



DEFENSE BASE CLOSURE AND REALIGNMENT COMMISSION
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July 29, 2005
JCS #33

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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:

Med 10: Enlisted Medical Training

How will the services be able to maintain integrity of teaching curricula given the varying emphasis that each service has on the training of their medical staff? Also, please discuss this as it relates Graduate Medical Education programs at locations affected by the other DOD BRAC recommendations.

Will the loss of students receiving their clinical experience create a cost for the hospitals (military, civilian and Dept. of Veterans Affairs) that relied on that labor?

Will there be additional transportation cost associated with the movement of students from Great Lakes which is co-located with the boot camp at Great Lakes to Fort Sam Houston? What is the projected cost and was it included in the Cobra analysis?

Med - 4: Walter Reed Army Medical Center

In your July 22, 2005 response to us, you stated that you "did investigate moving the Bethesda workload into Walter Reed Army Medical Center" and that it would "cost approximately \$400M more than moving Walter Reed into Bethesda." Please provide your analysis including the Cobra run.

Could you clarify a sentence in your July 22, 2005 response to us about the cost of refurbishing/upgrading Walter Reed -- the last sentence reads, "Our analyses showed that by reducing this infrastructure, without reducing healthcare provided to our beneficiaries."

On July 1, 2005, GAO reported that the “(Medical Joint Cross-Service Group) DGN 7515 incorrectly reported certain financial data for its recommendations involving the Walter Reed Army Medical Center”. Please provide a list of the incorrectly reported data and an updated Cobra run that reflects the use of the correct data.

Med – 12: Convert Inpatient Services to Outpatient Clinics and Ambulatory Surgery Centers

In your July 22, 2005 response to us, you stated that “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.” Did you consult with accredited civilian GME programs to determine that their programs can be utilized; with whom did you consult?

It has been reported that the Keesler Medical Center’s military value was incorrectly calculated, and on July 28, 2005 during our meeting at Bolling AFB it was stated that even with the correction to Keesler’s military value score and a re-running of the optimization model, Keesler still fell within the review curve. Please provide the updated military value list that includes the corrected military value for Keesler Medical Center.

I would appreciate your response by August 3, 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 7515

August 17, 2005

MEMORANDUM FOR OSD BRAC CLEARINGHOUSE

FROM: AF/SGE
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: OSD BRAC Clearinghouse Tasker C0755

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

Med 10: Enlisted Medical Training

How will the services be able to maintain integrity of teaching curricula given the varying emphasis that each service has on the training of their medical staff?

Curriculum issues and scope of practice concerns will be addressed during implementation. The Medical JCSG envisioned that a common basic core of medical training will be conducted jointly with the Service specific training accomplished as necessary. In addition, each Service will maintain administrative control of their students to ensure proper acculturation. As the implementation planning unfolds, we anticipate that we will discover more commonality rather than uniqueness. As this commonality is exploited, the Service unique training should decrease. The goal is to train medics that can operate in joint, interoperable environments.

It should be noted that several enlisted specialty training programs are already taught in a joint environment and have been consolidated when space was available using the Interservice Training Review Organization (ITRO) process. Some examples of bi or tri-service training that features a common core with Service specific training aspects are: biomedical equipment repair technician training; dental laboratory technician; respiratory therapy technician; physical therapy technician; nuclear medicine technologist; Physician Assistant.

This consolidation of the medical training at Ft Sam Houston is an evolution of the ITRO that leverages their successes. The programs mentioned provide a ready model for the use during the implementation deliberations on the integration of curricula and training syllabi. Consolidating all enlisted medical training in a single location takes advantage of economies of scale and synergies that can be developed within the San Antonio area.

Also, please discuss this as it relates Graduate Medical Education programs at locations affected by the other DOD BRAC recommendations.

The Medical JCSG carefully considered the impacts of the recommendations on the DoD's capability to meet its GME needs. In the end, of the over 750 annual in-house GME positions, 33 may have to be sourced to the civilian community if all of the recommendations are approved, the DoD GME requirement remains the same, and the services are unable to successfully recertify all GME programs under the proposed movement of inpatient delivery locations. The Medical JCSG also reviewed each of these 33 positions by specialty and determined that sourcing these positions to the civilian community would not adversely impact the services' ability to meet the mission.

Graduate Medical Education programs, particularly the integrated programs in both the National Capital Area and the San Antonio area, have demonstrated the ability to maintain the integrity of training curriculum in a Tri-Service environment since the integration of programs that took place in the mid 1990s. The Accreditation Council for Graduate Medical Education (ACGME), via its program requirements for each specialty, sets the standards for residency and fellowship

training against which all programs will be judged. Since all three Services must use the same yardstick, there should be no issue in maintaining integrity of curriculum.

Will the loss of students receiving their clinical experience create a cost for the hospitals (military, civilian and Dept. of Veterans Affairs) that relied on that labor?

The Navy reported the following information from their data call, 7 Feb 05, for Question 44 Non-DoD Federal Agency Impacts for the realignment of the Naval Hospital Corps School at Great Lakes.

“For the North Chicago, Veterans Affairs (VA) Medical Center, the loss of the Naval Hospital Corps School training program would result in a significant decrease in the capacity to provide the level of individualized attention currently afforded to veterans by the Naval Hospital Corps School students. This includes, but is not limited to, a wide variety of direct care interventions, including physical and psychological support, rehabilitative and diversional activities, and other quality of life enhancements which only a veterans, active duty members' intergenerational experience can offer. Additionally, the relationship between North Chicago, Veterans Affairs Medical Center and the Naval Hospital Corps School, dating back to the late 1970s is a key component of VA/DoD sharing. Information provided by Mr. Patrick Sullivan, CEO, VA Medical Center.”

