

BASE VISIT REPORT
Marine Corps Air Station
Cherry Point

May 28, 2005

LEAD COMMISSIONER:

The base visit was a staff visit without a Commissioner

ACCOMPANYING COMMISSIONER:

None

COMMISSION STAFF:

Thomas A. Pantelides

Colleen Turner

LIST OF ATTENDEES:

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BASE'S PRESENT MISSION:

A major tenant at Cherry Point Marine Corps Air Station is the Naval Air Depot
(NADEP). The Depot at Cherry Point performs major airframe modifications and repair
for a wide variety of DOD aircraft including:

- ➔ the AV-8B Harrier, the vertical takeoff and landing tactical attack jet
- ➔ the medium-lift transport H-46 Sea Knight helicopter
- ➔ the H-53D Sea Stallion and H-53E Super Stallion helicopter
- ➔ the Air Force's MH-53J helicopter

In addition, depot mechanics are modifying the F-4 Phantom, a jet fighter/reconnaissance aircraft, into drones which will enable pilots to fly them from the cockpit or by remote control. The drones will be used to tow targets during pilot training exercises.

Additionally, engineers and logisticians have worked with prime contractors to set logistics and maintenance requirements for the V-22 Osprey. The NADEP is the Designated Repair Point (DRP) for the V-22 which is slated eventually to replace the H-46 Sea Knight currently flown by the Navy and the Marine Corps. The Industrial Engines Repair and Modification Division overhaul and repair numerous aircraft engines for a wide variety of military aircraft.

Examples of this workload include:

- ➔ T58 used in the H-46 Sea Knight, the SH-2 Seasprite and the SH-3 Sea King
- ➔ T400 which powers the UH-1 Huey and AH-1 Cobra attack helicopters
- ➔ F402 that gives the AV-8 Harrier its unique vectored thrust flight capability
- ➔ J79 that can propel the F-4 Phantom at speeds greater than Mach 2
- ➔ T64 that drives the CH-53 Sea Stallion helicopter

The Naval Engine Airfoil Center (NEAC) located at NADEP Cherry Point provides specialized component repairs for the fleet and depots worldwide. The center's ability to repair worn and damaged aircraft turbine and compressor blades, vanes and other parts provides significant costs savings to its customers. The NEAC restores these expensive parts to "like new" condition at a fraction of the cost of purchasing new replacement parts. The center's integral engineering staff also develops new techniques to increase the number of airfoil components available for repair.

More than a third of the depot's production effort is dedicated to revamping aircraft subassemblies, avionics and engine accessories. The depot repairs thousands of types of avionics and dynamic components, such as pressurization units, air starters, valves, gauges, regulators and pneudraulic components.

Engineering personnel work side-by-side with depot production artisans to ensure a quality product is produced the first time. Engineers also develop overhaul, repair, test and troubleshooting procedures when needed. Materials engineering services, such as metallurgy, chemistry, high polymers, testing and related specialized instrumental analyses are also performed.

In addition, engineers and logisticians serve organizational and intermediate-level fleet activities through early identification and resolution of supply, maintenance and design-related problems. Daily interaction with the fleet and the depot establishes the broad base

of expertise need to solve problems and reduce ownership costs throughout the life of the weapon system.

SECRETARY OF DEFENSE RECOMMENDATION:

DOD is recommending a realignment of the Atlantic and Pacific Naval Air Depot (NADEP) and Intermediate Maintenance Activity (IMA) functions. The recommendation realigns bases by disestablishing Depots and establishing Fleet Readiness Centers (FRC) with workload realignments. The major personnel reductions from this realignment coming from Cherry Point Marine Corps Air Station, NC (Atlantic Fleet) and North Island, Naval Air Station, Coronado, CA (Pacific Fleet). The Proposal creates six Fleet Readiness Centers (FRCs) with 13 affiliated FRC Sites at satellite locations.

