LOGISTICALLY *speaking*

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Naval Medical Logistics Command, Fort Detrick, Md.

Special Section: A Government Civilian in Iraq

NMLC Biomedical Engineer Shines in Assisting with Walter Reed National Military Medical Center Realignment

By Sheila A. Gorman, NMLC

In 2005, under a Base Realignment and Closure (BRAC) recommendation, Walter Reed Army Medical Center and National Naval Medical Center were tasked with merging together as one to be called Walter Reed National Military Medical Center.

As the headquarters for Medical Logistics for Navy Medicine, Naval Medical Logistics Command (NMLC), Fort Detrick, Md., assisted in the integration.

Working on this task since 2009, Kim Hernandez has been the lead NMLC Biomedical Engineer to oversee the

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NMLC Biomedical Engineer Shines—continued

acquisition of materials necessary for the facilities to merge and open with minimal disruption to services. She received a Letter of Appreciation from NMLC in September to recognize her contribution to the effort.

Before general procurement contracts were in place, some of the smaller departments at Walter Reed were moved to Bethesda causing spaces to be renovated, which required new equipment. Hernandez was responsible for the definition and procurement of not only these smaller department items but also the Long Lead Need (Other Procurement) requirements for this effort.

Soldiers salute as members of the honor guard lower the U.S. flag for the final time at Walter Reed Army Medical Center in Washington, D.C., Aug. 27. Photo Sebastian J. Sciotti Jr., U.S. Department of Defense.

The smaller department items included things such as hampers and vacuum hoods, anything between $3,000 and $15,000.

"These were items we don't usually procure. One of my functions was to try and keep everything standardized, researching what was already on contract with DoD and trying to match the requirement," said Hernandez.

Long Lead Need requirements are described as those items needing either a long lead time to procure or install. This category included equipment such as magnetic resonance imaging systems, computed tomography scanners, angiography suites, and ultrasound imaging.

"One of the more challenging aspects of this task was facilitating communication between all the parties," said Hernandez. "Not everyone was familiar with Navy protocol for acquisition so there was a bit of training involved in the proper processes."

The last patient moved from Walter Reed to National Navel Medical Center in Bethesda on Aug. 29.

"It's been a tough and challenging two years," said Hernandez. "I am happy to see the last patient transferred successfully and this task moving off my plate."

Hernandez received a Letter of Appreciation from the command on Sept. 1 praising her efforts on the Walter Reed National Military Medical Center BRAC/MILCOM/Special Projects outfitting as, "above and beyond all expectations, changing customer attitudes and bringing the group to consensus."

Capt. J.B.'Bernie' Poindexter, III awards NMLC Biomedical Engineer Kim Hernandez a Letter of Appreciation on Sept 1. Hernandez was instrumental in assisting with smaller department items and Long Lead Need requirements for the BRAC transition from Walter Reed Army Medical Center to Walter Reed National Military Medical Center. Photo/Larry Sorcher, Visual Information, Fort Detrick.

Unauthorized Commitments

Kathryn Skowronski, Contract Support Division Team Lead

Joint Logistics and Financial Policy Directive on Unauthorized Commitments

BUMED POLICY

7000 Ser M8/M4/10UM82739

On June 23, 2010, the Navy Bureau of Medicine and Surgery (BUMED) issued Policy 7000 Ser M8/M4/10UM82739 titled "Joint Logistics and Financial Policy Directive on Unauthorized Commitments." This policy supplements FAR 1.602-3, NMCARs 5201.602-3, and NAVSUP Instruction 4200.81E. The NAVSUP Instruction has been replaced by the 4200.81F, however, the Unauthorized Commitment (UAC) guidance has been moved to the 4200.83H which has not yet been approved.

Naval Medical Logistics Command (NMLC) has created a guidebook titled "Ratification of Unauthorized Commitments Guidebook," which gives specific steps for completing a UAC package. The guidebook, as well as the BUMED policy, can be accessed at the NMLC MIL/GOV only webpage under Acquisitions Management, http://www.nmlc.med.navy.mil/.

The contracting officer responsible for processing UACs at NMLC is Kate Skowronski, Kathryn.skowronski@med.navy.mil, who will provide the preliminary decision in regard to the UAC being ratifiable. Once the preliminary decision is reached, the activity Comptroller should send a draft copy of the package to the respective Regional Command and to BUMED Resources Management/ Comptroller (M8) and Installations and Logistics (M4).

For UACs at or below $50,000, the Ratifying Authority is NMLC's Director for Acquisition Management, Mr. Gilbert Hovermale. All UACs above $50,000 will first be reviewed at NMLC and then forwarded to Naval Supply Systems Command (NAVSUP) for approval.

A Government Civilian in Iraq—the story of one volunteer

By Sheila A. Gorman

Not all of today's war heroes wear a uniform, are thanked for their service by passersby, or receive the special honors that military members experience. Nonetheless, without these men and women, who volunteer to put themselves in harm's way assisting in U.S. efforts overseas, the military would be stretched even thinner than it is now.

"I wanted a chance to make a difference." These words, uttered by Acting Director for Medical Equipment and Logistics Solutions (MELS) Margaret Ely, Naval Medical Logistics Command, Fort Detrick, Md., describe her nine-month volunteer tour of duty in Iraq as well as her current choice of career paths.

"I was working behind a desk in a cubicle," said Ely, of her assignment with Naval Supply Systems Command (NAVSUP) in Mechanicsburg, Pa. "I wanted the experience of getting out from behind the desk and doing more hands-on work. When this opportunity came along, I was ready to go."

In 2004, while working at NAVSUP, Ely answered a call to volunteer as a civilian for a temporary duty assignment to assist the Iraqi war effort. She didn't think it was a big deal until then NAVSUP Commanding Officer, Vice Adm. Justin D. McCarthy, SC, USN, now retired, appeared at her cubicle doorway to personally shake her hand, offer her any support he could, and reiterated what a big deal it was for her to volunteer.

Ely said, "I was shocked when he showed up in my cubicle but he was so supportive of my volunteering. He offered to talk to my family about my plans; he knew that would be one of my biggest hurdles.

"My family was reluctantly supportive; they understood, but did not want me to go," said Ely.

Before she left for Iraq, each member of Ely's family gifted her with a token; a cross, a favorite baseball cap, a special ring; each had a special meaning from the family member that bestowed it and brought thoughts of her family when she was in Iraq.

Working as an operational logistician, Ely was stationed at the Presidential Palace in Baghdad, working with Iraqi nationals and customs officials from neighboring nations in developing customs procedures.

Issued boots, a uniform, a Kevlar vest, and a helmet, Ely made several trips outside the Green Zone, or the safe zone, into unprotected areas of the city in order to complete her job. "No one forced me to go, but it was what the job required. When traveling outside the Green Zone, I had to travel as part of a security convoy. The Marines and Seabees who ran the convoys always made me feel safe, they were incredibly good at what they did," she said.

Working seven days a week, 12 to 14 hour days, with an occasional half day off, there was not a lot of free time. Entertainment sometimes consisted of sitting around picnic tables in the evenings and talking and watching for mortar fire; the group called this Mortar Watch. "After a while, the mortar fire became just background noise. I got used to it," Ely said. "Some days I didn't hear much at all and other days, it was constant."

During her tour, Ely said she was overwhelmed by the spirit and bravery of the Iraqi people.

Margaret Ely, center in white shirt, takes part in a shoe "sale" for the children of Iraq. She and four teammates asked family and friends back home to send new or gently used shoes and school supplies for dissemination. Both the shoes and the school supplies were given away free of charge on a first come, first served basis. From the personal collection/Margaret Ely.

A Government Civilian in Iraq—continued

"We worked side-by-side with the Iraqi people every day; they did what we did," said Ely. "The Iraqi people and the coalition troops put themselves in harm's way while we were relatively safe, living and working in the Green Zone."

One event that occurred during Ely's tour reinforced the precarious position of the Iraqi people and strengthened Ely's own resolve to work in a position where she could make a difference.

A father and daughter traveled each day into the Green Zone to assist the coalition personnel at the palace, they received death threats due to their efforts. While on their way to work, the two were ambushed by insurgents who awaited their arrival outside the Green Zone gates. The young woman suffered a gunshot wound to the face; her father did not survive.

After being discharged from the hospital, with nowhere safe to go, the woman was allowed by Ely and her friends to live in their housing trailers until she fully recovered. An attempt to get the woman out of Iraq and stateside was unsuccessful and the young woman was placed in an Iraqi woman's shelter. Ely lost track of her soon after.

