

MINUTES OF THE FEBRUARY 11, 2005 MEETING OF THE MJCSG PRINCIPALS

LOCATION: Pentagon, Rm 2C554,

Attending: LtGen Taylor – Chair; MGen Webb USA/SG; Mr. Chan – ASD (HA)/CP&P; VAdm Arthur- USN/SG; RAdm Cullison – USMC/SG; Col Hamilton – Secretary; Mr. Yaglom – USA/SG; Dr. Opsut – OSD/HA; CAPT Hight – BUMED; CAPT Shimkus – BUMED; COL Powers – Army GME; CAPT Deike – TMA/OCFD/FPMD; CAPT Taft – USN/NMETC; CAPT Miller – USN/NMETC; Dr. Christenson – CNA; Mr. Curry – USA OTSG; Maj Fristoe – HA/TMA; Maj Guerrero – AF/SG; Maj Harper – AF/SGSF; Mr. Porth – OSD/BRAC; Maj Chapman – USA/HFPA; CDR Bradley – Navy Analyst; Maj Coltman – AF/Recorder

Decisions:

- Approved** the following Candidate Recommendation with further data refinement/validation (**MJCSG approved with 5-0 vote**):
 - E&T-6 (MED-0029): Realign critical military functions and disestablish civilian related activities at the Armed Forces Institute of Pathology (AFIP)

Action Items:

- 0-6 Lead Follow-up:
 - Continuous validation of scenario data
 - De-conflict and integrate medical functions across all proposed recommendations
 - Follow up on Navy and Army COBRA runs to support de-confliction/integration efforts.
 - E&T group to follow up on actions items identified in GME Program/AFIP discussions
 - Research and refine joint basing medical analytic framework
 - HCS to develop proposals for the smaller MSMs scenarios

Meeting Overview:

- Voting Members: 5 present/1 absent
- Chair discussed the status of the MIL DEPs proposed recommendations and potential impact to the MJCSG's scenarios and overall analysis. De-conflicting and integrating the recommendations will be the next big step especially with the major Service moves that may affect the force structure. As previously stated, this is an iterative process with numerous opportunities for Services to vet issues and revise recommendations especially based on Services' proposed major force movements. In response, MJCSG recommendations may need to be revised. The Army rep informed the group of plans to move 100K troops to Fort Bliss and a brigade to Fort Riley. In addition, he informed the group that the Army's Integrated Global Presence and Basing Strategy (IGPBS) includes medical functions and that the enabling scenarios can also be supported through IGPBS. The AF rep reported Grand Forks, Pope, and Ellsworth as recommendations for proposed AF base closures. In addition, the AF has provided their COBRA runs and the Chair requested the same from the Navy and Army to support de-confliction and integration efforts. As part of the integration the Chair stressed to look at vacated space that could potentially be used in other MJCSG scenarios, such as RDA utilizing the laboratory space generated by the USUHS scenario. The MJCSG also has "markers on the table" for the estimated 400K square feet of AFIT vacated space at

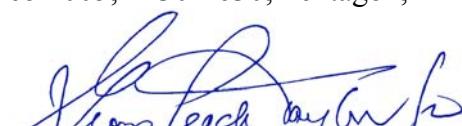
Wright-Patterson for E&T-3 (MED-12). The NCR/SA multi-market scenarios were announced to the BRAC leadership who are eager to review the strength of the MJCSG analysis.. The subgroups continue to work to finalize the NCR, SA, and RDA scenarios/recommendation and incorporate Service data updates. The Chair stressed the importance of validating all data and documenting in detail the supporting resources and analysis. The Secretary provided a status update of the MJCSG scenarios and highlighted that the enlisted medical training (MED-005), NCR (MED-002) and McChord (MED-022) recommendations are scheduled to be briefed at the next ISG. **(Info)**

