DEPARTMENTS OF THE ARMY AND THE AIR FORCE
NATIONAL GUARD BUREAU
111 SOUTH GEORGE MASON DRIVE
ARLINGTON, VA 22204-1382

NGB-ARP-H (10-5a) 4 June 1993

MEMORANDUM FOR THE ADJUTANTS GENERAL OF ALL STATES, PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND THE DISTRICT OF COLUMBIA, ATTN: CHIEFS OF STAFF

SUBJECT: (All States Log Number I93-0187) Medical Support of the Army National Guard (State/Installation Health and Dental Clinic)

1. As the National Guard enters the post cold war era it is obvious that many of the old solutions are no longer functional. One area requiring major redesign is the provision of medical services supporting readiness.

2. Enclosure 1 is the STARC medical structure developed by the Army Guard Quality Improvement Team and approved by the Director of the Army Guard for system wide staffing.

3. Please develop a TDA depicting all doctrinal, medical readiness and wartime requirements to your state. A computation system (Enclosure 2) is designed to maintain some degree of consistency across jurisdictions.

4. You should not program extra manpower to perform "MEDRETES USA". These exercises can form part of the yearly training of all medical soldiers.

5. It should be possible to support disaster response missions from within this basic structure, however states with smaller Guard populations may wish to review the final TDA and supplement the structure as may be required by state unique circumstances.

6. Remember you are developing requirements. Authorizations may be significantly different.

7. Please also provide any recommendations on the basic structure and missions as enumerated by the Quality Improvement Team (QIT).

8. Once all 54 TDAs are received a QIT will be convened to develop a final document.

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9. Please provide TDAs to NGB-ARP-H by COB 1 August 1993.

10. The point of contact is MAJ Wertz at DSN 327-7140 or Commercial (703) 607-7140.

FOR THE CHIEF, NATIONAL GUARD BUREAU:

Edward K. Jeffer

EDWARD K. JEFFER
Colonel, GS
Chief Surgeon, Army National Guard

3 Encls
1. STARC Medical Structure
2. TDA Computation
3. Information Paper S/IHDC

CF:
State Surgeon
Chief Nurse

ARMY NATIONAL GUARD

STATE HEALTH AND DENTAL CLINIC

DRAFT PROPOSAL

OBJECTIVES

QUALITY IMPROVEMENT TEAM

13-16 APRIL 93

- DEFINE STATE INSTALLATION HEALTH/DENTAL CLINIC
  - -MISSION STATEMENT
  - -FUNCTIONS PERFORMED
- DETERMINE BASE REQUIREMENTS
  - -PERSONNEL
  - -EQUIPMENT
- DEVELOP POSSIBLE COURSES OF ACTION FOR IMPLEMENTATION
  - -IDENTIFY BARRIERS
- DEVELOP PROJECT STRATEGY & TIMELINE
  - -DECISION BRIEF TO DARNG SEPTEMBER 93

FACTS

- ARNG HAS STATUTORY/REGULATORY REQUIREMENTS FOR PHYSICAL/DENTAL CARE
- ACTIVE DUTY SYSTEM CANNOT MEET REQUIREMENTS
- ARNG MTOE UNITS CARRY PART OF LOAD
- MTOE STRUCTURE DECREASING (MED FORCE 2000)

ASSUMPTIONS

- NOBODY HAS ANYTHING
- REQUIREMENTS DRIVEN
  -NOT AUTHORIZATIONS
  -NOT FTS
- BLANK PIECE OF PAPER
  "NOT A BLANK CHECK"
- ALL BILL PAYING COURSES OF ACTION ARE OPEN

STATE HEALTH AND DENTAL CLINICS MUST RELY ON OTHER ORGANIZATIONS FOR:

1. PERSONNEL ADMINISTRATION & PAY
2. ORGANIZATIONAL MAINTENANCE
3. DINING
4. UNIT SUPPLY

STATE HEALTH/DENTAL CLINIC

MISSION STATEMENT:

TO ASSURE MEDICAL/DENTAL MOBILIZATION READINESS OF ARMY NATIONAL GUARD UNITS AND INDIVIDUALS, AND TO PROVIDE APPROPRIATE OPERATIONAL SUPPORT OF FEDERAL, STATE AND COMMUNITY MISSIONS

DURING: -DISASTERS
-PRE-MOBILIZATION
-POST-MOBILIZATION
-DEMOB/RECONSTITUTION

CURRENT MEDICAL REQUIREMENTS AND MISSIONS:

1. IMMUNIZATIONS
2. PHYSICALS (PERIODIC/FLIGHT)
3. DENTAL EXAMS/PANOGRAPH
4. HIV (A)TESTING (B)COUNSELING
5. CARDIOVASCULAR SCREENING (PHASES I & II)
6. FITNESS FOR DUTY DETERMINATION
7. PREVENTIVE MEDICINE
8. MEDICAL SITE SUPPORT (AT & IDT)
9. EYE EXAMS
10. ADCO PROGRAM
11. MEDICAL TRAINING
12. WEIGHT CONTROL PROGRAM
13. APFT SUPPORT
14. LIVE FIRE MEDICAL SUPPORT
15. EMERGENCY MEDICAL RESPONSE (DISASTER)
16. MENTAL HEALTH/HYGIENE
17. OSHA/EPA
18. OCCUPATIONAL HEALTH
19. VETERINARY SUPPORT
20. CREDENTIALLING
21. (A) SICK CALL (B) LINE OF DUTIES
22. REVIEW BOARDS
23. FAMILY SUPPORT/DEPENDANT CARE
24. ADMIN QUALITY ASSURANCE
25. SCREENINGS
26. DENTAL SCREENING
27. DENTAL TREATMENT FOR EARLY DEPLOYERS
28. AGR MED/DEN SUPPORT
29. PROFILING/WAIVERS
30. MEDICAL SPECIALTY CONSULTANTS
31. MEDEVAC (AIR/GND)
32. MEDICAL HOLDING (A) PERSONNEL ACCT (B) WARD
33. AUDIO TESTING
34. FORMULARY
35. PHARMACY
36. LEVEL I & II HEALTH CARE
37. MODRE/REMOB/ORE
38. MEDICAL READINESS TRAINING (ODT/CONUS)
39. CLASS VIII SUPPLY
40. BIOMEDICAL MAINTENANCE

