Department of Defense Healthcare Management System Modernization (DHMSM) Program

Attachment 8: Health Service Delivery Concept of Operations (CONOPS)

DHMSM Program Management Office
DoD Healthcare Management Systems (DHMS) Program Executive Office

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Developed by:
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EXECUTIVE SUMMARY

Military medicine has achieved unprecedented and truly remarkable outcomes. We have achieved these results due to the foundation of a vibrant military medical culture - one based on innovation, service to others, and an unrelenting persistence to achieve excellence. We will continue to improve healthcare delivery across the full spectrum of operations in service to our warriors. To achieve this necessary goal we have created a Health Service Delivery (HSD) Concept of Operations (CONOPS) with the responsibility of improving the DoD health benefit. The HSD CONOPS is a strategic document which defines the capabilities required to deliver health services as prescribed by the MHS mission at military treatment facilities and through industry health partners. The problem the HSD CONOPS is designed to address is:

> *The military health enterprise must ensure that it functions as a fully integrated system to effectively and efficiently respond to rapidly changing economic conditions, missions, beneficiary demographics, technologies, and health education and research.*

This HSD CONOPS provides the framework necessary to support rigorous assessment and analysis of health service delivery to identify capability gaps, unnecessary redundancy and inefficiencies through a capabilities based assessment (CBA) process to reach appropriate materiel and non-materiel health-related solutions as part of the broader DoD Joint Capabilities Integration and Development System (JCIDS) effort.

HSD capabilities contribute to the overall ability of the DoD to perform its health mission and are designed to enable the four mission elements of the MHS Strategic Plan: casualty care and humanitarian assistance/disaster response; fit, healthy, and protected force; healthy and resilient individuals, families, and communities; education, research, and performance improvement.

Chapter 1 presents the strategic construct of the HSD CONOPS describing the primary mission of the MHS to provide a continuum of health services across the range of military operations. HSD provides the ability to build healthy communities by managing and delivering the DoD health benefit by using military treatment facilities and a network of industry healthcare providers via TRICARE and other federal healthcare partners. The purpose of the HSD CONOPS is to support rigorous CBAs to determine health service delivery capability gaps, unnecessary redundancies and inefficiencies, and ultimately guide the development of appropriate materiel and non-material solutions as part of the broader DoD JCIDS effort.

Chapter 2 describes emerging challenges and presents a problem statement addressing aspects of the *future* Joint Operating Environment (JOE) as related to the DoD health mission. The future challenges of providing effective and efficient HSD capabilities will require an MHS enabled to execute key supporting capabilities focused on the requirements of an integrated and interdependent DoD medical system.

Chapter 3 introduces the HSD concept and delineates the supporting roles of Force Health Protection (FHP) and Health System Support (HSS) capabilities and their interdependence with HSD amongst the four mission elements of the Military Health System (MHS) strategic plan.

The concept provided contributes to the overall ability of the DoD to perform its health care mission through the MHS.

Chapter 4 outlines HSD capabilities in six functional areas: Define the Health Benefit; Clinical Preventive Medicine; Diagnosis; Treatment; Rehabilitation; Reintegration
These capabilities are further developed in terms of specific tasks, conditions, attributes and standards in appendix (A).

Chapter 5 presents the vision for implementing this CONOPS. Effective HSD implementation will ensure new and existing HSD capabilities are entered into the formal JCIDS process to enable analysis of specific transformation investments addressing risk areas identified in the 2006 and 2010 Quadrennial Defense Reviews (QDR) and future Departmental reviews addressing Health Readiness (HR) or HSD.

In conclusion, this HSD CONOPS provides the framework to continue improving health service delivery through the CBA process to reach appropriate materiel and non-materiel solutions as part of the broader DoD JCIDS effort. It is a key component, in conjunction with the FHP and HSS CONOPS, supporting the overarching Health Readiness (HR) CONOPS in guiding combatant commanders and medical communities in the development and employment of solutions to address future health related challenges.

1.1 CHAPTER 1. STRATEGIC CONSTRUCT

Our Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen constitute our most critical strategic and most treasured resource. They deserve the unflinching support of a nation that clearly understands, from the outset, why the All-Volunteer Force has been placed in harm's way and what risks and costs come with the use of military force.

Quadrennial Defense Review Report, February 2010 *pg 10*

Health Service Delivery (HSD) provides the ability to build healthy communities by managing and delivering the DoD health benefit by using military treatment facilities and a network of industry healthcare providers via TRICARE and other federal healthcare partners. HSD includes the application of clinical preventive medicine, clinical diagnostics, treatment, rehabilitation, and reintegration for all those entrusted to our care. This is important not only for accomplishing the mission but also for meeting the expectations of military personnel, commanders, and Congress. The complexity of meeting these expectations across the four categories of military activity (combat, security, engagement, and relief/reconstruction) requires a common lexicon for medical capabilities among service component planners to assure the Military Health System (MHS) is provided appropriate resources to improve, maintain and restore health for beneficiary service members, their families and all other MHS beneficiaries.

1.2 PURPOSE

The purpose of this HSD Concept of Operations (CONOPS) is to support the Capabilities Based Assessment (CBA) process as a tool for rigorous analysis to determine HSD capability gaps and inefficiencies. Ultimately, the goal is to develop appropriate materiel and non-materiel HSD solutions as part of the broader Department of Defense (DoD) Joint Capabilities Integration and Development System (JCIDS) effort.

The HSD CONOPS provides the framework to:

- Ensure overall Health Readiness (HR) integration of the six HSD capability areas which are defined in Chapter 4 and decomposed into capabilities, tasks, attributes and standards in Appendix A.
- Support identification of capability gaps, shortfalls, and overmatch.
- Inform efforts to improve integrated HSD for Defining the Health Benefit, Clinical Preventive Medicine, Diagnosis, Treatment, Rehabilitation, and Reintegration.
- Support the four Mission Elements and related Mission Outcomes of the 2008 MHS Strategic Plan as described in Chapter 3.
- Focus on people, business practices, organizations and processes that are critical to the transformation of healthcare.

1.3 SCOPE

This CONOPS guides the development of integrated, high quality and efficient health service delivery to beneficiaries in either the direct or purchased care system.

It describes HSD capabilities available to Joint Force Commanders and is applicable to geographic and functional Combatant Commanders (CCDRs), military services, defense agencies, and joint staff for concept development and experimentation. The HSD CONOPS is focused on health service delivery and is designed to incorporate the four mission elements described in the *2008 MHS Strategic Plan*. Multiple factors impact the HSD capability development including: Task Force on the Future of Military Health Care recommendations, 2005 Base Realignment and Closure Act (BRAC), National Defense Authorization Act (NDAA) of 2008 related to the care of our wounded, ill, and injured as defined by the Senior Oversight Committee (SOC), 2010 Quadrennial Defense Review Report and service-specific missions.

The essential attributes of this HSD CONOPS are as follows:

- Must address the four MHS mission elements and related mission outcomes as described in the *2008 MHS Strategic Plan*.
- Must acknowledge service-unique medical missions and capabilities.
- Must consider MHS dimensions across the four categories of military activity (combat, security, engagement, and relief/reconstruction) and be developed in accordance with key elements of Joint Concepts outlined in Capstone Concept for Joint Operations (CCJO) v3.0 (January 2009), Chairman of the Joint Chiefs of 249 Staff Manual (CJCSM) 3010.02A, *Manual for Joint Concept Development and Experimentation* (January 2009) and *Manual for the Operation of the Joint Capabilities Integration and Development System (JCIDS)* (February 2009, updated 31 July 2009).

1.4 CONTEXT

The provision of health services and health benefits is an established and significant mission of each service branch of the U.S. Military. The extent and volume of healthcare services provided through military programs have grown dramatically since World War II resulting in the world's largest military healthcare system. This system serves several distinct categories of beneficiaries, including Active Duty military personnel, families of Active Duty personnel, reservists, and military retirees and their dependents. Unlike civilian healthcare systems, the Military Health System must give priority to military readiness; the Nation's engagement in a long term war on terror; the support of a conventional war, if necessary; the provision of humanitarian relief and response to natural disasters; and the achievement of other missions required by national command authorities.[1]

The Assistant Secretary of Defense for Health Affairs (ASD (HA) serves as program manager for all DoD health and medical resources. As such, ASD (HA) will exercise authority, direction, and control over the DoD medical and dental personnel authorizations and policy, facilities, programs, funding, and other resources in the Department of Defense.[2]

The *2008 MHS Strategic Plan* reflects the MHS response to guidance provided by the Secretary of Defense's (SECDEF) Independent Review Group, The President's Commission on Care for

[1] *Final Report of the Task Force on the Future of Military Healthcare*, December 2007.

[2] Department of Defense Directive (DoDD) 5136.01, 4 June 2008.

America‘s Returning Wounded Warriors, the Task Force on the Future of Military Health Care, the Task Force on Mental Health and the current environment of jointness within DoD.

The *2008 MHS Strategic Plan* provides a platform for increased collaboration with the Department of Veterans Affairs and civilian partners to improve coordinated care for Wounded Warriors and all who serve. It defines the MHS mission as follows: ―Our team provides optimal Health Services in support of our nation‘s military mission—anytime, anywhere.‖[3]

The primary mission of the MHS is to provide the continuum of health services across the range of military operations. This is contingent on the ability to create and sustain a fit, healthy and protected force. There are four major mission elements that support this primary mission: casualty care & humanitarian assistance/disaster response; fit, healthy & protected force; healthy & resilient individuals, families & communities; and medical education, research & performance improvement.

Each MHS mission element is interdependent and cannot exist alone. Chapter 3 will develop the relationship between HSD and the four mission elements of the MHS Strategic Plan and their integrating nature, as briefly described below:

- An integrated and responsive research methodology and education and training system must develop a capacity that is essential to achieving improvements in operational and en–route care.
- A critical aspect of the system is to produce the quality of medical professionals and assemblages needed for an anytime, anywhere mission.
- Sustaining the quality of these medical professionals cannot occur without a uniformed base and beneficiary platform that produces healthy individuals, families, and communities.
- The continuum of health services must include, when necessary, a seamless transition with the Department of Veterans Affairs (VA), civilian healthcare, and other governmental and non-governmental health care providers.

1.5 ASSUMPTIONS

The HSD CONOPS is based on the following assumptions.

- Success across the four categories of military activity (combat, security, engagement, and relief/reconstruction) depends on support of a single MHS mission with four independent but integrated, mission elements.
- The MHS will follow strategies to support medical transformation as described in the *2006 and 2010 Quadrennial Defense Reviews* (QDR).
- Generation of innovative use of personnel and technology to enhance the provision of care enables the DoD to improve quality and standard of care while reducing growth in overall costs.

[3] *2008 Military Health System Strategic Plan*

2.1 CHAPTER 2. MILITARY HEALTH SERVICE DELIVERY CHALLENGE

> *In order to help defend and achieve our national interests, the Department of Defense balances resources and risk among four priority objectives: prevail in today's wars, prevent and deter conflict, prepare to defeat adversaries and succeed in a wide range of contingencies, and preserve and enhance the All-Volunteer force…the Department must do all it can to take care of our people-physically and psychologically.*
>
> *Quadrennial Defense Review Report*, February 2010. p. v-vi

The MHS is a critical enabler for the DoD and Joint Force Commanders in virtually every aspect of the future Joint Operating Environment (JOE). The MHS leadership is acutely aware of the stress the force has encountered over nine years of continuous conflict. Public Health issues provide a common context for dialog in security, engagement, and relief and reconstruction efforts that often transcend political disagreements, and project a favorable image of the United States. The protection and care of military service members and their families will continue to be a crucial source of confidence and incentive for service. Military healthcare faces the same resource competition and heightened expectations for outcomes experienced in the U.S. national health sector. The MHS must identify and resource the capabilities necessary to adapt quickly, effectively and efficiently to the challenges outlined in the JOE and in the HR mission. HSD capabilities support the specific MHS requirements reflected in the overarching HR CONOPS and are fully integrated with the Health System Support (HSS) and Force Health Protection (FHP) CONOPS.

2.2 MATURE AND EMERGING CHALLENGES

To support evolving national interests and respond to the growing challenges and ever present danger facing U.S. military forces, the MHS must rapidly adapt to changing world events and prepare for natural disasters across the world. The MHS is prepared to apply comprehensive medical capabilities to support military operations and respond to man-made and natural disasters and humanitarian crises around the globe. The MHS must support the warfighter in limited and large scale conventional warfare and homeland defense, provide support to civil authorities as directed, and assist non-military health agency operations as required. Preservation and enhancement of the health of the All-Volunteer Force is a clear priority. In a time of rapid change and limited resources, the MHS leadership recognizes the necessity of innovative practices to maximize effectiveness and quality.

2.3 KEY ASPECTS OF THE HEALTH SERVICE DELIVERY ENVIRONMENT

The aspects listed below will influence concepts critical to the success of HSD capabilities:

- Prepare for and perform the healthcare mission anytime, anywhere to support a global patient community in diverse operational environments.
- Provide patient and family centered care that maximizes quality, incorporates innovation and judiciously expends limited resources.

- Continuously improve the overall healthcare of the population through focused prevention and increased resilience.
- Responsibly manage the total healthcare cost by eliminating waste, reducing variation, and reducing total cost of care over time.
- Health Readiness must develop new capabilities to support Whole-of-Government and Global Health Engagement approaches to mitigate conflicts beyond the conventional nation state domains within all environments and in accordance with CBRN Survivability policy.

2.4 FUTURE JOINT FORCE OPERATIONS IMPACTING HEALTH SERVICE DELIVERY

The future operating environment may be characterized by uncertainty, rapid change and persistent conflict. These conditions may produce humanitarian crises and internal or cross-border armed conflict. America's status as a global power with global interests requires continuous presence and engagement throughout the world through forward deployment of U.S. Joint forces. The HSD CONOPS must address this state and include capabilities that prepare Soldiers, Sailors, Airmen, Marines and Coast Guardsmen for this environment.

2.5 HEALTH SERVICE DELIVERY ELEMENTS OF THE PROBLEM

The emerging operating environment provides context for the HSD CONOPs, which must address the following elements of this environment to successfully guide the future of the MHS:

- Medical forces must be net-centric and interoperable by design to enable a fully integrated future health system that can accelerate its ability to inform, decide, and act in real time.
- Medical information systems must fully facilitate data sharing, net-centric operations, and sense and respond capabilities among U.S. Government, interagency and non-government industry partners.
- The medical training strategies and platforms will fully prepare medical forces to operate in an environment in which joint forces deliberately create situations that change at great speed and intensity.
- The medical logistics system must be capable of providing standardized, interchangeable and up-to-date supplies and equipment as medical technology changes and must anticipate and distribute medically necessary and serviceable medical supplies and equipment to the right person, in the right place, at the right time.
- Medical systems, equipment, and forces will be able to function in all types of operational environments, including multinational operations, security, transition, and reconstruction operations; operations with Non-Governmental Organizations (NGOs) and International/Agency Government Organizations (IGOs); medical capacity building; and public health services.[4]

[4] Joint Force Health Protection Concept of Operations, pages 8, 9.

2.6 HEALTH SERVICE DELIVERY PROBLEM STATEMENT

The MHS mission states: ―our team provides optimal Health Services in support of our nation's military mission—anytime, anywhere.‖[5]. The MHS mission can be broken down into four mission elements: casualty care and humanitarian assistance/disaster response; fit, healthy, and protected force; healthy and resilient individuals, families, and communities; and education, research, and performance improvement. The joint medical force must be capable of operating in complex and diverse operational environments; confronting a range of traditional and emerging adversaries and threats; employing and integrating new technologies; and collaborating with other organizations, agencies, nations, and cultures. Essentially:

> *Current projections for the geo-strategic environment out to 2016 indicate an unsettled and rapidly changing world. The MHS must be prepared to support sustained military operations characterized by unconventional warfare and continuing need for humanitarian assistance. More emphasis will be placed on reigning in healthcare costs, transparency and accountability as health services are projected to consume an increasing proportion of the GDP and the DoD budget.*
>
> *The military health enterprise must ensure that it functions as a fully integrated system to effectively and efficiently respond to rapidly changing economic conditions, missions, beneficiary demographics, technologies, and health education and research.*

[5] *2008 MHS Strategic Plan,* page 2.

3.1 CHAPTER 3. HEALTH SERVICE DELIVERY CONCEPT

3.2 SYNOPSIS OF THE CENTRAL IDEA

Providing effective and efficient Health Readiness capabilities for the DoD requires the MHS leadership to focus on the requirements of an interoperable and interdependent MHS interacting with whole-of-government and multi-national approaches to scenarios in the operational environment. This includes development and life cycle management of its people, infrastructure, technology, research, materiel, financial resources and strategic partnerships. These capabilities must be integrated into an agile _system of systems‘ in order to optimize FHP and HSD capabilities, and provide accountability to the DoD. As described in the HR CONOPS, the HSD JCA includes:

> *The ability to build healthy communities by managing and delivering the TRICARE health benefit, using military treatment facilities along with TRICARE network of healthcare providers and partnership development among health service organizations outside the DoD. This ability includes clinical preventive medicine, along with clinical diagnostics, treatment, rehabilitation, and reintegration, for all those entrusted to our care. It also includes activities associated with the health services contract development, health services contract management, and partnership development among health service organizations outside the DOD. (Health Readiness CONOPS 3.4.2)*

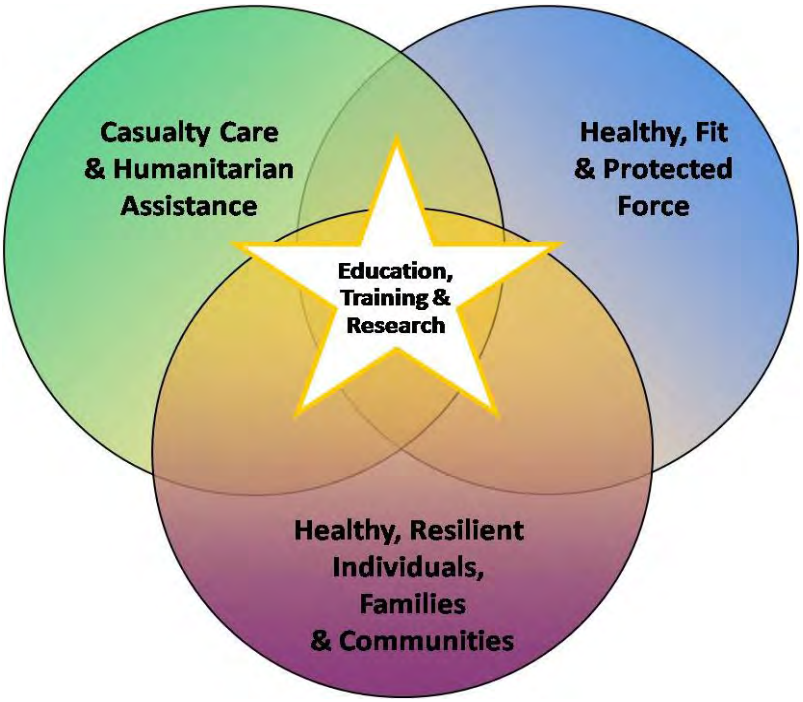
The overarching purpose of the HSD CONOPS is to focus MHS strategic planning activity on the core business in which we are engaged; creating an integrated medical team that provides optimal HSD for the entire MHS. Mission outcomes will be achieved through new and enhanced HSD capabilities integrated with FHP and HSS capabilities.

3.3 FOUR MISSION ELEMENTS

HSD includes capabilities that will provide for a fully integrated health system focused on the four mission elements of the MHS Strategic Plan: (1) casualty care and humanitarian assistance/disaster response; (2) fit, healthy and protected force; (3) healthy and resilient individuals, families, and communities; and (4) education, research, and performance improvement.[6] HSD encompasses the broad spectrum of medical capabilities required to support the ability of the MHS to promote, protect, improve, conserve, and restore the mental and physical well-being of service members, families and designated beneficiaries. As the figure 3-1 below illustrates, each of the MHS mission elements is interdependent and cannot exist alone. An integrated and responsive research methodology and development capacity is essential to achieve improvements in operational care and evacuation. A medical education and training system that produces health care providers of the quality needed for an anytime, anywhere mission is critical. Sustaining the quality of these health care providers cannot occur without a uniformed base and platform that produces healthy individuals, families and communities.

[6] *2008 MHS Strategic Plan*

Figure 3-1: Four Mission Elements



3.2.1 Mission Element 1: Casualty Care and Humanitarian Assistance/Disaster Response

The MHS maintains an agile, fully deployable medical force and a healthcare delivery system that enables state-of-the-art health services anytime, anywhere. It uses this medical capability to treat casualties, restore function, support humanitarian assistance and disaster relief, and build bridges to peace worldwide. The desired mission outcomes of Casualty Care and Humanitarian Assistance/Disaster Response are:

- Reduce Combat Losses (consequences of wounds).
- Effective Medical Transition from Service and Seamless Transition From Battlefield to VA or Other Rehabilitation.
- Improved Rehabilitation and Reintegration.
- Increased Interoperability With Allies, Other Government Agencies, and NGOs.
- Reconstitution of Host Nation Medical Capability.
- Strategic Deterrence for Warfare.

HSD is critical in the seamless integration of expeditionary healthcare (FHP) and home-based capabilities in the provision of Casualty Care, and is a clear enabler of the provision of Humanitarian Assistance. Table 3-1 identifies intersections of support between HSD and Mission Element 1 desired outcomes.

Table 3-1: HSD Integration with Mission Element 1 of the MHS Strategic Plan

MISSION ELEMENT 1: Casualty Care and Humanitarian Assistance/Disaster Response						
Reduce Combat Losses (consequences of wounds).						
Effective Medical Transition From Service and Seamless Transition From Battlefield to VA or Other Rehabilitation.						
Improved Rehabilitation and Reintegration.						
Increased Interoperability With Allies, Other Government Agencies, and NGOs.						
Reconstitution of Host Nation Medical Capability.						
Strategic Deterrence for Warfare.						
Health Service Delivery Capabilities						
Define the Health Benefit		✓	✓	✓	✓	✓
Clinical Preventive Medicine	✓	✓	✓	✓	✓	✓
Diagnosis		✓	✓	✓	✓	✓
Treatment		✓	✓	✓	✓	✓
Rehabilitation		✓	✓	✓	✓	✓
Reintegration				✓	✓	✓

3.2.2 Mission Element 2: Fit, Healthy, and Protected Force

The MHS will help commanders create and sustain the healthiest and medically prepared fighting force anywhere. The desired mission outcomes of a Fit, Healthy, and Protected Force are:

- Reduce Medical Non-Combat Loss.
- Improve Mission Readiness.
- Optimize Human Performance.

"Identifying and enhancing joint HSD capabilities for the future will ensure the Joint Force Commander (JFC) has a healthy, fit and protected force." For example, provision of Clinical Preventive Medicine must be synchronized with a myriad of medical information applications in order to track combat and non-combat loss injuries and track components of individual medical readiness and human performance while providing a supportive structure for Diagnostic and Treatment capabilities. Table 3-2 identifies intersections of support between HSD and Mission Element 2 desired outcomes.

Table 3-2: HSD Integration with Mission Element 2 of the MHS Strategic Plan

MISSION ELEMENT 2: Fit, Healthy, and Protected Force			
Reduce Medical Non-Combat Loss.			
Improve Mission Readiness.			
Optimize Human Performance.			
Health Service Delivery Capabilities			
Define the Health Benefit	✓	✓	✓
Clinical Preventive Medicine	✓	✓	✓
Diagnosis	✓	✓	✓
Treatment	✓	✓	✓
Rehabilitation		✓	✓
Reintegration		✓	

3.2.3 Mission Element 3: Healthy and Resilient Individuals, Families, and Communities

The MHS goal is to maintain a sustained partnership that promotes health and creates resilience to recover quickly from illness, injury, or disease. The desired mission outcomes of Healthy and Resilient Individuals, Families, and Communities are:

- Healthy Communities/Healthy Behaviors (Public Health).
- Healthcare Quality.
- Access to Care.
- Beneficiary Satisfaction and Perception of MHS Quality.
- Perception of MHS Quality by Recruitment Pool.

Maintaining healthy and resilient individuals, families and communities is a necessity and obligation the MHS can only accomplish with the help of partners such as TRICARE contractors, community organizations and educational institutions. Table 3-3 identifies intersections of support between HSD and Mission Element 3 desired outcomes.

Table 3-3: HSD Integration with Mission Element 3 of the MHS Strategic Plan

MISSION ELEMENT 3: Healthy and Resilient Individuals, Families, and Communities					
Healthy Communities/Healthy Behaviors (Public Health).					
Healthcare Quality.					
Access to Care.					
Beneficiary Satisfaction and Perception of MHS Quality					
Perception of MHS Quality by Recruitment Pool.					
Health Service Delivery Capabilities					
Define the Health Benefit	✓	✓	✓	✓	✓
Clinical Preventive Medicine	✓	✓	✓	✓	✓
Diagnosis	✓	✓	✓	✓	✓
Treatment	✓	✓	✓	✓	✓
Rehabilitation	✓	✓	✓	✓	✓
Reintegration	✓	✓	✓	✓	✓

3.2.4 Mission Element 4: Education, Research, and Performance Improvement

Sustaining mission success relies on the MHS' ability to adapt in the face of a rapidly changing health and national security environment. To accomplish this effort, the MHS must be a learning organization that values personal and professional growth and supports innovation. The desired mission outcomes of Education, Research, and Performance Improvement are:

- Capable Medical Workforce.
- Advancement of Medical Science.
- Advancement of Global Public Health.
- Create and Sustain the Healing Environment (Facilities).
- Performance-Based Management and Efficient Operations.
- Performance-Based Focus for Joint Medical Education and Training.

Effective support to health education, research and performance improvement requires health expertise and a complete understanding of priorities associated with delivery of care in conjunction with the ever present training mission. Table 3-4 identifies intersections of support between HSD and Mission Element 4 desired outcomes.

