Team Aerospace Gazette (TAG)

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USAF/SGOP
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SPECIAL Points of Interest:

- AFI 48-101, Aerospace Medical Operations, is being sent out for coordination

Inside this issue:

CRRA Process	*1, 3-5*
Code Silver	*2*
RSVP Update	*2*
AP SNCO Council	*6*
Final Thoughts–	*7*

Capabilities Review and Risk Assessment (CRRA) and Functional Area Working Groups (FAWGs) Provided by Mr. Dennis Pippy HQ USAF/S GOP

The US Air Force is currently transitioning to a capabilities-based planning, programming and budgeting execution system (PPBES) to more effectively develop and field operational capabilities required for the future. In order to facilitate this transition, the USAF has established Risk Assessment Teams to perform Capabilities Review and Risk Assessments (CRRA).

The AFMS is establishing a similar process. The AFMS is establishing 8 functional teams called Functional Area Working Groups or FAWGs. What exactly is a FAWG? They are permanently standing working groups established by the AF/SG to identify future AFMS capabilities and shortfalls, in addition to, working the day-to-day issues involving programs within their functional area. FAWGS are composed of subject matter experts from Air Staff, AFMSA and MAJCOMs who understand both operations and the requirement process. The size and composition of each FAWG will vary based on the number of programs, number of issues, and the amount of technical and subject matter expertise required in a given functional area.

FAWGs will address the full spectrum of current and future AFMS operational capabilities and include Line of the Air Force and Joint medical and health-related issues.

Membership includes: a representative from the following sections from the HQ USAF Surgeon Generals staff: Healthcare operations (SGO); Modernization (SGR); Medical Plans and Programs (SGM); Force Development (SGC); Medical Information Systems (SGK); Congressional and Public Affairs (SGI); members from several Air Force Medical Support Agency (AFMSA); members from the MAJCOMS who are Manpower Equipment Force Package (MEFPAK) Managers (ACC, AMC and AFSOC); MAJCOM/SG representatives; and representatives from the HQ ANG/SG and HQ AFRC/SG and others as required.

A FAWG acts as a clearinghouse for operational capabilities by coordinating, integrating and deconflicting the efforts of all components within its designated functional area.

FAWGs address doctrine, organization, training, materiel, leadership, personnel and facility (DOTMLPF), issues and propose courses of action to satisfy the capability shortfalls within their func-

Continued on page 3

CODE SILVER PROGRAM PREPARES BASES FOR A BIOLOGICAL/CHEMICAL ATTACK

The Weapons of Mass Destruction Emergency Responder (WMD-ER) Program has enhanced the ability of AF installations to respond to Weapons of Mass Destruction attacks and incidents in a coherent and integrated manner. However, there is still room for improvement. In particular, the integration of traditional first-responder organizations (security forces, hazmat, fire and rescue etc.) with Public Health, Bioenvironmental Engineers and medical treatment personnel has lagged. Further, exercises and planning have not always been comprehensive in scope, usually stopping short of testing medical resources and responsibilities.

The CODE SILVER program was sponsored by the Air Force Surgeon General to address these issues and help the Air Force achieve its goals for incident response (with an emphasis on consequence management) and installation force protection. The program is intended to expose personnel to a variety of chemical-biological situations, allow them to work through the issues interactively and facilitate the design of more efficient and effective plans and procedures to overcome these challenges. CODE SILVER also supports the AF Counter-CBRNE (Chemical, Biological, Radiological, Nuclear, and high explosive) Master Plan by providing an early opportunity to validate the initial planning work being accomplished under that effort.

The CODE SILVER program involves a tabletop exercise, which is designed to provide a unified exercise environment for various base organizations and other pertinent groups. Typical representation will include representatives from the Medical Group including either the Commander (or designated Representative); Disaster Teams and select members of the Base Disaster Response Force; State Emergency Medical System; local Public Health department; local, county or state laboratories and security or law enforcement (from both on and off base), etc.

It is important to note that CODE SILVER is not an adversarial test of organizational or individual proficiency. Rather, it is a constructive learning opportunity in which participants discuss and examine critical issues relative to base responses to chemical and biological incidents in an open, non-attribution environment. The tabletop exercise is conducted through a scenario-driven discussion focused on medical support and response operations in a chemical or biological environment exacerbated by mass casualty situations and high stress factors. This exercise methodology is ideal for promoting a productive exchange without imposing undue preparatory burdens on participants.

