DCN: 11373

MINUTES OF THE OCTOBER 28, 2004 MEETING OF THE MJCSG PRINCIPALS

LOCATION: Pentagon, Room 2C554, 1530 -1730

Attending: LG Taylor – Chair; RADM Woofter – Representing NAVY SG; MG Webb – USA SG; CAPT Cullison USMC SG; Mr. Yaglom – OTSG; Mr Opsut – OSD/HA; Col Hamilton – Secretary; Mr. Curry - USA OTSG; Mr. Andy Porth – OSD/BRAC; Mr. O'Connell – DoD/IG; Dr. Opsut - OSD/HA; Col Sager – AFMSA/SGS; Ms. Shifflett – SAF/IEBJ; CAPT Shimkus - BUMED; CAPT Hight – BUMED; Lt Col Jones – USAF/SG; CDR Bellas – USN Analyst; Mr. Barton – AF Analyst; Maj Cook – HA Analyst; Maj Fristoe – HA/TMA; Maj Guerrero – AF/SG; Maj Harper – AF/SGSF; Maj McDonald – Army J-4; Dr. Nailer- RDA SME; Mr. Christensen - CNA; Ms. Gail Mason – DoD OGC; Mr. Glenn – USA SME; Lt Col Cohen AF SME; CAPT Miller – USN SME; Ms. Sanflteben – TMA

Decisions:

- Approved Puget Sound Scenario
- Recommend no Consolidation Between Ft Jackson and Shaw
- Approved Medical Contract scenario
- Approved RDA Scenario with Additional E&T Subgroup Coordination

Action Items:

- DoD guidance needed, most of scenarios to be in the tasker by tomorrow
- GME Spreadsheet to Flag Officers, 1 Nov 04
- RDA to send completed scenario information to Secretary to post on tracker
- GME results 5 Nov 04
- HC brief NCA on 5 Nov 04

Meeting Overview:

- Chair opened by indicating that the pace is expected to pick up significantly and all senior leaders must be kept briefed by their staff and ready to come prepared to every decisional meeting. Starting Nov 04, decisional meetings will be weekly. It will be unwise to have principals participate in the decisional meetings without their staff pre-briefs.
- Chair turned briefing over to the secretary. ISG meeting canceled tomorrow. Nov schedule: Three 0-6 meetings occur this first week of November, two data and recommendation preparation meetings and one optimization run planning meeting with CNA. Per DoD guidance most of MJCSG scenarios must be loaded by tomorrow. AF has not loaded official scenarios. Secretary working deconflictions twice a week. Medical has had 17 with resolution. NCA data call, 1 Nov 04. Every critical data item must be loaded in the master database and analyzed by 20 Dec 04 to stay on schedule. Secretary expects to have the last Optimization run done by the first or second week of December.
- Critical data noted missing for specific scenarios is to be processed through the standing MJCSG SOP for 48 hour turnaround. Member asked who sets the time frame and why, and how does it work? The answer was that the ISG sets the schedule. Secretary and OSD discussed that the MJCSG plan must come out by 20 Dec 04.
- **MTF Definitions** (**Revisit-5 Nov).** Definitions presented. Discussion started over how and why definitions are needed. Subgroup leader explained that the capacity model allotted

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occupancy rates of 60 % for teaching hospitals, and 80% for Medical Centers, affecting RWPs. These formulas are the basis for the optimization model. In conclusion, the Flag Officers asked that since the facilities are no longer classified by their original capability but by the current needs of the Services, that the Subgroup should draft a document using an example of the following statement.

- "The following facilities listed are labeled Medical Centers, (teaching hospitals, community hospitals) based on the authority of the Service SG.
- "The matrix used for the optimization model is 80% for Medical Centers, and 70% for Community/Teaching Hospitals."

Have final slide ready for review for 5 Nov Principal meeting.

□ **RDA Scenario Brief: (Approval with additional work).** OTSG introduced Navy SME. USN raised the issue concerning complexity of the formula and brought about a better explanation of how the excess of the infrastructure was brought to light concerning so many different facilities. USN requested adding Pensacola (E&T) for Aerospace, also add Lackland, and take off Brooks. At the end of the brief, MJCSG requested RDA work with Medical E&T subgroup SMEs. Chair reviewed an medical educational model that suggest ed that the best educational opportunities are developed when the education facility is co-located with clinical and medical research facilities. Chair suggested that RD&A workglroup coordinate with E&T workgroup to maximize the opportunity to synergy.. RDA then began briefing the Med/Chem/Bio/Rad/Tox Policy. USN asked if we really want to see medical research integration? (See slides) Principals believe that RDA needs to coordinate with Medical E&T subgroup first; rewrite the quad chart; then forward their scenario to Secretary to place in the tracker.

