

August 4, 2003

**MINUTES OF THE JULY 10, 2003 MEETING OF THE MEDICAL JOINT CROSS SERVICE GROUP (MJCSG)**

ROOM: 1E801#5, 1300-1500 hrs

Members Attending: VADM Cowan - Acting Chair, BUMED, MG Farmer, Army Deputy Surgeon General, Col Davis - J4-MRD, USMC - Surgeon General, - ASD(HA), Mr Potochney - USD(AT&L), Col Hamilton, Secretary - See attached for additional attendees.

**Decisions:**

- Minutes from the June 12, 2003 meeting were approved as amended.
- All files used in MJCSG will be marked with the BRAC Sensitive label as a matter of standard practice.
- Workgroups will place all meetings on the calendar in the ERoom

**Action Items:**

- MJCSG Chair to investigate offsite to finalize the capacity data call
- TMA to conduct an assessment of the ERoom system to ensure that it meets both access and data protection criteria appropriate for the storage of BRAC sensitive data.
- Workgroups forward resource requirements to Col Hamilton by 21 July 2003
- MJCSG Chair will draft a policy that describes read/write access to the ERoom information.
- Each MJCSG Workgroup provide a paragraph summarizing the status of their deliberations for the minutes to Col Hamilton by 21 July 2003.

**Meeting Overview:**

The Acting Chair called the meeting to order at 1500 hrs. The minutes of the June 12, 2003 meeting were approved, as amended, without discussion. The milestone review highlighted that all dates were flexible except the Nov 04 date when the JCSG must forward its recommendations to the ISG. Mr Potochney confirmed this during his overview of the calendar. The OSD BRAC office indicated that the MJCSG would have to provide a briefing to the ISG in the August timeframe on its approach to the capacity analysis. The briefing will provide at least one example of the approach and overview the others. The MJCSG emphasized that the workgroups should not be asking for data from facilities or Service command structures.

The MJCSG was informed that ERoom access had been increased to include all members of the MJCSG workgroups that were on the contacts worksheet. At this point, the discussion opened on the security of the ERoom and whether or not it met BRAC 2005 requirements for information security. The MJCSG asked that the ERoom owner (TMA) work with the DoDIG and the OSD BRAC office to ensure that the ERoom is appropriately secure for both intended and unintended access. The OSD BRAC office indicated a need for a comprehensive policy on the use of chat rooms and other electronic means to conduct JCSG business. The MJCSG expressed concern that we need a policy to address read/write access to MJCSG documents within the ERoom and asked that the Chair develop a policy that would limit the changes

allowed. The MJCSG noted that none of the OSD personnel had been invited to join the ERoom and asked that this be addressed.

The DODIG asked the MJCSG to provide them with a calendar of workgroup meetings so that they could attend. The MJCSG noted that the ERoom includes a calendar feature and decided that all workgroups should maintain their schedules on this calendar. The DoDIG asked the MJCSG to review the management of their non-Disclosure Statements. The Secretary agreed to have the DODIG staff review the MJCSG nonDisclosure Statements on file.

In the May 29, 2003, meeting the MJCSG asked each workgroup to provide their projected resource requirements. These requirements should include the funding and manpower necessary to support the workgroups' deliberations. In addition, workgroups should identify shortfalls in Service or DOD representation. These requirements are due by July 21, 2003.

The MJCSG discussed the Transformation Alternatives. It was noted that only three other workgroups have provided a response to the USD(AT&L) memo. However, a response is expected. The MJCSG placed this item on the agenda for the next meeting.

Workgroup Reports were discussed by the MJCSG and the following synopses were submitted for the record.

- The Medical/Dental Research Development and Acquisition sub-working group** was convened by MG Farmer on 8 July 03 at Falls Church, Virginia, to discuss alternative staff configurations, potential issues, and how best to meet upcoming requirements. The meeting started with MG Farmer providing an overview and senior level guidance to the sub-working group. The group then proceeded with its assessment of how the sub-working group was organized, and recommended an alternative structure that collapsed the current three teams to two. Team One (headed by COL John Glenn) will focus on Science and Technology issues, and Team Two (headed by Mr Bill Howell) will focus on Medical Acquisition. Additional experts will be selected as the assessment of medical and dental RDA issues continues to evolve. It was also recommended that further insight on future requirements and capabilities was necessary to ensure all sub-working group members had a common understanding of out-year military medical requirements. Informational briefings presented by experts from the Joint Staff and the Services will be scheduled for presentation at the next meeting, which has been scheduled for 28 July, and will be conducted via VTC.
- Healthcare Education and Training Groups**
  - (Where we are?): The four subcommittees under the Healthcare Education and Training Group are in the process of holding weekly meetings, exchanging emails on a regular basis, brainstorming verbiage that is applicable to all three services, and standardizing definitions of terms and metrics for education and training across the spectrum.
  - (Where we have been?): The four subcommittees met with their respective members to formalize their individual Mission Needs Statements and Charters.
  - (Where we are going?): The next steps are to refine data elements, metrics and to develop the analytical framework. We will be asking for approval to populate corps

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specific and enlisted subgroups from the three services. During this process, we will identify areas of potential duplication between the subgroups and refine our metrics to optimize the data call.