In Fiscal Year 2004, there are 45 medical treatment facilities, (of which 5 are from the Air National Guard), that will participate in CODE SILVER exercises. In FY 2005, 45 additional medical facilities (including some ANG), will also receive the training opportunity. Though originally designed as medically-centric, the tabletop exercises received so much interest from the wing commanders that in FY05 the CODE SILVER tabletop exercises will include command and control (C2) components to test the wing's command and control involvement in Biological Warfare incidents. The Air Force Medical Support Agency staff has been designated the POC for the FY05 effort.

AEF CYCLE CHANGES: RSVP Updates. The AEF Cycle process has changed to five buckets of 120 days each (not 90 days each as they have been in the past). This extends the AEF out to 20 months for the entire cycle. This has caused some changes to many Readiness Skills Verification Programs (RSVP) for specific Air Force Specialty Codes (AFSCs). Many career fields had training spaced out every 15 or 30 months to align with the AEF cycle. Now that the cycle has moved to 20 months, you should check your AFSC's RSVP and see if the training requirements changed to align with the 20 month AEF Cycle.

CRAA Process

tional area.

FAWGs must address lessons learned and when appropriate, incorporate them into their capability shortfalls and proposed courses of action (COAs).

FAWGs will review MEFPAK mission capability statements, force packages, and proposed changes to allowance standards, and incorporate them into their capability shortfalls and proposed COAs.

The FAWGs work with AF/SGRR (Medical Modernization) to develop, evaluate and forward capability documents and other supporting documentation prior to forwarding to the Surgeon General Requirement for Operational Capabilities Council (SGROCC) for validation.

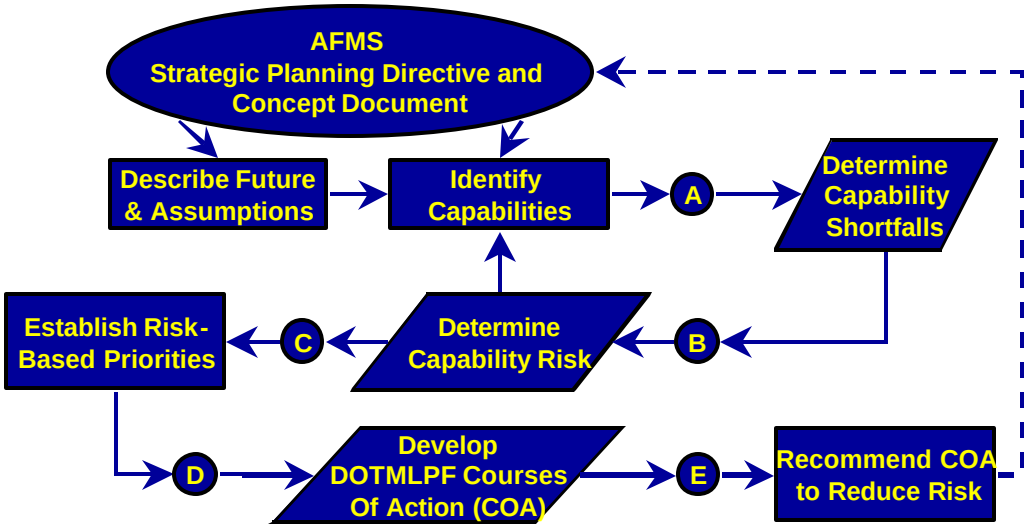
Each FAWG develops a Functional Area Plan (FAP), which contains a prioritized list of DOTMLPF operational capabilities and proposed COAs for filling the capability shortfalls. They brief the results of their risk assessment and proposed COAs to AF/SGO (Healthcare Operations) prior to presenting their capability shortfalls to the SGROCC or AFMS Corporate Structure.

Once prioritized, a list of materiel capability shortfalls identified in their respective FAP along with any proposed COAs are presented to the SGROCC.

FAWGS present their capability shortfalls to the AFMS Corporate Structure through the appropriate Panels, (SGROCC for materiel shortfalls).

Each FAWG coordinates or liaisons with other FAWGs to ensure that the AFMS is best served throughout the modernization and programming process.

FAWGs may task or solicit assistance from supporting organizations, specialists or subject matter experts to carry out specific reviews or to conduct analysis in support of the FAWG's responsibilities.