□ **AFMSA/SGS briefed Medical Contract scenario**. **(Approved).** Issues: 3 offices, 3 different Services, too few personnel for workload. Concern that there may be limited infrastructure savings. SMEs working this issue agreed to the proposal however they requested resources to accompany the proposal. Principals supported the proposal realizing that moving the personnel in one place may synergize the productivity, eliminate the need for 3 Service processes and streamline business practices increase cost savings.

□ **Scenario: Puget Sound (Approved)** HA expert briefed scenario for Puget Sound. Discussed Seattle, Bremerton and Oak Harbor medical capability. This allows the opportunity to analyze the closure of McChord AFB medical activity. **(Approved)**

□ **Ft Jackson/Shaw AFB** Recommended no consolidation between Ft Jackson and Shaw. Therfore these facilities will not be considered to constitute a multi Service market and will be analyzed with the system-wide model. **(Approved)**

□ **GME Education and Training brief. (Revisit-5 Nov)** GME handouts given to Principals and explained. One handout delineates where training exists in the system, the other expresses training recommendations made by the SMEs. Principals asked indicate the support the various GME programs provide to their medical force management. Chair asked why this to should drive the GME decision? Lead answered that it would hopefully give a direction on the significance of the various GME programs and allow for trhe distribution of GME programs as the BRAC process proceeds to recommendations. Tally sheets will be completed and sent out to Principals by 1 Nov 04; replies must be completed and returned to USN by 3 Nov 04. Revisit GME decision results 5 Nov 04, Principals meeting.

□ Healthcare Lead will brief the NCA scenario on 5 Nov 04

□ Recommendation Exercise #1 – Secretary briefed an actual recommendation using notional slides for the first time as a practice. Principals and staff impressed with the how the briefing

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flowed with the slides and formulas. Questions and ideas were raised on how to better present data.

- Data review: Military value RFCs out and on their way back. System working well with COBRA data calls.
- Admin notes: Conflict of Interest –Statements need to go to LG Taylor – SF 454 for senior officers and up. All have to have a filed SF 454.
- Chair requests that the team begin thinking if any of the JCSG scenarios might cause dis-enrollment from Prime. If so, how would the system handle that? Would we ever have to move enrollees from Prime to Standard? Would there ever be a situation where 50,000 people would have to be dis-enrolled? How would TROA do it? Would there be a cost for the patient? Could we work a deal that to absorb a piece or all of the cost? What is the risk? Let's start thinking about these issues now, not later.
- Chair thanked everyone for all the hard work.
- NEXT MEETING: 0-6 Lead Meeting, 4 Nov 2004, Pentagon Room, 2C554, 1530 -1700.
- NEXT PRINCIPAL MEETING: 5 Nov 2004, Pentagon Room, 2C554, 1330 – 1700.

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

Attachments:
1. Agenda
2. Combined Presentations: Request for MJCSG MTF Definitions; Medical/Dental RDA Proposals and Alternatives

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MJCSG Principals Meeting

10/28/2004
3:30 PM to 5:30 PM
Pentagon 2C554

Meeting called by:	Chair	Type of meeting:	Deliberative
Note taker:	Lt Col Jones		

Agenda

Chair Comments	Lt Gen Taylor	5
Process/Schedule	Col Hamilton	10
MTF Definitions	Dr Opsut	10
Scenario Proposal Review		
RDA Proposals	Mr Yaglom	20
Contracting Proposal	Col Sager	20
HCS Proposals	Dr Opsut	30
GME Review	CAPT Hight	10
Draft Recommendation Exercise		20
Hawaii	Col Hamilton	10
Around the Room	Lt Gen Taylor	10
Closing	Lt Gen Taylor	5

Additional Information

Medical Joint Cross Service Group

Principals Meeting

28 October 2004

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Current Schedule

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- Weekly ISGs – focus on deconfliction
- Scenario DOD Staff-level Deconfliction meetings: 2/ wk
- MJCSG O-6 Meetings 3/wk
  - 2/wk on data review and recommendation development
  - 1/wk prep meeting for MJCSG meeting
- "Vast majority' of scenarios to OSD by tomorrow – met
  - 19 Registered and 4-5 to go
- Scenario data calls (COBRA) start – 4 Nov 2004/ Navy 8 Nov 2004
- Recommendations due to OSD – 20 Dec 2004

Proposed Gameplan

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- Optimization runs should be done in 2 weeks for Healthcare and E&T (Non-GME)
  - GME should done by 15 Nov 2004
  - RDA should be done by 20 Nov 2004
- Scenario data calls should start end of 1 week in Nov 2004
- COBRA analysis completed by last week in November 2004
- Begin briefing optimization runs next Friday

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MJCSG Principals Task

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- Monitor workgroup progress - on schedule
  - ID issues and ensure focus
- Validate Optimization approach – operational impact
- Prioritize optimization recommendations
- Select candidate recommendations
- Resolve issues in data and process
- Decision cycle is very short – need to move quickly

