



Office of the Deputy Under Secretary of Defense

Installations

BRAC Knowledge Base

BRAC 1995

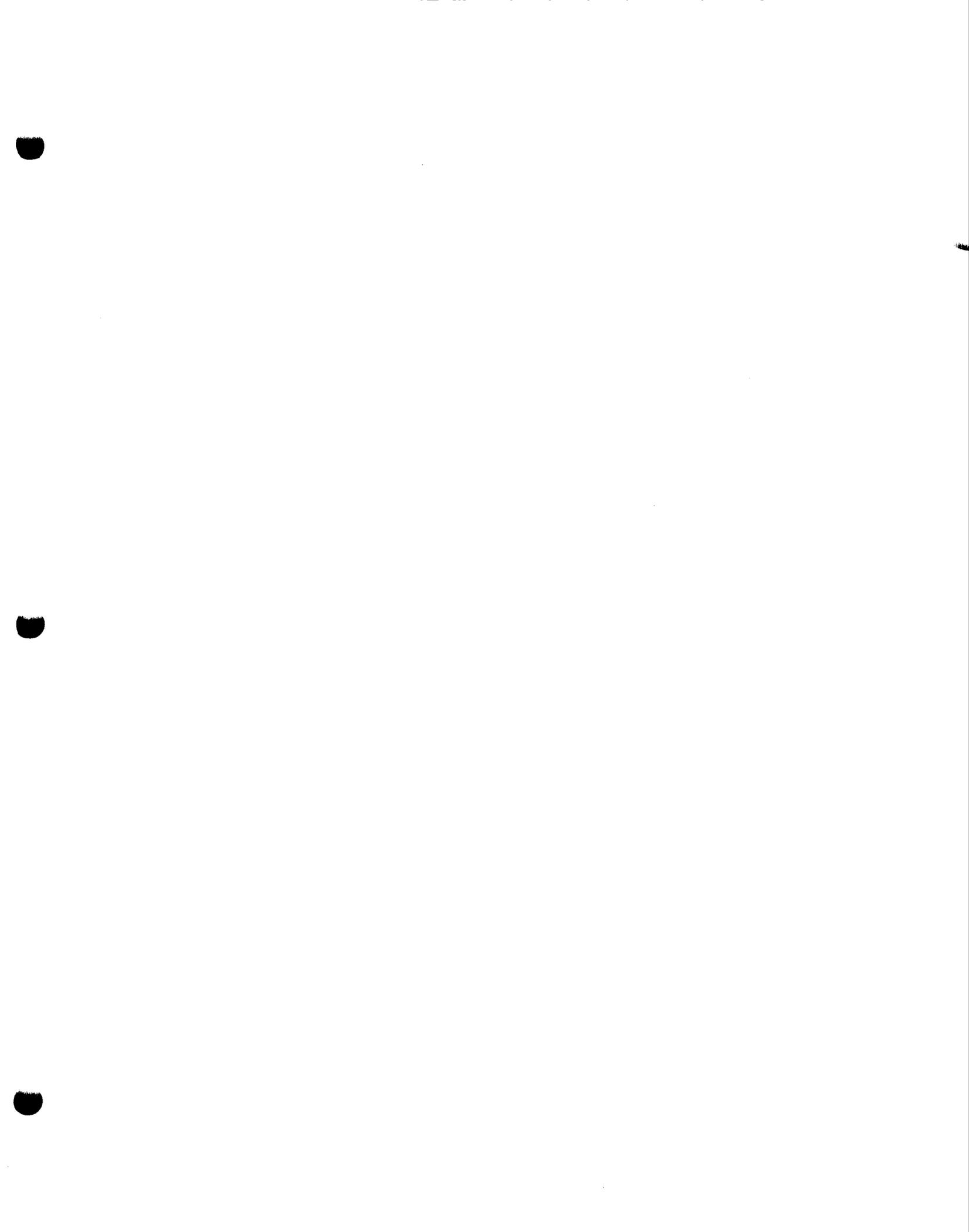
**Joint Cross-Service Group For
Medical Treatment Facilities and
Graduate Medical Education**

Meeting Minutes

**Volume II of III
March to December 1994**

**BRAC Knowledge Base
Room 3E1069, The Pentagon
Point of Contact: Mike McAndrew (703) 614-5356**

BRAC Knowledge Base No. MP952



CLOSE HOLD

MINUTES OF THE
MILITARY TREATMENT FACILITIES
AND GRADUATE MEDICAL EDUCATION
BRAC 95 JOINT CROSS SERVICE GROUP
MEETING OF MARCH 10, 1994

CLOSE HOLD

The sixth meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1400 hrs on March 10, 1994. The meeting was chaired by Dr. Edward D. Martin, Acting Assistant Secretary of Defense, Health Affairs.

After calling the meeting to order, the Chairman asked each of the members to review the minutes from the previous meeting (a copy of the minutes was passed around the table).

The Chairman then made several general comments to the Group:

1) While there seems to be some difficulty within several of the other Joint Cross-Service Groups on reaching a consensus on the Measures of Merit (MoMs), we appear to be doing well.

2) The third part of the "733" study will be briefed to the Group at its next meeting. The findings are compatible with what we are doing here.

3) The Air Force is in the process of closing some of its Emergency Rooms and realigning others (they are also looking at obstetrics). They could use the BRAC process to accomplish some of these actions if so desired.

4) The Inter Service Training Review Organization (ITRO) process is moving to closure with regard to the consolidation of medical training facilities. The review does not identify sites, but makes general recommendations relative to the streamlining of our training infrastructure.

5) Costing methodology. We needed a new costing methodology to allow us to compare the cost of DoD-provided care to that of the private sector. This will help us make better "make or buy" decisions. The costs will be part of our Measures of Merit.

The next item on the agenda was a discussion of the MoMs. It was noted that our MoMs do not include any measures of capacity. A discussion then ensued that included our data bases, utilization rates, population, demographics, peacetime vs wartime requirements and quality of life and their relationship to capacity. The working group was tasked to develop methods to measure and validate capacity.

The next subject was a presentation of a sample MoM summary scoring sheet. The Navy representative argued that the standard weights proposed by the working group are inconsistent with the Navy BRAC process.

CLOSE HOLD

The Chairman stated that Services are free to conduct analyses of their respective facilities using their own weights for the MoMs. However, their input to the Group will be based on analyses conducted in accordance with the weights agreed upon by the Group. The Navy responded that this would result in two scores and could have an adverse political impact. The Chairman stated the ultimately, the closure and realignment decisions will be made by the Service Secretaries and SECDEF. The Group, however, is tasked to provide the BRAC 95 Review Group with its views and opinions from a DoD perspective.

It was also noted that a precedent for two scores for a MoM had already been established. During the BRAC 91 and BRAC 93 analyses each of the Services estimated economic impact using their own models and also provided estimates using a DoD prescribed model. The estimates based on the DoD model became part of the Secretary's recommendations to the Base Realignment and Closure Commission.

The Chairman asked the Navy representative if the weights were the only problem seen with regards to the MoMs. He answered in the affirmative.

The next subject was a discussion of the beneficiary population required to justify a clinic, hospital and GME. Also, the absence of the retiree population from the Population MoM was questioned. The Chairman noted that the number of retirees in an area does not, in itself, justify the existence of a military treatment facility.

The Air Force representative asked that the Air Force's disagreement with the potential hospital population threshold of 25,000 be made a matter of record.

The Chairman asked the working group to re-run the population scoring system based on other than a linear scale in order to adjust the distribution to reflect the curve.

The Group briefly reviewed the remaining MoMs. The members were asked to peruse the MoM handouts prior to the next meeting.

The meeting adjourned at 1600 hrs. The next meeting is scheduled for March 17.

Approved Edward D. Martin
Edward D. Martin, MD
Acting ASD (HA)

Attachments

CLOSE HOLD

POSTED

BRAC 95
 JOINT CROSS SERVICE GROUP
 FOR MILITARY TREATMENT FACILITIES AND
 GRADUATE MEDICAL EDUCATION

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE#</u>	<u>ATTENDING 10 Mar 94</u>
CHAIR (AASD(HA) ASD(HA) (Designate)	Dr. Martin	703-697-2114	<u> x </u>
	Dr. Joseph	703-697-2114	<u> no </u>
DASD(ER/BRAC)	Mr. Bayer	703-697-1771	<u> x </u>
TEAM LEADER	RADM Koenig	703-697-8973	<u> x </u>
ARMY	BG Zajchuk	703-756-5680	<u> x </u>
NAVY NAVY	CAPT Golembieski	703-681-0461	<u> x </u>
	CDR Dilorenzo	703-681-0452	<u> x </u>
AIR FORCE AIR FORCE	Maj Gen Buethe	202-767-4343	<u> no </u>
	Brig Gen Hoffman	202-767-1849	<u> x </u>
JCS	COL Moore	703-697-4346	<u> x </u>
OASD (P&R)	Ms. St. Clair	703-696-8710	<u> (Mr. Monteleone) </u>
COMPT	Ms. Hiller	703-697-3101	<u> x </u>
PA&E	Mr. Dickens	703-697-2999	<u> x </u>
ODASD (ER/BRAC)	Mr. Miglionico	703-697-8050	<u> x </u>
DOD IG	Mr. Tomlin	804-766-3816	<u> x </u>
ODASD (HA)	Mr. Maddy	703-697-8979	<u> x </u>
ODASD (HA)	Dr. Mazzuchi	703-695-7116	<u> (Col Burkholder) </u>

OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 10 Mar 94</u>
OASD (HA)	Ms. Watson	703-697-8973	x
OASD (HA)	Ms. Giese	703-614-4705	x
OASD (HA)	Col Garner	703-614-4705	x
OASD (HA)	CDR Bally	703-614-4705	x
OASD (HA)	LTC Ponatoski	703-614-4705	x
OASD (HA)	LTC McClinton	703-614-4705	no
OASD (HA)	COL Baker	703-756-1918	x
ARMY	COL Barton	703-756-8319	no
ARMY	COL Wilcox	703-756-5681	no
ARMY	LTC Powell	703-697-3877	x
ARMY	LTC McGaha	703-697-6388	x
ARMY	MAJ Dudevoir	703-756-0286	x
ARMY	MAJ Parker	703-756-8036	no
ARMY	COL Lyons	703-756-0224	x
ARMY	MAJ Bond	703-256-8229	x
ARMY	COL Cassimatis	703-756-8036	x
NAVY	CAPT Buzzell	703-681-0475	no
NAVY	Ms. Davis	703-602-2252	no
NAVY	CDR DiLorenzo	703-602-0452	x
AIR FORCE	LtCol Silvernail	202-767-5550	no
AIR FORCE	LtCol Bannick	202-767-5066	x
AIR FORCE	Maj Costa	202-767-5066	x
AIR FORCE	Maj Pantaleo	202-767-5046	no
AIR FORCE	Capt Purcell	202-767-5066	x
LMI	Mr. Neve	301-320-7287	no
LMI	Ms. Dahut	301-320-7408	x
JS	LtCol Ferguson	703-697-4421	no
COMPT	Ms. Kopperman	703-697-4517	no
COMPT	Mr. Joseph Smith	703-697-4133	no
OASD(P&R)	Mr. Monteleone	703-696-8710	x
DODIG	Mr. Armstrong	804-766-3816	x

INTERSERVICE TRAINING REVIEW ORGANIZATION

HEALTH CARE COMMITTEE

PROPOSED MEASURES OF MERIT

MILITARY VALUE

Criterion 1 - Capability to Train to Meet the Wartime and Peacetime Mission Requirements

1. (C1) Number of students which must be trained annually to fill peacetime and wartime billet requirements
2. (C2) Availability/nonavailability of patient population at the training site

Criterion 2 - Availability of Training facilities and Clinical Sites

1. (F1) Condition codes of facilities based on DoD Real Property Inventory System
2. (F2) Age of facilities at existing site
3. (F3) Cost associated with training at the facility as determined by the process established by the ITRO-HCC
4. (F4) Medical equipment is consistent with accepted Standards of Care
5. (F5) Training facilities and equipment meet the Standards established by the ITRO-HCC
6. (F6) Military, Federal, and civilian educational and medical treatment facilities accessible to students and faculty

Criterion 3 - Ability to Accommodate Expansion of Training during Medical Contingency, Mobilization, and Operational Requirements

1. (R1) Access to sufficient additional space to erect temporary housing, messing, and training facilities
2. (R2) Ability of existing facilities to accommodate 24 hour, 7 day per week operations for a sustained period of time
3. (R3) Ability of existing facilities or access to new facilities to accommodate acute, emergent medical training requirements

Criterion 4 - Training Cost and Medical Manpower Implications

1. (M1) Training cost as calculated by the procedures established by the ITRO-HCC
2. (M2) Medical manpower cost as calculated by the procedures established by the ITRO-HCC

RETURN ON INVESTMENT (ROI)

Criterion 5 - Changes in the Efficacy of Medical Training

1. (V1) Analysis of potential cost/(savings) as calculated by the procedures established by the ITRO-HCC
2. (V2) Analysis of educational efficiencies
3. (V3) Changes in infrastructure resulting from command/organization consolidations

IMPACTS

Criterion 6 - Capacity of Communities' Infrastructure to Support Medical Personnel and Clinical Training Opportunities

1. (S1) Ability of the community to support the housing, educational, cultural, and recreational needs of the students, faculty, and their dependents
2. (S2) Availability of civilian and other Federal medical treatment facilities for clinical training opportunities

**BRAC 95 JOINT CROSS SERVICE GROUP
FOR MILITARY TREATMENT FACILITIES AND
GRADUATE MEDICAL EDUCATION**

**March 10, 1994
Room 4E327, 2:00 pm**

- Review/approve minutes from previous meeting Dr. Martin
- Rightsizing GME Dr. Martin
- Medical Training Facilities Dr. Martin
- Overview of Adjusted Standardized Amount (ASA) Cost Methodology Dr. Martin
- Measures of Merit (Mom) Issues LTC Ponatoski
- Action items for next meeting LTC Ponatoski
- Administrative Issues Dr. Martin

NEXT MEETING MARCH 17, 2:00 PM

PENTAGON 4E327

- Adjournment

ADJUSTED STANDARDIZED AMOUNTS

(ASAs)

Development for the Direct Care System

SUMMARY BRIEFING

DIRECT CARE ASA DEVELOPMENT: GOAL

- Develop a centralized set of Adjusted Standardized Amounts (ASA) per Relative Weighted Product (RWP) for use in the Direct Care System in a manner comparable to procedures utilized by the Health Care Financing Administration (HCFA) for Medicare and DoD for CHAMPUS reimbursement of inpatient care.
- These ASAs for FY 94 should include all expenses associated with Category III activities under capitation budgeting.

DIRECT CARE ASA DEVELOPMENT: OVERVIEW OF METHODOLOGY

(The following 8 steps are analogous to the CHAMPUS approach.)

1. Start with FY 92 total MEPRS-A inpatient expenses; remove selected MEPRS-E expenses; add selected MEPRS-F expenses to approximate Category III expenses. (Separate analysis for each of the three HCFA ASA application areas--Large Urban, Other Urban and Rural.)
2. Standardize for indirect medical education based on ratio of number of interns and residents to number of beds. Formula developed by HCFA.
3. Standardize for area wage rate differences. Area wage rate indices developed by HCFA.
4. Charge to cost conversion not applicable to Direct Care.

DIRECT CARE ASA DEVELOPMENT: OVERVIEW OF METHODOLOGY (CONT.)

5. Compute average Category III cost per Category III Relative Weighted Product (RWP) - preliminary base period standardized amount.
6. Adjust for inflation and the additional "burdening" of the MEPRS dollars exactly as in the centralized DRG method and the multiple services rate approach (OMS).
7. Split into labor and non-labor portions based on published Medicare and CHAMPUS proportions.
8. Apply ASAs to the local MTF to determine DRG-based third party reimbursement amounts for inpatient care.

DIRECT CARE ASA DEVELOPMENT:

1. Approximation of Category III expenses.
 - Data from all CONUS MTFs that treated inpatients throughout FY92 and submitted complete MEPRS and biometrics data.
 - From total MEPRS-A inpatient expenses, made additions and deletions.
 - Expenses Excluded:
 - Supplemental care stepped down to A-Accounts.
 - Selected MEPRS-E Accounts (overhead) as a percentage of total MEPRS-E expenses in each MTF.
 - Expenses Added:
 - Selected MEPRS-F Accounts (special programs) with selected MEPRS-E expenses removed.

DIRECT CARE ASA DEVELOPMENT:

2. Standardization for Indirect Medical Education (IME)

- **MEPRS-A expenses less approximated supplemental care and selected MEPRS-E expenses DIVIDED by the Medicare IME adjustment factor.**
- **Medicare IME factor based on operating beds and number of interns and residents.**

DIRECT CARE ASA DEVELOPMENT:

3. Area Wage Rate Standardization
 - For Direct Care ASA development, area wage adjustments applied only to estimated civilian pay and contract labor expense.
 - Each MTF associated with a large urban MSA, other urban MSA, or rural area -- the most likely source of civilian and contract labor force.
 - Area wage rate indices obtained from Health Care Financing Administration (HCFA).
 - Standardized amounts determined separately for MEPRS-A and MEPRS-F expenses so that the IME adjustments could be applied only to the MEPRS-A portion.

DIRECT CARE ASA DEVELOPMENT:

5. Computation of Category III Expense per Category III RWP
 - Relative Weighted Product (RWP) Calculation:
 - SIDR data mapped for FY94 ICD-9-CM coding changes.
 - FY92 RWPs computed using CHAMPUS Version 11.0 DRG weights and outlier thresholds.
 - RWPs Excluded as Category II Missions:
 - Diagnoses Not Normally Hospitalized (DXNNH); Potential Ambulatory Surgery (PAS); Active Duty Excessive Length of Stay (ADELS).

DIRECT CARE ASA DEVELOPMENT:

6. Burdening for Inflation and "Add-Ons"
 - DMDC/MEPRS Conversion Factor (\$77/day applied to MEPRS-A portion of ASAs only).
 - Civilian and Military Pay Raises.
 - Unfunded Civilian Retirement.
 - Asset Use Charge.
 - Inflation.

DIRECT CARE ASA DEVELOPMENT:

7. Report ASAs Separately for Labor and Non-Labor Portion of Expenses and MEPRS-A and MEPRS-F.
 - Labor and Non-Labor splits again based on published CHAMPUS/Medicare proportions.
 - MEPRS-A and MEPRS-F rates maintained separately.
 - ASAs published separately for each of the three ASA groups: Large Urban; Other Urban; Rural.

DIRECT CARE ASA DEVELOPMENT:

8. Application of ASAs
 - Thus far, preliminary ASAs have been developed by pooling MTF data in each of the three major ASA groups.
 - After development, ASAs are applied at the local MTF with adjustments for location, wage indices and teaching mission.
 - Labor portion of MEPRS-A and MEPRS-F ASAs multiplied by local area wage rate.
 - MEPRS-A portion multiplied by the MTF's IME factor.
 - Adjusted total multiplied by DRG relative weight to determine amount to bill third party payer.

DIRECT CARE ASA DEVELOPMENT: SUMMARY

- ASA approach unifies procedures.
- Direct Care more compatible with CHAMPUS and Medicare.
- Unified approach to DRG costing.
- Unified approach to billing.
- Entire MHSS can bill by DRG.
- Encoder/Grouper software.
- Enhanced utilization management.
- Can incorporate into RCMAS-OSE.
- Compatible with health care "market process."
- National urban vs. rural markets.
- Third-party payer comfort.
- Directly accounts for GME expenses.

SUBJECT: Third Party Payment for Inpatient Care Using DRGs

BACKGROUND: DoD has been using a Per Diem method to bill Third Party insurance companies since 1985. This Per Diem method used the average cost of an inpatient day as derived from the Medical Expense Reporting System (MEPRS). While this method was easy to compute insurance companies were less comfortable with this costing process. The use of Diagnosis Related Groups (DRGs) is industry standard for classifying patients and reimbursing for inpatient, acute care.

DISCUSSION: Adjusted Standardized Amount (ASA) is a term used to describe the method used by HHS, HCFA and OCHAMPUS to create payment amounts for hospitals. OCHAMPUS develops ASAs which represent the adjusted average operating costs for treating all CHAMPUS beneficiaries in all DRGs during a selected base period of time. Separate rates are developed for large urban areas, other urban areas and rural areas. The ASAs are divided into a labor and non-labor amount for application of area wage rate adjustments. *Hospitals* MTF with teaching programs receive an additional adjustment based upon the number of residents and interns in medical education. This DRG-based ASA methodology has been reproduced for MTF using Direct Care MEPRS data and the Metropolitan Statistical Area assignments of each MTF. A schematic chart is attached for reference.

Key Points:

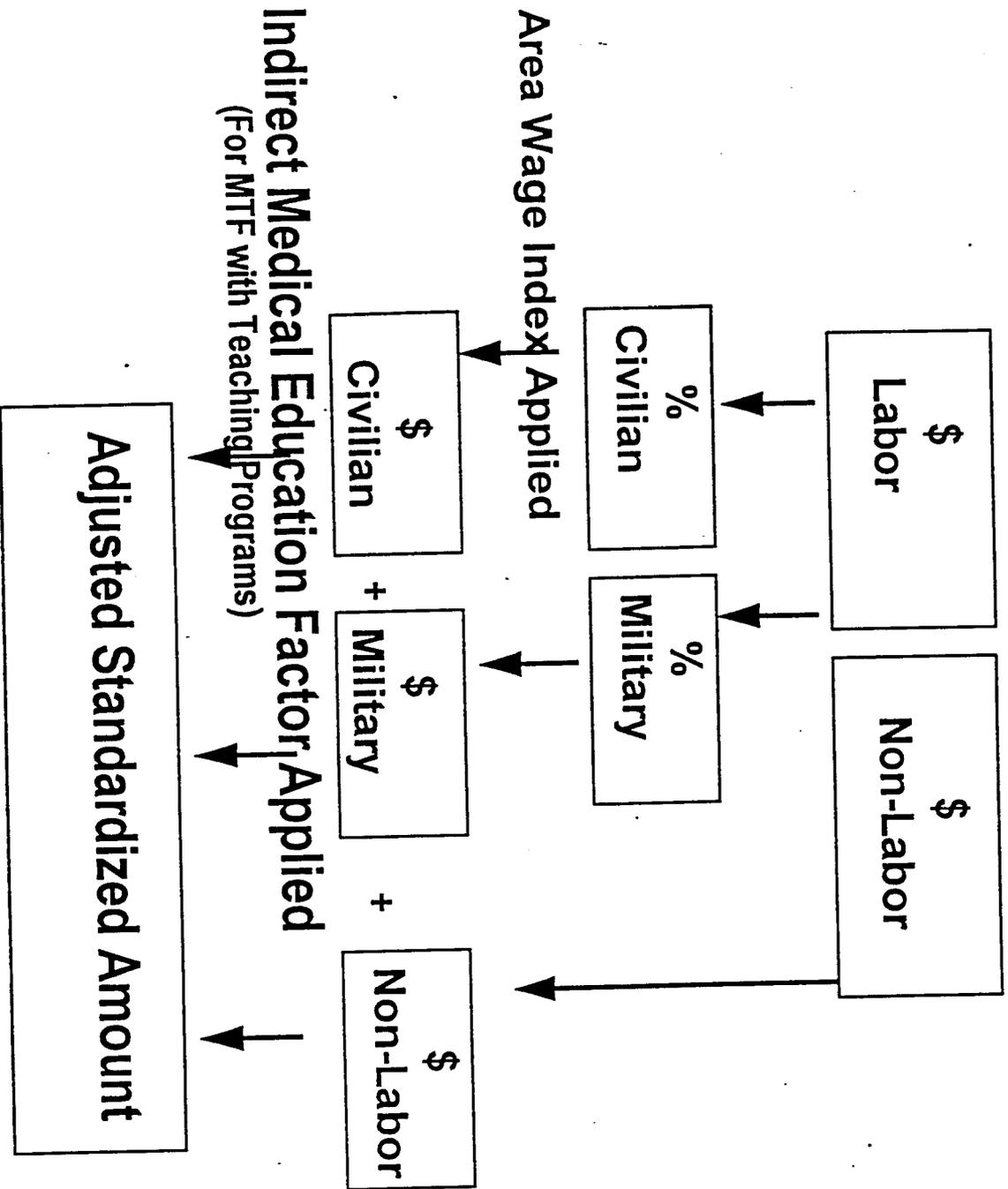
(1) *The ASA approach unifies procedures.* Using an ASA approach would make the CONUS Direct Care system more compatible with CHAMPUS and Medicare. The Direct Care System and CHAMPUS would use the same approach to DRG cost assignment. The entire Defense Health Program would be using the same method of billing for inpatient care across both components. There would be a unified approach to rate setting applied to most of the inpatient care funded by the Federal Government.

(2) The entire MHSS can bill by DRG. With the Encoder/Grouping software implemented in every Direct Care inpatient medical treatment facility, each patient can be assigned to the appropriate DRG and the appropriate billing information generated. In fact, concurrent DRG assignment, coupled with an "up front" knowledge of potential third party reimbursement amounts might provide incentive for enhanced utilization management. This could be incorporated in analysis provided in RCMAS-OSE to facilitate "make versus buy" decisions.

(3) Direct Care ASAs will be compatible with the current health care "market process". The ASA approach incorporates rates standardized to national hospital market regions (large urban markets, other urban markets and rural markets) and then adjusted for area wage rate differences and the costs of indirect medical education. Third party payors should be comfortable with this approach. This could potentially increase collection success.

(4) This Direct Care ASA approach best accounts for the costs associated with Graduate Medical Education (GME). Compared to alternative reimbursement methods (MEPRS-based per diem amounts), the ASA approach most directly accounts for the costs of indirect medical education (IME). The unique costs of each MTF would be more closely mirrored in rates determined at the MTF-specific level. In the ASA approach, the direct costs of medical education as well as capital costs as approximated by the asset use charge are averaged over all MTF in the particular ASA group (Large Urban, Other Urban or Rural).

Adjustment and Standardization Process



CENTRALIZED DRG/ASA DEVELOPMENT SUMMARY

31 January 1994

Direct Care ASA Implementation Topics

(1) **Advantages of the ASA approach.** Using an ASA approach would make the CONUS Direct Care system more compatible with CHAMPUS and Medicare. The Direct Care System and CHAMPUS would use the same approach to DRG cost assignment. The entire DHP would be using the same method of billing for inpatient care. There would be a unified approach to rate setting applied to most of the inpatient care funded by the Federal Government.

(2) **The entire MHSS can bill by DRG.** With the Encoder/Groupers implemented in virtually every Direct Care inpatient treatment facility, each patient can be assigned to the appropriate DRG and the appropriate billing information generated. In fact, concurrent DRG assignment, coupled with an "up front" knowledge of potential third party reimbursement amounts might provide incentive for enhanced utilization management. This could be incorporated in analysis provided in RCMAS-OSE to eventually facilitate "make versus buy" decisions (once marginal costing models are completed).

(3) **Direct Care ASAs will be compatible with the current health care "market process".** The ASA approach incorporates rates standardized to national hospital market regions (large urban markets, other urban markets and rural markets) and then adjusted for area wage rate differences and the costs of indirect medical education. Third party payors should be comfortable with this approach. This could potentially increase collection success.

(4) **This Direct Care ASA approach best accounts for the costs associated with Graduate Medical Education (GME).** Compared to alternative reimbursement methods (MEPRS-based multiple specialty per diem amounts; centralized, regional or MTF-specific rates), the ASA approach most directly accounts for the costs of indirect medical education (IME). The unique costs of each MTF would be more closely mirrored in rates determined at the MTF-specific level. In the ASA approach, the direct costs of medical education as well as capital costs as approximated by the asset use charge are averaged over all MTF in the particular ASA group (Large Urban, Other Urban or Rural). It should be noted, however, that a particular MTF may be underpaid or overpaid for its respective costs using the ASA method.

OVERVIEW OF CENTRALIZED DRG PROCESS

- Include all MTF providing inpatient care throughout FY 92.
- Start with FY 92 MEPRS-A inpatient expenses.
- Exclude approximation of supplemental care expenses.
- Exclude selected MEPRS-E (Admin/Overhead) expenses associated with Categories I/II.
- Incorporate selected MEPRS-F (Special Program) expenses associated with Category III.
- Exclude costs and RWPs associated with DXNNH, PAS and active duty excessive length of stay cases.
- Compute Category III cost per Category III RWP.
- Adjust for pay raises, inflation, MEPRS add-ons, etc.
- Present centralized, regional or MTF-specific rates.
- Apply CHAMPUS Version 11.0 weights, outlier thresholds and per diem policies to determine "bill" for care.

NOTES:

(1) Summary of calculations for Centralized rate, Region 1 rate and Bethesda rate attached.

(2) National average FY 94 civilian pay raise incorporated; regional information not available.

(3) Need final review of Category III policy regarding supplemental care and selected MEPRS E and F accounts.

CHAMPUS APPROACH: CHAMPUS develops ASAs which represent the adjusted average operating costs for treating all CHAMPUS beneficiaries in all DRGs during a selected base period of time. Separate rates are developed for large urban areas, other urban areas and rural areas. The ASAs are divided into a labor and non-labor amount for application of area wage rate adjustments. An overview of the process is shown below.

OVERVIEW OF CHAMPUS PROCESS

- Start with billed charges, apply record edits. (Separate database for each of the three ASA application areas.)
- Standardize for indirect medical education based on ratio of number of interns and residents to number of beds. Formula developed by HCFA.
- Standardize for area wage rate differences. Area wage rate indices developed by HCFA.
- Convert charges to costs using national average Medicare cost-to-charge ratio, currently 0.617, plus a 1% add-on for bad debt. Note that capital costs and the direct costs of medical education are excluded by this ratio. These costs are paid as a pass-through by CHAMPUS, although Medicare is beginning to allocate capital costs on the basis of DRGs.
- Compute average cost per discharge - preliminary base period standardized amount.
- Update for inflation and other ASA update factors. These factors have historically been used to correct for underpayments to rural hospitals.
- Split into labor and non-labor portions based on published Medicare proportions.
- Standardize to anticipated total DRG based outlays in each of the three ASA groups.

NOTES:

(1) In applying the CHAMPUS ASA to an individual hospital, the labor portion is multiplied by the area wage rate index and then added to the non-labor portion. This adjusted total is multiplied by the DRG relative weight and, finally, by the Indirect Medical Education (IME) factor for the individual hospital. This determines the hospital's Allowed Amount.

(2) The ASAs represent only hospital costs which are applied to DRGs and do not include professional services fees nor pass-throughs for direct medical education (DME) and capital expense. Average capital and DME payments to CHAMPUS hospitals total 11.64%. Average inpatient professional services fees add-on is 36.5% of DRG amount based on previous research.

(3) CHAMPUS ASAs for FY 1994 are shown in the following table together with approximations of the average impact of inpatient professional services fees as well as DME and capital pass-throughs.

(4) It is important to note that the published CHAMPUS ASAs include costs which some patients would pay due to required co-payments. Thus, the overall cost to the government can be less than as reflected in the ASAs.

FY 1994 CHAMPUS ADJUSTED STANDARDIZED AMOUNTS

CATEGORY	PUBLISHED ADJUSTED STANDARDIZED AMOUNT (ASA)	ESTIMATED CAPITAL & DIRECT MEDICAL EDUCATION	TOTAL INCLUDING DME AND CAPITAL	ESTIMATED PROFESSIONAL SERVICE FEES	ADJUSTED TOTAL
National Large Urban Adjusted Standardized Amount	\$3,240.36	\$377.18	\$3,617.54	\$1,182.73	\$4,800.27
Labor portion	2,294.82				
Non-labor portion	945.54				
National Other Urban Adjusted Standardized Amount	\$3,187.67	\$371.04	\$3,558.71	\$1,163.50	\$4,722.21
Labor portion	2,257.51				
Non-labor portion	930.16				
National Rural Adjusted Standardized Amount	\$3,213.45	\$374.05	\$3,587.50	\$1,172.91	\$4,760.41
Labor portion	2,430.33				
Non-labor portion	783.12				

Direct Care Adjusted Standardized Amount (ASA)

GOAL: Develop a centralized set of Adjusted Standardized Amounts (ASA) per Relative Weighted Product (RWP) for use in the Direct Care System in a manner comparable to procedures utilized by HCFA and CHAMPUS. These ASAs for FY 94 should include all expenses associated with Category III activities under capitation budgeting.

OVERVIEW OF DIRECT CARE PROCESS

- Start with FY 92 MEPRS-A inpatient expenses, remove selected MEPRS-E expenses and add selected MEPRS-F expenses to approximate Category III expenses as in the centralized DRG rate development. (Separate analysis for each of the three ASA application areas.)
- Standardize for indirect medical education based on ratio of number of interns and residents to number of beds. Formula developed by HCFA.
- Standardize for area wage rate differences. Area wage rate indices developed by HCFA.
- Charge to cost conversion not applicable to Direct Care.
- Compute average Category III cost per Category III Relative Weighted Product (RWP) - preliminary base period standardized amount.
- Adjust for inflation and the additional "burdening" of the MEPRS dollars exactly as in the centralized DRG method and the multiple service rate approach as shown before.
- Split into labor and non-labor portions based on published Medicare proportions.
- Standardize or adjust rates to apply to individual MTF, Health Services Regions, CHAMPUS/HCFA ASA groups, etc. as desired.

**PRELIMINARY FY 1994 DIRECT CARE
ADJUSTED STANDARDIZED AMOUNTS PER RWP**

CATEGORY	ASA PER RWP		
	MEPRS-A	MEPRS-F	TOTAL
Direct Care Large Urban Adjusted Standardized Amount	\$3,758.21	\$324.05	\$4,082.26
Labor portion	2,660.81	229.43	2,890.24
Non-labor portion (n = 27 CONUS MTF; 45.5% of Total RWP)	1,097.40	94.62	1,192.02
Direct Care Other Urban Adjusted Standardized Amount	\$3,999.99	\$328.93	\$4,328.92
Labor portion	2,831.99	232.88	3,064.88
Non-labor portion (n = 60 CONUS MTF; 48.1% of Total RWP)	1,168.00	96.05	1,264.04
Direct Care Rural Adjusted Standardized Amount	\$4,736.62	\$209.42	\$4,946.04
Labor portion	3,580.88	158.32	3,739.21
Non-labor portion (n = 29 CONUS MTF; 6.4% of Total RWP)	1,155.74	51.10	1,206.83
Overall Direct Care ASA	\$3,937.12	\$319.06	\$4,256.18

NOTES:

- (1) Preliminary FY 1994 direct care ASAs per RWP are shown in the table above.
- (2) In applying the Direct Care ASA to an individual hospital, the labor portion is multiplied by the area wage rate index and then added to the non-labor portion. The MEPRS-A adjusted total is multiplied by the Indirect Medical Education (IME) factor for the individual hospital. The MEPRS-F adjusted total is multiplied only by the area wage rate index. The MEPRS-A and -F amounts are then added together. This determines the total to be multiplied by the DRG relative weight (with appropriate outlier rules) to produce the amount for which the hospital would "bill" the third party payor.
- (3) An example of the above application to Bethesda is included.
- (4) Issues surrounding supplemental care and adjustments for MEPRS E and F expenses are applicable to ASAs also.
- (5) Refinement of current IME adjustment factors for Medical Centers needs to be explored. Current estimates of bed-size and numbers of residents and interns could be improved with newer information than was available when this portion of the analysis was completed.

BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

■ Approach to Development of Scoring Methodology for Measures of Merit

- Use what we know to develop criteria measurement points
- Define ranges, mean, standard deviation, and overall distribution of data. Develop rational scoring system using range and data distribution

BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

- Measures of Merit Worksheet consists of
 - Data Elements
 - What is to be measured
 - Source
 - Where to find it
 - Basis
 - How scoring methodology was developed
 - Calculation
 - Math required to score specific Measures of Merit

**MEASURE OF MERIT WORKSHEET
P1: Population**

COMMUNITY HOSPITALS

DATA ELEMENT: The number of active duty personnel and their families within a defined catchment area. The catchment area is defined as sets of zip codes emanating from the center of the MTF with a radius of 40 miles.

SOURCE: Defense Medical Information System (DMIS) - FY 93

Minimum = 3,024
 Maximum = 115,994
 Quartile 1 = 13,117
 Median = 17224
 Quartile 3 = 29,893
 Mean = 25,639
 STD Dev = 20558
 n= 81

GME CENTERS

DATA ELEMENT: The number of active duty personnel and their families residing within the Lead Agent Region as defined by the July 93 Health Affairs Policy Guidance.

SOURCE: Defense Medical Information System (DMIS) - FY 93

Minimum = 117,172
 Maximum = 562,254
 Quartile 1 = 170,049
 Median = 285,201
 Quartile 3 = 487,209
 Mean = 325,330
 STD Dev = 157,296
 n= 12

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS										
HOSPITAL	<5K	10K	15K	20K	25K	30K	35K	40K	45K	>50K
GME CENTER	<120K	160K	200K	260K	300K	360K	400K	460K	500K	>540K

MEASURE OF MERIT WORKSHEET
A1: Civilian Primary Care Physician Ratio

CLINICS & COMMUNITY HOSPITALS

DATA ELEMENT: The ratio of primary care civilian physicians to the total forty mile catchment area population.

BASIS: This ratio is based on the January 1993 Catchment Area Directory (CAD) using ratios defined in the HHS Federal Register, Sept, 1991. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians.

SOURCE: Donnelly Marketing Information Services

GME CENTERS

DATA ELEMENT: The ratio of primary care civilian physicians to the total population residing within the Lead Agent Region as defined by the July 93 Health Affairs Policy Guidance.

BASIS: This ratio is based on the January 1993 Catchment Area Directory (CAD) using ratios defined in the HHS Federal Register, Sept, 1991. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians.

SOURCE: Donnelly Marketing Information Services

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1:1000	1:1250	1:1500	1:1750	1:2000	1:2250	1:2500	1:2750	1:3000	1:3500
HOSPITAL	1:1000	1:1250	1:1500	1:1750	1:2000	1:2250	1:2500	1:2750	1:3000	1:3500
GME CENTER	1:1000	1:1250	1:1500	1:1750	1:2000	1:2250	1:2500	1:2750	1:3000	1:3500

**MEASURE OF MERIT WORKSHEET
A2: Civilian and VA Inpatient Acute Care Capability**

CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

DATA ELEMENTS:

- # of acute care hospitals within the catchment area
- # of operating beds at each hospital
- Bed occupancy rate at each hospital
- JCAHO accreditation status at each hospital
- MTF operating beds

SOURCE: Donnely Marketing Information Services
DMIS for MTF operating beds

BASIS: This MOM measures the ability of local community acute care facilities to provide comprehensive health services to the eligible beneficiary population. Due to competition issues, this measure is viable only if there is more than two local community hospitals.

CALCULATION:

- If # of JCAHO acute care facilities < 2, then score = 10, else
- $\sum \# \text{ of facilities } (1 - \text{occupancy rate}) \times (\text{operating beds}) + \text{MTF operating beds} = \text{ratio of civilian acute care operating beds to MTF operating beds}$

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS										
HOSPITAL	5 : 1	4.5 : 1	4 : 1	3.5 : 1	3 : 1	2.5 : 1	2 : 1	1.5 : 1	1 : 1	<1:1
GME CENTER	5 : 1	4.5 : 1	4 : 1	3.5 : 1	3 : 1	2.5 : 1	2 : 1	1.5 : 1	1 : 1	<1:1

MEASURE OF MERIT WORKSHEET

F1: Condition Code

1st Measure: CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

1st DATA ELEMENTS: Facility Condition Assessment Score.

SOURCE: MTF Commander

BASIS: This MOM reflects the summary score of the facility condition based on calculated weighted factors assigned to functional and building systems and then normalized to 100.

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
HOSPITAL	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
GME CENTER	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100

2d Measure: CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

2d DATA ELEMENT: Rating of the facility on a 1-3 scale by the installation engineer.

SOURCE: Installation Real Property Data Card

BASIS: This MOM reflects the condition of the facility as reported by the Base Engineer.

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1				2					3
HOSPITAL	1				2					3
GME CENTER	1				2					3

**MEASURE OF MERIT WORKSHEET
F2: AGE OF FACILITY**

CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

DATA ELEMENTS: Average Square Foot Age.

SOURCE: Real Property Data Card/DMIS

BASIS: Current MILCON planning procedures provide for a 25 year life cycle for medical facilities

CALCULATION: For each DMIS ID

$$\begin{aligned} & \sum (\text{Chronological Building Age} * \text{Building Gross Square Feet}) \\ & + \\ & \sum \text{Total Gross Square Feet} = \text{Average Square Foot Age} \end{aligned}$$

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
HOSPITAL	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
GME CENTER	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1

**MEASURE OF MERIT WORKSHEET
C1: COST OF MILCON**

CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

DATA ELEMENTS: Cost as described in DoD Medical MILCON Program over the Future Years Defense Program (FYDP)

SOURCE: Defense Medical Facilities Office, OASD (HA)

BASIS: MILCON projects range between \$500,000 and \$98,000,000 over the FYDP period.

Minimum = \$500,000
 Maximum = \$98,000,000
 Median = \$6,400,000
 Quartile 1 = \$3,350,000
 Quartile 3 = \$15,000,000
 Mean = \$13,065,000
 STD = \$17,212,000
 n = \$174

IN MILLIONS OF DOLLARS

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	<26	26	15	10	8	6.5	4.5	3.5	2	<1
HOSPITAL	<26	26	15	10	8	6.5	4.5	3.5	2	<1
GME CENTER	<26	26	15	10	8	6.5	4.5	3.5	2	<1

MEASURE OF MERIT WORKSHEET
F3: Joint Commission on Accreditation of Health Care Organizations
Plant, Technology, and Safety Management

CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

DATA ELEMENTS: Scores of most recent JCAHO accreditation surveys

SOURCE: Facility Commander

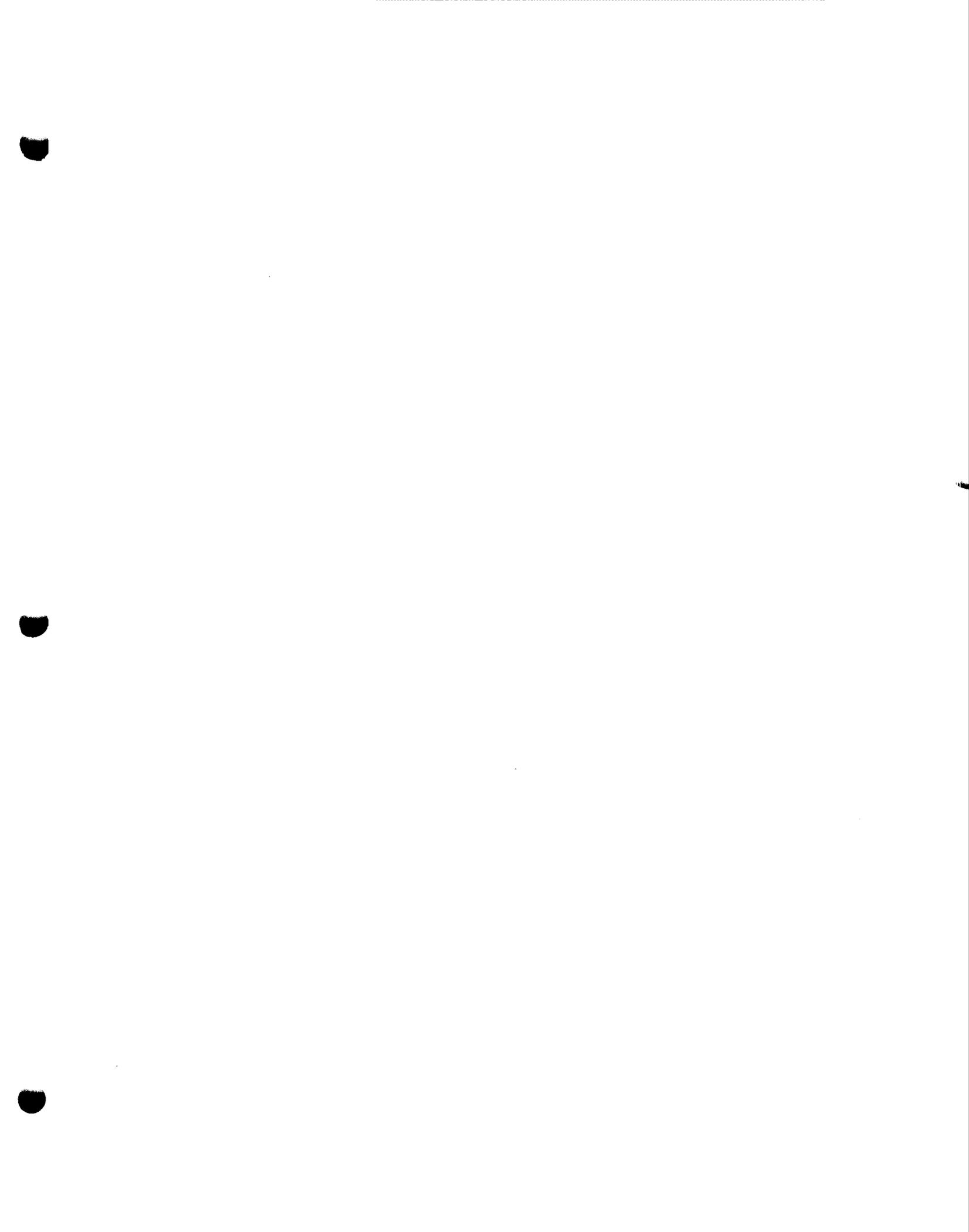
BASIS: Plant, Technology, and safety scores from the most recent JCAHO survey are summed and averaged. JCAHO evaluations encompass the following areas:

- Safety Management
- Life Safety Management
- Equipment Management
- Utilities Management

Scoring methods are as follows:

- 1 = Substantial compliance
- 2 = Significant compliance
- 3 = Partial compliance
- 4 = Minimal compliance
- 5 = No compliance

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS										
HOSPITAL	5		4		3			2		1
GME CENTER	5		4		3			2		1



CLOSE HOLD

**MINUTES OF THE
MILITARY TREATMENT FACILITIES
AND GRADUATE MEDICAL EDUCATION
BRAC 95 JOINT CROSS SERVICE GROUP
MEETING OF MARCH 17, 1994**

CLOSE HOLD

The seventh meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1500 hrs on March 17, 1994. The meeting was chaired by Dr. Edward D. Martin, Acting Assistant Secretary of Defense, Health Affairs.

The Chairman opened the meeting and informed the members that the minutes of the last meeting will be available at the next scheduled meeting.

A discussion related to inclusion of the medical training facilities as part of the Group's efforts ensued. The Navy representative objected to this and stated that it was not part of the Group's charter, was being handled separately by the Navy, and its inclusion is coming about too late in the process.

The Chairman stated that he would clarify the Group's charter with the Chairman of the BRAC 95 Steering Group. The Chairman also made the following observations regarding the inclusion of the training facilities in the Group's efforts:

- 1) The Inter-Service Training Review Organization (ITRO) has almost completed its review of the consolidation of the school curricula, etc.
- 2) Training site locations are greatly dependent on the location of hospitals.
- 3) Including training in the BRAC process is a logical undertaking.
- 4) The ITRO analysis is compatible with those of the Services.

The next item on the agenda was a discussion of the draft Internal Control Plan (ICP). It was noted that the ICP was reviewed by the BRAC 95 Steering Group at its last meeting. Several changes requested by the Steering Group members are being incorporated after which the ICP will go to the DoD IG and OGC for coordination.

A brief overview of the third part of the "733" study was then presented to the Group.

The last item was a review of the progress of the working group's development of the Measures of Merit (MoMs). The first item was the Population measure the working group had been asked to review. The Group discussed the alternatives and agreed upon option one.

MoMs for Contingency were presented, and after a short discussion, were agreed upon by the Group.

CLOSE HOLD

07/10/11
The draft report due to the BRAC 95 Steering Group on March 24 will be presented to the Group at the next scheduled meeting.

The meeting adjourned at 1630 hrs. The next meeting is scheduled for March 24.

Approved Edward D. Martin
Edward D. Martin, MD
Acting ASD (HA)

Attachments

CLOSE HOLD

CLOSE HOLD

BRAC 95
 JOINT CROSS SERVICE GROUP
 FOR MILITARY TREATMENT FACILITIES AND
 GRADUATE MEDICAL EDUCATION

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE#</u>	<u>ATTENDING 17 Mar 94</u>
CHAIR (AASD(HA) ASD(HA) (Designate)	Dr. Martin	703-697-2114	<u>X</u>
	Dr. Joseph	703-697-2114	<u>NO</u>
DASD(ER/BRAC)	Mr. Bayer	703-697-1771	<u>NO</u>
TEAM LEADER	RADM Koenig	703-697-8973	<u>NO</u>
ARMY	BG Zajchuk	703-756-5680	<u>(COL Lyons)</u>
NAVY NAVY	CAPT Golembieski	703-681-0461	<u>X</u>
	CDR Dilorenzo	703-681-0452	<u>X</u>
AIR FORCE AIR FORCE	Maj Gen Buethe	202-767-4343	<u>X</u>
	Brig Gen Hoffman	202-767-1849	<u>NO</u>
JCS	COL Moore	703-697-4346	<u>(CAPT Edwards)</u>
OASD (P&R)	Ms. St. Clair	703-696-8710	<u>X</u>
COMPT	Ms. Hiller	703-697-3101	<u>X</u>
PA&E	Mr. Dickens	703-697-2999	<u>X</u>
ODASD (ER/BRAC)	Mr. Miglionico	703-697-8050	<u>X</u>
DOD IG	Mr. Tomlin	804-766-3816	<u>X</u>
ODASD (HA) ODASD (HA)	Mr. Maddy	703-697-8979	<u>NO</u>
	Dr. Mazzuchi	703-695-7116	<u>(COL Burkhalter)</u>

OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 17 Mar 94</u>
OASD (HA)	Ms. Watson	703-697-8973	<u>NO</u>
OASD (HA)	Ms. Giese	703-614-4705	<u>X</u>
OASD (HA)	Col Garner	703-614-4705	<u>NO</u>
OASD (HA)	CDR Bally	703-614-4705	<u>X</u>
OASD (HA)	LTC Ponatoski	703-614-4705	<u>X</u>
OASD (HA)	LTC McClinton	703-614-4705	<u>NO</u>
OASD (HA)	COL Baker	703-756-1918	<u>X</u>
ARMY	COL Barton	703-756-8319	<u>NO</u>
ARMY	COL Wilcox	703-756-5681	<u>NO</u>
ARMY	LTC Powell	703-697-3877	<u>NO</u>
ARMY	LTC McGaha	703-697-6388	<u>NO</u>
ARMY	MAJ Dudevoir	703-756-0286	<u>X</u>
ARMY	MAJ Parker	703-756-8036	<u>X</u>
ARMY	COL Lyons	703-756-0224	<u>X</u>
ARMY	MAJ Bond	703-256-8229	<u>NO</u>
ARMY	COL Cassimatis	703-756-8036	<u>NO</u>
NAVY	CAPT Buzzell	703-681-0475	<u>NO</u>
NAVY	Ms. Davis	703-602-2252	<u>NO</u>
NAVY	CDR DiLorenzo	703-602-0452	<u>X</u>
AIR FORCE	LtCol Silvernail	202-767-5550	<u>X</u>
AIR FORCE	LtCol Bannick	202-767-5066	<u>X</u>
AIR FORCE	Maj Costa	202-767-5066	<u>X</u>
AIR FORCE	Maj Pantaleo	202-767-5046	<u>NO</u>
AIR FORCE	Capt Purcell	202-767-5066	<u>NO</u>
LMI	Mr. Neve	301-320-7287	<u>NO</u>
LMI	Ms. Dahut	301-320-7408	<u>NO</u>
JS	LtCol Ferguson	703-697-4421	<u>NO</u>
COMPT	Ms. Kopperman	703-697-4517	<u>NO</u>
COMPT	Mr. Joseph Smith	703-697-4133	<u>NO</u>
OASD(P&R)	Mr. Monteleone	703-696-8710	<u>X</u>
DODIG	Mr. Armstrong	804-766-3816	<u>NO</u>
DODIG	Ms. Givan	804-766-3816	<u>X</u>

**BRAC 95 JOINT CROSS SERVICE GROUP
FOR MILITARY TREATMENT FACILITIES AND
GRADUATE MEDICAL EDUCATION**

**March 17, 1994
Room 4C266, 3:00 PM**

- Review/approve minutes from previous meeting Dr. Martin
- 733 Study Update Mr. Dickens
- Medical Training Facilities Dr. Martin
- Draft Internal Control Plan (Handout) LTC Ponatoski
 - Validation of Data Sources
- Guidance on Draft Report LTC Ponatoski
- Measures of Merit (Mom) Update LTC Ponatoski
- Action items for next meeting LTC Ponatoski
- Administrative Issues Dr. Martin

NEXT MEETING MARCH 24, 2:00 PM

PENTAGON

- Adjournment

BRAC-95 STEERING GROUP

**DISCUSSION ISSUES ON THE INTERNAL CONTROL PLAN
FOR THE BRAC-95 JOINT CROSS-SERVICE GROUPS**

The proposed Internal Control Plan for the Joint Cross-Service Groups makes the following points:

- The Joint Cross-Service Groups will not be gathering original data, but will specify the data required to be gathered by the Military Departments and Defense Agencies.
- Only the BRAC-95 Review Group and the Secretaries of the Military Departments are empowered to make specific closure or realignment recommendations to the SECDEF.
- The use of other DoD and Federal agencies, private sector contractors, or any other private or public organization to conduct such analyses will not be permitted unless specifically authorized by the BRAC-95 Review Group.
- The Joint Cross-Service Groups will coordinate their information requests with the respective BRAC-95 organizations of each Military Department and the Defense Agencies.
- In addition to the full and open access granted to the GAO, such access will be granted to the DoD Inspector General regarding records, data, information and other materials either collected or retained by the Joint Cross-Service Groups.

DRAFT

***Internal Control Plan for Managing
the Identification of DoD Cross-Service Opportunities
as Part of the DoD 1995 Base Realignment and
Closure Process (BRAC-95)***

Background

The exclusive procedures by which the Secretary of Defense (SECDEF) may pursue realignment or closure of military installations inside the United States are contained in Part A, Title XXIX of Public Law 101-510, entitled as the Defense Base Closure and Realignment Act of 1990; as amended by Public Law 102-190 and Public Law 103-160; hereafter referred to as the Base Closure Act. The Base Closure Act also includes a provision for the President to appoint independent Base Closure and Realignment Commissions to review the Secretary of Defense's recommendations in calendar years 1991, 1993, and 1995.

The Deputy Secretary of Defense (DEPSECDEF), in a memorandum dated 7 January 1994, set forth guidance, policy, procedures, authorities and responsibilities for recommending bases for realignment or closure for submission to the 1995 Defense Base Closure and Realignment Commission. The DEPSECDEF guidance included a requirement for the establishment of BRAC-95 Joint Cross-Service Groups in six areas with significant potential for cross-service impacts in BRAC-95.

Five of the Joint Cross-Service Groups are functional areas encompassing Depot Maintenance, Test and Evaluation, Laboratories, Military Treatment Facilities including Graduate Medical Education, and Undergraduate Pilot Training. These functional groups shall, when operationally and cost effective, strive to: retain in only one Service militarily unique capabilities used by two or more Services; consolidate workload across the Services to reduce excess capacity; and assign operational units from more than one Service to a single base. A sixth Joint Cross-Service Group was formed as a Joint Economic Impact Group to establish guidelines for measuring economic impacts. The five functional area joint cross-service groups have been tasked by the DEPSECDEF to:

- o determine the common support functions and bases to be addressed by each cross-service group;
- o establish the guidelines, standards, assumptions, measures of merit, data elements and milestone schedules for DoD Component conduct of cross-service analyses of common support functions;
- o oversee DoD Component cross-service analyses of these common support functions;

DRAFT

DRAFT

- identify necessary outsourcing policies and make recommendations regarding those policies;
- review excess capacity analyses;
- develop closure or realignment alternatives and numerical excess reduction targets for consideration in such analyses; and
- analyze cross-service tradeoffs.

The economic impact joint cross-service group has been tasked by the DEPSECDEF to:

- establish the guidelines for measuring economic impact and, if practicable, cumulative economic impact; to analyze DoD Component recommendations under those guidelines; and
- develop a process for analyzing alternative closures or realignments necessitated by cumulative economic impact considerations, if necessary.

The DEPSECDEF directed the BRAC-95 Joint Cross-Service Groups to complete the above analytical design tasks and issue guidance to the DoD Components, after review by the BRAC-95 Review Group, no later than 31 March 1994.

Purpose

The primary purpose of this Internal Control Plan is to provide a consistent set of management controls for all Joint Cross-Service Groups and to meet the requirements established by the DEPSECDEF regarding the DoD Component cross-service analyses of all assets within each category, as announced in his Memorandum of 7 January 1994. More specifically, the DEPSECDEF directed the Joint Cross-Service Groups to develop and implement an Internal Control Plan to ensure the accuracy of data collection for conducting base realignment or closure assessments. At a minimum this Internal Control Plan includes:

- Uniform guidance defining data requirements and sources;
- Systems for verifying the accuracy of data at all levels of command;
- Documentation justifying changes made to data received from subordinate commands;
- Procedures to check the accuracy of the analyses made from the data; and

DRAFT

DRAFT

- Assessment by auditors of the adequacy of this Internal Control Plan.

