LOGISTICALLY speaking
July—Sept. 2018 Issue

Naval Medical Logistics Command's Area Senior Sailor of the Year Trip to Annapolis, Maryland Oct. 11, 2018

Naval Medical Logistics Command hosted Area Senior Sailors of the Year during a week of activities that featured a trip to the United States Naval Academy (USNA), Annapolis, Md. Events were a lead-up to the announcement of the selectee that would go on to compete in the next higher level of competition.

Annually, Navy commands identify their sharpest Sailors and nominate them to participate in a rigorous screening process that ultimately names one of them as the Senior Sailor of the Year. Naval Medical Logistics Command held its competition this Oct. 12. HM1 Anaberta Benitez represented Navy Expeditionary Medical Support Command (NEMSCOM), Williamsburg, VA. HM1 Alejandra McKeever represented Naval Ophthalmic Support and Training Activity (NOSTRA), Yorktown, VA. HM1 Joshua Scherrer represented Naval Medical Logistics Command (NMLC), Frederick, MD. "Not only are these individuals pillars of their command, their performance throughout their Naval careers have been stellar," said Capt. Tim Richardson, NMLC's Commander. "They were not selected merely on one year's performance. Their performance has been sustained year after year." Learn who was selected as the NMLC AOR Senior Sailor of the Year on page 22.

LOGISTICALLY speaking

Williamsburg, Va. - In this video clip, Capt. Michael Kemper, Commanding Officer, Navy Expeditionary Medical Support Command describes the 24-Bed Air Beam Tent evaluation. Capt. Tim Richardson, Commander, Naval Medical Logistics Command introduces and narrates the video. (U.S. Navy photo by Mass Communication Specialist 3rd Class Pat Morrissey. Video support provided by Navy Public Affairs Support Element EAST).

Navy Expeditionary Medical Support Command (NEMSCOM), Williamsburg, VA, provides comprehensive, shore-based medical support to U.S. and allied forces in the event of contingency operations anywhere in the world. It is responsible for designing, procuring, assembling, pre-positioning, storing, maintaining and providing life cycle support for EMFs. This global involvement allows NEMSCOM to support combatant commanders with the right medical resources through configured expeditionary medical logistics capabilities tailored to meet clinical missions.

Click on this link to start video

As the Navy Medicine center for logistics and procurement expertise, we deliver world class medical readiness and logistics solutions to military missions. Naval Medical Logistics Command's vision is - *We will become DoD's premier medical logistics support activity.*

On the Cover: SOY Week

Pictured from left to right are HMC Xavier Perezmendez, NMLC Command Master Chief HMCM Patrick West, Naval Health Clinic Annapolis Executive Officer Capt. Martin Kerr, Naval Health Clinic Annapolis Commanding Officer Capt. Kimberly Davis, NEMSCOM nominee HM1 Anaberta Benitez, HMC Chad Sinclair, NOSTRA nominee HM1 Alejandra McKeever, NMLC Junior Sailor of the Year, HM2 Jason Berube, NMLC nominee HM1 Joshua Scherrer, NEMSCOM Senior Enlisted Advisor HMC Melchor Larua, YNC Tillie Martinez, LSC Dexter Devonish, HMC Nevilin Davis, HMC Tony Manasrangsi, HMCS Cassandra Townsend, HMC Neville Facey, HMCS Kristina Goff and HMC Jorge Salas.

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Capt. Tim Richardson

Commander, Naval Medical Logistics Command

Can you believe I just surpassed my one year mark here at Naval Medical Logistics Command? It's been an incredibly rewarding experience and I can only imagine what 2019 will hold for the Navy Medicine enterprise as we navigate changes mandated by the FY 2019 National Defense Authorization Act. Throughout these changes, the incredible value our workforce provides that directly impact readiness is the one constant that has always remained unchanged in all that we do.

In this issue of *Logistically Speaking*, we highlight some of the people who help us achieve our mission to deliver patient-centered logistics support to military medicine.

Allow me to first welcome Rear Adm. Tina Davidson, Commander, Navy Medicine Education, Training and Logistics Command as our new Immediate Superior in Command. She visited us at Fort Detrick, MD, and later, she returned to visit Navy Expeditionary Medical Support Command, Williamsburg, VA, and Naval Ophthalmic Support and Training Activity, Yorktown, VA. Highlights of her visit are on page 6.

From our Operational Forces Support Directorate, Mrs. Erica Hunter spent the month of September on *USS Dwight D. Eisenhower* (CVN 69) providing On-site Installation Coordinator support as new X-ray equipment was installed aboard the ship. An overview of how NMLC helped ensure Ike maintains its shipboard readiness is highlighted through pictures on page 10.

Two NMLC Biomedical Equipment Technicians put to sea during this last period as well. HM2 Joseph McLaughlin of NMLC's Medical Equipment and Logistics Support Directorate and HM2 Jason Berube of NMLC's Operational Forces Support Directorate went to sea for their first time on USS Kearsarge (LHD 3). Read about their experiences in this candid interview featured on page 12.

Since 1990, Navy Medicine has used the Defense Medical Logistics Standard Support (DMLSS), however, as technology evolves, we must follow the evolution and have a core logistics system that is innovative, intelligent and integrated. DMLSS is currently undergoing a technical refresh and the replacement system, LogiCole, is being developed. Read all about it in our technical feature section on page 16.

For our history buffs, this issue features another contribution by BUMED's Historian, André B. Sobocinski, entitled Attaining Mobility: The Establishment of Navy Fleet Hospitals in World War II. You will really enjoy this feature.

Another feature you should review starts on page 26 and it describes the Expeditionary Medical Facility Assemblage Review. You had questions. We have answers.

One of our most important sections is 'Our Greatest Resource is Our People.' Here, you will see some of the movers and shakers that make everything we do possible and successful.

We touch on a lot of topics in this issue and we remain receptive to your suggestions. Reach out to my PAO to share your ideas. As always, I hope you enjoy this issue of *Logistically Speaking*. **LS**

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Deputy Commander
HMCM(SS/SW/FMF) Patrick B. West
Command Master Chief
Dr. Darin L. 'Cal' Callahan
Chief of Operations

Cmdr. Matthew P. Marcinkiewicz
Director for Administration
Lt. Cmdr. Kathleen A. Colter
Dir, Medical Equipment/Logistics Support
Lt. Cmdr. Robert Y. Barragan II
Dir, Resource Management
Mr. Richard J. Schlegel
Dir, Operational Forces Support
Mr. James E. Watkins
Director, Acquisition Management

Mr. Julius L. Evans
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Articles should be submitted to:
The Public Affairs Officer

LOGISTICALLY *speaking*

From the Command Master Chief

HMCM(SS/SW/FMF) Patrick West
NMLC Command Master Chief

Choosing your next assignment can be an exciting opportunity to increase your leadership opportunities and to step out of your comfort zone to enable you to be more competitive for promotion.

I will share how I believe the Career Management System (CMS) and Interactive Detailing (ID) can work for you. The three phases of CMS -ID important to you are:

1. Application Phase – you select your top five duty stations;

2. Command Phase – the command you are applying to reviews your data and makes recommendations to the detailer; and

3. Selection Phase – the detailer decides on where you go next.

The most important thing you can do for your career is to be the best Sailor you can be in the performance of your duties. During the Command Phase, the Command Master Chief (CMC) can review part of the applicant's personnel record. Although the CMC cannot distinguish the race, gender or identity of the applicant; they can see past promotion recommendations, career history, and PFA scores.

To give you an example: if Sailor A is performing at a high level and Sailor B is doing the bare minimum, the CMC will most likely select Sailor A since the command would benefit from Sailor A's initiative, quality of work and professional expertise. Another example may be that Sailor A is applying for a job but has a continuous record of scoring Marginal or Good Low on all physical fitness tests, however Sailor B has a continuous record of scoring Excellent High.

The CMC would probably be inclined to select Sailor B because they have a history of staying in shape and would be less of a risk to go on FEP or worse, a PFA failure.

If you are in Exceptional Family Member Program category 4 or 5, contact your detailer 13 months prior to your Projected Rotation Date to begin negotiation for your next duty assignment. I hope that the information I have just given you will enable you understand how CMS-ID works and how it can benefit your career.

One of my number one priorities as the Command Master Chief is to seek out professional development opportunities for our Sailors. Affording HM2 Jason Berube and HM2 Joseph McLaughlin the opportunity to get shipboard experience is a win-win for both NMLC and the USS Kearsarge.

First, it gives our Sailors an invaluable experience in medical equipment repair at sea.

Second, it allows our Sailors to participate in the day-to-day operations of a shipboard medical department. The ship benefited from NMLC Sailors being able to provide additional support to assist the ship's crew with troubleshooting and repairing lifesaving equipment.

If you have any questions on this or my previous topic, please contact your Command Career Counselor, Your Leading Chief Petty Officer or me for more information. **LS**

HM2 Joseph McLaughlin of NMLC's Medical Equipment and Logistics Support Directorate and HM2 Jason Berube of NMLC's Operational Forces Support Directorate put to sea for their first time on USS Kearsarge (LHD 3). Read about their experiences in their candid interview featured on page 12.

Next Generation Expeditionary Medical Facilities on Display at NEMSCOM

From left to right HMCM Patrick West, NMLC Command Master Chief; Capt. Tim Richardson, NMLC Commander; center, Rear Adm. Tina Davidson, Commander, Navy Medicine Education, Training and Logistics Command; Rear Adm. Bruce Gillingham, Director, Medical Resources, Plans and Policy, N0931, OPNAV; Capt. Michael Kemper, Commanding Officer, Navy Expeditionary Medical Support Command (NEMSCOM); and HMC Melchor Larua, NEMSCOM Senior Enlisted Advisor.

By Mass Communication Specialist 3rd Class Patrick Morrissey, NPASE East Public Affairs

Sailors from Navy Expeditionary Medical Support Command (NEMSCOM) conducted a field exercise at Naval Weapons Station Yorktown-Cheatham Annex, Sept. 10. This field exercise validates the new design for a 24-bed Air Supported Temper (Air Beam) tent-based Expeditionary Medical Facility (EMF), when traditionally a 10-bed EMF was used.

