

MINUTES OF THE SEPTEMBER 17, 2004 MEETING OF THE MJCSG

LOCATION: Pentagon, Room 4E1071, 1530 -1730

Attending: Lt Gen Taylor - Chairperson; VADM Arthur - Navy SG; Mr. Chan – ASD(HA)/CP&P; MGen Webb – Army Deputy SG; RADM Hufstader – USMC SG; Col Hamilton - Secretary; Mr. Yaglom – USA SG; CAPT Hight - BUMED; Mr. Curry – USA/OTSG; Mr. Col Jacob – USAF/SG; Col Sager – AFMSA/SGS; Lt Col Jones - USAF/SG; Dr. Opsut - OSD/HA; Mr. O’Connell – DoD/IG; Mr. Porth – OSD/BRAC; Mr. Sherman – OTSE; Ms. Shifflett – SAF/IEBJ; Maj Harper – AF/SGSF; Maj Fristoe – HA/TMA; Maj Guerrero – USAF/SG; Mr. Christenson – CNA; Mr. Barton – AF Analyst; CDR Morrison – DASN; CAPT Taft – NMETC; CAPT Mather – NMETC; Dr. Glenn – HQ USA/MRMC; CAPT Deike – OASD(HA) TMA/CPO; Maj Coltman – USAF/SG Recorder.

Decisions:

- **Framework For Analysis: Optimization Model Input Recommendations: (Approved)**
 - Requirements (Overall System Floor): Current workload of CONUS based system using FY02 certified data (due to OIF).
 - Minimum Workload Constraint: Inpatient: Min 675 RWPs/5.9 ADPL; Outpatient: Primary Care - Min 7950 RVUs ~ 3 PCMs, Specialty Care - Min 1800 RVUs ~ 1 Specialist; Dental – Min 800 AD to 1 dentist; E&T: classroom/laboratory - Min Student FTE – 1 student year; RDA cap. Domains - Min Tech FTE – 5 Tech FTE
 - E&T Constraint - No GME constraint in baseline model
 - Isolated Facilities – List approved with Fort Greeley removed
- Scenario Strategies/Ideas/Proposals (see attachment 3):
 - **E&T Overall Strategy/Proposed Scenarios (Approved)**
 - E&T-1: Initial Medical Enlisted Training Consolidation
 - E&T-2: Medical Enlisted Specialty Training Consolidation
 - E&T-3: Aerospace Medicine Training Consolidation
 - E&T-4: Medical Graduate Training Consolidation, pending recommendations
Healthcare Services sub-group scenario recommendations
 - **Medical/Dental Contracting Service Consolidation (Overall Strategy/Proposed Scenarios Approved)**
 - **HCS Overall Strategy/Ideas/Proposed Scenarios: (Approved)**
 - HCS-1: Close inefficient inpatient facilities
 - HCS-2: Close/Consolidate/move facilities within Multi-Service Markets
 - HCS-3: Maintain Primary Care for AD/ADFMs
 - HCS-4: Establish Civilian/VA Partnerships in Select Locations
 - HCS-6: Maintain Medicare Accrual Level of Effort
 - HCS-7: Lease Space for Clinics where beneficiaries are Concentrated Near a Base.
 - **HCS-5: Proposal to maintain 80% Service Specific requirement as a model constraint (HOLD)**
 - **Medical-Dental RDA Consolidation Strategy/Ideas/Proposed Scenarios (Approved)**
 - **Action Items:**

- Instruct 0-6 Lead Group to run optimization model using approved constraints and on proposed scenarios by 15 Nov to see interactions DCN: 11371
- Demand Constraint: Tabled for further review and approval
- Develop proposal for consolidating Preventative Medicine Function
- Develop recommended proposal for AFIP

Meeting Overview:

