

## MINUTES OF THE AUGUST 26, 2004 MEETING OF THE MJCSG PRINCIPALS

**LOCATION:** Pentagon, 2C554, 1500 -1700

**Attending:** Lt Gen Taylor - Chairperson; VADM Arthur - Navy SG; Mr. Curry – USA OTSG (Acting) Army SG; Mr. Ford/Mr. Chan - ASD(HA)/CP&P; Col Hamilton - Secretary; CAPT Shimkus - BUMED; CAPT Hight - BUMED; Col Jacob – USAF/SG; Lt Col Jones - USAF/SG; Mr. Opsut - OSD/HA; Mr. O’Connell – DoD/IG; Mr. Sherman – OTSE; Ms. Sanftleben – TMA; Mr. Nichel – CNA; Mr. Barton – AF Analyst.

### Decisions:

- Next Principals Meeting scheduled for 17 Sept 04 at 1530 – 1730, Pentagon, Room 2C554
- Concur with overall concept presented in Framework For Analysis: Optimization Model

### Action Items:

- Challenge 0-6 Lead Group review, track, and validate data that is coming in from the field.
- Framework for Analysis: Optimization Model Input/Decisions; OPR: Col Hamilton.
  - Services’ data call for RVUs/RWPs necessary to maintain provider currency, respond with numbers in 30 days.
  - Update slides with requested changes, revise tables with HCA/E&T input; OPR - 0-6 Leads by 3 Sept 04.
    - Define Opening-The-Door Constraints: RVUs/clinic and minimal ADPL
    - Define Minimum Size of GME Program/Floor
    - Identify critical GME programs/specialties
    - Provide list and/or definition of isolated facility

### Meeting Overview:

- Chair opened meeting with the Secretary’s brief on ISG Notional Scenarios. Examples of ISG notional scenarios were presented with emphasis on specificity and impact (i.e. closing base then close MTF, realign resources/manpower); thus far, they have been very generic. Chair stressed the importance of developing scenarios that make good analytical sense. Secretary presented graduate medical education and medical RDA consolidation as examples of transformational options.
- Secretary briefed the Scenario Analytical Framework (see attachment 2). Using the main metrics of the framework helps develop transformational options for final recommendations. Framework provides an outlook on how to develop scenarios, clarifies terminology, and focuses on platforms. Transformation options are “what if” exercises, they document benefit (savings/military value) over the baseline case, and guide updates to recommendations as needed during the iterative process. When options are analytically smart but do not meet operational needs, the MCSG will apply military judgment. The Principals voiced concerns over the decrease in available clinical experience in medical educational programs especially ones in smaller facilities. ISG pushing scenarios to help with issues of education across all work groups. Need to apply model to make massive changes, required by law to consider 20-year force structure.

Secretary outlined the scenario timeline and process; final recommendations due from the workgroups on the base closure piece during the iterative process. OSD signs final recommendations on 15 May 05. Need to document decision process for all transformational options put forth and reasons for approval or disapproval with detailed reporting of support data, analytical valuation, and military judgment decisions.