"The purpose of today's event is to display the next evolution of our expeditionary medical facilities," said Capt. Michael Kemper, NEMSCOM's Commanding Officer. "The units are modular, scalable and tailored for any type of mission."

NEMSCOM provides comprehensive, shore-based medical support to U.S. and allied forces in the event of contingency operations anywhere in the world. It is responsible for designing, procuring, assembling, prepositioning, storing, maintaining and providing life cycle support for EMFs. This global involvement allows NEMSCOM to support combatant commanders with the right medical resources through configured expeditionary medical logistics capabilities tailored to meet clinical missions.

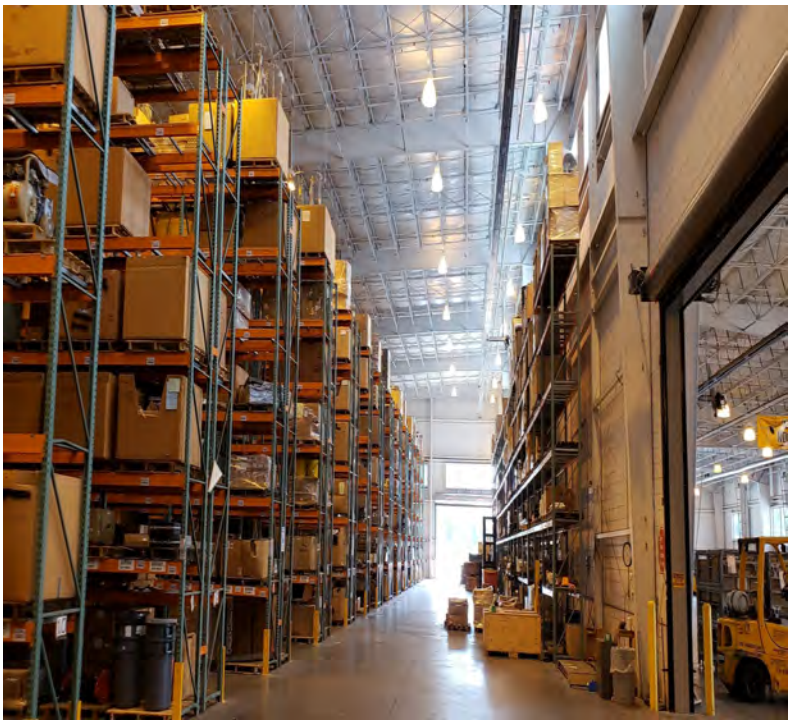
"The U.S. Navy Surgeon General's number one priority is readiness," said Capt. Tim Richardson, Commander, Naval Medical Logistics Command (NMLC), homeported in Fort Detrick in Frederick, Md. "The units can be

set up ahead of time or in a short time frame to provide medical care to the front lines."

NEMSCOM's mission is to plan and execute the design, acquisition, assembly, integration, storage, shipment, maintenance, and life-cycle support of Navy deployable medical systems and acts as a technical advisor for deployment of these assets. **LS**

Top, staff briefing on the 24-Bed Air Beam tent in the NEMSCOM conference room; middle left, William McHenry explains the layout to Rear Adm. Gillingham and Rear Adm. Davidson; middle right, model layout of the facility; bottom, William McHenry and Lt. Cmdr. Christopher Washington explain the inner workings and details of the 24-Bed Air Beam tent.

Rear Adm. Tina Davidson, NMETLC Commander, visits NMLC Area of Responsibility



Top; William McHenry of NEMSCOM explains positioning of the Air Beam Supported Tent structure to Rear Adm. Gillingham while others listen in. Bottom; the group tours the NEMSCOM warehouse. (U.S. Navy Photos by Mass Communication Specialist 3rd Class Pat Morrissey/Released).

(U.S. Navy Photos by Mass Communication Specialist 3rd Class Pat Morrissey/Released).

Top; NMLC Command Master Chief HMCM Patrick West; NMLC Commander, Capt. Tim Richardson; NMETLC Commander, Rear Adm. Tina Davidson; NOSTRA Commanding Officer, Capt. Richard Zeber and NOSTRA Executive Officer Cmdr. Brian Engesser. Right, in the NOSTRA conference room, Rear Adm. Davidson addresses the group. Middle left, Capt. Zeber describes the process by which a block is attached to a lens, assuring the correct prescription will be cut into the lens. Middle right, Rear Adm. Davidson admires the new eyewear frames. Bottom left, Capt. Zeber describes a piece of manufacturing equipment known as an edger. The edger is the machine that physically cuts the shape of the lens that will be inserted into the frame. (U.S. Navy Photos by Mass Communication Specialist 3rd Class Pat Morrissey/ Released).

Naval Medical Logistics Command Op
Assists USS Dwight D. Eisenh

Naval Medical Logistics Command (NMLC) through its Operational Forces Support Directorate headed by Mr. Richard Schlegel, is responsible for providing Class VIII medical material life-cycle logistics services to the naval Fleet Operating Forces.

This role directly supports fleet forces operational readiness.

The directorate has the sincere duty to address the needs of operational fleet forces by advocating 'end to end' supply chain management of Class VIII medical materials world-wide ensuring, "medical gear is at the tip of the spear," a slogan that had been with the cadre of professional civilian and military personnel who take their mission to heart.

In September, NMLC dispatched an On-site Installation Coordinator (OSIC) in support of the contractor installing Medical Digital Radiography X-Ray Equipment aboard *USS Dwight D. Eisenhower* (CVN 69).

The ship is undergoing a Planned Incremental Availability (PIA) at Norfolk Naval Shipyard during the maintenance phase of the Optimized Fleet Response Plan (OFRP).

PORTSMOUTH, Va. (Aug. 14, 2018) Erica Hunter, left, the Naval Medical Logistics Command On-site Installation Coordinator, talks to Hospital Corpsman 3rd Class Cody Budd, from Council Bluffs, Iowa, and Mike Denoto, a customer support engineer, aboard the aircraft carrier *USS Dwight D. Eisenhower* (CVN 69). The ship is undergoing a Planned Incremental Availability at Norfolk Naval Shipyard during the maintenance phase of the Optimized Fleet Response Plan. (U.S. Navy photo by MCSA Sophie A. Pinkham).

Erica Hunter, left, a logistics management specialist from NMLC, and Mike Denoto, a customer support engineer, work on an X-ray machine aboard the aircraft carrier *USS Dwight D. Eisenhower* (CVN 69). (U.S. Navy photo by MCSA Sophie A. Pinkham).

Erica Hunter was the OSIC. Her primary role was in support of the X-ray equipment updates, both fixed and mobile systems, aboard the ship to support modernization and initial outfitting efforts of equipment and other material allowance requirements. NMLC acts in representation of U.S. Fleet Forces Command and the U.S. Pacific Fleet Surgeon Staff. NMLC helps develop and review approved Authorized Material Allowance Lists (AMAL) and Authorized Dental Allowance Lists (ADAL), which are used in providing everyday shipboard healthcare. For the ship, NMLC was tasked with modernizing the fixed and mobile X-ray systems solutions by moving from a Computed Radiography (CR) to a modern Digital Radiography (DR) systems.

Hunter oversaw the removal of the

perational Forces Support Directorate
hower with X-Ray Installation

Hospital Corpsman 3rd Class Cody Budd, left, talks to Erica Hunter, a logistics management specialist, and Mike Denoto, a customer support engineer, aboard the aircraft carrier *USS Dwight D. Eisenhower* (CVN 69). (U.S. Navy photo by MCSA Sophie A. Pinkham).

CR system solution to be replaced by the DR system solution. She also monitored both the effectiveness and the quality of the Alteration Installation Team (AIT) by assessing their execution of quality assurance, overseeing the AIT work, attending briefs and coordinating with the AIT manager and ship's force to ensure satisfactory completion of the alterations. She worked closely with the Regional Maintenance Center/Naval Supervising Activity (NSA) to ensure the proper integration and installation of the ship changes.

Significant points

There were two major challenges that had to go through immediate remediation and mitigation:

1. The vendor was challenged to provide Navy approved test plan procedures to NSA test/engineering group to obtain the energized gear chit - this caused an unforeseen one-day delay in the install. Hunter was able to work with the test/engineer lead and the contractor to create procedures that would be executed and later signed by the ship's commanding officer.

2. During the testing/calibration of the X-ray table, it was discovered that some of the parts needed to be repaired which the vendor had not identified in their installation procedure. Hunter worked with the AIT and ship's force to gain access and replace the failed parts. This avoided a costly delay to the schedule and it avoided an increase to the budget.

Conclusion

1. Industrial Support and services are still a challenge with this project. There are specific parts of this installation which the AIT and ship's forces cannot be responsible such as welding equipment support rails to the deck which add support to the X-ray table. NMLC needs to continue working to obtaining a solution which closes the gap of industrial service support for any project equipment installation and/or modernization.

2. NMLC's support was vital to any modernization effort as it provided an imperative bridge ensuring there was no gap between communication and work effort to be accomplished by both the ship's forces and the AIT. **LS**

Naval Medical Logistics Command BioMedical Technicians Step Aboard Ship for the First Time

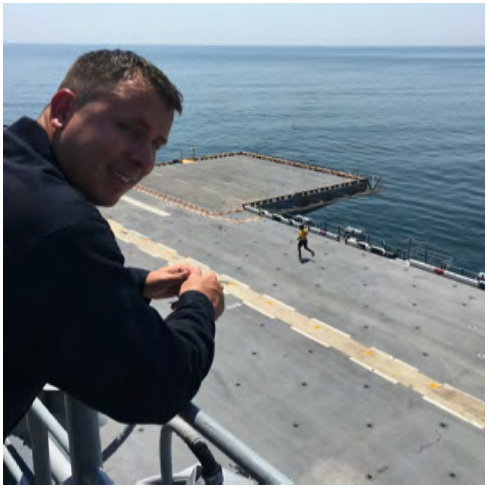
There's nothing more exciting than the first time a Sailor reports aboard a ship. Whether the visit is for a short period of time or whether the Sailor will spend the next several years of his or her life on that ship, the excitement that comes with stepping on the ladder for the first time well, let's just say there aren't many experiences that can top that.