- Chair opened meeting with overview of timeline with focusing on mid-November for primary recommendations. What the Service lines decide provides a big picture on force structure pushes so we can declare what we want to do. All work goes into developing ideas for proposals and then running registered scenarios through the optimization model.
- Secretary provided updates on ISG meetings now scheduled every Friday at 1030-1200. Standard invite to MCJSG Chair or Flag representative. Stressed the importance of working on scenario development in anticipation of briefing ISG. Suspense for MJCSG to brief recommendations and status of scenario analysis to ISG is 15 Nov 04. All analysis should be completed without scenario specific data. Principals will deliberate and vote on proposed numbers/standards to put into the optimization model and approve the list of isolated facilities to use as constraints for anticipated runs. These runs will be used for to develop ideas, proposals, and scenario recommendations.
 - Optimization model outputs help further develop scenario recommendations and transformational options for final recommendations. If the data is bad it also provides an opportunity to re-evaluate and document process to take other things into account as a means to going back to re-evaluate model constraints.
- **Framework for Analysis: Optimization Model Input/Decisions** (see attachment 2) was briefed detailing inputs and constraints. The methodology will provide guidelines for the creation of specific optimization models for use in generating multiple alternative solutions that will serve as starting points in the development of closure and/or realignment scenarios. The analysis and review of these scenarios will lead to final recommendations. This briefing described proposed optimization methodology developed from reviewing the BRAC '95 methodology. The optimization methodology requires, among other things, military value assessments.
- Specific constraints and modeling questions were outlined, discussed, and approved as follows:
 - Overall Requirements and minimum Assignment Constraint – identify minimum amount of workload that must be in the system, sets overall system floor. If site has increased demand, is it limited by site capacity? Would not recommend investing infrastructure for in-house portion of care. If site has increased capacity, is it limited by demand?
 - **Requirements (Overall System Floor):** Requirement system wide (as measured by output) - Propose use of current workload of CONUS based system using FY02 data (due to OIF). Up to Services to re-calculate major relocations based on deployments/returns. Chair recommended basing on maintaining provider currency but difficult to define. Problem is identifying CONUS requirements for provider currency, workload for provider to maintain clinical currency. Suggested to draw directly from capacity data. FY02 data complete except for RDA FY03 data.
 - **Minimum Workload Constraint:** Minimum requirement per activity will be used to open the excursion. **Approved for Min 675 RWPs/5.9 ADPL to keep inpatient open.** Numbers to be used for running the model as preliminary

analysis and then MILVAL will be applied based on the results. ^{DCN: 11871} SMES arrived at ADPL based on their expert opinion for minimal quality safe care for patients. No Primary Care constraint built in only for specialty care. Preventive Medicine not considered in model. **Agreed on minimal AD population of 800 to 1 dentist.** Using these constraints will help to discriminate/eliminate up front the sites/functions that are obvious. Constraints driven by a complicated model and will change after initial the run and the team will obtain further input for new optimization runs and excursions.

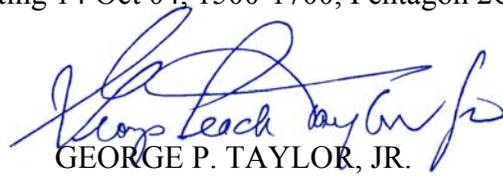
- **Demand Constraint:** For healthcare services functions, each activity's workload cannot be more than the population demand (AD demand for dental). This constraint requires estimates of annual individual demand. Add to table RWPs for FY02 total population enrollees in catchment area (direct care, private care, eligibles over 65). PRISM defined as 20-mile radius. Discussed utilization rate per enrollees (FY02 historical data) applied to demand and total population as the demand constraint. Enrollees multiplied by total population equals clinically available demand. Tabled for further review and approval (**Follow-up**).
 - **E&T Constraint - No GME constraint in baseline model, Approved.** E&T numbers used as a placeholder (requirement to run model), need to look at other criteria to make decisions. MJCSG will assess GME capability in the sites remaining open in the baseline case. Based more on MILVAL because it does not take into account professional/operational training only sites with an education function. Excursions may look at forcing all GME sites to remain open or limit a certain number of GME sites to close. Ultimately, E&T will be absorbed into the final structure. MJCSG will use military judgment to rationalize keeping a facility open with excess capacity if the driving force is their GME program.
 - **Isolated Facilities (Approved with the removal of Fort Greeley):** For healthcare services functions, if the activity is isolated, it must remain open. The following were identified and approved as isolated sites: Mountain Home AFB, Twenty-nine Palms, Fort Irwin, Altus AFB, Laughlin AFB, NAS Whidbey Island, NAS Lemoore, and Guam. Fort Greeley removed from the list because of available medical services in surrounding areas. Identified based on 733U to keep at current operating level but need additional support to justify.
- Scenario strategy and ideas were briefed by each subgroup: Secretary explained that scenario ideas and proposals are excursions from the baseline, which can be further developed into a scenario recommendation. Scenario ideas/proposals are created and developed, the associated subgroup (E&T, HCS, RDA) analyzes the data and model runs to refine the proposed scenario and identify other areas for possible excursions. It is then presented for approved by the MCJSG and if approved, registered in the ISG scenario tracking tool. The following strategies and ideas/proposed scenarios were presented to the MJCSG for approval to register, perform optimization model runs, and further analyze for possible scenario recommendations.
- E&T rep presented their overall scenario strategy to co-locate and/or consolidate medical education and training to achieve joint efficiencies across the Services IAW MILVAL and reported capacity (**E&T Overall Strategy Approved**).
 - **E&T-1: Initial Medical Enlisted Training Consolidation:** Idea/scenario proposal recommendation is to consolidate training at either Sheppard AFB or Fort Sam Houston and close Hospital Corps School at Great Lakes, pending