Table 3-4: HSD Integration with Mission Element 4 of the MHS Strategic Plan

MISSION ELEMENT 4: Education, Research, and Performance Improvement						
Capable Medical Workforce.						
Advancement of Medical Science.						
Advancement of Global Public Health.						
Create and Sustain the Healing Environment (Facilities).						
Performance-Based Management and Efficient Operations.						
Performance-Based Focus for Joint Medical Education and Training.						
Health Service Delivery Capabilities						
Define the Health Benefit	✓	✓	✓	✓	✓	✓
Clinical Preventive Medicine	✓	✓	✓	✓	✓	✓
Diagnosis	✓	✓	✓	✓	✓	✓
Treatment	✓	✓	✓	✓	✓	✓
Rehabilitation	✓	✓	✓		✓	✓
Reintegration	✓	✓			✓	✓

3.3 ENHANCED INTEROPERABILITY AND INTERDEPENDENCE WITHIN THE MILITARY HEALTH SYSTEM

An objective of this CONOPS is to transform the medical force into a fully integrated health system that operates across the full spectrum of global contingency operations to support a dynamic force. To this end, the future medical force must support service-unique missions while operating with an optimal degree of interoperability and interdependence, as a fully integrated system. The components of the future total medical force must be versatile and able to adapt quickly to collectively maintain all the capabilities required for supporting the joint force and to meet the health requirements of all MHS stakeholders and beneficiaries. In the past, the MHS capabilities largely represented the sum of independently developed service programs without maximizing opportunities for enhanced interoperability and interdependency through joint development and standardization. Current and future military strategies mandate that HSD be more responsive to support diverse operations at home and abroad without compromise to service-unique missions. HSD capabilities must be developed jointly and optimized to support HR operations ―anytime, anywhere‖ in support of our nation‘s military mission.

The definitions and discussion of the terms *interoperability, interdependent, and interchangeable,* are defined further in Appendix C and in the overarching HR CONOPS.

3.4 SUPPORTING CAPABILITY AREAS

3.4.1 Force Health Protection

FHP describes capabilities required to deliver MHS support for combatant commanders in the execution of global contingency operations and in cases of domestic emergency. FHP is composed of activities to promote human performance enhancement; provide for a healthy, fit, and protected force; engage in health surveillance; communicate the FHP level; do casualty management in the Joint Operations Area (JOA); and support Homeland Defense/Civil Support (HD/CS) operations.

3.4.2 Health System Support

HSS describes the organization and execution of capabilities to sustain, and continuously improve, MHS mission effectiveness through focused development of people, technology, and infrastructure. HSS includes health services contract development, health services contract management, and partnership development among health service organizations outside the DoD; managing the total medical force; health education and training; medical financial management; medical/health information management; creating and sustaining the healing environment; medical logistics and medical research and development.

HSD and HSS are further defined in the supporting HSD and HSS CONOPS as prescribed by the HR CONOPS and are subject to existing and future Department Policy.

4.1 CHAPTER 4. HEALTH SERVICE DELIVERY CAPABILITIES

HSD is described as an ability to build healthy communities by managing and delivering the health benefit, through the use of military treatment facilities, and the TRICARE network of healthcare providers. There are six capabilities areas of HSD which are the integral components to its support to the Department of Defense and designated beneficiaries. The capabilities are defined and further decomposed into specific capabilities. The 42 HSD capabilities are then decomposed into tasks, conditions/attributes and standards in Appendix A.

4.2 DEFINE THE HEALTH BENEFIT

This is the ability to identify and plan for specific healthcare needs associated with a population of beneficiaries and continuously measure, monitor, and positively influence health and wellness through evidenced-based preventive and interventional healthcare services. This care delivery model maintains a healthy, worldwide deployable force (and associated medical support component) to achieve U.S. national objectives and improves overall health, wellness, and satisfaction for all beneficiaries by managing access and demand, promoting healthy lifestyles, and controlling future healthcare costs.

Health Quality and Safety. The ability to gain and maintain awareness of advances in proven healthcare delivery practices and technologies; promote infusion into the scope of care; and use measurable approaches with outcome monitoring to enhance the quality of health and attain desired health outcomes. Safety includes the avoidance of unsafe events, or prevention, or amelioration of adverse outcomes or injuries stemming from the processes of healthcare. Health safety also involves the ability to establish operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them so that they will not occur. Health quality and safety includes quality assurance, quality improvement, and risk management.

- **Quality Assurance**: The ability to maintain active and effective organizational structures, management emphasis, and program activities to assure quality healthcare throughout the MHS.
- **Risk Management**: The ability of a hospital or other healthcare facility directed towards the identification, evaluation, and correction of potential risks that could lead to injury to patients, staff members or visitors and may or may not result in financial loss to the Government.
- **Patient Safety**: The ability to maintain freedom from accidental injury due to medical care or medical errors.
- **Quality Improvement (QI)**: The ability to maintain a formal approach to the analysis of performance and the systematic efforts to improve it. QI is embedded in the culture of every aspect of HSD.

4.3 CLINICAL PREVENTIVE MEDICINE

Clinical Preventive Medicine (CPM) is the ability to provide health promotion and disease prevention through effective methods of examinations, immunizations, screening tests, health counseling, communicating the current FHP level, and community health education that reduce overall disease burden in a population. CPM includes preventive medical and dental services,

occupational health services, and public health laboratory services. Prevention interventions include surveillance and analysis, immunization, counseling to modify high-risk behaviors, and screening. Effective CPM works together with HSS's medical research and development to enable FHP's expeditionary Public Health, Preventive Medicine and Health Surveillance capabilities to reduce non-battle injuries for warfighters and sustain deployed forces.

- **Preventive Medical Services.** The ability to conduct health promotion and disease prevention strategies to reduce death, disability, and suffering. This ability includes preventing disease onset (primary prevention), detecting and preventing progression of subclinical disease (secondary prevention), and mitigating or reversing the effects of symptomatic disease (tertiary prevention). Emphasis is placed on health promotion and disease prevention through examinations, immunizations, screening tests, health counseling, community health education and chemoprophylaxis.

    - **Screening:** The ability to detect disease in asymptomatic populations. DoD beneficiaries will receive health screening that has been demonstrated to be effective (reduces mortality, reduces morbidity and/or enhances quality of life).

    - **Preventive Health Counseling:** The ability to provide patient education on preventive measures that have been demonstrated to be effective by reducing mortality, morbidity and/or enhance quality of life.

    - **Community Health Education:** The ability to provide any combination of learning experiences provided to DoD beneficiaries with the end goal of attempting to bring about behavioral changes that improve or sustain an optimal state of health. Community health education programs begin with a needs assessment to identify population requirements and to determine whether a particular health education program is warranted and/or will be successful.

    - **Immunization:** The ability to protect susceptible patients from communicable diseases by administration of a living modified agent, a suspension of killed organisms, a protein expressed in a heterologous organism, or an inactivated toxin in order to induce antibody formation. Military members will receive all DoD-mandated routine immunizations (currently Hepatitis A/B, tetanus-diphtheria, inactive polio virus, MMR, and seasonal influenza) and all required contingency and travel-related immunizations (e.g. smallpox, anthrax, yellow fever, etc). Additionally, military members and other DoD healthcare beneficiaries will be offered all immunizations recommended (beyond those required by DoD) by the Advisory Committee of Immunization Practices (ACIP). These immunizations and any adverse events will be tracked and monitored. Future emerging/novel infectious disease threats to DoD forces may require rapid vaccine development and production capabilities beyond that which can be generated short-notice in the civilian sector. The DoD should have inherent capabilities that can be activated to meet this national security need.

- **Preventive Dentistry Services.** The ability to maintain the normal masticating mechanism by fortifying structures of the oral cavity against damage and disease using

primary (diagnostic and prophylactic treatment), secondary (direct dental restoration) or tertiary (indirect prosthetic) prevention.

- **Occupational Health Services.** The ability to protect the safety, health, and welfare of the warfighter, civilian employees, and contractors in the workplace. Occupational Health Services includes occupational medicine, occupational (or industrial) hygiene, public health, safety engineering, chemistry, health physics, ergonomics, toxicology, epidemiology, environmental health, industrial relations, public policy, sociology, and occupational health psychology.

- **Public Health Laboratory Services.** The ability to provide services to test and monitor the environment for specific health threats; assess the population‘s health status; detect and track communicable diseases; and, support medical officers, preventive medicine staff and deployed PM units/forces as they investigate and control disease outbreaks. PH Laboratory Services also provide the ability to assist military preventive medicine, veterinarian specialists and public health officials in assuring the safety of food and water through provision of laboratory testing and analytical services.

4.4 DIAGNOSIS

Diagnosis is the ability to assist clinicians in their identification of a medical or dental condition, disease, or injury. Diagnostic procedures are complementary to relevant history, signs and symptoms, and results of physical examination.

- **Ambulatory Diagnostic Services (Medical).** The ability to apply medical examinations and capabilities on an outpatient basis (return home the same day) without admission to a hospital.

- **Ambulatory Diagnostic Services (Dental).** The ability to apply dental examinations and capabilities on an outpatient basis (return home the same day) without admission to a hospital.

- **Inpatient Diagnostic Services.** The ability to apply diagnostic examination and capabilities that require or support an admission to a hospital. Examples are diagnostic laboratory and radiological services before or after inpatient surgery.

- **Laboratory Diagnostic Services.** The ability to provide chemical, hematological, microscopic, microbiologic, immunologic, or pathologic study of secretions, discharges, blood, or tissue sections to help diagnose a medical or dental condition or disease.

- **Radiology Diagnostic Services.** The ability to use various radiological techniques, mostly noninvasive, to diagnose an array of medical conditions using x-rays, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, and ultrasound. This includes the ability to provide oral and maxillofacial imaging techniques (e.g., bitewing, peri-apical, and occlusal radiographs; ultrasound, cone beam CT, MRI) and special tests (e.g., sialograph) to help diagnose oral or maxillofacial conditions or disease.

4.5 TREATMENT

Treatment is the ability to administer or apply remedies to a patient for a disease or injury, including medications, surgery, therapy, interventional radiology, or any combinations of these; and to provide for palliative and end of life care.

- **Non-Emergency Medical Transport.** The ability to effectively coordinate and transport stabilized patients who require special medical attention from one location to another.

- **Emergency Services.** The ability to provide the initial evaluation, diagnosis, treatment, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care. Emergency services may be provided in a hospital-based or freestanding emergency department (ED), in an urgent care clinic, in an emergency medical response vehicle, or at a disaster site.

- **Routine Ambulatory Care (Medical).** The ability to provide ambulatory (outpatient) primary and specialty diagnosis, observation, treatment, and rehabilitation for symptoms and conditions for which non-urgent or non-emergent intervention is required.

  - **Primary Care**: The ability to provide Patient and Family-Centered Care to our beneficiaries and is considered the foundation (gateway) of health and preventive care.

  - **Specialty Care:** The ability to provide ambulatory (outpatient) primary and specialty diagnosis, observation, treatment, and rehabilitation for symptoms and conditions for which non-urgent or non-emergent intervention is required.

- **Routine Ambulatory Care (Dental).** The ability to provide examination and assessment of teeth and supporting oral structures. Provide routine prophylactic treatment and care to restore integrity of the teeth and masticatory system to maintain dental health.

- **Surgery (Ambulatory).** The ability to promote health through surgical intervention in an outpatient setting. Ambulatory surgery encompasses procedures that require the patient to remain in the medical treatment facility less than 24 consecutive hours following completion of the procedure.

- **Medical Management (Chronic Illnesses).** The ability to provide an integrated managed care model that promotes utilization management, case management, and disease management programs as a hybrid approach to managing patient care. This ability includes evidence-based, outcome-oriented management of populations with common conditions emphasizing the integration of clinical practice guidelines and monitoring patient outcomes.

  - **Disease Management**: The ability to provide an organized effort to achieve desired healthcare outcomes in populations with prevalent, often chronic, diseases or conditions for which healthcare practices may be subject to considerable variation.

  - **Case Management**: The ability to assess and assist clients with complex health needs, utilizing a collaborative process, to promote the delivery and receipt of

appropriate medical care to achieve positive health outcomes in the most cost-

effective manner. Medical case management may include, but is not limited to, care assessment, including personal interview with the injured employee. May include assistance in developing, implementing and coordinating a medical care plan with healthcare providers, as well as the employee, military command/unit and/or his/her family and evaluation of treatment results. Medical case management requires the evaluation of a medical condition, developing and implementing a plan of care, coordinating medical resources, communicating healthcare needs to the individual, monitoring an individual‘s progress and promoting cost-effective care.

- **Utilization Management**: The ability to invoke processes designed to address the managing of resources expended or to be expended in the delivery of healthcare, while simultaneously measuring the quality associated with the care delivered in an effort to balance quality, risk and cost.

- **Inpatient Non-Surgical Treatment.** The ability to provide all non-surgical medical care and services to treat patients admitted to a hospital for at least one overnight stay.

- **Intensive Care.** The ability to provide comprehensive and highly specialized, life-saving methods and equipment with continuous monitoring and care to seriously ill or injured patients with specially trained provider, nursing, and technical staff.

- **Surgery (Inpatient).** The ability to treat disease or injury, improve or restore form or function, or close a previously sustained wound through surgical intervention. Inpatient surgery requires that the patient remain in the medical treatment facility for more than 24 consecutive hours following the completion of the procedure.

- **Pharmacy Services.** The ability to support clinical activities in all environments through expert clinical consultation, patient education, and appropriate handling and dispensing of drugs and other medical supplies to patients or family members.

- **Therapeutic Radiology Services.** The ability to apply ionizing radiation to treat patients with cancer and other diseases.

- **Mental Healthcare.** The ability to provide patients with tools to achieve a state of functional well-being and successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, an ability to adapt to change and cope with adversity, decreased stigma associated with a warfighter seeking mental health, and mitigated risks for post-traumatic stress disorder (PTSD). Activities include prevention, building psychological resiliencies, and providing early interventions, clinical treatment, and rehabilitation.

- **Substance Abuse Care.** The ability to provide medical and/or psychotherapeutic treatment for dependency on illegal drugs and prescription or over-the-counter drugs or alcohol or other mind altering substances, to enable the patient to avoid psychological, physical, legal, financial, social, and job-related consequences.

4.6 REHABILITATION

Rehabilitation is the ability to restore skills to a person who has had an illness or injury so as to

regain maximum self-sufficiency and function in a normal or as near normal manner as possible.

Rehabilitation addresses the patient's physical, psychological, social, vocational, educational, and environmental needs. Family members often are involved actively in the patient's rehabilitation program.

- **Physical Rehabilitation.** The ability to use therapeutic measures and reeducation to restore physical, psychological, social, vocational, speech, and educational potential consistent with neurological or anatomical impairment.
    - **Physical Therapy.** The ability to manage patient conditions involving the neuromuscular, musculoskeletal, cardiopulmonary, and integumentary systems through specific therapeutic and rehabilitative interventions based on the results of examination, evaluation, and testing. The ability to promote positive health behaviors in service members and beneficiaries of all ages through human performance optimization and injury prevention programs.
    - **Sensory Rehabilitation**. (Hearing, Speech, Vision) The ability to apply highly specialized rehabilitation training, resources, and technologies to prevent, manage, treat, and overcome injury, impairment, functional limitation, and disability of vision, speech, and audition to optimize human performance considering medical, neurological and psychological factors.
    - **Psychological Rehabilitation.** Subsumed in section 4.4 Mental Healthcare.
- **Amputee Care.** The ability to assist patients who will experience, or have experienced, amputation and/or limb deficiency at any point along the continuum of care, including preoperative assessment, surgery, acute hospitalization, rehabilitation, outpatient services, prosthetics, and life-long management.
- **Burn Care.** The ability to apply highly specialized medical training, resources, and technologies to manage, treat, and heal patients with deep burn injuries.
- **Occupational Rehabilitation.** The ability to help a wounded, ill, or injured worker regain the functional capability to participate in meaningful work/volunteer activities. This may include work-environment modifications, use of compensatory strategies, and/or adaptive equipment or technology to overcome physical, cognitive, or psychological impairments.
    - **Occupational Therapy.** The ability to help a client regain the capability to perform normal everyday tasks and life activities (occupations) that they find meaningful and purposeful by restoring old skills or teaching new skills to adjust to disabilities using adaptive techniques, equipment, orthotics, and modification of the client's home or work environment.

4.7 REINTEGRATION

Reintegration is the ability to provide a system of resources designed to assist severely ill or injured warfighters transition back to active duty or to civilian status and to their families, jobs, school, and community. The ability to assist and involve families in the transition process is a important component to reintegration success.

- **Disability Counseling and Coaching**. The ability to provide severely injured or ill service members and families access to a network of professional counseling, information and resources that provide personal support and assistance from injury to reintegration, separation or medical retirement.

- **Medical Support to Disability Evaluation.** The ability to evaluate service members who have achieved the optimal medical benefit from available treatment options against retention standards.

- **Transitional Services.** The ability to provide severely ill or injured warfighters who are transitioning to civilian life and possibly civilian or VA healthcare with the guidance and support to make the passage as seamless and trouble-free as possible.

5.1 CHAPTER 5. STRATEGY FOR HEALTH SERVICE DELIVERY CONOPS IMPLEMENTATION

5.2 ROLE OF HEALTH SERVICE DELIVERY CONOPS IMPLEMENTATION

The overarching HR CONOPS was developed in response to current and future operational challenges which requires that the MHS organize and execute key joint interoperable and interdependent capabilities within the DoD medical system. HSD CONOPS implementation is essential to ensure a fully integrated health system which supports the life cycle management of the entire capability portfolio in an effective and efficient manner.

The complexity of meeting this implementation across the four categories of military activity (combat, security, engagement, and relief/reconstruction) requires a common lexicon for the medical capabilities supporting service members, their families, and all those individuals entrusted to our care. It will require a fully integrated strategy with clear objectives, and commitment from DoD's senior leadership. In the end, effective HSD CONOPS implementation will address areas requiring improvement identified in the 2006 and 2010 Quadrennial Defense Reviews (QDR) and address future risks.

5.3 GUIDANCE FOR IMPLEMENTING HSD CONOPS

To achieve true transformation and the breakthrough performance we desire, we must profoundly transform our culture. Our culture is defined by the assumptions and mental models we use to understand the world and guide our behaviors.[7] We intend to change those assumptions in ways shown in Table 5-1.

Table 5-1: Changing the Way We Think and Act

Old Paradigm		New Paradigm
Why should we…	To	Why couldn't we…
Two competing missions: healthcare delivery and force health protection	To	One mission, three interdependent themes; HSS, HSD, FHP
Service-specific infrastructure	To	Jointly staffed facilities
Budget and rules based	To	Performance-based management
End year with no money left	To	End year with savings; meet performance goals
Beneficiary satisfaction surveys	To	Customer relationship building
Provider centered	To	Patient control and accountability
Direct care system of MTFs and network of civilian providers	To	Integrated health delivery team with shared accountability
Proprietary information	To	Data sharing
Fixed-fee contracts	To	Performance-based contracting
Active duty, reserve, guard, civilians, and contractors managed separately	To	Total force and team development

DoD and the MHS continue to pursue transformational business and planning practices such as adaptive planning and a more entrepreneurial, future-oriented, capabilities-based resource allocation planning process. We also are pursuing accelerated acquisition cycles built on spiral development, output-based management, and a reformed analytical support agenda. We must

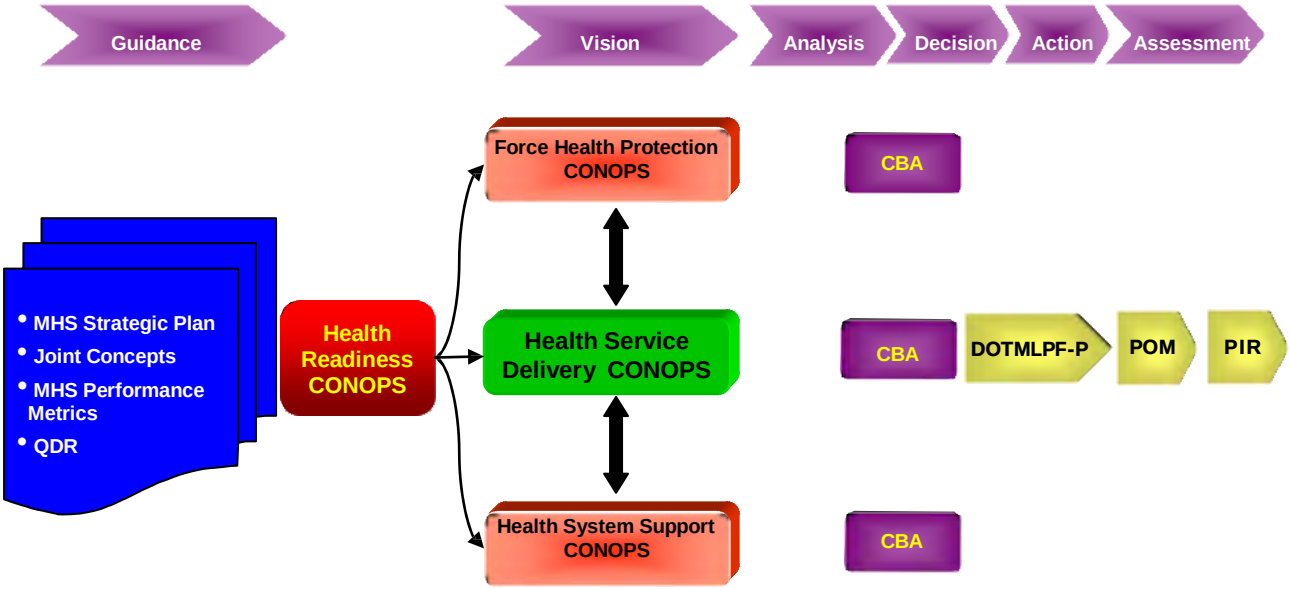
[7] *2008 Military Health System Strategic Plan, A Roadmap for Medical Transformation* (6).

foster innovation and adaptation of new information technologies and concepts within MHS organizational and functional areas, but it is equally important to remember the primary reason why the MHS exists. Increased reliance on civilian-based contract support for optimizing health care delivery for beneficiaries must be balanced with sustaining our expeditionary medical capabilities.[8]

5.4 INTEGRATION OF HSD ELEMENTS INTO THE MHS OF TOMORROW

This document sets the stage for validation of new and existing HSD capabilities in JCIDS. Capabilities introduced here will follow the path in Figure 5-1; be developed under the construct described in the HR CONOPS; and be integrated with FHP and HSS capabilities. The FHP, HSD and HSS capability areas are under Force Support and Health Readiness for conducting CBAs. This process should lead to any required Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, and Facilities (DOTMLPF) changes, the development of mission outcome measures, submission of Initial Capabilities Documents (ICD) and follow-on JCIDS documents and assessment of the DOTMLPF, thus allowing MHS to successfully prepare for the challenges and responsibilities that joint warfighters will face in 2016 and beyond.

Figure 5-1: Health System Support Implementation Plan Structure



The HSD capability area strategy is designed to focus attention on our core business, creating an integrated medical team that provides optimal HSD capabilities for the DoD. The HSD strategy centers on identifying and developing capabilities that support a fully integrated health system focused on the four mission elements of the MHS Strategic Plan. This provides the ability to not only sustain but also continuously improve MHS mission effectiveness by focusing efforts on developing people, technology, infrastructure, and joint organizational culture.

[8] *Joint Force Health Protection Concept of Operations*, July 2007 (29).

The HSD CONOPS will further translate into formal capability-based assessments; identification of needed DOTMLPF changes; and the creation of new health-related capabilities that the MHS must examine and pursue to achieve the DoD's transformation goals and mission.

5.5 CONCLUSION

America has given the MHS team a tremendous responsibility - to care for our country's fighting forces, their families, and those who served before us…more than 9 million in all. Our healthcare team has performed exceptionally. Military medicine has achieved unprecedented and truly remarkable outcomes. We have achieved these results from the foundation of a vibrant military medical culture - one based on innovation, service to others, and an unrelenting persistence to achieve excellence.

We must continue to improve MHS capabilities across the full spectrum of operations in support of our warriors. This HSD CONOPS provides the framework to support assessment of HSD capability gaps and inefficiencies, and to reach appropriate solutions.

APPENDIX A. HEALTH SERVICES DELIVERY CAPABILITIES, TASKS ATTRIBUTES AND STANDARDS

HSD is defined as an ability to build healthy communities by managing and delivering the health benefit, through the use of military treatment facilities, and the TRICARE network of healthcare providers. The Functional Area Analysis (FAA) led to the taxonomy of HSD into six capabilities areas.

The HSD capabilities as defined in Chapter 4 were developed into specific capabilities. The capabilities were further decomposed into tasks. To evaluate current performance of these tasks and analyze how these tasks must be measured for future requirements, the workgroup was challenged to assign the most critical attributes and respective metrics. Unless otherwise specified, standard is for 100% compliance. The below Table A-1 was a key reference to analyzing the capabilities and tasks and then identifying the most important attributes for performing the tasks to reach success both in current environments and future requirements.