NEXT MEETING: July 24, 2003, Room 1E801#1, Pentagon



MICHAEL L. COWAN  
VADM, USN  
Acting Chair

Attachment:  
Agenda

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10 Jul 03 MJCSG Meeting Minutes Updated Attachment List:

1. Additional Attendees (missing)
2. Agenda
3. BRAC 05 Timeline c Milestones
4. Top 9 Transformational Ideas
5. Medical/Dental Draft Metrics Status Report

# Medical Joint Cross Service Group

**07/10/2003**  
**3:00 PM to 4:42 PM**  
**Room 1E801 #3**  
**Pentagon, Washington DC**

Meeting called by:      Acting Chair                      Type of meeting:      Routine  
    VADM Cowan

Note taker:                      Col Hamilton

Please bring:                      Status of workgroup deliberations

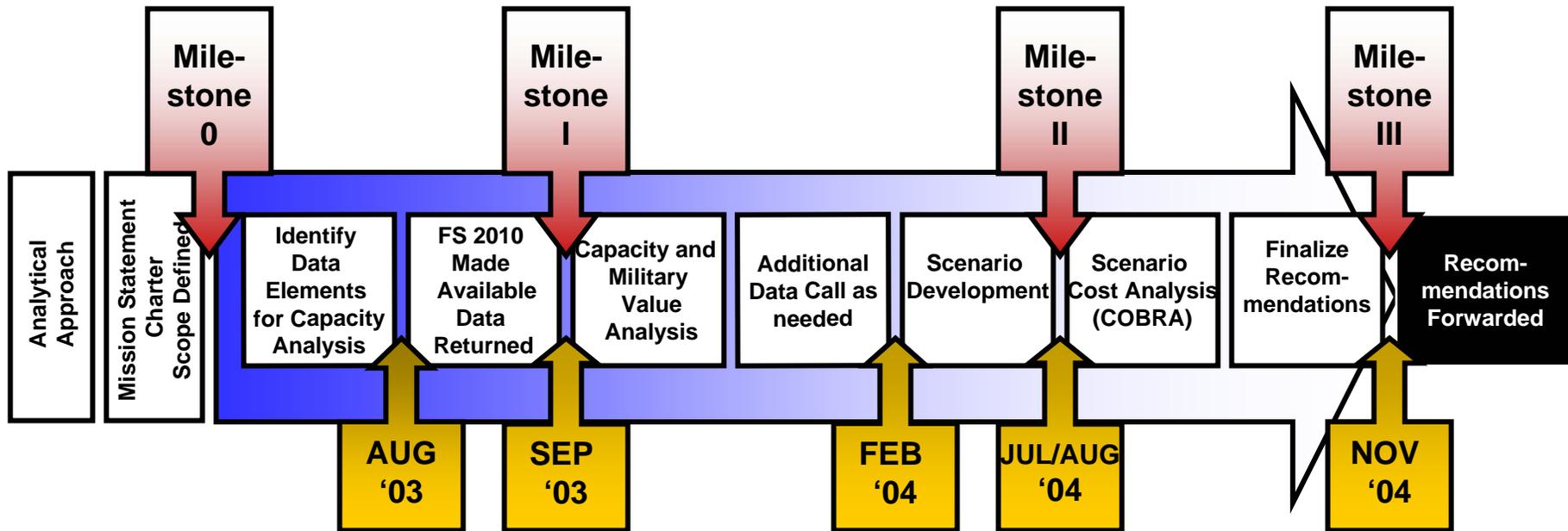
## Agenda

Chair Comments	Chair	10
Standard Items		
Minutes	Col Hamilton	2
Milestone Review	Capt McGue	5
BRAC Calendar Review	Mr Potochney	10
Workgroup Reports	MJCSG	30
New Business	All	10
Eroom/Appt Memo	Col Hamilton	5
Workgroup Requirements	Col Hamilton	5
Transformation Alternatives	Col Hamilton	10
Review of Taskings/Notes	Col Hamilton	10
Closing Comments	Chair	5