further data collection/analysis, other JCSG conflicts and Service input. DCN: 11371

(Approved)

- **E&T-2: Medical Enlisted Specialty Training Consolidation:** Idea/scenario proposal recommendation is to redistribute programs (Pharmacy, Radiographer, and Diet Therapy Enlisted Training Programs) to reduce number of locations. Need to identify/develop joint core curriculum and accommodate Service-specific training. **(Approved)**
- **E&T-3: Aerospace Medicine Training Consolidation:** Idea/scenario proposal recommendation is to consolidate programs at Pensacola NAS or Brooks AFB and close the other site. Chair stated that the programs will still run the same Service-specific platforms but will be co-located. **(Approved)**
- **E&T-4: Medical Graduate Training Consolidation:** Deferred until it has been determined which facilities will remain open, then realign and consolidate training at remaining facilities. Also will involve strong MILVAL decision by Services with option for outsourcing. **(Approved)**
- **Medical Professional Service Contracting Consolidation overall strategy and idea/proposal was presented. (Approved).**
- HCS rep presented overall scenario strategy to match provider readiness “currency” requirements to population demands (surrounding facility).
 - **HCS-1: Strategy is to close inefficient inpatient facilities.** “Open Door” Inpatient Policy proposal is to use a minimum RWPs corresponding to ADPL of 10. Scenario proposed to close non-isolated facilities with population below that needed to sustain ADPL 10. **(Strategy/Scenario Proposal Approved).**
 - **HCS-2: Close/Consolidate/move facilities within Multi-Service Markets** (NCA, Tidewater, San Antonio, Puget Sound, Ft Bragg, Hawaii, Charleston, Ft Jackson/Shaw, Colorado Springs). Keesler and San Diego rejected because of distance between medical treatment facilities. **(Strategy/Scenario Proposal Approved)**
 - **HCS-3: Maintain Primary Care for AD/ADFM**s for any location that generates 7.5K RVUs. **(Strategy/Scenario Proposal Approved).**
 - **HCS-4: Establish Civilian/VA Partnerships in select locations;** proposal is to close some military hospitals and have military providers treat beneficiaries in a civilian or VA hospital. Chair stressed importance of developing these partnerships and asked sub-groups to think broadly about possibilities. **(Strategy/Scenario Proposal Approved).**
 - **HCS-5: Maintain Service Specific requirement constraint - Must have at least 80% of Service workload requirement within the same service facility.** Forces the model to assign some providers to facilities of the same service. Group discussed questionable value of using because it supports the current inefficient system. **(HOLD)**
 - **HCS-6: Maintain Medicare Accrual Level of Effort:** forces model to have enough workload to maintain current Medicare level. Maintains direct care funding/commitment to Medicare eligible beneficiaries. **(Approved)**
 - **HCS-7: Lease Space for Clinics where beneficiary population is not concentrated near a base.** Most complex. Group discussed complexity of running proposal in optimization model and asked questions concerning cost/security outside the base. Also related discussion to comments in HCS-4. **(Approved)**

