



DEFENSE BASE CLOSURE AND REALIGNMENT COMMISSION
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July 13, 2005
JCS # 14

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 The Honorable James V. Hansen
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 General Lloyd W. Newton, USAF (Ret.)
 The Honorable Samuel K. Skinner
 Brigadier General Sue Ellen Turner, USAF (Ret.)

Executive Director:
 Charles Battaglia

Mr. Bob Meyer
Director
BRAC Clearinghouse
1401 Oak St.
Roslyn VA 22209

Dear Mr. Meyer:

I respectfully request a written response from the Department of Defense concerning the following requests submitted for the Medical Joint Cross-Service clearinghouse team:

The recommendations reduce the number of facilities that medical enlisted staff can use to obtain their Phase II inpatient care experience. How do the services plan to provide the necessary inpatient care given the reduced numbers of facilities available? What alternatives have been proposed and what are the timelines for the implementation of any alternatives? Please provide in as much detail as possible.

Additionally, the reduced number of facilities will also impact on the services ability to provide other medical education such as training of residents and specialized training necessary for deployment--have alternatives been proposed?

What will be the source of medics/how will billets be resourced when or if expeditionary force is required? Given the planned consolidation of training from four locations to one at Fort Sam Houston, will there be any potential problems in fielding the require medics needed by the services especially for the increased demand for medics in expeditionary force requirements.

If many bases are transitioning from in-patient care to ambulatory care, what will be the process for training the medical staff for deployment and in-patient care?

Given that Fort Carson does not show a cost savings, what is the benefit for implementing the recommendation?

As plans are formulated to downsize inpatient services, will the over 6DCN 5532 population affect the decision for either maintaining or constructing facilities to accommodate this workload? Have you considered the ripple effect of eliminating the inpatient function at the hospitals identified in the recommendations and has there been any effort to identify the extent of this ripple effect at said hospitals. If this ripple effect has been identified please list the hospitals that will be affected?

Given that there are many more hospitals that could have been recommended for realigning inpatient services and creating outpatient clinics with ambulatory surgery centers what criteria was used for selecting these ten?

Please describe how it was determined in all the areas affected by changes to medical services that the private sector could accommodate military beneficiaries.

What is the cost for tearing down Walter Reed and rebuilding in place? How would this be accomplished?

What is the cost of refurbishing/upgrading Walter Reed and maintaining it and the Armed Forces Institute of Pathology?

I would appreciate your response by July 19, 2005. Please provide a control number for this request and do not hesitate to contact me if I can provide further information concerning this request.

Yours sincerely,

Frank Cirillo
Director
Review & Analysis



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

DCN 5532

July 22, 2005

MEMORANDUM FOR OSD BRAC CLEARINGHOUSE

FROM: AF/SGE
1420 Air Force Pentagon
Washington, DC 20330-1420

SUBJECT: OSD BRAC Clearinghouse Tasker C0545/JCS#14

Attached is the Medical Joint Cross Service Group response to the referenced query.

If you have any questions, please contact me at (703) 692-6990 or
mark.hamilton@pentagon.af.mil.

A handwritten signature in black ink that reads "Mark A. Hamilton".

MARK A. HAMILTON, COL, USAF, BSC
Secretary
Medical Joint Cross Service Group

Attachments:

1. Response to Query

Q. The recommendations reduce the number of facilities that medical enlisted staff can use to obtain their Phase II inpatient care experience. How do the services plan to provide the necessary inpatient care given the reduced numbers of facilities available? What alternatives have been proposed and what are the timelines for the implementation of any alternatives? Please provide in as much detail as possible.

A. The ability to absorb Phase II training was examined by the Education & Training SMEs of all three services. There may be some reorganization required, but the capacity to train within the MHS remains. Additionally, some Phase II training can take place at ambulatory care centers - where same day surgery occurs. So those training for instance in San Antonio may do some clinical training at Brooke AMC and some at Willford Hall. The longer joint basic training, may also reduce the requirements for some AF Phase II training.

Q. Additionally, the reduced number of facilities will also impact on the services ability to provide other medical education such as training of residents and specialized training necessary for deployment--have alternatives been proposed?

A. The Medical JCSG determined enough capacity exists within the Military Health System to train residents. If a greater capacity is required, civilian programs can be utilized. Some resident and many fellowship training programs already occur within civilian facilities.

Q. What will be the source of medics/how will billets be resourced when or if expeditionary force is required? Given the planned consolidation of training from four locations to one at Fort Sam Houston, will there be any potential problems in fielding the require medics needed by the services especially for the increased demand for medics in expeditionary force requirements.