Medical Joint Cross Service Group

Request for MJSCG Approval of MTF Definitions

28 Oct 04

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Request for MJCSG Approval of MTF Definitions

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- Basic MTF Definitions from TMA research
- Modifications/additions/clarifications made by the Healthcare Services Workgroup
- Navy and Air Force approve September 04
- Army approves October 04
- Request MJCSG approval for final Capacity Report

❑ Revision of definitions 23 Oct by Healthcare Services working group

Hospital

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ADDED

- **A hospital is a health treatment facility capable of providing inpatient care.**

Medical Center

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OLD

- **A Medical Center is a large hospital that has been so designed and is appropriately staffed and equipped to provide a broad range of healthcare services. It also serves as a referral center with specialized and consultative support for facilities within a geographic area of responsibility: conducts, as a minimum, a surgical graduate medical program.**

NEW

- **A medical center is a large teaching hospital, designated by the respective Service Surgeon General, that has been designed and is appropriately staffed and equipped to provide a broad range of healthcare services. It also serves as a referral center with specialized and consultative support**

Community Hospital

DCN: 11373

OLD

- **A community hospital is a health treatment facility capable of providing definitive patient care. It is staffed and equipped to provide diagnostic and therapeutic services in the fields of general medicine and surgery and preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A community hospital may, in addition, discharge the functions of a clinic.**

NEW

- **A community hospital is a hospital that is not a teaching hospital.**

Teaching Hospital

DCN: 11373

OLD

- **A teaching hospital is a community hospital with at least one graduate medical education program.**

NEW

- **A teaching hospital is a hospital with at least one graduate medical education program.**

Medical-Dental RDA Proposals and Alternatives

28 October 2004

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CONUS-Based Organizations
Dept of the Army

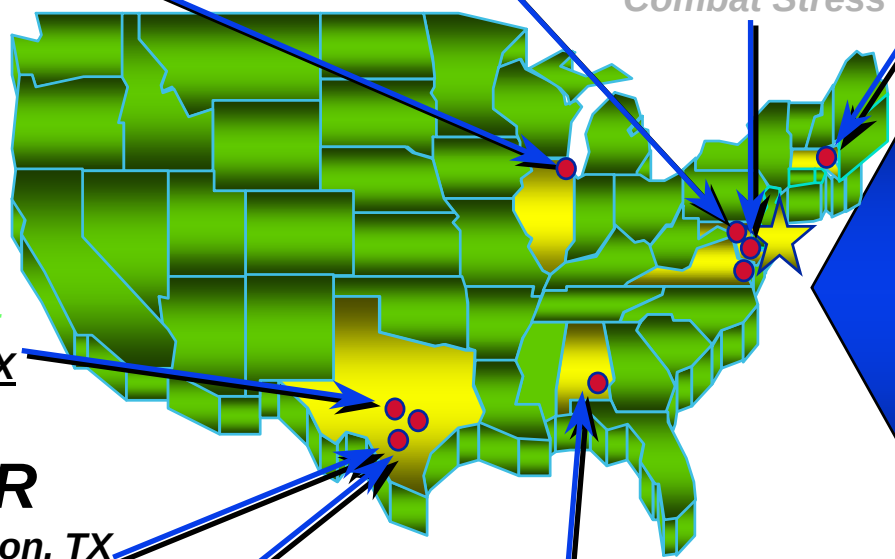
DCN: 11373

USADTRD
WRAIR Detachment
Great Lakes, IL
Military Dental Research

USAMRICD
APG, MD
Medical Chemical Defense

WRAIR
Silver Spring, MD
Infectious Diseases
Combat Stress

USARIEM
Natick, MA
Nutrition and Environmental Injury Prevention



HQ,USAMRMC
Fort Detrick, MD

USAMMA
Medical Materiel Life Cycle Management

USAMMDA
Advanced Medical Materiel Development

USAMRAA
Contract Support

USAMRIID
Medical Biological Defense

USACEHR
USAMRICD Detachment
Environmental Health Res.

USAMRD
WRAIR Detachment
Brooks City-Base, TX
Laser Bioeffects

USAISR
Fort Sam Houston, TX
Combat Casualty Care
Burn Trauma

USAMITC
Fort Sam Houston, TX
Information Systems

USAARL
Fort Rucker, AL
Future Force Safety and Survivability

Italics = research laboratory

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Medical Research & Development Worldwide Laboratories –Dept of the Navy