## Additional Information

# BRAC 05 Process Timeline with Milestones

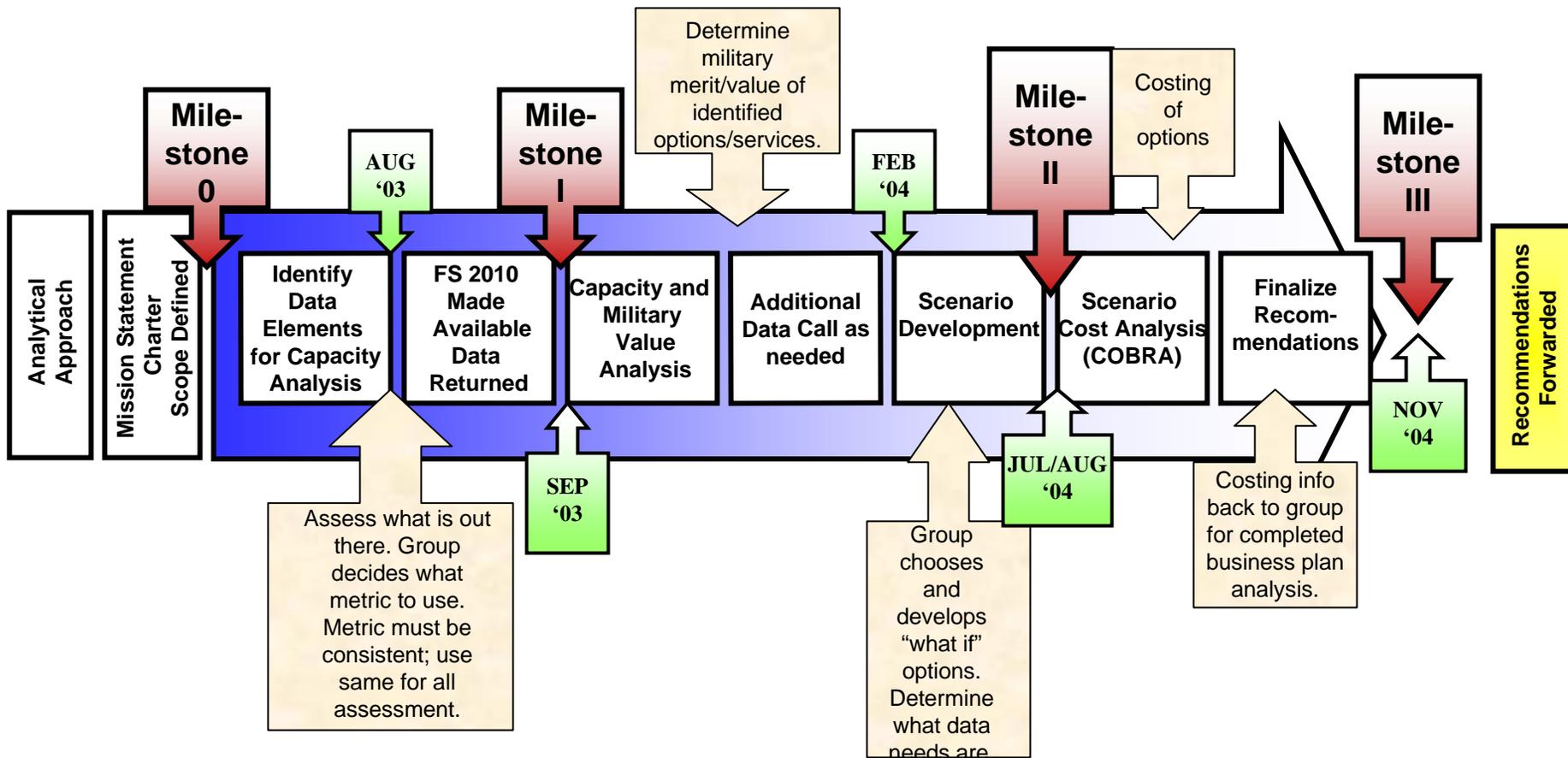
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# BRAC 05 Process Timeline with Milestones

DCN: 11354

**Think Capabilities, Capacity, and Military Merit**



Imagination has no boundaries!

## **TOP 9 TRANSFORMATIONAL IDEAS**

### **1. Consolidate federal contracting offices – personnel, TMA, equipment, facility asset management, and contract out facility management**

Contracting: All three services currently use almost identical rules governing contracting. The only major differences are in organizational structure. Create two DOD central contracting offices. First, Service contracts should be consolidated under a TMA contracting office. Second, Equipment and supply contracts should be consolidated under one DLA contracting office. Be sure to capitalize existing/developing DOD/VA Joint National Contracting initiatives.

Medical Facility Management: Every MTF requires a facility manager that has two primary functions, managing the environment of care (to comply with the Joint Commission on Accreditation of Health Care Organizations dictum) and coordinating facility sustainment functions. Contract out this function.

### **2. Develop 3<sup>rd</sup> Party Log Support Relationship – Public Private Supply Chain Management with FEDEX / UPS / DHL**

3PL capabilities exist to provide real-time logistics support using the most accurate tracking methods from manufacturer to the point of use. 3PL companies offer “moving” warehouses to customers today and provide other critical services such as In-transit Visibility (ITV), Total Asset Visibility (TAV), and information rich IT services throughout the supply chain. Partnering with our existing Prime Vendors, 3PL companies can provide DoD with the maximum flexibility to respond to anything, anywhere. Healthcare logistics is an emerging field for 3PL companies where timing and delivery are critical. 3PL companies easily integrate into logistics IT systems providing critical ordering, financial and payment information.

### **3. Contract out War Reserve Materiel (WRM) DoD-wide (Build them in house)**

While in garrison (not deployed), WRM must be rotated, replaced, and calibrated, and maintained. These tasks are repetitious and time consuming. Contract the in-garrison maintenance and upkeep of WRM. (The USAF already does this) When new WRM assemblies are created, it should be in a central location and shipped out to the responsible agency. (The USAF already does this)

### **4. Compete the COE and NAVFAC design and construction management**

Use of Army Corps of Engineers and Naval Facilities Command as Design and Construction Agents - Title 10 USC 2851 and 9540 and DODD 4270.5. By law only specified agents can be used to manage the design and construction of MILCON projects. This practice limits competition and potential market efficiency of the acquisition process. Alternative medical facility acquisition processes should be examined to determine whether the acquisition time and cost could be reduced. Current law restricts military construction to be directed and supervised through Military Department or other Government agency approved by the SECDEF. Suggest establishing a long-term acquisition demonstration program to test alternatives.