A copy of a photo that sits on Ely's desk at work. The photo depicts Ely's friend and co-worker, Barbara Heald, who was killed by mortar fire shortly after Ely left Iraq. Heald was on duty at the palace, where both friends worked, when she was killed. Photo from the personal collection of Margaret Ely, used with permission.

At the end of her tour, Ely returned to the United States. She said the hardest part of her time in Iraq was her return and transition back to civilian life.

"When you have that type of experience and come back home, all the petty issues that were once so important just aren't that important anymore. It's really hard to explain that to someone who has not experienced what I have," she said.

After she left Iraq, the palace where she worked took a direct hit from mortar fire. One of her close friends and co-workers was killed instantly in the attack. "I keep her photo on my desk here at work," said Ely. "Every day when I come to work, her photo reminds me why I'm here and why I'm doing what I do."

Upon her return to the U.S., Ely wanted to be more involved in assisting the Soldiers and Sailors who work on the front lines. She took a position as the Fleet Medical Commodities Manager for NAVSUP. Finding that didn't get her as involved as she wanted, Ely applied for and received her current position in the MELs Directorate at NMLC.

In MELS, Ely and her staff support the Military Treatment Facilities (MTFs) with purchasing and maintenance of centrally funded medical equipment, procurement and distribution of fleet and MTF vaccines, personal property accounting of medical equipment, and life cycle management for imaging equipment. They are also available to the MTFs for any logistics issues that may arise such as prime vendor purchases. "My staff is an amazing group of professionals who are subject matter experts in their field," said Ely.

She and her team are currently working on a historic initiative that would put Magnetic Imaging Resonance systems into theater. Ely said, "Putting an MRI in theater has a direct and positive impact on assisting to diagnose and treat mild traumatic brain injury in the field. I'm honored to be a part of this initiative and know that what I'm doing here has that direct impact to our service men and women in the field.

"I loved what I did in Iraq and knew that I made a difference every day. That's what I love about working at NMLC, knowing that each day I make a difference in the life of the brave men and women who put themselves on the line every day for our country," said Ely.

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ACQUISITION MANAGEMENT

Past Performance Surveys – to do or not to do?

By Melanie Muscar, Services Contracts Division Chief

If you've ever worked with contracts, you've likely received a request to complete a questionnaire on the performance of the contractor company. These may have come in the form of a request that you complete a satisfaction survey and return it to the contractor representative, that you complete an evaluation of a contractor employee providing services within your workplace, or that you complete a past performance questionnaire and provide it to another Government agency. If you're like most of us, you've probably ignored these requests because you weren't certain if you *should* complete them or not. But did you know that not all of the requests you receive are bad and that some of them have the ability to impact a contractor's ability to receive future contract awards? Let's debunk the myth that all past performance questionnaires should be trashed and instead, focus on the three types and better understand which should be completed and which should not.

1. *Contractor Surveys*. A contractor representative might send you a one or two page survey with questions relating to their past performance under their current contract. NMLC Legal counsel advises that Contracting Officer's Representatives (CORs) and other MTF officials refrain from completing such surveys as they may be viewed as an endorsement of a contractor by the Government, which would violate ethics regulations and could create the appearance of favoritism in future procurements. The Federal Government already has a means for capturing a contractor's past performance through the Contractor Performance Assessment Reporting System (CPARS). The Federal Acquisition Regulation (FAR) requires all federal agencies to collect past performance information on contracts for use in source selection decisions on subsequent contracting opportunities. The current contract should contain a Report on Contractor Performance form or some other type of form to conduct an annual review of a contractor's performance. These are completed by the COR, collected by the Contracting Officer and entered into CPARS. The CPARS feeds Past Performance Information Retrieval System (PPIRS) which enables Government agencies to retrieve past performance information on a particular contractor. Without the CPARS reports, the positive or negative past performance information may not be incorporated into proposal evaluations thus not impacting an agency's decision to award, or not to award, to that contractor.

2. *Contract Worker Performance Evaluation*. A contractor representative might inquire about the performance of their staff and ask you to complete a performance evaluation on the contract workers. NMLC advises that CORs and other MTF officials refrain from completing such surveys, even if the contractor representative says that monetary bonuses for the contract workers are tied to them. If a contract worker does not perform in accordance with the statement of work/ performance work statement, there are other means to communicate performance issues such as through the completion of a Contract Discrepancy Report (CDR) or CPARS. Similar to the contractor survey described above, commenting on a particular worker's negative performance might interfere with removal or substitution of personnel if future problems arise. Alternatively, if a contract worker receives an award by the MTF or is honored for the performance of their duties, it is recommended the contractor representatives be given that information.

3. *Past Performance Questionnaire*. There is a strong likelihood that a contractor company will use their current contracts as past performance references when they submit proposals in response to future contracting opportunities. Current contracts are the most recent and depending on the solicitation, they might be the most relevant experience for that contractor. Generally, the Contracting Officers or CORs will be named as the point of contact for the reference and their information will be provided to the Federal agency soliciting for proposals. You are encouraged to complete these questionnaires as long as the completed questionnaire is submitted to another Federal agency or the agency soliciting for proposals. Providing the information to the contractor company may revert to an endorsement situation as described with "Contractor Surveys". Federal agencies soliciting for proposals will collect the past performance information and in conjunction with the data retrieved from PPIRS, evaluate a contractor's proposal. Non-responsiveness to these questionnaires means that an agency cannot fully evaluate a contractor's past performance thus directly impacting their ability to receive future contracts.

ACQUISITION MANAGEMENT

Market Research for Healthcare Services Contracts

By Sheila A. Gorman

Naval Medical Logistics Command (NMLC) healthcare services strategies analysts utilize a plethora of tools when conducting market research for personal healthcare worker services contracting. Some of these tools include websites, subscriptions, publications, and other government contracts for similar services.

The first and most valuable tool a healthcare services analyst utilizes is the Internet. The Internet allows an analyst instant access to websites, subscriptions, and publications, providing the most up-to-date information as well as historical data.

Good starting places for collecting data points are salary.com, erisa.com, and the Department of Labor to research salary information and wage determinations by labor category and/or specialty.

Besides salary and wage determinations, websites provide information about labor category specific surveys; trends in the market place; number of students graduating in a specific specialty; accreditation and certification details; local, regional, and national economic data; and access to local competing hospitals and clinic sites that may be offering hiring bonuses or other unique incentives for recruitment.

Over time, NMLC has compiled a labor market database of the best websites to access when conducting market research for healthcare labor categories. This allows the newest recruit to the longest serving analyst access to years of combined experience.

In addition to websites, NMLC has several subscriptions to sites and publications that keep abreast of local and national salary information and economic indicators. Two subscriptions that are particularly helpful in the NMLC healthcare analyst's arsenal include PayScale and Economic Research Institute Salary Assessor (ERISA).

Publications that have proved helpful include the New England Journal of Medicine, American Medical Association publications, hospital and healthcare compensations services publications, and Medical Group Management Association publications.

Department head Debra Thomas (L) and healthcare program analyst Allison McCaa (R), both with NMLC Healthcare Support Services, collaborate on a Statement of Work. Photo Sheila Gorman, NMLC.

Besides online services, the second best indicator of hiring practices and labor rates is found by reviewing an active or previous government healthcare contract for similar services. Reviewing previous contracts provides historical data on rates, volatility, premiums, confidence/reliability information, and other data sources used for compilation.

NMLC has compiled a Healthcare Contracts Database, powered by Microsoft Access. The database is able to sort by geographical areas, labor bands, labor categories, Medical Treatment Facilities (MTFs) and/or contracting offices, contract types, and current or closed contracts. When possible, NMLC includes other Government healthcare services contracts into the database for comparison. However, care must be taken as other Government agencies price out healthcare services contracts by tasks and not by labor hour, making it difficult to compare similar rates.

Finally, and perhaps a unique tool to NMLC, is costing for realism. An offeror's minimum healthcare worker compensation rate is determined to be realistic if the proposed rate meets or exceeds the minimum compensation

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ACQUISITION MANAGEMENT

DAU Update

By Barbara Douglas-Rook

Important Memos regarding Contracting Certification for 1102s/Contract Specialists

Two memos were recently released by the OUSD(AT&L)DPAP, both regarding the contracting career field certification requirements that become effective 1 Oct 11.

The first memo addresses the lack of access to the DAU virtual campus and an extension period. If you are a contracting specialist and have met all requirements for certification, including education, on-the-job experience, and training, before 1 Oct 2011 and are only lacking the required online classes, you now have until 31 Jan 2012 to complete the online training and request/receive certification.