Table A-1. HSD Defined Attributes / Conditions

Conditions/Attribute	Definition
Accessible	Readily obtained, used, seen, or known.
Acceptable	Able to satisfy a need, requirement, or standard.
Accurate	Reflecting reality correctly; in exact conformity to fact; errorless.
Adaptable	Able to change or adjust to different circumstances or conditions.
Agile	Able to think or react quickly with acuity and coordination.
Appropriate	Suitable or fitting for a specific purpose or use.
Complete	Whole or intact, with all needed parts and elements.
Comprehensive	Inclusive of all relevant factors, issues, and capabilities.
Decentralized	Possessing lower echelon elements that are empowered to function quickly, independently, or autonomously when appropriate in order to take advantage of short duration opportunities to advance mission accomplishment.
Deployable	Structured in such a way as to be able to be transported to the field environment and rapidly readied for function in accomplishing its mission
Durable	Able to accomplish its functions over time without significant deterioration.
Effective	Able to produce the intended effect, result, or end state.
Ergonomic	Able to maximize productivity and minimize chronic injury by reducing operator fatigue and discomfort through intelligent workplace equipment design.
Expeditionary	Organized, postured, and capable of rapid deployment, employment, and sustainment.
Flexible	Able to adapt or be modified in order to effectively meet changing conditions or requirements.
Integrated	Composed of elements or parts that function together in a coordinated fashion to achieve unity of effort.
Interchangeable	Capable of substitution without loss of function and effectiveness.
Interoperable	Composed of systems, capabilities, and organizations that are functional in harmony across all joint force elements. Able to exchange knowledge and services among units and commands at all

Conditions/Attribute	Definition
	levels.
Intuitive	Able to be understood accurately through sensing and perception rather than by objective observation and hard, rational logic.
Net-centric	Relating to or representing the attributes of a robust, globally interconnected network environment (including infrastructure, systems, processes, and people) in which data are shared timely and seamlessly among users, applications, and platforms.
Networked	Able to share a common operating picture and be linked and synchronized electronically in order to increase operational effectiveness through coordinated movement and action.
Practical	Able to use common sense, judgment, and reason to find a simple, direct, and efficient path to the desired end.
Predictive	Capable of knowing or predicting future conditions in order to be prepared to operate effectively when they arrive.
Persistent	Capable of extended functioning in an environment and delivering intended effects—even in adverse circumstances.
Relevant	Able to have a practical, germane, and substantial effect on the matter at hand.
Reliable	Able to be used for an extended time under specified operating conditions without loss of critical function or capability.
Responsive	Able to reply or react or answer to queries or requests with timeliness appropriate to the situation.
Safe	Secure from liability, harm, injury, danger, or risk of mishap or error.
Scalable	Designed to be capable of being modified in magnitude according to the needs of the circumstances.
Secure	The ability to protect or ensure the privacy or secrecy of a system. Implies the ability to guard from danger, risk, or loss from danger or harm and to make safe from penetration or interception by unauthorized persons.
Shared	Held in common (whether conceptually or in electronic or other media) among individuals, groups, or organizations.
Standardized	Conforming to established criteria of size, weight, quality, strength, or functionality to permit substitution without loss of original function.
Synchronized	Functioning in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence.
Tailorable	Able to be modified or adjusted within a certain range to better meet the needs or demands of the circumstances.
Timely	Delivered or performed when needed to be most effective in the situation.
Total Asset Visibility (TAV)	The ability to know the location, functionality, and availability of all required resources, whether human, equipment, supplies, or systems.

The remainder of this appendix is organized into tables which decompose HSD into 42 capabilities and their key tasks. Each task is then described according to specific attributes selected as most critical for the respective task. Each attribute is defined with metrics that are used to provide a standard of measure for evaluating the level of success in the future. Although many metrics and attributes were considered, the ones selected for this appendix are those which

are most directly of use in determining the success or failure of task accomplishment. Normally, Joint Integrating Concepts (JICs), depending on special effects desired at a particular place and time in the continuum of the respective capability, would ultimately define the standards. In the absence of a Health Readiness or Health System Support (medical) JIC, this document presents metrics which are deemed most relevant; the resulting taxonomy of capabilities, tasks, attributes and standards may need to be reconsidered when seeking means for making measurable evaluations during the subsequent Capabilities-Based Assessments. The ―Standards‖ in most cases are long-term ―goals.‖ Some standards, alternatively, may later be determined inadequate to drive needed improvements. A broader treatment of the tasks to address either higher level of detail, or an expansion to include implied tasks and measurement of capabilities in the future, would be part of a Functional Area / Needs Analyses that would use this appendix as its primary source document. Recommendations may result in a need to revise the Standards or develop methods to collect objective measures, establish baselines and track progress during the Functional Solution Analysis and Testing phases.

HSD Capability 1: Quality Assurance

DESCRIPTION OF CAPABILITY: The ability of the MHS to maintain active and effective organizational structures, management emphasis, and program activities to assure quality healthcare throughout the MHS.

Tasks	Conditions/Attributes	Standards
A) Maintain confidentiality of Medical Quality Assurance (QA) Records	Secure	100% of records shall be maintained confidential and privileged-meaning they are so marked as QA documents and stored appropriately
	Interoperable	100% of the records will be available to all appropriate, designated entities as per the statutes and per the request. In cases of requests the requestor will be referred to non QA sources if available
	Standardized	100% of records will follow established criteria for content and accessibility
B) All fixed MTFs, as well as hospitals and other facilities used by managed care support contractors shall meet the standards of appropriate external accrediting bodies.	Complete	100% of MTFs shall be fully accredited by The Joint Commission, AAAHC, or other accrediting bodies as approved by ASD(HA). ASD(HA) will consider waiver requests on a case by case basis

Tasks	Conditions/Attributes	Standards
C) A person under the jurisdiction of the Secretary of a Military Department may not provide healthcare independently as a healthcare professional unless the person has a current license to provide such care.	Standardized	Healthcare practitioners who do not possess a license or other authorizing document may practice only under a written plan of supervision with a licensed person of the same or a similar discipline
D) Credentials shall be collected and verified before the selection, employment, or contract of healthcare practitioners.	Accurate	100% of Healthcare practitioners identified as critical for credentials management shall have their credentials collected and verified before selection, employment or contract. Credentials will be primary source verified. Once appointed, all appropriate practitioner credentials shall be documented in Centralized Credentialing and Quality Assurance System (CCQAS).
E) MTFs shall actively identify all Sentinel Events that occur in these facilities, conduct a root cause analysis and form a corrective action plan for each event.	Comprehensive	100% of Sentinel Events (SE) shall have a comprehensive Root Cause Analysis (RCA) performed to understand the causes that underlie the event
	Shared	100% of RCA results shall be shared with MTF leadership and MTF personnel, service headquarters and DoD Patient Safety Program (PSP) Center personnel to assist in reducing the risk of recurrence of similar events

References
Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA)* Program Regulation Chapter C2.1.1. June 11, 2004. Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA) Program* Regulation Chapter C3.1. June 11, 2004. Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA) Program* Regulation Chapter C4.1. June 11, 2004. Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA) Program* Regulation Chapter C4.3 and C5.1. June 11, 2004. Department of Defense Directive 6025.13-R, Military Health System Clinical *Quality Assurance (CQA) Program Regulation* Chapter C7.13. June 11, 2004.

HSD Capability 2: Risk Management

DESCRIPTION OF CAPABILITY: The ability of a hospital or other healthcare facility to direct the identification, evaluation, and correction of potential risks that could lead to injury to patients, staff members or visitors and may or may not result in financial loss to the Government.

Tasks	Conditions/Attributes	Standards
A) Every organization shall implement a Risk Management (RM) program	Effective	Organizations shall implement active RM systems and programs to reduce liability risks associated with actual or alleged medical malpractice and use those systems and programs to reinforce other Medical QA program activities.
	Accessible	100% of time-the DoD RM module of CCQAS will be utilized for documenting and managing all PCEs, including all medical malpractice claims and also cases of substandard care which result in service member death and disability.
	Secure	100% of RM documents are confidential MQA records protected according to Title 10 United States Code section 1102.
B) Unexpected adverse patient events shall be documented and investigated	Appropriate	100% of healthcare adverse events involving a MHS patient shall be reviewed regardless of whether or not it resulted in harm to the patient.
	Timely	100% of adverse patient outcomes or events that suggests a PCE shall be reviewed and the results of the investigation promptly reported to the PCE module of CCQAS within 180 days of the occurrence or initial identification.
	Relevant	The details of the PCE, the specifics of the investigation, and all significantly involved providers shall be documented in CCQAS
C) In cases of actual or potential product liability cases, evidence will be preserved	Accurate	100% of evidence shall be preserved, and potentially malfunctioning equipment removed from service
	Safe	There will be established processes in place to monitor all required devices per accreditation or other requirements to assure safety. The JC requires monitoring of certain types of medical equipment; routine use requires the user staff to do the checks and balances to make sure the equipment is functioning appropriately-

References

Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA) Program* Regulation Chapter C2.1.2. June 11, 2004.
Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA) Program* Regulation Chapter C5.2.2. June 11, 2004.
Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA) Program* Regulation Chapter C8.1. June 11, 2004.
Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA) Program* Regulation Chapter C8.2. June 11, 2004.
Department of Defense Directive 6025.13-R, Military Health System *Clinical Quality Assurance (CQA) Program* Regulation Chapter C8.8. June 11, 2004
Department of Defense Directive DODD 6025.13, *Medical Quality Assurance (MQA) in the Military Health System (MHS)* Chapter 5.2.4. May 2004.
Department of Defense Directive DODD 6025.13, *Medical Quality Assurance (MQA) in the Military Health System (MHS)* Chapter 5.2.7. May 2004.
Department of Defense Directive DODD 6025.13, *Medical Quality Assurance (MQA) in the Military Health System (MHS)* Chapter 5.2.7.1. May 2004.

HSD Capability 3: Patient Safety

DESCRIPTION OF CAPABILITY: Patient safety is defined as freedom from accidental injury due to medical care or medical errors.

Tasks	Conditions/Attributes	Standards
A) Assess staff's opinion of facility's patient safety culture	Accurate	95% of responses will reflect the safety culture of the facility
	Appropriate	100% of the staff will be offered the opportunity to participate
	Effective	In 100 % of cases the survey will focus on areas where opportunities exist for improvement
B) Select a patient safety improvement model	Adaptable	In 100% of cases model has ability to accommodate organizational change
	Acceptable	In 98% of cases, model has buy-in of key stakeholders
	Flexible	In 100% of cases model allows organization to change course when needed
C) Measure safety performance over time	Accurate	100% of data collected shall be reliable for use in assessing performance
	Standardized	100% of data should be collected according to national benchmark criteria when available
	Timely	A valid sample of data should be collected and analyzed when organization determines it is appropriate to do so
D) Perform Root Cause Analysis of Performance Data when appropriate	Comprehensive	100% of data will be fully analyzed to evaluate all factors
	Reliable	In 100% of cases, methodology utilized to analyze data will be scientifically sound
	Practical	In 100% of cases methodology will lead to a reasonable recommendation to prevent future occurrences
E) Implement tools &/or programs to improve safety	Appropriate	In 95% of cases, tools/programs selected will meet the needs identified from the root cause analysis process
	Deployable	In 95% of cases the tools/programs can be effectively implemented in the facility/system
	Timely	In 95% of cases, the tools/programs will be deployed when needed most

Tasks	Conditions/Attributes	Standards
F) MTFs shall identify and report actual and potential patient safety problems in medical systems	Accurate	100% of all actual or potential problems in medical systems are identified and reported
	Effective	In 100% of cases the assessment tool utilized will be capable of producing the desired results
G) MTFs shall actively identify Sentinel Events that occur in these facilities	Accurate	100% of sentinel events will be identified
	Timely	100% of the results of the analysis and plan for each event shall be promptly reported through their Military Department to the Armed Forces Institute of Pathology
	Shared	Each MTF accredited by the Joint Commission shall comply with Sentinel Event reporting requirements for those Sentinel Events.. If accredited by another source, service reporting requirements will be followed

References

Department of Defense Directive 6025.13-R, *Military Health System Clinical Quality Assurance (CQA) Program* Regulation Chapter C7.1.5. June 11, 2004.
Department of Defense Directive 6025.13-R, *Military Health System Clinical Quality Assurance (CQA) Program* Regulation Chapter C7.1.68.8. June 11, 2004.
Department of Defense Directive 6025.13-R, *Military Health System Clinical Quality Assurance (CQA) Program* Regulation Chapter DL1.1.44. June 11, 2004.
Department of Defense Directive DODD 6025.13, *Medical Quality Assurance (MQA) in the Military Health System (MHS)* Chapter 5.2.6. May 2004.
Department of Defense Directive DODD 6025.13, *Medical Quality Assurance (MQA) in the Military Health System (MHS)* Chapter 5.2.8. May 2004.
http://www.ahrq.gov/qual/patientsafetyculture/
http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/
Botwinick L, Bisognano M, Haraden C. *Leadership Guide to Patient Safety.* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare improvement; 2006. (Available on www.IHI.org)
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/IHIGlobalTriggerToolforMeasuringAEs.htm
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Changes/
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SystemsAnalysisofClinicalIncidentsTheLondonProtocol.htm
http://www.jointcommission.org/NR/rdonlyres/C8CE68F6-85D7-4EA4-B3E0-895FC1075EE6/0/rcawordframework.doc
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/

HSD Capability 4: Quality Improvement

DESCRIPTION OF CAPABILITY: The ability to use a formal approach to the analysis of performance and the systematic efforts to improve it. QI is embedded in the culture of every aspect of Health Service Delivery.

Tasks	Conditions/Attributes	Standards
A) Identify opportunities for quality improvement	Appropriate	95% of improvement opportunities will be chosen based on the availability of scientific evidence to support the desired outcome
	Relevant	100% of quality improvement initiatives shall address at least one of the following: safeness, effectiveness, patient-centeredness, timeliness, efficiency or equality of care
	Practical	100 % of QI improvement initiatives shall be realistic and practical to collect and analyze
B) Identify measures for quality improvement	Effective	100% of the measures should: produce data over time 90% of the measures should be obtained through sampling; be easy to obtain; and be both qualitative and quantitative
	Relevant	100% of measures should provide data to help determine whether aim of improvement action can be achieved
	Appropriate	100% of measures shall be a combination of process and outcome measures such that they are balanced to provide the most useful data At least 50% of measures should be criterion-based measures (AKA composite measures)
C) Analyze collected data	Accurate	100% of the data shall be accurately collected & recorded
	Relevant	100% of the data shall be related to the QI initiative under study

Tasks	Conditions/Attributes	Standards
	Timely	Data shall be analyzed in a timeframe that will allow for appropriate interventions 95% of the time
D) Make Improvements	Appropriate	100% of changes implemented will be believed to lead to some improvement
	Effective	100% of changes implemented are believed to lead to the desired improvement
	Timely	95% of changes will have a positive and desired improvement in a specified time frame
E) Reassess actions	Effective	95% of changes will have the desired improvement upon reassessment
	Relevant	95% of changes will have a desired improvement outcome
	Timely	95% of changes will result in the desired outcome within the predetermined timeframe
F) Integrate improvement	Reliable	50% of changes will be reassessed for continued integration 12 months out. 100% of reassessments for continued integration will show continued use.
	Deployable	Improvements will be integrated across 100% of the system.
	Timely	Improvements will be integrated across the system 100% of the time within 12 months.

References
Agency for Healthcare Research and Quality (AHRQ). <http://www.ahrq.gov/>. AHRQ Quality & Pt safety guidelines (www.ahrq.gov) Institute for Healthcare Improvement www.IHI.org/IHI/Topics/ImprovementMethods/Measures Institute of Medicine. <www.iom.edu>. Crossing the Quality Chasm Department of Defense Directive DODD 6025.13, *Medical Quality Assurance (MQA) in the Military Health System (MHS),* May 2004. American College of Medical Quality, Medical Quality Management Theory and Practice: (Desirable Characteristics of Quality Management – Relevance, Evidence-Based, Reliability or Reproducibility, Validity, and Feasibility). For this document, Evidence-Based was interpreted as Appropriate; Validity as Effective; and Feasible as Practical.

HSD Capability 5: Screening

DESCRIPTION OF CAPABILITY: The ability to detect disease in asymptomatic populations. DoD beneficiaries will receive healthcare screening that has been demonstrated to be effective (reduces mortality, reduces morbidity and/or enhances quality of life).

Tasks	Conditions/Attributes	Standards
A) Define the health screening requirements of specific DoD populations	Accurate	100% of military members will receive periodic health assessments (PHAs) (preferably Web-based) to accurately identify demographic and health risk information to appropriately recommend or require (per DoD) preventive health screenings. 100% of all non-active duty DoD healthcare beneficiaries will be offered annual health screenings (preferably web-based) to accurately identify demographic and health risk information to appropriately recommend preventive health screenings at the individual patient. point-of-service level and to plan and resource health screening programs at population levels. Additionally, demographic information, even in the absence of health assessment data, will be available at all levels within the military health system, to appropriately and accurately plan and resource health screening programs.
B) Provide evidence-based, cost-effective Class A & B health screening services	Effective	All (100%) United States Prevention Services Task Force (USPSTF)-recommended preventive health screening services will be available to all (100%) DoD beneficiary populations
	Standardized	All services (100%) will offer USPSTF-recommended throughout their respective medical commands

Tasks	Conditions/Attributes	Standards
C) Educate targeted populations and the healthcare teams who serve those populations on the need for screening (this may overlap with community health education)	Effective	Education efforts, where feasible, will be evidence-based. In cases where evidence of benefit is lacking, metrics should be collected on education initiatives to substantiate and document effectiveness.
D) Securely track, report, and archive currency of/compliance with recommended health screenings services at the individual and population levels.	Accurate	Medical personnel will accurately document preventive health screening services in the Electronic Health Record (EHR) every time these services are delivered
	Networked	100% of archived medical information will be accessible throughout the DoD, VA, and network civilian medical providers. Furthermore, all archived medical information will be portable beyond the DoD when members and their families transition to civilian medical care (e.g. the Joint Virtual Lifetime Electronic Record)
	Secure	Healthcare information archived in the EHR and other DoD support tools will meet patient privacy standards 100% of the time
E) Promote/do health screening research	Relevant	100% alignment to capability gaps derived by JCIDS process or equivalent

References

Department of Defense Instruction (DoDI) 3210.1, *Administration and Support of Basic Research by the Department of Defense*. 16 September 2005.
Department of Defense Instruction (DoDI) 6025.18*, Privacy of Individually Identifiable Health Information in DoD Health Care Programs.* 2 December 2009.
Department of Defense Instruction (DoDI) 6025.19, *Individual Medical Readiness*. 3 January 2006.
Healthy People 2010. <http://www.healthypeople.gov/>.
Chairman of the Joint Chiefs of Staff Instruction (CJCSI) 3170.01G, Joint Capabilities Integration and Development System. 1 March 2009.
Manual for Operation of the Joint Capabilities Integration and Development System. February 2009 (Updated 31 July 2009).
National Commission on Prevention Priorities, Partnership for Prevention. <http://www.prevent.org/content/view/42/70/>.
Presidential Initiative, President Obama Announces the Creation of a Joint Virtual Lifetime Electronic Record. <http://www.whitehouse.gov/the_press_office/President-Obama-Announces-the-Creation-of-a-Joint-Virtual-Lifetime-Electronic-Reco/>.
The Accreditation Association for Ambulatory Health Care. <www.aaahc.org>.
US Preventive Services Task Force, Retrieved from Agency for Healthcare Research and Quality (AHRQ). www.preventiveservices.ahrq.gov

Veterans Affairs/Department of Defense, *Manual for Facility Practice Guideline Champions*. 23 November 2004.
Guide to Community Preventive Services at http://www.thecommunityguide.org/index.html is a CDC sponsored evidence based compilation of systematic reviews of program and policy interventions.

HSD Capability 6: Health Counseling

DESCRIPTION OF CAPABILITY: The ability to provide DoD beneficiaries preventive health counseling that has been demonstrated to be effective (reduces mortality, reduces morbidity and/or enhances quality of life).

Tasks	Conditions/Attributes	Standards
A) Define the preventive health counseling requirements of specific DoD populations	Accurate	100% of military members will receive periodic health assessments (PHAs) (preferably Web-based) to accurately identify demographic and health risk information to appropriately recommend or require (per DoD) preventive health counseling. 100% of all non-active duty DoD healthcare beneficiaries will be offered annual health screening (preferably web-based) to accurately identify demographic and health risk information to appropriately recommend preventive health counseling at the individual patient level and to plan and resource health counseling initiatives at population levels. Additionally, demographic information, even in the absence of health assessment data, will be available at **all** levels within the military health system, to appropriately and accurately plan and resource health counseling initiatives.
	Comprehensive	100% of USPSTF-recommended preventive health counseling services will be available to **all** DoD healthcare beneficiaries
B) Provide evidence-based, cost-effective Class A & B preventive health counseling services	Effective	All (100%) USPSTF-recommended preventive health counseling services will be available to all (100%) DoD beneficiary populations
	Standardized	All services (100%) will offer USPSTF-recommended health counseling services throughout their respective medical commands

Tasks	Conditions/Attributes	Standards
C) Educate targeted populations and the healthcare givers who serve these populations on the need for preventive health counseling (this may overlap with community health education)	Effective	Education efforts, where feasible, will be evidence-based. In cases where evidence of benefit is lacking, metrics should be collected on education initiatives to substantiate and document effectiveness.
D) Track, report, and archive currency of/compliance with recommended preventive health counseling services at the individual and population levels.	Accurate	Medical personnel will accurately document preventive health counseling services in AHLTA every time these services are delivered
	Networked	100% of archived medical information will be accessible throughout the DoD, VA, and network civilian medical providers. Furthermore, all archived medical information will be portable beyond the DoD when members and their families transition to civilian medical care (e.g. the Joint Virtual Lifetime Electronic Record)
	Secure	Healthcare information archived in AHLTA and other DoD systems will meet patient privacy standards 100% of the time
E) Promote preventive health counseling research	Relevant	100% alignment to capability gaps derived by JCIDS process or equivalent

References
Department of Defense Instruction (DoDI) 6490.06, *Counseling Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and their Family Members*. 21 April 2009. Chairman of the Joint Chiefs of Staff Instruction (CJCSI) 3170.01G, Joint Capabilities Integration and Development System. 1 March 2009. Manual for Operation of the Joint Capabilities Integration and Development System. February 2009 (Updated 31 July 2009). The Community Guide, "The Guide to Community Preventive Services". www.thecommunityguide.org.

HSD Capability 7: Community Health Education

DESCRIPTION OF CAPABILITY: The ability to use any combination of learning experiences provided to DoD beneficiaries with the end goal of attempting to bring about behavioral changes that improve or sustain an optimal state of health.

Tasks	Conditions/Attributes	Standards
A) Assess the community health education requirements of specific DoD populations	Accurate	100% of community health education programs will have a needs assessment conducted prior to planning and implementing the program.
B) Develop evidence-based, cost-effective community health education programs	Effective	100% of community health education programs should be developed using the program planning model.
C) Deliver effective community health education programs	Appropriate	100% of community health education programs should be delivered using appropriate methods based on a thorough needs assessment and the program planning model.
D) Evaluate the effectiveness of community health education programs	Relevant	100% of community health education program evaluations should be germane to the program and amenable to change.

References
Centers for Disease Control and Prevention, *Framework for Program Evaluation in Public Health.* 17 September 1999. National Commission for Health Education Credentialing, Inc. (NCHEC). <http://www.nchec.org/>.

HSD Capability 8: Immunization

DESCRIPTION OF CAPABILITY: The ability of military members to receive all DoD-mandated routine immunizations (currently Hepatitis A/B, tetanus-diphtheria, inactive polio virus, MMR, and seasonal influenza) and all required contingency and travel-related immunizations (e.g. small pox, anthrax, yellow fever, etc). Additionally, military members and other DoD healthcare beneficiaries will be offered all immunizations recommended (beyond those required by DoD) by the Advisory Committee of Immunization Practices (ACIP). These immunizations and any adverse events will be tracked and monitored.

Tasks	Conditions/Attributes	Standards
A) Identify the health threats to specific DoD populations	Accurate	The DoD will accurately identify relevant immunization-preventable infectious disease health threats and make this information available to relevant command and medical authorities 100% of the time.
B) Define the immunization requirements of specific DoD populations	Accurate	100% of military members will receive periodic health assessments (PHAs) (preferably Web-based) to accurately identify demographic and health-risk information to appropriately recommend immunizations. The DoD will have the capability to offer all non-military DoD healthcare beneficiaries annual PHAs (preferably web-based) to accurately identify demographic and health risk information to appropriately recommend immunizations. The aggregated results of these PHAs will be available at all levels within the military health system to appropriately and accurately plan and resource immunization programs. Additionally, demographic information, even in the absence of PHA data, will be available at **all** levels within the military health system.
C) Provide immunization services	Effective	All (100%) ACIP-recommended and DoD-required immunizations will be available to DoD beneficiary populations.
	Comprehensive	100% of ACIP-recommended immunizations will be available to **all** DoD healthcare beneficiaries. Moreover, all DoD-required immunizations (particularly contingency-related immunizations) will be available to all DoD personnel who require them.

Tasks	Conditions/Attributes	Standards
	Standardized	All services (100%) will offer all ACIP-recommended immunizations throughout their respective medical commands.
D) Educate targeted populations and the healthcare teams who serve them on the need for immunizations (this may overlap with community health education)	Effective	Education efforts, where feasible, will be evidence-based. In cases where evidence of benefit is lacking, metrics should be collected on education initiatives to substantiate and document effectiveness.
E) Securely track, report, and archive currency of/compliance with recommended immunization services and vaccine adverse events at the individual and population levels.	Accurate	Medical personnel will accurately document immunizations in an EMR or other immunization tracking tool every time (100%) immunizations are given. Medical personnel will also accurately document/report adverse vaccine events.
	Networked	100% of archived medical information will be accessible throughout the DoD, VA, and network civilian medical providers. Furthermore, all archived medical information will be portable beyond the DoD when members and their families transition to civilian medical care.
	Secure	Healthcare information archived in the EHR and other DoD systems will meet patient privacy standards 100% of the time
F) Conduct/promote immunization research	Comprehensive	Standard undefined
G) Develop/maintain rapid vaccine development and production capabilities within the DoD	Comprehensive	Standard undefined

References

Advisory Committee on Immunization Practices (ACIP). <www.cdc.gov/vaccines/recs/acip/>.
AR 40–562, BUMEDINST 6230.15A, AFJI 48–110, CG COMDTINST M6230.4F *DoD Joint Instruction Immunizations and Chemoprophylaxis*. 29 September 2006.
Centers for Disease Control and Prevention (CDC) Yellow Book 2010. 2010.
Department of Defense Directive (DoDD) 6205.02E, *Policy and Program for Immunizations to Protect the Health of Service Members and Military Beneficiaries*. 19 September 2006.
National Committee for Quality Assurance. <www.ncqa.org>.
National Center for Medical Intelligence (NCMI). <www.intelink.gov/ncmi/index.php>.
Vaccine Adverse Event Reporting System (VAERS). <http://vaers.hhs.gov>.