- Optimization Model Capacity/MILVAL Analysis:** The CNA rep updated the results of the optimization model for inpatient care using current datasets. The modeling assumptions and constraints have not changed since Nov 2004, but the MJCSG continues to refine the military value and capacity data inputs into the optimization model. CNA presented model results for (1) the baseline model, (2) the baseline model with MJCSG decisions regarding the inpatient facilities they have decided to maintain or close, and (3) the baseline model with the inpatient maintain-close decisions plus decisions regarding the multi-service markets (MSMs) - National Capital Region and San Antonio. With the inpatient maintain-close and MSM decisions, the “no additional inpatient facilities can be closed all” still meet the inpatient workload requirement. **(Info)**
- E&T GME Program Review/Follow-up:** The E&T rep provided an overview of the GME program capacity lay down and impacts from the approved MJCSG recommendations (see slides).
 - Inpatient MTF Closures: E&T rep discussed the impact to the GME programs resulting from the proposed inpatient closures. The current capacity of the identified programs can be maintained by realigning them to DoD billets and absorbing in the projected MHS system or integrating them into existing civilian programs. The Chair noted that Family Practice programs at Offutt, Keesler, and Scott are already integrated with civilian programs.
 - NCR Scenario: E&T rep explained the effect of closing patient care services at Walter Reed Army Medical Center (WRAMC) on specific medical/dental residency/fellowship programs. Specifically addressed and discussed were the issues arising from realigning the GME program billets and other clinical training from WRAMC to National Naval Medical Center (NNMC) Bethesda and Fort Belvoir. The loss of a major training site (WRAMC), curriculum adjustments, and program realignments may result in an Accreditation Council for Graduate Medical Education (ACGME) institutional and program review by the Residency Review Council (RRC) at the remaining training facilities. These changes may also jeopardize the full accreditation status requiring the program to submit a new application to gain provisional and then full accreditation. This process takes approximately 8 years with RCC site visits. The Chair re-emphasized that the programs will still be operational and that capacity is not lost but realigned. The Chair also provided the opinion that civilian hospitals realign GME as well without significant risks to their certification. The Chair suggested that these actions would play out over several years, allowing time to address ACGME and RRC issues. The MJCSG noted the risks. Additional discussion was focused on how to integrate the programs and distribute trainees to NNMC and Belvoir’s proposed new community hospital with expanded services.

- SA Scenario: E&T rep continued with discussing program impacts of closing the inpatient function at Wilford Hall Medical Center (WHMC) and the required facility/services' expansion at Brooks Army Medical Center (BAMC) to meet the expanded GME requirements. Again, the concern of losing a major training function (WHMC), curriculum adjustments, and program realignments may result in losing accreditation and a RRC institutional review and site visits. Also noted was with the loss of WHMC's Level 1 ER the Emergency Medicine Residency would have decreased capacity. However, the Chair interjected that by expanding BAMC the plan is that the throughput will be the same and, therefore, no loss in capacity. The Chair also emphasized the need to look at innovative ways to meet various program requirements. For example, WHMC's proposed Ambulatory Surgical Center could be used to meet a portion of the orthopedic residency requirements by performing outpatient surgeries.
- Group discussed complexity of redesigning GME programs to fit proposed MHS structure and the ease of closing residency programs but difficulty in realigning and/or expanding programs at other sites. The Chair focused the discussion on looking at a more global view by applying these reported numbers across a joint-Service medical platform rather than on a platform-by-platform basis, and then comparing them to the Service SG's acceptable minimums. E&T was requested to perform the following:
 - o Reconcile the capacity shortages to other empty Service or DoD billets and then run the numbers against the SG's acceptable minimums
 - Look at each Service picking up one more general surgery/internal medicine residency slot as a DoD billet
 - o Follow up with the RRC on anticipated changes in training sites/curriculum and resulting requirements (**Info/Action Items; E&T Follow up**)
- The E&T rep presented E&T-6 (MED-0029) to re-align critical military functions and disestablish civilian related activities at the Armed Forces Institute of Pathology (AFIP) (See slides). AFIP is a nationally unique; Tri-service activity with functions located at various sites and provides services to DoD and civilian customers. Over half of AFIP's capacity is being dedicated to commercial activities with private industry. Since these are not DoD/DHP core business requirements they are considered excess and should be discontinued. Additionally, AFIP's low military value is reflective of its small portion of military related workload. The E&T subgroup recommended elimination of non-core product lines and retain through relocation only the critical military activities. Relocation would parse the different militarily relevant functions to locations of higher military value, such as Dover AFB, Fort Sam Houston, and NNMC Bethesda, that could provide for enhanced synergies and efficiencies. The Chair requested that the scenario be written identifying specifically where the military functions will be relocated and also research availability of vacated space at receiving sites. Also to evaluate the possibility of including certain activities with other recommendations (i.e. moving enlisted histology technician training to Fort Sam Houston in MED-05). The E&T rep then led discussion on proposed new and renovated infrastructure requirements. The Navy Member requested further analysis of high costs associated with MILCON and renovation citing possibility of other less expensive solutions. The Chair suggested looking at possible available space at Belvoir, Andrews, or Bethesda. The payback slides were discussed and the Chair challenged the high one time costs, specifically related to the Dover MILCON which accounts for one-half of the identified costs. The Navy Member questioned the manpower reductions and requested validation of the contractor and

student numbers. The MJCSG agreed that the payback and infrastructure data needed to be validated and refined but instructed E&T to proceed forward with the scenario. (**Action Items; E&T follow up**)