- Framework for Analysis: Optimization Model Input/Decisions (attachment 3) was briefed detailing inputs and constraints. Modeling questions were addressed; issues with requirements, constraints were discussed, and slides revisions as follows:
  - Slide 5, Requirements (overall system floor) – Numbers established by Service SMEs and utilizing standards from professional groups (i.e. ACOG).
    - ASD(HA) representative suggested currency concept be included in each box for clarification and easy reference.
    - PC/SC requirements inconsistent:
      - Outpatient – PC: Add to “keep PC Manager current”.
    - Dental – Revise to “Keep dental current to support AD population.”
    - Perform Service data call for RVUs/RWPs necessary to maintain provider currency, respond with numbers in 30 days.
  - Slide 8, Opening-The-Door Constraint:
    - Chair tasked members to apply analytical construct and decide on Opening-The-Door Constraints: RVUs/clinic and minimal ADPL by 3 Sept 04.
  - Slide 10, Demand Constraint – based on history/community standards.
    - Clarification on last three sub-categories in table confusing (AD PRISM, ADFM PRISM, Other PRISM).
  - Slide 11, GME Constraint – Minimum Size of GME Program/Floor:
    - Membership discussed what the minimal size of the GME programs should be and which critical programs/specialists to maintain.
    - Group agreed to maintain basic specialty GME programs.
      - Slide revision: delete “General” from Surgery Sub-specialists table category
    - Navy representative stressed the importance of meeting accreditation standards and lack of population to support GME programs. “Are we keeping larger, more complex hospitals to sustain small GME programs and not basing requirement on population demand?” One possible excursion would be to set the GME floor low to see what types of scenarios are generated, i.e. move small programs to another program location with excess capacity. If you close small program, loose surge capacity, GME, and military value. Chair suggested identifying which specific specialties will be trained where, based on excess capacity and the ability to absorb more GME programs.
      - Consider overall impact of moving GME programs: wartime mission; decrease in specialty services/hospital beds; available community medical resources/ability to absorb additional requirements, etc.
    - ASD(HA)/CP&P representative suggested developing DoD/VA relationship to support GME training requirements. Secretary provided guidance on bringing

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- VA into the process; approach directly to make them part of the process or commission process (bring in for DoD/VA integration scenario development).
- Chair suggested comparing wartime vs non-wartime requirements to assist in identifying total number of required GME programs across the system. Group discussed and agreed on concept of Service GME program consolidation as the logical answer.
- Slide 12, Other Constraints:
  - Need list and/or definition of isolated facilities; group identified as a hard constraint.
- Slide 13/14, Functional Importance:
  - MILVAL 60%/20%/20% within a function and associated relative functional importance across the system were presented and explained.
  - Leadership agreed on using the concepts described in the model.
- Closing Comments: Chair challenged 0-6 Lead group to apply vigilance in continued review, tracking, and validation of incoming data. Secretary requested decision on tables in Optimization Model brief, membership agreed on overall concept but deferred on approval until tables clarified as indicated. Chair requested Service data call for RVUs/RWPs numbers necessary to maintain provider currency. Secretary requested initiating biweekly Principals meetings due to BRAC timeline and associated increase in requirements and decisions; membership concurred and agreed to Thursday, 1500 as most convenient. Last meeting for Mr. Ford, Mr. Chan introduced as the new ASD(HA)/CP&P Principal.
- NEXT MEETING: MJCSG 0-6 Lead Meeting 2 Sept 2004, 1530-1730, Pentagon, 2C554.



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

**Attachments:**

1. Agenda
2. Scenario Analytical Framework
3. Optimization Model Inputs/Decisions Brief

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# MJCSG Principals Meeting

8/26/2004  
3:00 PM to 5:00 PM  
Pentagon 2C554

Meeting called by: Chair                      Type of meeting: Routine/Decisional  
Note taker: Maj Cottman

## Agenda

Chair Comments	Lt Gen Taylor	5
ISG Notional Scenarios	Col Hamilton	20
Optimization Model Inputs/Decisions	CNA	45
Scenario Analytical Framework	Col Hamilton	20
Closing	Chair	5

## Additional Information



Optimization Model  
Inputs\_081904.ppt



Analytical Frames -  
27 Aug 04.ppt

# *Medical Joint Cross Service Group*

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## Scenario Analytical Framework





# *Framework Outline*

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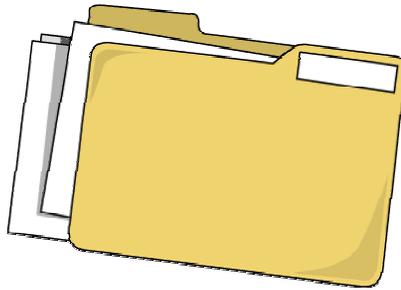
- **Iterative Process**
- **Infrastructure Related**
- **Meets requirements**
  - **Readiness**
  - **Currency**
- **Addresses Population Demand**
- **Transformational Options**