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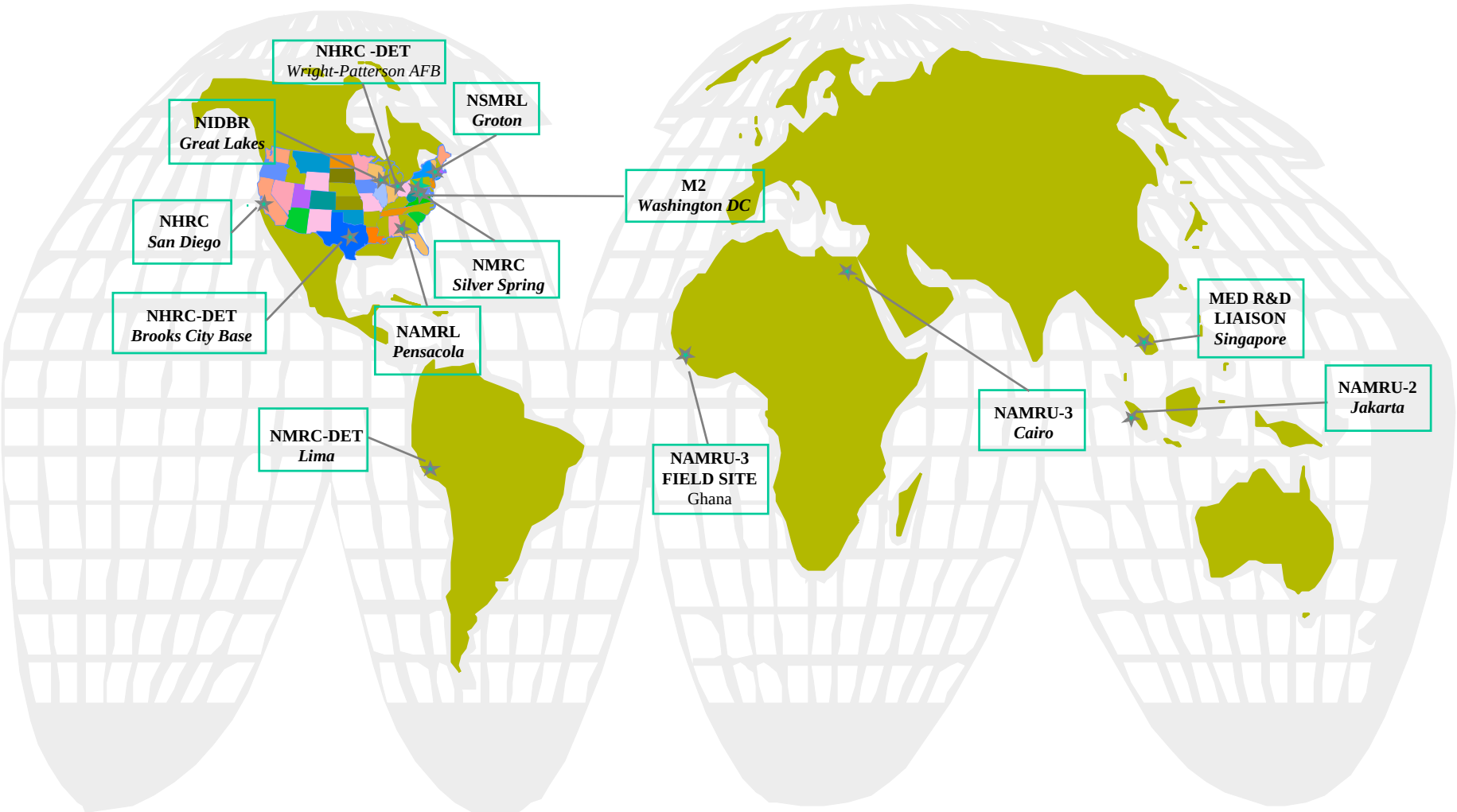