HSD Capability 9: Preventive Dentistry Services

DESCRIPTION OF CAPABILITY: The ability to maintain the normal masticating mechanisms by fortifying structures of the oral cavity against damage and disease using primary (fluoride gel), secondary (dental restoration) or tertiary (fixed bridge) prevention.

Tasks	Conditions/Attributes	Standards
A) Assess Risk Factors	Accurate	100% receive annual exam
	Comprehensive	Risk factors evaluated at 99% of annual exams
	Predictive	Accurately determined risks 95% of time
	Standardized	Appropriate Dental Class assigned 99% of time
B) Provide Appropriate Preventive Measures	Appropriate	Preventive measures based on risk 99% of the time
	Effective	Produced desired outcome 75% of time
	Timely	Actions meet requirements 99% of the time
C) Manage Oral Disease/Injury	Comprehensive	Appropriate care or restoration provided 95% of the time
	Effective	Treatment restores individual to deployable status 95% of the time
	Durable	Restoration functions without significant deterioration 95% of the time

References
American Dental Association (ADA) Clinical Practice Guidelines. January 2006
HA Policy 02-011, *Policy on Standardization of Oral Health and Readiness Classifications*. 4 June 2002.
HA Policy 06-001, *Policy on Oral Health and Readiness*. 9 January 2006.
United States Air Force Clinical Practice Guidelines (CPG). 2009.

HSD Capability 10: Occupational Health Services

DESCRIPTION OF CAPABILITY: The ability to protect the health and safety of workers through primary, secondary and tertiary preventive interventions; support military mission by maximizing work force fitness for duty; recognize and identify workplace health and safety hazards, illnesses and injuries, systemic hazards, inefficiencies related to human performance, casual relationships, adverse work-related medical findings; assess adequacy of controls; execute monitoring programs to detect adverse trends and initiate interventions; recognize and document medical conditions and treatments that are incompatible with assigned work activities and provide recommended work restrictions as appropriate to workers and supervisors; apply epidemiology, industrial hygiene data, toxicology, ergonomics, laboratory, clinical investigation, legal requirements, appropriate expert consultation and occupational medicine expertise to resolve real and suspected outbreaks/epidemics of illness, injury or potentially adverse medical findings; investigate environmental and community contamination and disaster concerns, advise leadership and support risk communication; oversee, execute or support mission essential programs for surety, security, drug and alcohol demand reduction, travel and deployment medicine, hearing conservation, reproductive health protection, return to duty, certification and others; support and (when assigned) function as the medical advisor to the base commander to prepare for and respond to public health emergencies; maintain awareness of industrial and worker related federal, state and local laws and official policy to protect workers, the environment and the interests of the military necessary to sustain mission accomplishment; provide consultative support to non-occupational medicine providers, human resources representatives, supervisors and military labor attorneys; provide expert witness in support of the military in Merit System Protection Board hearings; assist in resolution of health related union disputes/grievances and prevent union disputes; support disability retirement, Workers' Compensation cases and Safety, Health and Return-To Employment (SHARE) initiatives to ensure accurate and sufficient medical assessment and recommendations are provided to guide expenditure of funds, retention, removal, treatment and return to work. Support or manage wellness programs, immunizations, and other interventions to preserve and improve worker productivity.

Tasks	Conditions/Attributes	Standards
A) Execute Occupational Health Medical Surveillance Program	Comprehensive	All workers assigned to an occupational health monitoring protocol receive the prescribed examinations, studies, labs etc. in the time frames specified by the protocol.

Tasks	Conditions/Attributes	Standards
B) Match worker physical and mental capabilities to job requirements	Acceptable	For each employee, fitness for duty recommendations provided to the employee's supervisor are based on the functional requirements of the job in question and the employee's medical ability to safely perform the assigned tasks and meet security requirements when applicable
	Responsive	Assessments enable expeditious, safe, return to work that supports mission requirements
	Safe	Determinations ensure the health and safety of the individual worker and others in the work place
	Secure	When the assigned work requires a security clearance, applicable standards are met
	Accurate	All relevant medical information is obtained and reviewed, to include significant medical information from outside care and evaluation
C) Provide Occupational Environmental Medicine Consultation	Accessible	Local Occupational Environmental Medicine experts who have the appropriate knowledge, skills and abilities are available to advise and participate in responses to industrial, CBRNE and natural disasters, acute or unique medical issues, legal/administrative actions and applicable union disputes/grievances, and other mission essential or enhancing programs
	Accurate	Advice provided must be defensible
D) Determine Causality	Accurate	Advice provided must be defensible
E) Protect workers' Reproductive Health	Timely	A letter for pregnant civilian employees within 5 days of notification

Tasks	Conditions/Attributes	Standards
	Accurate	An exposure summary from Industrial Hygiene experts for review by the provider writing the profile
	Safe	Recommended limitations should protect both fetal and maternal health and safety
F) Support Other mission essential and mission enhancing programs	Comprehensive	Must comply with requirements specified for each program
G) Provide Medical Care	Accessible	All active duty are provided military medical care where available. When resources permit, civilian employees may elect care either from a military source or through resources in the civilian community. Contractors are responsible for making arrangements for their employees.
	Timely	Where medical care is provided, it should meet locally established standards of timeliness
	Accurate	Medical community standards of care must be met
H) Maintain Current understanding of laws, medicine, official policy	Accurate	Programs, consults and other activities are accurate to ensure protection of workers, populations and the military establishment

References

29 Code of Federal Regulations (CFR) 1910, Occupational Safety and Health Administration, Department of Labor. 21 April 2010.
Air Force Instruction 44-120, *Drug Abuse Testing Program*. 1 July 2000.
Air Force Instruction 44-154, *Suicide and Violence Awareness Education*. July 1999.
Air Force Materiel Command (AFMC) / American Federation of Government Employees (AFGE) Master Labor Agreement, Section 27.09 *Emergency Diagnosis and Treatment*. March 2002.
American College of Occupational and Environmental Medicine (ACOEM), Ten Core Competencies.<http://www.acoem.org/>.
Code of Federal Regulation Title 5, *Administrative Personnel*. 1 January 2010.
Department of Defense (DoD) 5200.2-R, *DoD Personnel Security Program.* 23 February, 1996.
Department of Defense (DoD) 6055.05-M, *Occupational Medical Examinations and Surveillance Manual.* 16 September 2008.
Department of Defense Directive (DoDD) 1010.1, *Drug Abuse Testing Program*. 11 January 1999.
Department of Defense Directive (DoDD) 1010.4, *Drug and Alcohol Abuse by DoD Personnel*. 11 January 1999Department of Defense Directive (DoDD) 1010.9, *DoD Civilian Employee Drug Abuse Testing Program*. 20 January 1992.
Department of Defense Instruction (DoDI) 1400.25-V1614, *DoD Civilian Personnel Management System: Investigation of Equal Employment Opportunity (EEO) Complaints*. 6 April 2009.
Department of Defense Instruction (DoDI) 1400.25-V810, *DoD Civilian Personnel Management System: Injury Compensation.* 16 April 2009.
Department of Defense Instruction (DoDI) 6055.05, *Occupational and Environmental Health (OEH).* 11 November 2008.
Department of Defense Instruction (DoDI) 6490.07, Deployment-Limiting Medical Conditions for

Service Members and DoD Civilian Employees. 5 February 2010.
HA Policy 08-005, *Policy for Mandatory Seasonal Influenza Immunization for Civilian Health Care Personnel Who Provide Direct Patient Care in Department of Defense Military Treatment Facilities.* 4 April 2008.
LONGSHOREMEN'S AND HARBORWORKERS' COMPENSATION ACT AND RELATED STATUTES
NIOSH Publication 99-104, "Effects of Workplace Hazards on Female Reproductive Health". February 1999.
Technical Manual NEHC-TM-OEM 6260.01A, *Reproductive and Development Hazards: A Guide for Occupational Health Professionals.* April 2006.

HSD Capability 11: Public Health Laboratory Services

DESCRIPTION OF CAPABILITY: The ability to provide services to test and monitor the environment; assess the population's health status; investigate and control disease outbreaks; detect and track communicable diseases; act as a reference laboratory for private laboratories; and assure the safety of food and water.

Tasks	Conditions/Attributes	Standards
A) Know what laboratory detectable health threats exist in specific populations	Accurate, Timely, Reliable, and Comprehensive	Standard undefined
B) Know the rates of specific illnesses that exist in specific populations	Accurate, Timely, Reliable, Predictive, and Comprehensive	Standard undefined
C) Know your population	Accurate, Reliable, Timely, and Comprehensive,	Demographic information will be collected and updated on both active duty, retirees, and their dependents who use military health services. Relevant risk behavior data from periodic health assessments (PHAs) and environmental exposures identified by environmental risk evaluations will be available at **all** levels within the military health system, to appropriately and accurately plan and resource immunization programs.
D) Provide laboratory services	Accurate, Reliable, Durable	Laboratory testing procedures and protocols will meet or exceed the requirements of the lab accrediting agencies Tests requested that cannot be performed at the receiving laboratory will be appropriately directed to an approved laboratory for completion
	Timely	100% of tests requested will be accessioned within 12-24 hours of arrival Tests requested that are not available at the receiving laboratory will be transferred to the appropriate laboratory within 48 hours Tests will be completed within industry accepted service times

Tasks	Conditions/Attributes	Standards
E) Report laboratory results	Accurate	Clinical results will be reported back to the requesting clinic or provider about the correct patient and the correct result of the test Laboratory testing will meet acceptable standards of accuracy and reliability. Public health results will be reported back to the correct requesting clinic or public health office.
	Timely	100% of clinical results will be reported back to the requesting clinic within the accepted time limit for the level of the test (e.g. STAT, urgent, routine) 100% of public health results will be reported back to the clinic or public health office within the accepted time limit for the level of the test.
F) Investigate outbreaks	Accurate, Agile, Deployable, Effective, Timely, Responsive	Standard undefined
G) Perform food safety inspections	Acceptable, Standardized, Timely, Responsive	100% of food service facilities will be inspected according to federal food safety guidelines (FDA Food Code).
H) Perform water safety inspections	Acceptable, Reliable, Effective, Safe	100% of unit field sanitation teams (FSTs) will be trained, equipped, and employed according to conduct routine inspections of unit water containers and trailers, daily checks of unit water supplies for chlorine residual, and, when necessary, disinfection (rechlorination) of unit water supplies. 100% of water sources will be evaluated according to TB MED 577 within the accepted time interval
I) Educate targeted populations and the healthcare teams who serve them on public health and laboratory services	Standardized, Appropriate, Responsive	Standard undefined
J) Conduct/promote laboratory diagnostics development and research	Networked, Flexible, Adaptable, Scalable, Timely	Standard undefined
K) Conduct/promote public health surveillance and epidemiologic research	Networked, Flexible, Adaptable, Scalable, Timely	Standard undefined

References
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November 2009.
Armed Forces Health Surveillance Center (AFHSC), *Tri-Service Reportable Events, Guidelines and Case Definitions*. June 2009.
Armed Forces Health Surveillance Center (AFHSC). <http://afhsc.mil/home>.
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CJCS Memo MCM-0006-02, *Updated Procedures for Deployment Health Surveillance and Readiness.* 1 February 2002.
Control of Communicable Diseases Manual - 19th Ed. 2008.
Department of Defense (DoD) 1338-10M, *Manual for the Department of Defense Food Service Program.* 23 March 1990.
Department of Defense Directive (DoDD) 4705.1, *Management of Land-Based Water Resources in Support of Contingency Operations.* 8 December 2003.
Department of Defense Directive (DoDD) 6200.3, *Emergency Health Powers on Military Installation.* 12 May 2003.
Department of Defense Directive (DoDD) 6490.2, *Joint Medical Surveillance.* 30 August 1997.
Department of Defense Instruction (DoDI) 1338.10, *Department of Defense Food Service Program*. 5 June 1991.
Department of Defense Instruction (DoDI) 6420.01, *National Center for Medical Intelligence (NCMI)*. 20 March 2009.
Department of Defense Instruction (DoDI) 6490.02E, *Comprehensive Health Surveillance.* 24 August 2009.
Department of Defense Instruction (DoDI) 6490.03, *Deployment Health Surveillance and Medical Readiness*. 11 August 2006.
Department of Defense Instruction (DoDI) 6490.3*, Implementation and Application of Joint Medical Surveillance.* 7 August 1997.
DEPARTMENT OF THE ARMY, 40-1, *WORLDWIDE DIRECTORY OF SANITARILY APPROVED FOOD ESTABLISHMENTS FOR ARMED FORCES PROCUREMENT,* June 2009.
Food and Drug Administration (FDA) Food Code U. S. Public Health Service. 2009.
Lachica, Dr. R.V., and CW3 R. Worfel. *Guide to the Salvage of Chilled/Frozen Foods Exposed to Refrigeration Failure.* December 1997.
MIL-HDBK-3006, *Department of Defense Military Handbook: Guidelines for Auditing Food Establishments.* 30 August 2000.
MIL-STD 904 A, *Guidelines for Detection, Evaluation and Prevention of Pest Infestation of Subsistence.* 10 March 2000.
Technical Bulletin (TB) Medical (MED) 577, *Sanitary Control and Surveillance of Field Water Supplies*. 15 December 2005.

HSD Capability 12: Ambulatory Diagnostic Services (Medical)

DESCRIPTION OF CAPABILITY: The ability to perform specific test or procedure in an ambulatory setting for the purpose of diagnosis or assisting with making a diagnosis. These diagnostic test or procedure are separate from laboratory or radiographic imagining but may use these ancillary services in addition to the actual test or procedure. Ambulatory diagnostic test include but are not limited to pulmonary function testing, EKG, echocardiograms, endoscopy, colonoscopy, colposcopy, EMG, etc when not performed as treatment.

Tasks	Conditions/Attributes	Standards
A) Identify patients who will benefit from ambulatory diagnostic testing	Accessible	Patient evaluated by specialist within 30 days
	Secure	Patient's privacy protected
	Appropriate	Benefit of diagnostic test outweighs potential harm and test is appropriate to the conditions suspected
B) Prepare patient for diagnostic test or procedure	Timely	Patient ready for surgery on time
	Secure	Patient's privacy protected
	Complete	All required elements of pre-op evaluation present and documented
	Safe	Patient is protected from harm
	Integrated	Healthcare team works in seamless fashion with information awareness
C) Perform diagnostic test or procedure	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
	Accurate	The right test is performed on the right patient 100% of the time
	Effective	Produces desired outcome >90% of the time
	Synchronized	Members of team function in a coordinated fashion
D) Recover Patient	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
E) Provide patient with post diagnostic test instructions	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
	Shared	Continuity of Care
F) Document care provided	Complete	All data elements present
	Comprehensive	Each data element includes all relevant information
	Accurate	Information is correct and legible
	Secure	Patient's privacy is protected

References
American College of Surgeons (ACS). <http://www.facs.org/>.
The American Recovery and Reinvestment Act (ARRA) / The Health Information Technology for Economic and Clinical Health Act (HITECH). 17 February 2009.

HSD Capability 13: Ambulatory Diagnostic Services (Dental)

DESCRIPTION OF CAPABILITY: The ability to perform specific test or procedure in an ambulatory setting for the purpose of diagnosis or assisting with making a dental diagnosis. These diagnostic test or procedure are separate from laboratory or radiographic imagining but may use these ancillary services in addition to the actual test or procedure.

Tasks	Conditions/Attributes	Standards
A) Identify patients who will benefit from ambulatory diagnostic testing	Accessible	Patient evaluated by provider in a timely fashion
	Secure	Patient's privacy protected
	Appropriate	Benefit of diagnostic test outweighs potential harm and test is appropriate to the conditions suspected
B) Prepare patient for diagnostic test or procedure	Secure	Patient's privacy protected
	Complete	All required elements necessary before starting test are completed
	Safe	Patient is protected from harm
	Integrated	Information
	Synchronized	Members of team function in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence
C) Perform diagnostic test or procedure	Secure	Patient's privacy is protected
	Accurate	The right test is performed on the right patient 100% of the time
	Effective	Produces desired outcome >90% of the time
	Synchronized	Members of team function in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence
	Safe	Patient is protected from harm
D) Recover Patient	Secure	Patient's privacy is protected
	Safe	Patient is protected from harm
E) Provide patient with post diagnostic test instructions	Secure	Patient's privacy is protected
	Comprehensive	Full scope as it impacts the continuum of care for follow-up and patient action
	Complete	All data elements present
F) Document care provided	Comprehensive	Each data element includes all relevant information
	Accurate	Information is correct and legible
	Secure	Patient's privacy is protected

References

HSD Capability 14: Inpatient Diagnostic Services

DESCRIPTION OF CAPABILITY: The ability to perform specific test or procedure in an inpatient setting for the purpose of diagnosis or assisting with making a medical or dental diagnosis. These diagnostic test or procedure are separate from laboratory or radiographic imagining but may use these ancillary services in addition to the actual test or procedure. They are the same capability as outpatient medical and dental diagnostic studies but are performed while the patient is an inpatient. Ambulatory diagnostic tests include but are not limited to pulmonary function testing, EKG, echocardiograms, endoscopy, colonoscopy, colposcopy, EMG, etc when not performed as treatment.

Tasks	Conditions/Attributes	Standards
A) Identify patients who will benefit from ambulatory diagnostic testing	Accessible	Patient evaluated by specialist within 30 days
	Secure	Patient's privacy protected
	Appropriate	Benefit of diagnostic test outweighs potential harm and test is appropriate to the conditions suspected
B) Prepare patient for diagnostic test or procedure	Timely	Patient ready for surgery on time
	Secure	Patient's privacy protected
	Complete	All required elements of pre-op evaluation present and documented
	Safe	Patient is protected from harm
	Integrated	Surgeon, anesthesia provider, perioperative nurse and technicians work as a team with excellent communication across the system
	Synchronized	Members of team function in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence
C) Perform diagnostic test or procedure	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
	Accurate	The right test is performed on the right patient 100% of the time
	Effective	Produces desired outcome >90% of the time
	Synchronized	Members of team function in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence
D) Recover Patient	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
E) Provide patient with post diagnostic test instructions	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
	Comprehensive	Full scope as it impacts the continuum of care for follow-up and patient action

Tasks	Conditions/Attributes	Standards
F) Document care provided	Complete	All data elements present
	Comprehensive	Each data element includes all relevant information
	Accurate	Information is correct and legible
	Secure	Patient‘s privacy is protected

References

HSD Capability 15: Laboratory Diagnostic Services

DESCRIPTION OF CAPABILITY: The ability to provide chemical, hematological, microscopic, microbiologic, immunologic, or pathologic study of secretions, discharges, blood, or tissue sections to help diagnose a medical or dental condition or disease.

Tasks	Conditions/Attributes	Standards
A) Provide Support for Human Specimen Source	Comprehensive	Maintain the capability to evaluate all categories of patients, make recommendations and provide analysis of results in the areas of chemistry, hematology, microbiology, pathology,
	Effective	Meet or exceed all national certifying standards for laboratory operations
	Synchronized	Cross level work and human capital support across direct care facilities and with civilian partners.
B) Provide Support for Veterinary Specimen Sources	Comprehensive	Maintain the capability to evaluate all categories of patients, make recommendations and provide analysis of results in the areas of chemistry, hematology, microbiology, pathology,
	Effective	Meet or exceed all national certifying standards for laboratory operations
	Synchronized	Cross level work and human capital support across direct care facilities and with civilian partners.
C) Support Research	Acceptable	Meet the GME requirements of medical and surgical specialties to conduct multi-modality research
	Relevant	Evaluate and carry out research that is pertinent to our patient populations and seeks to make substantial advancements in critical therapeutic areas
	Safe	Work within the guidelines of the Institutional Review Boards to ensure research is conducted in a manner that is ethical, minimizes risk and adheres to DoD standards
D) Provide Support for Environment Testing	Comprehensive	Maintain the capability to evaluate the unique testing, reporting, and analytic needs to support environmental testing and industrial hygiene related to MHS mission
	Effective	Achieve outcomes for all diagnoses that meet or exceed national standards of practice
	Synchronized	Coordinate information from environmental and industrial analysis with other healthcare and deployment data to provide a more comprehensive situational awareness and outcome research
E) Implement Advanced Technologies	Appropriate	Equipment acquisition and implementation is suitable to meet the needs of mission and keeps pace with the

		rapid ongoing technology advancements
	Integrated	Systems are acquired in a manner that facilitates coordinated functioning in order to achieve clinical goals, maximize efficiency and control costs
	Adaptable	Units and processes must be designed to be flexible within an environment of ever changing capabilities

References
Department of Defense Directive (DoDD) 3216.2, *Protection of Human Subjects and Adherence to Ethical Standards in DoD-Supported Research.* 24 April 2007. The International Organization for Standardization (ISO) / The International Electrotechnical Commission (IEC) 17025. ISO Committee on conformity assessment (CASCO). 15 May 2005.

HSD Capability 16: Radiology Diagnostic Services

DESCRIPTION OF CAPABILITY: (1) The ability to use various radiological techniques, mostly noninvasive, to diagnose an array of medical conditions using x-rays, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, and ultrasound. (2) The ability to provide oral and maxillofacial imaging techniques (e.g., bitewing, peri-apical, and occlusal radiographs; ultrasound, cone beam CT, MRI) and special tests (e.g., sialograph) to help diagnose oral or maxillofacial conditions or disease.

Tasks	Conditions/Attributes	Standards
A) Provide Support for Human Radiology Diagnostic Services	Comprehensive	Maintain the capability to provide examination of and analysis from radiology testing to include all modalities of care (plain films, CT Scan, MRI, Ultrasound, PET scan, Nuclear Medicine Imaging) for both medical and dental needs
	Effective	Meet or exceed all national certifying standards for laboratory operations
	Synchronized	Cross level work and human capital support across direct care facilities and with civilian partners.
	Safe	Occurs in environment that does not unnecessarily increase risk to radiology staff or patient
B) Provide Support for Veterinary Imaging	Comprehensive	Maintain the capability to evaluate all species of animals needs to support military mission which includes staff qualification and certification
	Effective	Meet or exceed all national certifying standards for veterinary radiology operations
	Synchronized	Cross level work and human capitol support across direct care facilities and with civilian partners.
	Safe	Occurs in environment that does not unnecessarily increase risk to radiology staff or patient
C) Support Research	Acceptable	Meet the GME requirements of medical and surgical specialties to conduct multi-modality research
	Relevant	Evaluate and carry out research that is pertinent to our patient populations and seeks to make substantial advancements in critical diagnostic areas
	Safe	Work within the guidelines of the Institutional Review Boards to ensure research is conducted in a manner that is ethical, minimizes risk and adheres to DoD standards
	Adaptable	Units and processes must be designed to be flexible within an environment of

Tasks	Conditions/Attributes	Standards
		ever changing capabilities

References
Department of Defense Directive (DoDD) 3216.2, *Protection of Human Subjects and Adherence to Ethical Standards in DoD-Supported Research.* 24 April 2007.

HSD Capability 17: Non-Emergency Medical Transportation

DESCRIPTION OF CAPABILITY: The ability to effectively coordinate and transport stabilized patients who require special medical attention from one location to another

Tasks	Conditions/Attributes	Standards
A) Provide patient transport	Reliable	Able to provide continuous movement between locations 99% of time
	Responsive	Able to respond to patient need for transport within reasonable timeframe 99% of time
	Interoperable	Medical equipment/supplies used for maintaining patient status during transport provide services to and accept services from like systems 99% of time
B) Develop patient transport plan	Comprehensive	All contributing elements; patients, family, staff and other stakeholders are included in planning 99% of time
	Timely	Information is provided within the desired period 99% of time
	Integrated	Operations necessary to initiate transport are linked and synchronous with a focused effort and unified purpose 99% of time
	Interoperable	Coordination of needed equipment/supplies will include capability for interoperability 99% of time
C) Validate administrative preparation for transport	Complete	All critical data/information is available, accurate and timely in 99% of cases
	Accurate	Accurate 100% of time
	Shared	Useable by 99% of the community of interest pre, intra and post transport
D) Coordinate patient movement	Timely	Patient will be moved in a time frame so as to not incur degradation in health 99% of time
	Appropriate	Transport appropriate to patient level of care provided 99% of time
	Total Asset Visibility (TAV)	Real time knowledge of the location, functionality, and availability of patient, medical attendant/s, equipment, supplies, and any other support systems is available in 99% of cases
E) Provide Enroute care	Safe	Patient care will be optimal without degradation of health status 99% of time

Tasks	Conditions/Attributes	Standards
	Appropriate	Qualified staff, equipment and supplies for projected level of care is provided in 100% of cases
	Timely	Monitoring of patient status and provision of appropriate care will occur in a timely fashion 99% of time
F) Conduct patient departure/ reception activities	Complete	All elements necessary to maintain continuity of care are provided 99% of time
	Accurate	All medical and administrative information is accurate 99% of time
	Secure	Maintenance of patient privacy and personal security is accomplished in 100% of cases
G) Document patient care delivered	Networked	Information is made accessible in a timely fashion to the electronic system of record in use within the DoD 100%
	Complete	All data elements of patient record will be updated with care performed during transport to insure continuity of care, quality of care monitoring and maintenance of patient safety 100% of time
	Accessible	Records of transport will be readily available for review and further provision of care 100% of time

References

HSD Capability 18: Emergency Medical Services

DESCRIPTION OF CAPABILITY: The ability to provide the initial evaluation, diagnosis, treatment, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care. Emergency services may be provided in a hospital-based or freestanding emergency department (ED), in an urgent care clinic, in an emergency medical response vehicle, or at a disaster site.

