

U.S. Army-Baylor University
Graduate Program in Health Care Administration

A Policy Analysis of
U.S. Army Professional Filler System (PROFIS) Sourcing Management
At the Regional Medical Command Level in Support of an Expeditionary Army at War

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Abstract

The United States Army is involved in the Global War on Terrorism as well as in its own Transformation since 2001. The Great Plains Regional Medical Command (GPRMC) has been charged with providing medical support during this evolutionary time period. Unfortunately, due to the increase in mission tasking requirements over this extended period of time, this mission has become almost untenable. The increased deployment requirements being placed on active duty Professional Filler System (PROFIS) providers and the risks associated with reoccurring deployments, have increased the chance for GPRMC mission failure.

The purpose of this study was to analyze the current GPRMC policy concerning PROFIS management and the current expeditionary Army at war. This analysis will include an examination of the current PROFIS sourcing and tasking methodology, using PROFIS tasking data from FY 2004, and use that analysis to develop a methodology to accurately manage this resource within the region. The resulting process should reduce the turbulence in the distribution of PROFIS taskings and allow for regional visibility. The goal of this study is to have the resulting process be utilized not only by this Regional Medical Command (RMC), but by all RMCs in the U.S. Army Medical Command (MEDCOM).

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A Policy Analysis of
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Introduction

The United States of America is a nation at war. The United States (U.S.) Army is involved in the Global War on Terrorism (GWOT) as well as in its own transformation. The U.S. Army Medical Department (MEDCOM) has been charged with providing strategic medical support to all missions that include major military operations as well as contingency operations. As a subordinate unit to the MEDCOM, the Great Plains Regional Medical Command (GPRMC), continues that mission at an operational level. Unfortunately, due to the increase in mission requirements over an extended period of time, this mission has become almost untenable. The following introductory information is provided for those not necessarily familiar with the U.S. Army and its medical support system and is intended as a preface that is in no particular chronological order.

On September 11th, 2001, the way all Americans lived changed forever. No longer would the effects of terrorism be viewed from afar, as terrorist brought to America what the rest of the world was well aware of.

Good evening. Today, our fellow citizens, our way of life, our very freedom came under attack in a series of deliberate and deadly terrorist acts ... Thousands of lives were suddenly ended by evil, despicable acts of terror.... Immediately following the first attack, I implemented our government's emergency response plans. Our military is powerful, and it's prepared ... America and our friends and allies join with all those

who want peace and security in the world, and we stand together to win the war against terrorism. (Bush, 2001)

The terrorist acts of September 11th ushered in a new reality for Americans and the rest of the world. The continental United States of America (CONUS) would no longer be safe from terrorist attacks. Attacks that were common to countries such as Israel, Lebanon, and South Africa, could now occur on our homeland.

Terrorist fight a new type of unconventional war, one that has no clear protagonist or enemy nation-state, one that targets civilians as combatants, and one that fights without adherence to the Geneva Convention. It is a new type of war that America is forced to fight. As of the publishing of this project, America has been a nation at war for over four years, and currently there is no culmination point established.

On October 7th, 2001, the Armed Forces of the United States of America and its Allies, invaded the sovereign nation of Afghanistan in the first of two major theater conflicts. This major military operation, which was assigned the name Operation Enduring Freedom (OEF), had several operational objectives. Some of these objectives included “the destruction of terrorist training camps and infrastructure within Afghanistan, the capture of al Qaeda leaders, and the cessation of terrorist activities in Afghanistan” (Operation Enduring Freedom – Afghanistan, Global Security, 2004). As of the publishing of this project, OEF is on its sixth iteration or sixth major military troop assignment; some of the objectives have not been met; and there is currently no termination point or scheduled troop withdraw established for this operation.

On March 19th, 2003, the Armed Forces of the United States of America and its Allies, invaded the sovereign nation of Iraq, the second of two major theater conflicts.

This major military operation, which was assigned the name Operation Iraqi Freedom (OIF), had very distinct objectives as compared to those identified with OEF. The primary military objectives of OIF consisted of ending the regime of President Saddam Hussein; collecting intelligence and eliminating the threat of weapons of mass destruction; removal of any terrorists from the country and to collect intelligence related to terrorist networks; and create conditions to foster the transition to a representative self-government (Operation Iraqi Freedom, Global Security, 2004). As of the publishing of this project, OIF is on its third major military troop assignment; some of the objectives have not been met; and there is currently no termination point or scheduled troop withdraw established for this operation. General Peter J. Schoomaker, the current U.S. Army Chief of Staff, in *The Army, the Way Ahead*, published in 2004, discusses the concerns about the requirements and length of the Global War on Terrorism (GWOT):

Our Army is serving a Nation at war. This war requires that all elements of our national power be applied in a broad, unyielding, and relentless campaign. This campaign will not be short; it will require deep and enduring commitment. (*The Army, the Way Ahead, 2004, Foreword*)

Reiterating the sentiments of General Schoomaker in his address to the National Security Complex in 2004, President George W. Bush discussed the progress of the war:

America's determination to actively oppose the threats of our time was formed and fixed on September the 11th, 2001. On that day we saw the cruelty of the terrorists, and we glimpsed the future they intend for us. They intend to strike the United States to the limits of their power.... America has the resources and the strength and the

resolve to overcome this threat. We are waging a broad and unrelenting war against terror, and an active campaign against proliferation. We refuse to live in fear. We are making steady progress. (Bush, 2004)

While both major military conflicts were simultaneously occurring, the U.S. Army was attempting to continue its evolution process. This evolutionary process, identified as the Army Transformation, began in 1999 with then U.S. Army Chief of Staff, General Erik K. Shinseki. Designed to modernize the conventional U.S. Army in tactics, resources, and capabilities, the Army Transformation, required the same resources as those required for the current operations in the Middle East. According to the former U.S. Army Chief of Staff and Secretary of the Army in 2003:

While helping to fight the Global War on Terrorism, The Army is in the midst of a profound transformation. Readiness remains our constant imperative – today, tomorrow, and the day after. Transformation, therefore, advances on three broad axes: perpetuating The Army's legacy by maintaining today's readiness and dominance; bridging the operational gap with an Interim Force of Stryker Brigade Combat Teams; and fielding the Objective Force to fight and win conflicts in the years beyond this decade. (Shinseki & White, 2003)

According to the same publication, *The U.S. Army – At War and Transforming*, the Army is fundamentally changing the way it fights, and is attempting to create “a force more responsive to the strategic requirements of the Nation... a joint precision maneuver capability that can enter a theater at the time and place of our choosing, maneuver at will... and, if necessary, close with and destroy the enemy” (*The U.S. Army – At War and Transforming*, 2003, p. 1).

The Transformation is divided into three major phases or force levels; the Legacy Force, the Interim Force, and the Objective Force. Currently, the U.S. Army is transitioning from the Legacy Force to the Interim Force, but it is only a transition. The goal of Army Transformation is the Objective Force. According to *The U.S. Army – At War and Transforming, 2003*:

The Objective Force is an army designed from the bottom up around a single, networked, integrated [Command, Control, Communications, Computers, Intelligence, Surveillance, and Reconnaissance] (C4ISR) architecture that will link us to joint, interagency, and multi-national forces. It will be a rapidly deployable, mounted formation, seamlessly integrated into the joint force and capable of delivering decisive victory across the spectrum of military operations. (*The U.S. Army – At War and Transforming, 2003, p. 25*)

As of the publishing of this project, the Army Transformation remains in transition between the Legacy Force and the Interim Force. There is currently no pre-determined transition point to the Objective Force, nor is there an established schedule for the completion of this operation. The U.S. Army will remain in a constant state of transformation for the foreseeable future.

As the U.S. Army continues with major military operations, such as OEF and OIF, contingency missions, as well as the mission of continual transformation, the U.S. Army Medical Command (MEDCOM) maintains the mission of providing medical support to these missions. The MEDCOM maintains direct command authority over all Army medical activities (e.g. Medical Treatment Facilities (MTFs) such as Walter Reed Army Medical Center and operations in the U.S. and Europe, except field medical units). As a

part of direct command authority, the MEDCOM has the responsibility of identifying, initiating, implementing, and enforcing Headquarters, Department of the Army (HQDA) policies and procedures.

The MEDCOM maintains its command relationship with the medical activities through six Regional Medical Commands (RMCs) such as the North Atlantic Regional Medical Command (NARMC), and five Major Subordinate Commands (MSCs) such as the U.S. Army Veterinary Command (VETCOM). Appendix A illustrates the organizational structure and complexity of the MEDCOM. The MEDCOM is commanded by the Army Surgeon General. Operationally, the MEDCOM consists of more than 80 major medical activities such as the nine Army Medical Centers (MEDCENs), and 28 installation Medical Department Activities (MEDDACs) (Army Medicine, 2004).

As of September 2004, the personnel resources of the MEDCOM consist of approximately 27,000 Active Duty (AD) soldiers and 28,000 civilian employees (Army Medicine, 2004). Approximately 20,000 additional AD medical soldiers are in field units, which include the Professional Filler System (PROFIS) soldiers. The National Guard (ARNG) and Army Reserve (USAR) contribute an additional 30,000 medical soldiers, for a total of over 77,000 soldiers to accomplish the medical support mission. The MEDCOM currently fiscally manages a \$9.7 billion annual budget and provides care to more than 5 million beneficiaries, to include service members, retirees, and family members (Army Medicine, 2004).

As a subordinate command and control structure of the MEDCOM, the Great Plains Regional Medical Command (GPRMC) also has the responsibility of maintaining

medical support to the current missions of the U.S. Army. The GPRMC, located on Fort Sam Houston, Texas, maintains direct command authority and supervision of ten medical activities throughout the central United States. As a part of direct command authority, the GPRMC has the responsibility of identifying, initiating, implementing, and enforcing MEDCOM policies and procedures. As of 2004, the mission of the GPRMC is to have:

Regional command and control of a cost effective, multidisciplinary, customer focused, quality integrated health service system that supports the DoD Lead Agent concept; accountable to develop and sustain technical health care and leader skills in support of U.S. Army Medical Command (MEDCOM) and maintenance of a readiness posture in support of America's Army. The Great Plains Regional Medical Command is responsible for analyzing requirements, allocating resources, and assessing performance across the region. (Great Plains Regional Medical Command, 2004)

Appendix B illustrates the current organizational structure and complexity of the GPRMC. GPRMC is comprised of ten medical activities (MEDDACs) that consist of three medical centers (MEDCENs), five Army Community Hospitals (ACHs), and two Army Health Centers (AHCs). MEDCENs are able to provide complete inpatient and outpatient services as well as provide Graduate Medical Education (GME) programs. ACHs are able to provide limited inpatient and complete outpatient services, and the AHCs are capable of only outpatient services (Hallmark, 2003, p. 8).

GPRMC employs 10,371 military and civilian personnel, to include 2,348 contract workers and 456 volunteers. Of the total military personnel assigned to the GPRMC,

1,110 officers and enlisted soldiers are also assigned as Professional Filler System (PROFIS) designees (Great Plains Regional Medical Command, 2004). Service members that are assigned PROFIS positions are Active Duty AMEDD personnel in table of distributions and allowances units that are designated for reassignment or attachment to vacancies in MTOE Active Army units upon initiation of contingency deployment or mobilization. PROFIS providers provide treatment at MEDCOM fixed medical facilities on a routine basis, but are also required to fill active duty and reserve Forces Command (FORSCOM) deployable field medical unit positions during mobilization requirements. When these FORSCOM units deploy, they require augmentation to fill their ranks, thus the MEDCOM MTFs are left with manpower shortages (Hallmark, p. 10). According to the June 23, 2004 HQDA Regulation (AR) 601-142, Army Medical Department (AMEDD) Professional Filler System:

The Army Medical Department (AMEDD) Professional Filler System (PROFIS... designates qualified Active Army AMEDD personnel serving in table of distribution and allowances units to fill U.S. Army Forces Command (FORSCOM) early deploying modified table of organization and equipment (MTOE) units, U.S. Army Pacific (USARPAC), U.S. Army Europe and Seventh Army (USAREUR), and Eighth U.S. Army (EUSA) forward deployed units upon execution of an approved Joint Chiefs of Staff Operation Plan (OPLAN) or upon execution of a no-plan contingency operation. The objective of the PROFIS is to resource MTOE units to their required level of organization of identified AMEDD personnel, in accordance with the Army Mobilization, Operations, Planning and Execution System (AMOPES). (AR 601-142, 2004, p. 1)

In other words, the pre-Cold War PROFIS management system allows for military health care providers to be assigned to both medical treatment facilities during peacetime, and then re-assigned to deployable units during wartime or when contingency mission requirements dictated. The implications of this limited resource situation are obvious, *how can one person be assigned to two places?* PROFIS health care providers were deployed in support of OIF and OEF beginning in October 2001, and continue to augment troop rotations to the present date. In order to replace the PROFIS individual that is deployed, GPRMC must request a *backfill* or augmentation from either the Reserve Component, another RMC, or from MEDCOM. According to Captain J. Scott Hallmark, 2003, who performed a similar study on PROFIS backfill resource requirements:

GPRMC like all regional medical commands deals with temporary physician loss on a daily basis. Requirements for military readiness often drive the volatility through removal of physicians for Professional Filler System (PROFIS) taskings, backfill taskings (temporary reassignment of physicians to replace another lost physician), and augmentation (augmenting facilities capabilities on a temporary basis).

(Hallmark, 2003, p. 10)

Additionally, GPRMC is also required to support backfill and augmentation requests from within the region and from other regions as well, continuing to strain an already strained situation. That strained situation is made even more tenuous as the medical treatment facilities health care requirements continue to grow.

In FY 2004, GPRMC provided health care to an eligible beneficiary population of 639,048, an increase of nearly 40,000 beneficiaries from the previous fiscal year. On a

daily average, the GPRMC experiences 112 admissions, 372 occupied beds, 20 live births, 183 surgical procedures, 9,448 outpatient encounters, and 15,034 ordered prescriptions. As of July 15th, 2004, GPRMC has a bed capacity of 717 beds and a total bed mission of 1606 beds (Great Plains Regional Medical Command, 2004).

Financially, GPRMC has an annual operating budget of over \$837.2 million, to include \$76.8 million authorized for GWOT expenses. As of the publishing of this project, in fiscal year (FY) 2004 (October 1, 2003 through July 31, 2004), GPRMC has expended over \$797.6 million on healthcare and support activities (Great Plains Regional Medical Command Budget Office, 2004),

From September 11th, 2001 to the present, the U.S. Army has been involved in the ever increasing numbers of major military and contingency operations. The resource requirements for support to these operations have also been increasing. The increase in deployment requirements being placed on active duty health care providers such as U.S. Army physicians, nurses, and enlisted technicians, and the risks associated with these reoccurring deployments requirements, have increased the chance for GPRMC mission failure.

Conditions That Prompted the Study

As evidenced from the introduction, the U.S. Army of today is involved in a *Spectrum of Military Operations*. See Appendix E for a representation of the spectrum. These operations can range from humanitarian relief to major theater conflicts and can include multiple combinations of operations and missions. At any given time, a U.S. Army Medical Department (AMEDD) Regional Medical Command (RMC) can be required to support the vast spectrum and number of current missions and operations of

the expeditionary Army at war. Over the past four years, from FY2001 to the present, taskings, measured in mandays, has increased over 45% each fiscal year. A manday is a measure of availability to work and this dramatic increase is a clear indication that the GWOT and additional contingency mission taskings have resulted in significant resource demands from MEDCOM (Great Plains Regional Medical Command, 2004). Unfortunately, as the commander of the GPRMC stated, “the current process for supporting these tasking requirements for low density Military Occupational Specialty (MOSS) and Areas of Concentration (AOCs) [for officers and enlisted soldiers] is a *Road to Perdition* wrought with shortfalls from the current PROFIS management system” (Fox, personal communication, July 22, 2004). The identified shortfalls of the current PROFIS management system included:

- The lack of PROFIS tasking equity at the individual, MTF, and regional levels
- The difficulties with civilian backfill support contracts due to contract gaps and seams
- Sourcing and manning problems associated with MTF and installation geographic isolation

The problems with predictability and turbulence of the current PROFIS management system were identified as:

- No guarantee RC Backfill will be on-hand and qualified, which leads to the Inability of the MTFs to plan and coordinate according
- and the inability to contract in a timely manner which causes confusion and is not cost effective [further analysis required].