- The E&T recommended approving the following:
 - E&T-6 (MED-0029): Realign critical military functions and disestablish civilian related activities at the Armed Forces Institute of Pathology (AFIP). (**MJCSG voted (5-0) to approve/proceed with recommendation but to refine/validate data and COBRA costs**)
- The Secretary presented the Joint Basing Concept brief for feasibility in applying to selected MJCSG scenarios (see slides). The Secretary described how the HS&A JCSG has developed a Joint/Consolidated basing initiative which excludes medical, this briefing focused on establishing precedence for medical joint basing initiatives and to demonstrate willingness to be apart of other joint initiatives. HS&A proposed joint base scenarios and consolidations were highlighted and discussed. Specific issues related to applying this concept to MJCSG scenarios were discussed concerning Service Lead, infrastructure responsibilities, joint manpower, and reduction/savings related to facility services [i.e. Lab, Supply, Base Operating Support (BOS)]. The Secretary applied this joint concept using Pearl Harbor/Hickam as an example. The Chair stated by applying this concept it allows for the right sizing, redirecting workload, and increasing efficiency while reducing excess infrastructure and cost. The ASD (HA)/CP&P rep voiced concern that we stand a risk of loosing DHP money where there is savings identified. The Secretary informed the group that the joint concept has been fully vetted through the ISG but there are still issues that need to be resolved concerning moving “real properties” and the handling of BOS. The MJCSG agreed to include medical in this initiative but requested further research and analysis. Requested the HCS to start developing joint basing proposals for the smaller MSMs scenarios. (**Action Item; HCS Follow up**)
- Closing: The Chair stated that the next ISG is a paper review and includes McChord (MED-022), Pope (MED-017) and Enlisted Training (MED-005) MJCSG recommendations. Also the MJCSG is scheduled to brief the Red Team on 25 Feb, place and time TBD. Continue to work action items identified during the discussion and follow up as required.
- NEXT MEETING: MJCSG Principals, 25 Feb 2005, 1430-1630, Pentagon, Rm 2C554



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

Attachments:

1. Agenda with Combined Briefing

MJCSG Principals Meeting

02/11/05
3:30 PM to 5:30 PM
Pentagon, Room 2C554

DCN: 11387

Meeting called by: Chair Type of meeting: Deliberative
Note taker: Maj Coltman

Agenda

Opening	Lt Gen Taylor	5
Status of Recommendations	Col Hamilton	5
Optimization Model Runs	Dr. Christenson	15
Candidate Recommendations		
GME	CAPT Hight	15
AFIP	CAPT Hight	15
Joint Basing Brief	TBD	20
Around the Table	All	5
Closing	Chair	5

Additional Information:

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

Medical Joint Cross Service Group

MJCSG Combined Brief 11 Feb 05

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OPTIMIZATION MODEL RESULTS:

9 Feb 05 Data





Baseline model IP closures

Activity	FuncMV	Baseline	IP	IP/MSM decisions	Activity	FuncMV	Baseline	IP	IP/MSM decisions
Fort Bragg	88.0	1			Pensacola	55.0	0		
NMC Portsmouth	79.9	1			USAFA	52.8	0		
NMC San Diego	77.8	1			Fort Gordon	52.4	0		
Fort Lewis	76.1	1			Fort Jackson	52.4	0		
Fort Hood	75.5	1			NAVSTA Great Lakes	52.3	0		
Fort Campbell	73.8	1			Wright-Patterson AFB	49.8	0		
Camp Pendleton	73.7	1			NAS Lemoore	49.4	0		
Lackland AFB	73.1	1			Fort Riley	49.1	0		
Tripler AMC	70.8	1			Fort Eustis	48.4	0		
Fort Sam Houston	69.6	1			Andrews AFB	48.1	0		
Fort Carson	67.9	1			Fort Polk	48.1	0		
Fort Stewart	65.0	1			Twenty-nine Palms	47.9	Isolated		
Camp Lejeune	63.7	1			NAS Whidbey Island	47.6	Isolated		
NAS Jacksonville	63.6	1			Fort Knox	47.4	0		
NNMC Bethesda	63.2	1			Elmendorf AFB	47.2	0		
Nellis AFB	59.9	1			MCAS Cherry Point	46.3	0		
Fort Benning	58.5	1			Mountain Home AFB	41.8	Isolated		
Fort Sill	58.4	1			Keesler AFB	39.4	0		
Fort Belvoir	58.0	1			MacDill AFB	38.3	0		
Eglin AFB	57.9	1			Fort Irwin	35.0	Isolated		
NH Bremerton	57.8	1			Scott AFB	29.3	0		
Fort Bliss	56.8	1			West Point	27.6	0		
Travis AFB	56.2	1			NH Beaufort	24.4	0		
Fort Leonard Wood	55.4	1			Fort Wainwright	24.2	0		
Walter Reed AMC	55.2	1			NH Guam	23.8	Isolated		
Langley AFB	55.2	0							

