Military Health System (MHS) Section 703 Workgroup Use Case Decision Package

AF-H-633^{d} MEDGRP-Langley – Joint Base Langley-Eustis (JBLE)

Volume I

Disclaimer: This Use Case provides information relevant to decisions to change capacity and capability of a military treatment facility. A detailed implementation plan is needed to accomplish a transition of clinical services.

Executive Summary

Site	**633rd MEDGRP-Langley – Joint Base Langley-Eustis (JBLE)**
Decision	Transition AF-H-633rd Medical Group-Langley to an ambulatory surgery center (ASC) and outpatient clinic. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.

Background and Context

The table below summarizes the findings and data informing the decision on the future of the Military Medical Treatment Facility (MTF). Information in the Use Case Package could include, but is not limited to: Base and MTF mission briefs, a site-visit trip report, and two network assessments (TRICARE Health Plan Network Review and an independent government network assessment). When determining the decision for each site, the mission impact and network impact were considered in conjunction with Service and MTF input.

Installation Mission Summary

Joint Base Langley-Eustis (JBLE) is one of 12 Department of Defense (DoD) join bases and is hosted by the 633 Air Base Wing (ABW) in Langley, Virginia (VA). The 633 ABW Mission is to provide premier installation support, mission partner/wing readiness, and a power protection platform enabling warfighters to deliver agile combat support, global sustainment operations, and worldwide medical humanitarian support through the Global Response Force. The 633 ABW supports 18,000 Army, Air Force, Navy, Marine Corps, and US Coast Guard personnel on JBLE, as well as 5,500 civilians that are assigned to the Joint Base team. Langley Air Force Base and Fort Eustis are approximately 30 miles apart and are supported by the 633 Mission Support Group (MSG) and the 733rd MSG, respectively. JBLE has a total of 64 mission partners, 30 General Officers, and 13 Senior Executive Service (SES) Civilian Leaders and is enrolling a local patient population of up to 40,000 Active Duty members, Active Duty Family Members, and retirees.

Criteria Matrix

Criteria	Rating or Value[1]	Key Takeaways or Findings	Use Case Package
Mission Impact	M	• OB/GYN is a high-demand product line for the 633 MEDGRP. On average, the MEDGRP delivers 75-80 babies per month. MTF and Tidewater eMSM leadership expressed that gynecological surgeries are directly correlated with readiness as those procedures increase provider currencies due to the vascular work within the abdomen. If the proposed decision to rescope the 633 MEDGRP to an ASC is accepted, provider readiness may be impacted • The 633 MEDGRP is one of two large inpatient medical platforms supporting Air Combat Command (ACC) Force Generation. Inpatient admissions provide vital clinical currency for all the medical personnel involved in the patients' care • The MEDGRP would be unable to sustain two EMEDS+25 and Ground Surgical Team UTCs by transitioning to an ambulatory surgical center • Maintaining the Emergency Room would enable retention of surgical and medical cases to generate workload • The 633 MEDGRP is one of two large inpatient medical platforms supporting ACC Force Generation. If rescoped to an ambulatory surgical center, the 633 MEDGRP would not be able to sustain two full EMEDS+25 UTCs. The EMEDS Pilot Unit would require reassignment from the 633 MEDGRP to another MTF, reducing ACC Commander's ability to quickly source medical forces in support of National Defense Strategy	Section 1.0
Network Assessment	L	• There are 16 hospitals within the 60-minute drive-time radius for Langley. 15 of these are General Medical / Surgical hospitals, with one (1) additional children's hospital • Current inpatient facilities in the market service area are covering current demand, and there will be capacity to accept the incremental MHS population with the current supply of inpatient facilities and admitting physician capacity • There are 12 network facilities within the drive time of the 633 MEDGRP that offer like services currently provided by the MTF and have more than adequate access to care • JBLE leadership expressed the unpredictable traffic associated with the bridges, tunnels, and tolls of the area can make travel times unreasonable for patients referred to Navy Medical Center Portsmouth for clinic appointments, surgeries, and hospital admissions • Although AF-H-633d MEDGRP JBLE-Langley and McDonald Army Health Center (MCAHC) have overlapping regions and share most of their specialty physicians in market, they each account for small portions of the surrounding population. Given that the impacted beneficiaries for both	Section 2.0

[1] See Appendix B for Criteria Ratings Definitions

		transitioning MTFs accounts for less than 10% of the population in the target market, their collective impact on the demand in the overall market will be minimal. Thus, the supply of physicians in overlapping portions of the Specialty Care markets can be considered unhindered by both populations being released into the commercial market	

Risk / Concerns and Mitigating Strategies

The Risk / Concerns and Mitigation Strategies table below represents a high-level summary of the risks identified throughout the process. Though not exhaustive, the mitigation strategies / potential courses of action were established by the 703 Workgroup and will be used to help develop a final implementation plan.

	Risk/Concerns	Mitigating Strategy
1	The patients' change in expectations from getting care at the MTF to getting care off the installation will have to be monitored and managed to maintain beneficiary satisfaction and access to timely definitive care	• The risk will be mitigated through the implementation and communication plan as well as case management and care coordination
2	Removal of inpatient capabilities at the 633 MEDGRP would decrease the readiness value that is generated at the MTF	• Create partnerships across supporting area hospitals where providers may be able to continue to practice and maintain readiness levels
3	Inability to staff two EMEDS+25 UTCs and subsequent loss of EMEDS Pilot Unit	• AF Medical Service should analyze UTC laydown and explore alternative solutions such as relocation of UTCs or embedding UTCs in local civilian facilities near 633MEDGRP

Next Steps:

Develop the implementation plan for the above decision, transition inpatient care to the network while retaining ambulatory surgery capabilities

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1.0. Installation and Military Medical Treatment Facility (MTF) Description

JBLE and the 633 ABW are in Hampton, VA, approximately 17 miles from Norfolk, VA. JBLE-Langley's key mission elements include Air Combat Command, 1st Fighter Wing, 480th Intelligence, Surveillance, and Reconnaissance (ISR) Wing, 363rd ISR Wing, 735th Supply Chain Operations Group, Air Land Sea Application Center, 192nd Fighter Wing, 633 MEDGRP, 633 Mission Support Group, and several other tenant units. Key lines of effort at the 633 ABW include supporting airmen, civilians, soldiers, and families, providing joint base installation support, increasing Wing and mission partner readiness capabilities, and enhance community partnerships.