A. The Services are very familiar with maintaining the benefit when medics are called to deploy. In these cases the Services have a variety of options: backfill with Reserves, Contract, or send beneficiaries to the TRICARE Network. The Medical JCSG does not anticipate any problems with fielding expeditionary force requirements.

Q. If many bases are transitioning from in-patient care to ambulatory care, what will be the process for training the medical staff for deployment and in-patient care?

A. The training requirements remain the same regardless of the location of the provider. The clinical competencies remain the same in either military or civilian hospitals. The Services have established training programs that already address this training for providers in both the civilian and military treatment facilities.

Q. Given that Fort Carson does not show a cost savings, what is the benefit for implementing the recommendation?

A: The Fort Carson/US Air Force Academy as a stand alone recommendation had a one year payback with a Net Present Value (Savings) of 3.9M and an annual savings of \$309K. However,

a distinguishing feature of the recommendation is the opportunity to place the providers at USAFA into a facility with a higher patient throughput and more opportunities for clinical practice.

Q. As plans are formulated to downsize inpatient services, will the over 65 population affect the decision for either maintaining or constructing facilities to accommodate this workload?

A. All beneficiary categories were considered in the Medical JCSG deliberations. In the San Antonio and NCR recommendations the over 65 population was critical for supporting DoD's Graduate Medical Education programs. Therefore in both these locations the new construction includes workload from the over 65 beneficiary group.

Q. Have you considered the ripple effect of eliminating the inpatient function at the hospitals identified in the recommendations and has there been any effort to identify the extent of this ripple effect at said hospitals. If this ripple effect has been identified please list the hospitals that will be affected?

A. As a part of its deliberations, the Medical JCSG considered the local communities ability to absorb the medical workload. The Medical JCSG was informed in these deliberations by the capacity reported by the local hospitals in annual surveys and by the Beneficiary Workgroup established by Congress to review the impacts of our healthcare decisions on the local healthcare markets. We did not identify a single hospital; rather we reviewed the hospitals within a 40-mile radius around the military hospital. The details of these deliberations are available in the minutes of the Medical JCSG meetings posted on the DOD BRAC Website.

Q. Given that there are many more hospitals that could have been recommended for realigning inpatient services and creating outpatient clinics with ambulatory surgery centers what criteria was used for selecting these ten?

A. The criteria used to determine the inpatient realignments were:

- 1. The outputs of the DoD Approved optimization model.*
- 2. Reviewed all sites with a low (less than 10) average daily census.*
- 3. Multi Service Market areas or sites where two or more medical treatment facilities exist in a geographic area.*

Q. Please describe how it was determined in all the areas affected by changes to medical services that the private sector could accommodate military beneficiaries.

A. The Medical JCSG used the data from the America Hospital Association on the number of beds for a given hospital. The Medical JCSG then compared the average daily patient load (ADPL) from the military hospital to determine if the civilian hospital had the capacity to absorb

the workload. The Medical JCSG used a 40-mile radius around each facility. The Medical JCSG also consulted with the NDAA Section 726 Beneficiary workgroup (appointed by the Secretary of Defense) to advise on the recommendations but not be a part of the deliberation process.

Q: What is the cost for tearing down Walter Reed and rebuilding in place? How would this be accomplished?

A: The Medical JCSG did not explore this option since it did not meet the BRAC charter for infrastructure reductions. This does not resolve the issue of having two large medical facilities working well under their design capacity within 7 miles of each other.

We did investigate moving the Bethesda workload into Walter Reed Army Medical Center. Our estimate was that this would require a complete refurbishing of the Walter Reed facility, as well as considerable construction. Moving Bethesda to Walter Reed Army Medical Center was estimated to cost approximately \$400M more than moving Walter Reed into Bethesda. This implies that the cost to refurbish Walter Reed would be well over \$1B. The refurbishment would also cause significant dislocations of services as the entire facility would have to be refurbished requiring the shifting of most of the current workload into the private sector.

Q: What is the cost of refurbishing/upgrading Walter Reed and maintaining it and the Armed Forces Institute of Pathology?

A: Refurbishing Walter Reed was not addressed by the Medical JCSG as this was not within the BRAC charter of infrastructure reduction. The Medical JCSG did evaluate moving Bethesda into the Walter Reed Army Medical Center and found that this action would cost approximately \$400M more than the recommendation. The Medical JCSG addressed the issue of having two large medical centers, working well under their design capacities, within 7 miles of each other. Our analyses showed that by reducing this infrastructure, without reducing healthcare provided to our beneficiaries.