Charts continued on page 4

FAWGs must also function as Integrated Process Teams (IPTs) to work special projects that fall into their functional area as time and workload permits.

FAWGs also represent the AFMS perspective and support AF and Joint Capability Reviews and Risk Assessment (CRRA) Processes when needed.

As a minimum, they meet face-to-face semiannually and conduct teleconference meetings as required. Additional meetings with Subject Matter Experts; System Program Offices; Battlelabs; Line, Joint, and other Services' staffs are conducted as needed.

You might be asking, in what functional areas will we have FAWGs?

1)Medical Chemical Biological Radiological Nu-

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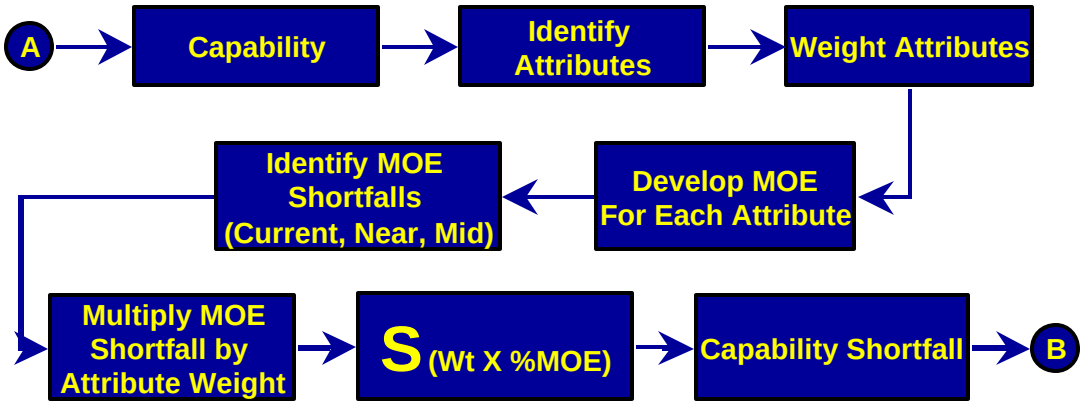
Capabilities Review and Risk Assessment (CRRA) Process



Step 1: Identify 1-3 attributes (See Backup Slide 18) important to this capability. [Example: Take the capability to manage mass casualties. Attributes selected: Throughput, Survival Rate, Interoperability]. **Step 2**: Weigh each attribute; all weights add to 1.0 [example: Throughput (.4); Survival Rate (.4); Interoperability (.2))] **Step 3:** Develop measure of effectiveness (MOE) for each attribute [Example: Throughput – 300 casualties w/in 2 hours (based on historical data from Khobar Towers, Lebanon Marine Barracks, USS Cole). Survival Rate – 99% of live casualties surviving through medical care. Interoperability – Born Joint (100%)]. **Step 4:** Identify Shortfalls currently, near (w/in FYDP), mid (w/in 2FYDP).

[Example:

Attribute	Current	Near	Mid
Throughput	30(90%)	50(83%)	50(83%)
Survival Rate	95%	98%	99%
Inter-Operability	40%	70%	90%

Step 5: Multiply MOE by Attribute Wt and Determine Total Shortfall [Example:

Attribute	Wt	Current	Near	Mid
Throughput	0.4	.36	.33	.33
Survival Rate	0.4	.02	.01	.00
Interoperability	0.2	.12	.06	.02
Total	0.50	0.40	0.35	

Severity	Probability: Frequent	Likely	Occasional	Seldom	Unlikely
Catastrophic	10	8	6	4	3
Critical	8	6	4	3	2
Moderate	6	4	3	2	1
Negligible	3	3	2	1	1

clear and Explosive (CBNRE) Defense
2) Ground Medical Support
3) Aeromedical Support
4)Special Operations Medicine
5)Human Performance Enhancement
6)Casualty Prevention
7)Clinical Medicine
8)Information Management and Information Technology

What is to be done with the work results of these FAWGs? The FAWGs are currently meeting to identify and prioritize AFMS capabilities within their functional areas

Once their work is completed, AF/SGO will compile and integrate the priorities of the individual FAWGs into an AFMS Transformation Flight Plan.

The AFMS Transformation Plan will then become one of the foundation documents that influences the AFMS spend plan.