This recommendation realigns and merges some personnel from depot into intermediate maintenance activities with some consolidation of IMA's with a projected reduction of personnel requirements across the naval air rework and repair enterprise.

Geographically the proposal can be viewed as an east (Atlantic Fleet) and west (Pacific Fleet) realignment. This portion of our review concentrated on the east coast realignment and with the NADEP at Cherry Point because that is the location identified in the proposal with personnel savings of 632 personnel.

East Coast proposal

FRC Mid-Atlantic will be located on NAS Oceana, VA, with affiliated FRC Sites at NAS Patuxent River, MD, NAS Norfolk, VA, and JRB New Orleans, LA. FRC East is located at Cherry Point, NC, with affiliated FRC Sites at MCAS Beaufort, SC, and MCAS New River, NC. The existing intermediate level activity associated with HMX-1 at MCB Quantico, VA, will also be affiliated with FRC East. FRC Southeast will be located on NAS Jacksonville, FL and will have an affiliated FRC Site at NAS Mayport, FL.

West Coast Proposal

FRC West will be located on NAS Lemoore, CA, and will have FRC affiliated sites at NAS JRB Fort Worth, TX, and NAS Fallon, NV. FRC Southwest will be located on Naval Station Coronado, CA, and will have affiliated sites at MCAS Miramar, CA, MCAS Pendleton, CA, MCAS Yuma, AZ, and NAS Point Mugu, CA. FRC Northwest will be located on NAS Whidbey, WA, with no affiliated FRC Sites.

In addition to the actions described in this recommendation, there are four additional actions involved in the comprehensive merger of depot and intermediate maintenance: Naval Air Station Joint Reserve Base Willow Grove, PA, Naval Air Station Corpus Christi, TX, Naval Air Station Brunswick, ME, and Naval Air Station Atlanta, GA. The actions at these installations are described in separate installation closure recommendations in the Department of the Navy section of the BRAC Report. The effect

of these actions will be the absorption of the IMA's at these bases into the east and west coast FRC's. Details of this absorption could not be obtained at NADEP Cherry Point.

The attached reorganization chart depicts the east coast realignment proposal.

SECRETARY OF DEFENSE JUSTIFICATION:

This recommendation reduces the number of maintenance levels and proposes a streamlining of the way maintenance is accomplished. It also transforms and blends some Depot and intermediate level maintenance; and positions maintenance activities closer to fleet concentrations. The recommendation is designed to enhanced effectiveness and efficiency, greater agility, and allows Naval Aviation to achieve the right readiness at the least cost. This transformation of NADEP's to FRC's are projected to produce significant reductions in the total cost of maintenance, repair and overhaul plus the associated Supply system PHS&T (Packaging, Handling, Storage and Transportation) as well as reparable inventory stocking levels as a result of reduced total repair turn-around times, reduced transportation, lower spares inventories, less manpower, and more highly utilized infrastructure.

MAIN FACILITIES REVIEWED:

Naval Air Depot Cherry Point, NC

KEY ISSUES IDENTIFIED:

The cost of operations (issue 4) and the manpower implications and the extent and timing of potential costs and savings (issue 5) were the two questionable issues identified in our visit.

The cost of operations

The DOD recommendation proposes a transformation and realignment of intermediate and Depot level maintenance facilities into a network of Fleet Readiness Centers (FRC)'s on both coasts. Cherry Point was the East Coast site identified as having a reduction of 632 positions as a result of the realignment to FRC's on the east coast.

Our review found that of the 632 positions listed for Cherry Point, only 190 were potential reductions with 104 positions being movements which may be offset by movements from other intermediate maintenance facilities not included in the FRC numbers. The remaining reductions of 338 were initially identified as coming from the Oceana Depot maintenance facility. However, it seems that all estimated reductions are based on workload movements and would be apportioned through-out all of the FRC's and their respective sites on the East Coast. Officials at Cherry Point could not clarify the numbers and have arranged a meeting with officials of the joint service group who calculated the numbers and projected savings for the FRC realignment. This overview of

how costs of operations were calculated and the assumptions used resulting in the estimates of savings are required in order to validate the costs of this proposal.

