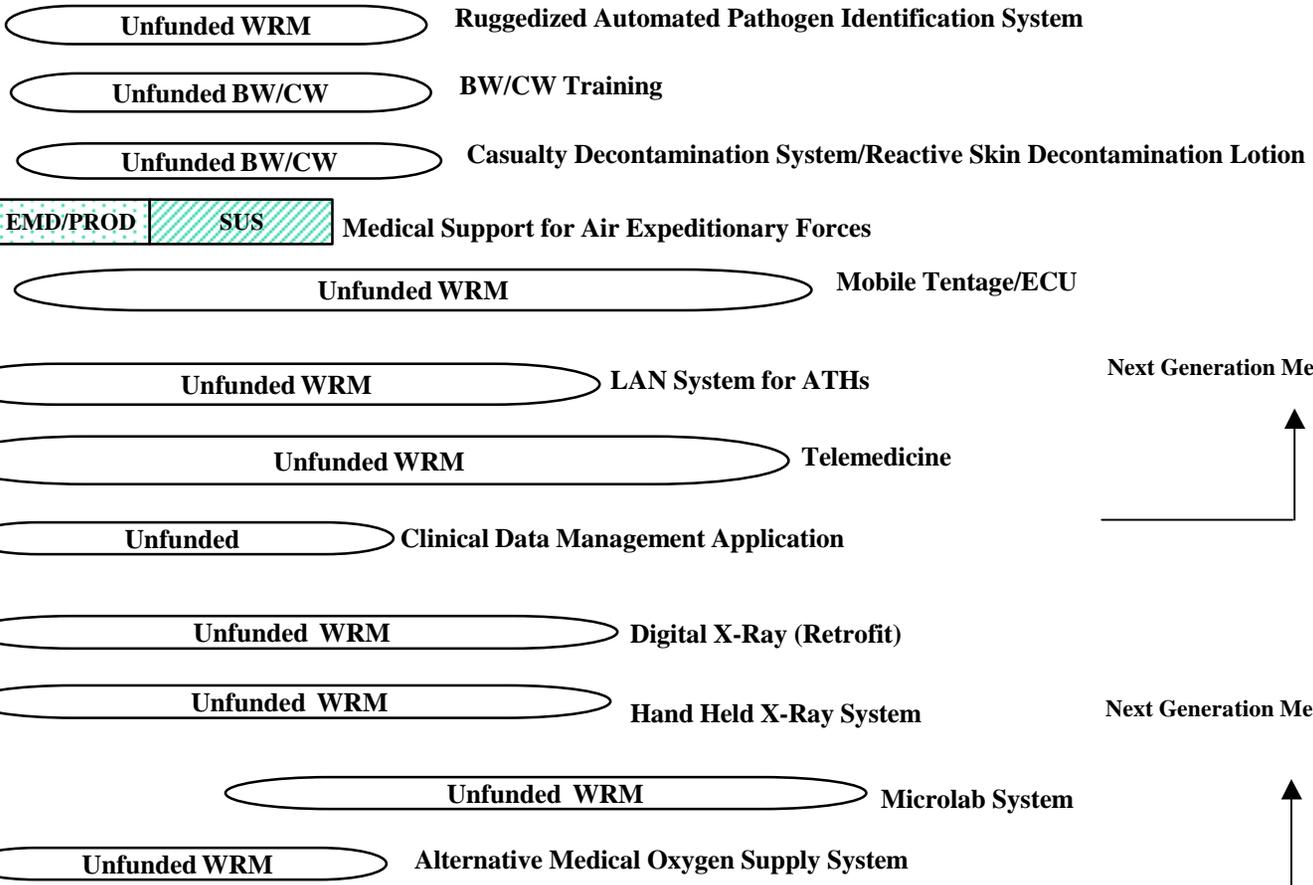
<b>Medical Solutions ACC/SG Priority</b>		<b>Rank</b>	<b>Funding (\$000)</b>
Hyperbaric Medicine	OT4	39	\$ 600
Alternative Medical Oxygen Supply system	OT1	40	\$ 1,000
Mobile Tentage/ECU	OT1	40	
Female Aircrew Member Bladder Relief Capability (FMBRC)	OT4	42	
Capital Equipment Funding (2F)	OT5	43	\$ 3,805
Workplace Surveillance Surveys	OT4	44	\$ 525
MAE Enrollment Capitation Funding	OT2	45	\$ 13,135
Mirror Force Operational Integration	OT1	46	\$ 91
Respirator Fit-testing	OT4	47	\$ 500
Command Core System Support	OT4	48	\$ 200
Command Core System Support at Lajes	OT4	48	\$ 150

<b>Medical Solutions by OT (guide for final review)</b>		<b>Rank</b>	<b>Funding (\$000)</b>
<b>Medical Solutions</b>			
BW/CW Training	OT1	1	\$ 140
Medical Support for Air Expeditionary Forces	OT1	3	\$ 295
Medical Decontamination System	OT1	4	
LAN System for ATHs	OT1	5	
Rapid Pathogen Detection System/ JBAID	OT1	6	\$ 1,625
WRM-ATC	OT1	8	\$ 6,800
Reactive Skin Decontamination Lotion (RSDL)	OT1	12	
Microlab System	OT1	15	
Training Exercises	OT1	17	\$ 500
Telemedicine	OT1	18	\$ 526
Latrine System for CHATH	OT1	28	\$ 550
Digital X-Ray (Retrofit)	OT1	31	\$ 500
Mobile Red Flag Course	OT1	34	\$ 1,439
Trauma Skills Maintenance	OT1	36	\$ 392
Causality Evacuation/Ambulance Platforms	OT1	37	\$ 563
Hand Held X-Ray system	OT1	38	\$ 50
Alternative Medical Oxygen Supply system	OT1	40	\$ 1,000
Mobile Tentage/ECU	OT1	40	
Mirror Force Operational Integration	OT1	46	\$ 91
Marketing	OT2	25	\$ 1,519
MAE Enrollment Capitation Funding	OT2	45	\$ 13,135

<b>Medical Solutions by OT (guide for final review)</b>		<b>Rank</b>	<b>Funding (\$000)</b>
<b>Medical Solutions</b>			
Implementation of Preventive Health Care Application (PHCA)	OT3	7	\$ 663
Preventive Health Assessment (PHA)	OT3	9	\$ 663
Disease Management Implementation Initiatives	OT3	11	\$ 275
Population-Based Health (PBH) Plan Implementation	OT3	14	\$ 273
Deployed Health Promotion and Fitness	OT3	16	\$ 25
Tobacco Cessation Programs	OT3	20	\$ 508
Preventive Dentistry	OT3	21	
HAWC Business Case Analysis	OT3	22	\$ 1,538
Fitness Assessment Program Modernization	OT3	23	
Breast Cancer Prevention	OT3	33	
Expand Fitness Program Assessment	OT3	35	
PJ Training	OT4	30	\$ 125
Hyperbaric Medicine	OT4	39	\$ 600
Female Aircrew Member Bladder Relief Capability (FMBRC)	OT4	42	
Workplace Surveillance Surveys	OT4	44	\$ 525
Respirator Fit-testing	OT4	47	\$ 500
Command Core System Support	OT4	48	\$ 200
Command Core System Support at Lajes	OT4	48	\$ 150
Enterprise Master Patient Index (EMPI)	OT5	2	\$ 2,250
Digital Radiology/Dental/Telemedicine	OT5	10	\$ 3,000
OA Platform Upgrade/PC Leasing	OT5	13	\$ 4,500
IM/IT Co-Sourcing	OT5	19	\$ 3,400
Medical Systems Infrastructure Modernization	OT5	24	\$ 2,000
Real Property Maintenance Activity (RPMA)	OT5	26	\$ 20,629
Clinical Integrated Workstation - Lite	OT5	27	\$ 2,720
Create A Customer Service Culture	OT5	29	\$ 134
Distance Learning	OT5	32	\$ 250
Capital Equipment Funding (2F)	OT5	43	\$ 3,805

# ACC/SG OT1 ROADMAP

98	99	00	01	02	03	04	05	06	07	08	09	10	11
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Next Generation Medical Facility

Next Generation Medical Systems

**Near Term**

**Mid Term**

**Far Term**



# ACC/SG OT1 ROADMAP

98 99 00 01 02 03 04 05 06 07 08 09 10 11

EMD/PROD SUS LSTAT/ATC/ATH WRM

LAB EMD/PROD SUS New Anesthesia Ventilator/ ATC/ATH WRM

Sustainment Preventative Aerospace Medical Team/ATC/ATH WRM

Sustainment Transportable Blood Transshipment Center (TBTC)/ATC/ATH WRM

Unfunded WRM Casualty Evacuation/Ambulances Platforms

Unfunded WRM Latrine System for CHATH

Sustainment Chemically Hardened Air Transportable Hospital (CHATH)

Sustainment Chemically Hardened Air Management Plant

Unfunded 2F

Unfunded 2F

Unfunded 2F

Unfunded 2F

Unfunded 2F

Next Generation Medical Systems

Mirror Force Integration

Trauma Skills Maintenance

Training Exercises

Mobile Red Flag Course

PJ Training

Near Term

Mid Term

Far Term

# ACC/SG OT2 ROADMAP

98	99	00	01	02	03	04	05	06	07	08	09	10	11
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Unfunded 2X

Marketing

Unfunded Disconnect 2X

MAE Capitation/Revised Financing

Unfunded 2X

Electronic Master Patient Index

Unfunded 2X

Clinical Integrated Workstation



# ACC/SG OT3 ROADMAP

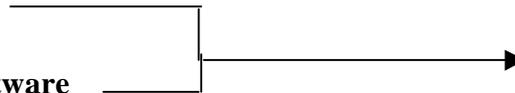
## Implementation of Population-Based Health Plan

98	99	00	01	02	03	04	05	06	07	08	09	10	11
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### Preventive Health Assessment

Implementation of PHCA

Immunization Tracking Software



Next Generation  
Medical Software

2X Unfunded

Putting Prevention Into Practice

### Ambulatory Data System



Next Generation  
Medical Software

2X Unfunded

Epidemiology Assessment

2X Unfunded

Demand Management

2X Unfunded

Disease Management Initiative Implementation

Occupational Health Training for PCMs

2X Unfunded

Preventive Dentistry Initiatives

2X Unfunded

Breast Cancer Prevention Initiatives



Near Term



Mid Term



Far Term



# ACC/SG OT3 ROADMAP

## Health Promotions/HAWC Programs

98		99		00		01		02		03		04		05		06		07		08		09		10		11
----	--	----	--	----	--	----	--	----	--	----	--	----	--	----	--	----	--	----	--	----	--	----	--	----	--	----