**5. Public Private Venture (PPV) for medical facilities.**

Almost half of the DoD health care budget goes to the private sector. There are opportunities for increased partnership with the private sector to provide increased facilities and services to the DoD. This could take the form of full spectrum of PPVs whereby private sector health care organizations might own and operate facilities on DoD installations or vice versa – DoD health care providers could work in private hospitals or could work out of leased space in the private sector. The BRAC process should take full advantage of PPVs.

**6. Outsource GME and enlisted technical education**

The three Services operate separate and nearly identical GME and enlisted technical training programs. Partnering with civilian GME programs and utilization of community college medical technician training programs may increase quality, eliminate duplication and produce significant cost savings to DoD.

**7. Consolidate/contract MTF refill prescription business**

DoD will outsource the refill business.

1. First fills (new Rx) will be filled at the MTF pharmacy.
2. All MTF refill requests will be filled by a commercial vendor or the VA and mailed to the patient's house.

Currently, all three services provide new and refill prescriptions through MTF pharmacies. The only difference between the three services when processing prescriptions is the organizational structure. First, original prescriptions (first fills) will be filled at MTF pharmacies. Secondly, more efficient prescription refill processing will be accomplished through the development of appropriate consolidation of triservice pharmacy resources and/or contracting an optional prescription refill mail service with a commercial vendor or VA.

**8. Integrate DHS into BRAC process**

There are several areas in which the Military Healthcare System (MHS) plays a supporting role in Homeland Security. An integrated emergency medical response system will include DoD medical treatment facilities – emergency, surgical, nursing and ancillary support. The BRAC process should take account of Homeland Security requirements to insure adequate capacity to deal with domestic emergency response.

The National Lab Response Network headed by the CDC establishes a network of reference labs capable of identifying potentially hazardous biological materials. Other DoD medical research facilities form important parts of the nations biodefense capabilities. The BRAC process should take account of Homeland security requirements to insure adequate capacity remains for biodefense.

**9. Standardize, consolidate, and centralize all DOD medical IT assets and asset management**

(Clinger-Cohen defines IT as “computers, ancillary services, equipment, software, firmware and similar procedures, services, and related resources”)

The idea includes:

- Infrastructure
- Automated Information Systems
- Support Services/Maintenance
- Hardware
- Equipment purchases
- Training
- Data

If all Services centralized IT asset management under one umbrella, the result would be:

- Reduced purchase costs based on large volume discounts for PCs, servers, peripheral devices, licensing, and sparing and maintenance
- All systems would be the same, which would allow for reduced cost for desktop support services - remote access could occur in centralized locations (hubs), which would reduce maintenance and support costs
- All DoD standard applications could be web-based allowing central management in a central DoD site like a DISA mega center thus reducing cost for security, maintenance and management. This would also result in a much smaller IMIT footprint in the MTF thereby allowing MTFs to reduce their IMIT support staff
- Centralizing data analysis would result in a reduced analyst requirement in each MTF and would consolidate resources. If systems and data elements are standardized, a central core of analysts (hub) could support all services at a reduced cost
- Standardized systems would reduce training costs from both the IMIT support and end- user perspective – similar applications in all services, in all MTFs, would eliminate or greatly reduce retraining as people moved from one location to another
- Standardized systems would increase interoperability between systems - less unique interfaces to develop
- Standardization of systems among the services would also result in common data elements for metrics to measure the health of MTFs – standard applications include systems like CHCS and DMLSS
- By standardizing the infrastructure among all service MTFs the result would be reduced support and maintenance costs, and reduced application development and deployment costs
- Standardized systems would make it easier to reuse hardware (PCs, servers, etc.) if a base closes and the IT equipment is moved to another MTF – like equipment would be easily absorbed with no learning curve

# **Medical/Dental Infrastructure**

## **Status Report**

**25 Jun 03**

**DRAFT METRICS**

Data Element	Subcategory	Definition	Measurements	Data Source	Civilian Source	Time Interval
Eligible Beneficiaries	Categorized by age (under, over 65)	All beneficiaries eligible to use the DoD pharmacy benefit	Total Number	DEERS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Defined Point in Time
	Categorized by beneficiary type	All beneficiaries eligible to use the DoD pharmacy benefit	Total Number	DEERS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Defined Point in Time
Unique Pharmacy Users	Categorized by Age	All beneficiaries that used the DoD pharmacy benefit (MTF, Retail Network, TMOP)	Total Number	PDTS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
	Categorized by beneficiary type	All beneficiaries that used the DoD pharmacy benefit (MTF, Retail Network, TMOP)	Total Number	CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
Prescriptions (Rx)	New Rx	Initial dispensing of a Provider Order Entry (POE) or Hard Copy (hand written) prescription filled in the MTF, Retail Network, or TRICARE Mail Order Pharmacy	Total Number, Cost (include cost of dispensing)	PDTS, CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
	Refill Rx	Additional dispensing of an original prescription filled in the MTF, Retail Network, or Tricare Mail Order Pharmacy	Total Number, Cost	PDTS, CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
	Rxs by Beneficiary Category	New and refill Rx's dispensed to eligible beneficiaries categorized by beneficiary type in the MTF, Retail Network, or Tricare Mail Order Pharmacy	Total Number	CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
	Rxs by Beneficiary Age	New and refill Rx's dispensed to eligible beneficiaries categorized by beneficiary age group (< 65, > 65) in the MTF, Retail Network, or Tricare Mail Order Pharmacy	Total Number, Cost	PDTS, CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
	Ave Days supply per Rx	Average days of therapy per prescription dispensed in the MTF, Retail Network, TMOP	Total Number, Cost	PDTS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months