The current problems that exist and continue to build with the current system, that often requires MTF commanders to react by deploying their PROFIS physicians and then providing healthcare under crisis management with less than optimal staffing

(Hallmark, 2003, p. 10), prompted the MEDCOM and thus the GPRMC to react. That is why on June 15, 2004, MEDCOM released a Memorandum for MEDCOM RMC and MTF Commanders on the subject of PROFIS OIF/OEF Policy Guidance, signed by the Deputy Surgeon General. The guidance directed the RMC and MTF staffs to initiate PROFIS management procedures previously not implemented. The guidance was as follows:

In order to reduce the turmoil in deploying units, request you continue to review all Soldiers in PROFIS positions for current and future OIF/OEF operations who would fall into the categories below during their deployment period. Recommend that you minimize the number of PROFIS Soldiers who would have to redeploy before the end of their unit's deployment time period.

- a. Graduate Medical Education (GME) selection.
- b. Approved ETS/REFRAD [Released From Active Duty]/Retirements.
- c. Permanent Change of Station (PCS) Orders.
- d. Oral/Written Board/ Licensure Exams.
- e. Orders to attend AOC-producing School / LTHET [Long Term Health Education Training].
- f. Soldiers within their stabilization period from previous deployments or unaccompanied tours. Soldiers that are in their stabilization period can be placed in PROFIS positions, and deploy with approval of the first General Officer in the chain of command.

(MEDCOM Policy Memorandum, 2004, p. 1-2)

On August 4, 2004, the then acting U.S. Army Surgeon General (TSG) issued the requirement to the Commanding General, GPRMC that required the command to identify and analyze the current tasking requirements and shortfalls:

They [the staff of Office of the Surgeon General (OTSG)] did not get the fidelity that I think I need to assess how we are doing. I need you and your staff [the staff of the GPRMC] to lay down for me next [sic] Friday the 13th after working with MEDCOM... this will help me better understand the dynamic. (Kiley, personal communication, 2004)

Similar to other GPRMC staff analysis requirements that have previously been proposed, the commander of GPRMC did not want a simple discussion of personnel and resource numbers and limitations presented to the TSG. Instead, the commander of GPRMC directed his staff to develop a methodology that would provide answers to the identified shortfalls, but more importantly, possibly provide a methodology to the MEDCOM for the evolution of the PROFIS Management System.

Statement of the Problem or Question:

As previously stated, the increased deployment requirements being placed on active-duty PROFIS physicians, nurses, and enlisted technicians, and the risks associated with these recurring deployments, have increased the chance for GPRMC mission failure when providing health care to its beneficiaries. The questions that arise based on this increased risk include:

1. What is the acceptable means of maintaining visibility and managing the taskable inventory for deploying and future deployments of PROFIS personnel in low density, critical AOCs and MOSs?
2. What is the acceptable level of people that can be deployed from an MTF without affecting core missions as defined by the MTF commanders?

Purpose

The purpose of this study is to analyze the current GPRMC policy concerning PROFIS management and the current expeditionary Army at war. The primary objective of this study is to evaluate the current GPRMC PROFIS Management Policy and determine whether it is the most efficient and effective methodology in supporting OIF and OEF PROFIS tasking requirements. This analysis will include an examination of the current PROFIS sourcing and tasking methodology, using PROFIS tasking data from FY 2004, and use that analysis to develop a methodology to accurately manage this resource within the region. This study will introduce the passback analysis process which includes the development of three decision-support tools as an alternative to the current process. These proposed management tools will allow GPRMC to manage personnel tasking requirements in support of an expeditionary Army at war. The three management tools include the Sourcing Analysis Tool (for region and MTF), the By-Name Analysis (for each identified critical MOS or AOC), and the RMC Mandays Equity Analysis. A secondary objective, or another beneficial outcome, of this study would be that after the management tools are developed by the staff of the GPRMC, propose to apply them to other RMCs in the MEDCOM, creating standard policy guidance for PROFIS taskings.

Literature Review

This policy analysis would be remiss if a review of Army Regulation 601-142, Army Medical Department Professional Filler System (June 23, 2004), the personnel procurement regulation that provides policy guidance, was not considered. AR 601-142, which was recently updated from the previous May 15th, 2001 edition, provides

“guidelines to identify, qualify, train, and implement assignment procedures for Active Army Medical Department personnel in rounding out Active Army units using the Professional Filler System during military operations with or without mobilization authority” (AR 601-142, 2004, p. i). This regulation also assigns responsibilities and provides HQDA policy and procedures for managing the AMEDD PROFIS management system between no less than ten separate U.S. Army entities. Those entities include the TSG, the chief proponent for the regulation, the Deputy Chief of Staff, G-1 (Personnel), primarily responsible for identifying PROFIS command authorizations, Human Resources Command (HRC), responsible for designating PROFIS individuals to MTOE units, the Commanding General (CG), MEDCOM, responsible for a PROFIS automation system and validating PROFIS requirements, CG, U.S. Army Material Command, also responsible for validating PROFIS requirements, the CG, U.S. Forces Command (FORSCOM), responsible for validating requirements and plans, the Commanding Generals (CGs) of the other major commands (MACOMs), the MTOE unit commander, and the commander of the PROFIS filler (losing unit) (AR 601-142, 2004, p. 1-2,). This number of entities with responsibilities for the management of PROFIS providers highlights only one of the difficulties with the current management system.

Other difficulties with the current PROFIS management system that can be readily identified from AR 601-142 include the responsibility for PROFIS soldier readiness and training, the unidentified proponent to manage requirements in order to resource MTOE units to their required level of organization of identified AMEDD PROFIS personnel, and the requirement to assign PROFIS providers based on locality to the MTOE deployable unit. According to the AR 601-142, “PROFIS requirements for

contingency units will be filled from the staff of the local MTF closest to the gaining unit to the maximum extent possible" (p. 3, 2004). The final difficulty in supporting AR 601-142 is directly attributed to the vagueness concerning the substitutability of certain PROFIS MOS or AOC qualified personnel for PROFIS personnel with another MOS or AOCs. Refer to Figure 1 for an example of substitutability criteria and respective level of substitutability for AOC 61J General Surgeon.

Table 1 Substitutability criteria—Continued			
Branch (See note 1, which applies to all branches.)	Level of replacement	Primary specialty (See note 2.)	Substitute specialty (See note 3.)
	75%	61H Family Physician	62A Emergency Medicine 62B Field Surgeon
	100%	61J General Surgeon (See note 4.)	60P Pediatrician (Non-fellowship trained) 61K Thoracic Surgeon 61L Plastic Surgeon (only if General Surgery training was completed) 61W Peripheral Vascular Surgeon
	35%	61J General Surgeon (See note 4.)	60J Obstetrician/Gynecologist (only if Gynecology-Oncology fellowship training was completed) 60K Urologist (only if Urology-Oncology fellowship training was completed) 60K Urologist 60J Obstetrician/Gynecologist
	25%	61J General Surgeon	None
	15%	61J General Surgeon (See note 4.)	None
		61K Thoracic Surgeon	None
		61M Orthopedic Surgeon	None
		61N Flight Surgeon	None
	100%	61R Diagnostic Radiologist	60B Nuclear Medicine 61Q Therapeutic Radiologist (only if Diagnostic Radiology training was completed)
		61U Pathologist	None
		61W Peripheral Vascular Surgeon	None
		61Z Neurosurgeon	None
	50%	62A Emergency Physician	61H Family Physician
	100%	62B Field Surgeon (See note 2.)	Substitution Tier 1 60P Pediatrician (Non-fellowship trained) 61H Family Physician

Figure 1. Substitutability criteria and respective level of substitutability for AOC 61J, Medical Corps Officers. From AR 601-142, dated 23 June 2004.

The second regulation that is required to be reviewed in order to fully comprehend the current situation with PROFIS management is MEDCOM Regulation 40-43, MEDCOM Tasking Procedures, dated June 6, 2002. This regulation establishes policy and procedures, and defines responsibilities for tasking and obtaining support personnel from MEDCOM subordinate organizations, such as GPRMC and other RMCs. According to MEDCOM Regulation 40-43, request for personnel can be in support of any of the following:

- a. Professional Filler System (PROFIS). Consists of officers, warrant officers, and enlisted soldiers assigned to MEDCOM tables of distribution and allowances (TDA) units to fill U.S. Army Forces Command (FORSCOM) early deploying modified table(s) of organization and equipment (MTOE) units. The PROFIS also fills forward deployed units belonging to U.S. Army Pacific, U.S. Army Europe, U.S. Army Central Command, U.S. Army Southern Command, and Eighth U.S. Army upon execution of an approved Joint Chiefs of Staff (JCS) Operation Plan or upon execution of contingency operations. PROFIS personnel are assigned to designated position numbers in accordance with (IAW) AR 601-142.
- b. Augmentation. Commander-in-Chief (CINC)/MEDCOM validated mission requirement not covered by PROFIS or other manning document.
- c. Backfill. Validated but vacant TDA or table(s) of organization and equipment (TOE) requirements/authorizations requiring temporary or recurring fill.
- d. Administrative. Command-directed missions (e.g., funeral detail, local support) that do not fall into any other category. (MEDCOM Regulation 40-43, 2002, p. 1-2)

According to the regulation, there is a standard procedure for requesting PROFIS providers. PROFIS fill requests are sent from the deploying unit headquarters to FORSCOM who in turn sends it to MEDCOM. Once the request is received specifying the position number for each assigned individual requested for the event based upon the authorization document for each particular unit, MEDCOM will then authorize the requirement for the RMC to fill. Wrought with outdated and time consuming procedures, this regulation reads as if integrated information management and coordinating automation systems are yet to be implemented, which it later states:

The request for PROFIS arrives at HQ MEDCOM Current Operations Branch (MCOP-0) via [AMEDD Resource Tasking System] ARTS, email, official message traffic, or fax. [Clinical Services Division] CSD is not normally involved in PROFIS requests. The desk officer prepares the tasking record in ARTS and an electronic notification is sent to the RMC, MSC, or command responsible for filling the PROFIS position(s) requested. A separate message is prepared for each requirement if the tasking is directed for two or more RMCs/MSCs. The desk officer informs the Personnel Operations Branch, Deputy Chief of Staff for Personnel (DCSPER), MEDCOM if the PROFIS position is unfilled. DCSPER is responsible for notifying a MEDCOM organization to fill a vacant position. Responsibility for filling a position may be transferred from one RMC/MS to another depending on the availability of the AOC/MOS within each command. These requirements are normally transferred to another RMC/MS based on availability of certain AOCs/MOSs at the time of a change in the TDA/MTOE or to support optimization. (MEDCOM Regulation 40-43, 2002, p. 3)

Another issue with the current MEDCOM tasking policy is the ability of a subordinate command to reclama a given tasking, or the ability of a subordinate unit to reclaim a tasking requirement from a higher headquarters, in order for that subordinate unit to be relieved of that particular tasking responsibility. Even if the subordinate unit, such as the GPRMC, reclaims a particular PROFIS tasking for whatever reason, according to the MEDCOM regulation 40-43, it can still be required to fulfill the tasking, nonetheless:

- c. Submitted reclaims do not automatically relieve RMC/MS commanders of the tasking. Taskings are valid until relieved. If justified and

approved, Current Operations Branch will notify the RMC/MSC by email and telephonic response.

d. If the reclama is denied, the Current Operations Branch will notify the RMC/MSC operations regarding the disposition of the reclama within 5 working days. RMCs/MSCs must in turn notify subordinate organization that same day.

(MEDCOM Regulation 40-43, 2002, p. 9)

While this regulation obviously requires further analysis, review, and updating, it is not the purpose of this paper to recommend disposal or complete revision. Military leaders and commanders routinely are required to fulfill mission requirements without adequate policy and regulation information. Due to the ambiguity of both HQDA and MEDCOM regulations, RMC, unit, and medical activity commanders and staffs are usually required to derive policy and procedure information from orders that are published from higher headquarters.

For that purpose a review of non-classified MEDCOM Operations Order (OPORD) is warranted. The following example of a portion of unclassified published MEDCOM OPORD is MEDCOM Operations Order for the Support of Operation Iraqi Freedom (OIF2) and Operation Enduring Freedom (OEF5) Supporting the Global War On Terrorism (GWOT) (UNCLASSIFIED), originally generated on March 31, 2004, clearly states that tasking missions, in particular PROFIS taskings will continue indefinitely:

1a. (1) [UNCLASSIFIED] SITUATION: For Official Use Only (FOUO) The Army is at war and will continue to support the Global War on Terrorism (GWOT) in the foreseeable future. The Army is preparing to enter one of the most demanding

periods in its modern history as it deploys forces to support Operation Iraqi Freedom 2 (OIF2) and Operation Enduring Freedom 5 (OEF5). Eight of ten active component (AC) divisions will be on the move between January and May 2004. Tens of thousands of reserve component (RC) soldiers will mobilize in addition to the approximately 130,000 RC soldiers currently serving on active duty. The Army rotation policy plans for Army forces currently in place in the theaters to redeploy to their home locations following deployment and arrival of replacement forces from the U.S. and coalition forces.

1a. (2). [UNCLASSIFIED] SITUATION. The MEDCOM will be prepared to provide assistance to rotational forces scheduled to deploy to the theater of operations to ensure units meet readiness and validation criteria prior to deployment.

2. [UNCLASSIFIED] MISSION. The MEDCOM will provide mobilization and deployment support to all Components of the Army during the GWOT to ensure medical readiness and deployment criteria and standards are met. Assistance will be provided at Army installations and the RC unit's home station in the areas of medical logistics, personnel, training, individual medical readiness, quality assurance, medical soldier readiness processing, and unit validation. (MEDCOM Operations Order for the Support of OIF2 and OEF5 (UNCLASSIFIED), 2004, p. 1-2)

Although this non-classified MEDCOM OPORD clearly identifies the tasking requirements, it marginalizes the more important issue of *how* the subordinate units are to accomplish this mission without adequate resources and the inability to reclama taskings. Looking at the overall picture, prior to the publishing of this MEDCOM OPORD, the MEDCOM perceived the situation with the scarcity of certain PROFIS

providers and their continual redeployment as less than significant. In fact, due to the ambiguity in AR 601-142 concerning management responsibilities of PROFIS providers, two controversial Office of the Deputy Chief of Staff, Personnel (ODCSPER) policies were previously implemented in 1999 and significantly impacted the current PROFIS management situation.

In an official statement to the U.S. Congress, then U.S. Army Surgeon General, lauds the current efforts of the PROFIS management system and the RMCs ability to maintain support. In the statement before the Senate Appropriations Committee (Defense) Second Session 108th Congress, April 28, 2004, The Surgeon General United States Army discusses:

The Army Medical Department has been very successful in supporting contingency operations and the Global War on Terrorism (GWOT) by using a Professional Filler System or PROFIS to man early deploying units. Our PROFIS system takes AMEDD personnel from our fixed facilities and assigns them to deploying units who do not have their full complement of medical personnel. Medical Command (MEDCOM) is currently prepared to provide [sic] 5,787 PROFIS personnel to deploying units. Of the 5,787: 1,177 are Active Component personnel slated against spaces in Reserve units and the remaining 4,610 personnel are PROFIS to active component units or multi-component units. We currently have 839 PROFIS deployed to support OIF and OEF and all the while, our Regional Medical Commands are still maintaining their baseline medical care workload despite personnel being deployed. (28 April 2004, p. 1)

In the same 2004 discussion to Congress, The Surgeon General also discusses the implications of the 2003 Reserve Component (RC), which constitutes either USAR or ARNG soldiers, 90-Day Rotation Policy. This policy, based on post Operation Desert Storm and Desert Shield (ODSS) studies, further restricts the already limited AMEDD PROFIS resources by limiting the amount of PROFIS and PROFIS backfill deployment time:

From late 1995 to early 1998, one third of RC physicians who deployed to the Balkans left the USAR due to the 270 day length of rotations. Recruitment and replacement of these physicians was difficult. The loss resulted in personnel shortfalls of physicians, dentists, and nurse anesthetists. A 1996 survey of 835 RC physicians found that 81% could be mobilized up to 90 days without serious impact to their civilian practice; however, extended deployments beyond 90 days had a severe negative impact. In late 1999 the Army conducted a pilot program deploying RC physicians, dentists, and nurse anesthetists for 90 day rotations. In 2001 a follow-on survey was conducted which validated the finding that RC physicians, dentists, and nurse anesthetists could deploy for that period of time without adversely affecting their private practice. The Army rotation policy was modified in early 2003 to provide for 90 day "Boots on the Ground" or BOG rotations either in the continental United States or outside of the continental United States for these specialties. Many medical professionals want the opportunity to serve their country. This policy enables them to stay with us in the Reserves and contribute to the mission. (28 April 2004, p. 1)

The implications of the RC 90-day policy have yet to be fully analyzed and properly studied, but this non-MEDCOM, Office of the Deputy Chief of Staff, Personnel (ODCSPER), U.S. Army, policy pales in comparison to the previously implemented, recently updated ODSCPER policy concerning Active Component (AC) 180-Day PROFIS/IA rotation policy.