In addition to the above requirements, DEPSECDEF requires that the Internal Control Plan incorporate certification procedures required by the Base Closure Act. The Joint Cross-Service Groups will not be gathering original data, but will specify the data required to be gathered by Military Departments and Defense Agencies. Therefore, all data and information provided to the Joint Cross-Service Groups for purposes of analysis and decision making are required to be certified as accurate and complete by the Military Departments and Defense Agencies in accordance with their respective BRAC-95 Internal Control Plans.

Responsibilities

The BRAC-95 Steering Group will oversee implementation and adherence to this Internal Control Plan by the Joint Cross-Service Groups. The basic goal of this Internal Control Plan is to ensure consistency in the data gathered and used, application of selection criteria, methodology and reports to the SECDEF and subsequently to the 1995 Base Closure and Realignment Commission.

The Secretaries of the Military Departments, the OSD Secretariats, and the Directors of the Defense Agencies are responsible for providing staff resources to the Joint Cross-Service Groups. The Chairs of the individual Joint Cross-Service Groups are responsible for ensuring that the members of the Groups are fully aware of the management controls presented in this Internal Control Plan. Team members are responsible for implementing and adhering to the controls while also reporting to the Chairs any noted control violations or weaknesses identified during the collection and analysis of data. The Chairs of the Joint Cross-Service Groups are authorized to implement further guidance to control the functioning of their respective Groups in a way as to meet the intent of this Internal Control Plan.

Internal Control Mechanisms

The objective of the internal control mechanisms to be employed by the Joint Cross-Service Groups is to ensure the accuracy, completeness, and integrity of the information upon which the SECDEF recommendations for closures and realignments will be based. The two principal mechanisms are organization and documentation.

Organization Controls.

Under the oversight and guidance of the DEPSECDEF, there are four groups/organizations within the DoD which have primary responsibility for assisting the SECDEF to identify cross-service asset sharing opportunities. To ensure the integrity of the selection process, the four groups/organizations are to be separated by distinct functional

DRAFT

DRAFT

boundaries and levels of decision making authority. The Chair and membership for each Joint Cross-Service Group have already been determined and assigned by the DEPSECDEF. Individual members to the Groups have also been appointed by the OSD Secretariats, the Secretaries of the Military Departments and the Directors of the Defense Agencies.

BRAC-95 Review Group. The BRAC-95 Review Group is empowered to develop recommendations to the SECDEF regarding cross-service tradeoffs and asset sharing opportunities. Only the BRAC-95 Review Group and the Secretaries of the Military Departments are empowered to make specific closure or realignment recommendations to the SECDEF. The BRAC-95 Review Group is responsible for ensuring that a fair and complete analysis was conducted for every cross-service tradeoff and asset sharing opportunity that results in a recommendation made to the SECDEF. This includes overseeing the work of the Steering Group and making decisions regarding definitions, assumptions, measures of merit, excess capacity, military value, return on investment, and other impacts deemed appropriate.

BRAC-95 Steering Group. The BRAC-95 Steering Group is a subordinate organization to the BRAC-95 Review Group. It will oversee the actions of the Joint Cross-Service Groups. The results of such direction and evaluations will be periodically reported to the BRAC-95 Review Group. The BRAC-95 Steering Group will rely on the Joint Cross-Service Groups to review analyses of potential cross-service tradeoffs, cross-service asset sharing and closure or realignment opportunities. The use of other DoD and Federal agencies, private sector contractors, or any other private or public organization to conduct such analyses will not be permitted unless specifically authorized by the BRAC-95 Review Group. This prohibition includes any analysis relating to capacity analysis, military value, return on investment, and other impacts that may eventually be provided to the BRAC-95 Review Group.

BRAC-95 Joint Cross-Service Groups. The basic purpose of the Joint Cross-Service Groups is to oversee and guide the Military Departments and the Defense Agencies in conducting fair cross-service analyses and in developing recommended alternatives for consideration by the DoD Components. The Joint Cross-Service Groups have been established to identify cross-service tradeoff opportunities that will maximize the military value and cost effectiveness of operating the entire DoD infrastructure of specified functional areas. The Joint Cross-Service Groups are subordinate to the direction and guidance of the BRAC-95 Steering Group. Other OSD elements, Military Departments, or Defense Agencies will not direct any particular data collection or analysis effort for a Joint Cross-Service Group unless such direction has been authorized by a group. The Joint Cross-Service Groups may employ any internal organization or subgroups to accomplish their tasks, but such subgroups shall comply with the terms of this Internal Control Plan. The membership of any internal organizations or subgroups employed shall be documented in the official records of the Joint Cross-Service Groups. The Joint Cross-Service Groups are responsible for protecting the integrity of the BRAC-95 by preventing either the improper dissemination or collection of BRAC-95 data and information.

DRAFT

DRAFT

Inspector General, DoD. The Inspector General, DoD will advise the BRAC-95 Steering Group and the Joint Cross-Service Groups on the implementation of this Internal Control Plan. As such, auditors from the Office of the Inspector General, DoD will be available to review the activities of the Joint Cross-Service Groups to ensure such activities comply with the requirements of the Internal Control Plan.

Documentation Controls.

All significant events in the DoD BRAC-95 process will be recorded and clearly documented to ensure the integrity of the process performed by the Joint Cross-Service Groups. Furthermore, controls will be implemented to ensure that the information used by the Joint Cross-Service Groups to identify opportunities for cross-service tradeoffs or recommended alternatives is certified for accuracy and completeness, and that the information is used consistently throughout the BRAC-95 process. To protect the integrity of the BRAC-95 documentation prepared, handled, or processed by the Joint Cross-Service Groups the following control elements will be adhered to:

Data Collection. Information utilized for analyses and/or decision making by the Joint Cross-Service Group will be obtained from the Military Departments and the Defense Agencies. The mechanism for requesting data from the Military Departments and the Defense Agencies will be in the form of information requests issued to the Military Departments and Defense Agencies by the Joint Cross-Service Groups. The Joint Cross-Service Groups will coordinate their information requests with the respective BRAC-95 organizations of each Military Department and the Defense Agencies. The Military Departments and Defense Agencies will use their BRAC-95 internal control mechanisms for collecting the requested information and ensuring such information collected is certified for accuracy and completeness before it is submitted to the Joint Cross-Service Groups. Information used by the Joint Cross-Service Groups to establish measures of merit for assessments of military value, and determining methods for conducting capacity analysis is not required to be certified. However, only certified information will be used to make decisions on prospective basing alternatives to the Secretaries of the Military Departments.

Certification. The statutory requirements for certification were enacted by the Base Closure Act. More specifically, all information used to make closure and realignment recommendations submitted to the SECDEF and the 1995 Defense Base Closure and Realignment Commission must be certified as accurate and complete to the best of the certifier's knowledge and belief. The preparation of responses to the information requests by the Military Departments and the Defense Agencies will adhere to the BRAC-95 certification procedures and the internal control plans implemented for those entities.

Any electronic data files or magnetic media forwarded to the Joint Cross-Service by the Military Departments or Defense Agencies must be accompanied with a

DRAFT

DRAFT

complete certified "hard copy" document of the entire data file or magnetic media. The Joint Cross-Service Groups will verify that a complete certified copy is obtained from the Military Departments or Defense Agencies and make such documentation and electronic data available for independent audit validation.

Record Keeping. Minutes will be maintained of formal meetings of the Joint Cross-Service Groups and will record who was in attendance and a synopsis of items discussed and deliberated upon. Responsibility for producing and maintaining these minutes will be determined by the Chair of each Group. The Chairs will be responsible for overseeing and enforcing certification procedures to ensure that any information and data collected and used by the Joint Cross-Service Groups are certified for accuracy and completeness. The responsibility for safeguarding BRAC-95 information and data rests with the Chairs of the Joint Cross-Service Groups. Records of meetings of sub-working groups are not required as their work product must be presented and approved by the pertinent Joint Cross-Service Group.

Oral Briefings. From time to time, the Joint Cross-Service Groups may receive formal and informal briefings from inside and outside the Federal Government. To ensure a record of all information provided to the Joint Cross-Service Group is maintained, the content of all oral briefings must be captured in the minutes prepared for the meeting at which a particular briefing was presented. All briefing slides presented will be attached to the minutes recorded for the meeting.

Outside Studies. During the BRAC-95 process, studies and reports may be brought to the attention of a Joint Cross-Service Group that originated outside of the BRAC-95 process and address such things as assessment of facilities, military value, and/or capacity. While such studies may be useful in developing policies or suggesting methods for making measurements or evaluations, no recommendations regarding actions at specific installations may be entertained nor may data from such studies be accepted by the Joint Cross-Service groups.

Technical Experts. Technical experts may be used to support both the development and/or the refinement of the analytical efforts of the Joint Cross-Service Groups. When technical experts provide information or data that a Joint Cross-Service Group considers relevant and appropriate for analyses, the experts shall be requested to submit that information or data in writing with the required certification. The use of technical experts will be communicated, either orally or in writing, to the BRAC-95 Steering Group. Technical experts will be granted only limited access to BRAC-95 data and information that will allow them to assist the Joint Cross-Service Groups in the development and/or refinement of analytical efforts. Upon completion of their efforts, technical experts will be advised not to release or discuss any BRAC-95 data or information outside of the Joint Cross-Service Groups.

DRAFT

DRAFT

complete certified "hard copy" document of the entire data file or magnetic media. The Joint Cross-Service Groups will verify that a complete certified copy is obtained from the Military Departments or Defense Agencies and make such documentation and electronic data available for independent audit validation.

Record Keeping. Minutes will be maintained of formal meetings of the Joint Cross-Service Groups and will record who was in attendance and a synopsis of items discussed and deliberated upon. Responsibility for producing and maintaining these minutes will be determined by the Chair of each Group. The Chairs will be responsible for overseeing and enforcing certification procedures to ensure that any information and data collected and used by the Joint Cross-Service Groups are certified for accuracy and completeness. The responsibility for safeguarding BRAC-95 information and data rests with the Chairs of the Joint Cross-Service Groups. Records of meetings of sub-working groups are not required as their work product must be presented and approved by the pertinent Joint Cross-Service Group.

Oral Briefings. From time to time, the Joint Cross-Service Groups may receive formal and informal briefings from inside and outside the Federal Government. To ensure a record of all information provided to the Joint Cross-Service Group is maintained, the content of all oral briefings must be captured in the minutes prepared for the meeting at which a particular briefing was presented. All briefing slides presented will be attached to the minutes recorded for the meeting.

Outside Studies. During the BRAC-95 process, studies and reports may be brought to the attention of a Joint Cross-Service Group that originated outside of the BRAC-95 process and address such things as assessment of facilities, military value, and/or capacity. While such studies may be useful in developing policies or suggesting methods for making measurements or evaluations, no recommendations regarding actions at specific installations may be entertained nor may data from such studies be accepted by the Joint Cross-Service groups.

Technical Experts. Technical experts may be used to support both the development and/or the refinement of the analytical efforts of the Joint Cross-Service Groups. When technical experts provide information or data that a Joint Cross-Service Group considers relevant and appropriate for analyses, the experts shall be requested to submit that information or data in writing with the required certification. The use of technical experts will be communicated, either orally or in writing, to the BRAC-95 Steering Group. Technical experts will be granted only limited access to BRAC-95 data and information that will allow them to assist the Joint Cross-Service Groups in the development and/or refinement of analytical efforts. Upon completion of their efforts, technical experts will be advised not to release or discuss any BRAC-95 data or information outside of the Joint Cross-Service Groups.

DRAFT

DRAFT

Access to BRAC-95 Files

To protect the integrity of the DoD BRAC-95 process, all files, data and materials relating to that process are deemed sensitive and internal to DoD. Any dissemination of such data or other materials shall be made only upon the express authorization of the BRAC-95 Review Group. Pending the forwarding to the Defense Base Closure and Realignment Commission by SECDEF of his recommendations for closure or realignment of military installations, requests under the Freedom of Information Act for release of DoD BRAC-95 data and materials shall be denied on the basis that both are predecisional and are internal government memoranda.

The members of the Joint Cross-Service Groups are entrusted to have access to BRAC-95 information and data that originated from either the Military Departments or the Defense Agencies. Consistent with the organization controls set forth in this Internal Control Plan, access will not be granted to any individuals, to include technical experts, without the consent of either the BRAC-95 Review Group or the BRAC-95 Steering Group. Such access carries a responsibility for ensuring that BRAC-95 information and data is treated as sensitive and predecisional. The members of the Joint Cross-Service Groups are required to protect the BRAC-95 process from either improper or unofficial disclosures. The group members must also take precautions to prevent the acceptance of information that is not certified or may be forwarded to a Joint Cross-Service Group through channels other than the official DoD BRAC-95 process implemented by the OSD Secretariats, the Military Departments and the Defense Agencies.

Audit Access to Records.

The Base Closure Act includes a requirement that the SECDEF make available to the Comptroller General of the United States, the agency head of the General Accounting Office (GAO), all information and materials used by DoD in making recommendations for closure and realignment. To meet these requirements, the GAO is being provided full and open access to all official BRAC-95 records and documentation. In addition to the full and open access granted to the GAO, such access will be granted to the DoD Inspector General regarding records, data, information and other materials either collected or retained by the Joint Cross-Service Groups. Information requests forwarded by the Joint Cross-Service Groups to the Military Components and Defense Agencies for processing will be subjected to review by the audit agencies cognizant to the Military Components and the Defense Agencies. The audit agencies of the Military Departments, the DoD Inspector General, and the Defense Agencies will coordinate their efforts in a way to avoid audit duplication of the same information, data, and other materials.

DRAFT

DRAFT

Dissemination

Members of the BRAC-95 Review Group, the BRAC-95 Steering Group, and the Joint Cross-Service Groups must use every precaution to prevent the improper release of and/or access to BRAC-95 information and data. Not only is access restricted to those individuals officially approved to take part in the BRAC-95 Process, care must also be taken to avoid inadvertent dissemination through either facsimile "FAX" transmissions or electronic "E" mail. Any dissemination of information that is not discussed in this Internal Control Plan will only be made with the expressed documented approval of the BRAC-95 Review Group.

The Chairs of the BRAC-95 Joint Cross-Service Groups shall disseminate this Internal Control Plan as widely as possible throughout their organizations. The BRAC-95 Steering Group will be advised of any control violations or weaknesses that are identified through application of this Internal Control Plan or of any modifications that may be needed.

DRAFT

SAMPLE

JOINT CROSS-SERVICE CATEGORY

CRITERIA MEASURES OF MERIT/COMMON DATA ELEMENTS

MILITARY VALUE

CRITERION I: The current and future mission requirements and the impact on operational readiness of the Department of Defense's total force.

1. Measure of Merit/Factor/Common Data Element
 - A. Data element (what to measure)
 - B. Description crafted to get accurate answer/data for the measure
2. Measure of Merit/Factor/Common Data Element
 - A. Data element (what to measure)
 - B. Description crafted to get accurate answer/data for the measure
3. etc.

NOTE: Clearly show measures of merit/factors/common data elements and carefully crafted descriptions to support each DoD military value criterion (criterion 1-4). Include guidelines, assumptions, definitions needed by the user to respond accurately to the data call. If a common source or method is to be used to respond to a data element, specify the source or method.

CRITERION II: (etc.)

CRITERION III: (etc.)

CRITERION IV: (etc.)

MEASURE OF MERIT WORKSHEET P1: Population

COMMUNITY HOSPITALS

DATA ELEMENT: The number of active duty personnel and their families within a defined catchment area. The catchment area is defined as sets of zip codes emanating from the center of the MTF with a radius of 40 miles.

SOURCE: Defense Medical Information System (DMIS) - FY 93

Minimum = 3,024
 Maximum = 115,994
 Quartile 1 = 13,117
 Median = 17224
 Quartile 3 = 29,893
 Mean = 25,639
 STD Dev = 20558
 n= 81

GME CENTERS

DATA ELEMENT: The number of active duty personnel and their families residing within the Lead Agent Region as defined by the July 93 Health Affairs Policy Guidance.

SOURCE: Defense Medical Information System (DMIS) - FY 93

Minimum = 117,172
 Maximum = 562,254
 Quartile 1 = 170,049
 Median = 285,201
 Quartile 3 = 487,209
 Mean = 325,330
 STD Dev = 157,296
 n= 12

SCORE	1	2	3	4	5	6	7	8	9	10
HOSPITALS (1)	<5K	10K	15K	20K	25K	30K	35K	40K	45K	≥50K
HOSPITALS (2)	<10.8	18.7	26.4	34.29	42.1	50	58	65.5	73.3	>73.3
GME CENTER	<161.7	206.1	250.7	295.2	339.7	384.2	428.7	473.2	517.7	562.2

**MEASURE OF MERIT WORKSHEET
A1: Civilian Primary Care Physician Ratio**

CLINICS & COMMUNITY HOSPITALS

DATA ELEMENT: The ratio of primary care civilian physicians to the total forty mile catchment area population.

BASIS: This ratio is based on the January 1993 Catchment Area Directory (CAD) using ratios defined in the HHS Federal Register, Sept, 1991. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians.

SOURCE: Donnely Marketing Information Services

GME CENTERS

DATA ELEMENT: The ratio of primary care civilian physicians to the total population residing within the Lead Agent Region as defined by the July 93 Health Affairs Policy Guidance.

BASIS: This ratio is based on the January 1993 Catchment Area Directory (CAD) using ratios defined in the HHS Federal Register, Sept, 1991. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians.

SOURCE: Donnely Marketing Information Services

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1:1000	1:1250	1:1500	1:1750	1:2000	1:2250	1:2500	1:2750	1:3000	1:3500
HOSPITAL	1:1000	1:1250	1:1500	1:1750	1:2000	1:2250	1:2500	1:2750	1:3000	1:3500
GME CENTER	1:1000	1:1250	1:1500	1:1750	1:2000	1:2250	1:2500	1:2750	1:3000	1:3500

MEASURE OF MERIT WORKSHEET
A2: Civilian and VA Inpatient Acute Care Capability

CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

DATA ELEMENTS:

- **Within each catchment area, determine the**
 - # of acute care hospitals
 - # of operating beds at each hospital
 - Bed occupancy rate at each hospital
 - JCAHO accreditation status at each hospital
 - MTF operating beds

SOURCE: Donnely Marketing Information Services
DMIS for MTF operating beds

BASIS: This MOM measures the ability of local community acute care facilities to provide comprehensive health services to the eligible beneficiary population. Due to competition issues, this measure is viable only if there is more than two local community hospitals.

CALCULATION:

- If # of JCAHO acute care facilities < 2, then score = 10, else
- $[\sum (1 - \text{occupancy rate}_i) \times (\text{operating beds}_i)] + \text{MTF operating beds} = \text{ratio of civilian acute care operating beds to MTF operating beds}$

The sum is over the civilian facilities within the MTF catchment area

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS										
HOSPITAL	5 : 1	4.5 : 1	4 : 1	3.5 : 1	3 : 1	2.5 : 1	2 : 1	1.5 : 1	1 : 1	<1:1
GME CENTER	5 : 1	4.5 : 1	4 : 1	3.5 : 1	3 : 1	2.5 : 1	2 : 1	1.5 : 1	1 : 1	<1:1

**MEASURE OF MERIT WORKSHEET
F1 & F2: Condition Code**

F1: CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

1st DATA ELEMENTS: Facility Condition Assessment Score.

SOURCE: MTF Commander

BASIS: This MOM reflects the summary score of the facility condition based on calculated weighted factors assigned to functional and building systems and then normalized to 100.

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
HOSPITAL	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
GME CENTER	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100

F2: CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

2d DATA ELEMENT: Rating of the facility on a 1-3 scale by the installation engineer.

SOURCE: Installation Real Property Data Card

BASIS: This MOM reflects the condition of the facility as reported by the Base Engineer.

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1				2					3
HOSPITAL	1				2					3
GME CENTER	1				2					3

**MEASURE OF MERIT WORKSHEET
F3: AGE OF FACILITY**

CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

DATA ELEMENTS: Average Weighted Age.

SOURCE: Real Property Data Card/DMIS

BASIS: Current MILCON planning procedures provide for a 25 year life cycle for medical facilities

CALCULATION: For each DMIS ID

$$\begin{aligned} & \sum (\text{Chronological Building Age} * \text{Building Gross Square Feet}) \\ + \\ & \sum \text{Total Gross Square Feet} = \text{Average Weighted Age} \end{aligned}$$

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
HOSPITAL	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
GME CENTER	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1

MEASURE OF MERIT WORKSHEET
F4: Joint Commission on Accreditation of Health Care Organizations
Plant, Technology, and Safety Management

CLINICS, COMMUNITY HOSPITALS, AND GME CENTERS

DATA ELEMENTS: Scores of most recent JCAHO accreditation surveys

SOURCE: Facility Commander

BASIS: Plant, Technology, and safety scores from the most recent JCAHO survey are summed and averaged. JCAHO evaluations encompass the following areas:

- Safety Management
- Life Safety Management
- Equipment Management
- Utilities Management

Scoring methods are as follows:

- 1 = Substantial compliance
- 2 = Significant compliance
- 3 = Partial compliance
- 4 = Minimal compliance
- 5 = No compliance

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS										
HOSPITAL	5		4		3			2		1
GME CENTER	5		4		3			2		1

**MEASURE OF MERIT WORKSHEET
C1: Cost of Inpatient Care**

DATA ELEMENTS: Expense Data
Operating Beds
Relative Weighted Product
of interns/residents by facility
Wage rates

SOURCES: Medical Expense Performance Review System (MEPRS) (expense data)
Retrospective Case Mix Analysis System (RCMAS) (relative weighted product)
(DMIS) Operating Beds
Military Departments (# of interns/residents)
Health Care Financing Administration (HCFA) (wage rates)

BASIS: This measure provides relative average cost information to a third party buyer of health services. It compares the average direct care costs to the computed Adjusted Standardized Amount. The measure is expressed as a ratio of MTF/ASA.

CALCULATION: See handout from meeting of 3/10/94.

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITAL										
GME CENTER										

* Scoring distribution pending FY 92 data analysis

MEASURE OF MERIT WORKSHEET
MCI: Facility is located near
Air Medical Evacuation Hubs and Spokes

COMMUNITY HOSPITALS AND GME CENTERS

DATA ELEMENT: Distance in miles from Hub and Spoke Site

SOURCE: Facility Commander

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITAL	>130	120	110	100	90	80	70	60	50	≤40
GME CENTER	>130	120	110	100	90	80	70	60	50	≤40

**MEASURE OF MERIT WORKSHEET
MC2: Bed Expansion Capability**

COMMUNITY HOSPITALS AND GME CENTERS

DATA ELEMENT: Total number of beds the facility can expand to without requiring additional bed utility support

SOURCE: Facility Commander

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITAL	≤50	100	150	200	250	300	350	400	450	>450
GME CENTER	≤100	200	300	400	500	600	700	800	900	>900

PROPOSED GUIDANCE ON JCSG PRODUCTS/DELIVERABLES

PURPOSE: To provide a framework for JCSGs to give clear guidance on the products/deliverables to be transmitted to the Military Departments in support of BRAC 95 joint cross-service analysis

PRODUCT 1: Category Scope/Size

- List installations/functions included in category/subcategory
 - By installation or by location and function/commodity
- Give rationale for and narrative description of each category/subcategory

Note: We need this to: describe the category scope to the Commission, Congress, and communities; give the Steering and Review Groups a chance for sanity check; and to provide confirmation to Military Departments on the scope of the joint cross-service categories which allows them to finalize the scope of their own data calls, categories, and analysis process.

PRODUCT 2: Excess Capacity

- Measure(s) of capacity (what to measure) by category/subcategory
- Measure(s) of workload (what to measure) by category/subcategory
- Clear descriptions of what is needed to collect information on the measures of capacity and workload
 - Include guidelines, assumptions, and definitions needed by the user for successful response to the data call
- Description of the analytic framework for calculating excess capacity by category/subcategory
- Milestones

PRODUCT 3: Selection Criteria Measures of Merit/Factors/Common Data Elements

- List (by criterion) the measures of merit/factors/common data elements which support each of the DoD military value selection criteria (criterion 1-4) for the category/subcategory (sample attached)
- Clear descriptions of what is needed to collect information on the measures of merit/factors/common data elements
 - Include guidelines, assumptions, and definitions needed by the user for successful response to the data call
- Description of the analytic framework for determining military value for category/subcategory. [Question remains on whether JCSG would specify weights for measures of merit]
- Milestones

SAMPLE

JOINT CROSS-SERVICE CATEGORY

CRITERIA MEASURES OF MERIT/Common DATA ELEMENTS

MILITARY VALUE

CRITERION I: The current and future mission requirements and the impact on operational readiness of the Department of Defense's total force.

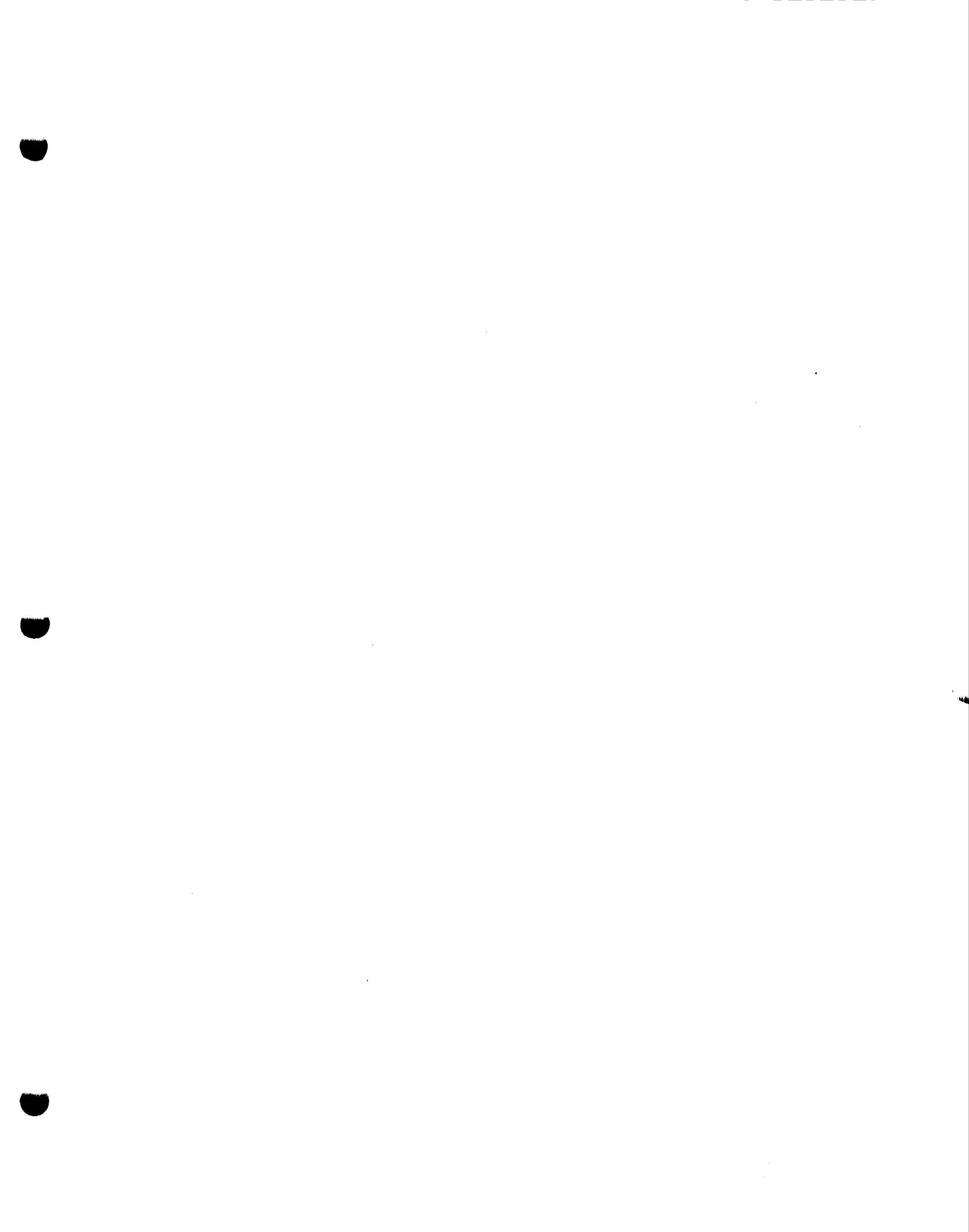
1. Measure of Merit/Factor/Common Data Element
 - A. Data element (what to measure)
 - B. Description crafted to get accurate answer/data for the measure
2. Measure of Merit/Factor/Common Data Element
 - A. Data element (what to measure)
 - B. Description crafted to get accurate answer/data for the measure
3. etc.

NOTE: Clearly show measures of merit/factors/common data elements and carefully crafted descriptions to support each DoD military value criterion (criterion 1-4). Include guidelines, assumptions, definitions needed by the user to respond accurately to the data call. If a common source or method is to be used to respond to a data element, specify the source or method.

CRITERION II: (etc.)

CRITERION III: (etc.)

CRITERION IV: (etc.)



MINUTES OF THE
MILITARY TREATMENT FACILITIES
AND GRADUATE MEDICAL EDUCATION
BRAC 95 JOINT CROSS SERVICE GROUP
MEETING OF MARCH 24, 1994

The eighth meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1500 hrs on March 24, 1994. The meeting was chaired by Dr. Edward D. Martin, Principal Deputy Assistant Secretary of Defense, Health Affairs.

The Chairman opened the meeting and asked each of the members to review the minutes from the last two meetings (a copy of the minutes were passed around the table).

The Chairman then noted that he had spoken to the Director of the OSD Base Closure and Utilization office regarding the inclusion of medical training facilities in the Group's BRAC 95 process. The Chairman reported that the Director agreed that this was within the Group's charter. The Chairman also stated that this was an appropriate juncture to include training and that it could easily be removed at a later date if deemed necessary.

At this point the Chairman informed the Group that Dr. Joseph had been confirmed and sworn in as the ASD(Health Affairs). Dr. Martin will serve as the Principal Deputy ASD(Health Affairs), and will continue to serve as Chairman of the Joint Cross Service Group for Military Treatment Facilities and Graduate Medical Education.

The next item of discussion was the draft report to the BRAC 95 Review Group due on March 31, 1994. The following reflect the essence of the discussion:

- o The report needs language on the ITRO report to characterize our transmittal of it to the Services.
- o The Civilian Primary Care Physician Ratio (MoM A1) is not a valid measurement for medical centers, but must be collected for possible further screening of the medical centers as hospitals and/or clinics. This also applies to Civilian and VA Inpatient Acute Care Capability (MoM A2).
- o The Adjusted Standardized Amount (ASA) inpatient-care costing system is 95% complete. We have sufficient time to refine and complete the ASA.
- o Data validation - the validation of DoD and commercial data systems is being worked with the DoD IG.
- o Air Medical Evacuation Hubs and Spokes (MoM MC1) will be changed to read "Distance an MTF is located from an airport capable of supporting C-9 aircraft operations."
- o The Army representative suggested that the section on "Graduate Medical Education" (pgs 17 and 18), include a discussion of militarily relevant subjects. The Chairman agreed and asked the Army representative to provide the Group with the proposed language.

CLOSE HOLD

- o It was noted that the report did not include milestones as specified in the standardized format provided to the Groups. The Chairman stated that we should include milestones, and that it was reasonable to ask for input by a specified date. We should also expect the Services to call the Group together if problems arise that could jeopardize the BRAC process.

- o A suggestion was made to expand the assumption that "...an MTF will close if the base or installation closes" to address situations where a significant active duty population will remain in the area. The Chairman agreed.

The Chairman asked the members to review the draft report and return their copies, with comments, by COB Tuesday, March 29.

The meeting adjourned at 1600 hrs. The next meeting is scheduled for March 31.

Approved *E. Martin*
Edward D. Martin, MD
PDASD (Health Affairs)

Attachments

CLOSE HOLD

BRAC 95
 JOINT CROSS SERVICE GROUP
 FOR MILITARY TREATMENT FACILITIES AND
 GRADUATE MEDICAL EDUCATION

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE#</u>	<u>ATTENDING 24 Mar 94</u>
CHAIR (AASD(HA))	Dr. Martin	703-697-2114	<u>X</u>
ASD(HA) (Designate)	Dr. Joseph	703-697-2114	<u>NO</u>
DASD(ER/BRAC)	Mr. Bayer	703-697-1771	<u>NO</u>
TEAM LEADER	RADM Koenig	703-697-8973	<u>X</u>
ARMY	BG Zajchuk	703-756-5680	<u>X</u>
NAVY	CAPT Golembieski	703-681-0461	<u>X</u>
NAVY	CDR Dilorenzo	703-681-0452	<u>X</u>
AIR FORCE	Maj Gen Buethe	202-767-4343	<u>NO</u>
AIR FORCE	Brig Gen Hoffman	202-767-1849	<u>X</u>
JCS	COL Moore	703-697-4346	<u>X</u>
OASD (P&R)	Ms. St. Clair	703-696-8710	<u>(Mr. Monteleone)</u>
COMPT	Ms. Hiller	703-697-3101	<u>X</u>
PA&E	Mr. Dickens	703-697-2999	<u>X</u>
ODASD (ER/BRAC)	Mr. Miglionico	703-697-8050	<u>X</u>
DOD IG	Mr. Tomlin	804-766-3816	<u>X</u>
ODASD (HA)	Mr. Maddy	703-697-8979	<u>X</u>
ODASD (HA)	Dr. Mazzuchi	703-695-7116	<u>(COL Burkehalter)</u>

OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 24 Mar 94</u>
OASD (HA)	Ms. Watson	703-697-8973	
OASD (HA)	Ms. Giese	703-614-4705	X
OASD (HA)	Col Garner	703-614-4705	
OASD (HA)	CDR Bally	703-614-4705	X
OASD (HA)	LTC Ponatoski	703-614-4705	X
OASD (HA)	LTC McClinton	703-614-4705	
OASD (HA)	COL Baker	703-756-1918	
OASD (HA)	LTC Guerin	703-756-1918	X
ARMY	COL Barton	703-756-8319	
ARMY	COL Wilcox	703-756-5681	
ARMY	LTC Powell	703-697-3877	X
ARMY	LTC McGaha	703-697-6388	X
ARMY	MAJ Dudevoir	703-756-0286	X
ARMY	MAJ Parker	703-756-8036	X
ARMY	COL Lyons	703-756-0224	X
ARMY	MAJ Bond	703-256-8229	
ARMY	COL Cassimatis	703-756-8036	
NAVY	CAPT Buzzell	703-681-0475	
NAVY	Ms. Davis	703-602-2252	
NAVY	CDR DiLorenzo	703-602-0452	X
AIR FORCE	LtCol Silvernail	202-767-5550	X
AIR FORCE	LtCol Bannick	202-767-5066	
AIR FORCE	Maj Costa	202-767-5066	X
AIR FORCE	Maj Pantaleo	202-767-5046	
AIR FORCE	Capt Purcell	202-767-5066	
LMI	Mr. Neve	301-320-7287	
LMI	Ms. Dahut	301-320-7408	
JS	LtCol Ferguson	703-697-4421	
COMPT	Ms. Kopperman	703-697-4517	
COMPT	Mr. Joseph Smith	703-697-4133	
OASD(P&R)	Mr. Monteleone	703-696-8710	X
DODIG	Mr. Armstrong	804-766-3816	
DODIG	Ms. Givan	804-766-3816	X



CLOSE HOLD

MINUTES OF THE
MILITARY TREATMENT FACILITIES
AND GRADUATE MEDICAL EDUCATION
BRAC 95 JOINT CROSS SERVICE GROUP
MEETING OF MARCH 31, 1994

CLOSE HOLD

The ninth meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 0900 hrs on March 31, 1994. The meeting was chaired by Dr. Edward D. Martin, Principal Deputy Assistant Secretary of Defense, Health Affairs.

✓ The Chairman opened the meeting and asked each of the members to review the minutes from the last two meetings (a copy of the minutes was passed around the table).

The Chairman informed the members that the BRAC 95 Review Group reviewed the MTF/GME Joint Cross Service Group's report the previous day. There are two issues that must be resolved before the report can be forwarded to the Military Departments. The first involves a concern raised at the meeting by the Deputy Director for Resource Analysis (PA&E), and the second was contained in a memorandum received by the Joint Process Group Chairman just prior to the Review Group meeting. The Chairman chose to address the later first.

The memorandum, from the Principal Deputy Under Secretary of Defense, Personnel and Readiness, recommended that the Measures of Merit (MoMs) include a screening criterion that would flag an MTF if the beneficiary population is less than 5,000. The memorandum stated that, given the proposed weighting system, the possibility existed that a new facility, with a relatively small beneficiary population, could escape consideration under the BRAC process.

The ODUSD (Personnel and Readiness) representative was reminded that all facilities were to be considered under BRAC. It was also pointed out that population, as a Measure of Merit, received approximately 10 times the weight that facility age did during the scoring process. These factors were considered by the working group during its deliberations and the resulting MoMs and weights were deemed to be appropriately balanced. The ODUSD (Personnel and Readiness) representative could not provide the group with a basis for the 5,000 (subsequently raised to 10,000) population criterion threshold.

Given the absence of a basis on which to support the inclusion of a population threshold criterion, the Chairman recommended that the Group decline to accept the proposal.

The members were polled: The members representing the Departments of the Army, Navy and Air Force, and the representatives from Health Affairs, DoD Comptroller, DoD Inspector General, Program Analysis and Evaluation, Joint Staff and Base Closure and Utilization voted against the proposed population threshold criterion. The member representing Personnel and Readiness voted in the affirmative.

The proposed population threshold criterion was rejected.

CLOSE HOLD

DO NOT HOLD

DO NOT HOLD

The second issue, raised by the Director for Resource Analysis (PA&E), was that the BRAC process could pre-judge some of the policy recommendations being considered for the Military Health Services System under various studies and/or reviews. No specific proposal was offered to resolve the perceived conflicts. A discussion ensued and the Chairman suggested that we include language in the report to address other ongoing studies and their relationship to the BRAC 95 process. The Chairman also stated that he would continue his discussions with the Director in an attempt to reach an expeditious resolution.

The Team Leader suggested that the date of the Health Affairs Policy Guidance (page 8 of the report) be changed to reflect the updated guidance.

The Chairman asked the members to ensure that they inform him if any issue arose that could substantially alter what the group is trying to accomplish.

The meeting adjourned at 0945 hrs. The next meeting will be at the call of the Chairman.

Approved Edward D. Martin
Edward D. Martin, MD
PDASD (Health Affairs)

Attachments

DO NOT HOLD

BRAC 95
 JOINT CROSS SERVICE GROUP
 FOR MILITARY TREATMENT FACILITIES AND
 GRADUATE MEDICAL EDUCATION

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE#</u>	<u>ATTENDING 31 Mar 94</u>
CHAIR (AASD(HA) ASD(HA) (Designate)	Dr. Martin	703-697-2114	✓
	Dr. Joseph	703-697-2114	
DASD(ER/BRAC)	Mr. Bayer	703-697-1771	
TEAM LEADER	RADM Koenig	703-697-8973	✓
ARMY	BG Zajtchuk	703-756-5680	✓
NAVY NAVY	CAPT Golembieski	703-681-0461	✓
	CDR Dilorenzo	703-681-0452	✓
AIR FORCE AIR FORCE	Maj Gen Buethe	202-767-4343	no
	Brig Gen Hoffman	202-767-1849	✓
JCS	COL Moore	703-697-4346	✓
OASD (P&R)	Ms. St. Clair	703-696-8710	(Mr. Monteleone)
COMPT	Ms. Hiller	703-697-3101	✓
PA&E	Mr. Dickens	703-697-2999	✓
ODASD (ER/BRAC)	Mr. Miglionico	703-697-8050	✓
DOD IG	Mr. Tomlin	804-766-3816	✓
ODASD (HA)	Mr. Maddy	703-697-8979	✓
ODASD (HA)	Dr. Mazzuchi	703-695-7116	(CAPT Butler)

OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 31 Mar 94</u>
OASD (HA)	Ms. Watson	703-697-8973	<input checked="" type="checkbox"/>
OASD (HA)	Ms. Giese	703-614-4705	<input checked="" type="checkbox"/>
OASD (HA)	Col Garner	703-614-4705	<input checked="" type="checkbox"/>
OASD (HA)	CDR Bally	703-614-4705	<input checked="" type="checkbox"/>
OASD (HA)	LTC Ponatoski	703-614-4705	<input checked="" type="checkbox"/>
OASD (HA)	LTC McClinton	703-614-4705	<input type="checkbox"/>
OASD (HA)	COL Baker	703-756-1918	<input type="checkbox"/>
OASD (HA)	LTC Guerin	703-756-1918	<input type="checkbox"/>
ARMY	COL Barton	703-756-8319	<input type="checkbox"/>
ARMY	COL Wilcox	703-756-5681	<input type="checkbox"/>
ARMY	LTC Powell	703-697-3877	<input type="checkbox"/>
ARMY	LTC McGaha	703-697-6388	<input type="checkbox"/>
ARMY	MAJ Dudevoir	703-756-0286	<input checked="" type="checkbox"/>
ARMY	MAJ Parker	703-756-8036	<input checked="" type="checkbox"/>
ARMY	COL Lyons	703-756-0224	<input checked="" type="checkbox"/>
ARMY	MAJ Bond	703-256-8229	<input type="checkbox"/>
ARMY	COL Cassimatis	703-756-8036	<input type="checkbox"/>
NAVY	CAPT Buzzell	703-681-0475	<input type="checkbox"/>
NAVY	Ms. Davis	703-602-2252	<input type="checkbox"/>
NAVY	CDR DiLorenzo	703-602-0452	<input checked="" type="checkbox"/>
AIR FORCE	LtCol Silvernail	202-767-5550	<input checked="" type="checkbox"/>
AIR FORCE	LtCol Bannick	202-767-5066	<input type="checkbox"/>
AIR FORCE	Maj Costa	202-767-5066	<input checked="" type="checkbox"/>
AIR FORCE	Maj Pantaleo	202-767-5046	<input type="checkbox"/>
AIR FORCE	Capt Purcell	202-767-5066	<input type="checkbox"/>
LMI	Mr. Neve	301-320-7287	<input type="checkbox"/>
LMI	Ms. Dahut	301-320-7408	<input type="checkbox"/>
JS	LtCol Ferguson	703-697-4421	<input type="checkbox"/>
COMPT	Ms. Kopperman	703-697-4517	<input type="checkbox"/>
COMPT	Mr. Joseph Smith	703-697-4133	<input type="checkbox"/>
OASD(P&R)	Mr. Monteleone	703-696-8710	<input checked="" type="checkbox"/>
DODIG	Mr. Armstrong	804-766-3816	<input type="checkbox"/>
DODIG	Ms. Givan	804-766-3816	<input checked="" type="checkbox"/>

**BRAC 95 JOINT CROSS SERVICE GROUP
FOR MILITARY TREATMENT FACILITIES AND
GRADUATE MEDICAL EDUCATION**

**March 31, 1994
Room 2E385, 9:00 AM**

- Review/approve minutes from previous meeting Dr. Martin
- Review Report to the BRAC 95 Review Group LTC Ponatoski
- Administrative Issues Dr. Martin
- Adjournment



PERSONNEL AND
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000



MAR 29 1994

MEMORANDUM FOR PRINCIPAL DEPUTY ASSISTANT SECRETARY OF
DEFENSE (HEALTH AFFAIRS)

SUBJECT: BRAC 95 Joint Cross-Service Group for MTFs and GME

I have reviewed the draft report produced by your committee on screening criteria for the BRAC process. It appears to be a thorough and well done document which takes into account the major issues revolving around facilities management in the medical community.

There is, however, one issue which I feel could be addressed better. I believe that the population served should be independent of the weighting criteria in the measures of merit. The weighting criteria, as they currently stand, leave open the possibility that a recently built or upgraded facility, in good condition, could rank high enough not to be considered even if it had a population reduction. A low population count, by itself, should be sufficient to flag a facility for BRAC review. I recommend that you include an additional screening criterion, whereby the MTF would automatically be flagged if the active duty population served is fewer than a specified number (for example 5,000). Then, other factors could be considered, such as isolation from other sources of care.

Albert V. Conte
Principal Deputy



MEASURES OF MERIT

SUMMARY SHEET

	RAW MOM	MOM	WEIGHTED		CRITERIA	WEIGHTED
	SCORE	WEIGHT	MOM SCORE		WEIGHT	CRITERIA SCORE
CRITERIA 1 MISSION						
P1 POPULATION	0	70%	0			
A1 CIVILIAN PRIMARY CARE RATIO	0	15%	0			
A2 INPATIENT CAPABILITY	0	15%	0			
		TOTAL C1	0		40%	0
CRITERIA 2 FACILITIES						
F1 FACILITY CONDITION	0	15%	0			
F2 REAL PROPERTY	0	15%	0			
F3 AVERAGE WGT AGE	0	40%	0			
F4 SAFETY SCORES (JCAHO)	0	30%	0			
		TOTAL C2	0		20%	0
CRITERIA 3 CONTINGENCY						
MC1 AIR PROXIMITY	0	50%	0			
MC2 STUBBED BEDS	0	50%	0			
		TOTAL C3	0		20%	0
CRITERIA 4 COST/MANPOWER						
C1 COST INPATIENT CARE	0	100%	0			
		TOTAL C4	0		20%	0
				FACILITY	SCORE	0

BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

Report to the BRAC 95 Review Group

March 31, 1994

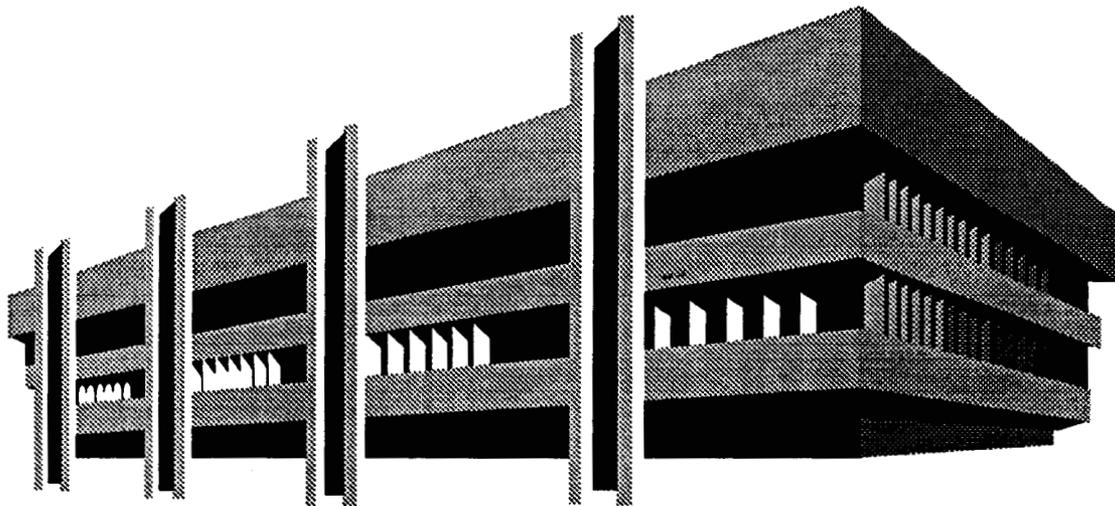


TABLE OF CONTENTS

Introduction.....	1
Section 1 - Analytical Process Development.....	2
Action Plan and Milestones through March 31, 1994	2
Statement of Principles	2
Major Analysis Assumptions	3
Roles of Joint Medical Group and Services	4
General Analytic Concept.....	5
Section 2 - Categories for Study.....	5
Health Clinics.....	5
Community Hospitals	6
Medical Centers	6
Section 3 - Capacity Measures.....	6
Contingency/Mobilization Beds Requirements	6
Peacetime Operating Bed Capacity	7
Section 4 - Development of Measures of Merit.....	7
Weighting and Scoring Descriptions.....	7
Criterion 1: Mission	8
Criterion 2: Facilities	11
Criterion 3: Contingency/Mobilization	13
Criterion 4: Cost.....	14
Summary Scoring Methods.....	15
Data Certification and Validation Process	16
Section 5 - Additional Service Guidance for Rightsizing Opportunities.....	17
Medical Laboratory and Research	17
Graduate Medical Education.....	18
Biostatistical Activities.....	19
Inter-Service Medical Training	21
Appendix A - Facility Listing.....	22
Appendix B - Summary Score Sheet.....	26
Appendix C - Glossary	27

Introduction

The Deputy Secretary of Defense 1995 Base Realignment and Closures guidance memorandum of January 7, 1994, provided the authority for establishment of the Joint Cross Service Group for Military Treatment Facilities (MTFs) and Graduate Medical Education (GME). This group is also referred to in this report as the Joint Medical Group. The first meeting was held January 25, 1994. A Tri-Service Ad Hoc Working Group was also established to develop and recommend draft criteria and process proposals for consideration by the Joint Medical Group.

The primary objectives of the Joint Medical Group are to seek opportunities for cross Service asset sharing, single Military Department support, and opportunities for rightsizing of the military medical infrastructure. This report is submitted to the BRAC 95 Steering and Review Group in accordance with the DepSecDef guidance memorandum.

The report is divided into five sections.

Section 1 addresses the development of the overall analytic process. This includes the Group's action plan, study assumptions, roles of the Services and Joint Medical Group, and the conceptual analytic approach.

Section 2 describes the functional study categories and the associated definitions/rationale for each functional category selected.

Section 3 describes the development of capacity measures. These include measures for contingency/mobilization bed requirements and peacetime operating bed capacity.

Section 4 discusses common measures of merit, the data element(s) to be collected by the Services, the source(s) for each data element, and the methodology for weighting and scoring each of the measures. This section also describes the relationship between each measure of merit and the major BRAC criterion. Procedures for certification and validation of both DoD and commercial data sources are also outlined.

Section 5 provides supplementary guidance to the Services relating to rightsizing opportunities within the Services'

biostatistical activities, Inter-Service military school system, medical laboratories and research facilities, and GME.

Section 1 - Analytical Process Development

Action Plan and Milestones through March 31, 1994

Action Plans and Milestones were developed and approved by the Joint Medical Group in early February 1994. Chart 1 depicts the approved Action Plan through March 31, 1994. Checked items indicate completed tasks.

BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME		
■ Action Plan & Timeline (thru 3/31/94)		
▶ Agree on Statement of Principles	2/4	✓
▶ Define role of Group & Services	2/4	✓
▶ Develop Analysis Assumptions	2/11	✓
▶ Determine Categories for Study	2/18	✓
▶ Determine General Analytical Approach	2/18	✓
▶ Review interim force structure plan	2/25	✓
▶ Submit list of irreconcilable differences, if necessary, to USD (A&T)	2/28	✓
▶ Define Measures of Merit & Data Sources	3/4	✓
▶ Determine weights for Measures of Merit	3/11	✓
▶ Complete Data Definitions	3/11	✓
▶ Establish Data Internal Control Plan	3/17	✓
▶ Draft report to Joint Group for review	3/17	✓
▶ Final report to Steering Group	3/31	✓

Chart 1. Action Plan and Milestones

Statement of Principles

One of the first efforts of the Joint Medical Group was achieving consensus on the Joint Declaration of Principles. This document established the purpose and focus of the Joint Medical Group's efforts. The Principles are shown below:

DECLARATION OF PRINCIPLES

1. The Joint Cross Service Group on Medical Facilities and Graduate Medical Education seeks to identify measures of merit (subcategories of the 8 BRAC criteria) data elements, and methodologies that will allow the DoD components to apply the DoD criteria in a uniform, fair,

reasonable, and consistent manner that complies with statutory and regulatory requirements and that adheres to the policy set forth in the January 7, 1994, DepSecDef memo, subject: 1995 Base Realignment and Closures (BRAC).

2. The Joint Cross Service Group on Medical Facilities and Graduate Medical Education recognizes the need for right-sizing, seeking opportunities for cross-Service asset sharing, and /or single military department support.

3. The measures of merit, data elements, and methodologies used to arrive at closure and realignment recommendations will be developed and approved by the Joint Cross Service Group on Medical Facilities and Graduate Medical Education by 31 March 1994. The approach developed should be easy to use, simple and straightforward, auditable, reproducible, and defensible.

Based on guidance from the March 15, 1994, Steering Group meeting, the Joint Cross Service Groups would only develop Measures of Merit for the Military Value criteria. The Services will be responsible for ensuring BRAC criteria 5-8 are addressed. These include Return on Investment, Economic Impact on Communities, Community Infrastructure, and Environmental Impact.

Major Analysis Assumptions

The Joint Medical Group developed four basic study assumptions as described in Chart #2. The most basic premise assumes that, in general, the MTF will close if the base or installation closes except when a significant active duty population remains after a base is closed. Another basic assumption is that the Joint Medical Group will focus primarily on peacetime requirements. The group also agreed to include organization with < 300 civilian full time employed personnel as part of the

**BRAC 95 JOINT CROSS-SERVICE GROUP
FOR MTFs AND GME**

■ **Analysis Assumptions agreed on 2/3/94**

- ▶ MTF will close if base closes unless a sufficient active duty population remains
- ▶ Joint Group efforts will focus on peacetime requirements
- ▶ Analysis will include facilities with < 300 civilian personnel
- ▶ Quantitative goals will not be initially defined
 - Revisit later if necessary

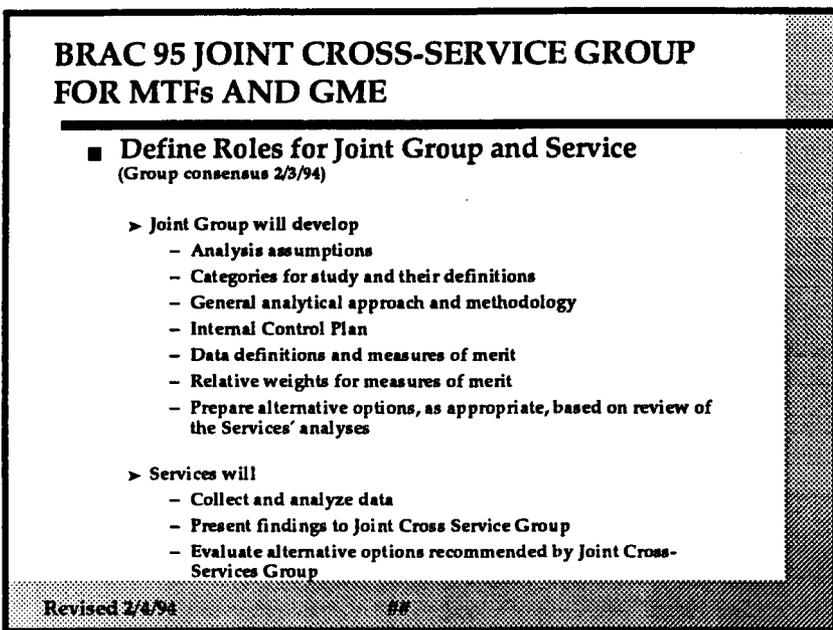
Revised 2/4/94

Chart 2. Chart 2 describes the Analytical Assumptions for the Joint MTF and GME Group.

overall analysis. The Joint Medical Group reached consensus on these assumptions on February 3, 1994.

Roles of Joint Medical Group and Services

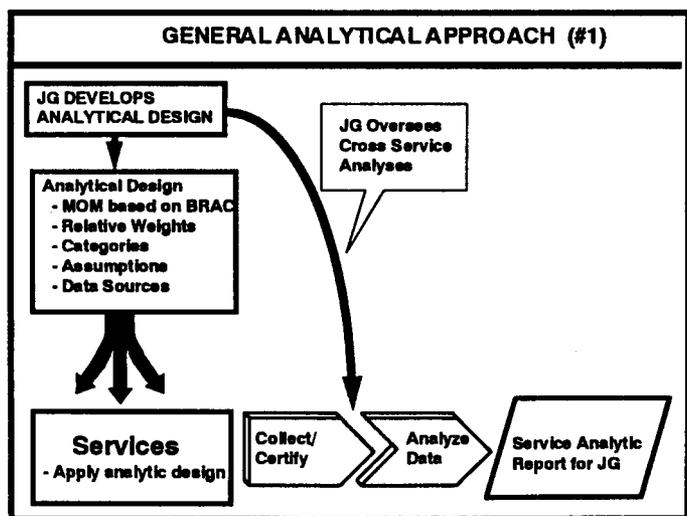
The roles of the Military Departments and the Joint Medical Group were developed based on the DepSecDef guidance memorandum of January 7, 1993.