The manpower implications and the extent and timing of potential costs and savings

The Cherry Point Depot level rework facility has made a number of improvements that have allowed the facility to under-execute indirect and to a lesser degree direct labor standards. Additionally, the Cherry Point facility has drastically reduced turnaround time for its work, this at a time of increased workload given significant extra wear and tear incurred within overseas theaters of operation. Consequently it was not surprising to find that not all authorized personnel positions were filled or that the proposed reductions in personnel could be accomplished with normal attrition.

The Cherry Point Depot currently has about 230 positions that are not filled. Given that cost savings are calculated across all FRC's the effect of this variance could not be determined from our visit at Cherry Point. However this variance would have the effect of reducing projected savings by a degree. We plan to follow-up at the headquarters and the West Coast depot maintenance facilities to assess the variance between authorized and actual personnel in order to assess the manpower implications and the extent and timing of potential costs and savings.

INSTALLATION CONCERNS RAISED:

Installation Officials agreed that the effect of not having all positions filled would result in a very small reduction in projected savings. However, they estimate that over the entire Naval Aviation Enterprise, the proposal will result in major savings.

COMMUNITY CONCERNS RAISED:

Comments by Base and NADEP Officials indicate the Cherry Point community is not concerned over the proposed realignment to FRC's. This may be due to the assurance that reductions in positions as a result of realignment would be over time and be made with normal attrition of personnel. Additionally, the community is aware of the proposed transfer of two squadrons from Oceana. The proposal would transfer one VFA 22 Squadron in fiscal 2008 and one VFA 18 squadron in fiscal 2009. The transfer of these squadrons would increase military personnel at Cherry Point by 500. It is estimated that the total population of Cherry Point will increase by about 3,000 due to the additional family members associated with the proposed transfer.

REQUESTS FOR STAFF AS A RESULT OF VISIT:

Not at this time.

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Naval Hospital Cherry Point, NC

May 28, 2005

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The base visit was a staff visit without a Commissioner

ACCOMPANYING COMMISSIONER:

None

COMMISSION STAFF

Colleen Turner*
Thomas A. Pantelides

LIST OF ATTENDEES

Captain Richard J. Fletcher, Jr., Commanding Officer, Naval Hospital Cherry Point
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Captain Stephen E. Mandia, M.D. Executive Officer, Naval Hospital Cherry Point

Other staff at initial briefing:

Captain De la Pena, Director Outpatient Clinics
Captain Pendrick, Director Surgical Clinics
Commander Perez-Lugo, Director for Administration
Lt Com Higgins, Director Ancillary Services
Lt Reyes Director for Resources
Lt Skorey, Head, Managed Care Department
Darleen Jones, BOD Project Manager

NAVAL HOSPITAL'S PRESENT MISSION

Enhance readiness while providing quality health care services.

SECRETARY OF DEFENSE RECOMMENDATION:

Realign Marine Corps Air Station Cherry Point, NC by disestablishing the inpatient mission at Naval Hospital Cherry Point; converting the hospital to a clinic with an ambulatory surgery center.

Note: This is one of nine hospitals that DoD is recommending be disestablished and converted to a clinic with an ambulatory surgery center. (The other facilities are: Ft. Eustis Medical Facility; Ft. Carson Medical Facility; Andres AFB, MD 89th Medical Group; MacDill AFB, FL 6th medical Group; Keesler AFB, MS 81st Medical Group; Scott AFB, IL 375th Medical Group; Naval Hospital Great Lakes, IL; and Ft. Know Medical Facility.)

SECRETARY OF DEFENSE JUSTIFICATION

The Department will rely on the civilian medical network for inpatient services. This recommendation supports strategies of reducing excess capacity and locating military personnel in activities with higher military value with a more diverse workload, providing them with enhanced opportunities to maintain their medical currency to meet COCOM requirements. Additionally, a robust network with available inpatient capacity of Joint Accreditation of Hospital Organizations (JCAHO) and/or Medicare accredited civilian/Veterans Affairs hospitals is located within 40 miles of the referenced facility.