2X Unfunded

**Deployed Health Promotion and Fitness**

Line Funding Based on Operation Budget Requirements (not fenced)

**Fitness Assessment Program Modernization**

2X Funded

**Expanded Fitness Assessment Program (Beta Testing)**

Line Funding Based on Operation Budget Requirements (not fenced)

-- AF Implementation

2X Unfunded

-- Equipment Procurement

Quality of Life Wedge Funding

-- Facilities Expansion

2X Unfunded

**HAWC Business Case Analysis**

2X Unfunded

-- Increased Manpower

Quality of Life Wedge Funding

-- Facilities Expansion

2X Unfunded

**HAWC Program Guidance (Prevention Funding)**

2X Unfunded

**Tobacco Cessation Programs**



**Near Term**



**Mid Term**



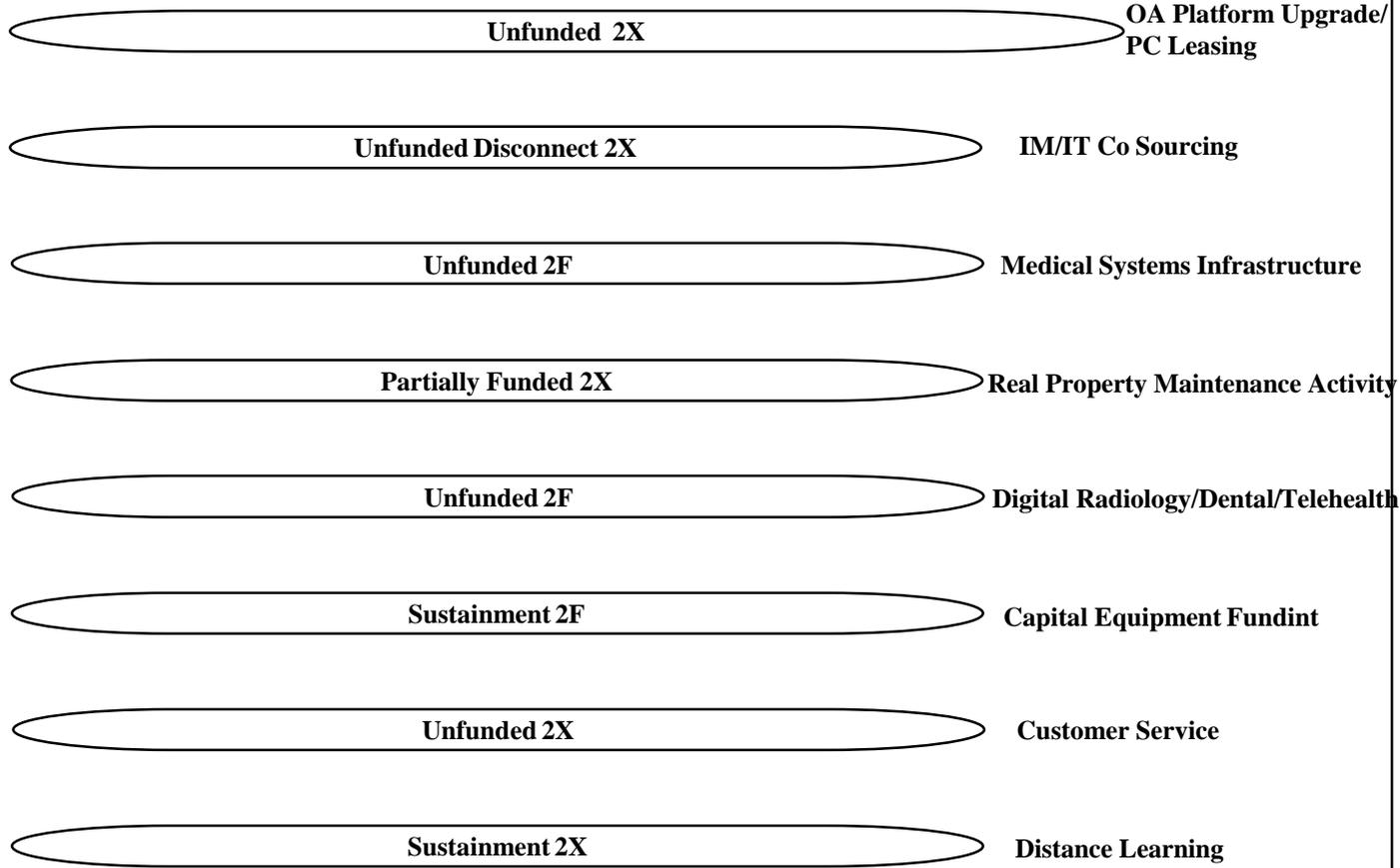
**Far Term**





# ACC/SG OT5 ROADMAP

98	99	00	01	02	03	04	05	06	07	08	09	10	11
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↑ **Near Term**                      ↑ **Mid Term**                      ↑ **Far Term** →

# Air Combat Command Command Surgeon

## Business Plan Development Guidance



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## 1. General Guidance

The Air Force Medical Service (AFMS) is on the leading edge of healthcare. From innovative resourcing strategies such as enrollment-based staffing and capitation to data feedback loops such as the performance measurement tool, to dramatic healthcare delivery processes such as the clinic of the future—the Air Force Medical Service is breaking new ground.

Many of these changes mirror the changing nature of providing healthcare in the civilian market. However, we have also undergone significant changes in the military environment in regard to planning and programming for the future. These changes include a stronger and more direct link to the planning process of the Line of the Air Force. Improved integration between planning and programming, including corporate review of enterprise initiatives, is essential to achieving our long-range goals.

We must “link” long-range planning with resource allocation. Medical Treatment Facility (MTF) planning processes support MAJCOM planning which, in turn, supports the Air Staff strategy. Base-level programming information is essential as each MAJCOM builds its Mission Support Plan (MSP). Additionally, MAJCOM programming information is essential for Air Staff programmers to ensure necessary resources are in place--both when and where required. Enterprise-wide prioritization is critical.

Focusing on the Operational Tasks (OT) is essential to supporting the Surgeon General's strategic pillars. The information provided by each MTF will drive planning and programming outcomes through FY 2010. Most MTFs already have Medical Group Strategic Plans or equivalent documents that should form the basis for business planning. Business plans will be compiled and presented at the March 1999 General Officer (G.O.) Round Table. Following the Round Table, facility level business plans must be coordinated and approved through the Wing Commander.

MTF business plans must recognize and plan for total Mirror Force integration and for transition to an "Expeditionary Aerospace Force." This transition will drive significant reassessment and modification to operational planning and future AFMS requirements. The Aerospace Expeditionary Force (AEF) at a minimum will have significant personnel scheduling effects. Consider Air Reserve Component (ARC) medical roles in supporting MTF taskings. While much of the information on the AEF is forthcoming, you will need to integrate as much of your MTF specific data that is available for your use at this time.

A vital part of the business plan is the identification and prioritization of needs across the OTs. These needs and respective solutions will be integrated into the MAJCOM MSP. Solutions should be linked to needs and show connectivity to Program Objective Memorandum (POM) initiatives. Use the end states provided in Section 4 as a guide in prioritizing needs.

Provided at Attachment 2 is a business plan template that you are to use in developing your plan. This template addresses MAJCOM and AFMS required data and information while providing a

uniform means for the MTF staff to plan and project into FY02. The business plan template has several linked spreadsheets (see Attachment 3) that must be completed. Data linkages are provided so that as data is entered into the spreadsheets, tables in the business plan template will be populated.

In the weeks ahead, you will have the responsibility to plan the actions implementing AFMS strategies. Your identification of needs, resource requirements, and cost savings opportunities will form the basis of the ACC MSP.

## **2. Marketing and Manpower Guidance**

### **2.1. Introduction**

2.1.1. The principle elements of the Manpower and Marketing tabs are contained in two spreadsheets: the MTF Enrollment/Resourcing Matrix and the Manpower Requirements Worksheet. Data collected for the spreadsheets will be analyzed with the resulting information used to project and make enrollment/manpower decisions and plans. This analysis should occur at both the MAJCOM and MTF.

2.1.1.1. The Marketing tab (in the business plan template) requires analyzing your beneficiary base, projecting enrollment levels, and developing plans to meet those levels. Under Enrollment Based Capitation (EBC), efficiencies are obtained by increasing throughput and reducing overhead. Enrolling more beneficiaries into TRICARE Prime increases general revenue. The Marketing tab focuses on enrolling the optimal number of beneficiaries and differentiating our services to further develop and maintain strong beneficiary loyalty to military health care.

2.1.1.2. The Manpower tab centers on tailoring support for enrollment projections. Unit manning projections must reflect the clinical support required for a beneficiary throughput with a 1 Primary Care Manager (PCM):1500 enrolled beneficiary ratio. The Enrollment Based Resourcing Model (EBRM) is significant in developing primary care throughput. Additionally, make/buy decisions for ancillary and support services need to be evaluated with the use of the Strategic Resourcing Portfolio (SRP). The SRP will help you identify services requiring further cost analysis and subsequent evaluation.

### **2.2. Maximum Achievable Enrollment (MAE)**

2.2.1. The first step in building the delivery system of the future is to determine the population to be served. The AFMS has several sources of population data (MCFAS, DEERS, and CHCS) and several definitions within these sources (in/out of catchment area, eligible, users). “Maximum Achievable Enrollment” is an MTF-level projection of the number of beneficiaries that could choose the MTF as their TRICARE Prime health benefit manager/provider.

2.2.1.1. Locally determined enrollment projections can more effectively account for local market conditions that are not always reflected in these retrospective-based sources (MCFAS, DEERS, and CHCS). For example, local projections can account for beneficiaries that are willing to enroll from outside the MTF's catchment area. Locally determined projections also account for beneficiary preferences in health plans (TRICARE Standard, Extra, and Prime) rather than assuming all "users" under the current system will enroll with the MTF under TRICARE Prime. MTFs are also asked to include in their estimate the number of Medicare eligible beneficiaries likely to choose the MTF as their PCM, given Medicare Subvention is legislatively permitted MHS-wide.

2.2.2. A PCM can be any of the following specialties that may be responsible for an enrolled population: family practice physicians, flight surgeons, nurse practitioners (excluding women's health nurse practitioners), physician's assistants, internal medicine physicians, and pediatricians. MTF PCMs include all military, civilians, and contractors working for the MTF. MTFs will provide the total number (actual and planned authorizations) of all PCMs and the number of those with an enrolled population for FY98-02.