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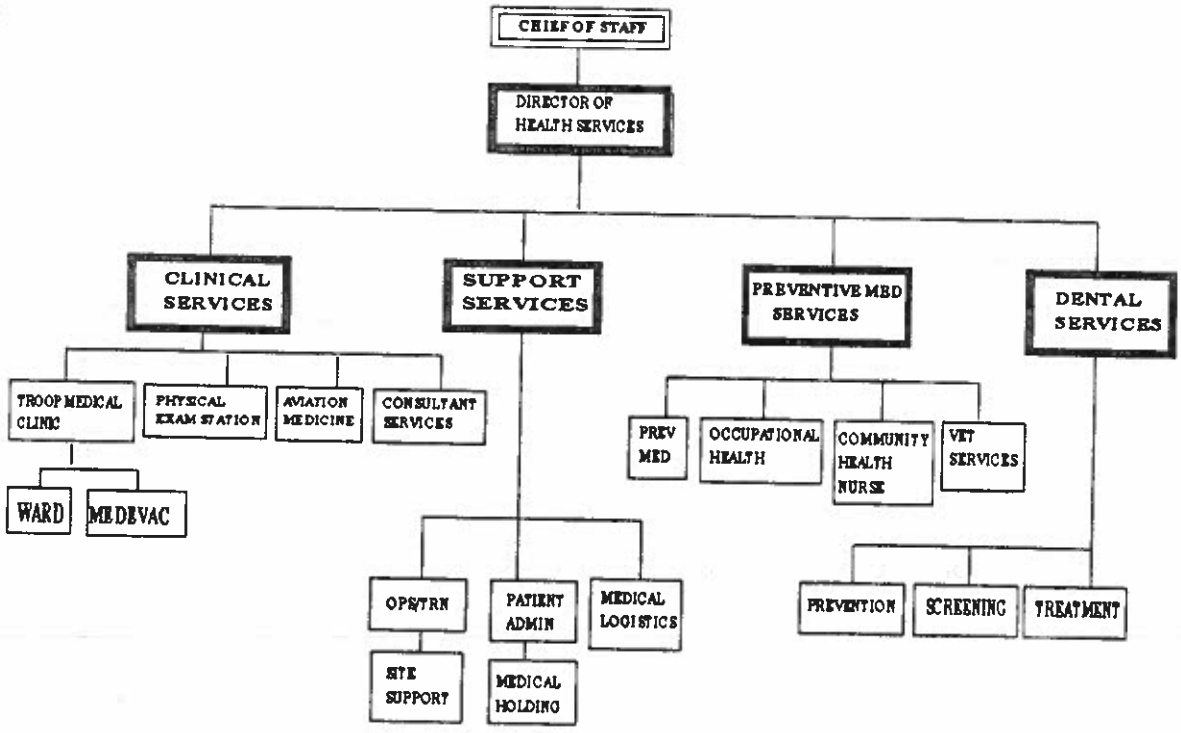
STATE HEALTH/DENTAL CLINIC ORGANIZATION