The second memo is *good news* for contracting specialists (1102s) who have not met their current contracting certification training standards. The time period has been extended from 24 to 40 months (from your start date) to achieve the certification level required of the position under the new standards.

The most recent news from DAU concerning their Virtual Campus states that online training should be up and running by mid-Sept for DoD CAC users, with full operational capability with new security hardened Learning Management System for all users by December 2011.

As always - be sure to check the DAU website: http://www.dau.mil/fault.aspx for updates.

Market Research for Healthcare Services Contracts (continued)

rate indicated on the IGCE. If the position is not being paid a realistic figure, there may be retention problems as healthcare workers move onto private positions that pay a more realistic salary. By incorporating a realistic figure at the onset, the government hopes to attract highly qualified new hires and then retain them as their experience and value to the government grows.

NMLC healthcare analysts follow a set of general guidelines when handling a new requirement.

Before any market research is compiled, the analyst meets with the MTF to discuss the Statement of Work (SOW) for the position. There must be concurrence with the MTF on the SOW before the analyst proceeds with any type of cost estimate or Independent Government Cost Estimate (IGCE).

After mandatory concurrence with the MTF, the analyst will begin the process of determining the IGCE and cost estimate though their market research analysis. This includes reviewing the NMLC Healthcare Contracts Database to determine if this type of position and/or contract has been put in place previously; reviewing any existing subscriptions to determine salary data points for specific labor categories; checking the Department of Labor for wage determinations; checking accrediting bodies where applicable; and checking local advertising mediums for information about competing hospitals or clinics, job advertisements and any special sign-on bonus for similar hiring information.

When the IGCE is complete, it's forwarded along with the SOW to the MTF for concurrence. Concurrence is required for both before the requirement can move to the procurement process. At this time, the MTF should provide funding based on the IGCE figures provided by the NMLC healthcare services analyst.

Each analyst has a slightly different style as well as favorite websites for research and surveys. The end result, however, is a comprehensive, well-researched, and rock-solid IGCE to present to the MTF for funding and then on to the acquisition team for procurement.

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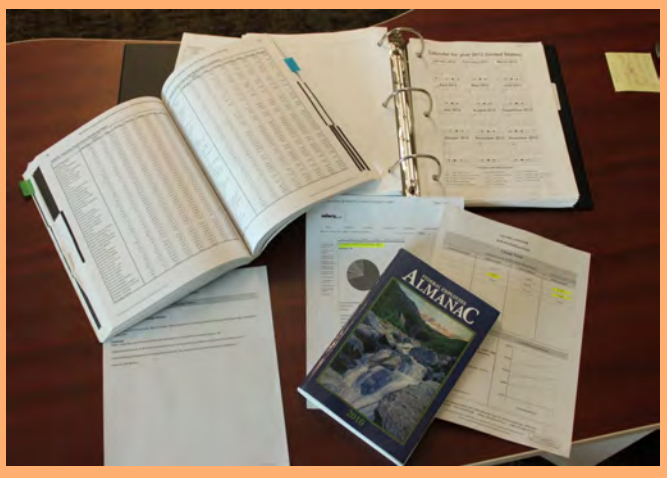

Market research utilizes a number of different publications to produce a fair and balanced Independent Government Cost Estimate (IGCE). Photo/NMLC.

ACQUISITION MANAGEMENT

COR CORNER
Michele Cameron
Division Chief, CAD

WHAT IS A STOP WORK ORDER?

In accordance with Part 42 of the Federal Acquisition Regulation, the Government has the authority to unilaterally stop work being performed under a contract and to require the contractor to stand by and be prepared to resume work when so directed by the Government. To accomplish this, the Contracting Officer will issue a stop-work order that has been approved at a level above the Contracting Officer prior to release.

Following are questions that frequently arise when stop-work orders are contemplated:

WHEN WOULD A STOP-WORK ORDER BE ISSUED?

Stop-work orders are generally issued by modification when an unsuccessful offeror files a protest against a contract award or when the Government is considering terminating a contract for its convenience, either because of potential changes in programs or requirements or contact performance problems. Stop-work orders are sometimes issued under NMLC's personal service contracts when performance problems arise with a health care worker (HCW) and those performance problems cannot be quickly resolved because an investigation will be required. Some examples might be if a HCW is suspected of drug abuse or stealing medication, accused of harassment, or may be guilty of a HIPAA violation. As always, if the COR believes successful performance under a contract is in danger, the COR should immediately contact the Administrative Contracting Officer (ACO) for guidance. After reviewing the performance problems, the ACO will determine whether a stop-work order is the best course of action. Depending on the language in both the contract and the modification issuing the stop-work order, the contractor may be required to provide another HCW to perform services.

WHAT SHOULD THE CONTRACTOR DO UPON RECEIPT OF A STOP-WORK ORDER?

The contractor should immediately suspend the work identified in the stop-work order, follow any instructions in the order concerning the contractor's issuance of further orders for materials or services, provide guidance to any subcontractors impacted by the order and take action to minimize costs during the work stoppage. The contractor shall stand by and be prepared to resume work when the order is lifted. However, the Government may eventually decide to terminate the contract for convenience rather than resume the performance that has been stopped. In either case, the contractor is entitled to an equitable adjustment to the contract price as compensation for the impact of the Government's unilateral decision to stop work. To be able to substantiate a request for equitable adjustment, the contractor should establish a plan to track all costs incurred as a result of the stop-work order

WHAT ARE THE COR'S RESPONSIBILITIES?

It's always wise to maintain thorough documentation of performance issues and continuously communicate with both the ACO and the contractor. If a stop work order is issued, the ACO will take over administration of the contractual process. Prior to the expiration of the stop work order the ACO shall take one of three actions: cancel the stop work order; terminate the contract; or extend the period of the stop work order. Stop work orders are time sensitive so it's prudent that an immediate investigation take place should one be required.

Fortunately, stop work orders are the exception rather than the rule. Since they can potentially have a serious impact to both the Government and the contractor, both parties generally prefer for performance to be completed if circumstances make this possible.

ACQUISITION MANAGEMENT

NMLC Contract Closeout Team Reaches $100 Million in Recouped Funding

By Sheila A. Gorman

Since 2006, when a Contract Closeout Team was stood up at Naval Medical Logistics Command, $100 million has been recouped in personal healthcare contract and equipment funding.

"By creating a team solely dedicated to closing out contracts and recouping funds, we have gotten more efficient, reaching the $100 million mark we have today," said Anna Marie Linton, team lead for the contract closeout team.

The idea of a team, totally dedicated to closing out contracts and recouping funds, was born of a Defense Acquisition University (DAWIA) class that Linton attended in 2006. The project assigned was to tackle something at a home office that could be made better. Linton's project tackled closing out contracts. After the class, Linton approached acquisitions management leadership about the possibility of implementing a dedicated closeout team at NMLC and they agreed, forming the Contract Closeout Team.

The team began by setting a starting point and creating Standard Operating Procedures (SOPs) for both the streamlined and non-streamlined closeout processes. Working by fiscal years, they created a workable format and forged ahead.

NMLC Contract Closeout Team. Front row, left to right: Jasmine Bhalla, Misty Perez, NMLC Contracting Officer and Team Lead Anna Marie Linton, Jason Winings, Katie Stansbery. Back row, left to right: Ben Reichlin, Min Aung, Kevin Moore. Photo/Sheila Gorman, NMLC.

"We said we were going to clear the overage from the oldest contracts and move ahead to the newest and that's what we've done," said Linton. "However, we weren't catching up, so we implemented something new."

Due to growth of new contacts being issued and always having to play catch-up, the team decided to dedicate one team member to closing from the front backwards, allowing the closeout process to be worked from the front end as well. As soon as current contracts are eligible for closeout, the process is started.

"We're working both ends of the closeout process," said Linton. "It makes sense."

By closing out contracts and moving the funds back to the U.S. Treasury, there is a more realistic accounting to Congress of what is being spent by Navy Medicine on healthcare services contracting and equipment. Additionally, there is more overall accountability of the funds and a clearer picture of where they are being spent.

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Logistics Assist Visit

Expanding from Equipment Lifecycle & Total Asset Management to Acquisition, Service Contracting, and Material Management Support

2011 Fiscal Year in Review

Fiscal Year 2011 witnessed the transformation of the Logistics Assist Visit (LAV) from a Medical Equipment & Logistics Solution Directorate (Code 03) initiative into a fully augmented program that includes subject-matter experts from Acquisitions Management (Code 02), Logistics Business Systems (Code 06), and Healthcare Services Strategies (Code 07).

Aside from the LAV, Code 03 also conducted site visits for pre and post BRAC implementation as well as for specific support. Including all visits, Code 03 was able to review 74,946 equipment records valued at $322 million.