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Model IP closures with MJCSG IP decisions



Activity	FuncMV	Baseline	IP	IP/MSM decisions	Activity	FuncMV	Baseline	IP	IP/MSM decisions
Fort Bragg	88.0	1	1		Pensacola	55.0	0	Maintain	
NMC Portsmouth	79.9	1	1		USAFA	52.8	0	Close	
NMC San Diego	77.8	1	1		Fort Gordon	52.4	0	0	
Fort Lewis	76.1	1	1		Fort Jackson	52.4	0	Maintain	
Fort Hood	75.5	1	1		NAVSTA Great Lakes	52.3	0	Close	
Fort Campbell	73.8	1	1		Wright-Patterson AFB	49.8	0	0	
Camp Pendleton	73.7	1	1		NAS Lemoore	49.4	0	Maintain	
Lackland AFB	73.1	1	1		Fort Riley	49.1	0	Maintain	
Tripler AMC	70.8	1	1		Fort Eustis	48.4	0	Close	
Fort Sam Houston	69.6	1	1		Andrews AFB	48.1	0	0	
Fort Carson	67.9	1	1		Fort Polk	48.1	0	Maintain	
Fort Stewart	65.0	1	1		Twenty-nine Palms	47.9	Isolated	Isolated	
Camp Lejeune	63.7	1	1		NAS Whidbey Island	47.6	Isolated	Isolated	
NAS Jacksonville	63.6	1	1		Fort Knox	47.4	0	Close	
NNIMC Bethesda	63.2	1	1		Elmendorf AFB	47.2	0	Maintain	
Nellis AFB	59.9	1	1	Maintain	MCAS Cherry Point	46.3	0	Close	
Fort Benning	58.5	1	1		Mountain Home AFB	41.8	Isolated	Isolated	
Fort Sill	58.4	1	1		Keesler AFB	39.4	0	Close	
Fort Belvoir	58.0	1	1		MacDill AFB	38.3	0	Close	
Eglin AFB	57.9	1	1		Fort Irwin	35.0	Isolated	Isolated	
NH Bremerton	57.8	1	1		Scott AFB	29.3	0	Close	
Fort Bliss	56.8	1	1		West Point	27.6	0	Maintain	
Travis AFB	56.2	1	1		NH Beaufort	24.4	0	Maintain	
Fort Leonard Wood	55.4	1	1	Maintain	Fort Wainwright	24.2	0	Maintain	
Walter Reed AMC	55.2	1	1		NH Guam	23.8	Isolated	Isolated	
Langley AFB	55.2	0	0	Maintain					

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Model IP closures with MJCSG IP/MSM decisions

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Fort Lewis	76.1	1	1	1	Fort Jackson	52.4	0	Maintain	Maintain
Fort Hood	75.5	1	1	1	NAVSTA Great Lakes	52.3	0	Close	Close
Fort Campbell	73.8	1	1	1	Wright-Patterson AFB	49.8	0	0	1
Camp Pendleton	73.7	1	1	1	NAS Lemoore	49.4	0	Maintain	Maintain
Lackland AFB	73.1	1	1	1	Fort Riley	49.1	0	Maintain	Maintain
Tripler AMC	70.8	1	1	1	Fort Eustis	48.4	0	Close	Close
Fort Sam Houston	69.6	1	1	1	Andrews AFB	48.1	0	0	Close
Fort Carson	67.9	1	1	1	Fort Polk	48.1	0	Maintain	Maintain
Fort Stewart	65.0	1	1	1	Twenty-nine Palms	47.9	0	Isolated	Isolated
Camp Lejeune	63.7	1	1	1	NAS Whidbey Island	47.6	0	Isolated	Isolated
NAS Jacksonville	63.6	1	1	1	Fort Knox	47.4	0	Close	Close
NNMC Bethesda	63.2	1	1	1	Elmendorf AFB	47.2	0	Maintain	Maintain
Nellis AFB	59.9	1	1	1	MCAS Cherry Point	46.3	0	Close	Close
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Fort Belvoir	58.0	1	1	1	MacDill AFB	38.3	0	Close	Close
Eglin AFB	57.9	1	1	1	Fort Irwin	35.0	0	Isolated	Isolated
NH Bremerton	57.8	1	1	1	Scott AFB	29.3	0	Close	Close
Fort Bliss	56.8	1	1	1	West Point	27.6	0	Maintain	Maintain
Travis AFB	56.2	1	1	1	NH Beaufort	24.4	0	Maintain	Maintain
Fort Leonard Wood	55.4	1	1	1	Fort Wainwright	24.2	0	Maintain	Maintain
Walter Reed AMC	55.2	1	1	1	NH Guam	23.8	0	Isolated	Isolated
Langley AFB	55.2	0	1	1	Maintain	Maintain			