Tasks	Conditions/Attributes	Standards
A) Access and Dispatch	Accessible	Public must be able to access service 100% of the time. Personnel are required to answer 95% of alarms within 15 seconds and 99% of alarms within 40 seconds.
	Accurate	Must dispatch the appropriate units 100% of the time.
	Agile	Must process a 911 callers request within 60 seconds from the time a call was received at the Public Safety Answering Point (PSAP) until the responding unit is notified 90% of the time.
	Networked / Interoperable	Must be linked with local community 911 centers to ensure coordinated response on large scale incidents.
	Durable/Tailorable	Must be capable of managing multiple calls/incidents simultaneously.
B) Triage and Treatment	Responsive	Must be capable of delivering an EMT-B with and Automated External Defibrillator (AED) to the incident scene to current standard
	Expeditionary	Must be capable of delivering a basic life support (BLS) transport unit to the incident scene within 12 minutes of the unit response.
	Practical	Triage and treatment protocols must be based on the level of care provided on the Installation.
	Reliable	All first responder personnel shall be trained to provide at a minimum basic life support (BLS) care. For Installations that do not have an organic First Responder program BLS care must be available from the local community.
	Standardized	Triage and treatment algorithms must be standardized among services
	Timely	All resources (personnel and equipment) must be delivered to the incident in a timely manner.

Tasks	Conditions/Attributes	Standards
C) Disposition	Acceptable	Patient must be delivered to the closest appropriate hospital that operates an emergency department that meets current State and/or Federal guidelines.
		Response and transportation modes shall be determined based on patient's condition, risk to response/transport personnel, distance to appropriate hospital, and Medical Direction.
	Integrated	Locations of _specialty' services, points of contact and hospitals including trauma, burn, pediatric, cardiac, stroke, psychiatric and hyperbaric must be maintained and integrated into the Installations medical treatment and disaster response systems.
	Predictive	Hospital capabilities as defined by local, regional or state directives must be published in an inventory and available to first responder personnel.
	Networked	EMS transport vehicles must be capable of communicating with any hospital in which they transport patients.
	Flexible	Procedures and plans must be established to mange emergency inter-facility transports and diversions.
D) Complete and Archive EMS incident reports	Accessible	A copy of the Patient Care Report (PCR) must be delivered to the hospital to become a part of the patient's medical record and available to the DoD for Quality Assurance purposes.
	Accurate	All applicable information must be accurately completed.
	Comprehensive	Documentation must include provider, system performance, and patient information.
	Relevant	Data must be collected for all EMS incidents regardless of patient encounters. This includes requests for services, refusals of treatment of transport, cancellations and stand-bys.
	Secure	All EMS documentation must be maintained for at least 7 years.
E) Medical Direction	Accessible	Appropriately trained staff above local level will be available for consultation
	Comprehensive	DoD EMS programs will be provided central oversight for maintenance of standards.

Tasks	Conditions/Attributes	Standards
	Integrated	Service Medical Departments will maintain overall coordination, quality assurance and training protocols for all personnel involved with EMS response.
	Responsive	Immediately follow up or refer EMS personnel or cases for review and potential administrative or disciplinary proceedings local EMS system established procedures as appropriate.
F) Provide Incident Site Care	Scalable	Pre-identify Memos of Understanding (MOU)s and Memos of Agreement (MOA)s for incidence events that exceed capacity.
	Responsive	Having 100% of resources to respond to either a planned or expected mass casualty incident.
G) Surge and Expand Hospital Capacity	Scalable	Pre-identify MOUs and MOAs for incidence events that exceed capacity. The organization maintains sufficient medical material to support planned surge capability requirements for a period of 72 hours.
	Responsive	Having 100% of resources to respond to either a planned or expected mass casualty incident.
	Accurate / Responsive	Provide the full scope of care and services to support the patient load. Maintain systems to track and follow, when required, patients discharged or moved to a higher level of care.
H) Receive and treat casualties	Acceptable	Patient will receive the highest level of hospital care that the emergency department is capable of providing that meets current State and/or Federal guidelines.
	Comprehensive	Assigned personnel are trained (including appropriate certification) to provide planned emergency care, treatment, and services.
	Interoperable / Effective	The hospitals are organized in such a manner to provide (support) emergency care that is required for all hazards/mass casualty response, including integration with civil, host nation, and other Federal systems.
	Accurate / Responsive	Provide the full scope of care and services to support the patient load. Maintain systems to track and follow, when required, patients discharged or moved to a higher level of care.

Tasks	Conditions/Attributes	Standards
I) Provide Acute and Routine care	Comprehensive	Plans and policies address how organizations integrate with other organizations and support planned affected populations with acute and routine care for the planned Populations at Risk.
	Scalable	Organizations are configured to provide required services to support the array of illness and injuries caused by an all hazards event, to an affected population.
	Relevant	Personnel planned to support the healthcare system are trained to provide both acute and routine care to the affected population.
	Integrated	ED care will be coordinated with Primary Care Manager

References
BUMED INSTRUCTION 1500.15C, *Resuscitation Training.* 31 October 2008. BUMED INSTRUCTION 6320.94, *Pre-Hospital Emergency Medical Services for Naval Facilities*. 8 August 2008. BUMEDINST 3440.10, *Navy Medicine Force Health. Protection (FHP) Emergency Management Program (EMP).* 20 November 2008. Commander Navy Installations Command (CNIC) Instruction 3440.17, *Navy Installation Emergency Management Program Manual.* 23 January 2006. Department of Defense Directive (DoDD) 3025.1, *Military Support to Civil Authorities (MSCA).* 15 January 1993. Department of Defense Instruction (DoDI) 6055.06, *DoD Fire and Emergency Services (F&ES) Program.* 12 March 2010. Office of The Chief of Naval Operations (OPNAV) CNIC M-11320.27, *NAVY INSTALLATION EMERGENCY MEDICAL SERVICES (EMS) PROGRAM,* January 2008. Office of The Chief of Naval Operations (OPNAV) CNIC M-11320.27, *NAVY INSTALLATION EMERGENCY MEDICAL SERVICES (EMS) PROGRAM,* January 2008. OPNAVINST 11320.27, *Navy Installation Emergency Medical Services (EMS) Program.* 7 January 08. Public Law 104-191, *Health Insurance Portability and Accountability Act of 1996*. 21 August 1996.

HSD Capability 19: Primary Care

DESCRIPTION OF CAPABILITY: The gateway for providing Patient and Family-Centered Care to our beneficiaries; it is the foundation of health and preventive care.

Tasks	Conditions/Attributes	Standards
A) Multidisciplinary Teams Reflecting Clinical Requirements of a Local Patient Population's Needs	Flexible	Personnel mix, organization, and training allows patients to receive needed care for their physical and psychological health 99% of the time
	Synchronized	
	Integrated	
	Comprehensive	
	Decentralized	95% of staff satisfied with working in primary care
	Scalable	
	Responsive	
	Timely	
B) Delivery of Patient Care that Addresses the Full Spectrum of Biopsychosocial Needs of an Individual (Pediatric-Geriatrics)	Adaptable	Continuous improvement activities a core component
	Acceptable	A target of 100% patient satisfaction
	Accessible	Access to care is maximal
	Deployable	Ensure 100% readiness
	Synchronized	Chronic disease and other care management activities core functions
	Integrated	Prevention/Wellness and Psychological Health metrics
	Standardized	Clear business rules for the optimal delivery of care
C) Provide High Quality Evidence Based Medicine to Patients for the Evaluation, Screening, Diagnosing, and Treatment of Illness and Injury	Appropriate	Sufficiently meets quality of care metrics in 99% of cases
	Effective	Produces desired outcome 99% of the time
	Safe	Decrease iatrogenic injury and illness from year to year to a minimal level
D) Document and Archive Data to Enhance Continuity of Care and Promote Ongoing Review and Analysis	Accurate	Maximize use of information technology
	Accessible	
	Complete	
	Networked	100% availability of a shared common operating picture linked and synchronized electronically in order to increase clinical effectiveness in MTFs and operationally.
	Reliable	
	Shared	
	Secure	System processes/procedures have enhanced security characteristics

References
Assistant Secretary of Defense (Health Affairs). Policy Memorandum *Implementation of the*

'Patient-Centered Medical Home' Model of Primary Care in Medical Treatment Facilities (MTF). 18 September 2009.
Department of Defense Directive (DoDD) 6040.41, *Medical Records Retention and Coding at Military Treatment Facilities*. 23 April 2007.
Department of Defense Directive (DoDD) 6200.04, *Force Health Protection*. 23 April 2007.
Department of Defense Directive DODD 6025.13, *Medical Quality Assurance (MQA) in the Military Health System (MHS).* May 2004.
Military Health System (MHS) Guide to Access Success. 15 December 2008.
The National Committee for Quality Assurance (NCQA). *Standards and Guidelines for Physician Practice Connections - Patient-Centered Medical Home (PPC-PCMH).* 6 October 2008.
United States Preventive Services Task Force, *Guide to Clinical Preventive Services*. August 2009.
Veteran Affairs (VA) / Department of Defense (DoD) Executive Council Annual Report, Establishment of VA/DoD Evidence-Based Practice Work Group in September 8, 2004. December 2004.

HSD Capability 20: Routine Ambulatory Specialty Care

DESCRIPTION OF CAPABILITY: The ability to provide ambulatory (outpatient) primary and specialty diagnosis, observation, treatment, and rehabilitation for symptoms and conditions for which non-urgent or non-emergent intervention is required.

Tasks	Conditions/Attributes	Standards
A) Multidisciplinary Teams Reflecting Clinical Requirements of a Appropriately referred Patient Population's Needs	Flexible	Personnel mix, organization, and training allows patients to receive needed care for their physical and psychological health 99% of the time
	Synchronized	
	Integrated	
	Comprehensive	
	Decentralized	95% of staff satisfied with working in specialty care
	Scalable	
	Responsive	
	Timely	
B) Delivery of Patient Care that Addresses the Full Spectrum of Biopsychosocial Needs of an Individual (Pediatric-Geriatrics)	Adaptable	Continuous improvement activities a core component
	Acceptable	A target of 100% patient satisfaction
	Accessible	Access to care is maximal
	Deployable	Ensure 100% readiness
	Synchronized	Chronic disease and other care management activities core functions
	Integrated	Prevention/Wellness and Psychological Health metrics
	Standardized	Clear business rules for the optimal delivery of care
C) Provide High Quality Evidence Based Medicine to Patients for the Evaluation, Screening, Diagnosing, and Treatment of Illness and Injury	Appropriate	Sufficiently meets quality of care metrics in 99% of cases
	Effective	Produces desired outcome 99% of the time
	Safe	Decrease iatrogenic injury and illness from year to year to a minimal level
D) Education (GME)	Acceptable	Meet the GME requirements of medical specialties to conduct multi-modality research
	Relevant	Evaluate and carry out research that is pertinent to the patient population and seeks to make substantial advancements in care
	Safe	Work within the guidelines of the Institutional Review Boards to ensure research is conducted in a manner that minimizes risk and adheres to the DoD standards
E) Document and Archive Data to Enhance Continuity of Care and Promote	Accurate	Maximize use of information technology
	Accessible	
	Complete	

Tasks	Conditions/Attributes	Standards
Ongoing Review and Analysis	Networked	100% availability of a shared common operating picture linked and synchronized electronically in order to increase clinical effectiveness in MTFs and operationally.
	Reliable	
	Shared	
	Secure	System processes/procedures have enhanced security characteristics

References
The Accreditation Council for Graduate Medical Education (ACGME). <www.acgme.org>.

HSD Capability 21: Routine Ambulatory Care (Dental)

DESCRIPTION OF CAPABILITY: The ability to apply dental examinations and capabilities on an outpatient basis (return home the same day) without admission to a hospital.

Tasks	Conditions/Attributes	Standards
A) Diagnostic Ambulatory Dental Care Active Duty Care (ADC)	Standardized	Requirement for annual T-2 Exam for 100% personnel.
	Comprehensive	Risk factors evaluated at 100% of exams.
	Accessible	100% of personnel will be scheduled pre-deployment.
B) Emergency ADC	Standardized	99% of recipients treated upon presentation.
	Agile	Emergency care at 100% of dental treatment facilities.
	Accessible	Availability 95% of time.
	Timely	Care received within 24 hours.
C) Definitive Restorative ADC	Comprehensive	Appropriate care or restoration provided 95% of time.
	Effective	Treatment restores individual to deployable status 95% of time.
	Durable	Restoration functions without significant deterioration 95% of time.
D) Definitive Surgical ADC	Comprehensive	Appropriate surgical care provided 99% of time.
	Effective	Treatment restores individual to deployable status 95% of time
	Durable	Surgical care results in no need for secondary emergency follow up 98% of time.
	Safe	99% error free care.
E) Recall ADC	Standardized	100% offered annual exam.
	Comprehensive	Risk factors evaluated at 99% of exams.
	Effective	95% of personnel receive exams pre-deployment.

References
Health Affairs Policies & Guidelines (HA) 60-007 *TRICARE Policy for Access to Care and Prime Service Area Standards*. 21 February 2006.

HSD Capability 22: Surgery (Ambulatory)

DESCRIPTION OF CAPABILITY: The ability to promote health through surgical intervention in an outpatient setting.

Tasks	Conditions/Attributes	Standards
A) Identify patients who will benefit from outpatient surgery	Accessible	Specialty referral available within established DoD or TRICARE standards
	Secure	Patient's privacy protected
	Appropriate	Patient meets criteria for outpatient surgery
B) Prepare patient for surgery	Timely	Patient ready for surgery on time
	Secure	Patient's privacy protected
	Complete	All required elements of pre-op evaluation present and documented
	Safe	Patient is protected from harm
	Integrated	Surgeon, anesthesia provider, perioperative nurse and technicians work as a team with excellent communication across the system
	Synchronized	Members of team function in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence
C) Perform surgical procedure	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
	Accurate	The right operation is performed on the right patient 100% of the time
	Effective	Produces desired outcome >90% of the time
	Synchronized	Members of team function in a coordinated fashion with specific actions across multiple agents occurring at the proper time and in the proper sequence
D) Recover Patient	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
	Standardized	Transfer criteria are standard for all outpatient procedures
E) Provide outpatient post-op care	Safe	Patient is protected from harm
	Secure	Patient's privacy is protected
	Accurate	Medications and treatment provided to the right patient 100% of the time
F) Discharge patient	Safe	Patient is protected from harm

Tasks	Conditions/Attributes	Standards
	Secure	Patient's privacy is protected
	Accurate	Instructions and prescriptions provided to the right patient 100% of the time
	Standardized	Discharge criteria are standard for all outpatient procedures
G) Document care provided	Complete	All data elements present
	Comprehensive	Each data element includes all relevant information
	Accurate	Information is correct and legible
	Secure	Patient's privacy is protected

Abbreviations:
ACS – American College of Surgeons
HIPAA – Health Insurance Portability and Accountability Act
JC – The Joint Commission

References

HSD Capability 23: Disease Management (DM)

DESCRIPTION OF CAPABILITY: Disease Management is an organized effort to achieve desired healthcare outcomes in populations with prevalent, often chronic, diseases or conditions for which healthcare practices may be subject to considerable variation.

Tasks	Conditions/Attributes	Standards
A) Population Identification	Accurate	Documentation reflects correct patient demographics, diagnosis, medication and testing
	Secure	HIPAA compliant
	Appropriate	Documentation reflects correct patient demographics, diagnosis, medication and testing
	Predictive	Programs are supported by population status
B) Adoption and Implementation of Evidence-Based Clinical Practice Guidelines	Adaptable	Reflects system, provider, and individualized patient needs and issues
	Practical	The MTF identifies and selects at least one clinical process each year for improvement through the application of CPGs.
	Standardized	At least one CPG of choice plus the Post Deployment Health CPG are implemented in all MTFs
	Integrated	Patient and population needs are established and addressed by a multidisciplinary treatment team
C) Utilization of Collaborative Practice Models	Effective	The MTF has a process to receive and share patient information when patient is referred to internal or external providers of care.
	Integrated	All stakeholders are involved in review of processes to improve clinical processes
	Accurate	Documentation reflects correct patient demographics, diagnosis, medication and testing
	Accessible	Treatment locations are appropriately staffed and readily accessible to all patients
D) Provide Patient Self-Management	Appropriate	Information is related to the needs of the intended audience and presented in a culturally competent manner
	Effective	Education strategies are employed which are appropriate for patient/family and presented in preferred modality

Tasks	Conditions/Attributes	Standards
	Safe	Creates an environment where patients feel comfortable addressing difficult, emotional, and sensitive issues free from risk of disclosure or judgment
E) Process and Outcome Measurement, Evaluation and Management	Accurate	Nationally recognized measures are utilized to benchmark program outcomes.
	Standardized	Nationally recognized measures are utilized to benchmark program outcomes.
	Timely	Program outcomes are reviewed on a predetermined schedule
F) Feedback and Reporting to Stakeholders	Accurate	Leadership and stakeholders are informed of status of health and care provided to population
	Accessible	Outcomes data are readily available to those stakeholders with a need to know
	Effective	Programs in place demonstrate steady improvement in health outcomes of population

References
Department of Defense Instruction (DODI) 6025.20, *Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas.* 5 January 2006. Disease Management Association of America (DMAA). <http://www.dmaa.org/>. Institute for Healthcare Improvement. <www.IHI.org/IHI/Topics/ImprovementMethods/Measures>.

HSD Capability 24: Case Management

DESCRIPTION OF CAPABILITY: The ability to assess and assist clients with complex health needs, utilizing a collaborative process, to promote the delivery and receipt of appropriate medical care to achieve positive health outcomes in the most cost-effective manner. Medical case management may include, but is not limited to, care assessment, including personal interview with the injured employee, and assistance in developing, implementing and coordinating a medical care plan with healthcare providers, as well as the employee, military command/unit and/or his/her family and evaluation of treatment results. Medical case management requires the evaluation of a medical condition, developing and implementing a plan of care, coordinating medical resources, communicated healthcare needs to the individual, monitors an individual's progress and promotes cost-effective care.

Tasks	Conditions/Attributes	Standards
A) Maintain a licensed professional staff	Standardized Practical	All licenses will be verified as part of application process
	Appropriate	License will be either RN or Social Work
B) Identification of potential clients	Effective	Documentation reflects patient is high-risk, chronic condition, high utilizer, polypharmacy as described by CMSA.
	Appropriate	Documentation reflects current needs of patients identified
	Secure	HIPAA compliant
C) Assessment of clients	Timely	Assessments will be completed and documented within 3 business days of acceptance to CM
	Responsive	Documentation of assessments in the electronic health record
D) Development and Implementation of Plan of Care	Comprehensive	Plan of Care documentation reflects review and agreement by patient and PCM.
	Integrated	Plan of Care documented in within 30 days of assessment.
	Relevant, Flexible	Plan of Care documentation shows action-oriented goals with designated timeframes specific to patient's needs.
E) Care Coordination	Accessible, Integrated	Documentation reflects timely and appropriate provision of services.
	Synchronized, Shared	Barriers to care identified and alternatives listed.
F) Evaluate and Monitor Outcomes	Timely	Documentation reflects timely follow up with patient/family.
	Appropriate Responsive	Clinical outcomes documented in health record.

Tasks	Conditions/Attributes	Standards
G) Assist with Transition of Care	Timely TAV Shared	Available resources offered and explained to patient/family.

References
Case Management Society of America (CMSA). *Standards of Practice for Case Management.* 2010.

HSD Capability 25: Utilization Management (UM)

DESCRIPTION OF CAPABILITY: Utilization Management is the processes designed to address the managing of resources expended or to be expended in the delivery of healthcare, while simultaneously measuring the quality associated with the care delivered in an effort to balance quality, risk and cost.

Tasks	Conditions/Attributes	Standards
A) Organizational Assessment and Analysis	Accessible	Treatment locations are appropriately staffed and accessible to patients.
	Appropriate	Care is provided at the level required based on patient condition
	Secure	HIPAA compliance is 100%
	Relevant	Selected measures, such as high utilizers of services and medications and provider profiles, are reviewed periodically to determine status
B) Program Plan and Design	Integrated	Programs are developed with collaboration between multiple disciplines and leadership in healthcare setting
	Practical	Treatment needs are prioritized and treatment methods are identified consistent with patient needs
	Standardized/Reliable	Programs are designed to include and utilize available tools which are designed to provide reliable and valid information regarding placement needs. Utilization review is accomplished on pre-determined percentage of patients (100% versus focus)
C) Program Implementation	Relevant	Referral sources are appropriate to identified patient issues and needs. Appropriate staff are available and educated so as to implement plan.
	Timely	Referrals and reviews are made as early as possible *to* decrease sequelae, decrease cost and improve patient satisfaction
	Synchronized	All healthcare team members are educated in program expectations and timeline

Tasks	Conditions/Attributes	Standards
	Appropriate	Appropriate and authorized treatment methodology are utilized and staff are utilized appropriately
D) Program Evaluation and Reporting	Appropriate	Local measures are aggregated and incorporated into MTF reporting systems
	Accurate	Leadership and stakeholders are informed of status of health and care provided to population
	Effective	Programs in place demonstrate steady return on investment for delivery of healthcare to population
	Timely	Reports are provided in a timely manner to MTF and service leadership

References
Carneal, G., Korsch, D. I. (Eds.), Utilization Review Accreditation Commission (URAC). <http://www.urac.org/>.

HSD Capability 26: Inpatient Non-surgical Treatment

DESCRIPTION OF CAPABILITY: The ability to provide all non-surgical medical care and services to treat patients admitted to a hospital for at least one overnight stay.

Tasks	Conditions/Attributes	Standards
A) Assess patient for appropriateness of admission	Timely	Assessment and decision must be made in a timely manner.
	Standardized	Based upon patient condition, staffing and accepted local community and based on nationally standards.
	Responsive	Patient seen in a timely manner in accordance with the standard of care for their clinical situation.
	Secure	Patient‘s privacy protected.
B) Manage the clinical problems of hospitalized patients.	Integrated	The In Patient healthcare team communicates in multiple modalities with patients, families, other healthcare providers and administrators. Patient-centered care requires that physicians and members of multidisciplinary teams effectively inform, educate, reassure, and empower patients and families to participate in the creation of a care plan
	Secure	Patient‘s privacy protected.
	Complete	All required elements of hospitalization are present and documented.
	Safe	Patient is protected from harm.
C) Evaluate and implement as appropriate advanced technologies and evidenced based medicine	Integrated	Facilitates coordinate functioning in order to achieve clinical goals, maximize efficiency and control costs
	Effective	Units and processes must be designed to be evidence based with use of best practices as indicated.
	Appropriate	Equipment acquisition and implementation is suitable to meet the needs of mission and keeps pace with the rapid ongoing technology advancements

Tasks	Conditions/Attributes	Standards
D) Support Research and Graduate Medical Education (GME)	Acceptable	Meet the GME requirements of medical and surgical specialties to conduct multi-modality research
	Relevant	Evaluate and carry out research that is pertinent to our patient populations and seeks to make substantial advancements in critical therapeutic areas
	Safe	Work within the guidelines of the Institutional Review Boards to ensure research is conducted in a manner that is ethical, minimizes risk and adheres to DoD standards
E) Ability to have ongoing Critical Incident Monitoring and Quality Improvement	Accurate	Dedicated personnel to establish and manage a Quality Improvement program
	Timely	Monthly-quarterly data review
	Responsive	Ability to implement and study real time improvement methods with qualified expert in quality improvement
	Persistent	Improvements to have a lasting effect. Dedicated time for all staff (MD, RN, RT, Pharmacy) for continuing education and training
F) Surge and Expand Capacity awaiting additional staffing or patient transfer	Scalable	Pre-identify MOUs and MOAs for incidence events that exceed capacity. The organization maintains sufficient medical material to support planned surge capability requirements
	Responsive	Having 100% of resources to respond to either a planned or expected mass casualty incident.
	Accurate / Responsive	Provide the full scope of care and services to support the patient load. Maintain systems to track and follow, when required, patients discharged or moved to a higher level of care.

Tasks	Conditions/Attributes	Standards
G) Completely document patient care delivered and have information included in patient medical record	Networked	Use a centralized electronic health record EHR that allows healthcare personnel worldwide to access complete, accurate health data to make informed patient care decisions - at the point of care - anytime, anywhere.
	Accurate	All data elements are present.
	Complete	Each data element includes all relevant information.
	Accurate	Information is correct and legible.
	Secure	Patient's privacy is protected
H) Sufficient Patient Volume	Safe	Acuity-based staffing models utilized Volume-outcome relationship well described in the literature; must have sufficient patient volume with the necessary infrastructure described above to safely and effectively support patient volume and acuity (allowing clinicians more clinical and less administrative responsibilities) to improve mortality and morbidity (length of stay, bounce backs, nosocomial infections etc)
	Appropriate	Must have established referral and transport agreements with hospitals to provide: tertiary and quaternary care and for ongoing education of physician and nursing staff
	Effective	Volume-outcome relationship well described in the literature; must have sufficient patient volume with the necessary infrastructure described above to safely and effectively support patient volume and acuity (allowing clinicians more clinical and less administrative responsibilities) to improve mortality and morbidity (length of stay, bounce backs, nosocomial infections etc)

References
Society of Hospital Medicine (SHM). <http://www.hospitalmedicine.org>. The Joint Commission. "2010 National Patient Safety Goals (NPSGs)".

<http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/>.