The ODCSPER for the U.S. Army, Personnel Programming Guidance (PPG), dated 20 April 2005, has proposed:

Active Component (AC) 180-Day PROFIS/IA [Individual Augmentation] Rotation Policy:

(a) The following Medical, Dental and Nursing Specialties serving in PROFIS assignments with EAD [Echelons Above Division] units, Level 3 Medical Treatment Facilities (MTF) and Forward Surgical Teams (FST) will be replaced at/around 180-days (reference ALARACT Message 108-2004, Subject: The 180-day AMEDD PROFIS Rotation Policy):

e60B	60K	60Q	61A	61J	61R	63E
60F	60L	60R	61B	61K	61U	63F
60G	60M	60S	61C	61L	61W	63N
60H (Intervent)	60N	60T	61D	61M	61Z	66F
60J	60P (Subspec)	60V	61G	61P	63D	

[Figure 2. PROFIS Authorized 180-day Assignments per AOC. From ODCSPER for the U.S. Army, Personnel Programming Guidance (PPG), 20 April 2005. For description of AOCs please see Appendix F]

(b) The policy pertains to COMPO 1 [Active Component] Personnel and does not change the Army Medical Department Reserve Components 90-day Rotation Policy dated 2 OCT 03. (ODCSPER for the U.S. Army, Personnel Programming Guidance (PPG), 20 April 2005)

Similar to the RC 90-Day Rotation Policy, this 180-Day Rotation Policy further restricts the already limited AMEDD PROFIS resources, and although the implications have been considered, the full ramifications have yet to be fully recognized.

Some of the ramifications of the numerous and sometimes conflicting PROFIS management policies have been identified in pre and post organizational unit OEF and OIF deployment After Action Reviews (AARs). AARs are a structured review process that allows training participants to discover for themselves what happened, why it happened, and how it can be done better, it is a learning tool that is utilized throughout the Department of Defense (DOD) and the U.S. Army. The following reviews of AARs and AAR comments are only a sample of the numerous accounts concerning the operational tempo (OPTEMPO), deployment, and management of PROFIS providers.

In the U.S. Army OPTEMPO Study by the RAND Arroyo Center for Lessons Learned (2001) the origins for the justification for the 90 and 180-day rotation policies are presented. According to the 2001 Rand Arroyo Center Study:

Over the past decade, numerous observers have expressed concerns that the U.S. armed forces have been stressed by the increased pace of overseas operations. Usually centered on a discussion of "increased tempo," these concerns focus on deployments and their possible effects on force readiness and morale ... Those issues continue as topics of debate today; in fact, continuing public and

congressional interest recently resulted in legislation requiring additional compensation for military personnel who are deployed for extensive periods. (U.S. Army OPTEMPO Study, 2001, p. xi)

Primarily concerned with the increase of the overall OPTEMPO, this HQDA commissioned study could not foresee the future deployment requirements associated with the GWOT. Once GWOT was in progress, though, the difficulties associated with the OPTEMPO and PROFIS resource requirements became evident. In October 2003, in the first of many AMEDD AAR / Rehearsal of Command (ROC) Drill conferences concerning OIF, Commanding General/Commandant, AMEDD Center and School, Fort Sam Houston, Texas summarized the current situation:

[The] Solution doesn't come just from education or training PROFIS better. Can we institutionalize how we did things on the fly? Filling the gaps in organization, doctrine, training, etc. ... let's not have to rewrite next time how we filled the gaps this time out. We need to build in sustainment process. We need to figure out ways as well on how to learn, how to training [sic]. Remember that we must account for the facts of life--- we can never put everything in the schoolhouse, and doctrine and policy will not answer every question. Hopefully, next time the lessons learned, issues etc. from OIF will be carried further than now. (U.S. Army OPTEMPO Study, 2003, p. 1)

Unfortunately, the lessons learned from that AAR would not change policy, nor would the comments prevent similar occurrences regarding PROFIS management from happening again. In more recent AARs published in the AMEDD publication, Medical Soldiers OUTLOOK, the comments concerning PROFIS management and deployment

taskings become more specific and blunt. From the Fall, 2004 Medical Soldiers OUTLOOK report, *Lessons Learned AAR from the 3rd Armored Cavalry Regiment (ACR)*:

ISSUE (PROFIS): Many don't want to be there. None want to deploy and do nothing. Their skills are at risk. Some PROFIS left Iraq for legitimate reasons (PCS [Permanent Change of Station], ETS [Estimates Time of Separation], retire, fellowship training); others skated out permanently for temporary issues such as board exams. Some argue that continuity is needed, keeping the same PROFIS for training and duration of the deployments. For some positions that might be true, but in general, the units don't listen to the PROFIS anyway. It happened in the ACR and it happened when I was with the CSH. RECOMMENDATION: Establish a rotation program. PROFIS need to rotate at 180 days. Some specialties may need to rotate to/from the CSH. Year-plus rotations of physicians into positions in which they do little will cause more physicians to leave the service. Allow docs to leave, take boards and CME [Continuing Medical Education], and return. (Medical Soldiers OUTLOOK, Fall 2004, p.5)

From the Winter, 2004 report, *After Action Report on Deployment to Iraq: Role of the Combat Support Hospital*:

ISSUE (PROFIS): The professional filler system did not work smoothly and has some shortcomings. The personnel management system operated by MEDCOM does not seem to know the actual personnel needs of the units in theater. Unexpected replacement surgeons arrived at units before the redeployment dates of physicians already on station. The relieved physicians were not allowed to return to

CONUS and the extra personnel are now not available for later deployment echelons where shortages exist. It is a very wasteful and inefficient use of professional resources ... We need to practice and train as we fight which means emphasizing rotations at civilian trauma centers for ALL surgeons and aligning our major military medical centers with civilian trauma networks. The use of surgical subspecialists such as gynecologists, urologists, thoracic surgeons, and plastic surgeons can only be justified if they spend some time rotating on general surgery services in peacetime to maintain these critical skills. Many PROFIS personnel never train with their units in peacetime. This problem, as well as cross leveling, meant that many personnel had little knowledge or understanding of their wartime units and jobs and met for the very first time when they arrived at the mobilization station. Varying lengths of deployments for augmentees vs [sic] PROFIS providers, and for active duty vs reservists, caused morale problems and some angst. (Unit members should train together in peacetime and with rare exceptions, deploy together as a group and redeploy at the same time. More frequent 6 month deployments would be better tolerated by professional staff than 1 year deployments because of concerns about loss of skills and not practicing one's primary specialty.).

(Medical Soldiers OUTLOOK, Winter 2004, p. 4)

With the increase in PROFIS taskings and mission requirements over an extended period of time, the ability of organizational units such as the GPRMC to support the mission has become almost untenable, or as previously stated, "It is a very wasteful and inefficient use of professional resources" (Medical Soldiers OUTLOOK, Fall 2004, p. 5).

The increased deployment requirements being placed on active duty PROFIS

physicians, nurses, and enlisted technicians, and the risks associated with these reoccurring deployments, have increased the chance for GPRMC mission failure when providing health care to its beneficiaries. "Failure of the medical mission for the GPRMC is neither acceptable nor negotiable; neither is anything less than excellence" (Fox, personal communication to the GPRMC Staff, July 22, 2004).

Although an overwhelming amount of literature has been collected citing the current shortcomings of the current PROFIS system, very little has been published citing solutions. One such U.S. Army – Baylor University study that attempted to address one aspect of the multiple problems relating to PROFIS management concerned the implications of TRICARE (CHAMPUS) on unit medical readiness. In this study designated by the MEDCOM, Mulkey, Hassell and LaFrance (2004), analyzed the requirements of backfilling a TDA medical treatment facility utilizing two options. The first option was the use of Reserve Component TDA backfill, the current policy, and the second option was the use of a TRICARE (CHAMPUS) Managed Care Support Contract (MCSC), an emerging policy. The two options were compared using a hypothetical deployment scenario and evaluated using three criteria, effectiveness, efficiency, and operational expenses.

Methods and Procedures

The methods and procedures for this project can be separated into two distinctive components, the presentation of the proposed GPRMC Passback Methodology and the Policy Analysis or comparison of the two systems. The Passback Methodology was developed at the GPRMC to fulfill the requirements set forth by

MEDCOM using the Military Decision Making Process as a template. The process included three phases, the initial management tool development phase, the decision brief phase, and the finally, the MEDCOM ROC Drill phase. The Policy Analysis portion of this project utilizes the text by Eugene Bardach's (1996) *The Eight-Step Path of Policy Analysis - A Handbook for Practice* as a framework for the analysis.

Development of the GPRMC Passback Methodology

The first part of the methods and procedures is a presentation of the proposed GPRMC Passback Methodology, also referred to as the *nadir methodology* because of the uncommon military use of terminology and the vital aspect it contributes to the process. This methodology was originally developed by the GPRMC CoS (Chief of Staff) and the Assistant Chief of Staff for Clinical Operations (ACofS, CLINOPS) after given a directive by the GPRMC Commanding General in July 2004.

What started as a time-consuming review of all PROFIS tasking requirements using a simple Microsoft Excel spreadsheets and data derived from the U.S. Army Standard Installation / Division Personnel System (SIDPERS) and the AMEDD Medical Operational Data Systems (MODS), quickly became the Passback Methodology. Once the initial foundation using the database created by GPRMC ACofS, CLINOPS was completed, a *datacall*, or request for real-time facility specific resource information, was initiated by the Clinical Operations (CLINOPS) staff to the MTFs and MEDDACs within the GRPMC.

After the data collection from the regional organizations was complete, a comparison and analysis to the other databases, SIDPERS and MODS, was completed. This *scrub* of databases ensured the most accurate and up to date information from

subordinate units within the region as well as higher echelon organizations outside of the region. After the data was collected and compared, it was further compared to tasking requirements being derived from OIF and OEF. The Assistant Chief of Staff for Operations (ACofS, OPS) and his staff provided the tasking information for comparison. See Appendix I for an example of the GRPMC compilation of the data from each organization and initial analysis.

During the initial analysis phase, the GPRMC CoS and the ACofS, CLINOPS made an observation that certain PROFIS provider AOCs and MOSs had a significant amount of required taskings as compared to the other PROFIS provider AOCs and MOSs. Of the 38 Medical Corps AOCs, the 16 Nurse and Medical Service Corps AOCs, and the hundreds of Enlisted MOSs, only 15 AOCs and MOSs were determined to have a significant reoccurring deployment requirements. Those low density and high criticality AOCs and MOSs are listed in Table 1 on the following page.

The next step in the initial analysis phase would be to determine the baseline value for mission success for further comparison. The nadir value, or mission

Table 1. AOCs and MOSs Identified as Low Density / High Criticality

Corps	AOC/MOS	Description
Medical	60J	Obstetricians and Gynecologists
	60N	Anesthesiologist
	60W	Psychologist
	61J	General Surgeon
	61M	Orthopedist
	61R	Radiologist
	62A	Emergency Room Physician
Nurse	66E	Operating Room Nurse
	66F	Certified Registered Nurse Anesthesiologist
	66HM5	Emergency Room Nurse
	66H8A	Intensive Care Unit Nurse
Enlisted	91D	Operating Room Technician
	91V	Respiratory Technician
	91WM6	Licensed Practical Nurse
	91X	Behavioral Health Technician

accomplishment baseline value, should be already determined by the organizational Modified Table of Organization and Equipment (MTOE), Table of Distribution and Allowances (TDA) authorization documents, the Officer Distribution Plan (ODP), and the Enlisted Distribution Target Model (EDTM). According to the 2003-2004 Edition of *How the Army Runs – A Senior Leader Reference Handbook* the ODP is:

Distribution planning. The officer distribution planners and managers at PERSCOM are influenced by three principal factors in doing their job: officer assets (inventory), authorizations, and priorities. All three are in a constant state of change. Therefore, there is a need for a master distribution plan that will ensure that all commands, agencies, and activities receive, according to priority, an appropriate share of the available officer assets/inventory. The foundation of

this master plan is a management tool known as the Officer Distribution Plan (ODP). The ODP brings assets/ inventory, authorizations, and priorities into balance and is one of the Army's most important documents for officer distribution planning. (*How the Army Runs*, 2003-2004 Edition, p. 304)

According to the 2003-2004 Edition of *How the Army Runs – A Senior Leader Reference Handbook* the EDTM is:

(1) The EDTM is an automated system which creates enlisted distribution targets by MOS, grade and UIC [Unit Identification Code]. The model fills each UIC reflected in the PMAD [Personnel Management Authorization Document] with projected available inventory from the MOSLS [Military Occupational Specialty Level System] in accordance with the DCS, G-1 distribution policy. This results in an optimum distribution of scarce resources consistent with distribution policy fill priorities. The EDTM constrains the assignment process to coincide with the projected OS [Operating Strength] targets. It represents the assets the Army realistically expects to be available for distribution. (*How the Army Runs*, 2003-2004 Edition, p. 304)

Simply stated, the MTOE and TDA tell *what and where* personnel positions are allowed, and the ODP and EDTM tell *who* fills those positions. Unfortunately, ask any AMEDD commander or human resource manager, and they will tell you that their units are never filled to the authorization document level. Also, during peacetime, the personnel inventory simply does not exist in order for the distribution plans to be capable to fill the units adequately. It is not that these numbers are fictitious or arbitrary; they simply are

based on a strategic war plan that is designed to fight two major theater conflicts simultaneously. The numbers are best used for planning purposes only.

The rationale behind the nadir value is that the authorization documents do not reflect the actual ability of an organization to complete its missions, and that an actual nadir value would be organization specific and therefore take into account several factors that are distinctive to that unit. These considerations focus primarily on care to the AD population but for the most part do not include care to the non-AD population. These considerations were identified by the staff and approved by the CG, GPRMC. These considerations were identified as a means for establishing the minimum baseline for AD care requirements for each MTF in the region. The considerations included: 1) the sourcing analysis objective is support to Warfighter, such as priority missions that included PROFIS, Soldier Readiness Program (SRP), Medical Hold-Over (MHO) and Medical Evaluation Boards (MEB), 2) the sourcing analysis focus is on Active Duty care, for example, specialty care such as trauma and burns, 3) Graduate Medical Education will be included in the considerations, and 4) Phase II AOC/MOS Training will be included in the considerations.

According to the GPRMC ACoS, CLINOPS, 2004, the development of the nadir value also took into account these considerations, some of which are listed below:

- Additional Considerations: The nadir is that level at which the MTFs cannot work more than the length of time it takes to get backfill support to the MTF (a week or less) without closing some service or services. Attempts to make the nadir amount determination any more objective, without taking into account particular individual and MTF situations, may not be accurate and

reliable. The nadir amount is dependent upon the “collective senses” within the RMC of what is sustainable and what is not. This idea of sustainability is dependent on firm guidance from the RMC CG.

- Specialty Care Factors: The usual 1200 [beneficiaries] / [Primary Care Manager] PCM standard is not valid because the GPRMC does not have primary care specialties (60J OB-GYN considered specialty for these purposes) in the low density, high criticality AOC/MOSs. In the GPRMC, there are relatively standard civilian numbers, for example: one general surgeon per 10,000 patients, but that tends to be for all-comers rather than the relatively young and healthy population that makes up our AD. Therefore, the determination of the nadir is dependant upon several other factors, and when the nadir amounts are minimized, the nadir value tends to be based more on coverage and human endurance factors rather than strictly formulaic.
- Additional Specialty Care Factors: Emergency medicine at GPRMC MTFs (BAMC, WBAMC, and DACH) requires separate considerations in reference to coverage, as does Residency Review Committee requirements and comments (our ED [Emergency Department] (62A). Training sites have received warning letters when the MTFs, as required, report changes in staffing due to deployments that reduce the personnel levels the MTFs feel are needed for training (regardless of annual in-service examination performance). (Carter, personal communication, 2004)

Once the general guidance on how to determine the nadir value for a specific AOC or MOS for a specific organization was approved by the GPRMC CG and staff, the information was disseminated and another datacall was initiated. Nadir values were then collected for each of the 15 low density, high criticality AOC / MOSs and a spreadsheet was developed. Table 2 represents the first attempt at combining all the nadir value data utilizing Microsoft Excel spreadsheets for the GPRMC.