2.2.3. The term enrollee refers to beneficiaries that have chosen, or are projected to choose the MTF to manage their healthcare needs. There are four categories of enrollees for the spreadsheet: TRICARE Prime enrollees, Medicare eligible beneficiaries, an Average Daily Student Load equivalent (applicable to MTFs at bases with technical training programs), and Other (e.g., Secretarial designees, foreign national populations, DoDDS personnel, etc.). See the explanation of MAE for additional guidance. MTFs will provide the total number (actual and projected) of enrollees for each category for FY98-02, as well as the number of TRICARE Prime enrollees with the MCSC.

### **2.3. Completing the MTF Enrollment/Resourcing Matrix (Attach 3)**

2.3.1. The MTF Enrollment/Resourcing matrix is designed to give AFMS leaders at all levels (MTF, MAJCOM, and Air Staff) a view on where the enterprise is and where it is heading, with particular emphasis on enrollment and primary care. The following information will assist you in completing the Enrollment & Resourcing Matrix.xls spreadsheet.

2.3.1.1. Use the MTF MAE reported for the EBRM IPT (Apr-Jul 98). Review your initial inputs and update the MAE as required based on current conditions. Provide a brief narrative explaining any changes.

2.3.1.2. The data for PCMs authorized is provided in the "Total PCMs" and the "PCMs with patients" worksheets. If you have changes please update and explain as required.

Row	Category	FY98	FY99	FY00	FY01	FY02
13	PCMs includes AD, Civ and Contractor PCMs					
14	Enrollees include: TRICARE Prime Enrollees, Avg Daily Student Load (ADSL), Expanded Medicare Eligibles, Subvention Enrolled, Misc (Foreign Nationals, DoDDs, DoD Contractors, etc.)					
16	MTF Maximum Achievable Enrollment From EBRM IPT (Apr-Jul 98)					
17	Revised MTF Maximum Achievable Enrollment After Analysis Post EBRM IPT					
18	*Please attach Rationals					
20	Physicians, Flight Surgeons, Nurse Practitioners (excluding Women's Health Nurse Practitioners), Physician's Assistants, Internal Medicine Physicians, and Pediatricians					
21	FY98 Total # of PCMs Authorized					
22	FY98 # of PCMs Authorized who are PCMs (excludes commanders, others who do not see patients)					
23	FY99 Total # of PCMs Authorized					
24	FY99 # of PCMs Authorized who are PCMs (excludes commanders, others who do not see patients)					
25	FY00 Total # of PCMs Authorized					
26	FY00 # of PCMs Authorized who are PCMs (excludes commanders, others who do not see patients)					
27	FY01 Total # of PCMs Authorized					
28	FY01 # of PCMs Authorized who are PCMs (excludes commanders, others who do not see patients)					
29	FY02 Total # of PCMs Authorized					
30	FY02 # of PCMs Authorized who are PCMs (excludes commanders, others who do not see patients)					
32	FY98 Enrollment Capacity Potential (line 22 * 1500)	0				
33	FY99 Enrollment Capacity Potential (line 24 * 1500)	0				
34	FY00 Enrollment Capacity Potential (line 26 * 1500)	0				
35	FY01 Enrollment Capacity Potential (line 28 * 1500)	0				
36	FY02 Enrollment Capacity Potential (line 30 * 1500)	0				
37	QUARTERLY DATA FY98-99					
38	FY9801 TRICARE Prime Enrollees					
39	FY9802 TRICARE Prime Enrollees					
40	FY9803 TRICARE Prime Enrollees					
41	FY9804 TRICARE Prime Enrollees					
42	FY9801 ADSL "Enrollees"					
43	FY9802 ADSL "Enrollees"					
44	FY9803 ADSL "Enrollees"					
45	FY9804 ADSL "Enrollees"					

2.3.1.3. Raw lives data is required for rows 38 through 96. The TRICARE Prime Enrollee data is sourced form Corporate Executive Information System (CEIS). Average Daily Student Load (ADSL) “enrollees” and other enrolled are sourced from your local Military Personnel Facility (MPF) alpha roster. Medicare eligible represents the “users” and is found using the Managed Care Forecasting and Analysis System (MCFAS) in CEIS.

2.3.1.4. Data for rows 98 through 102 represent the catchment area.

2.3.1.5. Rows 117 through 138 require you to generate a CHCS ad hoc report.

2.3.1.6. The worksheets titled “Dental FY99” and “Dental FY00-” has the data to complete rows 152 through 158.

2.3.1.7. Officer, enlisted and DA civilian authorizations are provided in the worksheets titled “AD Officers, Enlisted, and DA Civilians”.

## 2.4. Completing the Manpower Requirements Worksheet (Attach 3)

2.4.1. Listed below are a few of the strategies and tools available to the MTF to determine and resource their manpower requirements.

2.4.1.1. Quality Management/Utilization Management Strategy: This strategy requires a change in the AFMS culture toward “best value” healthcare. “Best value” health care is a function of cost, quality, and access. Major elements of the QM/UM strategy include leadership and accountability, provider ownership, demand management, and metrics. A basic QM/UM strategy is essential in defining your manpower requirements. The document outlining this strategy can be found at the Surgeon General’s Homepage, <http://usafsg.satx.disa.mil/~sgma/index.htm>.

2.4.1.2. Enrollment-Based Reengineering Model (EBRM): The EBRM’s basis is that a well-supported (nursing, medical, and administrative technicians) primary care manager provides the most effective and efficient delivery system.

2.4.1.2.1. EBRM includes PCM ratios, support staff, and specialty ratios. However, at this time the specialty ratios in the model are somewhat immature and untested. We believe the AFMS possesses more specialty providers than required and the EBRM tool is being used to evaluate manpower resources. EBRM PCM ratios, specialty ratios, and support staff ratios are available at the following web address: <http://usafsg2.satx.disa.mil/~ccx>

2.4.1.2.2. After an enrolled patient population forecast has been made, these figures can be “plugged” into the EBRM model (and SRP) tool to determine the manpower requirements needed to serve your enrolled population.

2.4.1.2.3. Use the EBRM to determine manning requirements for workcenters that are enrollment based. Non-enrollment-based workcenter manning requirements are determined by the SRP.

2.4.1.3. Strategic Resourcing Portfolio (SRP) Tool: The SRP tool is a planning tool to project workload generated by an enrolled population and who should accomplish the work (“make versus buy” analysis). The tool will also help determine the staffing requirements for work accomplished in the MTF. The SRP tool will assist in determining requirements for ancillary, support services and non-enrolled base workcenters not specifically covered in the EBRM; i.e., logistics, dental, and MPH.

2.4.1.3.1. When determining specialty care requirements, consider referral into and out of the MTFs. Coordinate any major changes with the affected facilities. Please remember to adjust the SRP tool manpower requirement output for the enrolled Primary Care Managers (PCM) workcenters to match the EBRM output.

2.4.1.3.2. “Make vs. Buy” Analysis: For functions not inherently governmental, use the SRP to perform initial make versus buy analysis on all requirements that do not support your readiness tasking. Availability of services in the local community, resource sharing

opportunities, and referral partnerships are important considerations in this phase of the resourcing process. Any reductions or closures of services need to be coordinated with your Lead Agent to consider any Bid Price Adjustment (BPA) implications.

2.4.1.3.3. Manpower standards are built into the SRP tool for determining requirements in some workcenters. Manpower standards provide a valuable reference when determining the optimal grade mix.

2.4.1.4. Performance Measurement Tool: A new manpower-related metric has been added to the Performance Measurement Tool. The tool will track the average number of enrollees for your PCM. A target of 1500 enrollees per PCM has been directed by AF/SG.

2.4.2. Other Considerations: After using the EBRM and SRP, ensure the requirements produced will effectively provide for:

2.4.2.1. Readiness Taskings: The first and most important step in sourcing your manpower requirements is to evaluate your requirements in relation to your readiness mission. These requirements should be traceable to the Medical Resourcing Letter (MRL). Requirements that support your readiness tasking should be “blue,” that is, sourced with active duty military personnel. In no case will the AFMS compromise its readiness taskings.

2.4.2.1.1. Disconnects: MTFs may substitute for a required AFSC in a Unit Type Code (UTC), where permitted, to optimize both the wartime and peacetime missions. The strategy is to minimize the cost of readiness. MTFs should identify disconnects and inefficiencies that may be corrected at the MAJCOM or AFMS level by moving UTC taskings to locations where the same peacetime healthcare requirements exist. If this cannot be accomplished, UTCs must be sourced by the MTF.

2.4.2.1.2. Individual Mobilization Augmentee (IMA) Authorizations.

2.4.2.1.2.1. IMA authorizations are used to backfill UTC personnel that deploy. Projected changes to existing guidance will enable IMAs to fill a UTC requirement as long as the UTC is not identified as a “first deployer” by HQ USAF/SGXR. This will prove to be a valuable tool in solving disconnects between peacetime requirements and UTC taskings. For example, if you have a peacetime requirement for five surgeons and you have seven requirements in your UTCs, the two disconnects can be filled with IMA authorizations as long as the UTC is not designated as a “first deployer.”

2.4.2.1.2.2. All authorizations for IMAs should be submitted on the same listing contained in the Manpower Requirements Worksheet using Program Element Code (PEC) “IMA.”

2.4.2.1.2.3. All requirements for IMAs, new or existing must be reevaluated and submitted on the Enrollment & Resourcing Matrix worksheet.

2.4.2.1.2.4. Review AFI 38-204, Individual Mobilization Augmentee (IMA) Authorizations and AFI 36-2629, Individual Mobilization Augmentee Management for specific instructions.

2.4.2.2. Aeromedical and Dental Services: These manpower requirements are set by policy since they directly support the military mission and enhance mission activities. For example, dental requirements are determined based on the population supported. The recently published Dental Manpower Standards (AFMS 54-21, AFMS 54-21a, and AFMS 54-22) are the appropriate tools to determine dental manpower requirements.

2.4.2.3. Force Protection/Force Enhancement: Manpower requirements support of these activities are driven primarily by the number of active duty personnel and the nature of the mission of the installation. Workcenters involved in these activities include dental services, physiological training, military public health, health promotions, flight/missile medicine, medical readiness plans, and bioenvironmental engineering.

2.4.2.4. Building a Healthy Environment: Manpower requirements in support of these activities are driven primarily by the number of active duty personnel and the type of work centers on the base. Workcenters involved in these activities include bioenvironmental engineering, military public health, and occupational health.