HSD Capability 27: Intensive Care

DESCRIPTION OF CAPABILITY: Ability to provide comprehensive and highly specialized, life-saving methods and equipment with continuous monitoring and care to seriously ill or injured patients with specially trained provider, nursing, and technical staff

Tasks	Conditions/Attributes	Standards
A) Assess patient for appropriateness of ICU admission, transfer or general medical/surgical/pediatric ward admission	Timely	Assessment and decision must be made in a timely manner.
	Standardized	Based upon patient condition, staffing and accepted local community and based on nationally standards.
B) Deliver the full spectrum of critical care medicine (medical and surgical; across all age continuums in age appropriate manner)	Comprehensive	Maintain the capability to evaluate all categories of patients, make recommendations and provide access to resuscitative equipment, supplies and emerging technologies
		Maintain appropriate medical professional staffing based upon historical and expected workload
	Effective	Achieve outcomes for all diagnoses that meet or exceed national standards of practice
	Interoperable	Coordinate complex multi-specialty care plans to optimize patient outcomes
C) Evaluate and implement as appropriate advanced Technologies to best preserve life and limb.	Integrated	Systems are acquired in a manner that facilitates coordinated functioning in order to achieve clinical goals, maximize efficiency and control costs
	Effective	Units and processes must be designed to be evidence based with use of best practices as indicated.
	Appropriate	Equipment acquisition and implementation is suitable to meet the needs of mission and keeps pace with the rapid ongoing technology advancements
D) Support Research and Graduate Medical Education (GME)	Acceptable	Meet the GME requirements of medical and surgical specialties to conduct multi-modality research
	Relevant	Evaluate and carry out research that is pertinent to our patient populations and seeks to make

Tasks	Conditions/Attributes	Standards
		substantial advancements in critical therapeutic areas
	Safe	Work within the guidelines of the Institutional Review Boards to ensure research is conducted in a manner that is ethical, minimizes risk and adheres to DoD standards
E) Ability to have ongoing Critical Incident Monitoring and Quality Improvement	Accurate	Dedicated personnel to establish and manage a database of all PICU patients to include demographics, diagnosis, procedures, length of stay, complications, nosocomial infections, bounce backs, morbidity and mortality. Must have ability to benchmark against similar sized PICU's (both DoD and civilian)
	Timely	Monthly-quarterly data review
	Responsive	Ability to implement and study real time improvement methods with qualified expert in quality improvement
	Persistent	Improvements to have a lasting effect. Dedicated time for all staff (MD, RN, RT, Pharmacy) for continuing education and training
F) Surge and Expand ICU Capacity awaiting additional staffing or patient transfer	Scalable	Pre-identify MOUs and MOAs for incidence events that exceed capacity. The organization maintains sufficient medical material to support planned surge capability requirements for a period of 72 hours.
	Responsive	Having 100% of resources to respond to either a planned or expected mass casualty incident.
	Accurate / Responsive	Provide the full scope of care and services to support the patient load. Maintain systems to track and follow, when required, patients discharged or moved to a higher level of care.
G) Completely document patient care delivered and have information included in patient medical record	Networked	Use a centralized electronic health record EHR that allows healthcare personnel worldwide to access complete, accurate health data to make informed

Tasks	Conditions/Attributes	Standards
		patient care decisions - at the point of care - anytime, anywhere.
	Accurate	All data elements are present.
	Complete	Each data element includes all relevant information.
	Accurate	Information is correct and legible.
	Secure	Patient's privacy is protected.
H) Sufficient Patient Volume	Safe	1, 3.Volume-outcome relationship well described in the literature; must have sufficient patient volume with the necessary infrastructure described above to safely and effectively support patient volume and acuity (allowing clinicians more clinical and less administrative responsibilities) to improve mortality and morbidity (length of stay, bounce backs, nosocomial infections etc)
	Appropriate	Must have established referral and transport agreements with stand alone Children's Hospitals to A) provide tertiary and quaternary care and B) for ongoing education of physician and nursing staff
	Effective	Same as Safe

References

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IHI Leadership Guide to Patient Safety http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/IHIGlobalTriggerToolformeasuringAEs.htm.
Jenkins KJ, Newburger JW, Lock JE, Davis RB, Coffman GA, Iezzoni LI (1995) In-hospital morality for surgical repair of congenital heart defects: preliminary observations of variation by hospital caseload. Pediatrics 95:323-330
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Maclaren R, Devlin JW, Martin SJ, Dasta JF, Rudis MI, Bond CA (2006) Critical Care pharmacy services in United States hospitals Ann Pharmacother Apr, 40(4):612-8
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Randolph AG, Pronovost P (2002) Reorganizing the delivery of intensive care could improve efficiency and save lives JEval Clin Practice Feb; 8(1): 1-8
Rosenberg D, Moss M, ACCM, SCCM (2004) Guidelines and levels of care for pediatric intensive care units Crit Care Med 32(10): 2117-2127

Society of Critical Care Medicine <http://www.sccm.org>
Tilford JM, Simpson PM, Green JW, Lensing S, Fiser DH (2000) Volume-Outcome Relationships in Pediatric Intensive Care Units Pediatrics Vol 306 no 2.

HSD Capability 28: Surgery (Inpatient)

DESCRIPTION OF CAPABILITY: The ability to treat disease or injury, improve or restore form or function, or close a previously sustained wound through surgical intervention. Inpatient surgery requires that the patient remain in the medical treatment facility for more than 24 consecutive hours following the completion of the procedure to recover from the procedure.

Tasks	Conditions/Attributes	Standards
A) Admit patient who has been identified as needing surgery	Accessible	Surgical available within national standards for type of procedure and location of care.
	Secure	Patient's privacy protected.
B) Prepare patient for surgery	Timely	Patient ready for surgery on time.
	Secure	Patient's privacy protected.
	Complete	All required elements of pre-op evaluation present and documented.
	Safe	Patient is protected from harm.
	Integrated	Surgeon, anesthesia provider and perioperative nurse work as a team with excellent communication across the system.
C) Perform operation	Safe	Patient is protected from harm.
	Secure	Patient's privacy is protected.
	Accurate	The right operation is performed on the right patient.
D) Recover Patient	Safe	Patient is protected from harm.
	Secure	Patient's privacy is protected.
E) Provide inpatient post op care.	Safe	Patient is protected from harm.
	Secure	Patient's privacy is protected.
	Accurate	Correct medications and treatment provided to the correct patient 100% of the time.
F) Document care provided	Complete	All data elements are present.
	Comprehensive	Each data element includes all relevant information.
	Accurate	Information is correct and legible.
	Secure	Patient's privacy is protected.

References

HSD Capability 29: Pharmacy Services

DESCRIPTION OF CAPABILITY: The ability to support clinical activities in all environments through expert clinical consultation, patient education, and appropriate handling and dispensing of drugs and other medical supplies to patients or family members.

Tasks	Conditions/Attributes	Standards
A) Dispensing Outpatient Medication and Inpatient Medications, to include sterile and bulk compounding	Accurate	A national or other regional medication error rate does not exist. Each facility is unique and must establish their own medication error rate
	Complete	The order contains all medications, additives, devices, and information are in the proper container 99.99966% of the time
	Safe	Assure the product is safely prepared and safe for end user for 100% of orders
	Timely	The final product is dispensed to the end user in the shortest time possible as defined by individual facilities
B) Ensure patients achieve the best use of medication	Appropriate	Ensure ambulatory and discharge patients are offered/receive appropriate medication education and counseling 100% of the time. Receives appropriate written education material.
	Comprehensive	Manage the patients' medication history. Manage medication regimens for complex and high risk inpatients. Manage medication therapy in collaboration with other health-care members.
	Effective	Pharmacists will use evidence-based therapeutic protocols.
C) Order pharmaceuticals and supplies and inventory management	Accurate	Process pharmaceutical orders with 99.99966% accuracy
	Timely	Order and receive the product in the shortest time possible. Maximize just in time inventory.
	Tailorable	Comply with mandatory source contracts to the maximum extent possible. Select clinical and cost effective substitutions when necessary. Adjust PAR levels to usage.
D) Medication distribution to clinics, hospital wards, and medical units	Accurate	Process, package and distribute bulk and clinic pharmaceuticals to end users with 99.99966% accuracy

Tasks	Conditions/Attributes	Standards
	Timely	Medication order processed, packaged and distributed to the end user in a time frame established by the facility and dependent on product availability
E) Support global operational forces	Comprehensive	Pharmacists and technicians adequately trained in sterile products preparation, prescription dispensing, controlled substance accountability, and ordering/maintaining supplies
	Expeditionary	Technicians maintain comprehensive pharmacy skills to work independently
F) Provide process improvement of pharmacy care and pharmacy services	Practical	Methods for monitoring and improving service will be readily available and understandable to staff
	Responsive	Methods used to analyze service improvement will occur as close to real time as possible
	Standardized	Standardize methodology to comply with Joint Commission and AAAHC
G) Pharmacy law and regulations	Accurate	Comply with law and regulations 100% of the time
H) Formulary Management	Accurate	100% compliance with DoD Uniform Formulary rules and guidelines
	Comprehensive	Medication formulary to meet the scope of practice at the individual MTF
	Safe	Assure medications added to the formulary are safe for patient treatment
	Standardized	Assure medication formulary is standardized to meet basic requirements for patient care at MTFs
I) Electronic prescription data integrity	Accurate	Measures specified in DoD Pharmacy Data Integrity/ Stoplight reports
	Complete	Measures specified in DoD Pharmacy Data Integrity/ Stoplight reports

References

Defense Supply Center Philadelphia. <http://www.dscp.dla.mil/>.
Department of Defense, (DoD) *Minutes of the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee Meeting,* May 2000.
Healthcare Effectiveness Data and Information Set (HEDIS) Measures
Institute for Safe Medical Practice (ISMP). <http://www.ismp.org/faq.asp#Question_1>.
The Joint Commission, The Joint Commission 2009 Requirements that Support Effective Communication, Cultural Competence, and Patient-Centered Care Hospital Accreditation Program (HAP). 2009.
United States Congress, Omnibus Budget Reconciliation Act of 1990 (OBRA '90). 5 November 1990.
United States Pharmacopoeia, USP <797> Guidebook to Pharmaceutical Compounding—Sterile

Preparation. 1 June 2008.

HSD Capability 30: Therapeutic Radiology Services

DESCRIPTION OF CAPABILITY: The ability to apply ionizing radiation to treat patients with cancer and other diseases.

Tasks	Conditions/Attributes	Standards
A) Deliver Therapeutic Radiation	Comprehensive	Maintain the capability to evaluate all categories of patients, make recommendations and provide access to all therapeutic radiation modalities
	Effective	Achieve outcomes for all diagnoses that meet or exceed national standards of practice
	Synchronized	Coordinate complex multi-specialty care plans to optimize patient outcomes
B) Implement Advanced Technologies	Appropriate	Equipment acquisition and implementation is suitable to meet the needs of mission and keeps pace with the rapid ongoing technology advancements
	Integrated	Systems are acquired in a manner that facilitates coordinated functioning in order to achieve clinical goals, maximize efficiency and control costs
	Adaptable	Units and processes must be designed to be flexible within an environment of ever changing capabilities
C) Support Research	Acceptable	Meet the GME requirements of medical and surgical specialties to conduct multi-modality research
	Relevant	Evaluate and carry out research that is pertinent to our patient populations and seeks to make substantial advancements in critical therapeutic areas
	Safe	Work within the guidelines of the Institutional Review Boards to ensure research is conducted in a manner that is ethical, minimizes risk and adheres to DoD standards

References
Commission on Cancer (CoC) Accreditation Program. <http://www.facs.org/cancer/coc/whatis.html>.
Technical Standard For The Performance Of Radiation Oncology Physics For External Beam Therapy. The American College of Radiology (ACR). 2004.
The American College of Radiology Oncology (ACRO). "ACRO Scope of Practice". 25 October 2002.
The American College of Radiology Oncology (ACRO). "ACRO Standards".

<http://www.acro.org/Accreditation/standards.cfm>.

HSD Capability 31: Mental Healthcare

DESCRIPTION OF CAPABILITY: The ability to provide service members accessing mental healthcare with tools to become free of mental disorder through decreasing present symptoms and dysfunction. In an ideal case, the patients will be able to achieve a state of subjective well-being and successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, an ability to adapt to change and cope with adversity without negative stigma associated with being a warfighter accessing mental healthcare, while mitigating risks for post-traumatic stress disorder (PTSD). Activities include prevention, early intervention, and clinical treatment.

Tasks	Conditions/Attributes	Standards
A) Prevention	Accurate	Information presented is correct and consistent with most current knowledge and research 90% of time
	Appropriate	Information is related to the needs of the intended audience and presented in a culturally sensitive manner. Indicators of cultural sensitivity: availability of interpreters, multi-lingual pamphlets.
B) Early Intervention	Accessible	Screening and assessment are universally standard.
	Complete	All relevant factors and issues are assessed with outcomes that reflects appropriate diagnosis and referral 90% of time
	Secure	Confidentiality, HIPAA compliance 99% of time
	Timely	Staffing and scheduling provide timely access to care 90% of time
C) Treatment Planning	Adaptable	Reflects individualized patient needs and issues 100% of time
	Practical	Treatment issues are prioritized and treatment methods are identified consistent with patient's abilities 90% of time
	Integrated	Established by and addressed by a multidisciplinary treatment team providing an evidence-based multi-modal approach to care
D) Service Coordination	Relevant	Referral sources are germane to identified patient issues and needs 90% of time
E) Treatment Methods	Appropriate	Appropriate treatment methodology are utilized 95% of time

Tasks	Conditions/Attributes	Standards
	Effective	Evidence based practices are utilized to 95% of time to assist the patient in becoming free of mental disorder through decreasing present symptoms and dysfunction.
	Tailorable	Therapeutic alliance promoted and measured through use of patient surveys 95% of time
	Safe	Creates an environment where patients feel comfortable addressing difficult, emotional, and sensitive issues free from risk of disclosure or judgment measured through use of patient surveys 95% of time.
F) Documentation	Accurate	All relevant patient documentation is completed 90% error free within established standards.
	Accessible	Documentation of outcome measures are readily available and reported to program manager and others as needed 95% of time.
G) Professional and Ethical Responsibilities	Acceptable	Perform within established scope of practice and ethical standards 100% of the time
	Relevant	Continuing professional development is relevant to the training needs of the professional 90% of time.

References

Air Force Instruction 44-153, *Critical Incident Stress Management*. 1 July 1999.
Combat and Operational Stress Control (COSCS) Doctrine MCRP 6-11 (Marine Corps Reading Program).
Department of Defense Directive (DoDD) 6490.1, *Mental Health Evaluations of Members of the Armed Forces*. 24 November 2003.
Department of Defense Instruction (DODI) 6490.4, *Requirements for Mental Health Evaluations of Members of the Armed Forces*. 28 August 1997.
Department of Defense, (DoD) PC 09-11-665, *Report of the DoD Independent Review*, January 2010.
National Defense. Authorization Act for Fiscal Year 1993. Public Law 102-484. 23 October 1992. 106 stat. 2725.
Navy Tactics, Techniques, and Procedures (NTTP) 1-15M, "Combat Stress". 23 June 2000.

HSD Capability 32: Substance Abuse Care

DESCRIPTION OF CAPABILITY: The ability to provide medical and/or psychotherapeutic treatment for dependency on illegal drugs and prescription or over-the-counter drugs or alcohol or other mind altering substances to enable the patient to avoid psychological, physical, legal, financial, social, and job-related consequences.

Tasks	Conditions/Attributes	Standards
A) Clinical Evaluation	Accessible	Treatment locations are identified and staffed at 90%
	Accurate	Outcome reflects appropriate diagnosis and placement 90% of time
	Comprehensive	All relevant factors and issues assessed 90% of time
	Integrated	Referral for screening and assessment and reporting of outcomes completed 90%
	Secure	Confidentiality, HIPAA compliance 99% of time
	Timely	Staffing and scheduling provide immediate access to care 90% of time
B) Treatment Planning	Adaptable	Reflects individualized patient needs and issues 100% of time
	Practical	Treatment issues are prioritized and treatment methods are identified consistent with patient's abilities 90% of time
	Integrated	Established by and addressed by a multidisciplinary treatment team 100% of time
C) Service Coordination	Relevant	Referral sources are germane to identified patient issues and needs 90% of time
	Timely	Referrals are made as early as possible to have the desired effect 90% of time
D) Counseling	Appropriate	Appropriate and authorized treatment methodology are utilized 95% of time
	Effective	Evidence based practices are utilized to support positive life style changes 95% of time
	Intuitive	Therapeutic alliance promoted through employment of counseling characteristics and skills measured through use of patient surveys 95% of time

Tasks	Conditions/Attributes	Standards
	Safe	Creates an environment where patients feel comfortable addressing difficult, emotional, and sensitive issues free from risk of disclosure or judgment 100% of the time
E) Client, Family, and Community Education	Accurate	Information presented is correct and consistent with most current knowledge and research 90% of time
	Appropriate	Information is related to the needs of the intended audience and presented in a culturally competent manner 90% of time
F) Documentation	Accurate	All relevant patient documentation is completed 90% error free within established standards.
	Accessible	Documentation of outcome measures are readily available and reported to program manager and others as needed 95% of time.
G) Professional and Ethical Responsibilities	Acceptable	Perform within established scope of practice and ethical standards 100% of the time
	Relevant	Continuing professional development is relevant to the training needs of the professional 90% of time.

References
Alcohol Abuse Amendments of 1983. Public Law 98-24. 26 April 1983. 97 Stat. 175, 182. Department of Defense Instruction (DODI) 1010.6, *Rehabilitation and Referral Services for Alcohol and Drug Abusers.* 13 March 1985. OPNAVIST 5350,4D, *Navy Drug and Alcohol Abuse Prevention and Control.* 4June 2004.

HSD Capability 33: Physical Therapy

DESCRIPTION OF CAPABILITY: The ability to manage patient conditions involving the neuromuscular, musculoskeletal, cardiopulmonary, and integumentary systems through specific therapeutic and rehabilitative interventions based on the results of examination, evaluation, and testing. The ability to promote positive health behaviors in service members and beneficiaries of all ages through human performance optimization and injury prevention programs.

Tasks	Conditions/Attributes	Standards
A) Determine the diagnosis, prognosis, and appropriate treatment plan related to impairments, disability or other health-related conditions that result in functional limitations.	Accessible	Complete baseline Physical Therapy evaluation by Physical Therapist IAW established Clinical Practice Guidelines and professional clinical practice standards.
	Comprehensive	Multi-system examination and evaluation, and testing of physical limitations. Request appropriate imaging studies, and diagnostic laboratory studies to further assess clinical findings. Implement a treatment plan directing acute interventions towards functional reintegration.
	Appropriate	Implementation of screening principles for medical pathology to include review of systems to determine appropriateness of the patient for physical therapy services. Application of relevant testing procedures to support clinical findings.
B) Maximize physical rehabilitation.	Appropriate	Provide evidence based efficient care maximizing resources. Interventions may include but are not limited to: therapeutic exercise; neuromusculoskeletal re-education; manual therapy to include peripheral joint and spinal manipulation; prescription, application and as appropriate, fabrication of assistive/adaptive orthotics, prosthetics, and protective and supportive devices and equipment; strength and conditioning training; debridement and wound care; rehabilitative ultrasound imaging; vestibular rehabilitation; and patient education.

Tasks	Conditions/Attributes	Standards
	Flexible	Modify and adapt dynamic treatment plans to meet the needs of a diverse Soldier/ patient population.
	Supplemental	When appropriate, provide specialized clinical services including but not limited to clinical electrophysiologic PT, dry needling, joint injection and aspirations, and pediatric PT by appropriately privileged and licensed providers.
	Comprehensive	Individualized treatment plans will address all aspects of the Soldier's/patient's functional rehabilitation goals.
C) Prevent injury, impairment, functional limitation, and disability and optimize human performance	Timely	Injury prevention and human performance optimization training IAW guidelines provided in the PT in the BCT Manual. Ongoing collaboration with other health professionals in the DoD, Department of Veteran Affairs, and unit Commanders to meet the needs of service members/patients and Families.
	Predictive	Utilize Functional Movement Screening Tools to assess potential for injury.
	Relevant	Apply principles set forth in the Building the Soldier Athlete (BSA) Program for physical training.
D) Facilitate return to duty or physical independence in the civilian community.	Effective	Apply evidenced based and practical way to safely recover injured service members IAW BSA Supplemental program.
	Flexible	Utilization of broad spectrum of therapeutic and functional re-education strategies to address individual needs.
	Integrated	Synchronization of inter-disciplinary clinical skills with technological assets to maximize physical function in discharge environment.
E) Promote standardized clinical practice models.	Relevant	Ongoing data collection and analysis from theater operations and metrics analysis
	Practical	Clinical studies resulting in improved quality and efficiency outcomes for service members and patients.

Tasks	Conditions/Attributes	Standards
	Disseminated	Utilization of knowledge management and approved social networking platforms to distribute best practices and encourage collaborative efforts.

References
American Physical Therapy Association (APTA), *CRITERIA FOR STANDARDS OF PRACTICE FOR PHYSICAL THERAPY,* December 2009. American Physical Therapy Association (APTA), Scope of Practice. 2009. Army Basic Training TRADOC, *Standardized Physical Training Guide,* November 2003. Army Regulation Medical Services: Clinical Quality Management, 40–68, Chapter 7. 26 February 2004. Department of Defense (DoD) High Performing Organization (HPO) Health Services Concept of Operations (CONOPS). December 2009. TC 3-22.20, Army Physical Readiness Training. 1 March 2010.

HSD Capability 34: Sensory Rehabilitation-Hearing and Audio-Vestibular Care

DESCRIPTION OF CAPABILITY: The ability to apply highly specialized rehabilitation training, resources, and technologies to prevent, manage, treat, and overcome injury, impairment, functional limitation, and disability of vision, speech, and audition to optimize human performance considering medical, neurological and psychological factors.

Tasks	Conditions/Attributes	Standards
A) Develop standardized clinical practices for hearing and audio-vestibular assessment and rehabilitation.	Accessible	Ensure that clinical practice standards are developed to ensure that evaluation and treatment is available and accessible to all identified clients as appropriate.
	Standardized	Develop screening and testing protocol to evaluate all categories of patients with hearing loss, audio-vestibular complaints and rehabilitation protocols to improve communication and/or audio-vestibular function.
	Comprehensive	Ensure that clinical practice standards are developed that ensure certified and licensed professionals are involved in the care of the patient and include, but not limited to, audiologists, otologists/otolaryngologists, hearing technicians, and other disciplines such as speech pathologists, physical therapists, and occupational therapists.
	Predictive	Ensure the validity and reliability of screens, assessments, and effectiveness of interventions which result in effective healthcare delivery and prevention/mitigation of illness and injury related to hearing and/or audio-vestibular problems.
B) Determine the diagnosis, prognosis, and appropriate treatment plan related to hearing or audio-vestibular impairments or disability that result in loss of hearing function, perceived communication deficit, vestibular complaints, or disabling tinnitus.	Accessible	Complete an audiological test battery by audiologist IAW established clinical practice guidelines and professional clinical practice standards upon referral and/or upon identification of an at-risk person as found through medical surveillance.

Tasks	Conditions/Attributes	Standards
	Comprehensive	Administer a comprehensive and appropriate battery of audiological tests to arrive at the proper diagnosis, prognosis, and to establish an appropriate treatment plan.
	Supplemental	When appropriate, provide additional diagnostic tests that are not a typical part of basic audiological test battery, by an audiologist privileged to perform those tasks, to arrive at the proper diagnosis, prognosis, and to establish an appropriate treatment plan.
C) Maximize rehabilitation for patients suffering from hearing impairment, perceived communication deficits, vestibular complaints, and/or disabling tinnitus.	Appropriate	Develop appropriate treatment or rehabilitation plans to meet the needs of a diverse Soldier/patient population by selecting the best option for addressing their specific communication problem through fitting of a hearing aid, assistive listening device, tactical communication and protective system, and/or tinnitus trainer/maskers. Determine if maneuvers such as canalith repositioning or similar exercises are appropriate for the specific vestibular complaint and perform when appropriate.
	Flexible	Plan should be adaptable and modified to meet the needs of a diverse Soldier/patient population by providing rehabilitation that is appropriate for the patient‘s specific impairment and, in the case of specialized aural rehabilitation equipment, adjustable to work within a number of different listening environments the patient most likely to be exposed to.
	Comprehensive	Individual treatment plans will address all aspects of the Soldier‘s/patient‘s functional rehabilitation goals.

Tasks	Conditions/Attributes	Standards
D) Prevent injury, impairment, functional limitation, and disability for hearing and/or tinnitus and optimize human performance.	Comprehensive	Addresses a full spectrum of intervention strategies to prevent and mitigate noise-induced hearing loss from hazardous noise exposures. This should include, but is not limited to: training of hearing professionals, medical surveillance, education of noise-exposed population, and intervention through engineering/administrative controls or hearing protective devices.
	Supplemental	Development of strategies to prevent and mitigate noise-induced hearing loss should include involvement by disciplines such as occupational health, industrial hygiene, environmental health, and safety.
	Tailorable	Utilize available technology and promote development of new technology which allows for use of hearing protection strategies for use across a variety of environments from quiet to noise-hazardous without serious compromise of communication ability.
E) Promote standardized clinical practice models for hearing healthcare.	Relevant	Ensure ongoing data collection through all applicable hearing data sources from both theatre and garrison operations and that metric analysis appropriate to analyze best clinical practice models.
	Practical	Clinical studies result in improved quality and efficiency in outcomes for service members and patients.
	Integrated	Ensure synchronization of clinical and research best practices across disciplines (i.e. audiology, otology/otolaryngology, speech pathology, physical therapy, occupational therapy, neurology) to maximize positive outcomes.

Tasks	Conditions/Attributes	Standards
	Disseminated	Utilize variety of platforms and technology to distribute best practices, engage in outreach, and encourage collaboration with other hearing professionals and professionals in related disciplines.

References
American Speech Language and Hearing Association (ASHA) and American Academy of Audiology (AAA), Evidence Based Practice-Clinical Practice Guidelines Army Regulation Medical Services: Clinical Quality Management, 40–68, Chapter 7. 26 February 2004.

HSD Capability 35: Vision Care (Sensory Rehabilitation)

DESCRIPTION OF CAPABILITY: The ability to apply highly specialized rehabilitation training, resources, and technologies to prevent, manage, treat, and overcome injury, impairment, functional limitation, and disability of vision, speech, and audition to optimize human performance considering medical, neurological and psychological factors.