Data Element	Subcategory	Definition	Measurements	Data Source	Civilian Source	Time Interval
Inpatient Orders	Intravenous Admixture (IV's)	Preparation and dispensing of intravenous admixtures for administration to inpatients	Total Number	CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
	Unit Doses (U.D.'s)	Preparation and dispensing of individually packaged (U.D.'s) for administration to inpatients	Total Number	CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
	Individual Inpatient Rxs	Preparation and dispensing of individual prescriptions for administration to inpatients	Total Number	CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
Clinic Orders	Clinic Bulk Orders	Preparation and dispensing of bulk medications for clinic use	Total Number	CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
	Clinic Unit of Use Orders	Preparation and dispensing of unit of use packaged medication for clinic dispensing	Total Number	CHCS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
Pharmacist Provided Appointments	Appt Type	Patient appointments completed by privileged pharmacists	Total Number	ADS, MEPRS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	12 months
Pharmacy Inventory Management	Formulary Line Items	All medication sizes, strengths, dosage forms approved as MTF formulary items	Total Number	DMLSS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Defined Point in Time
	Non-formulary Special Purchase Requests	Purchase of medication not approved as MTF formulary items	Total Number	DMLSS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Defined Point in Time
	Pharmacy Returned Goods	Medication returned for credit through a contracted returned goods company or directly by the MTF	Total Number, Cost	DMLSS, Contracted Company reports	??	12 months

Data Element	Subcategory	Definition	Measurements	Data Source	Civilian Source	Time Interval
	Surge Medication Line items	All medication sizes, strengths, dosage forms specifically managed by the pharmacy for treatment of casualties and deployment of personnel	Total Number	DMLSS	??	Defined Point in Time
Personnel	Military	Active duty and reserve personnel assigned to pharmacy services and categorized as required/non-required readiness position	Total Number, Cost, Pharmacy Manhours, Non-pharmacy Manhours, Training Manhours, Deployment Manhours	MEPRS, PERSLOAD, Service Personnel Reports	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Monthly ave base on 12 month time frame
	Civilian (GS)	Federal civilian employees assigned to pharmacy services	Total Number, Cost, Pharmacy Manhours, Non-pharmacy Manhours	MEPRS, PERSLOAD, Service Personnel Reports	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Monthly ave base on 12 month time frame
	Contracted Personnel	MTF contracted personnel assigned to pharmacy services	Total Number, Cost, Pharmacy Manhours, Non-pharmacy Manhours	RM reports	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Monthly ave base on 12 month time frame
	Resource Sharing Personnel	Resource sharing personnel assigned to pharmacy services	Total Number, Cost, Pharmacy Manhours, Non-pharmacy Manhours	MEPRS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Monthly ave base on 12 month time frame
	Volunteers	Volunteer personnel assigned to pharmacy services	Total Number, Cost, Pharmacy Manhours, Non-pharmacy Manhours	MEPRS	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Monthly ave base on 12 month time frame
Facility Infrastructure	Pharmacy MTF facility requirements	MTF facility costs attributed pharmacy based on square footage	Square Footage, Cost	RM reports	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Monthly ave base on 12 month time frame
	Pharmacy leased space requirements	Lease space attributed to pharmacy services including utilities, IM requirements, etc	Square Footage, Cost	RM reports	Aventis Managed Care Report, Lilly Digest, APhA, ASHP, AMCP	Monthly ave base on 12 month time frame
	Pharmacy Facility Lifecycle	Property condition as defined as identify need for repair, upgrades, or replacement through MILCON projects	JCAHO life safety scores, service facility score	JCAHO inspection reports, service facility reports	JCAHO	Defined Point in Time
Pharmacy Equipment	Purchased pharmacy equipment	Pharmacy equipment used in the preparation and dispensing of outpatient Rx and inpatient medications orders based on equipment life expectancy	Depreciated cost	MTF RM/facility equipment reports	??	Monthly ave base on 12 month time frame

Data Element	Subcategory	Definition	Measurements	Data Source	Civilian Source	Time Interval
	Leased pharmacy equipment	Leased pharmacy equipment used in the preparation and dispensing of outpatient Rx's and inpatient medications orders	Lease cost	MTF RM/facility equipment reports	??	Monthly ave base on 12 month time frame
Other	Projected Facility Casualty Capability	Projected facility casualty capability in support of homeland security and wartime mission	Total Number	Disaster and readiness plans	??	Defined Point in Time
Quality	Med Errors	Number of medication errors that are directly attributable to pharmacy	Total number and categorized by type	MedMARx	U.S.P., ISMP, ASHP, APhA, National Coordinating Council	12 months
Quality	Medication Treatment Management	Cost of care for patients who see pharmacists as part of the collaborative care process	medication cost per diagnosis/ Cost centers with pharmacists vs without pharmacists	Coding records	??	by patient

**MEDICAL AND DENTAL INFORMATION SYSTEMS**

Capacity Measures

**1. Maximum bandwidth**

Description: The amount of data that can be carried over a network, usually expressed in megabits per second. The higher the bandwidth, the more information that can be transmitted in a given time interval

Data Sources: Local MTF CIO, base/post line Communicators, TIMPO

**2. Total number of available data drops by type**

Description: This measure describes the type of cable plant is in each facility. There are several types of basic cable types each with its own ratings in terms of capability to carry network traffic. MTFs may have more than one type of cable within the facility or throughout campus.