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E&T Scenario Updates





Issues to Address

- Inpatient closure at AF MTFs
- NCR scenario
- SA scenario

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Scenario: IP Closures at AF MTFs

■ Andrews

- FP(10 to 6), FP-Psych(4 to 0), Tran(11 to 0)
- Should be able to maintain FP starts by

securing new inpatient training
institution/use DoD FP billets

■ Offutt and Scott

- FP(8) at each site
- Integrated with civilian program- should
maintain current capacity

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Scenario: IP Closures at AF MTFs

- Travis internal readjustment
 - IM (7), Ob/Gyn (3), Peds (6)
- Keesler
 - Gen Surg (4), IM (8), OB/GYN (3), Peds (6), CT Surg (2)
- IM – fill 1 empty AF billet, use 7 DOD billets, 7 civilian sponsored/delay
 - GS- 3 civilian sponsored/delay
 - OB/GYN - 3 DoD billets, 3 civilian sponsored/delay
 - Peds - 1 empty AF billet, 11 DoD billets
 - CT Surg - 2 civilian sponsored

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NCR Scenario- New Issues

- Can Consortium continue with loss of WRAMC; new institutional review for NNMC
- Informing RRC of change of training institutions might necessitate unprogrammed site visits (\$\$)
- Distribution of trainees and faculty(all to NNMC or some to Belvoir)
 - Travel time precludes split operations for integrated residency programs

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Notify RRC deletion WRAMC and Adjust curriculum

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■ Residencies

- Anes*, Derm, NeurSurg, Neurology, NucMed, OB/GYN, Oral Max Facial Surg, Oto, Peds, PM&R, PM, OM, Psych, Rad, RadOnc

■ Fellowships

- Anes CC, Pain, Cardiovascular*, Med CC, Endo, GI*, ID, Nephro, Rheum, Heme Onc, Pulm CC, Child Neuro, Peds (Endo, ID, Heme/Onc, GI, Neonat)
- Starts: Residents 69 Fellows 32
- Total Trainees: Residents 288 Fellows 103

*Decreased capacity



Add NNMC as training institution - New Program?

- Residencies
 - Ophth, Urol
- Fellowships
 - Allergy/IM, Clin/Lab Im, Child/Adol Psych, Ger Psych, Prev Psych, Vasc Surg*, CT Surg*, Hand Surgery, Clinical Neurophys, Gyn Onc**, UroGyn**
- Starts: Residents 5 Fellows 17
- Total Trainees: Residents 17 Fellows 31
 - *Considering civilian sponsored
 - **NIH programs with clinical at WRAMC

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Integrate Programs vs Increase one, Close one

- Residencies
 - IM, Gen Surg, Ortho, Transitional
 - Possibility for program at Belvoir in IM; doubtful for Gen Surg, Ortho
- Starts: Residents 44
- Total Trainees: Residents 68
- Lost capacity 8 IM, 3 GS, 3 Ortho (starts)

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Recapture Lost Capacity

- IM program at Belvoir (4 Army, 4 Navy) or 6 remaining DoD billets and 2 civilian sponsored/delay
- Increase Gen Surg capacity in Navy, new program at Bragg or 3 civilian sponsored/delay
- 4 Anes to civilian sponsored/delay (2 Army, 2 Navy)
- 3 civilian sponsored/delay for Ortho
- 1 Civilian sponsored for Cardio, GI

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SA Scenario- New Issues

- Consortium concern probably not operational
- Informing RRC of change of training institutions might necessitate un-programmed site visits (\$\$)
- Distribution of trainees and faculty (all to BAMC or some stay at WHMC?)

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Notify RRC and Adjust Curriculum



- Residencies
 - Anes, Derm, Emer Med*, OB/GYN, Ophth, Path, Peds, Rad, Urol
 - Fellowships
 - Cytopath, IM CC, Cardio, Endo, GI, ID, Rheum, Heme/Onc, Pulm CC, Adol Med
 - Starts: Residents 74 Fellows 32
 - Total Trainees: Residents 245 Fellows 81
- *Decreased capacity

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Add BAMC as training institution - New Program?