2.4.2.5. Graduate Medical Education (GME): GME infrastructure requirements will be sourced based on the student load provided by the Integrated Forecast Board.

2.4.3. The final phase in manpower resourcing is to apply a “gut check” on your program. One, can you meet your readiness requirement? Two, is your program consistent with the QM/UM Strategy and the Air Force Medical Service Reengineering and Rightsizing Plan? Finally, will your program meet measurement goals contained in the Performance Metric Tool?

2.4.4. The results of this effort will produce optimized manpower requirements that provide for appropriate care for the enrolled population, operational support to the wing, force protection/enhancement capability, and to build healthy communities. This information will be consolidated and used for force sculpting, personnel management, training forecasts, etc.

### **3. Financial Planning Guidance and Assumptions**

#### **3.1. General**

3.1.1. Rightsizing has been accelerated from FY03 to FY00 by direction of DoD.

3.1.2. Assume that EBC will be in effect FY01.

3.1.3. We must maintain a constant “level of effort” for beneficiaries age 65 and over (Medicare eligible). Maintain current levels of care to Medicare eligibles as you increase enrollment or throughput.

3.1.4. Resourcing of manpower requirements will be prioritized to meet the needs of the enrolled population.

3.1.5. Resource Optimization must focus on *realignment of baseline resources* to fund any new or expanded initiatives.

3.1.6. Readiness is the primary factor in developing manpower requirements.

3.1.7. Readiness costs are to be minimized without mission compromise. MTFs should review readiness taskings and identify proposed changes.

3.1.8. Optimizing direct care allocation is a main purpose of the MTF-level Business Plan.

3.1.9. Offsets must have equal emphasis as deficiencies and initiatives. Offsets are programmatic adjustments that free resources for investment in other programs.

3.1.10. All beneficiaries are eligible for care in the MTFs, not just TRICARE Prime enrollees. There may exist very valid reasons why a large proportion of the care you plan to provide is space available (non-TRICARE Prime enrollees). Provide explanations as required.

3.1.11. In FY99, each manpower authorization is the equivalent of \$87,600 for each officer and \$39,040 for each enlisted position.

## **3.2. Enrollment Based Capitation**

3.2.1. Direct care resources will be distributed using EBC-like methodology. We expect the number of enrollees will be multiplied by a national capitation rate, with regional adjustments.

3.2.2. Another portion of the Capitation Category 3, day-to-day clinical operational costs, will be allocated based on Medicare level of effort, number of students, special populations such as foreign personnel, and space-available care. This “required” space available care may be the care needed to maintain clinical skills or may be related to ancillary services such as civilian prescriptions filled at the MTF.

3.2.3. Capitation Category 1 and 2, CONUS and OCONUS medical unique support, funding remains at historical levels. In short, discretionary Operations & Maintenance (O&M) will be calculated and resourced based on the total number of TRICARE beneficiaries each MTF enrolls. If adequate funding remains, MTFs will receive the variable cost for the care they will provide to their non-enrolled TRICARE Prime eligibles.

3.2.4. MTF's must look at the EBC reports available through Corporate Executive Information System (CEIS).

3.2.4.1. Validate the number of enrollees reported in the MTF Equivalent Lives Summary Report. This number comes directly from DEERS, which is the official enrollment system. If the number here is incorrect, you will not get credit. If you believe this number is incorrect, work with your Lead Agent to correct this immediately.

3.2.4.2. The Quarterly Purchased Care/Provided Report shows the amount of care (and location) purchased for the MTF's own enrollees and provided to the MTF's external customers. To adequately project your purchased care requirements, you must address the following questions.

3.2.4.2.1. Do you expect the same level and pattern of purchased care for enrollees? Will there be population increases or decreases because of mission changes?

3.2.4.2.2. Will traditional external providers of care continue to support your enrollees? Will there be a significant service change in your provider network?

3.2.4.2.3. How much external customer care can be reduced without adversely affecting other nearby military MTF?

3.2.4.2.4. Are any service changes anticipated at your MTFs or other nearby network facilities?

### **3.3. Improving Efficiency**

3.3.1. One way to improve operations is by benchmarking. As you develop your MSP, follow a benchmarking strategy by comparing similar data (such as cost for an outpatient visit in primary care/family practice, number of patients seen by each provider, etc.) from similar-sized AF MTFs and conducting an analysis of the variation. The rationale behind analyzing this information is to review and analyze this productivity information for clues to reducing the cost per visit and/or increasing throughput.

3.3.1.1. By increasing throughput, each MTF may be able to enroll additional beneficiaries and thereby increase their O&M budget. Likewise, if an MTF is able to decrease the cost per visit per enrolled beneficiary, their discretionary O&M will also increase.

3.3.1.2. This information can be obtained using the MEPRS Executive Query System (MEQS.) MEQS data for all DoD MTFs is easily accessed by anyone with a MEQS password, so MTF commanders and MAJCOM/SGs can easily review other MTFs' information.

3.3.1.3. HQ USAF/SGMC has loaded four MEQS queries in the MEQS query repository. The MEQS queries have the naming convention: 00MSP1, 00MSP2, 00MSP3, and

00MSP4. Using our spreadsheet described later in this guidance, obtain the MEQS reports from the repository and import them into our spreadsheet provided. The spreadsheet will automatically calculate the average number of patients per day/per available provider FTE and the average cost per clinic visit. Additionally the MEQS reports and spreadsheet will break down the cost per visit and record the top 6 contributors. Lastly, for supply costs, MEQS will break down the expenses by ancillary service so that we can see exactly what ancillary services contribute to the cost of a visit

3.3.1.4. Once variation is identified, studying this variation may result in an operational change, which frees up some dollars for reinvestment. Determine if the cause of the variation is attributable to operational differences, simply facts of life based on different patient populations and other factors beyond their ability to control, or inaccurate data.

3.3.2. Performance Measurement Tool: The PMT should be an integral part of the analysis in each of the operational tasks as indicated or as appropriate for your planning. The performance measures are a key linkage and are interrelated to strategies and may be related to more than one operational task. You can access the PMT at <http://pmtsys.usafsg.bolling.af.mil/> and the workbook [http://www.ophsa.brooks.af.mil/ProjActive/AFMSPMT/AFMSPMT\\_sc.htm](http://www.ophsa.brooks.af.mil/ProjActive/AFMSPMT/AFMSPMT_sc.htm).

## **3.4. Financial Spreadsheet Instructions**

### **3.4.1. Background**

3.4.1.1. For many Resource Management Officers, developing an MTF business plan may be very familiar. Some may remember developing the Strategic Health and Resourcing Plan (SHRP) in 1996. Others may have participated in drafting the first AFMS MSP during 1997. For ACC, the FY98 MSP was primarily a MAJCOM driven process. However, the most recent guidance from the Air Staff, the MAPPG, dictates that MTFs more fully participate in the MSP process through development of an MTF business plan.

3.4.1.2. HQ ACC/SG has appointed MAJCOM Goal Champions for each AFMS OT. Likewise, your MTF may have "Champions" as well. Before writing the financial section of your business plan, you must know the requirements generated by each of the OTs. Since writing the financial plan centers on the OTs, you must determine the requirements. Your MTF OT Champions determine what is needed at the local level to reach the desired end states of each OT. Some of these "initiatives" will require resources, some won't. Your challenge is to review all initiatives and incorporate them into the financial plan. To fund these initiatives, you will have to identify offsets.

3.4.1.3. This section has been written specifically for RMOs to help draft the financial portion of your business plan. Two Excel workbooks have been developed for your use in writing your business plan. The "Finance Rqmts.xls" workbook will help project financial requirements for each OT while the "MEQS.xls" workbook will help analyze MEQS reports that must be incorporated into your business plan. While parts of the workbooks are just useful tools,

other parts are "must completes" and will be incorporated automatically (through links) to your business plan.

3.4.1.3.1. When using the "Finance Rqmts.xls" workbook, it's important to understand how the information will be used. There are essentially two distinct outputs of this workbook. One is "real funding" and the other is "EBC." You'll go through each OT and identify costs and offsets for your local initiatives. When doing this, you'll need to consider all three funding streams: O&M, MILPERS, and TRICARE. The end result is a "budget projections" worksheet that identifies changes in your "real" funding requirements. This information will be used when making allocation decisions.

3.4.1.3.2. The second output is a projected EBC scorecard. Since EBC is not yet fully implemented, and an actual EBC allocation tool is not yet developed, the scorecard results will not be used in making allocation decisions. However, that doesn't mean to ignore the EBC projections. You should still develop sound projections based on the results of your OT initiatives as described later in this document.

3.4.1.4. General Guidelines: Before we start to go through the workbooks step by step, below are some general guidelines to follow while completing the workbooks.

3.4.1.4.1. Ensure the business plan template (Business Plan Template.doc) and the financial workbooks (Finance Rqmts.xls and Meqs.xls) are located in the same directory. The appropriate tables from the spreadsheet will automatically link to the business plan template so that data entry is not required twice.

3.4.1.4.2. *Do not* modify any of the financial or MEQS tables in the business plan template. They are directly linked to the spreadsheets to ensure uniformity among MTFs. Likewise, do not change the names of the spreadsheets.

3.4.1.4.3. Do not adjust for inflation.

3.4.1.4.4. Enter actual dollar amounts. Do not round to the millions or thousands.

3.4.1.4.5. **DISCLAIMER:** The EBC scorecard section of the "Finance Rqmts.xls" workbook was developed by HQ ACC/SGMC in an effort to help you project financial requirements under an EBC environment. A new EBC allocation model is currently being developed by DoD but has not yet been released. The results of this model are in no way an indication of your future funding streams...it is not an allocation model. Rather it is a tool to help analyze the *potential* impact of EBC.

3.4.2. STEP 1: Projecting costs and offsets for each Operational Task.

3.4.2.1. Open the "Finance Rqmts.xls" workbook and click on the tab titled "OT1."

3.4.2.2. As stated earlier, the first step is to ensure each "OT Champion" is actively working their parts of the business plan. Your OT champions may have certain initiatives that need to be implemented at your MTF in support of the OTs. To reach the desired end states described in the guidance of this business plan and the AF MSP, you may need to commit resources. Conversely, implementation of certain initiatives may result in savings (or offsets). These spreadsheets will be used to project the costs and offsets of those initiatives. You must stress the need for offsets. If you don't, you'll end up with lots of requirements that won't be supported. Keep in mind that an initiative may have both costs and offsets. For example, strengthening your UM program may require an initial O&M expenditure but yield large "offsets" or savings in future years. Make sure your OT Champions are identifying all available offsets so you can reflect them in the financial plan.