The table below lists all the Commands NMLC visited in FY2011.

Date	Command	Remarks
Feb 17-18	NMCPHC	LAV: Code 03 + Code 02
Mar 04	NMRC Silver Spring	site visit
Mar 14-18	2nd Dental Battalion	LAV: Code 03
May 25-27	NAMRU-SA	LAV: Code 03
Jun 06-07	NH Lemoore	LAV: Augmented Team
Jun 09-10	NH 29 Palms	LAV: Augmented Team
July 11-19	NBHC Portsmouth Naval Shipyard NHC New England NBHC Sub Base New London	LAV: Augmented Team
Aug 08-09	NH Bremerton	LAV: Augmented Team
Aug 11-12	NH Oak Harbor	LAV: Augmented Team
Aug 30-Sep 01	NH Beaufort	LAV: Augmented Team
Sep 01-02	NHC Charleston	site visit
Sep 12	NHC Quantico	site visit
Sep 13	NHC Annapolis	site visit
Sep 14	NHC Patuxent River	site visit

Top 5 LAV Observations

- Valuation Information Error Rate above 10%
- Improper Equipment Nomenclatures/Creation of Local Device Codes
- Physical Inventory Accuracy below 98%
- IT Servers not recorded in DMLSS
- Maintenance Service Contract Information not in DMLSS

FY 2012 LAV Schedule

NMLC is currently collaborating with the Regional Commands in finalizing the list of sites to be included in the FY12 LAV Schedule.

Clinical Engineering

02 Sep 2011: Deadline for FY13 OP, DHP equipment request submission.

The CE support division manages hundreds of requirements from Navy Medicine activities each fiscal year. Complete equipment request packages are essential to the procurement process; the most important steps are defining the minimum requirements and including all necessary information.

Equipment Request Forms

NAVMED Forms 6700/12 and 6700/13 for initiating equipment requests can be found on the MIL/GOVT only section of the NMLC website at: https://gov_only.nmlc.med.navy.mil/int_code03/internal-code03-forms.asp (copy and paste text). The estimated dollar value of the equipment requested determines which form is required.

Minimum Requirements: Functional Aspects

Once the need for equipment has been identified, defining the functional aspects of a requirement means considering a variety of questions. What is the patient population on which the equipment will be used? Different pieces of equipment are required for pediatric, adult, or bariatric patient populations and that information is crucial for the review and procurement processes. Where in the hospital will the equipment be located? The requirements for equipment in a busy emergency room can be different than those of an ICU or those of an outpatient clinic. What treatment capabilities are required? For instance, if the need is identified for an ultrasound, the applications for which it will be used should also be identified. The requirements for an ultrasound in Labor and Delivery will be different than in Cardiology.

Minimum Requirements: Technical Specifications

Technical specifications include any of the specialized requirements for the technical performance of the equipment. This may be as simple as electrical requirements available in the space; both frequency and voltage should be specified so the procured equipment can be utilized. If a piece of equipment must meet a minimum size, measure within a given range, or reach a certain power level, that must be detailed in the equipment request.

Specialty Areas

The clinical engineers have assigned specialty areas as follows and are always standing by to assist with requirements definition, market research, or other questions.

Anthony Angelo — anthony.angelo@med.navy.mil
MRI/CT, Pharmacy, Anesthesia, Lasers

Erin Blair—erin.blair@med.navy.mil
General Radiology, General Patient Care, Medical IT

Kim Hernandez—kim.hernandez@med.navy.mil
Ultrasound, Cardiology, Radiation Oncology, Lab

Leora Frank—Leora.Frank.ctr@med.navy.mil
Centralized Maintenance Contracts

Any general questions, concerns, or comments can be sent to our team e-mail: NMLC-CE@med.navy.mil.

Imaging Informatics

Navy PACS Office

MEDICAL DEVICE INFORMATION ASSURANCE (IA) – Part 1

In order to achieve the greatest Information Assurance Vulnerability Management (IAVM) compliance possible, it is important to understand what a medical device is. Typically, those in the Information Technology (IT) field consider anything with an IP address that is connected to the Medical Treatment Facility network to be IT equipment. While it is true that nearly all medical devices have IT incorporated into them, and in some cases may be virtually indistinguishable, they are not simply IT products.

The Center for Devices and Radiological Health (CDRH) and, in specific cases, the Center for Biologics Evaluation and Research (CBER) of the Food and Drug Administration (FDA) is responsible for regulating medical devices in the United States. The CDRH performs this function under the authority of the Federal Food Drug and Cosmetic (FD&C) Act of 1938. The specific regulations covering medical devices is published by the FDA and are found in Title 21 Code of Federal Regulations (CFR), parts 800-1299.

A medical device is defined within the FD&C Act as "…an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes."

The CDRH groups medical devices into one of three Classes: Class I, Class II, or Class III. The three classes set out to define a devices' degree for potential harm to the patient, along with consideration of the devices' design complexity. The FDA also defines a set of controls required to be met by the varying classes. These controls are referred to as the "General Controls". These controls are defined in the Medical Device Amendments of 1976 to the FD&C Act of 1938.

- **To be continued in the next issue of *Logistically Speaking***

DIN-PACS/DDI Site Survey Schedule (Tentative, exact dates TBD)

- Oct 11: NHC New England—DDI
- Nov 11: NHC Corpus Christi
- Jan 12: NH Beaufort
- Jan 12: NHC Charleston
- May 12: NHC Great Lakes
- June 12: NH Camp Pendleton
- June 12: NH 29 Palms

Imaging Informatics Mission

Develops the strategic vision for, and executes the Imaging Informatics Program for Navy Medicine which includes successful and coherent planning, deployment, integration, sustainment and life-cycle management to the greatest clinical and financial benefit possible. Provides support to internal and external customers for Medical Equipment Information Assurance.

MEDICAL IMAGE MANAGEMENT

The production of visual representations of body parts, tissues, or organs, for use in clinical diagnosis; encompasses x-ray methods, magnetic resonance imaging, single-photon-emission and positron-emission tomography, and ultrasound

Equipment Management/ Analytics Division

Providing Personal Property Accounting and Inventory Management as well as Program and Systems Analysis Support to Navy Medicine Facilities

Due to personnel deployment, permanent change of station, and increased workload, the Equipment Management Division teamed up with the Analytics Division in order to provide sustained customer support and programs coordination.

When the FY11 Logistics Guidance was published at the beginning of the fiscal year, the Equipment Management/ Analytics Team became significantly engaged in answering inquiries about the Equipment Management updates included in the guidance.

Property Accounting Guidelines

- ADP Equipment
- PACS Equipment
- ANAM Computers
- Active Directory Servers

For the Triennial Inventory, the EM team rendered assistance through the following avenues: creation of a business objects template, responding to site inquiries; conducting monthly teleconferences; and collection of completion certificates.

The EM team also provided Property Accounting guidance for commands that were included in the BRAC process by conducting site visits, addressing inquiries, and coordinating data transfer.

BRAC Support

- CAPT James A. Lovell Federal Health Care Center (VA and NH Great Lakes)
- Navy Marine Corps Public Health Center
- Naval Medical Research Center—Silver Spring
- Naval Medical Research Center—Frederick (ongoing)

Other endeavors undertaken were: Patient Movement Item Tracking System (PMITS) coordination; activation of 10 servers for UID reporting; data mining for the Naval Audit Agency; collaboration with Kandahar Coalition Hospital; ECRI accounts creation for Equipment Management staff as well as Biomedical Equipment Technicians; partnering with the Material Support Office in launching the VIALS website; and the successful coordination between the various NMLC presenters and the venue's Events Coordinator during 2011 Navy Resources, Logistics, and Analytics Symposium in Lansdowne, Virginia.

2011 Fiscal Year in Review

Top EM Inquiries

- Equipment Nomenclatures
- Triennial Inventory
- UID Corrections
- General DMLSS Inquiries

Commands Activated in FY11 for UID Reporting

- NHC Charleston
- NH Bremerton
- NMC Portsmouth
- NMCPHC
- USNH Guam
- USNH Guantanamo Bay
- USNH Naples
- USNH Rota
- USNH Sigonella
- USNH Yokosuka

Training Support

- ✓ Logistics Symposium: 75 attendees/39 certificates
- ✓ NMLC EM Workshop: 29 attendees

FY 2012 EM Events

Oct 24-26: Property Accounting

Oct 24-28: Equipment Management

TBD: Spring EM Workshop

TBD: 2012 Navy Medicine Resource, Logistics, and Analytics Symposium

Biomedical Equipment Support Division

2011 Fiscal Year in Review

Fiscal Year 2011 began with an influx of personnel within the Biomedical Equipment Support Division. With sufficient staff, the BIOMED Division launched simultaneous short and long range initiatives.