Recently, two Naval Medical Logistics Command Sailors had that exact opportunity. Having spent years in the Navy, neither Sailor had ever been stationed aboard a ship. So, when they got the opportunity, both gladly accepted. Here, they share their experiences and how those experiences might shape their future.

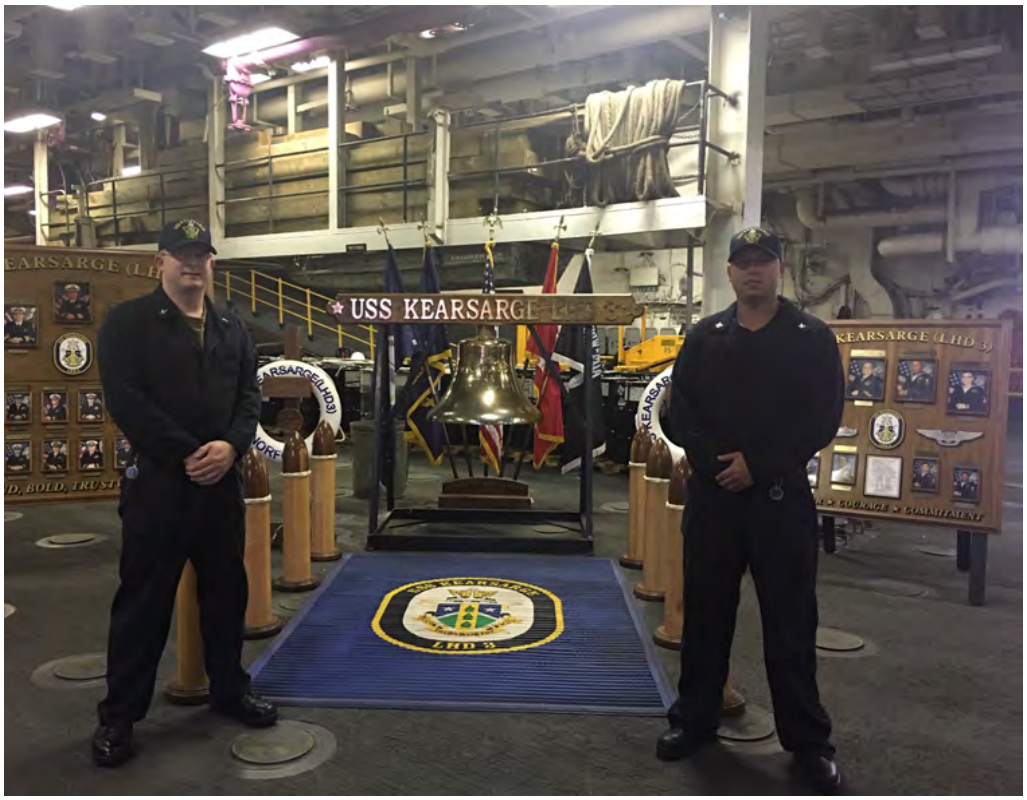
1. To the best of your knowledge can you please tell me how this trip came about and what was the desired result? Was that result achieved?

HM2 Joseph McLaughlin

Being that both myself and HM2 Jason Berube graduated Biomed school prior to reporting to NMLC, we have little to no experience actually working on equipment. I also have never been stationed on a ship so when the Command Master Chief heard this, he wanted to find a way he could to get us time aboard the ship and some biomed maintenance hands-on training. Sending us on this Temporary Additional Duty to the USS Kearsarge (LHD 3) enabled us to get hands on with how a ship really functions at sea as well as the differences of our worksite compared to life on a ship.



HM2 Jason Berube



HM2 Joseph McLaughlin and HM2 Jason Berube stepped aboard ship for the first time when they were assigned Temporary Additional Duties aboard USS Kearsarge (LHD 3) in Norfolk, Virginia. The Sailors are BioMedical Technicians assigned to various duties at NMLC.

HM2 Jason Berube

HMCM West asked me if I wanted to get to go on an underway with the Kearsarge to gain shipboard experience and shadow the shipboard BMET (Biomedical Equipment Technician). Yes the result was achieved.

2. What did you learn and what did they ask you to do?

HM2 Joseph McLaughlin

While with the medical department, we helped with everyday clinic operations and management as well as working with biomeds stationed on the ship. We learned how you complete preventative maintenance and repairs and how to document them and assisted with the installation of oxygen tanks for the intensive care unit. We also learned the nuances of the 3M maintenance program and how critical it was to the ship. We preformed electrical safety inspections and were able to troubleshoot a few devices that happened to go down while on board, including a washing and disinfecting unit and a dental delivery unit. We installed a new wet grinder in the dental lab as well as a buffer for polishing dental devices. We learned how strenuous ship life can be and how Sailors must multitask regularly to be able to juggle their watch standing duties and

primary jobs as well as collateral duties.

HM2 Jason Berube

I learned the 3M maintenance responsibilities and the daily duties of a Hospital Corpsman in the ship's medical department.

3. What are two or three unique things about being on a ship that are experiences you will remember throughout your Navy career?

HM2 Joseph McLaughlin

The ship staff was very motivated and efficient, there was a definite sense of comradery aboard the ship and help was around every corner regardless of their rate or workstation.

There was so many differences between working in a clinic setting and living and working aboard a ship. Sometimes certain supplies and support functions are taken for granted on land that may take months or more to get on a ship and this can affect the mission if not handled correctly and promptly.

HM2 Jason Berube

A unique experience I had on the ship was an alarm for white smoke in one of the berthing areas. As Corpsman, we were dispatched to the location for medical coverage in the event an injury could or had occurred while the DC (Damage Control) personnel or fire locker team investigated the source of the white smoke.

4. Was this your first time on a ship? Do you envision a life at sea in your future?

HM2 Joseph McLaughlin

This was my first experience of ship life and although I was only present for a few days I think the staff of the USS KEARSARGE helped to prepare me for the eventual shipboard orders in my future. Before this TAD I did not think I would enjoy being at sea, but after attending I have broadened my outlook on ship life and I am looking forward to see where my career takes me.

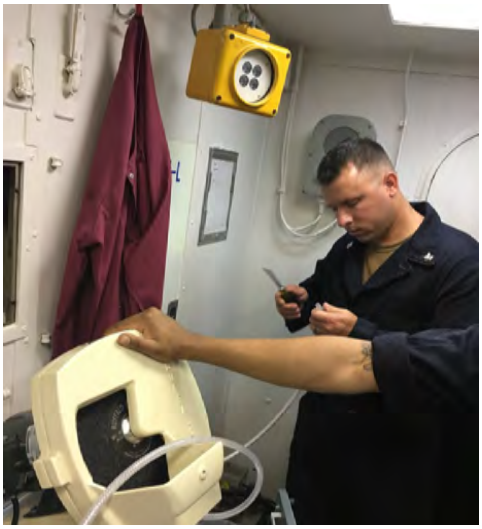
HM2 Jason Berube

This was my first time on a ship while underway. Yes I do envision myself at sea. I will be selecting orders in 3 months and hope to be selected for sea duty onboard an LHA, LPD, LHD or CVN.

5. Were you able to explain what NMLC does for the people you worked with and did you clarify any misconceptions they may have had?

HM2 Joseph McLaughlin

While working with the biomed department we were able to inform the staff that NMLC has many resources that may be hard to come by on a ship. One of the users was having issues with an approved parts list

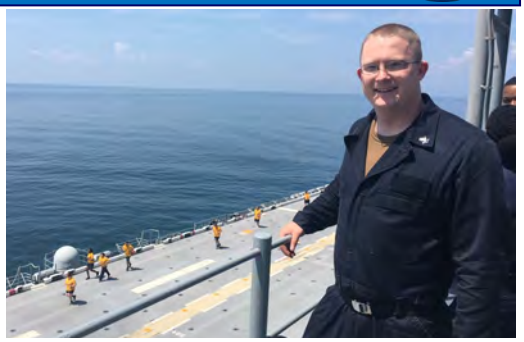


HM2 Jason Berube

not linking up to the system for ordering and we were able to contact Code 04 and rectify the discrepancy immediately and instructed the staff on procedures to find support in the future.

HM2 Jason Berube

Yes I was able to convey what our mission in support of operational forces. They had no misconceptions on what we do.



HM2 Joseph McLaughlin

6. How would you characterize your trip and what would you tell another Sailor how to prepare for a shipboard trip/visit like you recently completed?

HM2 Joseph McLaughlin

Overall, the trip provided an outlook on what everyday life on a ship is like and how biomed techs have to work around their different basic shipboard duties to complete maintenance and procedures. If I was to return to the ship, I would definitely prepare for being busy at all hours, having a book or an electronic device nearby is a nice way to wind down after a stressful project or day. Also, a lot of items you take for granted are hard to get your hands on while at sea, for example snacks, entertainment, as well as some consumables that are not available in the ships store.

HM2 Jason Berube

I would say that this trip was humbling. Seeing how hard and long the Sailors onboard a naval vessel work is something to admire. I look forward to one day being stationed on a ship.