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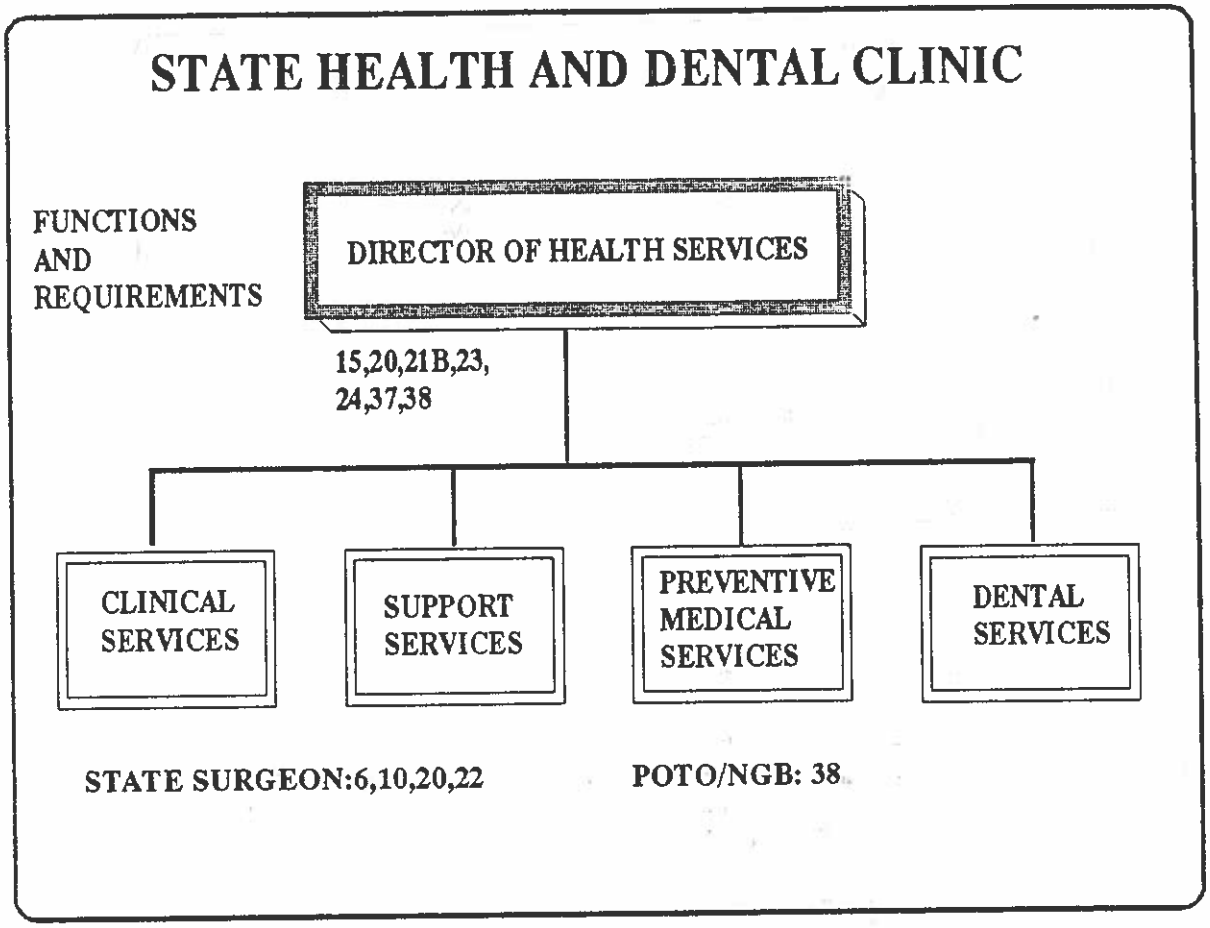
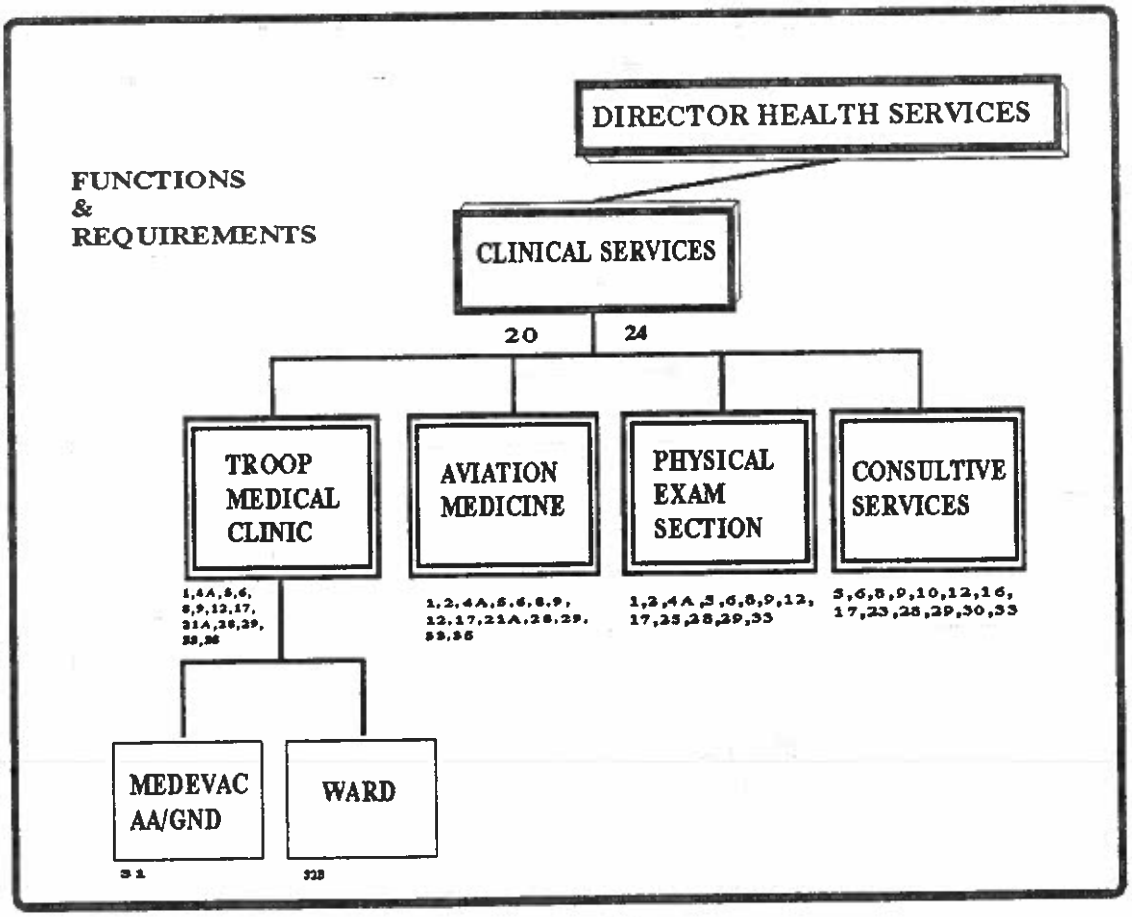
STATE HEALTH AND DENTAL CLINIC