3.4.2.3. There is a worksheet for each OT (5 of them). Each worksheet has been developed in the same format. There are five tables within each OT worksheet to identify your initiatives. Use one table per initiative. Additionally, each worksheet contains a "roll up" of all tables (initiatives).

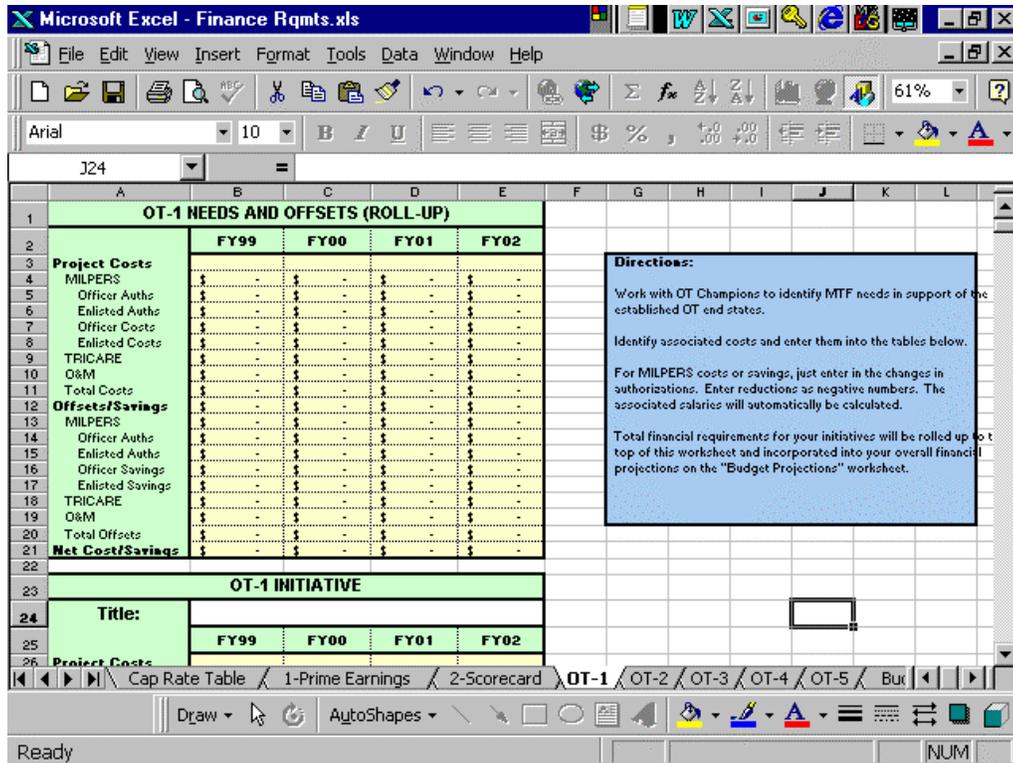
3.4.2.4. In analyzing your requirements, try to separate the costs/offsets into MILPERS, TRICARE, and O&M. If MILPERS is involved, you can enter the plus or minus of authorizations directly into the tables. The associated salaries will automatically be calculated.

3.4.2.5. Enter any costs as positive numbers and any offsets/savings as negative numbers.

3.4.2.6. Enter data into the white spaces only. The shaded areas contain formulas.

3.4.2.7. You may not have initiatives for all OTs - that's okay. Also, you may not need all five tables in all five OT worksheets - that's okay as well. If you have more than five initiatives for an OT, let us know so we can adjust the worksheet.

3.4.2.8. The net for each OT will be rolled up to the top of the worksheet and carried forward to the "Budget Projections" worksheet.



3.4.3. STEP 2: Finding your EBC capitation rates.

3.4.3.1. Click on the tab named "Cap Rate Table." The following should be displayed on your screen.

1	A	B C D			E	F	G	H	I	J
		Base	Total	Variable						
2										
3	<b>Barksdale</b>	\$ 2,687	\$ 1,657	\$ 1,030		11,561				
4	<b>Beale</b>	\$ 1,614	\$ 716	\$ 898		6,572				
5	<b>Cannon</b>	\$ 2,501	\$ 1,571	\$ 931		7,715				
6	<b>Davis Monthan</b>	\$ 2,320	\$ 1,413	\$ 907		14,960				
7	<b>Djess</b>	\$ 2,340	\$ 1,560	\$ 780		10,077				
8	<b>Ellsworth</b>	\$ 2,330	\$ 1,220	\$ 1,109		7,159				
9	<b>Holloman</b>	\$ 2,185	\$ 1,448	\$ 737		8,761				
10	<b>Langley</b>	\$ 1,738	\$ 611	\$ 1,126		15,964				
11	<b>Minot</b>	\$ 2,628	\$ 1,345	\$ 1,283		7,363				
12	<b>Moodys</b>	\$ 2,393	\$ 1,495	\$ 898		7,887				
13	<b>Mt. Home</b>	\$ 2,555	\$ 1,509	\$ 1,045		7,352				
14	<b>Nellis</b>	\$ 2,348	\$ 1,536	\$ 812		21,045				
15	<b>Offutt</b>	\$ 2,362	\$ 1,400	\$ 962		21,536				
16	<b>Seg-Johnson</b>	\$ 1,993	\$ 1,292	\$ 701		11,857				
17	<b>Shaw</b>	\$ 2,167	\$ 1,397	\$ 771		13,223				
18	<b>Whiteman</b>	\$ 2,832	\$ 1,792	\$ 1,040		6,558				
19										

3.4.3.2. Take note of the above numbers for your specific MTF. They will be used in the next section.

3.4.4. STEP 3: Determining your projected prime enrollment capitation earnings.

3.4.4.1. Click on the tab titled “1-Prime Earnings.”

3.4.4.2. The following table will be displayed.

Required Input		Source				
2	Capitation Rate:	"Cap Rate Table" Tab of this Workbook				
3	DoD(HA) Equivalent Life Enrollment Target:	"Cap Rate Table" Tab of this Workbook				
4	Actual Enrolled Equivalent Lives:	Local enrollment targets/goals over FYDP				
<b>PROJECTED CHANGES IN PRIME EARNINGS</b>						
<b>BASE</b>						
		FY98	FY99	FY00	FY01	FY02
9	Capitation Rate	\$0	\$0	\$0	\$0	\$0
10	Variable		\$0	\$0	\$0	\$0
11	Fixed		\$0	\$0	\$0	\$0
12	DoD(HA) Equivalent Life Enrollment Target	0	0	0	0	0
13	Projected Enrollee Cap Earnings	\$0	\$0	\$0	\$0	\$0
14	Actual Enrolled Equivalent Lives					
15	Equivalent Lives Delta	0	0	0	0	0
16	Actual Enrollee Cap Earnings	\$0	\$0	\$0	\$0	\$0
17	Potential Gain(Loss)	\$0	\$0	\$0	\$0	\$0
<b>Assumptions:</b>						
20	Capitation rate remains constant over the FYDP					
21	DoD(HA) equivalent life enrollment target remains constant over the FYDP					

Enter in your MTF specific capitation rates. These can be located at the "Cap Rate Table" tab.

Enter in your actual (for FY98) and projected (for FY99 – FY02) equivalent lives. This number should be based on your local targets and goals.

Enter in your MTF specific DoD(HA) enrollment target. This number is located at the "Cap Rate Table" tab

3.4.4.3. In determining your enrollment projections, ensure that any changes are also reflected in your OT tables. Any change in enrollment should be reflected as an initiative in OT2. Enrollment changes will have an impact not only on the O&M expenses but TRICARE expenses as well.

3.4.4.4. Once the numbers have been entered as displayed above, the spreadsheet will calculate your *potential* Category 3 gain or loss based on your enrollment targets. This number will be carried forward to the EBC scorecard in the next step.

3.4.5. STEP 4: Preparing your EBC scorecard projections.

3.4.5.1. As previously stated, the prime capitation earning projections will be carried forward to this spreadsheet from the “Prime Earnings” worksheet. You will need to fill in all blank white spaces. All of the shaded areas contain formulas and cannot be modified.

3.4.5.2. Using CEIS, enter FY98 actual data into column B. The figures for FY98 should match your CEIS scorecard information unless you know of a validated discrepancy.

3.4.5.3. For the FY99 to FY02 data, enter in projected *CHANGES* from the FY98 actual data. For example, if you plan to decrease your external customer care by \$100K for each year, you need to enter -100,000 in cells C13 through F13. The change must be entered in each year for a recurring change; it is not automatically carried forward.

3.4.5.4. For the purchased care portion, identify expenses for your top three referral sites, then group the remaining balance into the “Other MTF” category.

3.4.5.5. The “Net Revenues” reflects the potential impact of EBC on the Category 3 earnings. As stated earlier, this is not an indication of actual plus ups or decrements to your program. This table will be automatically linked to the business plan document.

EBC SCORECARD PROJECTIONS					
BASE	FY98 Actuals	FY99 Delta	FY00 Delta	FY01 Delta	FY02 Delta
<b>Revenues</b>					
Prime Capitation Earnings		\$0	\$0	\$0	\$0
External Customers (Enrolled MCSC or					
External Customers (Non-enrollees)					
Medicare Allocation					
<b>Total Revenues</b>	\$0	\$0	\$0	\$0	\$0
<b>Expenses</b>					
Purchased Care (Other MTF)	\$0	\$0	\$0	\$0	\$0
MTF X					
MTF X					
MTF X					
All Other MTFs					
Purchased Care (Civilian Care)					
<b>Total Expenses</b>	\$0	\$0	\$0	\$0	\$0
<b>Net Revenues</b>	\$0	\$0	\$0	\$0	\$0

3.4.6. STEP 5: Determining your financial projections.

3.4.6.1. Open the “Budget Projections” tab.

PROJECTED CHANGES IN FINANCIAL REQUIREMENTS					
	FY98 Actuals	FY99 Delta	FY00 Delta	FY01 Delta	FY02 Delta
Projected Change in Category 1 Funding					
Projected Change in Category 2 Funding		\$0	\$0	\$0	\$0
Projected Change in Category 3 Funding		\$0	\$0	\$0	\$0
Projected Change in TRICARE Costs		\$0	\$0	\$0	\$0
Projected Change in MILPERS		\$0	\$0	\$0	\$0
Total Changes to Funding	\$0	\$0	\$0	\$0	\$0
OT-1 Needs		\$0	\$0	\$0	\$0
OT-2 Needs		\$0	\$0	\$0	\$0
OT-3 Needs		\$0	\$0	\$0	\$0
OT-4 Needs		\$0	\$0	\$0	\$0
OT-5 Needs		\$0	\$0	\$0	\$0
Total OT Needs/Offsets		\$0	\$0	\$0	\$0
Change in Total Funding Requirement		\$0	\$0	\$0	\$0

3.4.6.2. Most of the information will already be in place from your input into the other areas of this workbook. The only information you must enter is your projected Category 1 & 2 funding levels. Enter your actual FY98 levels and projected changes for FY99 to FY02. Assume that Cat 1 & 2 funding will remain constant unless you know of significant changes.