CONUS-Based Organizations
Dept of the Air Force

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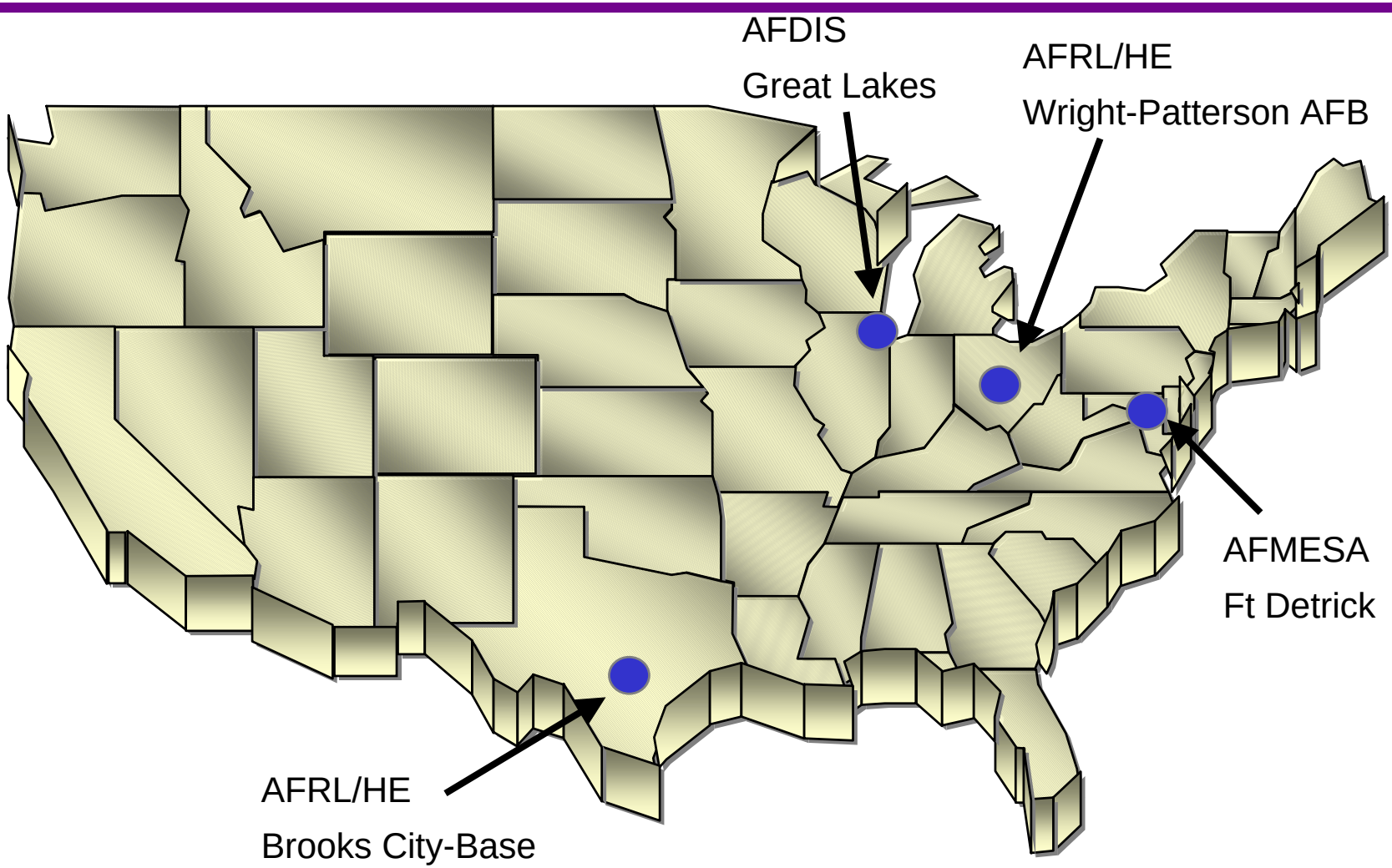

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MED/DEN RDA – 1: Minimize Excess Capacity Within Existing Facilities

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Scenario	Drivers/Assumptions
■ Realign workload within each capability domain/or selected groups of domains to reduce excess capacity. ■ Considers disestablishment and realignment of medical-dental RDA missions and activities at 22 existing installation sites (See Attached for Sites)	■ Redistribution of workload within a capability domain will not break unity of core competencies.
Justification/Impact	**Potential Conflicts**
■ Reduce/minimize excess capacity through relocation of functions ■ Impacts dependent on the outcomes of the Optimization Model	■ Workload within a capability domain/group of domains may only be moved to installations 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/Den RDA Sites

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22 Med/Den RDA Sites:

- Brooks
- Wright-Pat
- Rucker
- San Diego
- Pensacola
- Groton
- Great Lakes
- DTRA
- ONR
- APG
- Detrick
- NNMC
- WRAMC
- Ft. Sam
- Natick
- Panama City
- Pax River
- NRL
- DARPA
- BUMED
- Falls Church (2)

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MED/DEN RDA Centers of Excellence

DCN: 11373

- **Goals**
  - Co-locate laboratory activities based on shared equipment and competencies for increased efficiency and flexibility
  - Co-locate program management and adopt common policies and processes for planning, regulatory controls, contracting, and oversight
- **Centers**
  - Infectious Disease Research –interventions and products for endemic diseases of military significance
  - Battlefield Medicine & Trauma Research – interventions and products for casualty care and battlefield medicine
  - Medical CBRT Research – Medical response, countermeasures and hazard analysis for classical and emerging weapons of mass destruction, and occupational/environmental health threats (e.g., toxic chemicals and materials)
  - Aerospace and Operational Medicine Research – Operational medical issues unique to special military occupations and sustained operations, including biodynamics, crashworthiness and survival, acceleration, life support equipment(aviation and undersea/diving medicine), warfighting platform integration, special occupational health criteria, sensorimotor performance and injury, cognitive performance assessment and sustainment, directed energy and electric field bioeffects
  - Occupational Health and Medical Informatics Research – Research epidemiology and methods development, health promotion and wellness, modeling and simulation for medical operations and training, medical informatics and knowledge management, medical C2 technology, medical factors in personnel selection, field hygiene, behavior interventions for a fit and healthy force, deployment health monitoring
  - Environmental Medicine and Physiology Research – Thermal injury countermeasures and treatment, thermal stress and performance, mountain medicine and altitude physiology, exercise and high performance physiology, biomechanics (individual musculoskeletal performance & interactions with individual warfighter clothing and protective ensembles, including ergonomics), regulation of metabolism and fluid balance, nutrition, individual physiological monitoring, associated modeling of individual physiology and metabolism
  - Medical RDA Management – Centralized management with common policies and processes; cross-center coordination