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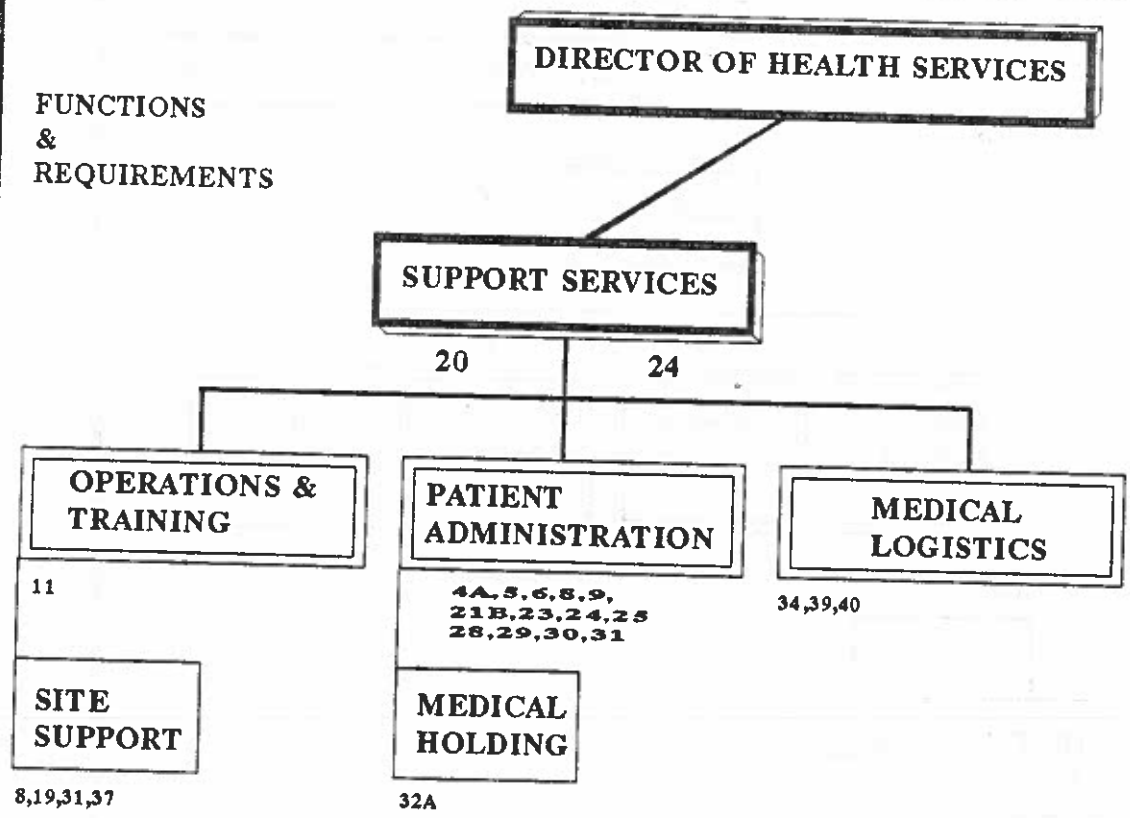
ACTIVITY DESCRIPTIONS

- CLINICAL SERVICES:
  A DIVISION PROVIDING PATIENT CARE, AVIATION MEDICINE SUPPORT, PHYSICAL EXAM SERVICES AND CONSULTATIVE SERVICES AT LEVEL I & II
- TROOP MEDICAL CLINIC:
  A ACTIVITY TO PROVIDE AMBULATORY HEALTH CARE AND LIMITED EMERGENCY CARE
- WARD:
  A NURSING CARE FACILITY (NO LARGER THAN 10 BEDS) WHICH PROVIDES PROFESSIONALLY SUPERVISED NURSING CARE OF LIMITED, NON EMERGENCY SCOPE FOR NOT GREATER THAN 72 HOURS.
- MEDICAL EVACUATION:
  A SECTION THAT PROVIDES ROUTINE AND EMERGENCY TRANSPORT OF OF SICK AND INJURED PATIENTS BY AIR AND OR GROUND TO NEAREST TREATMENT FACILITY
- AVIATION MEDICINE:
  AN ACTIVITY TO PROVIDE AVIATION MEDICAL SUPPORT AND SERVICES TO ELIGIBLE RECIPIENTS
- PHYSICAL EXAMINATION:
  A SECTION THAT PROVIDES PHYSICAL EXAMS, CARDIOVASCULAR SCREENING AND HEALTH SCREENING
- CONSULTATIVE SERVICES:
  A SECTION OF SPECIALISTS TO PROVIDE DEFINITIVE CONSULTS, EVALUATIONS AND/OR CARE