The Group membership reached role consensus on February 3, 1994 (See Chart 3). The Joint Medical Group will develop the study design, general analytical approach, measures of merit, common data elements, and a methodology for weighting and scoring the measures of merit. The Military Services will be responsible for data

Chart 3. Roles of Services and Joint Medical Group

collection and analysis, development of findings, and will evaluate alternative options recommended by the Joint Medical Group. The Department of the Navy expressed concerns that weighting done outside of the Military Departments' evaluative process is in conflict with the above statement. The Joint Medical Group recognize there are differences in the manner the Services approach their respective BRAC process. The Joint Medical Group's expectation is that the

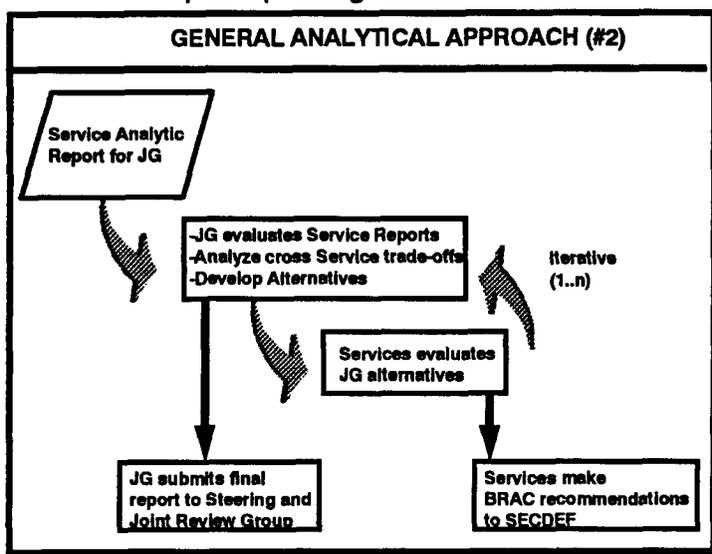


Services will consistently apply the methodology as outlined in this report; i.e., to collect data, score facilities, and weight the Measures of Merit and BRAC Military Value Criteria. The Group recognizes that each Military Departments will use its own methodology in making BRAC recommendations to the Secretary of Defense.

Chart 4. General Analytical Approach

General Analytic Concept

The conceptual description of the General Analytical Approach is shown in Charts 4 and 5. This concept is based on the DepSecDef Base Closure memorandum and the agreed upon roles of the Military Departments and the Joint Medical Group. Chart 5 depicts an iterative process where the Military Services will submit analyses and findings to the Joint Medical Group. The Joint Medical Group, in conjunction with the Services, will subsequently develop alternative option packages for Service consideration. The Services will



evaluate the alternatives and submit their findings to the Joint Medical Group. Once the iterative process is completed, the process culminates in the Services making their BRAC recommendations to the Secretary of Defense and the Joint Medical Group submitting its report to the BRAC 95 Steering Group and Review Group.

Chart 5. General Analytical Approach

Section 2 - Categories for Study

Three major categories were selected for study. They are stand alone health clinics, community hospitals, and medical centers. These categories were selected because they are the basic functional elements in the Military Health Services System (MHSS). A listing, by functional category, of all facilities is at Appendix A. MTFs closed or scheduled to close as a consequence of previous BRAC actions are not considered in this analysis. Only facilities located within the Continental United States (CONUS), Alaska, and Hawaii are included.

Health Clinics

This category encompasses a total of 43 facilities. Health Clinics are defined as health treatment facilities primarily staffed and equipped to provide ambulatory services to active duty and other beneficiaries. In some cases, the

facility may also be capable of providing emergency treatment. A clinic may also be staffed and equipped to provide physical examinations, immunizations, medical administration, and preventive medicine services. For purposes of this study, Health Clinics are considered stand alone and located on an installation without a hospital. Navy and Air Force Health Clinics are also characterized as having a Commanding Officer, their own funding source, and reporting directly to a major command.

Community Hospitals

This category totals 86 facilities. A community hospital is defined as an inpatient health treatment facility capable of providing diagnostic and therapeutic services in the fields of general medicine, surgery, preventive medicine services, and having the supporting facilities to perform its assigned mission and functions.

Medical Centers

This category contains 14 facilities. Medical Centers are defined as tertiary care facilities that include at least two Graduate Medical Education programs, provide a broad range of health services, and serve as a referral center with specialized and consultative support within the geographic area of responsibility.

Section 3 - Capacity Measures

Contingency/Mobilization Beds Requirements

The purpose of this measure is to ensure that any closure or realignment alternative will be greater than or equal to the minimum number of Contingency/Mobilization Beds required to conduct wartime operations. This measure is based on the mobilization requirements generated from 1995-1999 Defense Planning Guidance. Any proposed alternative must be compared to the USACOM COMPLAN 2730, The Integrated CONUS Medical Mobilization Plan. The Military Departments will collect this data from MTF Commanders based on the definition of expanded beds below:

The number of beds that can be used in wards or rooms designed for patient beds. Beds are spaced on 6 foot centers and include embedded electrical and gas utility support for each bed. Beds must be set up and ready within 72 hours. Use of portable gas or electrical utilities is not considered in this definition.

Peacetime Operating Bed Capacity

This measure compares aggregate acute care operating beds to inpatient bed requirements generated by active duty personnel and their families. The total bed requirement will be compared to the aggregate number of CONUS based MHSS operating beds and aggregate Lead Agent Region capacity.

The total bed requirement for active duty and family members will be estimated by multiplying the total direct care and CHAMPUS bed requirement (Fiscal Year 1993 data) times the active duty and active duty family member population. This is based on the Fiscal Year 1993 bed requirement of 1.8 and 1.9 beds per thousand respectively. Chart 6

describes bed requirements for these beneficiary groups from Fiscal Year 1989 through 1993. Taking a conservative approach, the Joint Medical Group assumed the actual bed requirements would stabilize at FY 93 rates. The Services will collect operating bed data and active duty and family member population data during the data collection process. Operating bed data will be computed as of September 31, 1993.

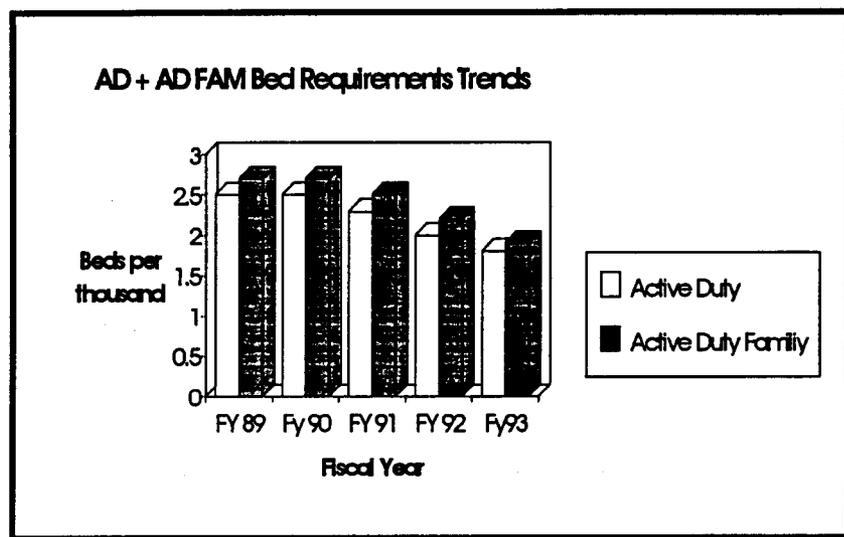


Chart 6 Active Duty and Active Duty Family Bed Requirements from Fiscal Year 1989 through Fiscal Year 1993.

Operating bed data will be computed as of September 31, 1993.

Section 4 - Development of Measures of Merit

Weighting and Scoring Descriptions

The Joint Medical Group developed a total of 10 Measures of Merit in support of the Military Value BRAC criteria (# 1-4). Chart 7 describes the BRAC criteria and the associated measures of merit (MoMs) approved by the Joint Medical Group. Each MoM measures characteristics related to the viability of a given military treatment facility.

For each of the BRAC criteria and the Measures of Merit within those criteria, the Joint Cross- developed the following weighting and scoring methodology.

MoM	MoM WEIGHT	CRITERIA WEIGHT
CRITERIA 1 MISSION		40%
P1 - POPULATION	70%	
A1 - CIVILIAN PRIMARY CARE RATIO	15%	
A2 - INPATIENT CAPABILITY	15%	
CRITERIA 2 FACILITIES		20%
F1 - FACILITY CONDITION	15%	
F2 - REAL PROPERTY	15%	
F3 - AVERAGE QS FT AGE	40%	
F4 - SAFETY SCORES (JCAHO)	30%	
CRITERIA 3 CONTINGENCY		20%
MC1 - AIR HUB	50%	
MC2- STUBBED BEDS	50%	
CRITERIA 4 COST/MANPOWER		20%
C1 - COST OF INPATIENT CARE	100%	

Chart 7. BRAC military value criteria, Measures of Merit, and Weighting/Scoring System

Criterion 1: Mission

The current and future mission requirements and the impact on operational readiness of the Department of Defense total force.

P1 Population: *A factor that helps determine if an MTF is necessary in a given area.*

Data Element:

Clinics and Community Hospitals - The number of active duty personnel and their families residing within a defined catchment area. The catchment area is defined as sets of zip codes emanating from the center of the MTF with a radius of 40 miles.

Medical Centers - The number of active duty personnel and their families residing within the Lead Agent Region as defined by the July 93 Health Affairs Policy Guidance.

Source: The source for active duty and active duty family member populations will be obtained from the Defense Medical Information System (DMIS). Fiscal Year 1993 data will be used and incorporate results of BRAC 88, 91, and 93.

Description: The total population number for the specific MTF is compared to the various population ranges on the scoring table below. There are different population ranges for clinics, community hospitals and medical centers.

Directly above the population range score is a corresponding score from one to ten which is the raw score for the MTF on this particular measure of merit. By way of example, a community hospital with a total active duty and active duty family population between 10,001 and 15,000 receives a score of three.

P1: Population

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	<1K	2K	3K	4K	5K	6K	7K	8K	9K	>10
HOSPITALS	<5K	10K	15K	20K	25K	30K	35K	40K	45K	>45K
MED CENTER	<120	160	200	260	300	360	400	460	500	>500

A1 Civilian Primary Care Physician Ratio: *An indicator of the availability of primary care physicians to provide services to the beneficiary population. This Measure is not applicable to Medical Centers.*

Data Element:

Clinics and Community Hospitals - The ratio of primary care civilian physicians to the total forty mile catchment area population. This ratio is based on the January 1993 Catchment Area Directory (CAD) using ratios defined in the Health and Human Services (HHS) Federal Register, Sept, 1991. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians.

Source: The source for the number of civilian primary care physicians within a given catchment area will be obtained from Donnelly Marketing Services.

Description: The number of physicians will be divided by the total population (census data to include military and civilian population) which results in a physician per population ratio. This ratio is then compared to the various ratio ranges on the scoring

table below. The ratio ranges for clinics and community hospitals are the same. Directly above the ratio range score is a corresponding score from one to ten which becomes the raw score for the MTF on this particular measure of merit. By way of example, a community hospital with a ratio up to 1/1000 would receive a score of two. An MTF with a ratio form 1/1901 to 1/2200 would receive a score of six.

A1: Civilian Primary Care Ratio

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1:700	1:1000	1:1300	1:1600	1:1900	1:2200	1:2500	1:2800	1:3100	1:3400
HOSPITALS	1:700	1:1000	1:1300	1:1600	1:1900	1:2200	1:2500	1:2800	1:3100	1:3400
MED CENTER										

A2 Civilian and VA Inpatient Acute Care Capability: *This MoM measures the ability of local community acute care facilities to provide comprehensive health services to the eligible beneficiary population. Due to competition issues, this measure is viable only if there are more than two local community hospitals. This measure is not applicable to Clinics and Medical Centers.*

Data Element:

Community Hospitals: Within each catchment area, determine the : 1) # of acute care hospitals; 2) # of operating beds at each hospital; 3) Bed occupancy rate at each hospital; 4) JCAHO accreditation status at each hospital; and 5) MTF operating beds

Source: The source for this measure is Donnelly Marketing Services.

Calculation:

- If # of JCAHO acute care facilities ≤ 2 , then score = 10, else
- $$\left[\sum (1 - \text{occupancy rate}_i) (\text{operating beds}_i) \right] + \text{MTF operating beds} = \text{ratio of civilian acute care operating beds to MTF operating beds}$$

The sum is over the civilian facilities within the MTF catchment area

Description: The ratio of unoccupied civilian beds to MTF beds is compared to the various ratio ranges on the scoring table below. Directly above the ratio range score is a corresponding score from one to ten which becomes the raw score for the MTF on this particular measure of merit. By way of example, a community hospital with a ratio of five or more unoccupied civilian beds for each MTF bed would receive a raw score of one.

A2 Civilian and VA Inpatient Acute Care Capability:

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITALS	5:1	4.5:1	4:1	3.5:1	3:1	2.5:1	2:1	1.5:1	1:1	<1:1
MED CENTER										

Criterion 2: Facilities

The availability and condition of land, facilities, and associated airspace at both the existing and potential receiving locations.

F1 Facility Condition Assessment Score: *The condition code is an indication of plant condition. A low score indicates potential high maintenance and renovation costs. It further suggests that significant resources may be required to correct deficiencies.*

Data Element: Facility Condition Assessment Score

Source: MTF Commander.

Description: Scores range from 0-100 and are compared to the various ranges on the scoring table below. The ratio ranges for clinics, community hospitals, and medical centers are the same. Directly above the range score is a corresponding score from one to ten which becomes the raw score for the MTF on this particular measure of merit. By way of example, a community hospital with a score between 51-60 receives a raw score of six.

F1 Facility Condition Assessment Score:

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
HOSPITALS	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
MED CENTER	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100

F2 Installation Real Property Rating

Data Element: Rating of the facility on a 1-3 scale by the installation engineer.

Source: Installation Real Property Data Card (DODI 4165.14 Inventory of Military Real Property).

Description: This number is located on the Measure of Merit Worksheet for installation Real Property Rating (see table below). A

score of 1 produces a raw score of one; a score of two produces a raw score of five.

F2 Installation Real Property Rating

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1				2					3
HOSPITALS	1				2					3
MED CENTER	1				2					3

F3 Average Weighted Age: This MoM develops an MTF age based on the age and square footage of various buildings that comprise the MTF.

Data Element: The chronological age and building gross square feet for each of the medical facility buildings as of September 30, 1994. The scoring for clinics, community hospitals, and medical centers is identical.

Source: MTF Commander/Installation real property data card.

Description: The age is calculated in the following manner.

CALCULATION: For each Defense Medical Information System Identification number (DMIS ID)

$$\frac{\sum (\text{Chronological Building Age} * \text{Building Gross Square Feet})}{\sum \text{Total Gross Square Feet}} = \text{Average Weighted Age}$$

The calculated age score is compared to the various age ranges on the scoring table. Directly above the ratio range is the corresponding score from one to ten which becomes the raw score for the facility on this particular measure.

F3 Average Weighted Age:

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
HOSPITALS	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
MED CENTER	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1

F4 JCAHO Life Safety Score

Important note: Some facilities will not have Joint Commission on Accreditation of Healthcare Organizations (JCAHO) life safety scores because they do not seek accreditation by the JCAHO. In those specific cases, the weighting normally associated with Life Safety Scores is absorbed in the Measure of Merit F3, the Average

Weighted Age. This measure takes on a weighted score of 70 percent rather than the 40 percent, when all four facility scores are available.

Data Element: The life safety score (measured from 1-5) from the medical facility's most recent JCAHO accreditation survey.

Source: MTF Commander

Description: The accreditation survey score is located on the scoring table below. A score of 3 on the survey corresponds to a raw score of 5.

F4 JCAHO Life Safety Scores

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITALS	5		4		3			2		1
MED CENTER	5		4		3			2		1

Note: Programmed Military Construction (MILCON) covering the FY 95-99 period will be collected by the Military Departments. This data will not be scored or weighted. It is for information purposes only.

Criterion 3: Contingency/Mobilization

The ability to accommodate contingency, mobilization, and future total force requirements at both the existing and potential receiving locations.

MC1 Air Medical Evacuation Site: *This measure looks at the distance a facility is located from a aeromedical evacuation site as one measure of its ability to readily receive and treat casualties.*

Data Element: Distance an MTF is located from any military or civilian airfield that can accommodate a C-9 aircraft. This measure is applicable only for community hospitals and medical centers.

Source: MTF Commander

Description: The further a facility is located from a defined site, the lower the raw score. The distance score is located on the appropriate worksheet. Directly above the distance range is the corresponding score from one to ten which becomes the raw score for the facility on this particular measure.

MC1 Air Medical Evacuation Sites

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITALS	>130	120	110	100	90	80	70	60	50	<40
MED CENTER	>130	120	110	100	90	80	70	60	50	<40

MC2 Bed Expansion Capability

Data Element: . The number of beds that can be used in wards or rooms designed for patient beds. Beds are spaced on 6 foot centers and include embedded electrical and gas utility support for each bed. Beds must be set up and ready within 72 hours. Use of portable gas or electrical utilities is not considered. This measure is applicable only for community hospitals and medical centers.

Source: MTF Commander

Description: The fewer beds a facility has available to treat casualties, the lower the raw score. The facility bed number is located on the scoring table. Directly above the bed number range is the corresponding score from one to ten which becomes the raw score for the facility on this measure.

MC2 Bed Expansion Capability

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITALS	<50	100	150	200	250	300	350	400	450	>450
MED CENTER	<100	200	300	400	500	600	700	800	900	>900

Note: Data will be collected by the Services on percent of the MTF staff assigned to operational contingency/mobilization platforms. This data will not be scored or weighted. It is for information only.

Criterion 4: Cost

The cost and manpower implications.

C1 Cost of Inpatient Care: *This measure looks at MTF Inpatient Cost rate and compares it to the CHAMPUS Adjusted Standardized Amount (ASA). This measure is used to compare direct care inpatient costs to inpatient costs at local civilian hospitals and is expressed as a ratio of CHAMPUS ASA rate / MTF rate.*

Data Element:

- # of Dispositions
- Expense Data
- Operating Beds
- Relative Weighted Product
- # of interns/residents by facility
- Wage rates

Source:**CHAMPUS hospital data**

- CHAMPUS Master Provider File
- Metropolitan Statistical Area 93 File (MSAX.93)
- American Hospital Association 1993 Guide to the Health Care Field
- Federal Register, Vol 58, No 204, October 25, 1993

MTF Data

- Defense Medical Information Systems (DMIS)
- Unpublished FY 94 Direct Care Rates
- Medical Expense Performance Review System (MEPRS)
- Retrospective Case Mix Analysis System (RCMAS)
- Military Departments (# of interns/residents)
- Health Care Financing Administration (HCFA)

Description: The higher the direct care cost in comparison to the civilian cost, the lower the raw score. This measure is calculated as a ratio of ASA rate/MTF rate. The ratio is compared to the various ratio ranges on the scoring table. The ratio score is located on the worksheet below. Directly above the ratio range is the corresponding score from one to ten which becomes the raw score for the facility on this measure.

C1 Cost Inpatient Care (ASA rate/MTF rate)

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITALS	<.3	.45	.6	.75	.9	1.05	1.2	1.35	1.5	>1.5
MED CENTER	<.9	.95	1.0	1.05	1.1	1.15	1.20	1.25	1.3	>1.3

Summary Scoring Methods

Once all the data has been collected and the raw scores have been determined, the raw scores are transferred from the worksheets to the Measures of Merit summary sheet, as depicted in the sample sheet located in Chart 8.

Each raw score and weight are multiplied to produce a weighted Measure of Merit score. For each criterion, the weighted Measure of Merit scores are totaled. The criterion score and the criteria weights are multiplied to produce a weighted criteria score. These scores are totaled for the facility score.

	RAW MoM SCORE	MoM WEIGHT	WEIGHTED MoM SCORE	CRITERIA WEIGHT	WEIGHTED CRITERIA SCORE
CRITERIA 1 MISSION					
P1 POPULATION	9	70%	6.3		
A1 CIVILIAN PRIMARY CARE RATIO	5	15%	0.75		
A2 INPATIENT CAPABILITY	5	15%	0.75		
		TOTAL C1	7.8	40%	3.12
CRITERIA 2 FACILITIES					
F1 FACILITY CONDITION	8	15%	1.2		
F2 REAL PROPERTY	8	15%	1.2		
F3 AVERAGE QS FT AGE	6	40%	2.4		
F4 SAFETY SCORES (JCAHO)	10	30%	3		
		TOTAL C2	6.6	20%	1.32
CRITERIA 3 CONTINGENCY					
MC1 AIR HUB	9	50%	4.5		
MC2 STUBBED BEDS	5	50%	2.5		
		TOTAL C3	7	20%	1.4
CRITERIA 4 COST/MANPOWER					
C1 COST INPATIENT CARE	5	100%	5		
		TOTAL C4	5	20%	1
FACILITY SCORE					6.84

Chart 8. Sample Summary Scoring Sheet

Appendix B contains a blank form of this summary sheet which can be used to record calculations.

Data Certification and Validation Process

Data certification and validation will be in accordance with the final "Internal Control Plan for Managing the Identification of DoD Cross-Service Opportunities as Part of the DoD 1995 Base Realignment and Closure Process (BRAC - 95)". As such, only certified data and validated data sources will be used by the Military Departments to make BRAC recommendations to the Secretary of Defense. All local data collected by the MTF Commander will be certified for accuracy and completeness, based on the respective Military Department's own BRAC95 internal control mechanisms. Data collected from centralized data sources will be validated for accuracy and completeness by an independent audit agency.

As an integral part of the data collection and validation process, the MTF Commander will be provided the relevant centralized data concerning his/her specific MTF and catchment area. The Commander will have the opportunity to surface any significant discrepancies he/she observes in the reported data. A

significant difference is defined as a difference effecting the overall score of the MTF. If there are significant differences, the MTF Commander will provide source data to the applicable audit agency for review, evaluation, and resolution.

Section 5 - Additional Service Guidance for Rightsizing Opportunities

The Services, in conjunction with the Assistant Secretary of Defense, Health Affairs, have consistently sought opportunities to achieve economies in the delivery of health services to our beneficiary population. The Air Force, in its "Rightsizing Study", applied quantitative and qualitative approaches to realigning its medical infrastructure. As a consequence, 15 emergency rooms were realigned. The Air Force is currently implementing a hospital-to-health clinic realignment and considering realignment of two more facilities. Additionally, there have been a number of analyses focused on rightsizing of the Military Health Services System (MHSS). These include the Small Hospital Study and The Medical Facilities Operation Report.

There are numerous opportunities to achieve additional economies and efficiencies within the overall MHSS. These include consolidation of the Services biostatistical functions, consolidation of inter Service military school programs, consolidation of medical laboratories and research facilities, and consolidation of GME programs.

The Military Departments, as part of their overall BRAC process, are requested to strongly consider these opportunities for achieving significant economies. Each of these areas are discussed below.

Medical Laboratory and Research

The Armed Services Biomedical Research and Evaluation (ASBREM) Committee successfully negotiated the consolidation of several medical research programs which were subsequently incorporated into the Base Realignment and Closure Act of 1991 (BRAC91). As the Department of Defense (DoD) undertakes planning for the next round of base closures and realignments in the BRAC95 process, it is important that the ASBREM provide its recommendations and guidance for further collections and consolidations.

The ASBREM Secretariat will coordinate development of several concepts for additional programmatic collections and consolidations with his counterparts in the other Services. These concepts should delineate programmatic, management and other issues requiring resolution within and among the Services, as well as any assumptions upon which the successful implementation of the options might depend. The draft concepts should focus on maximizing efficiency of management and operations while sustaining the ability of the

biomedical research community to respond effectively to both Service-unique and Joint Service requirements in all mission areas under ASBREM oversight.

Graduate Medical Education

In assessing GME programs, a variety of items should be considered that may not necessarily be considered by MTFs which do not have GME programs. The following paragraphs cover many of the items, but the list is not all-inclusive.

Military unique education should be considered when determining their merit. Unlike civilian GME programs, military programs stress military unique problems that better prepare military physicians for wartime casualties. All interns attend the Combat Casualty Care Course and become certified in Advanced Trauma Life Support (ATLS). Lecture topics covered during residency training include the surgical management of battlefield injuries, unusual tropical and parasitic infectious diseases, management of nuclear, biological, and chemical casualties, military ethics, and military leadership.

GME programs must have a patient population sufficient to support the program. All GME programs are structured around providing patient care. For example, it is impossible to support a GME program for Family Practice without having a patient population with a wide spectrum of medical problems. The population must include older patients who suffer from atherosclerotic heart disease, younger patients who have otitis media, and all the patients in between. Without such a population base, it is impossible to sustain a GME program.

GME programs should support the training mission of the Services. The number of trainees and the number of GME programs should match the personnel and readiness requirements established by the Services. Training should not be in excess of the requirements. The Services should consider the known training requirements and ensure that the MTF being evaluated is not training in excess of the requirement.

A very important criteria is the accreditation status of the GME programs provided by the Accreditation Council for Graduate Medical Education (ACGME). Almost all military GME programs are fully accredited by the ACGME, but failure to be fully accredited is a significant factor that could lead to closure of the GME program. It should also be a significant factor in the BRAC 95 process.

Coincidentally, the accreditation status of the MTF by the JCAHO is also an important factor when evaluating a hospital with GME programs. It is a requirement of the ACGME that hospitals be fully accredited by the JCAHO if they want to enjoy the privilege of sustaining GME programs. JCAHO

accreditation is a sign of the quality of care provided at the MTF and ensures, to the degree humanly possible that the institution provides high quality care.

In evaluating the MTF, opportunities for consolidation, integration, elimination, or transfer to another MTF, of GME programs must be evaluated. As the configuration of DoD MTFs changes, and the population base that the MTFs support is altered, opportunities may arise to alter GME programs which would result in a stronger program. Wherever possible, these opportunities should be seized and developed.

Finally, the academic strength of the GME programs should be assessed during the BRAC 95 evaluation. Possible items to assess would include the Board-certification rate of recent graduates of the GME programs; the number and type of scientific publications by the GME program faculty and trainees; the number of active research projects; the quality of the lectures and other didactic sessions in the GME program; and the academic and clinical stature of the GME faculty.

Biostatistical Activities

This section develops a rationale and method for aligning biostatistical function processes, automated information support, and organizational structure requirements within the MHSS environment. The project will rely on the existing work of other related work groups. By including the producers and the users of biostatistic information, the project will establish a dynamic interface back to other work groups and Offices.

Health care delivery and management practices are evolving in the federal and civil sectors. Capitation budgeting, Lead Agent responsibilities, and TRICARE support contracts all require that consistent data be available to decision makers at all levels of the MHSS. The data must also be consistent with that used in other federal agencies and the civil sector to support valid comparisons and decisions.

Biostatistical data is a key component in the information that decision makers require. We must ensure the data gathered is consistent across the Services, the other federal agencies, and the civil sector to support MHSS decision making over the planning horizon. To ensure this, we must determine whether current business rules, automation, and organizational structures can support expected information requirements.

A focused analysis, building on previous work, is needed to implement a uniform business utility that will ensure the proper biostatistical data is gathered throughout the MHSS, in both the direct and indirect care systems; e.g., at risk contractors. The uniform biostatistic utility would include such things as consistent definitions of inpatient and outpatient episodes of care.

Military departments, beginning in April 1994, will strongly consider development of a uniform biostatistic utility for MHSS.

The process includes:

- Defining the biostatistic business environment over the planning horizon that would allow for the construction of unified business practices to support the future biostatistic business environment.
- Developing alternative means to implement the unified business rules.
- Evaluating the impact of the unified biostatistic utility and any implementation alternatives on resources and effectiveness.

TASK	ACTIVITY	PURPOSE
1.0	SCOPING AND ASSUMPTION SETTING EFFORT	<ul style="list-style-type: none"> ■ To set framework of proposed future biostatistical function, business environment for work group activities, and provide "read-ahead." This document will provide the future biostatistic business vision definition to sufficient detail to provide the basis of the future biostatistic business analysis. The output of this project will be integrated within the MHSS environment. ■ To identify Stakeholders (both the producers and the users of biostatistic information, such as the Services, the Office of CHAMPUS, the Defense Medical Program Activity, etc), key resources, critical success factors, unified goals and objectives, strategies
2.1	ANALYZE THE ABILITY OF EXISTING "Biostatistic Information Infrastructure" (information flows, data structures, reporting requirements, etc) TO SUPPORT FUTURE BIOSTATISTIC BUSINESS ENVIRONMENT	<ul style="list-style-type: none"> ■ To synthesize existing work group documents to perform analysis to identify changes to the biostatistic information flow and data structures needed to support the future biostatistic business environment in an efficient and effective way ■ To perform simulation modeling of resource and cost changes as a result of the changes in biostatistic information infrastructure ■ To document changes in financial results, and impacts on other resources and effectiveness in support of migration systems selection strategies and POM exercises
2.2	ANALYZE THE ABILITY OF EXISTING "Biostatistic Organization" TO SUPPORT FUTURE BIOSTATISTIC BUSINESS ENVIRONMENT	<ul style="list-style-type: none"> ■ To use results from "Biostatistic Information Infrastructure" to develop alternative organizational implementations to deliver and support the Biostatistic Information Infrastructure improvements ■ To perform simulation modeling of resource and cost changes as a result of the changes in Biostatistic Organization ■ To document changes in financial results, and impacts on other resources and effectiveness to support POM exercises
3.0	EXECUTE IMPROVEMENT PLAN	<ul style="list-style-type: none"> ■ To implement changes to both the Biostatistic Information Infrastructure and Organization identified ■ To monitor the success of the improvements using change management techniques

Inter-Service Medical Training

The Health Care Committee (HCC) of the Interservice Training Review Organization (ITRO) negotiated the consolidation and collocation of several courses for training enlisted personnel in medical skills. Currently, the HCC continues to conduct military medical training structure reviews as directed by the Chairman, Joint Chiefs of Staff.

The mission of the HCC is to develop a system for health care education and training that meets nationally accepted standards of quality, supports individual service requirements, and promotes fiscal responsibility. The HCC is developing a master plan for consolidation that includes Consolidated Training Centers of Excellence, sequencing, and use of civilian training contracts. As the medical community begins to plan for the BRAC 95 process, it is important to consider the work of the ITRO HCC for further consolidations and collocations.

The Services are requested to strongly consider the ITRO HCC's master plan in their overall BRAC 95 process. The analysis should include officer/enlisted training requirements, resource requirements, and alternatives for accomplishing consolidation. The review should address policy and operational/organizational changes required to make maximum use of common support assets. The review should evaluate core curriculums for consolidation; i.e., basic medical corpsman and dental technician training. Finally, the review should consider opportunities within the medical training community to reduce infrastructure consistent with the Defense Medical Programming Guidance and DoD's planned force reductions.

Appendix A - Facility Listing

STAND ALONE HEALTH CLINICS

SERVICE	STATE	INSTALLATION
ARMY	ALASKA	FT GREELY
ARMY	CALIFORNIA	OAKLAND ARMY BASE
ARMY	GEORGIA	FT MCPHERSON
ARMY	GEORGIA	HUNTER AAF
ARMY	MARYLAND	ABERDEEN APG
ARMY	MARYLAND	FT DETRICK
ARMY	MARYLAND	FT RITCHIE
ARMY	MASSACHUSETTS	NATICK R&D CENTER
ARMY	NEW YORK	FT DRUM
ARMY	NEW YORK	FT HAMILTON
ARMY	PENNSYLVANIA	CARLISLE BKS
ARMY	PENNSYLVANIA	FT INDIANTOWN GAP
ARMY	VIRGINIA	PENTAGON
ARMY	VIRGINIA	FT A.P. HILL
ARMY	VIRGINIA	FT MONROE
ARMY	VIRGINIA	FT MYER
ARMY	VIRGINIA	FT PICKETT
ARMY	VIRGINIA	FT STORY
ARMY	WASHINGTON, DC	FT MCNAIR
NAVY	CALIFORNIA	NMC LONG BEACH
NAVY	FLORIDA	NMC KEY WEST
NAVY	GEORGIA	NMC KINGS BAY
NAVY	HAWAII	NMC PEARL HARBOR
NAVY	LOUISIANA	NMC NEW ORLEANS
NAVY	MARYLAND	NMC ANNAPOLIS
NAVY	NEW HAMPSHIRE	NMC PORTSMOUTH
NAVY	VIRGINIA	NMC QUANTICO
USAF	ARKANSAS	EIELSON AFB
USAF	CALIFORNIA	LOS ANGELES AFS
USAF	COLORADO	PETERSON AFB
USAF	HAWAII	HICKAM AFB
USAF	KANSAS	MCCONNELL AFB
USAF	MASSACHUSETTS	HANSCOM AFB
USAF	MONTANA	MALMSTROM AFB
USAF	NORTH CAROLINA	POPE AFB
USAF	OKLAHOMA	VANCE AFB
USAF	SOUTH CAROLINA	CHARLESTON AFB
USAF	TEXAS	BROOKS AAFB
USAF	TEXAS	KELLY AFB
USAF	TEXAS	RANDOLPH AFB
USAF	TEXAS	GOODFELLOW AFB
USAF	WASHINGTON, DC	BOLLING AFB
USAF	WASHINGTON	MCCHORD AFB

COMMUNITY HOSPITALS

SERVICE	STATE	INSTALLATION	DMIS ID
ARMY	ALABAMA	FOX AH-REDSTONE ARSENAL	0001
ARMY	ALABAMA	NOBLE AH-FT MCCLELLAN	0002
ARMY	ALABAMA	LYSTER AH-FT RUCKER	0003
ARMY	ALASKA	BASSETT ACH-FT WAINWRIGHT	0005
ARMY	ARIZONA	BLISS AH-FT HUACHUCA	0008
ARMY	CALIFORNIA	WEED ACH-FT IRWIN	0131
ARMY	COLORADO	EVANS AH-FT CARSON	0032
ARMY	GEORGIA	MARTIN AH-FT BENNING	0048
ARMY	GEORGIA	WINN AH-FT STEWART	0049
ARMY	KANSAS	IRWIN AH-FT RILEY	0057
ARMY	KANSAS	MUNSON AH-FT LEAVENWORTH	0058
ARMY	KENTUCKY	BLANCHFIELD ACH-FT CAMPBELL	0060
ARMY	KENTUCKY	IRELAND AH-FT KNOX	0061
ARMY	LOUISIANA	BAYNE-JONES AH-FT POLK	0064
ARMY	MARYLAND	KIMBROUGH AH-FT MEADE	0069
ARMY	MISSOURI	WOOD AH-FT LEONARD WOOD	0075
ARMY	NEW JERSEY	PATTERSON AH-FT MONMOUTH	0081
ARMY	NEW YORK	KELLER AH-WEST POINT	0086
ARMY	NORTH CAROLINA	WOMACK ARMY MED CTR-FT. BRAGG	0089
ARMY	OKLAHOMA	REYNOLDS AH-FT SILL	0098
ARMY	SOUTH CAROLINA	MONCRIEF AH-FT JACKSON	0105
ARMY	TEXAS	DARNALL AH-FT HOOD	0110
ARMY	VIRGINIA	MCDONALD AH-FT EUSTIS	0121
ARMY	VIRGINIA	KENNER AH-FT LEE	0122
ARMY	VIRGINIA	DEWITT AH-FT BELVOIR	0123
NAVY	CALIFORNIA	NH CAMP PENDLETON	0024
NAVY	CALIFORNIA	NH LEMOORE	0028
NAVY	CALIFORNIA	NH TWENTYNINE PALMS	0030
NAVY	CONNECTICUT	NH GROTON	0035
NAVY	FLORIDA	NH PENSACOLA	0038
NAVY	FLORIDA	NH JACKSONVILLE	0039
NAVY	ILLINOIS	NH GREAT LAKES	0056
NAVY	MARYLAND	NH PATUXENT RIVER	0068
NAVY	NORTH CAROLINA	NH CAMP LEJEUNE	0091
NAVY	NORTH CAROLINA	NH CHERRY POINT	0092
NAVY	RHODE ISLAND	NH NEWPORT	
NAVY	SOUTH CAROLINA	NH CHARLESTON	0103
NAVY	SOUTH CAROLINA	NH BEAUFORT	0104
NAVY	TENNESSEE	NH MILLINGTON	0107
NAVY	TEXAS	NH CORPUS CHRISTI	0118
NAVY	WASHINGTON	NH BREMERTON	0126
NAVY	WASHINGTON	NH OAK HARBOR	0127
USAF	ALABAMA	AIR UNIVERSITY RGN HOSP-MAXWELL	0004
USAF	ALASKA	USAF HOSP ELMENDORF	0006
USAF	ARIZONA	832nd MED GRP-LUKE	0009
USAF	ARIZONA	836th MED GRP-DAVIS MONTHAN	0010
USAF	ARKANSAS	USAF HOSP LITTLE ROCK	0013
USAF	CALIFORNIA	814th STRAT HOSP-BEALE	0015
USAF	CALIFORNIA	323rd FTW HOSP-MATHER	0016

USAF	CALIFORNIA	1st STRAT HOSP-VANDENBERG	0018
USAF	CALIFORNIA	AFSC HOSP-EDWARDS	0019
USAF	COLORADO	USAF ACADEMY HOSP	0033
USAF	DELAWARE	USAF HOSP DOVER	0036
USAF	FLORIDA	USAF RGN HOSP EGLIN	0042
USAF	FLORIDA	325th MED GRP-TYNDALL	0043
USAF	FLORIDA	56th MED GRP-MACDILL	0045
USAF	FLORIDA	AFSC HOSP-PATRICK	0046
USAF	GEORGIA	347th MED GRP-MOODY	0050
USAF	GEORGIA	USAF HOSP ROBINS	0051
USAF	IDAHO	366th MED GRP-MOUNTAIN HOME	0053
USAF	ILLINOIS	USAF MED CTR SCOTT	0055
USAF	LOUISIANA	2nd STRAT HOSP-BARKSDALE	0062
USAF	MARYLAND	MALCOLM GROW MED CTR-ANDREWS	0066
USAF	MISSISSIPPI	14th FTW HOSP-COLUMBUS	0074
USAF	MISSOURI	351st STRAT HOSP-WHITEMAN	0076
USAF	NEBRASKA	EHRLING BERQUIST RGN HOSP-OFFUTT	0078
USAF	NEVADA	554th MED GRP-NELLIS	0079
USAF	NEW MEXICO	USAF HOSP KIRTLAND	0083
USAF	NEW MEXICO	833rd MED GRP-HOLLOMAN	0084
USAF	NEW MEXICO	27th MED GRP-CANNON	0085
USAF	NORTH CAROLINA	4th MED GRP-SEYMOUR JOHNSON	0090
USAF	NORTH DAKOTA	842nd STRAT HOSP-GRAND FORKS	0093
USAF	NORTH DAKOTA	857th STRAT HOSP-MINOT	0094
USAF	OKLAHOMA	USAF HOSP TINKER	0096
USAF	OKLAHOMA	USAF HOSP ALTUS	0097
USAF	PENNSYLVANIA	WALSON-MCGUIRE AFB	0082
USAF	SOUTH CAROLINA	363rd MED GRP-SHAW	0101
USAF	SOUTH DAKOTA	812th STRAT HOSP-ELLSWORTH	0106
USAF	TEXAS	64th FTW HOSP-REESE	0111
USAF	TEXAS	96th STRAT HOSP-DYESS	0112
USAF	TEXAS	SHEPPARD TTC HOSP	0113
USAF	TEXAS	47th FTW HOSP-LAUGHLIN	0114
USAF	UTAH	USAF HOSP HILL	0119
USAF	VIRGINIA	1st MED GRP-LANGLEY	0120
USAF	WASHINGTON	92nd STRAT HOSP-FAIRCHILD	0128
USAF	WYOMING	90th STRAT HOSP-F.E. WARREN	0129

MEDICAL CENTERS

SERVICE	STATE	INSTALLATION	DMIS ID
ARMY	COLORADO	FITZSIMONS AMC	0031
ARMY	GEORGIA	EISENHOWER AMC-FT GORDON	0047
ARMY	HAWAII	TRIPLER AMC-FT SHAFTER	0052
ARMY	TEXAS	WILLIAM BEAUMONT AMC-FT BLISS	0108
ARMY	TEXAS	BROOKE AMC-FT SAM HOUSTON	0109
ARMY	WASHINGTON	MADIGAN AMC-FT LEWIS	0125
ARMY	WASHINGTON, DC	WALTER REED AMC	0037
NAVY	CALIFORNIA	NH SAN DIEGO	0029
NAVY	MARYLAND	NNMC BETHESDA	0067
NAVY	VIRGINIA	NH PORTSMOUTH	0124
USAF	CALIFORNIA	DAVID GRANT MED CTR-TRAVIS AFB	0014
USAF	MISSISSIPPI	KEESLER TTC MED CEN- KEESLER AFB	0073
USAF	OHIO	USAF MED CTR WRIGHT-PATTERSON AFB	0095
USAF	TEXAS	WILFORD HALL MED CTR-LACKLAND AFB	0117

Appendix B - Summary Score Sheet

	RAW MOM	MOM	WEIGHTED	CRITERIA	WEIGHTED
	SCORE	WEIGHT	MOM SCORE	WEIGHT	CRITERIA SCORE
CRITERIA 1 MISSION					
P1 POPULATION	0	70%	0		
A1 CIVILIAN PRIMARY CARE RATIO	0	15%	0		
A2 INPATIENT CAPABILITY	0	15%	0		
		TOTAL C1	0	40%	0
CRITERIA 2 FACILITIES					
F1 FACILITY CONDITION	0	15%	0		
F2 REAL PROPERTY	0	15%	0		
F3 AVERAGE WGT AGE	0	40%	0		
F4 SAFETY SCORES (JCAHO)	0	30%	0		
		TOTAL C2	0	20%	0
CRITERIA 3 CONTINGENCY					
MC1 AIR HUB	0	50%	0		
MC2 STUBBED BEDS	0	50%	0		
		TOTAL C3	0	20%	0
CRITERIA 4 COST/MANPOWER					
C1 COST INPATIENT CARE	0	100%	0		
		TOTAL C4	0	20%	0
				SCORE	0

Appendix C - Glossary

ADJUSTED STANDARDIZED AMOUNT (ASA): A term used to describe the method used by the Department of Health and Human Services, the Health Care Financing Administration and the Office of Civilian Health and Medical Program of the Uniformed Services to create payment amounts for hospitals.

ASA: See **ADJUSTED STANDARDIZED AMOUNT**.

BASE REALIGNMENT AND CLOSURE (BRAC): The BRAC process is an established procedure for closing and realigning military installations. The procedure is defined by the Defense Base Closure and Realignment Act of 1990 (Public Law 101-510), as amended.

CASE-MIX INDEX (CMI): Total Relative Weighted Products (RWPs) for an MTF or other levels of aggregation (e.g., beneficiary category, clinical area, etc.) divided by the total number of Biometrics dispositions less DRGs 469 and 470. The CMI is the average RWPs per disposition and is viewed as a measure of average case complexity.

CATCHMENT AREA: Inpatient catchment areas are defined as sets of ZIP codes having centroids within 40 miles of an MTF. Using rules to uniquely allocate beneficiaries who live within 40 miles of more than one hospital, and allow for natural barriers, each eligible beneficiary is assigned to a unique catchment area. Catchment area overlap summaries included in this document analysis are based upon the January 1993 Catchment Area Directory (CAD).

CATCHMENT AREA DIRECTORY (CAD): The official reference published by OASD(Health Affairs) that indicates MHSS catchment area assignments by 5-digit ZIP code. The CAD is published annually with quarterly updates and is used by MTF Health Benefits Advisors (HBAs) to determine Non-availability Statement (NAS) issuance at MTFs. The CAD is used for beneficiary-level data processing by the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), CHAMPUS Fiscal Intermediaries (FIs), Defense Manpower Data Center (DMDC), and by the Defense Medical Information System (DMIS) for ZIP code-level data processing. The CAD is the basis for determining whether or not two or more catchment areas overlap.

CATCHMENT AREA OVERLAP: A flag that indicates whether or not the listed MTF's 40-mile catchment area overlaps with the 40-mile catchment area of any other MTF. See Catchment Area.

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services. The program that serves as the principal means by which care is furnished by civilian institutional and professional providers to non-active duty MHSS beneficiaries.

CLINIC: An outpatient treatment facility that has a commanding officer, receives funds directly from the Service headquarters, and provides care to active duty and other beneficiaries.

COMMUNITY HOSPITAL: See HOSPITAL.

CONSTRUCTION REQUIREMENT: Total programmed Military Construction (MILCON) resources over all years in the FY95 to FY00 Program Objective Memorandum (POM).

CONUS: Continental United States including Alaska and Hawaii.

DIAGNOSIS-RELATED GROUPS (DRGs): DRGs, or diagnosis-related groups, were developed by Yale University under contract with the Health Care Financing Administration (HCFA). Based primarily on the principal diagnosis a case is assigned a Major Diagnostic Category (MDC). MDCs are classified based upon the major body system affected. The MDCs are partitioned into several hundred DRGs that are intended to group medically homogeneous conditions as defined by a set of attributes. These include the principal diagnosis, specific secondary diagnoses, operating room procedures, complications and morbidity, age, and discharge status. Each DRG represents a class of patients who are clinically similar and should have similar length of stay and resource requirement (cost) patterns.

DMIS: The Defense Medical Information System (DMIS) is a management information system used to support the formulation and execution of plans, programs, and policy within the Office of the Assistant Secretary of Defense (Health Affairs) and Service headquarters staffs.

DMIS ID: The unique numeric code assigned by the Defense Medical Information System (DMIS) to MTFs, clinics, and geographic areas that is used for MHSS data reporting and processing purposes.

EXPANDED BED CAPACITY: The number of beds that can be used in wards or rooms designed for patients' beds. Beds are spaced on 6-foot centers (approximately 72 square feet per bed), and include electrical and gas utility support for each bed. Space for beds used only in connection with examinations or brief treatment periods, such as in examining rooms or in the physical therapy department, is not included in expanded bed capacity. Nursery space is not included.

FACILITY CONDITION ASSESSMENT SCORE or FACILITY CONDITION SCORE: Refers to Military Treatment Facility (MTF) Condition Assessment Score assigned by the OASD(Health Affairs) Defense Medical Facilities Office (DMFO). The Facility Condition Assessment Score reflects the summary score of the facility calculated based on the weighted factors assigned to each assessment criterion and the condition of each facility reported by the Services. The total calculated weight factor of each facility is normalized to a standard score of 100 by providing due credit to the functions and/or systems non-applicable to that MTF. This normalization method allows for comparisons of physical conditions between facilities irrespective of their size and/or complexity.

FISCAL YEAR (FY): The 12-month accounting period used by the Federal Government (currently from 1 October to the next 30 September).

FORTY-MILE OVERLAPPING CATCHMENT AREA: See Overlapping Catchment Areas.

GRADUATE MEDICAL EDUCATION (GME): Full-time, structured, medically related training, accredited by a national body, e.g., the Accreditation Council for Graduate Medical Education, approved by The Commissioner of Education, and obtained after receipt of the appropriate doctoral degree.

GRADUATE MEDICAL EDUCATION TEACHING FACILITY: A hospital that conducts residency and fellowship training.

HEALTH CLINIC: See **CLINIC**.

HOSPITAL: A health treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the fields of general medicine and surgery, and preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A hospital may, in addition, discharge the function of a clinic.

LEAD AGENT: The lead agent is a person designated to develop a tri-service, regional health plan for beneficiaries of the MHSS, including the development of a single, integrated health care network for the Health Service Region. Lead agents are responsible for maximizing the use of all direct care assets in the region, then supplementing that health care through competitive contracts developed in coordination with OASD(HA).

JCAHO ACCREDITATION STATUS: Medical centers and hospitals that have been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) within the past 3 years.

MEDICAL CENTER: A large hospital, which has been so designated, appropriately staffed, and equipped, that provides a broad range of health care services and serves as a referral center with specialized and consultative support for medical facilities within the geographic area of responsibility. Conducts, as a minimum, two graduate medical education programs. The definition includes those CONUS medical centers defined in OASD(Health Affairs) Health Services Operations (HSO)-Defense Medical Facilities Office (DMFO) Memorandum, 1 April 1992, Department of Defense Training Facilities (approved by OASD(Health Affairs) Health Services Operations (HSO), 3 April 1992).

MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM (MEPRS) FOR FIXED MILITARY MEDICAL AND DENTAL TREATMENT FACILITIES:

A uniform reporting methodology designed to provide consistent principles, standards, policies, definitions, and requirements for accounting and reporting of expense, manpower, and performance data by DoD MTFs. Within these specific objectives, the Medical Expense and Performance Reporting System (MEPRS) also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology. For specific details, see *Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities*, DOD 6010.13-M, January 1991.

MILITARY TREATMENT FACILITY (MTF): A facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

MHSS: Military Health Service System.

NUMBER OF ACUTE CARE HOSPITALS: The number of non-DoD hospitals in a catchment area is based on 1992 Donnelly Marketing Information Services

data, which include all reporting AHA members. Army, Navy, and Air Force hospitals have been excluded from the count of hospitals. The hospitals were linked to catchment areas based on the hospital ZIP code and include all hospitals within 40 miles of the MTF. Note that a hospital may be within 40 miles of more than one MTF and therefore will be linked to more than one catchment area. The mapping of civilian institutions to catchment areas was based on the January 1994 Catchment Area Directory (CAD).

OPERATING BED CAPACITY: Accommodation in a functioning military treatment facility that is currently set up and ready in all respects for the care of a patient. It must include supporting space, equipment, medical material, ancillary and support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds, and recovery beds.

OUTPATIENT: An individual receiving health service for an actual or potential disease or injury that does not require admission to an MTF for inpatient care.

OVERLAPPING CATCHMENT AREAS: Overlapping catchment areas occur when the 40-mile catchment area of one MTF intersects with the 40-mile catchment area of another MTF. Thus, two MTFs with overlapping catchment areas may be up to 80 miles apart (i.e., two 40-mile circles with minimal overlap). Numerous areas exist within CONUS that fall into multiple MTF catchment areas. The Catchment Area Directory provides the basis for catchment area assignment as well as unique allocation to avoid double-counting MHSS catchment area beneficiaries and utilization.

PHYSICIAN-TO-POPULATION RATIO: The 1992 Donnelly Marketing Information Services data contains the civilian population and physician data, which can be searched to develop catchment area ratios. The physician providers information includes non-Federal primary care physicians only. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians. The mapping of civilian physicians and population to catchment area is based on the January 1994 Catchment Area Directory (CAD).

POPULATION - ACTIVE DUTY & DEPENDENTS OF ACTIVE DUTY: This is the level the catchment area active duty and dependent of active duty population would reach if the Service-specific changes in active duty end-strength described in the FY92 Program Objective Memorandum (POM) were spread equally across all catchment areas, after base realignment and closure takes

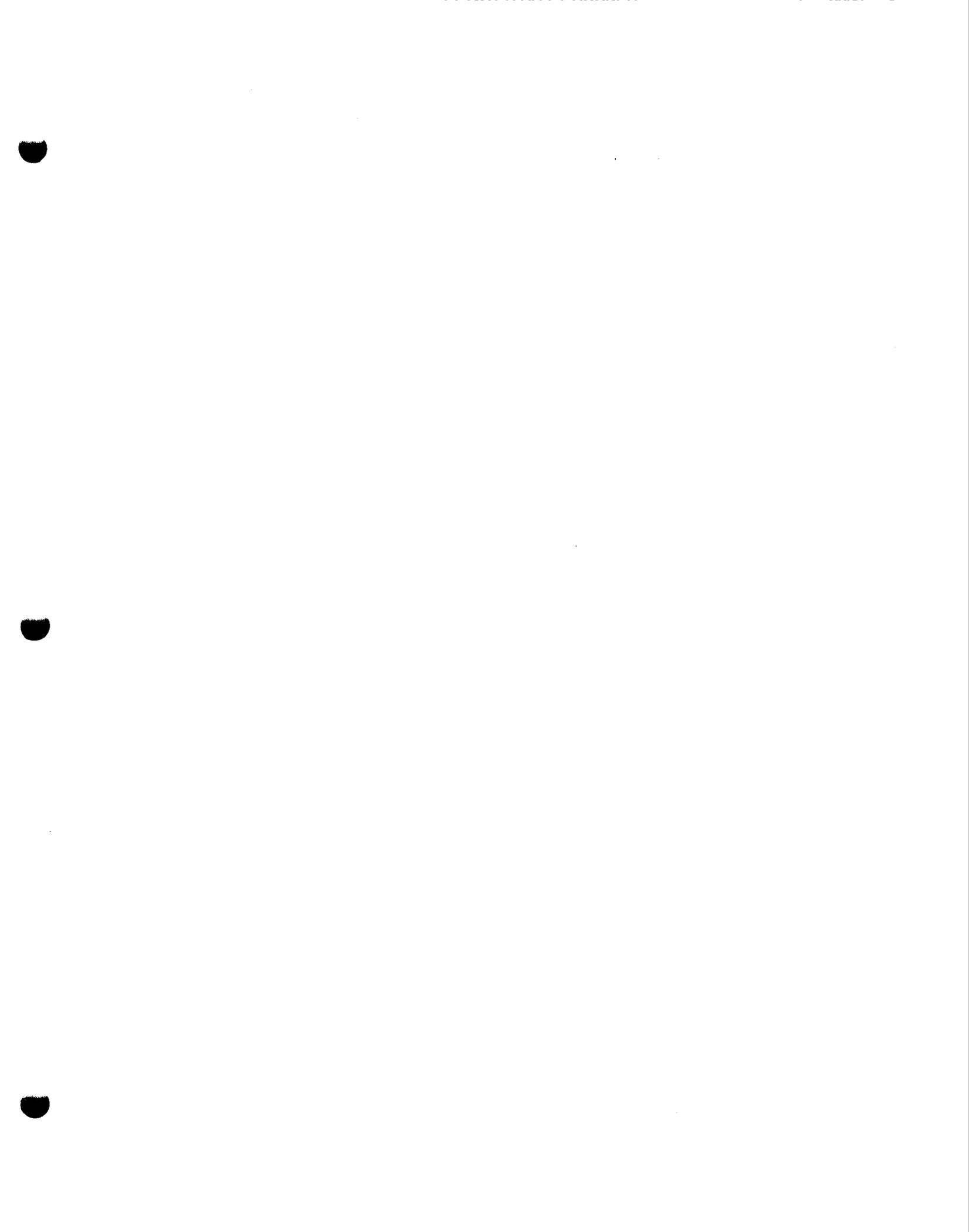
place as specified for BRAC III. This reflects the best estimate of the catchment area's expected active duty and dependent of active duty population in FY97.

RELATIVE WEIGHTED PRODUCT (RWP): The sum of weighted dispositions computed by multiplying each disposition by the relative weight of the DRG assigned and adjusting for short and long stay outlier credit. RWPs are frequently summed over clinical service, diagnostic category, facility, etc. The sum of the RWPs divided by the number of dispositions for a given aggregation provides an average credit per disposition commonly referred to as the case-mix index (CMI). See Case-Mix Index (CMI).

STAND ALONE CLINIC: See **CLINIC**.

WAGE RATES: Wage rates are standard rates of pay computed for a specific geographical area by the Health Care Financing Administration in the Department of Health and Human Services, and used as indices to standardize area differences in wage rates. A formula is then applied to describe the method and amount of payment for health services.

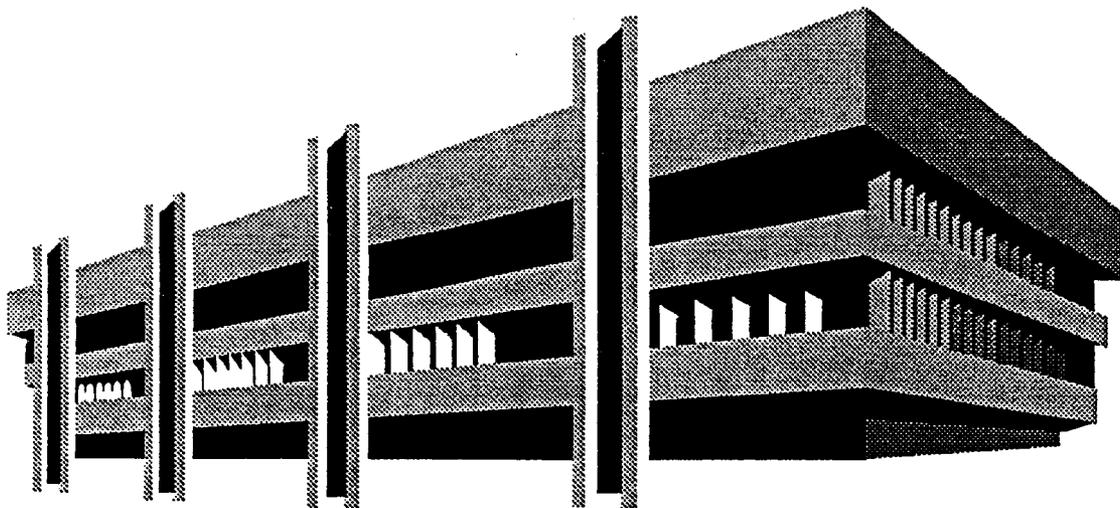
YEAR CONSTRUCTED: The year in which the named MTF was constructed.



BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

CLOSE HOLD

Report to the BRAC 95 Review Group



CLOSE HOLD

Revised April 15, 1994

TABLE OF CONTENTS

Introduction.....	1
Section 1 - Analytical Process Development.....	3
Action Plan and Milestones through March 31, 1994	3
Statement of Principles	3
Major Analysis Assumptions	4
Roles of Joint Medical Group and Services.....	5
General Analytic Concept.....	6
Section 2 - Categories for Study.....	7
Health Clinics.....	7
Community Hospitals	7
Medical Centers.....	7
Section 3 - Capacity Measures.....	8
Contingency/Mobilization Beds Requirements	8
Peacetime Operating Bed Capacity.....	8
Section 4 - Development of Measures of Merit.....	10
Weighting and Scoring Descriptions.....	10
Criterion 1: Mission	10
Criterion 2: Facilities	13
Criterion 3: Contingency/Mobilization	16
Criterion 4: Cost.....	17
Summary Scoring Methods	18
Data Certification and Validation Process	19
Section 5 - Additional Service Guidance for Rightsizing Opportunities.....	20
Medical Laboratory and Research	20
Graduate Medical Education.....	21
Biostatistical Activities.....	22
Inter-Service Medical Training	24
Appendix A - Facility Listing.....	25
Appendix B - Summary Score Sheet.....	29
Appendix C - Glossary	30
Appendix D - Medical Laboratory and Research Concept Paper	36
Appendix E - ITRO Health Care Committee Report.....	40

Introduction

The Deputy Secretary of Defense 1995 Base Realignment and Closures guidance memorandum of January 7, 1994, provided the authority for establishment of the Joint Cross Service Group for Military Treatment Facilities (MTFs) and Graduate Medical Education (GME). This group is also referred to in this report as the Joint Medical Group. The first meeting was held January 25, 1994. A Tri-Service Ad Hoc Working Group was also established to develop and recommend draft criteria and process proposals for consideration by the Joint Medical Group.

The BRAC 95 Joint Medical Group process seeks to establish the policies and criteria through which DoD may use BRAC to identify opportunities in the medical establishment for cross Service asset sharing and single Military Department support of joint medical missions, and other closure and realignment opportunities. Such opportunities have not been sought out systematically in past BRAC efforts, largely because of the absence of a mechanism to provide needed cross military department information and coordination. The establishment of this Joint Medical Group provides that mechanism.

This report is submitted to the BRAC 95 Steering and Review Group in accordance with the DepSecDef guidance memorandum. It is divided into five sections.

Section 1 addresses the development of the overall analytic process. This includes the Group's action plan, study assumptions, roles of the Services and Joint Medical Group, and the conceptual analytic approach.

Section 2 describes the functional study categories and the associated definitions/rationale for each functional category selected.

Section 3 describes the development of capacity measures. These include measures for contingency/mobilization bed requirements and peacetime operating bed capacity.

Section 4 discusses common measures of merit, the data element(s) to be collected by the Services, the source(s) for each data element, and the methodology for weighting and scoring each of the measures. This section also describes the relationship between each measure of merit and the major BRAC criterion. Procedures for certification and validation are also outlined.

Section 5 provides supplementary guidance to the Services relating to rightsizing opportunities within the Services' biostatistical activities, Inter-Service military school system, medical laboratories and research facilities, and GME.

The BRAC process is designed to identify facilities or military locations that must be realigned or closed to implement extant decisions to reduce force structure. Sizing the medical establishment is fundamentally different from a normal BRAC issue in that DoD has yet to decide whether the MTF system should be sized to the wartime mission or whether, instead, much of the medical care due non-active-duty beneficiaries should be provided in DoD facilities. The DoD 733 study concludes that the latter position is cost-effective only if the following conditions are satisfied:

- Single-plan enrollment and lockout.
- Collection from third-party insurance and MEDICARE subvention.
- Efficient use of enrollment premiums and copayments.
- Effective implementation of capitation budgeting and managed care.

None of these conditions has yet been met. Hence, the Joint Medical Group process can identify in a cross service venue only the more obvious candidates for closure or realignment based on mission functionality, facility age, inappropriate duplication of effort, and so on. In identifying only the more obvious candidates, this process can not substitute for the efforts of DoD decision makers in the programming and budgeting arena. Indeed, decisions concerning management of peacetime demand for MTFs may have a more far-reaching effect on the size and composition of the DoD medical establishment than decisions arising from the BRAC process.

Most important, the Joint Medical Group has developed a consensus on data and criteria definitions so that implementation of the Relative Military Value criteria will be consistent and standardized across the Military Departments. These criteria will not tell the Group where to "draw the line" about the overall size of the military medical establishment (these decisions will be made by the Department in other venues), but they will enable DoD for the first time to develop the relative rankings of facilities so that decisions involving facilities of more than one Military Department may be based on consistent definitions and criteria.

Section 1 - Analytical Process Development

Action Plan and Milestones through March 31, 1994

Action Plans and Milestones were developed and approved by the Joint Medical Group in early February 1994. Chart 1 depicts the approved Action Plan through March 31, 1994. Checked items indicate completed tasks.

BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME		
■ Action Plan & Timeline (thru 3/31/94)		
> Agree on Statement of Principles	2/4	✓
> Define role of Group & Services	2/4	✓
> Develop Analysis Assumptions	2/11	✓
> Determine Categories for Study	2/18	✓
> Determine General Analytical Approach	2/18	✓
> Review Interim Force Structure Plan	2/25	✓
> Submit list of irreconcilable differences, if necessary, to USD (A&T)	2/28	✓
> Define Measures of Merit & Data Sources	3/4	✓
> Determine weights for Measures of Merit	3/11	✓
> Complete Data Definitions	3/11	✓
> Establish Data Internal Control Plan	3/17	✓
> Draft report to Joint Group for review	3/17	✓
> Final report to Steering Group	3/31	✓

Chart 1. Action Plan and Milestones

Statement of Principles

One of the first efforts of the Joint Medical Group was achieving consensus on the Joint Declaration of Principles. This document established the purpose and focus of the Joint Medical Group's efforts. The Principles are shown below:

DECLARATION OF PRINCIPLES

1. The Joint Cross Service Group on Medical Facilities and Graduate Medical Education seeks to identify measures of merit (subcategories of the 8 BRAC criteria) data elements, and methodologies that will allow the DoD components to apply the DoD criteria in a uniform, fair, reasonable, and consistent manner that complies with statutory and regulatory requirements and that adheres to the policy set forth in the January 7, 1994, DepSecDef memo, subject: 1995 Base Realignment and Closures (BRAC).

2. The Joint Cross Service Group on Medical Facilities and Graduate Medical Education recognizes the need for right-sizing, seeking opportunities for cross-Service asset sharing, and /or single military department support.

3. The measures of merit, data elements, and methodologies used to arrive at closure and realignment recommendations will be developed and approved by the Joint Cross Service Group on Medical Facilities and Graduate Medical Education by 31 March 1994. The approach developed should be easy to use, simple and straightforward, auditable, reproducible, and defensible.

Based on guidance from the March 15, 1994, Steering Group meeting, the Joint Cross Service Groups would only develop Measures of Merit for the Relative Military Value criteria. The Services will be responsible for ensuring BRAC criteria 5-8 are addressed. These include Return on Investment, Economic Impact on Communities, Community Infrastructure, and Environmental Impact.

Major Analysis Assumptions

The Joint Medical Group developed four basic study assumptions as described in Chart #2. The most basic premise assumes that, in general, the MTF will close if the base or installation closes except when a significant active duty population remains after a base is closed. Another basic assumption is that the Joint Medical Group will focus primarily on peacetime requirements. The group also agreed to include organizations with < 300 civilian full time employed personnel as part of the overall analysis. The Joint Medical Group reached consensus on these assumptions on February 3, 1994.

BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME	
<p>■ Analysis Assumptions agreed on 2/3/94</p> <ul style="list-style-type: none"> > MTF will close if base closes unless a sufficient active duty population remains > Joint Group efforts will focus on peacetime requirements > Analysis will include facilities with < 300 civilian personnel > Quantitative goals will not be initially defined <ul style="list-style-type: none"> - Revisit later if necessary 	
Revised 2/4/94	2

Chart 2. Chart 2 describes the Analytical Assumptions for the Joint MTF and GME Group.

Roles of Joint Medical Group and Services

The roles of the Military Departments and the Joint Medical Group were developed based on the DepSecDef guidance memorandum of January 7, 1993.

BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

■ Define Roles for Joint Group and Service (Group consensus 2/3/94)

- Joint Group will develop
 - Analysis assumptions
 - Categories for study and their definitions
 - General analytical approach and methodology
 - Internal Control Plan
 - Data definitions and measures of merit
 - Relative weights for measures of merit
 - Prepare alternative options, as appropriate, based on review of the Services' analyses
- Services will
 - Collect and analyze data
 - Present findings to Joint Cross Service Group
 - Evaluate alternative options recommended by Joint Cross-Services Group

Revised 2/4/94

##

The Group membership reached role consensus on February 3, 1994 (See Chart 3). The Joint Medical Group will develop the study design, general analytical approach, measures of merit, common data elements, and a methodology for weighting and scoring the

Chart 3. Roles of Services and Joint Medical Group

measures of merit. The Military Services will be responsible for data collection and analysis, development of findings, and will evaluate alternative options recommended by the Joint Medical Group. The Department of the Navy expressed concerns that weighting done outside of the Military Departments' evaluative process is in conflict with the above statement. The Joint Medical Group recognize there are differences in the manner the Services approach their respective BRAC processes. The Joint Medical Group's expectation is that the Services will consistently apply the methodology as outlined in this report; i.e., to collect data, score facilities, and weight the Measures of Merit and BRAC Relative Military Value Criteria. The Group recognizes that each Military Department will use its own methodology in making BRAC recommendations to the Secretary of Defense.

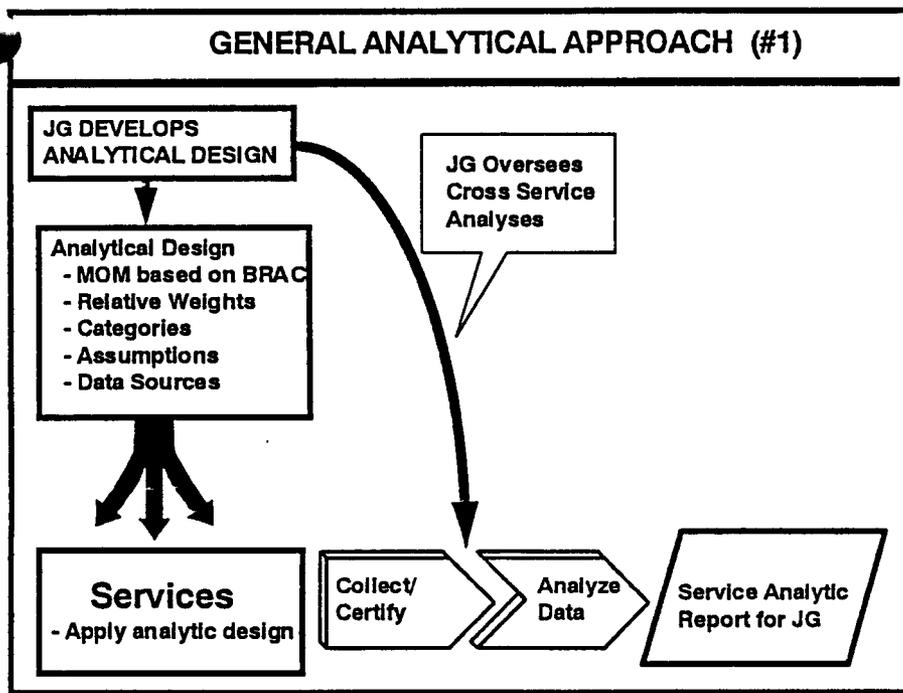


Chart 4. General Analytical Approach

General Analytical Concept

The conceptual description of the General Analytical Approach is shown in Charts 4 and 5. This concept is based on the DepSecDef Base Closure memorandum and the agreed upon roles of the Military Departments and the Joint Medical Group. Chart 5 depicts an iterative process where the Military Services will submit analyses and findings to the Joint Medical Group. The Joint

Medical Group, in conjunction with the Services, will subsequently develop alternative option packages for Service consideration. The Services will evaluate the alternatives and submit their findings to the Joint Medical Group. Once the iterative process is completed, the process culminates in the Services making their BRAC recommendations to the Secretary of Defense and the Joint Medical Group submitting its report to the BRAC 95 Steering Group and Review Group.

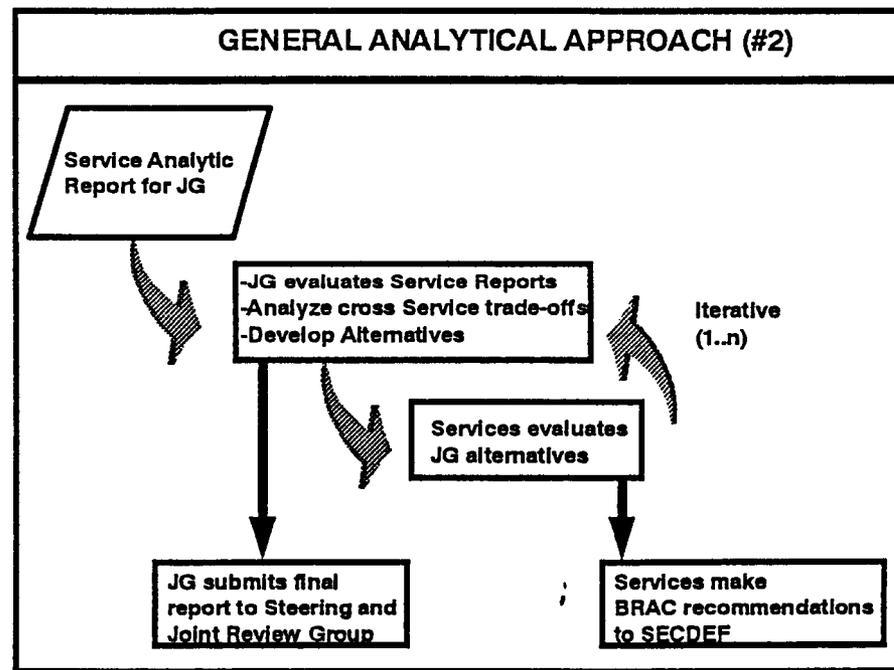


Chart 5. General Analytical Approach

Section 2 - Categories for Study

Three major categories were selected for study. They are stand alone health clinics, community hospitals, and medical centers. These categories were selected because they are the basic functional elements in the Military Health Services System (MHSS). A listing, by functional category, of all facilities is at Appendix A. MTFs closed or scheduled to close as a consequence of previous BRAC actions are not considered in this analysis. Only facilities located within the Continental United States (CONUS), Alaska, and Hawaii are included.

Health Clinics

This category encompasses a total of 43 facilities. Health Clinics are defined as health treatment facilities primarily staffed and equipped to provide ambulatory services to active duty and other beneficiaries. In some cases, the facility may also be capable of providing emergency treatment. A clinic may also be staffed and equipped to provide physical examinations, immunizations, medical administration, and preventive medicine services. For purposes of this study, Health Clinics are considered stand alone if they are located on an installation without a hospital. Navy and Air Force Health Clinics are also characterized as stand alone if they have a Commanding Officer, their own funding source, and reporting directly to a major command.

Community Hospitals

This category totals 86 facilities. A community hospital is defined as an inpatient health treatment facility capable of providing diagnostic and therapeutic services in the fields of general medicine, surgery, preventive medicine services, and having the supporting facilities to perform its assigned mission and functions.

Medical Centers

This category contains 14 facilities. Medical Centers are defined as tertiary care facilities that include at least two Graduate Medical Education programs, provide a broad range of health services, and serve as a referral center with specialized and consultative support within the geographic area of responsibility.

Section 3 - Capacity Measures

Contingency/Mobilization Beds Requirements

The purpose of this measure is to ensure that any closure or realignment alternative will be greater than or equal to the minimum number of Contingency/Mobilization Beds required to conduct wartime operations. This measure is based on the mobilization requirements generated from 1995-1999 Defense Planning Guidance. Any proposed alternative must be compared to the USACOM COMPLAN 2730, The Integrated CONUS Medical Mobilization Plan. The Military Departments will collect this data from MTF Commanders based on the definition of expanded beds below:

The number of beds that can be used in wards or rooms designed for patient beds. Beds are spaced on 6 foot centers and include embedded electrical and gas utility support for each bed. Beds must be set up and ready within 72 hours. Use of portable gas or electrical utilities is not considered in this definition.

Peacetime Operating Bed Capacity

This measure compares aggregate acute care operating beds to inpatient bed requirements generated by active duty personnel and their families. The total bed requirement will be compared to the aggregate number of CONUS based MHSS operating beds and aggregate Lead Agent Region capacity. The total bed requirement for active duty and family members will be estimated by multiplying the total direct care and CHAMPUS bed requirement (Fiscal Year 1993 data) times the active duty and active duty family member population. This is based on the

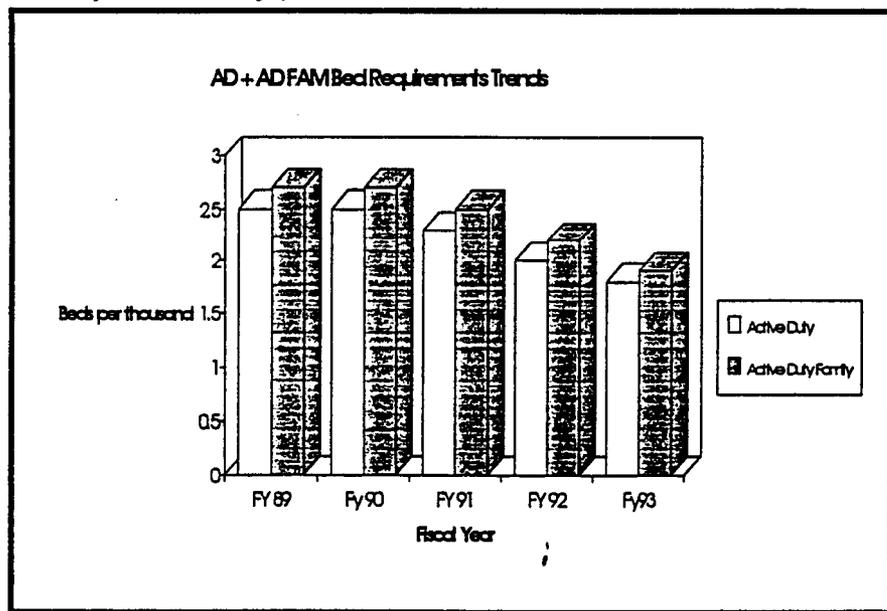


Chart 6 Active Duty and Active Duty Family Bed Requirements from Fiscal Year 1989 through Fiscal Year 1993.

Fiscal Year 1993 bed requirement of 1.8 and 1.9 beds per thousand respectively. Chart 6 describes bed requirements for these beneficiary groups from Fiscal Year 1989 through 1993. Taking a conservative approach, the Joint Medical Group assumed the actual bed requirements would stabilize at FY 93 rates. The Services will collect operating bed data and active duty and family member population data during the data collection process. Operating bed data will be computed as of September 31, 1993.

Section 4 - Development of Measures of Merit

Weighting and Scoring Descriptions

The Joint Medical Group developed a total of 10 Measures of Merit in support of the Relative Military Value BRAC criteria (# 1-4). Chart 7 describes the BRAC criteria and the associated measures of merit (MoMs) approved by the Joint Medical Group. Each MoM measures characteristics related to the viability of a given military treatment facility.

For each of the BRAC criteria and the Measures of Merit within those criteria, the Joint Medical Group developed the following weighting and scoring methodology.

MoM	MoM WEIGHT	CRITERIA WEIGHT
CRITERION 1 MISSION		40%
P1 - POPULATION	70%	
A1 - CIVILIAN PRIMARY CARE RATIO	15%	
A2 - INPATIENT CAPABILITY	15%	
CRITERION 2 FACILITIES		20%
F1 - FACILITY CONDITION	15%	
F2 - REAL PROPERTY	15%	
F3 - AVERAGE QS FT AGE	40%	
F4 - SAFETY SCORES (JCAHO)	30%	
CRITERION 3 CONTINGENCY		20%
MC1 - AIR HUB	50%	
MC2- STUBBED BEDS	50%	
CRITERION 4 COST/MANPOWER		20%
C1 - COST OF INPATIENT CARE	100%	

Chart 7. BRAC relative Military Value criteria, Measures of Merit, and Weighting/Scoring System

Criterion 1: Mission

The current and future mission requirements and the impact on operational readiness of the Department of Defense total force.

P1 Population: *A factor that helps determine if an MTF is necessary in a given area.*

Data Element:

Clinics and Community Hospitals - The number of active duty personnel and their families residing within a defined catchment area. The catchment area is defined as sets of zip codes emanating from the center of the MTF with a radius of 40 miles. In the Defense Medical Information System (DMIS) source data, populations contained in overlapping catchment areas are assigned to one MTF.

Medical Centers - The number of active duty personnel and their families residing within the Lead Agent Region as defined by the April 94 Health Affairs Policy Guidance. If further changes are made in the lead agent regions, population and data collection adjustments will be made. In those regions where there is more than one Medical Center, a portion of the regional population will be allocated to each Medical Center by a process to be developed by the Joint Medical Group.

Source: The source for active duty and active duty family member populations will be obtained from the Defense Medical Information System (DMIS). Fiscal Year 1993 data will be used and incorporate results of BRAC 88, 91, and 93.

Description: The total population number for the specific MTF is compared to the various population ranges on the scoring table below. There are different population ranges for clinics, community hospitals and medical centers. Directly above the population range score is a corresponding score from one to ten which is the raw score for the MTF on this particular measure of merit. By way of example, a community hospital with a total active duty and active duty family population between 10,001 and 15,000 receives of score of three.

P1: Population

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	<1K	2K	3K	4K	5K	6K	7K	8K	9K	>10K
HOSPITALS	<5K	10K	15K	20K	25K	30K	35K	40K	45K	>45K
MED CENTER	<120K	160	200	260	300	360	400	460	500	>500K

A1 Civilian Primary Care Physician Ratio: *An indicator of the availability of primary care physicians to provide services to the beneficiary population. This Measure is not applicable to Medical Centers.*

Data Element:

Clinics and Community Hospitals - The ratio of primary care civilian physicians to the total forty mile catchment area population. This ratio is based on the January 1993 Catchment Area Directory (CAD) using ratios defined in the Health and Human Services (HHS) Federal Register, Sept, 1991. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians.

Source: The source for the number of civilian primary care physicians within a given catchment area will be obtained from Donnelly Marketing Services.

Description: The number of physicians will be divided by the total population (census data to include military and civilian population) which results in a physician per population ratio. This ratio is then compared to the various ratio ranges on the scoring table below. The ratio ranges for clinics and community hospitals are the same. Directly above the ratio range score is a corresponding score from one to ten which becomes the raw score for the MTF on this particular measure of merit. By way of example, a community hospital with a ratio up to 1/1000 would receive a score of two. An MTF with a ratio from 1/1901 to 1/2200 would receive a score of six.

A1: Civilian Primary Care Ratio

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1:700	1:1000	1:1300	1:1600	1:1900	1:2200	1:2500	1:2800	1:3100	1:3400
HOSPITALS	1:700	1:1000	1:1300	1:1600	1:1900	1:2200	1:2500	1:2800	1:3100	1:3400
MED CENTER										

A2 Civilian and VA Inpatient Acute Care Capability: *This MoM measures the ability of local community acute care facilities to provide comprehensive health services to the eligible beneficiary population. Due to competition issues, this measure is viable only if there are more than two local community hospitals. This measure is not applicable to Clinics and Medical Centers.'*

Data Element:

Community Hospitals: Within each catchment area, determine

the : 1) # of acute care hospitals; 2) # of operating beds at each hospital; 3) Bed occupancy rate at each hospital; 4) JCAHO accreditation status at each hospital; and 5) MTF operating beds

Source: The source for this measure is Donnelly Marketing Services.

Calculation:

- If # of JCAHO acute care facilities < 2, then score = 10, else
- $$\left[\sum (1 - \text{occupancy rate}_i) (\text{operating beds}_i) \right] + \text{MTF operating beds} = \text{ratio of civilian acute care operating beds to MTF operating beds}$$

The sum is over the civilian facilities within the MTF catchment area

Description: The ratio of unoccupied civilian beds to MTF beds is compared to the various ratio ranges on the scoring table below. Directly above the ratio range score is a corresponding score from one to ten which becomes the raw score for the MTF on this particular measure of merit. By way of example, a community hospital with a ratio of five or more unoccupied civilian beds for each MTF bed would receive a raw score of one.

A2 Civilian and VA Inpatient Acute Care Capability:

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITALS	5:1	4.5:1	4:1	3.5:1	3:1	2.5:1	2:1	1.5:1	1:1	<1:1
MED CENTER										

Criterion 2: Facilities

The availability and condition of land, facilities, and associated airspace at both the existing and potential receiving locations.

F1 Facility Condition Assessment Score: *The condition code is an indication of plant condition. A low score indicates potential high maintenance and renovation costs. It further suggests that significant resources may be required to correct deficiencies.*

Data Element: Facility Condition Assessment Score

Source: MTF Commander.

Description: Scores range from 0-100 and are compared to the various ranges on the scoring table below. The ratio ranges for

clinics, community hospitals, and medical centers are the same. Directly above the range score is a corresponding score from one to ten which becomes the raw score for the MTF on this particular measure of merit. By way of example, a community hospital with a score between 51-60 receives a raw score of six.

F1 Facility Condition Assessment Score:

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
HOSPITALS	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
MED CENTER	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100

F2 Installation Real Property Rating

Data Element: Rating of the facility on a 1-3 scale by the installation engineer.

Source: Installation Real Property Data Card (DODI 4165.14 Inventory of Military Real Property).

Description: This number is located on the Measure of Merit Worksheet for installation Real Property Rating (see table below). A score of 1 produces a raw score of one; a score of two produces a raw score of five.

F2 Installation Real Property Rating

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1				2					3
HOSPITALS	1				2					3
MED CENTER	1				2					3

F3 Average Weighted Age: *This MoM develops an MTF age based on the age and square footage of various buildings that comprise the MTF.*

Data Element: The chronological age and building gross square feet for each of the medical facility buildings as of September 30, 1994. The scoring for clinics, community hospitals, and medical centers is identical.

Source: MTF Commander/Installation real property data card.

Description: The age is calculated in the following manner.

CALCULATION: For each Defense Medical Information System Identification number (DMIS ID)

$$\frac{\sum (\text{Chronological Building Age} * \text{Building Gross Square Feet})}{\sum \text{Total Gross Square Feet}} = \text{Average Weighted Age}$$

The calculated age score is compared to the various age ranges on the scoring table. Directly above the ratio range is the corresponding score from one to ten which becomes the raw score for the facility on this particular measure.

F3 Average Weighted Age:

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
HOSPITALS	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
MED CENTER	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1

F4 JCAHO Life Safety Score

Important note: Some facilities will not have Joint Commission on Accreditation of Healthcare Organizations (JCAHO) life safety scores because they do not seek accreditation by the JCAHO. In those specific cases, the weighting normally associated with Life Safety Scores is absorbed in the Measure of Merit F3, the Average Weighted Age. This measure takes on a weighted score of 70 percent rather than the 40 percent, when all four facility scores are available.

Data Element: The life safety score (measured from 1-5) from the medical facility's most recent JCAHO accreditation survey.

Source: MTF Commander

Description: The accreditation survey score is located on the scoring table below. A score of 3 on the survey corresponds to a raw score of 5.

F4 JCAHO Life Safety Scores

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS (N/A)										
HOSPITALS	5		4		3			2		1
MED CENTER	5		4		3			2		1

Note: Programmed Military Construction (MILCON) covering the FY 95-99 period will be collected by the Military Departments. This data will not be scored or weighted. It is for information purposes only.

Criterion 3: Contingency/Mobilization

The ability to accommodate contingency, mobilization, and future total force requirements at both the existing and potential receiving locations.

MC1 Air Medical Evacuation Site: *This measure looks at the distance a facility is located from a aeromedical evacuation site as one measure of its ability to readily receive and treat casualties.*

Data Element: Distance an MTF is located from any military or civilian airfield that can accommodate a C-9 aircraft. This measure is applicable only for community hospitals and medical centers.

Source: MTF Commander

Description: The further a facility is located from a defined site, the lower the raw score. The distance score is located on the appropriate worksheet. Directly above the distance range is the corresponding score from one to ten which becomes the raw score for the facility on this particular measure.

MC1 Air Medical Evacuation Sites

SCORE	1	2	3	4	5	6	7	8	9	10
HOSPITALS	>130	120	110	100	90	80	70	60	50	<40
MED CENTER	>130	120	110	100	90	80	70	60	50	<40

MC2 Bed Expansion Capability

Data Element: . The number of beds that can be used in wards or rooms designed for patient beds. Beds are spaced on 6 foot centers and include embedded electrical and gas utility support for each bed. Beds must be set up and ready within 72 hours. Use of portable gas or electrical utilities is not considered. This measure is applicable only for community hospitals and medical centers.

Source: MTF Commander

Description: The fewer beds a facility has available to treat casualties, the lower the raw score. The facility bed number is located on the scoring table. Directly above the bed number range is the corresponding score from one to ten which becomes the raw score for the facility on this measure.

MC2 Bed Expansion Capability

SCORE	1	2	3	4	5	6	7	8	9	10
HOSPITALS	<50	100	150	200	250	300	350	400	450	>450
MED CENTER	<100	200	300	400	500	600	700	800	900	>800

Note: Data will be collected by the Services on percent of the MTF staff assigned to operational contingency/mobilization platforms. This data will not be scored or weighted. It is for information only.

Criterion 4: Cost

The cost and manpower implications.

C1 Cost of Inpatient Care: *This measure looks at MTF Inpatient Cost rate and compares it to the CHAMPUS Adjusted Standardized Amount (ASA). This measure is used to compare direct care inpatient costs to inpatient costs at local civilian hospitals and is expressed as a ratio of CHAMPUS ASA rate / MTF rate.*

Data Element:

- # of Dispositions
- Expense Data
- Operating Beds
- Relative Weighted Product
- # of interns/residents by facility
- Wage rates

Source:

CHAMPUS hospital data

- CHAMPUS Master Provider File
- Metropolitan Statistical Area 93 File (MSAX.93)
- American Hospital Association 1993 Guide to the Health Care Field
- Federal Register, Vol 58, No 204, October 25, 1993

MTF Data

- Defense Medical Information Systems (DMIS)
- Unpublished FY 94 Direct Care Rates
- Medical Expense Performance Review System (MEPRS)
- Retrospective Case Mix Analysis System (RCMAS)
- Military Departments (# of interns/residents)
- Health Care Financing Administration (HCFA)

Description: The higher the direct care cost in comparison to the civilian cost, the lower the raw score. This measure is calculated as a ratio of ASA rate/MTF rate. The ratio is compared to the various ratio ranges on the scoring table. The ratio score is located on the worksheet below. Directly above the ratio range is

the corresponding score from one to ten which becomes the raw score for the facility on this measure.

C1 Cost Inpatient Care (ASA rate/MTF rate)

SCORE	1	2	3	4	5	6	7	8	9	10
HOSPITALS	<.3	.45	.6	.75	.9	1.05	1.2	1.35	1.5	>1.5
MED CENTER	<.9	.95	1.0	1.05	1.1	1.15	1.20	1.25	1.3	>1.3

Summary Scoring Methods

Once all the data has been collected and the raw scores have been determined, the raw scores are transferred from the worksheets to the Measures of Merit summary sheet, as depicted in the sample sheet located in Chart 8.

Each raw score and weight are multiplied to produce a weighted Measure of Merit score. For each criterion, the weighted Measure of Merit scores are totaled. The criterion score and the criteria weights are multiplied to produce a weighted criteria score. These scores are totaled for the facility score.

	RAW MoM SCORE	MoM WEIGHT	WEIGHTED MoM SCORE	CRITERIA WEIGHT	WEIGHTED CRITERIA SCORE
CRITERIA 1 MISSION					
P1 POPULATION	9	70%	6.3		
A1 CIVILIAN PRIMARY CARE RATIO	5	15%	0.75		
A2 INPATIENT CAPABILITY	5	15%	0.75		
		TOTAL C1	7.8	40%	3.12
CRITERIA 2 FACILITIES					
F1 FACILITY CONDITION	8	15%	1.2		
F2 REAL PROPERTY	8	15%	1.2		
F3 AVERAGE QS FT AGE	6	40%	2.4		
F4 SAFETY SCORES (JCAHO)	10	30%	3		
		TOTAL C2	6.6	20%	1.32
CRITERIA 3 CONTINGENCY					
MC1 AIR HUB	9	50%	4.5		
MC2 STUBBED BEDS	5	50%	2.5		
		TOTAL C3	7	20%	1.4
CRITERIA 4 COST/MANPOWER					
C1 COST INPATIENT CARE	5	100%	5		
		TOTAL C4	5	20%	1
FACILITY SCORE					6.84

Chart 8. Sample Summary Scoring Sheet

Appendix B contains a blank form of this summary sheet which can be used to record calculations.

Data Certification and Validation Process

Data certification and validation will be in accordance with the final "Internal Control Plan for Managing the Identification of DoD Cross-Service Opportunities as Part of the DoD 1995 Base Realignment and Closure Process (BRAC - 95)". As such, only certified data and validated data sources will be used by the Military Departments to make BRAC recommendations to the Secretary of Defense. All local data collected by the MTF Commander will be certified for accuracy and completeness, based on the respective Military Department's own BRAC95 internal control mechanisms. Data collected from centralized data sources will be validated for accuracy and completeness by an independent audit agency.

As an integral part of the data collection and validation process, the MTF Commander will be provided the relevant centralized data concerning his/her specific MTF and catchment area. The Commander will have the opportunity to surface any significant discrepancies he/she observes in the reported data. A significant difference is defined as a difference effecting the overall score of the MTF. If there are significant differences, the MTF Commander will provide source data to the applicable audit agency for review, evaluation, and resolution.

Section 5 - Additional Service Guidance for Rightsizing Opportunities

The Services, in conjunction with the Assistant Secretary of Defense, Health Affairs, have consistently sought opportunities to achieve economies in the delivery of health services to our beneficiary population. The Air Force, in its "Rightsizing Study", applied quantitative and qualitative approaches to realigning its medical infrastructure. As a consequence, 15 emergency rooms were realigned. The Air Force is currently implementing a hospital-to-health clinic realignment and considering realignment of two more facilities. Additionally, there have been a number of analyses focused on rightsizing of the Military Health Services System (MHSS). These include the Small Hospital Study and The Medical Facilities Operation Report.

There are numerous opportunities to achieve additional economies and efficiencies within the overall MHSS. These include consolidation of the Services biostatistical functions, consolidation of inter Service military school programs, consolidation of medical laboratories and research facilities, and consolidation of GME programs.

The Military Departments, as part of their overall BRAC process, are requested to strongly consider these opportunities for achieving significant economies. Each of these areas are discussed below.

Medical Laboratory and Research

The Armed Services Biomedical Research and Evaluation (ASBREM) Committee successfully negotiated the consolidation of several medical research programs which were subsequently incorporated into the Base Realignment and Closure Act of 1991 (BRAC91). As the Department of Defense (DoD) undertakes planning for the next round of base closures and realignments in the BRAC95 process, it is important that the ASBREM provide its recommendations and guidance for further collections and consolidations.

The ASBREM Secretariat will coordinate development of several concepts for additional programmatic collections and consolidations with his counterparts in the other Services. These concepts will delineate programmatic, management and other issues requiring resolution within and among the Services, as well as any assumptions upon which the successful implementation of the options might depend. The draft concepts will focus on maximizing efficiency of management and operations while sustaining the ability of the biomedical research community to respond effectively to both Service-unique and Joint Service requirements in all mission areas under ASBREM oversight. Appendix D contains the first draft concept paper.

Graduate Medical Education

In assessing GME programs, a variety of items should be considered that may not necessarily be considered by MTFs which do not have GME programs. The following paragraphs cover many of the items, but the list is not all-inclusive.

Military unique education should be considered when determining their merit. Unlike civilian GME programs, military programs stress military unique problems that better prepare military physicians for wartime casualties. All interns attend the Combat Casualty Care Course and become certified in Advanced Trauma Life Support (ATLS). Lecture topics covered during residency training include the surgical management of battlefield injuries, unusual tropical and parasitic infectious diseases, management of nuclear, biological, and chemical casualties, military ethics, and military leadership.

GME programs must have a patient population sufficient to support the program. All GME programs are structured around providing patient care. For example, it is impossible to support a GME program for Family Practice without having a patient population with a wide spectrum of medical problems. The population must include older patients who suffer from atherosclerotic heart disease, younger patients who have otitis media, and all the patients in between. Without such a population base, it is impossible to sustain a GME program.

GME programs should support the training mission of the Services. The number of trainees and the number of GME programs should match the personnel and readiness requirements established by the Services. Training should not be in excess of the requirements. The Services should consider the known training requirements and ensure that the MTF being evaluated is not training in excess of the requirement.

A very important criteria is the accreditation status of the GME programs provided by the Accreditation Council for Graduate Medical Education (ACGME). Almost all military GME programs are fully accredited by the ACGME, but failure to be fully accredited is a significant factor that could lead to closure of the GME program. It should also be a significant factor in the BRAC 95 process.

Coincidentally, the accreditation status of the MTF by the JCAHO is also an important factor when evaluating a hospital with GME programs. It is a requirement of the ACGME that hospitals be fully accredited by the JCAHO if they want to enjoy the privilege of sustaining GME programs. JCAHO accreditation is a sign of the quality of care provided at the MTF and ensures, to the degree humanly possible that the institution provides high quality care.

In evaluating the MTF, opportunities for consolidation, integration, elimination, or transfer to another MTF, of GME programs must be evaluated. As the configuration of DoD MTFs changes, and the population base that the MTFs support is altered, opportunities may arise to alter GME programs which would result in a stronger program. Wherever possible, these opportunities should be seized and developed.

Finally, the academic strength of the GME programs should be assessed during the BRAC 95 evaluation. Possible items to assess would include the Board-certification rate of recent graduates of the GME programs; the number and type of scientific publications by the GME program faculty and trainees; the number of active research projects; the quality of the lectures and other didactic sessions in the GME program; and the academic and clinical stature of the GME faculty.

Biostatistical Activities

This section develops a rationale and method for aligning biostatistical function processes, automated information support, and organizational structure requirements within the MHSS environment. The project will rely on the existing work of other related work groups. By including the producers and the users of biostatistic information, the project will establish a dynamic interface back to other work groups and Offices.

Health care delivery and management practices are evolving in the federal and civil sectors. Capitation budgeting, Lead Agent responsibilities, and TRICARE support contracts all require that consistent data be available to decision makers at all levels of the MHSS. The data must also be consistent with that used in other federal agencies and the civil sector to support valid comparisons and decisions.

Biostatistical data is a key component in the information that decision makers require. We must ensure the data gathered is consistent across the Services, the other federal agencies, and the civil sector to support MHSS decision making over the planning horizon. To ensure this, we must determine whether current business rules, automation, and organizational structures can support expected information requirements.

A focused analysis, building on previous work, is needed to implement a uniform business utility that will ensure the proper biostatistical data is gathered throughout the MHSS, in both the direct and indirect care systems; e.g., at risk contractors. The uniform biostatistic utility would include such things as consistent definitions of inpatient and outpatient episodes of care.

Military departments, beginning in April 1994, will strongly consider development of a uniform biostatistic utility for the MHSS.

The process includes:

- Defining the biostatistic business environment over the planning horizon that would allow for the construction of unified business practices to support the future biostatistic business environment.
- Developing alternative means to implement the unified business rules.
- Evaluating the impact of the unified biostatistic utility and any implementation alternatives on resources and effectiveness.

TASK	ACTIVITY	PURPOSE
1.0	SCOPING AND ASSUMPTION SETTING EFFORT	<ul style="list-style-type: none"> ■ To set framework of proposed future biostatistical function, business environment for work group activities, and provide "read-ahead." This document will provide the future biostatistic business vision definition to sufficient detail to provide the basis of the future biostatistic business analysis. The output of this project will be integrated within the MHSS environment. ■ To identify Stakeholders (both the producers and the users of biostatistic information, such as the Services, the Office of CHAMPUS, the Defense Medical Program Activity, etc), key resources, critical success factors, unified goals and objectives, strategies
2.1	ANALYZE THE ABILITY OF EXISTING "Biostatistic Information Infrastructure" (information flows, data structures, reporting requirements, etc) TO SUPPORT FUTURE BIOSTATISTIC BUSINESS ENVIRONMENT	<ul style="list-style-type: none"> ■ To synthesize existing work group documents to perform analysis to identify changes to the biostatistic information flow and data structures needed to support the future biostatistic business environment in an efficient and effective way ■ To perform simulation modeling of resource and cost changes as a result of the changes in biostatistic information infrastructure ■ To document changes in financial results, and impacts on other resources and effectiveness in support of migration systems selection strategies and POM exercises
2.2	ANALYZE THE ABILITY OF EXISTING "Biostatistic Organization" TO SUPPORT FUTURE BIOSTATISTIC BUSINESS ENVIRONMENT	<ul style="list-style-type: none"> ■ To use results from "Biostatistic Information Infrastructure" to develop alternative organizational implementations to deliver and support the Biostatistic Information Infrastructure improvements ■ To perform simulation modeling of resource and cost changes as a result of the changes in Biostatistic Organization ■ To document changes in financial results, and impacts on other resources and effectiveness to support POM exercises
3.0	EXECUTE IMPROVEMENT PLAN	<ul style="list-style-type: none"> ■ To implement changes to both the Biostatistic Information Infrastructure and Organization identified ■ To monitor the success of the improvements using change management techniques

Inter-Service Medical Training

The Health Care Committee (HCC) of the Interservice Training Review Organization (ITRO) negotiated the consolidation and collocation of several courses for training enlisted personnel in medical skills. Currently, the HCC continues to conduct military medical training structure reviews as directed by the Chairman, Joint Chiefs of Staff. A copy of the HCC Standards Committee final report is at Appendix E.

The mission of the HCC is to develop a system for health care education and training that meets nationally accepted standards of quality, supports individual service requirements, and promotes fiscal responsibility. The HCC is developing a master plan for consolidation that includes Consolidated Training Centers of Excellence, sequencing, and use of civilian training contracts. As the medical community begins to plan for the BRAC 95 process, it is important to consider the work of the ITRO HCC for further consolidations and collocations.

The Services are requested to strongly consider the ITRO HCC's master plan in their overall BRAC 95 process. The analysis should include officer/enlisted training requirements, resource requirements, and alternatives for accomplishing consolidation. The review should address policy and operational/organizational changes required to make maximum use of common support assets. The review should evaluate core curriculums for consolidation; i.e., basic medical corpsman and dental technician training. Finally, the review should consider opportunities within the medical training community to reduce infrastructure consistent with the Defense Medical Programming Guidance and DoD's planned force reductions.

Appendix A - Facility Listing

STAND ALONE HEALTH CLINICS

SERVICE	STATE	INSTALLATION
ARMY	ALASKA	FT GREELY
ARMY	CALIFORNIA	OAKLAND ARMY BASE
ARMY	GEORGIA	FT MCPHERSON
ARMY	GEORGIA	HUNTER AAF
ARMY	MARYLAND	ABERDEEN APG
ARMY	MARYLAND	FT DETRICK
ARMY	MARYLAND	FT RITCHIE
ARMY	MASSACHUSETTS	NATICK R&D CENTER
ARMY	NEW YORK	FT DRUM
ARMY	NEW YORK	FT HAMILTON
ARMY	PENNSYLVANIA	CARLISLE BKS
ARMY	PENNSYLVANIA	FT INDIANTOWN GAP
ARMY	VIRGINIA	PENTAGON
ARMY	VIRGINIA	FT A.P. HILL
ARMY	VIRGINIA	FT MONROE
ARMY	VIRGINIA	FT MYER
ARMY	VIRGINIA	FT PICKETT
ARMY	VIRGINIA	FT STORY
ARMY	WASHINGTON, DC	FT MCNAIR
NAVY	CALIFORNIA	NMC LONG BEACH
NAVY	FLORIDA	NMC KEY WEST
NAVY	GEORGIA	NMC KINGS BAY
NAVY	HAWAII	NMC PEARL HARBOR
NAVY	LOUISIANA	NMC NEW ORLEANS
NAVY	MARYLAND	NMC ANNAPOLIS
NAVY	NEW HAMPSHIRE	NMC PORTSMOUTH
NAVY	VIRGINIA	NMC QUANTICO
USAF	ALASKA	EIELSON AFB
USAF	CALIFORNIA	LOS ANGELES AFS
USAF	COLORADO	PETERSON AFB
USAF	HAWAII	HICKAM AFB
USAF	KANSAS	MCCONNELL AFB
USAF	MASSACHUSETTS	HANSCOM AFB
USAF	MONTANA	MALMSTROM AFB
USAF	NORTH CAROLINA	POPE AFB
USAF	OKLAHOMA	VANCE AFB
USAF	SOUTH CAROLINA	CHARLESTON AFB
USAF	TEXAS	BROOKS AAFB
USAF	TEXAS	KELLY AFB
USAF	TEXAS	RANDOLPH AFB
USAF	TEXAS	GOODFELLOW AFB
USAF	WASHINGTON, DC	BOLLING AFB
USAF	WASHINGTON	MCCHORD AFB

COMMUNITY HOSPITALS

SERVICE	STATE	INSTALLATION	DMIS ID
ARMY	ALABAMA	FOX AH-REDSTONE ARSENAL	0001
ARMY	ALABAMA	NOBLE AH-FT MCCLELLAN	0002
ARMY	ALABAMA	LYSTER AH-FT RUCKER	0003
ARMY	ALASKA	BASSETT ACH-FT WAINWRIGHT	0005
ARMY	ARIZONA	BLISS AH-FT HUACHUCA	0008
ARMY	CALIFORNIA	WEED ACH-FT IRWIN	0131
ARMY	COLORADO	EVANS AH-FT CARSON	0032
ARMY	GEORGIA	MARTIN AH-FT BENNING	0048
ARMY	GEORGIA	WINN AH-FT STEWART	0049
ARMY	KANSAS	IRWIN AH-FT RILEY	0057
ARMY	KANSAS	MUNSON AH-FT LEAVENWORTH	0058
ARMY	KENTUCKY	BLANCHFIELD ACH-FT CAMPBELL	0060
ARMY	KENTUCKY	IRELAND AH-FT KNOX	0061
ARMY	LOUISIANA	BAYNE-JONES AH-FT POLK	0064
ARMY	MARYLAND	KIMBROUGH AH-FT MEADE	0069
ARMY	MISSOURI	WOOD AH-FT LEONARD WOOD	0075
ARMY	NEW JERSEY	PATTERSON AH-FT MONMOUTH	0081
ARMY	NEW YORK	KELLER AH-WEST POINT	0086
ARMY	NORTH CAROLINA	WOMACK ARMY MED CTR-FT. BRAGG	0089
ARMY	OKLAHOMA	REYNOLDS AH-FT SILL	0098
ARMY	SOUTH CAROLINA	MONCRIEF AH-FT JACKSON	0105
ARMY	TEXAS	DARNALL AH-FT HOOD	0110
ARMY	VIRGINIA	MCDONALD AH-FT EUSTIS	0121
ARMY	VIRGINIA	KENNER AH-FT LEE	0122
ARMY	VIRGINIA	DEWITT AH-FT BELVOIR	0123
NAVY	CALIFORNIA	NH CAMP PENDLETON	0024
NAVY	CALIFORNIA	NH LEMOORE	0028
NAVY	CALIFORNIA	NH TWENTYNINE PALMS	0030
NAVY	CONNECTICUT	NH GROTON	0035
NAVY	FLORIDA	NH PENSACOLA	0038
NAVY	FLORIDA	NH JACKSONVILLE	0039
NAVY	ILLINOIS	NH GREAT LAKES	0056
NAVY	MARYLAND	NH PATUXENT RIVER	0068
NAVY	NORTH CAROLINA	NH CAMP LEJEUNE	0091
NAVY	NORTH CAROLINA	NH CHERRY POINT	0092
NAVY	RHODE ISLAND	NH NEWPORT	
NAVY	SOUTH CAROLINA	NH CHARLESTON	0103
NAVY	SOUTH CAROLINA	NH BEAUFORT	0104
NAVY	TENNESSEE	NH MILLINGTON	0107
NAVY	TEXAS	NH CORPUS CHRISTI	0118
NAVY	WASHINGTON	NH BREMERTON	0126
NAVY	WASHINGTON	NH OAK HARBOR	0127
USAF	ALABAMA	AIR UNIVERSITY RGN HOSP-MAXWELL	0004
USAF	ALASKA	USAF HOSP ELMENDORF	0006
USAF	ARIZONA	832nd MED GRP-LUKE	0009
USAF	ARIZONA	836th MED GRP-DAVIS MONTHAN	0010
USAF	ARKANSAS	USAF HOSP LITTLE ROCK	0013
USAF	CALIFORNIA	814th STRAT HOSP-BEALE	0015
USAF	CALIFORNIA	323rd FTW HOSP-MATHER	0016

USAF	CALIFORNIA	1st STRAT HOSP-VANDENBERG	0018
USAF	CALIFORNIA	AFSC HOSP-EDWARDS	0019
USAF	COLORADO	USAF ACADEMY HOSP	0033
USAF	DELAWARE	USAF HOSP DOVER	0036
USAF	FLORIDA	USAF RGN HOSP EGLIN	0042
USAF	FLORIDA	325th MED GRP-TYNDALL	0043
USAF	FLORIDA	56th MED GRP-MACDILL	0045
USAF	FLORIDA	AFSC HOSP-PATRICK	0046
USAF	GEORGIA	347th MED GRP-MOODY	0050
USAF	GEORGIA	USAF HOSP ROBINS	0051
USAF	IDAHO	366th MED GRP-MOUNTAIN HOME	0053
USAF	ILLINOIS	USAF MED CTR SCOTT	0055
USAF	LOUISIANA	2nd STRAT HOSP-BARKSDALE	0062
USAF	MARYLAND	MALCOLM GROW MED CTR-ANDREWS	0066
USAF	MISSISSIPPI	14th FTW HOSP-COLUMBUS	0074
USAF	MISSOURI	351st STRAT HOSP-WHITEMAN	0076
USAF	NEBRASKA	EHRLING BERQUIST RGN HOSP-OFFUTT	0078
USAF	NEVADA	554th MED GRP-NELLIS	0079
USAF	NEW JERSY	WALSON-MCGUIRE AFB	0082
USAF	NEW MEXICO	USAF HOSP KIRTLAND	0083
USAF	NEW MEXICO	833rd MED GRP-HOLLOMAN	0084
USAF	NEW MEXICO	27th MED GRP-CANNON	0085
USAF	NORTH CAROLINA	4th MED GRP-SEYMOUR JOHNSON	0090
USAF	NORTH DAKOTA	842nd STRAT HOSP-GRAND FORKS	0093
USAF	NORTH DAKOTA	857th STRAT HOSP-MINOT	0094
USAF	OKLAHOMA	USAF HOSP TINKER	0096
USAF	OKLAHOMA	USAF HOSP ALTUS	0097
USAF	SOUTH CAROLINA	363rd MED GRP-SHAW	0101
USAF	SOUTH DAKOTA	812th STRAT HOSP-ELLSWORTH	0106
USAF	TEXAS	64th FTW HOSP-REESE	0111
USAF	TEXAS	96th STRAT HOSP-DYESS	0112
USAF	TEXAS	SHEPPARD TTC HOSP	0113
USAF	TEXAS	47th FTW HOSP-LAUGHLIN	0114
USAF	UTAH	USAF HOSP HILL	0119
USAF	VIRGINIA	1st MED GRP-LANGLEY	0120
USAF	WASHINGTON	92nd STRAT HOSP-FAIRCHILD	0128
USAF	WYOMING	90th STRAT HOSP-F.E. WARREN	0129

MEDICAL CENTERS

SERVICE	STATE	INSTALLATION	DMIS ID
ARMY	COLORADO	FITZSIMONS AMC	0031
ARMY	GEORGIA	EISENHOWER AMC-FT GORDON	0047
ARMY	HAWAII	TRIPLER AMC-FT SHAFTER	0052
ARMY	TEXAS	WILLIAM BEAUMONT AMC-FT BLISS	0108
ARMY	TEXAS	BROOKE AMC-FT SAM HOUSTON	0109
ARMY	WASHINGTON	MADIGAN AMC-FT LEWIS	0125
ARMY	WASHINGTON, DC	WALTER REED AMC	0037
NAVY	CALIFORNIA	NH SAN DIEGO	0029
NAVY	MARYLAND	NNMC BETHESDA	0067
NAVY	VIRGINIA	NH PORTSMOUTH	0124
USAF	CALIFORNIA	DAVID GRANT MED CTR-TRAVIS AFB	0014
USAF	MISSISSIPPI	KEESLER TTC MED CEN- KEESLER AFB	0073
USAF	OHIO	USAF MED CTR WRIGHT-PATTERSON AFB	0095
USAF	TEXAS	WILFORD HALL MED CTR-LACKLAND AFB	0117

Appendix B - Summary Score Sheet

	RAW MOM	MOM	WEIGHTED	CRITERIA	WEIGHTED
	SCORE	WEIGHT	MOM SCORE	WEIGHT	CRITERIA SCORE
CRITERIA 1 MISSION					
P1 POPULATION	0	70%	0		
A1 CIVILIAN PRIMARY CARE RATIO	0	15%	0		
A2 INPATIENT CAPABILITY	0	15%	0		
		TOTAL C1	0	40%	0
CRITERIA 2 FACILITIES					
F1 FACILITY CONDITION	0	15%	0		
F2 REAL PROPERTY	0	15%	0		
F3 AVERAGE WGT AGE	0	40%	0		
F4 SAFETY SCORES (JCAHO)	0	30%	0		
		TOTAL C2	0	20%	0
CRITERIA 3 CONTINGENCY					
MC1 AIR HUB	0	50%	0		
MC2 STUBBED BEDS	0	50%	0		
		TOTAL C3	0	20%	0
CRITERIA 4 COST/MANPOWER					
C1 COST INPATIENT CARE	0	100%	0		
		TOTAL C4	0	20%	0
				SCORE	0

Appendix C - Glossary

ADJUSTED STANDARDIZED AMOUNT (ASA): A term used to describe the method used by the Department of Health and Human Services, the Health Care Financing Administration and the Office of Civilian Health and Medical Program of the Uniformed Services to create payment amounts for hospitals.

ASA: See ADJUSTED STANDARDIZED AMOUNT.

BASE REALIGNMENT AND CLOSURE (BRAC): The BRAC process is an established procedure for closing and realigning military installations. The procedure is defined by the Defense Base Closure and Realignment Act of 1990 (Public Law 101-510), as amended.

CASE-MIX INDEX (CMI): Total Relative Weighted Products (RWPs) for an MTF or other levels of aggregation (e.g., beneficiary category, clinical area, etc.) divided by the total number of Biometrics dispositions less DRGs 469 and 470. The CMI is the average RWPs per disposition and is viewed as a measure of average case complexity.

CATCHMENT AREA: Inpatient catchment areas are defined as sets of ZIP codes having centroids within 40 miles of an MTF. Using rules to uniquely allocate beneficiaries who live within 40 miles of more than one hospital, and allow for natural barriers, each eligible beneficiary is assigned to a unique catchment area. Catchment area overlap summaries included in this document analysis are based upon the January 1993 Catchment Area Directory (CAD).

CATCHMENT AREA DIRECTORY (CAD): The official reference published by OASD(Health Affairs) that indicates MHSS catchment area assignments by 5-digit ZIP code. The CAD is published annually with quarterly updates and is used by MTF Health Benefits Advisors (HBAs) to determine Non-availability Statement (NAS) issuance at MTFs. The CAD is used for beneficiary-level data processing by the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), CHAMPUS Fiscal Intermediaries (FIs), Defense Manpower Data Center (DMDC), and by the Defense Medical Information System (DMIS) for ZIP code-level data processing. The CAD is the basis for determining whether or not two or more catchment areas overlap.

CATCHMENT AREA OVERLAP: A flag that indicates whether or not the listed MTF's 40-mile catchment area overlaps with the 40-mile catchment area of any other MTF. See Catchment Area.

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services. The program that serves as the principal means by which care is furnished by civilian institutional and professional providers to non-active duty MHSS beneficiaries.

CLINIC: An outpatient treatment facility that has a commanding officer, receives funds directly from the Service headquarters, and provides care to active duty and other beneficiaries.

COMMUNITY HOSPITAL: See HOSPITAL.

CONSTRUCTION REQUIREMENT: Total programmed Military Construction (MILCON) resources over all years in the FY95 to FY00 Program Objective Memorandum (POM).

CONUS: Continental United States including Alaska and Hawaii.

DIAGNOSIS-RELATED GROUPS (DRGs): DRGs, or diagnosis-related groups, were developed by Yale University under contract with the Health Care Financing Administration (HCFA). Based primarily on the principal diagnosis a case is assigned a Major Diagnostic Category (MDC). MDCs are classified based upon the major body system affected. The MDCs are partitioned into several hundred DRGs that are intended to group medically homogeneous conditions as defined by a set of attributes. These include the principal diagnosis, specific secondary diagnoses, operating room procedures, complications and morbidity, age, and discharge status. Each DRG represents a class of patients who are clinically similar and should have similar length of stay and resource requirement (cost) patterns.

DMIS: The Defense Medical Information System (DMIS) is a management information system used to support the formulation and execution of plans, programs, and policy within the Office of the Assistant Secretary of Defense (Health Affairs) and Service headquarters staffs.