- Residencies
 - Neuro
- Fellowships
 - Allergy/IM, Neonatal, Vascular and Int Rad
- Starts: Residents 2 Fellows 5
- Total Trainees: Residents 7 Fellows 14

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Combine Programs vs Increase one, Close one



■ Residencies

- IM, ?Ortho; Gen Surg , Transitional no real problem
- Might be able to sell Ortho at WHMC on innovation
(same for Oral Max Facial Surg)
- Starts: Residents 22(26)
- Total Trainees: Residents 76(96)
- Lost capacity 8 IM, 4 Ortho (worst case)

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Recapture lost capacity

- IM – 8 civilian sponsored/delay - 4AF, 4 Army
- 4 civilian sponsored/delay for Ortho (worst case)
- ER- 8 civilian sponsored/delay - 4 AF, 4 Army

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MJCSG Education and Training MED 029 - AFIP





AFIP Functions

- DNA Registry (Transferred)
- Training
 - Enlisted (Transferred)
 - Five Pathology Fellowships (Eliminated)
 - Continuing Education (Eliminated)
- Armed Forces Medical Examiner (Transferred)
 - DNA Repository (Transferred)
 - Pathology Laboratories (Outsourced)
- Armed Forces Legal Medicine (Transferred)
- National Museum of Health and Medicine (Remains)
- Tissue Repository (Remains)
- Research functions (includes two (2) BSL3 Labs)
(Eliminated)

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AFIP Functions

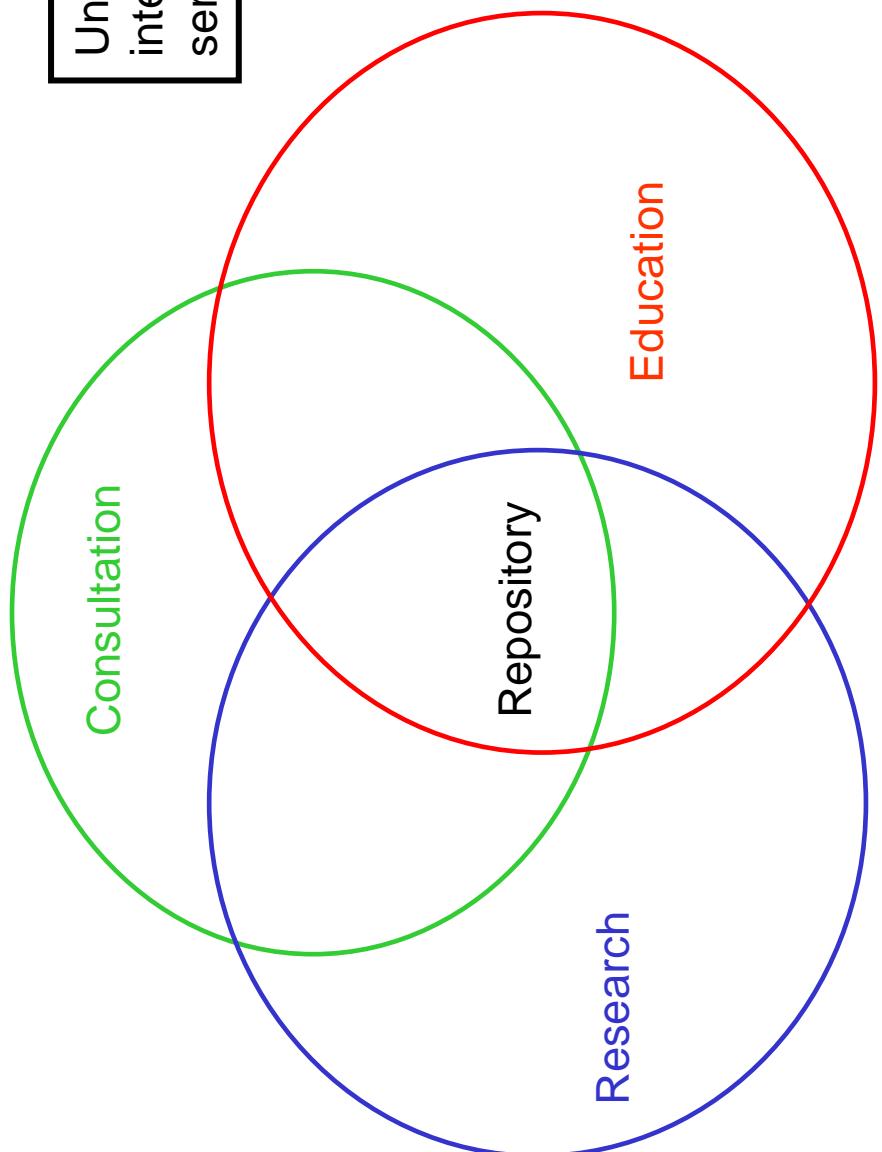
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Function	Transferred	Eliminated	Remains
AFME	X		
DNA Registry	X		
Enlisted Histo Training	X		
Legal Medicine	X		
Patient Safety	X	X	
Pathology Labs		X	
Pathology Research		X	
Two BSL3 Labs		X	
Officer Fellowships		X	
CME		X	
Tissue Repository			X
Museum			X