FUNCTIONS
&
REQUIREMENTS



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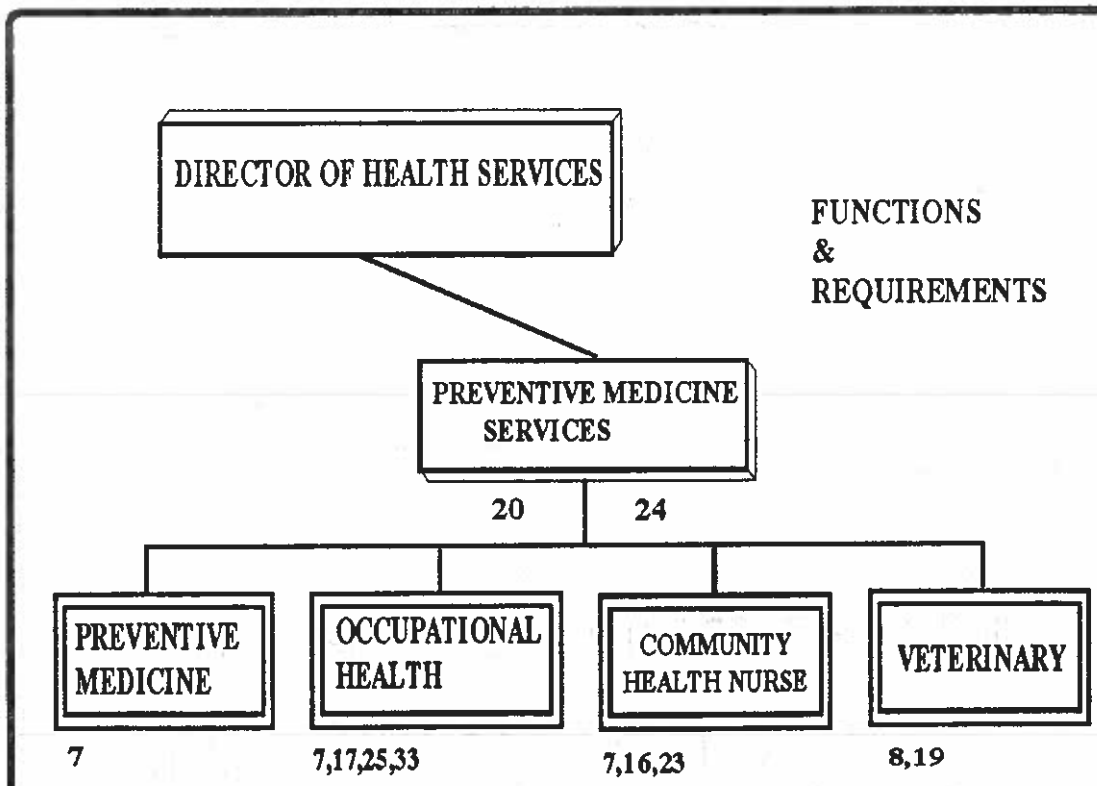
SUPPORT SERVICES

- PURPOSE:
- OPERATIONS AND TRAINING SECTION:
  SITE SUPPORT IDT & AT
  UNIT/INDIVIDUAL TRAINING/PLANNING
- PATIENT ADMINISTRATION SECTION
  MEDICAL HOLDING DETACHMENT
  LINE OF DUTY INVESTIGATIONS
  PATIENT REFERRALS
  MEDICAL REGULATING
- MEDICAL LOGISTICS
  CLASS VIII
  MEDICAL MAINTENANCE



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PREVENTIVE MEDICINE SERVICES

- PURPOSE: PREVENTIVE MEDICAL OFFICER
- IDENTIFIES & CONTROLS COMMUNICABLE DISEASES
- REPORTS/RECORDS MORTALITY STATICS OF COMMUNICABLE DISEASES
- PROVIDES TECHNICAL GUIDANCE TO MODRE/REMOB (EX: IMMUNIZATIONS REQUIRED)
- INTERACTS WITH STATE/FEDERAL HEALTH AGENCIES (REF COMMUNITY DISEASES ETC)
- PROVIDES TECHNICAL ASSISTANCE TO THE ISU/FIELD SANITATION DINING OPERATIONS