DMIS ID: The unique numeric code assigned by the Defense Medical Information System (DMIS) to MTFs, clinics, and geographic areas that is used for MHSS data reporting and processing purposes.

EXPANDED BED CAPACITY: The number of beds that can be used in wards or rooms designed for patients' beds. Beds are spaced on 6-foot centers (approximately 72 square feet per bed), and include electrical and gas utility support for each bed. Space for beds used only in connection with examinations or brief treatment periods, such as in examining rooms or in the physical therapy department, is not included in expanded bed capacity. Nursery space is not included.

FACILITY CONDITION ASSESSMENT SCORE or FACILITY CONDITION SCORE: Refers to Military Treatment Facility (MTF) Condition Assessment Score assigned by the OASD(Health Affairs) Defense Medical Facilities Office (DMFO). The Facility Condition Assessment Score reflects the summary score of the facility calculated based on the weighted factors assigned to each assessment criterion and the condition of each facility reported by the Services. The total calculated weight factor of each facility is normalized to a standard score of 100 by providing due credit to the functions and/or systems non-applicable to that MTF. This normalization method allows for comparisons of physical conditions between facilities irrespective of their size and/or complexity.

FISCAL YEAR (FY): The 12-month accounting period used by the Federal Government (currently from 1 October to the next 30 September).

FORTY-MILE OVERLAPPING CATCHMENT AREA: See Overlapping Catchment Areas.

GRADUATE MEDICAL EDUCATION (GME): Full-time, structured, medically related training, accredited by a national body, e.g., the Accreditation Council for Graduate Medical Education, approved by The Commissioner of Education, and obtained after receipt of the appropriate doctoral degree.

GRADUATE MEDICAL EDUCATION TEACHING FACILITY: A hospital that conducts residency and fellowship training.

HEALTH CLINIC: See CLINIC.

HOSPITAL: A health treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the fields of general medicine and surgery, and preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A hospital may, in addition, discharge the function of a clinic.

LEAD AGENT: The lead agent is a person designated to develop a tri-service, regional health plan for beneficiaries of the MHSS, including the development of a single, integrated health care network for the Health Service Region. Lead agents are responsible for maximizing the use of all direct care assets in the region, then supplementing that health care through competitive contracts developed in coordination with OASD(HA).

JCAHO ACCREDITATION STATUS: Medical centers and hospitals that have been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) within the past 3 years.

MEDICAL CENTER: A large hospital, which has been so designated, appropriately staffed, and equipped, that provides a broad range of health care services and serves as a referral center with specialized and consultative support for medical facilities within the geographic area of responsibility. Conducts, as a minimum, two graduate medical education programs. The definition includes those CONUS medical centers defined in OASD(Health Affairs) Health Services Operations (HSO)-Defense Medical Facilities Office (DMFO) Memorandum, 1 April 1992, Department of Defense Training Facilities (approved by OASD(Health Affairs) Health Services Operations (HSO), 3 April 1992).

MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM (MEPRS) FOR FIXED MILITARY MEDICAL AND DENTAL TREATMENT FACILITIES:

A uniform reporting methodology designed to provide consistent principles, standards, policies, definitions, and requirements for accounting and reporting of expense, manpower, and performance data by DoD MTFs. Within these specific objectives, the Medical Expense and Performance Reporting System (MEPRS) also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology. For specific details, see *Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities*, DOD 6010.13-M, January 1991.

MILITARY TREATMENT FACILITY (MTF): A facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

MHSS: Military Health Service System.

NUMBER OF ACUTE CARE HOSPITALS: The number of non-DoD hospitals in a catchment area is based on 1992 Donnelly Marketing Information Services

data, which include all reporting AHA members. Army, Navy, and Air Force hospitals have been excluded from the count of hospitals. The hospitals were linked to catchment areas based on the hospital ZIP code and include all hospitals within 40 miles of the MTF. Note that a hospital may be within 40 miles of more than one MTF and therefore will be linked to more than one catchment area. The mapping of civilian institutions to catchment areas was based on the January 1994 Catchment Area Directory (CAD).

OPERATING BED CAPACITY: Accommodation in a functioning military treatment facility that is currently set up and ready in all respects for the care of a patient. It must include supporting space, equipment, medical material, ancillary and support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, labor beds, and recovery beds.

OUTPATIENT: An individual receiving health service for an actual or potential disease or injury that does not require admission to an MTF for inpatient care.

OVERLAPPING CATCHMENT AREAS: Overlapping catchment areas occur when the 40-mile catchment area of one MTF intersects with the 40-mile catchment area of another MTF. Thus, two MTFs with overlapping catchment areas may be up to 80 miles apart (i.e., two 40-mile circles with minimal overlap). Numerous areas exist within CONUS that fall into multiple MTF catchment areas. The Catchment Area Directory provides the basis for catchment area assignment as well as unique allocation to avoid double-counting MHSS catchment area beneficiaries and utilization.

PHYSICIAN-TO-POPULATION RATIO: The 1992 Donnelly Marketing Information Services data contains the civilian population and physician data, which can be searched to develop catchment area ratios. The physician providers information includes non-Federal primary care physicians only. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians. The mapping of civilian physicians and population to catchment area is based on the January 1994 Catchment Area Directory (CAD).

POPULATION - ACTIVE DUTY & DEPENDENTS OF ACTIVE DUTY: This is the level the catchment area active duty and dependent of active duty population would reach if the Service-specific changes in active duty end-strength described in the FY92 Program Objective Memorandum (POM) were spread equally across all catchment areas, after base realignment and closure takes

place as specified for BRAC III. This reflects the best estimate of the catchment area's expected active duty and dependent of active duty population in FY97.

RELATIVE WEIGHTED PRODUCT (RWP): The sum of weighted dispositions computed by multiplying each disposition by the relative weight of the DRG assigned and adjusting for short and long stay outlier credit. RWPs are frequently summed over clinical service, diagnostic category, facility, etc. The sum of the RWPs divided by the number of dispositions for a given aggregation provides an average credit per disposition commonly referred to as the case-mix index (CMI). See Case-Mix Index (CMI).

STAND ALONE CLINIC: See **CLINIC**.

WAGE RATES: Wage rates are standard rates of pay computed for a specific geographical area by the Health Care Financing Administration in the Department of Health and Human Services, and used as indices to standardize area differences in wage rates. A formula is then applied to describe the method and amount of payment for health services.

YEAR CONSTRUCTED: The year in which the named MTF was constructed.

Appendix D - Medical Laboratory and Research Concept Paper

CONCEPT PAPER

SGRD-ZC

28 March 1994

SUBJECT: Realignment of Defense Medical Research and Development Assets Under Armed Services Biomedical Research, Evaluation and Management (ASBREM) Committee Oversight.

1. **VISION:** Provide the Defense Department with the superior medical technology required to enable the full spectrum of military operations for crisis and conflict resolution, protecting and sustaining service men and women from battle and non-battle threats to health, enabling optimal military performance supported by the world's best combat casualty care.
2. **GOAL:** Determine the most effective and efficient medical R&D infrastructure for the 21st century in coordination with the Base Realignment and Closure 1995 (BRAC95) process.
3. **OBJECTIVE:** An affordable medical R&D infrastructure that provides essential capabilities across the entire spectrum of military medical concerns, assuring sustainment of critical mass and unique facilities in areas of core competency.

4. **BACKGROUND:**

a. The ASBREM Committee has been a DoD pacesetter in inter-Service R&D coordination and collaboration since its 1981 inception. It was the model for TriService Project Reliance. Extensive collocations and other efficiencies identified by the ASBREM community during TriService Medical Project Reliance and incorporated into BRAC91 remain a benchmark for other Tri-Service efforts.

b. Despite efficiencies projected under Medical Reliance and individual Service initiatives, the cumulative magnitude of multiple resource decrements accruing since the Defense Management Review in 1988 and projected to continue through FY99, jeopardizes affordability of existing and projected Defense medical R&D infrastructure and capabilities as contained in the three separate Service organizations under ASBREM oversight.

c. With the advent of BRAC95 planning the ASBREM Co-Chairs, Dr. Osterman representing DDR&E and RADM Martin representing ASD(HA), convened a special strategy meeting of the ASBREM Committee, 11 March 1994, to discuss the feasibility of expanding realignments achieved under TriService Project Medical Reliance and BRAC91 to include greater consolidation of defense medical R&D programs and assets. At this meeting consensus was reached on the following points:

- (1) Further piecemeal collocations and consolidations are not likely to result in savings sufficient to sustain the necessary core medical R&D capabilities.
- (2) Consolidation of program management and organizational structure may facilitate maintenance of critical mass in core R&D capabilities.

(3) Consolidation of all medical R&D programs into a single jointly-staffed, organization with a reduced number of subordinate laboratories, and with detachments as necessary to retain access to unique facilities or military operations and populations, should be seriously explored as a method of achieving necessary affordability.

d. At the conclusion of the 11 March meeting, the ASBREM Co-Chairs directed the Army ASBREM Secretariat member to coordinate a study of an organizational structure with two or three primary laboratories (attach 1 & 2). The study is to address both the potential economic and programmatic effectiveness of such a Tri-Service organization, including exploration of and recommendations for resolution of any issues impacting implementation.

5. STUDY CONSIDERATIONS:

a. Coordination with BRAC95 analysis and decision-making activities at both Service and OSD levels and integration with DoD BRAC95 implementation activities.

b. Sustainment of responsive warfighting customer linkages (for requirements and medical R&D support to military operations, doctrine and training); creation of efficient, high-level oversight mechanisms through a DAB-JROC like structure as adjusted for Category IV; and maintaining OSD-DoD Component medical modernization and readiness linkages (for continuity of care) through an reorganized ASBREM Committee.

c. Identification and sustainment of essential, core medical R&D capabilities, and their sizing, proposed location and organizational linkages to foster critical mass affordability.

d. Clear lines of authority, responsibility and accountability including:

(1) Resource planning, programming, budgeting and execution (e.g.; OSD lines, DoD Component accounts; PEO, PM or other reimbursable funding for biomedical support to non-medical systems, and combinations of these alternatives).

(2) Manpower and personnel resource management (e.g.; billet (authorization) ownership, career development; classification authority, and Defense Acquisition Workforce Improvement Act implementation).

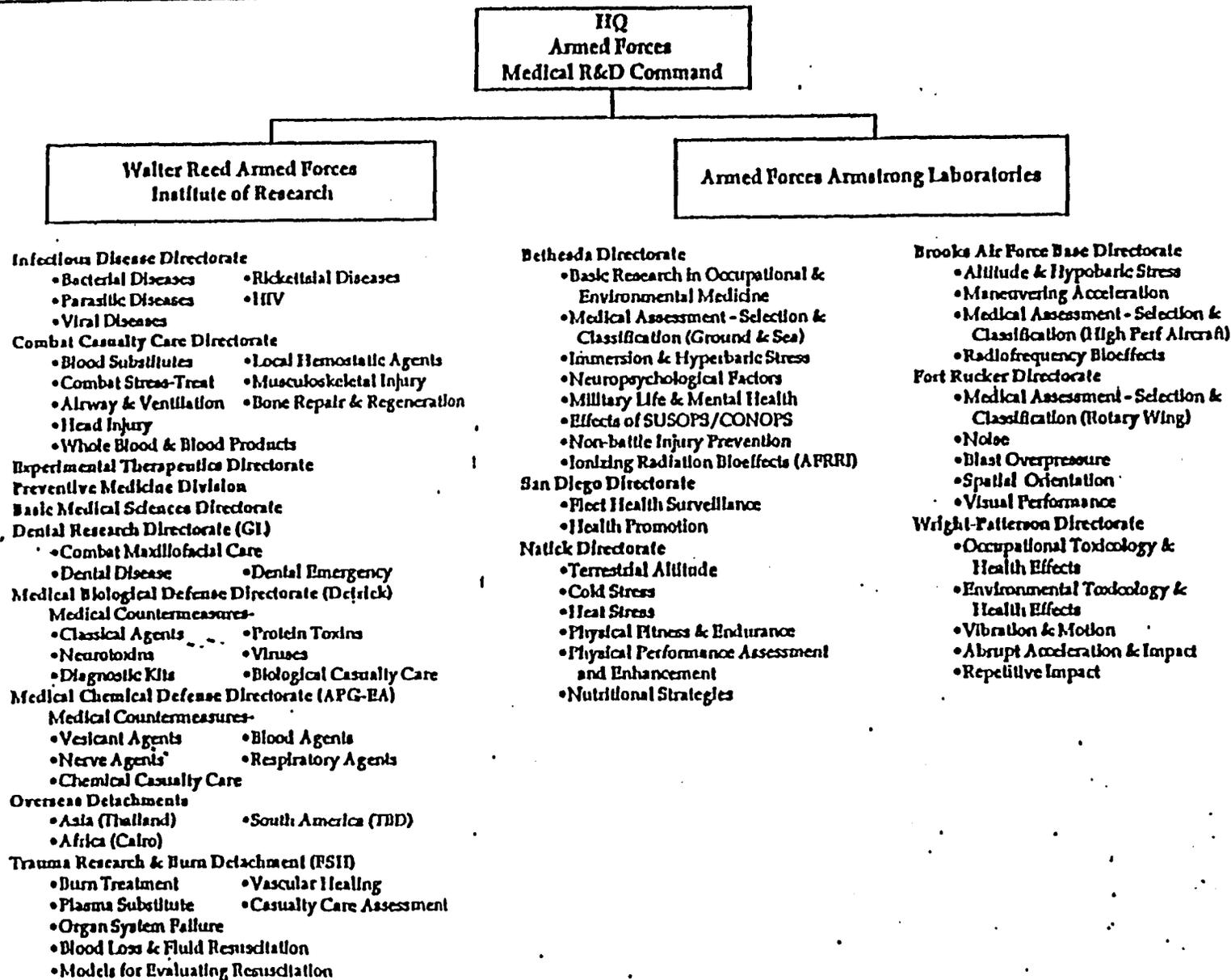
(3) Facilities management (e.g.; MILCON, RPMA, BASOPS, and DBOF).

e. Separate Defense Agency vs. Military Department Executive Agent (e.g., Armed Forces Institute of Pathology) status. Pertinent issues include resource management and accounting; Defense and Service Acquisition Executive relationships, administrative and management support functions (e.g.; personnel, public affairs, internal review, legislative liaison, international activities, contracting policy and regulations).

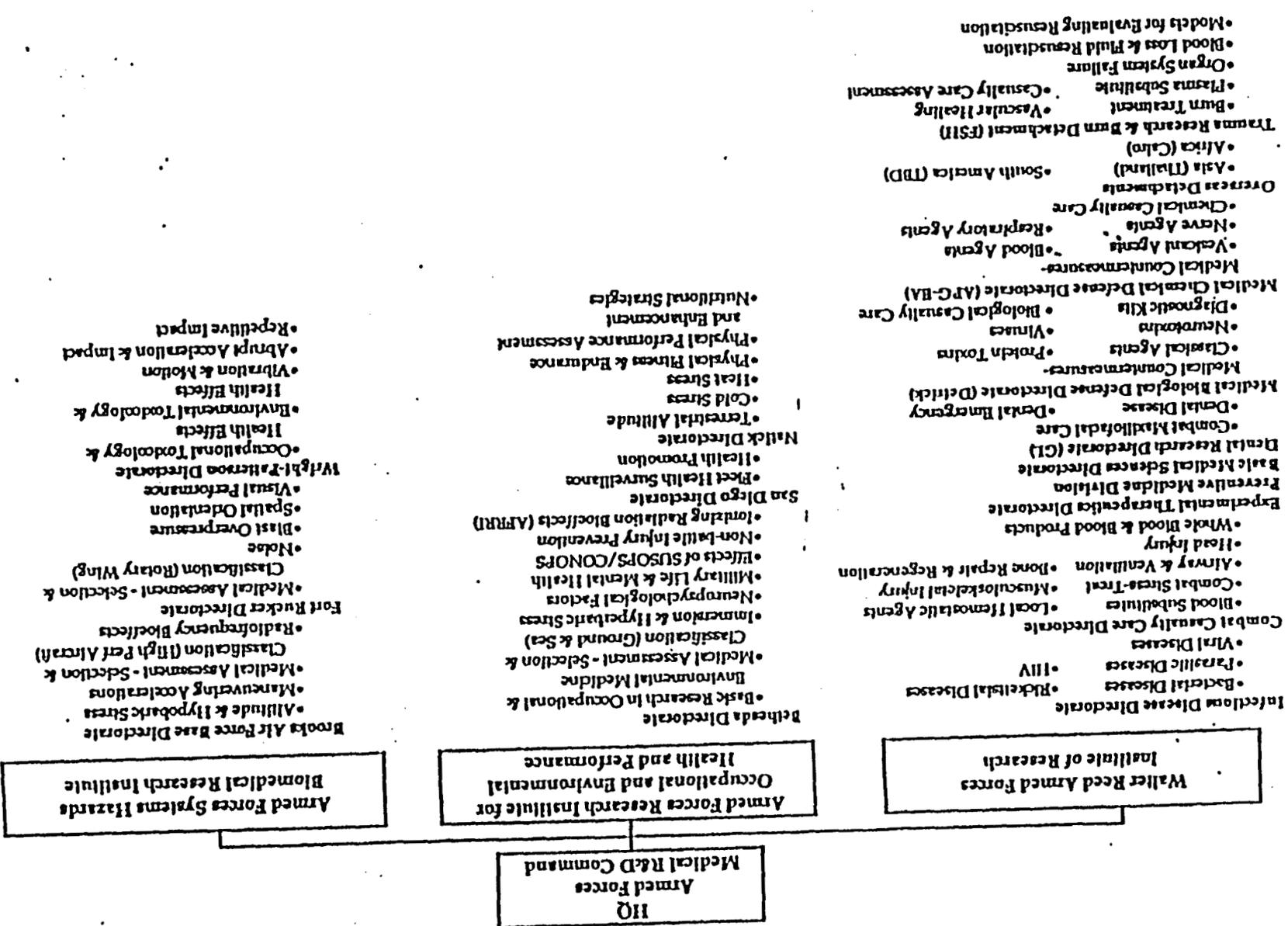
f. Expansion of scope of realignment to include assessing potential synergy of realignments with R&D activities under other Project Reliance Oversight Bodies (e.g., TAPSTEM).

ARMED FORCES MEDICAL R&D COMMAND

Two Lab Option



ARMED FORCES MEDICAL COMMAND Three Lab Option



Appendix E - ITRO Health Care Committee Report

INTERSERVICE TRAINING REVIEW ORGANIZATION HEALTH CARE COMMITTEE STANDARDS COMMITTEE FINAL REPORT

Mortimer W. Lockett

Dr. Mortimer W. Lockett
Chairman

James C. Kulild

COL James C. Kulild
Dean, Medical Field Service School
AMEDD Center and School
Fort Sam Houston, Texas

Donald E. Lee

Col Donald E. Lee, USAF, MSC
Commander, 380th Training
Support Squadron
939 Missile Road
Sheppard Air Force Base, Texas

Michael A. Brophy

CDR Michael A. Brophy, MSC, USN
Associate Dean, Medical Field
Service School
AMEDD Center and School
Fort Sam Houston, Texas

Karen S. Roper

CDR Karen S. Roper, MSC, USN
Director, Technical Training
Department
Naval School of Health Sciences
Bethesda, Maryland

Karen L. Natkin

Ms. Karen L. Natkin
Senior Education Specialist
Naval School of Health Sciences
San Diego, California

EDUCATIONAL QUALITY

Standard 1 - Accreditation

Accreditation of education and training programs is strongly supported by the services' medical departments. There are two levels of accreditation, institutional and programmatic.

a. Institutional accreditation will be maintained with the regional education accreditation agency responsible for the geographic region, such as the Southern Association of Colleges and Schools.

b. Programmatic accreditation will be achieved or maintained with the professional society responsible for educational standards for that profession, such as the American Medical Association, American Dental Association, American Nurses Association, or the American Society for Radiologic Technology.

c. The host service will be responsible for maintaining accredited status.

Standard 2 - University/College Affiliation

Affiliation with university(ies)/college(s) is encouraged. Any joint service training program, wherein the host service is associated with a university/college by agreement or contract, will make the university offerings available to the participating services. Any host service-college affiliation program will not make any changes to the affiliation agreement that would affect student eligibility, course content, or course completion requirements without written coordination with the participating service(s). The participating service(s), operating in a joint environment on the host service's premises, will meet the requirements of the host college to assure university/college affiliation privileges. All participating service instructors and educational support personnel will meet the standards of the host service university/college contract requirements if an affiliation contract exists.

Standard 3 - Associate Degrees/College Credits

All programs will meet the following degree/credit requirements:

a. Associate degree when required by law (e.g., CLIA)

b. All courses, except Community College of the Air Force (CCAF) programs, will maintain college credit evaluation/recommendations through the American Council on Education (ACE).

c. All Army and Navy instructors, course directors, and administrators, hosting Air Force students or participating in school training at an Air Force facility, will meet the standards of the CCAF as required by the Commission on Colleges, Southern Association of Colleges and Schools.

Standard 4 - Certification

Education and training programs will qualify graduates for eligibility to take certification or licensure examinations.

Standard 5 - Curriculum

The curriculum will be standardized. Service-specific requirements will be taught by the individual services, but will not be added to the core curriculum without the participating services' agreement.

Standard 6 - Evaluation

Evaluation will be a requirement for all joint service programs. At a minimum, Input, Process, and Outcome evaluation will apply. The host service has lead responsibility for evaluation efforts, which may consist of all means for collecting data (telephone, surveys, site visits, etc.).

The evaluation process, while a responsibility of the host service, will be a full participatory process with active representation by the participating service(s). The final evaluation reports will be forwarded to each service's headquarters command, and the evaluation cycle (annual or otherwise) will be listed in the Memorandum of Understanding (MOU). Each service will assume funding responsibility for its own evaluation team members.

Standard 7 - Instructor/Student Ratio

Instructor/student ratios will be dependent upon content, content difficulty, accreditation requirements, and didactic/laboratory requirements. The normal standard for didactic instruction will be 24 students to 1 instructor. That may vary considerably, dependent upon classroom physical size, content, and instruction method employed. The normal standard for laboratory instruction will be 8 students per 1 instructor. That

also will vary considerably dependent upon space, content, accreditation standards, and safety. Evaluation of instructor/student ratios must be conducted annually.

Standard 8 - Shifts

Single-shift teaching programs will be standard for courses of the Health Care Committee (HCC), Interservice Training Review Organization (ITRO), except during mobilization or to meet other special needs to support operational requirements to maximize use of physical facilities. If a participating service, for whatever reason, needs to conduct training on a basis other than single-shift, the participating service will provide all resources required to the host service.

Standard 9 - Instructor Training

All instructors, prior to teaching, will be qualified as an instructor by completing one of the service-specific instructor training schools. The host service and participating service will accept instructor training qualification from another service and not require additional instructor training in a service-specific school. Instructors will meet all course accreditation standards.

Standard 10 - Educational Support Services

The host service will be responsible for providing educational support services. Educational support services include all the processes found in the twelve standards of the Regional Accreditation Agency, and the standards of the professional programmatic accreditation agency.

Standard 11 - Technology Use/Funding

The use of technology is strongly encouraged. Technology applications will be considered for program improvement and implementation during annual program evaluation.

Standard 12 - Graduation/Setback/Recycle

Graduation requirements and procedures will be the responsibility of the host service. Setback/recycle is a process of permitting/requiring promising students in academic difficulty or for administrative reasons to repeat instruction missed or failed, to complete the course.

Standard 13 - Instructional Program Review

For all consolidated courses, the host service will conduct an annual instructional program review with representation by all participating services.

PHILOSOPHICAL

Standard 1 - Quality of Life

Quality of life includes not only educational quality but also all aspects of living and accommodations that support the students, instructors, and administrators at the host service installation. Quality of life defined herein:

a. Didactic classrooms that contribute to learning--noise reduction structures such as wall treatments, floor treatments; adequate lighting and ventilation; barrier-free space such as posts obstructing student views of instructors, video materials, and demonstrations; acoustic enhancements; student desks designed for teaching/learning; and other quality materials that contribute to learning.

b. Laboratory spaces as part of the instructional program that are sufficient for each student to practice and demonstrate competence--not merely to observe a practice or procedure.

c. Instructional equipment such as sufficient books, aids, kits, simulators, mock-ups, and student handouts for each student, not group sharing techniques. All laboratory/demonstration equipment will be the same equipment or effectively simulate work environment equipment.

d. Technology should be considered for all training programs. If technology can more effectively deliver course material versus an instructor, it should be considered. The use of technology is also a major cost consideration when determining implementation costs.

e. School personnel are expected to demonstrate the same levels of professionalism and dedication in education as they are to other military requirements. School administrators are expected to recognize that instructors must have time to research and prepare lessons, score papers, construct tests and examinations, counsel students, and constantly improve teaching-learning processes. A sufficient number of support personnel is strongly encouraged as a principle of joint-service training.

Quality of life issues also include living conditions and all base operating support. Base officer quarters (BOQ)/base enlisted quarters (BEQ) standards as adopted in the ITRO Facilities Manual shall apply to all combined courses. If a service, host or participant, desires to exceed the ITRO standards, that service will provide the resources required.

In addition to meeting the standards in the ITRO Facilities Manual, the host service will meet its obligation to provide facilities and an environment conducive to learning. This

includes adequate desks, lighting, learning resource center, and places and quiet times for study.

If the mission of a host service requires field training, combat exercises, administrative requirements, or physical fitness specific to that service, participating service students will not be required to participate in specific mission requirements of the host service. Issues of whether students will be required to march to class and other such procedures required by the host service will be specifically addressed and written into the MOU/Interservice Support Agreement (ISA).

Standard 2 - Mobilization

The host service will meet the mobilization requirements of participating service(s), unless the requirement is physically impossible for the host service to accomplish. While the host service is required to meet mobilization requirements, the host service has every right to request assistance and the participating service(s) is expected to provide assistance as required for instructor or administrative personnel. However, the host service is expected to provide supplies and equipment to meet training requirements.

Standard 3 - Entry-level Requirements

Entry-level requirements shall remain in the domain of each service. Reasonable academic standards will remain constant and the consolidated course director/instructors will teach to the standard, not to student background and preparation or lack thereof. The course curriculum will meet the knowledge, skills, attitudes, and job performance required for the jobs identified in the common core training requirements inventory, and not altered to compensate for individual student entry-level knowledge/experience which falls below the prerequisite requirements for entering the training program.

Each service retains the right for determining methods to provide its students with sufficient entry-level background. It is the responsibility of each service to determine its rate of attrition acceptability and to provide solutions to its members if the attrition rate in a consolidated course is judged to be caused by inadequate student prerequisite knowledge. It is not the responsibility of the consolidated course directors or instructors.

Standard 4 - Career Progression

Student career progression is the sole domain of each service. Consolidated courses will not detrimentally impact on career progression but should enhance career progression. It is

the responsibility of each service's Detailed Analysis Group (DAG) representative to assure that career progression content knowledge to satisfy a particular service requirement(s) is either provided during the consolidated core curriculum, or is provided in the service unique track (railroad) after the consolidated curriculum is taught to meet unique service operational mission needs.

Standard 5 - Service-Specific Utilization

Factors such as independent duty, service deployment readiness requirements, and usage of personnel do not necessarily preclude consolidation of courses. The determinant for consolidation is the amount and kind of content material needed based upon the training requirement inventory to successfully meet the requirements of independent duty work, not upon where or how the technician or specialist is used by a particular service.

EDUCATIONAL ADMINISTRATION**Standard 1 - Terminology**

Standard terminology should be identified and defined for use in consolidated courses.

Standard 2 - Memorandum of Understanding (MOU)/Interservice Support Agreement (ISA)

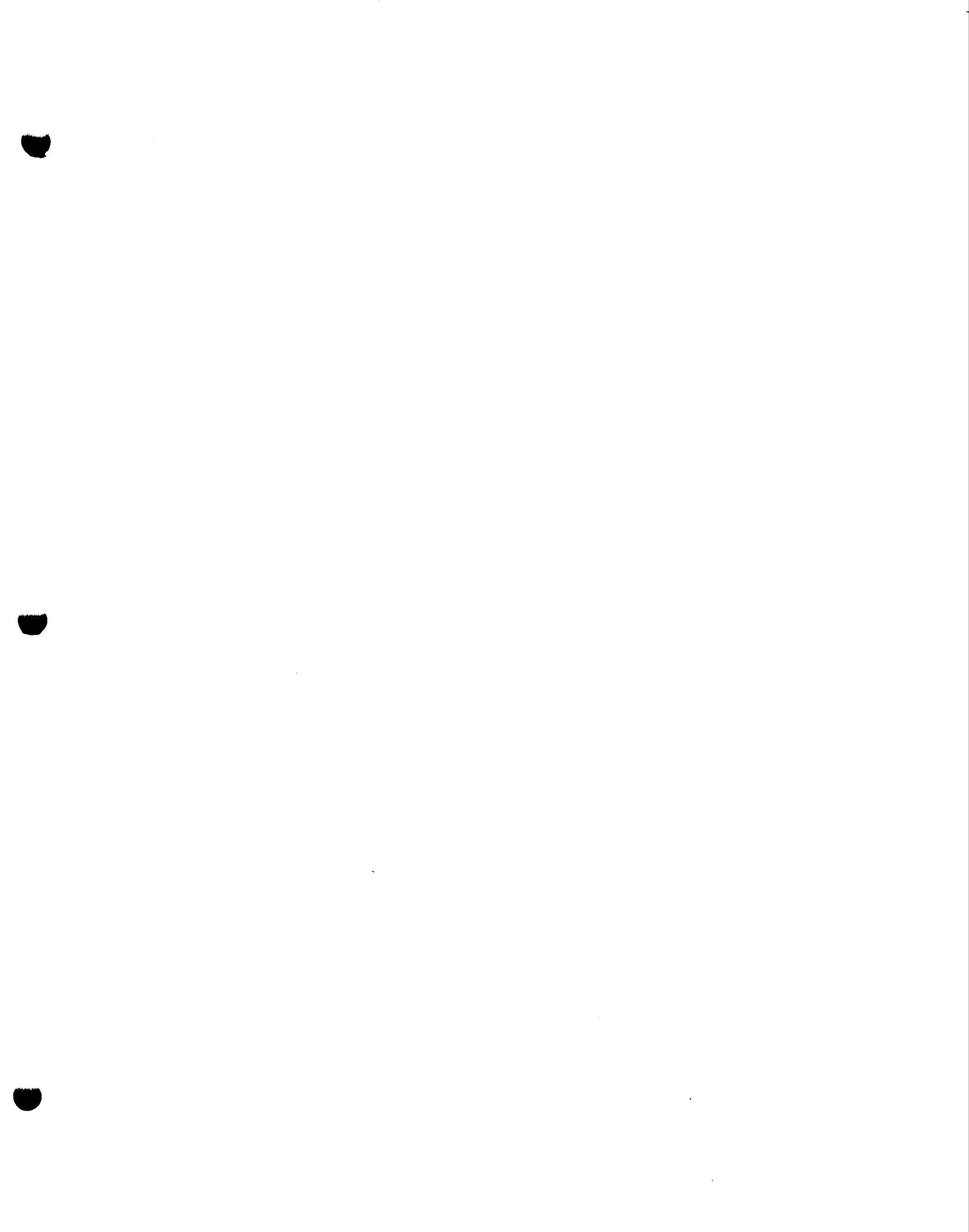
MOUs/ISAs will incorporate the approved Health Care Committee ITRO Standards.

Standard 3 - Administrative Staff

Administrative staff will be determined by established standards of the ITRO Manpower Subcommittee. Additional requirements for administrative staff will be paid for by the service requiring additional staff.

Standard 4 - Program Director Rotation

Program Director rotation is required except in those instances where the participating services agree otherwise. The host service will normally provide the first tour Program Director/Course Director, after which the Program Director/Course Director will be rotated to the participating services.



Medical Joint Cross Service Group Process Summary

Initial Study Design and Development

The Deputy Secretary of Defense 1995 Base Realignment and Closures guidance memorandum, dated January 7, 1994, provided the authority for establishment of the Joint Cross Service Group for Military Treatment Facilities (MTFs) and Graduate Medical Education (GME). A Tri-Service Ad Hoc Working Group was also established to develop and recommend draft criteria and process proposals for consideration by the Joint Medical Group. The Assistant Secretary of Defense (Health Affairs) chaired the Joint Medical Group. The membership, as outlined in the Department's guidance, included representatives from the Services and major staff elements of the Office of the Secretary of Defense.

The Group developed an overall analytic process that included study assumptions, roles of the Services and Joint Medical Group, and an analytic approach. Functional study categories were developed consisting of Graduate Medical Education Centers and Community Hospitals. Two capacity measures were developed which consisted of measures for contingency/mobilization bed requirements and peacetime operating bed capacity.

The Joint Medical Group study assumptions included the basic premise that, in general, the MTF will close if the base or installation closes except when a significant active duty population remains after a base is closed. The group also agreed to include organizations with < 300 civilian full time employed personnel as part of the overall analysis.

The roles of the Military Departments and the Joint Medical Group were developed based on the DepSecDef guidance memorandum of January 7, 1994. The Joint Medical Group developed the study design, general analytical approach, measures of merit, common data elements, and a methodology for weighting and scoring the measures of merit. The Military Services conducted the data collection and analysis, development of findings, and evaluated alternative options recommended by the Joint Medical Group.

The Medical Group developed ten common measures of merit within the framework of the overall Military Value BRAC Criteria. These measures included the data element(s) to be collected by the Services, the source(s) for each data element, and the methodology for weighting and scoring each of the measures. Mission criterion encompassed active duty and active duty family populations. Facility condition elements included a weighted age calculation and condition assessments by the Military Treatment Facility (MTF) Commander and Installation Engineer. Contingency factors were measured by the number of expanded beds within the MTF and proximity to air transport locations. Finally, average cost of MTF inpatient care was measured against the Adjusted Standardized CHAMPUS rate for each MTF geographic area. Each of the measures of merit was scored on a scale of 1 - 10. The measures were weighted and a functional value score was obtained for each MTF.

2d Stage Analysis

The primary tool used in developing alternatives for consideration by the Military Departments was the DoD approved Fixed Integer Linear Programming Model. This model incorporates characteristics based on the goal to minimize excess capacity and maintain high quality facilities within the Military Health Services System. The model also ensures that facilities are located at sites with significant active duty and family member populations.

CLOSE HOLD

The specific linear formulation incorporates operating beds as the primary capacity measure and also maintains the minimum number of wartime beds based on the most recent defense guidance. Bed demand is generated based on acute care and medical center requirements using beneficiary specific FY 94 direct care inpatient rates. Medical Center beds are allocated to the eastern and western United States based on requirements generated within those areas. There are a number of binary constraints within the model that ensures facilities remain open if they reside in an underserved primary care area, there are insufficient acute care beds in the community, or less than 2 accredited acute care facilities. In overlapping catchment areas, the model flows patients if any binary constraint is met and attempts to consolidate inpatient care.

The model results produced a number of possible facilities to consider for downsizing or closure. The Chairman sent a set of alternatives to the Service Secretaries for their consideration. The alternatives and Service responses are provided below.

Infrastructure Reductions 1988 - 1997

Since the end of the cold war, the DHP has aggressively sought to reduce excess infrastructure. Over 58 hospitals will have closed or realigned by 1997. The DHP has also experienced approximately 12,000 normal bed reduction during this period. These reductions account for a 43% decrease in beds and a 35% decrease in number of inpatient facilities since 1988.

Within the continental United States, 41 hospitals will have closed by the end of BRAC 95. Overseas hospitals account for an additional 17 closures. These hospitals include four medical center closures, 2 within CONUS and 2 overseas. These actions were accomplished by the cumulative Base Realignment and Closure Rounds and by Defense Health Program initiatives.

CLOSE HOLD

**Military Treatment Facilities
Realignment and Closure Candidates**

<u>Facility Name</u>	<u>Location</u>	<u>Alternative</u>	<u>Service Response</u>
Noble Army Community Hospital	Fort McClellan, AL	Realign to Clinic	Concur
Lyster Army Community Hospital	Fort Rucker, AL	Realign to Clinic	Non-Concur
Fitzsimons Army Medical Center	Aurora, CO	Close	Concur
USAF Academy Hospital	Air Force Academy	Realign to Clinic	POM reduction
USAF Medical Center Scott AFB	Scott AFB, IL	Realign to Clinic	Realigned to CH
Kimbrough Army Community Hospital	Fort Meade, MD	Realign to Clinic	Concur
Wright Patterson USAF Medical Center	Wright Patterson AFB, OH	Realign to Clinic/CH	BRAC 95 Impact
Naval Hospital Beaufort	Beaufort, SC	Realign to Clinic	Non-Concur
363rd Medical Group	Shaw AFB, SC	Realign to Clinic	Non-Concur
6th Medical Squadron	Reese AFB, TX	Realign to Clinic	Concur
Naval Hospital, Corpus Christi	Corpus Christi, TX	Realign to Clinic	Concur via POM
Wilford Hall Medical Center	Lackland AFB, TX	Realign to Clinic/CH	Non-Concur
396th Medical Group	Sheppard AFB, TX	Realign to Clinic	Non-Concur
1st Medical Group	Langley AFB, VA	Realign to Clinic	Non-Concur
Dewitt Army Community Hospital	Fort Belvoir, VA	Realign to Clinic	Non-Concur
Kenner Army Community Hospital	Fort Lee, VA	Realign to Clinic	Concur

CLOSE HOLD

NOBLE	1892	10927	19	0.99	4.90	.
LYSTER	1804	15351	25	1.13	5.60	.
BASSETT	1456	14790	17	0.64	5.02	.
BLISS	2403	12360	18	1.06	5.51	.
FITZSIM	867	13022	37	1.34	5.37	6.35
EVANS	2208	54150	71	1.03	7.62	.
WREED	572	19260	34	1.22	6.10	7.72
IKE	878	28710	45	1.38	7.59	8.25
MARTIN	1622	45386	63	0.99	7.16	.
WINN	1409	41933	51	0.83	7.06	.
TRIP	859	100380	121	1.39	7.94	4.52
IRWIN	3175	49615	55	0.98	7.62	.
MUNSON	821	18320	31	1.05	4.49	.
BLANCH	2205	58250	68	1.18	8.18	.
IRELAND	1105	32435	48	1.01	6.30	.
BJONES	2405	26021	31	0.85	5.83	.
KIMB	687	40659	62	1.15	6.76	.
LWOOD	1928	34541	41	1.01	7.51	.
PATT	820	10476	20	1.21	4.76	.
KELLER	716	13924	24	1.41	5.34	.
WOMACK	1542	113185	141	1.34	8.52	.
REYNOLDS	1571	36714	48	1.10	7.58	.
MONCRF	1130	33276	49	1.44	7.55	.
BEAUMT	1689	30999	50	1.29	7.51	5.91
BROOKE	950	37939	73	1.17	7.50	7.18
DARN	1014	91766	113	1.40	8.36	.
MCDEE	1143	28586	40	1.22	6.10	.
KENNER	865	14800	28	1.38	5.43	.
DEWITT	1593	59530	97	1.39	7.49	.
MADIG	935	63078	104	1.13	8.22	6.14
WEED	2380	10687	12	1.21	5.10	.
MAXWELL	1092	14410	28	1.78	3.83	.
ELM	1389	25834	34	1.23	6.03	.
LUKE	1226	19503	52	1.11	5.02	.
DMONTH	833	18327	37	1.24	5.22	.
LROCK	1786	13484	27	1.10	4.83	.
TRAVIS	1179	36257	71	1.53	7.88	5.52
BEALE	548	9488	16	1.07	3.76	.
MATHER	587	11084	40	1.28	5.06	.
VANBERG	1154	8848	15	1.47	5.00	.
EDWARDS	1098	13152	18	0.84	3.82	.
USAFAC	1631	24269	37	1.02	5.68	.
DOVER	1183	13663	22	1.25	4.69	.
EGLIN	2276	39369	59	0.88	6.62	.
TYNDALL	3138	15424	25	0.56	4.26	.
MACDILL	831	15542	62	1.16	5.35	.
PATRICK	2696	10556	30	1.10	4.82	.
MOODY	794	9611	14	0.62	3.81	.
ROBINS	1377	11640	22	0.74	4.24	.
MHOME	2814	11957	18	0.94	5.92	.
SCOTT	1125	24566	45	0.95	5.48	.
BARKS	538	15532	26	1.08	5.04	.
ANDREWS	91	29651	49	0.99	5.89	.
KEESLER	1408	38690	53	1.13	7.10	5.06
COLMBS	1170	3633	7	0.74	3.24	.
WHITEMN	2902	8310	12	0.82	4.04	.
OFFUTT	866	26703	41	1.08	5.85	.
NELLIS	1331	20071	41	0.98	5.90	.
KIRT	1389	14162	29	1.23	5.40	.
HOLLOMN	2733	14414	22	0.86	4.68	.
CANNON	1014	15591	18	0.83	4.87	.
SJOHNS	1557	12920	21	0.83	4.45	.
GFORKS	1106	12545	14	0.87	3.82	.
MINOT	1265	12000	19	0.76	4.64	.
WPATT	1202	22131	39	0.88	5.90	5.58
TINK	1111	23596	42	0.80	4.76	.
ALTUS	2138	7507	10	0.64	3.92	.
SHAW	980	16596	23	0.96	5.02	.
ELLS	1623	14000	18	0.97	4.80	.
REESE	876	3831	7	0.64	3.18	.
DYESS	1524	13057	18	0.88	4.26	.
SHEPP	1300	12420	18	0.73	5.00	.
LAUGH	1919	3009	4	0.48	3.72	.
LACKLND	870	43110	71	1.01	7.16	6.74

HILL	1827	15002	28	1.25	5.88	.
LANGLY	1815	31455	45	0.79	5.68	.
FAIRCH	1694	13407	23	1.15	4.71	.
WARREN	1650	8700	12	0.84	3.98	.
FTDIX	498	26282	58	1.16	6.07	.
PEND	908	74874	100	1.12	7.28	.
LEMOORE	2686	22516	30	0.66	5.12	.
SDIEG	956	188255	259	1.32	8.48	7.84
29PALMS	2627	23000	26	1.45	7.58	.
GROTON	1217	20151	31	1.25	5.41	.
PENS	2112	47769	71	0.92	7.19	.
JAX	1252	64858	98	0.91	6.98	.
GLAKES	469	37555	55	0.81	6.48	.
BETH	725	42361	70	0.96	6.82	7.40
PAX	4231	8985	13	0.57	3.74	.
LEJU	1226	79722	93	0.95	7.76	.
CHPT	990	27792	36	0.66	4.52	.
CHAR	769	26954	47	1.11	5.56	.
BEAU	1105	17078	22	0.74	4.70	.
MILL	3546	7005	20	0.78	4.37	.
CORP	1384	8433	14	0.71	4.26	.
PTSMTH	1893	226784	281	0.99	6.55	7.01
BREM	1259	35678	48	1.14	6.98	.
OAKHAR	1104	18918	25	1.13	5.38	.

param	cl_accred_hosp	cl_civ_bed_avail	cl_civ_bed_ratio	cl_pcp_ratio	cl_act_dut_pop :=
DENVER	8	970	4.75	1486	78419
WASHDC	40	7000	5.53	800	191769
TEXAS	15	1586	1.67	995	81049
SOCAR	18	1432	11.83	1310	49872
NORFOLK	13	1200	3.51	1099	283825;
#SEATTLE	23	2130	4.35	1009	98756

param wartime_req_USAF := 980;
 param wartime_req_USA := 6030;
 param wartime_req_USN := 2600;

param MC_bed_req_EAST := 1492;
 param MC_bed_req_WEST := 1262;

set PATIENT_ARCS :=
 (EVANS, USAFAC) (USAFAC, EVANS)

 (WREED, ANDREWS) (ANDREWS, WREED)
 (WREED, BETH) (BETH, WREED)
 (WREED, KIMB) (KIMB, WREED)
 (WREED, DEWITT) (DEWITT, WREED)
 (ANDREWS, BETH) (BETH, ANDREWS)
 (ANDREWS, KIMB) (KIMB, ANDREWS)
 (ANDREWS, DEWITT) (DEWITT, ANDREWS)
 (BETH, KIMB) (KIMB, BETH)
 (BETH, DEWITT) (DEWITT, BETH)

 (BROOKE, LACKLND) (LACKLND, BROOKE)

 (SHAW, MONCRF) (MONCRF, SHAW)

 (LANGLY, MCDEE) (MCDEE, LANGLY)
 (LANGLY, PTSMTH) (PTSMTH, LANGLY)
 (MCDEE, PTSMTH) (PTSMTH, MCDEE);

(MADIG, BREM) (BREM, MADIG);

param distance :=

EVANS USAFAC 21.7 USAFAC EVANS 21.7

WREED	ANDREWS	23.2	ANDREWS	WREED	23.2
WREED	BETH	5.1	BETH	WREED	5.1
WREED	KIMB	22.9	KIMB	WREED	22.9
WREED	DEWITT	37.1	DEWITT	WREED	37.1
ANDREWS	BETH	24.9	BETH	ANDREWS	24.9

ANDREWS	KIMB	33.8	KIMB	ANDREWS	33.8
ANDREWS	DEWITT	25.5	DEWITT	ANDREWS	25.5
BETH	KIMB	23.2	KIMB	BETH	23.2
BETH	DEWITT	31.5	DEWITT	BETH	31.5
BROOKE	LACKLND	15.6	LACKLND	BROOKE	15.6
SHAW	MONCRF	21.1	MONCRF	SHAW	21.1
LANGLY	MCDEE	9.9	MCDEE	LANGLY	9.9
LANGLY	PTSMTH	28.9	PTSMTH	LANGLY	28.9
MCDEE	PTSMTH	34.6	PTSMTH	MCDEE	34.6;
#	MADIG	BREM	38.9	BREM	MADIG 38.9;

Form: 2 Beds: oper

M1202D

MINNFV 1.4766
 Flow clusters 0
 Jse chv beds 1
 Min AD pop 25000
 Oper beds 1
 MC FV avg req 0
 MC_flow 1
 Ngt Pct 1

ATF	OPEN	MV	FV	MC FV	Blns	Oper be	Beds av	Exp bed	AC bed	Patients	Civ beds	GME bed	EVANS	USAFAC	WREED	ANDREW	BETH	DEWIT	KIMB	BROOK	LACKLN	SHAW	MONCF	LANGL	MCDEE	PTSMT	Total assigned
PEND	1	3	7.28		1	120	222	265	100	100	0															100	
EMOORE	1	3	5.12		1	37	69	37	30	30	0															30	
SDIEG	1	3	8.48	7.84	1	422	617	583	259	259	0	163														422	
9PALMS	1	3	7.58		1	30	70	40	26	26	0															26	
3ROTON	1	3	5.41		0	25	100	96	31	31	0															31	
PENS	1	3	7.19		1	104	221	161	71	71	0															71	
JAX	1	3	6.98		1	131	176	228	98	98	0															98	
BLAKES	1	3	6.48		1	136	228	718	55	55	0															55	
BETH	1	3	6.82	7.40	0	342	459	779	70	70	0	249			0	0		0	23							342	
PAX	1	3	3.74		1	20	20	32	13	13	0															13	
EJU	1	3	7.76		1	176	224	238	93	93	0															93	
CHPT	1	3	4.52		1	40	40	27	36	36	0															36	
JHAR	1	3	5.56		1	90	90	90	47	47	0															47	
BEAU	0	3	4.70		0	49	80	54	22	0	22															0	
MILL	1	3	4.37		1	66	102	106	20	20	0															20	
CORP	0	3	4.26		0	42	65	65	14	0	14															0	
TSMTH	1	3	6.55	7.01	0	431	437	176	281	281	0	107											43	0		431	
IREM	1	3	6.98		1	109	137	139	48	48	0															48	
JAKHAR	1	3	5.38		0	25	26	31	25	25	0															25	
MAXWELL	1	3	3.83		0	30	71	118	28	28	0															28	
ILM	1	3	6.03		1	75	139	32	34	34	0															34	
LUKE	1	3	5.02		0	40	60	100	52	52	0															52	
MONTH	1	3	5.22		0	30	70	112	37	37	0															37	
ROCK	1	3	4.83		0	20	39	68	27	27	0															27	
RAVIS	1	3	7.88	5.52	1	195	408	388	71	71	0	124														195	
HEALE	1	3	3.76		0	9	14	14	16	16	0															16	
MATHER	1	3	5.06		0	30	35	70	40	40	0															40	
ANBERG	1	3	5.00		0	20	48	46	15	15	0															15	
DWARDS	1	3	3.82		0	10	30	33	18	18	0															18	
ISAFAC	0	3	5.68		0	55	80	157	37	0	0		0													0	
XOVER	1	3	4.69		0	20	39	60	22	22	0															22	
GLIN	1	3	6.62		1	85	120	275	59	59	0															59	
YNDALL	1	3	4.28		1	25	57	79	25	25	0															25	
ACDILL	1	3	5.35		0	50	69	142	62	62	0															62	
ATRICK	1	3	4.82		0	15	20	72	30	30	0															30	
OODY	1	3	3.81		0	10	47	47	14	14	0															14	
OBINS	1	3	4.24		0	15	31	32	22	22	0															22	
HOME	1	3	5.92		1	20	31	31	18	18	0															18	
COTT	0	3	5.48		0	95	120	348	45	0	45															0	
ARKS	1	3	5.04		0	25	46	70	26	26	0															26	
NDREWS	1	3	5.89		0	185	244	388	49	49	0				0		0	97	39							185	
EESLER	1	3	7.10	5.06	1	235	306	433	53	53	0	175														228	
OLMBS	1	3	3.24		0	5	17	17	7	7	0															7	
HITEMN	1	3	4.04		0	15	26	29	12	12	0															12	
FFUTT	1	3	5.85		1	50	107	123	41	41	0															41	
ELLIS	1	3	5.90		0	20	77	77	41	41	0															41	
IRT	1	3	5.40		0	25	40	40	29	29	0															29	
OLLOMN	1	3	4.68		1	8	30	28	22	22	0															22	
ANNON	1	3	4.87		1	15	29	36	18	18	0															18	
JOHNS	1	3	4.45		0	15	44	48	21	21	0															21	
FORKS	1	3	3.82		0	15	34	34	14	14	0															14	
INOT	1	3	4.64		0	25	47	75	19	19	0															19	
IPATT	0	3	5.90	5.58	0	160	175	433	39	0	39	0														0	
INK	1	3	4.76		0	25	65	90	42	42	0															42	

Form: 2 Beds: oper

M1202D

MINNFV 1.4766
 Flow clusters 0
 Use civ beds 1
 Min AD pop 25000
 Oper beds 1
 MC FV avg req 0
 MC flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Blna	Oper be	Beds a	Exp bed	AC bed	Patients	Civ beds	GME bed	EVANS	USAFAC	WREED	ANDREW	BETH	DEWIT	KIMB	BROOK	LACKLN	SHAW	MONCR	LANGL	MCDEE	PTSMT	Total assigned
ALTUS	1	3	3.92		0	7	39	39	10	10	0															10	
SHAW	0	3	5.02		0	25	48	90	23	0	0												0			0	
ELLS	1	3	4.80		0	15	35	58	18	18	0															18	
REESE	0	3	3.18		0	4	10	20	7	0	7															0	
DYESS	1	3	4.26		0	15	35	100	18	18	0															18	
SHEPP	0	3	5.00		0	80	197	318	18	0	18															0	
LAUGH	1	3	3.72		1	5	28	40	4	4	0															4	
LACKLND	0	3	7.16	6.74	0	585	1006	1033	71	0	0	0									0					0	
HILL	1	3	5.88		0	25	42	55	28	28	0															28	
LANGLY	0	3	5.68		0	40	71	120	45	0	0													0	0	0	
FAIRCH	1	3	4.71		0	30	61	90	23	23	0															23	
WARREN	1	3	3.98		0	15	24	43	12	12	0															12	
FTDIX	1	3	6.07		1	20	350	350	58	58	0															58	
FOX	1	3	4.86		0	20	42	57	21	21	0															21	
NOBLE	0	3	4.90		0	48	100	106	19	0	19															0	
LYSTER	0	3	5.60		0	42	69	77	25	0	25															0	
BASSETT	1	3	5.02		1	43	74	100	17	17	0															17	
BLISS	1	3	5.51		0	30	103	107	18	18	0															18	
FITZSIM	0	3	5.37	6.35	0	174	335	375	37	0	37	0														0	
EVANS	1	3	7.62		0	149	195	212	71	71	0			37												108	
WREED	1	3	6.10	7.72	0	694	718	847	34	34	0	660						0	0	0	0					694	
IKE	1	3	7.59	8.25	1	346	757	757	45	45	0	301														346	
MARTIN	1	3	7.16		1	172	282	380	63	63	0															63	
WINN	1	3	7.06		1	114	148	165	51	51	0															51	
TRIP	1	3	7.94	4.52	1	423	439	617	121	121	0	195														316	
IRWIN	1	3	7.62		1	60	127	192	55	55	0															55	
MUNSON	1	3	4.49		0	20	65	65	31	31	0															31	
BLANCH	1	3	8.18		1	146	241	350	68	68	0															68	
IRELAND	1	3	6.30		1	84	172	333	48	48	0															48	
BJONES	1	3	5.83		1	96	169	169	31	31	0															31	
KIMB	0	3	6.76		0	36	68	170	62	0	0				0	0	0									0	
LWOOD	1	3	7.51		1	122	480	670	41	41	0															41	
PATT	1	3	4.76		0	15	67	67	20	20	0															20	
KELLER	1	3	5.34		0	30	62	62	24	24	0															24	
WOMACK	1	3	8.52		1	226	272	454	141	141	0															141	
REYNOLDS	1	3	7.58		1	100	157	264	48	48	0															48	
MONCRF	1	3	7.55		0	96	432	435	49	49	0											23				72	
BEAUMT	1	3	7.51	5.91	1	330	482	684	50	50	0	280														330	
BROOKE	1	3	7.50	7.18	0	367	450	651	73	73	0	223									71					367	
DARN	1	3	8.36		1	203	241	359	113	113	0															113	
MCDEE	1	3	6.10		0	42	116	116	40	40	0															42	
KENNER	0	3	5.43		0	49	67	87	28	0	28													2	0	0	
DEWITT	0	3	7.49		0	68	93	105	97	0	0				0	0	0									0	
MADIG	1	3	8.22	6.14	1	381	414	622	104	104	0	277														381	
WEED	1	3	5.10		1	25	27	27	12	12	0															12	

4436

254 2754

6936

	DOD	Army	Navy	AF
Total sites =	99	32	19	48
Tot. retained =	83	26	17	40

	Total beds			Retained beds		
	Oper	Avail	Exp	Oper	Avail	Exp
USN	2395	3383	3865	2304	3238	3746
USAF	2538	4761	6501	1494	3054	3982
USA	4751	7464	9682	4334	6732	8762
DOD	9684	15608	20048	8132	13024	16490

Before After
 Avg MV = 3.00 3.00
 Avg FV = 5.72 5.77
 Avg MC FV = 6.52 6.60

Checked by DODIG

12/2/94

Shelly Dean

John Delaware

C:\AMPLOSL\JCSG\MEDICAL\MTF.DAT 12/2/94

Data file for MTF model.