The 633 MEDGRP works and trains as a team to maintain a maximum state of readiness for any contingency while providing quality service to its internal and external customers. The group's 1,400 personnel maintain a full-service, 65-bed hospital providing inpatient, outpatient, and emergent care.

1.1. Installation Description

Name	Joint Base Langley-Eustis (JBLE)
Location	Hampton, VA; approximately 17 miles from Norfolk, VA
Mission Elements	JBLE-Langley • Air Combat Command Headquarters (HQ) • 1st Fighter Wing • 480th ISR Wing • 363rd ISR Wing • 735th Supply Chain Operations Group • Air Land Sea Application Center • 192 Fighter Wing • 633 MEDGRP • 633 MSG JBLE-Eustis • U.S. Army Training and Doctrine Command HQ • Futures and Concepts Center • Joint Task Force – Civil Support • Initial Military Training • 7th Transportation Brigade • 93rd Signal Brigade • 597th Transportation Brigade • U.S. Army Training Support Center • Aviation Applied Technology Directorate • Joint Deployment Training Center • Fort Eustis Dental Academy
Mission Description	Provide premier installation support, mission partner/wing readiness, and a power protection platform enabling warfighters, to deliver agile combat support, global sustainment operations, and worldwide medical humanitarian support through the Global Response Force
Regional Readiness / Emergency Management	633 Mission Support Group at JBLE-Langley provides mission-ready expeditionary Airmen to Combatant Command (COCOM) operations worldwide
Base Active or Proposed Facility Projects	N/A
Medical Capabilities and Base Mission Requirements	As an Air Force Medical Home, the 633 MEDGRP provides Family Medicine, Pediatrics, Internal Medicine, and Flight Medicine. The mission also includes a Global Response Force for Combat or Humanitarian Operations with a 72-hour response time.

1.2. MTF Description

The 633 MEDGRP is in Hampton, VA and is located on JBLE-Langley. The 633 MEDGRP is a state-of-the-art 65-bed hospital that supports a total enrolled population of 36,000 and has more than 236,000 outpatient visits on an annual basis. The MEDGRP is a part of the Tidewater enhanced Multi-Service Market (eMSM) which has a total area population of more than 400,000 and includes Langley, Fort Eustis, and Portsmouth. Services offered at the 633 MEDGRP include but are not limited to Family Practice, Pediatrics, Internal Medicine, and Flight Medicine, as well as several specialty services.

Name	633 Medical Group Langley
Location	Langley Air Force Base, Hampton, VA; approximately 17 miles from Norfolk, VA
Market	Tidewater (Large Market)
Mission Description	Provide fit expeditionary forces and mission-ready medics while delivering Trusted Care to all we serve The
Vision Description	premier Department of Defense (DoD) trusted healthcare organization
Goals	Focus on Readiness • Medically ready combat force • Ready medical/currency Focus on Beneficiaries • Improve Access to Care • Continue partnerships • Mature Trusted Care
Facility Type[3]	Inpatient Facility
Square Footage	153,626 Net Square Feet
Deployable Medical Teams	• Critical Care Air Transportation Team (CCATT) • EMEDS/AFTH 10 BED PSNL AUG • EMEDS/AFTH 25 BED PSNL AUG • EMEDS/AFTH-NURSIN-ANCIL AUG • GROUND SURG TEAM • EMEDS SPEC CARE AUG TM • EMEDS +10 – 3 Teams with 201 total personnel authorizations • EMEDS +25 – 1 Team with 99 total personnel authorizations • Ground Surg Tm – 5 Teams with 30 personnel authorizations (embedded in EMEDS) • Crit Care Air Tm – 4 Teams with 12 total personnel authorizations • Tac Crit Care Evac Tm – 1 Team with 3 total personnel authorizations • Prev Med Team – 1 Team with 2 total personnel authorizations • EMEDS Spec Care – 2 Teams with 14 total personnel authorizations
MTF Active or Proposed Facility Projects	$55M MILCON funded project to expand the central utility plant
Performance Metrics	See Volume II for Part E Partnership 4 Improvement (P4I) measures and Part F for Joint Outpatient Experience Survey - Consumer (JOES-C) data
Fiscal Year (FY) 2018 Assigned Full-time Equivalents (FTEs)[4]	

	Civilian	Contractor	Military	Total
Medical	166.7	13.2	855.2	**1,035.**

Department of Veteran's Affairs (VA) Partnership	The VA has a Medical Center in Hampton Roads and two outpatient clinics in Virginia Beach and Chesapeake. The Chesapeake Clinic was opened recently to help absorb patient demand from the Hampton Roads Medical Center. The 633 MEDGRP has a partnership opportunity with the VA which could bring a possible

[2] Defined by FY17 NDAA Section 702 Transition
[3] Source: AF-H-633rd MEDGRP-Langley MTF Portfolio
[4] Source: AF-H-633rd MEDGRP-Langley MTF Portfolio

	increase of 70 OB referrals per month. The VA patient caseload would serve as a readiness opportunity as their caseload typically is of higher acuity.
Healthcare Services	As an Air Force Medical Home, the 633 MEDGRP provides Family Medicine, Pediatrics, Internal Medicine, and Flight Medicine. The mission also includes a Global Response Force for Combat or Humanitarian Operations with a 72-hour response time. Specialty Services include: • Emergency Services • Orthopedics • Ophthalmology/Optometry • Urology • ENT • Dermatology • Dental/Oral Surgery • Pulmonology • Neurology • Allergy • General Surgery • OB/GYN • Critical Care • NICU Level II • Behavioral Health • Physical Therapy • Developmental Pediatrics • Pediatric Cardiology • Chiropractic • Podiatry • Pediatric Neurology • Pediatric Gastroenterology • Gastroenterology • Cardiology • Adolescent Medicine • Pediatric Endo • Nutritional Medicine • Pathology
Base Plan Impact	This MTF is in the Continental United States (CONUS) Patient Distribution Plan (CPDP), which addresses CONUS patient distribution in support of large scale overseas contingency operations. It coordinates DoD and other United States Government (USG) strategic stakeholder efforts to care for and move patients from CONUS arrival to definitive medical care. The CPDP model identifies a network of regional "hubs," to initially receive casualties from overseas locations and deliver timely Specialty Care, and "spokes," to maintain casualty flow at the hubs while alleviating problems related to casualty bottlenecking at larger specialty facilities. Spoke sites also allow the added benefit of providing locations for casualties to receive care closer to their home units and/or family members, offering additional support during treatment and recovery
Projected Workforce Impact	