7. Are there any other comments you would like to add?

HM2 Joseph McLaughlin

I believe that operational or shipboard training is essential to all Navy personnel that have not had the opportunity to experience what life is like in a different environment. The training I received will prove valuable when I am looking for sea duty orders and evaluating where to go with my career. **LS**

The Importance of Medical Equipment Scheduled Services

By Hospital Corpsman 2nd Class Joseph McLaughlin, Medical Equipment and Logistics Solutions Directorate

What is the first thing you notice when you walk into a healthcare facility? Is it the landscaping, the color of the walls, or even what program is on the television in the waiting area? There is always a noticeable sense of trust between a patient and the staff of a healthcare facility. Patients put their lives in the hands of the medical/clinical staff and expect to receive nothing less than World Class Medical Care while experiencing the highest degree of patientcare. Experience of clinical and hospital support staff plays a significant role in establishing a safe Environment of Care (EOC) for patient and staff; however, a lot goes on behind the scenes to support a safe environment. For a Medical Treatment Facility (MTF) to function successfully day-to-day, many processes must be established, such as medication dispensing, safe guarding Patient Identifying Information and most importantly, ensuring all medical devices, instruments and equipment that provides the required medical care is available when needed. Several types of equipment can be used by clinicians in the pursuit of a diagnosis and in the treatment of a patient, but who keeps the equipment running? Biomedical Equipment Technicians (BMET) are the ones tasked with the critical responsibility to install, repair and maintain medical equipment and devices and are vital to ensuring a safe EOC.

When a provider reaches for a medical device, he expects it to be fully operational per the Original Equipment Manufacturers (OEM) specifications. Although you as a patient or clinician may not think much of the maintenance status of the equipment, it could easily effect the well-being of yourself or even the staff treating you. Ensuring equipment is properly maintained decreases the risk of downtime, reduces wear and tear on the unit, enables the facility to see more patients, and spend less on repair parts or consumables, but most importantly it can reduce the risk of a patient or staff injuries, death or other misfortunes. If you think changing the oil in your car's engine is important, then think about how important it might be to check the battery pack on an Automated External Defibrillator (AED) used to resuscitate a patient in Cardiac Arrest. If not checked regularly for functionality it may not provide an adequate shock when it is needed causing adverse reactions, serious injury or even death. It may seem tedious at times to check an O-ring for wear, or to put a drop of oil on a hinge but ultimately any discrepancy can pose a potential risk. A piece of equipment used to treat a patient with expired maintenance contributes to an unnecessary risk and is unacceptable and creates additional work for staff as well as increases the risk of a possible mishap. Next time you are in a MTF waiting for the provider, take a look around at the room and take notice of the equipment in the room. You may notice Preventative Maintenance (PM) stickers indicating that the devices have been verified by a BMET and will be fully operational. To minimize the risk of electrical shock, burns or flying objects and other hazards, each medical equipment is categorized by Risk Level upon completion of a Risk Assessment. The Risk Level of the equipment establishes the maintenance frequency and activities (steps) to complete the assigned PM. Due to the critical nature of Risk Level 1 medical equipment, only a qualified BMET(s), Field Service Engineers from the OEM, or authorized third party repair, may perform necessary repairs or maintenance on Risk Level 1 equipment.

Authorized non-BMETs should only be allowed to maintain/repair items of Risk Level 3-4 "Low Risk to No Significant Risk" Level equipment. Maintenance and repair of High Risk to Medium Risk Level equipment must only be performed by a qualified BMET or qualified service support contract. All maintenance and repair, regardless of risk level, completed by a non-BMET must be verified and documented in DMLSS by a qualified BMET.

Risk Level 1 equipment is considered the most critical due to the nature or its intended use, life support, resuscitation, or monitoring of a patient that can cause death in the event of malfunction. Risk Level 2 or "Medium-Risk" is medical equipment and other essential devices if fail, can cause a significant impact of patient care but is not likely to cause a direct injury. Risk Level 3 or "Low-Risk" identifies any medical equip-

HM2 Jason Berube of Naval Medical Logistics Command's Operational Forces Support Directorate performing preventative maintenance on a psychological monitor aboard USS Kearsarge.

ment that could potentially fail and is unlikely to cause serious injury. The lowest is Risk Level 4 or "No Significant Risk" medical equipment, referring to equipment that poses no significant threat of injury to staff or patients.

Assignment of Risk Levels for medical equipment is essential to an MTF, they provide the MTF leadership with necessary information to ensure sufficient resources (BMETs or funding) are available to perform repairs or maintenance, to reduce the risk of equipment malfunctions, to ensure safe operation and use of equipment, and to ensure the devices are available when needed.

There are some major factors that can affect the Preventive Maintenance Completion Rates (PMCR) that needs to be monitored and managed. The number One priority for Maintenance Managers is the completion of Risk Level 1 equipment Scheduled Services (PM) by the 15th day of each month. Due to the criticality of Risk Level 1 equipment, The Joint Commission has established the PMCR Standard for Risk Level 1 equipment to be 100% completed/addressed. BUMED acceptable PMCR for Risk level 2-4 equipment is 90%; however, a goal of 96% should be sustained by the MTF to ensure the clinicians are ready to provided day to day medical care without any unforeseen equipment failures. If an item cannot be located or classified as "Unable to Locate" (UTL) in order to complete the Preventive Maintenance; it is essential that a thorough search of the MTF is conducted to avoid any unconscious use by clinical staff.

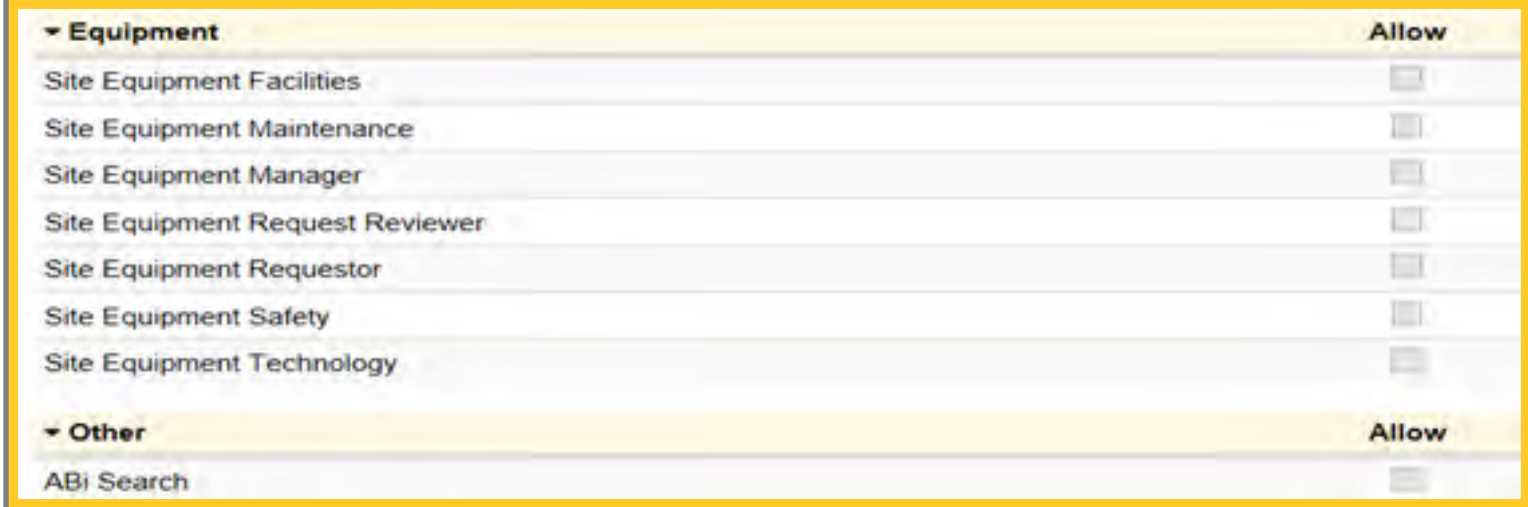
If a Risk Level 1 device is UTL, a DD200 "Financial Liability Investigation of Property Loss" form must be initiated by the Responsible Officer (RO) of the equipment and signed by the Appointed Command Equipment Manager prior to canceling the Scheduled Service work order. It is imperative to never cancel a Risk Level 1 Scheduled Service work order for UTL equipment before the PM is completed or a completed DD200 is received.

As you can see equipment maintenance and the processes involved play a large part in the operation and readiness of a medical treatment facility. Effective PM can reduce the risk of a mishap or interruption of patient care. So next time you visit your primary care provider or other healthcare facility, remember that there is always someone behind the scenes making sure that the devices to be used to treat you are in good working order, so that you will receive World Class Medical Care. **LS**

Log Talk print blog ... LogiCole - *An Application of the Defense Medical Logistics Enterprise*

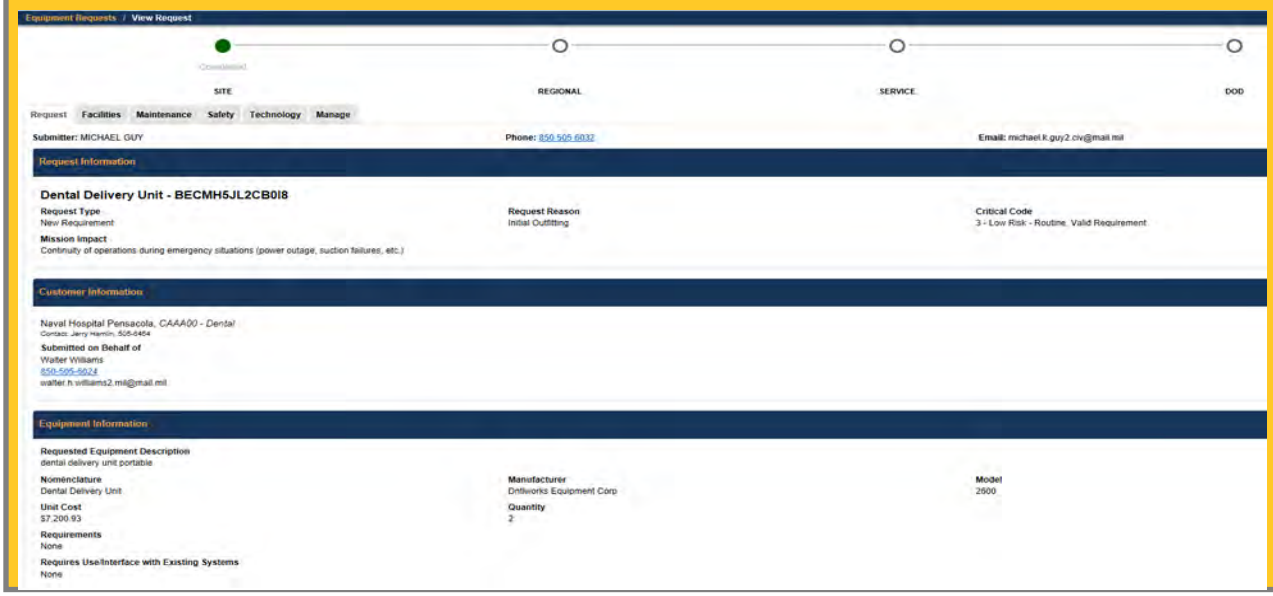
Since 1990 Navy Medicine has used the Defense Medical Logistics Standard Support (DMLSS), however, as technology evolves, we must follow the evolution and have a core logistics system that is innovative, intelligent and integrated. DMLSS is currently undergoing a technical refresh and the replacement system LogiCole is being developed. LogiCole will consolidate DMLSS, Joint Medical Asset Repository (JMAR) and Theater Enterprise Wide Logistics Systems (TEWLS) into one system. It will be a highly flexible, loosely-coupled and cloud-based technology stack that is scalable and proactive while remaining highly cohesive to offer powerful logistics management capabilities. Users access the full suite of medical logistics capabilities via the web from anywhere in the world using a single log-in page.

