

**MINUTES OF THE MAY 10, 2004 MEETING OF THE MEDICAL JOINT CROSS SERVICE GROUP**

**LOCATION:** Pentagon, 2C554, 1530 -1730

**Attending:** Lt Gen Taylor - Chairperson; MGen Farmer - Army Deputy SG; RADM Wooffter - COS BUMED; Mr. Ford - ASD( HA)/CP&P; Col Hamilton - Secretary; CAPT Shimkus - BUMED; CDR Hight - BUMED; Mr. Curry - USA OTSG; Mr. Opsut - OSD/HA; Mr. Yaglom - USA SG; Maj Fristoe - HA/TMA; Col Sager - AFMSA/SGS; Maj Harper - AF/SGSF; Mr. Christensen - CNA; Lt Col Jones - AF/SG; Lt Col Stultz-Lalk - AF/SG; Lt Col Fitch - AF Rep; Maj Guerrero - AF/SG; Cpt Malloy - AF/SGE; Mr. Porth - OSD/BRAC.

**Decisions:**

- ☐ Principals gave tentative approval to the Navy formula to resolve data inconsistencies.
- ☐ Organize the transformation changes from smallest impact to largest impact in command organization or operations.
- ☐ Revise MJCSG Imperatives.

**Action Items:**

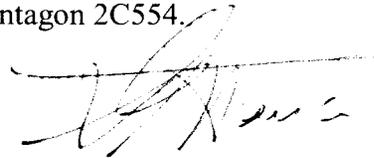
- ☐ 0-6 Lead Group rework the imperatives.
- ☐ Draft capacity analysis data report is due 24 May with the second report due in June. The final data must be done before the beginning of scenario development.

**Meeting Overview:**

- ☐ Army Deputy SG opened the meeting. The Secretary reviewed the agenda. AF Representative briefed the status of the capacity data. The draft report is due 24 May and it should show us the excess and surge capacity. The briefer discussed the issues of broad interpretation of questions, numerical inconsistencies and how JCSG plans to work issues through the service principals. The secretary asked OSD/BRAC how corrected data would be managed. The data will be sent out weekly to the Services for correction and should be entered into the database at Rosslyn. The Secretary discussed the due dates for capacity data. Draft capacity analysis data report is due 24 May with the second report due in June. The final data must be done before the beginning of scenario development.
- ☐ BUMED representative presented the group with the Navy analyst solution to manage data inconsistencies. The analyst developed a formula to resolve data inconsistencies. The group tentatively approved the formula. The tentative approval allows the group to continue to progress with their analysis.
- ☐ Army SG stated HQ organizational and structural issues were the purview of the MJCSG and, therefore, does not want to abrogate decision making to HSA without Medical JCSG involvement. The Secretary will further discuss this issue with HQ and support personnel.
- ☐ Navy and Army Principles and Imperatives have been sent forward. The Secretary believes we maybe formally asked to give our Medical Principles and Imperatives. OSD/BRAC does not think we will be asked separately from the services about our principles and imperatives. OSD/BRAC recommended we review the Services Principles and Imperatives.

DELIBERATIVE DOCUMENT - FOR DISCUSSION PURPOSES ONLY  
DO NOT RELEASE UNDER FOIA

- 7 The Principles and Imperatives were briefed line by line by Secretary. Ed. ~~1006~~ ~~1006~~ were made. The group debated to resolution any disagreements in principles, transformational options, imperatives, constraints, and services considerations. MJCSG principals were edited with one line about “divesting functions or capabilities that were not core competencies” was deleted. A discussion of potential transformational changes ranges from suggestions with low impact to those that reflected major changes. A recommendation was made to list changes by order of impact to the organization and operations. The principles felt the MJCSG Imperatives contained more transformation options rather than stated imperatives and asked the 0-6 lead group to revise them. . In addition, ASD/(HA) challenged the imperative to keep Graduate Medical Education as a military capability. He stated there was no research to back up the assumption that it was required to meet physician readiness requirements. The MJCSG constraints were discussed and many were deleted. Finally, AF considerations were discussed and there were disagreements about the need for blue on blue but were left unchanged. Army and Navy felt blue on blue was an unnecessary constraint. The Chairman stated that this was a requirement by the CSAF and needed to remain.
- 8 NEXT MEETING: 20 May 1500-1700, Pentagon 2C554.