Ron Nickel
1 December 1994

set Army_MTF := FOX NOBLE LYSTER BASSETT BLISS FITZSIM EVANS WREED IKE
MARTIN WINN TRIP IRWIN MUNSON BLANCH IRELAND BJONES
KIMB LWOOD PATT KELLER WOMACK REYNOLDS MONCRF BEAUMT
BROOKE DARN MCDEE KENNER DEWITT MADIG WEED;

set AF_MTF := MAXWELL ELM LUKE DMONTH LROCK TRAVIS BEALE MATHER VANBERG
EDWARDS USAFAC DOVER EGLIN TYNDALL MACDILL PATRICK MOODY
ROBINS MHOME SCOTT BARKS ANDREWS KEESLER COLMBS WHITEMN
OFFUTT NELLIS KIRT HOLLOMN CANNON SJOHNS GFORKS MINOT
WPATT TINK ALTUS SHAW ELLS REESE DYESS SHEPP LAUGH LACKLND
HILL LANGLY FAIRCH WARREN FTDIX;

set Navy_MTF := PEND LEMOORE SDIEG 29PALMS GROTON PENS JAX GLAKES BETH PAX LEJU
CHPT CHAR BEAU MILL CORP PTSMTH BREM OAKHAR;

set Army_MC_E := WREED IKE;

set Army_MC_W := FITZSIM TRIP BEAUMT BROOKE MADIG;

set AF_MC_E := KEESLER WPATT;

set AF_MC_W := TRAVIS LACKLND;

set Navy_MC_E := BETH PTSMTH;

set Navy_MC_W := SDIEG;

#set CLUSTERS := DENVER WASHDC TEXAS SOCAR NORFOLK SEATTLE;
set CLUSTERS := DENVER WASHDC TEXAS SOCAR NORFOLK;

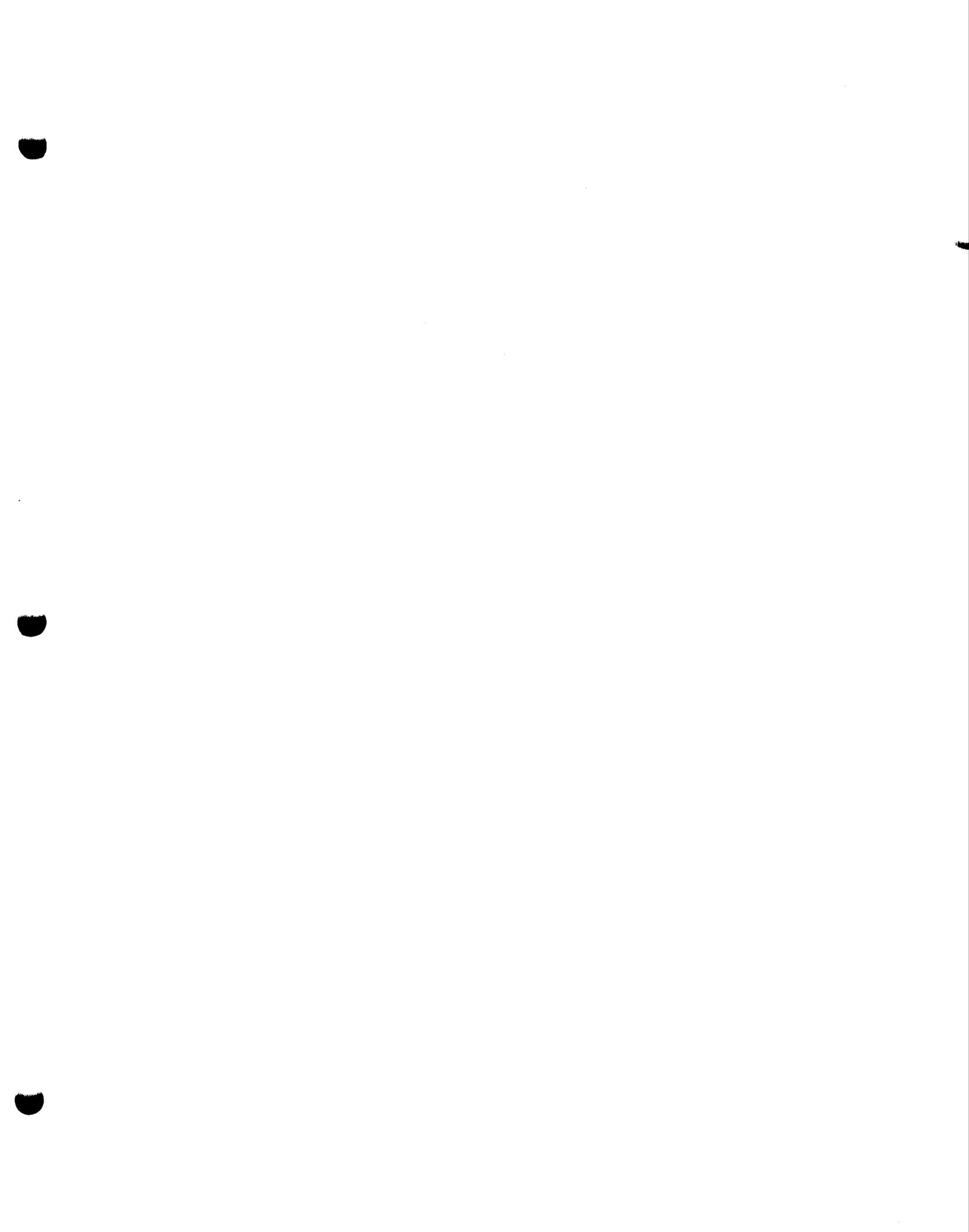
set MTF_CLUSTER :=

(EVANS, DENVER) (USAFAC, DENVER)
(WREED, WASHDC) (ANDREWS, WASHDC) (BETH, WASHDC) (DEWITT, WASHDC) (KIMB, WASHDC)
(BROOKE, TEXAS) (LACKLND, TEXAS)
(SHAW, SOCAR) (MONCRF, SOCAR)
(LANGLY, NORFOLK) (MCDEE, NORFOLK) (PTSMTH, NORFOLK);
(MADIG, SEATTLE) (BREM, SEATTLE);

param :	DMIS	oper_beds	avail_beds	exp_beds	accred_hosp	civ_bed_avail :=
FOX	0001	20	42	57	15	1165
NOBLE	0002	48	100	106	10	787
LYSTER	0003	42	69	77	8	515
BASSETT	0005	43	74	100	0	0
BLISS	0008	30	103	107	3	110
FITZSIM	0031	174	335	375	20	1976
EVANS	0032	149	195	212	7	767
WREED	0037	694	718	847	27	2108
IKE	0047	346	757	757	6	487
MARTIN	0048	172	282	380	8	875
WINN	0049	114	148	165	5	241
TRIP	0052	423	439	617	8	289
IRWIN	0057	60	127	192	5	206
MUNSON	0058	20	65	65	27	2904
BLANCH	0060	146	241	350	6	504
IRELAND	0061	84	172	333	16	2081
BJONES	0064	96	169	169	3	110
KIMB	0069	36	68	170	28	2173
LWOOD	0075	122	480	670	4	263
PATT	0081	15	67	67	69	9464
KELLER	0086	30	62	62	39	1979
WOMACK	0089	226	272	454	9	626
REYNOLDS	0098	100	157	264	5	406
MONCRF	0105	96	432	435	7	435
BEAUMT	0108	330	482	684	8	1201
BROOKE	0109	367	450	651	18	2689
DARN	0110	203	241	359	7	471
MCDEE	0121	42	116	116	7	1414
KENNER	0122	49	67	87	17	1467
DEWITT	0123	68	93	105	8	468

MADIG	0125	381	414	622	20	1955
WEED	0131	25	27	27	1	66
MAXWELL	0004	30	71	118	7	573
ELM	0006	75	139	32	2	276
LUKE	0009	40	60	100	20	1537
DMONTH	0010	30	70	112	9	782
LROCK	0013	20	39	68	9	1221
TRAVIS	0014	195	408	388	22	1721
BEALE	0015	9	14	14	6	288
MATHER	0016	30	35	70	16	1279
VANBERG	0018	20	48	46	3	126
EDWARDS	0019	10	30	33	4	221
USAFAC	0033	55	80	157	2	361
DOVER	0036	20	39	60	7	467
EGLIN	0042	85	120	275	5	278
TYNDALL	0043	25	57	79	2	155
MACDILL	0045	50	69	142	24	2884
PATRICK	0046	15	20	72	5	437
MOODY	0050	10	47	47	4	292
ROBINS	0051	15	31	32	11	560
MHOME	0053	20	31	31	0	0
SCOTT	0055	95	120	348	24	2668
BARKS	0062	25	46	70	7	700
ANDREWS	0066	185	244	388	35	3166
KEESLER	0073	235	306	433	6	574
COLMBS	0074	5	17	17	7	438
WHITEMN	0076	15	26	29	4	165
OFFUTT	0078	50	107	123	10	989
NELLIS	0079	20	77	77	6	394
KIRT	0083	25	40	40	9	965
HOLLOMN	0084	8	30	28	1	38
CANNON	0085	15	29	36	1	37
SJOHNS	0090	15	44	48	6	382
GFORKS	0093	15	34	34	3	172
MINOT	0094	25	47	75	2	176
WPATT	0095	160	175	433	19	1917
TINK	0096	25	65	90	17	1325
ALTUS	0097	7	39	39	3	77
SHAW	0101	25	48	90	4	236
ELLS	0106	15	35	58	3	242
REESE	0111	4	10	20	6	575
DYESS	0112	15	35	100	2	45
SHEPP	0113	80	197	318	2	201
LAUGH	0114	5	28	40	1	48
LACKLND	0117	585	1006	1033	14	2430
HILL	0119	25	42	55	14	1250
LANGLY	0120	40	71	120	15	1239
FAIRCH	0128	30	61	90	5	547
WARREN	0129	15	24	43	2	160
FTDIX	0326	20	350	350	8	729
PEND	0024	120	222	265	24	1666
LEMOORE	0028	37	69	37	3	51
SDIEG	0029	422	617	583	20	1941
29PALMS	0030	30	70	40	1	20
GROTON	0035	25	100	96	3	195
PENS	0038	104	221	161	8	915
JAX	0039	131	176	228	7	879
GLAKES	0056	136	228	718	67	7100
BETH	0067	342	459	779	53	4048
PAX	0068	20	20	32	2	72
LEJU	0091	176	224	238	2	83
CHPT	0092	40	40	27	2	116
CHAR	0103	90	90	90	8	621
BEAU	0104	49	80	54	2	113
MILL	0107	66	102	106	15	1737
CORP	0118	42	65	65	12	551
PTSMTH	0124	431	437	176	17	1538
BREM	0126	109	137	139	1	122
OAKHAR	0127	25	26	31	2	56

param : pcp_ratio act_dut_pop AC_bed_req ASA FV MC_FV :=
 FOX 1420 8566 21 1.06 4.86 .



**BRAC 95 JOINT CROSS SERVICE GROUP
FOR MILITARY TREATMENT FACILITIES AND
GRADUATE MEDICAL EDUCATION**

**June 22, 1994
Room 4E327 1:00 PM**

- Review minutes from previous meeting Dr. Martin
- Data Collection Update LTC Ponatoski
- Validation of Centralized Data Sources Update Mr. Jack Armstrong
DoD IG
- Joint Cross Service Group Optimization Model LTC Ponatoski
- Timeline and Milestone Update LTC Ponatoski
- Closing Remarks Dr. Martin
- Adjournment



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
3300 DEFENSE PENTAGON
WASHINGTON, DC 20301-3300



14 JUN 1994

ECONOMIC SECURITY

MEMORANDUM FOR BRAC 95 JOINT CROSS-SERVICE GROUP CHAIRPERSONS

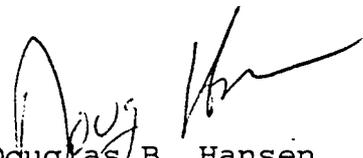
SUBJECT: Joint Cross Service Optimization Model

At the June 8, 1994, BRAC 95 Steering Group Meeting, we agreed that a team of Service and OSD representatives would evaluate and adapt the proposed optimization model by making it more flexible and therefore of more use as a common tool for each Joint Cross-Service Group. Each Joint Cross-Service Group would then individually evaluate the model, develop the necessary inputs to the model (functional capacity, functional value, policy imperatives) and report on its utility and how it would be employed to the Steering Group.

The Service/OSD team has completed its evaluation and incorporated Air Force improvements into the model that have resulted in a more flexible and useful tool. I ask that each Joint Cross Service Group perform its own evaluation of the resulting "Joint Cross Service Analysis Tool" (documentation attached) in order to determine how it will be employed and what specifications and assumptions will be needed for its operation. This evaluation can include "dry-runs" using notional data.

Dr. Ron Nickel is the Navy representative to the Tri-Department Team that will run the model on behalf of each Joint Cross-Service Group, based on direction of the group. Ron is standing by to work with each group. He can be reached at 681-0494. Please contact him to make arrangements to begin your evaluations. Due to security concerns, we have arranged for the model to be available for your evaluations only at the Center for Naval Analysis building in Arlington.

Finally, my staff will be in contact with your Study Team Leaders to arrange individual meetings to discuss the results of your evaluations. As further agreed to at the Steering Group meeting, I expect these meetings to be conducted late during the week of June 20-24.


Douglas B. Hansen
Executive Secretary
BRAC 95 Steering Group

Attachment

cc: Army, Navy & AF



Joint Cross-Service Analysis Tool

Executive Summary

Background

The integrity of the BRAC process will be enhanced if each of the Joint Cross-Service Groups (JCSG) uses a common analytical approach to assist in the generation of cross-service functional alternatives for consideration by the Military Departments. Defending base closure and realignment recommendations before the BRAC Commission, Congress, and the affected communities requires an analytical approach that can be audited, that generates results that can be reproduced, and that ensures compatibility across multiple JCSGs. This document describes an analytical tool that will aid the JCSGs in meeting these criteria.

DoD BRAC Goals

Goals of the DoD BRAC process include:

- elimination of DoD excess capacity,
- maintaining a high-quality infrastructure,
- making sure that required capabilities are retained, and
- being in compliance with all BRAC legislation and directives.

While it is true that the JCSGs are to focus on common support functions, it is also true that BRAC is about the closure and realignment of bases and installations. An analytical approach that does not give consideration to opportunities to close bases and installations is not likely to lead to any significant reductions in infrastructure. The shuffling of functions from one site to another does not, in general, require the burden of the BRAC process. The formulations described here will provide families of solutions for consideration by the JCSGs. Each solution will correspond to a different cross-service functional workload assignment.

Role of the Joint Cross-Service Groups

The JCSGs have been given the following responsibilities by the Deputy Secretary:

- Establish common data elements for analysis of assigned cross-service functions,
- Establish excess capacity reduction targets for their assigned functions, and
- Develop cross-service functional alternatives for consideration by the Military Departments. The JCSGs do not recommend installation or site closures.

Role of the Military Departments

The Military Departments have a number of responsibilities to support the work of the JCSGs. These include:

- Participate as members of each JCSG,
- Provide data as directed by the JCSGs,
- Provide analytical support to the JCSG such as running the analytical tool described here,
- Provide the JCSGs with the military value of their installations or sites, and
- Analyze cross-service functional alternatives within their BRAC process as directed by the JCSGs.

Analytical Approach

A standard resource allocation tool comprises the core of the analytical approach described in detail in the main body of this document. A standard tool used to find optimal solutions to complex allocation problems is the mixed-integer, linear program (MILP). Allocation of common support functional requirements to military department sites and activities is a complex allocation problem.

The MILP formulation described in the main body of this document can be used to generate cross-service functional alternatives. The data elements required for this approach are derived from the certified data available to the JCSGs. Policy imperatives agreed to by the members of the JCSGs and any other JCSG-unique considerations can be incorporated into a formulation in the form of additional constraints. This will allow the tailoring of the formulations to accommodate the unique perspectives of each JCSG.

While each JCSG will develop their model formulations independently, the structure of the analytical approach would allow the functional data and constraints from each JCSG to be combined into a single formulation that models all of the functions from all of the JCSGs. Without a common formulation, it is possible that cross-service functional alternatives generated from individual JCSG formulations will be inconsistent, i.e., one will be moving functions into a site or activity while the other is moving them out. If the outputs from different JCSGs are inconsistent, a common formulation could be run to resolve the inconsistencies.

The objective function for a formulation can be varied to obtain families of solutions. A solution defines a set of functional allocations and identification of sites or activities where cross-service functional workload could be assigned. An objective function that combines military value of sites and activities with functional values is discussed in the main body of this document. This particular objective function will tend to consolidate common support functions into high military value sites or activities. At the same time, this objective function will assign common support functions to sites having high functional values. The weighting between these two

goals can be parameterized to obtain families of solutions for further consideration by the JCSGs.

Other objective functions that the JCSGs may wish to consider in addition to the one mentioned above, include minimizing excess functional capacity or minimizing the total number of sites performing cross-service functions. This tool will also allow the JCSGs to explore the sensitivity of the optimal solution for a given formulation to particular model inputs.

The JCSGs will use the MILP formulation described in the body of this document as the basic analytical tool to generate cross-service functional alternatives to be assessed by the military departments.

Document Organization

An overview of the analytical process proposed in this document is presented in the next section. That section describes the products of the process. The section also discusses terminology relating to what a *site or activity* is relative to a *function*.

The next section describes the basic data elements that are used in the process. This section discusses the data elements in terms of what these elements are meant to represent. This section also discusses who would be responsible for determining how to calculate the data elements.

The different optimization problem formulations that the JCSGs may choose to use to explore alternatives are discussed in the next section. These include finding a small set of high military value sites or activities that can perform the functional requirement, minimizing excess capacity, and minimizing the number of sites. All of these formulations are parameterized in such a way that the JCSGs can explore trade-offs between different factors, such as military value or excess capacity, and assignments of functional requirement based upon functional value. This section also discusses the incorporation of policy imperatives in the optimization problem formulations.

The next section uses an example to demonstrate the application of each of these formulations. The last section identifies the commercial software product used to find the optimal solutions to the optimization example problems. Input files for this package used to prepare the examples are included in the appendices.

Analytical Process Overview

The optimization formulations described in this document require a set of data elements as inputs. All of the formulations require a functional value and functional capacity for each site capable of performing that specific cross-service function. The DoD requirement for each cross-service function is required. Some of the formulations will also require the military values for each site as determined by the Military Departments.

A preliminary formulation that allocates cross-service functional requirements based upon functional capacities and functional value will be conducted. The objective function of this formulation will assign the DoD requirement for each cross-service function to sites or activities having the highest functional value for each function. These assignments will only be constrained by the functional capacities at each site. This analysis will not require the military values for the sites.

The primary formulations optimize the assignment of cross-service functions based upon military values of sites, functional values, and capacities. These formulations are very flexible in that multiple objective functions and policy imperatives modeled as constraints may be used to explore different solutions.

A standard resource allocation tool comprises the core of the analytical approach. A standard tool used to find optimal solutions to complex allocation problems is the mixed-integer,

linear program (MILP). Allocation of common support functional requirements to military department sites and activities subject to constraints is a complex allocation problem.

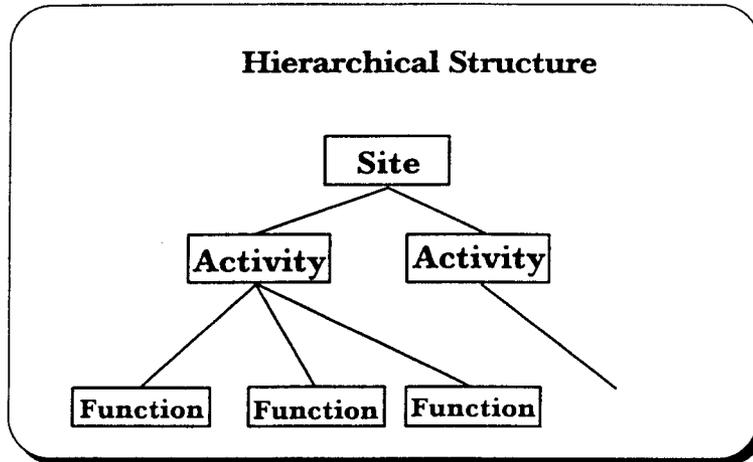
Process Products

The following table lists the various products of the analytical approach defined in this document.

Process products	Description
Capacity analyses	Develop methodology to measure the capacity of a site or activity to perform a function. Use data call responses to calculate capacities.
Requirements analyses	For each function, develop methodology to estimate the out-year DoD requirement to perform the function. Calculate the required capacity and identify excess capacity reduction goals.
Functional value (FV) assessments	Develop measures and weights for assessing the value of performing a function at a site or an activity based upon data call responses. Compute FV for all appropriate functions and site/activity combinations.
Optimize functional requirement allocations (preliminary formulation)	Find the best allocation of functional requirements to sites or activities based solely upon functional capacities and functional values.
Optimize allocations of functional requirements to high military value sites or activities (primary formulations)	Develop solutions based upon the first three products, above, and policy imperatives. Solutions will be developed using the optimization formulations described later in this document as a tool to explore alternatives.

Hierarchical Structure

The Office of the Secretary of Defense (OSD), the departments, and other groups all use different terms to describe the various components of infrastructure that are to be considered by the JCSGs. In this document a *site* refers to an installation, base, or station. An *activity* refers to a component of the site such as depot or test facility residing on the site. A site may have one or more activities. A *function* is the capability to perform a particular support action or produce a particular commodity. A common support function is a function. An activity includes a collection of functions. For example, a depot (an activity) may repair engines and airframes. These would be two functions performed at this activity. A function may be further broken down into subfunctions or facilities required to perform functions, but the approach described here does not consider the subfunctions or facilities. Subfunctions or facilities can be incorporated into the process described here if the appropriate data is available. The following diagram illustrates this hierarchical structure.



Data Elements

The analytical approach assumes that the following data will be available for all of the sites and functions under review by the JCSGs:

Data Elements	Description
mv_s	Military value of site s expressed as 3 (high), 2 (medium), or 1 (low).
fv_{sf}	Functional value for performing function f at site/activity s expressed as a number from 0 (low) to 100 (high).
cap_{sf}	Capacity of site/activity s to perform function f .
req_f	The total DoD requirement or goal to perform function f .

The military value of a site, mv_s , should measure the overall value of the site to the department in terms of the four DoD criteria: readiness, facilities, mobilization, and cost and manpower. Since sites that remain open after the BRAC process is complete will be the only resources available for many years into the future, it is imperative that this analytical process make the best use of those sites having the highest utility to the department. Each department should plan to band all of their sites under consideration by any joint cross-service group into three relatively equal-sized sets.

The JCSGs will develop methods to determine the functional value for performing functions at sites or activities. The methodologies must use data that is available in the joint data call responses. The Tri-Department BRAC Team will use the data call responses to calculate functional values. The military departments will provide the military value for each site.

The fv_{sf} functional value for performing function f at site (or activity) s should measure the capability and quality of performing work of type f at site (or activity) s . Since the two formulations described below consider capacity in the allocation of cross-service functions to sites or activities, functional capacity should not be an element of functional value. Capacity to

perform a specialized subfunction that is not one of the functions called out in the formulation can be considered in calculating functional value.

Optimization Formulations

The mixed integer linear programming (MILP) model formulations, that are described below, will serve as the basic analytical tools to be used by the JCSGs. The JCSGs may modify these formulations with the consent of all of the military departments. Modifications would include the incorporation of policy imperatives.¹

Preliminary Formulation.

The preliminary formulation of the optimization problem will be solved once the initial data (fv_{sf} , cap_{sf} , req_f) are available. This formulation, called **MAXFV** will maximize the functional values weighted by the assigned workload with no constraints other than the functional capacities at each site and meeting the DoD requirement for each cross-service function. The output from this formulation will be provided to the JCSGs and the departments to be used at their discretion. This solution will serve as a baseline of what is possible if no other factors, such as military values of sites or costs, are considered.

For each function, this formulation will load as much of the functional DoD requirement as it can into the site or activity having the highest functional value for that function. If that site or activity does not have the capacity to accommodate the full requirement, the site or activity having the next highest functional value will be allocated any remaining requirement up to its capacity, and so on.

The mathematical description of this formulation follows:

$$\text{Maximize } \sum_{s \in S} \sum_{f \in F} l_{sf} \times fv_{sf} \\ l_{sf}$$

subject to :

$$\sum_{s \in S} l_{sf} = req_f : \text{ for all functions } f \in F,$$

$$\sum_{f \in F} l_{sf} \leq o_s \times \sum_{g \in F} cap_{sg} : \text{ for all sites } s \in S,$$

$$o_s \leq \sum_{f \in F} l_{sf} : \text{ for all sites } s \in S,$$

$$0 \leq l_{sf} \leq cap_{sf} : \text{ for all functions } f \in F \text{ and sites } s \in S;$$

$$0 \leq o_s \leq 1, \text{ integer} : \text{ for all sites } s \in S;$$

where

$S =$ The set of all sites under consideration by joint cross-service groups;

¹A *policy imperative* is a statement that restricts the solutions that are acceptable and that can be modeled as a constraint in the formulation. An example of a policy imperative is included in one of the examples.

$F =$ The set of all functions under consideration by joint cross-service groups;
 $o_s =$ 1 if any functional requirement is assigned to the site, and 0 otherwise;

Decision variable

$l_{sf} =$ amount of the DoD requirement for function f to be assigned to site s .

The o_s variables are included in this formulation only to keep count of the number of sites that actually have some functional requirement assigned to them. Their inclusion in the model does not affect the assignment of the functional requirement to sites or activities. The two constraints involving the o_s variables are used to ensure that these variables are set to the correct values.

Primary Formulations

These formulations will also be used by the JCSGs to explore potential cross-service functional alternatives. The basic formulation is shown below. Specification of the objective function, $f(o_s, l_{ig}, k_{uh})$, will create a different optimization problem.

Minimize $f(o_s, l_{ig}, k_{uh})$

o_s, l_{ig}, k_{uh}

subject to

$$\sum_{s \in S} l_{sf} = req_f : \text{for all functions } f \in F,$$

$$\sum_{f \in F} l_{sf} \leq o_s \times \sum_{g \in F} cap_{s,g} : \text{for all sites } s \in S,$$

$$o_s \leq \sum_{f \in F} l_{sf} : \text{for all sites } s \in S,$$

$$0 \leq l_{sf} \leq k_{sf} \times cap_{s,f} : \text{for all functions } f \in F \text{ and sites } s \in S,$$

$$0 \leq o_s \leq 1, \text{ integer} : \text{for all sites } s \in S,$$

$$0 \leq k_{sf} \leq 1, \text{ integer} : \text{for all sites } s \in S \text{ and functions } f \in F,$$

where

$S =$ The set of all sites under consideration by joint cross-service groups;

$F =$ The set of all functions under consideration by joint cross-service groups;

Decision variables

$o_s =$ 1 if any cross-service functional requirements are assigned to the site or activity, 0 otherwise;

$l_{sf} =$ amount of the DoD requirement for function f to be assigned to site or activity s .

$k_{sf} =$ 1 if any DoD requirement for function f is to be assigned to site s , 0 otherwise.

Three different optimization formulations are discussed next that vary only in the specification of the objective function.

The MINNMV Formulation. This formulation will find a small number of sites having the highest military value that can accommodate the DoD required workload. In addition, it will assign the DoD requirement for each cross-service function to the retained sites (or activities) having the highest functional value for that function. The purpose of this formulation is to assign, to the extent possible, the cross-service functional requirements to sites or activities having high military value and high functional values. The rationale for this approach is that sites having high military value are the ones most likely to be retained by the military departments. The objective function for this formulation is as follows:

$$\text{Minimize } f(o_s, l_{tg}, k_{uh}) = w \times \sum_{s \in S} o_s \times nmv_s - \sum_{t \in S} \sum_{g \in F} l_{tg} \times fv_{tg}$$

o_s, l_{tg}

where

$w =$ weight parameter used to vary the emphasis between military value and functional value, and

$$nmv_s = 4 - mv_s.$$

This formulation will be referred to as the **MINNMV** model since it minimizes the sum of $4 - mv_s$ for retained sites or activities. Site or activities having a high military value (3) will have 1 as their value. Site or activities with low military value (1) will have 3 as their value.

The weight parameter, w , can be varied to change the emphasis the formulation gives to military value versus functional value. If $w = 0$, this formulation matches the preliminary formulation (**MAXFV**) as site military value would have zero weight. Conversely, if w was set to a very large value ($w = \infty$), functional value would have no weight. The **MAXFV** and **MINNMV** formulations are the same formulation, only differing in the parameter w . Varying w in the formulation allows the model to be used to create a family of solutions. These points are illustrated by an example in the next section.

The component of the objective function that addresses military value of sites, $\sum_{s \in S} o_s \times nmv_s = \sum_{s \in S} o_s \times (4 - mv_s)$, affects the optimal solution as follows. (For this discussion we will ignore the functional value component of the objective function, $-\sum_{t \in S} \sum_{g \in F} l_{tg} \times fv_{tg}$.)

If there were no constraints in the formulation, i.e., satisfy the DoD requirement, the minimum value of the objective function would be achieved by setting $o_s = 0$ for all sites since $4 - mv_s \geq 1$ for all sites. Given that some sites have to be open, all else being equal, it is better to open a site with $mv_s = 3$ because it increases the objective function by the least amount.

The MINXCAP Formulation. If the parameter w is set to a large value, this problem formulation will find the set of retained sites having the smallest total functional capacity but still able to perform the DoD functional requirement. Depending on w , functional assignments are also optimized. The objective function for this formulation is:

$$\text{Minimize } f(o_s, l_{tg}, k_{uh}) = w \times \sum_{s \in S} o_s \times \left(\sum_{f \in F} cap_{sf} \right) - \sum_{t \in S} \sum_{g \in F} l_{tg} \times fv_{tg}$$

o_s, l_{tg}, k_{uh}

If $w = 0$, this formulation, like the **MINNMV** formulation, is also equivalent to the **MAXFV** formulation. If w is set to a large value, excess capacity is reduced as much as possible without regard to functional values.

The MINSITES Formulation. This formulation, depending on the value of w , will find the minimum-sized set of site or activities that can perform the DoD functional requirement. As in the previous formulations, if $w = 0$, this formulation is also equivalent to **MAXFV**. The objective function for this formulation is given by:

$$\text{Minimize } f(o_s, l_{tg}, k_{uh}) = w \times \sum_{s \in S} o_s - \sum_{t \in S} \sum_{g \in F} l_{tg} \times fv_{tg}$$

o_s, l_{tg}, k_{uh}

If w is set to a large value, the cross-service functional workload is assigned to the smallest possible number of sites regardless of functional values.

Policy Imperatives

A policy imperative is any statement that can be formulated as a constraint in the model. The model described here is very flexible in its capacity to handle imperatives. Examples of imperatives that can be modeled include:

- assigning functions in groups,
- increasing the average DoD military value of the sites assigned any cross-service functional workload,
- requiring the weighted functional value for a given common support function to be at least as great as some value,
- limiting the number of sites that have any cross-service functional workload assigned to them,
- requiring that each department's average military value is not allowed to go below some level,
- requiring a certain number of sites in a geographic area to remain open, and
- requiring the distribution of functional workload to follow a certain pattern, e.g., in one department, in one location, or on both coasts.

This is not an exhaustive list of the possibilities for policy imperatives. An example of a policy imperative added to the **MINNMV** formulation is given in the following section.

Consistent Alternatives

The functional data and constraints from all of the JCSGs may be combined into a single formulation since the functions of different JCSGs should be independent. In the event that two

JCSGs obtain solutions that are inconsistent in that the solutions have a site or activity receiving cross-service functional workload in one and losing all of its cross-service functional workload in the other, this capability can be used to resolve the inconsistency.

Optimization Examples

The following examples use representative, notional data to demonstrate the formulations. Three different departments, X, Y, and Z, each have 5 sites (A, B, C, D, and E). Six functions are considered: air vehicles, munitions, electronic combat, fixed-wing avionics, conventional missiles and rockets, and satellites. Table 1 shows the basic data for these sites.

Table 2 shows the DoD requirement by function and the percent of excess capacity. Percent excess capacity is calculated as

$$100 \times \left(\frac{\sum_{s \in S} cap_{sf}}{req_f} - 1 \right).$$

Preliminary Formulation (MAXFV).

Results for the **MAXFV** formulation are shown in table 3. If there is no functional requirement assigned to a site, the capacity for that function is shown as zero at that site even if the site has requirements for other functions assigned. Notice that, for this solution, *all sites have some cross-service functional workload assigned.*

The column in table 3 labeled *Wgt FV* shows the weighted functional value for each function. *Wgt FV* for function $f \in F = \frac{\sum_{s \in S} f_{v_{sf}} \times req_{sf}}{\sum_{s \in S} req_{sf}}$. *Wgt FV* is an indicator of the quality of the cross-service allocation of the functional requirement across all sites and activities.

Primary Formulation (MINNMV).

Table 4 shows the data for the optimal solution to the **MINNMV** formulation. The number of sites having cross-service functional workload assigned has been reduced from 15 to six. Excess capacity is greatly reduced. The DoD military value average is increased by 21.2 percent. The military value averages for the departments have all been increased. The weighted functional value scores are not as good as the scores obtained from the (**MAXFV**) formulation.

The weight variable, w , was set to 100000 for this example. This value was chosen to make sure that military value of the sites dominates the functional allocations. The large value is necessary because, for this example, functional requirements are measured in thousands while the use or do not use variables, o_s , are either 0 or 1 and nmv_s is 1, 2, or 3.

Primary Formulation (MINNMV) with Policy Imperative

As an example of a policy imperative, consider the following. Suppose the JCSG responsible for the missile function determines that only three sites should perform the conventional missiles and rockets function. The optimal solution to the original **MINNMV** formulation assigned the missile function to six different sites. Modifying the **MINNMV** formulation such

that only three sites are allowed to perform the missile function results in the solution shown in table 5. The same six sites are shown as in use for cross-service functions, but the missile function is assigned to only three sites. Since the model has an additional constraint, the weighted functional value for the conventional missiles and rockets function has decreased compared to the original **MINNMV** formulation.

Parameterization of the **MINNMV** Formulation

Table 6 summarizes the results of varying the parameter w in the **MINNMV** formulation over the values 0, 300, 1,000, 5,000, 7,000, 8,000, 10,000, 20,000, 40,000, 60,000, and 100,000. As is to be expected, the number of sites and activities with cross-service functional workload assigned, the percent of excess capacity, and weighted functional value decrease as w increases. With two exceptions, the decline in weighted functional value is not great compared to the significant decreases in excess capacity. Though these results pertain only to this particular example, they clearly illustrate qualitative differences between the **MAXFV** and **MINNMV** formulations.

This example illustrates how the parameter w can be used to generate a family of cross-service functional solutions. For instance, a JCSG with this table before it could decide that from this family of solutions, the solution obtained by setting $w = 20000$ is worth exploring further since the weighted functional values are very close to the best values obtained in the **MAXFV** formulation and the remaining excess capacity has been significantly reduced.

Figure 1 displays this information in graphical form. The figure shows the sharp decrease in the average functional value for conventional missiles and rockets when going from eight sites with any cross-service functional workload assigned to seven. The figure also displays the increase in average military value that is achieved by using the **MINNMV** formulation.

Primary Formulation (**MINXCAP**)

Table 7 shows the output of the **MINXCAP** formulation with $w = 100000$. As would be expected, this formulation produces a solution that greatly reduces excess capacity, but the weighted functional values have suffered.

Primary Formulation (**MINSITES**)

The results of using the **MINSITES** formulation are given in table 8. The w parameter was set to 100000. For this particular example, this formulation gives the same result as the **MINNMV** formulation.

Optimization Software

The solutions to these optimization problems were obtained using the commercially-available, IBM Optimization Subroutine Library (OSL)² interfaced with AMPL³. The text file

²Optimization with OSL by Ming S. Hung, Walter O. Rom, and Allan D. Waren, published by The Scientific Press.

describing these formulations in the AMPL format is contained in appendix A. Note that all of the different objective functions are defined in this single text file. The AMPL-format data file for the example is given in appendix B. These files are processed by the AMPL/OSL package to produce the outputs discussed in the examples section of this document.

³*AMPL: A Modeling Language for Mathematical Programming* by Robert Fourer, David M. Gay, and Brian Kernighan, published by The Scientific Press, 1993.

**Table 1. Joint Cross-Service Groups Analysis Examples
Basic Data**

Function	Department															Totals
	X					Y					Z					
	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E	
Capacities																
Air vehicles	450	7000	2500	0	0	5000	500	0	0	0	3000	1200	0	2857	0	22,507
Munitions	850	200	4500	0	0	300	0	2000	0	0	1000	0	1000	0	0	9,850
Electronic combat	3000	0	0	0	0	1000	0	0	0	0	2000	0	0	1543	20	7,563
Fixed-wing avionics	0	0	250	3500	0	0	0	400	3500	0	1000	4000	0	2000	500	15,150
Conv. missiles/rockets	0	0	200	0	3000	0	0	200	100	2000	3000	700	200	300	200	9,900
Satelites	0	0	300	4000	0	0	0	500	0	0	250	50	0	300	2200	7,600
Function FV Scores																
Air vehicles	50	70	68	0	0	57	72	0	0	0	81	92	0	86	0	
Munitions	88	71	58	0	0	54	0	88	0	0	72	0	75	0	0	
Electronic combat	67	0	0	0	0	91	0	0	0	0	52	0	0	78	77	
Fixed-wing avionics	0	0	92	94	0	0	0	78	69	0	72	93	0	66	71	
Conv. missiles/rockets	0	0	62	0	89	0	0	59	93	92	56	59	50	65	91	
Satelites	0	0	71	58	0	0	0	64	0	0	85	61	0	73	93	
Department Military Value	3	3	3	2	1	2	1	3	2	1	3	3	2	3	1	

Table 2. Functional Requirement Data

Function	Requirement	Percent excess
Air vehicles	9,463	137.8
Munitions	5,503	79.0
Electronic combat	3,234	133.9
Fixed-wing avionics	3,775	301.3
Conv. missiles/rockets	3,743	164.5
Satelites	2,480	206.5

Table 3. MAXFV Model Output

Function	Department															Retained totals	Percent excess
	X					Y					Z						
	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E		
Retain=1, Close=0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	15	
Capacities																	
Air vehicles	0	7000	0	0	0	0	500	0	0	0	3000	1200	0	2857	0	14557	53.8
Munitions	850	200	4500	0	0	0	0	2000	0	0	1000	0	1000	0	0	9550	73.5
Electronic combat	3000	0	0	0	0	1000	0	0	0	0	0	0	0	1543	20	5563	72.0
Fixed-wing avionics	0	0	0	3500	0	0	0	0	0	0	0	4000	0	0	0	7500	98.7
Conv. missiles/rockets	0	0	0	0	3000	0	0	0	100	2000	0	0	0	0	200	5300	41.6
Satellites	0	0	0	0	0	0	0	0	0	0	250	0	0	300	2200	2750	10.9
Workload assigned																	
Air vehicles	0	1906	0	0	0	0	500	0	0	0	3000	1200	0	2857	0	9463	
Munitions	850	200	453	0	0	0	0	2000	0	0	1000	0	1000	0	0	5503	
Electronic combat	671	0	0	0	0	1000	0	0	0	0	0	0	0	1543	20	3234	
Fixed-wing avionics	0	0	0	3500	0	0	0	0	0	0	0	275	0	0	0	3775	
Conv. missiles/rockets	0	0	0	0	1443	0	0	0	100	2000	0	0	0	0	200	3743	
Satellites	0	0	0	0	0	0	0	0	0	0	250	0	0	30	2200	2480	
Department average MV			2.4					1.8					2.4				
Percent change			-0.0					0.0					-0.0				
DoD average MV								2.20									
Percent change								0.0									

DoD weighted FVs	
Function	Wgt FV
Air vehicles	81.2
Munitions	79.6
Electronic combat	79.7
Fixed-wing avionics	93.9
Conv. missiles/rockets	90.8
Satellites	92.0

Table 4. MINNMV Model Output

Function	Department															Retained totals	Percent excess
	X					Y					Z						
	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E		
Retain=1, Close=0	0	0	1	1	0	0	0	1	0	0	1	1	0	1	0	6	
Capacities																	
Air vehicles	0	0	2500	0	0	0	0	0	0	0	3000	1200	0	2857	0	9557	1.0
Munitions	0	0	4500	0	0	0	0	2000	0	0	1000	0	0	0	0	7500	36.3
Electronic combat	0	0	0	0	0	0	0	0	0	0	2000	0	0	1543	0	3543	9.6
Fixed-wing avionics	0	0	0	3500	0	0	0	0	0	0	0	4000	0	0	0	7500	98.7
Conv. missiles/rockets	0	0	200	0	0	0	0	200	0	0	3000	700	0	300	0	4400	17.6
Satelites	0	0	300	4000	0	0	0	500	0	0	250	50	0	300	0	5400	117.7
Workload assigned																Totals	
Air vehicles	0	0	2406	0	0	0	0	0	0	0	3000	1200	0	2857	0	9463	
Munitions	0	0	2503	0	0	0	0	2000	0	0	1000	0	0	0	0	5503	
Electronic combat	0	0	0	0	0	0	0	0	0	0	1691	0	0	1543	0	3234	
Fixed-wing avionics	0	0	0	3500	0	0	0	0	0	0	0	275	0	0	0	3775	
Conv. missiles/rockets	0	0	200	0	0	0	0	200	0	0	2343	700	0	300	0	3743	
Satelites	0	0	300	1080	0	0	0	500	0	0	250	50	0	300	0	2480	
Department average MV			2.5					3.0					3.0				
Percent change			4.2					68.7					25.0				
DoD average MV								2.83									
Percent change								28.8									

DoD weighted FVs	
Function	Wgt FV
Air vehicles	80.6
Munitions	71.4
Electronic combat	64.4
Fixed-wing avionics	93.9
Conv. missiles/rockets	57.8
Satelites	65.4

Table 5. MINNMV with Policy Imperative Model Output

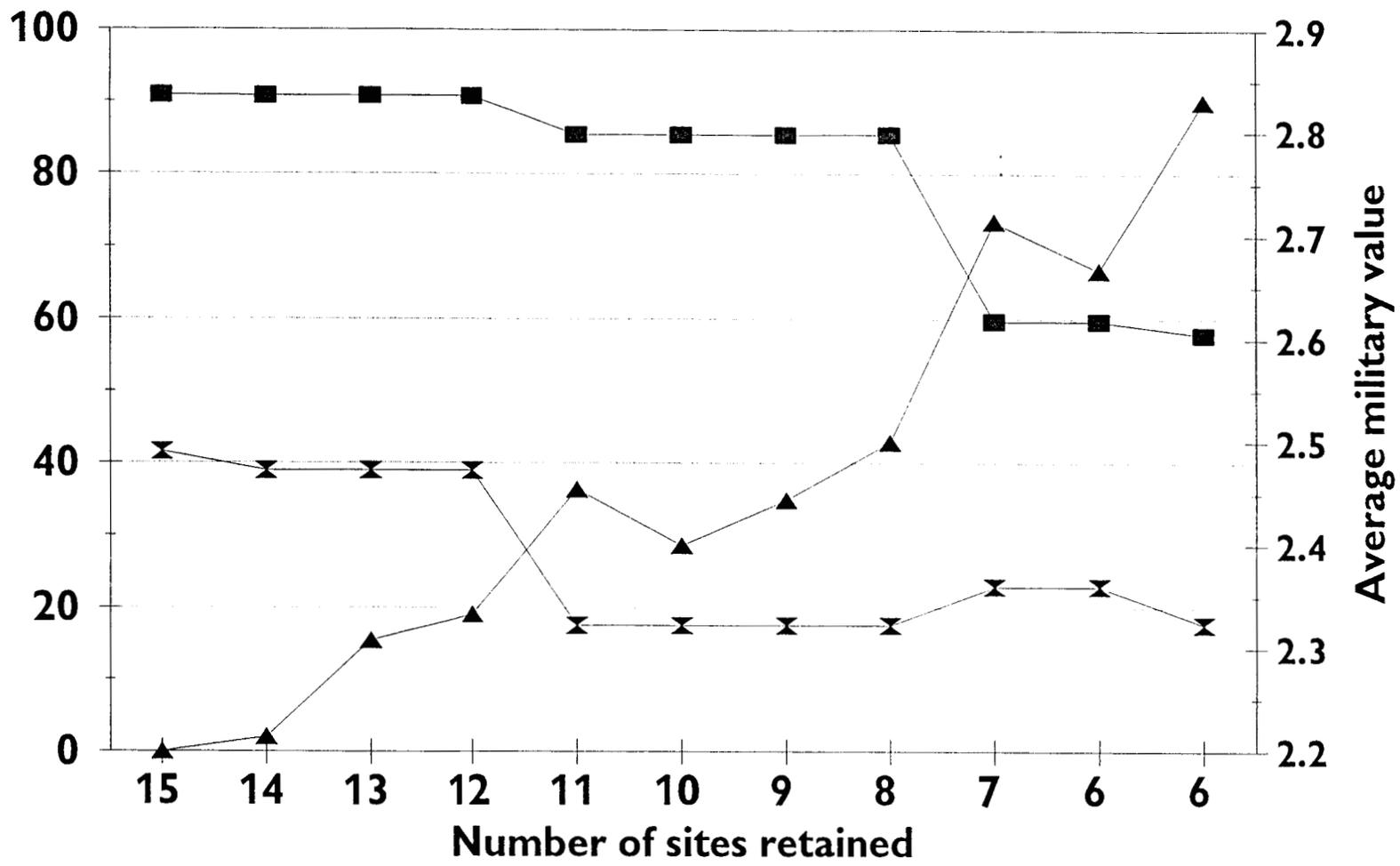
Function	Department															Retained totals	Percent excess
	X					Y					Z						
	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E		
Retain=1, Close=0	0	0	1	1	0	0	0	1	0	0	1	1	0	1	0	6	
Capacities																	
Air vehicles	0	0	2500	0	0	0	0	0	0	0	3000	1200	0	2857	0	9557	1.0
Munitions	0	0	4500	0	0	0	0	2000	0	0	1000	0	0	0	0	7500	36.3
Electronic combat	0	0	0	0	0	0	0	0	0	0	2000	0	0	1543	0	3543	9.6
Fixed-wing avionics	0	0	0	3500	0	0	0	0	0	0	0	4000	0	0	0	7500	98.7
Conv. missiles/rockets	0	0	0	0	0	0	0	0	0	0	3000	700	0	300	0	4000	6.9
Satellites	0	0	300	4000	0	0	0	500	0	0	250	50	0	300	0	5400	117.7
Workload assigned																Totals	
Air vehicles	0	0	2406	0	0	0	0	0	0	0	3000	1200	0	2857	0	9463	
Munitions	0	0	2503	0	0	0	0	2000	0	0	1000	0	0	0	0	5503	
Electronic combat	0	0	0	0	0	0	0	0	0	0	1691	0	0	1543	0	3234	
Fixed-wing avionics	0	0	0	3500	0	0	0	0	0	0	0	275	0	0	0	3775	
Conv. missiles/rockets	0	0	0	0	0	0	0	0	0	0	2743	700	0	300	0	3743	
Satellites	0	0	300	1080	0	0	0	500	0	0	250	50	0	300	0	2480	
Department average MV			2.5					3.0					3.0				
Percent change			4.2					66.7					25.0				
DoD average MV								2.83									
Percent change								28.8									

DoD weighted FVs	
Function	Wgt FV
Air vehicles	80.6
Munitions	71.4
Electronic combat	64.4
Fixed-wing avionics	93.9
Conv. missiles/rockets	57.3
Satellites	65.4

Table 6. Parameterization of the MINNMV Model

	Parameter w										
	0 MAXFV	300	1000	5000	7000	8000	10000	20000	40000	60000	100000 MINNMV
Sites/activities open	15	14	13	12	11	10	9	8	7	6	6
Percent excess											
Air vehicles	53.8	53.8	48.5	48.5	48.5	1.0	1.0	1.0	1.0	1.0	1.0
Munitions	73.5	73.5	73.5	73.5	73.5	69.9	51.7	51.7	51.7	36.3	36.3
Electronic combat	72.0	72.0	72.0	72.0	72.0	72.0	72.0	41.1	41.1	10.2	9.6
Fixed-wing avionics	98.7	98.7	98.7	6.0	6.0	6.0	6.0	6.0	6.0	6.0	98.7
Conv. missiles/rockets	41.6	38.9	38.9	38.9	17.6	17.6	17.6	17.6	22.9	22.9	17.6
Satelites	10.9	10.9	10.9	10.9	10.9	10.9	10.9	10.9	10.9	10.9	117.7
Weighted FV											
Air vehicles	81.2	81.2	81.1	81.1	81.1	80.6	80.6	80.6	80.6	80.6	80.6
Munitions	79.6	79.6	79.6	79.6	79.6	79.2	76.1	76.1	76.1	71.4	71.4
Electronic combat	79.7	79.7	79.7	79.7	79.7	79.7	79.7	72.3	72.3	64.6	64.4
Fixed-wing avionics	93.9	93.9	93.9	93.0	93.0	93.0	93.0	93.0	93.0	93.0	93.9
Conv. missiles/rockets	90.8	90.7	90.7	90.7	85.4	85.4	85.4	85.4	59.6	59.6	57.8
Satelites	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	65.4
DoD average MV	2.20	2.21	2.31	2.33	2.45	2.40	2.44	2.50	2.71	2.67	2.83

Figure 1. Comparison of Alternatives



▲ Average military value ■ Missile avg. functional value
 × Percent excess capacity

Table 7. MINXCAP Model Output

Function	Department															Retained totals	Percent excess
	X					Y					Z						
	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E		
Retain=1, Close=0	1	0	1	0	1	1	1	0	0	0	0	1	0	0	1	7	
Capacities																	
Air vehicles	450	0	2500	0	0	5000	500	0	0	0	0	1200	0	0	0	9650	2.0
Munitions	850	0	4500	0	0	300	0	0	0	0	0	0	0	0	0	5650	2.7
Electronic combat	3000	0	0	0	0	1000	0	0	0	0	0	0	0	20	4020	24.3	
Fixed-wing avionics	0	0	0	0	0	0	0	0	0	0	0	4000	0	0	4000	6.0	
Conv. missiles/rockets	0	0	200	0	3000	0	0	0	0	0	0	700	0	0	200	4100	9.5
Satelites	0	0	300	0	0	0	0	0	0	0	0	0	0	2200	2500	0.8	
Workload assigned																Totals	
Air vehicles	263	0	2500	0	0	5000	500	0	0	0	0	1200	0	0	0	9463	
Munitions	850	0	4500	0	0	153	0	0	0	0	0	0	0	0	0	5503	
Electronic combat	2214	0	0	0	0	1000	0	0	0	0	0	0	0	20	3234		
Fixed-wing avionics	0	0	0	0	0	0	0	0	0	0	0	3775	0	0	3775		
Conv. missiles/rockets	0	0	200	0	3000	0	0	0	0	0	0	343	0	0	200	3743	
Satelites	0	0	280	0	0	0	0	0	0	0	0	0	0	2200	2480		
Department average MV			2.3					1.5					2.0				
Percent change			-2.8					-16.7					-16.7				
DoD average MV								2.00									
Percent change								-9.1									

DoD weighted FVs	
Function	Wgt FV
Air vehicles	64.9
Munitions	62.5
Electronic combat	74.5
Fixed-wing avionics	93.0
Conv. missiles/rockets	84.9
Satelites	90.5

Table 8. MINSITES Model Output

Function	Department															Retained totals	Percent excess
	X					Y					Z						
	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E		
Retain=1, Close=0	0	0	1	0	0	0	0	1	0	0	1	1	0	1	1	6	
Capacities																	
Air vehicles	0	0	2500	0	0	0	0	0	0	0	3000	1200	0	2857	0	9557	1.0
Munitions	0	0	4500	0	0	0	0	2000	0	0	1000	0	0	0	0	7500	36.3
Electronic combat	0	0	0	0	0	0	0	0	0	0	2000	0	0	1543	20	3563	10.2
Fixed-wing avionics	0	0	0	0	0	0	0	0	0	0	0	4000	0	0	0	4000	6.0
Conv. missiles/rockets	0	0	200	0	0	0	0	200	0	0	3000	700	0	300	200	4600	22.9
Satellites	0	0	0	0	0	0	0	0	0	0	250	0	0	300	2200	2750	10.9
Workload assigned																	
Air vehicles	0	0	2406	0	0	0	0	0	0	0	3000	1200	0	2857	0	9463	
Munitions	0	0	2503	0	0	0	0	2000	0	0	1000	0	0	0	0	5503	
Electronic combat	0	0	0	0	0	0	0	0	0	0	1671	0	0	1543	20	3234	
Fixed-wing avionics	0	0	0	0	0	0	0	0	0	0	0	3775	0	0	0	3775	
Conv. missiles/rockets	0	0	200	0	0	0	0	200	0	0	2143	700	0	300	200	3743	
Satellites	0	0	0	0	0	0	0	0	0	0	250	0	0	30	2200	2480	
Department average MV			3.0					3.0					2.5				
Percent change			25.0					66.7					4.2				
DoD average MV								2.67									
Percent change								21.2									

DoD weighted FVs	
Function	Wgt FV
Air vehicles	80.6
Munitions	71.4
Electronic combat	64.6
Fixed-wing avionics	93.0
Conv. missiles/rockets	59.6
Satellites	92.0

Appendix A
AMPL Model Input File

```

# JCSG Model Examples

# Ron Nickel
# 6-8-94

set X_sites;           # The set of Department X sites.
set Y_sites;           # The set of Department Y sites.
set Z_sites;           # The set of Department Z sites.

set SITE := X_sites union Y_sites union Z_sites;
                    # The set of all labs and T&E sites.

set FUNC;              # The set of functions.

param no_func := card(FUNC);    # The number of function types.

# Define the set performing missile functions.

set MISSLE_FUNC within {FUNC};

param missile_sites >= 0, default 15;
                    # Number of sites allowed to perform the
                    # missile function. Used in the policy
                    # imperative example (missile_sites = 3).

param CAP {SITE, FUNC}; # The functional capacity at each site for each
                    # function.

param REQ {FUNC};      # The DoD requirement for each function.

param MV {SITE};       # Military value for each site.

param NMV {s in SITE} := 4 - MV[s];    # Negative MV scoring.

param FV {SITE, FUNC} >= 0.0;    # Functional value by site and function.

param WGT >= 0, default 100000; # Scaling weight for objective function.
                    # If WGT = 0, this formulation is equivalent
                    # to the MAXFV formulation.

#
# Decision variables
#

var OPEN {SITE} binary >= 0;    # Open or closed decision variable for
                    # each site.

var SITE_LOAD {s in SITE, f in FUNC} >= 0.0;
                    # Amount of the requirement for function f to
                    # be assigned to site s . Amount assigned
                    # is limited by capacity of site s to perform
                    # function f.

var SITE_FUNC {s in SITE, f in FUNC} binary;
                    # 1 if any assignment of workload for function
                    # f is made to site s; 0 otherwise.

```

```

#
# Objective Function.
#

# Minimize total open site negative military value and
# maximize the FV-weighted assignment of functional workload to sites.

minimize MINNMV:
    WGT * sum {s in SITE} OPEN[s]*NMV[s]
        - sum {t in SITE, g in FUNC} FV[t,g]*SITE_LOAD[t,g];

# Minimize the number of open sites and maximize the FV-weighted
# assignment of functional workload to sites.

minimize MINSITES:
    WGT * sum {s in SITE} OPEN[s]
        - sum {t in SITE, g in FUNC} FV[t,g]*SITE_LOAD[t,g];

# Minimize total capacity and maximize the FV-weighted assignment
# of functional workload to sites.

minimize MINXCAP:
    WGT * sum {s in SITE} OPEN[s] *(sum {f in FUNC} CAP[s,f])
        - sum {t in SITE, g in FUNC} FV[t,g]*SITE_LOAD[t,g];

#
# Constraints
#

# The requirement for each function has to be met.

subject to func_assgn {f in FUNC}:
    sum {s in SITE} SITE_LOAD[s,f] = REQ[f];

# Cannot assign functional workload to a site unless
# the site is open for assignment of that function.

subject to func_open {f in FUNC, s in SITE}:
    SITE_LOAD[s,f] <= SITE_FUNC[s,f]*CAP[s,f];

# Sites with no functional requirement assigned
# are closed.

subject to site_closed {s in SITE}:
    OPEN[s] <= sum {f in FUNC} SITE_FUNC[s,f];

# Allocation of functional requirements cannot be made
# to sites that are not open.

subject to site_open {s in SITE}:
    sum {f in FUNC} SITE_FUNC[s,f] <= OPEN[s] * no_func;

# This constraint is an example of a policy imperative.
# Constrain the number of sites doing munitions work.

subject to missile_3 {f in MISSLE_FUNC}:
    sum {s in SITE} SITE_FUNC[s,f] <= missile_sites;

```

Appendix B
AMPL Data Input File

Data file for JCSG optimization examples.

Ron Nickel

6-8-94

set X_sites :=

X_A
X_B
X_C
X_D
X_E;

set Y_sites :=

Y_A
Y_B
Y_C
Y_D
Y_E;

set Z_sites :=

Z_A
Z_B
Z_C
Z_D
Z_E;

set FUNC :=

Air_Veh
Mun
E_Cmbt
Avion
Mis
Sat;

Used to model the policy imperative.

set MISSLE_FUNC := Mis;

param CAP:	Air_Veh	Mun	E_Cmbt	Avion	Mis	Sat :=
X_A	450	850	3000	0	0	0
X_B	7000	200	0	0	0	0
X_C	2500	4500	0	250	200	300
X_D	0	0	0	3500	0	4000
X_E	0	0	0	0	3000	0
Y_A	5000	300	1000	0	0	0
Y_B	500	0	0	0	0	0
Y_C	0	2000	0	400	200	500
Y_D	0	0	0	3500	100	0
Y_E	0	0	0	0	2000	0
Z_A	3000	1000	2000	1000	3000	250
Z_B	1200	0	0	4000	700	50
Z_C	0	1000	0	0	200	0
Z_D	2857	0	1543	2000	300	300
Z_E	0	0	20	500	200	2200;

param FV:	Air_Veh	Mun	E_Cmbt	Avion	Mis	Sat :=
X_A	50	88	67	0	0	0

X_B	70	71	0	0	0	0
X_C	68	58	0	92	62	71
X_D	0	0	0	94	0	58
X_E	0	0	0	0	89	0
Y_A	57	54	91	0	0	0
Y_B	72	0	0	0	0	0
Y_C	0	88	0	78	59	64
Y_D	0	0	0	69	93	0
Y_E	0	0	0	0	92	0
Z_A	81	72	52	72	56	85
Z_B	92	0	0	93	59	61
Z_C	0	75	0	0	50	0
Z_D	86	0	78	66	65	73
Z_E	0	0	77	71	91	93;

```

param REQ :=
Air_Veh 9463
Mun      5503
E_Cmbt  3234
Avion    3775
Mis      3743
Sat      2480;

```

```

# Banded military values for each site.
# 3 is good, 1 is bad.