COMMUNITY HEALTH NURSE

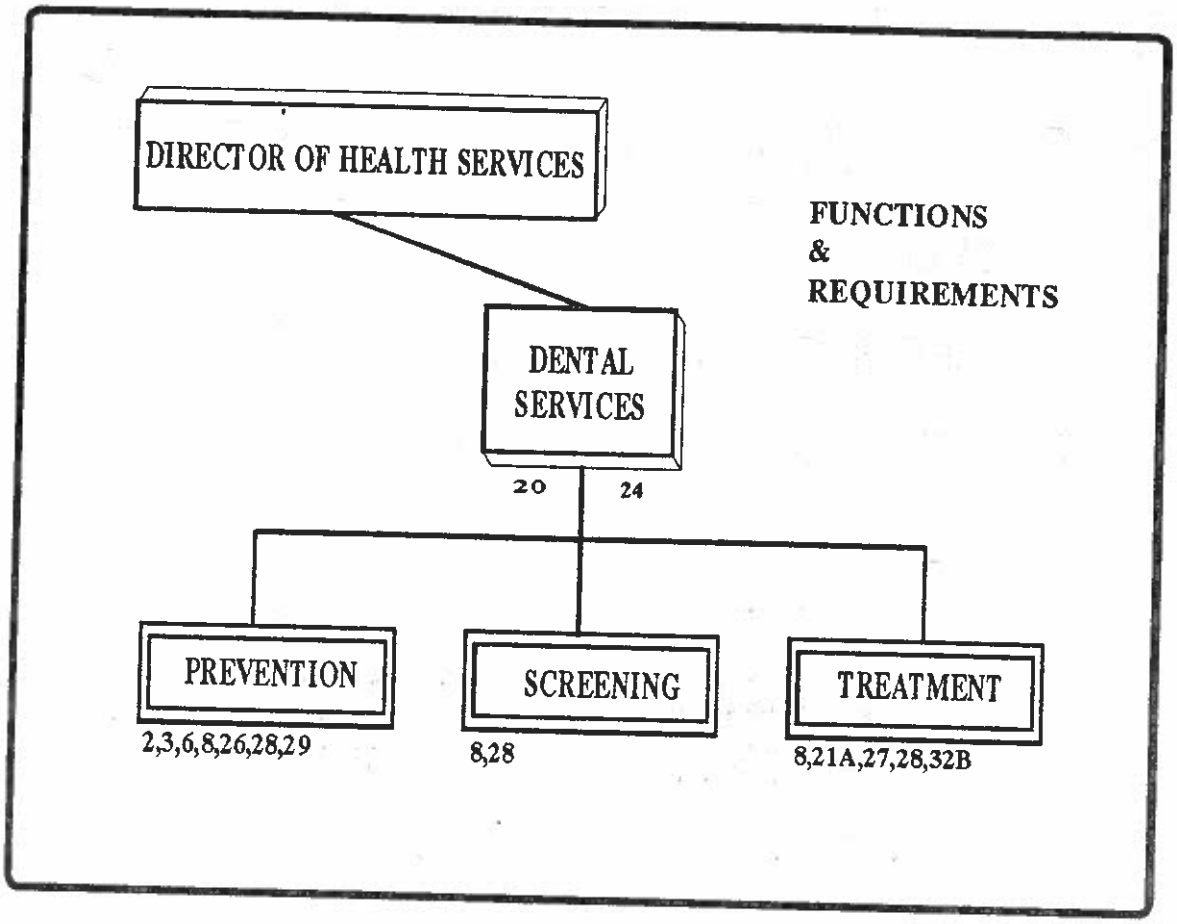
- PURPOSE OF CHN:
- SERVES AS HEALTH CARE ADVOCATE TO THE FAMILY ASSISTANCE/SUPPORT PROGRAM
- INTERACTS WITH LOCAL, STATE, FEDERAL HEALTH AGENCIES WITH RESPECT TO PUBLIC HEALTH ISSUES
- ASSIST IN PLANNING NEEDS OF FAMILY MEMBERS OF SOLDIERS DURING PRE, MOB AND POST MOB

OCCUPATIONAL HEALTH NURSE

- PURPOSE OF OHN:
  - RESPONSIBLE FOR HEARING CONSERVATION
  - MONITORS USE OF REQUIRED SAFETY EQUIPMENT IN WORKPLACE
  - PERFORMS HEATH RISK ANALYSIS FROM IDENTIFIED BIOHAZARDS WITHIN THE WORKPLACE AND SURROUNDING ENVIRONMENT
  - RESPONSIBLE FOR RADIATION PROTECTION PROGRAM
  - HEPATITIS B VACCINATION PROGRAM

VETERINARY SERVICES

- PURPOSE :
  - ENSURES RATION PROCUREMENT, HANDLING, STORAGE AND DISTRIBUTION MEETS ACCEPTABLE STANDARDS
  - INSPECTS RATIONS AT UNIT DINING FACILITIES TO INSURE PROPER STORAGE AND HANDLING
  - PROVIDES ANIMAL HEALTH CARE SERVICES



DENTAL SERVICES DIVISION

- SCREENING: PROVIDES DENTAL PROFILING, PANOGRAPHIC, DENTAL EXAMINATION, REFERRAL, AND AGR PERSONNEL SUPPORT TO ELIGIBLE PERSONNEL.
- PREVENTION: PROVIDES DENTAL PROPHYLAXIS, AND TRAINING. ASSISTS IN THE MAINTENANCE OF CLASS II STANDARDS FOR EARLY DEPLOYING M-DAY SOLDIERS AND IN THE MAINTENANCE OF CLASS I STANDARDS FOR AGR PERSONNEL, IF TASKED.
- TREATMENT: PROVIDES ROUTINE, EMERGENCY, CONSULTATIVE, AND REFERRAL SERVICES. MAINTAINS CLASS I STANDARDS FOR EARLY DEPLOYING SOLDIERS AND CLASS II STANDARDS FOR AGR PERSONNEL, IF TASKED. PROVIDES WARD DENTAL SUPPORT AS NECESSARY.

COMPUTATION OF PERSONNEL REQUIREMENTS

Providers: Physician (MC), Physicians Assistant (AMSC), and Nurse Practioner (ANC).

1. **Over 40 Physicals/Year**
   State Guard population >40 yrs of age X .5 = no. of physicals (Title XI requires >40 physical every 2 years = 50% per year)

2. **Annual Flight Physicals/Year**
   State personnel requiring annual flight physicals = no. of physicals

3. **School Physicals/Year**
   Airborne/Ranger/Basic SF/OCS/Appt/Svc School applications etc. = based on previous years historical data

4. **Cardiovascular Screenings (Phase II)/Year**
   State Guard population >40 yrs of age X .5 (50% per year) X .2 (20% require Phase II) = no. of physicals/screenings

5. **Periodic/Quadrennial Physicals/Year**
   State Guard population minus # 1 minus # 2 minus # 3 = subtotal divide by 4 (25% per year) = no. of physicals

6. **Annual Medical Appraisals/Year**
   State Guard population minus # 1 minus # 2 minus # 3 minus # 5 = appraisals divide by 6 = no. of number of physical exam equivalents

7. **Total Annual Physicals**
   Add # 1 through # 6

8. # 7 divided by 10 = Provider Mandays X 115% = Total Needed Provider Mandays (for no shows, lost time, equipment down time etc.)