Table 2. Nadir Assessment for Great Plains Regional Medical Command

MTF

Critical AOC/MOS		BAMC	WBAMC	EACH	DACH	RWBACH	MACH	GLWACH	BJACH	IACH	RACH	GPRMC Nadir	GPRMC 05 ODP
	AOC												
	60J	5	4	3	7	0	1	3	3	2	2	30	46
	60N	6	3	1	5	0	0	1	1	0	0	17	24
	60W	3	4	1	3	0	1	1	2	0	1	16	17
	61J	4	6	3	3	1	0	2	2	0	2	23	38
	61M	8	6	2	5	1	1	2	2	0	1	28	38
	61R	11	4	1	5	0	1	2	1	0	1	26	32
	62A	7	5	3	10	0	0	3	3	0	1	32	47
	66E	9	9	2	9	2	1	4	4	4	3	47	74
	66F	5	6	0	10	1	2	4	4	3	2	37	48
	66HM5	8	7	0	6	0	0	3	2	1	2	29	30
	66H8A	52	18	0	5	0	0	4	2	2	3	86	105
	91D	37	23	16	26	3	3	16	11	7	8	150	
	91V	18	8	2	4	0	0	4	4	4	4	48	
	91WM6	47	43	3	25	4	2	24	11	8	8	175	
	91X	9	16	6	17	5	1	8	5	4	9	80	

UNCLASSIFIED

Table 3 represents the first attempt at combining all the data utilizing Microsoft Excel spreadsheets for the Darnell Army Community Hospital. Table 3 is presented on the following page.

Table 3. Nadir Analysis for Darnell Army Community Hospital, Fort Hood, Texas

DACH	Assigned Military					Assigned Civilian		Total	FY01 Baseline	Minimum you must have on hand to conduct AD health care		
AOC/MOS	AD (includes deployed)	OJT	Deployed	USAR	ARNG	GS	Contract			NADIR (total mil and civ)	NADIR (military only)	05 ODP
60J	7		1	0	0	0	2	9	14	9	7	11
60N	5		0	0	0	0	0	5	3	5	4	4
60W	4		0	0	0	0	0	4	4	3	2	2
61J	5		1	0	0	0	1	6	5	4	3	6
61M	7		1	0	0	0	0	7	5	5	5	6
61R	5		0	0	0	0	2	7	5	7	5	5
62A	13		3	0	0	0	4	17	31	14	10	13
66E	9		1	2	0	5	5	21	16	19	9	11
66F	11		1	0	0	0	11	22	13	21	10	9
66HM5	1	+ 5 66H	0	1	0	6	8	20	21	20	4	4
66H8A	4	+ 3 66H	3	3	0	10	1	18	12	18	5	6
91D	27		0	1	0	1	9	38	39	37	26	
91V	4		0	0	0	9	1	14	15	14	4	
91WM6	25		5	2	0	67	100	194	93	190	25	
91X	17		0	0	0	5	0	22	35	22	17	

NOTE: "****" trained on site and functional in AOC.

as of 16 Jul 04

After the initial data collection, the determination of the nadir values, the next step was to further develop the methodology in order to assist the GPRMC in predicting shortfalls and inconsistencies, and developing the initial spreadsheet into an actual decision support management tool. This was accomplished by the staff work of the author and the other GPRMC Staff. After several iterations, Table 4 represents the final attempt at combining all the data utilizing Microsoft Excel spreadsheets for Brooke Army Medical Center (BAMC), Fort Sam Houston, Texas. The Sourcing Analysis for the entire GPRMC will be presented in the Results section of this study. Table 4 represents the first attempt at combining all the data utilizing Microsoft Excel spreadsheets as a Sourcing Analysis Model for Brooke Army Medical Center and is presented on the following page.

Table 4. Sourcing Analysis Model for Brooke Army Medical Center

Report as of: 30-Aug-04

FT Sam Houston		Military				Civilian	Mission Support	Nadir		Taskable/Deployable Analysis					Mission Analysis						
Corps	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support			o. AC/RC Available to Cross Level in RMC			
																		A	C1	C2	
Medical	60J	8	1	4	0	1	2	7	6	8	1	1	1	3	2	1	0	-1			
	60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	0	0	1			
	60W	4	0	0	0	1	0	3	2	5	2	2	2	4	0	0	0	2			
	61J	6	0	5	0	1	3	5	4	7	2	2	2	1	1	0	2	1			
	61M	10	0	8	0	0	3	6	6	10	4	4	4	2	2	0	1	2			
	61R	13	0	7	0	9	1	16	11	22	6	2	2	6	1	0	0	1			
62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0	0	0				
Nurse	66E	26	4	10	5	9	5	14	1	36	22	26	22	12	5	0	0	17			
	66F	4	1	2	0	7	1	5	1	10	5	2	2	1	1	0	0	1			
	66HM5	13	2	3	1	13	3	12	2	25	13	10	10	8	3	0	0	7			
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	0	0	18			
Enlisted	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	0	0	11			
	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	0	0	1			
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	0	7	4			
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	1	0	0	2			

A Accept
 C1 Cross Level (Nadir)
 C2 Cross Level (MOS/AOC)

When properly populated, the Sourcing Analysis Management Tool can provide quick and easily accessible analysis. This decision support management tool will provide three decision recommendations – Accept the tasking, which is self explanatory, Out of RMC Backfill Request, which means the tasking can be supported but requires backfill from out of region, and Passback, which implies that the tasking should be sent back to MEDCOM for reclama. See Appendix J – Step by Step Description for a complete description on how to utilize the Sourcing Analysis decision support management tool. Although not fully implemented, at a minimum, the GPRMC staff has recommended the Sourcing Analysis Management Tool should be updated from regional organizations on a quarterly basis. With the current strides in modern automation and high-speed internet access, this recommendation could easily be increased to a monthly data call or eventually a real-time management decision support tool.

After completion of the Sourcing Analysis Management Tool and presentation and approval from the CG, GPRMC, the next phase was to develop a decision briefing that could be presented to other RMC Commanders and eventually to the OTSG staff and the U.S. Army Surgeon General. For this decision briefing, the GPRMC staff set about using the DOD Military Decision Making Process as a template. The MDMP is a deliberate planning process that focuses on accomplishing the mission within the commander's intent. Deliberate planning is a continuous process and commanders and staffs must reassess new information as it is received, in this case, from datacalls from regional organizations. For orders production, the MDMP is a sequential and continuous planning process that begins with the receipt of the higher headquarters' order. The MDMP sequential steps include: 1) Receipt of the mission, 2) Mission analysis, 3) Course of Action development, 4) COA Analysis, 5) COA Comparison, 6) COA Approval, and 7) Orders Production.

During the Mission Analysis step of the process, the GPRMC staff derived the following facts in relation to the implementation of the Sourcing Analysis Management Tool. These facts are what we knew to be true about the situation concerning the deficiencies with the current PROFIS tasking policy. Most of these facts were derived from current regulation and policy. The facts that were identified include:

- PROFIS requirements for contingency units will be filled from the staff of the local MTF closest to the gaining unit to the maximum extent possible (AR 601-142, 2004, p. 3)
- MEDCOM has approval authority for reclaims (Implication that no taskings are ever truly reclaimed)

- Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA/M&RA RC) Backfill Policy provides for 1:2 backfill (1 RC for 2 AC Deployed)
- RMC mitigation strategies include:
 - Cross Leveling
 - Contracting
- PROFIS Non-assignment Criteria per the PROFIS Regulation AR 601-142
- Stabilization policy per the Personnel Planning Guidance (PPG) dated 20 MAY 2004 that states for each month deployed a soldier will receive one month stabilization
- Non-availability or non-deployable criteria based upon the USR regulation AR 220-1

During the Mission Analysis step of the process the GPRMC staff derived the following assumptions in relation to the implementation of the Sourcing Analysis Management Tool. These assumptions are statements about the situation but do not have facts to support. In the absence of facts, these assumptions were made based upon what likely to be true, presumed to be true, and essential to generate alternatives. Some of the sources of assumptions were personal experiences, members of the organization, subject matter experts, or written observations. The assumptions for the decision briefing included:

- No change to current PROFIS management for non-critical MOS/AOCs
- Identified high tasked, low density, critical MOS/AOCs *exist in AC, RC, and CIV*
- Identified high tasked, low density, critical MOS/AOCs *may change*
- Nadir (Total and Military) values may change

- Current RC Backfill Policy increases risk for RMC
 - Forecasted versus Actual On-hand
 - Credentialing and Licensure
 - MOS Qualification
- Contract and RC Backfill are accounted for when on-hand and qualified
- MTF's and RMC will have enough monies to defer non-AD care to the TriCare Network
- Non-active duty health care will be transferred to the Network when critical staffing levels are reached
- Network inability to absorb non-active duty healthcare will necessitate exceptions in geographically isolated areas

The final phase of the Sourcing Analysis Management Tool was to present the decision briefing via Video Tele-Conference (VTC) to the OTSG staff and the Surgeon General. The OIF / OEF Passback Brief to the Acting CDR, MEDCOM, and the Acting TSG, on 13 August 2004. The primary presenter was the CG, GPRMC, and secondary presenters were the GPRMC staff, headed by the GPRMC CofS, and this author. The VTC audience included a majority of the MEDCOM staff, headed by the Chief, Clinical Services Division and representatives of the OTSG staff, headed by the Assistant Surgeon General/Deputy Chief of Staff for Force Projection.

The Acting CDR, MEDCOM had the following issues and comments:

1. TSG directed that all deployable AC service members (SMs) will fill taskings – whether or not it will break RMC nadir amount
2. TSG directed the development of two types of passbacks:

- a. Passback due to no deployable AC Service Members
 - b. Passback due to RMC tasked below nadir amount, and required inter-regional cross-level through MEDCOM
3. TSG directed RMC to scrutinize nadir (total and military) values
4. TSG required the validation of nadir values to include "intellectual integrity" and input from consultants
5. TSG directed that nadir values require MTF and RMC command approval
6. TSG reviewed and concurred with RMC facts and assumptions
7. TSG directed the development of two tasking available categories: *Deploy* and *Other than Deploy* categories
8. TSG directed all GMEs / students to be placed at the bottom of the By-Name Analysis spreadsheet
9. TSG required RMC to define "network inability to absorb non-active duty healthcare"

The decision briefing was presented to the other RMC Commanders during the following weeks, and received laudatory comments. The RMC Commanders had the following issues and comments:

- The ability to adequately define the nadir value in order to implement the passback methodology requires standardization across AMEDD
- The data quality of MODS data is not reliable; and recommendations to improve the MODS database include:
 - Timely and accurate data entry at the organizational level
 - Command validation of MODS data

- Availability of funds for care transferred to the TriCare Network is questionable
- Recommended integrating the Sourcing Analysis Management Tools into existing databases and decision support tools (e.g. MODS, ARTS)
- Reserve Component Backfill management process is not reliable
- Contract shortfalls may preclude contracting from being a viable mitigation strategy
- PROFIS management needs to be more equitable and managed centrally

The final phase, presentation during the MEDOM ROC Drill, will be discussed in the results section of this project.

Policy Analysis or Comparison of the Two Management Systems

The second part of this methods and procedures section is the policy analysis based on *The Eight-Step Path to Policy Analysis, A Handbook for Practice* by Eugene Bardach, Fifth Edition, which was published in 1996. This handbook, a step by step procedure of concepts and methods for policy analysis, was developed as a general approach to policy analysis that need not conform to any specific style. More importantly, Bardach believes that policy analysis goes beyond individual or small group decision making for two reasons: 1) the outcomes of policy analysis affect a large number of people or citizens, and 2) the “process and results of policy analysis usually involve other professionals and interested parties” (Bardach, 1996, Introduction). This is exactly the current situation that the GPRMC PROFIS policy and policy development finds itself. Bardach (1996) further relates, “I have also found this handbook useful in teaching an undergraduate introduction to public policy and for executive education groups” (Bardach, 1996, Foreword,). The comparison of the two PROFIS management

systems, the current policy and the proposed Passback Methodology, are presented in the following steps of the *Eight-Step Path to Policy Analysis*.

Step 1. Define the Problem – As with any decision making process, such as the MDMP, a clearly defined problem is the single most important initial step in the process. With the MDMP, the receipt of the mission usually defines the problem, if not, the commander normally does. Without a clearly defined problem, preferably a quantifiably rather than qualitatively defined problem, there is no adequate way to establish a sense of direction for the second step, assembling evidence. The problem should be defined in a way as to be evaluative and should suggest the significance of the problem.

Step 2. Assemble Some Evidence – Once again, similar to the MDMP mission analysis step, clear analysis of gathered data in order to derive useful and timely information is also a crucial step in policy analysis. As with the intelligence preparation of the MDMP, assembling evidence is an on-going process through policy analysis that truly never ceases, even after policy implementation. The only draw back to this step is the fact that the development of useful information requires large amount of resources, particularly time and funding. It is important to make all data and information count.

Step 3. Construct the Alternatives – The equivalent step in the MDMP to this step would be the development of courses of action (COAs), which follows the mission analysis phase. Whether constructing COAs or alternatives, the entire staff must be involved in their development in order to develop the most comprehensive courses. After deducing the problem, or receiving guidance from the commander, the staff should develop multiple COAs for analysis and comparison. The first approach to the problem or COA to be considered should be to “Take no action; let present trends continue

undisturbed” (Bardach, 1996, p. 20). If the problem is defined well and ample evidence assembled, this COA normally will not remain throughout the rest of the analysis. For the purpose of this study, two courses of action, or one alternative, will be analyzed. The first course of action is to maintain the current PROFIS Management System. The second course of action or alternative is to implement the Passback Methodology to the current PROFIS Management System.

Step 4. Select the Criteria – Up to this point, the majority of analysis has been more quantitative and less qualitative, Bardach refers to this as “two plot lines, the analytical and the evaluative” (Bardach, 1996, 25). With the selection of criteria, the evaluative or qualitative, which are derived from the defined problem, emerge. This step is “the most important step for permitting values and philosophy to be brought into the policy analysis, because “criteria” are evaluative standards used to judge the “goodness” (Bardach, 1996, 25). For the purpose of this evaluation, the criteria used for evaluation will include the MDMP criteria: 1) Suitability, 2) Feasibility, 3) Acceptability, and 4) Distinguishability, and 5) Equity. Equity was defined as the ability of the MEDCOM to equally distribute the PROFIS requirements amongst the RMCs and for those individual deploying providers, equity amongst their deployment time requirements. Based upon the guidance of the CG, GPRMC, equity was weighted the greatest among the criteria. Acceptability was defined by this study as a subjective criteria based upon the ability of the RMC, MTF, and individual deploying provider to be able to readily accept the PROFIS requirement and therefore accomplish the PROFIS mission. Acceptability is closely related to organization, facility, or individual readiness. Based upon the guidance of the CG, GPRMC, acceptability was weighted the second

most important among the criteria. Feasibility was defined as the ability of the MTF and RMC to provide the appropriate personnel for the requested PROFIS requirement while maintaining the appropriate healthcare mission. Feasibility was weighted equally among the three remaining criteria, suitability and distinguishability. Suitability was defined by this study as the ability for other RMCs to accept and incorporate a PROFIS management system, with minimal impact to readiness and current operations. Distinguishability was defined by this study as the ability of the RMCs, MTFs, and individual deploying providers to discern between the two possible courses of action or alternatives.

Step 5. Project the Outcomes – Referred to as the “hardest step in the Eight-Step Path” (Bardach, 1996, p. 35), this step, or its equivalent in the MDMP, the COA Analysis Wargaming process, is the most difficult because it is the most time and resource consuming. Projecting the outcomes is resource intensive because this is the first combination of the analytical and evaluative steps of the process, or commonly referred to as *combining the art with the science*. The outcome for each alternative or COA must be thoroughly analyzed first and then the magnitude must be predicted, using intuition as well as *number crunching*. According to FM 5-0, Army Planning and Orders Production (2005), wargaming will also allow for discovery of new alternatives:

Wargaming stimulates ideas, highlights critical tasks, and provides insights that might not otherwise be discovered. It is a critical step in the MDMP and should be allocated more time than any other step During the wargame, the staff takes each COA and begins to develop a detailed plan, while determining its strengths or weaknesses. Wargaming tests and improves COAs. The commander and staff (and

subordinate commanders and staffs if the wargame is conducted collaboratively) may change an existing COA or develop a new COA after identifying unforeseen events, tasks, requirements, or problems. (FM 5-0, 2005, p. 3-42)

Once the wargaming process has been initiated, the next phase would be to collect the all the information concerning the alternatives.

