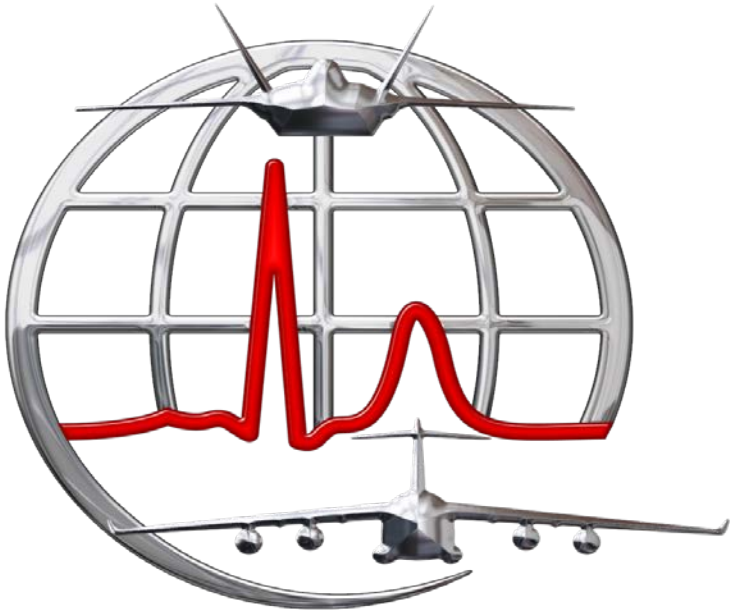
Headquarters Air Combat Command

Integrity - Service - Excellence

Operational Medical Readiness Squadron (OMRS)

21 Mar 19



Col Duncan 'SLASH' Hughes
ACC/SGP

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Disclosures

- **Data and opinions are mine alone and do not represent any official DoD or USAF policy.**

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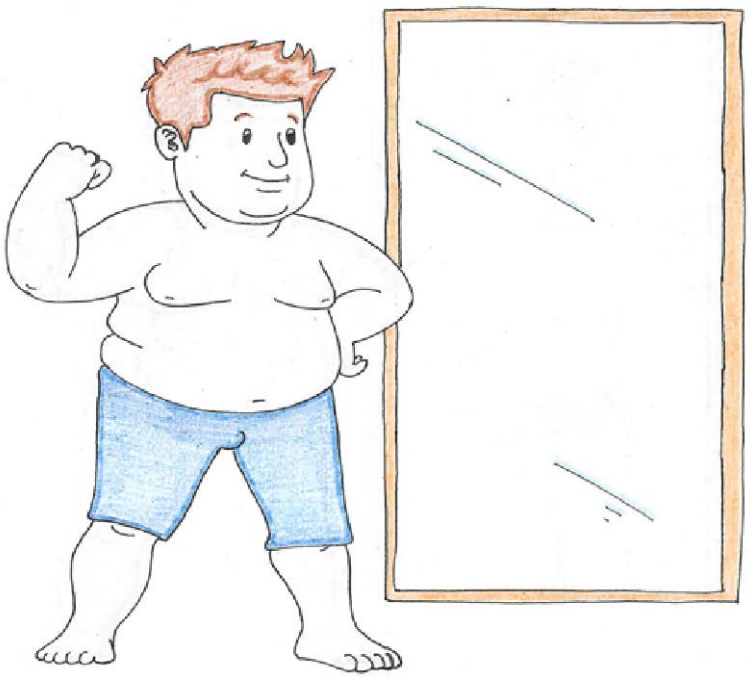
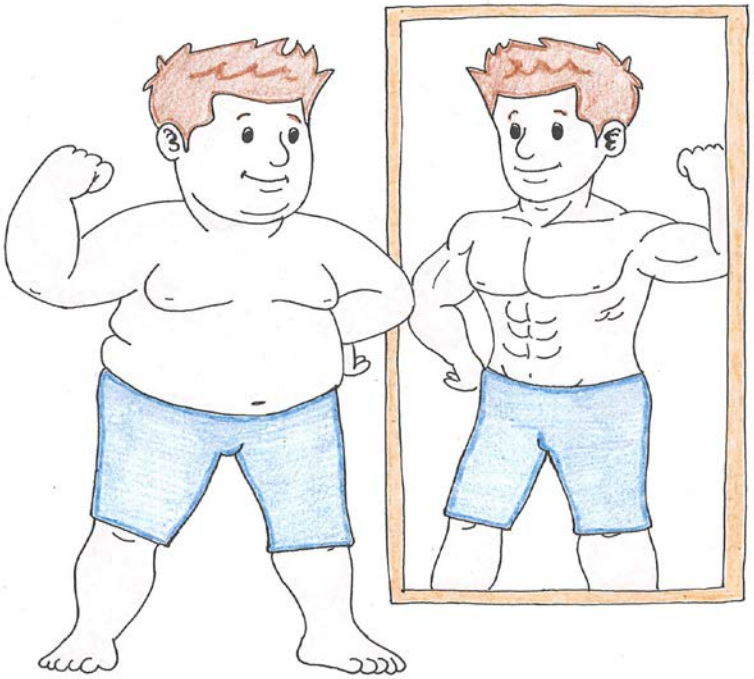
Where Are We?