GEORGE P. TAYLOR, JR.  
Lieutenant General, USAF, MC, CFS  
Chair

Attachments:

1. Agenda
2. Capacity Data
3. MJCSG Principles & Imperatives Ver. 3
4. MJCSG Principles and Imperatives Ver. 4

# Medical Joint Cross Service Group Meeting

05/10/2004  
3:30 PM to 5:30 PM  
2C554, Pentagon

Meeting called by: Chair                      Type of meeting: Decision  
Note taker: Lt Col Stultz-Lalk

Please read:

## Agenda

Chair Comments	Chair	5
Discussion		
Capacity Update	Maj Guerrero	20
Plan for Data Correction	CAPT Shimkus	20
Principles and Imperatives	Col Hamilton	40
Questions/Concerns	All	10
Closing Remarks	Chair	5

## Additional Information

**DELIBERATIVE DOCUMENT - FOR DISCUSSION PURPOSES ONLY - DO NOT RELEASE UNDER FOIA**



DCN: 11366

# MJCSG Principles & Imperatives

As of 20 May 04



# MJCSG Principles

DCN: 11366

- Provide Joint Force Health Protection to our soldiers, sailors, airmen, and marines remains the focus of the Military Health System
- Preserve high quality, cost efficient healthcare for all eligible beneficiaries
- Align military medical support infrastructure to better execute the National Defense Strategy
- Maximize the “jointness” of healthcare facilities (including treatment, research, and education and training) to meet current and future requirements of the Combatant Commanders and the Services
- Divest functions or capabilities not considered core military medical and dental competencies
- Leverage external (e.g. other government, civilian) capabilities to strengthen the military healthcare system

As of 20 May 04



# MJCSG Transformational Options

DCN: 11366

- DoD will maintain effective and affordable Force Health Protection across the full spectrum of *Joint* military operations, and provide cost efficient access to healthcare from fixed treatment facilities as Service components of the Military Healthcare System.
  - **Status quo**
  - **Operational Change**
    - ❑ **Interoperable/interchangeable in-garrison**
    - ❑ **Interoperable/interchangeable deployed**
    - ❑ **Joint Military Medical Contracting Activity**
  - **Organizational change**
    - ❑ **Joint Manning of Military Treatment Facilities**
    - ❑ **Joint Functional Commands**
      - **Joint Education and Training Facilities**
      - **Joint Medical Contracting Activity**
      - **Joint RDA Facilities**
    - ❑ **Defense Health Agency**
    - ❑ **Joint Medical Command**
    - ❑ **Federal Healthcare System (DoD/VA)**

As of 20 May 04



# MJCSG Imperatives

DCN: 11366

- Align military health support capabilities near large service member populations
- Maximize Jointness/hub and spoke opportunities
- Optimize Military Medical RDA Capability to Meet COCOM Requirements
- Optimize co-location of deployable assemblages at strategic locations to support COCOM needs
- Integrate Class VIII "retail" logistics system at strategic locations to support deployable medical and dental units stationed
- Maintain the capability to conduct graduate medical/dental education (interns, residents and fellows), practical clinical training, and research

As of 20 May 04



# MJCSG Constraints

DCN: 11366

- MTF will be retained in an isolated geographical area where no acceptable civilian alternative is available
- Casualty Care reception points will be provided on the East and West coast (or at strategic locations). The location will have sufficient DoD/VA & civilian medical resources to handle min 100 pt 24 hr thru-put with a robust aerial hub
- DoD will retain preventative medicine and laboratory consultative function
- DoD will retain veterinary capability

As of 20 May 04