Due to the overwhelming amount of information that is derived from the wargaming process, a method for simplifying the entirety of each alternative must be considered. "A convenient way to take in the highlights of all this information is to display it in outcomes matrix ... The typical matrix format arrays your policy alternatives down the rows and your evaluative criteria across the columns" (Bardach, 1996, p. 44). The MDMP military equivalent to the *outcomes matrix* described by Bardach is the Decision Matrix (DECMAT). The DECMAT, which uses evaluation criteria to assess the effectiveness and efficiency of each COA, was automated using Microsoft Excel in order to assist student officers at the U.S. Army Command and General Staff College (CGSC). DECMAT version 2.2 offers the user two different methods for developing a decision, the relative value matrix and the multiplication matrix. For this policy study the relative value matrix will be utilized. The relative value DECMAT uses a method of assigning appropriate ranks to the alternatives and assigns a relative weight to each of the evaluation criteria developed in the first step. "The relative value method computes the total for each COA by adding the products of each evaluation criterions relative value times the evaluation criterions weight along a COA row as follows:

$$(RV1)(W1) + (RV2)(W2) + \dots + (RVn)(Wn) = \text{TotalREL VAL}$$

Where: RVn = Relative Value for the Raw Data of the

nth Evaluation Criterion

W_n = Weight of the nth Evaluation Criterion

(Stickers, 1997, Relative Value Method)

Each criteria was then weighted, the most desirable (as per guidance of the commander or Chief of Staff), Equity, was nearly twice the weight of Acceptability. Equity was nearly four times the weight of Feasibility, Suitability, and Distinguishability, each being equally weighted. Each alternative or COA was then ranked, with the best evaluative alternative ranked 1 and the least evaluative alternative ranked 2. The relative value DECMAT for this policy analysis is shown in the following Figure 3.

DECISION MATRIX		PROFIS Policy				
Weight Criteria COA	5.29 Equity	2.49 Acceptability	1.00 Feasibility	1.00 Suitability	1.00 Distinguishability	Total
Current PROFIS Policy	2	2	1.5	1	2	20.048
Passback Methodology	1	1	1.5	2	1	12.274

Relative Values Matrix
Less is better
Consistency Ratio = 96.65

Figure 3. Relative Value Decision Matrix – PROFIS Management Policy

Step 6. Confront the Tradeoffs. Sometimes, when evaluating the COAs in an analysis, a particular COA or alternative under consideration produces consistently desired results. Bardach (1996) refers to this as alternative *dominance*. If there is no dominance evaluated then, therefore there must be a *tradeoff* or compromise of some sort in order to derive a decision. Prior to a decision, the tradeoffs between outcomes

associated with different policy alternatives or options must be reconciled. In order to do this, the outcomes of both policy alternatives must be projected and the tradeoffs analyzed and evaluated.

Step 7. Decide! In this step the policy maker, in this case the Commanding General, GPRMC, is presented the evidence, presented discussion on the COAs and the evaluation of the COAs, presented the DECMAT, and asked for a decision.

According to FM 5-0 (2005):

After the decision briefing, the commander selects the COA he believes will best accomplish the mission. If the commander rejects all COAs, the staff starts COA development again. If the commander modifies a proposed COA or gives the staff an entirely different one, the staff wargames the new COA and presents the results to the commander with a recommendation. (FM 5-0, 2005, p. 3-56)

A decision brief is the best method for presenting the information to the commander, and usually, the best decision brief is simple and to the point. Another aspect to consider in the decision brief is the ability of the presenter to *sell* the recommendation to the policy decision maker or leader.

Step 8. Tell Your Story. The last step in the Eight-Step Path to Policy Analysis is to document the following proceedings and present them to other policy makers as a recommendation. In *telling your story*, the policy analyst must provide the most information in the most efficient and effective means possible. The orders production step in the MDMP process, whether that is orders or policy memorandum production, is the logical equivalent step.

Results

The results of this study are evidenced in the presentation of the Sourcing Analysis Management decision support tool for the entire GPRMC, presented in Table 5, the approval by the Commanding General, GPRMC, and the presentation to the OTSG and the U.S. Army Surgeon General.

Table 5. Sourcing Analysis Model for Great Plains Regional Medical Command

Report as of: 30-Aug-04

RMC		Military				Civilian	Mission Support	Nadir		Taskable/Deployable Analysis					Mission Analysis			
Corps	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	Nadir Comparison			m. Military Deployable	n. Decision Support	Nadir		
											j. Total Taskable	k. Military Taskable	l. Taskable Inventory			o. AC/RC Available for Out of RMC Backfill		
															A B P			
Medical	60J	36	3	13	0	8.5	2	31	21	41.5	10.5	12	10	20	2	0	0	8
	60N	28	3	11	0	5	2	23	16	30	7	9	6	14	2	0	0	4
	60W	21	4	5	0	7	2	20	12	24	4	5	3	12	2	0	0	1
	61J	33	5	11	0	5	14	22	16	33	11	12	10	17	14	4	0	-4
	61M	35	3	17	0	4	5	27	17	36	9	15	9	15	5	0	0	4
	61R	30	1	10	0	19	1	37.5	21	48	10.5	8	6	19	1	0	0	5
	62A	44	6	18	0	21.5	6	54	29	59.5	5.5	9	4	20	6	2	0	-2
Nurse	66E	73	15	20	21	39	10	67	16	118	51	63	49	38	10	0	0	39
	66F	49	12	20	2	36.5	7	54	11	75.5	21.5	28	16	17	7	0	0	9
	66HM5	28	6	6	8	70.5	4	70	14	100.5	30.5	16	12	16	4	0	0	8
	66H8A	81	25	19	27	137.5	15	162	27	220.5	58.5	56	49	37	15	0	0	34
Enlisted	91D	172	17	17	17	69	12	176	90	241	65	82	59	138	12	0	0	47
	91V	49	6	2	9	56	8	83	27	108	25	25	20	41	8	0	0	12
	91WM6	194	40	42	30	405	44	541	103	589	48	81	40	112	44	4	0	-4
	91X	97	3	9	5	29	1	107	75	128	21	24	12	85	1	0	0	11

A Accept
 B Out of RMC Backfill Request
 P Passback

When properly populated, the Sourcing Analysis Management Tool can provide quick and easily accessible analysis in order to make decisions concerning the tasking of the 15 low density, high criticality AOCs and MOSs. This decision support management tool will provide three decision recommendations – Accept the tasking, which is self

explanatory, Out of RMC Backfill Request, which means the tasking can be supported but requires backfill from out of region, and Passback, which implies that the tasking should be sent back to MEDCOM for reclama. See Appendix J – Step by Step Description for a complete description on how to utilize the Sourcing Analysis decision support management tool. Although not fully implemented, at a minimum, the GPRMC staff has recommended the Sourcing Analysis Management Tool should be updated from regional organizations on a quarterly basis. With the current strides in modern automation and high-speed internet access, this recommendation could easily be increased to a monthly data call or eventually a real-time management decision support tool.

Presentation of the GPRMC Sourcing Analysis Management Tools to the CG, GPRMC occurred on several occasions, with the final approval being given to the GPRMC staff on Tuesday, 10 August 2004. The CG, GPRMC provided the following, although summarized, comments on that day when presenting the decision brief to the Commanding General of the Southeast Regional Medical Command (SERMC):

Decision Recommendation and Expected Results:

- These tools truly provide a new and highly developed sustainment model and methodology to support an expeditionary Army at war
 - The effective management of PROFIS taskings through the use of these tools is critical for the future sustainment and management of high-task/low-density MOSs/AOCs
- This model allows RMC commanders to validate the taskable inventory, which in turn will allow for greater inter- and intra-regional visibility

- The future use of the Sourcing Management Decision Support Tools by the MEDCOM would allow development of a RMC taskable inventory. This would reduce turbulence in distribution of high-task/low-density MOS/AOC taskings

The Commanding General also commented on the applicability to all other RMCs in the MEDCOM:

- Use of this methodology would ensure *standardization and equity*
- It would also assist all RMCs in that it identifies and manages *aggregate impact* of PROFIS and tasking requirements
- Use of this methodology allows for partial tasking passback

(Fox, personal communication to the GPRMC Staff, 10 August 2004)

The results of developing a new passback methodology process will maintain the current PROFIS manning and training strategy to the greatest extent possible. The passback methodology included the development of three decision-support tools and will allow RMCs to manage personnel tasking requirements in support of an expeditionary Army at war.

Discussion

Based upon the initial guidance by the CG, GPRMC and the use of the abbreviated MDMP, this study was limited to analysis of only two courses of action or alternatives. Although this may not be considered the most effective method of producing a deliberate decision with qualified results for general RMC application, it is none the less the most expedient. In order to manage the risks and constraints involved with developing multiple courses of action, the most significant risk being an

undeveloped analysis and the most significant constraint being time, the staff proceeded with only two alternatives. The first alternative was to maintain the current PROFIS policy, and the second alternative was the incorporation of the Passback Methodology into the PROFIS Management System. The fact that only two alternatives were analyzed was identified as the first limitation with this study, and this will be discussed in the latter limitations discussion.

The first course of action considered, labeled Current PROFIS Policy, was to maintain the "status quo" or as previously mentioned to "Take no action; let present trends continue undisturbed" (Bardach, 1996, p. 20). This course of action (COA), which was clearly identified as not the desired end state of this command directed requirement. The PROFIS management system has gone through evolutionary changes since the implementation of the PROFIS system in accordance with the U.S. Army Regulation in the early 1980's. This system, developed and based upon the strategic goal of supporting a two-front global conventional conflict, has never been fully executed to the extent planned. Instead, it has been subjectively and selectively utilized, filling requirements with assigned and unassigned personnel. In reaction to this lack of proper execution, facility productivity has been stressed because of the sudden removal of provider assets without the required qualified backfill filling in. This is clearly documented in the literature review; neither the losing facility nor the gaining field units fully embrace the current PROFIS system. The most basic shortfall of the system was asset visibility and asset tracking. Therefore, when identifying and analyzing this COA, the historical data was identifying this shortfall was readily available and quickly processed.

The second course of action or alternative was the implementation, incorporation, and utilization of the Passback methodology. This methodology, which has been referred to as an automated physician deployment duty roster, incorporates the basic principle of the legacy PROFIS system, but adds the improved tracking systems made possible by the available automation systems of today. Although not certified by the OTSG as an official AMEDD process, it has been implemented and utilized successfully at the GPRMC since April of 2005, focusing on the fifteen critical AOCs and MOSs. The COA was developed by the staff at GPRMC with the initial impetus provided by the CG. The system currently requires data input from the subordinate reporting units to the regional command on a quarterly basis. The quarterly reporting requirement was a subjective decision and can be adjusted based upon the situation for future requirements. This information is consolidated by the Clinical Operations Section and forwarded to MEDCOM to be further consolidated. If implemented by the AMEDD, this system will have the ability to take the current available PROFIS assets, and provide global visibility to any user with access to AMEDD automated systems. Once this system is incorporated into other Department of the Army systems, such as the Medical Operational Data Systems (MODS), and Department of Defense systems, the future Joint Medical Commands will have asset visibility and utilization at near real time acquisition.

One of the first limitations discussed is the fact that only two courses of action or alternatives were studied. The decision to use an abbreviated process with only two alternatives was a staff recommendation and a command decision. The decision to use two alternatives was made to overcome the constraints of time and to focus on the

desired effects of the Passback Process. As a result, the study is based more on an effects based planning process rather than a deliberate military decision-making process, which is ingrained into most military officers and planners. Most military planners begin planning with a mixture of rules-based thinking and assumption-based thinking. Current military thought and instruction actually prescribes to using an effects based process due to the failure to rapidly assess the current situation and adapt operational results in a timely and effective manner. The fact that only two alternatives were studied may not be a limitation, but based upon the trend towards effects based planning and operations, a benefit.

Another limitation of this study is the fact that the majority of the data collected on the seventeen PROFIS positions is based upon historical data. The data collected was from over the time period of six months in 2005, during OEF and OIF 04-06, and may not be reflective of new developments involving the modern Army of Transformation organizational force structure. The recommendation to overcome this limitation is to extend this study over a future planned extended period of time, possibly thru one upcoming and complete iteration or OEF or OIF force rotation. This would allow for the Army Transformation from the Legacy Force to Force XXI and beyond to the Objective Force, and the AMEDD to complete transformation involving the Medical Re-engineering Initiative to be more complete. Unfortunately, this ideal study would require time consuming methods that would negate the applicability and utility of the PROFIS Management System. A study of this length and magnitude also may prove to be financially unfeasible. This is cause for further research and further related study.

Conclusion

The purpose of this study was to analyze the current GPRMC policy concerning PROFIS management and the current expeditionary Army at war. This analysis included an examination of the current PROFIS sourcing and tasking methodology, using PROFIS tasking data from FY 2004, and used that analysis to develop a methodology to accurately manage this resource within the region. The resulting process should reduce the turbulence in the distribution of PROFIS taskings and allow for regional visibility.

The goal of this study is to have the resulting process be utilized not only by this Regional Medical Command (RMC), but by all RMCs in the U.S. Army Medical Command (MEDCOM). That goal was met when the CG, GPMRC presented the PROFIS Management Decision Support Tools, to include the Passback Methodology to the Surgeon General, the entire OTSG and MEDCOM senior staff, as well as the entire senior staff of the RMCs on 21 September 2004 at the MEDCOM General Officer ROC Drill for Support to OIF3 and OEF6. The purpose of this conference was to identify and resolve MEDCOM health care execution and support issues related to OIF3 and OEF 6 transition of authority (TOA) and sustainment from 01 October 2004 to 30 September 05. The conference objectives included:

- Provision of a common operating picture of OIF 3 and OEF 6 requirements
- Determine RMC and MSC ability to support mission requirements
- Identification of the impact and mitigation strategies

- Identification and resolution of issues, and the assistance requirements from MEDCOM CG or higher headquarters that is beyond the capability of the RMC or MSC.

The information security level for the MEDCOM General Officer ROC Drill was held at the SECRET level, and therefore the outcomes cannot be discussed in this study. What can be published is that the MEDCOM is currently developing an automation module for the Medical Operational Data Systems that incorporates the PROFIS Management Decision Support Tools and Passback Methodology. This automation module is currently termed the PROFIS Deployment System or PDS and is expected to be implemented sometime by the Fall, 2005.

Appendix A

Definitions

Admin Mission	Command directed missions (e.g. funeral detail, local support, that do not fall into any other category) also know as contingency operations
Augmentation	MACOM / MEDCOM validated mission requirement not covered by PROFIS or other manning authorization document
Backfill	Validated but vacant TDA or table(s) of organization and equipment (TOE) requirements / authorizations requiring temporary or recurring fill
Cross Leveling	Mitigation strategy used to fill tasking requirements between subordinate units within an RMC
Datacall	A request for real-time facility specific resource information, usually given with a suspense requirement
Nadir (Total)	The total of all military and civilians (GS and contractors) necessary to execute only the core missions less non-active duty care
Nadir (Military)	The number below which an MTF cannot be tasked for a given AOC/MOS without causing mission failure
Passback	(to MEDCOM) A validated return of ownership and responsibility for a tasking requirement to MEDCOM; reclamation
Reclama	The act or process of reclaiming a MEDCOM tasking; returning a non - supportable tasking to MEDCOM with justification
Regional Nadir	the combined nadirs for each AOC/MOS from all MTFs in the region

Appendix A - Continued

Acronyms

AD	Active Duty
ACH	Army Community Hospital
AHC	Army Health Center
AMEDD	Army Medical Department
AR	Army Regulation
ARNG	Army National Guard
ASAM&RA	Assistant Secretary of the Army for Manpower and Reserve Affairs
BAMC	Brooke Army Medical Center
CONUSA	Continental United States Army
DA	Department of the Army
DECMAT	Decision Matrix
DOD	Department of Defense
ERMC	European Regional Medical Command
FORSCOM	U.S. Army Forces Command
FM	Field Manual
GPRMC	Great Plains Regional Medical Command
GWOT	Global War on Terrorism
HQDA	Headquarters, Department of the Army
IA	Individual Augmentee
MAMC	Madigan Army Medical Center
MDMP	Military Decision Making Process

Appendix A - Continued

Acronyms

MEB	Medical Evaluation Board
MEDCEN	Medical Center
MEDDAC	Medical Activity
MEDCOM	U.S. Army Medical Command
MHO	Medical Hold Over
MODS	Medical Operational Data Systems
MTF	Medical Treatment Facility
MSC	Major Subordinate Commands
NARMC	North Atlantic Regional Medical Command
ODCSPER	Officer of the Deputy Chief of Staff, Personnel
ODSS	Operations Desert Storm and Desert Shield
OEF / OIF	Operation Enduring Freedom and Operation Iraqi Freedom
OTSG	U.S. Army Office of the Surgeon General
PDS	PROFIS Deployment System
PRMC	Pacific Regional Medical Command
PROFIS	Professional Filler System
RC	Reserve Component
RMC	Regional Medical Command
SERMC	Southeast Regional Medical Command
SIDPERS	Standard Installation / Division Personnel System
SRP	Soldier Readiness Program