So What's Wrong with the Status Quo?

- 6 FOMCs evaluated for IFC PE process
  - 10 IFC PE processes identified! 0 error free!
- AAA findings: 2014 audit 10 MTFs over 13 yr span:
  - 36% all profiles inaccurate
  - 58% profiles not reviewed during PHAs
  - 30% >365 day profiles w/ no DAWG rvw
  - 44% profiles cx deployment/PCS w/ no DAWG rvw
  - >50% MEBs exceeding 30 day timeline
  - 73% psych meds w/ no mobility restriction profile
  - > 1/3 all CC designees receiving ASIMs emailed profiles not authorized (i.e. HIPAA violations)

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So What's Wrong with the Status Quo?

- Any of this sound like a High Reliability Organization to you? Trusted Care?
- We should be REALLY good at this stuff! How long has the AFMS been doing profiles and deployment clearances? Our bread and butter?
- "Islands of excellence in a sea of mediocrity"
- Common cause for all of the above?
- Lack of standardization/training!
- So, why all the variability?
- Any disagreement a change is needed?

AF SG Question to Wing/CCs

- What do you think of when your hear “AF Medic”?
  - Pharmacy line is too long
  - Don’t know who to call
  - MTF doc taskings all get RECLAMA’ed
  - Takes forever to get an appointment
  - No one in MTF seems to know status of member availability

- Combat capability provider and/or human performance optimization were absent from their remarks!
- That is the voice of our customer!

ARE WE RELEVANT?

The Proposed 2 squadron AFMS MTF model

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How do we build Flt Med for all AD Service Members?

- The Mt. Home AFB model/pilot
  - Condensed 3 sqds (AMDS, MDSS, MDOS) into 2
  - An AD-only sqdn and a healthcare delivery squadron
  - 3 old sqdns split 50/50 to support 2 new sqdns
    - (one sqdn has bandwidth, the other is swamped)

- OAME summit WG believes this 2 sqdn model to be a HUGE headstart!
  - ACC only as pilot? All MTFs?

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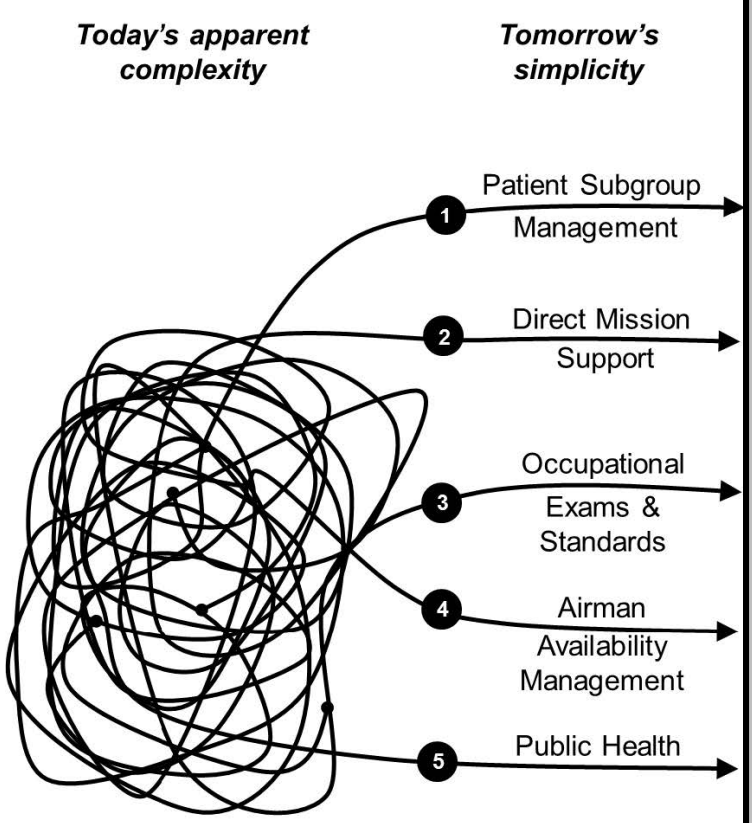
Disruptive Innovation: Fuel



Relationship with Line CCs

Understanding of Line Squadron Missions

--Profile and MEB Decisions

Management of "Down Airmen"

-- Equivalent of 1041 Meeting

-- Case Management

-- Floundering

Awareness of AFSCs about to Cause Mission Failure

Lines of Effort & Initial Results

ACTIVE DUTY CLINIC

- Individual Sq/CC engagement & rapport
- Increased PCM mission understanding
- Proactive "Down Amn" Management
- Weekly Mini DAWG & Daily Sick Call

45 Down SFS Amn:

32 Returned
5 MEB
8 Case Managed

K9 Handlers

MENTAL HEALTH OUTREACH

- Getting "out from behind the glass"
- Goal: Pre-establish Rapport & Earlier Intervention

Line CC Quotes:

"Complete Game Changer for My Mission"