The year kicked off with the coordination of the Biomedical Equipment Technician of the Year Award (Shore & Operational) between NMLC and BUMED. This initiative culminated with the presentation of awards at the 2011 Navy Resources, Logistics, and Analytics Symposium in Lansdowne, Virginia by Navy Surgeon General Vice Admiral Adam Robinson.

The BIOMED Support Division participated in multiple Tri-Service initiatives such as the X-Ray Acceptance Program Review, DMLSS Device Code Review and the Joint DOD BIOMED Symposium.

The X-Ray Acceptance Program was revitalized and reemphasized. Throughout the fiscal year, NMLC received 25 acceptance packages.

Another initiative that was launched was the ECRI Hazards, Alerts and Recall management tool for BMETs to receive notifications of medical equipment recalls and alerts in order to perform quality assurance actions.

Several generic maintenance plan and procedures (MPPs) in DMLSS were reviewed by the BIOMED Support Division and drafted into a more manufacturer-specific format. These drafts were then sent to various BMET shops that volunteered to validate the procedures.

Finally, the BIOMED Support Division procured approximately $1 million worth of test equipment for various shops.

MPP Reviews

- Ventilator, Bunnell, Life Pulse
- Ventilator, Carefusion, SIPAP, Infant
- Ventilator, Drager, Evita
- Ventilator, Drager, Babylog 8000

Top MA Inquiries

- X-Ray Acceptance documentations & procedures
- Maintenance Interval changes
- Maintenance Plan and Procedures revision
- NMLC MA Workshop

FY 2012 MA Events

Oct 17-21: NMLC MA Workshop

TBD: Spring MA Workshop

TBD: Deadline for submission of the BMET of the Year packages for Shore and Operational platforms

TBD: Joint DOD BIOMED Symposium @ Charlotte, NC

Jun 02-04: AAMI Conference @ Charlotte, NC

Biomedical Equipment Division Support

The X-Ray Acceptance Program

By Eric Elane

X-Ray Imaging Equipment, from small dental x-ray units to complex CT Scanners, are essential diagnostic tools in health care facilities.

Their specifications are strictly regulated by the Food & Drug Administration to prevent the possible overexposure of harmful radiation to patients and staff.

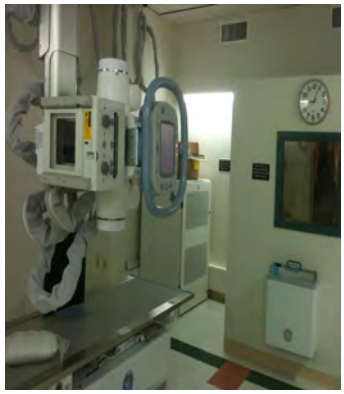
An X-Ray Acceptance Inspection is required on all new x-ray imaging equipment after proper site installation and before an exposure is made on a patient. The tests are performed by Biomedical Equipment Technicians (BMETs) and Radiation Physicists to ensure that the machine operates within manufacturer's specifications and produces consistent and accurate exposures.

The inspection results are documented and kept on file during the operational period of the x-ray machine. Equipment Managers must notify NMLC upon receipt and successful completion of the acceptance inspection and BMETs must forward an electronic copy of the inspection results to NMLC-ETM@med.navy.mil. Please refer to the following references for more information:

- 21 Code of Federal Regulations (CFR) 1000.55, 1020.20, 1020.30 to 1020.33, and 1020.40
- BUMEDINST 6470.22a (19 Mar 2004)
- Chapter 10, Article 10-5 of NAVMED P-5132

Modalities requiring X-Ray Acceptance

- Radiographic Units (Analog/Digital, Fixed/Mobile)
- Radiographic/Fluoroscopic Units (Analog/Digital, Fixed/Mobile)
- Mammographic Units (Analog, Digital)
- Computed Tomography (CT) Units



Branch Medical Clinic Key West Radiographic Unit

Naval Hospital Jacksonville Radiographic/Fluoroscopic Unit

Naval Medical Center San Diego Mammography Unit

Naval Hospital Rota Computed Tomography Unit

To coincide with influenza vaccine administration, the NMLC Material Support Office requested a reprint of the following article, which appeared on www.navy.mil on Sept. 15, 2011.

GTMO Prepares Service Members For Flu Season

Story Number: NNS110915-07 • Release Date 9/15/2011 12:59:00 PM

By Mass Communication Specialist 2nd Class (SW/AW) Justin Ailes Naval Station Guantanamo Bay, Cuba Public Affairs

GUANTANAMO BAY, Cuba (NNS) -- U.S. Naval Hospital (USNH) staff at Naval Station (NS) Guantanamo Bay, Cuba will administer mandatory influenza vaccinations for active-duty military personnel, beginning Oct. 5.

The combined H1N1 and seasonal influenza vaccine will be offered at the Windjammer Ballroom to combat the spread of the virus during the flu season. The flu season usually begins in October and can last until May.

"Service members will be required to fill out a medical questionnaire, and depending on their answers, will be provided either the injectable or inter-nasal mist vaccine," said Hospital Corpsman 2nd Class Clint Messerschmidt, NS Guantanamo Bay preventive medicine representative. The recommended vaccine will be available for civilians and government contractors at NS Guantanamo Bay at a later date.

"No one likes getting sick, so the best thing to do is get the flu shot," said Messerschmidt. "Administering the vaccine is a precautionary measure to prevent and or subside the symptoms of influenza."

110912-N-WW127-108 GUANTANAMO BAY, Cuba (Sept. 12, 2011) Hospital Corpsman 2nd Class Clint Messerschmidt administers the H1N1 flu vaccination to Capt. Kirk Hibbert, commanding officer of Naval Station Guantanamo Bay, Cuba. (U.S. Navy Photo by Mass communications Specialist Justin Ailes/Released)

OPERATIONAL FORCES SUPPORT

WHAT IS THE PURPOSE OF AN AUTHORIZED MEDICAL ALLOWANCE LIST

By Rick McManis
Deputy Director, Engineering Services

Within the Operational Forces Support Directorate at Naval Medical Logistics Command (NMLC), the Assemblage Management Section is in charge of maintaining all Authorized Medical Allowance Lists (AMALs) for U.S. Navy fleet ships.

AMALs are Class VIII, or expeditionary, medical assemblages that are designed for different classes of ships tasked with different missions. The Assemblage Management Section maintains AMALs for five Type Commanders under the purview of Fleet Forces Command: Surface Forces; Submarine Forces; Military Sealift Command; Naval Expeditionary Combat Command; and Air Forces.

The purpose of an AMAL review is to get real time feedback from Subject Matter Experts aboard each ship on the appropriate medical capabilities within each assemblage, with frequency occurring every 12-18 months.

In addition to receiving real time feedback within each medical specialty aboard, AMAL Management Planning is critical to the fleet, especially during the deployment cycle. Medical material planning allows each ship's Medical Planner to forecast medical materials and budgets for operational medicine supported missions, force flow movement planning in support of Combatant Commanders operational plans, and posture medical supply chain to support contingency and pre-planned missions.

In an effort to ensure medical material readiness for deploying units, NMLC is collaborating with Defense Logistics Agency Troop Support (DLA-TS) to ensure that high use, critical items within fleet AMAL assemblages are included in contingency contracts. The Assemblage Management Section provides fleet usage data semi-annually to ensure that DLA-TS stocks demand items, allowing deploying fleet units to place high priority orders through these contracts with minimal backorders. Currently, 65 percent of medical, surgical, and pharmaceutical items are covered under these contracts.

The latest AMAL review conducted by the NMLC Assemblage Management Team occurred Aug. 10-19, aboard the Navy hospital ship USNS Comfort (T-AH 20). Comfort was en route from Costa Rica to Haiti, on the last leg of the Continuing Promise 2011 mission, a five-month humanitarian and civic assistance mission in the southern hemisphere. While Comfort was underway, the Assemblage Management Team was able to complete a review of 29 hospital ship medical capabilities. Some of the key areas the review addressed included: surgical core; nursing core; intermediate care wards; x-ray; and orthopedics.

Below is the projected 2011 fleet type command projected AMAL review schedule

-Oct . 4-6 T-AH Surgical Core AMAL Review (Tentative)
-Oct. 11-14 Military Sealift Command AMAL Review
-Nov. 14-18 Fleet Dental ADAL Review

OPERATIONAL FORCES SUPPORT

What Does a Biomedical Engineering Platform Manager Do?