Active Duty	Civilian	Total
182	28	**210**

2.0. Healthcare Market Surrounding the MTF

Description	633 MEDGRP is an inpatient facility that is being evaluated for removal of inpatient capabilities with outpatient ambulatory surgical services remaining. 633 MEDGRP is a part of the Tidewater enhanced Multi-Service Market (eMSM). 89% of beneficiaries are living within the 30-minute drive-time boundary for Primary Care, and 100% of beneficiaries are living within the 60-minute drive-time boundary for Specialty Care.
Top Hospital Alignment	• Sentara Leigh Hospital (Norfolk, VA) • Sentara Norfolk General Hospital (Norfolk, VA) • Chesapeake Regional Medical Center (Chesapeake, VA) • Sentara Virginia Beach General Hospital (Virginia Beach. VA) • Riverside Regional Medical Center (Newport News, VA) • Children's Hospital of the King's Daughters (Norfolk, VA)
Likelihood of Offering Specialty Care Services to TRICARE Members[5]	

	Number of Practices	Number of Physicians
Contracted with TRICARE	106	173
High Likelihood	12	29
Medium Likelihood	245	720
Low Likelihood	14	35
Total	**377**	**957**

2.1. TRICARE Health Plan Network Assessment Summary

Facts:

- Joint Base Langley Eustis has a market area population of approximately 1.8M[6]
- 633 MEDGRP supports Langley AFB's 633 ABW
- Changing the 60-bed 633 MEDGRP to an outpatient-only clinic would require the 75K[7] TRICARE beneficiaries to rely on the local Managed Care Support Contractor (MCSC) network or NMC Portsmouth for inpatient care
- In 2018, 633 MEDGRP had 2,722 admissions and 949 births[8]. Given the average daily census of 15.7, the average 633 MEDGRP patient is admitted for 12.1 days
- During FY18, 633 MEDGRP performed 515 inpatient surgeries and 3,272 outpatient surgeries[9]
- There are 9 network hospitals within 40 miles of 633 MEDGRP-Langley that offer like services currently provided by the MTF with more than adequate access to care
- Three hospitals are located in Hampton or Newport News, not requiring transit over a bridge or through a tunnel
    - According to MCSC, Sentara Careplex Hospital (3 miles from MTF) averages 400 deliveries a year and has 7 inpatient OB beds. Sentara reports having capacity for an additional 400 deliveries
    - According to MCSC, Riverside Regional Medical Center (9 miles from MTF) averages 840 deliveries a year and has 12 inpatient OB beds. Riverside reports having capacity for an additional 280 deliveries
    - According to MCSC, Mary Immaculate Hospital (13 miles from MTF) had 1,474 deliveries in 2018 and has 14 inpatient OB beds. Mary Immaculate reports having capacity for an additional 526 deliveries
- Navy Medical Center Portsmouth is approximately 26 miles south of Langley on the southern side of the James River
- All hospitals have ERs and most have ICU beds available
- There are ten urgent care centers within 40 miles of ACH 633 MEDGRP
- Although there are an adequate number of specialty providers contracted, access to care is over 28 days for Surgical sub-specialties, Gastroenterology, and OB/GYN and Ophthalmology. Patient preference (e.g., choice of provider) is a large influencer for those visits calculated over 28 days. All are under 36 days to care

[5] Contracted with TRICARE: Providers are currently contracted to provide services to TRICARE beneficiaries; High Likelihood: Providers are connected to organizations currently providing services to TRICARE beneficiaries; Medium Likelihood: Providers are accepting Medicare and/or Medicaid; Low Likelihood: Providers are neither providing Medicare nor Medicaid

[6] Network Insight Assessment Summary (Independent Government Assessment)

[7] M2

[8] J-5 MTF Portfolio (M2)

[9] 633 MDG

- The nearby network hospitals have variable quality and safety ratings, and all are Joint Commission accredited[10]
- TRICARE Inpatient Satisfaction Survey (TRISS) FY18 Total "Overall Hospital Rating"
    - 633 MEDGRP: 70.0% (430 respondents)
    - NMC Portsmouth: 68.6% (2,172 respondents)
    - Sentara Princess Anne Hospital (VA Beach): 79.2% (470 respondents)
    - Chesapeake General Hospital (Chesapeake, VA): 66.1% (287 respondents)
- TRICARE Prime Out-of-Pocket Costs for Retirees and their family members
    - Preventive Care Visit: $0
    - Primary Care Outpatient Visit: $20
    - Specialty Care Outpatient or Urgent Care Center Visit: $30
    - Emergency Room Visit: $61
    - Inpatient Admission: $154

Assumptions:

- Transition to an outpatient clinic would result in the elimination of 633 MEDGRP's surgical specialties and potentially some nonsurgical specialties
- Transition to an outpatient clinic would close the emergency room and eliminate the ambulance service

Analysis:

- Closing inpatient services would require the surrounding network facilities to absorb approximately 2,722 admissions, increasing the network admissions by 8% if spread among the three nearest hospitals
- Most OB deliveries (949 in 2018) would be expected to occur in Sentara Careplex, Riverside, or Mary Immaculate hospitals increasing their deliveries by 35%
- MCSC's report that these three hospitals could take on 1206 more deliveries indicates a borderline capacity for the increased demand

Implementation Risks:

- Retirees and their family members may seek less emergency care due to out-of-pocket costs (+/-)
- Airmen may miss more training time if requiring surgical or inpatient care
- Lack of surgical capability may delay definitive surgical care for service members
- Lack of 633 MEDGRP ED may delay definitive emergency care
- Lack of OB providers in the local area may place expectant mothers at greater risk

[10] Source: hospitalsafetygrade.org; Medicare.gov; DHA J3; JC qualitycheck.org

2.2. Network Insight Assessment Summary (Independent Government Assessment)

Facts:

- There is an MHS impacted population of over 75,000 which makes up 4.2% of the population total in the 60-minute drive-time radius. The impact of MHS beneficiaries entering the commercial market will not materially impact the projected demand for services
- The majority of key medical and surgical specialty providers that correlate with the top-10 DRGs are located in Newport News, Norfolk, and Virginia Beach counties, all of which are in close proximity to the MTF
- There are 15 General Medical / Surgical hospitals within the 60-minute drive-time radius of the 633 MEDGRP with one (1) additional children's hospital
- There is a mix of overall shortages and surpluses across specialties in the market area, with surpluses projected in nearly all specialties in Norfolk and Newport News counties
- This area has experienced moderate population growth over the past five years (2014 –2018) at 3.3%. Growth is expected to remain level at 2.6% over the next five years (2019 –2023)