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SCENARIOS 2 & 3: MED/DEN RDA CENTERS of EXCELLENCE

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Center of Excellence	Future Main Campus	Satellite Campuses	Current Performing Sites
Infectious Disease	Silver Spring, MD	Fort Detrick (BL-4 Biohazards), OCONUS Labs	Silver Spring, Fort Detrick, Brooks CB, leased space
Battlefield Medicine & Trauma	Ft. Sam Houston		Great Lakes, Silver Spring, Ft. Sam Houston
Aerospace and Operational Medicine	Brooks CB **OR** Wright-Pat AFB **OR** Tidewater **OR** Seattle **OR** Randolph AFB	Panama City (Diving Medicine)	Fort Rucker, Wright-Pat AFB, Brooks CB, Groton, WRAIR, Pensacola, Panama City, Pax River
Occupational Health and Medical Informatics	San Diego **OR** Silver Spring **OR** Tidewater **OR** Seattle		San Diego, Silver Spring, Natick SSC, Brooks CB, Wright-Pat AFB, Groton, WRAIR
Environmental Medicine and Physiology	Natick SSC **OR** Tidewater **OR** Seattle		Natick SSC, Groton, Brooks CB, San Diego,
Medical Chemical, Biological, Radiological and Toxicological Defense	Fort Detrick (Biological)	Aberdeen Proving Ground - Edgewood Area (Chemical and Toxicological) **AND** National Naval Medical Center (Radiological)	Fort Detrick, Aberdeen Proving Grounds - Edgewood Area, National Naval Medical Center, Wright-Pat AFB, Brooks CB, Silver Spring
Medical RDA Management	Fort Detrick (Primarily centalized planning, programming, regulatory, contracting and oversight management activities. Common policies and processes a major goal.)	Falls Church (PEO MHIS). Other sites as required for decentralized execution management.	Fort Detrick, ONR, BUMED, DTRA, DARPA, Brooks CB, Wright-Pat AFB, Ft. Sam Houston, Falls Church

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MED/DEN RDA 2a: Establish 7 Centers of Excellence (COEs) – Current Sites (Alt A)

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Scenario	Drivers/Assumptions
■ Reduce medical RDA presence from 22 sites to 7 COEs at 15 campus sites ■ 7 Vacated Sites: Wright-Pat, Rucker, Pensacola, Groton, Great Lakes, DTRA,ONR ■ 15 Retained/Expanded Sites: APG, Detrick, NNMC, WRAMC, Ft. Sam, Brooks, Natick, San Diego, Panama City, Pax River, NRL, DARPA, BUMED, Falls Church (2 sites)	■ 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. ■ Geographically separate detachments may be required to meet unique locational requirements and cost efficiencies
Justification/Impact	**Potential Conflicts**
■ Allow expansion at existing sites up to maximum required for a capability domain ■ Allow for reduction in capacity requirement due to efficiencies realized with collocation. ■ Dependent on the outcomes of the Optimization Model and further COBRA data analysis.	■ 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/DEN RDA 2b: Establish 7 Centers of Excellence (COEs) – Current Sites (Alt B)

DCN: 11373

Scenario	Drivers/Assumptions

■ Reduce medical RDA presence from 22 sites to 7 COEs at 15 campus sites
  ■ 7 Vacated Sites: Brooks, Rucker, Pensacola, Groton, Great Lakes, DTRA, ONR
  ■ 15 Retained/Expanded Sites: APG, Detrick, NNMC, WRAMC, Ft. Sam, Wright-Pat, Natick, San Diego, Panama City, Pax River, NRL, DARPA, BUMED, Falls Church (2)
	■ 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.
	■ Geographically separate detachments may be required to meet unique locational requirements and cost efficiencies

Justification/Impact	**Potential Conflicts**
■ Allow expansion at existing sites up to maximum required for a capability domain ■ Allow for reduction in capacity requirement due to efficiencies realized with collocation. ■ Dependent on the outcomes of the Optimization Model and further COBRA data analysis.	■ 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/DEN RDA 2c: Establish 7 Centers of Excellence (COEs)– Current Sites (Alt C)

