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SAIE-IA

26 February 2004

MEMORANDUM FOR Mr. Peter Potochney, Director, BRAC Office, OUSD (AT&L)

SUBJECT: Medical JCSG Military Value Analysis Report and ISG Briefing

1. I appreciate the opportunity to review the draft Military Value (MV) Analysis Report. In general, we found the report sufficiently detailed to understand the framework and work-breakdown structure; the approach is generally sound with minor technical issues to fix.
2. We have concern about using a function entitled infrastructure. This seems to be too tightly correlated with Criterion 2. We also are concerned with assigning Criteria 2 and 3 weights of "0". We request that the Medical JCSG considers infusing infrastructure into other functions rather than treating it separately. Without additional justification, the Army expects the "0" weights to be abolished to eliminate a possible violation of selection criteria.
3. The Medical JCSG reports using a sensitivity analysis to estimate the potential degree of variability and its ability to differentiate activities from one another. We request that your report make clear that this data was notional and not certified, so that it is clear that the scoring plan was not biased through the use of actual data.
4. Before we concur with the final report, we will need to review the final and complete list of questions and data elements that will be included by the MJCSG in Data Call #2. We are also attaching a few specific comments on the approach for review and action.
5. TABS looks forward to continuing to work with the MJCSG on MV and other efforts.

Encl
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Craig E. College
Deputy Assistant Secretary of the Army
(Infrastructure Analysis)

CF:
VCSA
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MG Farmer, Army Rep, Medical JCSG

Specific Comments

Several concepts in the report are insufficiently clear to gather data that will be useful to MJCSG. For example:

p. 3. Selection Criteria: Please update the definitions of Criteria 1 through 4 to reflect those used in the Final Selection Criteria from the 12 February Federal Register. The current wording appears to reflect an earlier set of definitions.

p. 7, 11, 19, 27. Unique capabilities. “A consequence of these assumptions is that the closure of any activity that is unique in its ability to train a particular element of the medical/dental ET mission, or provide unique capabilities in support of that mission, will have an immediate impact on the ability of the DoD to continue to meet the full spectrum of mission requirements.” The statement seems to indicate that closure is not possible for a facility with a unique capability. This is untrue, as the capability may need to be preserved but could be better accomplished elsewhere. The transition would have to be executed carefully to preclude “an immediate [disruptive] impact. A better statement for the report would be, “A consequence of these assumptions is that the closure of any activity and the relocation of its unique training or other mission must be executed so as to preclude and immediate disruptive impact...”

p. 10, 13, 15, 17, 23. Weight vs. Contribution: We fail to understand the distinction made between “weights per se” and “contribution.” We recommend that you call them weight -- as do all other JCSGs and the services -- rather than create a difference in language that may confuse the Commission or the Congress.

p. 14. Dental Market. Because dental care is a benefit only for active duty members, only active duty populations will be considered. How is the family member considered?

p. A-15 and on. Max Scores: The max score for Attribute 1, Metric 1 is infinity, the min score is 1. Attribute 2, Metric 1’s max score is 1, the min score is 0. How do you normalize these (and other) metrics? For your weighting scheme to work, all max scores for each weighted metric or attribute must be the same. TJCSG is using 1, Army is using 10, others are using 100. Will you normalize all scores? If so, that process must be described in your report.

p. A-16. We fail to see how any facility would answer No to this question. Don’t all facilities enhance the care they provide because of the presence of training programs? Why would an MTF answer otherwise?

p. B-1/2. Quality of Life. “The MJCSG believes that in addition to operational readiness, quality of life for members of our armed services and their beneficiaries, is of the utmost importance, and thus translates into high military value.” We believe that operational readiness is of utmost importance and that quality of life is an important supporting factor. Do the weights given to quality of life factors support this priority?

p. C-16. How variable is the U_m metric? Only 1 facility (by definition) can exceed 70% in any area, and often no facility will exceed 70%. This metric does not appear to have enough variability to assist in discriminating among facilities.

p. C-18. Both of the metrics are based on a facility's self-report of "ability to support" an S&T core competency or an AD/ACC. Is "ability to support" well defined? Can't a facility support them all with sufficient resources? Is it better to ask for those that are supported? Or perhaps to better define conditions under which to report an ability to support?

p. D-9. Class VIII (Blood). Define population. Does it consider family members, civilian government workers, students/trainees, etc.? Does it consider the population that cannot give blood due to inoculations or other factors that prevent donating? Are there off-post capabilities? How do we define this question to get commensurate data from the field?

p. D-24. This formula does not seem to provide the insight that is suggested. What FCI is being used? What is its range? Why does dividing a weighted sum of medical facility sizes by the total installation size make sense?

p. D-26. Define a "unique medical facility." Facility or equipment or capability or what is intended? How will the question be phrased?