9. # of Provider Mandays for site spt to ensure IDT & AT Tng x .50 (factor to allow for dual functions) = Site Supoort Mandays

10. # of Providers needed for Medical Functions = # 8 plus # 9 divided by 19.5 (days per year) = Supportable M-Day Man Years/Providers

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11. Supportable M-Day Providers (#10) minus MTOE Providers in State CFP & R/U & R/O Units at '96 end strength X .25 (25% tng time available for care) minus MTOE Providers in State non CFP, R/U, R/O Units at '96 end strength X .5 = Required TDA Providers (subtotal) (DARNG Guidance)

12. Additional Man Years for Specialty Consultation (30% of Provider strength may be specialists who reserve 30% of their time for Specialty Consultations) # 11 X 6.1% = specialty consultation man years

13. # 11 plus #12 = total TDA Providers

13a. Repeat #1 - #13 for ANG = TDA providers required for ANG

13b. Add #13 and #13a = Total TDA Providers (subtotal)

14. (a) Anticipated total physicals provided by the USAR, USAFR, USNR divided by 10 (exams per day) divided by 19.5 (days per year) = borrowed provider days

(b) Repeat for Active Components

(c) Add A & B, then subtract total (14c) from # 13b = Required TDA providers for state support

15. Enlisted Clinical Support (excluding 91C MOS) = one per Provider (#14c) [assume MTOE supported by own enlisted pers]

16. Nursing (RN and 91C) support, 1.5 x # 14c (Up to 50% can be 91C MOS)

17. MSC Support = .35 X # 14c (allows for Administration, Pharmacy, Optometry, Laboratory)

18. Enlisted Administrative Support (MS) = # 17 x 1.25

19. Dentists required for Annual Screenings = State Strength (Army and Air) divided by 40 divided by 19.5

20. Dentists required for treatment = State strength of CFP plus R/U x .3 (30% required treatment) x 2 (hours per case) divided by 8 (hours per day) divided by 19.5 (days per year)

21. TDA dentists required
= #19 plus #20 minus (MTOE Dentists CFP, R/U, R/O x .25) minus (MTOE Dentists Non CFP, R/U, R/O x .5) minus (# of dentist equivalents available from other reserve and Active Components) X 115% (to cover geographic problems, no shows, equipment down time etc.)

22. Enlisted Dental Techs
(2 X # 21)

23. Total # of positions needed not included in above calculations (e.g. occupational health nurse, health systems specialist)

24. #14c + #15 + #16 + #17 + #18 + #21 + #22 + #23 = State Medical/Dental TDA

25. (a) Use these spaces to staff organization based on wire diagram provided.

    (b) Treatment sections may be of varying sizes to allow staffing of more than one within a state based on population centers and distances involved.

NGB-ARP-H
6 May 1993

INFORMATION PAPER

SUBJECT: State/Installation Health and Dental Clinics

1. Discussion:

a. Facts:

(1) All 54 Army National Guard jurisdictions have ongoing medical requirements which are statutory and regulatory in nature. These requirements include, but are not limited to, reviewing, and supervising the following:

(a) Physical Examinations (minimum every 4 years)
(b) Flight Physicals (annually)
(c) Dental exams and Panographic X-rays
(d) Immunizations
(e) HIV testing and required counseling
(f) Cardiovascular Screening (phases I and II)
(g) Fitness for duty determinations
(h) Preventive Medicine
(i) Medical support/coverage for Inactive Duty Training (IDT) and site support for Annual Training (AT).

(2) At current level of force structure medical support to the programs noted above, has not always been satisfactory.

(3) During the "build down", medical force structure is programmed to decrease as much as 62%. At this level the minimum cost for replacement of lost medical services would be approximately $30 million to the ARNG. This does not include costs for coverage of IDT or AT and assumes a best case for geographic distribution of assets. This also does not include Title XI costs.

(4) A structure needs to be available for States to utilize in developing an organization to fulfill current and potential medical wartime and readiness missions.

(5) At the time of Desert Shield/Storm the medical force structure was 5% of the total Army Guard force structure, however medical personnel comprised 18% of the ARNG forces deployed to Southwest Asia (SWA) not including integral medical assets in non-medical units.

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(6) Concerns were raised in the Desert Storm after action reports concerning the medical and dental readiness of Army National Guard soldiers.

(7) Acceptance of contact lenses as standard for flight status personnel may place another requirement for medical services on all jurisdictions.

(8) Nation building (Forward Presence Forces) will continue to be one of the major concerns of the State Department, the CINCs, and the Director of the Army National Guard. Decreased medical force structure will severely constrain or eliminate these activities in the ARNG.

b. General:

(1) Utilizing the enclosed structure developed by a Guardwide Quality Improvement Team, development of a State/Installation Health and Dental Clinic TDA is designed to be an exercise in capturing 100% of the unique State/Territorial requirements. The actual allocation of authorizations against the TDAs will be dependent upon both the final end state of the Army National Guard as determined by the Congress and the priority the Govenor and TAG place on medical programs.