70 Down EMS Amn:

51 Returned (78%)
Half "Hard Kills"

INTEGRATED OPERATIONAL SUPPORT

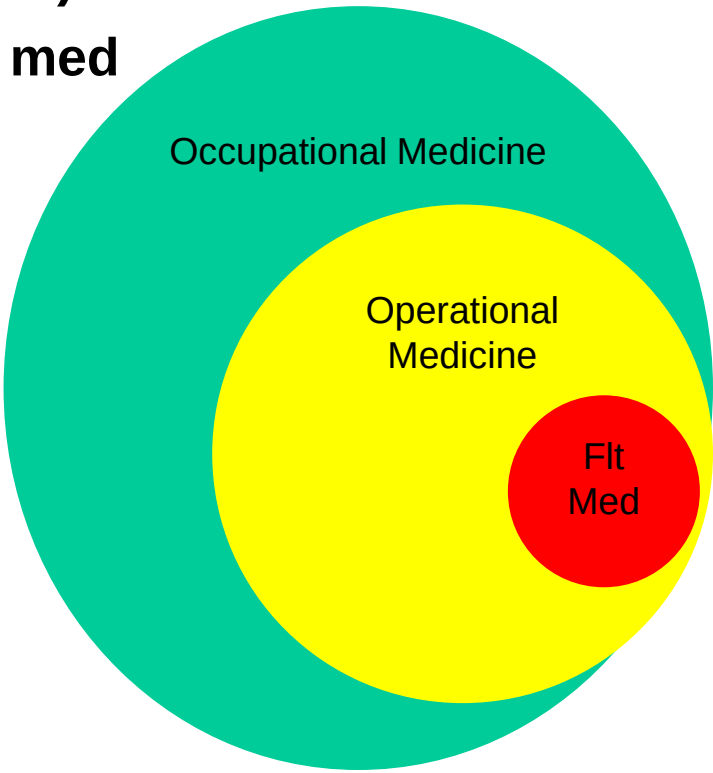
- Customized 3 Mo Sq Interventions (PT, HAWC, IOS)

TriCare Clinic

0.05 24 HR **2.03 FTR**

Not just a bigger Flt Med clinic!

- Not just Flight Medicine
  - Flt Med is small, niche subset of Occ Med
  - Occ Med not taught (in med school or AF)
  - Military applied Occ Med = Operational med
- Operational Medicine Definition



Operational Med Definition

DRAFT

- AFPD 48-1, Aerospace and Operational Medicine Enterprise (2018 Draft) “Operational Medicine is a **specialized medical community** led by Aerospace Medicine and Occupational Medicine specialists which addresses **military service as its own occupation** with a unique set of requirements, hazards, risks, controls, and interventions in support of military operational requirements, which advises military leaders on **medical fitness of personnel for employability, deployability, and assignability**, and which advises military leaders on the **integration of traditional medical capabilities into operational settings**.”
- AOME DRAFT: Operational medicine is medicine applied to the human weapon system to maximize readiness by developing, supporting, and reconstituting combat capability.

So, what should the ORMS look like?

- AD-only squadron
- Aligned under OG/CC or Wing/CC
  - Agent responsible for readiness should own this/be graded on it
  - Not re-discussion of ground already covered in dual-hat decision
- Empaneled by squadron
  - Not OPC in 1999 all over again
  - To build relationship/trust/SA requires time
- 50%/50% time split?
  - Percentage unimportant! Objectives, outcomes, reporting are!
- METALS specific to every AFSC
- 'Down Airmen' management processes
- What is an operational medicine provider? How are they trained?

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What is Readiness?

- New DoDI definition
- Is this commonly understood and applied?
- 95% ready does not equal IMR!
  - So why is IMR all we discuss with our Wing/CCs?
- What about readiness across the services?
  - Code 31 example
  - USAF = 12,000
  - USA = 600
  - USN = 400
- What percentage of 12,000 are truly Code 31 vs. short-term light duty only?

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What is Our Priority?

- Readiness!
- Readiness MUST trump everything else!
  - Force Development
  - Promotion
  - RVUs
  - Access
  - Continuity
  - Medical Model
  - Etc.

- When everything is important, nothing is!

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Relevance!

- **Spare Tire or Pit Crew?**

Our View of Airman Performance

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ENABLE – Optimization physical and cognitive health

ENHANCE – Creating new technologies/knowledge/approaches to enhance airman performance (and reduce errors)

SUSTAIN – Increase resilience and reduce injuries/illness

RECOVER – Rapid access to treat illness and provide aggressive rehab of injuries

GOAL – Optimize availability and job performance as efficiently as possible

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AOME Re-design

- **From**
  - MTF-centric svcs delivery
  - Reactive med model
  - PCM rate-limiting pro
  - Restricted comms w/unit leaders, commanders
  - Limited understanding of unit mission challenges
  - Wait in line, wait your turn construct
  - HEDIS and IMR focused
  - Occ health for a few
- **To**
  - In-unit svcs delivery
  - Proactive med model
  - No limits, all teammates deliver
  - Robust comms w/unit leaders, commanders
  - Clear understanding of unit mission
  - Amn up first construct
  - Deployability, Availability, and Employability focused
  - Occ health for everyone

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Questions