3.4.6.3. The bottom line in this worksheet is your change in funding requirements over the FYDP due to EBC, rightsizing, and implementation of the AFMS OTs.

### 3.5. MEQS Spreadsheet Instructions

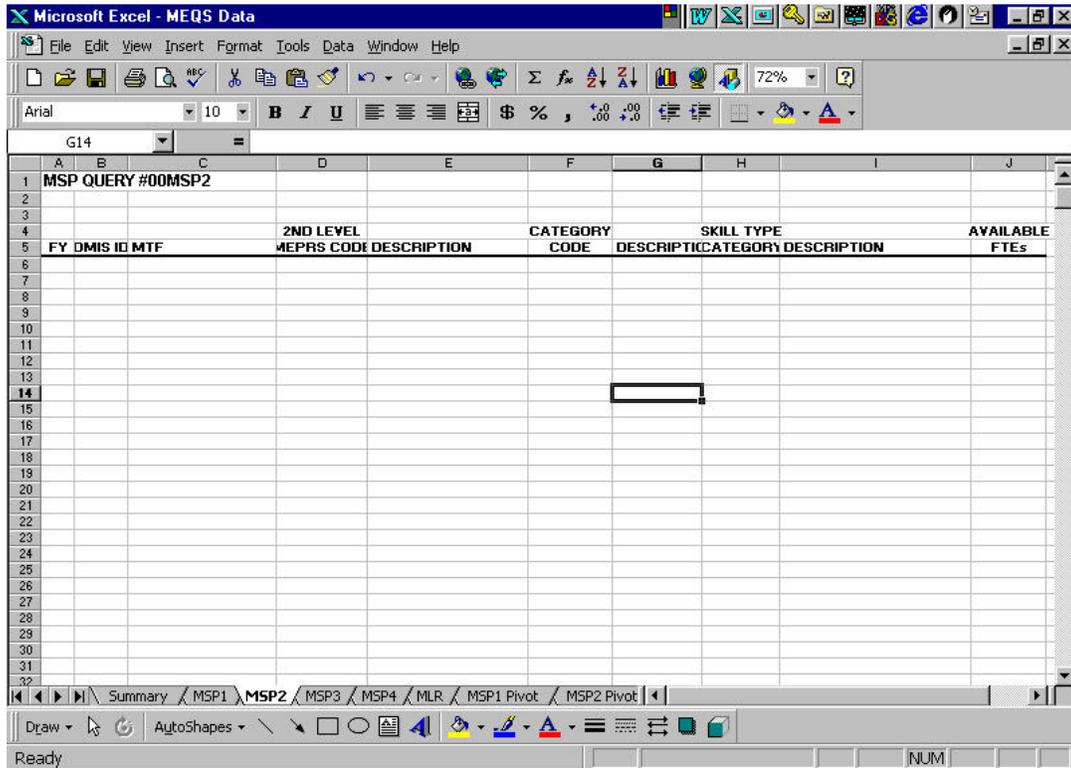
3.5.1. Using the MEQS Workbook: As described in the MAPPG, each MTF must look at potential areas where efficiency can be improved. Any area where you improve efficiency can lower costs, increase throughput, and free up resources for other investment opportunities. One tool available for you to use in analyzing your MTF’s efficiency is MEQS. Furthermore, the MAPPG identifies some specific MEQS queries that have been developed specifically for your business plan. We have developed a spreadsheet that will take these MEQS queries and manipulate the data into the required format for the business plan. Prior to following the steps below, you will need to enter MEQS and retrieve the MSP reports from the MEQS repository. Once in MEQS, select “File” then “Import from Repository.” The file names are 00MSP1,



3.5.3.2. Enter Excel and open the MEQS.xls workbook.

3.5.3.3. Select the "MSP2" tab.

3.5.3.4. Your screen will look like this:



3.5.3.5. From the edit menu in MEQS, select <copy all>.

3.5.3.6. Go back to Excel.

3.5.3.7. In the "MSP2" tab, position your cursor in cell A6 and select <paste> from the edit menu.

3.5.3.8. The MEQS data will now be imported into your workbook.

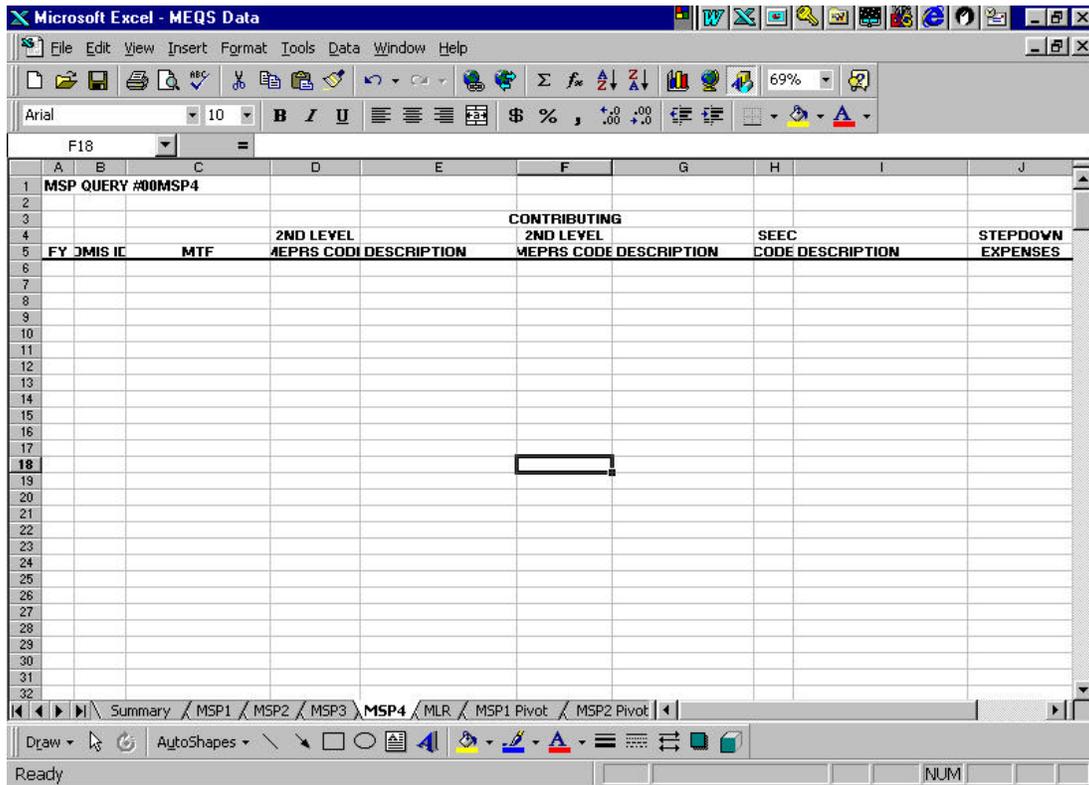
3.5.4. STEP 3: Obtaining the required MEQS data (MSP3 Report).

3.5.4.1. Enter MEQS and retrieve the 00MSP3 global report.

3.5.4.2. Enter Excel and open the MEQS.xls workbook.

3.5.4.3. Select the "MSP3" tab.





3.5.5.5. From the edit menu in MEQS, select <copy all>.

3.5.5.6. Go back to Excel.

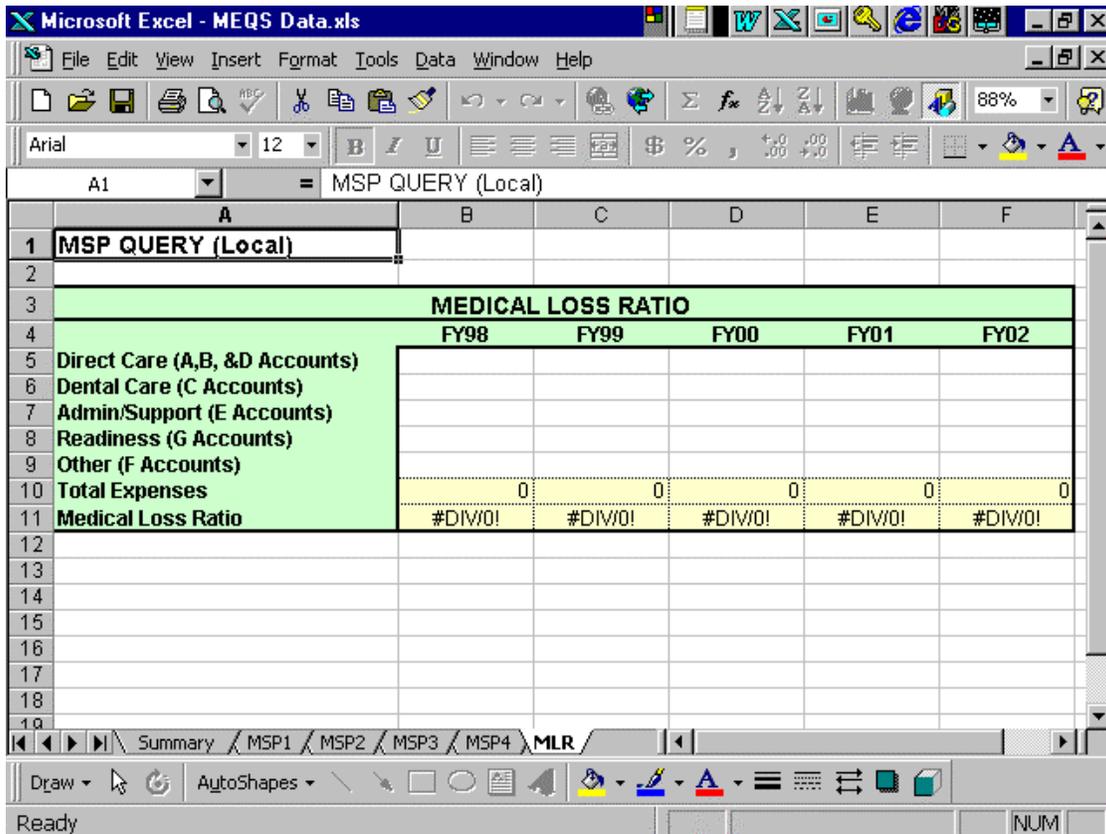
3.5.5.7. In the "MSP4" tab, position your cursor in cell A6 and select <paste> from the edit menu.