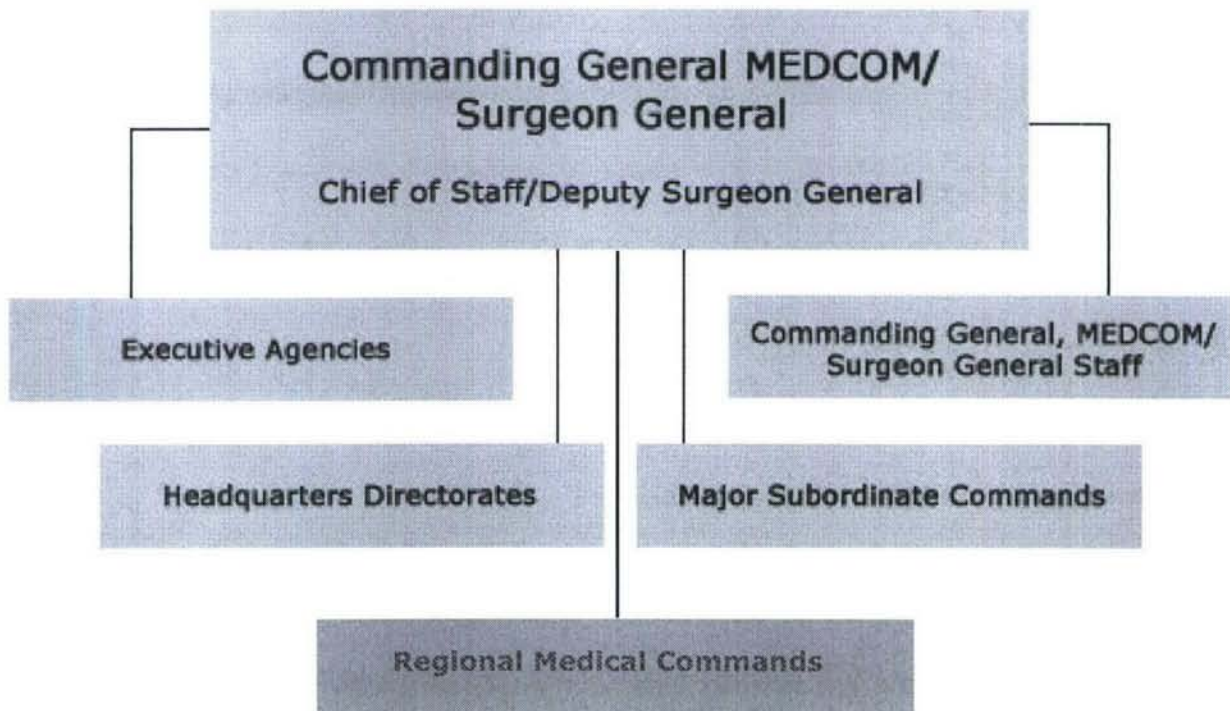
Appendix A - Continued

Acronyms

TSG	U.S. Army Surgeon General
USAR	U.S. Army Reserves
VETCOM	U.S. Army Veterinary Command
WRMC	Western Regional Medical Command

Appendix B

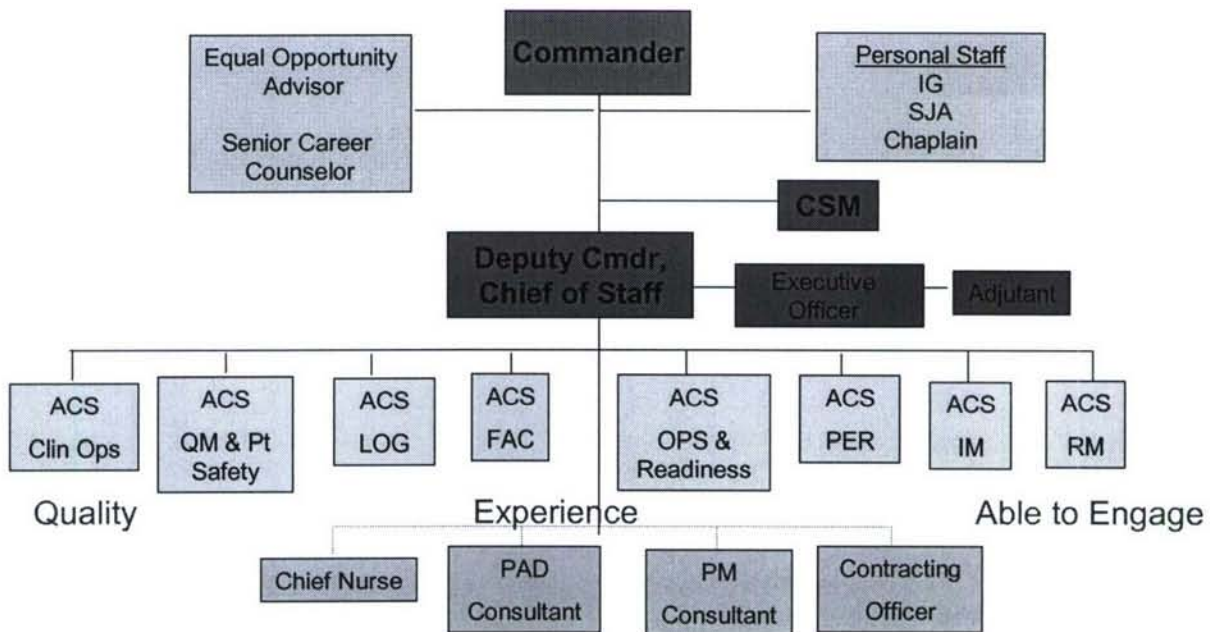
U.S. Army Medical Command Organizational Structure