(2) The S/I HDC needs to have sufficient personnel to accomplish the mission for physical exams, immunizations, cardiovascular screens, and site support for IDT and AT. TOE medical elements, if present in a state, can contribute to these missions. However, with the increased emphasis on readinesss, TOE medical elements must be allowed to dedicate sufficient time to both individual and collective training to reach C-1 or a C-rating consistent with the unit's Authorized Level of Organization (ALO). As a general rule no more than 25% of the training time (IDT/AT) of TOE medical units should be diverted to physical exams etc. if they are either Contingency Force Pool units or part of Round-up/Round-out Brigades other TOE units may divert upto 50% of their time.

(3) While the soldiers of the S/I HDC will be receiving training to prepare them for mobilization and deployment as individuals or sections, the S/I HDC has a local deployment mission. It is unnecessary for the S/I HDC to have its own motor pool or food service. These services should be provided as needed by other elements within the state.

(4) Ensure adequate TDA medical force structure (S/I HDC) to maintain medical readiness of units, to provide home

station medical mobilization capability and to provide post mobilization services to rear detachment soldiers and family members.

(5) All S/I HDC should have at least a minimal x-ray, lab, and pharmacy capability.

(6) As is noted, there is no intention of fielding any significant number of beds at any time. The majority of tentage, equipment, and personnel to maintain beds is unnecessary.

(7) S/I HDCs could provide cost effective care for Title 32 and Active Component personnel in areas not serviced by DOD health care facilities. This group of beneficiaries would include Active Guard/Reserve (AGR) soldiers and the increased number of active component individuals who are programmed to be assigned to ARNG units to increase readiness. S/I HDCs would serve as an organization which could accept, through the American Red Cross, volunteer services from both professionals and paraprofessionals in providing health care. This is a large untapped resource pool.

(8) S/I HDCs could support a basic preventively oriented health and dental treatment program for M-Day soldiers. This would be a significant contribution to readiness and is essential for round-out/round-up brigades and contigency force soldiers. A supplementary insurance program based on drill pay deductions would be considerable less costly with this type of program in place. With or without supplementary insurance this type of care would be a significant recruiting and retention factor.

(9) CONSULTANTS SECTION

a. It will be extremely valuable to have a wide array of medical and allied specialists available to provide consultation and case review. In addition to their positive impact on readiness and utility for emergencies, these medical professionals are critical to any program to decrease the costs of the Incap pay and FECA (Federal Employment Compensation Act) claims programs. Personnel would also function as generalists part of the time. Physicians would be expected to spend up to 70% of their time as general medical officers and Medical Service Corps officers would be expected to perform a variety of administrative duties as assigned.

b. Good candidates include but are not limited to:

1. Surgical:

a. Thoracic
b. Vascular
c. Otolaryngology
d. Neurosurgery
e. Orthopedic
f. Ophthamology
g. Urology

2. Medical:

a. Cardiology
b. Dermatology
c. Pulmonary medicine
d. Allergy

3. Other:

a. Podiatry
b. Physical Therapy
c. Occupational Therapy

c. An appropriate medical enlisted assistant should be included for those specialities where separate MOSs exist.

d. In order to provide refractions for mask inserts, contact lenses for approved aviators, and government furnished spectacles the S/I HDC needs an eye section. The number of optometrists and eye techs (91Y) would depend on workload.

e. Each S/I HDC could have a mental hygiene section. Professional personnel could include psychiatrists, psychologists, and social workers while each professional should have as a minimum one 91G as an assistant.

f. While d. and e. are described as sections, the personnel could be distributed throughout a state attached to detachments allowing maximal geographic coverage.

g. Additional personnel who could provide valuable services would be a veterinarian assisted by food inspection technicians and an audiologist. At a minimum the S/I

HDC needs to have an audiometry capability with appropriate equipment and at least one technician. Even though food service would not be a part of the S/I HDC a dietician would be extremely useful to design, implement, manage, and evaluate a weight reduction program and to assist with individual and group weight reduction counseling.

(10) EMERGENCY MEDICAL RESPONSE CAPABILITY

a. Many states will wish to build into the S/I HDC a capability to respond to natural disasters and civil unrest.

b. States without TOE ground evacuation units may need to supplement the S/I HDC with an appropriate number of wheeled ambulances. These could be stationed with separate detachments depending upon the size of the state. Maintenance support would have to be provided by nearby units having this capability. In some states civilian ambulance capability (fire and rescue, etc.) may be considered sufficient.

c. Equipment to support a small surgical capability would either be a Deployable medical Systems (DEPMEDS) Operating Room shelter or a Modular Medical (MOD MED) lightweight field surgical squad set. Lab, x-ray, pharmacy, and CMS would be tailored to the individual emergency. Anesthesia support could either be with anesthesiologists, nurse anesthetists, or a combination. Equipment may be available from drawdown from TOE RC&AC units or purchased independently through out-year funding.

d. The emergency response capability would be built out of the regular S/I HDC detachments and personnel from the consultants section. Transportation assets, food service, maintenance and security personnel would come from other state assets.

e. The triage and treatment are would be the main center of activity for any emergency and its size would be based on the situation. The concept of operations would be for treatment and return to duty or stabilization and immediate evacuation to the nearest appropriate fixed facility. A small number of beds would need to be programmed for patients awaiting transport.

f. While the S/I HDC has no fixed deployment mission they would serve as the medical element for all necessary tasks during mobilization. Additionally, the soldiers would form a pool for cross leveling to other ARNG

medical units and the units would in effect be the nuclei for building a large number of field medical units if this nation faced a full mobilization.

Encl 3