Data Source: Local MTF CIO, TIMPO

**3. Total number of client licenses per MHS/Service/COTs system/application**

Description: This measure describes the maximum number of individuals who can legally use an application that requires a license.

Data Source: Local MTF CIO, System/Application Program Manager

Utilization Measures

**4. Total number of users**

Description: Total number of unique users on the MTFs network

Data Source: Local MTF CIO

**5. Current peak bandwidth utilization**

Description: This measure will show how much excess bandwidth capacity is available when combined with Measure 1. Although the average bandwidth utilization may show greater excess capacity than peak utilization, it is peak utilization that drives the need for greater bandwidth in an MTF. Once peak utilization reaches the maximum bandwidth in an MTF, throughput begins to diminish.

Data Source: Local MTF CIO, base/post Line Communicators

**6. Percent of network drops in use**

Description: The measure, when combines with Measure 2, describes excess network capacity. Network drops can support PCs or shared peripheral devices.

Data Source: Local MTF CIO

**7. Current users of licensed systems/applications**

Description: This measure, when combined with Measure 3, will determine excess capacity within licensed systems. For example, an MTF may have a 10-user Oracle license but may only have 3 unique users.

Data Source: Local MTF CIO, System/Application Program Manager

**8. Number of support staff FTEs by specialty and type (military, civilian, contractor)**

Description: This measure determines the robustness of support service within an MTF. It also defines the specialty services that each MTF provides and the qualifications of support personnel

Data Source: Local MTF CIO

Efficiency Measure**9. Help Desk Work Orders**

- a. Total number of work orders per month
- b. Average number of backlogged work order tickets
- c. Average time to close work order tickets

Description: This measure will determine the efficiency of the IT support staff and their ability to maintain systems within the MTF. It will also show if there is any excess support capacity when measured against industry standards for resolving IT work orders.

Data Source: Local MTF CIO

Value Measure**10. Total MTF IT budget**

- a. Hardware
- b. Software
- c. Contract support
- d. Maintenance
- e. Training

Description: This measure describes the total amount of resources spent on providing IT services in the MTF. It includes the cost for contract support, hardware/software, sparing and maintenance, and training for IT supports staff. This measure will be compared to industry standards.

Data Source: Local MTF CIO

## Calculated Metrics

- Support staff efficiency – Measures 4,8, and 9 are used to determine efficiency of support staff
- Projected maximum number of concurrent users
- Projected number of supportable users
- Value of IT services

**Medical Dental Staff Contracting**

**Current Capacity to Contract:**

1. Number Mil/Civ in contracting office (fill rates) Army MEDCOM and DENCOM, NAVMEDLOGCOM, VASS, VA NAC
2. Percent of budget spent on contracting (funds spent on contracts vs. TOA) (Source: Support contract – TMA facility.)
3. Lag time from requirement identification to contract award (Procurement Action Lead Time – PALT) by specialty
4. Lag time to hire (number of days from award to arrival for workers)
5. Current number of FTE professional services contracts
6. Fill rates on Contractor FTEs by Specialty
7. List of specialties that would be contracted for if funds were unconstrained
8. Contract administrative overhead costs

**Projected or Surge Contracting Capacity:**

1. Projections 5 years from now using same Metrics as above
2. Projected change in lag time to hire 5 years out
3. If funds were unlimited, how many new contracts would you do
4. Mission/Homeport changes
5. Demographic changes (age demographics of population)
6. Major industry changes in catchments area (relocations, closures)
7. Co-located civilian hospital closures (increase in contractors vs. decrease of options downtown)
8. Major technology and/or policy changes that would impact contracts

**Current Utilization:**

1. Contracts have now vs. unfulfilled requirements – hard to fill requirements/scarce specialties.
2. Geographic non-availability (% of contracts not executed)
3. Resource sharing agreement change (shifts from agreements to contracts due to T-NEX)

**Data Sources:**

1. Service Pers Offices
2. HA/TMA and Lead Agents
3. SG Pers Offices
4. HSOs/Major Commands
5. MTF/DTFs contracting offices
6. Service contracting offices

**Medical Functions for Logical Service Areas:**

1. Define Logical Service Areas as 40 mile catchments areas using zip codes
2. Functions within VA and CIVs: surveys or same metrics as above
3. Capacity within VA and CIVs: surveys or same metrics as above
4. Utilization within VA and CIVs: surveys or same metrics as above
5. Surge within VA and CIVs: surveys or same metrics as above

**Medical Functions outside of Logical Service Areas:**

1. TRICARE Regional Office Assessments

**DRAFT**  
**MILCON AND FACILITY MANAGEMENT**  
**BRAC METRICS**

**0. ASSUMPTIONS**

A. Scope – We will evaluate supply, demand and efficiency inside and outside the gate – DoD, Other Federal Health Care (like VA) and Private Sector. One of the questions common to most of the metrics that follow is how we get at the necessary data from other systems (private sector, VA, etc.)