Appendix C

Great Plains Regional Medical Command Organizational Structure

GPRMC Organizational Structure



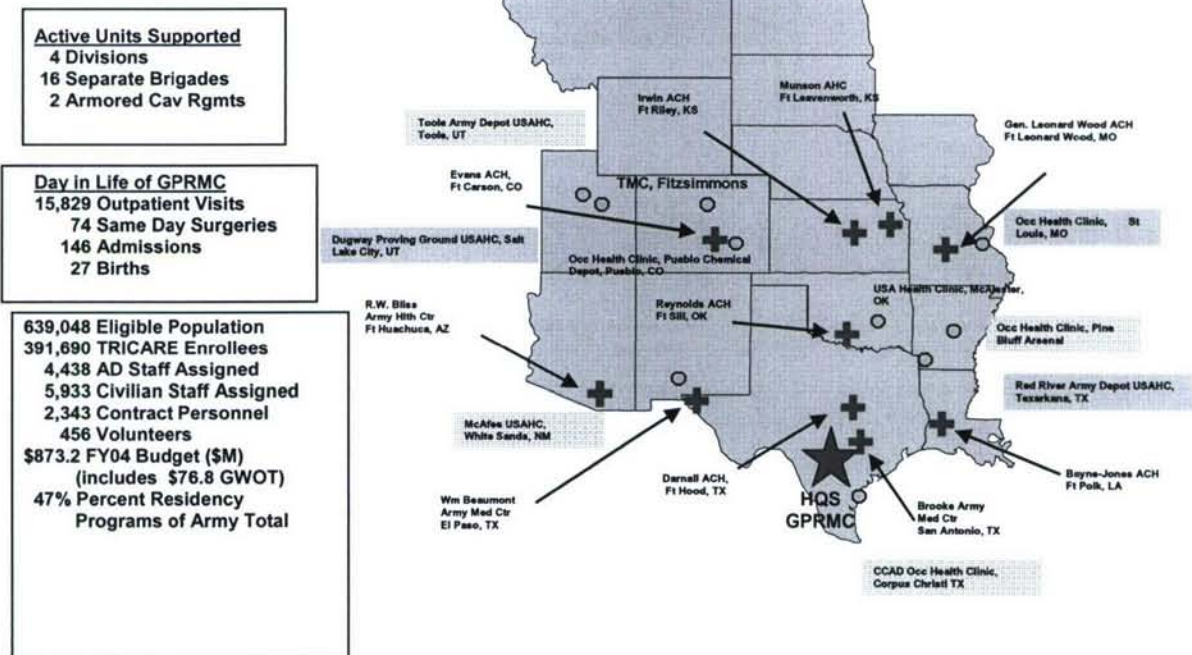
As of: 8 July 2004

GPRMC STAFF: 31 Military + 17 Civilians + 13 Contractors = 61 TOTAL

Appendix D

Great Plains Regional Medical Command Areas of Responsibility

GPRMC Area of Responsibility



Appendix E

Great Plains Regional Medical Command Support to GWOT

GPRMC Support to the Global War on Terrorism

Medical Personnel Deployed: 689



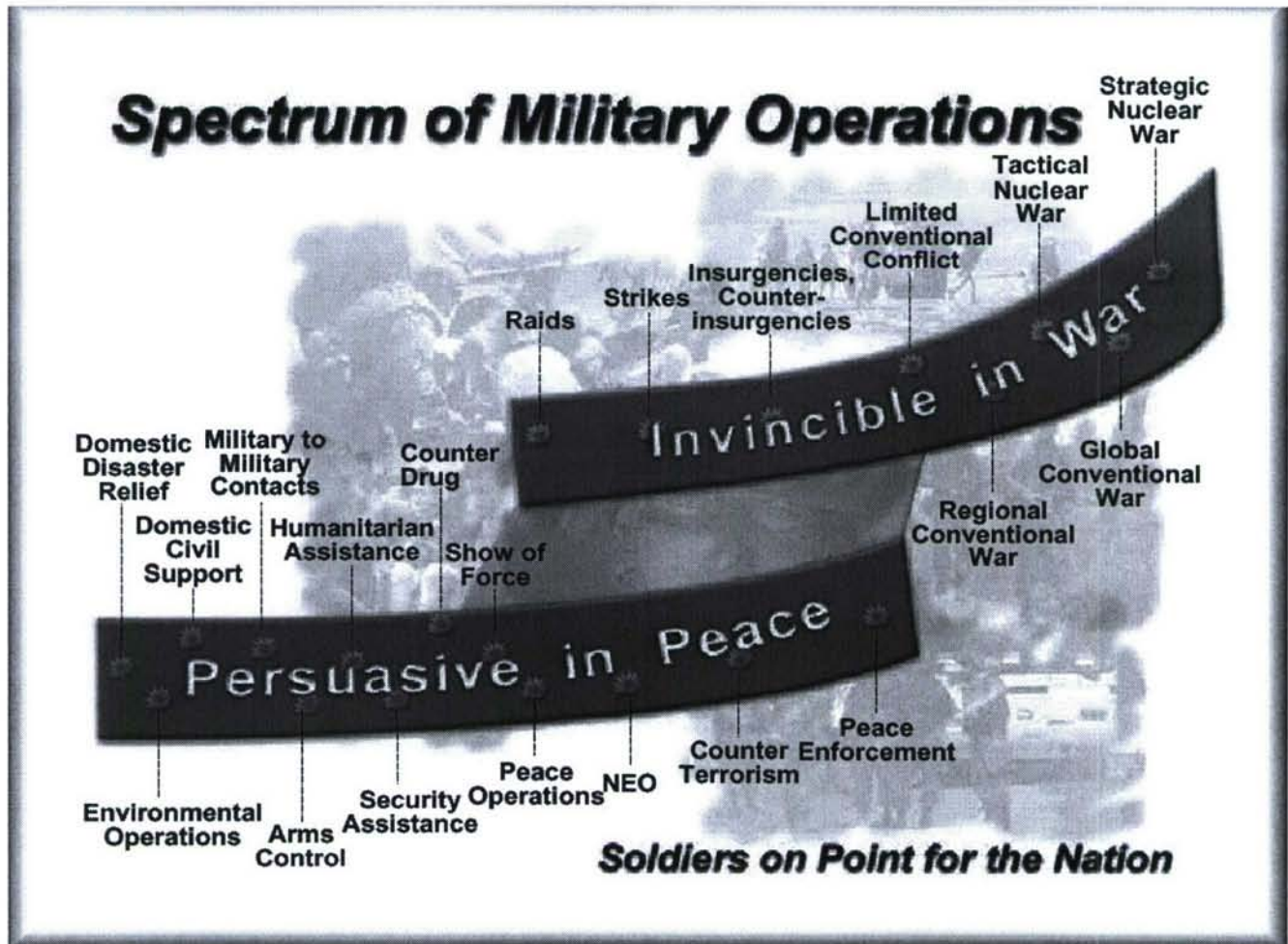
Physicians:	203
Nurses:	206
Medics:	280



As of: 1 Jan 2003 – 8 July 2004

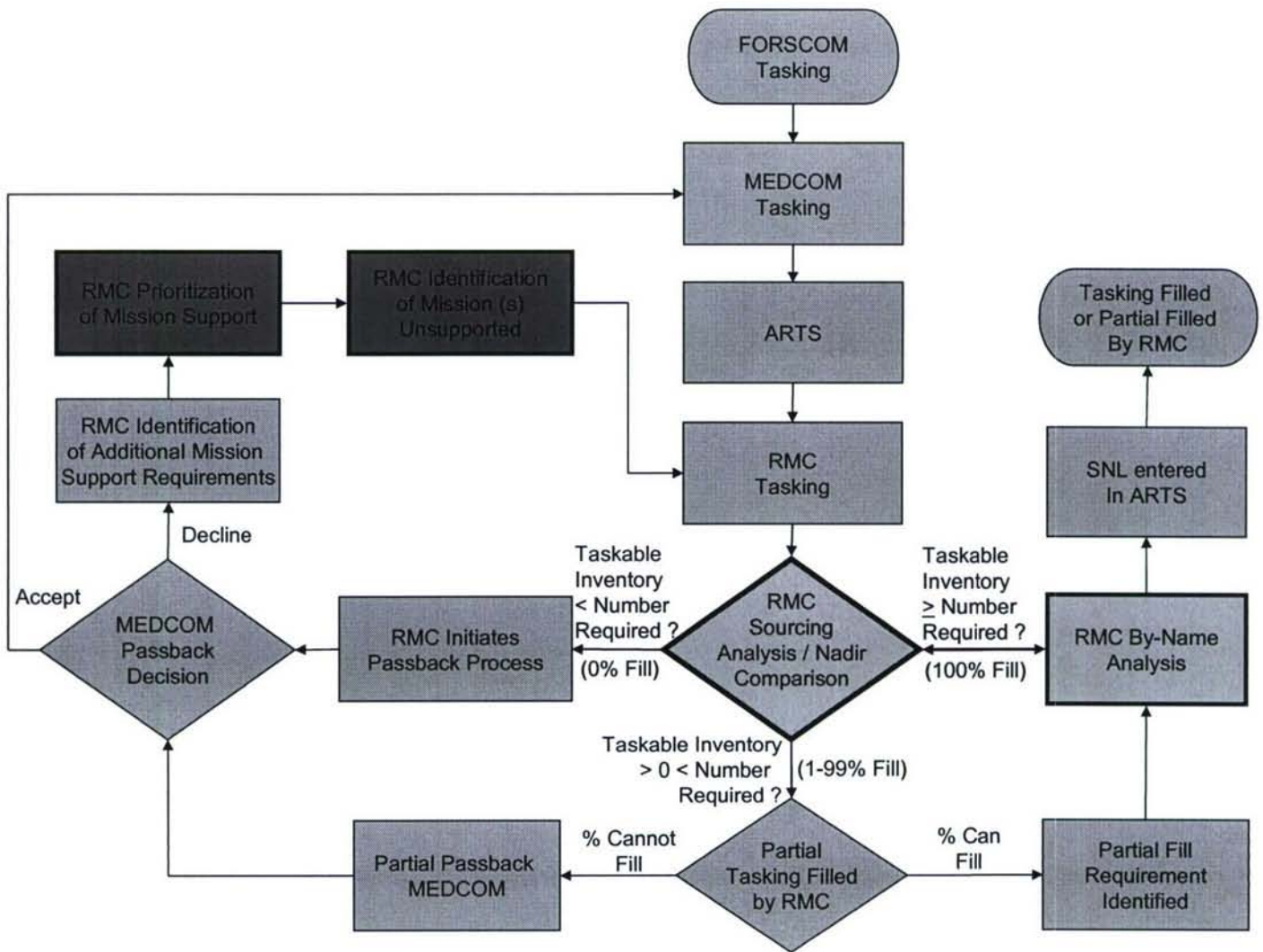
Appendix F

U.S. Army Spectrum of Military Operations



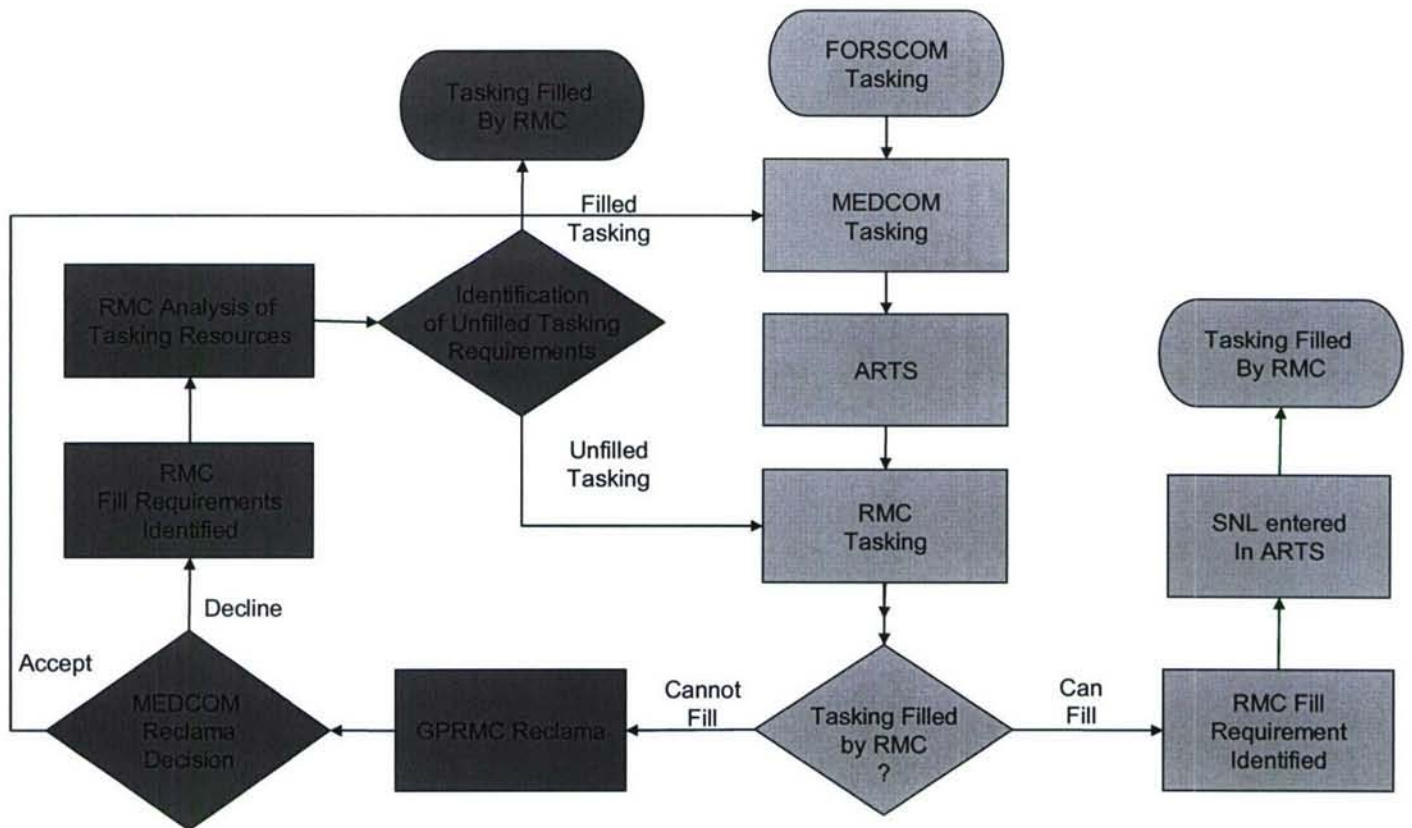
Appendix G

Proposed GPRMC Passback Methodology for PROFIS Management Algorithm



Appendix H

Current GPRMC Methodology for PROFIS Management Algorithm



Appendix I

Example of GPRMC Data Compilation for AOC 60 – Medical Corps Officers

MED1	DESCRIPTION	O1	O2	O3	O4	O5	O6	TOTAL
00E	STUDENT OFFICER	<u>0</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>1</u>	<u>0</u>	<u>4</u>
60B	NUCLEAR MEDICINE OFFICER	<u>0</u>	<u>0</u>	<u>0</u>	<u>3</u>	<u>3</u>	<u>1</u>	<u>7</u>
60C	PREVENTIVE MEDICINE OFFICER	<u>0</u>	<u>0</u>	<u>3</u>	<u>5</u>	<u>6</u>	<u>2</u>	<u>16</u>
60D	OCCUPATIONAL MEDICINE OFFICER	<u>0</u>	<u>0</u>	<u>2</u>	<u>2</u>	<u>2</u>	<u>1</u>	<u>7</u>
60F	PULMONARY DISEASE OFFICER	<u>0</u>	<u>0</u>	<u>2</u>	<u>8</u>	<u>10</u>	<u>5</u>	<u>25</u>
60G	GASTROENTEROLOGIST	<u>0</u>	<u>0</u>	<u>1</u>	<u>13</u>	<u>3</u>	<u>5</u>	<u>22</u>
60H	CARDIOLOGIST	<u>0</u>	<u>0</u>	<u>6</u>	<u>12</u>	<u>10</u>	<u>2</u>	<u>30</u>
60J	OBSTETRICIAN AND GYNECOLOGIST	<u>0</u>	<u>0</u>	<u>21</u>	<u>36</u>	<u>11</u>	<u>4</u>	<u>72</u>
60K	UROLOGIST	<u>0</u>	<u>0</u>	<u>4</u>	<u>5</u>	<u>5</u>	<u>3</u>	<u>17</u>
60L	DERMATOLOGIST	<u>0</u>	<u>0</u>	<u>15</u>	<u>14</u>	<u>4</u>	<u>1</u>	<u>34</u>
60M	ALLERGIST	<u>0</u>	<u>0</u>	<u>2</u>	<u>2</u>	<u>1</u>	<u>2</u>	<u>7</u>
60N	ANESTHESIOLOGIST	<u>0</u>	<u>0</u>	<u>22</u>	<u>20</u>	<u>7</u>	<u>1</u>	<u>50</u>
60P	PEDIATRICIAN	<u>0</u>	<u>0</u>	<u>37</u>	<u>32</u>	<u>12</u>	<u>9</u>	<u>90</u>
60R	CHILD NEUROLOGIST	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>3</u>
60S	OPHTHALMOLOGIST	<u>0</u>	<u>0</u>	<u>10</u>	<u>5</u>	<u>9</u>	<u>4</u>	<u>28</u>
60T	OTOLARYNGOLOGIST	<u>0</u>	<u>0</u>	<u>4</u>	<u>10</u>	<u>3</u>	<u>2</u>	<u>19</u>
60U	CHILD PSYCHIATRIST	<u>0</u>	<u>0</u>	<u>0</u>	<u>5</u>	<u>1</u>	<u>4</u>	<u>10</u>
60V	NEUROLOGIST	<u>0</u>	<u>0</u>	<u>1</u>	<u>4</u>	<u>1</u>	<u>2</u>	<u>8</u>
60W	PSYCHIATRIST	<u>0</u>	<u>0</u>	<u>5</u>	<u>9</u>	<u>3</u>	<u>5</u>	<u>22</u>
61A	NEPHROLOGIST	<u>0</u>	<u>0</u>	<u>0</u>	<u>4</u>	<u>0</u>	<u>2</u>	<u>6</u>
61B	MEDICAL ONCOLOGIST/HEMATOLOGIST	<u>0</u>	<u>0</u>	<u>2</u>	<u>9</u>	<u>1</u>	<u>1</u>	<u>13</u>
61C	ENDOCRINOLOGIST	<u>0</u>	<u>0</u>	<u>1</u>	<u>4</u>	<u>1</u>	<u>3</u>	<u>9</u>
61D	RHEUMATOLOGIST	<u>0</u>	<u>0</u>	<u>0</u>	<u>2</u>	<u>0</u>	<u>2</u>	<u>4</u>
61F	INTERNIST	<u>0</u>	<u>0</u>	<u>55</u>	<u>19</u>	<u>6</u>	<u>8</u>	<u>88</u>
61G	INFECTIOUS DISEASE OFFICER	<u>0</u>	<u>0</u>	<u>3</u>	<u>8</u>	<u>2</u>	<u>2</u>	<u>15</u>
61H	FAMILY PHYSICIAN	<u>0</u>	<u>0</u>	<u>43</u>	<u>55</u>	<u>13</u>	<u>12</u>	<u>123</u>
61J	GENERAL SURGEON	<u>0</u>	<u>0</u>	<u>23</u>	<u>37</u>	<u>13</u>	<u>13</u>	<u>86</u>
61K	THORACIC SURGEON	<u>0</u>	<u>0</u>	<u>1</u>	<u>3</u>	<u>3</u>	<u>2</u>	<u>9</u>
61L	PLASTIC SURGEON	<u>0</u>	<u>0</u>	<u>0</u>	<u>2</u>	<u>3</u>	<u>1</u>	<u>6</u>
61M	ORTHOPEDIC SURGEON	<u>0</u>	<u>0</u>	<u>30</u>	<u>34</u>	<u>17</u>	<u>4</u>	<u>85</u>
61N	FLIGHT SURGEON	<u>0</u>	<u>0</u>	<u>3</u>	<u>9</u>	<u>3</u>	<u>3</u>	<u>18</u>
61P	PHYSIATRIST	<u>0</u>	<u>0</u>	<u>3</u>	<u>2</u>	<u>2</u>	<u>0</u>	<u>7</u>
61Q	THERAPEUTIC RADIOLOGIST	<u>0</u>	<u>0</u>	<u>3</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>4</u>
61R	DIAGNOSTIC RADIOLOGIST	<u>0</u>	<u>0</u>	<u>18</u>	<u>27</u>	<u>10</u>	<u>7</u>	<u>62</u>
61U	PATHOLOGIST	<u>0</u>	<u>0</u>	<u>11</u>	<u>7</u>	<u>13</u>	<u>8</u>	<u>39</u>
61W	PERIPHERAL VASCULAR SURGEON	<u>0</u>	<u>0</u>	<u>0</u>	<u>4</u>	<u>2</u>	<u>1</u>	<u>7</u>
61Z	NEUROSURGEON	<u>0</u>	<u>0</u>	<u>0</u>	<u>3</u>	<u>1</u>	<u>0</u>	<u>4</u>
62A	EMERGENCY PHYSICIAN	<u>0</u>	<u>0</u>	<u>60</u>	<u>36</u>	<u>13</u>	<u>3</u>	<u>112</u>
62B	FIELD SURGEON	<u>0</u>	<u>0</u>	<u>23</u>	<u>6</u>	<u>0</u>	<u>0</u>	<u>29</u>
	Other Codes Not On File	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
	Total	<u>0</u>	<u>0</u>	<u>415</u>	<u>460</u>	<u>196</u>	<u>126</u>	<u>1197</u> q

Appendix J

Sourcing Analysis Management Tool – MS Excel Logic Formulas

Notes & Formulas:

- a. Enter the number of AC assigned.
- b. Enter the number of AC assigned who are currently deployed.
This number includes individuals on post-deployment block leave.
- c. Enter the number of AC who meet authorized non-deployment criteria.
This includes individuals stabilized after deployment.
- d. Enter the total number of Reserve Component (RC) personnel assigned to the MTF.
- e. Enter the total number of civil service (GS) and contract employees who are equivalent to the respective military area of concentration (AOC) or military occupational specialty (MOS).
- f. Enter the number of AC required for mission.
- g. Total Nadir is the minimum number of staff (AC, RC, GS & Contract) required to support health care delivery to active duty personnel only & core missions.
- h. Military nadir is the minimum number of military staff required to support health care delivery to active duty personnel only & core missions.
- i. Total Available in MTF is the number of personnel (AC, RC, GS & Contract) available to staff the MTF.
Total Available in MTF is computed using the following formula: $i = a - b + d + e$.
- j. Total Taskable determines the number of total staff (AC, RC, GS & contract) available greater than Total Nadir.
Available taskable is computed using the following formula: $j = i - g$.
- k. Military Taskable determines the number of AC deployable soldiers available greater than the adjusted Military Nadir.
Military taskable is computed using the following formula: $k = a - b + d - h$.
- l. Taskable inventory is the number of AC deployable soldiers that can be deployed & still allow the MTF to complete its core missions (Total & Military Nadir).
Taskable inventory is computed using the following formula:
 $l = \text{IF}((j < k), \text{ROUNDDOWN}(j, 0), \text{ROUNDDOWN}(k, 0))$
- m. Military Deployable is the number of military personnel eligible to be deployed with no consideration to any Nadir value.
Military Taskable is computed using the following formula: $m = a - b - c$.
- n. Decision support automatically evaluates the capability to support mission requirements in block f.
A in the Decision support area represents the number of military able to deploy to meet the mission with no consideration to any Nadir; the number the facility can Accept.
A is computed by using the following formula:
 $A = \text{IF}(f=0, 0, \text{IF}(m > f, f, m))$

C1 in the Decision support area represents the number personnel the facility needs Cross Leveled to it to allow the facility to Accept the number in column A.
C1 Cross Level (Nadir) takes into consideration both the total Nadir & military Nadir.
C1 is computed by using the following formula:
 $C1 = \text{IF}(l > A, 0, \text{ABS}(l - A))$

Appendix J - Continued

Sourcing Analysis Management Tool - MS Excel Logic Formulas

C2 in the Decision support area represents the number personnel the facility needs Cross Leveling within region by higher HQ because facility does not have enough deployable AC to deploy (meet mission).

C2 Cross Level (MOS/AOC) takes into consideration the total AC less the AC deployed or non-available for deployment & compares their number to the mission requirement.

C2 is computed by using the following formula:

$$C2 = IF(f-m < 0, 0, f-m)$$

B in the Decision support area represents the number personnel the RMC needs Out of RMC Backfill Request to Accept the number in column A.

B (Out of Region Backfill Request) takes into consideration both the total Nadir & military Nadir as well as intra-regional cross leveling.

B is computed by using the following formula:

$$B = IF(I > A, 0, ABS(I-A))$$

P in the Decision support area represents the number personnel the region needs passback to higher HQ because region does not have enough deployable AC to deploy (meet mission).

P (Passback) takes into consideration the total AC less the AC deployed or non-available for deployment & compares their number to the mission requirement.

P is computed by using the following formula:

$$P = IF(f-m < 0, 0, f-m)$$

o. Intra MTF (Post) & MOS/AOC Tables

AC/RC Available to Cross Level in Region (RMC) represents the number personnel the facility has or does not have to cross level with other facilities under the same region.

This number takes into consideration both the total & military Nadir as well as the number of personnel tasked to support this mission.

AC/RC Available to Cross level is computed by using the following formula:

$$AC/RC \text{ Available to Cross level} = I - A \quad (A = \text{Accept column})$$

o. Inter Regional Roll-Up Table slide

AC/RC Available for Out of Region Backfill represents the number personnel the RMC has or does not have to for out of region backfill.

This number takes into consideration both the total & military Nadir as well as the number of personnel tasked to support this mission and intra-regional cross leveling..