In addition to identifying capabilities and conducting risk assessments, the FAWGs are also responsible for:

1)Briefing and defending their programs to the AFMS, MAJCOM or AF Corporate Structure during POM submissions.
2)Representing the AFMS during the AF Line CRRA to ensure AFMS capabilities are fully integrated into AF operational concepts.

HQ USAF/SGOP Top Issues

#1 Institutionalizing Operational Medicine: Our mission has changed dramatically (new missions, increased missions); our manning has not kept up with new demands - the LONG HAUL STUDY supports an increase for AFMS in Public Health (PH), Bioenvironmental Engineering (BE), Flight Surgeon (FS) (Flight Medicine), and Independent Duty Medical Technician (IDMT); The PERSLOAD STUDY supported an increase in PH, BE, and IDMT; we need to re-prioritize the support for operational medicine functions – and strengthen the "Cornerstone" of Aerospace Medicine.

#2 Transforming AFMS Expeditionary Operations: In light of new the various external forces and recent lessons learned from OPERATION ENDURING FREEDOM (OEF) and OPERATION IRAQI FREEDOM (OIF), we must transform our expeditionary medical support we provide the USAF.

#3 Environmental Quality Realignment: We must work to realign the Bioenvironmental Engineering's environmental quality support to emphasize the environmental health risk-based mission versus the current environmental compliance sampling support.

#4 Emergency Health Powers: We must work to align the USAF Medical Service with the new DoDD 6200.3, Emergency Health Powers on Military Installations, which tasks installation commanders to protect their installations against public health emergencies; and to appoint a Public Health Emergency Officer (PHEO); we also need to define and clarify the guidance for the PHEO, explaining their duties and responsibilities as well as training requirements.

#5 Medical (Physical) Standards: We have to tackle the difficult issues regarding fitness for duty in the USAF from initial accessions, USAF retention during a member's career, USAF Military and Civilian deployments, as well as the disability evaluation issues concerning Active Duty and Air Reserve Component (ARC) and DoD and Veterans Administration Resource Sharing.

#6 AFMS CRRA Process: Discussed elsewhere in this issue.

Aerospace Physiology SNCO Council Holds First Teleconference Meeting

CMSgt William Jennings, CFM for the 4M0X1 community facilitated the creation of the Aerospace Physiology SNCO Council. This group held their first meeting via teleconference recently. Other membership includes CMSgt Tim Conley from HQ ACC Langley AFB, VA; CMSgt Dave Pridgen from Beale AFB, CA; CMSgt John Kettinger from HQ AETC, Randolph AFB, Tx; CMSgt Rick Riddle from AETC at Sheppard AFB, Tx; SMSgt Manny Topete from AFMC at USAFSAM, Brooks City Base, Tx; SMSgt Bheng Delacruz from PACAF, Kadena AB, Japan; SMSgt Doug Schmidt from USAFE, Ramstein AB, Germany; MSgt Joe Montalvo, AFSOC, Hurlburt AFB, Fl; MSgt Doug Runels, AFSPC, Peterson AFB, Co; and MSgt John Busby, AMC, Andrews AFB, MD.

They held discussions in the following key areas: AP Chamber Flights, High Altitude Airdrop Mission Support (HAAMS), High Altitude Reconnaissance Mission Support (HARMS), Hyperbaric Medicine and Human Performance Training Teams (HPTT).

AP Training Flights: The discussion covered some recent proposed policies that derived out of some recent incidents. Another topic of interest included the proper fire extinguisher to use within the chambers. Members of the group will conduct more research to determine which system is the best for use in the chamber. The Technical Order does not give specific guidance on this matter. The final topic concerning the chambers was communications systems and altimeters in the chambers. There is an approved wireless communication headset available for use in and around the chamber. Units will have to order them and fund them, however, the Depot will install them. The Depot is also working on a digital altimeter for use with the chambers and will be testing one soon at Brooks City Base.

High Altitude Airdrop Mission Support (HAAMS): AFI 11-409 is being revised and will be separated into different working volumes similar to other flying AFIs. Since HQ ACC is the lead for HAAMS Unit Type Codes (deployable teams), they are developing a Tactics, Techniques, and Procedures (TTP) Air Force Instruction for the HAAMS Teams. This TTP will detail the specific procedures regarding the deployment of HAAMS UTCs and what they need to do to set-up operations. One key area of this TTP is the detailing of training requirements which will lead to improved chances of appropriate funding. HQ ACC desires to establish a training course (most likely through USAFSAM) to standardize and provide critical training to newly assigned HAAMS personnel to get them ready for deployment missions. The group is researching ways to obtain the proper funding stream to establish and maintain this needed training.