- **RDA rep briefed overall strategy to relocate/consolidate/reduce medical dental RDA** to a minimum number of geographic sites by establishing centers of excellence while retaining essential capabilities and encourages joint processes for whole system.
 - Scenario proposals co-locate to reduce/constrain number of sites at existing facilities or with proposed new site(s). **(Approved)**
- Closing: Chair requested 0-6 Leads to run optimization model by the 15 Nov 04 and also to further evaluate, analyze, and develop scenario ideas/proposals presented and approved. Army rep requested an evaluation of the non-military work RDA centers are performing, specifically AFIP. Navy rep requested a look consolidating preventative medicine function and Service medical headquarters. All agreed on evaluation of AFIP and Preventative Function. Chair requested approval for proposals pending additional data call, all concurred. Chair stressed the need for documentation of analysis and back up analysis (through COBRA), the first iteration will be on 15 Dec. OSD wants scenario proposals registered and optimization model run ASAP.
- NEXT MEETING: MJCSG Principals Meeting 14 Oct 04, 1500-1700, Pentagon 2C554.



GEORGE P. TAYLOR, JR.

Lieutenant General, USAF, MC, CFS

Chair

Attachments:

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

Medical Joint Cross Service Group

DCN: 11371



MJCSG FRAMEWORK FOR ANALYSIS: Optimization Model Inputs

17 Sep 04



Overall Requirement and Minimum Assignment Constraint

Requirement: minimum amount of workload that must be in the system

Site A

Min. workload

Capacity

Demand

Site B

Min. workload

Capacity

Demand

Site limited by capacity

Site C

Min. workload

Capacity

Demand

Site limited by demand



Requirements (Overall System Floor)

DCN: 11371

Function	Requirement system wide (as measured by output)
Inpatient	RWP floor
Outpatient – primary care Outpatient – specialty care	PC RVU floor SC RVU floor
Dental	AD population to support
E&T – classroom E&T – laboratory	Current number of classroom student FTEs - 377,450 Current number of laboratory student FTEs - 10,468
RDA capability domains	Current technical FTEs (plus 10% surge) by capability domain or capability-domain group



Minimum Workload Constraint

DCN: 11371

Function	Minimum requirement per activity if open
Inpatient	Min RWPs – 650/700 RWPs ~ 5.7/6.1 ADPL
Outpatient – prim. care	Min PC RVUs – 7950 RVUs ~ 3 PCMs
Outpatient – spec. care	Min SC RVUs – 1800 RVUs ~ 1 Specialist
Dental	Min AD population – 500(1)/800(1)/1201(2) AD Pop(dentist)
E&T – classroom E&T – laboratory	Min Student FTE – 1 Student
RDA cap. domains	Min Tech FTE – 5 Tech FTE



- 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)				--	--	--
OP PC (RVUs)	--	--	--			
OP SC (RVUs)	--	--	--			
Dental (AD pop)	--	--	--	1	--	--



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- **Baseline model: no GME constraint**
 - **MJCSG will assess GME capability in the sites remaining open in the baseline case**
 - **Excursions may look at forcing all GME sites to remain open or limit the number of GME sites closed**



- **For healthcare services functions, if the activity is isolated, it must remain open**
 - **Mountain Home AFB**
 - **Twenty-nine Palms**
 - **Fort Irwin**
 - **Altus AFB**
 - **Laughlin AFB**
 - **NAS Whidbey Island**
 - **NAS Lemoore**
 - **Guam**
 - **Fort Greeley**

Medical Joint Cross Service Group



Scenario “Ideas”



17 Sep 04



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- **Scenario Strategy**
 - **Ideas/Proposed Scenarios**
 - **Quad Chart**
 - **Scenario**
 - **Drivers/Assumptions**
 - **Justification/Impact**
 - **Potential Conflicts**



Scenario Strategy

Education & Training

DCM: 11371

- **Co-Locate and/or Consolidate Medical Education and Training to achieve efficiencies IAW Military Value and reported capacity**