Tasks	Conditions/Attributes	Standards
A) Determine ocular status, diagnosis, prognosis, and appropriate treatment plan dependent on examination findings and the patient's apparent or perceived loss of visual function or comfort.	Accessible	Complete a comprehensive eye exam IAW established clinical practice guidelines and professional clinical practice standards upon referral or upon identification of an at-risk person as found through medical surveillance.
	Comprehensive	Administer a comprehensive and appropriate battery of ocular health assessment and visual function tests to arrive at the proper diagnosis, prognosis, and to establish an appropriate treatment plan. The provider incorporates the full scope of skills and talents in accordance with DA PAM 600-4 (10-4)
B) Maximize patient rehabilitation for loss of visual comfort or function.	Appropriate	Develop appropriate treatment or rehabilitation plans to meet the needs of a diverse Soldier/patient population by selecting the best option for addressing their specific communication problem.
	Flexible	Plan should be adaptable and modified to meet the needs of a diverse Soldier/patient population by providing rehabilitation that is appropriate for the patient's specific impairment and, in the case of specialized visual equipment, adjustable to work within a number of different visual environments the patient most likely to be exposed to.

Tasks	Conditions/Attributes	Standards
	Comprehensive	Individual treatment plans will address all aspects of the Soldier's/patient's functional rehabilitation goals. The optometrist incorporates the full scope of skills and talents in accordance with DA PAM 600-4 (10-4)
C) Prevent injury, impairment, functional limitation, and disability of vision and preserve ocular health to optimize human performance.	Comprehensive	Address a full spectrum of intervention strategies to prevent and mitigate ocular injury or vision loss from hazardous exposures. This should include, but is not limited to: training of vision professionals, medical surveillance, education of exposed population, and intervention through engineering/administrative controls or vision protective devices. The provider incorporates the full scope of skills and talents in accordance with DA PAM 600-4 (10-4)
	Supplemental	Development of strategies to prevent and mitigate ocular injury and vision loss this should include involvement by disciplines such as occupational health, industrial hygiene, environmental health, and safety.

References
American Optometric Association, Optometric Clinical Practice Guidelines, http://www.aoa.org/x4813.xml Army Regulation Medical Services: Clinical Quality Management, 40–68, Chapter 7. 26 February 2004. DA PAM 40-506, The Army Vision Conservation and Readiness Program, July 2009 DA PAM 600-4, —Army Medical Department Officer Development and Career Managementll, June 2007.

HSD Capability 36: Occupational Therapy

DESCRIPTION OF CAPABILITY: The ability to help a client regain the capability to perform normal everyday tasks and life activities (occupations) that they find meaningful and purposeful by restoring old skills or teaching new skills to adjust to disabilities using adaptive techniques, equipment, orthotics, and modification of the client's home or work environment.

Tasks	Conditions/Attributes	Standards
A) Maximize functional independence and performance	Adaptable	OT service delivery is client-centered, involving collaboration with the client (e.g. individual, family, institution, community) throughout each aspect of service delivery.
	Comprehensive	Intervention includes assessing client needs, planning and implementing occupational therapy services and reassessing impact. Intervention involves therapeutic use of self, activities, and occupations, as well as consultation and education.
	Flexible	All screening and evaluation and intervention will address one or more of the domains that influence occupational performance.
	Appropriate	OT and OTA incorporate occupation-based theories, frames of reference, evidence, and clinical reasoning to guide interventions 100% of time.
B) Minimize injury and impairment	Comprehensive	Addresses full spectrum of intervention strategies including health promotion and prevention, deficit remediation/restoration, performance maintenance, compensation/adaptation to long term impairments, and disability prevention.
	Safe	Reduce risk and barriers to effective performance of work and functional tasks.

Tasks	Conditions/Attributes	Standards
	Effective	OT services are provided to promote the health and wellness of those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.
	Predictive	Ensure validity and reliability of screens, assessments, and effectiveness of interventions toward effective care delivery for prevention and care of illness and injury.
	Integrated	Ergonomic strategies, policies, and programs incorporate all appropriate healthcare providers and support personnel 100% of the time.
C) Facilitate cognitive, psychological & social coping / adaptation skills	Adaptable	Apply a functional approach by matching the individual's interests, skills, and abilities with activities that have meaning and purpose, including a "just right" challenge to help clients attain a sense of mastery as they transition back to independent, productive living.
	Intuitive	Focus on the mind-body interrelationship and the importance of healing through doing using a collaborative and client-centered process.
	Flexible	Applies a broad range of therapeutic principles in both, individual and group settings, to include environmental adaptation, therapeutic use of self, consultation, education, and occupation (purposeful activity)
D) Facilitate return-to-duty or work in the civilian community	Relevant	Teach goal setting to facilitate self-empowerment and guide Soldier toward reasonable short and long-term goals that reflect their interests.
	Predictive	Analyze jobs and job tasks for underlying performance requisites.

Tasks	Conditions/Attributes	Standards
	Networked	Incorporate automated Comprehensive Transition Plan when available, including Self-Assessment to guide appropriate therapeutic work assignment.
E) Facilitate community integration & participation in life roles	Integrated	Promote knowledge of and communication with military and community organizations and military, legal, economic and political systems that impact individual and family.
	Effective	All occupational therapists and occupational therapy assistants, regardless of their individual practice roles, have the professional responsibility to not only use evidence to inform their professional decision-making but also to generate new evidence through independent or collaborative research, or both.
	Interoperable	Comprehensive Transition Plan followed to assure service Member and Family fully reintegrate into home, school, work and community roles.

References

American Journal of Occupational Therapy (AJOT), Pediatrics and Child Health Vol 58 No 6 p. 669-670. May 2004.
Army Regulation Medical Services: Clinical Quality Management, 40–68, Chapter 7. 26 February 2004.
DEPARTMENT OF THE ARMY 09-001, *Comprehensive Transition Plan Policy,* March 2009.
FM 4-02.51, Combat and Operational Stress Control, Ch 3.8. 6 July 2006.
Reference Manual of the Official Documents of the American Occupational Therapy Association (AOTA), Psychosocial Aspects of Occupational Therapy, p.317-321. 2004.
Reference Manual of the Official Documents of the American Occupational Therapy Association (AOTA), Scope of Practice, pp 353-360. 2009.
The American Journal of Occupational Therapy (AOTA), Scholarship in occupational therapy, pp. 63, 790-796. 2009.
The American Occupational Therapy Association (AOTA), Occupational Therapy Practice Framework: Domain and process (2nd ed.). 2008.
Warrior Transition Unit (WTU) Comprehensive Transition Plan (CTP) Guidance.

HSD Capability 37: Amputee Care

DESCRIPTION OF CAPABILITY: The ability to assist patients who will experience, or have experienced, amputation and/or limb deficiency at any point along the continuum of care, including preoperative assessment, surgery, acute hospitalization, rehabilitation, outpatient services, prosthetics, and life-long management.

Tasks	Conditions/Attributes	Standards
A) Identify those with limb loss, at risk of limb loss, or who have had limb salvage	Accurate	Identifies 100% of those with limb loss, 95% of those at risk for future limb loss, and 95% of those with significant limb injury or disease requiring limb salvage procedures
	Responsive	95% of the time the standards are available for application to a particular situation
	Reliable	Sensitive to change over time and able to identify 90% of patients at risk of limb loss as conditions change
B) Coordinate all medical and therapeutic services	Adaptable	99% identifies unique providers to address specific patient's needs
	Integrated	Incorporates all appropriate healthcare providers and support personnel 99% of the time
	Comprehensive	Team covers the spectrum of care from initial involvement to long-term healthcare
C) Provide holistic rehabilitation treatment	Appropriate	Patient focused address 95% of healthcare/patient team established goals
	Effective	95% patient satisfaction with achievement of established goals
	Comprehensive	Address full spectrum of patients needs: 95% of patient and rehab team identified goals are addressed and accomplished
	Efficient	90% of treatment goals are met within established treatment guidelines
D) Establish a registry for limb loss, limb at risk and limb salvage patients	Accessible	100% of those with an approved requirement for registry access have access
	Accurate	99% error free
	Secure	100% Compliant with HIPAA and Privacy Act requirements, and DoD regulation
	Interoperable	Able to exchange %100 of required data between all applicable electronic health systems.
E) Incorporate advanced capabilities as they become	Comprehensive	Incorporates all aspects of rehabilitation and reintegration

Tasks	Conditions/Attributes	Standards
available, including identification of candidates for limb transplantation	Appropriate	Advances are offered to the those who would clearly benefit 100% of the time
	Timely	Appropriate advances are incorporated MHS wide within 3 months of validation of standard of care.

References

HSD Capability 38: Burn Care

DESCRIPTION OF CAPABILITY: The ability to apply highly specialized medical training, resources, and technologies to manage, treat, and heal patients with deep burn injuries.

Tasks	Conditions/Attributes	Standards
A) Provide burn care	Comprehensive	All elements required for burn care shall be available within the MHS at the appropriate time and taxonomy of care
	Timely	Burn care shall be available within the standard for all trauma care: burns requiring specialized care shall be available within 24-72 hrs of injury
	Integrated	All aspects of burn care will be coordinated with care for all other traumatic conditions or concurrent disease
	Standardized	Burn evaluation and care will be done according to established care protocols at all times.
B) Coordinate all medical and therapeutic services	Adaptable	99% identifies unique providers to address specific patient's needs
	Integrated	Incorporates all appropriate healthcare providers and support personnel 99% of the time
	Comprehensive	Team covers the spectrum of care from initial involvement to long-term healthcare
C) Provide holistic rehabilitation treatment	Appropriate	Patient focused address 95% of healthcare/patient team established goals
	Effective	95% patient satisfaction with achievement of established goals
	Comprehensive	Address full spectrum of patients needs: 95% of patient and rehab team identified goals are addressed and accomplished
	Efficient	90% of treatment goals are met within established treatment guidelines
D) Establish a registry for those beneficiaries with skin, deep tissue or respiratory burns	Accessible	100% of those with an approved requirement for registry access have access
	Accurate	99% error free
	Secure	100% Compliant with HIPAA and Privacy Act requirements, and DoD regulation

Tasks	Conditions/Attributes	Standards
	Interoperable	Able to exchange %100 of required data between all applicable electronic health systems.
E) Incorporate advanced capabilities as they become available	Comprehensive	Incorporates all aspects of rehabilitation and reintegration
	Appropriate	Advances are offered to the those who would clearly benefit 100% of the time
	Timely	Appropriate advances are incorporated MHS wide within 3 months of validation of standard of care.

References
Emergency War Surgery, 3rd United States Revision. December 2004.

HSD Capability 39: Occupational Rehabilitation

DESCRIPTION OF CAPABILITY: The ability to help a wounded, ill, or injured worker regain the functional capability to participate in meaningful work/volunteer activities. This may include work-environment modifications, use of compensatory strategies, and/or adaptive equipment or technology to overcome physical, cognitive, or psychological impairments (Not the description utilized in HR CONOPS).

Tasks	Conditions/Attributes	Standards
A) Develop standardized military occupational rehabilitation model	Comprehensive	Occupational Rehabilitation practitioners will be licensed professionals (including but not limited to Occupational Therapy practitioners; Occupational Medicine physicians; Physical Therapy practitioners, Vocational Rehabilitation consultants)
	Standardized	Fully capable to screen and evaluate all categories of patients, make recommendations and provide access to occupational rehabilitation services
	Accessible	Occupational Rehabilitation services are available and accessible to all identified clients.
	Predictive	Ensure validity and reliability of screens, assessments, and effectiveness of interventions toward effective care delivery of prevention and care of illness and injury.
B) Match worker physical, cognitive, social, and behavioral capabilities to job requirements	Timely	Identify potential clients within established practice standards
	Synchronized	Evaluations are relevant to job requirements and are constructed and performed in order to provide evidence based recommendations to supervisors/medical board that must make decisions re: employee placement, return to work, accommodation of impairment, retention, removal or administrative action.
	Appropriate	Perform appropriate evaluation and intervention including job analysis, transferable skills analysis, career counseling, vocational evaluation, work adjustment, functional capacity evaluations or physical capacity assessments, work hardening, work conditioning, job seeking skills training, rehabilitation engineering, ergonomic evaluations.

Tasks	Conditions/Attributes	Standards
C) Minimize work related injury and impairment	Comprehensive	Addresses full spectrum of intervention strategies including health promotion and prevention, deficit remediation/restoration, performance maintenance, compensation/adaptation to long term impairments, and disability prevention
	Standardized	Ergonomic programs shall be carried out according to established protocols, or where no protocols exist, according to best practices.
	Integrated	Ergonomic strategies, policies, and programs will incorporate all appropriate healthcare providers and support personnel 100% of the time.
	Accessible	All Wounded, Injured, Ill Service members will be expected to participate in an adaptive physical fitness program within their ability level.
D) Facilitate return-to-duty or work/volunteer activities in the civilian community	Appropriate	Facilitate, cognitive, psychological, behavioral & social coping / adaptation skills aimed at return to work.
	Interoperable	Facilitate care and transition to other medical facilities or VA care
	Adaptable	Service members' Assistive Technology and Adaptive Uniform needs are met in a timely manner.
	Responsive	Assistive Technology needs assessments will include aspects of service members' functional limitations, computing or communication tasks, technical specifications for computers and/or telecommunication systems, and identification of training needs.
E) Facilitate community integration & participation in work roles	Safety	Research and develop standardized driving reintegration programs for injured workers to assure road safety.
	Practical	Identify driving rehab equipment and clinician training needs
	Relevant	Select the most effective method of community mobility (e.g. mass transit, individual driving)

References
DA PAM 40-21, Ergonomics Program. 14 January 2006. Department of Defense Directive (DoDD) 6025.22, Assistive Technology (AT) for Wounded Service

Members. 9 September 2008.
Department of the Army 09-001, *Comprehensive Transition Plan Policy,* March 2009.
Proponency Office for Rehabilitation and Reintegration (PR&R), Mild Traumatic Brain Injury OT/PT Toolkit. 2010.
United States Army, Building the Soldier Athlete: Reconditioning (Profile) Physical training Supplement. 7 October 2009.

HSD Capability 40: Disability Counseling and Coaching

DESCRIPTION OF CAPABILITY: The ability to provide severely injured or ill service members and families access to a network of professional counseling, information and resources that provide personal support and assistance from injury to reintegration, separation or medical retirement.

Tasks	Conditions/Attributes	Standards
A) Identify severely ill or injured service members	Accessible	Required information is available to members of the care/management/ transition team when needed to meet requirements 100% of the time
	Accurate	Information reflects correct severely ill or injured service member's data 99% of the time
	Appropriate	Documentation captures required information 95% of the time
	Secure	Required information is available to authorized individuals given role-based access 100% of the time
	Timely	Severely ill or injured service members undergoing evaluation by the DES must be identified at the onset and the appropriate Physical Evaluation Board (PEB) Liaison Officer (PEBLO) and/or counselor notified immediately 99% of the time
B) Educate PEBLOs/ Counselors	Accessible	Training programs are available across the DoD
	Appropriate	The training programs need to provide PEBLOs/counselors from novice to expert the requisite knowledge to prepare a Medical Evaluation Board (MEB) package and to appropriately counsel each seriously ill or injured service member and provide the PEBLOs/counselors with current policies, rules, regulations and available resources and benefits under DoD Directive 1332.35; Veteran's Administration Schedule for Rating Disabilities

Tasks	Conditions/Attributes	Standards
	Relevant	Training provides PEBLOs/counselors from novice to expert the requisite knowledge to prepare a Medical Evaluation Board (MEB) package and to appropriately counsel each seriously ill or injured service member and provide participants with current policies, rules, regulations and available resources
C) Counsel	Accessible	PEBLOs/counselors are available when needed by the severely ill or injured service member and their families when needed 99% of the time
	Effective	Processes are in place to receive and share relevant information and assistance with the required stakeholders 95% of the time
	Integrated	Counseling services are coordinated with all required stakeholders 95% of the time
	Secure	Facilities ensure privacy during counseling services, etc., 99% of the time.
D) Coordinate	Integrated	Counseling services are coordinated between/among all required stakeholders 95% of the time
	Interoperable	A process is in place where all involved entities receive and share required information 99% of the time
	Networked	A process is in place where all involved entities receive and share required information 99% of the time
E) Document/ Manage Medical and Non-medical Information	Accessible	Documentation of counseling activities is available 95% of the time
	Shared	All involved entities have access to required documentation 100% of the time.
	Secure	HIPAA and Privacy Act compliance are 100%
	Standardized	The documentation system for counseling services is standardized across all services

Tasks	Conditions/Attributes	Standards
F) Case closure	Accessible	Documentation of case closure is available to all involved entities 95% of the time.
	Comprehensive	All relevant factors, issues and capabilities are considered 95% of the time prior to closure.
G) Measure Outcomes	Accurate	Nationally recognized measures are used to benchmark program outcomes.
	Effective	Programs provide/ enhance quality, access and cost effective outcomes 95% of the time
	Relevant	Policies are implemented, consistent and current and assign/prescribe uniform guidelines, procedures and standards for improvements to the care, management and transition of the severely ill or injured service member.
H) Research and Knowledge transfer capability	Accurate	Leadership and stakeholders are informed of status
	Accessible	Outcomes data are readily available to those stakeholders with a need to know.
	Effective	Programs demonstrate steady improvement in processing time.

References
Department of Defense Directive (DoDD) 1332.18, Separation or Retirement for Physical Disability. 1 December 2003. Department of Defense Directive (DoDD) 3216.2, Protection of Human Subjects and Adherence to Ethical Standards in DoD-Supported Research. 24 April 2007. Department of Defense Instruction (DoDI) 1300.24 Recovery Coordination Program (RCP). 1 December 2009. Department of Defense Instruction (DoDI) 1332.38, Physical Disability Evaluation. 10 July 2006. DoD Medical Management Guide. January 2006. (available for download on www.dodmedicalmanagement.info) Wounded, Ill and Injured Compensation & Benefits Handbook. 1 October 2008.

HSD Capability 41: Medical Support to Disability Evaluation

DESCRIPTION OF CAPABILITY: The ability to evaluate service members who have achieved the optimal medical benefit from available treatment options against medical retention standards.

Tasks	Conditions/Attributes	Standards
A) Case review and referral into the DES and the creation of a case file.	Appropriate	Condition(s) are of the severity and/or recovery is of the duration to demonstrate a level of impairment to warrant DES referral at the appropriate stage of care and/or recovery (usually after up to 12 months of evaluation and treatment for return to duty)
	Effective	95% of referrals result in case file creation within established time frame.
	Standardized	Same form and process is used by physicians to refer members into the DES, along with understood definitions of stable for any condition
B) Networked Information Transfer	Interoperable	Information systems are established linked and allow exchange or information and services between units, commands, and between DoD and VA
	Standardized	Systems provide same format and capabilities to all users, with appropriate role-based data entry and access levels limits
C) Service Member Counseling	Standardized	Patients receive same accurate information and access to options and services in 100% of cases
	Timely	Clinical and administrative counseling provided by the right agency when needed and appropriate within the process 100% cases
D) Disability medical evaluation	Comprehensive	<5% of DES cases terminated or returned to the MTF by the PEB for clinical data obtained by the DoD that was inadequate to determine fitness or unfit
	Standardized	For 95% of cases, exams are conducted based on all potentially unfitting and claimed conditions, and they adhere to protocols established by VA for Compensation and Pension Examinations

Tasks	Conditions/Attributes	Standards
	Interoperable	<5% of DES cases terminated or returned to the MTF by the VA Rating Office (VARO) for clinical data obtained or C&P exams performed by DoD that was inadequate for Disability Rating determination by the VA
E) MEB Narrative Summary Creation & MEB disposition	Relevant	<5% of DES cases terminated or returned to the MTF by the PEB for inadequate description of occupational impact of physical impairment to determine FITNESS or UNFITNESS
	Comprehensive	<5% of DES cases terminated or returned to the MTF by the PEB due to missing clinical data or lack of alignment between impairment and impact that did not permit PEB to determine FITNESS or UNFITNESS
	Timely	MEBRs are completed within prescribed timeframes 95% of cases
F) MEB case file completion	Comprehensive	Case Files include all required elements, proper reviews by physicians and counseling of service members, and are accepted 95% of cases
	Standardized	Case Files contain the prescribed elements 100% of cases
	Timely	Case Files are processed and submitted within prescribed timeframes 95% of cases
	Secure	Patient privacy protected 100% of cases
G) MEB case rebuttal and impartial provider review	Accurate	Member is provided with information and documentation that correctly informs them of their rights and ensures understanding of the process 100% cases
	Relevant	70% of SMs are at least satisfied with the rebuttal and/or impartial provider review process
	Timely	Guidance ensures the member is able to request reviews or provide rebuttals at the proper time and complies with prescribed timeframes so it does not reduce efficiency of case processing

Tasks	Conditions/Attributes	Standards
H) Transfer the case file to the PEB and serve as a liaison between the PEB, MTF and the SM.	Comprehensive	Case File contains all relevant documentation and required elements to allow proper processing and service continuation determination by the PEB 100% of cases
	Responsive	Case File addresses potential questions or queries of the PEB or service member and is understood 100% of cases
	Timely	Case File is transferred to PEB within prescribed timeframes in at least 80% of cases
I) Security of Personal Health Information	Complete	There are no breaches of PHI
J) Education and Training	Comprehensive	95% training currency compliance with HIPAA, Privacy Act, and other policy/statutory training requirements.
	Timely	100% training prior to use of information systems

References

HSD Capability 42: Transitional Services

DESCRIPTION OF CAPABILITY: The ability to provide severely ill or injured warfighters who are transitioning to civilian life and possibly civilian or VA healthcare with the guidance and support to make the passage as seamless and trouble-free as possible.

Tasks	Conditions/Attributes	Standards
A) Identify severely ill or injured warfighters and their family member(s)/ caregiver(s) (case finding)	Accessible	Required information is available to members of the care/management/transition team when needed to meet requirements 100% of the time
	Accurate	Information reflects correct severely ill or injured warfighters and their family member(s)/ caregiver(s)' data 100% of the time
	Appropriate	Documentation captures required information 100% of the time
	Secure	Required information is available to members of the care/management/transition team 100% of the time
B) Assess	Appropriate	All relevant sources (military and civilian) are used to identify the severely ill or injured warfighter's and their family member(s)/ caregiver(s)' needs 95% of the time
	Comprehensive	Assessment must include all assessment categories 95% of the time
	Relevant	Information and data gathered for the assessment of the severely ill or injured warfighter and their family member(s)/caregiver(s) must be relevant 99% of the time
	Timely	Assessment must be completed within established timeframes 99% of the time
C) Plan	Adaptable	The plan reflects the need for ongoing assessments/ re-evaluations of health and progress as a result of changes occurring over time 95% of the time
	Comprehensive	The plan is such that it enhances quality, access and cost-effective outcomes 95% of the time
	Integrated	Plans of care are developed with input of all required stakeholders 95% of the time
	Timely	The plan must be implemented within established timeframes 95% of the time

Tasks	Conditions/Attributes	Standards
D) Implement Plan of Care	Acceptable	The severely ill or injured warfighter and their family member(s)/caregiver(s) agree to the provided services 95% of the time
	Accurate	Nationally recognized measures/evidence based guidelines are used within the plan of care 95% of the time
	Adaptable	Due to changes in the needs of the severely ill or injured warfighter and their family member(s)/ caregiver(s), a plan is in place for ongoing assessments/re-evaluations of health and progress 95% of the time
	Effective	Processes are in place to receive and share relevant information with the required stakeholders
	Integrated	Plans of care are implemented with coordination of all required stakeholders 95% of the time
	Secure	Facilities ensure privacy during counseling services, etc., 99% of the time.
E) Coordinate	Integrated	Plans of care are coordinated between/among all required stakeholders 99% of the time
	Interoperable	A process is in place where all involved entities receive and share required information 99% of the time
	Networked	A process is in place where all involved entities receive and share required information 99% of the time
F) Monitor	Comprehensive	A process is in place to ensure that the case manager continually assesses and monitors the severely ill or injured warfighter's and their family member(s)/caregiver(s)' response and adherence to treatments 95% of the time
	Flexible	A process is in place to ensure identified variance(s) from the plan of care are identified and used to update the plan accordingly 95% of the time
	Reliable	A process is in place to ensure utilization of healthcare resources is tracked 95% of the time
G) Case closure	Accessible	Documentation of case management continuum of care activities is available 100% of the time.

Tasks	Conditions/Attributes	Standards
	Comprehensive	All relevant factors, issues and capabilities are considered 95% of the time prior to closure.
H) Document/ Manage Medical and Non-medical Information	Accessible	Documentation of case management continuum of care activities is available 100% of the time.
	Shared	All involved entities have access to required case management documentation 100% of the time.
	Secure	HIPAA and Privacy Act compliance are 100%
	Standardized	The documentation system for case management services is standardized across all services and captures the case management continuum of care 100% of the time. (AHLTA CM templates)
I) Measure Outcomes	Accurate	Nationally recognized measures are used to benchmark program outcomes.
	Effective	Programs provide/enhance quality, access and cost effective outcomes 95% of the time
	Relevant	Policies are implemented, consistent and current and assign/prescribe uniform guidelines, procedures and standards for improvements to the care, management and transition of the severely ill or injured warfighter.

Tasks	Conditions/Attributes	Standards
	Timely	Data (including number of clinical case managers (CCMs)on hand (both within the direct care system and through the Managed Care Support Contractors; Percent of CCMs Having Completed the Required Training; Number of active duty service members receiving case management services; percent of active duty service members receiving case management services who are in the highest two acuity levels; percent of active duty service members who need case management services who are receiving care coordination Wounded Ill and Injured Programs; and percent of active duty service members and their family members who are satisfied with the healthcare received) are provided in a timely manner to MTF and service leadership 95% of the time
J) Educate Case Managers	Accessible	Online training programs are available across the DoD/Department of Veterans Affairs.
	Appropriate	Medically appropriate training addresses detection, notification, and tracking of early warning signs of post-traumatic stress disorder, suicidal or homicidal thoughts or behaviors, and other behavioral health concerns among the severely ill or injured warfighter. The training needs to include procedures for the appropriate specialty consultation and referral following detection of such signs.
	Relevant	Training provides case managers from novice to expert current realistic approaches to effective case management and resources to ensure they possess the education and skills required to render appropriate services within the DoD based on sound principles of practice.