**2. DEMAND (Utilization / Eligibility / Enrollment)**

## A. Direct Care Population:

- Description: current and projected eligible beneficiary population in all categories – Active Duty (by Service), Active Duty Family Member, Retiree, VA and other beneficiary categories.
- Data Source: We assume that the Medical and Dental Market Requirements sub-group of the Medical Joint Cross Service Group will collect this data

## B. Direct Care Utilization

- Description: Market by market utilization rates for all medical services in the MHS and private sector. Data should be associated with a unique user if possible, so one can discern which beneficiary category the user comes from.
- Data Source: We assume that the Medical and Dental Market Requirements sub-group of the Medical Joint Cross Service Group will collect this data.

## D. MHS Enrollment

- Description: Measures current and projected enrollment rates as a percentage of eligible beneficiaries.
- Data Source: We assume that the Medical and Dental Market Requirements sub-group of the Medical Joint Cross Service Group will collect this data.

## E. Medical Research Laboratory Requirements

- Description: DoD does not currently have an objective set of criteria for validating requirements for medical research laboratories.
- Action: Work with Medical and Dental Research and Development and Acquisition sub-group and the Deployment Force Sizing sub-group and the Health Facility Steering Committee to develop metrics for evaluating the quality and quantity of the lab inventory against projected requirements.

## 1. SUPPLY (capacity)

### A. Complete Inventory

- Description: Complete inventory of health facilities by category (MTF, health clinic, dental clinic, vet clinic, lab, medical admin, medical warehouse etc.)
- Data Source: Services' facility planning and local facility managers.

### B. Facility Condition Index

- Description: Provides an index for comparison of the physical condition of facilities.
- Data Source: Services' facility planning and local facility managers.
- Questions: Is there funding available to develop data where there are gaps?

### C. Facility Quality Index

- Description: evaluates various *Common Building Areas* such as building exterior, parking, service access, corridors, utilities and others as well as *Facility Specific Areas* such as emergency services, inpatient nursing, outpatient clinics, radiology and other medical services. Based on Army Installation and Stationing Report (ISR) evaluation tool.
- Data Source: Services' facility planning and local facility managers
- Action: Gain Tri-Service consensus in the Health Facility Steering Committee for using ISR evaluation tool to create a common the Facility Quality Index

### D. Bed Count (Available / Active / Contingency)

- Description: Quantity of inpatient beds available in the military facility and in the surrounding market; average daily utilization rate; and projected contingency expansion capability.
- Data Source: We assume that the Medical and Dental Market Requirements or Deployment Force Sizing sub-groups of the Medical Joint Cross Service Group will collect this data from MTFs and from other private sector data sets tracked by the HCFA or other federal health care data sets.
- Action: Define Tri-Service standard for definition of contingency bed (space, utilities, etc.)

### E. Operating Room Count

- Description: Measures basic surgical capacity primarily as it relates to Homeland Security requirements.
- Data Source: We assume that the Medical and Dental Market Requirements or Deployment Force Sizing sub-groups of the Medical Joint Cross Service Group will collect this data from MTFs and from

other private sector data sets tracked by the HCFA or other federal health care data sets.

- Action: Need further guidance on Homeland Security Missions for MHS.

#### F. Exam Rooms (Optimization)

- Description: Provides a measure for primary care capacity
- Data Source: We assume that the Medical and Dental Market Requirements sub-group of the Medical Joint Cross Service Group will collect this data from MTFs and from other private sector data sets tracked by the HCFA or other federal health care data sets.

#### G. Dental Treatment Rooms (DTRs)

- Description: Provides a measure of dental treatment capacity.
- Data Source: We assume that the Medical and Dental Market Requirements sub-group of the Medical Joint Cross Service Group will collect this data from MTFs and from other private sector data sets tracked by the HCFA or other federal health care data sets.

### 3. EFFICIENCY

#### A. RVU (relative value unit) / Provider / Square Foot.

- Description: measures the “quantity of services” provided.
- Granularity: At what level do we want to measure this? Product Line or MTF? We have the data for both.
- Data Source: TMA is developing the data.
- Questions:
  - \* We need a primer from TMA on RVUs so we can explain the concepts
  - \* How do you get the data for how much space a given provider or class of providers is using. Army does not keep square footage utilization rates to the provider level.

#### B. Cost / Patient / SF

- Description: Unit cost of care in that market.
- Granularity: MTF
- Data Source: We assume that the Medical and Dental Market Requirements sub-group of the Medical Joint Cross Service Group will collect this data

#### C. Backlog of Maintenance

- Description: measures the cost of correcting deferred maintenance required for facility to meet existing health care standards
- Action: Define Tri-Service standard for capturing Backlog of Maintenance

D. Base Ops Cost / SF (FM)

- Description: Measures energy, operations and maintenance, housekeeping and other costs.
- Action: Define Tri-Service standard for what facility related costs are attributable to Base Ops Cost.