Ideas/Proposed Scenarios

Education & Training

DCN: 11371

- **Consolidate Initial Enlisted Phase I Training**
- **Consolidate Enlisted Specialty Training**
- **Consolidate Medical Flight Training**
- **Consolidate Graduate Education**



Med E&T-1: Initial Medical Enlisted Training Consolidation

<h2>Scenario</h2>	<h2>Drivers/Assumptions</h2>
<ul style="list-style-type: none">■ Consolidate Initial Medical Enlisted Training at Sheppard AFB or Brooke AMC and close Hospital Corps School at Great Lakes; realign all svcs to one training location.	<ul style="list-style-type: none">■ Principles: Organize■ Transformational Options: Develop joint enlisted initial medical training.■ Other: Reduce average infrastructure age and locations.
<h2>Justification/Impact</h2> <ul style="list-style-type: none">■ Reduces infrastructure■ Develops joint training site, making joint utilization of personnel more feasible■ Reduces average age and location of training infrastructure	<h2>Potential Conflicts</h2> <ul style="list-style-type: none">■ Military Culture■ Scope of practice and utilization differs between services■ Enlisted programs are not equivalent



Med E&T- 2: Medical Enlisted Specialty Training Consolidation

<h2>Scenario</h2>	<h2>Drivers/Assumptions</h2>
<ul style="list-style-type: none">■ Redistribute medical enlisted specialty training programs amongst existing school houses to reducing number of locations if possible.	<ul style="list-style-type: none">■ Principles: Organize■ Transformational Options: Develop joint enlisted specialty medical training.■ Other: Reduce number of infrastructure locations.
<h2>Justification/Impact</h2> <ul style="list-style-type: none">■ Reduces infrastructure■ Develops joint specialty training, making joint utilization of personnel more feasible■ Reduces number of training locations and infrastructure	<h2>Potential Conflicts</h2> <ul style="list-style-type: none">■ Military Culture■ Scope of practice and utilization differs between services■ Enlisted programs are not equivalent



Med E&T- 3: Medical Flight Training Consolidation

<h2>Scenario</h2>	<h2>Drivers/Assumptions</h2>
<ul style="list-style-type: none">■ Consolidate Initial Medical Flight Training at either Pensacola NAS or Brook AFB and close the other site■ Realign other follow on training as required	<ul style="list-style-type: none">■ Principles: Organize■ Transformational Options: Develop joint flight initial medical training.■ Other: Reduce infrastructure locations.
<h2>Justification/Impact</h2> <ul style="list-style-type: none">■ Reduces infrastructure■ Develops joint training making joint utilization of personnel more feasible and reducing redundancy	<h2>Potential Conflicts</h2> <ul style="list-style-type: none">■ Military Culture■ Scope of practice and utilization differs between services■ Enlisted programs are not equivalent



Med E&T-4: Medical Graduate Training Consolidation

DCN: 11371

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ After the healthcare service group has determined which facilities should remain open – identify which facilities conducting graduate education would close■ Realign and consolidate training at remaining facilities■ If insufficient capacity in MTFs is there availability in the civilian sector	<ul style="list-style-type: none">■ Principles: Organize■ Transformational Options: Develop joint graduate training.■ Other: Reduce locations where graduate education is conducted. Eliminate or utilize civilian programs as indicated.
Justification/Impact	Potential Conflicts
<ul style="list-style-type: none">■ Reduces infrastructure■ Develops joint training■ Reduces location and redundancy of training infrastructure	<ul style="list-style-type: none">■ Military Culture



Scenario Strategy

Infrastructure

DCN: 11371

- **Consolidation of medical professional services contracting has potential to reduce redundant contracting activities, standardize procurement of these services, comply with DoD IG audit recommendations, and potentially reduce amount paid**



Ideas/Proposed Scenarios

Infrastructure

DCN: 11371

- **Consolidate medical professional services contracting to a single organization**



Med INF-1: Med Pro Svc Consolidation

DCN: 11371

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Consolidate medical professional services contracting to a single organization■ All MTFs obtain contract support from single entity specializing in medical professional services contracting	<ul style="list-style-type: none">■ Principles: Organize■ Transformational Option: Consolidate medical professional services contracting to single organization
Justification/Impact <ul style="list-style-type: none">■ Reduces infrastructure■ Improves efficiency■ Reduces infrastructure costs■ Increases negotiating leverage with industry■ Complies with DoD IG Audit recommendations	Potential Conflicts <ul style="list-style-type: none">■ Military Culture■ Differing training/oversight requirements