# Final Recommendation



# Recommendation Outline

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Recommendation

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$\Sigma$  Scenarios



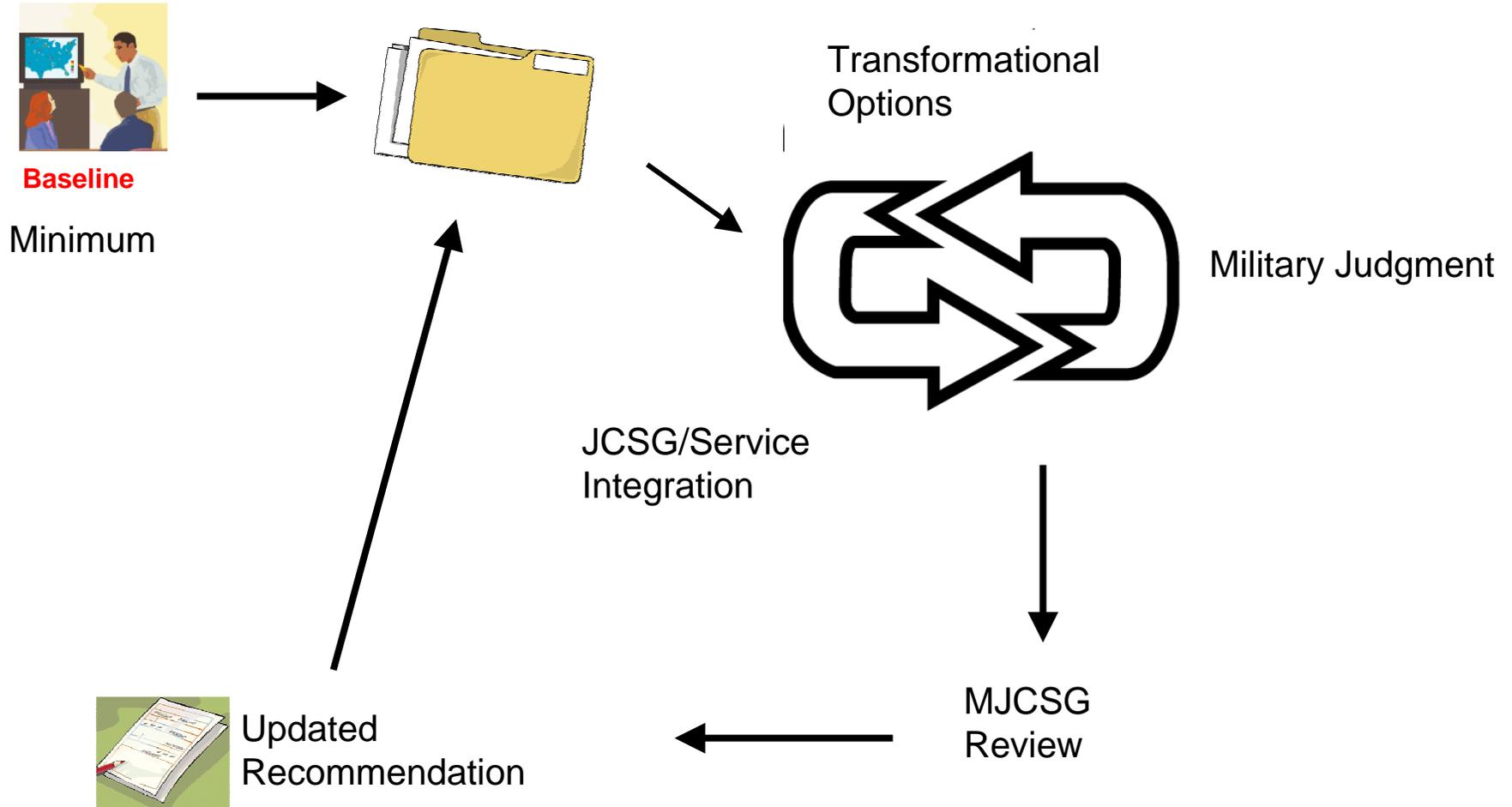
Close  
Downsize  
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Realign