DCN: 11373

Scenario	Drivers/Assumptions

■ Reduce medical RDA presence from 22 sites to 7 COEs at 14 campus sites
  ■ 8 Vacated Sites: Wright-Pat, Rucker, San Diego, Pensacola, Groton, Great Lakes, DTRA, ONR
  ■ 14 Retained/Expanded Sites: APG, Detrick, NNMC, WRAMC, Ft. Sam, Brooks, Natick, Panama City, Pax River, NRL, DARPA, BUMED, Falls Church (2)
	■ 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.
	■ Geographically separate detachments may be required to meet unique locational requirements and cost efficiencies

Justification/Impact	**Potential Conflicts**
■ Allow expansion at existing sites up to maximum required for a capability domain ■ Allow for reduction in capacity requirement due to efficiencies realized with collocation. ■ Dependent on the outcomes of the Optimization Model and further COBRA data analysis.	■ 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.

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MED/DEN RDA 2d: Establish 7 Centers of Excellence (COEs) – Current Sites (Alt D)

DCN: 11373

Scenario	Drivers/Assumptions
■ Reduce medical RDA presence from 22 sites to 7 COEs at 14 campus sites ■ 8 Vacated Sites: Brooks, San Diego, Rucker, Pensacola, Groton, Great Lakes, DTRA, ONR ■ 14 Retained/Expanded Sites: APG, Detrick, NNMC, WRAMC, Ft. Sam, Wright-Pat, Natick, Panama City, Pax River, NRL, DARPA, BUMED, Falls Church (2)	■ 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. ■ Geographically separate detachments may be required to meet unique locational requirements and cost efficiencies
Justification/Impact	**Potential Conflicts**
■ Allow expansion at existing sites up to maximum required for a capability domain ■ Allow for reduction in capacity requirement due to efficiencies realized with collocation. ■ Dependent on the outcomes of the Optimization Model and further COBRA data analysis.	■ 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.

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MED/DEN RDA 3a: Establish 7 Centers of Excellence(COEs)-NEW Tidewater Site (Alt. A)

DCN: 11373

Scenario

- Reduce medical RDA presence from 22 sites to 7 COEs at 14 sites (including new Tidewater site combining 2 elements of Military Operational Medicine research)
  - 9 Vacated Sites: Brooks, Wright-Pat, Rucker, San Diego, Pensacola, Groton, Great Lakes, DTRA, ONR
  - 14 Retained/Expanded Sites: APG, Detrick, NNMC, WRAMC, Ft. Sam, Natick, Panama City, Pax River, NRL, DARPA, BUMED, Falls Church (2), including Tidewater

Drivers/Assumptions

- 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.
- Geographically separate detachments may be required to meet unique locational requirements and cost efficiencies.

Justification/Impact

- Allow expansion at existing sites up to maximum required for a capability domain
- Allow for reduction in capacity requirement due to efficiencies realized with collocation.
- Dependent on the outcomes of the Optimization Model and further COBRA data analysis.

Potential Conflicts

- Military operational medicine research requires unique geographic and climatic features and linkages to non-medical RDA
- Combat casualty care research requires collocation with a military trauma center.

MED/DEN RDA 3b: Establish 7 Centers of Excellence(COEs) –New Seattle Site (Alt. B)

DCN: 11373

Scenario

- Reduce medical RDA presence from 22 sites to 7 COEs at 14 sites (including new Seattle site combining 2 elements of Military Operational Medicine research)
  - 9 Vacated Sites: Brooks, Wright-Pat, Rucker, San Diego, Pensacola, Groton, Great Lakes, DTRA, ONR
  - 14 Retained/Expanded Sites: APG, Detrick, NNMC, WRAMC, Ft. Sam, Natick, Panama City, Pax River, NRL, DARPA, BUMED, Falls Church (2), including Seattle

Drivers/Assumptions

- 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.
- Geographically separate detachments may be required to meet unique locational requirements and cost efficiencies.

Justification/Impact

- Allow expansion at existing sites up to maximum required for a capability domain
- Allow for reduction in capacity requirement due to efficiencies realized with collocation.
- Dependent on the outcomes of the Optimization Model and further COBRA data analysis.

Potential Conflicts

- Military operational medicine research requires unique geographic and climatic features and linkages to non-medical RDA
- Combat casualty care research requires collocation with a military trauma center.