Scenario Strategy

Health Care Services

DCN-11371

- **Match requirement to keep providers “current” for the readiness mission with population surrounding facility**



Ideas/Proposed Scenarios

Health Care Services

DCN: 11371

- **Minimum “Open Door” Policy: RWPs corresponding to Average Daily Patient Load of 10**
- **Examine Organization of Facilities within MSMs**
 - **NCA, Tidewater, San Antonio, Puget Sound, Ft Bragg, Hawaii, Charleston, Ft Jackson/Shaw, Colorado Springs**
 - **Taken off: Keesler, San Diego**
 - **Still Investigating: Alaska**
- **Maintain Primary Care for AD and ADFMs**
- **Establish Civilian/VA Partnerships in select locations**
 - **Eglin, Charleston, Beaufort, Ft Sill, Sheppard, Ft Jackson, Nellis, MacDill, Great Lakes, Luke, Ft Polk, West Point, Ft Rucker**



Ideas/Proposed Scenarios

Health Care Services

DCN: 11371

- **Service Specific Requirement Constraints**
 - **Must have at least 80% of Service workload requirement within same service facility**
- **Maintain Medicare Accrual Level of Effort**
- **Lease Space for clinics where Beneficiary Population is not Concentrated near a base**



Med HCS-1: Minimum ADPL

DCN: 11371

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Close non-isolated facilities with population below that needed to sustain an ADPL of 10	<ul style="list-style-type: none">■ Principles: Organize■ Other: Match providers with population
Justification/Impact	Potential Conflicts
<ul style="list-style-type: none">■ Reduces infrastructure■ Improves efficiency■ Keeps providers “current”	<ul style="list-style-type: none">■ Military Culture



Med HCS-2: Reorganize Facilities within MSMs

DCN: 11371

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Close/Consolidate/Move facilities within Multi-Service Markets	<ul style="list-style-type: none">■ Principles: Organize■ Other: Match providers with population
Justification/Impact	Potential Conflicts
<ul style="list-style-type: none">■ Reduces infrastructure■ Improves efficiency■ Improves Quality of Life	<ul style="list-style-type: none">■ Military Culture



Med HCS-3: Maintain Primary Care for AD and ADFMS

DDN: 4371

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Maintain Primary Care clinic at any location whose AD and ADFM population generates 7,500 RVUs	<ul style="list-style-type: none">■ Principles: Organize■ Other: Provide Military care for military members
Justification/Impact	Potential Conflicts
<ul style="list-style-type: none">■ Improves Quality of Life	<ul style="list-style-type: none">■ Maintains Excess Infrastructure



Med HCS-4: Establish Civilian Partnerships in Select Locations

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Close some military hospitals and have military providers treat beneficiaries in civilian hospitals	<ul style="list-style-type: none">■ Principles: Organize
Justification/Impact <ul style="list-style-type: none">■ Reduces infrastructure■ Improves efficiency■ Keeps providers “current”	Potential Conflicts <ul style="list-style-type: none">■ Military Culture



Med HCS-5: Maintain Service Specific Requirement Constraints

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Must have at least 80% of Service workload requirement within same service facility	<ul style="list-style-type: none">■ Principles: Organize■ Other: Provide Military care for military members with the same uniform
Justification/Impact <ul style="list-style-type: none">■ Forces model to assign some providers to facilities of the same service	Potential Conflicts <ul style="list-style-type: none">■ Maintains Excess Infrastructure



Med HCS-6: Maintain Medicare Eligible Level of Effort

DCM 1371

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Force model to have enough workload to maintain Medicare Level of Effort	<ul style="list-style-type: none">■ Principles: Organize■ Other: Provide Military care for military members with the same uniform
Justification/Impact <ul style="list-style-type: none">■ Maintain direct care funding from Medicare Accrual Fund■ Maintain commitment to Medicare Eligible beneficiaries	Potential Conflicts <ul style="list-style-type: none">■ Maintains Excess Infrastructure