- Can affect any number of MTFs
- Show movement of resources
- Action orientated



# Iterative Process

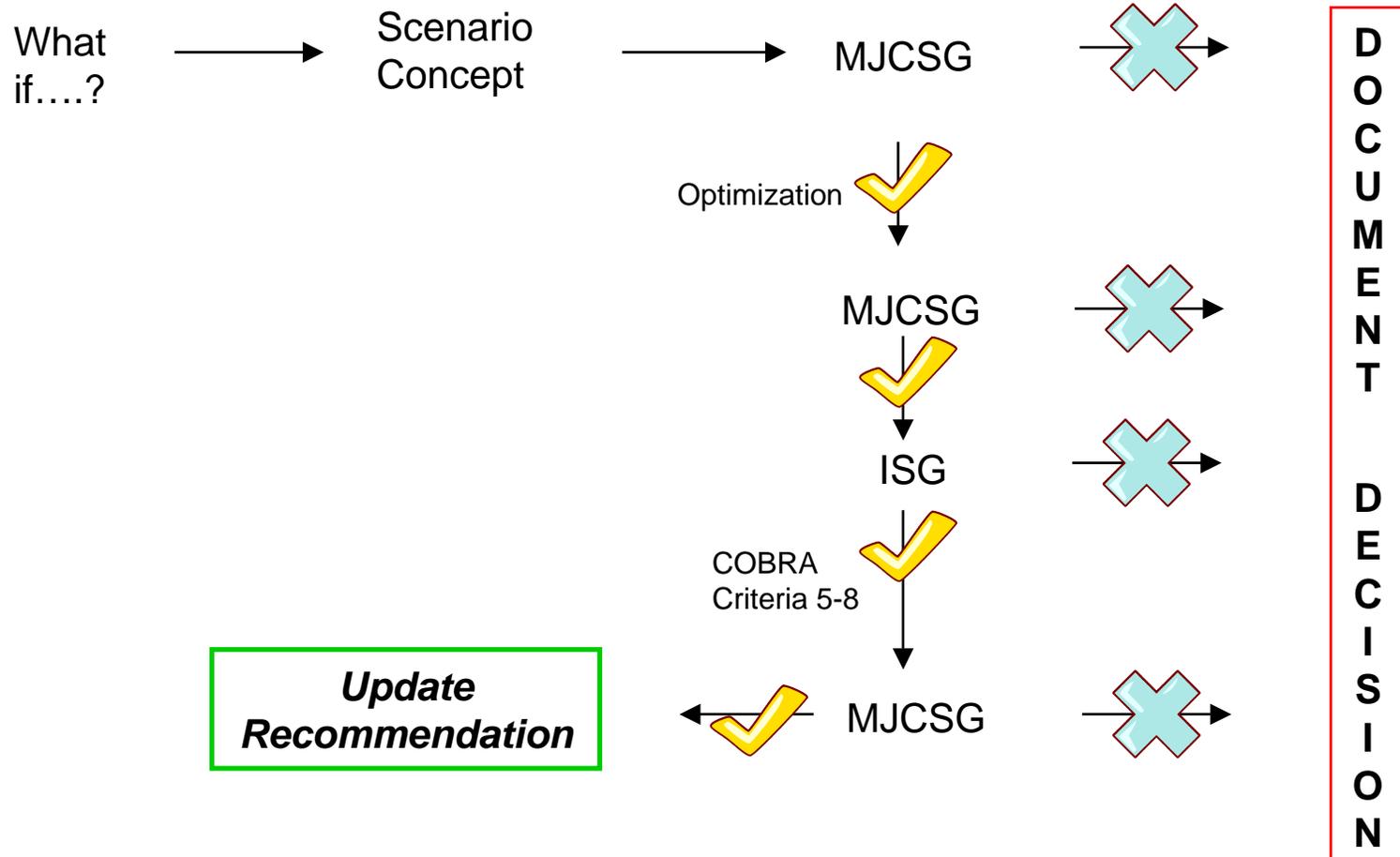
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# MJCSG Scenario Process