High Altitude Reconnaissance Mission Support (HARMS): The group discussed the courses offered at the USAFSAM Operating Location at Beale AFB, California. This unit conducts courses in Pressure Suit Maintenance, Seat Kit Maintenance, and Launch Supervision. These courses are being evaluated for awarding of Community College of the Air Force (CCAF) credits to those completing the course. Officials from Brooks City-Base are working with the instructor cadre to insure compliance with CCAF requirements.

Human Performance Training Teams (HPTT): There was a suggestion of establishing an annual award to recognize the outstanding work that these teams are routinely performing at base level. There will be a formal proposal drafted and submitted to the Aerospace Physiology corporate structure for consideration.

New Business: At a recent AP Corporate Board meeting, the leadership reviewed the requirements for upgrade to the 7-skill level (core tasks) as listed in the current Career Field Education and Training Plan (CFETP). The core tasks relating to altitude chambers cannot always be trained because not all units have access to an altitude chamber. The leadership decided to remove the altitude chamber related core tasks for 7-skill level upgrade training. These changes will be reflected in the next revision of the CFETP which is currently in the rewrite process. The instructor positions at USAFSAM at Brooks City Base have been advertised as EQUAL Plus special duty advertisements. However, there have not been any volunteers for these advertisements. If this continues as a problem, the next step in filling these critical positions is to go with the less desirable choice of selecting non-volunteers with CCAF degrees. Qualified base level members should consider volunteering for these great assignments. Contact your newly designated AP SNCO Council representative for more information.

New Airman's Manual Available (Dated 1 June 2004)

Combines Airman's Manual and ATSO Guide (AFH 32-4014, Vol 4).

SUMMARY OF REVISIONS: This revision includes revised strategies and procedures for the way Aerospace Expeditionary Forces (AEF) will prepare, fight, and operate on the NBCC battlefield. Operational updates include changes in improvised explosive devices, counter-chemical warfare operations, contamination avoidance strategies, warning and notification signals/sirens, and the addition of the M45 Land Warrior Chemical-Biological Mask. Informational updates include embedded media journalists, self-aid buddy care, chemical protective over-garments, mask

Final Thoughts...TDY Statistics for Team Aerospace Medicine Personnel

The following is a listing for Team Aerospace personnel consisting of the number of TDYs taken by how many people of a particular AFSC; the number of days total that AFSC has been TDY; the average number of days for each TDY taken and the percentage of that AFSC that has been TDY.

This data does NOT include any deployment information and is not 100 percent accurate. Often times, members do not update their status in their Commander's Support Staff office and the personnel data system is not updated with TDY information. This is only a representation (from the data available) and should not be used as definitive information. This does include manning assistance and other TDYs.

AFSC	People	TDYS	Days	Avg	Rate
OFFICER:					
Flt Docs	221	828	14,601	66	20%
RAMS	156	487	8,405	54	20%
BEE –A	298	1145	13,269	45	15%
BEE—B	10	39	257	26	9%
BEE –C	5	28	272	54	15%
BEE– D	9	28	173	19	6%
BEE—E	29	217	1,076	37	15%
Med Ent	12	46	734	61	18%
PHO	171	491	7,560	44	14%

AFSC	People	TDYS	Days	Avg	Rate
ENLISTED					
4A0X1	1323	2,123	36,253	27	3%
4A CEM	55	181	1,069	19	6%
4B0X1	619	1,349	22,105	36	7%
4B CEM	10	30	291	29	9%
4N0X1	3,177	6,244	152,809	48	7%
4N CEM	36	150	1,069	30	10%
4M0X1	256	604	9,863	39	8%
4M CEM	3	8	40	30	5%
4V0X1	97	163	2,352	24	4%
4V CEM	2	10	62	31	8%
4E0X1	678	1,277	24,249	36	7%
4E CEM	8	42	356	44	12%

This is just one snapshot of information to help show how busy you folks are! As I come across statistics and demographics where I can break down the Team Aerospace data and show it easily, I include them in this section of the newsletter. Thanks for all of your hard work and dedicated contributions to our important mission!

Chief Strout