Assumptions:

- Assumptions can be found in Section 4.3.2 of the NDAA Section 703 Report

Analysis:

- **Specialty Outpatient:** The market can potentially cover incremental demand from impacted beneficiaries, however the market should be monitored to ensure that increased demand can be managed over time, especially in Cardiology, Gastroenterology, and Dermatology
- **Inpatient:** Current inpatient facilities in the market service area are covering current demand. There will be capacity to accept the incremental MHS population with the current supply of inpatient facilities and admitting physician capacity, with the top 10 facilities by Total Performance Score projected to be at ~69% after absorption of incremental beneficiary demand, which is well beneath the recommended max capacity of 80%
- The commercial provider market is more than adequate to absorb the inpatient volume(s) for the impacted beneficiary groups

3.0. Appendices

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Appendix A: Use Case Assumptions

General Use Case Assumptions

1. Population impact that is greater than 10% of total population will impact the supply and demand of the provider network market
2. There will be no change in the TRICARE benefit to accommodate decisions
3. Readiness requirements for the final decision will be addressed in the Service Quadruple Aim Performance Process (QPP)
4. There will be no changes to the existing Managed Care Support Contract (MCSC)
5. The MCSC could contract an additional 50% of the existing non-network Primary Care Providers (PCPs)
6. The average PCP panel is approximately 2000[11]

[11] MGMA

Appendix B: Criteria Ratings Definition

Criteria Ratings Definition

Mission Impact	High: High probability of impacting the mission or readiness with the impacted population receiving network care Medium: Moderate probability of impacting the mission or readiness with the impacted population receiving network care Low: Low probability of impacting the mission or readiness with the impacted population receiving network care
Network Assessment	High: Both network assessments confirm inadequate network for primary and Specialty Care. Low probability of network growth or MCSC recruitment in the future Medium: Mixed findings from both network assessments for primary and Specialty Care. Moderate probability of network growth in the future Low: Both network assessments confirm adequate network for Primary Care and Specialty Care

Appendix C: Glossary

Term (alphabetical)	*Definition*
Ambulatory Care	Ambulatory care is care provided by health care professionals in outpatient settings. These settings include medical offices and clinics, ambulatory surgery centers, hospital outpatient departments, and dialysis centers (AHRQ.gov)
Beneficiary	Individuals who have been determined to be entitled to or eligible for medical benefits and therefore are authorized to receive treatment in a military treatment facility or under Department of Defense auspices (Source: health.mil)
Critical Access Hospital Designation	Critical Access Hospitals (CAHs) is a designation given to eligible hospitals by the Centers for Medicare and Medicaid Services (CMS). … (CAHs) represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method. CoPs for CAHs are listed in the Code of Federal Regulations (CFR) at 42 CFR 485.601–647(Source: CMS.gov)
Direct Care	Care provided to eligible beneficiaries throughout the Military Health System at DoD hospitals, clinics, and pharmacies (usually MTFs) (Direct Care); (Source: McEvoy, L. N., 2Lt, USAF. (2018). A Study of Military Health Care Costs: Direct Versus Purchased Care in a Geographical Region. Defense Technical Information Center, 1-6. Retrieved from https://apps.dtic.mil/dtic/tr/fulltext/u2/1056374.pdf.)
Eligible	To use TRICARE, you must be listed in DEERS as being eligible for military health care benefits. TRICARE-eligible persons include the following: Military members and their families, National Guard/Reserve members and their families, Survivors, Some former spouses, Medal of Honor recipients and their families (Source: tricare.mil)
Enrollee	The Cambridge Dictionary defines Enrollee as "someone who is on the official list of members of a group, course, or college." For the purposes of this Use Case, Enrollee is defined as an eligible Military Health System beneficiary that is currently participating in one of the TRICARE Health plans
JOES	Joint Outpatient Experience Survey (Source: health.mil)
JOES-C	Joint Outpatient Experience Survey – Consumer Assessment of Health Providers and Systems (Source: health.mil)
Managed Care Support Contractor (MCSC)	Each TRICARE region has its own MCSC who is responsible for administering the TRICARE program in each region. The MCSCs establish the provider networks and conduct provider education. Humana is the MCSC in the East, and HealthNet is the MCSC in the West (Source: health.mil)
Network	A provider network is a list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care to its members. These providers are called "network providers" or "in-network providers." (Source: cms.org)
Occupational Therapy	Occupational therapy is the use of individualized evaluations, customized intervention strategies, and outcome evaluations to help people across their lifespan participate in activities they want and need through the therapeutic use of everyday activities (occupations) (Source: The American Occupational Therapy Association)
Remote Overseas	TRICARE Prime Remote Overseas is a managed care option in designated remote overseas locations: Eurasia-Africa, Latin America and Canada, Pacific (Source: tricare.mil)
P4I	A set of MHS clinical, quality, safety and readiness performance measures (Partnership for Improvement)
Panel	A panel is a list of patients assigned to each care team in the practice. The care team (e.g., a physician, a medical assistant, and a health educator) is responsible for preventive care, disease management, and acute care for all the patients on its panel. This means that a patient will have the opportunity to receive care from the same clinician and his or her care team. The panel's population are the patients associated with a provider or care team, the physician care team is concerned with the health of the entire population of its patient (Source: AHRQ.gov)
Plus	With TRICARE Plus patients receive free Primary Care at their respective military hospital or clinic. The beneficiary is not required to pay anything out-of-pocket. TRICARE Plus does not cover Specialty Care (Source: health.mil)
Prime	TRICARE Prime is a health insurance program offered to active duty members, retirees, activated guard and reserve members, and families. Active Duty members are required to enroll in TRICARE Prime, while all others may choose to enroll or use TRICARE Select. TRICARE Prime offers fewer out-of-pocket costs than TRICARE Select, but less freedom of choice for providers (Source: health.mil)
Purchased Care	TRICARE provides care to its eligible beneficiaries in two broad settings: a system of DoD hospitals, clinics, and pharmacies (usually MTFs) (Direct Care); and a supplemental network of participating civilian health care professionals, institutions, pharmacies, and suppliers (Purchased Care) (Source: McEvoy, L. N., 2Lt, USAF. (2018). A Study of Military Health Care Costs: Direct Versus Purchased Care in a Geographical Region. Defense Technical Information Center, 1-6. Retrieved from https://apps.dtic.mil/dtic/tr/fulltext/u2/1056374.pdf.)
Reliant	Active Duty Service Members who are not enrolled to TRICARE Prime (e.g. students and recruits) (Source: MHS Modernization Study, Feb 2016)
Value Based Payment	**Value Based Payment** (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care (Source: AAFP)