References
Department of Defense (DoD) TRICARE Management Activity (TMA), Medical Management Guide, Version 3.0. October 2009.

APPENDIX B. REFERENCE DOCUMENTS

29 Code of Federal Regulations (CFR) 1910, Occupational Safety and Health Administration, Department of Labor. 21 April 2010.

Accreditation Association for Ambulatory Health Care (AAAHC), Standards Revisions for 2010. 14 November 2009.

Action Memorandum for the Deputy Secretary of Defense, SUBJ: ―Joint/Unified Medical Command Way Ahead,‖ 27 November 2006.

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APPENDIX C. GLOSSARY

Part I. Acronyms

AAAHC	Accreditation Association for Ambulatory Health Care
AB	Air Base
ACIP	Advisory Committee on Immunization Practices
AE	Aeromedical Evacuation
ASD (HA)	Assistant Secretary of Defense (Health Affairs)
BA	Battlespace Awareness
BI	Business Intelligence
BRAC	Base Realignment and Closure
C2	Command and Control
C4	Command, Control, Communications, and Computers
CASEVAC	Casualty Evacuation
CBA	Capabilities-Based Assessment
CBO	Congressional Budget Office
CBRNE	Chemical, Biological, Radiological, Nuclear, and High Yield Explosives
CCDR	Combatant Commander
CCJO	Capstone Concept for Joint Operations
CCQAS	Centralized Credentialing and Quality Assurance System
CDHP	Consumer-Directed Health Plan
CERP	Commander‘s Emergency Response Program
CJCS	Chairman of the Joint Chiefs of Staff
CM	Case Management
CMS	Centers for Medicaid and Medicare Services
CMSA	Case Management Society of America
COI	Community of Interest
CONOPS	Concept of Operations
CONUS	Continental United States
CPG	Clinical Practice Guidelines
CS	Civil Support
CT	Computed Tomography
CWMD	Combating Weapons of Mass Destruction
DCS	Direct Care System
DepSecDef	Deputy Secretary of Defense
DES	Disability Evaluation System
DHAPP	Department of Defense HIV/AIDS Prevention Program
DHP	Defense Health Program
DIMEFIL	Diplomatic, Information, Military, Economic, Financial, Intelligence, and Law Enforcement
DNBI	Disease and Non-Battle Injury
DoD	Department of Defense
DoDD	Department of Defense Directive
DOTMLPF	Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel and Facilities
ED	Emergency Department

EHR	Electronic Health Record
EMR	Electronic Medical Record
FCB	Functional Capability Board
FDA	Food and Drug Administration
FFS	Fee-For-Service
FHP	Force Health Protection
FP	Force Protection
FRC	Forward Resuscitative Care
FRS	Forward/Resuscitative Surgery
FS	Force Support
FST	Field Sanitation Team
GDP	Gross Domestic Product
GEIS	Global Emerging Infections Surveillance and Response System
GME	Graduate Medical Education
GS	Global Strike
HA/DR	Humanitarian Assistance/Disaster Response
HD	Homeland Defense
HFSC	Health Facility Steering Committee
HIT	Health Information Technology
HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
HN	Host Nation
HR	Health Readiness
HRA	Health Risk Assessment
HS	Homeland Security
HSD	Health Service Delivery
HSS	Health System Support
IA	Information Assurance
ICD	Initial Capabilities Document
IGO	International/Agency Government Organization
IM/IT	Information Management/Information Technology
IT	Information Technology
IW	Irregular Warfare
JCA	Joint Capabilities Area
JCD	Joint Capabilities Document
JCIDS	Joint Capabilities Integration and Development System
JFC	Joint Functional Concept
JFHP	Joint Force Health Protection
JHPE	Joint Human Performance Enhancement JIC (Joint Integrating Concept)
JP	Joint Publication
JMROC	Joint Medical Readiness Oversight Committee
JOA	Joint Operations Area
JOC	Joint Operating Concept
JOE	Joint Operational Environment
JOpsC	Refers to the Family of Joint Operations Concepts
JROC	Joint Requirements Oversight Council

JTF CapMed	Joint Task Force National Capital Region Medical
KM/DS	Knowledge Management/Decision Support
LAWG	Local Authorities Working Group
MCO	Major Combat Operation
MEB	Medical Evaluation Board
MEDCAP	Medical Civic Action Program
MEDEVAC	Medical Evacuation
MEDRETE	Medical Readiness Training Exercises
MHS	Military Health System
MHSER	Military Health System Executive Review
MHS-OT	Military Health System Office of Transformation
MILCON	Military Construction
MilPers	Military Personnel
MIPITS	Medical Infrastructure Portfolio Investment Tracking System
MIPOE	Medical Intelligence Preparation of the Operational Environment
MOPP	Mission-Oriented Protective Posture
MRI	Magnetic Resonance Imaging
MRO	Medical Regulating Office (Army)
MTF	Medical Treatment Facility
NCOE	Net-Centric Operational Environment
NDAA	National Defense Authorization Act
NGO	Non-Governmental Organization
NMS	National Military Strategy
NRF	National Response Framework
OCO	Overseas Contingency Operations
OEG	Operational Exposure Guidance
OEH	Occupational and Environmental Health
OLAP	Online Application Processing
OMB	Office of Management and Budget
PBD	Program Budget Decision
PCE	Patient Care Encounter
PDHRA	Post-Deployment Health Readiness Assessment
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PET	Positron Emission Tomography
PHI	Personal Health Information
PHL	Public Health Laboratory
PHR	Personal Health Record
PM	Patient Movement
PMI	Patient Movement Item
PMOC	Portfolio Management Oversight Committee
PMR	Patient Movement Request
POM	Program Objective Memorandum
PSP	Patient Safety Program
PTSD	Post-Traumatic Stress Disorder
QA	Quality Assurance

QDR	Quadrennial Defense Review
RCA	Root Cause Analysis
RMSC	Resource Management Steering Committee
SAMMC	San Antonio Medical Center
SAR	Search and Rescue
SE	Sentinel Event
SECDEF	Secretary of Defense
SME	Subject Matter Expert
SMWG	Strategy Management Working Group
SSTRO	Stability, Security, Transition, Reconstruction, and Operations
TBI	Traumatic Brain Injury
TMA	TRICARE Management Activity
USAFE	United States Air Forces in Europe
USD (P&R)	Under Secretary of Defense for Personnel and Readiness
USPSTF	United States Preventive Services Task Force
USNORTHCOM	United States Northern Command
VA	Department of Veterans Affairs
WG	Working Group
WMD	Weapons of Mass Destruction

Part II. Glossary

Board. An organized group of individuals within a Joint Force Commander‘s headquarters, appointed by the commander (or other authority), that meets with the purpose of gaining guidance or decision. Its responsibilities and authority are governed by the authority that established the board. (JP 3-33)

Capability. The ability to execute a specified course of action. (A capability may or may not be accompanied by an intention.) (JP 1-02.) It is defined by an operational user and expressed in broad operational terms in the format of an initial capabilities document or a DOTMLPF change recommendation. Also called capabilities.

Capstone Concept for Joint Operations (CCJO). The overarching concept of the Joint Operational Concepts family of documents that guides the development of future joint capabilities. It applies to operations worldwide conducted unilaterally or in conjunction with multinational military partners and other government and non-government agencies.

Casualty. Any person who is lost to the organization by having been declared dead, duty status—whereabouts unknown, missing, ill, or injured. (JP 1-02.) See also Casualty Category; Casualty Status; Casualty Type; Duty Status—Whereabouts Unknown; Hostile Casualty; Non-Hostile Casualty.

Casualty Evacuation. The unregulated movement of casualties that can include movement to and between medical treatment facilities. Also called CASEVAC. See also Casualty; Evacuation; Medical Treatment Facility. (JP 1-02)

Cell. A subordinate organization formed around a specific process, capability, or activity within a designated larger organization of a Joint Force Commander‘s headquarters. A cell is usually part of a functional and traditional staff structure. (JP 3-33)

Combatant Command. A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense, and with the advice and assistance of the Chairman of the Joint Chiefs of Staff. Combatant commands typically have geographic or functional responsibilities. (JP 1-02)

Combatant Commander. A commander of one of the unified or specified combatant commands established by the President. Also called CCDR. (JP 1-02)

Compatibility. The ability of systems, equipment, devices, and materiel to operate in their intended operational environments without suffering unacceptable degradation or without causing unacceptable performance interactions or responses. It involves the application of sound system, equipment, device, and materiel design configurations that ensures interference free operation, and clear concepts that maximize operational effectiveness. (JP 1-02)

Concept. A notion or statement of an idea; an expression of how something might be done. See Joint Concept. (Source: JFHP CONOPS)

Definitive Care. Care rendered to conclusively manage a patient‘s condition. It includes the full range of preventive, curative, convalescent, restorative, and rehabilitative medical care. This normally leads to rehabilitation, return to duty, or discharge from the service. (JP 4-02)

Effect. (1) The physical or behavioral state of a system that results from an action, a set of actions, or another effect. (2) The result, outcome, or consequence of an action. (3) A change to a condition, behavior, or degree of freedom. (JP 3-0)

End of Life Care. The care that patients and their families receive when patients are dying or near death. It incorporates multiple forms of care, including supportive care, hospice care and palliative care.

En Route Care. Continuation of the provision of care during movement (evacuation) between the health service support capabilities in the continuum of care, without clinically compromising the patient‘s condition. (JP 4-02)

En Route Care Capability. The ability to provide uninterrupted medical care from the point of injury or initial illness until patients arrive at a medical facility or between capabilities in the continuum of essential care, without compromise to the patient‘s condition. See also En Route Care. (JP 4-02)

Evacuation. (1) Removal of a patient by any of a variety of transport means (air, ground, rail, or sea) from a theater of military operation, or between health service support capabilities, for the purpose of preventing further illness or injury, providing additional care, or providing disposition of patients from the military healthcare system. (2) The clearance of personnel, animals, or materiel from a given locality. (3) The controlled process of collecting, classifying, and shipping unserviceable or abandoned materiel, US or foreign, to appropriate reclamation, maintenance, technical intelligence, or disposal facilities. (4) The ordered or authorized departure of noncombatants from a specific area by the Department of State, DoD, or appropriate military commander. This refers to the movement from one area to another in the same or different countries. The evacuation is caused by unusual or emergency circumstances and applies equally to command or non-command sponsored family members. See also Evacuee; Noncombatant Evacuation Operations. (JP 4-02)

First Responders. Primary healthcare providers whose responsibility is the provision of immediate clinical care and stabilization in preparation for evacuation to the next health service support capability in the continuum of care. In addition to treating injuries, they treat service members for common acute minor illnesses. (JP 4-02)

First Responder Capability. The healthcare capability that provides immediate clinical care and stabilization to the patient in preparation for evacuation to the next health service support capability in the continuum of care. (JP 4-02) It involves several tiers of first responders with training in field sanitation and preventive medicine; highly proficient medical teams and organic medical structures that support combat formations and operational units that provide treatment of battlefield trauma within the first few minutes after injury; and those organic preventive medicine units/teams and medical biological detection teams that provide prevention and protection support to the force from natural, environmental, occupational, operational, industrial, behavioral, and chemical, biological, radiological and nuclear hazard health threats.

Force Health Protection. Joint healthcare capabilities and measures to promote, improve, conserve and restore the mental and physical wellbeing of deployed forces. FHP includes preventive, protective, restorative and rehabilitative medical and dental care for injuries and illnesses from health hazards and threats within a Joint Operations Area (JOA). FHP activities sustain a healthy and fit force, and include all measures taken by commanders, supervisors, individual service members, as well as the Military Health System (MHS) to support all beneficiaries and ensure the success of joint warfighters across the range of military operations. FHP activities are enabled by the integration of Health Service Delivery (HSD) and Health System Support (HSS) capabilities as applied to expeditionary task force operations. (See also HSD and HSS)

Foreign Humanitarian Assistance (Abroad). Programs conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions such as human pain, disease, hunger, or privation that might present a serious threat to life or that can result in great damage to or loss of property. Foreign humanitarian assistance (FHA) provided by US forces is limited in scope and duration. The foreign assistance provided is designed to supplement or complement the efforts of the host nation civil authorities or agencies that might have primary responsibility for providing FHA. FHA operations are those conducted outside the United States, its territories, and possessions. Also called FHA. See also Humanitarian Assistance. (JP 1-02)

Forward Resuscitative Care. Care provided as close to the point of injury as possible based on current operational requirements to attain stabilization and achieve the most efficient use of life, limb, and eyesight saving medical treatment. Forward resuscitative care typically provides essential care for stabilization to ensure that the patient can tolerate evacuation. Also called FRC. See also Essential Care (JP 4-02) (Normally provided by medical personnel and also includes efforts to relieve pain and administer Forward/Resuscitative Surgery [FRS] care capabilities.)

Healthcare Provider. Any member of the Armed Forces, civilian employee of the DoD, or personal services contract employee under 10 United States Code (USC) 1091 authorized by the DoD to perform healthcare functions. The term excludes any contract provider who is not a personal services contract employee. Also called DoD Healthcare Provider. (JP 4-02)

Health Service Delivery. The ability to provide acute or long-term primary or specialty care capabilities to all eligible beneficiaries outside the theater in either the direct or purchased care system.

Health System Support. The ability to perform healthcare administrative and support related functions to sustain and continuously improve MHS mission effectiveness through focused development of people, technology, infrastructure, and joint organizational culture.

Health Surveillance. The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential risks to health, thereby enabling timely interventions to prevent, treat, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance. (JP 4-02 and approved for next edition of JP 1-02.)

Health Threat. A composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of nuclear, biological, and chemical weapons (e.g., weapons of mass destruction) that have the potential to affect short- or long-term health (e.g., psychological impact) of personnel. (JP 4-02)

Homeland Defense. The protection of United States sovereignty, territory, domestic population, and critical infrastructure against external threats and aggression or other threats as directed by the President. Also called HD. (JP 3-0)

Homeland Security. As defined in the National Strategy for Homeland Security, a concerted national effort to prevent terrorist attacks within the United States, reduce America‘s vulnerability to terrorism, and minimize the damage and recover from attacks that do occur. The DoD contributes to homeland security through its military missions overseas, homeland defense, and support to civil authorities. Also called HS. (JP 3-26)

Hospital. A medical treatment facility capable of providing inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well as the necessary supporting services required to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic. (JP 1-02)

Humanitarian and Civic Assistance. Assistance to the local populace provided by predominantly US forces in conjunction with military operations and exercises. This assistance is specifically authorized by title 10, USC, section 401, and funded under separate authorities. Assistance provided under these provisions is limited to (1) medical, dental, and veterinary care provided in rural areas of a country; (2) construction of rudimentary surface transportation systems; (3) well drilling and construction of basic sanitation facilities; and (4) rudimentary construction and repair of public facilities. Assistance must fulfill unit training requirements that incidentally create humanitarian benefit to the local populace. Also called HCA. See also Foreign Humanitarian Assistance. (JP 3-05.1)

Humanitarian Assistance. Programs conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions (e.g., human pain, disease, hunger, or privation) that might present a serious threat to life or that could result in great damage to or loss of property. Derived from Foreign Humanitarian Assistance (FHA) (JP 3-05.1) See also Humanitarian and Civic Assistance (JP 1-02, JP 3-07.6)

Humanitarian Relief. Material or logistical assistance provided for humanitarian purposes, typically in response to humanitarian crises. The primary objective of humanitarian relief operations is to save lives, alleviate suffering, and maintain human dignity. It therefore may be distinguished from development aid, which seeks to address the underlying socioeconomic factors that might have led to a crisis or emergency.

Interchangeable. The ability of systems, units, or forces to replace like systems, units, or forces that possess common capabilities and like characteristics to fulfill relevant requirements without causing unacceptable performance degradations when exchanged. (Definitions for the purpose of HR CONOPS)

Interdependent. A service‘s purposeful reliance on another service‘s capabilities to maximize complementary and reinforcing effects, while minimizing relative vulnerabilities to achieve mission requirements of the Joint Force Commander. (Definitions for the purpose of HR CONOPS)

Interoperability. (1) The ability to operate in synergy in the execution of assigned tasks. (JP 1-02) (2) The ability of systems, units, or forces to provide data, information, materiel and services to, and accept the same from, other systems, units, or forces and use the data, information, materiel, and services so exchanged to enable them to operate together effectively. (Manual for Operation of the Joint Capabilities Integration and Development System, February 2009 (Updated 31 July 2009)) (3) The degree of interoperability should be defined when referring to specific cases. (JP 3-32)

In-Transit Visibility. The ability to track the identity, status, and location of DoD and non-unit cargo (excluding bulk petroleum, oils, and lubricants) and passengers; medical patients; and personal property from origin to consignee or destination across the range of military operations. Also called ITV. (JP 1-02)

Joint. Connotes activities, operations, organization, etc., in which elements of two or more military departments participate. (JP 0-2)

Joint Concept. Links strategic guidance to the development and employment of future joint force capabilities and serve as ―engines for transformation‖ that may ultimately lead to doctrine, organization, training, materiel, leadership and education, personnel and facilities (DOTMLPF) and policy changes (This term and its definition modify the existing term and its definition and are approved for inclusion in JP1-02. Source CJCSI 3010.02) . (CJCSI 5120.02)

Joint Force. A general term applied to a force composed of significant elements, assigned or attached, of two or more military departments, operating under a single Joint Force Commander. (JP 1-02)

Joint (Force) Commander. A general term applied to a combatant commander, subunified commander, or joint task force commander authorized to exercise combatant command (command authority) or operational control over a joint force. Also called JFC. (JP 1-02) Note: Concept documents also use JFC for the name of a series of Joint Functional Concept documents, as defined below. (Note: To avoid confusion, the term ―joint commander‖ without the acronym is used throughout this document.)

Joint Functional Concept. An articulation of how a future Joint Force Commander will integrate a set of related military tasks to attain capabilities required across the range of military operations. Although broadly described within the joint operations concepts, they derive specific context from the joint operating concepts and promote common attributes in sufficient detail to conduct experimentation and measure effectiveness. Also called JFC. Per CJCSI 3010.02B, a JFC is one of a series of concept documents that apply elements of the CCJO solution to describe how the joint force, 8 to 20 years into the future, will perform an enduring military function across ROMO. It identifies the operational-level capabilities required and the key attributes necessary to compare capability or solution alternatives. (Note: JFC also is the JP 1-02 acronym for Joint Force Commander; however, but to avoid confusion with joint functional concepts documents referenced throughout this concept document, only the term ―joint commander‖ is used.)

Mass Casualty. Any large number of casualties produced in a relatively short time period, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack that exceeds local logistical support capabilities. See also Casualty. (JP 1-02)

Materiel. Equipment and supplies in military and commercial supply chain management. In a military context, materiel relates to the specific needs of a force to complete a specific mission. The term also is used often in a general sense (―men and materiel‖) to describe the needs of a functioning army.

Medical Civil-Military Operations. All health-related activities in support of a Joint Force Commander that establish, enhance, maintain, or influence relations between the joint or multinational force and host nation, multinational governmental and nongovernmental civilian organizations and authorities, and the civilian populace to facilitate military operations, achieve US operational objectives, and positively impact the health sector. Also called MCMO. (JP 4-02)

Medical Intelligence. A category of intelligence produced from the collection, evaluation, and analysis of information concerning the medical aspects of foreign areas that have immediate or potential impact on policies, plans, and operations; it includes the observation of the fighting strength of enemy forces, occupational and environmental information, and formation of assessments of foreign medical capabilities in the military and civilian sectors. Also called MEDINT. (JP 2-01)

Medical Intelligence Preparation of the Operational Environment. A systematic continuing process that analyzes information on medical and disease threats, enemy capabilities, terrain, weather, local medical infrastructure, potential humanitarian and refugee situations, transportation issues, and political, religious, and social issues for all types of operations. Medical intelligence preparation of the operational environment is a component of the health service support mission analysis process, and the resulting statistics are used as a basis for developing health service support estimates and plans. It includes defining the operational environment, describing the operational environment effects on health service support operations, evaluating the operational environmental threats, and determining courses of action to meet actual and potential threats. Also called MIPOE. Previously called Medical Intelligence Preparation of the Battlefield (MIPB). (JP 4-02)

Medical Regulating. Actions and coordination necessary to arrange for the movement of patients through different levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities, ensures that bed space is available (JP 1-02) and allocates appropriate en route care resources (teams and PMI) to accompany patients.

Medical Surveillance. The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population‘s health, well-being, and performance. (JP 4-02)

Military Health System (MHS). A health system that supports the military mission by fostering, protecting, sustaining, and restoring health. It also provides the direction, resources, healthcare providers, and other means necessary for promoting the health of the beneficiary population. These include developing and promoting health awareness issues to educate customers, discovering and mitigating environmentally based health threats, providing health services, including preventive care and problem intervention, and improving the means and methods for maintaining the health of the beneficiary population by constantly evaluating the performance of the healthcare services system. (JP 4-02 and approved for next edition of JP 1-02.)

Multinational. Between two or more forces or agencies of two or more nations or coalition partners. See also Alliance; Coalition. (JP 5-0)

Natural Disaster. Effect of a natural hazard (e.g., flood, volcanic eruption, earthquake, or landslide) that affects the environment and leads to financial, environmental, and/or human losses.

Occupational and Environmental Health (OEH) Surveillance. The regular or repeated collection, analysis, archiving, interpretation, and dissemination of occupational and environmental health-related data for monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury when determined necessary. (JP 4-02 and approved for next edition of JP 1-02)

Operational Capability. The ability to effectively employ a system, a weapon, or an item of equipment of approved specific characteristics that is staffed or operated by an adequately trained, equipped, and supported military unit or force. See also Initial Operational Capability. (JP 1-02)

Palliative Care. A comprehensive approach to treating serious illness that focuses on the physical, psychological and spiritual needs of the patient. Its goal is to achieve the best quality of life available to patients and their families by relieving suffering and controlling pain and symptoms.

Patient. A sick, injured, wounded, or other person requiring medical/dental care or treatment. (JP 1-02)

Preventive Medicine. The anticipation, communication, prediction, identification, prevention, education, health risk assessment, and control of communicable diseases, illnesses and exposure

to endemic, occupational, and environmental threats. These threats include non-battle injuries, combat stress responses, WMD, and other threats to the health and readiness of military personnel. Communicable diseases include arthropod-, vector-, food-, waste-, and waterborne diseases. Preventive medicine measures include field sanitation, medical surveillance, pest and vector control, disease/health risk assessment, environmental and occupational health surveillance, waste (e.g., human, hazardous, and medical) disposal, food safety inspection, and potable water surveillance. Also called PVNTMED. (JP 4-02)

Quality Assurance. Planned and systematic production processes that provide confidence in a product‘s suitability for its intended purpose.

Rehabilitative Care. Therapy that provides evaluations and treatment programs using exercises, massage, or electrical therapeutic treatment to restore, reinforce, or enhance motor performance and restores patients to functional health, allowing for their return to duty or discharge from the service. Also called Restorative Care. (JP 4-02)

Resuscitative Care. Advanced emergency medical treatment required for preventing immediate loss of life or limb and attaining stabilization to ensure that the patient could tolerate evacuation. (JP 4-02)

Risk Communication. The process of adequately and accurately communicating the magnitude and nature of potential environmental and occupational health risks to commanders and to service members. (Source: N/A)

Risk Management. The process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risk cost with mission benefits. Also called RM. See Risk. (JP 3-0)

Seriously Ill or Injured. The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that there is cause for immediate concern, but there is not imminent danger to life. Also called SII. See also Casualty Status. (JP 1-02)

Seriously Wounded. A casualty whose injuries or illness are of such severity that the patient is rendered unable to walk or sit, thereby requiring a litter for movement and evacuation. (JP 1-02)

Slightly Wounded. A casualty whose injuries or illness are relatively minor, permitting the patient to walk and/or sit. (JP 1-02)

Stable. One who, in the best clinical judgment of the responsible physician, can withstand a bed to bed evacuation, and is unlikely to require intervention beyond the scope of standard en-route care capability during the evacuation. (Source: N/A)

Stability Operations. An overarching term encompassing various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. (JP 3-0)

Standardization. The process by which the DoD achieves the closest practicable cooperation among the services and DoD agencies for the most efficient use of research, development, and production resources, and agrees to adopt on the broadest possible basis the use of a (1) common or compatible operational, administrative, and logistic procedures; (2) common or compatible

technical procedures and criteria; (3) common, compatible, or interchangeable supplies, components, weapons, or equipment; and (d) common or compatible tactical doctrine with corresponding organizational compatibility. (JP 4-02)

Telemedicine. Rapid access to shared and remote medical expertise by means of telecommunications and information technologies to deliver health services and exchange health information for the purpose of improving patient care. (JP 4-02)

Theater Hospitalization Capability. Essential care and health service support capabilities to either return the patient to duty and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the theater. It includes modular hospital configurations required to support the theater (emergency medical services, surgical services, primary care, veterinary services, dental services, preventive medicine, and combat and operational stress control, blood banking services, hospitalization, laboratory and pharmacy services, radiology, medical logistics and other medical specialty capabilities as required). (JP 4-02)

Total Asset Visibility. The capability to provide users with timely and accurate information on the location, movement, status, and identity of units, personnel, equipment, materiel, and supplies. It also includes the capability to act on that information to improve overall performance of DoD‘s logistic practices. Also called TAV. See also Automated Identification Technology; In-Transit Visibility; Joint Total Asset Visibility. (JP 4-01.8)

Wounded. See Seriously Wounded; Slightly Wounded. (JP 1-02)