MED/DEN RDA 3c: Establish 7 Centers of Excellence(COEs) – New Tidewater Site (Alt. C)

DCN: 11373

Scenario	Drivers/Assumptions
■ Reduce medical RDA presence from 22 sites to 7 COEs at 13 sites (including new Tidewater site combining 3 elements of Military Operational Medicine research) ■ 10 Vacated Sites: Brooks, Wright-Pat, Rucker, Natick, San Diego, Pensacola, Groton, Great Lakes, DTRA, ONR ■ 13 Retained/Expanded Sites: APG, Detrick, NNMC, WRAMC, Ft. Sam, Panama City, Pax River, NRL, DARPA, BUMED, Falls Church (2), including Tidewater	■ 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. ■ Geographically separate detachments may be required to meet unique locational requirements and cost efficiencies.
Justification/Impact	**Potential Conflicts**
■ Allow expansion at existing sites up to maximum required for a capability domain ■ Allow for reduction in capacity requirement due to efficiencies realized with collocation. ■ Dependent on the outcomes of the Optimization Model and further COBRA data analysis.	■ Military operational medicine research requires unique geographic and climatic features and linkages to non-medical RDA ■ Combat casualty care research requires collocation with a military trauma center. ■ Requires concurrent relocation of medical and non-medical RDA from Natick SSC to new site

MED/DEN RDA 3d: Establish 7 Centers of Excellence(COEs) – New Seattle Site (Alt. D)

DCN: 11373

Scenario	Drivers/Assumptions
■ Reduce medical RDA presence from 22 sites to 7 COEs at 13 sites (including new Seattle site combining 3 elements of Military Operational Medicine research) ■ 10 Disestablished Sites: Brooks, Wright-Pat, Rucker, Natick, San Diego, Pensacola, Groton, Great Lakes, DTRA, ONR ■ 13 Retained/Expanded Sites: APG, Detrick, NNMC, WRAMC, Ft. Sam, Panama City, Pax River, NRL, DARPA, BUMED, Falls Church (2), including Seattle	■ 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. ■ Geographically separate detachments may be required to meet unique locational requirements and cost efficiencies.
Justification/Impact	**Potential Conflicts**
■ Allow expansion at existing sites up to maximum required for a capability domain ■ Allow for reduction in capacity requirement due to efficiencies realized with collocation. ■ Dependent on the outcomes of the Optimization Model and further COBRA data analysis.	■ Military operational medicine research requires unique geographic and climatic features and linkages to non-medical RDA ■ Combat casualty care research requires collocation with a military trauma center. ■ Requires concurrent relocation of medical and non-medical RDA from Natick SSC to new site

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Contracting Consolidation

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Transformational Option

Ideas/Proposed Scenarios

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Infrastructure

- Consolidate medical professional services contracting to a single organization at Ft. Sam Houston TX
  - Close Veterans Affairs Special Svc office at Ft. Detrick MD
  - Close the portion of COMNAVLOG at Ft. Detrick that supports med/dent professional services contracting

Initiative Reminders

DCN: 11373

- Initiative looks only at Med/Dent Professional Services contracting
  - Not Equipment
  - Not services localized to single base/post
  - Not WRM or Readiness activities
- DoD IG report estimates Med/Dent contracting will reach $1B/yr in FY'05
- Several other Service initiatives pushing consolidation of contracting
- Implementation is a 5 yr process

Scenario Concerns

DCN: 11373

- Why do it?
- It won't save infrastructure
- It won't save personnel
- It may cause initiative to centralize all contracting

Why do it?

DCN: 11373

- Currently 3 services; 3 contracting approaches
- Simplifies how MTFs obtain medical/dental professional services
  - Customers (MTFs) must learn 3 contracting "languages"; 3 contracting approaches
- Not all contracts are "open" to all MTFs/Services
- Contract oversight disjointed; under-executed
- SAF/AQC established a Medical Commodity Council to oversight those procurements… yet another player

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Why do it?

DCN: 11373

- Leveraged buying reduces costs
  - One face to industry
  - TRICARE support contracts
    - All 3 services executed separate contracts
    - Wilford Hall and BAMC did separate actions
- For our customers it simplifies processing; user interface
- Consolidates/strengthens contract oversight

Infrastructure Savings

DCN: 11373

- Currently 3 services; three infrastructures
- All medical contracting activities feel current space is inadequate due to growth experienced over last 5 years
- Estimate infrastructure savings minimal
  - "Nose under tent-flap" for transformational idea
  - Currently 40K sq ft; savings approx 9K sq ft

Personnel Savings

DCN: 11373

- All services feel current operations greatly understaffed given program growth
- Currently 184 personnel reported as working Med/Dent Pro Svc contracting; many do other contracting work (equipment purchases)
- Personnel could be re-allocated to work understaffed areas of contract administration and Quality Assurance oversight
- No/Little personnel reduction; more efficient use of available staffing for long neglected other functions
- One shop; flexibility and cross functionality

Centralization Initiative

DCN: 11373

- Concern that this will drive consolidation of all contracting activities
  - These initiatives are already underway
- BRAC exists in a whirlwind of other forces, initiatives and studies
- Is consolidation of all contracting really a bad thing?
  - Leave that to others to decide/judge

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