Appendix D: Volume II Contents

Part A	Data Call
Part B	Relevant Section 703 Report Detail
Part C	DHA TRICARE Health Plan Network Review
Part D	Network Insight Assessment Summary (Independent Government Assessment)
Part E	P4I Measures
Part F	JOES-C 12-month Rolling Data Base
Part G	Mission Brief
Part H	MTF Mission Brief
Part I	Tidewater eMSM Brief
Part J	Langley Future Construct Brief MTF
Part K	Portfolio (Full)

Appendix E: MTF Trip Report

MHS Section 703 Workgroup Site Visit Trip Report

MTF: Joint Base Langley-Eustis- 633 Medical Group

12 July 2019

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Purpose of the Visit

This was a fact-finding visit to assist the MHS Section 703 Workgroup in understanding unique mission aspects, as well as base and MTF's leadership perspective of the capacity of the current civilian network market. This information will be used for making MTF specific capability and capacity options and decisions to be included in a report to Congress.

Summary of Site Visit

Base/Mission Impact:

- Joint Base Langley-Eustis (JBLE) is located in the Tidewater region of Virginia. JBLE is home to 64 Mission Partners, including two (2) four-star commands, 30 general officers, and 13 Senior Executive Service (SES) Civilian Leaders. JBLE serves as the headquarters for the Air Combat Command and headquarters for the Army's Training and Doctrine Command (TRADOC). The mission of JBLE is to provide premier installation support, mission partner/wing readiness and a power projection platform enabling warfighters, to deliver agile combat support, global sustainment operations and worldwide medical humanitarian support through the Global Response Force
- Some of the EMEDS and Ground Surgical Team UTCs are negatively impacted by transitioning to an ambulatory surgical center

MTF Impact:

- The 633 Medical Group (MDG) employs 1,400 personnel to maintain a full-service, 60-bed hospital providing inpatient, outpatient, and emergent care. As part of the Tidewater Enhanced Multi-Service Market (eMSM), the facility shares services and resources with McDonald Army Community Health Center, Hampton Veterans Administration (VA) Medical Center, and Naval Medical Center Portsmouth (NMCP)
- As part of the Tidewater eMSM, 633 MDG serves as a feeder for high acuity cases to NMCP. As a large force projection platform, it is critical to the mission of NMCP to receive high acuity cases. Surgical Operating Rooms (ORs) at McDonald Army Health Center (MCAHC) were suspended in June 2018, so their surgeons rely on the services of Langley to ensure valuable OR time and that their patients are cared for
- OB/GYN is a high-demand product line for the 633 MDG, with gynecological surgery volume second to orthopedic surgery. On average, they deliver 75-80 babies per month. MTF and Tidewater eMSM leadership expressed that gynecological surgeries are directly correlated with readiness as many of those patients are active duty and military providers can return them to work and deployable status faster than off-base providers. If the proposed decision to rescope the 633MDG to an Ambulatory Surgery Center (ASC) was confirmed, the acuity of surgical cases would be impacted which would adversely impact provider, nurse, technician, and ancillary staff clinical skills and readiness of active duty patients.

Network Impact:

- JBLE leadership expressed that while the network may be adequate to provide certain services to beneficiaries, the unpredictable traffic associated with the bridges, tunnels, and tolls of the area can make travel times unreasonable for patients referred to NMCP for clinic appointments, surgeries, and hospital admissions

Summary of Base Leadership Discussion

List of Attendees

The following were in attendance during the Base Leadership discussion:

Name	Title	Affiliation
Col Clinton Ross	Commander	633 ABW
COL Ed Vedder	Vice Commander	633 ABW
Col Brian Sidari	Vice Commander	480 ISRW
Col Nathan Rabe	Vice Commander	363 ISRW
Col Steven Fino	Vice Commander	1FW
SMSgt. Marsha Obrien		735 SCOG
Col Ronald Johnson	ACC SG/SGS	633 MDG
Col Craig Keyes	MDG/CC	633 MDG
CMSgt. Lisa Williams	MDG/CCC	633 MDG
Col Robert Paz	Administrator	633 MDG
SMSgt. Dale McCollum	MDOS Superintendent	633 MDG
Ms. Melissa Blanco	Senior Analyst	GAO
Ms. Hannah Hubbard	Analyst	GAO
Dr. David Smith	OSD OUSD P-R	703 Workgroup
Dr. Mark Hamilton	DHA J-5	703 Workgroup
Col James A. Mullins	Director, BSC Operations, AFMRA	703 Workgroup
Lt. Col. Dolphis Z. Hall	AF/SG8	703 Workgroup
CAPT Nate Price	Chief, Facilities Enterprise, DHA	703 Workgroup
Ms. Summer Church	Contract Support Team	703 Workgroup

Below is the summary of the topics that were discussed during the Base Leadership Discussion:

Base Mission Overview: JBLE is located in the Tidewater region of Virginia. JBLE is home to 64 Mission Partners, including two four-star commands, 30 general officers and 13 SES Civilian Leaders. JBLE serves as the headquarters for the Air Combat Command and headquarters for the Army's TRADOC. The mission of JBLE is to provide premier installation support, mission partner/wing readiness and a power projection platform enabling warfighters, to deliver agile combat support, global sustainment operations and worldwide medical humanitarian support through the Global Response Force.