Capabilities are presented in a web based style storefront with highly intuitive and integrated processes. The approach to this tech refresh applies a more flexible agile Enterprise Resource Planning (ERP) construct that has a postmodern-ERP. A postmodern-ERP moves beyond the monolithic, off-the-shelf ERP solutions of the last two decades balancing the benefits of vendor-delivered integration against business flexibility and agility. This new logistics system will bring improved business agility, real time analytics, enterprise data integrity, and reduced variance in business processes. NMLC Logistics Business Systems (LBS) will parallel the pace of industry innovation and clinical change to better help our customers and clinicians that provide patient care.



LogiCole – Where we are Today
Access Management Access Managers are introduced in LogiCole and perform the same functions as DMLSS System Administrators.

Due to the elevated privileges assigned to Access Managers, LBS will approve and create these accounts. All required Access Managers will be required to submit an approved OPNAV 5239/14 and requisite training certificate's to be maintained at NMLC LBS. Access Managers are responsible for maintaining approved OPNAV 5239/14 SAAR-N and related training documentation for each local user created. Additionally, Access Managers are responsible for creating LogiCole user profiles prior to sending as an individual or group invitation. As in DMLSS



ABi Search / Related Site Records

Selected Product:

Description: Tape Surgical 10ydx3in 3m Durapore Cloth Hypoallergenic Water Resistant Bidirectional Tear Latex Free White

Manufacturer: 3m Healthcare

Enterprise Product Identifier: 00707387007447

Manufacturer Catalog Number: 1538-3

Packaging Description: Case of 10 Box of 4 Roll

Product's Related Site Records

Site DODAAC	Site Name	Item ID	Long Item Description	Manufacturer	Manufacturer Catalog Number	National Drug Code (NDC)	Primary Supplier Name	SOS Type Code	Annual Order Cost	Annual Order Count	Price	Packaging
N48246	USNS Comfort (T-AH 20)	1538-3	TAPE SURGICAL ADHESIVE DURAPORE SILK LIKE CLOT...	3M	1538-3		ROF PRIMARY - CARDINAL HEALTH	DPV	$0.00	0	$5.93	BX/4
N46246	USNS Comfort (T-AH 20)	15383	TAPE SURGICAL ADHESIVE DURAPORE SILK LIKE CLOT...	3M	1538-3		ROF PRIMARY - CARDINAL HEALTH	DPV	$0.00	0	$82.81	CS/40
N61337	Naval Hospital Beaufort	450915383D	TAPE SURGICAL ADHESIVE DURAPORE SILK LIKE CLOT...	3M	1538-3		ROF PRIMARY - OWENS & MINOR	DPV	$241.00	3	$60.32	CS/40
N61564	U.S. Naval Hospital Guantana...	4509-015383	TAPE SURGICAL ADHESIVE DURAPORE SILK LIKE CLOT...	3M	1538-3		ROF PRIMARY - OWENS & MINOR	DPV	$103.00	2	$17.21	BX/4
N62645	Naval Medical Logistics Com...	6510009268804	TAPE SURGICAL ADHESIVE DURAPORE SILK LIKE CLOT...	3M	1538-3		POE FISC SAN DIEGO	DLA	$0.00	0	$10.12	PG/4
N66094	Naval Health Clinic Cherry Point	1538-3*	TAPE SURGICAL ADHESIVE DURAPORE SILK LIKE CLOT...	3M	1538-3		ROF PRIMARY - CARDINAL HEALTH	DPV	$94.00	7	$6.92	BX/4

today, roles assigned to a user's profile should be limited based on business needs. Each profile contains a Profile Name, Profile Expiration Date, First and Last name, email, phone number and reason for access. Each LogiCole profile can be given access to a specific level of Service (NMLC), Region (NMW/NME) or Site (MTF).

New Equipment Request (NER)

LogiCole is currently in Alpha Testing with the New Equipment Request at 4 MTF's: NH Bremerton, NH Pensacola, NHC Camp Lejeune and NMC San Diego. Originally, Equipment Requests and supporting documentation were physically routed between departments and higher level approvers. This routing increased processing times and risk of requests being misplaced. LogiCole improved the efficiency of the process, allowing all coordination to be achieved electronically in a single system. The LogiCole NER functionality will allow users the capability to submit and track digitized equipment requests where the site, region and service level review and approval can performed entirely online. The LogiCole NER has also been simplified and is more user friendly. The current DMLSS NER is being transitioning from 14 tabs to 6 tabs in LogiCole with all required information found on a single page.

Moving forward, we are pursuing replicating the 6700/12/13, sending email notifications and capturing electronic signatures. In its end state users will create an NER, attach supporting documentation and acquire the required approvals at the MTF level. If the NER requires regional approval, the NER can be electronically routed to the respective Region. The Region will then review and or approve the NER and submit for higher (Service/NMLC) approval if required. Once the NER is fully approved it will be electronically sent to DMLSS where it can be funded and procured.

Additional functionality being introduced in LogiCole is ABi. The goal of ABi is to be the authoritative master view of catalog data for the DoD Healthcare Supply Chain. It will provide a single enterprise-level avenue to information systems. ABi is not an acronym, but a unique name for a capability that's more than an enterprise catalog search engine. ABi addresses the challenges of authoritatively identifying medical products and supplies. It is central to improving medical logistics interoperability with clinical systems and trading partners in and outside the DoD. ABi is an evolving IT capability using authoritative data to enable highly reliable logistics business process. The potential benefits of ABi are enterprise operations, sourcing standardization, DoD buying power, agile supply chain and business intelligence. ABi does inherit data from commercial sources and DLA's Medical Master Catalog and identifies 50,000+ medical items.

ABi's goals are to bring uniformed, authoritative, enterprise item master view of catalog data across the DoD healthcare supply chain. It also intends to provide a single, enterprise level, item master to information systems such as MHSS Genesis. The design of ABi is the ease of access and ease of use by non-logisticians.

Where We Go From Here

LogiCole is being designed and developed to direct the DoD to operate medical logistics business in a parallel manner with no service specific coding. Each current DMLSS module is being redesigned and the services have been tasked with provided SME representation during LogiCole "White-Boarding" sessions which currently covers Purchasing, Inventory and Warehousing, Finance and Organizational Structure. Functionality will be incrementally introduced with LogiCole scheduled to be fully implemented across DoD by spring of 2021.

Additional Resources

Additional resources for LogiCole can be found on the Joint Medical Logistics Functional Development Center (JMLFDC) LogiCole milSuite page. This site contains step-by-step guides, training videos, LogiCole release notes, FAQ's and much more: https://www.milsuite.mil/book/groups/LogiCole/pages/logicole-home.

LogiCole eLearning can be found on the Joint Knowledge Online (JKO) site: http://jko.jfcom.mil. Please use the keyword LogiCole to locate applicable courses.

As new LogiCole eLearning courses are created they will be add to this site. **LS**

Attaining Mobility: The Establishment of Navy Fleet Hospitals in World War II

By André B. Sobocinski, Historian, BUMED

"Mobility as a characteristic of hospitals has always been elusive."
~Rear Adm. Lucius Johnson, MC, USN, 1945

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World War II posed many new challenges for Navy Medicine. Chief among them was how to ensure the continuum of care for combat personnel serving throughout Pacific. Navy Medicine's response to the quandary was the Fleet Hospital.

The Navy first began experimenting with the fleet hospital concept as early as 1940. Dubbed simply Mobile Hospital No. 1, the Navy's first fleet medical facility was assembled at the Navy Medical Supply Depot in Brooklyn, N.Y., (currently, Naval Medical Logistics Command, Fort Detrick, MD, headed by Capt. Tim Richardson), packaged in an assortment of "barrels, bales, boxes and crates," and shipped to Guantanamo Bay, Cuba. Over a period of two months, Hospital Corpsmen assigned to this "experimental hospital unit," sorted the material and assembled the series of buildings. As Navy physician and medical observer Cmdr. Thomas Magath would remark, "Probably the most interesting part of the whole experiment was to observe the efficiency of the hospital corpsmen. Not only was he able to be a good mechanic, electrician, or plumber, but he was able to clear the land of virgin brush, lay water lines, erect shower baths, build concrete foundations for buildings and, of course, carry out with usual naval proficiency laboratory and operating room techniques and general nursing care."

As it had been originally conceived, the mobile hospital was Navy Medicine's answer to the "do-it-yourself" Sears Catalog Home of the 1920s and 30s. And as would be the case throughout the war, all medical

personnel assigned to the mobile medical facility were responsible for construction and its maintenance.