```

```

param MV :=
  X_A  3
  X_B  3
  X_C  3
  X_D  2
  X_E  1
  Y_A  2
  Y_B  1
  Y_C  3
  Y_D  2
  Y_E  1
  Z_A  3
  Z_B  3
  Z_C  2
  Z_D  3
  Z_E  1;

```

Joint Cross Service Analyses

- **There has been significant discussion on what form 2d stage Joint Cross Service Analyses would take.**
- **Goal of a common analytical tool for all JCSGs**
- **Linear Programming Model proposed late May**
- **Steering Group approval 8 June - JCSGs requested to evaluate model**

Linear Programming (What is it?)

- **A mathematical technique for finding the best uses of an organization's resources**
 - **Linear describes relationship between two or more variables**
 - **Programming refers to mathematical techniques to obtain the best possible solution involving limited resources**

JCSG Proposed Linear Programming Model

- **Allows for consistent and reproducible results**
- **Model based on Joint Cross Service Group inputs and Services' assessment of installation military value**
- **Model has value for MTF JCSG because it allows for tailoring of medical unique inputs and development of medical unique constraints**
- **Only a tool - There may be valid reasons not to accept results of model (Military Judgment)**

Proposed Linear Programming Model

■ Data Required for Proposed Model

- **Functional Values.** The merit of performing a cross-service function at a given site or activity
- **Functional Capacities.** The capacity at each site to perform a given function
- **Functional Requirements.** The future requirement to perform the function at a given site
- **Military Value.** The Military Department numerical assessment of the value of each site

Four Alternative Formulations

- **Maximize functional value**
 - Model will allocate requirements to sites which have the highest functional value
- **Minimize Negative Military Value**
 - Allocates requirements to a small number of sites having the highest Military Value that can accommodate the workload
- **Minimize Excess Capacity**
 - Allocates requirements to sites having the smallest total functional capacity, but still able to perform the DoD function
- **Minimize number of Sites**
 - Allocates based on the minimum number of sites that can perform DoD functional requirement

Proposed Linear Programming Model (cont)

- **Functional value is obtained from scores of each MTF based on approved measures of merit and weighting system**

Proposed Linear Programming Model (cont)

■ Capacity and Functional Requirements

- Can be based on our current wartime and peacetime capacity measure**
 - » Projected aggregate health care bed demand**
 - » Can be MTF specific**
 - » Overlapping catchment areas**
 - » By lead agent region**
 - » Cumulative for entire system**

Policy Imperative Constraints

- MHSS Policy Imperatives can be translated to constraints within the model. Possible examples include:
 - Aggregate inpatient beds \geq Wartime bed requirements
 - Minimum of 2 acute care JCAHO accredited facilities in catchment area before realignment or closure consideration (unless base closes)

Recommendation

■ Use Linear Programming Model to conduct Medical JCSG analyses

- Model output provides additional information for management to further develop and evaluate alternatives**
- Will provide consistent and reproducible results**
- Adequate time to develop meaningful inputs**

Steering Group Projected Timeline

TASK	WHO	WHEN
Develop methodology for inputs to model	JCSGs	July
Approve model inputs methodology	Joint Steering Gp	July
Provide Data to JCSGs	Mil Depts	July
Provide site Military Value input to JCSGs	Mil Depts	August
Develop Inputs to Model	JCSGs	August
Run Unconstrained Model	Tri BRAC Gp	August
Run Constrained Model	Tri BRAC Gp	September
Analyze Results	JCSGs	October
Analyze Alternatives	Mil Depts	Nov-Dec
As of 5/31/94		

**MINUTES OF THE
MILITARY TREATMENT FACILITIES
AND GRADUATE MEDICAL EDUCATION
BRAC 95 JOINT CROSS SERVICE GROUP
MEETING OF JUNE 22, 1994**

DRAFT

The tenth meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1300 hours on June 22, 1994. The meeting was chaired by Dr. Edward D. Martin, Principal Deputy Assistant Secretary of Defense, Health Affairs.

The Chairman opened the meeting by stating the two primary reasons the group was asked to meet. First, to discuss the status/progress of various efforts and, second, to discuss the optimization model and its applicability to the MTF/GME environment. The Chairman then asked each of the members to review the minutes from the last meeting (a copy of the minutes was passed around the table).

The Group was then briefed on the status of data collection. The DoD IG representative reported that the IG's validation of centralized data sources and the reliability of data bases was 90 percent complete and no problems are anticipated. With regards to the DoD data bases, the IG is looking at the data elements that will be used during the BRAC process and the ability to verify and certify this data. The IG anticipates completion by the end of August.

The next item was that of the optimization model. The Group was told of the request made by the ASD(Economic Security) for each of the Joint Cross-Service Groups to evaluate the model with regards to its applicability and utility for the Group's respective functional areas.

After some discussion it was agreed that with one exception, all of the data necessary to run the model was being collected. Collection of beneficiary data must be expanded to include the number of retirees and their dependents. It was recommended that the Group's response to the ASD(ES) should be that the model can accommodate our needs but a data call for retirees beneficiaries was necessary.

The representative from the OASD(Program Analysis and Evaluation) stated that the model should be run on wartime requirements also. After some discussion the Chairman agreed to evaluate a methodology for doing so if PA&E would devise one.

DRAFT

The Chairman restated the Group's position on the optimization model: Given the peacetime requirements, and the data the Group originally planned to gather, the model will work. In the interim the working group will continue to evaluate the model and develop constraints for its application.

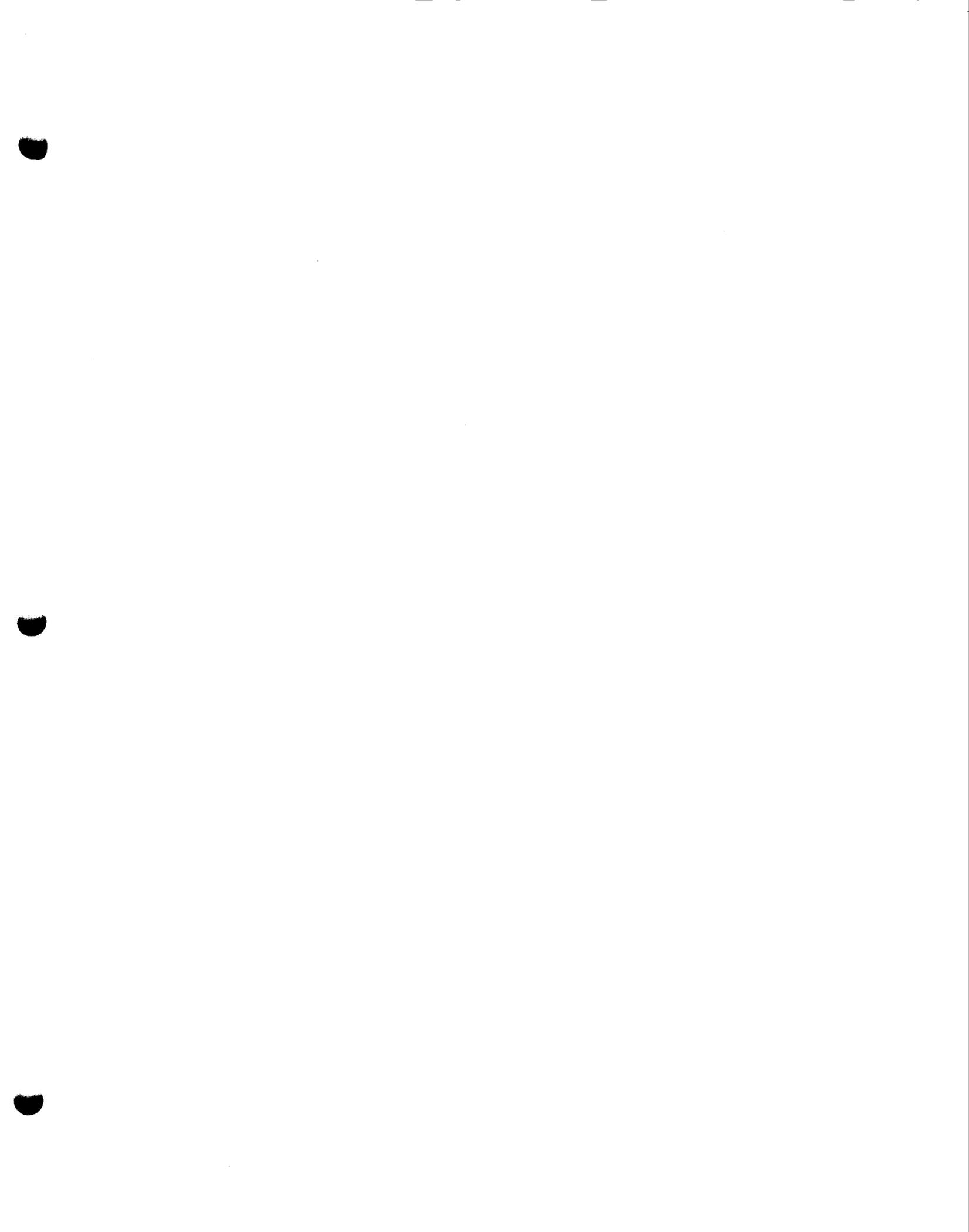
DRAFT

The meeting adjourned at 1400 hrs. The next meeting will be at the call of the Chairman.

Approved Edward D. Martin
Edward D. Martin, MD
PDASD(Health Affairs)

Attachments

DRAFT



DRAFT

MINUTES OF THE
MILITARY TREATMENT FACILITIES
AND GRADUATE MEDICAL EDUCATION
BRAC 95 JOINT CROSS SERVICE GROUP
MEETING OF AUGUST 1, 1994

The eleventh meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1400 hours on August 1, 1994. The meeting was chaired by Dr. Edward D. Martin, Principal Deputy Assistant Secretary of Defense, Health Affairs.

The Chairman opened the session by reminding the members that the issue of wartime requirements was raised by the ODASD(PA&E) at the last meeting and that the working group and PA&E were to work together to resolve this issue.

The members were then briefed on the results of the working group's review:

- o No changes were recommended to implementation of the facility score and integer program methodologies
- o There would be no new data calls
- o The Group should evaluate the ability of the remaining infrastructure to support the required wartime requirements, both by type and service (This proposal was subsequently approved by the members)

A comment was made that if we do {establish constraints} the optimization model correctly we should be at or near the wartime bed requirement floor. The importance of the geographic location of the beds was also raised. The Chairman agreed that geographic location was important, but an analysis at this time would be premature.

Minor adjustments to the Measures of Merit were presented to the Group and approved.

The Group was also asked to approve the removal of Health Clinics as a category for study under BRAC 95. After some discussion the proposal was approved. It was decided, however, that the working group should develop recommendations on how many active duty and dependents of active duty personnel should justify the presence of a health clinic.

A report on the progress of the working group's efforts vis-a-vis the optimization followed. Notional data was being run with output expected within a day or two. Proposed policy constraints were offered for the Group's consideration.

DRAFT

DRAFT

Timelines for the remainder of the Group's BRAC 95 efforts were then discussed. It was noted that these may change based on input from other Groups, OSD, etc.

The Chairman restated the need to reduce the size of the Group once certified data is received.

The meeting adjourned at 1450 hrs. The next meeting will be at the call of the Chairman.

Approved Edward D. Martin
Edward D. Martin, MD
PDASD(Health Affairs)

Attachments

DRAFT

DRAFT

**MINUTES OF THE
MILITARY TREATMENT FACILITIES
AND GRADUATE MEDICAL EDUCATION
BRAC 95 JOINT CROSS SERVICE GROUP
MEETING OF AUGUST 1, 1994**

The eleventh meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1400 hours on August 1, 1994. The meeting was chaired by Dr. Edward D. Martin, Principal Deputy Assistant Secretary of Defense, Health Affairs.

The Chairman opened the session by reminding the members that the issue of wartime requirements was raised by the ODASD(PA&E) at the last meeting and that the working group and PA&E were to work together to resolve this issue.

The members were then briefed on the results of the working group's review:

- o No changes were recommended to implementation of the facility score and integer program methodologies
- o There would be no new data calls
- o The Group should evaluate the ability of the remaining infrastructure to support the required wartime requirements, both by type and service (This proposal was subsequently approved by the members)

A comment was made that if we do {establish constraints} the optimization model correctly we should be at or near the wartime bed requirement floor. The importance of the geographic location of the beds was also raised. The Chairman agreed that geographic location was important, but an analysis at this time would be premature.

Minor adjustments to the Measures of Merit were presented to the Group and approved.

The Group was also asked to approve the removal of Health Clinics as a category for study under BRAC 95. After some discussion the proposal was approved. It was decided, however, that the working group should develop recommendations on how many active duty and dependents of active duty personnel should justify the presence of a health clinic.

A report on the progress of the working group's efforts vis-a-vis the optimization followed. Notional data was being run with output expected within a day or two. Proposed policy constraints were offered for the Group's consideration.

DRAFT

DRAFT

Timelines for the remainder of the Group's BRAC 95 efforts were then discussed. It was noted that these may change based on input from other Groups, OSD, etc.

The Chairman restated the need to reduce the size of the Group once certified data is received.

The meeting adjourned at 1450 hrs. The next meeting will be at the call of the Chairman.

Approved Edward D. Martin
Edward D. Martin, MD
PDASD(Health Affairs)

Attachments

DRAFT

DRAFT

MINUTES OF THE MILITARY TREATMENT FACILITIES AND GRADUATE MEDICAL EDUCATION BRAC 95 JOINT CROSS SERVICE GROUP MEETING OF AUGUST 1, 1994

The eleventh meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1400 hours on August 1, 1994. The meeting was chaired by Dr. Edward D. Martin, Principal Deputy Assistant Secretary of Defense, Health Affairs.

The Chairman opened the session by reminding the members that the issue of wartime requirements was raised by the ODASD(PA&E) at the last meeting and that the working group and PA&E were to work together to resolve this issue.

The members were then briefed on the results of the working group's review:

- o No changes were recommended to implementation of the facility score and integer program methodologies
- o There would be no new data calls
- o The Group should evaluate the ability of the remaining infrastructure to support the required wartime requirements, both by type and service (This proposal was subsequently approved by the members)

A comment was made that if we do {establish constraints} the optimization model correctly we should be at or near the wartime bed requirement floor. The importance of the geographic location of the beds was also raised. The Chairman agreed that geographic location was important, but an analysis at this time would be premature.

Minor adjustments to the Measures of Merit were presented to the Group and approved.

The Group was also asked to approve the removal of Health Clinics as a category for study under BRAC 95. After some discussion the proposal was approved. It was decided, however, that the working group should develop recommendations on how many active duty and dependents of active duty personnel should justify the presence of a health clinic.

A report on the progress of the working group's efforts vis-a-vis the optimization followed. Notional data was being run with output expected within a day or two. Proposed policy constraints were offered for the Group's consideration.

DRAFT

DRAFT

Timelines for the remainder of the Group's BRAC 95 efforts were then discussed. It was noted that these may change based on input from other Groups, OSD, etc.

The Chairman restated the need to reduce the size of the Group once certified data is received.

The meeting adjourned at 1450 hrs. The next meeting will be at the call of the Chairman.

Approved Edward D. Martin
Edward D. Martin, MD
PDASD(Health Affairs)

Attachments

DRAFT

**BRAC 95 JOINT CROSS SERVICE GROUP
FOR MILITARY TREATMENT FACILITIES AND
GRADUATE MEDICAL EDUCATION**

**August 1, 1994
Room 4E327, 2:00 pm**

- Review/approve minutes from previous meeting Dr. Martin
- Wartime Medical Considerations Dr. Martin
- Measures of Merit scoring adjustments LTC Ponatoski
 - Facility Condition Code adjustment
 - ASA scoring adjustment
- Health Clinics as a category for study LTC Ponatoski
- Status of Linear Programming Model Development LTC Ponatoski
 - Model Development Issues
 - Proposed Policy Constraints
- Closing Comments Dr. Martin
- Adjournment

Wartime Medical Considerations

- **The current implementation of the facility score and integer program methodologies will continue as planned**
- **The JCSG will explicitly evaluate the ability of the facilities identified for retention to satisfy the wartime CONUS bed requirements**

Wartime Medical Considerations (cont)

- **Adjustments to the Section 733 wartime CONUS bed requirements will not be taken up during this validation process**
- **Wartime CONUS bed requirements based on current Defense Planning Guidance and Defense Medical Program Guidance - Approximate 733 numbers**

Capacity Definitions

- **Operating Beds - Beds that are set up, staffed, and equipped for patient care**
- **Expanded Beds - Spaced on 6 foot centers with embedded electrical and gas utility support**

Condition Code Proposed Adjustments

- **Codes are building specific**
- **Condition codes are summed by DMIS ID and averaged for each activity**
- **Revised methodology for computing condition code allows for greater degree of specificity**

Condition Code Proposed Adjustments

Previous Scoring

F2 Installation Real Property Rating

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1				2					3
HOSPITALS	1				2					3
MED CENTER	1				2					3

Proposed Scoring

F2 Installation Real Property Rating

SCORE	1	2	3	4	5	6	7	8	9	10
CLINICS	1	1.2	1.4	1.6	1.8	2.0	2.2	2.4	2.6	>2.8
HOSPITALS	1	1.2	1.4	1.6	1.8	2.0	2.2	2.4	2.6	>2.8
MED CENTER	1	1.2	1.4	1.6	1.8	2.0	2.2	2.4	2.6	>2.8

ASA Proposed Scoring Adjustments

- **Minimal change from previous scale**
- **Neutral ratio (1:1) = score of 5**
- **Consistent Medcen and Community Hospital scale**
- **Allows for better discrimination between facilities**

ASA Proposed Scoring Adjustments

Previous Scoring Cost Inpatient Care (ASA rate/MTF rate)

SCORE	1	2	3	4	5	6	7	8	9	10
HOSPITALS	<.3	.45	.6	.75	.9	1.05	1.2	1.35	1.5	>1.5
MED CENTER	<.9	.95	1.0	1.05	1.1	1.15	1.20	1.25	1.3	>1.3

Proposed Scoring Cost Inpatient Care (ASA rate/MTF rate)

SCORE	1	2	3	4	5	6	7	8	9	10
HOSPITALS	<.6	.7	.8	.9	1.0	1.1	1.2	1.3	1.4	>1.4
MED CENTER	<.6	.7	.8	.9	1.0	1.1	1.2	1.3	1.4	>1.4

Health Clinics as a Category for Study

- **Continued evaluation of Clinics will not produce meaningful results**
 - Ambulatory facilities will be maintained if active duty presence
 - Do not have meaningful measures for evaluation
 - No industry standard for ambulatory care evaluation
- **Recommendation**
 - Delete health clinics as a category for study
 - Ensure Services evaluate potential impact from “base” closures

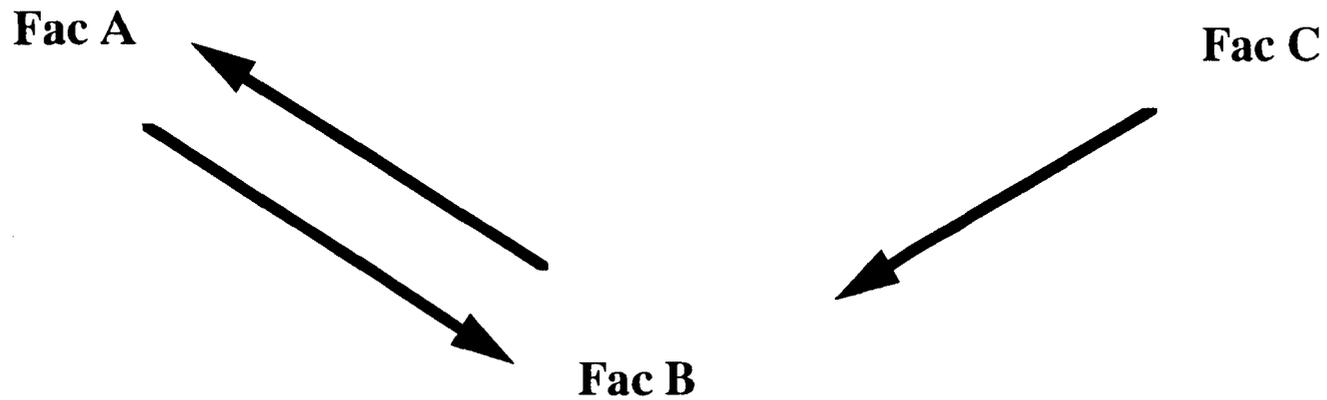
Model Development

- **Services developed notional region and representative MTF/Medcen data**
 - 2 Medcens
 - 11 MTFs
 - 2 overlapping catchment areas
- **Results due by 2 August**

Model Development (cont)

- **Use 1.5 to 2.0 as operating bed rate for beneficiaries**
- **Model should allow for adequate dispersion factor ~.8**
- **Model will allow development of patient flows from MTF to MTF in overlapping catchment areas**

Relationships may be established to allow for patient flow



Relationship for flow from A to B and B to A

Relationship for flow from C to A

No relationship for flow from B to C

No relationship for flow from A to C or C to A

Proposed Constraints

- **Maintain MTF if considered underserved primary care area (unless base closes) 1:3000**
- **Maintain MTF if < 2 accredited community facilities (unless base closes)**
- **Maintain by Service and MHSS the aggregate number of expanded beds to meet wartime requirements**

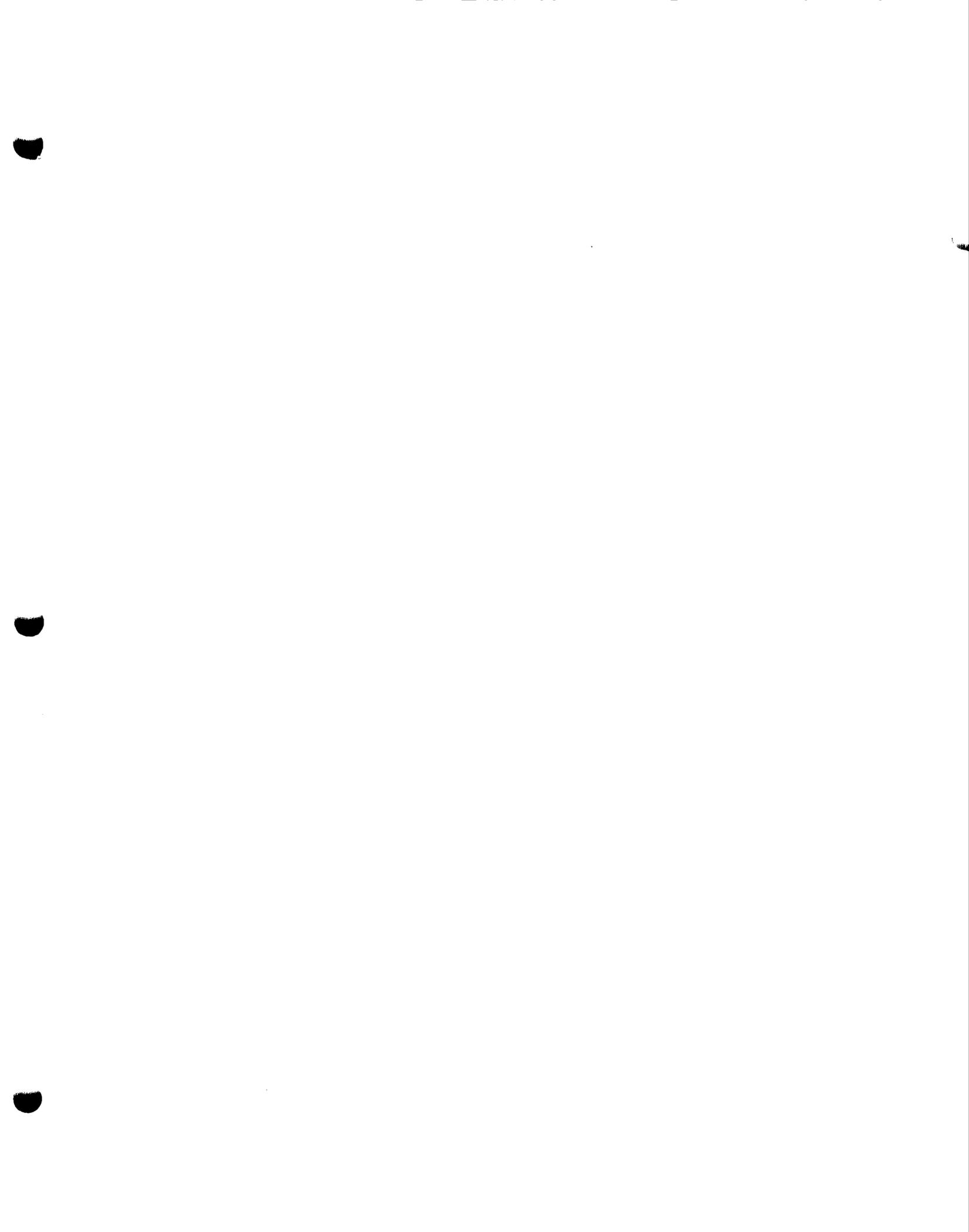
Proposed Constraints (cont)

- **Maintain 1 Medcen per Lead Agent Region**
- **Maintain average functional value within the aggregate MHSS**

Projected Timeline

TASK	WHO	WHEN
Develop methodology for inputs to model	JCSGs	Jul-Aug
Approve JCSCG model inputs methodology	Steering Gp	24 Aug
Provide Data to JCSCGs	Mil Depts	1 Sep
Provide site Military Value input to JCSCGs	Mil Depts	15 Sep
Run Unconstrained Model	Tri BRAC Gp	1-15 Sep
Run Constrained Model	Tri BRAC Gp	15-30 Sep
Analyze Results	JCSGs	October
Analyze Alternatives	Mil Depts	Nov-Dec

* Timeline negotiations ongoing with Military Departments and ASD (ES)





DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND (PROV)
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000



REPLY TO
ATTENTION OF

S: 18 August 1994

MCHO-OP-MR (5-10c)

09 AUG 1994

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Base Realignment and Closures (BRAC) 95 Data Call #8--
Medical Treatment Facility (MTF)

1. Reference memorandum, HQ, U.S. Army Medical Command (Provisional), MCHO-OP-MR, subject as above, dated 25 May 1994.
2. The Army Audit Agency (AAA) audited six of our MTF replies to Data Call #8. They recommended that all MTF commanders and officers-in-charge (OIC) review and certify the data for their MTF before we provide a final report to The Army Basing Study (TABS). We support the AAA recommendation. We ask that MTF commanders and OICs also do a "sanity check" on data not provided by the MTF. This data came from the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and Donnelley Marketing Information Services.
3. In addition, we ask MTF commanders and OICs to provide a brief narrative describing their role (if any) in supporting their Regional Lead Agent's health care support plan.
4. Enclosure 1 contains the proposed input for your MTF. Please review it, noting any desired changes. Provide documents supporting any changes and include a certification statement for data provided by the MTF. Reply by FAX to our points of contact not later than 18 August 1994. If we do not receive your reply by the suspense date, we will forward your report to TABS without changes.
5. As you review Enclosure 1, pay particular attention to the following:
 - a. Enclosure 1 contains "raw data" only, not Measure of Merit scores. The MTFs need not provide scores. The TABS will "score" the data.
 - b. The MTFs were responsible for providing the following data:

CLOSE HOLD

MCHO-OP-MR

SUBJECT: Base Realignments and Closures (BRAC) 95 Data Call #8--
Medical Treatment Facility (MTF)

(1) Number of operating beds must have staff and physical plant to support them. If the hospital contains space for 450 beds and has staff for only 367, use 367 as the number of operating beds. Do not count bassinets as operating beds. (A2c) (Data provided by hospitals and medical centers.)

(2) Facility Condition Assessment Document (FCAD) reflects the commander's assessment of the condition of medical buildings, medical support buildings including veterinary, excluding dental buildings. Our staff (MEDCOM) computed the FCAD for those MTFs providing us with a DD Form 2407, Facility Condition Assessment Document. One completed DD Form 2407 was to cover all buildings listed above. Incorporate ongoing construction and construction contracts awarded before 1 October 1994. The FCAD and Installation Real Property Rating should be "reasonably correlated." Check into why the FCAD is high and Installation Real Property Rating is "red" or "1." (F1) (Data provided by all MTFs.)

(3) Installation Real Property Rating reflects the installation engineer's building rating of buildings used for the FCAD. The MTF was to weight the engineer's rating by square foot of buildings and include ongoing construction or construction contracts let before 1 October 1994. Most real property ratings weighted by square feet would not result in a whole number answer. (F2) (Data provided by all MTFs.)

(4) Weighted Age provides an average age per square foot for each Defense Medical Information System (DMIS) Identification Number. This should reflect ongoing construction and construction contracts let before 1 October 1994. (F3) (Data provided by all MTFs.)

(5) The Joint Commission for the Accreditation of Healthcare Organization (JCAHO) Life Safety Score reflects the most recent score adjusted for ongoing construction or contracts let before 1 October 1994 to JCAHO deficiencies. (F4) (Data provided by hospitals and medical centers.)

(6) Distance from Air Hub provides the distance in miles to the nearest airfield that can accommodate a C-9 aircraft or is greater than 5500 feet long. (MC1) (Data provided by hospitals and medical centers.)

(7) Bed Expansion Capability reflects the number of beds in areas designed for patient beds. Count beds on 6 foot centers

MCHO-OP-MR

SUBJECT: Base Realignments and Closures (BRAC) 95 Data Call #8--
Medical Treatment Facility (MTF)

with embedded electrical and gas. Include beds resulting from ongoing construction or construction to begin by 1 October 1994. (MC2) (Data provided by hospitals and medical centers.)

(8) The MTF Cost per Relative Weighted Product (RWP) for your MTF is at Enclosure 2. Data from the ASD(HA) was E-mailed to MTF Resource Managers or Medical Expense and Performance Reporting technicians on 8 July 1994 to complete this section. The MEDCOM staff computed the cost per RWP for those MTFs that did not reply to the 8 July 1994 E-mail message. The MEDCOM staff used Medical Support and Performance Review System data provided by ASD(HA). (C1(b)) (Data provided by hospitals and medical centers.)

(9) Operating Beds should be the same as I, A2 (c). (II, B) (Data provided by hospitals and medical centers.)

(10) Programmed Military Construction for 1995-1999. These projects must be "programmed" into a specific fiscal year budget and not just requested. (II, C) (Data provided by all medical treatment facilities.)

(11) Number of Primary Care Physicians reflects the number of full-time equivalents as of 1 June 1994 and includes military, civilian employees, contract physicians, and partnership physicians. Note the number of partnership physicians, if any, included in the total. (III, B, 1) (Data provided by all MTFs.)

(12) Number of Normal Beds shows the peace time bed with embedded gas and electrical support with 140-200 square feet per bed. Do not consider staff availability. (III, B, 2) (Data provided by hospitals and medical centers.)

(13) Facilities lists all MTF buildings over 10,000 square feet and reflects renovations costing over \$300,000. (III, C) (Data provided by all MTFs.)

MCHO-OP-MR

SUBJECT: Base Realignment and Closures (BRAC) 95 Data Call #8--
Medical Treatment Facility (MTF)

6. Our points of contact are Major DeVries and Captain Harper,
Directorate of Operations, Missions and Realignments Division,
DSN 471-8801, FAX 471-6039.

FOR THE COMMANDER:

s/ David W. Foxworth, LTC
JG BRUCE G. FURBISH
Colonel, MS
Deputy Director of Operations

2 Encls

1. Proposed Data
2. RWP Computation

DISTRIBUTION:

Commanders, U.S. Army MEDCENS (less Fort Bragg)
Commanders, U.S. Army MEDDACS (less Fort Ord & Drum, incl
Fort Bragg)
Commanders and Officers in Charge,
Pentagon, WASH DC 20310-2300
Aberdeen Proving Ground, MD 21005-5131
Carlisle Barracks, PA 17013-5003
Fort Detrick, MD 21702-5000
Fort Drum, NY 13602-5004
Fort Greely, AK APO 96508
Fort Hamilton, NY 11228
Fort A.P. Hill, VA 22427
Hunter AAF, GA 31409-5180
Fort Indiantown Gap, PA 17003-5001
Fort Myer, VA 22211-5050
Fort McNair, WASH DC 20319
Fort McPherson, GA 30330-5000
Fort Monroe, VA 23651
Natick Laboratory, MA 01760-5007
Oakland, CA 94626-5050
Fort Pickett, VA 23824
Fort Ritchie, MD 21719
Fort Story, VA 23459

CF (w/encl):

HQDA (DASG-RMP), 5109 Leesburg Pike, Falls Church, VA 22041-
3258

CLOSE HOLD

Medical Joint Cross Service Group Process Summary

Initial Study Design and Development

The Deputy Secretary of Defense 1995 Base Realignment and Closures guidance memorandum, dated January 7, 1994, provided the authority for establishment of the Joint Cross Service Group for Military Treatment Facilities (MTFs) and Graduate Medical Education (GME). A Tri-Service Ad Hoc Working Group was also established to develop and recommend draft criteria and process proposals for consideration by the Joint Medical Group. The Assistant Secretary of Defense (Health Affairs) chaired the Joint Medical Group. The membership, as outlined in the Department's guidance, included representatives from the Services and major staff elements of the Office of the Secretary of Defense.

The Group developed an overall analytic process that included study assumptions, roles of the Services and Joint Medical Group, and an analytic approach. Functional study categories were developed consisting of Graduate Medical Education Centers and Community Hospitals. Two capacity measures were developed which consisted of measures for contingency/mobilization bed requirements and peacetime operating bed capacity.

The Joint Medical Group study assumptions included the basic premise that, in general, the MTF will close if the base or installation closes except when a significant active duty population remains after a base is closed. The group also agreed to include organizations with < 300 civilian full time employed personnel as part of the overall analysis.

The roles of the Military Departments and the Joint Medical Group were developed based on the DepSecDef guidance memorandum of January 7, 1994. The Joint Medical Group developed the study design, general analytical approach, measures of merit, common data elements, and a methodology for weighting and scoring the measures of merit. The Military Services conducted the data collection and analysis, development of findings, and evaluated alternative options recommended by the Joint Medical Group.

The Medical Group developed ten common measures of merit within the framework of the overall Military Value BRAC Criteria. These measures included the data element(s) to be collected by the Services, the source(s) for each data element, and the methodology for weighting and scoring each of the measures. Mission criterion encompassed active duty and active duty family populations. Facility condition elements included a weighted age calculation and condition assessments by the Military Treatment Facility (MTF) Commander and Installation Engineer. Contingency factors were measured by the number of expanded beds within the MTF and proximity to air transport locations. Finally, average cost of MTF inpatient care was measured against the Adjusted Standardized CHAMPUS rate for each MTF geographic area. Each of the measures of merit was scored on a scale of 1 - 10. The measures were weighted and a functional value score was obtained for each MTF.

2d Stage Analysis

The primary tool used in developing alternatives for consideration by the Military Departments was the DoD approved Fixed Integer Linear Programming Model. This model incorporates characteristics based on the goal to minimize excess capacity and maintain high quality facilities within the Military Health Services System. The model also ensures that facilities are located at sites with significant active duty and family member populations.

CLOSE HOLD

The specific linear formulation incorporates operating beds as the primary capacity measure and also maintains the minimum number of wartime beds based on the most recent defense guidance. Bed demand is generated based on acute care and medical center requirements using beneficiary specific FY 94 direct care inpatient rates. Medical Center beds are allocated to the eastern and western United States based on requirements generated within those areas. There are a number of binary constraints within the model that ensures facilities remain open if they reside in an underserved primary care area, there are insufficient acute care beds in the community, or less than 2 accredited acute care facilities. In overlapping catchment areas, the model flows patients if any binary constraint is met and attempts to consolidate inpatient care.

The model results produced a number of possible facilities to consider for downsizing or closure. The Chairman sent a set of alternatives to the Service Secretaries for their consideration. The alternatives and Service responses are provided below.

Infrastructure Reductions 1988 - 1997

Since the end of the cold war, the DHP has aggressively sought to reduce excess infrastructure. Over 58 hospitals will have closed or realigned by 1997. The DHP has also experienced approximately 12,000 normal bed reduction during this period. These reductions account for a 43% decrease in beds and a 35% decrease in number of inpatient facilities since 1988.

Within the continental United States, 41 hospitals will have closed by the end of BRAC 95. Overseas hospitals account for an additional 17 closures. These hospitals include four medical center closures, 2 within CONUS and 2 overseas. These actions were accomplished by the cumulative Base Realignment and Closure Rounds and by Defense Health Program initiatives.

CLOSE HOLD

**Military Treatment Facilities
Realignment and Closure Candidates**

Facility Name	Location	Alternative	Service Response
Noble Army Community Hospital	Fort McClellan, AL	Realign to Clinic	Concur
Lyster Army Community Hospital	Fort Rucker, AL	Realign to Clinic	Non-Concur
Fitzsimons Army Medical Center	Aurora, CO	Close	Concur
USAF Academy Hospital	Air Force Academy	Realign to Clinic	POM reduction
USAF Medical Center Scott AFB	Scott AFB, IL	Realign to Clinic	Realigned to CH
Kimbrough Army Community Hospital	Fort Meade, MD	Realign to Clinic	Concur
Wright Patterson USAF Medical Center	Wright Patterson AFB, OH	Realign to Clinic/CH	BRAC 95 Impact
Naval Hospital Beaufort	Beaufort, SC	Realign to Clinic	Non-Concur
363rd Medical Group	Shaw AFB, SC	Realign to Clinic	Non-Concur
6th Medical Squadron	Reese AFB, TX	Realign to Clinic	Concur
Naval Hospital, Corpus Christi	Corpus Christi, TX	Realign to Clinic	Concur via POM
Wilford Hall Medical Center	Lackland AFB, TX	Realign to Clinic/CH	Non-Concur
396th Medical Group	Sheppard AFB, TX	Realign to Clinic	Non-Concur
1st Medical Group	Langley AFB, VA	Realign to Clinic	Non-Concur
Dewitt Army Community Hospital	Fort Belvoir, VA	Realign to Clinic	Non-Concur
Kenner Army Community Hospital	Fort Lee, VA	Realign to Clinic	Concur

CLOSE HOLD





DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND (PROV)
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000



REPLY TO
ATTENTION OF

MCHO-OP-MR (5-10c)

17 AUG 1994

MEMORANDUM THRU HQDA (DASG-2A), 5109 Leesburg Pike, Falls Church,
VA 22041-3258

FOR Assistant Secretary of Defense (Health Affairs), Pentagon,
Room 3E346, Washington, DC 20301-1200

SUBJECT: Reductions in Services

1. Reference Department of Defense Instruction (DODI) 6015.20, Changes in Services at Military Treatment Facilities (MTFs) and Dental Treatment Facilities (DTFs).
2. On 12 August 1994, we were notified that Headquarters, Department of the Army (HQDA), approved the decrement of 5,600 civilian manpower authorizations and associated work years from the U.S. Army Medical Command (MEDCOM) (Provisional) for Fiscal Years (FY) 1995 through 2001.
3. We cannot accommodate a manpower decrement of this magnitude through staff reductions to selected functions across the command.
4. In accordance with DODI 6015.20, we are informing you of our proposal to make the following major changes in services to accommodate this mandated reduction:
 - a. Close Fitzsimons Army Medical Center.
 - b. Downsize Dwight David Eisenhower Army Medical Center to a community hospital configuration.
 - c. Downsize William Beaumont Army Medical Center to a community hospital configuration.
 - d. Reduce health care services and/or eliminate services and contract out health care at the following locations: Redstone Arsenal, Fort Monmouth, Fort McClellan, Fort Eustis, Fort Lee, Fort Huachuca, and Fort Rucker.

MCHO-OP-MR

SUBJECT: Reductions in Services

5. We expect to eliminate approximately 2,990 civilian manpower authorizations based on the above actions.

6. Concurrent with these actions to reduce the civilian work force, we plan on realigning approximately 2,949 military manpower authorizations from the above medical treatment facilities to other locations in order to eliminate additional civilian authorizations at the gaining locations.

7. We need your support to obtain relief from existing commercial activities (CA) rules and regulations to implement the above proposals. Relief from CA restrictions is absolutely critical for this command to accommodate civilian reductions of any significant magnitude.

8. We also need your support to obtain relief from the Congressional requirement for certification that this reduction of medical personnel will not result in an increase in the cost of health care services provided under the Civilian Health and Medical Program of the Uniformed Services. Where we have attempted to minimize the cost of health care under this plan, these actions will result in an increase in the government share of the cost of health care provided across the command.

9. Because these plans involve the shifting of military personnel from activities that are closing or downsizing, we request your assistance in obtaining relief from directives that preclude the militarization of civilian positions.

10. Please note that the three medical centers addressed in paragraph 4, above, serve as Lead Agents for their respective Department of Defense regions. It is too early in the evolving process of developing Lead Agent roles and responsibilities to determine the full effect this proposal will have on the Department of Defense TriCare Program. As a minimum, the proposed closures will necessitate a redesignation of Lead Agency.

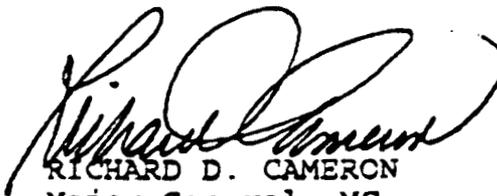
11. We fully support the proposals of the administration and Congress to reduce the size of the federal civilian work force. However, we request your assistance to obtain relief from current legal, regulatory (including Army Regulation 5-10, Reduction and Realignment Action Reporting Procedures), and administrative restrictions in order to implement operational plans critical to achieving these mandated savings.

MCHO-OP-MR

SUBJECT: Reductions in Services

12. Our points of contact are LTC Huddleston and Mr. Binkley, Missions and Realignment Division, Operations Directorate, DSN 471-8506/6101.

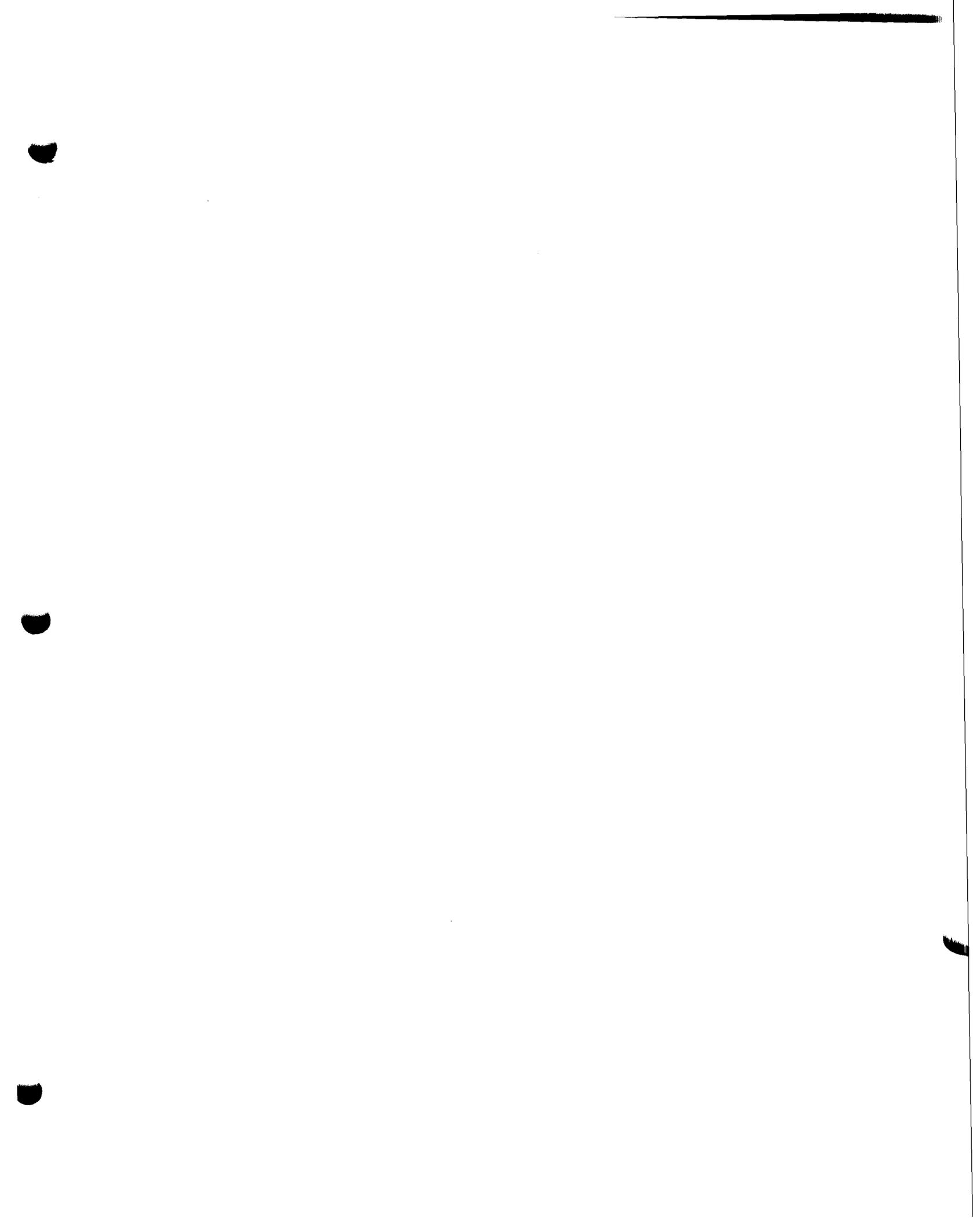
FOR THE COMMANDER:



RICHARD D. CAMERON
Major General, MC
Deputy Commander



1



**MINUTES OF THE
MILITARY TREATMENT FACILITIES
AND GRADUATE MEDICAL EDUCATION
BRAC 95 JOINT CROSS SERVICE GROUP
MEETING OF NOVEMBER 29, 1994**

The twelfth meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1330 hours on November 29, 1994. The meeting was chaired by Dr. Edward D. Martin, Principal Deputy Assistant Secretary of Defense, Health Affairs.

The Chairman reviewed the agenda. The attendance was intentionally limited to the principals because of the sensitivity of the discussions regarding proposed alternatives for Military Department consideration.

The utilization improvement factor was discussed first. The consensus was that the improvement factor was too aggressive and should be removed.

Also removed from the model were the Madigan and Bremerton overlap clusters. Significant geographical barriers made these overlap areas unrealistic.

The recently announced problems with the Pentium (computer) chip was discussed. According to Dr. Nichel, although there was some initial concern regarding the accuracy of the optimization model runs, the chip problems did not effect the results.

The group then reviewed the various alternative model formulations and their characteristics. The group concurred that formulation 2a, which uses operating beds as the capacity measure was the most appropriate. This formulation also recognizes the value in maintaining facilities with large active duty populations.

It was reported that since the model's objective is to reduce excess capacity, it has a tendency to reduce facilities with large differences in capacity to requirements. The model does, however, appear to retain MTFs with large differences if the MTF has a high functional value.

Having agreed upon the alternatives identified by the accepted model formulation, the Chairman announced that he would forward the list of alternatives to the Military Departments for consideration. The Military Departments are expected to evaluate these alternatives and provide feedback.

The Chairman adjourned the meeting and expressed his appreciation for everyone's efforts over the course of this process.

Approved _____

E. Martin

Edward D. Martin, MD
PDASD(Health Affairs)

Attachments

**BRAC 95 JOINT CROSS SERVICE GROUP
FOR MILITARY TREATMENT FACILITIES AND
GRADUATE MEDICAL EDUCATION**

**November 29, 1994
Room 4E987, 1:30 pm**

- **Welcome and overview of meeting objectives** Dr. Martin
 - Review policy and data revisions
 - Review of most recent model output
 - Determine formulations for development of alternatives
 - Discuss draft alternative scenarios for Service consideration
- **Policy and data revisions incorporated into model** LTC Ponatoski
 - Walter Reed and Brooke functional value changes
 - Removal of improvement factor
 - Removal of Madigan/Bremerton as an overlap area
- **Review of updated results** LTC Ponatoski
 - Formulation 1a and 1b
 - Formulation 2a and 2b
 - Formulation 3a and 3b
- **Determine formulations for use in development of alternatives** Dr. Martin/Group
- **Discuss potential Scenarios** Dr. Martin/Group
- **Action Items** Dr. Martin
- **Adjournment**

Agenda for 11/29 Medical JCSCG Meeting

- **Policy and Data revisions**
- **Review of most recent model results**
- **Define formulations to use in development of alternatives**
- **Discuss potential scenarios**
- **Follow on actions**

Model Revisions

- **Brooke and Walter Reed understated regional populations - Functional values adjusted:**

- Walter Reed 6.12 to 7.78
- Brooke 6.38 to 7.58

- **Improvement Factor removed to reflect more conservative demand**

- FY 93 = 307 bed days/1000
- FY 94 = 213 bed days/1000 with improvement factor
- FY 94 = 260 bed days/1000 w/o improvement factor

Model Revisions (cont)

■ **Madigan and Bremerton cluster removed**

- **Bremerton isolated**
- **Bridge over Puget Sound subject to freezing**
- **Hazardous road conditions in winter**

■ **Intel Pentium Chip Issues**

- **Chip is subject to errors in complex mathematical formulations**
- **Did effect Medical formulations**
- **486 machines used to produce latest results**

Formulations

■ # 1a and 1b

- Output with operating & available bed capacity measures
- Presumption of direct care
- Flows patients in overlap areas

■ # 2a and 2b

- Output with operating & available bed capacity measures
- Adds binary constraint of 25K AD + ADFAM
- Considers other constraints as community
- Flows patients in overlap areas

■ #3a and 3b

- Output with operating & available bed capacity measures
- No 25K AD + ADFAM constraint
- Applies constraints to each hospital
- Flows patients in overlap areas

Medical Centers Eastern U.S

<u>Facility</u>	<u>FV</u>	<u>OP</u>	<u>AV</u>	<u>AC REQ</u>
Eisenhower	8.25	346	757	44
WRAMC	7.72	694	718	33
Bethesda	7.40	342	459	69
Portsmouth	7.01	431	437	113
Wright Patt	5.58	160	175	38
Keesler	5.06	235	306	52
Totals		2208	2852	

**Medcen bed demand East = 1491 - 68% of Operating Beds and
52% of Available Beds**

Medical Centers Western U.S

<u>Facility</u>	<u>FV</u>	<u>OP</u>	<u>AV</u>	<u>AC REQ</u>
San Diego	7.84	422	617	254
Brooke	7.58	367	450	71
Willford Hall	6.74	585	1006	70
FAMC	6.35	174	335	36
MAMC	6.14	381	414	101
Beaumont	5.91	330	482	49
Travis	5.52	195	408	69
Tripler	4.52	423	439	119
Totals		2877	4151	

**Medcen bed demand West = 1262 - 44% of Operating Beds and
30% of Available Beds**

Wartime Bed Requirements

Army	6030
Navy	2600
Air Force	980

Model Results

- **Model objective is to reduce excess capacity**
- **Has tendency to close facilities that have large excess capacity compared to requirement**
- **Does appear to retain many facilities with large difference in requirements to capacity if facility has high functional value**

Results # of Closures

1 Operating

5 DOD
1 Army
0 Navy
4 AF
0 MC

1 Available

5 DOD
3 Army
0 Navy
2 AF
1 MC (WRAMC)

Results # of Closures

2 Operating

17 DoD

9 Army

2 Navy

6 AF

2 MC (FAMC/Lack)

1 MC to CH (Travis)

2 Available

20 DoD

10 Army

3 Navy

7 AF

3 MC (WRAMC/Lack/FAMC)

1 MC to CH (Travis)

3 Operating

18 DoD

7 Army

3 Navy

8 AF

2 MC (MAMC/Lack)

3 Available

13 DoD

6 Army

1 Navy

6 AF

**4 MC (FAMC/WRAMC
Lack/Travis)**

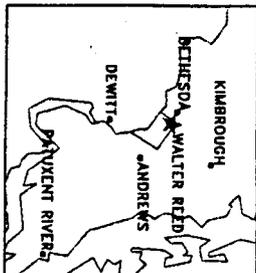
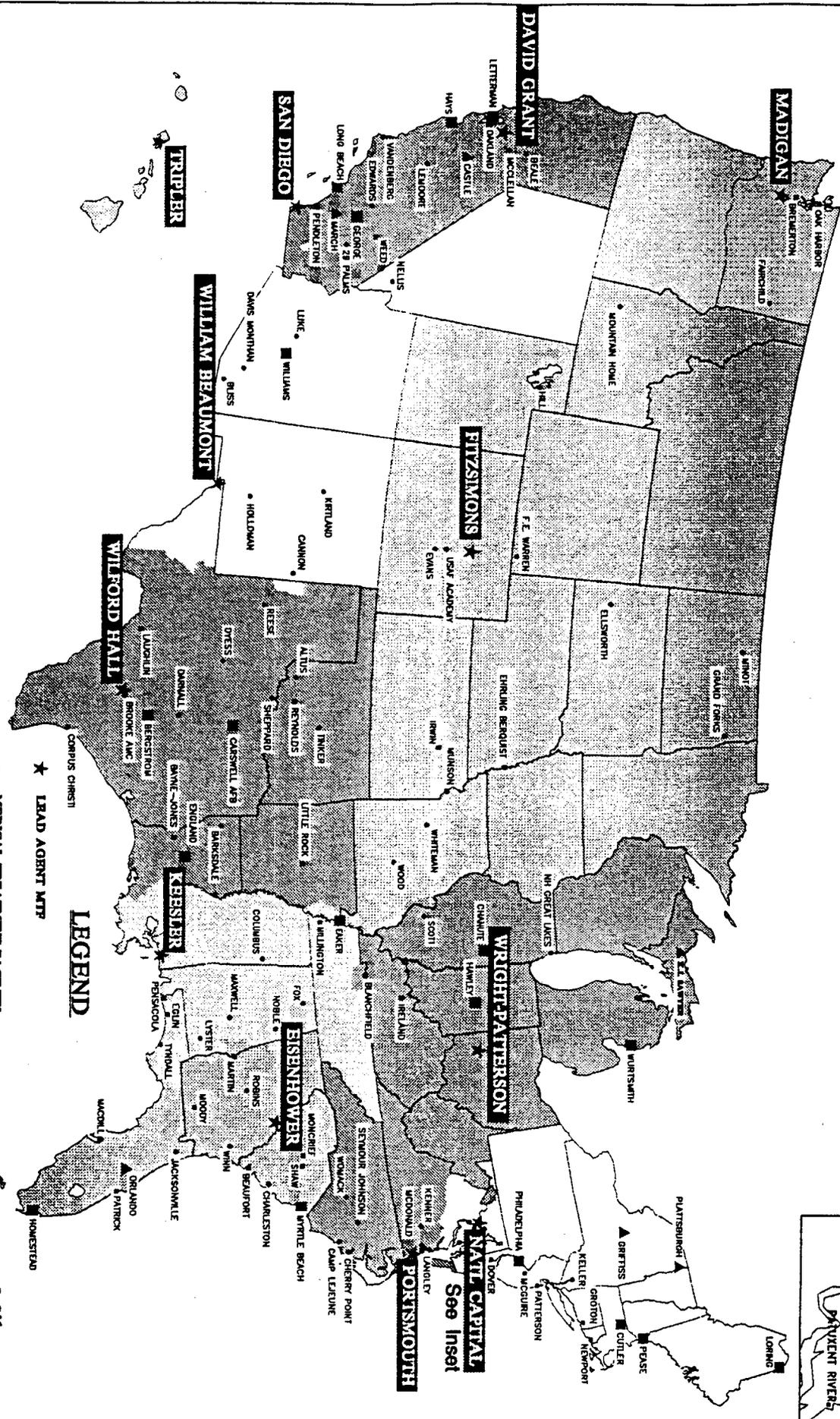
Form: 3 Beds: oper

M1128F

WNV 1.0249
 Flow clusters 1
 Use civ beds 1
 Min AD pop 226785
 Oper beds 1
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bln	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WF
ALTUS	1	3	3.92		0	7	39	39	10	10	0				
SHAW	0	3	5.02		0	25	48	90	23	0	0				
ELLS	1	3	4.80		0	15	35	58	18	18	0				
REESE	0	3	3.18		0	4	10	20	7	0	7				
DYESS	1	3	4.26		0	15	35	100	18	18	0				
SHEPP	1	3	5.00		0	80	197	318	18	18	0				
LAUGH	1	3	3.72		1	5	28	40	4	4	0				
LACKLND	0	3	7.16	6.74	0	585	1006	1033	70	0	19	0			
HILL	1	3	5.88		0	25	42	55	27	27	0				
LANGLY	0	3	5.68		0	40	71	120	44	0	0				
FAIRCH	1	3	4.71		0	30	61	90	23	23	0				
WARREN	1	3	3.98		0	15	24	43	12	12	0				
FTDIX	1	3	6.07		0	20	350	350	56	56	0				
FOX	1	3	4.86		0	20	42	57	20	20	0				
NOBLE	0	3	4.90		0	48	100	106	19	0	19				
LYSTER	1	3	5.60		0	42	69	77	25	25	0				
BASSETT	1	3	5.02		1	43	74	100	17	17	0				
BLISS	1	3	5.51		0	30	103	107	18	18	0				
FITZSIM	1	3	5.37	6.35	0	174	335	375	36	36	0	138			
EVANS	0	3	7.62		0	149	195	212	70	0	51				0
WREED	1	3	6.10	7.72	0	694	718	847	33	33	0	661			
IKE	1	3	7.59	8.25	1	346	757	757	44	44	0	302			
MARTIN	0	3	7.16		0	172	282	380	62	0	62				
WINN	0	3	7.06		0	114	148	165	51	0	51				
TRIP	1	3	7.94	4.57	1	423	439	617	119	119	0	304			
IRWIN	1	3	7.62		1	60	127	192	55	55	0				