Cost considerations developed by DoD

Note: These cost considerations are for all 9 inpatient conversions.

- One-Time Costs: \$ 12.9 million
- Net Savings (Cost) during Implementation: \$ 250.9 million
- Annual Recurring Savings: \$ 60.2 million
- Return on Investment Year: Calendar Year (20 Years)
- Net Present Value over 20 Years: \$ 818.1 million

MAIN FACILITIES REVIEWED

Naval Hospital Cherry Point, NC
Craven Regional Medical Center 2000 Neuse Boulevard New Bern, NC 28560
Carteret General Hospital 3500 Arendell St. Morehead City, NC 28557

KEY ISSUES IDENTIFIED

In considering the closure of the in-patient function at Cherry Point Naval Hospital a number of issues arose. Although the hospital provides a wide array of medical services, the in-patient services provided are overwhelmingly labor and delivery (92%)

constituting 586 total deliveries per year for an average of approximately 50 births per month (Range 40-70). If these in-patient services are eliminated they must be provided by the local community.

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: APV performed at MTF and inpatient care at civilian facilities
 - Quantico: Outpatient care performed at MTF and all other care shifted to network or other MTFs
 - Newport: APV performed at MTF and military providers credentialed at civilian hospital(s).
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- To maintain quality of care and continuity of services, the Newport Model was preferred by the Cherry Point staff and exploration of the feasibility raised a number of other issues.
 - Two hospitals, Craven Regional Medical Center and Carteret General Hospital, are within 20 miles of the installation in opposite directions requiring at least a half hour drive. Only one of the hospitals is currently a Tricare network provider. Visits to each hospital revealed the following:
 - Neither of the hospitals have the capacity to handle the total extra workload by themselves. If both hospitals accepted approximately half the workload each, they could provide the needed services.
 - For primarily financial reasons, the ObGyn staff at the hospital that is currently a network provider may be reluctant to take Tricare labor and delivery in-patients at the current rate offered and would most likely require a higher rate to provide the services.
 - The hospital that is not currently a network provider (and thus receives a higher rate for labor and delivery services) was more inclined to add the base's population to their workload.
 - By laws of each hospital presented obstacles of varying degrees of difficulty related to the credentialing of military physicians to work as staff at these civilian hospitals
 - Requirements for the doctor to live within 30 minute access to the hospital.
 - Malpractice insurance

- Care for other patients who come to the hospital while they are in attendance.

The Cherry Point Naval Hospital staff had the following concerns:

- Emergency room implications
- Adequacy of the OB provider network
- Ability to credential military providers at civilian hospitals
- Outpatient workload impacts
- Potential future additions of other squadrons at Cherry Point Marine Air Station

The following analysis was provided by the staff of CPNH:

1. Average daily census (or workload):

Fiscal Year	Average Daily Patient Load
2001	8.31
2002	9.84
2003	8.57
2004	9.20
2005	7.81

2. Excess capacity:

Additional bed spaces and square footage available to accommodate surges in inpatient care for short periods of time. No excess capacity based on staffing.

Staffing:

NHCP	COB FY03	COB FY04	COB FY05	BA ¹	NMP ²
Officers	83	83	80	88	73
Enlisted	154	162	153	196	158
Civilian Gs	136	128	120	123	
Civilian Contract	87	95	88		
Total	461	447	441		

Note 1: Basic allowance (BA) essentially equals those billets projected in the FYDP.

Note 2: Navy Manning Plan (NMP) represents our fair share of BA based on actual end-strength. For CONUS facilities NMP is +/- 90% of BA. As our BA is increased or decreased, our NMP allowance increases/decreases as well.