3.5.5.8. The MEQS data will now be imported into your workbook.

3.5.6. STEP 5. Medical Loss Ration Calculation.

3.5.6.1. Click on the "MLR" tab of the MEQS.xls workbook.

3.5.6.2. The spreadsheet will look like this:



3.5.6.3. Enter in your actual FY98 MEPRS expenses and projected FY99-02 expenses for each MEPRS category.

3.5.7. STEP 6 Completing MSP Analysis.

3.5.7.1. Save and close the MEQS.xls workbook.

3.5.7.2. Re-open the MEQS.xls workbook (this will recalculate the necessary pivot tables).

3.5.7.3. Click on the "summary" tab.

3.5.7.4. Your screen should look like this.

The screenshot shows an Excel spreadsheet with two main tables. The first table, 'EXPENSE AND WORKLOAD DATA', is located in rows 2-5 and columns B-H. The second table, 'TOP 6 EXP', is located in rows 2-15 and columns I-K. The spreadsheet interface includes the menu bar, toolbar, and worksheet tabs at the bottom.

EXPENSE AND WORKLOAD DATA							
	Months of Data	OPVS	Expenses	Cost Per Visit	FTEs	Avg Visits Per FTE	Avg Daily Visits Per FTE
FAMILY PRACTICE CARE	12	38,320	\$4,834,633	\$126	183.20	209	10
PRIMARY MEDICAL CARE	12	8,447	\$557,514	\$66	41.53	203	10
<b>TOTAL</b>	12	46,767	\$5,392,147	\$115	224.73	208	10

TOP 6 EXP	
CLINIC	
FAMILY PRACTICE CARE	MILI
	CIVII
	SUP
PRIMARY MEDICAL CARE	MILI
	CIVII
	SUP

3.5.7.5. Scroll to the right to see the three roll up tables that will be imported into your business plan document.

3.5.7.6. If you would like to use this tool for other clinics, save the file name as a different name (for your own use) and change the MEQS query to retrieve other clinic data.

## 4. Support of the Pillars Through Operational Tasks (OT)

### 4.1. General

4.1.1. The AFMS strategic link to the line of the AF is reflected in the four pillars of the AFMS Parthenon: Reengineer Medical Readiness, Deploy “TRICARE,” Tailored Force, and Build Healthy Communities. Five operational tasks support these pillars. The operational tasks are further defined by end states. The end states listed in the MAPPG, Chapter 1, Section 5, are the results of the blending of MAJCOM inputs and Air Staff prioritization.



4.1.2. Tying your plans to the end states is in direct support of the AFMS strategic objectives.

4.1.2.1. We are providing the end states from the MAPPG; however, not all of them will have MTF applicability.

4.1.2.2. You will need to use the end states as you identify and develop your initiatives and offsets for the financial tab of your business plan.

4.1.2.3. OT1 end states should be addressed in the Readiness tab. OTs 2, 3, and 4 end states should be addressed in the Population Health Plan, Marketing, Manpower, and Finance tabs. OT 5 end states should be addressed in the Facility/IMIT/Customer Service Plans tab.

## **4.2. Provide Support to Employed Forces and Returning Casualties While Minimizing the Impact on the Medical Benefit (OT 1)**

4.2.1. End State 1: In the near term (NLT CY02), field a sizeable, modularized Deployable Medical Support System, including lighter, more capable infrastructure assets and embedded CBW protection, capable of meeting Air Expeditionary Force and Joint Service operational requirements upon demand. Work within existing assets and AEF guidance as a baseline.

4.2.2. End State 2: In the near term (NLT CY03), field an aeromedical evacuation system capable of transporting Joint Service stabilized patients to definitive care from any place in the world upon demand. Work within existing POM'd assets (manpower and materiel) as a baseline. When the aeromedical evacuation program transfers to the Line of the Air Force, medical planners must continue to ensure resource needs are clearly articulated.

4.2.3. End State 3: In the midterm (NLT CY05), field an integrated, worldwide medical command, control, communications, computers, and intelligence (C<sup>4</sup>I) capability with the ability to support evolving Information Superiority (IS) technologies such as telehealth and medical informatics, across the range of potential contingencies.

4.2.4. End State 4: In the near term (NLT CY03), field an integrated medical logistics system, based upon tenets of the Focused Logistics Roadmap, which is capable of supporting Joint Service requirements and providing full-spectrum supportability.

4.2.5. End State 5: In the near term (NLT CY03), field an improved capability to respond to directed energy and weapons of mass destruction threats, including links with Line Intelligence Surveillance Reconnaissance (ISR) programs, standardized medical countermeasures, and enhanced partnerships with national and state emergency response agencies.

4.2.6. End State 6: In the near term (NLT CY00), field an Operational Health Support Development Center which formulates and integrates operational requirements to meet field CONOPs, develops capabilities using COTs/GOTs technologies and rapid prototyping, conduct field testing, and makes recommendations to the Air Staff for fielding in deployable assets.  
OPR: ACC OCR: AMC

4.2.7. End State 7: In the near term (NLT CY01), field a coordinated AFMS First Responder concept tailored to AEF and Force Health Protection tenets.

4.2.8. End State 8: In the near term (NLT CY02), field an AFMS organizational structure supportive of FHP tenets.

4.2.9. End State 9: In the near term (NLT CY00), field an improved capability to integrate Reserve Component personnel into AFMS operations.

4.2.10. End State 10: In the midterm (NLT CY10), field an improved, modularized, right sized Deployable Medical Support System capable of meeting Air Expeditionary Force and Joint Service operational requirements. This system should employ evolving medical technologies of telehealth, remote medical informatics/diagnostics, artificial intelligence triage systems, and advanced simulation training, as well as the integration of products of the other end states.

4.2.11. End State 11: In the near term (NLT CY00), field comprehensive deployment surveillance and force health protection. This includes pre-, post-, and during deployment surveillance in accordance with DoD directives and 100% completion of Preventive Health Assessments (PHAs). In addition, systems must provide full integration with the automated Preventive Health Care Assessment (PHCA).

4.2.11.1. The AFMS will maintain a consistent modernization track while sustaining current readiness. As reengineered assets come on line, MTF personnel will train and be familiar with them, in order to meet combat support deployment requirements. Existing air transportable hospital and aeromedical evacuation personnel will meet readiness and clinical training requirements to meet their designed operational capability (DOC) taskings. Equipment assets will be sustained using Risk Based Readiness concepts which prioritize forward presence, AFSOC, and early deploying units.

### **4.3. Build a Managed Care System that Integrates Quality, Cost, and Access (OT 2)**

4.3.1. End State 1: Seamless health care system that provides a uniform benefit by FY04.

4.3.2. End State 2: Employ a managed care system in which delivery of care meets or exceeds national standards (Quality Management - QM), delivered at least cost (Utilization Management - UM), and has the capability to measure and compare productivity and effectiveness of care across AFMS by FY04.

4.3.3. The AFMS must deploy effective population-based health care in order to provide the “best value” care to our beneficiaries. Building healthy communities requires strong internal and external marketing and educational programs with a focus on system-wide metric development to evaluate progress.

4.3.4. In this extremely competitive environment, the AFMS continues to encounter fiscal and personnel constraints. Business plans and MSPs should address the following issues:

4.3.4.1. How communication and coordination among medical treatment facilities (MTFs), Lead Agents and MAJCOMs can be improved.

4.3.4.2. How each MTF is applying the Best Value Health Care (QM/UM) Model (See <http://usafsg2.satx.disa.mil/~ccx/sggoals/goal2.htm>).

4.3.4.3. Methods for ensuring a uniform benefit is provided to all beneficiaries.

4.3.4.4. What analytical tools are used to make decisions/evaluate health care program (cost-benefit analysis, outcome measures, AF Performance Measurement Tool, etc.)?

4.3.4.5. How each MTF plans to maximize Primary Care Managers’ ability to care for their enrolled population?

4.3.4.6. Seek out programmatic opportunities which focus on operational health support requirements, maintaining a clinical training base at the MTF or in the civilian sector.

### **4.4. Be the Leader of Comprehensive and Integrated Programs of Disease Prevention, Health Promotion, and Fitness (OT 3)**

4.4.1. End State 1: Wellness is intrinsically valued by the AFMS at all levels. Appropriate resources are available to support wellness/prevention efforts, including facilities (such as HAWCs), personnel, and funding.

4.4.2. End State 2: Primary, secondary, and tertiary preventive services are integrated community-wide and are an essential part of the daily activities of all medical staff.

4.4.3. End State 3: Wellness of all troops (including medical) is optimized and personnel are ready for immediate deployment.

4.4.4. End State 4: Customers are invested in prevention. There is a self-directed and self-motivated focus on wellness/prevention supported by the executive management of the line and medical community.

4.4.5. Describe efforts for “Alcohol abuse control, Life skills enhancement, Fitness enhancement, Injury prevention, and Tobacco control” (ALFIT) implementation.

4.4.6. Explain implementation of demand management strategies such as the use of self-care manuals and Health Care Information Lines (HCIL) to get the individual to the right level of care, at the right time, and for the right cost.

4.4.7. Explain migration to Population Based Health (to include defining the population, identifying needs and health status of population, delivering comprehensive preventative services, managing conditions and diseases, and continuously evaluating health status improvement and the system’s effectiveness and efficiency).

#### **4.5. Promote a Safe and Healthy Environment (OT 4)**

4.5.1. End State 1: Environmental and occupational health risk identification, measurement, and assessment techniques and decision tools (including risk communication processes) are developed and mature (NLT FY03).

4.5.2. End State 2: Occupational support of aircrew includes fact-based determinations of fitness for flying duties and provisions for force protection and performance enhancement (NLT FY03).

4.5.3. End State 3: The Air Force will use risk based decision making to eliminate or mitigate unacceptable risks to human health and enhance human performance in the conduct of AF operations and to assure full compliance with applicable environmental and occupational health laws and attendant regulations (NLT FY10).