TRICARE LEAD AGENTS AND HEALTH SERVICE REGIONS



LEGEND

- MEDICAL TREATMENT FACILITY
- ★ LEAD AGENT MTF
- CLOSED MEDICAL TREATMENT FACILITY
- ▲ MEDICAL TREATMENT FACILITY SATED FOR CLOSURE

Miles



Sources: DMIS and Defense Base Closure and Realignment Commission, 1993 Report to the President

MINNFV 3.0307
 Form: 1 Beds: oper MI129U
 Flow clusters 1
 Use civ beds 0
 Min AD pop 228785
 Oper beds 1
 MC FV avg req 0
 MC flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
PEND	1	3	7.28		0	120	222	265	98	98	0																98
LEMOORE	1	3	5.12		1	37	69	37	29	29	0																29
SDIEG	1	3	8.48	7.84	0	422	617	583	254	254	0	168															422
29PALMS	1	3	7.58		1	30	70	40	26	26	0																26
GROTON	1	3	5.41		0	25	100	96	30	30	0																30
PENS	1	3	7.19		0	104	221	161	69	69	0																69
JAX	1	3	6.98		0	131	176	228	97	97	0																97
GLAKES	1	3	6.48		0	136	228	718	54	54	0																54
BETH	1	3	6.82	7.40	0	342	459	779	69	69	0	225			0	48		0	0								342
PAX	1	3	3.74		1	20	20	32	12	12	0																12
LEJU	1	3	7.76		1	176	224	238	92	92	0																92
CHPT	1	3	4.52		0	40	40	27	36	36	0																36
CHAR	1	3	5.56		0	90	90	90	46	46	0																46
BEAU	1	3	4.70		0	49	80	54	22	22	0																22
MILL	1	3	4.37		1	66	102	106	20	20	0																20
CORP	1	3	4.26		0	42	65	65	14	14	0																14
PTSMTH	1	3	6.55	7.01	0	431	437	176	277	277	0	0												44	39	360	
BREM	1	3	6.98		1	109	137	139	47	47	0																47
OAKHAR	1	3	5.38		0	25	26	31	24	24	0																24
MAXWELL	1	3	3.83		0	30	71	118	27	27	0																27
ELM	1	3	6.03		0	75	139	32	33	33	0																33
LUKE	1	3	5.02		0	40	60	100	50	50	0																50
DMONTH	1	3	5.22		0	30	70	112	36	36	0																36
LROCK	1	3	4.83		0	20	39	68	26	26	0																26
TRAVIS	1	3	7.88	5.52	0	195	408	388	69	69	0	0															69
BEALE	1	3	3.76		0	9	14	14	16	16	0																16
MATHER	1	3	5.06		0	30	35	70	38	38	0																38
VANBERG	1	3	5.00		0	20	48	46	14	14	0																14
EDWARDS	1	3	3.82		0	10	30	33	17	17	0																17
USAFAC	0	3	5.68		0	55	80	157	36	0	0		0														0
DOVER	1	3	4.69		0	20	39	60	21	21	0																21
EGLIN	1	3	6.62		0	85	120	275	58	58	0																58
TYNDALL	1	3	4.26		1	25	57	79	24	24	0																24
MACDILL	1	3	5.35		0	50	69	142	60	60	0																60
PATRICK	1	3	4.82		0	15	20	72	29	29	0																29
MOODY	1	3	3.81		0	10	47	47	14	14	0																14
ROBINS	1	3	4.24		0	15	31	32	21	21	0																21
MHOME	1	3	5.92		1	20	31	31	18	18	0																18
SCOTT	1	3	5.48		0	95	120	348	44	44	0																44
BARKS	1	3	5.04		0	25	46	70	26	26	0																26
ANDREWS	0	3	5.89		0	185	244	388	48	0	0				0		0	0	0								0
KEESLER	1	3	7.10	5.06	0	235	306	433	52	52	0	181															233
COLMBS	1	3	3.24		0	5	17	17	7	7	0																7
WHITEMN	1	3	4.04		0	15	26	29	11	11	0																11
OFFUTT	1	3	5.85		0	50	107	123	40	40	0																40
NELLIS	1	3	5.90		0	20	77	77	40	40	0																40
KIRT	1	3	5.40		0	25	40	40	28	28	0																28
HOLLOMN	1	3	4.68		1	8	30	28	21	21	0																21
CANNON	1	3	4.87		1	15	29	36	18	18	0																18
SJOHNS	1	3	4.45		0	15	44	48	21	21	0																21
GFORKS	1	3	3.82		0	15	34	34	14	14	0																14
MINOT	1	3	4.64		0	25	47	75	19	19	0																19
WPATT	1	3	5.90	5.58	0	160	175	433	38	38	0	122															160
TINK	1	3	4.76		0	25	65	90	41	41	0																41

Form: I Beds: oper M1129B

MINNFV 3.0307
 Flow clusters 1
 Use civ beds 0
 Min AD pop 228785
 Oper beds 1
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
ALTUS	1	3	3.92		0	7	39	39	10	10	0															10	
SHAW	0	3	5.02		0	25	48	90	23	0	0												0			0	
ELLS	1	3	4.80		0	15	35	58	18	18	0															18	
REESE	1	3	3.18		0	4	10	20	7	7	0															7	
DYESS	1	3	4.26		0	15	35	100	18	18	0															18	
SHEPP	1	3	5.00		0	80	197	318	18	18	0															18	
LAUGH	1	3	3.72		1	5	28	40	4	4	0															4	
LACKLND	1	3	7.16	6.74	0	585	1006	1033	70	70	0	515									0					585	
HILL	1	3	5.88		0	25	42	55	27	27	0															27	
LANGLY	0	3	5.68		0	40	71	120	44	0	0													0	0	0	
FAIRCH	1	3	4.71		0	30	61	90	23	23	0															23	
WARREN	1	3	3.98		0	15	24	43	12	12	0															12	
FTDIX	1	3	6.07		0	20	350	350	56	56	0															56	
FOX	1	3	4.86		0	20	42	57	20	20	0															20	
NOBLE	1	3	4.90		0	48	100	106	19	19	0															19	
LYSTER	1	3	5.60		0	42	69	77	25	25	0															25	
BASSETT	1	3	5.02		1	43	74	100	17	17	0															17	
BLISS	1	3	5.51		0	30	103	107	18	18	0															18	
FITZSIM	1	3	5.37	6.35	0	174	335	375	36	36	0	138														174	
EVANS	1	3	7.62		0	149	195	212	70	70	0			336												149	
WREED	1	3	6.10	7.72	0	694	718	847	33	33	0	661				0	0	0	0							694	
IKE	1	3	7.59	8.25	1	346	757	757	44	44	0	302														346	
MARTIN	1	3	7.16		0	172	282	380	62	62	0															172	
WINN	1	3	7.06		0	114	148	165	51	51	0															114	
TRIP	1	3	7.94	4.52	1	423	439	617	119	119	0	0														423	
IRWIN	1	3	7.62		1	60	127	192	55	55	0															60	
MUNSON	1	3	4.49		0	20	65	65	30	30	0															20	
BLANCH	1	3	8.18		0	146	241	350	67	67	0															146	
IRELAND	1	3	6.30		0	84	172	333	47	47	0															84	
BJONES	1	3	5.83		1	96	169	169	30	30	0															96	
KIMB	1	3	6.76		0	36	68	170	61	61	0				0	0	0									36	
LWOOD	1	3	7.51		1	122	480	670	40	40	0															122	
PATT	1	3	4.76		0	15	67	67	20	20	0															15	
KELLER	1	3	5.34		0	30	62	62	23	23	0															30	
WOMACK	1	3	8.52		0	226	272	454	139	139	0															226	
REYNOLDS	1	3	7.58		0	100	157	264	47	47	0															100	
MONCRF	1	3	7.55		0	96	432	435	48	48	0											25				96	
BEAUMT	1	3	7.51	5.91	0	330	482	684	49	49	0	0														330	
BROOKE	1	3	7.50	7.58	0	367	450	651	71	71	0	296									0					367	
DARN	1	3	8.36		0	203	241	359	111	111	0															203	
MCDEE	0	3	5.78		0	42	116	116	39	0	0													0	0	0	
KENNER	1	3	5.43		0	49	67	87	27	27	0															49	
DEWITT	1	3	7.49		0	68	93	105	95	95	0				0	0	0									68	
MADIG	1	3	8.22	6.14	0	381	414	622	101	101	0	145														381	
WEED	1	3	5.10		1	25	27	27	12	12	0															25	

4347

0 2753

7100

	DOD	Army	Navy	AF
Total sites =	99	32	19	48
Tot. retained =	94	31	19	44

	Total beds			Retained beds		
	Oper	Avail	Exp	Oper	Avail	Exp
USN	2395	3383	3865	2395	3383	3865
USAF	2538	4761	6501	2233	4318	5746
USA	4751	7464	9682	4709	7348	9566
DOD	9684	15608	20048	9337	15049	19177

Avg MV = Before 3.00 After 3.00
 Avg FV = 5.72 5.72
 Avg MC FV = 6.54 6.87

MINNFV 4.7569
 Flow clusters 1
 Use civ beds 0
 Min AD pop 228785
 Oper beds 0
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

Form: 1 Beds: avail

M1129A

MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME br	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
PEND	1	3	7.28		0	120	222	265	98	98	0															98	
LEMOORE	1	3	5.12		1	37	69	37	29	29	0																29
SDIEG	1	3	8.48	7.84	0	422	617	583	254	254	0	363															617
29PALMS	1	3	7.58		1	30	70	40	26	26	0																26
GROTON	1	3	5.41		0	25	100	96	30	30	0																30
PENS	1	3	7.19		0	104	221	161	69	69	0																69
JAX	1	3	6.98		0	131	176	228	97	97	0																97
GLAKES	1	3	6.48		0	136	228	718	54	54	0																54
BETH	1	3	6.82	7.40	0	342	459	779	69	69	0	318			33	41		0	0								459
PAX	1	3	3.74		1	20	20	32	12	12	0																12
LEJU	1	3	7.76		1	176	224	238	92	92	0																92
CHPT	1	3	4.52		0	40	40	27	36	36	0																36
CHAR	1	3	5.56		0	90	90	90	46	46	0																46
BEAU	1	3	4.70		0	49	80	54	22	22	0																22
MILL	1	3	4.37		1	66	102	106	20	20	0																20
CORP	1	3	4.26		0	42	65	65	14	14	0																14
PTSMTH	1	3	6.55	7.01	0	431	437	176	277	277	0	448											0	42			437
BREM	1	3	6.98		1	109	137	139	47	47	0																47
OAKHAR	1	3	5.38		0	25	26	31	24	24	0																24
MAXWELL	1	3	3.83		0	30	71	118	27	27	0																27
ELM	1	3	6.03		0	75	139	32	33	33	0																33
LUKE	1	3	5.02		0	40	60	100	50	50	0																50
DMONTH	1	3	5.22		0	30	70	112	36	36	0																36
LROCK	1	3	4.83		0	20	39	68	26	26	0																26
TRAVIS	1	3	7.88	5.52	0	195	408	388	69	69	0	0															69
BEALE	1	3	3.76		0	9	14	14	16	16	0																16
MATHER	1	3	5.06		0	30	35	70	38	38	0																38
VANBERG	1	3	5.00		0	20	48	46	14	14	0																14
EDWARDS	1	3	3.82		0	10	30	33	17	17	0																17
USAFAC	0	3	5.68		0	55	80	157	36	0	0		0														0
DOVER	1	3	4.69		0	20	39	60	21	21	0																21
EGLIN	1	3	6.62		0	85	120	275	58	58	0																58
TYNDALL	1	3	4.26		1	25	57	79	24	24	0																24
MACDILL	1	3	5.35		0	50	69	142	60	60	0																60
PATRICK	1	3	4.82		0	15	20	72	29	29	0																29
MOODY	1	3	3.81		0	10	47	47	14	14	0																14
ROBINS	1	3	4.24		0	15	31	32	21	21	0																21
MHOME	1	3	5.92		1	20	31	31	18	18	0																18
SCOTT	1	3	5.48		0	95	120	348	44	44	0																44
BARKS	1	3	5.04		0	25	46	70	26	26	0																26
ANDREWS	0	3	5.89		0	185	244	388	48	0	0				0		0	0	0								0
KEESLER	1	3	7.10	5.06	0	235	306	433	52	52	0	477															229
COLMBS	1	3	3.24		0	5	17	17	7	7	0																7
WHITEMN	1	3	4.04		0	15	26	29	11	11	0																11
OFFUTT	1	3	5.85		0	50	107	123	40	40	0																40
NELLIS	1	3	5.90		0	20	77	77	40	40	0																40
KIRT	1	3	5.40		0	25	40	40	28	28	0																28
HOLLOMN	1	3	4.68		1	8	30	28	21	21	0																21
CANNON	1	3	4.87		1	15	29	36	18	18	0																18
SJOHNS	1	3	4.45		0	15	44	48	21	21	0																21
GFORKS	1	3	3.82		0	15	34	34	14	14	0																14
MINOT	1	3	4.64		0	25	47	75	19	19	0																19
WPATT	1	3	5.90	5.58	0	160	175	433	38	38	0	437															175
TINK	1	3	4.76		0	25	65	90	41	41	0																41

MINNFV 4.7569
 Flow clusters 1
 Use civ beds 0
 Min AD pop 226785
 Oper beds 0
 MC FV avg req 0
 MC flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
ALTUS	1	3	3.92		0	7	39	39	10	10	0															10	
SHAW	0	3	5.02		0	25	48	90	23	0	0												0			0	
ELLS	1	3	4.80		0	15	35	58	18	18	0															18	
REESE	1	3	3.18		0	4	10	20	7	7	0															7	
DYESS	1	3	4.26		0	15	35	100	18	18	0															18	
SHEPP	1	3	5.00		0	80	197	318	18	18	0															18	
LAUGH	1	3	3.72		1	5	28	40	4	4	0															4	
LACKLND	1	3	7.16	6.74	0	585	1006	1033	70	70	0	520									0					590	
HILL	1	3	5.88		0	25	42	55	27	27	0															27	
LANGLY	1	3	5.68		0	40	71	120	44	44	0													27	0	71	
FAIRCH	1	3	4.71		0	30	61	90	23	23	0															23	
WARREN	1	3	3.98		0	15	24	43	12	12	0															12	
FTDIX	1	3	6.07		0	20	350	350	56	56	0															56	
FOX	1	3	4.86		0	20	42	57	20	20	0															20	
NOBLE	1	3	4.90		0	48	100	106	19	19	0															19	
LYSTER	1	3	5.60		0	42	69	77	25	25	0															25	
BASSETT	1	3	5.02		1	43	74	100	17	17	0															17	
BLISS	1	3	5.51		0	30	103	107	18	18	0															18	
FITZSIM	1	3	5.37	6.35	0	174	335	375	36	36	0	0														36	
EVANS	1	3	7.62		0	149	195	212	70	70	0			36												106	
WREED	0	3	6.10	7.72	0	694	718	847	33	0	0	0				0	0	0	0							0	
IKE	1	3	7.59	8.25	1	346	757	757	44	44	0	713														757	
MARTIN	1	3	7.16		0	172	282	380	62	62	0															62	
WINN	1	3	7.06		0	114	148	165	51	51	0															51	
TRIP	1	3	7.94	4.52	1	423	439	617	119	119	0	0														119	
IRWIN	1	3	7.62		1	60	127	192	55	55	0															55	
MUNSON	1	3	4.49		0	20	65	65	30	30	0															30	
BLANCH	1	3	8.18		0	146	241	350	67	67	0															67	
IRELAND	1	3	6.30		0	84	172	333	47	47	0															47	
BJONES	1	3	5.83		1	96	169	169	30	30	0															30	
KIMB	1	3	6.76		0	36	68	170	61	61	0			0	7	0										68	
LWOOD	1	3	7.51		1	122	480	670	40	40	0															40	
PATT	1	3	4.76		0	15	67	67	20	20	0															20	
KELLER	1	3	5.34		0	30	62	62	23	23	0															23	
WOMACK	1	3	8.52		0	226	272	454	139	139	0															139	
REYNOLDS	1	3	7.58		0	100	157	264	47	47	0															47	
MONCRF	1	3	7.55		0	96	432	435	48	48	0											23				71	
BEAUMT	1	3	7.51	5.91	0	330	482	684	49	49	0	0														49	
BROOKE	1	3	7.50	7.58	0	367	450	651	71	71	0	379									0					450	
DARN	1	3	8.36		0	203	241	359	111	111	0															111	
MCDEE	0	3	5.78		0	42	116	116	39	0	0													0	0	0	
KENNER	1	3	5.43		0	49	67	87	27	27	0															27	
DEWITT	1	3	7.49		0	68	93	105	95	95	0				0	0	0									95	
MADIG	1	3	8.22	6.14	0	381	414	622	101	101	0	0														101	
WEED	1	3	5.10		1	25	27	27	12	12	0															12	

4347 0 2753

	DOD	Army	Navy	AF
Total sites =	99	32	19	48
Tot. retained =	94	30	19	45

	Total beds			Retained beds		
	Oper	Avail	Exp	Oper	Avail	Exp
USN	2395	3383	3865	2395	3383	3865
USAF	2538	4761	6501	2273	4389	5866
USA	4751	7464	9682	4015	6630	8719
DOD	9684	15608	20048	8683	14402	18450

Before After
 Avg MV = 3.00 3.00
 Avg FV = 5.72 5.72
 Avg MC FV = 6.54 6.93

MINNFV 1.4456
 Flow clusters 0
 Use civ beds 1
 Min AD pop 25000
 Oper beds 1
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bln	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
PEND	1	3	7.28		1	120	222	265	98	98	0															98	
LEMOORE	1	3	5.12		1	37	69	37	29	29	0															29	
SDIEG	1	3	8.48	7.84	1	422	617	583	254	254	0	168														422	
29PALMS	1	3	7.58		1	30	70	40	26	26	0															26	
GROTON	1	3	5.41		0	25	100	96	30	30	0															30	
PENS	1	3	7.19		1	104	221	161	69	69	0															69	
JAX	1	3	6.98		1	131	176	228	97	97	0															97	
GLAKES	1	3	6.48		1	136	228	718	54	54	0															54	
BETH	1	3	6.82	7.40	0	342	459	779	69	69	0	100			0	17		95	61							342	
PAX	1	3	3.74		1	20	20	32	12	12	0															12	
LEJU	1	3	7.76		1	176	224	238	92	92	0															92	
CHPT	1	3	4.52		1	40	40	27	36	36	0															36	
CHAR	1	3	5.56		1	90	90	90	46	46	0															46	
BEAU	0	3	4.70		0	49	80	54	22	0	22															0	
MILL	1	3	4.37		1	66	102	106	20	20	0															20	
CORP	0	3	4.26		0	42	65	65	14	0	14															0	
PTSMTH	1	3	6.55	7.01	0	431	437	176	277	277	0	154											0	0		431	
BREM	1	3	6.98		1	109	137	139	47	47	0															47	
OAKHAR	1	3	5.38		0	25	26	31	24	24	0															24	
MAXWELL	1	3	3.83		0	30	71	118	27	27	0															27	
ELM	1	3	6.03		1	75	139	32	33	33	0															33	
LUKE	1	3	5.02		0	40	60	100	50	50	0															50	
DMONTH	1	3	5.22		0	30	70	112	36	36	0															36	
LROCK	1	3	4.83		0	20	39	68	26	26	0															26	
TRAVIS	1	3	7.88	5.52	1	195	408	388	69	69	0	0														69	
BEALE	1	3	3.76		0	9	14	14	16	16	0															16	
MATHER	1	3	5.06		0	30	35	70	38	38	0															38	
VANBERG	0	3	5.00		0	20	48	46	14	0	14															0	
EDWARDS	1	3	3.82		0	10	30	33	17	17	0															17	
USAFAC	1	3	5.68		0	55	80	157	36	36	0		19													55	
DOVER	1	3	4.69		0	20	39	60	21	21	0															21	
EGLIN	1	3	6.62		1	85	120	275	58	58	0															58	
TYNDALL	1	3	4.26		1	25	57	79	24	24	0															24	
MACDILL	1	3	5.35		0	50	69	142	60	60	0															60	
PATRICK	1	3	4.82		0	15	20	72	29	29	0															29	
MOODY	1	3	3.81		0	10	47	47	14	14	0															14	
ROBINS	1	3	4.24		0	15	31	32	21	21	0															21	
MHOME	1	3	5.92		1	20	31	31	18	18	0															18	
SCOTT	0	3	5.48		0	95	120	348	44	0	44															0	
BARKS	1	3	5.04		0	25	46	70	26	26	0															26	
ANDREWS	0	3	5.89		0	185	244	388	48	0	0			0		0	0	0								0	
KEESLER	1	3	7.10	5.06	1	235	306	433	52	52	0	183														235	
COLMBS	1	3	3.24		0	5	17	17	7	7	0															7	
WHITEMN	1	3	4.04		0	15	26	29	11	11	0															11	
OFFUTT	1	3	5.85		1	50	107	123	40	40	0															40	
NELLIS	1	3	5.90		0	20	77	77	40	40	0															40	
KIRT	1	3	5.40		0	25	40	40	28	28	0															28	
HOLLOMN	1	3	4.68		1	8	30	28	21	21	0															21	
CANNON	1	3	4.87		1	15	29	36	18	18	0															18	
SJOHNS	1	3	4.45		0	15	44	48	21	21	0															21	
GFORKS	1	3	3.82		0	15	34	34	14	14	0															14	
MINOT	1	3	4.64		0	25	47	75	19	19	0															19	
WPATT	1	3	5.90	5.58	0	160	175	433	38	38	0	122														160	
TINK	1	3	4.76		0	25	65	90	41	41	0															41	

MINNFV 1.4458
 Flow clusters 0
 Use civ beds 1
 Min AD pop 25000
 Oper beds 1
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
ALTUS	1	3	3.92		0	7	39	39	10	10	0																10
SHAW	0	3	5.02		0	25	48	90	23	0	0												0				0
ELLS	1	3	4.80		0	15	35	58	18	18	0																18
REESE	1	3	3.18		0	4	10	20	7	7	0																7
DYESS	1	3	4.26		0	15	35	100	18	18	0																18
SHEPP	0	3	5.00		0	80	197	318	18	0	18																0
LAUGH	1	3	3.72		1	5	28	40	4	4	0																4
LACKLND	0	3	7.16	6.74	0	585	1006	1033	70	0	3	0									0						0
HILL	1	3	5.88		0	25	42	55	27	27	0																27
LANGLY	1	3	5.68		0	40	71	120	44	44	0													0	0		44
FAIRCH	1	3	4.71		0	30	61	90	23	23	0																23
WARREN	1	3	3.98		0	15	24	43	12	12	0																12
FTDIX	1	3	6.07		1	20	350	350	56	56	0																56
FOX	1	3	4.86		0	20	42	57	20	20	0																20
NOBLE	0	3	4.90		0	48	100	106	19	0	19																0
LYSTER	0	3	5.60		0	42	69	77	25	0	25																0
BASSETT	1	3	5.02		1	43	74	100	17	17	0																17
BLISS	0	3	5.51		0	30	103	107	18	0	18																0
FITZSIM	0	3	5.37	6.35	0	174	335	375	36	0	36	0															0
EVANS	0	3	7.62		0	149	195	212	70	0	51			0													0
WREED	1	3	6.10	7.72	0	694	718	847	33	33	0	630				31	0	0	0								694
IKE	1	3	7.59	8.25	1	346	757	757	44	44	0	302															346
MARTIN	1	3	7.16		1	172	282	380	62	62	0																62
WINN	1	3	7.06		1	114	148	165	51	51	0																51
TRIP	1	3	7.94	4.52	1	423	439	617	119	119	0	304															423
IRVIN	1	3	7.62		1	60	127	192	55	55	0																55
MUNSON	1	3	4.49		0	20	65	65	30	30	0																30
BLANCH	1	3	8.18		1	146	241	350	67	67	0																67
IRELAND	1	3	6.30		1	84	172	333	47	47	0																47
BJONES	1	3	5.83		1	96	169	169	30	30	0																30
KIMB	0	3	6.76		0	36	68	170	61	0	0				0	0	0										0
LWOOD	1	3	7.51		1	122	480	670	40	40	0																40
PATT	1	3	4.76		0	15	67	67	20	20	0																20
KELLER	0	3	5.34		0	30	62	62	23	0	23																0
WOMACK	1	3	8.52		1	226	272	454	139	139	0																139
REYNOLDS	1	3	7.58		1	100	157	264	47	47	0																47
MONCRF	1	3	7.55		0	96	432	435	48	48	0											23					71
BEAUMT	1	3	7.51	5.91	1	330	482	684	49	49	0	281															330
BROOKE	1	3	7.50	7.58	0	367	450	651	71	71	0	229									67						367
DARN	1	3	8.36		1	203	241	359	111	111	0																111
MCDEE	1	3	5.78		0	42	116	116	39	39	0													0	0		39
KENNER	0	3	5.43		0	49	67	87	27	0	27																0
DEWITT	0	3	7.49		0	68	93	105	95	0	0				0	0	0										0
MADIG	1	3	8.22	6.14	1	381	414	622	101	101	0	280															381
WEED	1	3	5.10		1	25	27	27	12	12	0																12

4347

314 2753

6786

	DOD	Army	Navy	AF
Total sites =	99	32	19	48
Tot. retained =	82	23	17	42

17 9 2 6

	Total beds			Retained beds		
	Oper	Avail	Exp	Oper	Avail	Exp
USN	2395	3383	3865	2304	3238	3746
USAF	2538	4761	6501	1548	3098	4278
USA	4751	7464	9682	4125	6372	8381
DOD	9684	15608	20048	7977	12708	16405

Before After
 Avg MV = 3.00 3.00
 Avg FV = 5.72 5.73
 Avg MC FV = 6.54 6.64

MINNFV 31318
 Flow clusters 0
 Use civ beds 1
 Min AD pop 25000
 Oper beds 0
 MC FV avg req 0
 MC flow 1
 Wgt Pct 1

Units: 7 beds: avail
 Inl 1230

MTF	Open	HW	FV	MC FV	Bin	Oper b	Beds a	Exp be	Ac bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREEDY	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
PEND	1	3	7.28		1	120	222	265	98	98	0															98	
LEMOORE	1	3	5.12		1	37	69	37	29	29	0															29	
SDIEG	1	3	8.48	7.84	1	422	617	583	254	254	0	363														617	
29PALMS	1	3	7.58		1	30	70	40	26	26	0															26	
GROTON	0	3	5.41		0	25	100	96	30	30	0															0	
PENS	1	3	7.19		1	104	221	161	69	69	0															69	
JAX	1	3	6.98		1	131	176	228	97	97	0															97	
GLAKES	1	3	6.48		1	136	228	718	54	54	0															54	
BETH	1	3	6.82	7.40	0	342	459	779	69	69	0	390														459	
PAX	1	3	3.74		1	20	20	32	12	12	0															12	
LEJU	1	3	7.76		1	176	224	238	92	92	0															92	
CHPT	1	3	4.52		1	40	40	27	36	36	0															36	
CHAR	1	3	5.56		1	90	90	90	46	46	0															46	
BEAU	0	3	4.70		0	49	80	54	22	0	22															0	
MILL	1	3	4.37		1	66	102	106	20	20	0															20	
CORP	0	3	4.26		0	42	65	65	14	14	0															0	
PTSMTH	1	3	6.55	7.01	0	431	437	176	277	277	0	148														437	
BREM	1	3	6.98		1	109	137	139	47	47	0															47	
OAKHAR	1	3	5.38		0	25	26	31	24	24	0															24	
MAXWELL	1	3	3.83		0	30	71	118	27	27	0															27	
ELM	1	3	6.03		1	75	139	32	33	33	0															33	
LUKE	1	3	5.02		0	40	60	100	50	50	0															50	
DMONTH	1	3	5.22		0	30	70	112	36	36	0															36	
LROCK	1	3	4.83		0	20	39	68	26	26	0															26	
TRAVIS	1	3	7.88	5.52	1	195	408	388	69	69	0	0														69	
BEALE	1	3	3.76		0	9	14	14	16	16	0															16	
MATHER	1	3	5.06		0	30	35	70	38	38	0															38	
VANBERG	0	3	5.00		0	20	48	46	14	14	0															0	
EDWARDS	1	3	3.82		0	10	30	33	17	17	0															17	
USAFAC	1	3	5.68		0	55	80	157	36	36	0															80	
DOVER	1	3	4.69		0	20	39	60	21	21	0															21	
EGLIN	1	3	6.62		1	85	120	275	58	58	0															58	
TYNDALL	1	3	4.26		1	25	57	79	24	24	0															24	
MACDILL	1	3	5.35		0	50	69	142	60	60	0															60	
PATRICK	1	3	4.82		0	15	20	72	29	29	0															29	
MOODY	0	3	3.81		0	10	47	47	14	14	0															0	
ROBINS	1	3	4.24		0	15	31	32	21	21	0															21	
MHOME	1	3	5.92		1	20	31	31	18	18	0															18	
SCOTT	1	3	5.48		0	95	120	348	44	44	0															44	
BARKS	1	3	5.04		0	25	46	70	26	26	0															26	
ANDREWS	1	3	5.89		0	185	244	388	48	48	0															159	
KEESLER	1	3	7.10	5.06	1	235	306	433	52	52	0	103														155	
COLMBS	0	3	3.24		0	5	17	17	7	7	0															0	
WHITEMN	0	3	4.04		0	15	26	29	11	11	0															0	
OFFUTT	1	3	5.85		1	50	107	123	40	40	0															40	
NELLIS	1	3	5.90		0	20	77	77	40	40	0															40	
KIRT	1	3	5.40		0	25	40	40	28	28	0															28	
HOLLOWIN	1	3	4.68		1	8	30	28	21	21	0															21	
CANNON	1	3	4.87		1	15	29	36	18	18	0															18	
SJOHNS	1	3	4.45		0	15	44	48	21	21	0															21	
GFORKS	0	3	3.82		0	15	34	34	14	14	0															0	
MINOT	1	3	4.64		0	25	47	75	19	19	0															19	
WPATT	1	3	5.90	5.58	0	160	175	433	38	38	0	137														175	
TINK	1	3	4.76		0	25	65	90	41	41	0															41	

MINNFV 3.1318 Form: 2 Beds: avail M1129C

Flow clusters 0
 Use civ beds 1
 Min AD pop 25000
 Oper beds 0
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bln	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
ALTUS	0	3	3.92		0	7	39	39	10	0	10																0
SHAW	1	3	5.02		0	25	48	90	23	23	0													25			48
ELLS	1	3	4.80		0	15	35	58	18	18	0																18
REESE	1	3	3.18		0	4	10	20	7	7	0																7
DYESS	1	3	4.28		0	15	35	100	18	18	0																18
SHEPP	1	3	5.00		0	80	197	318	18	18	0																18
LAUGH	1	3	3.72		1	5	28	40	4	4	0																4
LACKLND	0	3	7.16	6.74	0	585	1006	1033	70	0	0	0									0						0
HILL	1	3	5.88		0	25	42	55	27	27	0																27
LANGLY	1	3	5.68		0	40	71	120	44	44	0													27	0		71
FAIRCH	1	3	4.71		0	30	61	90	23	23	0																23
WARREN	1	3	3.98		0	15	24	43	12	12	0																12
FTDIX	1	3	6.07		1	20	350	350	56	56	0																56
FOX	1	3	4.86		0	20	42	57	20	20	0																20
NOBLE	0	3	4.90		0	48	100	106	19	0	19																0
LYSTER	1	3	5.60		0	42	69	77	25	25	0																25
BASSETT	1	3	5.02		1	43	74	100	17	17	0																17
BLISS	0	3	5.51		0	30	103	107	18	0	18																0
FITZSIM	0	3	5.37	6.35	0	174	335	375	36	0	36	0															0
EVANS	0	3	7.62		0	149	195	212	70	0	26			0													0
WREED	0	3	6.10	7.72	0	694	718	847	33	0	0	0			0			0	0	0							0
IKE	1	3	7.59	8.25	1	346	757	757	44	44	0	713															757
MARTIN	1	3	7.16		1	172	282	380	62	62	0																62
WINN	1	3	7.06		1	114	148	165	51	51	0																51
TRIP	1	3	7.94	4.52	1	423	439	617	119	119	0	0															119
IRWIN	1	3	7.62		1	60	127	192	55	55	0																55
MUNSON	1	3	4.49		0	20	65	65	30	30	0																30
BLANCH	1	3	8.18		1	146	241	350	67	67	0																67
IRELAND	1	3	6.30		1	84	172	333	47	47	0																47
BJONES	1	3	5.83		1	96	169	169	30	30	0																30
KIMB	1	3	6.76		0	36	68	170	61	61	0																68
LWOOD	1	3	7.51		1	122	480	670	40	40	0																40
PATT	0	3	4.76		0	15	67	67	20	0	20																0
KELLER	0	3	5.34		0	30	62	62	23	0	23																0
WOMACK	1	3	8.52		1	226	272	454	139	139	0																139
REYNOLDS	1	3	7.58		1	100	157	264	47	47	0																47
MONCRF	0	3	7.55		0	96	432	435	48	0	23												0				0
BEAUMT	1	3	7.51	5.91	1	330	482	684	49	49	0	277															326
BROOKE	1	3	7.50	7.58	0	367	450	651	71	71	0	309												70			450
DARN	1	3	8.36		1	203	241	359	111	111	0																111
MCDEE	0	3	5.78		0	42	116	116	39	0	0														0	0	0
KENNER	1	3	5.43		0	49	67	87	27	27	0																27
DEWITT	0	3	7.49		0	68	93	105	95	0	0					0	0	0									0
MADIG	1	3	8.22	6.14	1	381	414	622	101	101	0	313															414
WEED	1	3	5.10		1	25	27	27	12	12	0																12

4347 301 2753

6799

	DOD	Army	Navy	AF
Total sites =	99	32	19	48
Tot. retained =	79	22	16	41

20 10 3 7

	Total beds			Retained beds		
	Oper	Avall	Exp	Oper	Avall	Exp
USN	2395	3383	3865	2279	3138	3650
USAF	2538	4761	6501	1881	3544	5256
USA	4751	7464	9682	3405	5243	7250
DOD	9684	15608	20048	7565	11925	16156

Avg MV = Before 3.00 After 3.00
 Avg FV = 5.72 5.83
 Avg MC FV = 6.54 6.75

MINNFV 1.1412
 Flow clusters 1
 Use civ beds 1
 Min AD pop 226785
 Oper beds 1
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

Form: J Beds: oper Utilizat

MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
PEND	1	3	7.28		0	120	222	265	98	98	0																98
LEMOORE	1	3	5.12		1	37	69	37	29	29	0																29
SDIEG	1	3	8.48	7.84	0	422	617	583	254	254	0	168															422
29PALMS	1	3	7.58		1	30	70	40	26	26	0																26
GROTON	1	3	5.41		0	25	100	96	30	30	0																30
PENS	1	3	7.19		0	104	221	161	69	69	0																69
JAX	1	3	6.98		0	131	176	228	97	97	0																97
GLAKES	1	3	6.48		0	136	228	718	54	54	0																54
BETH	1	3	6.82	7.40	0	342	459	779	69	69	0	130			0	48		95		0							342
PAX	1	3	3.74		1	20	20	32	12	12	0																12
LEJU	1	3	7.76		1	176	224	238	92	92	0																92
CHPT	1	3	4.52		0	40	40	27	36	36	0																36
CHAR	0	3	5.56		0	90	90	90	46	0	46																0
BEAU	0	3	4.70		0	49	80	54	22	0	22																0
MILL	1	3	4.37		1	66	102	106	20	20	0																20
CORP	0	3	4.26		0	42	65	65	14	0	14																0
PTSMTH	1	3	6.55	7.01	0	431	437	176	277	277	0	113												41	0	431	
BREM	1	3	6.98		1	109	137	139	47	47	0																47
OAKHAR	1	3	5.38		0	25	26	31	24	24	0																24
MAXWELL	1	3	3.83		0	30	71	118	27	27	0																27
ELM	0	3	6.03		0	75	139	32	33	0	33																0
LUKE	1	3	5.02		0	40	60	100	50	50	0																50
DMONTH	1	3	5.22		0	30	70	112	36	36	0																36
LROCK	1	3	4.83		0	20	39	68	26	26	0																26
TRAVIS	1	3	7.88	5.52	0	195	408	388	69	69	0	126															195
BEALE	0	3	3.76		0	9	14	14	16	0	16																0
MATHER	1	3	5.06		0	30	35	70	38	38	0																38
VANBERG	1	3	5.00		0	20	48	46	14	14	0																14
EDWARDS	1	3	3.82		0	10	30	33	17	17	0																17
USAFAC	1	3	5.68		0	55	80	157	36	36	0					19											55
DOVER	1	3	4.69		0	20	39	60	21	21	0																21
EGLIN	1	3	6.62		0	85	120	275	58	58	0																58
TYNDALL	1	3	4.26		1	25	57	79	24	24	0																24
MACDILL	1	3	5.35		0	50	69	142	60	60	0																60
PATRICK	1	3	4.82		0	15	20	72	29	29	0																29
MOODY	1	3	3.81		0	10	47	47	14	14	0																14
ROBINS	1	3	4.24		0	15	31	32	21	21	0																21
MHOME	1	3	5.92		1	20	31	31	18	18	0																18
SCOTT	1	3	5.48		0	95	120	348	44	44	0																44
BARKS	1	3	5.04		0	25	46	70	26	26	0																26
ANDREWS	0	3	5.89		0	185	244	388	48	0	0				0		0	0	0								0
KEESLER	1	3	7.10	5.06	0	235	306	433	52	52	0	163															215
COLMBS	0	3	3.24		0	5	17	17	7	0	7																0
WHITEMN	1	3	4.04		0	15	26	29	11	11	0																11
OFFUTT	1	3	5.85		0	50	107	123	40	40	0																40
NELLIS	1	3	5.90		0	20	77	77	40	40	0																40
KIRT	1	3	5.40		0	25	40	40	28	28	0																28
HOLLOMN	1	3	4.68		1	8	30	28	21	21	0																21
CANNON	1	3	4.87		1	15	29	36	18	18	0																18
SJOHNS	1	3	4.45		0	15	44	48	21	21	0																21
GFORKS	1	3	3.82		0	15	34	34	14	14	0																14
MINOT	1	3	4.64		0	25	47	75	19	19	0																19
WPATT	1	3	5.90	5.58	0	160	175	433	38	38	0	122															160
TINK	1	3	4.76		0	25	65	90	41	41	0																41

MINNFV 1.1412
 Flow clusters 1
 Use civ beds 1
 Min AD pop 228785
 Oper beds 1
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
ALTUS	1	3	3.92		0	7	39	39	10	10	0																10
SHAW	0	3	5.02		0	25	48	90	23	0	0												0				0
ELLS	1	3	4.80		0	15	35	58	18	18	0																18
REESE	0	3	3.18		0	4	10	20	7	0	7																0
DYESS	1	3	4.26		0	15	35	100	18	18	0																18
SHEPP	1	3	5.00		0	80	197	318	18	18	0																18
LAUGH	1	3	3.72		1	5	28	40	4	4	0																4
LACKLND	0	3	7.16	6.74	0	585	1006	1033	70	0	19	0									0						0
HILL	1	3	5.88		0	25	42	55	27	27	0																27
LANGLY	0	3	5.68		0	40	71	120	44	0	0													0	0		0
FAIRCH	1	3	4.71		0	30	61	90	23	23	0																23
WARREN	1	3	3.98		0	15	24	43	12	12	0																12
FTDIX	1	3	6.07		0	20	350	350	56	56	0																56
FOX	1	3	4.86		0	20	42	57	20	20	0																20
NOBLE	0	3	4.90		0	48	100	106	19	0	19																0
LYSTER	1	3	5.60		0	42	69	77	25	25	0																25
BASSETT	1	3	5.02		1	43	74	100	17	17	0																17
BLISS	1	3	5.51		0	30	103	107	18	18	0																18
FITZSIM	1	3	5.37	6.35	0	174	335	375	36	36	0	*138															18
EVANS	0	3	7.62		0	149	195	212	70	0	51			0													0
WREED	1	3	6.10	7.72	0	694	718	847	33	33	0	661				0	0	0	0								694
IKE	1	3	7.59	8.25	1	346	757	757	44	44	0	*302															346
MARTIN	0	3	7.16		0	172	282	380	62	0	62																0
WINN	0	3	7.06		0	114	148	165	51	0	51																0
TRIP	1	3	7.94	4.52	1	423	439	617	119	119	0	*304															423
IRWIN	1	3	7.62		1	60	127	192	55	55	0																55
MUNSON	1	3	4.49		0	20	65	65	30	30	0																30
BLANCH	1	3	8.18		0	146	241	350	67	67	0																67
IRELAND	1	3	6.30		0	84	172	333	47	47	0																47
BJONES	1	3	5.83		1	96	169	169	30	30	0																30
KIMB	1	3	6.76		0	36	68	170	61	61	0				0	0	0										61
LWOOD	1	3	7.51		1	122	480	670	40	40	0																40
PATT	1	3	4.76		0	15	67	67	20	20	0																20
KELLER	1	3	5.34		0	30	62	62	23	23	0																23
WOMACK	1	3	8.52		0	226	272	454	139	139	0																139
REYNOLDS	1	3	7.58		0	100	157	264	47	47	0																47
MONCRF	1	3	7.55		0	96	432	435	48	48	0												23				71
BEAUMT	1	3	7.51	5.91	0	330	482	684	49	49	0	281															330
BROOKE	1	3	7.50	7.58	0	367	450	651	71	71	0	*245															367
DARN	1	3	8.36		0	203	241	359	111	111	0																111
MCDEE	1	3	5.78		0	42	116	116	39	39	0														3	0	42
KENNER	0	3	5.43		0	49	67	87	27	0	27																0
DEWITT	0	3	7.49		0	68	93	105	95	0	0				0	0	0										0
MADIG	0	3	8.22	6.14	0	381	414	622	101	0	101	0															0
WEED	1	3	5.10		1	25	27	27	12	12	0																12

4347

475 2753

6625

	DOD	Army	Navy	AF
Total sites =	99	32	19	48
Tot. retained =	81	25	16	40

18 7 3 8

	Total beds			Retained beds		
	Oper	Avall	Exp	Oper	Avall	Exp
USN	2395	3383	3865	2214	3148	3656
USAF	2538	4761	6501	1610	3212	4787
USA	4751	7464	9682	3770	6165	8005
DOD	9684	15608	20048	7594	12525	16448

	Before	After
Avg MV =	3.00	3.00
Avg FV =	5.72	5.72
Avg MC FV =	6.54	6.56

MINNFV 3.0621
 Flow clusters 1
 Use civ beds 1
 Min AD pop 226785
 Oper beds 0
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
PEND	1	3	7.28		0	120	222	265	98	98	0																98
LEMOORE	1	3	5.12		1	37	69	37	29	29	0																29
SDIEG	1	3	8.48	7.84	0	422	617	583	254	254	0	363															617
29PALMS	1	3	7.58		1	30	70	40	26	26	0																26
GROTON	1	3	5.41		0	25	100	96	30	30	0																30
PENS	1	3	7.19		0	104	221	161	69	69	0																69
JAX	1	3	6.98		0	131	176	228	97	97	0																97
GLAKES	1	3	6.48		0	136	228	718	54	54	0																54
BETH	1	3	6.82	7.40	0	342	459	779	69	69	0	390				0	0		0	0							459
PAX	1	3	3.74		1	20	20	32	12	12	0																12
LEJU	1	3	7.76		1	176	224	238	92	92	0																92
CHPT	1	3	4.52		0	40	40	27	36	36	0																36
CHAR	1	3	5.56		0	90	90	90	46	46	0																46
BEAU	1	3	4.70		0	49	80	54	22	22	0																22
MILL	1	3	4.37		1	66	102	106	20	20	0																20
CORP	0	3	4.26		0	42	65	65	14	0	14																0
PTSMTH	1	3	6.55	7.01	0	431	437	176	277	277	0	148												0	112		437
BREM	1	3	6.98		1	109	137	139	47	47	0																47
OAKHAR	1	3	5.38		0	25	26	31	24	24	0																24
MAXWELL	1	3	3.83		0	30	71	118	27	27	0																27
ELM	1	3	6.03		0	75	139	32	33	33	0																33
LUKE	1	3	5.02		0	40	60	100	50	50	0																50
DMONTH	1	3	5.22		0	30	70	112	36	36	0																36
LROCK	1	3	4.83		0	20	39	68	26	26	0																26
TRAVIS	0	3	7.88	5.52	0	195	408	388	69	0	69	0															0
BEALE	1	3	3.76		0	9	14	14	16	16	0																16
MATHER	1	3	5.06		0	30	35	70	38	38	0																38
VANBERG	1	3	5.00		0	20	48	46	14	14	0																14
EDWARDS	1	3	3.82		0	10	30	33	17	17	0																17
USAFAC	1	3	5.68		0	55	80	157	36	36	0			0													36
DOVER	1	3	4.69		0	20	39	60	21	21	0																21
EGLIN	1	3	6.62		0	85	120	275	58	58	0																58
TYNDALL	1	3	4.26		1	25	57	79	24	24	0																24
MACDILL	1	3	5.35		0	50	69	142	60	60	0																60
PATRICK	1	3	4.82		0	15	20	72	29	29	0																29
MOODY	1	3	3.81		0	10	47	47	14	14	0																14
ROBINS	1	3	4.24		0	15	31	32	21	21	0																21
MHOME	1	3	5.92		1	20	31	31	18	18	0																18
SCOTT	1	3	5.48		0	95	120	348	44	44	0																44
BARKS	1	3	5.04		0	25	46	70	26	26	0																26
ANDREWS	1	3	5.89		0	185	244	388	48	48	0				26		0	95	0								169
KEESLER	1	3	7.10	5.06	0	235	306	433	52	52	0	102															154
COLMBS	0	3	3.24		0	5	17	17	7	0	7																0
WHITEMN	1	3	4.04		0	15	26	29	11	11	0																11
OFFUTT	1	3	5.85		0	50	107	123	40	40	0																40
NELLIS	1	3	5.90		0	20	77	77	40	40	0																40
KIRT	1	3	5.40		0	25	40	40	28	28	0																28
HOLLOMN	1	3	4.68		1	8	30	28	21	21	0																21
CANNON	1	3	4.87		1	15	29	36	18	18	0																18
SJOHNS	1	3	4.45		0	15	44	48	21	21	0																21
GFORKS	0	3	3.82		0	15	34	34	14	0	14																0
MINOT	1	3	4.64		0	25	47	75	19	19	0																19
WPATT	1	3	5.90	5.58	0	160	175	433	38	38	0	137															175
TINK	1	3	4.76		0	25	65	90	41	41	0																41

MINNFV 3.0621
 Flow clusters 1
 Use civ beds 1
 Min AD pop 228785
 Oper beds 0
 MC FV avg req 0
 MC_flow 1
 Wgt Pct 1

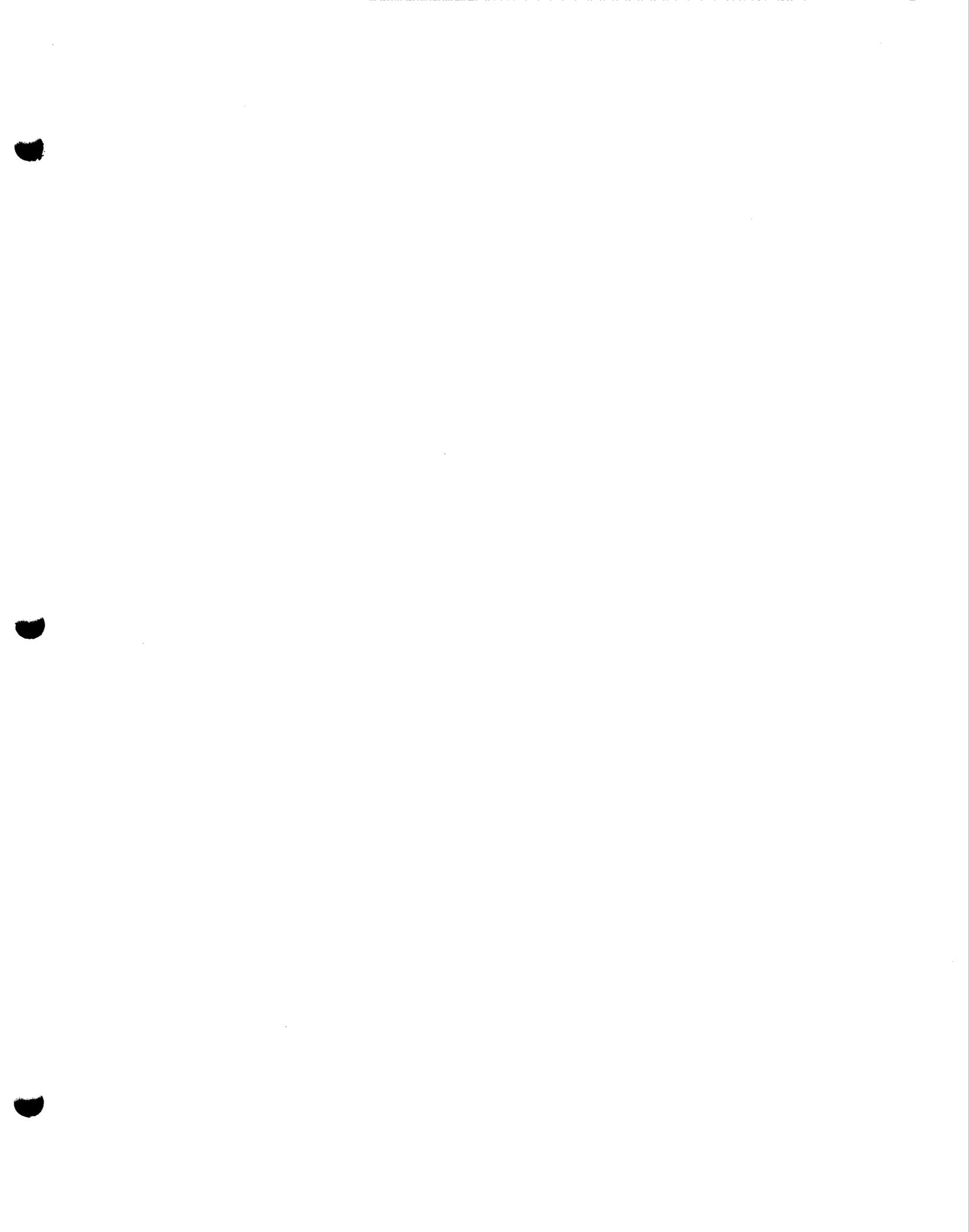
MTF	OPEN	MV	FV	MC FV	Bin	Oper b	Beds a	Exp be	AC bed	Patient	Civ bed	GME be	EVANS	USAFAC	WREED	ANDRE	BETH	DEWIT	KIMB	BROOK	LACKL	SHAW	MONC	LANG	MCDE	PTSM	Total assigned
ALTUS	0	3	3.92		0	7	39	39	10	0	10																0
SHAW	1	3	5.02		0	25	48	90	23	23	0												F 25				48
ELLS	1	3	4.80		0	15	35	58	18	18	0																18
REESE	1	3	3.18		0	4	10	20	7	7	0																7
DYESS	1	3	4.26		0	15	35	100	18	18	0																18
SHEPP	1	3	5.00		0	80	197	318	18	18	0																18
LAUGH	1	3	3.72		1	5	28	40	4	4	0																4
LACKLND	0	3	7.16	6.74	0	585	1006	1033	70	0	0	0									0						0
HILL	1	3	5.88		0	25	42	55	27	27	0																27
LANGLY	1	3	5.68		0	40	71	120	44	44	0														F 27	0	71
FAIRCH	1	3	4.71		0	30	61	90	23	23	0																23
WARREN	1	3	3.98		0	15	24	43	12	12	0																12
FTDIX	0	3	6.07		0	20	350	350	56	0	56																0
FOX	1	3	4.86		0	20	42	57	20	20	0																20
NOBLE	1	3	4.90		0	48	100	106	19	19	0																19
LYSTER	1	3	5.60		0	42	69	77	25	25	0																25
BASSETT	1	3	5.02		1	43	74	100	17	17	0																17
BLISS	0	3	5.51		0	30	103	107	18	0	18																0
FITZSIM	0	3	5.37	6.35	0	174	335	375	36	0	36	0															0
EVANS	1	3	7.62		0	149	195	212	70	70	0			0													70
WREED	0	3	6.10	7.72	0	694	718	847	33	0	0	0					0	0	0	0							0
IKE	1	3	7.59	8.25	1	346	757	757	44	44	0	F 713															757
MARTIN	1	3	7.16		0	172	282	380	62	62	0																62
WINN	1	3	7.06		0	114	148	165	51	51	0																51
TRIP	1	3	7.94	4.52	1	423	439	617	119	119	0	0															119
IRWIN	1	3	7.62		1	60	127	192	55	55	0																55
MUNSON	1	3	4.49		0	20	65	65	30	30	0																30
BLANCH	1	3	8.18		0	146	241	350	67	67	0																67
IRELAND	1	3	6.30		0	84	172	333	47	47	0																47
BJONES	1	3	5.83		1	96	169	169	30	30	0																30
KIMB	1	3	6.76		0	36	68	170	61	61	0				F 7	0	0										68
LWOOD	1	3	7.51		1	122	480	670	40	40	0																40
PATT	1	3	4.76		0	15	67	67	20	20	0																20
KELLER	1	3	5.34		0	30	62	62	23	23	0																23
WOMACK	1	3	8.52		0	226	272	454	139	139	0																139
REYNOLDS	1	3	7.58		0	100	157	264	47	47	0																47
MONCRF	0	3	7.55		0	96	432	435	48	0	23												0				0
BEAUMT	1	3	7.51	5.91	0	330	482	684	49	49	0	F 277															326
BROOKE	1	3	7.50	7.58	0	367	450	651	71	71	0	F 309										F 70					450
DARN	1	3	8.36		0	203	241	359	111	111	0																111
MCDEE	0	3	5.78		0	42	116	116	39	0	0														0	0	0
KENNER	1	3	5.43		0	49	67	87	27	27	0																27
DEWITT	0	3	7.49		0	68	93	105	95	0	0					0	0	0									0
MADIG	1	3	8.22	6.14	0	381	414	622	101	101	0	F 313															414
WEED	1	3	5.10		1	25	27	27	12	12	0																12
						4347				247	2752																6852

	DOD	Army	Navy	AF
Total sites =	99	32	19	48
Tot. retained =	86	26	18	42

13 6 1 6

	Total beds			Retained beds		
	Oper	Avall	Exp	Oper	Avall	Exp
USN	2395	3383	3865	2353	3318	3800
USAF	2538	4761	6501	1711	2907	4640
USA	4751	7464	9682	3647	5667	7697
DOD	9684	15608	20048	7711	11892	16137

Avg MV = Before 3.00 After 3.00
 Avg FV = 5.72 5.72
 Avg MC FV = 6.54 6.75





THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

DEC 05 1994

HEALTH AFFAIRS

MEMORANDUM FOR SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE

SUBJECT: BRAC 95 Joint Cross Service Group for Military Treatment Facilities
(MTFS) and Graduate Medical Education (GME) Revised Alternatives

Attached for your consideration are revised MTF and GME closure and realignment alternatives. These revisions are due to a minor error in the methodology for calculating acute care bed demand and were detected by the DoD IG on the final data review. The revised list is based on the data corrections as incorporated into the Medical Linear Programming Model.

I request your response by December 19, 1994. Comments or questions may be referred to LTC Ed Ponatoski, 703-614-4705.

Edward D. Martin

Edward D. Martin, M.D.

Chairman, Medical Joint Cross Service Group

Attachment:
As stated

Close Hold - Sensitive

DEC 05 1994

**Military Treatment Facilities
Realignment and Closure Candidates**

Facility Name	Location	Proposed Alternative
Noble Army Community Hospital	Fort McClellan, AL	Realign to Clinic
Lyster Army Community Hospital	Fort Rucker, AL	Realign to Clinic
Fitzsimons Army Medical Center	Aurora, CO	Close
USAF Academy Hospital	Air Force Academy	Realign to Clinic
USAF Medical Center Scott AFB	Scott AFB, IL	Realign to Clinic
Kimbrough Army Community Hospital	Fort Meade, MD	Realign to Clinic
Wright Patterson USAF Medical Center	Wright Patterson AFB, OH	Realign to Clinic
Naval Hospital Beaufort	Beaufort, SC	Realign to Clinic
363rd Medical Group	Shaw AFB, SC	Realign to Clinic
6th Medical Squadron	Reese AFB, TX	Realign to Clinic
Naval Hospital, Corpus Christi	Corpus Christi, TX	Realign to Clinic
Willford Hall Medical Center	Lackland AFB, TX	Realign to Clinic
396th Medical Group	Sheppard AFB, TX	Realign to Clinic
1st Medical Group	Langley AFB, VA	Realign to Clinic
Dewitt Army Community Hospital	Fort Belvoir, VA	Realign to Clinic
Kenner Army Community Hospital	Fort Lee, VA	Realign to Clinic

Close Hold - Sensitive