Voice of the Customer Summary:

- Mission-Driven Medical Requirements:
  - 1st Fighter Wing The 1st Fighter Wing consists of two F-22 fighter squadrons and an associated maintenance group. The Wing very likely will gain the F-22 Formal Training Unit mission from Tyndall, adding a third F-22 squadron and 800-900 active duty and their dependents. The training program would involve teaching approximately 300 students for nine (9) months out of the year on piloting the F-22 and performing aircraft maintenance. The 1FW also may provide quick response to operational taskings, one of which occurred within the last 30 days. Typically, the 633 MDG extends hours throughout the weekend to get the personnel through medical clearance and prepared to deploy. 1st Fighter Wing leadership expressed that given the population of female pilots, OB and women's health need to be sustained
  - 480th Intelligence, Surveillance, and Reconnaissance (ISR) Wing: The headquarters of the 480th ISR wing is located at JBLE and the mission is considered critical to JBLE leadership. The 900

personnel at JBLE provide 24/7 support to combatant commanders using imagery and signals intelligence. The 480th ISR wing personnel work 12-hour night shifts, watching full motion videos of warzones, including Iraq and Syria, for the entire DoD. Given the nature of this work, many of the personnel experience ergonomic related health issues and require access to mental health services. The network has 60-day delays for psychiatric care and the 633 MDG currently does not have any psychiatry providers. In order to combat mental health issues, the Air Force line funded billets for chaplains and mental health providers to be embedded with the 480th ISR

- 363d ISR: The 363d ISR Wing performs target systems analysis and employs about 500 personnel. Leadership expressed that their group experiences the same issues as mentioned above related to access to mental health services. As referenced above, the Wing also has funded positions for chaplains and mental health technicians in their unit, but they have experienced difficulty in filling those positions
- 735 Supply Chain Operations Group (SCOG): The 735th SCOG provides combat aircraft and vehicle parts for the entire Air Force. The unit has approximately 700 personnel assigned. Leadership did not express any specific medical concerns related to their mission

- Additional Medical Requirements:
  - ISR Campus Buildout: JBLE predicts that building out the ISR Campus will bring 3,500 newly assigned personnel to JBLE. This figure does not reflect dependents and base leadership anticipates increased support needed from the 633 MDG
  - F-22 Formal Training Unit: Due to the damages of Hurricane Michael to Tyndall AFB, JBLE is likely to be selected as the training wing for the F-22 Raptor pilots. JBLE leadership anticipates 31 jets and 17 T38s in addition to the 56 jets assigned to the wing. In order to accommodate the increased inventory arriving in May 2021, JBLE is working to renovate existing hangars. JBLE estimates that this will bring 800-900 newly assigned personnel plus dependents
- Network Adequacy:
  - JBLE leadership expressed that while the network may be adequate to provide certain services to beneficiaries, the unpredictable traffic associated with the bridges and tunnels of the area can make travel time unreasonable

Summary of MTF Commander Discussion

List of Attendees

The following were in attendance during the MTF Leadership discussion:

Name	Title	Affiliation
RDML Anne Swap	Commander	Tidewater MHS
Dr. Jeff Cole	Interim Chief Operating Officer	Tidewater MHS
Col Craig Keyes	MDG/CC	633 MDG
CMSgt. Lisa Williams	MDG/CCC	633 MDG
Col Robert Paz	Administrator	633 MDG
Col Ronald Johnson	ACC SG/SGS	ACC
Col Amy Parker	Medical Operations Sq Commander	633 MDG
Col Aquilla Highsmith-Tyler	633 SGCS/CC	633 MDG
Col Tracy Allen	ACC/SGX	ACC
Col Idona E. Henry	Director, Business Operations	Tidewater MHS
Col Bryce G. Whisler	633 DS/SGDR	633 MDG
Col Jennifer A. Brooks	633 MDOS/SGM	633 MDG
Lt. Col. Kevin M. Cot	633 IPTS/CC & Chief Nurse	633 MDG
Lt. Col. John Cargioli	633 MDG/SGB	633 MDG
Lt. Col. James D. Ulrich	633 MDSS Commander	633 MDG
Maj Dave Johnson	633 AMDS/CC	633 MDG
SMSgt. Amanda Barrett	Dental Operations Fit Chief	633 DS/SGD
SMSgt. Erica Rose	Medical Support Squadron Support	633 MDSS
SMSgt. Valerie McBurney	Medical Readiness Supt	633 MDG
SMSgt. Dale McCollum	633 MDOS Supt	633 MDG
CMSgt. William Condon	633 AMDS Supt	633 AMDS
MSgt. Jason Stoven	633 Surgical Ops Sq. Supt	633 SGCS
MSgt. Danny Au	633 IPTS Supt	633 IPTS
CDR Joel Shofer	Director for Healthcare Business	NMCP
CMDCM Michael Hinkle	NME CNC	Tidewater MHS
Mr. Robert Snipes	Chief, Dec Support	MCAHC
Ms. Angel Armentrout	Deputy Commander	MCAHC
Ms. Melissa Blanco	Senior Analyst	GAO
Ms. Hannah Hubbard	Analyst	GAO
Dr. David Smith	OSD OUSD P-R	703 Workgroup
Dr. Mark Hamilton	DHA J-5	703 Workgroup
Col James A. Mullins	Director, BSC Operations, AFMRA	703 Workgroup
Lt. Col. Dolphis Z. Hall	AF/SG8	703 Workgroup
CAPT Nate Price	Chief, Facilities Enterprise, DHA	703 Workgroup
Ms. Summer Church	Contract Support Team	703 Workgroup

Below is the summary of the topics that were discussed during the MTF Leadership Discussion:

MTF Medical Mission Overview:

- MDG Mission: USAF Hospital Langley is supported by the medical professionals of the 633 MDG. The group's 1,400 personnel maintain a full-service, 60-bed hospital providing inpatient, outpatient and emergent care. As part of the Tidewater eMSM, the facility shares services and resources with McDonald Army Community Health Center, Hampton VA Medical Center, and NMCP
- Enrollment: The Tidewater eMSM has an average monthly beneficiary population of over 393,000, which ranks second in size to the National Capital Region

Voice of the Customer Summary:

- Readiness: As part of the Tidewater eMSM, the 633 MDG serves as a feeder for high acuity cases to NMCP. As a large force projection platform, it is critical to the mission of NMCP to receive high acuity cases. Surgical Operating Rooms (ORs) at McDonald Army Health Center (MCAHC) were suspended in June 2018, so their surgeons rely on the services of Langley to ensure valuable OR time and that their patients are cared for
    - OB/GYN: OB/GYN is a high demand product line for the 633 MDG, with gynecological surgery second in volume to orthopedic surgery. On average, they deliver 75-80 babies per month. MTF and Tidewater eMSM leadership expressed that obstetrical cases are directly correlated with readiness as those procedures increase clinician currencies because those surgeries can require massive blood transfusion protocol work and build teamwork skills amongst providers. If the proposed decision to rescope the 633MDG to an Ambulatory Surgery Center (ASC) was confirmed, the acuity of surgical cases would be impacted which would adversely impact provider, nurse, and technician clinical currency and readiness
    - OR Utilization: The OR utilization at the 633 MDG had been at 40% prior to optimization but has steadily increased over the past year and is currently operating at the market goal of 80% utilization. They complete an average of 366 cases per month
- Network Adequacy: 633 MDG leadership expressed concerns about the ability for beneficiaries to have timely access to care given that the bridges and tunnels throughout the area often cause traffic back- ups. Anecdotally, the commute time from Hampton to Norfolk can take up to two (2) hours during high traffic. This travel time will have a negative effect on readiness through lost duty time. The goal of 633 MDG is to keep care within the direct care system to improve currency, readiness and reduce costs. Additionally, receipt of Clear and Legible Reports (CLRs) from network providers is currently at 47% five months after a referral for care was submitted. Without timely and accurate CLRs, active duty readiness is negatively impacted
    - OB/GYN: Given the high volume of deliveries performed at the MTF, leadership feels that the network would be capable of accepting only 85% of demand, about 765 deliveries. The 633 MDG expressed concerns that sending active duty pregnant females (33% of OB demand) to the network would have a negative impact to medical readiness rates. OB appointments at the 633 MDG are available within 10 days while network appointments are available in 31 days
    - Mental Health: Throughout the discussion with the 633 MDG leaders and JBLE leadership, access to mental health was highlighted as a key issue. Currently, the 633 MDG has three available positions for psychiatrists but have been unable to fill those positions. Within the network, access to mental health care is limited. JBLE has experienced 60 day wait times for appointments which negatively impacts the mission of the base. MTF leadership and the 703 Workgroup discussed the opportunities for tele-psychology, but their current agreements are insufficient. The MTF is currently partnered with Charleston but they only accept three (3) patients a week which does not keep up with demand
- VA Partnership: The VA has a Medical Center in Hampton Roads and two outpatient clinics in Virginia Beach and Chesapeake. The Chesapeake Clinic was opened recently to help absorb patient demand from the Hampton Roads Medical Center. The 633 MDG has a partnership opportunity with the VA which could bring a possible increase of 70 OB referrals per month. The VA patient caseload would serve as a readiness opportunity as their caseload typically is of higher acuity

- Proposed Future Construct: The 633 MDG provided the 703 Workgroup with a brief to discuss their proposed future scope options to support the eMSM OR optimization, in support of QPP. In this brief, the 633 MDG proposed closure of the NICU and ICU, while maintaining eight (8) multispecialty beds (a reduction down from the 20 current beds) and 14 OB/GYN beds, and reducing from six (6) to five (5) squadrons. In order to optimize capability, the MTF would maintain all five (5) ORs while reserving one for OB related emergencies. The OR utilization at the 633 MDG has steadily increased over the past year and is currently operating at 80% utilization. OR case volume by service and total number of competed OR cases have steadily increased as well. The MTF suggested maintaining the emergency room (ER) where they see 90+ patients per day, with acuity consistent with the MHS average. Maintaining the ER would enable retention of surgical and medical cases to generate both surgical and inpatient workload

Visit Due-Outs for Additional Information and Clarification (provided after the visit):

- Gynecological (GYN) care: The MTF leadership emphasized that OB/GYN is much more than just delivering babies. GYN care includes initial, intermittent, and continuous evaluation and treatment of gynecologic conditions (i.e. abnormal bleeding, chronic pelvic pain syndromes, etc.), evaluation and treatment of endocrine dysfunction and infertility, evaluation and treatment of incontinence, evaluation and treatment of breast conditions, evaluation and treatment of cervical dysplasia (colposcopies, LEEPs), and procedures for long-acting reversible contraceptives and management of complications. Specialized obstetrical care includes early pregnancy loss management of miscarriages and ectopic pregnancies and evaluation of trimester-specific complications
    - Most of these OB/GYN conditions and procedures cannot be performed by primary care providers and many of them cannot be performed by women's health nurse practitioners (a GYN trained physician/surgeon is required). The volume of gynecological surgeries for FY19 is projected to be 539 surgeries and 30% of the OB/GYN workload is for active duty personnel. GYN surgeries/procedures include, but are not limited to, laparoscopies, laparotomies, salpingectomies, hysteroscopies, dilation and curettage, hysterectomies, polypectomies, myomectomies, LEEP, biopsies, and tubal ligations/occlusions, amongst other possibilities as needed by specific conditions
    - OB-specific care: The local hospitals have adequate capacity for labor and delivery, but the OB physician network is limited. Network physicians currently can only care for 85% of the patients and their average wait time for an appointment is 31 days (compared to Langley's 10 day wait for an appointment). 33% of OB patients are active duty. If the active duty patients have to travel for outpatient OB care, they would incur a cumulative 2,250 lost work days per year. Additionally, network providers are very slow at providing physician reports back to the MTF providers, which lengthens care times and the time patients are not available for readiness/deployments (e.g., profiles, medical evaluation boards, deployment availability [limitation] codes, etc.). For example, as of June 2019, only 47% of the off-base provider reports were available for referrals created in February 2019. In terms of quality and satisfaction for the three hospitals within 20 miles of Langley, the 633 MDG was rated 5 stars (out of 5, 5 being the best) as compared to the 2 to 3-star ratings of the civilian hospitals. Per NPIC data, the 633 MDG compares favorably to the three civilian hospitals. OB and labor and delivery services at the 633 MDG also provide inpatient, ancillary, and massive blood transfusion clinical currency experience for military physicians, nurses, technicians, and ancillary personnel (i.e., lab, radiology, pharmacy) that are needed to support high-quality combat trauma care
- Inpatient surgical care: the 633 MDG is projecting 423 non-OB related surgeries will require an inpatient admission during FY19. This represents 9% of all surgical caseload. An additional 680 OB surgeries will require an admission, which is 15% of all surgical caseload. In total, 24% of surgeries will require an admission to the Langley Hospital. In terms of unplanned surgical admissions, 5% of same day surgeries will require an unpredicted inpatient admission due to the nature of what's found during the surgery, the extent of additional work performed during a surgery, and/or the pace of the patient's

recovery. In CY18, per NSQIP data (hospitals are rated against each other via surgical metrics on a 1st decile (best) to 10th decile (worst) scale), the 633 MDG scored in the 1st or 2nd decile for 83% of 173 separate metrics, with the remaining 17% being no lower than the 3rd decile (inpatient +ambulatory surgery combined). This level of performance is significantly better in terms of quality care than the comparative data (hospitals and surgery centers). These admissions, just like OB non-surgical deliveries, provide vital clinical currency for all the medical personnel involved in the patients' care.
More complex and higher-risk surgical care is completed at NMCP or referred to the network