Beds:

NHCP Beds	Active	Inactive	Total	Constructed
IPCU	22	6	28	23
L&D	3		3	3
PACU	6	4	10	10
ER	10		10	10

Square Footage for Inpatient Care (3rd floor):

IPCU	9981
L&D	1172
OR	11351

Square Footage for other activities (3rd floor):

Nursing Administration	278
Training & Education	3182
Religious Services	554
Performance Improvement & Patient Safety	803

3. Proportion of outpatient to inpatient visits Approximately 1 percent:

Fiscal Year	Inpatient Dispositions	Outpatient Encounters
2001	1,393	149,746
2002	1,620	149,035
2003	1,506	159,504
2004	1,547	162,204

4. Proportion of total cost of inpatient to outpatient services:

FY 2004

Total Costs for Inpatient Care (Including indirect costs)	\$ 5,648,900 (17%)
Total Cost for Outpatient Care (Including indirect costs)	<u>\$27,545,918</u> (83%)
Grand Totals	\$33,194,818

5. Service population for outpatient vs. inpatient services:

Inpatient population primarily mothers and newborns (92%). Average inpatient population younger than outpatient population age mixture which includes TFL (TRICARE for Life) and retirees.

6. Present service population (i.e. number of active duty (AD), active duty family members (ADFM), retirees, etc.):

Naval Hospital Cherry Point Catchment Area May 2005	
Enrolled to Naval Hospital Cherry Point	
AD	2090
ADFM	9621
Retiree/Retiree FM	4196
Total	15907
Supported by NHCP	
Ops Forces	7166
TFL (TFL patients that have PCM at NHCP)	860
Total	8026
Prime Patients Enrolled to Civilian PCM	
ADFM	265
Retiree/Retiree FM	396
Total	661
Non-Prime Patients in Catchment Area	
**Standard/TFL(TFL patients that do not have PCM at NHCP)	9887
Total Catchment Area Population	32482

**Standard/TFL patients are not enrolled to the MTF or HealthNet; therefore, we do not track the exact numbers for this category. NHCP tracks TFL patients that receive healthcare services in the MTF.

Proportion of service population getting care from the civilian provider network:

Total catchment area population: 33 % $(661+9887)/32482$ (see chart above)

Percentage based on patients opting for TRICARE Prime less than 3% $(661/(15907+8026+661))$

7. Inpatient care through emergency department:

FY 03	FY 04	FY 05
33	131	82

8. Where emergency care can be diverted once hospital becomes a clinic and ambulatory surgical center:

- Craven Regional Medical Center, New Bern, NC - 20 miles
- Carteret General Hospital, Morehead City, NC - 20 miles (non-network)
- Naval Hospital, Camp Lejeune, Jacksonville, NC - 45 miles
- Pitt Memorial Hospital, Greenville, NC - 75 miles
- New Hanover Regional Medical Center, Wilmington, NC - 87 miles

9. Medical services remaining as part of clinic and ambulatory surgery center:

Primary Care	Specialty Care
Force Health Protection (1) (2) (3)	Emergency++ Med/Urgent Care Center (1) (2) (3)
Family Medicine/Primary Care/Peds (1)(2)(3)	Internal Medicine (1) (2) (3)
Health Promotions (HELMS) (1) (2) (3)	Mental Health (1) (2) (3)
Aviation Medicine (1) (2) (3)	OB (2)
Ancillary Services	Optometry (1) (2) (3)
Diagnostic Radiology (1) (2) (3)	Preventive Medicine (1) (2) (3)
Laboratory Services (1) (2) (3)	Oral Surgery (1) (2) (3)
Pharmacy (1) (2) (3)	Orthopedics (1) (2)
Physical Therapy (1) (2) (3)	Industrial Hygiene (1) (2) (3)
Specialty Care	Occupational Medicine (1) (2) (3)
General Surgery (1) (2)	Chiropractic (1) (2) (3)
Anesthesia (1) (2)	Dietetics (1) (2) (3)
GYN (1) (2) (3)	Podiatry (1) (2)