**WAY AHEAD**

- Tri-Service Health Facility Steering Committee meets 9-10 July. We will reserve some time on the agenda for vetting facility metrics and data requirements.
- Meet w/ COE & NAVFAC real estate and acquisition staff on Public Private Ventures
- Meet w/ other key medical groups to compare approach, metrics and information requirements

**LIST OF REFERENCES:**

1. DoD Medical Space Planning Criteria
2. DODI 4165.14, Real Property Inventory of Real Property Inventory Forecasting. Available on the R&K Website, publication in august.
3. Facility Sustainment Model 5.0

Rate	Data Element	Unit	Source	Notes
<b>Inventory Value by Facility</b>				
numerator	Acquisition cost per item	\$	Legacy System	Data call requires facilities to provide inventory by each DMIS code and any subordinate DMIS codes
denominator	Total value of all facility's equipment	\$	Legacy System	
<b>Sustainment Cost</b>				
numerator	Annual repair, service , and maintenance cost	\$	Legacy system	Express as cost for year 1, year 2, etc... (in-house and contract maintenance costs)
denominator	Acquisition cost	\$		
<b>Useful Age</b>				
numerator	Age of each item (by device code)	years	Legacy System	
denominator	Life expectancy	years		
<b>Operator (user) Training</b>				
numerator	Annual training cost for operators (users) of each item	\$		Express as cost for year 1, year 2, etc... (in-house and contract maintenance costs)
denominator	Acquisition cost	\$	Legacy System	
<b>Maintainer Training</b>				
numerator	Annual training cost for maintainers of each item	\$		Express as cost for year 1, year 2, etc... (in-house and contract maintenance costs)
denominator	Acquisition cost	\$	Legacy System	
<b>Market Density (MHS Enrolled)</b>				
numerator	number of items by device code	N	Market Density Spreadsheet	
denominator	enrolled population	N	TMA	
<b>Market Density (MHS Eligible)</b>				
numerator	number of items by device code	N	Market Density Spreadsheet	
denominator	eligible population	N	TMA	
<b>Market Density Community Enrolled)</b>				
numerator	number of items by device code	N	Market Density Spreadsheet	
denominator	enrolled population	N	TMA	
<b>Market Density (Community Eligible)</b>				
numerator	number of items by device code	N	Market Density Spreadsheet	
denominator	eligible population	N	TMA	
<b>Utilization Rate (MHS)</b>				
numerator	number of hours of actual operation	Hours		Per item
denominator	number of hours capable of operation	Hours		Per item
<b>Utilization Rate (Community)</b>				
numerator	number of hours of actual operation	Hours		Per item
denominator	number of hours capable of operation	Hours		Per item

<b>Capacity Rate (MHS)</b>				
	number of hours/procedures (as applicable)	hours/procedures		per item
multiplied by:	number of hours capable of operation	hours		per item
<b>Capacity Rate (Community)</b>				
	number of hours/procedures (as applicable)	hours/procedures		per item
multiplied by:	number of hours capable of operation	hours		per item
<b>Surge Rate (MHS)</b>				
	number of hours/procedures (as applicable)	hours/procedures		
multiplied by:	number of hours extended of operation	hours		
<b>Surge Rate (Community)</b>				
	number of hours/procedures (as applicable)	hours/procedures		
multiplied by:	number of hours extended of operation	hours		
<b>Efficiency (MHS)</b>				
numerator	total operating cost	\$		Annual labor by FTE required to operate + annual consumables for operation + annual utility cost
denominator	number of hours/procedures (as applicable)	hours/procedures		
<b>Efficiency (Community)</b>				
numerator	total operating cost	\$		Annual labor by FTE required to operate + annual consumables for operation + annual utility cost
denominator	number of hours/procedures (as applicable)	hours/procedures		
<b>Nonavailability Rate (Repair)</b>				
numerator	number of unscheduled work orders	N	legacy system	
denominator	actual annual hours of operation	hours		
<b>Nonavailability Rate (Maintenance)</b>				
numerator	number of scheduled work orders	N	legacy system	
denominator	actual annual hours of operation	hours		
<b>Cost Rate (hours)</b>				
numerator	Maintenance costs	\$		This rate will not be included in data call. It will be calculated from other rates
denominator	actual annual hours of operation	hours		
<b>Cost Rate (procedure)</b>				
numerator	Maintenance costs	\$		This rate will not be included in data call. It will be calculated from other rates
denominator	total annual procedures	hours		
<b>Reliability Rate (MHS)</b>				
numerator	Total down time	hours	maint time in legacy system	
denominator	number of hours capable of operation	hours		
<b>Reliability Rate (Community)</b>				

numerator	Total down time	hours	maint time in legacy system	
denominator	number of hours capable of operation	hours		
<b>Market Geographics</b>				
<b>Market Demographics</b>	<b>Co-location (&lt;= 30 Miles)</b>	<b>TRICARE Market Area (&gt;30 Miles, &lt; 100 Miles)</b>	<b>TRICARE Market Area (&gt; 100 Miles)</b>	<b>Metropolitan Statistical Area</b>
<b>MHS Enrolled Population</b>				
<b>MHS Population Served</b>				
<b>Community Enrolled Population</b>				
<b>Community Population Served</b>				
Yellow=data obtained from non-MTF source				