Med HCS-7: Lease Space for Clinics where Beneficiary Population is not Concentrated Near a Base

DCN: 11371

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Model some infrastructure as leased space	<ul style="list-style-type: none">■ Principles: Organize
Justification/Impact	Potential Conflicts
<ul style="list-style-type: none">■ Reduces infrastructure■ Increases base security■ Keeps providers “current”	<ul style="list-style-type: none">■ Military culture■ Security risks at leased location■ Increased leased costs due to security requirements



Scenario Strategy

Medical-Dental RDA

DCN 1137

- **Reallocate DoD Medical-Dental Research, Development and Acquisition resources to a minimum number of geographic sites while retaining essential RDA capabilities.**



Ideas/Proposed Scenarios

Medical-Dental RDA

DCN: 11871

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- **Base case – minimize footprint**
 - **Reduce number of sites by establishing centers of excellence – constrained to current sites**
 - **Reduce numbers of sites by establishing centers of excellence – proposed new sites**



Med RDA – 1: Base Case – Minimize Foot Print

DCN: 11B1

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Reduce excess square footage within each capability domain/or selected groups of domains.	<ul style="list-style-type: none">■ Redistribution of workload within a capability domain will not break unity of core competencies.
Justification/Impact	Potential Conflicts
<ul style="list-style-type: none">■ Reduce/minimize excess capacity.	<ul style="list-style-type: none">■ Workload within a capability domain/group of domains may only be moved to sites that already perform work within the same domain/group of domains.



Med RDA – 2: Establish Centers of Excellence – At Current Sites

DCN: 11371

<h2>Scenario</h2>	<h2>Drivers/Assumptions</h2>
<h3>Justification/Impact</h3> <ul style="list-style-type: none">■ Collocate within each capability domain/group of domains to achieve a single site for each domain. <ul style="list-style-type: none">■ Maximum of 7 sites will be developed■ Allow expansion existing sites up to maximum required for a capability domain■ Allow for a reduction in capacity requirement due to efficiencies realized with collocation.	<h3>Potential Conflicts</h3> <ul style="list-style-type: none">■ Collocation is the method to achieve efficiencies.■ Current sites can expand to meet required capacity for the capability domain(s) that will be located there. <ul style="list-style-type: none">■ Workload within a capability domain/group of domains may only be moved to sites that already perform work within the same domain/group of domains.■ Military operational medicine research requires unique geographic and climatic features■ Combat casualty care research requires collocation with a military trauma center.



Med RDA – 3: Establish Centers of Excellence – Possible New Site

DCN: 11371

Scenario	Drivers/Assumptions
<ul style="list-style-type: none">■ Collocate within each capability domain/group of domains to achieve a single site for each domain. Allow either (a) a single new site for technology maturation domains in combat casualty care and military operational medicine, or (b) 2 new sites; 1 for technology maturation in military operational medicine and 1 for technology maturation in combat casualty care	<ul style="list-style-type: none">■ Collocation is the method to achieve efficiencies■ Current sites can expand to meet required capacity for the capability domain(s) that will be located there.■ Military value of new site is a composite of existing sites.
Justification/Impact <ul style="list-style-type: none">■ Maximum of 7 sites will be developed■ Allow expansion existing sites up to maximum required for a capability domain■ Allow for a reduction in capacity requirement due to efficiencies realized with collocation.	Potential Conflicts <ul style="list-style-type: none">■ Workload within a capability domain/group of domains may only be moved to sites that already perform work within the same domain/group of domains.■ Military operational medicine research requires unique geographic and climatic features■ Combat casualty care research requires collocation with a military trauma center.



Med RDA : Backup

DCN: 11371

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- Capability Domain Groups:
 - **Domain Group 1: Combine Technology Maturation domains for Human Systems and Military Operational Medicine.**
 - **Domain Group 2: Combine Acquisition domains**
 - **Domain Group 3 (as alternative): Combine Technology Maturation domains for Infectious Disease and Medical Biological Defense**

 - Analysis of Basic Research:
 - **Exclude Basic Research from separate optimization, but include pro-rata share of workload attributable to this domain in analyses of other Technology Maturation domains**