- Notes: (1) Outpatient + Ambulatory Surgical Center on-site
 (2) Outpatient + Ambulatory Surgical Center on-site + civilian hospital privileges
 (3) Outpatient Clinic only

10. Construction or remodeling needed to convert the hospital to a clinic and ambulatory surgery center? Cost; MILCON?

NA

11. Hospitals, including VA medical centers, within 40 miles of your facility:

- Craven Regional Medical Center - New Bern, NC 20 miles
- VA Outpatient Clinic-Morehead City (do not see our patients-not on network)

Carteret General Hospital, Morehead City, NC (not on network) 20 miles

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12. How can you assure that service members, their dependents and retirees will receive timely inpatient services through the civilian provider network?

Naval Hospital Cherry Point will continue to work with the MCSC to ensure that there is an adequate civilian network for our beneficiaries. It is the responsibility of the contractor to ensure that there is an ample specialty network to provide needed services to the NHCP beneficiaries. The current contractor is Health Net. Health Net employs a local Field Optimization Manager and will be hiring a local Community Provider Representative. Both of these people work closely with the MTF and the civilian community to ensure timely, safe, appropriate care for our beneficiaries. We believe the MCSC will be readily able to ensure adequate civilian hospital capacity for our patients. However, the MCSC may encounter some difficulty in ensuring the availability of civilian providers, given the sparseness of the local, eastern-NC network.

13. Estimated additional cost of providing inpatient services through the civilian network:

\$3,321,000 (Cost estimated from 586 births at a rate of \$5,700 per birth as estimated with our network provider.

14. Cost savings and how they were calculated by providing inpatient services through the civilian medical network:

\$2,327,900 - calculated by taking the total costs as derived from our Expense Assignment System which include:

Direct Costs (personnel, supplies, contracts, misc.):	\$2,788,200
Ancillary Services (Lab, Radiology, Pharmacy):	\$1,117,700
Support Services (Administrative Costs):	\$1,743,000
Total:	\$5,648,900

Total estimate for services in the civilian network then subtracted for total savings.

Total MTF Cost:	\$5,648,900
Total Network Cost:	\$3,321,000
Total Savings:	\$2,327,900

Credentialing of NHCP Military Physicians at Local Civilian Hospitals

Issue: Granting of Civilian Hospital Staff Privileges to Military Physicians

Background: In anticipation of various post-BRAC scenarios for Naval Hospital Cherry Point, the BRAC committee members and the CO/XO of Naval Hospital visited both Craven Regional Medical Center and Carteret General Hospital to hold discussions on the BRAC issue and their ability to absorb the hospital's inpatient workload (primarily OB). We also discussed their position of credentialing military providers and allowing them to provide inpatient services at their facility (i.e., the "Newport" model).

Discussion: In order to work at a civilian hospital, military physicians will need to be granted privileges based on each hospital's Medical Staff By-laws. These by-laws are similar for both hospitals and include the following requirements:

- Medical license issued by the state of North Carolina
- Board certified or actively pursuing board certification (board eligible)
- Able to respond to emergencies within 30 minutes
- ER call with the acceptance of "unassigned" patients – this would mean that military physicians need to take care on non-military patients that present to the ER for care. This implies that each military physician carry NC medical malpractice coverage since these patient's are not covered under the federal tort system. Craven Hospital and the OB/GYN group that supports Craven would not support a waiver of this requirement for military physicians. Carteret Hospital was willing to work the issue – for example, have a military call schedule that would take care of military patients in conjunction with a civilian call schedule that would take care of non-military patients.
- Medical malpractice coverage – military physicians taking care of military patients would be covered under federal tort system.
- Cannot be on-call for more than one hospital at a time – this would preclude having the same military physician cover call at both Craven and Carteret Hospitals at the same time.

Recommendation: None. For information purposes only.

INSTALLATION CONCERNS RAISED

None

COMMUNITY CONCERNS RAISED

None

REQUESTS FOR STAFF AS A RESULT OF VISIT

None