In an article published *The Naval Medical Bulletin* in 1941, Mobile Hospital No. 1's commanding officer commented that medical personnel, "have done the work of stevedores,

ditch diggers, cement workers, pipe fitters, carpenters and laborers. . .Our laboratory officer has been in charge of laying water pipes and concrete work. Our x-ray specialist has been in charge of digging latrines. Our psychiatrist has become an expert in planning and erecting shower baths. All sorts of latent talent have been developed. . .”

Designed as a 500-bed facility, Mobile Hospital No. 1 was equipped with a self-contained power plant, refrigeration facilities, a water purification plant, commissary, laundry, galley, x-ray, dental, laboratory, wards, and quarters. The experimental hospital would not only be assembled but dismantled. After months in operation, mobile hospital was broken down, crated and then shipped to Bermuda for reassembly.

In August 1941, the second mobile hospital was commissioned. As was common practice for all Mobile/Fleet Hospitals throughout the war, the facility was again commissioned at the Naval Medical Supply Depot in Brooklyn with assigned medical personnel present and shipped to its point of destination. Assigned personnel would undergo a period of indoctrination in administrative, construction and medical problems, and be trained with the equipment and deciphering the special markings placed on packages and crates containing the building facilities.

Mobile Hospital No. 2 arrived in Pearl Harbor, just weeks before the attack on the naval base. On December 7, 1941, despite still being under construction, personnel attached to the hospital were able to improvise a makeshift facility and assist in the care of 110 casualties.

Deploying Mobile Hospitals to the Pacific

As naval forces moved further west into the Pacific to engage in campaigns at Guadalcanal, Tarawa, and a host of other Pacific battlefields, additional mobile hospitals were established and deployed in quick succession. By the end of 1943, mobile medical facilities had been set up on Samoa, New Caledonia; New Zealand; the Solomon Islands, and Australia. Separate from mobile medical facilities, Navy base hospitals were also established across the great swath of the islands in the Pacific.

Mobile medical facilities and base hospitals differed primarily in the size, location and the relationships with their chains of command. Base hospitals were smaller than mobile facilities, were located at established

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naval bases and the medical officer in charge reported to commanding officer of the base. Mobile hospitals were typically located further from the combat operations, they could be independent commands and their officer in charge reported to the commander of the fleet to which he was attached.

The year 1944 saw the construction of two additional mobile facilities as well as a new designation for them—Fleet Hospitals.[1]

Although the individual structures could vary in size, all mobile hospital buildings were constructed out of prefabricated steel (Quonset Huts), wood and canvas. Established in 1942, Mobile Hospital No. 4 (later known as "Fleet Hospital 104"), in Auckland, New Zealand, was comprised of 98 structures—44 Quonset huts and 55 wooden-framed buildings. Mobile Hospital No. 5 in Noumea, New Caledonia (later known as "Fleet Hospital 105"), was comprised of 55 prefabricated steel structures and just three temporary wooden buildings.

One of two Mobile/Fleet hospitals located on Noumea, New Caledonia, the hospital included CO/XO quarters, nurses' quarters, crew barracks, main hospital and wards, sick officer quarters, a recreation building, galley, laundry, craft shop, chapel and athletic field. The hospital even had its own medical storehouse that furnished supplies to other naval medical facilities in the Pacific.

Mobile Hospital No. 9/Fleet Hospital 109 in Brisbane, Australia, had a printing press which produced a newsletter (called the "The *Mobster*") and a baseball team that for a time even included the likes of professional ballplayers turned Sailors. like Phil Rizzuto.

Treating Casualties

Mobile/fleet and base hospitals successfully hospitalized thousands of patients throughout the war in the Pacific. Patients ranged from battle casualties from Guadalcanal and the Battle of Coral Sea to thousands sidelined by tropical diseases and those suffering from neuropsychiatric breakdowns.

Pharmacist's Mate First Class Charles Stackpoole, assigned to Mobile Hospital No. 7 [MOB-7] in Noumea remembered one Marine who was brought to the hospital who he would refer to in later years as simply "Tommy": "MOB-7 had some pretty bad cases especially when a new beachhead was taken. 'Tommy' was such case. He was struck by a piece of shrapnel, this removed his eyebrow, the bone structure above the eye, and about two plus inches of his skull. The shrapnel must have been hot because he did not bleed a great amount. He was unconscious and passed by as 'dead' on the first sweep. On a more detailed examination his heartbeat was detected [and] he was brought in for care and transport."

Tommy would remain at the mobile facility for weeks. Eventually regaining consciousness, he was transferred to a hospital ship and brought back to the United States where he was treated at the Naval Hospital Bremerton, Wash., before being discharged.

Early in the war malaria proved a significant issue for U.S. forces fighting in the Pacific. Malaria admissions to Mobile hospitals outweighed combat casualties in 1942 and 1943. At Mobile Hospital No. 6 in Wellington, New Zealand malaria had been the primary cause for admission and by March 1943 76 percent of all of patients were being treated for the disease.

In the 2010 HBO series, *The Pacific,* Pfc. Robert Leckie is sent to a mobile medical facility after suffering from nocturnal enuresis caused by combat stress. Combat stress or psychoneurosis was one of the leading causes for admission to mobile medical facilities. In 1943, some 22 percent (2,208) of all patients admitted to Mobile Hospital No. 8 on Guadal-

canal suffered from war-induced psychoneurosis.

To better administer to the needs several of the mobile hospitals were designated for treating certain types of patients. Until 1944, Mobile Hospital No. 4 received most of the neuropsychiatric patients; and Mobile Hospital No. 3, operated as a filariasis center in the Pacific.

The Fact of Mobility

By 1944, patient loads of several of the mobile hospitals/fleet hospitals had dropped drastically. As the war progressed many of these facilities had become further removed from the areas of combat. As a result, several hospitals were either disestablished or dismantled and relocated. Fleet Hospital 109 would relocate from Brisbane to Samar, P.I. where it would be combined with Fleet Hospital 114. Fleet Hospital 104, formerly located in Auckland was moved to Noumea and then Okinawa.

By 1945, Guam would serve as the home of Fleet Hospitals 3 (formerly of Samoa), 111 and 115. Interestingly, after World War II Fleet Hospital 103 would form part of the reestablished Naval Hospital Guam and Fleet Hospital 111 would become the Guam Memorial Hospital.

The problem of mobile medical facilities and base hospitals would be clearly framed by one fleet medical officer serving in April 1945: "Although Fleet and Base Hospitals as presently planned are excellent as to comfort for patients and working conditions for Medical Department personnel, they do possess the distinct disadvantage that they are bulky and require considerable shipping space to transport, and time and effort to establish; even more is necessary to dismantle, refit, and move forward.

In a fast-moving type of warfare over vast distances as had typified operations in the Southwest Pacific, Naval Hospitals have not been capable of receiving casualties until the assault beaches have moved far ahead, often over 1,000 miles. With the consistent shortages of AH's, APH's and APA's in the Seventh Fleet, it had been necessary to resort to hospitalizing naval patients in Army hospitals in many areas. The latter are easily transported and quickly erected, and while they do not afford many of the refinements mobile naval hospitals, they are able to offer excellent early care to casualties at a time when the need is urgent."

The Navy was aware of the limitations of hospital mobility. It is as Rear Adm. Lucius Johnson, one of the fathers of the fleet hospital concept, later quipped: "A point to be remembered is that when a hospital stays in one place for a considerable amount of time it loses its mobility."

By the Okinawa campaign of April 1945, the Navy sought newer, and more mobile medical units called "Special Augmented Hospitals." These would serve as part fleet hospital and part Marine Corps field hospital and designed to bring services like X-ray, surgery, dentistry, laboratory and neuropsychiatry to the frontlines within a matter of weeks. Eight of these hospital units were planned and five of them would be established in Okinawa.

Although fleet hospitals would not be used in Korea or Vietnam, the need for mobile hospitalization for deployed assets would ensure that the concept would not die. In 1976, the fleet hospital program was reborn and over the next decades fleet hospitals would be effectively deployed again and again in support of an assortment of combat and humanitarian efforts covering the globe. **LS**

References:

1. Hospital components arrived on Guantanamo Bay on October 30, 1940. Hospital was fully operation on January 10, 1941.

2. Johnson, Lucius. "Mobile and Base Hospitals." *The History of the Medical Department of the United States Navy in World War II*. Vol. 1 Government Printing Office, 1953.

3. Mobile Hospital No. 1 would soon after be transferred to Bermuda where it became

4. "Mobile Base Hospital No. 1" Johnson, Lucius. "United States Naval Mobile Base Hospital No. 1." *The Naval Medical Bulletin*, October 1941.

5. "Mobile, Base and Special Augmented Hospitals." U.S. Navy Medical Department Administrative History, 1941-1945. Volume II: Organizational History, Chapters X-XVI. 1946 (Unpublished).

6. On June 8, 1944 All Mobile hospitals were redesignated Fleet Hospitals.

7. By war's end on September 2, 1945, some 16 Fleet Hospitals had been in commission during the war.

8. Stackpole, Charles. U.S. Navy Mobile Hospital # 7 (Later Renamed Fleet Hospital # 107), 15 April 2002.

9. "Mobile, Base and Special Augmented Hospitals." U.S. Navy Medical Department Administrative History, 1941-1945. Volume II: Organizational History, Chapters X-XVI. 1946 (Unpublished).

10. Ibid.

11. Ibid.

12. Johnson, Lucius. "Mobile and Base Hospitals." *The History of the Medical Department of the United States Navy in World War II*. Vol. 1 Government Printing Office, 1953.

Navy Birthday and Sen

Rear Adm. Mary C. Riggs, Director, Research and Development (J-9), Defense Health Agency was NMLC's special guest speaker during the Navy's 243rd Birthday celebration.

Rear Adm. Riggs, OS2 Robin Peskin and Cmdr. Steve Romero cut the Navy Birthday cake.