Inter-dependencies



Underscores the interdependency of the three service lines



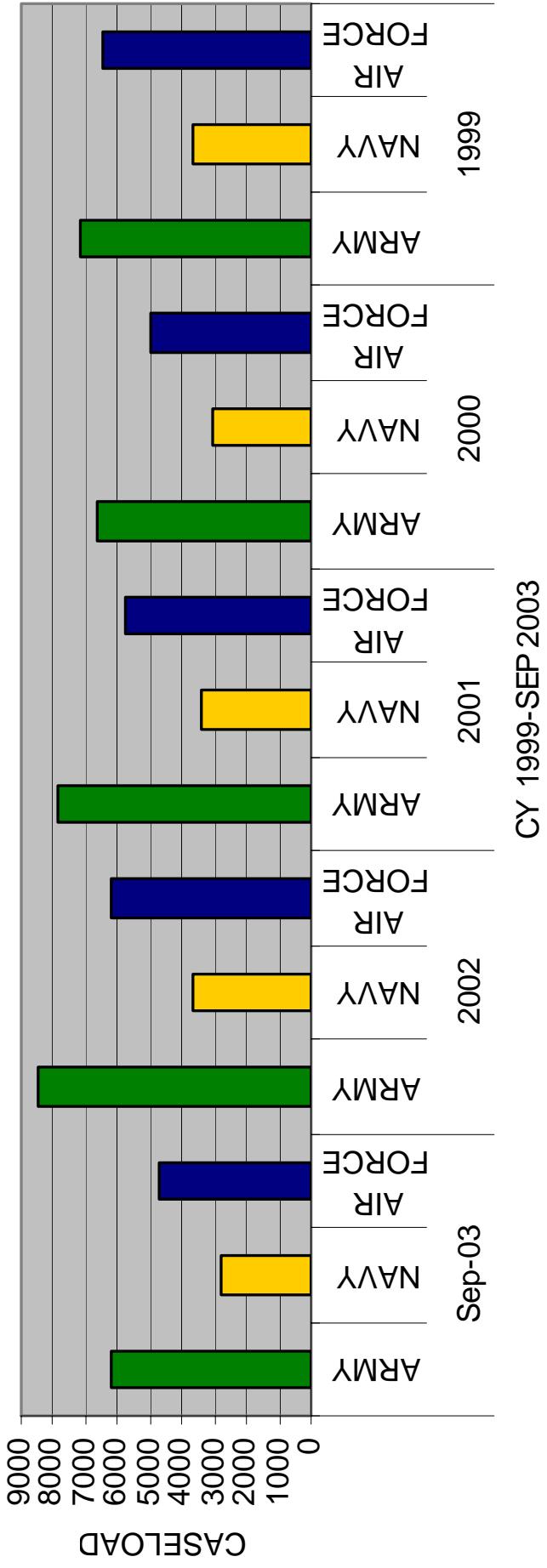
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More than the sum of its parts

Usage by Military Service



2ND OPINION CONSULTATION CASES BY MILITARY SERVICE



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- Additional 23,000 Cytology Cases through a contract with US Air Force and 10,000 QU cases each year; cytology lab services terminated in 2004
- Not Certified data through capacity data call, but certified through COBRA Scenario questionnaire for 2002 as a typical year



Military Value

- Functional RDA MV Score = 9.28
 - Represents 10% of AFIP mission
 - No MV score for Health Services or Education & Training

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Infrastructure (in SF)

Scenario	WRAMC	Dover AFB	Bethesda	FSH	Belvoir	Leased Space	Total
Function	AFME/ DNA Reg/ Medgl Inv/ Beh& Mort Surv	Leg Med/Pt Sft Ctr (Admin/prk)	Enl Hist (lab/brks)	Army Bio- surety			
MILCON	147,593	504		6000			154,097
Renovation		19,980	14300				33,280
Facility Shutdown	258,000				143,000	401,000	

