

DEFENSE BASE CLOSURE AND REALIGNMENT COMMISSION
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MEMORANDUM OF PHONE CONVERSATION

DATE: June 23, 2005

TIME: 8:00 AM

CONVERSATION WITH:

Capt (USN) Richard "Dick J. Fletcher, Commanding Officer, Naval Hospital,
Marine Corps Air Station, Cherry Point
Phone: (252) 466-0337/0336, E-Mail: rjfletcher@nhcp.med.navy.mil

SUBJECT: Obtain follow-up information

PARTICIPANTS:

Thomas A. Pantelides

SUMMARY OF DISCUSSION:

Background

Prior to leaving Cherry Point Naval Hospital a number of issues remained. After talking to local hospital officials we questioned if the local community would accept the increase in patient workload if in-patient services are eliminated at Cherry Point. Additionally, we questioned how the Cherry Point Naval Hospital would configuration its workload to implement the proposed realignment?

Three different models were offered by the Cherry Point Naval Hospital staff for consideration based on prior experiences at other bases that have been similarly affected:

- Corpus Christi: Ambulatory Patient Visit (APV) performed at Military Treatment Facility (MTF) and inpatient care at civilian facilities
- Quantico: Outpatient care performed at MTF and all other care shifted to Civilian network or other MTFs
- Newport: APV performed at MTF and military providers credentialed at civilian hospital(s) perform inpatient care.

We agreed to follow up with Captain Fletcher on the outstanding issues.

PHONE DISCUSSION:

Captain Fletcher said that he confirmed with local hospital officials that they could handle the additional workload at an acceptable costs. In addition he provided his estimates of personnel costs given the three models proposed. He noted that the first model would not be acceptable from the perspective of quality patient care. (Attached is the E-mail provided)

Sir:

Attached are our estimates of the potential billets and bodies lost under the 3 outpatient scenarios. We included estimates only about services that could be affected and assumed billets/staffing for outpatient services would remain unchanged.

Right now our current onboard strength for these specific departments is 11 less than authorized billets (BA - basic allowance). We added this difference (11) to the COB numbers projected to be lost to determine billets lost.

As we discussed earlier, the actual BRAC recommendation was for us to close inpatient services and establish an outpatient clinic with an ambulatory surgery center. As such, converting to purely an outpatient clinic is unlikely. This is also the scenario that would have potentially resulted in the greatest loss of billets and staff.

Finally, these numbers represent our best guess and are subject to change. But I think they are still useful in: 1) demonstrating that the BRAC recommendation will impact more than just inpatient billets; and 2) providing you an understanding of the relative magnitude, in terms of lost billets/bodies, each outpatient model would effect.

Please let me know if you have any questions about the data or our estimates.

V/R

CAPT Fletcher

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Post- 45 (34 currently filled and 11 empty billets)
 Personnel lost- 34 (11 Officers, 13 Enlisted, 10 Civilian)
 Difference between BA and COB is 11
 Original BRAC scenario called for the loss of 55 positions (12 Officer, 21 Enlisted, 22 Civilian)
 Not identified as separate departments in the AMD.

Scenario 3

Department	BA			Scenario 3 Losses		
	Officer	Enlisted	Civilian	Officer	Enlisted	Civilian
Specialty Care	-	-	-			
General Surgery	6	3	2	4	8	2
Anesthesia	5	0	0	5	1	0
OB	6	3	4	5	2	4
Orthopedics	1	2	0	1	2	0
*IPCU				7	10	3
*L&D				4	8	8
*OR				2	6	0
*PACU	22	32	11	1	3	0
TOTAL	40	40	17	(29)	(40)	(17)
(NET LOSS)					(86)	

Billets Lost- 97(86 currently filled and 11 empty billets)
 Personnel lost- 86 (29 Officers, 40 Enlisted, 17 Civilian)
 Difference between BA and COB is 11 Billets
 Original BRAC scenario called for the loss of 55 positions (12 Officer, 21 Enlisted, 22 Civilian)
 Not identified as separate departments in the AMD.