By Ross Mackey, NMLC Biomedical Engineer

Being one of the newest members of the Naval Medical Logistics Command (NMLC) Operational Forces Support team, one function of my job as a biomedical engineer is to assess equipment request packages.

I am assigned to the U.S. Navy's hospital ship USNS Mercy (T-AH 19), as the Biomedical Engineering Platform Manager.

The Mercy is stationed on the west coast of the U.S. and every alternate year, beside their primary mission of providing rapid, flexible, and mobile acute medical and surgical services to U.S. military units, the ship provides mobile surgical hospital service in Humanitarian Civic Assistance, disaster or humanitarian relief.

USNS Mercy (T-AH 19) transfers cargo aboard the Royal Australian Navy heavy landing craft HMAS Labuan (L128) while anchored near Timor-Leste supporting Pacific Partnership 2010. U.S. Navy photo by Mass Communication Specialist 2nd Class Eddie Harrison/released.

Hospital corpsman 1st Class Eiyeen Haschke reviews a patient's CAT Scan aboard the hospital ship USNS Mercy (T-AH 19) supporting Pacific Partnership 2010. U.S. Navy photo by Mass Communications Specialist 2nd Class Eddie Harrison/released.

While I do have to verify that all the forms are filled out properly, my primary efforts are to ensure that I have a full understanding of what is being requested. Some of the questions I need to ask myself when a request comes in include: is the unit that is being requested different from what is currently aboard; if so, will this piece of equipment be physically able to be installed on the ship; is the space big enough; are there overhead or ground level obstructions; do other pieces of equipment in the this area pose a threat to the operation of this equipment; and what would happen if the ship did not receive the equipment they requested? I also have to address these types of logistic questions: is there enough power and is it the right voltage to run this piece of equipment; will this piece of equipment operate in conjunction with other units that are currently installed; will there be magnetic, electrical, or other disruptions; does this piece of equipment require additional units to operate that the ship does not currently have aboard; and does this ship have the properly trained personnel to run this piece of equipment?

By taking pictures of the medical and dental spaces, noting how existing pieces of equipment are fastened down (bolted, welded, tied-down, loose), touring the ship to determine access routes for equipment installations and maintenance, and talking to the biomedical technicians aboard who are my eyes and ears on the ship, I want to have as complete a picture as possible of the spaces aboard. When I am looking at these spaces, I assess for Form, Fit, and Function: all medical and dental equipment is evaluated upon its ability to fit into the required spacing available; be configured properly for operations and maintenance access; and meet all functional/operational requirements.

A hospital ship is expected to have the functional capability to deploy at a moment's notice, as the hospital ship USNS Comfort did for Operation Unified Response – Haiti after an earthquake devastated their capital in 2010. If the ship is already deployed and is experiencing a problem, I have to make decisions based on the information I already have and the information being relayed to me by the biomedical technicians aboard, which is sparse at best, due to typical communications difficulties while deployed. That's why it is important I have as much information upfront as possible, because if I get it wrong, it compromises the mission, and when you work for Navy Medicine, it could mean more than just functional downtime; it could mean someone's life.

On my recent visit to the Mercy, I concentrated on the Radiology and Radiology/Fluoroscopic Rooms. NMLC is evaluating a large dollar project to revamp this equipment and these rooms aboard both the Mercy and the Comfort. As this is one of the highest scope projects to either ship in almost a decade, it's my chance to really show-off what I can do and make sure that I limit any post-contract award issues by knowing my product.

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MEDICAL MATERIEL STANDARDIZATION

An enterprise-wide effort

By Susan Ferguson, Cheryl Bither, Darryl Lloyd, and Buddy Ryan, MMESO

For over a decade, the Military Health System (MHS) has recognized and understood the value of medical material standardization. In September 2010, the Medical Materiel Enterprise Standardization Offices (MMESO) effort was launched.

The Defense Medical Materiel Program Office (DMMPO) was established in 2010 and organizationally falls under the The Office of the Deputy Assistant Secretary of Defense for Health Affairs, Force Health Protection and Readiness (DASD HA/FHP&R), TRICARE Management Activity (TMA).

The MMESO effort is under the direction of the DMMPO with a focus on enterprise-wide standardization. The MMESO effort aims to improve efficiencies and effectiveness for institutional and operational medicine; serve greater joint commonality and interoperability; and provide a cost effective infrastructure that will meet unique service requirements.

The MMESO effort integrates product selection for fixed facilities, operational medical sets, theater re-supply; includes all Services' medical departments; and spans the continuum of care from first response to definitive surgery and long-term care. Through clinical product selection and reduction of variation and redundancy, this effort is expected to add benefits in patient safety and clinical outcomes, enhanced readiness and training, and transportation and warehousing efficiencies in addition to controlling acquisition costs. "Given the tremendous operational tempo for both the institutional and operational health care providers, standardization of medical materiel reduces unnecessary 'noise' in the duty day. It's a win-win situation if our healthcare providers essentially can move seamlessly from facility to facility, and use the same equipment in Theater as they do at their MTF's," said Col. Colleen Shull, DMMPO, Chief of Staff and MMESO Designated Senior Clinician.

Defense Medical Materiel Program Office

The ultimate goal of the MMESO is to provide quality medical materiel that supports service members, veterans, and family members. "We are excited about the MMESO effort. The professionals involved are working hard to implement a method that provides the opportunity for all military treatment facilities to participate in the product selection process," said Lt. Col. Stephen Casimir, DMMPO, MMESO Contracting Officer's Representative.

Product selection involves the development of technical and clinical criteria, from required factors such as FDA clearance and safety mechanisms, to more subjective features such as ease of use and quality. After an announcement to industry for interested vendors to respond, and initial screening to ensure requirements are met, hands on evaluations to select clinically preferred products are conducted worldwide by Clinical Product Teams of subject matter experts.

Five MMESO's, located in Washington, D.C., San Antonio, Texas, San Diego, Calif., Honolulu, Hawaii, and Heidelberg, Germany serve as forward operating offices of the medical standardization effort. The offices assist in the integrated, collaborative product standardization process. Each leads and facilitates in the coordination, validation, and implementation of Standardization Actions for selected product lines. Across the enterprise, more than 200 people are actively contributing to the development of this effort.

For additional information about the MMESO and enterprise-wide medical materiel standardization please visit the DMMPO MMESO Website.

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HEALTHCARE SERVICES STRATEGIES

Personal Services Contract Supervision

By Art Cronk, Healthcare Services Strategies Department Head

There are two basic types of medical service contracts, a Non-Personal Services Contract (NPSC) and a Personal Services Contract (PSC).

Under a NPSC, the contractor provides all contract supervision and the contractor is responsible for medical malpractice insurance. NPSCs are generally used when the contractor's personnel are not comingled with government personnel. For example, a military treatment facility may have an emergency room that is staffed and operated solely by contract personnel. The contractor is responsible for providing and supervising all staff, from administrative assistants to emergency medicine physicians. The contractor ensures that appropriate staffing levels are maintained, completes appropriate documentation and tracks work hours and process payments for their employees.

The use of PSCs is authorized under U.S. Code – Title 10 Section 1091 Personal Services Contracts. Unlike a NPSC, a PSC may only be used for provision of direct healthcare service; PSCs comprise the majority of Navy contract healthcare services.

Under a PSC, contract workers are often working side-by-side with uniformed and civil service personnel providing similar services. In this type of working environment, Section 1089 of Title 10, United States Code states that the government will defend personal services contract healthcare workers against medical malpractice actions based on negligent or wrongful acts or omissions incident to performance within the scope of the contract. To manage the risk associated with that section of the U.S. Code, the government is required to supervise the contract workers.

So what does this all mean? If you are a department head or Officer in Charge (OIC) of a medical clinic that makes use of personal services contractors, you are required to provide appropriate supervision. This supervision may entail specific instructions as to how to perform a task, patient and clinic assignment, duty hours and leave approval, etc.

When a contract or task order is awarded, the first action the Contracting Officer's Representative and the OIC/ department head should do is to go over the contract and position-specific Task Order (TO).

The contract provides generic contract worker qualifications and duties and administrative requirements; it is the "go to" document for all contract issues.

The TO provides the specific requirements of the position(s). It will identify work hours, locations, and any flexibility with regard to changing those hours and locations. Additional qualifications and duties may be further refined over those provided in the basic contract. However, information in the TO may not conflict with the basic contract. It is imperative that OICs/supervisors be familiar with the basic contract and TO to ensure that they understand their latitude with regard to changes in location, overtime, schedules, etc. This will enable them to appropriately and effectively supervise their contract workers.