4.5.4. ACC.

4.5.4.1. Respiratory and personnel protective equipment.

4.5.4.2. Prioritization of supporting research initiatives.

4.5.4.3. Portable hyperbaric treatment chambers.

4.5.4.4. Forward decontamination procedures.

## **4.6. Provide a Responsive and Sensitive Health Care Atmosphere (OT 5)**

4.6.1. End State 1: Develop, implement, and sustain processes where we provide quality service, put customers first, empower staff, eliminate barriers and reinforce the customer service basics.

4.6.2. End State 2: Plan, design, construct, and maintain customer-focused facilities with flexibility to meet the current and future needs of the populations being served.

4.6.3. End State 3: Provide timely delivery of services, equipment, supplies, and systems (including automated information systems) that meet customer-identified requirements to support delivery of healthcare in contingency operations and community-based healthcare.

4.6.4. Major changes effective this planning cycle include:

4.6.4.1. Deployment of customer satisfaction (AFMSA-led Skunkworks) initiatives has begun.

4.6.4.2. By the end of FY00, 80% of the medical commodity will be standardized by DoD region. EEIC 604 purchases will be from committed volume regional contracts.

4.6.4.3. Excluding inflation, a 5% across the board reduction for 80% of the commodity will be achieved.

4.6.4.4. By the end of FY00, medical maintenance contracts will be negotiated by region. Costs are estimated to remain constant, excluding inflation.

4.6.4.5. Clinic of the Future model implementation on-track.

4.6.4.6. Y2K strategy (FY99-00) will be in place.

4.6.4.7. A computer leasing strategy is in-place. Consider leasing clients and servers as a strategy to reduce costs.

4.6.5. Information Management/Information Technology (IM/IT) is a key element for the future of the AFMS. MSPs need to include analysis of how MAJCOMs have migrated to the standard MHS environment. For planning and programming purposes, the following information is provided to identify existing IM/IT funding profiles for each goal. Use this information as you begin to identify shortfalls in your system's wellness and incorporate into your strategy for planning.

4.6.5.1. This analysis should take into consideration all IM/IT components which support all goals. Some of these components are: Infrastructure, e-mail, and office automation; facility connectivity; Category V structured cable plant; connectivity with outlying buildings;

wide area connectivity to DISN NIPRNET; Ethernet protocol; servers; MS NT 4.0 operating system; UNIX on exception basis (purchases after Jul 98 should meet the MHS minimum specifications); operating systems and communications; MS NT 4.0 or higher as the network operating system; MS Exchange 4.0 or higher as the mail server; clients; MS NT 4.0 (or transitionally, Windows 95) or higher as client operating system; purchases after Jan 95 should meet the MHS Pentium 90 MHz PC minimum; purchases after Jul 98 should meet the MHS Pentium 233 MHz minimum; MS Office 97 (or transitionally, MS Office 95).

## **5. Business Plan Template Guidance**

### **5.1. The Business Plan Template**

5.1.1. Times New Roman.

5.1.2. 12 Font Size.

5.1.3. .25 inch tabs.

5.1.4. 1 inch margins.

5.1.5. If color graphics to include shading are used in your product, be sure your graphics are reproducible/readable when printed in black and white.

### **5.2. Use Of Embedded Tables Linked To Excel Spreadsheets**

5.2.1. The linked tables in the business plan template are updated by data from the spreadsheets. Do not input to the linked tables directly. Data entered to the table directly won't appear after updates or worse, will destroy the link.

5.2.2. Maintain all spreadsheets in a single folder.

5.2.3. The worksheets are color-coded.

5.2.3.1. Clear cells require data input.

5.2.3.2. Light yellow cells have automatic calculations.

5.2.3.3. Blues cells provide narrative information.

5.2.3.4. Green cells are data labels.

### 5.3. Business Plan Template Update Procedures For Linked Data

- 5.3.1. Enter the Business Plan Template document in Word.
- 5.3.2. On the menu bar, click “edit” then “links”.
- 5.3.3. Highlight the link(s) you want to update.
- 5.3.4. Click on the “update now” button.

## 6. Deliverable Timeline and POC List

### 6.1. Deliverable Timeline

6.1.1. The MTF business plan timeline is driven by the Air Force Planning, Programming, and Budgeting System (PPBS) cycle. The following milestones are planning targets for accomplishing the tasks described in this document:

MAPPG forwarded to MAJCOM SGs	Oct 98
Review of MAPPG at G.O. Round Table	Oct 98
MAJCOMs task MTFs to develop Business Plans	20 Nov 98
<b>Provide MTF Enrollment/Resourcing Matrix spreadsheet to ACC/SG</b>	<b>21 Dec 98</b>
<b>MTF Business Plans returned to MAJCOMs</b>	<b>22 Jan 99</b>
<b>MTF Commander Business Plan Brief via VTC</b>	<b>1-9 Feb 99</b>
MAJCOM Business Plan developed using MTF Business Plans	Feb 99
MAJCOM MTF-level Business Plan Review at G.O. Round Table	Mar 99
MAJCOM Revise Business Plan (incorporate into final MSP)	Mar 99
MAJCOM MSP (fully coordinated) forwarded to CCX	16 Apr 99

**6.1.2. Forward MTF Business Plans, via email, to arrive at SGMR NLT:  
22 January 1999.**

6.1.3. Mail two copies of finalized plans to:

HQ ACC/SGMR  
162 Dodd Blvd, Suite 202  
Langley AFB, VA 23665-1995

## 6.2. MTF Business Plan Point of Contacts

<b>Name</b>	<b>Area of Responsibility</b>	<b>DSN Phone #</b>
Col Eugene Raynaud	Goal Champion OT 1	574-1279
Lt Col Mike Quinnelly	Goal Champion OT 2	574-3608
Col Robert Williams	Goal Champion OT 3	574-1268
Col Michael Browne	Goal Champion OT 4	574-1269
Lt Col Mike Quinnelly	Goal Champion OT 5	574-3608
Col John Watkins	Customer Service	574-1328
Lt Col Gail Therrien	Managed Care	574-1380
TSG Susan Seker	Population Enrollment	574-1294
Maj Mark Lewandowski	Finance	574-1344
Capt Joseph Burger	Finance -- worksheets	574-1339
Maj Tom Haines	Manpower	574-7813
MSgt Richard Burton	SRP/UMD	574-0170
Major Carol Robbins	Prevention	574-1277
Mr. Willard Kiefner	Program Manager	574-1355
Maj Carolyn Bell	Program Manager	574-1208

6.2.1. Note e-mail addresses consist of: [firstname.lastname@langley.af.mil](mailto:firstname.lastname@langley.af.mil)

## 7. Acronyms

AF	Air Force
ACC/SG	Air Combat Command/Command Surgeon
AEF	Aeromedical Expeditionary Force
AFCS	Air Force Corporate Structure
AFDD	Air Force Doctrine Document
AFI	Air Force Instruction
AFMAM	Air Force Medical Applications Model
AFMC	Air Force Materiel Command
AFMOA	Air Force Medical Operations Agency
AFMS	Air Force Medical Service
AFMSA	Air Force Medical Support Agency
AFPMT	Air Force Performance Measurement Tool
AFSC	Air Force Specialty Code
AFSOC	Air Force Special Operations Command
AFTL	Air Force Task List
ALFIT	Alcohol Abuse Control, Life Skills Enhancement, Injury Prevention, and Tobacco Control
AMC	Air Mobility Command
APES	Automated Patient Evacuation System
ARC	Air Reserve Component
ASIMS	Aeromedical Services Information Management System
BPA	Bid Price Adjustment
C4I	Command, Control, Communications, Computers and Intelligence
CBW	Chemical Biological Warfare
CCQAS	Centralized Credentials and Quality Assurance System
CEIS	Corporate Executive Information System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCS	Composite Health Care System
CINC	Commander in Chief
CINC JMETL	Commander in Chief Joint Mission Essential Task List
CONOP	Concept of Operation
COTs	Commercial off the shelf
CPD	Central Processing and Distribution
DE	Directed Energy
DEERS	Defense Enrollment Eligibility Reporting System
DL	Distance Learning/Distributed Learning
DOC	Desired Operational Capability
DoD(HA)	Department of Defense Health Affairs
EAF	Expeditionary Aerospace Force
EAS III	Expense Assignment System Version III
EBC	Enrollment Based Capitation
EBRM	Enrollment Based Resourcing Model
EEIC	Element of Expense/Investment Code

ESOH	Environmental Safety, Occupational Health
FHP	Force Health Protection
FTE	Full Time Equivalent
FY	Fiscal Year
GMO	General Medical Officer
GO	General Officer
GOTs	Government Off The Shelf
HAWC	Health and Wellness Center
HEAR	Health Evaluation and Assessment Review
HQ USAF/SGMC	Headquarters United States Air Force Surgeon General's Financial Management Division
HQ USAF/SGMM	Headquarters United States Air Force Surgeon General's Medical Manpower Division
HQ USAF/SGXR	Headquarters United States Air Force Surgeon General's Medical Readiness Division
IH	Industrial Hygiene
IM/IT	Information Management/Information Technology
IMA	Individual Mobilization Augmentee
IPT	Integrated Product Team
IS	Information Systems
MAE	Maximum Achievable Enrollment
MAJCOM	Major Command
MAP	Mission Area Plan
MAPPG	Medical Annual Planning and Programming Guidance
MCFAS	Managed Care Forecasting and Analysis System
MCSC	Managed Care Support Contract
MEPRS	Medical Expense Performance Reporting System
MEQS	MEPRS Executive Query System
METL	Mission Essential Task List
MHS	Military Health System
MHSS	Military Health Services System
MILPERS	Military Personnel
MRDSS	Medical Readiness Decision Support System
MRL	Medical Resourcing Letter
MSP	Mission Support Plan
MTF	Military Treatment Facility
O&M	Operations and Maintenance
OCR	Office of Collateral Responsibility
OT	Operational Task
PAM	Preventive Aerospace Medicine
PCM	Primary Care Manager
PEC	Program Element Code
PHA	Preventive Health Assessment
PHCA	Preventive Health Care Assessment
PMT	Performance Measurement Tool

POM	Program Objective Memorandum
PPBS	Planning, Programming, Budgeting System
QM	Quality Management
RAPS	Resource Analysis and Planning System
RFP	Request for Proposal
S&T	Science and Technology
SRP	Strategic Resourcing Portfolio
TDY	Temporary Duty
TMIP	Theater Medical Information Program
TMSSC	Tri-Service Medical Systems Support Center
TPIPT	Technical Planning Integration Product Team
UM	Utilization Management
UTC	Unit Type Code
UTL	Universal Task List
WMD	Weapons of Mass Destruction
WRM	War Reserve Materiel
Y2K	Year 2000