Story and Photos by Julius L. Evans, NMLC Public Affairs

Naval Medical Logistics Command (NMLC) celebrated the Navy's 243rd Birthday in a ceremony held at Fort Detrick, Frederick, MD. Oct. 12.

Rear Adm. Mary C. Riggs, Director, Research and Development (J-9), Defense Health Agency was the special guest speaker. The celebration was held in conjunction with NMLC's Area of Responsibility Senior Sailor of the Year ceremony.

Capt. Tim Richardson, NMLC's Commander, welcomed the attendees and then turned the program over to HM1 Joseph Toms, the Master of Ceremonies.

Various members of the command read birthday letters widely distributed by Navy leaders and then Rear Adm. Riggs, OS2 Robin Peskin and Cmdr. Steve Romero represented the most senior, the youngest and the eldest Navy member present during the cake

HMC Xavier Perezmendez addresses the audience during the Navy's celebration of its 243rd Birthday.

HM2 Jason Berube receives recognition from Rear Adm. Riggs during the NMLC Junior Sailor of the Year ceremony.

nior Sailor of the Year

cutting ceremony.

After the cake cutting ceremony, the Senior Sailor of the Year nominees were announced.

The nominees were: representing Navy Expeditionary Medical Support Command (NEMSCOM) was HM1 Anaberta Benitez. Representing Naval Ophthalmic Support Training Activity (NOSTRA) was HM1 Alejandra McKeever. Representing Naval Medical Logistics Command (NMLC) was HM1 Joshua Scherrer. Congratulations on being selected NMLC's AOR Senior Sailor of the Year to HM1 Joshua Scherrer.

NMLC is Navy Medicines center for operational logistics and procurement expertise. It delivers world-class medical readiness and logistics solutions to military missions. NEMSCOM, Williamsburg, VA, NOSTRA, Yorktown, VA and NMLC Detachment Pirmasens Germany all have integral roles in achieving that mission.

Congratulations to all the Senior Sailors of the Year nominees and a special congratulations to HM1 Joshua Scherrer on being selected as the NMLC AOR Senior Sailor of the Year. He now moves on to the Immediate Superior in Command competition to be held at Navy Medical, Education, Training and Logistics Command, San Antonio, Texas.

HM1 Anaberta Benitez, NEMSCOM, HM1 Joshua Scherrer, NMLC and HM1 Alejandra McKeever are NMLC's Area of Responsibility Senior Sailors of the Year nominees. Congratulations to HM1 Scherrer on being selected for the top prize.

SMALL BUSINESS PROGRAMS

WELCOME TO BIZ BUZZ !

Biz Buzz is where you will find what's happening with NMLC's Small Business Program Office, as well as general small business information and news you can use.

What's the BUZZ?

Biz Buzz is where you will find what's happening with NAVMEDLOGCOM's Small Business Program Office, as well as general, small business information and news you can use.

What's the *Buzz?* This edition will be one of a four-part series of informative articles about the various individual socio-economic categories for whom the Small Business Administration (SBA) has dedicated programs. Moreover, these are the same socio-economic categories for which Navy medicine establishes annual goals, tracks performance toward meeting those goals, and reports performance to the Navy Secretary, via the Navy Office of Small Business Programs (OSBP). These categories include, Historically Underutilized Business Zones (HUBZones), Service-Disabled Veteran-Owned Small Businesses (SDVOSBs), Small Disadvantaged Businesses (SDBs), and Woman-Owned Small Businesses (WOSBs).

The first in the series of articles will feature HUBZONE small businesses. It will provide an overview of the HubZone program, it's history and how it originated, the value of establishing this program, and why it's a win-win for all involved.

The "Historically Underutilized Business Zone" or "HubZone" program was officially recognized as its own designation within the Federal small business program with the amendment of the Small Business Act of 1997, under Public Law 105-135. According to the Code of Federal Regulations (13 CFR 126), HubZone is defined as, "a historically underutilized business zone, which is an area located within one or more qualified census tracts, qualified non-metropolitan counties, or lands within the external boundaries of an Indian reservation."

Further, 13 Code of Federal Regulations (CFR) Section 126 states that the purpose of the HubZone program is, "…to provide federal contracting assistance for qualified SBCs [small business concerns] located in historically underutilized business zones in an effort to increase employment opportunities, investment, and economic development in such areas."

In order for a firm to receive this designation, they must apply to the Small Business Administration (SBA) for HubZone certification. The SBA provides detailed information for small businesses to determine if they meet the criteria for HubZone certification – and if so, there is an application process to obtain this certification.

LOGISTICALLY *speaking*

SBA Certified

HUBZone

Historically Underutilized Business Zone

In order for a firm to be HubZone-certified, they must demonstrate to the SBA that "at least 35% of the firm's employees reside in a HubZone, and the HubZone firm must certify that it will attempt to maintain this percentages during the performance of any HubZone contract it receives" (13 CFR 126.200(b)).

Once a firm is HubZone-certified by the SBA, it must re-certify every three years. The SBA maintains a list of HubZone-certified firms and only those firms are eligible for HubZone contracting preferences and awards, to include sole source, and set-aside awards. Additionally, to be eligible for a HubZone contract, the firm must be on the list of certified firms, both at the time it submits its initial offer AND at the time of contract award (as outlined in 13 CFR 126).

Meeting the HubZone goal can be

a challenge to many contracting offices, to include Navy medicine's contracting offices. The type of requirements a particular contracting office receives has a direct bearing on how easily it is to meet target HubZone goals. For example, requirements for multi-disciplinary healthcare staffing services make it difficult to find capable HubZone firms, as firms with these capabilities are seldomly located in a HubZone areas. That notwithstanding, Navy medicine acquisition officials are mindful of conducting sufficient market research to ensure HubZone firms have the maximum practicable opportunity for business where the requirement is better aligned with the HubZone capabilities. New HubZone small businesses are formed every day. In FY17, Navy Medicine East (NME) and Navy Medicine West (NMW) received requirements that enabled both contracting offices to exceed their goal targets for contract awards to HubZone firms; each achieving 2.68% and 3.50%, respectively. The target goal was .86%.

Depending upon the types of acquisitions, some contracting offices are more inclined to match capable HubZone firms to their requirements. Typically, these contracting offices buy base support services (e.g., custodial or landscaping services) or larger systems acquisitions, where there are many subcontracting opportunities for HubZone firms. Recently, the Naval Facilities Engineering Command (NAVFAC) awarded a $12.8 contract to a HubZone small business to construct a storage facility on Andersen Air Force Base, Guam. In addition to the structure, the contractor will provide site improvement services to include interior plumbing and electrical services.

There are currently some pending SBA rules that pertain to HubZone firms. These rules are aimed at reducing regulatory burdens for both the HubZone firms and government agencies, to promote stability with program requirements, and to make the HubZone program a more attractive acquisition strategy for buying activities.

Contract awards that support HubZone firms are a win-win; they strengthen the economy and help to build up areas that have seen a decline, while the government benefits from capable contractors and meeting regulatory goals.

For any questions on this article or if you have any suggestions for future articles, please contact Ms. McReal at Marianna. mcreal.civ@mail.mil.

Expeditionary Medical Facility Assemblage Review

By Lt. David Guajardo, MSC, USN, Medical Logistics Program Office, U.S. Navy Bureau of Surgery and Medicine

Navy Expeditionary Medical Support Command (NEMSCOM) located at Cheatham Annex, in Williamsburg, VA, conducted its first formal Authorized Medical Allowance List (AMAL) review of the Expeditionary Medical Facility (EMF) June 2018. This is a historic event for the command in that it is the first time medical equipment and consumables within the EMF have gone through a thorough clinical review to ensure the current line items meet the EMF's Role 3 capability. The review was led by the Expeditionary Medical Logistics Program Office at Bureau of Surgery and Medicine (BUMED M-42), in collaboration with NEMSCOM, Defense Logistics Agency Troop Support [Functional Executive Agent Medical Support) (FEAMS) and Medical Contingency Requirements Workflow (MCRW) Team], Defense Health Agency (DHA) Medlog Division.

EMF's Mission, Clinical Capabilities & Past Deployments

The mission of the EMF is to provide standardized, modular, flexible Theater Hospitalization and Health Systems Support (HSS) functionality to an advanced base environment throughout the full range of military operations. It is able to support the theater unified commander, joint task force commanders, Marine air-ground task forces, the naval expeditionary group, and forward elements of the Navy, Army, and Air Force units deployed ashore. Although the EMF is designed primarily to support ground-based operations, it can also support concurrent air and maritime operations. The EMF mission is also to provide HSS and civil support care for U.S. government agencies involved in foreign humanitarian assistance and peacetime operations with manning, medical materiel, equipment, and provision tailored according to individual missions. Operations are governed by the principles of the "Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of August 12, 1949."

The clinical capabilities of the EMF include Casualty Receiving, Advanced Laboratory Services, Radiology, Pharmacy, Blood Bank, Intensive Care Unit, Acute Care Services, Operating Room (OR) Surgery [to include: Trauma, Abdominal / Vascular, Urological, Orthopedic, Obstetrics / Gynecology, Thoracic, Eye, Maxillofacial / Otolaryngology, and Neurosurgery], Dentistry, and Preventive Medicine.