To increase your knowledge of personal services contracting, or contracting in general, it is strongly recommended attending an NMLC COR class. The NMLC COR class is specific to healthcare contracting, and CORs attached to the BUMED Budget Submitting Office are required to attend this course. The NMLC COR class is the only course sanctioned by both BUMED and NAVSUP.

SOME GUIDELINES

❖Read the contract and any supporting documentation.

❖Become acquainted with the COR, who is the liaison with the contractor and contracting office.

❖Monitor time and attendance and ensure that the contract workers know the process for leave request and approval.

❖Maintain procurement integrity. The government's business should remain in the government realm and should not be shared with contractors.

❖Be familiar with the personnel who are contractors. Generally, contracts last 5 years. Be sure that incoming military personnel are aware of any contractors working in their area.

❖Limit your involvement in contractor recruitment. The contractor is being paid for their recruitment expertise; it is not the government's responsibility to do the recruiting.

❖Try to resolve performance issues at the lowest level.

❖Don't make promises that are outside your authority, such as additional work, pay raises, waivers or modifications, these issues remain in the domain of the contacting officer.

❖Document, document, and then document some more. It is very difficult to take action on a contractor for poor performance if it isn't documented.

❖And of utmost importance, BE A SUPERVISOR!! As you have the ability to supervise PSC workers, you also have the responsibility to do so. Failure to properly supervise a contractor can result in unauthorized commitments, patient safety problems, and may have a negative impact on clinical operations.

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.

Most likely you've received any number of calls from small business vendors who, from their perspective, are happy to have reached a live person, and also one who they think can open the door for them into the world of government contracting. Well . . . sometimes they have hit the target and other times, not. However, even if this initial contact only results in a referral to a more appropriate individual, that's a small success to the vendor. What's the best way to handle vendor inquiries? This article will provide some helpful suggestions to address this routine issue.

The best approach depends on where you work in the organization. Oftentimes, vendors have a general phone number to the Commander's office and are just trying to make contact. If you are not with the procurement or contracting department of your facility, you should generally refer the vendor to that office or preferably, to the organization's small business specialist.

As NMLC's Small Business Programs Officer, when I receive a call or email from a vendor, I will review their capabilities to see if those match the services or products that our contracting office procures. If the vendor's capabilities align with what our organization buys, I consider scheduling a meeting between the vendor, senior contracting officers, and appropriate technical or program management staff to learn more about what this vendor can offer. That may sound simple enough, but what about those who offer services or products that are completely unrelated to anything the organization buys – what then?

Small Business Programs Officer Mimi McReal greets a visitor in her office. When possible, McReal refers any small business vendor contacts to the correct office or individual who may be helpful to that vendor. Photo Sheila Gorman, NMLC.

SUGGESTION #1:

MAINTAIN A ROBUST LIST OF CONTACTS.

These are names, phone numbers, and email addresses of individuals at various Navy or Federal acquisition offices who work with small business vendors and with whom I have networked during small business conferences or other similar forums. This has greatly benefitted me in connecting numerous small businesses with the appropriate government entity.

Here are some examples of inquiries that I have received, from vendors whose products or services are not among what NMLC procures, and how they were handled. I have been contacted by vendors who provide construction or engineering services and I have referred them to the Naval Facilities and Engineering Command (NAVFAC)'s small business point of contact. I was also contacted by different vendors who offer chaplain services, consulting services, as well as medical administrative services (e.g., medical

Continued on next page

SMALL BUSINESS PROGRAMS

coding, medical transcription). I have referred these vendors to the Fleet Logistics Centers (FLCs – formerly the FISCs) who routinely procure these types of services. I refer vendors who offer information technology/information management products and services to the Navy Medicine Information Systems Support Activity (NAVMISSA). Conversely, I am happy to get referrals from fellow Navy/Federal government small business specialists who forward healthcare staffing vendors to my attention.

SUGGESTION #2:

START A COLLECTION OF EMAIL RESPONSES TO VENDORS.

Another tool in my toolbox is a collection of email responses to vendors that I can use for reference. These emails discuss general information about our organization and what services and products we procure. Establishing a file with these emails helps in several ways: (1) it provides basic information on 'Doing Business with NAVMEDLOGCOM' and explains to the vendor what we generally procure; (2) it serves as a template for responding to future, similar inquiries (the responses of which could be tailored more specifically, as needed); and (3), it helps to track the types of vendors who contact your organization, should you want to use this information for future market research or data collection. Moreover, the vendor is getting applicable information to go to the next step.

So as you receive inquiries from small business vendors, here are some considerations. If the inquiry comes in to the Command other than through the contracting office, refer the vendor there. Once the vendor is connected to the contracting office, determine what it is that they sell. If their products or services are not a match with your organization and you are not sure where they should be referred, contact my office and I can provide you with additional contact information to get the vendor to the right place. If the vendor sells a product or service that your organization does procure, get a copy of their 'Capability Statement;' you may want to arrange a meeting with the vendor to more specifically discuss their capabilities. *[A word of caution: when meeting with vendors, always remember not to discuss any specific information concerning ongoing, active procurements or any other procurement sensitive information.]* As an alternative to meeting with the vendor, pass along any of the company's product information to the other contracting and technical/program management personnel at your facility and consider establishing a catalog (or file drawer) of vendors' capabilities statements and information. This information may be useful future market research material.

Handling inquiries from vendors doesn't have to be arduous. While it seems like taking the time to respond adds to your workload, it's only a brief amount of time and could turn out to be time well spent. If you look at these inquiries as opportunities to promote small business acquisition, achieve small business contracting goals, grow the pool of available sources, and further your market research, it can ultimately be a win-win for everyone – and it's all in making the connection.

If you have questions regarding how to best field inquiries from small business vendors or any other Navy small business programs, please contact Ms. McReal at Mimi.McReal@med.navy.mil or via phone at (301) 619-3097.

Small Business Programs Officer Mimi McReal confers with small business representative Anthony Briggs, US Nuclear Regulatory Commission, at the SMART PROC 2010 Conference. The event is primarily geared toward small business vendors who are interested in doing business with the Government. McReal plans to attend SMART PROC 2011 in October. Photo/Sheila Gorman, NMLC.

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USAMMCE
UNITED STATES ARMY MEDICAL MATERIEL CENTER, EUROPE
A SUBORDINATE UNIT OF THE U.S. ARMY MEDICAL RESEARCH & MATERIEL COMMAND

Class VIII supply availability of Material & Equipment centrally located in Pirmasens, Germany

The United States Army Medical Materiel Center-Europe (USAMMCE), is a subordinate unit of the U.S. Army Medical Research and Materiel Command at Fort Detrick, Md. They serve as the Defense Logistics Agency's Theater Lead Agent for Medical Materiel for Europe.

- ✓ **The USAMMCE mission is to provide and project medical logistics support and training across the full spectrum of military operations to EUCOM, CENTCOM, AFRICOM and Department of State.**
- ✓ **The core competencies include life cycle management of Class VIII (medical expeditionary) material, clinical engineering support, clinical advice and consultation, optical fabrication, assembly, reconstitution, disassembly of medical sets, kits, and outfits (MESKOs), and training logisticians on supply chain management.**

NMLC Pirmasens Detachment Overview
Naval Medical Logistics Command (NMLC) – Pirmasens Detachment

The Detachment is located in Pirmasens, Germany which is located approximately 30 miles south of Ramstein AFB on Husterhoeh Kaserne with the U.S. Army Medical Materiel Center – Europe (USAMMCE). The Detachment supports all Naval Activities with Medical Logistics Class VIII commodities within AFRICOM, EUCOM, CENTCOM, SOCSE, and the 5th & 6th Fleets. The detachment is available to assist with Class VIII procurement training, special mission requirements, and basic procurement support. The Detachment works in coordination with USAMMCE and is able to provide core competencies that include life cycle management of Class VIII material, clinical engineering support, clinical advice, optical fabrication, assembly, reconstitution, and training logisticians on cold chain management.

To contact us:

LCDR Rebecca Gels Rebecca.V.Gels@US.ARMY.(SMIL)MIL and DSN 495-7427
HM2 Michael Price Michael.Price@AMEDD.ARMY.MIL and DSN 495-7170
HM2 Nana Bonsu Nana.Bonsu@AMEDD.ARMY.MIL and DSN 495-6675

Pharmaceutical Returns Program
Customers are authorized to turn in the following types of Class VIII materials: Controlled, Nuclear & Biological, Chemical Defense Materiel, Medical Sets Kits and Outfits, medical equipment, and pharmaceutical and medical supplies.