AC/RC Available for Out of Region Backfill is computed by using the following formula:

$$AC/RC \text{ Available for Out of Region Backfill} = I - A \quad (A = \text{Accept column})$$

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military				Civilian	Mission Support	Nadlr		Taskable/Deployable Analysis					Mission Analysis		
Corps	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	o. ACRC Available to Cross Level in RMC	
Medical	60J	8	1	4	0	1	2	7	6	8	1	1	1	3	2	1	0
	60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	0	0
	60W	4	0	0	0	1	0	3	2	5	2	2	2	4	0	0	2
	61J	6	0	5	0	1	3	5	4	7	2	2	2	1	1	0	2
	61M	10	0	8	0	0	3	6	6	10	4	4	4	2	2	0	1
	61R	13	0	7	0	9	1	16	11	22	6	2	2	6	1	0	0
62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0	0	
Nurse	66E	26	4	10	5	9	5	14	1	36	22	26	22	12	5	0	0
	66F	4	1	2	0	7	1	5	1	10	5	2	2	1	1	0	0
	66HM5	13	2	3	1	13	3	12	2	25	13	10	10	8	3	0	0
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	0	0
Enlisted	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	0	0
	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	0	0
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	0	7
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	1	0	0

A Accept
C1 Cross Level (Nadlr)
C2 Cross Level (MOS/AOC)

- Enter the number of AC assigned.
- Enter the number of AC assigned who are currently deployed.
- Enter the number of AC who meet authorized non-deployment criteria.
- Enter the total number of Reserve Component (RC) personnel assigned to the MTF.
- Enter the total number of civil service (GS) and contract employees who are equivalent to the respective military area of concentration (AOC) or military occupational
- Enter the number of AC required for mission.
- Total Nadlr is the minimum number of staff (AC, RC, GS & Contract)
- Military nadlr is the minimum number of military staff required

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military				Civilian	Mission Support	Nadir		Taskable/Deployable Analysis				Mission Analysis			
Corps	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non- Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available In MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	Nadir	
Medical	60J	8	1	4	0	1	2	7	6	8	1	1	1	3	2	0	-1
	60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	0	1
	60W			0			0	3	2	5	2	2	2	4	0	0	2
	61J	6	0	5	0	1	3	5	4	7	2	2	2	1	1	0	2
	61M	10	0	8	0	0	3	6	6	10	4	4	4	2	2	0	1
	61R	13	0	7	0	9	1	16	11	22	6	2	2	6	1	0	1
62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0	0	
Nurse	66E	26	4	10	5	9	5	14	1	36	22	26	22	12	5	0	17
	66F	4	1	2	0	7	1	5	1	10	5	2	2	1	1	0	1
	66HM5	13	2	3	1	13	3	12	2	25	13	10	10	8	3	0	7
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	0	18
Enlisted	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	0	11
	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	0	1
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	0	7
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	0	0	2

A	Accept
C1	Cross Level (Nadir)
C2	Cross Level (MOS/AOC)

i. Total Available in MTF is the number of personnel (AC, RC, GS & Contract) available to staff the MTF. Total Available in MTF is computed using the following formula: $i = a - b + d + e$.

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military				Civilian	Mission Support	Nadir		Taskable/Deployable Analysis				Mission Analysis			
		a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	o. AC/RC Available to Cross Level In RMC	
Corps	ADCIMOS																
	Medical	60J	8	1	4	0	1	2	7	6	8	1	1	1	3	2	-1
		60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	0
		60W	4	0	0	0	1	0	3	2	2	2	2	2	4	0	1
		61J	6	0	5	0	1	3	5	4	7	2	2	2	1	0	2
		61M	10	0	8	0	0	3	6	6	10	7	4	4	2	0	1
61R		13	0	7	0	9	1	16	11	22	6	2	2	6	1	2	
Nurse	62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0	
	66E	26	4	10	5	9	5	14	1	36	22	26	22	12	5	17	
	66F	4	1	2	0	7	1	5	1	10	5	2	2	1	1	1	
	66HM5	13	2	3	1	13	3	12	2	25	13	10	10	8	3	0	
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	7	
	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	18	
Enlisted	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	11	
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	4	
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	1	2	

A	Accept
C1	Cross Level (Nadir)
C2	Cross Level (MOS/AOC)

j. Total Taskable determines the number of total staff (AC, RC, GS & contract) available greater than Total Nadir. Available taskable is computed using the following formula: $j = i - g$.

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military				Civilian		Mission Support		Nadlr		Taskable/Deployable Analysis				Mission Analysis		
Corps	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non- Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support			
Medical	60J	8	1	4	0	1	2	7	6	8	1	1	1	3	2	1	0	
	60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	0	0	
	60W			0	0	1	0	3	2	5	2	0	2	4	0	0	0	
	61J	6	0	5	0	1	3	5	4	7	2	2	2	1	1	0	2	
	61M	10	0	8	0	0	3	6	6	10	4	4	4	2	2	0	1	
	61R	13	0	7	0	9	1	16	11	22	6	2	2	6	1	0	0	
	62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0	0	
Nurse	66E	26	4	10	5	9	5	14	1	36	22	26	22	12	5	0	0	
	66F	4	1	2	0	7	1	5	1	10	5	2	2	1	1	0	0	
	66HM5	13	2	3	1	13	3	12	2	25	13	10	10	8	3	0	0	
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	0	0	
Enlisted	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	0	0	
	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	0	0	
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	0	7	
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	1	0	0	

A	Accept
C1	Cross Level (Nadir)
C2	Cross Level (MOS/AO)

k. Military Taskable determines the number of AC deployable soldiers available greater than the adjusted Military Nadlr. Military taskable is computed using the following formula: $k = a - b + d - h$.

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military				Civilian	Mission Support	Nadiv		Taskable/Deployable Analysis				Mission Analysis		
	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	o. AC/RC Available to Cross Level in RMC
Medical																
	60J	8	1	4	0	1	2	7	6	8	1	1	1	3	2	-1
	60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	0
	60W	4	0	0	0	1	0	3	2	5	2	2	0	4	0	0
	61J	6	0	5	0	1	3	5	4	7	2	2	2	1	1	2
	61M	10	0	8	0	0	3	6	6	10	2	2	2	2	0	1
Nurse	61R	13	0	7	0	9	1	16	11	22	2	2	2	6	1	0
	62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0
	66E	26	4	10	5	9	5	14	1	36	22	12	22	12	5	17
	66F	4	1	2	0	7	1	5	1	10	2	1	2	1	1	0
	66HM5	13	2	3	1	13	3	12	2	25	10	8	10	8	3	0
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	0
Enlisted																
	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	0
	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	0
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	0
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	1	0

A	Accept
C1	Cross Level (Nadiv)
C2	Cross Level (MOS/AOC)

I. Taskable inventory is the number of AC deployable soldiers that can be deployed & still allow the MTF to complete its core missions (Total & Military Nadiv).
 Taskable inventory is computed using the following formula:

$$I = IF((j < k), ROUNDOWN(j, 0), ROUNDOWN(k, 0))$$

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military					Civilian	Mission Support	Nadir		Taskable/Deployable Analysis				Mission Analysis			
	Corps	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	o. AC/RC Available to Cross Level in RMC		
Medical																		
	60J	8	1	4	0	1	2	7	6	8	1	1	1	3	2	1	0	-1
	60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	0	0	1
	60W	6	0	5	0	1	0	3	2	5	2	2	2	7	0	0	0	2
	61J	6	0	5	0	1	3	5	4	7	2	2	2	1	1	0	2	1
	61M	10	0	8	0	0	3	6	6	10	4	4	4	1	2	0	1	2
Nurse	61R	13	0	7	0	9	1	16	11	22	6	2	2	6	1	0	0	1
	62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0	0	0
	66E	26	4	10	5	9	5	14	11	36	22	26	22	12	5	0	0	17
	66F	4	1	2	0	7	1	5	1	10	5	2	2	1	1	0	0	1
	66HM5	13	2	3	1	13	3	12	2	25	13	10	10	8	3	0	0	7
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	0	0	18
Enlisted																		
	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	0	0	11
	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	0	0	1
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	0	7	4
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	1	0	0	2

A	Accept
C1	Cross Level (Nadir)
C2	Cross Level (MOS/AOC)

m. Military Deployable is the number of military personnel eligible to be deployed with no consideration to any Nadir value.
 Military Taskable is computed using the following formula: $m = a - b - c$.

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

Corps	FT Sam Houston	Military				Civilian	Mission Support	Nadiri		Taskable/Deployable Analysis				Mission Analysis		
		a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/Contract		f. Total	g. Military	h. Total Available in Support	i. Total Taskable	j. Military Taskable	k. Taskable Inventory	l. Military Deployable	m. Decision Support	n. ACRC Available to Cross Level in RMC
Medical	60J	8	1	4	0	1		6	8		1	1	2	1	0	-1
	60N	12	2	7	0	2		10	12		2	2	4	0	0	1
	60W	4	0	0	0	1		3	2	5	2	2	4	0	0	2
	61J	6	0	5	0	1		5	4	7	2	2	2	1	0	1
	61M	10	0	8	0	0		6	10	4	4	4	2	0	1	2
	61R	13	0	7	0	9		16	11	22	6	2	6	1	0	1
Nurse	62A	11	0	8	0	1		10	9	12	2	2	3	2	0	0
	66E	26	4	10	5	9		14	1	36	22	26	12	5	0	17
	66F	4	1	2	0	7		5	1	10	5	2	2	1	0	1
	66HM5	13	2	3	1	13		12	2	25	13	10	8	3	0	7
	66H8A	41	9	11	6	71		80	11	109	29	27	21	9	0	18
	91D	37	4	9	0	38		50	12	71	21	21	24	10	0	11
Enlisted	91V	21	3	1	3	22		32	13	43	11	8	8	7	0	1
	91WM6	44	9	21	7	59		83	24	101	18	18	14	14	0	4
	91X	10	1	2	3	0		9	9	12	3	3	3	1	0	2

Accept

Cross Level (Nadiri)

Cross Level (MOS/AOC)

n. Decision support automatically evaluates the capability to support mission requirements in block f.

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military				Civilian	Mission Support	Nadir		Taskable/Deployable Analysis				Mission Analysis		Nadir
	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	o. AC/RC Available to Cross Level in RMC
Medical																
	60J	8	1	4	0	1	2	7	6	8	1		1	3	1	0
	60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	0
	60W	4	0	0	0	1	0	3	2	5	2	?	?	4	0	1
	61J	6	0	5	0	1	3	5	4	7	2		2	1	0	2
	61M	10	0	8	0	0	3	6	6	10	4		4	2	2	1
Nurse	61R	13	0	7	0	9	1	16	11	22	6	2	2	6	1	0
	62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0
	66E	26	4	10	5	9	5	14	1	36	22	26	22	12	5	0
	66F	4	1	2	0	7	1	5	1	10	5	2	2	1	1	0
Enlisted	66HM5	13	2	3	1	13	3	12	2	25	13	10	10	8	3	0
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	0
	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	0
	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	0
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	0
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	0	0

A	Accept
C1	Cross Level (Nadir)
C2	Cross Level (MOS/AOC)

n. Decision support automatically evaluates the capability to support mission requirements in block f.

C1 in the Decision support area represents the number personnel the facility needs

Cross Levelled to it to allow the facility to Accept the number in column A.

C1 Cross Level (Nadir) takes into consideration both the total Nadir & military Nadir.

C1 is computed by using the following formula:

$$C1 = \text{IF}(L > \text{Accept}, 0, \text{ABS}(L - \text{Accept}))$$

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military				Civilian	Mission Support	Nadir		Taskable/Deployable Analysis				Mission Analysis		
	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	Nadir o. AC/RC Available to Cross Level in RMC
Corps																
Medical	60J	8	1	4	0	1	2	7	6	8	1	1	1		A	-1
	60N	12	2	7	0	2	2	10	8	12	2	2	2		C1	0
	60W	4	0	0	0	1	3	3	2	5	2	0	2		C2	0
	61J	6	0	5	0	1	3	5	4	7	2	1	2		C1	2
	61M	10	0	8	0	0	3	6	6	10	4	4	4		C1	2
	61R	13	0	7	0	9	1	16	11	22	6	2	2		C1	1
62A	11	0	8	0	1	2	10	9	12	2	2	2		C2	0	
Nurse	66E	26	4	10	5	9	5	14	1	36	22	26	22		5	0
	66F	4	1	2	0	7	1	5	1	10	5	2	2		1	0
	66HM5	13	2	3	1	13	3	12	2	25	13	10	10		3	0
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27		9	0
																0
																0
Enlisted	91D	37	4	9	0	38	10	50	12	71	21	21	21		10	0
	91V	21	3	1	3	22	7	32	13	43	11	8	8		7	0
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18		14	0
	91X	10	1	2	3	0	1	9	9	12	3	3	3		1	0

A

C1

C2

Accept
Cross Level (Nadir)
Cross Level (MOS/AOC)

n. Decision support automatically evaluates the capability to support mission requirements in block f.

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

FT Sam Houston		Military				Civilian	Mission Support	Nadir		Taskable/Deployable Analysis				Mission Analysis		
	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	o. AC/RC Available to Cross Level in RMC
Corps																
	60J	8	1	4	0	1	2	7	6	8	1	1	1	3	2	-1
	60N	12	2	7	0	2	1	10	8	12	2	2	2	3	1	1
	60W	4	0	0	0	1	0	3	2	5	2			4	0	0
	61J	6	0	5	0	1	3	5	4	7	2	2	2	1	0	2
Medical	61M	10	0	8	0	0	3	6	6	10	4	4	4	2	2	2
	61R	13	0	7	0	9	1	16	11	22	6	2	2	6	1	1
	62A	11	0	8	0	1	2	10	9	12	2	2	2	3	2	0
Nurse																
	66E	26	4	10	5	9	5	14	1	36	22	26	22	12	5	17
	66F	4	1	2	0	7	1	5	1	10	5	2	2	1	1	1
	66HM5	13	2	3	1	13	3	12	2	25	13	10	10	8	3	0
	66H8A	41	9	11	6	71	9	80	11	109	29	27	27	21	9	18
Enlisted																
	91D	37	4	9	0	38	10	50	12	71	21	21	21	24	10	11
	91V	21	3	1	3	22	7	32	13	43	11	8	8	17	7	1
	91WM6	44	9	21	7	59	21	83	24	101	18	18	18	14	14	4
	91X	10	1	2	3	0	1	9	9	12	3	3	3	7	1	2

A

C1

C2

Accept

Cross Level (Nadir)

Cross Level (MOS/AOC)

o. **Intra MTF (Post) & MOS/AOC Tables**
AC/RC Available to Cross Level in Region (RMC) represents the number personnel the facility has or does not have to cross level with other facilities under the same region. This number takes into consideration both the total & military Nadir as well as the number of personnel tasked to support this mission.
AC/RC Available to Cross level is computed by using the following formula:
AC/RC Available to Cross level = **L-Accept (A=Accept column)**

Appendix J - Continued

Sourcing Analysis Management Tool – Step by Step Description

Report as of: 29-Apr-05

GPRMC		Military				Civilian	Mission Support	Nadir		Taskable/Deployable Analysis					Mission Analysis		Nadir
Corps	AOC/MOS	a. AC Assigned	b. AC Deployed	c. AC Non-Available	d. RC Assigned	e. GS/ Contract	f. Number Required	g. Total	h. Military	i. Total Available in MTF	j. Total Taskable	k. Military Taskable	l. Taskable Inventory	m. Military Deployable	n. Decision Support	o. AOC/RC Available to Cross Level in RMC	
Medical																	
	60J	36	3	13	0	8.5	2	31	21	41.5	11	12	10	20	A	8	
	60N	28	3	11	0	5	2	23	16	30	7	9	6	14	2	4	
	60W	21	4	5	0	7	2	20	12	24	4	5	3	12	2	0	
	61J	33	5	11	0	5	14	22	16	33	11	12	10	17	4	-4	
	61M	35	3	17	0	4	5	27	17	36	9	15	9	15	5	4	
Nurse	61R	30	1	10	0	19	1	37.5	21	48	11	8	6	19	1	5	
	62A	44	6	18	0	21.5	6	54	29	59.5	6	9	4	20	6	-2	
	66E	73	15	20	21	39	10	67	16	118	51	63	49	38	10	39	
	66F	49	12	20	2	36.5	7	54	11	75.5	22	28	16	17	7	9	
Enlisted	66HM5	28	6	6	8	70.5	4	70	14	100.5	31	16	12	16	4	8	
	66H8A	81	25	19	27	137.5	15	162	27	220.5	59	56	49	37	15	34	
	91D	172	17	17	17	69	12	176	90	241	65	82	59	138	12	47	
	91V	49	6	2	9	56	8	83	27	108	25	25	20	41	8	12	
	91WM6	194	40	42	30	405	44	541	103	589	48	81	40	112	44	-4	
	91X	97	3	9	5	29	1	107	75	128	21	24	12	85	0	11	

A	Accept
B	Out of RMC Backfill Request
P	Passback

B in the Decision support area represents the number personnel the RMC needs Out of RMC Backfill Request to Accept the number in column A.

B (Out of Region Backfill Request) takes into consideration both the total Nadir & military Nadir as well as intra-regional cross leveling. **B** is computed by using the following formula:

$$B = \text{IF}(L > \text{Accept}, 0, \text{ABS}(L - \text{Accept}))$$

P in the Decision support area represents the number personnel the region needs passback to higher HQ because region does not have enough deployable AC to deploy (meet mission).

P (Passback) takes into consideration the total AC less the AC deployed or non-available for deployment & compares their number to the mission requirement. **P** is computed by using the following formula:

$$P = \text{IF}(f - m < 0, 0, f - m)$$

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14. Abstract Cont'

The resulting process should reduce the turbulence in the distribution of PROFIS taskings and allow the regional visibility. The goal of this study is to have the resulting process be utilized not only by this Regional Medical Command (RMC), but by all RMCs in the U.S. Army Medical Command (MEDCOM).