This Role 3 capability, in different configurations, has deployed in the past to support major combat operations globally. A brief history of these deployed expeditionary medical facilities include:

Participants review the Authorized Medical Allowance List

1990 - Operations Desert Shield/ Desert Storm Activated Fleet Hospital (FH)-5, Al Jubayl, Saudi Arabia Activated FH-6, Bahrain Activated FH-15, Al Jubayl, Saudi Arabia
2002 - Operation Enduring Freedom
Relocated FH-8, Miesau, Germany
Activated FH-20, GTMO, Cuba
2003 - Operation Iraqi Freedom
Activated FH-5 & FH-8, Rota, Spain
Activated FH-3, Iraq
2009 - Operating Enduring Freedom-Afghanistan
Material/Equipment support and establishment, Kandahar Military Hospital

AMAL Review Scope & Background

With assistance from 11 Navy health care providers and technicians, the focus of the review centered on the medical core of the EMF: Casualty Receiving, Operating Room Prep and Hold, Operating Room, Intensive Care Unit and Major/Minor Surgical Sets. Focusing on these assemblages ensured a review of the highest percentage of medical materiel used in the primary flow of patients through the expeditionary hospital. The Subject Matter Experts (SMEs) participating in the review included Emergency Room Physicians, General Surgeons, an Operating Room Nurse, a Critical Care Nurse, a Certified Registered Nurse Anesthetist, an Independent Duty Corpsman (Surface), Surgical Technicians, and a Biomedical Repair Technician. These experts were selected by their Specialty Leaders and Commands due to their expertise in their field and/or their experience with a deployed expeditionary medical unit.

The road leading up to this AMAL review took over a year in development to comprise the best practices used by all Services. In collaboration with DLA Troop Support (specifically FEAMS/MCRW Team), the review processes were conducted and developed through numerous mock reviews at NEMSCOM and with the Marine Corps. Service review processes were approved and modeled with DLA

Troop Support, MCRW Team continuously providing the review leads with MCRW training and support. NEMSCOM staff worked tirelessly in the lead up to provide us with 99% line item health, meaning the National Stock Numbers (NSN) were still valid, making this first AMAL review all the more possible. Since this review was relatively large in scope, two weeks prior to beginning of the review sessions, all attendees were given read ahead material to assist with the familiarity of the EMF and the target assemblages. Read ahead material included: line items listing of each AMAL, Statement of Need, Range of Capability & Projected Operating Environment, and weekly schedule. With the objective of reviewing over 1,515 line items during a five day period, preparation was critical.

Review participants being guided by Mr. Lawrence Caldwell on the use of the Medical Contingency Requirements Workflow (MCRW) tool.

Review Process

After the agenda review and opening remarks by NEMSCOM's Commanding Officer, CAPT Kemper, each line item of the AMAL was identified by the facilitator and opened up for a brief discussion regarding efficacy, quantity, quality, and appropriateness for inclusion in the assemblage, based on the Statement of Need for this core component of the EMF. Discussions included relevance of medical materiel based on current treatment modalities, standards of care, and cube & weight restrictions. Our review process was not looking to modify the capability, but merely to optimize each assemblage. The recommended changes to a line item were documented "live" in MCRW. Each line item in MCRW was assigned a change action for example increase, decrease, add, delete, replace, or research for further action. Alongside these change actions were justifications or reasons these change action recommendations were made such as clinical, redundancy, technology, package change, Navy Standardization, or Joint Standardization. To aid in understanding some of the more complex pieces of medical equipment, NEMSCOM staff were available to provide visual aids to enhance the groups' knowledge. At the conclusion of each day, and again on the final day of the review, attendees complete a verification and validation where last minute recommendations, saved rounds, and mutual agreement to the documented change recommendations were discussed prior to securing to ensure all pertinent information has been captured.

Review Results

During the five days, we were not only able to achieve our initial review objective of 1515 line items, but were also able to surpass it by reviewing additional planned line items as time allowed. In total we reviewed 1572 line items which averaged into 314 line items reviewed per day! This large quantity was in part due to the enthusiasm and intent that the group had on achieving the objective. Mr. Abeya, from DHA Medlog Division, said "it was nice to see the "SMART" approach applied to the review (Specific, Measurable, Achievable, Realistic, and a Timetable. Great process!" This review assisted in identifying opportunities to improve efficiency in some of the AMALs through consolidation. Navy Medicine as a whole embarked on yet another historical accomplishment by being the first Service to complete a formal AMAL review contained entirely in MCRW! The end of the event was highlighted when CAPT Kemper awarded each participant a command coin to commemorate this significant accomplishment.

The Way Forward

While we have successfully achieved our first AMAL review by reviewing 1572 line items this accomplishment while commendable, remains only a start. As a Role 3 capability, the EMF is such a large asset that we still have nearly 18 thousand Class VIII line items remaining to be addressed! However, we have are developing a new process to further reduce line items through segregation and prioritization so that the subsequent reviews will be smaller in scope and therefore executable in fewer days. Future AMAL reviews will be included in the BUMED Training Effective Evaluation Plan (TEEP) calendar so that the enterprise as whole can plan resources more effectively to this necessary component of operational readiness. The success of this and future AMAL reviews ensures that Navy Medicine optimizes health services globally. **LS**

Our People is the Reas

Naval Medical Logistics Command Deputy Director for Administration Mike Burns wear multiple hats. Not only is he responsible for the command's administrative staff and the command's Emergency Management and Force Protection, during his off duty hours, he is also the Fire Chief for the Upper Montgomery County Volunteer Fire Department. So while he ensure the paperwork at the command is right, he also saves lives.

Congratulations to Kara Williams on receiving a Letter of Appreciation from Capt. Tim Richardson, Commander, Naval Medical Logistics Command.

Congratulations to Heather Clipson on receiving a Letter of Appreciation from Capt. Tim Richardson, Commander, Naval Medical Logistics Command.

HM2 Jason Berube is NMLC's Sailor of the Year, and was presented his award by Capt. Tim Richardson, Commander, Naval Medical Logistics Command.

Congratulations to Jayme Fletcher on receiving a Letter of Appreciation from Capt. Tim Richardson, Commander, Naval Medical Logistics Command.

on for Our Success

HM2 Jason Berube, HM1 Joshua Scherrer and HM2 Joseph McLaughlin after the NMLC uniform inspection in front of the Navy anchor.

Naval Medical Logistics Command presented an incredible Diversity Day sponsored by the Diversity committee. Pictured from left to right are HM1 Joshua Scherrer, Lt. Cmdr. Robert Barragan, Gerardo Delacruz, Lt. Jenny Frasco, Marilisse Gonzalez, NMLC Commander, Capt. Tim Richardson, Linda O'Brien, Phillip Marshall, HM2 Joseph McLaughlin, HMC Neville Facey, HMC Xavier Perezmendez and Richard Taylor.

Our People is the Reas

Congratulations to Lt. Cmdr. Audrey J. Carter, BUMED's Senior Shore-based Medical Logistician of the Year. Presented by Capt. Tim Richardson, Commander, Naval Medical Logistics Command.

Congratulations to HM1 Joshua Scherrer for being selected Senior Sailor of the Year, presented by Capt. Tim Richardson, Commander, Naval Medical Logistics Command.

Congratulations to Benjamin Marcus for receiving a Letter of Appreciation from Capt. Tim Richardson, Commander, Naval Medical Logistics Command.

HM2 Jason Berube is congratulated by Rear Adm. Mary Riggs, Director, Research and Development (J-9), Defense Health Agency on being selected NMLC Junior Sailor of the Year.

Congratulations to Mark Coover, 10 years of service to the Government of the United States of America, presented by NMLC Commander, Capt. Tim Richardson.

Congratulations to Nick Dankanich for receiving a Letter of Appreciation presented by NMLC Commander, Capt. Tim Richardson.

on for Our Success

NMLC Deputy Commander, Cmdr. Steve Aboona, NMLC Commander, Capt. Tim Richardson, NMLC AOR and Senior Sailor of the Year HM1 Joshua Scherrer, Rear Adm. Mary Riggs, Director, Research and Development (J-9), Defense Health Agency and NMLC Command Master Chief HMCM Patrick West at the NMLC 243rd Navy Birthday celebration and the announcement of the SSOY ceremony.

NMLC Commander, Capt. Richardson congratulates Lt. Cmdr. Robert Barragan by presenting his Letter of Appreciation for his participation in Diversity Day.

HM2 Jason Berube, HM1 Alejandra McKeever, HM1 Anaberta Benitez and HM1 Joshua Scherrer at the U.S. Naval Academy in Annapolis, MD, during Sailor of the Year festivities.

Congratulations to Dr. Karen Wartella for receiving a Letter of Appreciation presented by NMLC Commander, Capt. Tim Richardson.

LOGISTICALLY *speaking*

Naval Medical Logistics Command , Fort Detrick, Maryland

In each issue of ***Logistically Speaking,*** the Commander, Naval Medical Logistics Command, sends a note encouraging readers to take time to view the publication. Through the pages of this professional journal, we provide you with a variety of material about Logistics, Logistics Readiness and the professionals who bring those things to you. Now, you will be able to find all things that have to do with ***Logistically Speaking*** in a single location.

Current Issue

Annually, Navy commands identify their sharpest Sailors and nominate them to partici-pate in a rigorous screening process that ultimately names one of them as the Senior Sailor of the Year. Naval Medical Logistics Command held its competition this Oct. 12. HM1 Anaberta Benitez represented Navy Expeditionary Medical Support Command (NEMSCOM), Williamsburg, VA. HM1 Alejandra McKeever represented Naval Oph-thalmic Support and Training Activity (NOSTRA), Yorktown, VA. HM1 Joshua Scherrer represented Naval Medical Logistics Command (NMLC), Frederick, MD. "Not only are these individuals pillars of their command, their performance throughout their Naval careers have been stellar," said Capt. Tim Richardson, NMLC's Commander. "They were not selected merely on one year's performance. Their performance has been sustained year after year." Learn who was selected as the NMLC AOR Senior Sailor of the Year on page 22.

Archived Issues

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NAVAL MEDICAL LOGISTICS COMMAND
PODCAST

A "Ready Medical Force" / A "Medically Ready Force"

I Read Logistically Speaking

Strategic Initiatives FY18

NMLC Recognized at NMBOTS

NMBOTS brings together Navy Medicine's logistics and comptroller experts from around the world -- to share in the learned tools and experiences that help keep patient-centered logistics solutions at the forefront of all that Navy Medicine does for its patients...

NEMSCOM Medical Payload Shelter

Navy Expeditionary Medical Support Command, (NEMSCOM), production facility for the Expeditionary Medical Facility located at Naval Weapons Station Yorktown...