No other Services reported impacts on other agencies as a result of the recommendation to consolidate training.

Will there be additional transportation cost associated with the movement of students from Great Lakes which is co-located with the boot camp at Great Lakes to Fort Sam Houston? What is the projected cost and was it included in the Cobra analysis?

There will be associated cost with the movement of 1,700 students from Great Lakes Navy “boot camp” to Ft Sam Houston rather than to the current Great Lakes medical training site. The Navy did not quantify this cost in their Scenario Data Calls. Likewise, there will be a cost savings associated with the movement of 1,578 students from Lackland Air Force “boot camp” in San Antonio across town to Ft Sam Houston rather than to Sheppard AFB. The Air Force did not quantify these savings in their Scenario Data Calls. The Medical JCSG did not receive detailed cost figures but judged the costs and savings for transportation costs to be neutral for the recommendation. However, transportation costs were expected to increase in the case of consolidation at Sheppard or Great Lakes.

Med – 4: Walter Reed Army Medical Center

In your July 22, 2005 response to us, you stated that you “did investigate moving the Bethesda workload into Walter Reed Army Medical Center” and that it would “cost approximately \$400M more than moving Walter Reed into Bethesda.” Please provide your analysis including the Cobra run.

We are providing the Commission with a COBRA run of Scenario MED 003 Close Bethesda with input data from 21 Apr 05. The following summary data is provided for a quick comparison with the Medical JCSG proposed Scenario MED 002 Close Walter Reed.

	<i>MED 002 Close Walter Reed</i>	<i>MED 003 Close Bethesda</i>
<i>Medical JCSG Action</i>	<i>Approved</i>	<i>Disapproved</i>
<i>Net Present Value in 2025</i>	<i>\$301M savings</i>	<i>\$122M cost</i>
<i>Payback</i>	<i>10 years in 2021</i>	<i>19 years in 2028</i>
<i>One-Time Cost</i>	<i>\$989M</i>	<i>\$1,214M</i>
<i>Annual Recurring Savings</i>	<i>\$100M</i>	<i>\$79M</i>

Could you clarify a sentence in your July 22, 2005 response to us about the cost of refurbishing/upgrading Walter Reed -- the last sentence reads, " Our analyses showed that by reducing this infrastructure, without reducing healthcare provided to our beneficiaries. "

Closing the Walter Reed Army Medical Center allows the Department to reduce excess infrastructure (capacity) without reducing healthcare provided to our beneficiaries (military value). This scenario (Walter Reed National Military Medical Center at Bethesda) allows the Department to eliminate one of two medical centers within 7 miles of each other in the north sector of the National Capital Region (NCR) and expand capacity at Ft Belvoir in the southern sector of the NCR where the population growth is driving increased healthcare demands. The recommendation maintains the healthcare levels as measured by RWPs, RVUs while sizing the available beds to the population demand.

On July 1, 2005, GAO reported that the "(Medical Joint Cross-Service Group) incorrectly reported certain financial data for its recommendations involving the Walter Reed Army Medical Center". Please provide a list of the incorrectly reported data and an updated Cobra run that reflects the use of the correct data.

The Medical JCSG incorrectly categorized a \$22,854K savings as a "misc. recurring cost" on COBRA Screen 5. The updated COBRA is provided and the numbers agree with the GAO

report (pages 200-201). This change improves the economic metrics for this scenario over those contained in the BRAC report.

MED 002 Close Walter Reed

<i>Data Info</i>	<i>6 May 05</i>	<i>3 Aug 05</i>
		<i>includes GAO updates</i>
<i>Net Present Value in 2025</i>	<i>\$301M savings</i>	<i>\$831M savings</i>
<i>Payback</i>	<i>10 years in 2021</i>	<i>6 years in 2017</i>
<i>One-Time Cost</i>	<i>\$989M</i>	<i>\$989M</i>
<i>Annual Recurring Savings</i>	<i>\$100M</i>	<i>\$145M</i>

Med – 12: Convert Inpatient Services to Outpatient Clinics and Ambulatory Surgery Centers

In your July 22, 2005 response to us, you stated that “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.” Did you consult with accredited civilian GME programs to determine that their programs can be utilized; with whom did you consult?

Placement in accredited civilian residency training programs is achieved via the National Residency Match Program. Each year there are approximately 23,000 training positions available to graduates of US medical schools. In 2005, there were 15,306 graduates from allopathic medical schools and 2,043 graduates from osteopathic medical school. There is more than sufficient capacity for training opportunities in the civilian sector to address the 33 additional sponsored residents that would be placed by DOD, assuming the residency requirement remains the same

It has been reported that the Keesler Medical Center’s military value was incorrectly calculated, and on July 28, 2005 during our meeting at Bolling AFB it was stated that even with the correction to Keesler’s military value score and a re-running of the optimization model, Keesler still fell within the review curve. Please provide the updated military value list that includes the corrected military value for Keesler Medical Center.

The adjusted score for Keesler of 50.65 is still below the cutoff developed by the optimization model of 54. The recommendation from the working group would have been the same as the process of evaluating Keesler would have remained the same. This error does not affect the

other information and metrics used by the principals during the deliberations of these recommendation. The outcome of the deliberations would have remained the same.