Take note that non-medical materiel will not be accepted. Materiel returned prior to or WITHOUT the proper coding WILL BE returned to the sending unit.

In order for Class VIII materiel to be considered for turn in, customers are required to complete the following prior to mailing the materiel(s): segregate materiel by type (medsurg, pharm, expired, equipment, controlled substances, etc.); annotate expiration and manufacture dates; and quantities of each line.

One of the following codes will be assigned:
TA: Request for T/I has been accepted with the potential of receiving credit.
TB: Request for T/I has been accepted but with no credit.
TC: Request for T/I has been rejected.
TD: Not Returnable. Special instructions for disposition are stated in remarks field.

View of the USAMMCE warehouse where Class VIII medical materiel and commodities are staged for use in theater. NMLC Pirmasens Detachment is responsible for Class VIII commodities in AFRICOM, EUCOM, CENTCOM, and SOCSE. Courtesy photo/NMLC-Pirmasens Detachment.

Controlled substance turn-in

Controlled substances MUST be returned to USAMMCE via registered mail. If not, the Unit's command will be notified of the neglect for proper accountability of controlled substances.

The goal is to earn credit by returning expired pharmaceuticals and to ensure proper handling.

Continued on next page

NMLC– Pirmasen's Detachment (cont.)

Returns from overseas customers will not include the following: Schedule II-V controlled substances, due to DEA regulatory prohibitions, or IV solutions, due to shipment costs exceeding credits to customer.

Process for customers receiving credit through EXP and/or Cardinal
EXP Pharmaceutical Services (EXP) and Cardinal are both utilized to process pharmaceutical returns. EXP comes to USAMMCE every quarter and ships materiel to facilities in the U.S., then to manufactures for credit. EXP sends an Estimated Credit, Returnable, and Non-Returnable Report, while Cardinal sends an Actual Credit Report. Credit is then applied to USAMMCE customer accounts. In some cases, credit is applied in portions, depending on how the pharmaceutical return service received the credit from its manufacturers. For Navy customers, the credit is applied to a general account for the major DODAACs and the credit is allocated by comptrollers.

Feedback for customers on returns
Contact the USAMMCE Pharmacy Consultant or the Pharmacy Technician for questions regarding status of returns. Email: usammce_pharmacy@amedd.army.mil.

EXP provides reports and tools to allow the customer to keep track of returned goods and account information. A USAMMCE Pharmacy Consultant or the Pharmacy Technician can assist in establishing a unique username and password that will give access to an account.
Click the following link to access the EXP Homepage.

For each type of medical material: Cylinder; Pharmaceuticals; Expired Pharmaceuticals; Med Surge; Expired Med Surge; Controlled Substances; Expired Controlled Substances; MES Trauma Field Set; and Equipment; a new DA Form 3161 is required.

Logistic Customer Site Visits
In order to stay current with increasing mission requirements and meet customer needs, the NMLC Pirmasens Detachment conducts customer site visits. During a site visit, the Detachment assists local logisticians in improving internal and external asset procurement and management. The site visit is a way for both the Detachment and the customer to improve their processes by addressing strengths, weaknesses, and identifying areas of poor understanding, it is not an inspection.

Visit Agenda:
Material Receipts
Inventory Management
Equipment Life Cycle Management
Document Control
Materiel Requests
Materiel Due-Ins
Emergency Requisition Management Plan

Visit Team Members (varies by site requirements)
NMLC – Pirmasens Detachment Staff
Clinical Engineering Staff
Logistical System Support

View of the USAMMCE warehouse in Pirmasens, Germany where Class VIII medical materiel and commodities are staged for use in theater. Pictured is a completed medical kit for a Unit in theater. Photo/Holger Kolsch, USAMMCE VI Department.

How to Become a Customer

Following up on its goal to provide increased customer support, the NMLC – Pirmasens Detachment, in cooperation with the U.S. Army Medical Materiel Center, Europe, has created an interactive website where customers can request an account for both the internal logistical system and the real-time Online Web Ordering system. Once an account has been created, the website can provide dynamic information on materiel, requisitions, and tracking information.

The website can be accessed at www.pirmasens.amedd.army.mil, click on Customer Support, click on New Customer.

This online management system has increased the information provided to the customer for materiel management. This site has assisted in improving customer databases and the ordering and distribution of supplies for both Navy and Marine Corps.

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Welcome Aboard

Julius Evans	Public Affairs Officer
HMCS Michael Holmes	Acting Master Chief
Seymour Davis	Information Management/Information Technology
Kimberly Conley	Medical Equipment and Logistics Solutions
Elizabeth Erdman	Medical Equipment and Logistics Solutions

Farewell

HMCS Ludwig	Transferred to USS George H.W. Bush (CVN-77)
Leah Barber	Maternity
CAPT Kaime	Transferred to Walter Reed
Tammy Buzzard	Transferred to Department of Veterans Affairs

PUBLIC AFFAIRS

2011 Senior Sailor of the 2nd Quarter

HM1 Kerry Tester-NEMSCOM

2011 Junior Sailor of the 2nd Quarter

OS2 Julius Wiseman, III-NMLC

Blue Jacket of the 2nd Quarter

HN Adam Walters-NOSTRA

Marian Tilliman

Junior Civilian of the 2nd Quarter

Deniz B. Mackey

Senior Civilian of the 2nd Quarter

NMLC hosted a visit from Capt. Raquel Bono (L), Deputy Director, Medical Resources, Plans and Policy for the Chief of Naval Operations and Rear Adm. Elaine Wagner (R), Director, Medical Resources Plans and Policy Division and Chief, Navy Dental Corps, on Aug. 19. The two were briefed on the state of NMLC. Photo/Sheila Gorman, NMLC.

Capt. J. B. 'Bernie' Poindexter, III, NMLC commanding officer, introduces the command brief during a visit from Capt. Raquel Bono, Deputy Director, Medical Resources, Plans and Policy for the Chief of Naval Operations and Rear Adm. Elaine Wagner, Director, Medical Resources Plans and Policy Division and Chief, Navy Dental Corps. The two paid a visit on Aug. 19 to become more familiar with NMLC. Photo/Sheila Gorman, NMLC.

PUBLIC AFFAIRS

Force Master Chief Laura A. Martinez (L) and Chief Cody Carter (R), enlisted technical leader of the Navy biomedical technicians at the Medical Education and Training Complex in San Antonio, Texas, address biomedical technicians at the first joint DoD Biomedical Equipment Technician Symposium, held June 23-25, 2011 in San Antonio, Texas. The symposium was held in conjunction with the 2011 Association for Advancement of Medical Instruction Conference and Expo. The event brought together biomedical equipment technicians from Army, Navy, and Air Force communities as well as their civilian counterparts. Photo/Eric Elane, NMLC.

(Left to right) Chief Casey Payne, NMLC, facilitates an open floor forum regarding effective biomedical equipment technician issues within the fleet. The open floor forum was part of the first joint DoD Biomedical Equipment Technician (BMET) Symposium, held June 23-25, 2011 in San Antonio, Texas. Members of the panel include, from left to right, Chief Richard Untalan, BMET representative, Commander Naval Surface Force, U.S. Atlantic Fleet; Chief Gerald Lee, BMET representative, Commander Naval Surface Force, U.S Pacific Fleet, Chief John McGilvery, NMLC; and Cliff Dunlap, Amphibious Ships, Medical and Dental Complex and Equipment Platform Manager, NMLC. Photo/Eric Elane, NMLC.

Hospital Corpsman 1st Class Michaeljames Soliven (L) and Chief Pete Mistica (R) examine a SimCube at the Pronk Technologies booth at the 2011 Association for Advancement of Medical Instruction Conference and Expo. A SimCube is a vital signs machine and analyzer that can be carried as part of equipment issue for a biomedical equipment technician. The event was held in conjunction with the first joint DoD Biomedical Equipment Technician Symposium, held June 23-25, 2011 in San Antonio, Texas. The event brought together biomedical equipment technicians from Army, Navy, and Air Force communities as well as their civilian counterparts. Photo/Eric Elane, NMLC.

LOGISTICALLY *speaking*

NAVAL MEDICAL LOGISTICS COMMAND

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Fort Detrick, Maryland 21702
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FRONT COVER PHOTO: Navy Rear Adm. Matthew L. Nathan, commander of the National Naval Medical Center, center, greets one of the last 18 patients at Walter Reed Army Medical Center being transferred to what will become the new Walter Reed National Military Medical Center in Bethesda, Md., Aug 27, 2011. Photo/Donna Miles, U.S. Department of Defense.

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