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# Baseline Case

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- **Size Infrastructure to Pop Demand**
  - **Reduce Excess Capacity**
  - **Address *Cats and Dogs* –**
    - **PM Labs**
    - **Vet Clinics**
    - **Hyperbaric Units**



# *Transformational Options*

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- Focused *What if* exercises
  - Provide a benefit (\$ or Mil value) over baseline case
  - Update Recommendation as necessary
  - Record actions in minutes and reports



# Next Steps

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- **Baseline case definition**
  - **Trans Options**

# ***Medical Joint Cross Service Group***

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## **MJCSG FRAMEWORK FOR ANALYSIS: Optimization Model Input/Decisions**

19 Aug 04



- **Objective function**
  - **Max MILVAL –  $\rho$  (retained resources)**
  - **$\rho$  (rho) is the penalty parameter that facilitates the tradeoff between military value and resource reduction**
- **Subject to constraints**
  - **MJCSG-specific constraints and parameters for these constraints are on the following slides**
  - **Need to identify values for the parameters in the constraints**



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- **Total workload across the system must meet requirements**
    - **This constraint sets the floor for the overall size of the system**
    - **Need to define functions and requirements for each function**



# Functions in the Model

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Function	Sub-functions	Output measure	Resources (inputs)
Healthcare services	Inpatient	RWPs	Beds
	Outpatient – primary care Outpatient – specialty care	PC RVUs SC RVUs	Primary care exam rooms Specialty care exam rooms
	Dental	AD population	DTRs
Education & training	Classroom Laboratory	Student FTEs	Classroom SQFT Laboratory SQFT
RDA	Capability Domain (CD) 1 Capability Domain (CD) 2 Capability Domain (CD) 3 ⋮ Capability Domain (CD) 13	Tech. FTEs (CD 1) Tech. FTEs (CD 2) Tech. FTEs (CD 3) ⋮ Tech. FTEs (CD 13)	Tech. & admin. SQFT (CD 1) Tech. & admin. SQFT (CD 2) Tech. & admin. SQFT (CD 3) ⋮ Tech. & admin. SQFT (CD 13)

- Total of 19 functions
- Capacity formulas translate resources into outputs
  - i.e., PC RVUs is function of PC exam rooms



# Requirements (overall system floor)

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<b>Function</b>	<b>Requirement (as measured by output)</b>
<b>Inpatient</b>	<b>RWPs necessary to keep providers current</b>
<b>Outpatient – primary care</b> <b>Outpatient – specialty care</b>	<b>PC RVUs necessary to care for AD and ADFM</b> <b>SC RVUs necessary to keep specialists current</b>
<b>Dental</b>	<b>AD population to support</b>
<b>E&amp;T – classroom</b> <b>E&amp;T – laboratory</b>	<b>Current number of classroom student FTEs</b> <b>Current number of laboratory student FTEs</b>
<b>RDA capability domains (13)</b>	<b>Current technical FTEs (plus 10% surge) for each capability domain</b>



# *Resource or Capacity Constraint*

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- **Each activity's workload cannot be more than the activity's resources can produce.**
  - **Constrains how the model assigns workload across the system based on activities' resources**
  - **Baseline assumption: the amount of resources are fixed at current size at each activity**
  - **Possible excursion: allow resources to expand at certain sites**
    - **Ex 1: expand class/lab SQFT for new school house**
    - **Ex 2: expand RDA SQFT for new lab**
    - **Ex 3: expand PC exam rooms for a new or bigger clinic**



# Baseline Resource Expansion Assumption

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Activity	Beds	PC exam rooms	SC exam rooms	DTRs	Class SQFT	Lab SQFT	RDA SQFT
Activity 1	0	0	0	0	0	0	0
Activity 2	0	0	0	0	0	0	0
Activity 3	0	0	0	0	0	0	0
⋮	⋮	⋮	⋮	⋮	⋮	⋮	⋮
Activity N	0	0	0	0	0	0	0

- Zeros mean no expansion is possible
- For excursions where building new clinics (or expanding existing clinics), school houses, and laboratories are considered, the MJCSG needs to decide which activities can expand and how much.