- Future inpatient bed capacity proposal: The 633 MDG (based on prior AF analysis) is recommending reducing the multi-service unit (MSU) from 20 beds to 8 beds based on the historical inpatient average census of 6 patients. This will generate a significant cost savings via personnel reductions. A small inpatient capability is heavily interdependent and supportive of the ER (which can generate a few admissions per day), the 9% of non-OB surgical cases that require an inpatient stay, OB overflow for the occasional but recurrent times when OB patients exceed the labor and delivery beds and manning, and the ancillary services that are already in-house to support the ER, OB, and OR. Of note, the ER is one of the busiest in the Air Force and the triage acuity is on average with other DoD ERs. Inpatient care also benefits PACU staffing by being able to recover patients from cases that end late, patients who recovery very slowly, and weekend/holiday unplanned surgeries that come in through the ER. The acuity of MSU patients will be relatively low to moderate, in accordance with a community hospital setting and clearly within the physician and nursing skill sets of a community hospital and the 633 MDG personnel. High-acuity patients will be transferred to NMCP or network hospitals, depending on the severity of the patient's condition. An 8-bed hospital model is similar to the 5-bed emergency hospital model which is becoming commonly found across parts of the mid-west US. For Labor and Delivery beds, the current proposal is to maintain all 14 beds, but this can be reduced to 10, possibly 8, due to reduced demand following the long- term diversion of NICU patients and high-risk deliveries to NMCP. A reduction in Labor and Delivery beds will generate further cost savings, right-size capacity to demand (if the NICU is closed), retain quality services with very-high customer satisfaction ratings, and retain readiness currency opportunities for clinical and ancillary personnel

- MTF capability and capacity requirements to support Air Force deployment requirements (information provided by the Air Combat Command Surgeon General's Office as due-out information following the site visit):
- The 633 MDG is one of two large inpatient medical platforms supporting ACC Force Generation. If rescoped to an ambulatory surgical center, the 633MDG would not be able to sustain two full EMEDS+25 UTCs. The EMEDS Pilot Unit would require reassignment from the 633MDG to another MTF, reducing ACC Commander's ability to quickly source medical forces in support of National Defense Strategy
- The Air Combat Command Surgeon General (ACC/SG) serves as the ground medical manpower and equipment force packaging responsible agency for ground medical capabilities. In this capacity, on 28 June 2019, ACC completed the "Expeditionary Medical Support (EMEDS) 3.0 Ground Medical Capability Report". EMEDS 3.0 was and remains an initiative to review and align expeditionary ground medical support capability requirements with national strategic guidance and recommend materiel and non- materiel solutions. EMEDS in a contested, cyber-degraded environment must mitigate NDS challenges and provide commanders with greater flexibility and range of options. It requires a more decentralized and non-linear continuum of care optimized across all roles of care (Role 1-Role 4). To effectively support air forces in forward and vulnerable areas across highly dispersed distances, modular and scalable forward treatment capabilities will provide resuscitative care on both traditional and non-traditional platforms. This forward treatment must be agile and responsive to support distributed forces with increased levels of care as close to the front lines as possible. It must minimize the logistical burden for treatment of combat casualties and aid in the generation and sustainment of fast-moving air maneuver operations and an unrelenting operational tempo. This includes highly mobile, small-footprint resuscitation and surgical capabilities able to function in austere environments.

The future EMEDS requires enhanced patient movement and en route care (ERC) capabilities able to integrate not only with mature airfields but with surface, air, and sea (multimodal) platforms. Enemy threats to air, sea and ground assets will require extended patient-holding capabilities in more distributed, resource-limited environments

- In order to meet these future challenges, ACC anticipates an increase in requirements for medical personnel in the following areas: surgical, forward resuscitation, critical care, mental health, bio-environmental engineering, public health, and rehabilitation. We have already begun bottom and top-line coordination of future state unit type codes (2-years out) in support of distributed operations that include enhanced forward surgical, forward resuscitation, and prolonged field care with more proposed changes pending in the next 6-12 months. Any reduction in medical personnel that are associated with these future high demand skill sets has the potential to hinder the AFMS's ability to transition to the medical force we need to counter NDS challenges
- ACC/SG also supports the Commander of ACC (COMACC) in his role as the Force Provider for conventional force requirements. For medical, this encompasses the ground medical capabilities commonly referred to as EMEDS. As the force provider, ACC organizes, trains, and equips its personnel in support of combatant commander requirements worldwide. It is imperative that the command is able to ensure the ready status of forces and provide forces when requested, sometimes with little to no notice. Presently, ACC is in the process of developing force presentation packages of its assigned forces in order to provide the combatant commanders with the complement of forces needed in a contingency. The intent is to ensure that units deploy together and that "crowd-sourcing" (a team of people built from multiple units and/or MAJCOMs) be eliminated to the greatest extent possible. Agile Combat Support, to include medical, is part of this effort. At present, ACC does not have enough medical capability assigned into EMEDS hospitalization packages to fully support the force presentation packages assigned within the command
- Presently, there are only two ACC bases that contain a full complement of UTCs that together would provide a complete EMEDS bedded capability (10-bed, 25-bed). In total, ACC has ready access to only five EMEDS+25s and three EMEDS+10s. Of these, the 633 MDG has one EMEDS+25 and 3 EMEDS+10s. Any degradation to the UTCs at the 633 MDG directly impacts ACC's ability to monitor and ensure forces are ready and to rapidly deploy an EMEDS bedded capability downrange and further exacerbates the shortage in EMEDS hospitalization within ACC needed to support the new construct

- The 633 MDG, in particular, has two more readiness missions that should be highlighted. First, a Langley EMEDS+25 capability is rotationally put "on-call" in support of the Global Response Force and have forces on call to fulfill this duty during the Air Forces deployment periods P1, P3 normally in primary status and during P5 in secondary/back-up status. Second, the 633 MDG is the pilot unit for EMEDS+25. In this capacity, the unit has staff and equipment for an EMEDS+25 on the installation. If there are questions or concerns with current personnel or equipment packages, the 633 MDG serves as the consultant to ACC/SG. They also help ACC/SG in fielding and testing of any new capabilities. If Langley no longer has the full complement of personnel to staff the EMEDS+25 assigned, we will have to re-assign pilot unit responsibilities to another unit and will need funding for transportation and warehouse storage