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Payback (*Excl. lost Revenues*)

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One-Time Costs	\$81,813K
MILCON	\$41,668K
NPV in 2025	\$28,998
Recurring Savings	-\$2,541
Payback Years	51 yrs
Break Even Year	2060
Mil/Civ Reductions	0 Mil / 81 Civ / 156 Contract

Payback (Incl. lost Revenues)



DCN: 11387

One-Time Costs	\$83,504K
MILCON	\$43,359K
NPV in 2025	131,877
Recurring Costs	\$5,869
Payback Years	Never
Break Even Years	Never
Mil/Civ Reductions	0 Mil / 81 Civ / 156 Contract



Impacts

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- Criteria 6 (Economic)
 - Net job loss less than 100
 - Criteria 7 (Community) – None
 - Criteria 8 (Environmental) – TBD
 - Other impacts

Medical Joint Cross Service Group

Joint Basing

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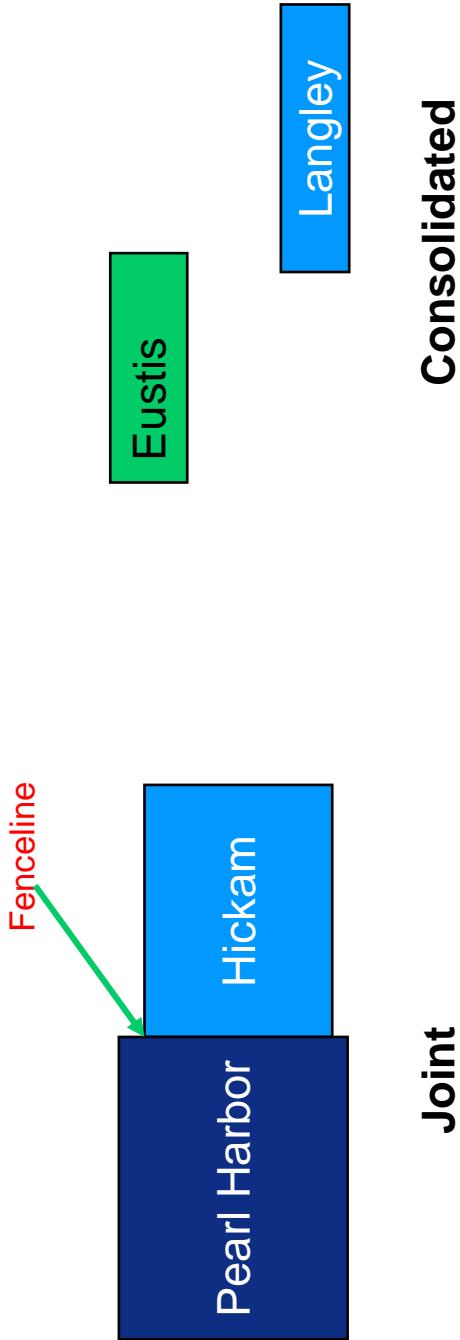
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Issue

- H&SA JCSG developed a Joint/Consolidated basing Initiative
- Includes on BOS management
- Excludes medical



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Joint Basing Scenarios

Scenario

- Dix-McGuire/Lakehurst ■ Army
- Andrews/Washington ■ AF
- Pearl Harbor/Hickam ■ Navy
- Lewis/McChord ■ Army
- Anacostia/Bolling/NRL ■ Navy
- Monmouth/Earle Colts Neck ■ Army
- Elmendorf/Richardson ■ AF
- Myer/Henderson Hall ■ Army
- Dobbins/Atlanta ■ AF
- Bragg/Pope ■ Army

Lead Service

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Consolidations



Scenario

Lead Service

- Charleston AFB/NWS
Charleston
 - South Hampton Roads
 - North Hampton Roads
 - Lackland/Sam
 - Houston/Randolph
 - Andersen
 - AFB/COMNAVMARIANNAS
- AF
- Navy
- AF
- AF
- AF

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Proposed MJCSG Scenario

- Lead Service responsible for the medical infrastructure
- ADCON/OPCON remains in Service channels
- Joint Manning
- Reductions in infrastructure services:
 - Lab, Supply, BOS, ...

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Example - Pearl Harbor/Hickam

- Pearl Harbor operates Hickam Clinic as a satellite
- Manning at Hickam is AF
- AF Commander at Hickam Clinic for ADCOM
- AF Commander could be Deputy Commander at Pearl Harbor
- Pearl Harbor would program all infrastructure, BOS and common service costs (logistics, IMIT, etc)

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Issues

- Credit for Production
- Efficiency issues
- Revised Financing/PPS

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