- **What is the minimum amount of workload required for a function to exist at an activity**
  - **Ex 1: how many RVUs are required to open a PC clinic?**
    - **What is the minimum number of PCMs?**
  - **Ex 2: how many RWPs are required to maintain a hospital?**
    - **What is the minimum ADPL?**



# Open-the-door Constraint

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Function	Minimum requirement per activity
Inpatient	RWPs (implies some minimum ADPL)
Outpatient – prim. care	PC RVUs (implies some minimum number of PCMs)
Outpatient – spec. care	SC RVUs (implies some minimum number of specialists)
Dental	AD population (implies some minimum number of dentists)
E&T – classroom E&T – laboratory	Minimum student FTE requirement
RDA cap. domains (13)	Minimum number of technical FTEs (across all capability domains not for each domain)

- For some functions, the MJCSG may want to set these minimum requirements relatively low for the baseline case and raise the constraint in some excursions.
  - Ex: a possible scenario would be to raise the minimum RWP requirement for the open-the-door constraint. This would drive scenarios for closing “small” hospitals.



- For healthcare services functions, each activity’s workload cannot be more than the population demand (AD demand for dental)
  - Constraint requires estimates of annual individual demand

Function	AD catch	ADFM catch	Other catch	AD PRISM	ADFM PRISM	Other PRISM
IP (RWPs)	0.05	0.075	.125	--	--	--
OP PC (RVUs)	--	--	--	6	6	6
OP SC (RVUs)	--	--	--	2	2.5	3.5
Dental (AD pop)	--	--	--	1	--	--

Values in table are notional – for illustration only



- **Minimum size of GME program (GME floor)**
  - This is the floor for in-house GME not overall GME
  - What are the critical programs/specialists that the MJCSG wants to put in a GME constraint for (see below table)?
  - Possible excursion: set a low GME floor to see the types of scenarios it may generate

<b>GME Program</b>	<b>Minimum Constraint</b>
<b>General surgery</b>	<b>?</b>
<b>General surgery subspecialists</b>	<b>?</b>
<b>Internal medicine</b>	<b>?</b>
<b>IM subspecialists</b>	<b>?</b>
<b>Oral surgery</b>	<b>?</b>



- 
- **For healthcare services functions, if the activity is isolated, it must remain open.**
    - **Need a list of isolated facilities or a definition of what makes a facility isolated**
  - **For each hospital, if inpatient care remains open specialty care must remain open.**



## Other issues (functional importance)

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- **MJCSG decided that for computing an overall MILVAL for an activity, it would weight the functions as follows:**
  - **60% - healthcare services**
  - **20% - E&T**
  - **20% - RDA**
- **Model allows for separate MILVAL for each function**
  - **But, MILVAL is only a relative ranking within a function *not* across functions**
    - **For example, a MILVAL of 80 for E&T is not necessarily better or worse than a MILVAL of 50 for RDA.**
- **Because MILVAL by function does not indicate importance across functions, the model allows for indicating the relative functional importance**



**MV weights of**

- HCS – 60%
- E&T – 20%
- RDA – 20%

**Implies a certain functional importance**

Function	Functional Importance
Inpatient	3
OP PC	3
OP SC	3
Dental	3
E&T – class. & lab.	1
RDA – 13 cap. domains	1

- Are these the functional importance values the MJCSG wants in the optimization model?
- Does the MJCSG want the same functional importance within functional groups?
  - For example, should OP PC have the same, higher, or lower functional importance than OP SC?